COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

ESTIMATES

(Supplementary Budget Estimates)

WEDNESDAY, 21 OCTOBER 2009

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SENATE COMMUNITY AFFAIRS

LEGISLATION COMMITTEE

Wednesday, 21 October 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, Mark Bishop, 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, Lundy, 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, Back, Bilyk, Boswell, Carol Brown, Boyce, Colbeck, Collins, Cormann, Fielding, Fifield, Heffernan, Humphries, McEwen, Moore, Parry, Ronaldson, Sterle, Siewert, Williams, Wortley and Xenophon

Committee met at 9.01 am

HEALTH AND AGEING PORTFOLIO

In Attendance

Senator Ludwig, Special Minister of State

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
Ms Rosemary Bryant, Chief Nurse and Midwifery Office
Business Group
Ms Margaret Lyons, Chief Operating Officer
Mr Stephen Sheehan, Chief Financial Officer
Ms Samantha Palmer, General Manager, Communication and People Strategy
Ms Tracey Frey, Assistant Secretary, Business Group Task Force
Mr Joseph Colbert, Assistant Secretary, Corporate Support Branch
Ms Patricia O'Farrell, Assistant Secretary, Legal Services Branch
Mr Leo Kennedy, Assistant Secretary, People Branch
Ms Sharon McCarter, Acting Assistant Secretary, IT Solutions Development Branch
Mr Gary Aisbitt, Acting Assistant Secretary, IT Strategy and Service Delivery Branch

Portfolio Strategies Division

Ms Linda Powell, Acting First Assistant Secretary, Portfolio Strategies Division
Ms Cath Patterson, Assistant Secretary, International Strategies Branch
Mr Paul McGlew, Acting Assistant Secretary, Policy Strategies Branch
Ms Carolyn Driessen, Acting Assistant Secretary, Ministerial and Parliamentary Support Branch
Mr Michael Culhane, Assistant Secretary, Budget Branch
Mr Greg Coombs, Assistant Secretary, Economic and Statistical Analysis Branch

Health Reform Taskforce

Ms Megan Morris, First Assistant Secretary, Health Reform Taskforce
Mr Alan Singh, Assistant Secretary, Policy Branch
Mr Nathan Smyth, Assistant Secretary, Communications Branch

Audit and Fraud Control

Mr Colin Cronin

Outcome 1—Population Health

Population Health Division

Ms Cath Halbert, First Assistant Secretary
Mr Bill Rowe, Assistant Secretary, Sport Branch
Dr Masha Somi, Acting Assistant Secretary, Population Health Strategy Unit
Mr Colin Sindall, Senior Adviser, Population Health Strategy Unit
Ms Janet Quigley, Acting Assistant Secretary, Healthy Living Branch
Ms Andriana Koukari, Assistant Secretary, Population Health Programs Branch
Ms Julianne Quaine, Director NBCS Recovery Project, Population Health Programs Branch

Regulatory Policy and Governance Division

Ms Kylie Jonasson, Acting First Assistant Secretary, Regulatory Policy and Governance Division
Ms Jenny Hefford, Assistant Secretary, Blood and Regulatory Policy Branch
Ms Alice Creelman, Assistant Secretary, Governance, Safety and Quality Branch
Mr Matthew Murphy, Acting Assistant Secretary, Research, Regulation and Food Branch
Ms Teressa Ward, Assistant Secretary, Office of Hearing Services

Mental Health and Chronic Disease Division

Ms Georgie Harman, Acting First Assistant Secretary, Mental Health and Chronic Disease Division
Associate Professor Rosemary Knight, Principal Adviser, Mental Health and Chronic Disease Division
Ms Colleen Krestensen, Assistant Secretary, Mental Health and Suicide Prevention Programs Branch
Ms Virginia Hart, Assistant Secretary Mental Health Reform Branch
Professor Harvey Whiteford, Principal Medical Advisor, Mental Health
Ms Sharon Appleyard, Assistant Secretary, Cancer Services Branch
Ms Jennie Roe, Assistant Secretary, Chronic Disease Branch
Mr Simon Cotterell, Assistant Secretary, Drug Strategy Branch

Therapeutic Goods Administration (TGA)
Dr Rohan Hammett, National Manager
Dr Ruth Lopert, Principal Medical Adviser
Mr Charles Maskell-Knight, Principal Adviser, Regulatory Reform
Dr Gary Lacey, Head, Office of Medicine Safety Monitoring
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 Regulatory Integrity and Compliance
Mr Pio Cesarin, Acting Head, Office of Prescription Medicines
Mr Michel Lok, Head, Office of Manufacturing Quality
Mr Michael J Smith, Head, Office of Complementary Medicines
Dr Peter Bird, Acting Head, Office of Non Prescription 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 Office
Ms Melanie Fisher, General Manager, Food Standards (Canberra)
Dr Paul Brent, Chief Scientist
Mr Dean Stockwell, General Manager, Food Standards (Wellington)
Mr John Fladun, General Manager, Legal and Regulatory Affairs
Dr Andrew Bartholomaeus, General Manager, Risk Assessment Branch

Australian Radiation Protection and Nuclear Safety Agency (ARPANSA)
Mr Peter Burns, Acting Chief Executive Officer, ARPANSA

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

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

Outcome 2—Access to Pharmaceutical Services

Pharmaceutical Benefits Division
Mr Andrew Stuart, First Assistant Secretary, Pharmaceutical Benefits Division
Ms Sue Campion, Assistant Secretary, Pharmaceutical Benefits Division
Ms Linda Jackson, Assistant Secretary, Pharmaceutical Evaluation Branch
Ms Gay Santiago, Assistant Secretary, Policy and Analysis Branch
Mr Declan O'Connor-Cox, Assistant Secretary, Access and Systems Branch
Ms Andrea Kunca, Acting Assistant Secretary, Community Pharmacy Branch
Mr Kim Bessell, Principal Advisor, Pharmaceutical Benefits Division

Outcome 3—Access to Medical Services

Medical Benefits Division

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

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 Lesley Podesta, First Assistant Secretary
Dr David Cullen, Assistant Secretary, Policy and Evaluation Branch
Mr Keith Tracey-Patte, Assistant Secretary, Community Programs Branch
Mr Peter Broadhead, Assistant Secretary, Residential Program Management Branch
Ms Sallyann Ducker, Acting Assistant Secretary, Indigenous Aged Care Taskforce
Ms Melinda Bromley, Assistant Secretary, Office for an Ageing Australia

Office of Aged Care, Quality and Compliance

Ms Carolyn Smith, First Assistant Secretary
Mr Iain Scott, Assistant Secretary, Prudential and Approved Provider Regulation Branch
Ms Fiona Nicholls, Assistant Secretary, Quality, Policy and Programs Branch
Ms Lucelle Veneros, Acting Assistant Secretary, Compliance Branch
Ms Allison Rosevear, Assistant Secretary, CIS Review and Accreditation, Review and Policy

Aged Care Standards and Accreditation Agency (ACSAA)

Mr Mark Brandon, Chief Executive Officer
Mr Ross Bushrod, General Manager, Operations
Mr Chris Falvey, General Manager, Corporate Affairs and Human Resources

Outcome 5—Primary Care

Primary and Ambulatory Care Division

Ms Jan Bennett, First Assistant Secretary, Primary and Ambulatory Care Division
Mr Lou Andreatta, Acting Principal Adviser, Office of Rural Health
Mr David Dennis, Assistant Secretary, Workforce Distribution Branch
Ms Vicki Murphy, Assistant Secretary, Service Access Programs Branch
Ms Meredeth Taylor, Assistant Secretary, GP Super Clinics Branch
Ms Tuija Harms, Acting Assistant Secretary, Primary Care Practice Support Branch
Ms Judy Daniel, Assistant Secretary, Policy Development Branch
Ms Liz Forman, Assistant Secretary, eHealth Branch
Mr Rob Cameron, Acting Assistant Secretary, Rural Health Services and Policy Branch

General Practice Education and Training

Mr Erich Janssen, Chief Executive Officer

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
Ms Penny Shakespeare, Assistant Secretary
Acute Care Division
Professor Rosemary Calder, First Assistant Secretary, Acute Care Division
Mr Doug Hartley, Assistant Secretary, Acute Care Strategies Branch
Ms Veronica Hancock, Assistant Secretary, Hospital Development, Indemnity and Dental Branch
Mr Louise Clarke, Assistant Secretary, Healthcare Services Branch
Dr Andrew Singer, Principle Medical Adviser
Dr David Martin, Director, Healthcare Services Information Branch
Private Health Insurance Administration Council (PHIAC)
Mr Paul Groenewegen, PHIAC
Mr Neil Smith, PHIAC
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
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
Ms Rosemary Bryant, Chief Nurse and Midwifery Officer
Mr Allan Groth, Assistant Secretary, Nursing, Allied and Indigenous Workforce Branch
Mr Dave Hallinan, Acting Assistant Secretary, Medical, Education and Training Branch
Ms Natasha Cole, Assistant Secretary, Workforce Development Branch

Outcome 13—Acute Care
Acute Care Division
See Outcome 9
National Blood Authority (NBA)
Dr Alison Turner, National Blood Authority
Mr Peter Hade, National Blood Authority
Ms Jill Divorty, National Blood Authority
Australian Organ and Tissue and Transplant Authority
Ms Karen Murphy, Chief Executive Officer
Dr Gerry O'Callaghan, National Medical Director
Mr Jeff Barnes, Acting Chief Financial Officer
Outcome 14—Biosecurity and Emergency Response
Office of Health Protection
Ms Jenny Bryant, First Assistant Secretary, Office of Health Protection
Ms Linda Addison, General Manager, Procurement Project, 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
TBC, Assistant Secretary, Immunisation Branch
Ms Angela McKinnon, Director, Immunisation Branch
Ms Judy Cook, Director, Immunisation Branch
Dr Bernie Towler, Medical Officer, Office of Health Protection
Ms Shirley Browne, Assistant Secretary, 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 Greg Nance, Director, Sport Performance and Development Division
Ms Judy Flanagan, Director, Community Sport Division
Ms Christine Magner, Director, Corporate Services
Mr Steve Jones, Director, Commercial and Facilities
Mr Laurie Daly, Chief Financial Officer
Mr Phil Borgeaud, Assistant Director, Australian Institute of Sport
Australian Sports Anti-Doping Authority (ASADA)
Mr Richard Ings, Chair, ASADA
Mr Kevin Isaacs, Chief Operating Officer, ASADA
Ms Geetha Nair, General Manager, Anti-Doping Programs and Legal Services

CHAIR (Senator Moore)—Good morning, everyone. The supplementary hearing of our Senate Community Affairs Committee looking at budget estimates for the portfolio of Health and Ageing is now occurring. The committee has before it a list of the outcomes relating to matters which senators have indicated that they wish to raise at this hearing. In accordance

with the standing orders relating to supplementary hearings, today's proceedings will be confined only to those matters. We will always, Ms Halton, have the need to confirm at each stage whether we are in the right portfolio. That is just standard practice.

Senators are reminded that written questions on notice in respect of the supplementary hearings must be lodged with the secretariat by the conclusion of the hearings—that is, committee adjournment on Friday, 23 October 2009. The committee has set 11 December 2009 as the date for the return of answers to questions taken on notice. Officers and senators are familiar with the rules of the Senate governing estimates hearings. If you need assistance, the secretariat always has copies of the rules. I particularly draw attention to Senate order of 13 May 2009 specifying the process by which a claim of public interest immunity should be raised and which I now incorporate in *Hansard*.

The extract read as follows—

Public interest immunity claims

That the Senate—

(a) notes that ministers and officers have continued to refuse to provide information to Senate committees without properly raising claims of public interest immunity as required by past resolutions of the Senate;

(b) reaffirms the principles of past resolutions of the Senate by this order, to provide ministers and officers with guidance as to the proper process for raising public interest immunity claims and to consolidate those past resolutions of the Senate;

(c) orders that the following operate as an order of continuing effect:

(1) If:

(a) a Senate committee, or a senator in the course of proceedings of a committee, requests information or a document from a Commonwealth department or agency; and

(b) an officer of the department or agency to whom the request is directed believes that it may not be in the public interest to disclose the information or document to the committee, the officer shall state to the committee the ground on which the officer believes that it may not be in the public interest to disclose the information or document to the committee, and specify the harm to the public interest that could result from the disclosure of the information or document.

(2) If, after receiving the officer's statement under paragraph (1), the committee or the senator requests the officer to refer the question of the disclosure of the information or document to a responsible minister, the officer shall refer that question to the minister.

(3) If a minister, on a reference by an officer under paragraph (2), concludes that it would not be in the public interest to disclose the information or document to the committee, the minister shall provide to the committee a statement of the ground for that conclusion, specifying the harm to the public interest that could result from the disclosure of the information or document.

(4) A minister, in a statement under paragraph (3), shall indicate whether the harm to the public interest that could result from the disclosure of the information or document to the committee could result only from the publication of the information or document by the committee, or could result, equally or in part, from the disclosure of the information or document to the committee as in camera evidence.

(5) If, after considering a statement by a minister provided under paragraph (3), the committee concludes that the statement does not sufficiently justify the withholding of the information or document from the committee, the committee shall report the matter to the Senate.

(6) A decision by a committee not to report a matter to the Senate under paragraph (5) does not prevent a senator from raising the matter in the Senate in accordance with other procedures of the Senate.

(7) A statement that information or a document is not published, or is confidential, or consists of advice to, or internal deliberations of, government, in the absence of specification of the harm to the public interest that could result from the disclosure of the information or document, is not a statement that meets the requirements of paragraph (I) or (4).

(8) If a minister concludes that a statement under paragraph (3) should more appropriately be made by the head of an agency, by reason of the independence of that agency from ministerial direction or control, the minister shall inform the committee of that conclusion and the reason for that conclusion, and shall refer the matter to the head of the agency, who shall then be required to provide a statement in accordance with paragraph (3).

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

CHAIR—I welcome the minister, Senator the Hon. Joseph Ludwig, the departmental secretary, Ms Jane Halton, and all the officers of Health and Ageing who are with us today. I also wish to note at this stage, to stop any embarrassment at the end of the day, that this Senate estimates hearing is the last hearing in community affairs for our secretary, Mr Elton Humphery. All of us who have been working in this area know how long and what service Mr Humphrey has given to our committee. Minister, would you like to make an opening comment?

Senator Ludwig—No, thank you.

CHAIR—Thank you, Minister. Ms Halton, do you wish to make any opening comments from the department?

Ms Halton—No, thank you.

CHAIR—We will start today's proceedings with cross-outcome corporate matters and then follow the order as set out in the circulated program with one change. I have been requested in the agenda after dinner this evening to swap outcome 3 and outcome 10. So at 7.30 pm we will move into outcome 10, which is the various agencies. Then at 8.30 pm, or as close as possible to that, we will move to outcome 3, Access to medical services. But if there are other particular issues or people need something, just let us know and we will try and work with you. So we will now move to outcome 1.

Senator BOYCE—Ms Halton, the annual report for the Department of Health and Ageing has you as chair of the National Aboriginal and Torres Strait Islander Health Council and as a board member of the Australian Institute of Health and Welfare and the National e-Health Transition Authority. Have there been any changes to your board positions since that time?

Ms Halton—The Aboriginal and Torres Strait Islander Health Council has now been replaced—that will be last year's annual report you are reading from—by the new independent body that is responsible, so that position is no longer in existence.

Senator BOYCE—No longer in existence?

Ms Halton—Correct.

Senator BOYCE—But there is no change to the AIHW or the e-Health Transition Authority?

Ms Halton—No.

Senator BOYCE—I want to start by looking at programs that the department administers. Chronic disease, for example, in outcome 1 has available resources of $61.77 million, but the actual estimated expenses for 2009-10 were $48.8 million. What underspend are you anticipating in that program?

Ms Halton—Senator, we need to do that under outcome 1.

Senator BOYCE—I want to work through which programs you are expecting an underspend in across the board.

Ms Halton—We would have to do that program by program.

Senator BOYCE—It is a more general question.

Ms Halton—Sorry?

Senator BOYCE—I was leading up to working through the programs and where you have underspends and where you do not.

Ms Halton—We do not have the officers from program 1 here. They will be here tonight.

CHAIR—Ms Halton, you prefer to have that as a standing question against each outcome.

Senator BOYCE—So we will ask that question in each outcome?

Ms Halton—Absolutely.

Senator CORMANN—Can I ask one question here. Ms Halton, just in relation to the annual report, when does the department expect to table this year's annual report?

Ms Halton—Inside the tabling deadline.

Ms Powell—The annual report will be tabled on the 30th of this month.

Senator CORMANN—These are the second supplementary estimates under this government where your department's annual report has not been available for us to peruse. Other departments have tabled their annual reports. Before the change of government, there were annual reports always available—

Senator Ludwig—That is not right.

Senator CORMANN—for the supplementary estimates.

Senator Ludwig—That is not right, Senator. I would not like you to mislead the Senate.

Senator CORMANN—I invite you to check it because I have checked it. Your government made a decision to bring those supplementary estimates forward a little while ago.

Senator Ludwig—I think you will find the Senate agreed. I think you should be very careful about how you use your language. I think you will also find that in previous times I can recall—but I am happy for you to check the record because I am a little more careful than you are in making open and wide statements—there occasionally have been times when we have had estimates where the annual reports were not available.

Senator CORMANN—Well, can I ask a question on notice?

Senator Ludwig—I am speaking, Senator, and you should let me finish. There are two circumstances in which it can occur. One is where estimates is held early prior to the usual tabling date, which is the end of October. Secondly, there are a range of committee reports by agencies that are not conditional upon that date. They have their own reporting date. They are not available. I do know at this estimates there has been, because of the concern that was expressed in the past about not having the annual reports available, great activity amongst departments that can provide their annual reports early, because I think they do think it is important that it is available for senators during estimates to be able to use the annual reports to question them. That is not always possible. There are a range of matters that may prevent departments from providing them on time. But, as always, there is the following estimates in February, which I think, from recollection, although I am happy to be corrected, is available and continues to be available for annual reports to be used. That is the usual time that they are more likely to be used in any event because this is a supplementary budget estimates. So, as the title suggests, it is where you ask questions supplementary to that round in the budget.

Senator CORMANN—Minister, I will place a question on notice for Ms Halton. In the last 10 years, on how many occasions was the annual report of the Department of Health and Ageing available before and on how many occasions did it only become available after the supplementary estimates hearings? Again, this is to review the performance of the department. Clearly, there are different things that we do at different times in the year. Supplementary estimates are clearly an occasion when the annual report is a key document for us to review the performance of the department. Anyway, I have placed my concerns on record. I am sure the government is going to take due note of it.

Ms Halton—I would like to make a comment about that. The bottom line is that the tabling deadline for that report is the end of the month. Our report is at the printers. It is in a queue at the printers with a bunch of other departments' reports. In fact, I made inquiries about whether or not we could actually get it any earlier and the answer from the printer was no. So, change the deadline for the report, and that will change everyone's deadlines. The bottom line is that it will be tabled inside that deadline. The printer basically said it could not be printed any earlier. In anticipation of this question, I asked exactly that of the printer.

Senator CORMANN—I am pleased you anticipated the question.

Senator BOYCE—Could we get back to this question of underspend in programs. What about agencies? Can we ask about the agency underspends at this stage—

Ms Halton—No.

Senator BOYCE—or would you prefer that they were handled one by one?

Ms Halton—Yes, Senator.

Senator BOYCE—How many reports have been commissioned by the government within the Department of Health and Ageing since November 2007? Are you able to give us that figure?

Ms Halton—No, we will have to take that on notice.

Senator BOYCE—When you are taking that on notice, could you also give me details of when each report was commissioned, when it was handed to the government and the date of public release, the terms of reference and the committee members for each report?

Ms Halton—Senator, I will do that. I should ask you to be completely clear about what is meant by reports. You would understand extremely well that there is any number of consultancies, all of which are published as appropriate. We are talking about reports commissioned by the minister and announced by the minister, I am assuming?

Senator BOYCE—Yes.

Ms Halton—That is fine. Thank you.

Senator BOYCE—And, whilst we are about it, the cost of each report and whether departmental staff or external staff were involved in the development of the report.

Ms Halton—Actually development of the content as against writing the terms of reference?

Senator BOYCE—Yes. The development of the content. Again, in terms of reports, completed reports versus reports that are currently in train.

Ms Halton—We can indicate that in the answer, Senator.

Senator BOYCE—We have had a lot of reviews and reports. Could you talk me through some of the outcomes that have been achieved since November 2007?

Ms Halton—In which ones?

Senator BOYCE—I think we have had 30 reports published so far in 2009, from my list here.

Ms Halton—Senator, why not nominate one and we can discuss it line by line if I have enough detail?

Senator BOYCE—I was looking at handling those in the actual outcome areas as well.

Ms Halton—Fine.

Senator BOYCE—We will leave the actual detail until we get to the other end of this one.

Ms Halton—Yes.

Senator BOYCE—Perhaps one we could talk about is the National Health and Hospitals Reform Commission. You had the interim report earlier this year. The final report came out four months ago. What actions have been taken around the recommendations of that report?

Ms Halton—This is all listed on the website, which I think you will be aware of. It is yourhealth.gov.au.

Senator BOYCE—Yes.

Ms Halton—There is at the moment a series of discussions and consultations occurring about that report. Comprehended in those discussions are views being sorted out for the primary care strategy but also the report of the national prevention task force. As at the other day, we were up to 62 consultations.

Senator BOYCE—Sixty-two consultations?

Ms Halton—I beg your pardon, it is 60 consultations.

Senator BOYCE—With?

Ms Halton—Doctors, consumers—

Senator BOYCE—Stakeholders?

Ms Halton—Stakeholders. That is a good label for it, Senator. The idea is that because the recommendations in those reports are fairly—I will be the master of understatement—far-reaching, getting people's perspective on those and what might be the priorities in terms of implementation is something that both the minister and, in fact, the entire ministerial team and the Prime Minister have been out asking people their views about. The idea is that once all of those views are gathered, people are also giving us views on the website. Dare I suggest that there is a twitter available for anyone who knows how to twitter. I will confess here that I have no idea about how to twitter—

Senator Ludwig—Let me show you.

Ms Halton—but I am going to get a lesson from Senator Ludwig.

Senator BOYCE—Does this cover whole of portfolio, Minister?

Senator Ludwig—What I was actually going to add was that if you look at particularly the breakdown of the ministerial involvement, the Prime Minister has attended 15; Minister Roxon, 26; Minister Elliott, 14; and Minister Snowdon, 12; and it goes on. It shows that there has been a significant amount of consultation but also the numbers of people that have been engaged is of the—

Senator BOYCE—Thousands?

Senator Ludwig—The number of attendees is—correct me if I am wrong—about 4,528. That is fewer than those who have been invited. I will rephrase it. The breadth and width of the number of consultations—I have a list; I will not go through them in the interests of time—is covered quite broadly and it is continuing at this point.

Ms Halton—Yes.

Senator BOYCE—But you would expect the more serious the problem, the more people there would be prepared to come and consult on the topic. I was a bit interested, Ms Halton, in your comment that prioritisation of the implementation was one of the issues being considered by this round of consultations. The priorities will be determined according to the consultations? That is correct?

Ms Halton—No. The commission report, for example, does indicate some things which they think are worthy of consideration in the longer term. So in terms of asking people their views about the report, you would be asking them not just about the specific content. Some of the qualitative feedback you would be looking for is whether people actually agree with the commission's comments about priorities.

Senator BOYCE—When will the results of those consultations be collated and published? Will the department do that?

Ms Halton—I do not know whether 'published' is quite the right language. It is not like we are about to publish *War and Peace* with everyone's comments.

Senator BOYCE—No. But it would be normal to publish a summary of the sorts of views, to report on the content of the consultations, would it not?

Ms Halton—That will be a matter for the minister as to what she wishes to put in the publish arena. Certainly the consultations themselves are well attended. There is a lot of stuff on the website in relation to matters about health reform. The Prime Minister, I think, has indicated that he will be looking to have a dialogue with his state colleagues later this year in relation to their views, with a view to then having a further discussion with the states next year. So this will be a process that will go on into the new year.

Senator BOYCE—So we will not know until next year whether there will be any move by the Commonwealth to take over state public hospitals?

Ms Halton—Well, I think the Prime Minister has indicated fairly clearly the timetable which will enable the consideration of what people have said to have a conversation with the states and territories prior to the Commonwealth finalising its view, which would be at some point early next year.

Senator CORMANN—Firstly, in relation to the roadshow, who is organising the logistics of that? Is that your department?

Ms Halton—That is right, Senator.

Senator CORMANN—How many people in your department are involved in that?

Ms Halton—There is a very long-suffering assistant secretary—who is joining us at the table—who is the master of logistics.

Mr Smyth—Could you ask that again?

Senator CORMANN—Essentially, you are responsible for the logistics. How many people are involved in this exercise in the department?

Mr Smyth—In terms of the actual logistics, we have a team that is broken into the development of the website, the content and then the actual putting together of the consultations on the ground. It is about 18 to 20 people, but it does vary, depending on the workload that is coming forward from the actual sites.

Senator CORMANN—I will put this back into perspective. So we have had the National Health and Hospitals Reform Commission report. I assume, Ms Halton, that has been wound up now, has it?

Ms Halton—Yes. The commission itself?

Senator CORMANN—That is entirely wound up?

Ms Halton—Yes, that is right.

Senator CORMANN—So at present we are going through this review and consultation process of that review report and its recommendations. And there are about 18 to 20 people who support the visits of the Prime Minister and the Minister for Health and Ageing at hospitals around Australia with photo opportunities and the website support. That is 18 to 20

people in your department. Are there any people outside the health department that you work with on that as well?

Mr Smyth—We certainly work with the venue—the people that are—

Senator CORMANN—Sorry, I meant within government. Are there any other areas of government that have teams of people involved in supporting that?

Mr Smyth—No. There is not, Senator.

Ms Halton—Other than, as you would understand, the usual security arrangements.

Senator CORMANN—Yes, sure. So we have 18 to 20 people from the Department of Health and Ageing. We have the usual security arrangements. Of course, we have presumably state and territory health departments that would have to make available resources. You are nodding.

Mr Smyth—The key thing that the state and territory health departments provide assistance with is the invitation list. They give us the actual names of the clinicians in the hospitals, the local health department staff and GPs et cetera who are local to that area where the consultation is. So it is primarily around the provision of names for the invitation list.

Senator CORMANN—Have you been allocated a specific budget for this sort of roadshow exercise?

Mr Smyth—We do have a budget for the consultation phase of the exercise, yes, Senator.

Senator CORMANN—How much is that?

Mr Smyth—We are forecasting that the consultations themselves will cost in the order of about $350,000.

Senator CORMANN—So $350,000. Does that include the cost for 18 to 20 staff or is that on top of that?

Mr Smyth—The staffing costs would be in addition to that, Senator.

Senator CORMANN—So how long do you expect this to go? Six months? Twelve months? What is the time frame, again?

Mr Smyth—The time frame really was from the middle of the year until the end of this year, when the Prime Minister would go to the states and territories.

Senator CORMANN—So what happens to those 18 to 20 people then?

Mr Smyth—Predominantly those people have been seconded into the task force from other areas of the department.

Senator CORMANN—What would be the cost of those 18 to 20 people for six months?

Mr Smyth—I would have to take that on notice.

Senator CORMANN—If you could, that would be great. Following up on those questions by Senator Boyce about a federal takeover, has the department been involved in any discussions to plan for the eventuality of a federal takeover of public hospitals in any way, shape or form?

Ms Halton—Senator, that sounds a bit like a when-did-you-stop-beating-your-wife kind of question.

Senator CORMANN—No, it does not. It is a very specific question. Have you been involved in any discussions in relation to a possible takeover at a federal level of public hospitals either internally with your minister or with other government departments? I think it is very specific.

Ms Halton—As you would know, in the Health and Hospitals Reform Commission report there is a discussion about that matter in terms of the respective roles of the states and territories and the Commonwealth. Certainly and obviously we have discussed the report, which includes that matter.

Senator CORMANN—So the answer is yes, you have?

Ms Halton—But not in isolation from the broad discussion about the report.

Senator CORMANN—Have you been asked by the government to start planning for a possible referendum on a federal takeover of public hospitals?

Ms Halton—We are not responsible for referenda, Senator.

Senator CORMANN—You would be providing input into any planning on the takeover of public hospitals, surely, whatever process would lead up to that. Presumably you would be providing input into that process.

Ms Halton—Not in terms of a referendum, no, we would not. You would have to ask Attorney-General's.

Senator CORMANN—What sort of input have you provided into the process towards a possible federal takeover of public hospitals?

Ms Halton—We have provided input in respect of the totality of the report and the options that are covered in the report.

Senator CORMANN—Minister Roxon was quoted in the *Sydney Morning Herald* on 9 June as saying that there will be a fairly quick response to at least some of the recommendations from the Health Reform Commission. I see you nod, so I assume you are aware of that quote.

Ms Halton—Yes, I am.

Senator CORMANN—Have you got any clearer indication as to what 'fairly quick' would mean?

Ms Halton—No, I have not.

Senator CORMANN—So the minister has not said to you, 'We want a response from the department in response to those recommendations by X, Y, Z date?'

Ms Halton—As I said, we have been looking at all of the recommendations in the report. You would obviously have read the report in some detail. You would know that some of the recommendations are quite specific, narrow and particular and, therefore, lend themselves potentially to some earlier discussions and potentially implementation. Some of them are very wide-ranging which go to those macro issues you have just been canvassing—the

Commonwealth role with the states, who would do what and what have you. They absolutely by definition would have to be on a longer timetable.

Senator CORMANN—Let me be more specific. As I understand it, there are going to be two core meetings scheduled to discuss the report of the National Health and Hospitals Reform Commission. You nod.

Ms Halton—Yes. That is my understanding, Senator.

Senator CORMANN—So my understanding is right. As I understand it, one is later this year in a couple of weeks and then one is early next year. Is there an anticipation, as far as you are aware, that the government's response to the National Health and Hospitals Reform Commission report will be released before COAG, at COAG? What is the timetable?

Ms Halton—That is a matter for the government, Senator.

Senator CORMANN—So you are in the dark?

Ms Halton—It is a matter for the government.

Senator CORMANN—In what way is it a matter for government?

Senator Ludwig—The timing is a matter for the government.

Senator CORMANN—The timing in terms of an answer is. But have you been asked to provide your input by a certain date?

Senator Ludwig—No. You can ask in a range of different ways, Senator Cormann, but timing is a matter for the government. You should direct questions in relation to timing to the government. What I have indicated is—

Senator CORMANN—So, Senator Ludwig, would you be able to answer the question?

Senator Ludwig—What I have said is the timing is a matter for the government.

Senator CORMANN—So we are not going to get any indication as to when we can expect a response to the National Health and Hospitals Reform Commission?

Senator Ludwig—The difficulty which you pose of course is if the government were, through me, to give you an indication of what date, then I would have, by default, announced the date. So you are not going to hear it from me. What I can say is that the matter of timing for these things is a matter for government. That is the answer that all governments have given in relation to this. You know that as well as I do. I wanted to finalise this issue. I do have—

Senator CORMANN—Just finally on this—

Senator Ludwig—No. I do have the ability to finalise this issue, and then I am sure you can ask another question. If you look at the progress to date, the draft national—

Senator CORMANN—The progress to date is that you have had a review into a review into a review, Senator Ludwig.

CHAIR—Senator Cormann, the minister is speaking.

Senator Ludwig—Look at the range of work that has already been done in terms of the consultation. This government does take it very seriously.

Senator CORMANN—You have done a lot of time wasting. I understand that.

Senator Ludwig—We did not waste the 12 years, Senator Cormann, that you wasted. But if you want to get into that, I do not want to. What I want to do is to be able to provide accurate answers in estimates for you. But if we want to get into a slanging match, I am happy to do that.

Senator CORMANN—Me too, Minister. Ms Halton, I have a final question on this. Has the department advised the minister on various options for a financial takeover of public hospitals? Have you provided advice to the minister about options on how a financial takeover of public hospitals at the Commonwealth level could be structured?

Ms Halton—We have advised the minister in relation to the terms of the health and hospitals commission report. In terms of the financial matters that you have just referred to, that would actually more properly be a matter for the Treasury. The financial matters go to Commonwealth-state financing arrangements.

Senator CORMANN—You would end up running those hospitals, would you not, as the secretary of the health department?

Senator Ludwig—Is that a question or a statement?

Ms Halton—I think it might have been a statement, Senator.

Senator Ludwig—I think it may have been. I heard the inflexion at the end. It is a hypothetical question.

Senator CORMANN—It is not a hypothetical question because there is a pre-election—

Senator Ludwig—There was a 'You would end up running the hospital, would you not?' inflexion. No, I am not sure that I would agree with you in respect of your calling of that question.

Senator BOYCE—Ms Halton, my question is specifically relevant to the reform of hospitals. Has the department done any scoping of what would be required to prepare to take over public hospitals?

Ms Halton—Again, the meaning of that question is very hard to determine, Senator. Have we advised on the commission's report? Yes, we have.

Senator BOYCE—Have you deliberately considered what would be involved in doing so?

Senator Ludwig—They have deliberately considered the report.

Ms Halton—That is right, exactly.

Senator Ludwig—We are not trying to be difficult.

Senator BOYCE—Considering the report and deciding what might be involved in acting on the report are two different things, are they not?

Ms Halton—I just think this is a semantic debate. The bottom line is we have advised on the report. The report includes in it a number of options. We have advised on that report.

Senator BOYCE—If you were required to take over the state public hospitals, how long would it take you to be ready to do so?

Ms Halton—That is a hypothetical question, Senator.

Senator BOYCE—Thank you, Ms Halton.

Senator ADAMS—Mr Smyth, just with your roadshow program, could you tell me if any of the multipurpose service sites are included?

Ms Morris—You mean as consultation venues, Senator?

Senator ADAMS—Yes, I do. It is very, very important. I have just been looking at where the show has gone so far and what is programmed. These are major rural and regional hospitals that you have down. As far as Western Australia—I speak for Western Australia because there are far more multipurpose service sites there—I think it is very important for the government to go and visit those sites just to see how the flexibility issue is with the funding from state and federal governments. It is terribly important, especially in Western Australia, because the smaller community health services have very good programs. It really worries me when you are visiting places like Wagga and that is considered to be a rural hospital or rural health service. There is a lot of very small services that provide very good health care to people. As I said, there is the flexibility of the Commonwealth, with aged care especially, which I am very interested in, and acute services. I would like to see if there is any possibility that they could go and visit some of those areas.

Ms Halton—Senator, I will make a distinction here between the formal consultations, which actually tend to be quite large affairs—

Senator ADAMS—I know.

Ms Halton—simply because—we have done a huge number—you are trying to get as many people in as you can to those discussions. We certainly have not to date, that I am aware of, gone to something which is a multipurpose site. I actually would not anticipate that we will. That said, for example, Minister Snowdon is going all over the country talking to people. While he is out also talking to them about reform, I think there will be a number of opportunities. Certainly I will find out whether or not he has actually had any of those side visits, if I can describe them in that way—not to deny how important they are. In fact, we will see if we can find this out at some point while we are here. If he has not done that already, I will certainly feed back that issue because I think you are absolutely right. I think the likelihood that we will have one of these larger consultations at a multipurpose service is not high. But I think the issues do have an opportunity and the people will have an opportunity to have an input.

Senator Ludwig—I think it is an important point you make. I am just looking at the list. It includes places such as Geraldton, Murray Bridge, Whyalla, Orange and Bathurst. I expect that it will also include the catchment area—

Ms Halton—Yes.

Senator Ludwig—to try to ensure that there is a broader coverage. I understand the point you are making.

Ms Halton—We will pass that on.

Senator ADAMS—Coming from Western Australia, we do not have those sort of communities over there. For the ones out in the rural areas, as I said, that flexibility of state and federal funding is very, very important. I wanted to raise that so that it could be kept up.

Mr Smyth—Senator, I will make the point that in Derby in Western Australia, Minister Snowdon visited every health service that was in the town there in the day prior and the day of the consultations. It included the AMSs, the aged-care residence there and the GP practices as well. The consultation there was held in the community hall, so all health professionals from the catchment area were invited to that to put their views forward.

Senator ADAMS—Has that been replicated down in the southern area?

Mr Smyth—We have had a consultation at Bunbury at the Bunbury Hospital, but that is probably not what you are referring to, Senator.

Senator ADAMS—No.

Senator SIEWERT—I want to turn to the AIHW.

CHAIR—Are there any questions on general outcomes before AIHW?

Senator BOYCE—Yes. Just a few. They are on FOI requests. As of 3 June, you had 40 FOI requests with decisions outstanding. How many of those have been resolved to date?

Ms Lyons—In 2008-09, we had a total of 229 requests. Of those, decisions were made on 218.

Senator BOYCE—What about the ones that were not decided? What have we got left? Is it 11?

Ms Lyons—Yes.

Senator BOYCE—What were the decisions made in those 11?

Ms Lyons—Those decisions are still outstanding as at this date.

Senator BOYCE—I think at the last meeting there had been 201 requests. Two had been refused because of the very large number of documents that had been asked for. It was considered an unreasonable diversion of the department's resources to process that request. Can you tell me what those two requests related to?

Ms Lyons—I do not have that information. I can take that on notice, Senator.

Senator BOYCE—Thank you. What are the criteria for an unreasonable diversion of resources?

Ms Lyons—Senator, there are some guidelines that PM&C promulgates that we adhere to. Generally, what we look at is the broad spectrum of the number of documents that we would have to be either retrieving electronically or physically and arrive at what resources it would take to get those documents back.

Senator BOYCE—Is there some sort of rough guideline? If it takes more than 20 hours?

Ms Lyons—It often can depend on the nature of the request, Senator.

Ms Halton—The rule of thumb I would apply to this, Senator, is basically when someone has asked for something which encompasses sometimes thousands of documents, when

someone asks for something which requires all areas of the department to go burrowing through files, getting stuff back out of archives et cetera, and particularly where those requests are what might be best described as fishing expeditions, we ask people if they can narrow their request. So we do not start with a proposition where we say no. What we say is, 'Look, you have asked for ...'

Senator BOYCE—Have those requests, the two that were considered an unreasonable diversion of resources, been narrowed by the people seeking the information?

Ms Lyons—I do not have that detail here. I would have to take it on notice.

Senator BOYCE—Can you tell me what they related to, if the request has been narrowed and if they have since been finalised, please? Thank you.

Senator CORMANN—Is the National Health and Hospitals Fund something I can ask about?

Ms Halton—Sure.

Senator CORMANN—On 14 October 2008, as you would recall, the Prime Minister announced that the government committed $5 billion to the National Health and Hospitals Fund tour, one of three nation-building funds. Can you tell us what the expenditure of the fund has been to date and, perhaps on notice, itemise each project and amount and location of the spend to date? What is the amount of funding still available?

Ms Halton—While people are opening their folders, I think you will find that in the budget projects from the fund—I will be corrected by colleagues if I am wrong—$3.2 billion was announced. I think the mathematics would suggest that $1.8 billion, therefore, was not committed in terms of what we have actually spent to date. I suspect we may have to take that on notice, but I will ask my colleagues whether they have that with them.

Senator CORMANN—What I am looking for is expenditure to date. I know it was in the budget.

Mr McGlew—In 2008-09, $185 million was spent. To 30 September 2009, $2.934 million has been spent.

Senator CORMANN—So at this stage, out of the $3.2 billion that has been allocated in the budget, $3 billion is still sitting there?

Mr McGlew—That is right.

Senator CORMANN—What is your expected rollout speed?

Ms Powell—Most of those projects have been approved. We have either signed contracts with the proponents or are currently negotiating and finalising them. The process that we go through is normally that there is a payment made on the signing of the contract, and the amount of that payment varies according to how much the proponent needs immediately. Then we will negotiate as part of the contract negotiations a series of milestones which will trigger a subsequent payment. So there is quite a lot of variability.

Senator CORMANN—Sure. Let me specify. Out of the $3.2 billion, just under $300 million has been spent. A proportion would then be committed to projects that are already signed up to?

Ms Powell—Yes.

Senator CORMANN—You have money that is already spent. Then you have money that is allocated in the budget. In between, presumably, you have money that is already committed to a project that is underway?

Ms Powell—Yes.

Senator CORMANN—But you have not spent it yet. How much is committed to a specific project that is underway?

Ms Halton—It is $3.2 billion minus the amount we have already spent.

Ms Powell—That is right.

Senator CORMANN—Because it is allocated in the budget. Have you actually—

Ms Halton—They are committed projects. They are formally committed projects.

Senator CORMANN—And you have signed contracts with all of those projects?

Ms Halton—We are in the process of signing contracts. That is what—

Senator CORMANN—How many of those projects have not got their contracts signed and how many of them do?

Ms Halton—They have all been notified that they have been approved. We are in negotiation with all of them.

Mr McGlew—Across the three themes of the fund, which is the national cancer statement, there are five major projects within there and three agreements have been executed. That is with Lifehouse RPA, Garvan St Vincent's and Parkville Comprehensive Cancer Centre in Victoria. In relation to hospital infrastructure and other projects of national significance, there are 18 projects and six agreements have been executed. In relation to the translational research and workforce training, there are 12 projects and agreements have been executed for three projects.

Senator CORMANN—The Prime Minister announced $5 billion on 14 October 2008. I think that was down from $10 billion from an earlier announcement. So there is still $1.8 billion hanging out there. Have you been given any indication when that is going to be forthcoming?

Ms Halton—That is a matter for the government, Senator.

Senator CORMANN—So, at this stage, the only thing that you have been given out of that $5 billion that was announced is $3.2 billion?

Ms Halton—The only thing that the government has committed to expenditure on is the $3.2 billion in the budget estimates process.

Senator CORMANN—Is that $1.8 billion somewhere else in the budget? I take it there is an answer there.

Ms Halton—There is a commitment to the $5 billion in the fund. That was the whole point. What they decided to spend out of the fund was $3.2 billion.

Senator CORMANN—So within your budget the $1.8 billion is sitting somewhere?

Ms Powell—The remainder of the fund—the $1.8 billion—is sitting in the Future Fund. In fact, there was a media release issued earlier this week that spelt out the three investment funds and how they are going in their investments.

Senator CORMANN—I must have missed that one. Thank you very much for that.

Ms Powell—I think it was the finance department.

CHAIR—We will move to the Australian Institute of Health and Welfare. I know Senator Siewert has questions. Does anyone else have questions? We will go through until about five to 10. Good morning.

[9.43 am]

Australian Institute of Health and Welfare

Senator SIEWERT—I would like to ask some questions around health expenditure and the report that you recently released and some questions that have arisen from me out of that, if that is okay.

Dr Allbon—Okay.

Senator SIEWERT—First, in terms of the duplication of expenditure, from what I understand, the estimates of the cost of duplication are around $2 billion a year. Is that a correct understanding?

Dr Allbon—I am not sure what you mean by duplication of expenditure.

Senator SIEWERT—Where state and federal governments duplicate expenditure or the provision of services.

Ms Halton—Senator, I think we need to be clear about whether you are referring to some particular data item or matter that the institute deals with—whether you are talking about one of their reports. There has been historically this mythical figure about alleged duplication between the Commonwealth and the states.

Senator SIEWERT—That is what I am trying to find out—in relation to the work that you have done, whether there is in fact duplication. You are right; the figure that goes around is about $2 billion.

Ms Halton—We do not believe that figure is accurate.

Senator SIEWERT—Do you believe there is some duplication? On what basis do you not believe that that figure is accurate?

Ms Halton—Dr Allbon can talk about whether they have any data that goes to this, but she cannot obviously give you an opinion because that is not what we do.

Senator SIEWERT—That is fine. But you just made a statement saying that you do not believe that is accurate.

Ms Halton—That is correct. So the department has in the past looked at that. I would have to go back and check the records because it is actually some time since we looked at the particular study from which I think that derived. My memory is it was someone from the ANU and my memory is that it misclassified a whole series of data and information. The

conclusion we came to when we looked at it—this is now some years ago, but I am sure this is where that comment comes from—is that it was just wrong.

Senator BOYCE—Is it greatly over or greatly under, Ms Halton?

Ms Halton—Greatly over.

Senator SIEWERT—That is what I was presuming. So that is not an issue that has caused you concern during the work that you have been doing?

Dr Allbon—No, it is not. As the secretary has said, we have not got data that supports that $2 billion figure.

Senator SIEWERT—In terms of issues around needs based funding versus other forms of funding provision, have you looked at that in much detail?

Dr Allbon—When you refer to needs based funding, the difficulty there is in measuring the need. There are different ways that the needs can be measured. We certainly, in some of the performance indicator work we have been doing, have looked at the assessment of need. That is often done by survey. Then we have to marry that up with actual service provision and service delivery. So it is something that we looked at in a number of areas. I cannot give you anything specific, but I am happy to provide some information in relation to that.

Senator SIEWERT—That would be useful. In terms of using it as a basis for funding, as I understand it, the NHMRC has called for needs based funding in regional areas only. I wonder whether it is a model that could be used across the board. Why is it specifically suggesting it for regional and rural areas?

Dr Allbon—I am not aware of why they have or the background to their suggesting regional based only. But the methodologies that are involved to measure need and make sure you are measuring need in a consistent way and that you are measuring a level of need that might be considered reasonable as opposed to expectation requires quite a lot of methodological understanding. So I think it is something that is more easily applied to a defined population and a smaller population.

Senator SIEWERT—So there are two ways. You could start doing it in regional and rural areas. If it were successful, you refine the methodology. You could then roll it out more broadly. That would be a potentially good way to start, if you were to follow that model?

Dr Allbon—Yes. For example, if what you wanted to measure was avoidable mortality—in a health system, you could have prevention or treatment services that could have avoided mortality—there is a well-defined methodology for looking at avoidable mortality. That cannot be applied to too small a population, but it is something that can be applied across the board. Certainly we do measure avoidable mortality across the board as the ultimate proxy, I guess, for health service need. But we also measure things like potentially preventable hospitalisations—so how well the primary care system is dealing with issues before they get to the acute hospital end.

Senator SIEWERT—In terms of the value of fee-for-service funding, have you evaluated that? Have you looked at the value of taking that approach?

Dr Allbon—We analyse the amount of out-of-pockets that people in the health system are spending. That is part of the health expenditure report. To date, I do not believe we have gone further to research or analysis on how that might impact on usage of the health system, if that is what you are inquiring about.

Senator SIEWERT—Yes. And where the funding goes or where the providers go in terms of that method of funding. I am wondering if it is an area that you will be following up further.

Dr Allbon—There is some upcoming work, particularly some survey work, which the ABS is doing which will be looking at the extent to which financial cost is a barrier to use of services. That is something that is being measured in a survey that the ABS has in the field at the moment. We have done that sort of thing with, say, dental services in the past as well. That is trying to get some data around where financial cost is a barrier. But in terms of an analysis of what the impact would be, if I think what you mean is the impact of greater out-of-pockets on health service provision, that is not something we have done at this stage.

Senator SIEWERT—Is it something that you are likely to be doing in the future?

Dr Allbon—That would depend on the funding and the availability of data that would ensure we could get an outcome from such a piece of work. So I could not give you a definite answer on that.

Senator SIEWERT—This may be an inappropriate question. In your evidence to date in terms of whether the cost of service is a barrier, I think you mentioned dental services. It is an issue there. Is there evidence that increasing costs are proving a barrier to access to medical services?

Dr Allbon—We do not have any evidence around that across the general health system. As I say, the ABS survey, which is in the field at the moment, is measuring.

Senator SIEWERT—When will that be reporting?

Ms Halton—You would have to ask the ABS that.

Dr Allbon—It is in the field at the moment.

Senator SIEWERT—I was wondering if you could save me having to go to ask them.

Ms Halton—I could send them a text.

Senator SIEWERT—That is fine. We can chase it up. In terms of the new national health care funding agreements, are you involved in any assessment of them or setting any performance indicators for them?

Dr Allbon—The performance indicators for those agreements were already set by the COAG processes.

Senator SIEWERT—Were you involved in establishing those or in monitoring those?

Dr Allbon—We worked with the COAG core, I think it was, in the development of those indicators, so we were one of the parties involved. We certainly currently have developed detailed specifications around the collection of that data. We are in the process of putting the reports on as indicators through to the review of government services steering committee,

which is collating those across the board. They then go to the COAG Reform Council for analysis and reporting.

Senator SIEWERT—That is a process to the COAG Reform Council. Would you then be reporting on that publicly?

Dr Allbon—The COAG Reform Council would do the public reporting.

Senator SIEWERT—So your involvement in that will be wholly through that process and not as a separate reporting process?

Dr Allbon—That is correct. Many of the indicators we already report on in other forms, or some of the indicators we do. But this process goes through the COAG Reform Council.

Senator SIEWERT—Thank you very much.

Senator BOYCE—We talked last time about how the size of your offerings would be reduced by constraints. How is that going? Have you overspent or underspent for the year?

Dr Allbon—For this current year?

Senator BOYCE—Yes.

Dr Allbon—We are tracking pretty much as expected at the end of September. Our amounts are pretty small compared with others.

Senator BOYCE—Yes, I realise that.

Dr Allbon—We are not into the billions. Certainly at the moment there are some delays, particularly with a big consultation process around the homelessness data collection. That has resulted in some delays. But we certainly anticipate we will need all the funding that is there.

Senator BOYCE—So the delays are with funding or with—

Dr Allbon—No. The development of—

Senator BOYCE—You cannot go about collecting the data for homelessness because you do not have the resources to do so?

Dr Allbon—No. Because we have not had the consultation with the sector required to set up the new homelessness data collection. So it is a matter that we have the resources but we are having some delay in spending them at this point. I fully anticipate that we will need all the resources that we do have.

Senator BOYCE—For 2009-10?

Dr Allbon—Yes.

Senator BOYCE—You talked at last estimates about how you would have to trim your sails, basically. What has been cut back to date?

Dr Allbon—I believe that the last estimates process was before the budget. In relation to the new year, the 2009-10 budget, we have received additional appropriation funding. So the things we were going to have to cut back, which were some restrictions around the *Australia's welfare* report et cetera, they have taken place because it was last year's funding. But, moving forward, those restrictions have been removed by some additional appropriation funding.

Senator BOYCE—You will be able to reclaim that ground?

Dr Allbon—Yes.

Senator BOYCE—Can you make it up in terms of the *Australia's welfare* report?

Dr Allbon—For *Australia's welfare*, because the majority of the work for that was done in the earlier financial year, it will still be a couple of chapters short. But we will be able to later produce that information. So, yes, we will be able to make it up.

Senator BOYCE—So there will be a supplement? We will not end up with a gap in the data, so to speak?

Dr Allbon—It will be some additional work. That is correct..

Senator BOYCE—I want to go to definitions. They are an interesting field.

Dr Allbon—Some people find them so.

Senator BOYCE—The *State of our public hospitals* report published by the department says that their statistics differ from your statistics because you define a private patient differently. Can you talk to that, please?

Dr Allbon—I cannot talk to the department's definition of a private patient at this point in time. I would have to take that on notice.

Senator BOYCE—Why would there be a different definition between the Institute of Health and Welfare, which collects data, and the department of health around something that would seem to be a fairly standard unit?

Dr Allbon—The detail of that one escapes me at the moment. I would have to take that on notice.

Senator BOYCE—Do you have a list of where definitions differ from your definitions?

Dr Allbon—We certainly have national definitions which are in place across the board and which jurisdictions comply with. So a very fundamental part of our work is developing those nationally consistent definitions. They are all housed in our online metadata registry—the data about the data—and they are adhered to across the board. I just cannot comment on them—

Senator BOYCE—Adhered to across the board by?

Dr Allbon—By all jurisdictions that are signatories to the national health information agreement, which is all governments in Australia.

Senator BOYCE—Is the Department of Health and Ageing a signatory to the national health agreement?

Dr Allbon—Yes, it is.

Senator BOYCE—But on page 4 of one of their reports, they note that their statistics are different to yours because they define a private patient differently. How do you keep that coherent? Do you monitor use of definitions?

Dr Allbon—We do not have a program of specific audits, but we certainly meet regularly with jurisdictions. There is a lot of interaction. We validate the data and ensure that the definitions are being adhered to. So there is a big process around that.

Ms Halton—I think, Senator, we actually need to be quite clear here. There is actually a lot of diversion in the use of definitions in different parts of the health system. For example, what Victoria classifies as an inpatient versus what New South Wales classifies as an inpatient are different things. So whilst there is a national—

Senator BOYCE—But that is not desirable, is it? We should be moving towards uniformity?

Ms Halton—No, it is not desirable. That is agreed. But there are sometimes perfectly good reasons why historically that has been the case. Whilst the institute has a charter in respect of collecting data, when people run systems, for a number of reasons, they sometimes use different definitions.

Dr Allbon—That is often because of system issues. The systems they have in place—

Ms Halton—That is right.

Dr Allbon—need to be upgraded. That is always an expensive proposition. But that is our aim—to work towards getting nationally consistent data.

Senator BOYCE—I guess the other thing I will ask you about is that same state of our public hospitals. Why does it take so long for that data to be published? It is always 12 months out of date by the time it comes out.

Dr Allbon—The provision of health data, the basis of it, is out of hospital systems.

Senator BOYCE—State hospital systems?

Dr Allbon—State hospital systems, yes.

Senator BOYCE—Providing the information directly to you or to their own departments?

Dr Allbon—Each hospital first has to code the data into the ICD classification. There is always a delay with that because there is a national shortage of coders for coding the data.

Senator BOYCE—A national shortage of coders?

Dr Allbon—Yes. To code that data into the ICD classification, which is what allows us to count and measure the particular events that come out of hospital. So that creates one part of the delay. Then each hospital's data goes to the state jurisdiction, which then collates it together. Then there is an on-passing to us. So there is a considerable delay before we actually get the data. We are working on speeding that up. We are working with all jurisdictions looking at faster, smarter ways of validating the data. But some of those delays go back to things like the need for financial statements to be audited et cetera. So we are investigating all of those to try to speed up the supply of data.

Senator BOYCE—What is your KPI in terms of speeding it up? What are you aiming to achieve?

Dr Allbon—Well, the COAG process has set a KPI, which is within three to six months of the end of the financial year. The nation does not meet that at the moment, but that is certainly the aim.

Senator BOYCE—Thank you.

CHAIR—That is the end of the time for whole of portfolio, corporate matters and AIHW questions, so any other questions will have to go on notice. Thank you very much. After the break we will go to outcome 4.

Proceedings suspended from 10.02 am to 10.14 am

Aged Care Standards and Accreditation Agency

CHAIR—We are now moving to outcome 4, aged care and population. I know there are questions from Senator Siewert, Senator Adams and maybe Senator Brown, depending on what is happening, but we will just see how we go. We will start with you, Senator Siewert.

Senator SIEWERT—Thank you, Chair. I want to go to a question I asked last time on the breakdown of the places that were made available and applied for for beds in the last round. I appreciate the answers that I received. You took the question on notice. I wonder if I could ask for a further breakdown of information on those places or just see if it is possible to get a breakdown by residential and community packages.

Ms Podesta—We will provide the information that we have available to you, Senator. We have the question on notice.

Senator SIEWERT—It is EO09276. You made the total places available, the total applications received and the total places sought. I am wondering if it is possible to get a further breakdown of the use for residential places.

Ms Podesta—So you would like a further level of detail on community and residential?

Senator SIEWERT—Yes.

Ms Podesta—We will take that on notice, Senator.

Senator SIEWERT—I realise that you would need to take it on notice, thanks. Can I do the aged-care standards and accreditation process here as well, or are you just aged care? I am going to be swapping around a bit. Is that okay?

Ms Podesta—That is fine, Senator. We are all here and we can come up and back to the table as you wish.

Senator SIEWERT—I am sorry about that.

Ms Podesta—It is all right. It is complex.

Senator SIEWERT—When will the review of the accreditation process be completed?

Ms Smith—We have been doing a lot of work on the review of accreditation processes. There was a discussion paper that was released I think in May with submissions that were received through that process. We got 147 submissions from a range of organisations. We are currently in the process of analysing those submissions before we provide advice to the minister. We will also be doing a consultation process through the ageing consultative committee once we are a little further down the track.

Senator SIEWERT—What will that process be about? About your draft recommendations?

Ms Smith—It will be a matter of distilling the issues that have been raised and looking at what options there are to change the process. We will be consulting with the sector on what that would mean.

Senator SIEWERT—So the process is you are analysing the submissions, you will take that back to the council and you will carry out a consultation process through them. Will they be able to go out broader to the stakeholders or will you do it?

Ms Smith—We imagine we will go out more broadly as well. But, in the first instance, we want to get the views of the committee itself.

Senator SIEWERT—And what is the timeframe for that?

Ms Smith—We have not got a defined timeframe at this point. There is a related project that is going on, which is the review of accreditation standards. We put out a request for tender for consultants to do some work on developing revised draft standards. That tender has now closed and we are assessing the submissions that we received. We have had the advice of an expert technical reference group for that piece of work. We want to keep the two projects aligned, because obviously the standards and the processes by which they are assessed are linked.

Senator SIEWERT—Are related somewhat.

Ms Smith—Yes. We are also mindful that there are a number of other reviews going on in the aged care arena, so we want to make sure that we are cognisant of the broader reform activity that is occurring.

Senator SIEWERT—So, overall, when do you anticipate having the whole process completed?

Ms Smith—In terms of implementation, I think it would be a bit down the track. In terms of a clear direction forward, we would hope to have something early to mid next year.

Senator SIEWERT—That is in terms of the final report?

Ms Smith—In terms of options around what direction we will be heading.

Senator SIEWERT—Sorry. I am trying not to be thick here. But in terms of the options paper, that will be an options paper that goes out for further consultation or to the minister for the minister to make some decisions around?

Ms Smith—We would be hoping to have some advice to the minister later this year and hope that the government would be in a position to consider that early next year.

Senator SIEWERT—So the government would consider it next year and then announce the intention and then proceed to implementation. Would that be the process?

Ms Smith—But obviously the timing of any implementation is still a matter to be decided.

Senator SIEWERT—Presumably, any funding associated with resourcing the implementation of the recommendations would be an announcement that would be made at the same time the government releases its options, or would it be further down the track?

Ms Halton—I do not think we know the answer to that, Senator. That will be something the government will have to consider.

Senator SIEWERT—By mid next year, we can expect to have some clear positions on where the process of accreditation and the standards will go?

Ms Smith—Yes.

Ms Halton—Yes. We expect so.

Senator SIEWERT—I do not know if anybody else has any questions about that process. I have another review I want to ask about.

CHAIR—Senator Williams has something.

Senator WILLIAMS—The ACATs are carried out by the state governments, of course. Is that correct? This is about quality.

CHAIR—Does anyone want to have a go at answering Senator Williams?

Ms Halton—It is not this group of people, so we will have to change team.

CHAIR—Sorry, Senator Williams. It is not on the same point that Senator Siewert had.

Senator WILLIAMS—Sorry.

CHAIR—Senator Siewert, we believe that that particular review process has been finalised, unless there are questions on notice. Are you moving on to your next review?

Senator SIEWERT—Yes. The review of the complaints investigations scheme. Where are we up to with that?

Ms Smith—About 25 July, I think, there was a call for public submissions for the review. A discussion paper was released. That was put on the department's website and advertised in a range of newspapers. The review is being conducted by Merrilyn Walton, who is associate professor in medical education at the University of Sydney. Submissions closed on 28 August. The review received 119 submissions from a range of different groups. Professor Walton also met with a wide number of stakeholders personally as part of that process. So those submissions have been distilled. Professor Walton has provided a report to the minister.

Senator SIEWERT—The report has been completed already?

Ms Smith—Yes.

Senator SIEWERT—Is the review itself expected to be a publicly available document?

Ms Smith—I imagine there will be public release at some point.

Ms Halton—It is a matter for the minister.

Senator SIEWERT—The fact it will be released has not been determined or the release date has not been determined?

Ms Halton—It has only just been received, Senator.

Senator SIEWERT—So the answer to both those questions is no? It has not been determined whether in fact it will be publicly available?

Ms Smith—I think the minister is considering the report and its recommendations and determining a way forward.

Senator SIEWERT—So, following on from that, there is no date that has been set for making any reform announcements or implementing any reforms?

Ms Smith—Not at this stage. Senator, the department already had in place a number of quality improvement initiatives that we were working on in respect of the CIS. As we have said before, it is a relatively new scheme and we were keeping an eye on what was happening and doing a number of things to improve the way it operated. We are continuing with those ahead of any broader decisions the government might make.

CHAIR—Does anyone have anything else on the review of complaints? No. Next one, Senator Siewert?

Senator SIEWERT—I have other aged-care questions, but I think that is all I have in terms of accreditation.

CHAIR—We will go to Senator Adams now. We will do the same thing—let her start and then you come in, Senator Siewert.

Senator ADAMS—Thank you very much. My questions firstly are on ACFI. My first question, which I would like you to take on notice, is just a general overview. Which programs administered by the department and its agencies are currently experiencing underspends? In each instance, can you please provide full details, including the amount of the underspend, the reasons they have occurred and whether the underspend will be used elsewhere within the department? If so, where? That is a question on notice. Now I will get to the questions on the aged-care funding instrument. Could you please update the committee on the status of the government's ACFI review set to begin in September 2009?

Ms Podesta—There is a strong desire to ensure that the new funding arrangements are achieving the desired objectives. We have been closely monitoring the implementation of ACFI since it was introduced in March. We have been working very closely with the aged-care industry—with consumers and health care professionals. We have been having very regular meetings with the ACFI industry reference group and the ACFI technical reference group. We have now commenced the formal process for the review of ACFI. The reference group has been closely involved in the development of the terms of reference, Senator.

Senator ADAMS—When did it start?

Ms Podesta—It is about to commence, Senator.

Senator ADAMS—So about to commence next week, the week after or when?

Ms Podesta—We have undertaken a range of statistical analyses internally to commence information provision for the review, Senator. We will shortly have public announcements with the terms of reference and the review.

Senator ADAMS—Why has it been delayed? It was supposed to start in September.

Ms Podesta—The preliminary work has commenced to ensure that it is able to be undertaken. We have had extensive consultation with the industry group and the reference group to ensure that the terms of reference make sense for everyone and that they are achievable, Senator.

Senator ADAMS—When do you expect to complete the review?

Ms Podesta—It has not been determined yet, Senator. We have not publicised the terms of reference. But we will be calling for submissions. This has been a process that has been a very cooperative process of the sector, so we anticipate a strong interest and involvement. To some degree, the timeline will be determined by the volume of work generated by the level of interest in submissions. But we do not expect this to be a long, drawn-out process, Senator.

Senator ADAMS—What do you mean by a long, drawn-out process? Are we looking at a year, two years?

Ms Podesta—We have not finalised a timeline yet, Senator, but I do not anticipate that it will be anything like a two-year review, no.

Senator ADAMS—What are the proposed terms of reference, then?

Ms Podesta—The terms of reference have not been released yet, Senator.

Senator ADAMS—You said that, I know. But when are they going to be released?

Ms Podesta—We provided advice to government, Senator.

Senator ADAMS—Well, I am not really very satisfied with that answer.

Senator CORMANN—Are you suggesting that you cannot answer because it is advice to government?

CHAIR—Senator Cormann, I think Senator Adams had the call.

Senator ADAMS—I am trying to get it.

CHAIR—Minister, do you have any comment on where the questions are going about the time frame for the review and the publication of the terms of reference?

Senator Ludwig—I think the correct answer is it is a matter for government. It is not a matter of whether it is advice to government. It is a matter of timing for the government. It will determine that in due course. I think that is the usual statement ministers make. I can ask whether Minister Roxon wants to add anything further to the record and, if she does, she will provide a written response to the committee in relation to this matter.

Senator ADAMS—Thank you. I would certainly appreciate that. As the review was supposed to start in September, this does concern me, because the aged-care industry will be very, very active in coming forth with witnesses for your review. They are certainly concerned about why it has not started. What has happened to the commitment to release Access Economics data to the industry?

Ms Podesta—Senator, you might need to give us a little more information.

Senator ADAMS—Could you just take that on notice? I am really worried. Has the department received correspondence from providers regarding the inadequacy of ACFI?

Dr Cullen—I am always happy to take something on notice, but I need to understand what it is. There is, as far as I am aware—and I would be aware if there were—no data set that I could identify as being called the Access Economics data. There is no such data set that I know of.

Senator ADAMS—I will get some more information on that. The next question I have asked. Has the department received correspondence from providers regarding the inadequacy of ACFI?

Senator Ludwig—Of what?

Senator ADAMS—It is the aged-care funding instrument, Minister. I would be very surprised if you have not.

Ms Halton—I think we will have to take it on notice, Senator, by the look of this. Ms Podesta, as you know, has only recently joined aged care, so if there is correspondence she would not be aware of it necessarily. Can we take that on notice?

Senator ADAMS—Yes.

Ms Podesta—The branch head is looking through this. We are trying to take a record of the department and we cannot get anything to the department.

Senator ADAMS—I really do want to move on, so take that on notice. In the 2008-09 budget, how much money was allocated to ACFI? Can you answer that?

Dr Cullen—Senator, the aged care funding instrument determines the amount of basic subsidy that is payable to a resident under the standing appropriation in the Aged Care Act. As a standing appropriation, the money is appropriated as required. There is a forward estimate, but the answer as to how much money is appropriated in the budget is whatever is required.

Senator ADAMS—As far as the department goes, how much has it spent on managing the ACFI process, from your point of view?

Dr Cullen—You mean departmental expenses?

Senator ADAMS—Yes.

Dr Cullen—We will have to take that on notice.

Senator ADAMS—How much money was allocated to ACFI in the 2009-10 budget?

Ms Halton—There will not be a separate allocation.

Senator ADAMS—There will not be a separate allocation for that?

Ms Halton—No. The question, Senator, goes to how much out-of-department money did we spend on its administration and its operation. Is that what I understand to be the question?

Senator ADAMS—That is one of the questions. Another one is about ACFI going to the residential facilities. As far as ACFI, we have had problems with the classification of the sixes and sevens. Therefore, I am really wondering whether there has been an underspend on the budget on ACFI because of the sixes and sevens not being eligible.

Ms Halton—So what you are actually interested in is whether or not as a consequence of classification issues there has been a lower than expected expenditure of subsidy?

Senator ADAMS—That is right.

Ms Halton—We will find that out for you.

Dr Cullen—The answer to that question is no. The budget measure which introduced the ACFI expected that the long-term effect of the ACFI would be that it would increase spending

by one per cent. The Access Economics report, which we have talked about previously here, demonstrated that the long-term impact of the ACFI was to increase expenditure on the basic subsidy by 2.9 per cent—so more than what had been budgeted.

Senator ADAMS—So what was the forward estimate for ACFI? What has been the delivered funding? I really want to get to the bottom of this.

Dr Cullen—There is no forward estimate for ACFI itself. There is a forward estimate for the residential care program, but there is no forward estimate for the elements of that program. The following information may be of assistance. In 2006-07, the total amount spent on the basic care subsidy was $4.9 billion. In 2007-08, which includes three months of the ACFI, the total amount spent was $5.1 billion. In 2008-09, the total amount spent on the basic subsidy was $5.5 billion. That, of course, includes resident growth, so I will now give you the daily figures. If I convert that to day on day, in 2006-07, before the introduction of the ACFI, the average basic subsidy was $85.15 a day. In 2007-08, which included three months of the ACFI, the average subsidy was $87.12 a day. Last year, in 2008-09, which was the first year where the ACFI was fully implemented, the average subsidy was $92.71 a day, $5 more than the previous year.

Senator ADAMS—So what you are telling me really is that within the budget there has not been any underspend? All the money that has been budgeted has been spent?

Ms Halton—Noting that we do not actually have a budget because it is a standing appropriation. But, as Dr Cullen is indicating, we have not seen a lower than anticipated expenditure.

Senator ADAMS—Does the department believe that the funding made available through ACFI sufficiently meets the needs of aged and frail Australians?

Ms Halton—You are asking us to make a value statement, which I think would be very difficult for the officers to make. What I think we can say—my colleagues can contradict me if they do not agree with this—is that in terms of the objectives set for the instrument, the funding and the mechanism delivers on the objectives set for the instrument. Is that a fair statement?

Dr Cullen—Yes.

Senator ADAMS—I would like to come back to the Access Economics report. You were not happy about that before. Now you have quoted from it.

Dr Cullen—No. What I said was that there was no such thing as an Access Economics data set, which are the words you used earlier.

Senator ADAMS—So as far as the Access Economics—

Senator CORMANN—Helpful as ever.

Senator ADAMS—report goes—

Dr Cullen—Access Economics were commissioned to undertake a report. That report has been discussed at the ACFI reference group. As is acknowledged, we were then asked to do further work at the request of the reference group which would look at the split-up of expenditure trends, not at a global level but by providers of different sizes or in different

locations. That work is still underway, but when that work is completed, it will be again discussed with the ACFI reference group and form input to the ACFI review.

Senator ADAMS—We will now move to the aged care approvals round.

Ms Podesta—Any specific year?

Senator ADAMS—I will have it placed on notice. The aged planning regions where bed shortages exist and the total bed shortage in each region—that is overall. Could you take that on notice so that we are aware of where there are bed shortages at the present time.

Ms Halton—Against the benchmark?

Senator ADAMS—Against the benchmark.

Ms Podesta—We will take that on notice.

Senator ADAMS—Are waiting times for residential aged care increasing? Are you aware of those numbers?

Ms Podesta—You want to know the entry period?

Senator ADAMS—Overall. We know that there have been bed licences handed back. We also know that there are problems with capital funding for new providers to be able to build more residential care and care facilities. I am just going from Western Australia's figures. I am fully aware there that we have a large shortage in actual physical beds.

Dr Cullen—On your question about entry periods for residential care, the department measures entry periods for residential care as the time between when an ACAT is completed and when the resident first enters care. We do not use the term 'waiting period' because there are many reasons for the gap between that time. Many people receive an ACAT prior to having made the decision to enter residential care. Therefore, they are not technically waiting through the entire entry period time. But the best measure that we have is entry period. You asked if that had been increasing. There are a number of measures that one might use. Let me try to explain them to you. In 2008-09, the median entry period for entry to high care was 23 days; that is, half of all people entered before 23 days and half entered after 23 days. In 2007-08 and in 2006-07, that number had been 22. In 2005-06, that number had been 21 and, in 2004-05, that number had been 22. So the number has remained relatively stable.

Senator ADAMS—That is not really where I wanted to go. I will ask you the next question and you will see where I am coming from. Given that the department recognised the need for 7,663 new bed licences in the 2008-09 aged care approvals round to meet the demands of an ageing population, why did the department allocate only 5,748 new bed licences? This was actually a shortage of 1,915 bed licences from your original assessment.

Ms Podesta—In the 2008-09 aged care approvals round, 10,447 new aged care places were made available for allocation and 10,447 places were allocated. They are a mixture of aged care, residential places, community aged care packages, extended aged care at home packages and extended aged care at home dementia packages. There is a very strong desire within the community for care at home. The approvals round certainly reflects that very strong consumer demand, Senator.

Senator ADAMS—I am fully aware of that. I will get to those individual packages later. With the 1,915 bed licences that were short, did the department get wrong the original assessment of the number of new bed licences needed? It is fine to go off and say, 'Well, aged care packages have taken the place of residential aged care beds,' but that is not what I am after. I really do want to know why we were 1,915 bed licences short.

Ms Podesta—We will provide significant additional detail, Senator, but I think it is really important to make this point. It is a competitive process in the aged care approvals round and we take into account a large number of factors. It would be fair to say that whilst there were a higher number of residential beds sought in the round than were allocated, to some degree that was a result of a number of factors, which I am sure you would be very appreciative of. Sometimes people sought to place residential services in areas where we did not believe there was a need at this point for additional places, or they had records as providers which did not mean they were regarded as the most competitive, or the plans they submitted seeking approval for those places were not sufficiently robust.

Senator ADAMS—We are running out of time. I have a question about the licences that were approved and had to be handed back because of a lack of capital funding. In my home state of Western Australia, the department recognised the need for an additional 1,208 bed licences in 2008-09 and delivered just 519. This shortfall of 689 beds followed a shortfall of 342 beds in the previous ACAR round. Given that the department has provided an indicative figure of 1,776 for the number of new bed licences needed in Western Australia in 2009-10, what confidence can the people of Western Australia have that their aged care needs will be met?

Ms Podesta—The number of places that are released as forward indications are released for the future years as indicative planning. They represent the highest levels of places that may be made available under the approval round if in the competitive process that we just described all of those conditions are met. We will certainly have a further approvals round this year. There will be information sessions made available. There are a range of additional measures that are in place to provide information for approved providers to encourage them.

Senator ADAMS—Have those beds been reallocated anywhere else?

Ms Podesta—I am not sure what you mean by 'those beds'. Do you mean beds that have been—

Senator ADAMS—Beds that have been handed back, which is mainly because the capital funding has not been available. In Western Australia, we have a huge problem, as does Queensland, with the price of land. The expense that has to be put out to build a new facility is far, far higher. I have asked this question time and time again at every estimates to be told that it is a national averaging of the cost of providing new residential aged care beds.

Ms Podesta—There are a range of reasons why provisional places are either surrendered, lapsed or revoked. There is also a range of reasons why operational places are relinquished or revoked. In general, when places are no longer either provisionally allocated or operationalised, those places are made available for future allocation.

Senator ADAMS—It still does not help the problem of the necessary number of beds needed and which are available. That is the reason I was asking about waiting lists earlier, but

it was not quite the answer that I got. The ACAT assessments are done. Coming back to my own state, I am fully aware of just how hard it is to get an elderly person into residential aged care. Despite having step-down facilities for the so-called bed blockers from acute care hospitals, which is causing huge problems too, there just does not seem to be an answer to the problem. Therefore, how are we going to get on? Obviously, the beds available are far less than what is needed.

Mr Broadhead—In the financial year just gone, we had only 29 operational places actually returned.

Senator ADAMS—Twenty-nine?

Mr Broadhead—Twenty-nine nationally.

Senator ADAMS—That was nationally?

Mr Broadhead—Yes, that were relinquished.

Senator SIEWERT—I have been told by providers that when they have offered to hand back beds, they have been told, 'No. Hold on to them for a bit longer and try to operationalise them.' How many requests to hand back have you had? We have had this conversation, I know, numerous times.

Mr Broadhead—I am not aware of requests such as you have just mentioned. That is not to say that perhaps somewhere there has been a conversation between providers.

Senator SIEWERT—I am not going to dob in Western Australian providers, but they have actually personally told me that.

Senator Ludwig—I think you may have.

Mr Broadhead—I am not being party to this conversation. I cannot say what other people may have found.

Senator SIEWERT—We have also taken it in evidence at a Senate inquiry.

Ms Podesta—There are different reasons why approved providers choose not to operationalise places. As part of the monitoring process that the department undertakes during the two years when approved providers have an obligation to meet certain milestones towards making places operational, they certainly will discuss with us, sometimes in distress, some of the structural reasons why the delay is frustrating them. We try to be sympathetic and helpful during that process. I will not allude to some of the famous provisional allocations which have taken a long time. I know that this committee has a lot of detail about some of the more famous cases. But at all times it is an opportunity for the approved provider and the department to try to identify if there are ways forward for the approved provider within the restrictions that sometimes are placed within their condition of allocation.

Senator ADAMS—I would like to move on to the community aged care packages. Obviously a decision was made to replace bed licences with additional community aged care packages. When was this decision made?

Ms Halton—Just to be clear, my understanding is that we overallocated community aged care packages in Western Australia. I am sure my colleagues have the numbers somewhere.

Senator ADAMS—Was this decision made to alleviate the bed shortages?

Ms Podesta—Do you mean the additional 1,915 community care places?

Senator ADAMS—That is right.

Ms Podesta—The decision was made as part of the aged care approvals round. Unfortunately, neither myself nor Mr Broadhead was there at that time.

Ms Murnane—Senator, every consultation we have tells us that more community aged care packages of all sorts—the extended care ones, the EACH ones—are wanted by the public; that is, there is a great demand that we are not meeting. That is the primary motivation for that decision—to meet what is a real upswell of demand from the community, from aged people and their families, for packages so that they can be looked after in their homes.

Senator WILLIAMS—On those packages, we are obviously not meeting the demand of them, though, are we? Let me give you an example. In the New England area, there are 71 approved CACP packages. Just six of them can go under vacant packages. They are still 65 short. For EACH packages, 36 people have been approved by the ACAT assessment. There are six vacant packages, so there will be 30 still waiting. For EACH dementia, seven were approved but there are only two vacant packages, so five are waiting. For home and community care, 47 were approved but there are no packages. Probably 150 people have been approved for care at home and there are no packages available.

Ms Murnane—Well, there is a gap between supply and demand in packages.

Senator WILLIAMS—Obviously.

Ms Murnane—That is the point I am making. That is the reason for the increase. But what we strive to do always—we do work within an upper limit—is maintain what is an appropriate balance between residential care and packages. Now, there are areas in which there are, as you say, demand that has not been met. That is what we are being responsive to in increasing the numbers available, Senator.

Senator WILLIAMS—Well, I know of one instance where an 80-year-old elderly lady in the early stages of dementia cannot go into a package. There are no packages available for her. She has certainly been assessed for the assistance. Her family have to travel a long way to just help her with her medication, for example. These providers are screaming out for packages and cannot get them. We have elderly out there who have been assessed by the ACAT team saying, 'These people need help', but they cannot give them any help. There is a big problem. This is a really serious issue. If this is how we are treating the elderly, it is something that must be addressed and addressed immediately.

Ms Murnane—Senator, I would say that one of the things that could be explored for that lady is the home and community care program, particularly the home nursing side of it, to manage her medication. We would be happy to talk to you later about where she lives and to talk to the New South Wales state government that manage the health department that manage the home and community care program. I am sorry; it is the department of ageing and disability that manages it. They can try to make sure she can get that service through HACC. I know that the packages offer more integrated, holistic and flexible care and that is why we want to increase them.

Senator XENOPHON—I want to ask a supplementary question to Senator Williams's question. You talked about the need to maintain an appropriate balance between community care and residential care. Can you elaborate on the criteria for that appropriate balance? Has any modelling been done on the cost effectiveness of having people in community care compared to residential care if they are suitable for community care?

Ms Murnane—In terms of the balance—I will ask Dr Cullen to talk about modelling that has been done on that—we have an upper limit of a ratio. Over the years, successive governments have been increasing the number of community care packages without depleting very much at all the number of residential care places.

Senator XENOPHON—Is the balance qualitative or quantitative or a bit of both?

Ms Murnane—There will be some people, particularly in terms of high care, who are not going to be able to, with the best efforts from everybody, including their families, be satisfactorily looked after at home. So there will need to be residential care available for those sorts of people. This is something that we have to assess. There is not a gold standard here. It is an assessment that we are making in response to what we are seeing from the community and in response to what we are seeing in terms of the much greater acuity—that is, frailty—and need of people with dementia for care. In many cases, people at extreme levels of these impairments will not be able to be cared for in the community.

Ms Halton—Senator, I will make a comment about this. This is actually one of the most complicated issues. What we have with the ratios as they currently stand is an evidence base that says 'about there is about right'. What we have done over the years—this is a matter of interest as well in the academic community—is look to see what it is that distinguishes people who can remain at home at fairly high levels of frailty, what levels of support they need. That is one of the reasons why, as Ms Murnane has indicated, over a period of 20 years or so now we have moved to enable more packaged type care in the community. But exactly as Ms Murnane says, the things that denote people who can stay at home, even with high levels of dependency, are very complex. Partly they are psychosocial. Partly they are about the instrumental support they get from others—that is, family, carers, et cetera. There are some people who need a residential option. It may be because they have severe dementia and they cannot be managed at home. It may also just be because of those psychosocial factors that they cannot remain at home. Finding that balance is part science and part judgement.

What has happened over a period of years is that, as our knowledge has become greater about the kind of people who with the right support can stay at home, there has been an expansion of that. The fact that we even now have something called EACH, the much higher level care packages, is a reflection of that experimentation and that program design that has gone over literally 20 years. So it just is not possible to say that there is a kind of categorical answer to that. It is always a matter of judgement and experience and academic debate and design.

Senator XENOPHON—But the benchmark is the judgement. As to the standards, though, to make a decision there would be some benchmark, would there not?

Ms Halton—The residential care benchmark includes both the packages and the beds that we work to when we plan to. As I have said—this was put in place under the former Labor

government over 20 years ago—it was the best guesstimate, based on science and experience, that people in the sector came to. HACC was always the community based program that provided the sort of supports Ms Murnane was referring to when she was answering Senator Williams and, in fact, still forms the majority of community based supports for people. The fact is that over a period we have gradually expanded the packaged up options for people in the community. That is a Commonwealth response. But the home and community care program is still the majority of support provided to frail elderly people in the community. It is, as you know, funded slightly in the majority by us but delivered by state governments. I do not know whether Dr Cullen has a more technical answer than that. There probably is not one.

CHAIR—Senator Williams, any more on the EACH and CACP programs?

Senator WILLIAMS—I just find it concerning that so many people have been approved for this care and, of course, they are waiting so long. My concern is that this queue is going to get longer and longer. I want to bring it to the department's attention that it is a very, very serious issue. Ms Halton, could you take that on board? I am sure you are aware of it.

Ms Halton—We are very aware of that, Senator. Again, at this point I sound crashingly middle age, which depresses me no end. This is an issue that we have been actively looking at for, in my experience, 25 years. On the question of how long people wait and what that is a proxy for, the word 'reasonable' does not apply here. But what is a fair measure of the system being under strain or working relatively well is something which people have published on ad nauseam. Dr Cullen went through the data. What we look at is this gap between when the approval was given and when someone is actually provided with care. In the community care space, it is a more complicated equation because HACC is actually the majority provider. We know that some people take out a pre-emptive ACAT approval so they have it if and when they need it. It is one of those very difficult areas and it is something we are highly aware of.

Senator WILLIAMS—I want to talk to you about the ACAT assessment. I found it alarming to be told by one of the providers just recently that they know of some of these assessments—I do not think there are many—that have been carried out over the phone. To me, if that is true—and I have no reason to believe it is not from the people who told me—I do not think asking, for example, an elderly lady to answer questions over the phone for an assessment is acceptable. Would you agree with that?

Ms Halton—The issue is what the circumstances are. I would not want to give a blanket answer to that kind of question. If there is a particular issue that you have a concern about, if you would like to provide that to us I would absolutely be happy to look at it.

Senator WILLIAMS—When my mother was assessed, I made sure I sat there because my mother is in the early stages of Alzheimer's. They can say yes to an answer which is obviously no.

Ms Halton—Absolutely.

Senator WILLIAMS—So I think it is important that ACAT do their assessment face to face and, if possible, have a family member there to assist. That is the way I see it.

Ms Halton—We all know, Senator, that particularly if you are assessing someone with some potential form of cognitive impairment, the question of understanding some answers in

context is an incredibly important thing. We all know someone who to the outside world may appear completely cognitively intact but in reality is suffering from some considerable deficit. Taking account of all the evidence and information about that person's circumstances is necessary to make an assessment. I do not want to give you a blanket answer to that question. If you would like to give us some detail, I would be really happy to look at it.

Senator WILLIAMS—I endorse the government and the previous government having these packages to keep people at home as long as they possibly can, where they are safe, secure and well cared for. In the area where I live in northern New South Wales, we have seen a situation now where the waiting lists for nursing beds in home care facilities have gone down. I know of one major provider that has actually shut down six beds because people are being kept at home. An example is the Grace Munro centre at Bundarra; I think the minister has just made available some assistance for three months to try to keep it open. When that facility was full, it had 10 or 11 beds, I think, at maximum capacity and the provider was barely covering costs. When it went down to seven beds, they were losing money. Hence, they have had to pull out and look like closing the facility.

We have a gap in the demand for nursing beds, but these people are being kept at home. Surely in five or six years they are going to come along and need extra care and these facilities may be closed. Every nursing facility I talk to as far as nursing beds go actually loses money. This is the biggest concern I am having brought to my attention. A lot of these providers are going broke. We have had some 48 hand their licence in over the past 14 months or whatever. We must keep these businesses—and they are businesses—viable because when this lull, if I can call it, on demand for nursing beds goes away because people will need extra care, these facilities must be open. That is the biggest complaint I have brought to my attention all the time.

Ms Halton—Again that is something we are very aware of. There are several things confounded in that statement, some of which are about the express preferences of people for where they would like to be cared for. I think if you ask any person in this room where our collective preference would be in terms of care, it would be at home. I would be gobsmacked if any person in this room said, 'I would rather be admitted to a high-care or low-care facility.' So that is where people have the express preference. You are quite right; some people do need institutional care. It is a fact, not necessarily a desirable fact. The question of industry viability is something which in this room we have talked about, Senator Cormann, ad nauseam and Senator Adams—

Senator CORMANN—I have been very quiet today.

Ms Halton—You have, I know.

Senator WILLIAMS—He has.

Senator Ludwig—There is still time.

Ms Murnane—I want to follow on what the secretary just said about how complex this is. We do know about this particular home. We will talk to them; it is a real problem.

Senator WILLIAMS—As far as them being open? It is a small community. Sorry for interrupting.

Ms Murnane—I was just going to say that we are aware of it. We cannot prop up, but there may be some way we can talk to them and provide assistance so that they can remain viable. The essence of the problem is, as you said, that these beds may not be wanted today but in three months they may.

Senator WILLIAMS—Three years.

Ms Murnane—Three years, maybe.

Ms Halton—We also need to understand—this is a fact—that really small facilities may not be viable. The question of how you provide residential care to people is something which has to be taken account of in terms of what is viable. Again, there is no one-size answer to this other than to acknowledge that we need to have a system that does enable care of those various types.

Senator WILLIAMS—I want to bring to your attention, Ms Halton, a problem we have in these small communities. Take Bundarra, which has 400 or 500 people. We have an elderly couple married for 50 or 60 years. Let us say the man has to go into a home. If there is not a local aged care facility to care for him, he might be taken to Inverell or Glen Innes and then we have an 80-or 85-year-old lady driving 50 or 80 kilometres to visit her husband of 50 years. We nearly had one case of a road accident because of that. I think that is very unfair to our elderly—to have them separated in the twilight of their lives, where one of the couple has to travel so far to visit their husband or wife in that situation. That is why these smaller communities—I know you are saying they are not viable—must remain viable to prevent this in the future.

Ms Halton—That is why, Senator, over a period of years we have looked at some alternative models. Senator Adams has already raised one of the most successful alternative models earlier this morning, which are the MPSs. The multipurpose services are precisely around—

Senator WILLIAMS—I am very aware of them.

Ms Halton—creating an alternative model which is able to be viable and which includes a number of different services for a small community. These are problems we are highly alert to. Finding ways to keep services in those smaller communities sometimes involves creative alternative options. Again, they are things that we are very alive to.

Senator WILLIAMS—Are we out of time, Chair?

CHAIR—We are.

Senator ADAMS—I would like to come back to the reduction in the aged-care beds. There is the figure of 1,915. This is an unprecedented thing that has happened. I really wonder where it is going to go. As far as I know, you have talked about the community packages. Where are we going to go in the future if we are 1,915 bed licences short now? What is going to happen next time? I really would like to know when the department is going to invite applications for the 2009-10 aged-care approval round. When will that happen?

Ms Podesta—The 2009-10 approvals round will be advertised shortly.

Senator ADAMS—Shortly—as in how many months, days?

Ms Podesta—We anticipate that it will be advertised within the next month, Senator.

Senator ADAMS—Within the next month. So it will definitely be before Christmas. My second question is: going back to the 1,915 bed licences which were short this last round, are we going to have this round plus the 1,915 beds?

Ms Podesta—The indicative numbers for future years are being considered. We will be receiving information, as part of the aged-care advisory committee process, from those committees in the states and territories about where they see priorities. As we finalise that process, we will be able to provide information for potential applicants around the number of places that will be made available by region.

Senator ADAMS—As far as the community aged-care packages, will that number be increased?

Ms Podesta—We have not finalised—

Ms Halton—I think the earlier answer applies.

Senator ADAMS—I would like to know about the cost difference between a bed licence and a community aged- care package.

Ms Halton—Cost as in the subsidies and the cost?

Senator ADAMS—Yes. As far as the budget goes.

Ms Podesta—I am opening the bible here.

Ms Halton—It is a well-thumbed bible, clearly.

Dr Cullen—Senator, in broad terms, a high-level residential care place attracts a subsidy of $45,000 a year. An EACH package attracts a subsidy of $43,000 a year. An EACH D package attracts a subsidy of $47½ thousand, on average, per year. EACH D packages are slightly more expensive than high-level residential care, on average, but not more expensive than the top of high-level residential care. In community care, a CACP attracts an average subsidy of $13,000 per year. A residential care low-care place attracts an average subsidy of about $18,000 per year.

Senator ADAMS—So there are definitely some savings there. Has the cost difference been allocated to the extra community aged-care packages from the beds? With the shortage of the beds, that would have gone into extra community aged-care packages. Therefore, you have utilised that funding to actually expand the number of packages.

Dr Cullen—Senator, again, because the community care packages and residential care are funded through standing appropriations, those appropriations simply appropriate the amount of money necessary to fund the number of packages or beds which are in operation. So the net effect would be that the appropriations for community care packages have gone up, yes.

Senator ADAMS—Thank you for that. I will come back to the applications. I have asked about the 2009-10 aged-care approvals round, which is hopefully going to be in November. When will the department invite applications for the 2010-11 aged-care approvals round? We are right at the end of 2009 now. I just want to know when the next lot will come up.

Ms Podesta—Do you mean—

Senator ADAMS—The one after it. It is 2010 next year. Are we going to have to wait another year? These are a lot later than normal. Are we going to have to wait until November?

Ms Podesta—The usual practice is that they are advertised around November.

Ms Halton—And they run into Christmas.

Ms Podesta—We try to ensure that people are not writing their applications on Christmas Day. We try to make sure that the staff who are seconded to do the assessment get a short break. After Christmas, they come back and work through January. It is roughly around the same time most years, Senator. It was when I was in the program doing it a few years ago.

Mr Broadhead—The closing date for the last round, the one that was announced in June, was 19 December last year. That sort of a time frame is what we are proposing for the coming round. We would expect that—obviously it is into the future so who would know what may happen—all else being equal, it would be similar the following round as well. Obviously I cannot predict the future.

Senator ADAMS—Well, that is the thing. I would now like to ask a question about the licences that were allocated in the last aged-care approvals round that have not yet become operational, because this seems to be quite a problem as well.

Ms Podesta—Places that were provisionally allocated for residential aged care in the 2008-09 aged-care approvals rounds?

Senator ADAMS—Yes. The ones that have been approved but are not yet operational. So how long have we got for those to become operational?

Mr Broadhead—In general, under the act, there is two years after the provisional allocation of a place that it is expected to become operational. In practice, due to a variety of factors, it may take longer in a number of instances to become operational. But unless somebody happens to have received places in respect of a facility already built, you would not expect the provisional allocation of residential places to become operational within months of the allocation.

Senator ADAMS—I realise that.

Ms Podesta—Undoubtedly some are.

Mr Broadhead—Some are, yes, but that is the general rule.

Senator ADAMS—So could you provide a breakdown of the number of licences in each aged-care planning region for the previous three aged-care approval rounds that have not yet become operational? I want to get an idea about that. You could take that on notice.

Ms Podesta—Yes, Senator.

Senator ADAMS—This one may be on notice as well. How many bed licences have been handed back since 1 March 2009?

Ms Podesta—How many operational places have been—

Senator ADAMS—Bed licences have been handed back, yes. These are approved ones.

Ms Podesta—So they have been surrendered?

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

Senator ADAMS—If you could do that.

Mr Broadhead—In relation to operational places handed back, or 'relinquished' is the term we use, there were 29 in the last financial year.

Senator ADAMS—Twenty-nine in the last financial year?

Mr Broadhead—Twenty-nine in the last financial year. That is not from March, but that is nationally, yes, in the 2008-09 financial year.

Senator ADAMS—Are there any others out there that you think they will not go on with? Have you had any notification from anyone that there are more that will be handed back?

Mr Broadhead—I am not aware of any such notifications. Again, it is not to say that some part of the department may be aware of something. But I am not aware that we have had any other notifications of places to be relinquished.

CHAIR—For what funding rounds?

Senator ADAMS—The last three.

Ms Halton—The operational places that have been surrendered are unlikely to have been in the last three years.

Senator SIEWERT—So they are prior to the last three years?

Ms Halton—Yes. Operational places. They could in fact date back to whenever and we may not be able to tell you.

Ms Podesta—We do not keep a database of places. We do not have an historical database that lists all the places that have been revoked or returned.

Mr Broadhead—'Relinquished' is the word we use for operationals.

Ms Podesta—We have commenced keeping that information as a result of the questions.

Ms Halton—Obviously, some of these facilities have been in operation under various historical iterations of the act. In fact, when they were first subsidised, we probably did not have a record.

Senator BOYCE—Is this an appropriate time to ask about facilities where the applications are outstanding?

Ms Halton—What do you mean by applications outstanding, Senator Boyce?

Senator BOYCE—An instance is the wonderfully popular Evans Head. Applications of more than five-years duration.

Ms Halton—So they are not applications; they are bed approvals?

Senator BOYCE—Approvals, yes, that are outstanding. I am happy to do that now or leave it until later.

Ms Podesta—We can do that now, Senator. Surprisingly enough, in preparation for estimates, I chose to look at Evans Head.

Senator BOYCE—Where there is a zoning application. The council has finally agreed to rezone the land after 12 years.

Ms Podesta—I could not comment on the decisions of local government, Senator.

Senator BOYCE—But it is 12 years that this application has been on foot.

Ms Podesta—We think it is around 10, Senator.

Senator BOYCE—Only 10 years.

Senator Ludwig—But one of the difficulties, of course, is that it was inherited from the previous government. It is a complex problem. I think you know that. The department, I think, has met with the approved providers and council and followed up in writing.

Ms Halton—Ad nauseam.

Senator Ludwig—Yes, unfortunately. There is the Richmond Valley Council, which announced on 30 September the approval—

Senator BOYCE—I am aware of that. I know we have had something that looks vaguely like progress on Evans Head in the last month or so.

Ms Podesta—We will all seek atonement here because I will give you the exact date. The approved provider was allocated 40 low care places in 2001 and 15 low care places in 2005.

Senator BOYCE—And the approved provider continues to be RSL LifeCare. Is that correct?

Ms Podesta—It is the RSLs combined, Senator.

Senator BOYCE—Could you give me a list of all approvals that are more than five years outstanding and, hence, becoming operational?

Ms Podesta—We can, Senator.

Senator BOYCE—Is the department involved with the very robust objection to the location of this facility in Evans Head? What interaction have you had with those groups?

Ms Halton—That is the planning objection?

Senator BOYCE—Objections to the fact that it is going on the aerodrome site, yes.

Ms Podesta—We are aware of those, Senator, but we do not get involved in decisions with regard to planning at all. They are under the jurisdiction of the local government and the state government.

Senator BOYCE—I think we are still in for a long and tortuous ride with this facility if the current site is proceeded with. It would seem to me that perhaps you could short-circuit some of these very lengthy processes by becoming involved in whether the site is a suitable site or not.

Ms Halton—Actually, Senator, I do not agree with that. We do not have very many of these cases at all. In fact, there are very few. We will give you the information about that.

Senator BOYCE—I am talking about this particular one here.

Ms Halton—Well, on this particular one, it is just a series of circumstances. In fact, my officers have had endless dealing with all manner of people in relation to this project.

Senator BOYCE—Mr Stewart has lost the opportunity to be involved in Evans Head.

Ms Halton—Some more, yes. Although if he feels any notion of nostalgia, Senator, I can absolutely indulge him, I promise you.

Ms Podesta—We are planning to have him there when he is in.

Senator BOYCE—To break the bottle of champagne.

Senator ADAMS—I have one more question on ACAR rounds. How much money was appropriated for residential care in the 2008-09 ACAR round compared to the 2007 round?

Mr Broadhead—My colleague is coming to the table. We do not appropriate money for places. As explained, the act basically says the money is appropriated accordingly. So to the extent that places are operational and occupied, subsidy flows. It depends on the person's care needs et cetera as assessed by the act as to what the level of subsidy is. So the money flows under the act as a standing appropriation. It is not an annual amount which is determined in advance. It flows according to the numbers and kinds of people in care and the kinds of care provided.

Senator ADAMS—So you do not have a total for that particular round?

Mr Broadhead—No. We do not have a total in dollar terms for a particular round. For example, if residential places are allocated, they may be occupied by people at different levels of care. According to their level of care, money flows. It depends on who is occupying the places.

Senator ADAMS—With aged care on the increase and the way things are going into the future, I really want to know what was spent on those subsidies for 2007 and what was spent on the 2008-09 round.

Ms Halton—The problem with the question, Senator, is the ACAR round is a different matter. There is a question about how much we actually spent from that year. We can tell you that.

Senator ADAMS—On these rounds.

Ms Halton—No. You do not spend on rounds. There is a problem with the question. What happens is we have a certain number of beds operational. We have a way of estimating what that expenditure level will be in a particular year. We know that in the following year we expect the following number of beds to be operational. We, again, have a way of estimating how much we will spend. So we can tell you that. ACAR rounds do not have an appropriation. We can tell you what we spent in the year so the government can manage its budget, but ACAR rounds do not have an appropriation.

Senator ADAMS—I want to find out what was spent in the 2007 year and then 2008. Can we have that?

Dr Cullen—Senator, you can. Unfortunately, I have the 2008-09 year here and every year after that, but I do not have 2007-08, so I will have to take it on notice.

Senator ADAMS—What was spent in the 2008-09 year?

Dr Cullen—In 2008-09, on residential care, the Department of Health and Ageing spent $5.514 billion. The Department of Veterans' Affairs spent $960 million. An added complexity to the Aged Care Act is that funding for veterans in residential care is actually appropriated through the Department of Veterans' Affairs but administered by this department. So we normally add those two numbers together to get the total amount spent on residential care.

Senator ADAMS—That is the end of my questions for that.

Senator SIEWERT—I have some more that I will put on notice, but there is a couple I want to ask now. One of the reviews I forgot to ask about is the review of the conditional adjustment payments, the CAP payments. When is that likely to be released?

Ms Murnane—Senator, we do not have a date for the release of the report. At the last estimates, there were quite a number of questions about the data in the report. That has now been released. So that was the data that was used in forming the report and its conclusions and that has now been released.

Senator SIEWERT—But the report itself has not been released?

Ms Murnane—The report has not been released, no.

Senator SIEWERT—Is it still likely to be released? If so, when?

Ms Murnane—It is something that we would have to get advice on, Senator, because this was tied up with a submission to cabinet in the context of last year's budget.

Senator SIEWERT—I do not, quite frankly, want to have to wait until next estimates to ask, so perhaps you could take it on notice to look into when it could be released. Otherwise I will be asking the same thing in February.

Ms Murnane—We will take it on notice.

Senator SIEWERT—Thank you. I know we have been on this for quite some time, and that is the financial returns data for aged-care providers for 2007-08 and 2008-09. I know that we have had lots of discussions about this. Is that data likely to be released?

Ms Murnane—That is what I referred to, Senator.

Senator SIEWERT—All that data has been released now?

Ms Murnane—For 2007-08, yes. Sorry, the 2006-07 data.

Senator SIEWERT—Which is why I am asking about the following years.

Ms Murnane—That is the data that was used.

Senator SIEWERT—That was the data used in the CAP assessment?

Ms Murnane—That is right.

Senator SIEWERT—But what I am after is the data from the subsequent financial years.

Ms Murnane—I do not think that is ready for release yet.

Ms Podesta—No. It is not correct. The department is working on that data now, Senator, to make sure that it is deidentified. As you said, the 2006-07 data is now on the website. When

we have finished making sure it is complete, the 2007-08 data, and any technical challenges there are over 1,100 returns, we will post that data as well, Senator.

Senator SIEWERT—So we are likely to get the 2007-08 data in the relatively near future?

Ms Podesta—I believe so, Senator.

Senator SIEWERT—End of the year?

Ms Podesta—I do not want to make a prediction, Senator. I know what an enormous job 2006-07 was.

Ms Halton—The answer is as soon as we are able.

Senator SIEWERT—And 2008-09 is obviously further down the track.

Dr Cullen—We have not even inspected the general purpose financial reports for 2008-09.

Senator SIEWERT—Hopefully you have streamlined the process for now. This has been an ongoing issue for fixing the data.

Ms Podesta—No. It is not a fixing. It is a cleaning.

Senator SIEWERT—That is the word I am looking for—cleaning of the data. Hopefully, you will refine that process.

Ms Podesta—Unfortunately, and I know you have probably heard this before, it is partially to do with the quality of the inputs. Sometimes you need to go back and check information. But we are working as closely as possible with the sector to make sure it is complete and it is accurate. We have made a commitment, as we have demonstrated recently, that we will publish that data.

Senator SIEWERT—I have one Western Australian question.

CHAIR—Senator Cormann has one question on that data.

Senator SIEWERT—Okay.

Senator CORMANN—I am following up on the questions Senator Siewert just asked but also a question that I placed on notice in relation to the same issue during the last estimates. Essentially, I wanted to know:

What is the full analysis and methodology used to arrive at the conclusion that there was a 10% return on investment on 31 December 2008?

I understand that it was based on the 2006-07 general purpose financial reports. Is that right?

Dr Cullen—Correct, Senator.

Senator CORMANN—And the de-identified data in the general purpose financial reports is what has been loaded onto the Department of Health and Ageing website recently. It contains a caveat as to the accuracy of the data, doesn't it?

Dr Cullen—It contains a caveat which indicates that the data is signed off by the auditors but the department has not independently been able to verify or does not have the capacity to independently verify what particular accounting standards were followed.

Senator CORMANN—The reason for my question is that a 10 per cent return on investment is obviously quite a bit higher than what the industry is generally would indicate, and that was your justification for saying that things were looking better in segments of the market. Your answer to my question on notice last estimates was:

This figure was derived from an analysis of the financial performance of the providers in the top quartile as assessed by their earnings before interest, tax, depreciation and amortisation …

Was the data that you uploaded cleansed of inaccurate outliers before being loaded onto the website?

Dr Cullen—No, Senator. The data which is loaded is the data that was provided. In some cases it involved consultations back with the providers themselves to understand the data.

Senator CORMANN—So it could well still include inaccurate outliers in terms of the data that you relied on to make that assessment?

Dr Cullen—Senator, I want to assure you that the caveat which is attached to that document should not be interpreted by anyone that we do not have reliance on that data. That data is the data that was provided, and it was signed off by auditors as a true and accurate reflection of the business of those aged-care providers.

Senator CORMANN—Have you reviewed the data that you have loaded onto the website for inaccurate outliers? Because, clearly, if you look at the top quartile to assess financial returns and performance, if there are significant incorrect outliers, that will skew the results.

Dr Cullen—Senator, each data item loaded onto that system is derived from financial reports which have been audited by registered company auditors who have signed off that the data is a true and accurate representation of the business that has been audited.

Senator CORMANN—Can I please ask you—and you can take it on notice—to review the data you have loaded onto your website for any significant and incorrect outliers and to assess whether that has impacted the analysis that you have put forward to the Senate inquiry into residential and community care in terms of the financial viability of aged care.

Senator Ludwig—Through you, Chair—I think it is reasonable for you to ask a question; I am not sure it is reasonable to you to ask the department to do analysis for you.

Senator CORMANN—I have reviewed it. Let me put this proposition to you. There are significant incorrect outliers that are included in the data and that skews the results that come out of the analysis, and stating that there is a 10 per cent return on investment on 31 December 2008 is therefore inaccurate. I would like the department to review this because this has been, as Ms Halton has said, an issue for significant debate. There is clearly concern across the industry about the financial viability of aged-care facilities, moving forward, in particular in the high care sector. I am concerned that the analysis the department is relying on is not accurate.

Senator Ludwig—You can have that concern. I am not sure you can go to the next stage of asking the department to undertake work on your behalf, but, be that as it may—

Senator CORMANN—It is not on my behalf; it is on behalf of people who want timely access to aged-care facilities around Australia, Minister, because there is a public policy interest. If we do not base our decision making on proper data we will never get to the bottom

of this. What I am saying to the department is: given that this has been an ongoing dialogue, please have another look at this to see whether that 10 per cent return on investment that has been used as a justification to say 'everything is fine' still stands.

Senator Ludwig—I think it is best if we take it on notice. We will see what we can provide.

Ms Halton—I do not want to leave anybody with a misapprehension in relation to this. As Dr Cullen has indicated—and he can correct me if I am wrong—you cannot say that because there is an outlier it is inaccurate. But, as part of the process of looking at the data, if we see something which is an outlier we go back to the provider and ask them about the veracity of that data. Is this correct, Dr Cullen?

Dr Cullen—Yes.

Ms Halton—We ask them to confirm that that data is accurate.

Senator CORMANN—Can you confirm that on this occasion that has happened—that, in relation to outliers in the 2006-07 data, you have gone back to providers to confirm that the data is accurate?

Dr Cullen—I can confirm that, for those reports about which I have had some concern, we have gone back to providers and asked a question about it, yes.

Senator CORMANN—I might privately send you some specific examples.

Ms Halton—If you have some, we would be more than happy to have them.

Senator SIEWERT—I want to go to the Care Awaiting Placement Program. If I remember rightly, there was extra funding committed to that program.

Ms Podesta—The care awaiting program is a state government program.

Mr Broadhead—The one you might be referring to is the Care Awaiting Placement Program in WA.

Senator SIEWERT—Yes.

Mr Broadhead—That is a state government funded program.

Senator SIEWERT—Do you commit any funding to that?

Mr Broadhead—Not specifically to that program. We have a Transition Care Program which is funded. That is a different one program.

Senator SIEWERT—I apologise. I recall that last year there was additional funding committed to that transition program. Do you provide any funding from that program to Western Australia to supplement their Care Awaiting Placement Program?

Mr Broadhead—The government made a commitment to increasing the Transition Care Program from 2,000 places to 4,000 places nationally, so there is funding associated with that build-up over time. It also committed to fully funding the new places, the additional 2,000 places on top of the 2,000 that already existed. So the Commonwealth contribution as a proportion of the total is increasing over time. Both the number of places and the Commonwealth contribution are increasing. Yes, some of those places are going to WA. The

approved provider in WA is the WA state government. However, we do not fund their Care Awaiting Placement Program, which is a different program.

Senator SIEWERT—So you provide funding in addition to their funding.

Mr Broadhead—Yes. They are side by side programs. Care awaiting placement is, as its name suggests, essentially maintenance care, whereas transition care has a restorative component. So they are complementary.

Senator SIEWERT—There is a facility in WA that is cutting back the places it provides under the Care Awaiting Placement Program. Would there be a circumstance where a reduction in funding from the Commonwealth would lead to them having to close beds?

Mr Broadhead—No. My understanding is that the one you are referring to is Mertome.

Senator SIEWERT—Yes.

Mr Broadhead—That is a state funded program. It is a unit run by Uniting Church Homes. It is purely state funded; there is no Commonwealth decision about the future of that program. I understand the current funding arrangement ends at the end of December this year. Again, that is a decision of the state government.

Senator SIEWERT—So the state government have wound back their funding for the program.

Mr Broadhead—Yes.

Senator SIEWERT—But the Commonwealth has not.

Mr Broadhead—No.

Senator SIEWERT—Because you fund the state—

Mr Broadhead—We fund the state to do transition care but we do not fund the state to do care awaiting placement.

Ms Podesta—In fact, our state office has already commenced discussions with the service about possible service models and options that they may wish to pursue with us, potentially in partnership with other providers. We understand the record of this provider and we know that, by and large, they potentially have something to offer. So there are good, positive, constructive discussions happening at our state office level with this provider.

Senator SIEWERT—Thank you. That is much appreciated.

Senator CAROL BROWN—I am hoping you will be able to provide some updated information about what I think you called the Cradle Coast initiative. It is a pilot program in Tasmania.

Dr Cullen—The Cradle Coast project, which is the term we refer to it as. In January this year, Minister Elliot agreed to support a proposal from care providers on the Cradle Coast area in Tasmania for the development of models to strengthen aged care services in that area. The department has been working with representatives of care providers on the Cradle Coast to clearly define the scope of that work. We have committed funding of $150,000 for a scoping project to be undertaken by that consortium. That project commenced on 7 September this year, and will be completed by 30 June next year.

Senator CAROL BROWN—And the project was recently widened to allow providers from outside the region, the north-west coast region, to come on board if they wish?

Dr Cullen—Indeed. The project has a particular emphasis on the Cradle Coast region, but all providers in Tasmania are able to join in the project and benefit from the learnings that will come from the project. My understanding is that the consortium intends to advertise this weekend for the consultant to undertake the project for them.

Senator CAROL BROWN—I know it is early days since it was opened up for other providers around Tasmania, but do you have any indication of the interest?

Dr Cullen—I do not, except to say that we opened it because there was interest from other providers.

Senator CAROL BROWN—I know ACST warmly welcomed the opening up of the project.

Dr Cullen—Yes, correct.

Senator CAROL BROWN—So what happens after 30 June next year?

Dr Cullen—The project is essentially designed to help the industry in that region, and in all of the Tasmania, which faces particular issues about a large number of smaller providers rather than being structured in a way similar to other parts of the country. It is to help them discover ways in which they may be able to better work together: joined up staffing arrangements, joined up training arrangements, common procurement arrangements. Once the scoping project has worked those things out, it will be up to the consortium to then work out how they want to arrange their own business in order to take advantage of the benefits which the scoping project identifies.

Senator CAROL BROWN—Will there be discussions with the consortium? I am trying to work out how the ACST, the peak body in Tasmania, might fit into the consortium. Have they got a representative on the committee?

Dr Cullen—I will have to take that on notice. I know this department has a representative and the Tasmanian department has a representative as well as providers, but I will take on notice whether the peak body itself or just providers are represented.

Senator CAROL BROWN—Thank you.

Senator FIFIELD—At the budget estimates we had a discussion about the transition from the Continence Aids Assistance Scheme to the Continence Aids Payment Scheme. You might recall that.

Ms Halton—You asking about continence? Yes, I do.

Senator FIFIELD—It was a budget announcement, and essentially it is moving from a sole provider system to one where individuals can source the aids that they need from a range of sources. The contract for Intouch Direct, who were the sole provider, expired at the end of June 2009. Is that right?

Ms Bromley—It was extended at June 2009 for the transition period to 30 June 2010.

Senator FIFIELD—Are the new arrangements intended to come in on 1 January next year?

Ms Bromley—No, 1 July.

Senator FIFIELD—At the moment, the 58,000-odd people under the scheme are still receiving their aids from Intouch?

Ms Podesta—There are actually 64,000 clients, and, yes, they are.

Senator FIFIELD—So there has been no change for those people as yet?

Ms Bromley—No.

Senator FIFIELD—When we last met, because this was a budget announcement there had not been the opportunity to have consultations with the stakeholder groups. Can you take me through what consultations have taken place to date?

Ms Bromley—Yes. We have been working with Medicare Australia on transition activities for the program to go from a subsidy program to a payment program. A lot of the activities undertaken in the past couple of months have been about administrative systems to make sure that the payment systems, business rules, IT systems, data transfer, that stuff are in place so that the scheme can work immediately from 1 July next year. So we have worked with Medicare Australia and we have provided business rules for the new program so that Medicare can build an IT system that will make the payment directly to clients. We have developed service arrangements for the administration. There is also a letter being sent to all current clients of the scheme. That letter reassures them that that they do not need to reapply; if they are currently a CAAS client they will be transferred to the new scheme. It also let them know that they would be receiving correspondence from Medicare Australia and what they would need to do so that they did not first get a letter from Medicare Australia saying, 'Give us your bank account details please'. The letter is letting them know some of the things they will need to do in the coming months.

We are also going through the process of getting a provider on board to do information sessions for health workforce, for consumers, for the industry. That is likely to be happening in the coming couple of months. It is probable those information sessions will start early next year. However, that does not mean we have not provided information to date. We do have a website that has questions and answers on it. We have a 1-800 information line. The Continence Foundation of Australia runs a 1-800 number for us, the continence helpline, and there have been quite a number of questions come through there.

Ms Podesta—Basically there has been a system build and administered properly, an information letter to current clients so that they know what is happening, and more detailed information sessions are being planned now for health professionals and consumer organisations.

Ms Bromley—And the transition also includes a range of activities that we are undertaking with the current provider: the transfer of all CAAS records and databases back to the department and how that will be managed, destruction of the records subsequent to that, all of those sorts of things.

Senator FIFIELD—Okay, but have there actually been consultations with organisations like Australian Nurses for Continence, actual stakeholder groups, as opposed to people who will be delivering elements of the system?

Ms Bromley—Not directly. We have had correspondence with a number of those groups. Under the National Continence Management Strategy we also have a continence management advisory group, which has a number of representatives from different organisations. That group is going to be meeting shortly. We will be receiving advice from members of that group as to what specific information materials and other activities we can undertake with the professions.

Senator FIFIELD—Would you be able to table or provide a copy of the letter that has gone out to current clients?

Ms Bromley—Most certainly. Yes.

Senator FIFIELD—That would be useful. Also, I think—and correct me if I am wrong—Intouch currently provide a continence aids assistance help line as part of their contract.

Ms Bromley—As part of their contract they have people who assist in advising on products. They do have a health professional on the team. The telephone line to Intouch has trained advisers about continence products, yes.

Senator FIFIELD—It was not clear at the last estimates whether there would be an equivalent service, an equivalent helpline, provided in some form. Has a decision been taken in relation to that?

Ms Bromley—The Continence Foundation of Australia is funded under the National Continence Management Strategy, which is a complementary program. It has a 1800 number. It will continue. We have a 1800 number policy line into the department for people who wish to ask specific questions about the program. Medicare Australia will also have a 1800 number for the scheme.

Senator FIFIELD—The level of advice and service as to what aids might be appropriate for an individual in their particular circumstance, which is currently provided by the Intouch helpline, will be provided by those other lines?

Ms Bromley—It will be provided by the Continence Foundation of Australia—

Senator FIFIELD—which is already there.

Ms Bromley—and other providers.

Senator FIFIELD—What does the Intouch line do that that one does not?

Ms Bromley—Intouch currently has the contract to provide continence aids to some 60,000 people. As part of their model of business, they have a range of people who will provide advice on continence products. When the continence payment comes into effect, there will be a range of other continence providers who do have a similar—can I say—business model and will have similar advisers on their teams.

Senator FIFIELD—One of the issues from last time was the issue of postage or freight.

Ms Bromley—Freight.

Senator FIFIELD—Under the current scheme, clients get up to four deliveries a year paid for by the Commonwealth. At that time we asked if it was possible to break down from the $10.7 million in administrative savings the component that was postage. At the time you were not able to do that. Have you had any success since then?

Ms Bromley—In terms of administrative components, the current contract with Intouch has a range of administrative activities that they undertake for us.

Senator FIFIELD—Freighting?

Ms Bromley—Freight is actually—

Senator FIFIELD—Or postage or however you want to—

Ms Bromley—Postage and freight are two separate things.

Senator FIFIELD—I mean that which gets it from A to B.

Ms Podesta—We are not being disingenuous, Senator. We just want to be precise.

Ms Bromley—You are asking for the cost of freight?

Senator FIFIELD—I am asking for the cost of freight, postage—that is, I am asking for the cost of that which is reimbursed and which an individual can get four times a year.

Ms Podesta—We might have to take that on notice, because it is quite specific. You are asking us the cost of postage, the cost of freight.

Senator FIFIELD—There is an entitlement for an individual to receive up to four deliveries a year. I do not know whether that is with a stamp on it or whether you use some other sort of freight service, but the individual gets that reimbursed. Is that right? Or do they not have to expend it in the first place? It is just a cost that is covered for them.

Ms Bromley—That is correct.

Senator FIFIELD—Now, as a matter of logic, that is a cost they will have to bear, given that it is not an entitlement they have anymore. I am endeavouring to establish what that possible cost is. I know it is not comparing like with like, because people might go here or there, they might jump in their car or they might do any range of things. But it would be an interesting and useful number to have.

Senator Ludwig—Who bears the cost? The person who is obtaining the product does not seem to bear the cost. But let me be clear about this. Maybe I will go through a couple of things. It might have got lost in the wash in the questioning.

Senator FIFIELD—I can explain what it is I am asking, if that would be of assistance.

Senator Ludwig—In terms of the scheme, it will continue to be administered in the same way until 30 June 2010. A letter about the changes has already been sent to customers. More information about the changes will be available to clients and health professionals in the coming months. Importantly, customers will not be required to reapply for the new scheme. It is about ensuring that the changes will bring increased flexibility for consumers and choice for consumers—

Senator FIFIELD—I know this.

Senator Ludwig—to be able to access the best value and most appropriate products for their individual needs at locations and retailers.

Senator FIFIELD—I appreciate that.

Senator Ludwig—Are you—

Senator FIFIELD—But there is a fundamental difference between the new scheme and the old scheme.

Senator Ludwig—The new scheme is providing choice for consumers.

Senator FIFIELD—I appreciate that. That is not my question.

Senator Ludwig—Are you against choice?

Senator FIFIELD—Sorry?

Senator Ludwig—Are you against choice?

Senator FIFIELD—No, I am not against choice. There is no inconsistency between choice and having a postage and freight cost covered, which currently is. At the moment, a person could get on the phone to Intouch and say, 'Four times a year deliver this to my house.' In the future, they could go to another firm or they might go to four different firms and ask for the same range of materials to be delivered four times a year.

Senator Ludwig—Or their local chemist or their local retailer—

Senator FIFIELD—But the difference is that at the moment that cost is covered by the Commonwealth and that in the future it will not be. There will be a new cost, an additional cost, to a number of clients.

Senator Ludwig—Sorry. Now I understand your point. I am not sure that holds up in the market. I take it you are not into a—

Senator FIFIELD—I am just talking about people's hip pockets. I am just talking about people having to put their hands in their pockets.

Senator Ludwig—No, no. If you move from one sole provider and you allow a choice in the market, it generally creates—and I suspect this is what is behind it, but correct me if I am wrong—an ability for competition to come in. It also provides the customers with the flexibility of seeking individual types of outcomes that they may want to engage in to provide them with the money to be able to choose that and to go to local retailers and fulfil their requirements. A whole range of things open up, which then—in a general sense, I would have thought, with competition in the marketplace—will also ensure that there is not only choice amongst the types of products people might want to access but also a greater focus on competition, which generally means there is price competitiveness. All of those things, as I understand them—plus others, I suspect—probably underpin the argument for why we are moving to a scheme. I was failing to understand why you thought that that would not happen.

Senator FIFIELD—I am not saying that will not happen.

Senator Ludwig—We are on the same page at least.

Senator FIFIELD—I am saying that the subsidy under the old scheme is $479.40. The money they will be entitled to to purchase products will still be $479.40.

Ms Bromley—Plus indexation.

Senator FIFIELD—Plus indexation.

Senator Ludwig—I have $489.95.

Ms Bromley—It is $489.95.

Senator FIFIELD—Okay. It has gone up. I probably missed the last indexation increase. It will be the same indexed arrangement. But people can get four free deliveries a year, and they will not be able to in the future. My question is, simply: what is the cost of those deliveries each year? Whether they are delivered by postage or freight, what is the cost to the Commonwealth? It will not give us a perfect indication of how much additional money clients will be up for, but it will give us some sort of indication.

Ms Podesta—We will take that on notice and provide you with the information that is in the contract with Intouch at the moment for the allocation that is made for postage and freight. I would draw your attention, though, to this. We will not be able to tell you how much that is for four mail-outs per year. It will be a total.

Senator FIFIELD—That is fine. Just the aggregate for the year will be fine. Also, how many individuals in a year seek to have their deliveries—I guess they have to be delivered that way?

Ms Bromley—It does currently, yes. People can elect to have one delivery or—

Senator FIFIELD—Yes, that is right, because they cannot go to Intouch's local shop and get it.

Ms Halton—That is precisely the point. Under this arrangement they can have, dare I say, a more personal relationship with their provider in the most professional sense.

The **Senator FIFIELD**—That is right, but they may well live in a remote or regional area and have no option but to still receive their aids by post. They may be in a situation where they find it difficult to get out of the house. So they may still receive it by post.

Senator Ludwig—For all of those reasons it just tells me that when you provide a broader opening of the market to either specialists or retailers then it will increase choice. I think that is very important. You will also see greater value for money for consumers. Rather than just simply one provider four times a year, they may be able to work through providers online for regional and remote. They may have retailers who are close who they already deal with for a range of other products to supply of through. The other area, of course, is that if the contract does provide for an amount for freight, it would be a lump sum, I suspect. But I would rather we take that on notice. But I am not sure that is a good indicia of how you would compare apples with apples; I think you are trying to compare apples with pears.

Ms Halton—There are too many metaphors in here.

Senator LUDWIG—What more concerns me is your lack of choice.

Senator FIFIELD—That is the difficult business we are in—trying to make comparisons. We do the best we can on the information that we are given. If that information could be provided, which was difficult to ascertain—in fact, was not ascertained last estimates—then

that would be helpful. Chair, in the interests of time, I will leave it there. Senator Cormann will put that on notice.

CHAIR—There will be quite a number of questions put on notice.

Senator ADAMS—I have questions on the nursing home dental initiative, whoever that belongs to. What progress has been made in implementing the $3 million allocated to the nursing home dental initiative?

Ms Nicholls—We are well on the way in relation to this plan in terms of organising for both the training and for the preparation of the products—the training kit that needs to go with it. We advertised for the training component. The applications closed on 11 September. We are in the process of finalising the procurement for that, so we would hope to be in a position to very shortly have contracts in place for the training. We are also in the process of negotiating the contracts for the delivery of the training kit that will go with the training.

Senator ADAMS—I could not find any mention of this particular program in the 2009-10 budget papers. Is that $3 million sitting there waiting for your program? I could not find it anywhere.

Ms Smith—We have in the existing program called EBPRACP—Encouraging Best Practice in Residential Aged Care—which is a program that can be used to fund a range of initiatives to improve quality in residential aged care.

Senator ADAMS—So that is where the money is coming from?

Ms Smith—That is the funding source, yes.

Senator ADAMS—Do you believe that this initiative will provide sufficient expertise to deliver oral hygiene services to frail and often demented residents?

Ms Nicholls—The project builds on a piece of work that was undertaken a number of years ago which looked at the skills of GPs and registered nurses in delivering health assessments in aged-care homes and then moved to look at what were the necessary skills to ensure that care workers in aged-care homes could provide the appropriate basic daily oral and dental hygiene for residents, including residents with dementia.

We have been funding that project to look at how you could provide skills and support the staff in aged-care homes to deliver that care through one of the Encouraging Better Practice in Residential Aged Care projects, and the training that we are rolling out is building on that package, which has been very successful.

Ms Smith—That is a project that is very successful in South Australia. It has been very successful We would be happy to give you some information on notice about that.

Senator ADAMS—That would be good if I could have that. Thank you. I have another quick question.

CHAIR—This is being put on notice, Senator Adams. Ask your question and it will be put on notice.

Senator ADAMS—When is the government going to update the Government Directory of Services for Older People? This was last done in 2007 and it is quite out of date.

Senator Ludwig—We will take that on notice and get back to you.

Senator ADAMS—I have just one more question on notice. When I was asking about the bed licences before, I asked just about operational places. I would like to know the total of bed licences handed back since 1 March 2009, and that includes all bed licences, not just operational places.

Ms Halton—Okay, yes.

CHAIR—Do we have any clarifications on questions on aged care and population?

Ms Podesta—We have one clarification. In regard to the question of the Cradle Coast project in Tasmania, Aged and Community Services Tasmania is part of the steering committee.

CHAIR—Thank you very much. We are now going to move to outcome 13, Acute Care. Again I put my apologies on record for the personnel from the Aged Care Standards and Accreditation Agency. We were told you would be required, but we now find that the questions are not there. I wish to put my personal apologies to you. Depending on time with acute care, we may extend this session until 12.45. Senator Back, I believe you have a question on acute care. I am just waiting to see whether Professor Calder has anybody else who is coming with her to the table.

Senator BACK—My question is on whooping cough, which may not be in the scope of the three areas.

CHAIR—It is not in acute care, Ms Halton. I would say population health.

Ms Halton—Yes, most likely.

Senator BACK—Population health?

Ms Halton—Give me a précis of your question, Senator Back.

CHAIR—Senator Back, why don't you give the question and then we can clarify where it fits.

Senator LUDWIG—We can then take it on notice or find the location.

Senator BACK—I have a range of questions relating to the increased incidence of whooping cough in adults, particularly older adults, and reasons why, numbers, distribution et cetera?

Ms Halton—It has recently moved within the department. I just need to confirm whether it has moved program or not. When we know that we will come back to you.

CHAIR—The one thing we do know is that it is not acute care.

Ms Halton—It is not acute care. That I am completely confident about.

Senator BACK—It is for the poor people who are suffering.

CHAIR—Yes. I take it that we are going to Senator Cormann to start in this area.

Senator CORMANN—I have questions in relation to the pre-election commitment to spend $600 million in an elective surgery reduction strategy. We have previously discussed this. You will be aware of the AMA Public Hospital Report Card 2009, which indicated that

there was no evidence that that particular strategy had actually worked to reduce waiting times were waiting lists. As I understand it, $150 million was allocated in the first financial year, 2007-08—that is in additional services; and $150 million was allocated in 2008-09 for systems and process improvements. What I am interested in is, one, what has been happening with that 2008-09 allocation and, secondly, what the intentions are in relation to the $300 million which was subject to performance targets being met by various states and territories?

Prof. Calder—The second stage of the elective surgery waiting list program is a distribution of funds to the states for the development of new capacity or the addition of new equipment. The third stage, the $300 million that you referred to, is to again target waiting lists, particularly focusing on longer-wait patients. The process of negotiation for that stage is being concluded at the moment.

Senator CORMANN—So, at this stage, the only money out of that $600 million that has been allocated to additional services is the $150 million that was allocated in January 2008—is that right?

Prof. Calder—No—there are two lots of $150 million.

Senator CORMANN—The second lot is not for services, it is for systems improvement.

Prof. Calder—That is true.

Senator CORMANN—So, let me ask again: the only money that has been allocated to additional services, in terms of additional elective surgery services, is $150 million, which was allocated in January 2008?

Prof. Calder—That is correct.

Senator CORMANN—In terms of the $300 million, which should be available for the 2009-10 and 2010-11 period, have the states and territories been given any indication as to what performance targets they have to meet in order to be able to qualify for that funding?

Prof. Calder—We are concluding the negotiations on that at the moment, and we will then provide advice to the minister.

Senator CORMANN—When you say you are concluding negotiations at the moment, what do you mean? There was a commitment that in 2009-10 and 2010-11 the $300 million would be made available to states that met certain targets. Now that we are looking at 2009-10, presumably the states should know by now what they are aiming for to be able to qualify for that.

Prof. Calder—Stage 3 has had to take into account the achievements in stage 1, so there has been some further discussion about how to apply the new funds to get greater stretch in outcomes where that is appropriate.

Senator CORMANN—I am just reading from the 2008-09 budget papers—Budget Paper No. 2, page 211—and what it says is:

A further $300.0 million will be available in incentive payments to States and Territories that meet elective surgery waiting list reduction targets.

Surely, you would have to have an indication as to what those waiting list reduction targets are so that individual states and territories know what they have to do to meet those targets.

Prof. Calder—You would be aware, Senator, that in stage 1 we saw a considerable increase in the expected targets. Some states have in fact been able to review the targets that they would like to put forward for stage 3 on the basis of that.

Senator CORMANN—The thing is that the IAHW report indicated that average waiting times for elective surgery have actually blown out by a further two days, from 34 to 36 days. We have the AMA public hospital report which says that, if anything, things are worse now, not better. But you have the $300 million sitting there, which is going to be available to those states that meet elective surgery waiting list reduction targets. I assume that nobody would have been able to meet an elective surgery waiting list reduction target. Is any state performing better than others in terms of achieving elective surgery reduction targets?

Prof. Calder—States and territories have performed in different ways. For example, New South Wales has removed the long-waits from their list completely. Others have done variously well against that target.

Senator CORMANN—When you say they have removed the long waits from their lists completely, what does that mean?

Prof. Calder—At the last point of reporting they had zero people waiting for longer than clinically recommended.

Senator CORMANN—Is that because they removed them from the lists or because they are no longer waiting?

Prof. Calder—No—because of their increased throughput target in that area.

Senator BOYCE—But New South Wales included dental surgery treatment in their list, didn't they?

Prof. Calder—Can I check on that, Senator?

Senator BOYCE—No-one else did and, as I understand it, they included dental surgery treatment amongst their additional elective surgery procedures that went on the waiting list. The point is that there is evidence from the Auditor-General in Victoria that the lists were manipulated and there have been concerns expressed in New South Wales and South Australia that the lists are being manipulated by the states. So what trust can you possibly have in the information you are being given?

Prof. Calder—The information I just gave on the longer-wait patients in New South Wales was on those who were waiting longer than clinically recommended. They reduced that to zero. Overall, in their elective surgery list, they include dental patients because they regard them as having elective surgery.

Senator CORMANN—You said, 'different states achieve these things in different ways.' Are you saying that different states have been given different elective surgery waiting list reduction targets or are you taking a uniform approach across Australia where states that perform better will get additional incentives compared to those that do not perform as well?

Prof. Calder—In stage 1 each state and territory had a particular target which was agreed. For stage 3 a particular target is being agreed.

Senator CORMANN—That is different from the way it is written up in the budget though, isn't it? The way it is written up in the 2008-09 budget is as if everybody gets a share of the initial $150 million allocation, which for my home state of Western Australia was about $15 million. Out of a multibillion dollar health budget it is a very, very small amount. The way the second part is written says, 'A further $300 million will be available in incentive payments to states and territories that meet elective surgery waiting list reduction targets.' So the implication is that some states will qualify and others will not and presumably the states would had have to have known by now what the targets were that they were aiming for.

Prof. Calder—Senator, as I said, we are in the process of finalising negotiations on the new targets given that in the first stage the targets were set in agreement with the states and all of them exceeded those targets. For example, the Western Australian situation that you quoted, $15.4 million, the target agreed was 2,720 additional elective surgery procedures and the achievement was 3,727.

Senator CORMANN—What you have just described is not an elective surgery waiting list reduction target, it is an additional services target. That is very different.

Prof. Calder—A throughput target. In the third stage because of this, states and territories are discussing with us how they will target the waiting lists given that they have had increased throughput.

Senator CORMANN—If you are only giving them the target now, presumably you have to give them some time to work towards achieving that target. So when does the money actually become available? Does it become available once you are satisfied that they have achieved an elective surgery waiting list reduction target or will it be another throughput target? What sort of time frame are we talking about before that $300 million will actually be spent?

Prof. Calder—This part of the program is to conclude by December 2010 and the funds will flow once the agreement has been signed between the states and territories and ourselves.

Senator CORMANN—So there will be no additional funds until 1 July 2010.

Prof. Calder—No. The program is to conclude by the end of December 2010. The funds will flow through the period once the national partnership agreement for the agreed targets is signed.

Senator CORMANN—When will the first money out of that $300 million be spent?

Prof. Calder—That will be dependent on when a national partnership agreement is signed.

Senator BOYCE—Can we go back as I want to collect some of that data you have mentioned. The first $150 million was for 25,000 elective surgery procedures. How many were actually carried out?

Prof. Calder—There were 41,584 carried out.

Senator BOYCE—That is the figure that the health minister and the Prime Minister used. How do you actually collect that data? Where did it come from?

Prof. Calder—States and territories agreed to report on their performance through the process of stage 1.

Senator BOYCE—Could we have a list of the expenditure in each state and the number of elective surgery procedures undertaken in each state, on notice, thank you?

Prof. Calder—We can supply that.

Senator BOYCE—Is there an agreed definition of an elective surgery procedure; a nationally accepted definition of elective surgery procedure?

Prof. Calder—Yes, Senator, there is.

Senator BOYCE—There is. But it means that some states put dental in and other states do not.

Prof. Calder—The answer is that dental is included where it is so desired by the states and territories as an elective surgery procedure.

Senator BOYCE—I spoke earlier about the fact that the Victorian Auditor-General had suggested that the information had been manipulated by some hospitals and that concerns had been raised in New South Wales and South Australia about those figures. How do you know those figures are accurate?

Prof. Calder—We have had assurance from the states and territories about the accuracy of the data. Where data has been called into question, in particular in Victoria, there have been steps taken by the state to keep us informed of what they are doing to rectify the problem.

Senator BOYCE—What have they done to rectify the problem?

Prof. Calder—To summarise the advice that I have, Victoria's response was based on the Victorian Auditor-General releasing a report which indicated that access indicators were required to assist in identifying the full comprehensive data that was required but that there were systematic problems with the data that had been developed that needed to be rectified. They announced a range of reforms including removing a performance funding pool, independent hospital audits requiring patients to be notified of waiting list status changes and appointment of a delegate to two hospital boards where data issues had been identified.

Senator BOYCE—But that has not caused any change to the number of elective surgery procedures that are understood to have been done in Victoria?

Prof. Calder—Victoria are still clarifying their data and will be providing us with clean data at some point soon.

Senator BOYCE—So how do we know we had 41,580 if we do not know how many there were from Victoria?

Prof. Calder—There are two hospitals that are likely to have caused some difficulties with the numbers. We do not expect that to have changed the numbers substantially.

Senator BOYCE—On the basis of this, how have you checked the veracity of information from the other states?

Prof. Calder—We have a national partnership steering committee which meets regularly. The issues identified by the Victorian data were discussed. We have had assurances from all states and territories about the veracity of their data.

Senator BOYCE—If not for the Auditor-General's report, would you have been aware of the Victorian problem?

Prof. Calder—That is a hypothetical question.

Senator BOYCE—But it seems to me that we are asking the fox to look after the chicken coop in asking organisations that have presumably been called into question for potentially manipulating data to hold their hand on their heart and say, 'We promise our data is good.'

Prof. Calder—There has been, I think, widespread recognition that data on hospitals is not nationally consistent and needs a considerable amount of work. There has been a considerable investment in that, particularly through the activity based funding strategy that is in place and that is designed to ensure that we have nationally consistent and robust data into the future.

Senator BOYCE—I guess the question is: how far into the future? It may be simplistic of me not to understand how we can agree that we have a nationally consistent definition of elective surgery procedure and yet not be able to come up with a figure.

Prof. Calder—But we have a figure. We have some concerns about the source of some of that data, but it is a very small component of the overall source of the data. There was a very quick response to addressing the issues. We have a range of strategies in place to increase the robustness of national hospital data.

Senator BOYCE—When would you anticipate that you would have the actual number of elective surgery procedures that were done—the additional information?

Prof. Calder—We continue to get routine reports from the states as required under the national partnership agreement and we will have reporting under stage 3.

Senator BOYCE—You said New South Wales had no waiting list—is that correct?

Prof. Calder—No overdue patients by the end of stage 1.

Senator BOYCE—And is the definition of 'overdue' a nationally consistent definition?

Prof. Calder—It is those patients who have waited longer than clinically recommended times for the procedure for which they are scheduled.

Senator BOYCE—The clinical recommendation according to each surgery—

Prof. Calder—Varies according to the procedure, yes.

Senator BOYCE—But is that nationally consistent?

Prof. Calder—Are the clinical recommendations about waiting times nationally consistent—is that what you are asking me?

Senator BOYCE—Yes.

Prof. Calder—By and large I think that is the case, but I am not the expert. I am sorry, we might have to take that on notice.

Senator BOYCE—If you could, because there is a lot of public of disquiet at what they perceive to be manipulation of waiting lists. We have had the situation where, whilst something looks great, the definition has shifted ground completely from underneath alleged wonderful activity. For example, Queensland has for many years had the problem of people

being on a secret waiting list waiting to get on the waiting list, which keeps them off the real waiting list. What I am trying to get to is how transparent the information is, and the only way I see that happening is with nationally consistent definitions.

Ms Halton—This is a matter which is not peculiar to Australia. You are probably aware there is significant international literature—

Senator BOYCE—But it is Australia's waiting lists I am most interested in, Ms Halton.

Ms Halton—Yes, and indeed I understand that. I think there is an understanding amongst the state colleagues that greater comparability and robustness in respect of the data is important. As Professor Calder has indicated, in the Victorian case the Auditor has taken that very seriously. So I would not underestimate the fact that people understand that this needs to be managed appropriately. The problem we all have is that data collection systems right through very complicated health services do take some time to change. But I think everyone is absolutely cognisant of the need for comparability and accountability.

Senator BOYCE—Good. I am glad to hear that, Ms Halton. Could you give me a list of the waiting lists for each state, following that $150 million phase 1expenditure.

Prof. Calder—It is publicly available, Senator; but, yes, we can provide a list.

Senator Ludwig—It is on our website.

Senator BOYCE—It is on the website. How robust is that list, in your view?

Prof. Calder—We have had that discussion, I think, Senator. It is based on the states and territories assuring us of the veracity of their data.

Senator BOYCE—So you are relying on the elective surgery data to give you the second set of data, on the waiting lists; is that correct?

Prof. Calder—Yes.

Senator BOYCE—Has the federal department itself undertaken any work on the information about the waiting lists to ascertain if it is correct?

Prof. Calder—The process has been a discussion process under the partnership agreement with states and territories on developing the data and developing the data reporting requirements. So, to the extent that we are working with the states and territories, the answer is yes.

Senator BOYCE—Do you examine the states' methodologies in this area?

Prof. Calder—We do look at the methodologies that the states use, but I will ask one of my colleagues to give you some more information on that.

Dr Martin—Some degree of data quality assessment can be done at the Commonwealth level, and it is done, based on the submissions to us by the states, and face validity tests can be done and are done. But they cannot be guaranteed to identify every error, whether the error is deliberate or accidental. So, yes, the Commonwealth can do some data checking, but it is limited because it cannot track all the way back to the source.

Senator BOYCE—If you find methodologies that you consider inadequate or wrong, what happens then?

Dr Martin—Conversations with our state colleagues.

Senator BOYCE—And how many of those have occurred, Dr Martin?

Dr Martin—I have not enumerated them, but they do occur. There are also formal meeting arrangements, fora in which data quality issues can be discussed and are in fact discussed.

Senator BOYCE—Can you give us an example?

Dr Martin—Yes. They were many long and detailed discussions with state colleagues, as I remember it, in the formulation of the Elective Surgery Waiting List Reduction Plan and the reporting requirements, on the consideration of precisely how they were to be reported and on the data issues. The discussions are held often and they are both formal and informal.

Senator BOYCE—And that would have preceded the—

Dr Martin—Preceded, and are still ongoing. There is an ongoing arrangement.

Senator BOYCE—What I am getting at is that the behaviour that led to the Auditor-General's report in Victoria would have occurred after you have had those discussions with the Victorian—

Ms Halton—Certainly after we commenced them, yes.

Senator BOYCE—So there is really no way of ascertaining whether anyone is playing politics with the list at source.

Ms Halton—Not definitively.

Senator BOYCE—Thank you.

Senator Ludwig—I am not clear about the time frame in which they collected the data for the Victorian report. Sorry to be asking the question, but what was the time line, just so that we are comparing apples with apples?

Senator BOYCE—I am not sure if I have that figure with me.

Senator Ludwig—We always have to be careful with that. Part of the question you raised was: when was the Victorian report—

Senator BOYCE—I was asking whether the behaviour had occurred post the report, and the answer from the officer was yes.

Senator Ludwig—But what is important, I think, is whether the data that was collected for that report related to that period or whether it was post or before that period. Sometimes that gets missed in all of this. Look at the significant reform: the four-year elective surgery waiting list reduction plan, the performance reporting, the quarterly plan reporting. States and territories are also looking at how they will provide this data at the end of each quarter. We are looking at the performance indicators for the program that cut across a range of areas, such as the number of additional patients receiving elective surgery. There is a lot of work being done on ensuring that we are addressing elective surgery waiting lists and we are moving with the states and territories to address performance indicators. It seems that there is a hiccup in relation to some figures that is being addressed quite quickly. This is unprecedented compared to what has been done in the past. But I do encourage your questions to ensure that it continues to work effectively.

Senator BOYCE—And so that we do not have too many more hiccups.

Senator Ludwig—Well, a hiccup in the figures.

CHAIR—Any further questions on acute care will have to go on notice.

Proceedings suspended from 12.32 pm to 1.32 pm

CHAIR—We will now move to outcome 14, which is Biosecurity and Emergency Response.

Senator BACK—I would like to kick off with the media release yesterday by the health minister and her associates on the easing up of restrictions and the allowance for the importation of beef from countries that are known to have or have had the bovine spongiform encephalopathy. The media release was put out yesterday. Did the department provide advice to the minister in advance of this decision being made?

Ms Murnane—Yes, we did.

Senator BACK—Can I ask what that advice was?

Ms Murnane—Yes. On the basis of the expert health advice we received from Professor John Mathews—and Professor Bishop will speak more about that—we advised that there was not a health issue that would mean that we had to keep exactly the same rules as had been in place since the advent of variant CJD. However, we did say that Professor Mathews had also recommended that the opening up of trade from countries who may have had some cases of BSE in cows would be subject to those countries putting in place certain requirements that would then be audited by FSANZ. That is essentially the situation.

Senator BACK—What other departments cooperated in providing advice to the minister or ministers in advance of this decision?

Ms Murnane—The Department of Foreign Affairs and Trade—mainly the trade part of that—and the Department of Agriculture, Forestry and Fisheries were involved.

Senator BACK—As I understand it, the media release speaks about there being appropriate risk mitigation strategies in place. Could you describe to us what advice the department may have given in terms of what constitutes those risk mitigation strategies?

Ms Murnane—Those risk mitigation strategies are the protocols and procedures that will be in place in relation to the importation of beef products. As you know, there is no live beef importation into Australia allowed anyway. They relate to the importation of beef products from countries that have had, in the past, a downer cow that was, on autopsy, shown to have BSE. These arrangements are quite detailed and we were hoping to have FSANZ, Food Standards Australia and New Zealand, here when we discussed them. That is scheduled for 9.20 tonight.

Senator BACK—In the unconscionable situation that we might in fact get this condition—and you speak of a downer cow—would one of those risk mitigation strategies be a requirement that the animal or farm of origin was identified so that we could get a confirmation of that circumstance? Is that the sort of risk mitigation that you are speaking about?

Ms Murnane—There are two parts to this. There is the part that would be primarily handled by trade and DAFF. There is another part that would be handled by this portfolio through Food Standards Australia and New Zealand in ensuring that food product that was imported into Australia was free of BSE. In a sense, the decision by government is to repudiate the causal connection that had been implicit before that, if you had a downer cow that was established to have BSE, there was then likely to be, or you could not exclude, BSE presence in imported food product from that country. What has essentially happened is that that nexus has been broken and it has been said that one cow with BSE does not inexorably constitute a risk that food product imported into Australia would carry BSE that would in humans become variant CJD.

I do not know whether DAFF has had its estimates hearing yet, but, in terms of the agriculture and trade side and the considerations that were given there, I can say there were considerations from those two portfolios. But I cannot answer questions on that and I would not like to speculate because it is simply not an area that we have policy responsibility for.

Senator BACK—We will pursue those. You are correct in saying that those particular elements of DAFF have not been addressed, but they will be in estimates. Dr Bishop, I understand that, of the 212 people who contracted variant CJD in the UK following 2001, 207 died and five survived.

Prof. Bishop—It is a fatal disease in most individuals. I think the important aspect of this is, firstly, to understand the risk. We have the expert advice on that. That advice is available to you in terms of that expert report. I would refer you to it, and obviously you could then take that advice and look at it yourself. Secondly, that report was reviewed by the committee that is standing on this particular disease issue by the NHMRC. They reviewed the science behind it—not the policy but the science—and agreed with the science. We have two world experts on this—namely, Dr John Mathews and Dr Colin Masters, both of who are experts in this type of disease and its epidemiology. The advice in that report, as you will see, is that the risk to the population in Australia from any change that would allow countries to be assessed on the merits of the process leading up to the food chain was 'negligible'—that is the word in the report. The amount of risk had been quantified in that report, and you will see it there. I am just using information from the report. The report states that the risk is 40 million times greater than the risk of motor car accident in Australia. That is helpful in the sense of looking to see what level of risk we are talking about. Nothing is without any risk in these situations, of course.

It also makes the point that, if disease occurred in this country, by far the highest risk would be from people who were resident in the UK at the time when the epidemic was high. You will remember that the epidemic peaked in animals in about 1992, with a reported 37,000 cattle involved. The report for this year is six. While I think you could argue about whether the report represents all of the cattle that could be affected, that gives you some idea of the degree of the change in the epidemic.

As to the human epidemic that was seen in terms of the people who may have been exposed in the UK at that time, it is estimated that up to half of the population may have been exposed and, as a result, there was the number of deaths that we have been taking about. In

terms of an idea of risk around the medical side of things, that gives you an idea of scale and size.

Medical science has moved forward in understanding how this disease develops and how it propagates. I will talk a little bit about that, because it is relevant to, but not all in, this portfolio. The way the disease would develop is to do with the fact that, firstly, the meat and bonemeal is provided to the animal. That may be an infected meal. Therefore, that has been banned in some countries. That is one of the process issues that will be looked at. That is probably one of the most significant things: older cows—that is, those older than 30 months—the progeny of cows or cows in herds could be affected.

Finally, this disease resides mainly in the neurological system and in the tonsils and appendix, as you are aware. Again, banning those products is a large mitigation exercise before you get to anything else. One of the difficulties with this disease is understanding what the infective agent is, which I think you would be aware of. The important thing is that the rapid test for the prion is available and there is an active surveillance requirement under the guidelines of the World Organisation on Animal Health for active surveillance, testing and also passive surveillance. In other words, there is a requirement for the reporting of cows that might be affected.

They are the processes in detail and that is understanding how the disease might actually develop. Therefore, obviously the human would then need to eat it. The report comes out quite clearly in saying that it is to do with volume and exposure. There are examples in Spain where there is a lot of exposure in one family—eating a lot of the material I am talking about—where there is a higher likelihood of risk. With exposure to a product that has been tested and is a very small import into Australia, that risk can be quantified, and it has been quantified to the level that I and Dr John Matthews have quoted back to you. That is the medical background on which we felt, from a health perspective, we could develop an opinion.

Senator BACK—We will consider trade and other matters in another committee. From an emergency and biosecurity viewpoint, where do you see the most likely area of breakdown in the event that a country successfully applies and is allowed to import meat products? Where do you see the greatest risk to Australians, to our health and, of course, ultimately the health of our beef herd as well—well, not our beef herd but our reputation? We will leave that to one side. Where do you see the greatest opportunities for a breakdown or a failure in the surveillance systems that would allow this into our country?

Ms Murnane—As Professor Bishop said, that risk has been quantified and it is very low. It is almost infinitesimal.

Senator BACK—I understand that and I agree; thankfully it is. Where should we focus our attention, funding and effort to prevent this in the first place?

Ms Murnane—I would prefer that the food authority were here. I will go where angels fear to tread and just make this point. It would probably be in the requirements of the country in terms of what they were required to do with the running of their herds, the biosecurity around their abattoir and the autopsy practices that will be mandated. It would be a failure of one of those practices that then allowed some meat with BSE to get into the food chain. We

would then come to Professor Bishop's point again. What we have put in place there—and the food authority will have funds to do this—is inspection and assurance of the quality of practice in a country that has had or does have BSE present. We are not talking about vast herds of cows with BSE. What we are talking about is a number and we are also talking about time.

Senator BACK—Minister, I imagine there will be more than adequate funding following this decision to ensure into the long term that these funds and these resources will be available?

Senator Ludwig—As the representative of the minister, I can take that on notice. I think Professor Bishop has provided some information about the particular matter, but of course this evening we will hear from the relevant authority as well. It may be worth while discussing it there as well.

Senator BACK—I will leave the question of BSE now and move on to another area of biosecurity.

Senator HEFFERNAN—I have questions on BSE. Obviously what this is really all about, as Senator Back has pointed out, is lowering our herd status to the status of countries that have BSE. That is behind it all. It is driven by the trade department and Minister Crean's office. I have been backgrounded by everyone and I had a long discussion with Professor Mathews this morning. He indicated in his report that it is timely to reconsider the possibility that BSE can occasionally be transmitted to calves from milk from cows and so on. It will be America and Canada that will want to get cattle in here. Bear in mind that AMIC, which has ticked this off today, is dominated by Cagill's, Swift's, Nipon and Rangers Valley—all foreign companies that want to get our credentials. We are one of the only countries in the world that are BSE and foot and mouth free. We have an edge into Korea, Japan and places like that. Given that you have said there are going to be requirements that FSANZ will deal with protocols, if a country does not have national livestock identification, which a lot of countries do not, and there is no live test for BSE, how do you trace it?

Ms Murnane—I am just turning the pages here to see if I have the exact document that gives this, but I do not think I have because we are waiting for tonight to do this. The issue is that it is in the good biosecurity practices of the herds, the feed of the herds, the practices at the abattoirs and the absolute binding rule that every downer cow is autopsied. I am sorry. I do not have the detail of that with me.

Senator HEFFERNAN—Could we have the details of the actual protocols put forward to support this case?

Ms Murnane—We can table that, and FSANZ can talk about that in detail.

Senator HEFFERNAN—Surely full livestock traceability would be a minimum requirement?

Ms Murnane—Traceability—of the mixing of the downer cow?

Senator HEFFERNAN—Of the life's adventure of the animal.

Ms Murnane—Yes.

Senator HEFFERNAN—Countries that do not have full traceability would be ineligible?

Ms Murnane—There is a lot of detail in this. I would prefer not to venture into that area without having the full detail before me, but we will get the document and table it.

Senator HEFFERNAN—I will just put on the record that I have spoken to AMIC, beef processors, the Cattle Council and the Red Meat Advisory Council this morning regarding the processes. They all said that it has been a very clandestine operation to arrive at this decision within the industry and within the government. I am sorry to have to say that. They were sworn to secrecy with the government that these negotiations were going on. I spoke this morning to the various individuals—Steve Martin and the various officials. They all said to the government, as part of agreeing to this, that they wanted us to be consulted. Mr Justin Toohey told me this morning, 'Bill, the reason you weren't consulted was we knew you would disagree with us.' I think that is a disgrace.

Senator BACK—We will move on, but before doing so I have to endorse what Senator Heffernan has said. That is exactly the advice that has come back to me. I guess as somebody new into the Senate it is particularly disappointing that that would be the attitude taken. I would like to move on to an overview of swine flu. Presumably the pandemic must be now winding down. What is the current status? What were the mortalities? I would also like to ask a couple of questions about the vaccine, if I may.

Prof. Bishop—The main thrust of the pandemic lasted over around an 18-week period. We are now getting beyond that. In total 186 people have, sadly, died from the disease. Around 36,900 have been confirmed with the disease, noting that appropriately the testing regime that we put in place does not test everyone who actually ended up getting it. Around 4,886 people were hospitalised. Importantly, there were around 737 in intensive care. The Indigenous population were over-represented in the poor outcomes because they would harbour many of the chronic illnesses that are associated with poor outcomes from this disease.

I think the feeling was that it had a moderate impact on our population but, because of that percentage that is rather small but did leave a large number of people up the bad end of the spectrum, the intensive care units have reported that this was a much worse flu season than they would normally see. These are young people with viral pneumonia. I am happy to say, however, that the Australian innovation of using the ECMO, which is the heart-lung bypass approach, was able to salvage two-thirds of people who went onto that approach. That means that in fact, of these people who were unable to be ventilated and who were destined to die, two-thirds were salvaged with the recovering lung which you would expect from a viral pneumonia. So that is very good and it is very much an Australian innovation.

Senator BACK—Of the 186 who regrettably did pass away do you have any view as to the number you would confidently say that the primary cause of their demise was the actual H1N1 virus?

Prof. Bishop—We cannot really quantify that exactly. We will be doing some further work on that but the problem is of course that, when a person who has a chronic illness dies because their heart failure went out of control when they got an illness, those sorts of issues may never be resolved. But we will be providing as much information as possible to the parliament and also to the world as we understand more.

Senator BACK—I am sure there will be exhaustive evaluations et cetera. What was the outcome of cooperation between the Commonwealth and the states and were you satisfied with the level of cooperation at state health minister and department levels?

Ms Murnane—The answer to that is yes. We worked very effectively together. The Commonwealth actually does not have its own people on the ground on the front line. We rely on our colleagues in the states, led by their chief health officers, to organise that and we had a continual flow of information and things worked very smoothly.

Senator BACK—I am conscious of time. Very briefly on the question of the vaccine, what proportion of the vaccine that is now available do you think will be used here in Australia? My next question will be: what will be the fate of the vaccine that is unused?

Prof. Bishop—We cannot predict that. That would be a prediction. There was very good take-up initially. A lot of people were very interested in the vaccine. The reason that we think it is important is that, being a pandemic virus, it is unpredictable as to what is going to happen next, and I think I mentioned that last time I was here. Essentially we hope that the comfort scenario will occur, and that is that nothing will happen until the next flu season. But that is only one scenario.

The other one is that there are now an increasing number of infections in the Northern Hemisphere. They are running about twice the level of flu in the United States at the moment and we are concerned that there will be a second wave into this country. Alternatively, as in the US and the UK, there may be large or small outbreaks in various geographical areas throughout summer, which occurred in Manchester and London through their summer. I think the important thing is that we have urged people to consider those possibilities and not expect that, since flu and winter is over, this problem is over. We will be continuing to make that case with ongoing discussion with the population.

Senator BACK—To that extent, what is the shelf life of the vaccine?

Prof. Bishop—The TGA would normally allow a shelf life of 12 months, but it would then be extended. All of these vaccines have long shelf lives, but they are routinely given 12 months at initial registration.

Senator BACK—Could you take on notice what the state-by-state distribution of the vaccination has been? Has there been any difficulty as a result of the decision to go with a multidose bottle rather than a single-dose vial?

Prof. Bishop—The Australian government's advisory group ATAGI, the Australian Technical Advisory Group on Immunisation, and the Royal Australasian College of General Practitioners jointly worked to develop guidelines for the use of those vials, which will be used in all of the vaccination programs for this pandemic throughout the world. I do not believe there is any country not using them as their main vaccination vehicle. That has been part of regular pandemic planning. There has been no difficulty. In fact, we would have to say that general practitioners had always thought that they would manage this well and they have. So we are not aware of practical problems on the ground with its rollout at this point.

Senator BACK—My final question in this particular section relates to the spread of the swine flu now, not from animals to humans but from humans to pigs on the piggery in New

South Wales. Did the department have any role in that incident and what are the lessons learnt?

Ms Halton—Animals are not our business. I say that with some—

Senator BACK—I am going to move away from swine flu unless—

Ms Halton—I knew someone would say that.

Senator BACK—There is one health approach, but we will get onto that at some other time. Can I move on now to a topic that I have no doubt you would expect to come up: the recent outbreak of the Hendra virus in which, regrettably, a veterinarian in Queensland died. What role has the agency played in this recent Hendra outbreak?

Ms Bryant—The management of outbreaks on the ground is the responsibility of the jurisdictions. We do not have a direct role in the management of the present outbreak.

Senator BACK—Was the department consulted at all? Did the department have any influence or input?

Ms Goodspeed—Yes. The department, through its membership of Communicable Diseases Network of Australia and other jurisdictional committees, works through the jurisdictions to share information and to make sure that we have a picture of what is going on. We work with other departments as well. So it was really about gathering information and, where necessary, providing advice. But we were not required to do so through the Hendra outbreak. We were relying on our colleagues in Queensland.

Senator BACK—Is the department a signatory and a member of the World Health Organisation?

Ms Halton—Yes.

Senator BACK—In that capacity the department would support the One Health Initiative dealing with infectious diseases in humans and animals?

Ms Halton—The initiative that you refer to is given effect in different ways by different countries. Everyone ascribes to the general principles but the WHO has a series of high-level statements in that area, yes.

Senator BACK—Is the department's policy embracing of the one health approach in terms of its direction with infectious diseases, particularly new and emerging diseases?

Ms Halton—We do take a very real interest in those matters, yes.

Senator BACK—I was going to ask whether the department was aware of an international conference held last week in Queensland, but, since you opened it—

Ms Halton—You could say we take an interest in that!

Senator BACK—Certainly. For the information of colleagues, it was an international conference examining all aspects of the henipaviruses, which are a bat born series of viral diseases, of which Hendra is, of course, just one. Are you aware of the recommendations from that international conference last week?

Ms Murnane—I actually have not seen them yet. Professor Mackenzie has said he will send them to me but they have not yet arrived.

Senator BACK—Basically the symposium addressed itself to the importance of regional research and cooperation in this whole area. Of course we, as you know, examined instances of these bat-borne viral diseases in Australia, Malaysia, India and Bangladesh. I think it really emphasised the need for this. One of the key recommendations from this symposium was that there be the development of a Hendra vaccine for horses, bearing in mind of course the importance in terms of human health. Can you advise at this stage whether or not the department would pick this up or look favourably upon that recommendation?

Ms Murnane—I think that the vaccine for animals first is the heart of the matter here, but the actual issue of the vaccine for animals would need to be looked at—you as a veterinarian will appreciate this—by people who are specifically qualified in this area. But we do work closely with that department on diseases that have both an animal and human dimension.

Senator BACK—Which brings me to the Australian Biosecurity CRC on new and emerging diseases. You would be aware that funding is being withdrawn for that CRC?

Ms Murnane—Yes.

Senator BACK—From the human health side, given the critically important role that CRC has played, can you advise what direction the department would be recommending in terms of not losing the excellence of the outcomes of that particular CRC?

Ms Murnane—I did talk to you about the CRC. That is a competitive process and that decision was not made within this portfolio, and neither was anyone from this portfolio—actually that is wrong. I retract that straightaway because the CEO of the NHMRC was on the panel that assessed it. Nobody from the department was. But the nature of a CRC is that it is in a sense a linkage of a number of universities and other institutes of learning that cooperate on a subject. The fact that the hub of it, which was at Curtin University, does not get funding will not mean that work on these areas stops. Indeed, Professor Mackenzie has foreshadowed to me that there is a proposal he wants to talk about which involves coordinated information sharing and does not involve more funds.

I would also point to the fact that many of these zoonotic diseases and the arboroviruses are focused on our north, although they could come further south. There is, as you know, an agriculture veterinarian committee that links the northern states, the states that have top ends of Australia—WA, the Northern Territory and Queensland—into a committee. One of the things that we would like to do is to have a human disease version of that committee—that is, another committee focused on the way in which those diseases translate into human diseases to work in the first instance in the far north of our country to look at what can be done in countries to our north where animals and insects with these diseases are likely to come from.

As you probably know from the DAFF hearing, they conduct some sentinel work in PNG. We also conduct work in the Torres Strait and in PNG on the human health side. I would agree with you that this needs to be brought together. In particular, what we need to do is to bring together the work that is done by state jurisdictions in our far north, the work that is done by our department and the work that is done by DAFF and draw the relevant parts of the academic world into that. Professor Mackenzie is very keen to do that. That is something that we will be working with him on.

Senator BACK—I think you eloquently make the case for a continuation of a one-committee approach. Thank you very much for that summary. I am well aware of that particular process. The concern is that the benefits and the initiatives over time will be lost.

[2.06 pm]

CHAIR—We will move on to Outcome 11, which is mental health.

Senator BOYCE—I would like to start off by asking about the status of the National Action Plan on Mental Health that COAG signed off on in 2006.

Ms Hart—You asked about the COAG National Action Plan on Mental Health which started in 2006 and runs to 2011. I can tell you that implementation is fully underway on the plan. It contained some 17 Commonwealth measures that sat under the plan. I understand that the combined total of the state and territory measures was over 120 initiatives.

Senator BOYCE—They fell under the 17, didn't they?

Ms Hart—They were across a broad spectrum of areas. I do not have a full list of those with me but I can talk in detail about the 17 Commonwealth initiatives. They are jointly being implemented by our department, FaHCSIA and DEEWR. Our department is the lead agency for 12 of those 17 initiatives. They are being reported on two fronts. One is an annual report, which is a COAG requirement, which tracks progress across all jurisdictions in achieving the 12 key indicators that are measures of the successive reforms under that plan. To date there has been an annual report published which covers 2007 data and progress against indicators. It also includes jurisdiction by jurisdiction accounts of the progress made under each of the initiatives. The 2008 COAG implementation report went to health ministers on 4 September. It has been endorsed by health ministers and will now go to COAG for their endorsement. Once COAG has signed off on the report then it will be publicly released on the COAG website.

Senator BOYCE—Would you anticipate that that would be soon—before Christmas?

Ms Hart—I think that is the timetable. I can just check for you and see whether I have something in my notes about that.

Senator BOYCE—It is becoming fairly old data by the time it is released, is it not?

Ms Hart—There is a lag, given the range of data is collected across a very large number of initiatives.

Senator BOYCE—Is there any KPI around the timeliness of the reporting of the progress?

Ms Hart—The reporting of the progress is in line with the COAG decision to report annual progress.

Senator BOYCE—But not within six months of the end of the year or whatever?

Ms Hart—No, some of the data is only available after a financial year has concluded and then the data is validated, but I might add, though, that there is a report which covers the Commonwealth's components—the 17 initiatives I mentioned earlier that are on the mentalhealth.gov.au website—and it provides quite a lot of detail. It was put on the website last month, in September.

Senator BOYCE—Sorry, I had missed that.

Ms Hart—I can provide you with a copy of that or, as I said, it is available on the website. It provides the most up-to-date data on the Commonwealth initiatives—for example, in regard to the Better Access program it includes information up to 31 August 2009. Some data is available there that is highly current.

Senator BOYCE—Does that include a list of the 17 measures, who is responsible for them and expenditure to date?

Ms Hart—Yes, it identifies each of the measures and who is responsible. I am just checking to see whether they all include expenditure to date. They certainly have total amount allocated and I think for a number of them they do have expenditure to date, but that may not be uniform for all measures.

Senator BOYCE—Is the expenditure on these measures in line with the projections in the plan?

Ms Hart—I am not sure I could say that at the global level for the programs that I have responsibility for, because they do range over three agencies and even—

Senator BOYCE—Can you tell me whether the 12 that you have responsibility for are underspent or overspent?

Ms Hart—Yes. I look after the Better Access program, which is currently tracking within agreed forward estimates. I also look after Mental Health Services in Rural and Remote Areas, which is currently tracking, though we are in the process of renewing contracts for stage 1 of that. We are in the process of writing, making assessments and in a short time entering into new contracts for the 15 organisations in stage 1.

Senator BOYCE—That is to continue the services they have been delivering?

Ms Hart—To continue the services in those identified areas.

Senator BOYCE—So there would be no changes? They did not have to tender for this? These are three-year contracts being renewed?

Ms Hart—This is contracts being renewed. The only instance that might change continuation of service is if they raised any issues about their capacity to continue to provide services, but the intention is that those services will have a renewed and extended contract.

Senator BOYCE—Are there any other major ones within that 12?

Ms Hart—Yes, the other measure that I look after is the non-government organisations capacity building grants program. That was a small grants program that was awarded to over 200 organisations to improve their capacity in business planning, IT, consumer participation, research, service and needs planning. We are just waiting for the final evaluation of that program, but that has gone as expected.

Senator BOYCE—That program is now complete or would there be a second round?

Ms Hart—That program is now complete.

Senator BOYCE—As we said, this is the plan for 2006-2011. What other measures have been introduced in mental health since November 2007 outside the plan?

Ms Hart—Do you mean in addition to the initiatives in the plan?

Senator BOYCE—Yes.

Ms Hart—That is quite a broad range.

Ms Krestensen—I will just add to Ms Hart's answer. There are four programs for which I am responsible which arose from the COAG action plan—the telephone and web based counselling measure, the suicide prevention COAG funding, the day-to-day living program, and the early intervention for children, parents and young people initiative. Those four programs are on track. We have had a full spend within one per cent of budget over the last two financial years, and there were small savings to two of those measures, which we have previously discussed at previous Senate estimates in the 2007-08 budget. There was a $2.5 million saving to the tele-web measure and $0.5 million saving to the day-to-day living measure, but over and above those savings they have been fully expended over that period.

In relation to your second question about the new measures that have come in since the COAG plan came in in 2006, the biggest measure has been the perinatal depression measure, which provided $55 million in the 2008-09 budget towards the better detection and management of perinatal depression. There was the continuation of the drought measure in this year's budget, which provided a further $5.2 million for the mental health support for drought impacted communities program.

Senator BOYCE—That was not a new program but more a continuation?

Ms Krestensen—That was a continuation, yes.

Senator BOYCE—But funding outside the plan?

Ms Krestensen—That is correct. It was new funding, because that program was due to terminate this financial year. It was an additional year's funding for that program.

Senator BOYCE—If only the drought would terminate.

Ms Krestensen—It has in some places but not in others. We have also had new funding this financial year for the mental health response to the 2009 Victorian bushfires, which was additional $3 million in the 2009-10 financial year. Finally, this year we also had $5.1 million for telephone based peer support in the perinatal period, which was part of the maternity services review.

Senator BOYCE—That funding went to Lifeline, did it not?

Ms Krestensen—No, we are still negotiating with four organisations about that funding. The minister has announced that the funding is to be spread across both support for mothers impacted by grief and loss and families impacted by perinatal depression. She has announced that the four organisations receiving that funding will be the Bonnie Babes organisation, SANDS, SIDS and Kids and PANDA, which is a perinatal and neonatal depression association.

Senator BOYCE—Regarding funding in 2009-10 for bushfire support, is that money being expended within the guidelines? Is it underspent or overspent?

Ms Krestensen—It is actually right on track. We spent almost all of the $4.5 million that we had planned to spend last year. We have spent to date $3.6 million on psychological

services under ATAPS, $600,000 for a specific program supporting children and young people impacted by the fires through a schools project, $600,000 on frontline training for community leaders through Beyondblue and a further $600,000 for phone counselling through Lifeline, Kids Helpline and Crisis Support Services. There has been very strong uptake from the divisions of general practice for those services. We are right where we expected to be in terms of that uptake. Some divisions, particularly those providing services in areas such as King Lake and those areas most affected by the fires, have had a very high level of uptake. Some of the other divisions in those areas that have been more minimally impacted have not had such a great uptake, but certainly overall the uptake has been about where we thought it would be.

Senator BOYCE—Have you any sense of how many individuals or how many individual services have been provided this year under that?

Ms Krestensen—We do. Since we started funding back in March there have been 1,270 referrals under the bushfire program for ATAPS.

Senator BOYCE—You have $55 million set aside for perinatal depression. How is that funding tracking?

Ms Krestensen—That is also tracking as it should be. Last financial year we provided funding to the divisions of general practice under ATAPS to provide specific perinatal psychological services. We have provided funding to states and territories for their part of providing screening and better service pathways. A framework has been developed with states and territories, which was endorsed by AHMAC and is being considered by health ministers at the next meeting for taking forward activities over the next five years. That will include jurisdictional investment plans for the money which states and territories are going to be putting on the table towards perinatal depression. That is on track.

Senator BOYCE—Thank you. I note that Centrelink is undertaking a review of why people may not go to services that they have been referred to by officers within Centrelink where there is a suggestion, 'It could help if you go and talk to organisation X.' Have you any sense at all of organisations that come within your programs and how much the take-up actually happens and, if not, why not?

Ms Harman—I think one of the barriers that generally exists in service access in mental health is the understanding of the individual about whether or not they actually need services. For example, in the latest population survey of mental disorders, which took place in 2007 and has just been published, 90 per cent of those people who did not access services did not feel that they needed services. There is a fundamental kind of barrier there.

Senator BOYCE—The 'I'm not nuts' response.

Ms Harman—That is exactly right. That is a general statement about a universal barrier as to why people do not access services. In terms of data around why, I do not think we have specific service-level detail about why people do not access particular services, but at a universal level there is a general barrier.

Senator BOYCE—It would seem that perhaps quite a significant number of resources are being wasted, so to speak, by assessing and referring people if those referrals are not being taken up. This leads me into my next area, which is the one I always ask questions about, and

that is the stigma attached to mental health issues. What changes have you initiated since we last discussed stigma?

Ms Krestensen—We discussed stigma at the last Senate estimates in May.

Senator BOYCE—Yes.

Ms Krestensen—I think it is fair to say that we have not introduced any further programs or significant changes since last May. We certainly have been in significant discussions with stakeholders and in the context of the fourth National Mental Health Plan. Of course, we are very keen to hear what the community is saying in response to the mental Health and Hospitals Reform Commission report, which also identifies the problem of stigma. There have been no further program changes, but clearly there is a lot of discussion going on about ways that we can use in particular the investment we have already in a range of programs, such as StigmaWatch, school based programs, programs that go across sectors that try to increase the understanding of mental illness, promote help-seeking and understand the broad spectrum of mental illness. There is a very strong view coming forward from the sector at the moment that we have made considerable progress in raising understanding in Australia of common disorders such as depression particularly and also anxiety, but we have not made as much progress as we would have liked to in terms of understanding more serious disorders.

Senator BOYCE—Such as schizophrenia?

Ms Krestensen—Exactly. So, we share a concern with our stakeholders about how better to do that.

Senator BOYCE—When you say there is a view coming forward, are we talking about a large degree of expert anecdotal evidence, so to speak, or other more formal analysis?

Ms Krestensen—Both. We are certainly getting letters from individuals who have serious disorders themselves who are giving us their experience of the stigma they have experienced. In the discussions that have taken place throughout the sector—throughout the health system—in the context of social inclusion, there has certainly been a lot of anecdotal information and broader information about the need to improve understanding of the needs and issues of people with serious disorders.

Senator BOYCE—I have one question perhaps more from experience of people I know, and that is about the issue of dual diagnosis where, for example, you might have a mental health disorder and an intellectual disability. Is there any protocol about who takes the lead in that sort of situation?

Prof. Whiteford—It would depend on what the primary condition was perceived to be. If the primary condition was intellectual disability and the person was in treatment for that and had depression on top of that we would expect and hope that intellectual disability services would refer them for appropriate mental health care. There are people with intellectual disability who are not in any treatment services for that but are receiving perhaps additional education or other assistance who might access mental health services or health services generally, and they should be treated in an equitable and no-discriminatory way for their mental health problems. I acknowledge what may be behind your question—that is, it is quite difficult sometimes and the fact that some—

Senator BOYCE—Do you mean the diagnosis?

Prof. Whiteford—Yes, the diagnosis. Some people, perhaps even clinicians, might attribute a depressed mood to the intellectual disability rather than identifying the existence of the mental health condition, and I think, therefore, that that is an area where we need to continue to upgrade our skills and knowledge.

Senator BOYCE—The states would be the ones who would be responsible for that upgrading?

Prof. Whiteford—If the people who have a significant intellectual disability are in some sort of care from a state service, that would be something that would be their responsibility. But for many people with—

Senator BOYCE—But the vast majority would not be in state services.

Prof. Whiteford—No; that is right. They have milder forms of intellectual disability and they would access the general practitioner or other healthcare providers, as everybody else in the community does.

Senator BOYCE—I want to talk a little about the KidsMatter initiative. We have $6.5 million for that, do we not, over three years? Is that right?

Ms Krestensen—There is $6.5 million for the primary school KidsMatter program; that is correct.

Senator BOYCE—We are talking about moving that into the early childhood sector; is that correct? What stage is that at?

Ms Krestensen—That is correct. I will just correct the answer I gave before. It is actually $12.5 million over three years for the KidsMatter primary program, $6.5 million over three years for the early childhood KidsMatter program.

Senator BOYCE—That is right. That is where I was confusing myself as well.

Ms Krestensen—My mistake. The early childhood program will be modelled on the KidsMatter primary school initiative. The KidsMatter primary school initiative has been a partnership between the Department of Health and Ageing, beyondblue, the Australian Psychological Society and Principals Australia. We have had an evaluation that has come in which has shown very strong results from the schools that we have piloted that in. On the strength of those results and because of the importance of early intervention we are exploring the rollout of that sort of program to an early childhood setting. It is very early days. We have developed some resources, but the minister has allocated some funds for the rollout of that to an early childhood setting in the next three years.

Senator BOYCE—Can we talk about how that is going to be rolled out in the early childhood setting? Where is it going to go? What is going to be taught? I am sure that is the wrong word. 'Disseminated' is perhaps the word I should be using.

Ms Krestensen—It is very early days. The approach to this, of course, will be different from a school based approach. We are engaging the childcare sector as well in the development of the resources that we do. It will be very much building skills and resilience, focusing on developing strengths and the capacity of children to thrive in the years ahead. It

will also have a strong emphasis on support for parents to enable them to do what the evidence suggests they can do to ensure that their children develop in terms of mental health promotion issues. It will take the broad approach that the other school based programs have taken in terms of a mixture of professional development for the workers in child care and also resources for parents and the centres themselves. It will be working with the existing sector to build upon the work they already do in terms of that broad population level—mental health promotion activities and also building their ability to refer those children that they might be worried about for good reasons. It is also about building their capacity to work out what a good reason is to be worried as opposed to normal childhood development.

Senator BOYCE—Yes, because it is a bit of a balancing act to distinguish normal child behaviour from perhaps aberrant behaviour, is it not?

Ms Krestensen—Yes, it is.

Senator BOYCE—I would like to go back to the primary school aspect of this. I am told the results were published in peer review journals. Is that correct? Were the results of your 2008 pilot project published anywhere else?

Ms Krestensen—The evaluation has not been published, although I think it is about to be. A summary of the evaluation was made available at the recent launch in Melbourne of the KidsMatter program and the actual document is still being finalised before being made public.

Senator BOYCE—Where will that be published?

Ms Krestensen—Beyondblue will make that available. Beyondblue have invested quite considerably in this fairly robust evaluation of the KidsMatter program and, given their delight with the results of the evaluation, I am very confident that they will be making that evaluation report widely available.

Senator BOYCE—Given that it has been considered successful, could you give us a couple of the high-level findings of that evaluation?

Ms Krestensen—Yes. I have not seen the final report, but I understand that the evaluation found a real and significant increase in the mental health outcomes of the children who have been participating in the KidsMatter activities at those schools. There have also been better educational and social outcomes for those children since participating in the program.

Senator BOYCE—Could you give me an example of what you mean by better mental health outcomes for children?

Ms Krestensen—There is a particular scale that is being used to measure the mental health of the children. It is like a mental health promotion scale. It is not a measure of mental disorder; it is a measure of their mental healthiness. The instrument was used before and after, with a control group, to assess the impact of the intervention on the mental health of the children. I am sorry I cannot be more technically accurate, but I do not have any detailed information with me at the moment.

Senator BOYCE—You say it is being published shortly—will that be before the end of the year?

Ms Krestensen—Yes, I am very confident of that.

Senator BOYCE—My other questions related to the national action plan that finishes in 2011. What will be in train after 2011?

Ms Harman—This is a consideration of the current health reform agenda that is being consulted on by government. There are a number of mental health recommendations made by the National Health and Hospitals Reform Commission. As I said, there is a broad consultation underway in terms of what future reforms might look like.

Senator BOYCE—Thank you.

Senator WORTLEY—Ms Harman, can you tell me about developments with the headspace program? Also, more specifically, can you tell me whether you have seen an increase in the use by youth of headspace, particularly the sections dealing with depression in relation to cyberbullying?

Ms Harman—I will start by addressing the current status of funding for headspace. As you would be aware, the operations of headspace are now auspiced under an independent company. That company's structure is now fully established and on 1 October we entered into new funding arrangements with them for the next three years. That has now been completed. In terms of the take-up of services under the headspace program, I will refer you to my colleague, Ms Krestensen.

Ms Krestensen—Since the program was originally funded, there have been over 95,000 occasions of service by local headspace sites, and 13,900 young people between 12 and 25 years of age have benefited from services.

Ms Harman—I do not think that we have detailed information specifically about cyberbullying at this stage.

Senator WORTLEY—Can you take that on notice?

Ms Harman—Yes, of course.

Ms Krestensen—There is the measure that the other portfolio has implemented for cyberbullying. They have provided some funding to support schools in the event of cyberbullying. We know that headspace certainly have it on their radar as an issue. They will be working with other organisations in the sector, including organisations such as Principals Australia, but we have not funded any specific cyberbullying measures.

Senator WORTLEY—I am familiar with the government funding of the various initiatives that have occurred in that area. I was specifically asking in relation to headspace. I am just trying to see how widespread it is. I know that Senator Siewert has some questions on headspace as well.

Senator SIEWERT—I just wanted to follow up the questions that I was asking last estimates regarding ongoing funding for agencies that provide the services. Was that all resolved in the agencies that were previously providing services where they were then refunded?

Ms Harman—That is my understanding. As I said, we have now entered into new funding arrangements for the next three years. You would understand that the headspace company itself is responsible for funding the 30 headspace sites. It is my understanding that those

arrangements are in place and, whilst not all funding agreements are signed with the 30 sites, it has been indicated that they have agreed to a funding amount with the headspace company, and there is just an administrative process to go through at this stage.

Senator SIEWERT—In the meantime, before those agreements are signed, are services continuing?

Ms Harman—Absolutely.

Senator SIEWERT—Thank you.

Senator WILLIAMS—Is there a problem at schools with bullying text messages being sent to youngsters?

Ms Krestensen—There are two sides to this story. There has been a lot of high-profile discussion about the possible impact of phone based bullying as well as cyberbullying in recent months, but there are also suggestions that the greater use of mobile phones and internet has provided a connectedness or a protective factor for some young people as well. There is a downside but there is also a very positive side to the availability of mobile phones and web based support. There is some anecdotal information that there has been some bullying by telephone as well. We do not have any data on that; it is a bit beyond the capacity of our programs to measure that. But there has been some concern.

Senator WILLIAMS—You probably would not have heard of a program called My Mobile Watchdog. The minister might be interested in listening to this. I had a chap in my office this week who said that you can set it up with a mobile carrier so that a copy of whatever text messages your son or daughter receive or send goes straight to you or to a phone that they wish to nominate.

Senator Ludwig—My inbox would crash.

Ms Halton—There are a number of parents of teenagers here. Keep talking; we are fascinated.

Senator WILLIAMS—In the first 90 days of one of these groups in America, 40 paedophiles were put behind bars. You can set up which text messages come to you. Once every 24 hours those texts can be emailed to you. If your child receives a strange text message, some sort of pornography or whatever from a strange number, that automatically goes to you. Paedophiles are being traced through this thing around the world. I am finding it very interesting. In fact, the chap who brought it to my attention is meeting with Minister Conroy next week to discuss it with him.

If you give your 12-year-old son or daughter a mobile telephone and they get bullying messages or the bad people out there in the world are sending them things they simply should not be exposed to, you find out because the copy goes direct to you. You can see what text messages your children are sending out and receiving. I think in the near future you will find it a very interesting program. If you want any more information on it, I will gladly give you the person's contact details if you wish to discuss it with him.

Senator Ludwig—That would be helpful, but not on the record.

Senator WILLIAMS—I am only trying to help.

Senator Ludwig—I appreciate that. You can let my office know as well. It is all very helpful.

Senator WILLIAMS—It could be very interesting as far as putting a stop to a lot of the smut, if I can call it that, that travels around the electronic world today. I would like to ask a couple of questions on rural mental health. Who is handling that?

Ms Hart—It depends on which program you are interested in. I look after a program that provides services to targeted rural and remote areas that are underserviced by MBS. Is that the program that you are interested in?

Senator WILLIAMS—Yes, that will be fine. I am concerned about the mental health status, and how you see its progress, of a lot of farmers who are doing it very tough financially because of the drought. How are things going in that area? Do you have any information in that sector?

Ms Hart—About the mental health status of people who might be experiencing those things?

Senator WILLIAMS—Yes. Are mental health problems increasing because of droughts and financial situations in regional areas?

Ms Hart—I do not have definitive data on that. We do have data on the status and the prevalence of common disorders in the population, principally with a focus on anxiety and depression from our 2007 population survey, which provides information on rural and remote areas. We also have a number of programs. The one I just mentioned, Mental Health Services in Rural and Remote Areas, recognises two things. As you said, there may well be external stressors—drought, bushfire, economic difficulties and social isolation—that are particularly prominent contributors to distress and may ultimately contribute to mental disorders in rural populations. Consequently, we have a targeted program under that initiative which is largely funding divisions of general practice for a range of allied health workers to work with the rural and remote population. That complements our broader Medicare subsidised program.

If you give me a moment I can find some figures on rural and remote access of the MBS Better Access initiative, although they work in conjunction, because as you would appreciate the access to the MBS services is dependent on access to a GP, so they are supposed to be complementary to reach services into rural and remote areas.

Senator WILLIAMS—Last time we met figures were given where there were about 12.5 suicides per 100,000 people in rural areas. I was wondering whether you had any up-to-date figures on those statistics.

Ms Krestensen—We have dug a little bit further since last Senate estimates because we thought it was an interesting question. The one piece of information that I will raise with you about suicides in rural areas—and I do not have a lot to add to it as Ms Hart said—is that there does seem to be a particular concern about agricultural workers within rural areas for whom suicide rates appear to be quite high.

We have a centre of excellence on suicide prevention which runs through Griffith University. One study it has done has suggested that a rate as high as 27 per 100,000 people might be the case for agricultural workers. It is important when you look at drought and rural

areas to really dig a bit below the surface to see which particular groups in those areas are most affected. That is certainly a source of concern to us and one that we have discussed with the Australian Suicide Prevention Advisory Council.

Senator WILLIAMS—When you say 'agricultural workers', are you referring to people on the land who are the owners of the land, employees working on those properties, or both?

Ms Krestensen—Mainly employees. I think it is agricultural workers and farm workers, as opposed to landowners. I know that we all share a very significant concern about landowners and farmers, but this finding suggests that we do need to think about what we do in terms of frontline support for agricultural workers. We are digging into this issue to get further data on it to see if this is a study that can be replicated elsewhere or if there is any further data on this. It does suggest that there are certain groups in rural areas that we need to be particularly concerned about and we are trying to get a better handle on that at the moment.

Senator WILLIAMS—I appreciate you directing your attention to that area. Four out of five suicides right across Australia are male, or close to those figures. I imagine that would be the case in rural areas as well, especially for those people involved in rural industries.

Ms Hart—I can add to my earlier answer on the Better Access program. Our current data shows that, of the 1.9 million people who have been accessing Better Access, 600,000 of those are from rural and remote areas, so they are well represented. Similarly, we know that of those who are claiming services, about 21 per cent are from rural and remote areas. Proportionately they are accessing a reasonable rate of MBS subsidised services.

Senator WILLIAMS—Thank you.

Senator BOYCE—I would like to follow up with some questions on mental health services that are available in Normanton, the Gulf of Carpentaria area. You might be aware that this area went through floods, which has now caused drought.

Ms Harman—There would be a range of programs available.

Senator BOYCE—Would they all be out of Cairns?

Ms Harman—No. They would be locally based if it is under the Better Access program. There is also the ATAPS program.

Senator BOYCE—What is available through Better Access in the far north of Queensland, particularly around Normanton and the Gulf of Carpentaria?

Ms Harman—Better Access is available through any GP. GP services in that area would be able to refer individuals to mental health treatment programs. There is also the ATAPS program, which works towards referring people to allied health psychological services.

Senator BOYCE—I would like to know how many individuals within far northern Queensland, particularly the Normanton area, have accessed mental health services under those statistics that you gave me earlier? I am happy for that to go on notice.

Ms Harman—I will need to take that on notice. Is it the Normanton area and—

Senator BOYCE—Within the Gulf of Carpentaria.

Ms Harman—I am happy to take that on notice.

Senator BOYCE—I do not need figures for the coastal area of far northern Queensland, only the inland area of far northern Queensland. Thank you.

CHAIR—Thank you. We are running slightly ahead of time, but that is a good thing.

[2.50 pm]

CHAIR—We now turn to outcome 15, the Population Health Division. Senator Fifield, you will lead off.

Senator FIFIELD—I would like to ask some questions about the government's objectives for the upcoming Commonwealth Games in 2010 and the Olympics in 2012. I will start with the 2010 Commonwealth Games. What are the benchmarks that have been set for the Commonwealth Games, including the associated Paralympics events? In other words, what are our goals? How many gold medals do we want to win? How many medals do we want to win in total?

Mr Miller—I am advised that we have not set explicit targets for gold medals, or any medals for that matter, for any of the games going forward.

Senator FIFIELD—No indicative targets, general aspirations or ballpark hopes?

Mr Miller—Clearly the Australian Olympic Committee and the Australian Paralympic Committee would be expecting, as we always do as it seems to me in sport, to try to improve on the performances that have been achieved in Beijing and, in the case of the Commonwealth Games, in Melbourne.

Senator FIFIELD—How much money do we commit to elite sport in Australia through the ASC and the Institute of Sport each year?

Mr Miller—Approximately $140 million.

Senator FIFIELD—We commit $140 million each year for those activities and you are seriously telling me that we do not have any benchmark, any objective, any target as a government in relation to the medals which we will seek to achieve at those games.

Ms Halton—When we took these questions in the run-up to the last Olympics—I think that is when we took them, but I can be corrected on that—we were asked for our estimate of where we might end up. We were asked for an estimate of the medal outcomes. I think this is best qualified as something of a dark science because I do not understand it. My colleagues in the commission and elsewhere have some algorithm, which is quite a mystery to me, about what we might be expecting based on what we have done in assorted world championship and other competitions as to what the likely outcome is. I am not being corrected so I am still gathering that is right. I know that in relation to the Olympics we were asked what we thought might be the outcome and we were not too far off the mark. We might have actually been a bit under.

Mr Nance—That is correct. We carefully analyse international results through the course of a year leading up to the big events and we come to what we believe to be relatively accurate estimates of what our medal performances will be at Commonwealth Games, world championships and the Olympic Games, but we do not bind sports to contracts or set medal goals. They do that, themselves, as sports.

Senator Ludwig—You might be getting confused with what I have been advised the Commonwealth Games Association does. Those questions that you are asking are more apt for them to work out what their expectations are and set that out. That is where we see news reports that say what is likely. It is from those people who are experts—if I can use the word—in that field. I am sure Mr Miller can answer for the commission, but as I understand it and have been advised, it deals with the overall aspirational issues and a whole range of support for the industry. I will leave Mr Miller to deal with that.

Senator FIFIELD—I may have chosen the wrong word. Is it more an estimate that I should be asking about, rather than a benchmark, goal, objective or an aspiration?

Ms Halton—As to what you think we will achieve?

Senator FIFIELD—Yes.

Ms Halton—What is your best guess?

Senator FIFIELD—Yes.

Ms Halton—That is a good question to ask.

Senator FIFIELD—Let me ask that question: what is your best guess for the Commonwealth Games in terms of gold medals and medals in total?

Ms Halton—Is this in the no pressure category?

Senator FIFIELD—Absolutely.

Ms Halton—You will not be holding him accountable, or would you put him on a performance bonus if he is right?

Senator FIFIELD—The readers of the *Herald Sun* or the *Daily Telegraph* may, but I certainly will not.

Mr Nance—In the case of the Commonwealth Games or the Olympic Games, we would have to take it on notice as to what our estimate would be right now. It is based on cumulative performances over a period of time. All of the disciplines and all of the sports are quite different. I can take that on notice and certainly get back to you about what the estimate would be right now.

Senator FIFIELD—Could you do that for the Commonwealth Games, the 2012 Olympic Games as well as the Paralympics?

Ms Halton—Let us be clear that guessing now in respect of the Commonwealth Games is a reasonable prospect, all other things, including organisation, being an assumed component of the guessing. I suspect that anything that asks for guesses in respect of the next Olympics and Paralympics—I gather that you were not referring to the Winter Olympics, but rather to the summer—

Senator FIFIELD—Let us do the winter as well.

Ms Halton—That will be a relatively small number, because we have a relatively small team.

Senator FIFIELD—That is right. It is a number between zero and—

Ms Halton—Potentially not so much more, but potentially you never know.

Senator FIFIELD—I appreciate that there are estimates that you have which are based on performances at recent international competitions. It sounds like you have an algorithm which tries to bring some science to the process or at least put some parameters around the guesstimates. Going from one Olympics to another, I guess we at least have the aim to do as well as we can and we at least have the aim to do better each time. There is a range of factors and variables outside your control. Maybe you can assist me. What are the actual objectives other than we spend the money as well as we can and we will do the best that we can? Is there anything more than that?

Mr Miller—The objectives are clearly set out in the portfolio budget statements. Obviously we are striving to improve international success. As you have indicated, that is not just a function of the amount of money that is put into sport, it is a function of, for example, what our international competitors are putting into sport.

Senator FIFIELD—And how well others go in comparison to you. It is not a static thing. It is not just your own performance; it is always relative to the performance of other nations.

Mr Miller—The answer to your first question is largely garnered by looking and talking to the individual national sporting organisations and aggregating their assessments of their likely performance, given what they know with their athletes, what they have been able to develop, the impacts of injury and a whole range of factors that might impact on the number of medals that are actually won. As you said, and as I think I said earlier, the overarching objective is to try to improve on what we have achieved at previous games.

Ms Halton—Let us be clear for individuals: we might have individuals on the team and their objective is to have a personal best and to get into the top five. You have to think about the individual concerned as to what the actual objective is. For someone who has been running in the top 10, if they manage to get into the top five, you would be collectively delighted. If they happen to fluke it into dais position then that is great.

Senator FIFIELD—Is it possible, or meaningful for that matter, to compare where we are at this stage in the Olympic cycle with where we have been say in the previous two Olympic cycles? Is that something that is possible to measure or useful to look at? Do we do that? Do we say, 'Yes, we are doing better overall than the various meets at this stage of the Olympic cycle compared to this point in the previous Olympic cycle or the one before that'?

Mr Nance—You could do that exercise, but there are so many variables applied over the 12-year span in your example, so it would be difficult to draw hard evidence from it. The estimates that you are making are bringing performances together, looking at them very closely, sport by sport, and running into each event, and that is the best way to do it. That exercise could be done. It is done in a very general way, but not in an analytical manner because of the variable factors applying to that time period.

Mr Miller—I think you get some line of sight as well from what we are seeing in terms of No. 1 world rankings and international success in team sports as well post the Olympics. That gives you some line of sight, I would portend, in terms of where to for 2012.

Senator FIFIELD—To the extent that you said you do compare the equivalent points of previous cycles are you able to provide that to the committee?

Mr Nance—I said you can do that. It is an exercise you would not do as rigorously as leading into—

Senator FIFIELD—I appreciate that.

Mr Nance—But if you could do it along the way, yes.

Senator FIFIELD—But it is something you do along the way and to the extent that you do do it along the way are you able to provide that to the committee?

Mr Nance—I would have to take that on notice.

Senator FIFIELD—I guess this is a leading question but why not. Are the funding levels you have adequate to achieve what you hoped to achieve, based on your estimates at this point in time as to what is likely?

Ms Halton—You know I am going to say something about that kind of question.

Senator FIFIELD—I would be disappointed if you did not.

Ms Halton—Then I am not disappointing you.

Senator Ludwig—That is a hypothetical question.

Senator FIFIELD—I do not know that it is hypothetical. You have an estimate, which will be taken on notice, as to the medals that it is possible or likely that we will get at the next Commonwealth Games or Olympic Games. One would assume that, for that estimate to be achieved, a certain funding level would be required to support the activities leading up to that. It is a serious question as to whether the funding going forward is sufficient to achieve that estimate.

Ms Halton—That is a hypothetical question and the bottom line is—

Senator FIFIELD—It is a hypothetical question, because the Olympics have not happened yet, obviously. The Olympics is at a point in the future.

Senator Ludwig—I am pleased you have conceded the point.

Senator FIFIELD—The only time it would not be a hypothetical question would be until after the Olympics.

Ms Halton—I think even though it is not entirely a portfolio proper thing to say I will say: good try, no cigar.

Senator FIFIELD—One would assume that the ASC would have a view as to whether the funding is adequate to achieve the estimated total number of medals.

Ms Halton—If it has that view it will tell me as the portfolio secretary and I will tell the minister. Indeed, they will tell the minister themselves as well.

Senator FIFIELD—But not this committee?

Ms Halton—No, that would be right.

Senator FIFIELD—This is a question you may need to take on notice.

Senator Ludwig—It may be worth while, going to funding, looking at what we actually get. There is an issue around funding. I think that you have raised that. But in the 2008-09 a total of $74 million has been allocated to support sports at the Summer Olympics and the Paralympics program and their high-performance athletes. That is raising total funding to those sports to over $282 million over four years. In November last year the government announced $12.6 million to extend the support for high-performance sport. I will not go into other funding in any detail. For example, there is $11 million for a European training centre in the 2009-10 budget. I think the short answer—notwithstanding the hypothetical nature of the question—is that this government does take our sports very seriously. I think Australians take sport very seriously. But in terms of ensuring that we have allocated support for the Summer Olympics and the Paralympics programs it seems that we have certainly looked at that well.

Senator FIFIELD—I have some further questions in relation to benchmarks. As I say, you may need to take these on notice because it may involve consultation with the relevant national bodies. I would be interested in the medal aspirations—if I can go that far—for swimming, athletics, cycling, sailing, canoeing and rowing for the 2012 Olympics. How many medals does each of those sports expect/hope to win at those games? This may be something that you can tell me now or again you may need to take it on notice. I would be interested in how each sport performed at the major international events in 2009, where they ranked and how many medals they won. As you say, that is part of what goes into helping determine the estimate for the 2012 games.

Ms Halton—In 2009?

Senator FIFIELD—Yes.

Ms Halton—That is not finished yet.

Senator FIFIELD—No, that is right. The year to date, 2009. Let us say the previous 12 months or going back a little further. That is Olympic sports at international events—the ones I mentioned.

Ms Halton—Summer?

Senator FIFIELD—Summer, yes. I do not know that there is winter swimming or cycling. The sports I mentioned were swimming, athletics, cycling, sailing, canoeing and rowing. Also, just to assist us, what major international events are going forward for the remainder of 2009, 2010 and 2011? That would be helpful. That is all on the Commonwealth and Olympic games. I might turn to the Crawford review now. Has the review now been completed?

Ms Halton—Yes.

Senator FIFIELD—Are you able to advise the date on which the review was completed? I guess that would have been when it was handed to the minister.

Ms Halton—I cannot tell you precisely. I would have to take it on notice, but I can tell you it was very recently.

Senator FIFIELD—Could you tell us when the minister received a copy? Do you know when it is anticipated that the review will be made public?

Ms Halton—No, it is a matter for the government.

Senator FIFIELD—I just thought that they may have made a decision.

Ms Halton—Not that I am aware of.

Senator FIFIELD—As to the transmission of the report, the Crawford review did the report but the department acted as the secretariat for the review; is that correct?

Ms Halton—That is correct.

Senator FIFIELD—Would the department have seen the review? Did it go direct from the—

Ms Halton—It is fair to say some parts of the department.

Senator FIFIELD—Mr Rowe, for instance, would have seen it?

Mr Rowe—Yes.

Ms Halton—That is a fair assumption.

Senator FIFIELD—I am only asking for what is publicly available, but is it expected that the government will respond to the review this year?

Ms Halton—Again, that is a matter for the government. They have not made a decision.

Senator FIFIELD—That is all I am checking, that is, whether the government has stated anything publicly as to when it is anticipates responding to the review. Has the department or the ASC for that matter received any feedback from sporting organisations in relation to concern at the length of time that the review has taken?

Ms Halton—I think the timetable is consistent with the timetable as promulgated. Certainly I have not had anything raised with me. Colleagues in the department say, no.

Senator FIFIELD—It can be positive feedback or negative feedback. No?

Ms Halton—No.

Mr Miller—In the five months I have been in this role it is clear to me that there is a great deal of interest by NSOs and sport generally in Australia in the report when it is released, but there have not been any concerns raised about the timing.

Senator FIFIELD—I guess my questions were going to whether the time the review has taken, even though it may be within the parameters that the government has set, is affecting preparations for the 2010 Commonwealth Games or the 2012 Olympics.

Mr Miller—It has certainly not been raised in discussions with me. As I say, they are keenly interested in what might flow from the report.

Senator FIFIELD—The government released its illicit drugs in sports plan on 26 June this year.

Mr Miller—That is right.

Senator FIFIELD—That is worth $20.1 million. Is that the figure?

Ms Halbert—Yes. That is correct.

Senator FIFIELD—Will all national sporting organisations have access to education funding under this policy?

Mr Rowe—There certainly is provision and the intention within the policy for those who want to have access to funding for education.

Senator FIFIELD—They will all be eligible to have part of that—

Mr Rowe—For education—correct.

Senator FIFIELD—For education. What requirements do national sporting organisations need to meet to be eligible for out-of-competition testing?

Mr Rowe—There is a standard that is being developed as part of the policy. This Friday we have arranged an information session for those sports that have been interested. Around 50 or so sports have been invited and those that are interested will be attending the information session. That will be one of the matters that we will be discussing with them and seeking feedback on.

Senator FIFIELD—So that has not been fully determined during the consultation process?

Mr Rowe—It is close, but we wanted to consult with sports before finalising all aspects of the program.

Senator FIFIELD—However, you would have an idea as to which organisations are likely to be eligible at this stage. It is at that stage of preparedness, for instance, that we would know whether the AFL, NRL, Tennis Australia or Cricket Australia would meet those requirements?

Mr Rowe—Eligibility for education or—

Senator FIFIELD—I mean eligibility for out-of-competition testing.

Mr Rowe—The government decided that there were some sports that would be able to afford testing and indeed that conduct testing at the present time. The sports that I recall you mentioned would not be eligible for funding under the program for testing.

Senator FIFIELD—How many national sporting organisations would meet those requirements?

Mr Rowe—I do not have that number. I can try to get that number for you.

Senator FIFIELD—Thank you. If you have a general number in your head at the moment that would be useful, that would be good, but if you would prefer take it on notice.

Mr Rowe—I do not have too many general numbers in my head.

Senator FIFIELD—I know you like specificity. If it is not premature can I ask: how many grants does the department expect to deliver to national sporting organisations with regard to out-of-competition testing?

Mr Rowe—That is unknown at the moment, because it is a voluntary program and it really depends on the take-up.

Senator FIFIELD—As I say, it was in the expectation that you would probably have an estimate from discussions as to what the likely take-up would be.

Mr Rowe—I am sorry; I really do not have a firm figure on what that might be.

Senator FIFIELD—How many of the national sporting organisations currently undertake out-of-competition testing for illicit drugs?

Mr Rowe—My understanding—and it is only an understanding—is that there are currently two: the AFL and the NRL.

Senator FIFIELD—How much can an organisation apply for in relation to out-of-competition testing?

Mr Rowe—That will depend on the testing program that the sport in question develops. That will in itself depend on the coverage that they are seeking and that will vary from sport to sport.

Senator FIFIELD—Will it be just a one-off grant that can be applied for or will it be a situation where they can reapply?

Mr Rowe—The program is ongoing, so there will be funds available in this and subsequent years for that purpose.

Senator FIFIELD—Is the policy finalised?

Mr Rowe—The policy is finalised and announced. The government's policy is finalised. There is a sport template policy that we are discussing with Sports this coming Friday.

Senator FIFIELD—When do you anticipate that organisations will be able to start applying for education money and also for the out-of-competition testing?

Mr Rowe—They can as soon as they feel comfortable about submitting an application. The guidelines for the program are being discussed with Sports this Friday and we are hoping to finalise those guidelines so that Sports have clear parameters in the very near future, but I do not have a precise date for that. It will largely depend on some of the feedback that we are expecting to get on Friday.

Senator FIFIELD—I might just move to the $20.8 million Sport and Recreation Facilities: Contribution to Funding measure from the 2008-09 budget. I understand, essentially just from reading the newspapers at the time, that this particular measure was created to fund 91 commitments to sport and recreation facilities made by Labor candidates during the 2007 election. Is that an appropriate characterisation of the genesis of this particular program?

Mr Rowe—I need to clarify that there is not a facilities program as such. There are a number of commitments.

Senator FIFIELD—I am sorry—a series of measures I guess is a better way to put it. Is that an appropriate characterisation as to the genesis of these measures?

Mr Rowe—That is correct, but there are also similar commitments from the former government that continued into the administration of that collection of facilities programs. There were 91 projects under the current government from the 2007 election commitments. That is correct.

Senator FIFIELD—I am not suggesting that there is anything unusual about political parties making campaign commitments and then seeking to honour them.

Mr Rowe—No. I was just trying to give a complete picture of the breadth of the administration that we are responsible for.

Senator FIFIELD—Am I correct in understanding that funding has been allocated for all of those 91 projects except for two?

Mr Rowe—By 'allocated' do you mean paid?

Senator FIFIELD—I mean that whatever relevant commitments that have been entered into are being progressed towards finality. The reason I am asking this, too, is this. In an answer given by Minister Ellis to a question on notice, she indicated that Helensburgh Netball Club and Ingle Farm Amateur Soccer Club were marked as awaiting further information from the proponent. Are those two still at the earlier stage?

Mr Rowe—They are. Since the question was raised last time and the information was provided—I think to you through a question on notice—seven projects are still to receive funds. The two that you mentioned, Helensburgh Netball Club and Ingle Farm Amateur Soccer Club, are among those.

Senator FIFIELD—Could you take me through the nature of the project at the Helensburgh club. I think $50,000 was proposed there.

Mr Rowe—I might have some brief details here.

Senator FIFIELD—And also the nature of the project at the Ingle Farm Soccer Club.

Mr Rowe—Helensburgh Netball Club was for the completion of the clubhouse and an upgrade of courts. Ingle Farm Amateur Soccer Club was for the upgrade of club facilities. We could get more detail, but that is all I have here.

Senator FIFIELD—If you could, thank you. The answer to the question on notice indicated 'awaiting further information'. Are you able to indicate what the further information is that was being sought from the proponent?

Mr Rowe—For one project we are waiting for project plans and for the other project we are waiting for their advice on other sources of funding.

Senator FIFIELD—Which one was waiting for other sources of funding and which for the project plan?

Mr Rowe—Ingle Farm was for the additional sources and Helensburgh for the project plans.

Senator FIFIELD—For Ingle Farm you need to be satisfied that there are sufficient sources so that combined with the Commonwealth's money the project can be completed; is that the nature of that issue?

Mr Rowe—Yes.

Senator FIFIELD—That is two. What are the other five that are at a relatively early stage of development?

Mr Rowe—The Bathurst Soccer Club, Biloela Sporting Fields, Gladstone Hockey Fields, Lithgow Hockey and Palm Island Community Sports Field.

Senator FIFIELD—Are you able to indicate what information is still required for those?

Mr Rowe—Yes. All of those other five requested that, because of project delays, their funding be moved to 2009-10 and so we are going through that process at present.

Senator FIFIELD—That are delays at their end?

Mr Rowe—That is correct.

Senator FIFIELD—Moving to the Local Sporting Champions program now, of the $1.6 million allocated to the program, how much has been allocated to individuals and how much to teams?

Mr Miller—I am just trying to get the breakdown for you. In 2008-09, $601,136 was paid prior to the end of the financial year, and 3,344 team and individual applications were received. I am sorry, that is for round 1—this year. I do not have that figure. I would have to take it on notice.

Senator FIFIELD—Could you also check how many individual grants were allocated in 2008-09? You have given me the dollar figure for 2008-09. Could you take on notice the number for individual grants and team grants? Has every member of parliament participated in this program? My understanding is that local members have the opportunity to choose who the recipients will be. Have all local members in the relevant electorates taken up that opportunity?

Mr Miller—My understanding is that through some concerted effort we have been able to engage all MPs, but I would just like to check that answer.

Ms Flanagan—The majority of local members of parliament have taken up the opportunity. We are still working with a few of those who did not take that opportunity in the last round who have indicated that they will look to take up that responsibility this round. We are actually meeting with all of the MPs either here at Parliament House or in their own electorates over the next couple of months.

Senator FIFIELD—Is it only members of the House who have that opportunity, is it?

Ms Flanagan—That is right. And the Senate, I am sorry.

Senator FIFIELD—And the Senate as well?

Ms Flanagan—Yes.

Senator FIFIELD—I thought it might have just been members of the House and I thought that would be outrageous discrimination. It is good to hear that is not the case. How is it determined when a senator has input as opposed to a member of the House?

Ms Flanagan—There is no difference in criteria.

Senator FIFIELD—I thought that it might be done on a geographic basis, that that is how you might determine who the member of the House is who has input. But given senators cover the same territory as members of the House in a particular state how do you determine when a senator's input is sought?

Ms Flanagan—I will take that on notice.

Senator FIFIELD—Correct me if I am wrong, but my assumption was that—and I did not know senators were involved until you confirmed that—in a particular geographic area within

a particular federal seat as to the sporting teams and individuals in that area who applied and who were eligible input of the member of parliament from that area would be sought. Is that roughly how it works?

Ms Flanagan—Yes, it is.

Senator FIFIELD—That is why I assumed it would just be members of the House. Given that it is members of the House and senators there must be criteria for determining when you go to a senator as opposed to the local House member.

Ms Flanagan—As I said, I will take that one on notice and we will get back to you with that.

Senator FIFIELD—Are you responsible for running the local sports—

Ms Flanagan—It sits under my division, yes.

Senator FIFIELD—You are saying you do not know what the criteria are for determining when a senator is approached as opposed to a member of the House?

Ms Halbert—She said she will take it on notice.

Senator FIFIELD—I appreciate that. I am just expressing surprise that that is not something readily known. I know as a senator how sensitive my House colleagues often get when a senator is approached rather than themselves. I guess I am just displaying uncharacteristic concern for the sensitivities of my House colleagues. We like to maintain good and cordial relations between the chambers. I thank you for taking on notice to advise me of the criteria for determining that. Could you also advise how many members of the House of Representatives have taken part in this program, and also how many members of the Senate have done so? Could you indicate whether there are cases where a member of the House in a particular electorate and a senator have both had input in that same area? Could you indicate in each case where a senator has had the input, and why that was the case?

Ms Flanagan—Yes, we will take that on notice for you.

Senator FIFIELD—Have there been any teething problems with the program at all?

Ms Flanagan—Obviously in the first rollout of a program like this, which was quite extensive, we have received feedback from members of parliament and the public. We have taken that feedback on board and been able to streamline administration of the program and also taken on board the administration processes and how they can be streamlined. We are very confident that in this second iteration of the program a number of efficiencies and a far more effective process can be implemented.

Senator FIFIELD—What are those efficiencies? What are the changes between the first and second iterations?

Ms Flanagan—We have more flexibility in relation to the allocation of grants between teams and individuals. For example, in some electorates there was undersubscription for team grants and oversubscription for individuals and vice-versa. We are allowing more flexibility in the movement between the grants and also between electorates that may be undersubscribed and oversubscribed. Also, the commission will provide more support to members of parliament who may be finding it difficult to administer the program. We can step in and

assist them to do that. In addition, we have included young coaches, umpires and officials, who are now eligible to apply under the same criteria as individuals for the grants themselves.

Senator FIFIELD—Have there been any complaints received from organisations and individuals who applied but missed out?

Ms Flanagan—There have been expressions and communication from individuals who have missed out as to why they have missed out. In all cases we have been able to address that in relation to the criteria and also the actual amount of funding that is available, encourage them to apply again and give them other options of grants at state government and local government level they could also access.

Senator FIFIELD—When there are those complaints, do members and senators like to handle them themselves or do they like to refer them to your area?

Ms Flanagan—It varies. We allow them to make that choice and they usually refer to us for advice either way.

Senator FIFIELD—I would imagine it is an invidious position for a member find themselves in, having to choose between local worthy organisations that have applied. It is an interesting process.

Ms Flanagan—The grants have been very well received, though, in all electorates that have been participating in the program.

Senator FIFIELD—Thank you for that.

Senator CAROL BROWN—With respect to the changes to the program, how are you going to communicate those changes to individual members of parliament?

Ms Flanagan—We have redone the members of parliament information packages. We will currently be meeting with a number of members of parliament over the next two weeks here in Canberra. Where we actually cannot meet with them here we are going out to the electorates to meet with them.

Senator CAROL BROWN—You intend to see each member of the House of Representatives; is that what you mean?

Ms Flanagan—That is right.

Senator CAROL BROWN—That is good. Thank you.

Senator FIFIELD—I might just move to the idea that has been floating around for quite some time and about which there is some speculation. It may have been something covered in the Crawford review, and that is the concept of a HECS-style arrangement for elite athletes who are graduates of the Institute of Sport. I would be interested in the thoughts at the table as to whether that idea has merit, if it is something that has been looked at in the past and why it may have been rejected if looked at in the past.

Ms Halton—I am sure you would not be asking me to hypothecate or speculate, because we have already had that conversation.

Senator FIFIELD—I would not assume that, Ms Halton.

Ms Learmonth—You have to work harder.

Ms Halton—You have to work harder. You have to try harder. You absolutely have to try harder. It is not something we are considering and we are not going to get into vague discussion and speculation.

Senator FIFIELD—I have done well. You have just said that it is not something you are considering, so that is news in itself.

Ms Halton—There you go.

Senator FIFIELD—It was worth asking, if only to find out that.

CHAIR—It does touch on policy.

Senator FIFIELD—I know and I am grateful for Ms Halton being so forthcoming in light of that. It is obviously something that is bubbling along, also prompted by a piece in *The Punch* by Minister Ellis where she was canvassing the relative merits of the concept.

Ms Halton—We can all make the observation about people and column inches. The reality is that academics are very interested in this. We are very aware of all of that. That is an absolutely appropriate and robust debate amongst those people who are interested, and good luck to them.

Senator FIFIELD—Yes. Tennis Australia is more than interested. It has introduced an athlete repayment scheme. Might Mr Rowe or the ASC, from their knowledge, outline their understanding of how that scheme operates for Tennis Australia?

Ms Halton—No, they would not be able to do any such thing. If you are asking for one of the officers to outline a scheme operated by a private organisation, that is not appropriate.

Senator FIFIELD—I just thought it may be something that has been looked at in terms of taking an interest in these arrangements—

Ms Halton—Whether or not—

Senator FIFIELD—in light of the discussion and debate that is happening. If it is not, then that is an answer in itself. I have just one last question on that, Ms Halton. You said that this style of scheme is not something that the department is looking at. Is it fair to take from that that it is something that the Crawford review has not examined?

Ms Halton—Going for the second cigar?

Senator FIFIELD—Yes.

Ms Halton—The Crawford review has just been received. I am not going to make any more comment about it than that.

Senator FIFIELD—I was just wanting to be clear that when you say it is not something that you have looked at you are referring to the department specifically. You are not excluding the possibility that it is being looked at elsewhere? You were just talking in the sense of the department?

Ms Halton—I am not going to make any other statement and, if any of these people do, I will be talking to them later.

Senator FIFIELD—You did confirm that the department is not looking at it, so that much we know; that is correct, is it not?

Ms Halton—I said what I said. It is on the *Hansard*.

Senator FIFIELD—You are not prepared to say it a second time. I will take something from that.

Ms Halton—You can take what you wish.

Senator FIFIELD—I shall.

Ms Halton—You can read the tea leaves all you like, but nothing more will be said.

Senator FIFIELD—It is always interesting how keen people are to answer something the same way a second time. I am done. Thank you.

CHAIR—I thank representatives of the agencies.

Proceedings suspended from 3.42 pm to 4.03 pm

CHAIR—We are going to reconvene with outcome 9, Private health.

Senator CORMANN—In relation to the changes to the Medicare levy surcharge thresholds which took effect about this time last year, has the department revised the estimated savings from that measure?

Ms Shakespeare—No.

Senator CORMANN—That is a nice, short, sharp answer; I like it. This follows on from a discussion last time. In your forward estimates there is a figure of the privately insured population of 9.7 million people in each of the out years. Are you with me?

Ms Shakespeare—Yes.

Senator CORMANN—Our population growth is currently running at about 2.1 per cent per annum. Is it true to say that according to your budget estimates you are expecting a proportion of Australia's private health insurance to drop as we move forward?

Ms Shakespeare—The 9.7 million figure is a performance measure in our portfolio budget statements against the performance indicator: maintain the number of people with private health insurance hospital cover.

Senator CORMANN—That is right. If you will reach your performance target of maintaining the number of people with private health insurance at 9.7 million and nothing else—given that our population is increasing by about 400,000 people a year—then it is fair to say that you expect the proportion of the Australian population with private health insurance to decline over the forward estimates.

Prof. Calder—You asked this question at the last estimates.

Senator CORMANN—We did not get to the bottom of it so I have given some more thought to how I can put it to you.

Prof. Calder—The measure that has been used for some time is the number. We respond on the measure that is used, which is the number.

Senator CORMANN—PHIAC has reported for many years on the proportion of the population that is privately insured, which is highly relevant. For many years, in the budget papers there was a reference to the number, which was increasing, and the percentage, which

has been increasing for some time. I can understand why you do not want to answer the question, but it stands to reason that if you do not expect the number of people with private health insurance to go up—because you say it remains static over the four years of the forward estimates at 9.7 million—but the population does go up then the proportion of Australians with private health insurance is going to go down over the forward estimates, if your forward estimates are right.

Prof. Calder—The number has been used since 2005-06. In that year it was 8.85 million. Over time the number has increased and the number is the target.

Senator CORMANN—You would have seen in those budget papers that there was a percentage figure next to that 8.8 million. Furthermore, it has been increasing since 2005-06. The percentage has plateaued now. If you were to look at the last couple of quarters of PHIAC data, it has been plateauing at around about 44.6 per cent, from memory. The question still stands. If you expect the number no longer to increase moving forward—the number which is now 9.7 million—and to stay static at 9.7 million while the population is increasing, then you essentially expect that the entire population increase is not going to take up private health insurance or that at least proportionately speaking there will be a reduction in the percentage of Australians with private health insurance. Is that right? That is mathematically correct; there is no way around it.

Prof. Calder—It is not our role to speculate about what might be the target in the future.

Senator CORMANN—It is not speculation.

Prof. Calder—The target we are working to this year is the number and it has held.

Senator CORMANN—I am not asking you to speculate about the target in the future, I am asking you to comment about the target in the budget papers. The target in the budget papers over a four-year period is 9.7 million people. Over that period the Australian population will increase by about 300,000 to 400,000 per annum. If you do not expect the number of Australians with private health insurance to increase, then you actually expect that there will be a reduction in the proportion of people with private health insurance. I think the point is well made and we will move on. Have you reviewed the Productivity Commission draft report on the performance of private and public hospitals?

Prof. Calder—We have looked at the Productivity Commission's report.

Senator CORMANN—What is your assessment of the Productivity Commission draft report? That was commissioned by the government in the context of the Medicare levy surcharge threshold changes and further changes that are coming. Can you give us an explanation of your assessment of the findings in that report?

Prof. Calder—We provided information and data to the Productivity Commission for that report. It is not for us to assess the report.

Senator CORMANN—The purpose of the report, as indicated by the minister, was to inform your public policy decisions moving forward. Surely you will be providing advice based on the findings in the report.

Prof. Calder—It is a draft report. They are asking for responses to the draft report and we will obviously consider that.

Senator CORMANN—I am well aware it is a draft report. You mentioned that you have contributed to the report and that is great, but are you surprised that it was so difficult to get data about how billions of dollars that are going to public hospitals in Australia are being spent?

Prof. Calder—I said earlier today that it was widely recognised that hospitals data need considerable work. There has been work ongoing for some time. In the current climate there is a great emphasis on activity based funding costing data so that we have robust data going into the future. It is recognised that there is work to be done.

Senator CORMANN—We will move along. You would be aware that in some states—New South Wales, Queensland and Victoria—state health ministers are pursuing policies which attract privately insured patients and have them elect to be treated privately in public hospitals to essentially increase cash flow for those hospitals. Does the department have a view on that?

Prof. Calder—No.

Senator CORMANN—You do not have a view on that? Is that not something that is covered under the Australian Health Care Agreements anymore?

Prof. Calder—The fact that it occurs is known. We do not have an opinion on it.

Senator CORMANN—Do you essentially condone it? Are you happy for it to happen?

Ms Shakespeare—Under the Australian Health Care Agreements public hospitals have to ensure that people, at the point of electing to be a public or private patient, are fully informed of their rights to be treated as a public patient. We ensure that a fully informed election is made by the states and territories. The department will investigate if there are allegations that people are not able to make a fully informed election to be treated as a public or private patient.

Senator CORMANN—Thank you for your answer. That indicates to me that you do appreciate that there is a risk that state governments could go too far in the way they incentivise privately insured patients to be electively treated as private patients in public hospitals. Every Australian is entitled to be treated as a public patient, are they not?

Ms Shakespeare—Yes.

Senator CORMANN—Where is the line? Are there any practices that go across the line where the department does become concerned? Have you taken any action against practices where state governments went too far in providing incentives for privately insured patients to elect to be treated as private patients?

Ms Halton—Certainly if there is no choice, yes.

Senator CORMANN—Have there been instances where that has happened?

Ms Shakespeare—There have been complaints made by particular health insurers that have been referred to the area of the department that looks after the Health Care Agreements that they investigate.

Senator CORMANN—So you do not—

Ms Shakespeare—No. That does not occur in the private health area.

Senator CORMANN—From a private health point of view, what is your involvement in an issue like that?

Ms Shakespeare—We will often receive phone calls from concerned insurers and we point out to them what the process is under the health care agreements for raising concerns about patients not being able to make fully informed elections.

Senator CORMANN—We have obviously got the issue of having informed consent and I understand all of that, but if you have state governments which pay insurance excesses or waive other fees, then is that something that crosses the line?

Ms Shakespeare—The charging practices of hospitals are a matter for individual hospitals.

Senator CORMANN—The Commonwealth has an interest in this. The more state governments are successful, the more it will push up the price of health insurance premiums of which the Commonwealth pays 30 per cent for every individual. Are you quite comfortable if state-run public hospitals maximise their income from privately insured patients by actually electing to pay their excesses and waiving fees that otherwise would apply? It is a cost transfer to the Commonwealth, surely?

Prof. Calder—That issue has to be addressed by the state and territory and the hospital on the basis that it does not introduce any anticompetitive practices.

Senator CORMANN—Have you ever conducted an assessment as to how widespread these incentive practices are where privately insured patients are strongly encouraged to be treated publicly?

Prof. Calder—We respond when issues are raised with us and investigate the information that is provided.

Senator CORMANN—Is it on a case-by-case basis?

Prof. Calder—Yes.

Senator CORMANN—You have not detected a theme to the extent where there is a requirement for a more proactive response?

Ms Halton—I would not say that we have not, on the odd occasion, taken what may look like a more systemic issue which is of concern to us forward to the relevant department. Yes, we do case-by-case, but on the odd occasion there will be something which looks to be a widespread practice which we can be sometimes unclear about whether it is actually legitimate, and if that is the case we would write to the head of department, for example.

Senator CORMANN—My home state of Western Australia some years ago did a review. It was similar to the National Health and Hospital Review Commission. We had the Reid review in Western Australia which explicitly recommended that this is what state public hospitals should do—waive excess fees, pay for additional services and so on—but has there been no circumstance where, as a matter of general approach, you have taken action against the state government to say you cannot do this?

Ms Halton—As I said, it depends on what the particular practice is. In some cases there have been issues that we have raised with the state where it looks to contravene the principles

and the rules in respect of genuine choice and consent. The issues about choice, particularly in respect of choice of doctor and consent in relation to those matters, are crucial, as you would understand given your background.

Senator CORMANN—I would like to get an indication, on notice, of some of the circumstances in which action has been taken by the Commonwealth towards state and territory governments.

Ms Halton—Yes. I will take some advice about what I am able to release. We will come back to you about that.

Senator CORMANN—You mentioned informed financial consent. In the context of the 2008 premium approval process, the minister wrote to the Australian Health Insurance Association outlining her intention to legislate to require informed financial consent. There has been an understanding in the industry that there would be an announcement as far back as March this year. To date there has not been any announcement. Can you tell us where this is up to?

Prof. Calder—We provided advice on this to the minister and it is with the minister.

Senator CORMANN—I am now wondering whether I should ask you about the advice and whether you can possibly claim a relevant public interest ground or not. Can you help us a bit more in terms of what it is that you are actually doing?

Prof. Calder—I am sorry, I was distracted. Can you repeat that?

Senator CORMANN—Can you go into a bit more detail as to what it is that you are proposing to do?

Prof. Calder—No, because that is a matter that is before the minister. She will make a decision and/or announcement or whatever is her choice in due course.

Senator CORMANN—Given that it is with the minister we do not know what the timeline is going to be for an announcement?

Prof. Calder—No, we do not.

Senator CORMANN—Even though the industry was led to believe the announcement was going to be March this year.

Ms Halton—Yes.

Senator CORMANN—Can you talk us through the preparatory work that has been performed by the Department of Health and Ageing in relation to implementing the policy to mandate for full informed financial consent?

Ms Halton—That is the full matter that was in front of government so we cannot take you through the detail of that.

Senator CORMANN—Is it in front of cabinet or just in front of government?

Ms Halton—It is a matter being considered by government, taking into account all of government processes. We can tell you, as you know, that we have given advice on the matter and that is all that we can tell you.

Senator CORMANN—What is the public interest ground on which you cannot give me any more information?

Ms Halton—About the content?

Senator CORMANN—The content of what it is that you are proposing to do.

Ms Halton—We are not proposing. The minister is considering.

Senator CORMANN—You would have put some options forward to the minister on how informed financial consent could be implemented. The minister has told the industry that she intended to legislate. You have put something to the minister. I am asking what it is that you have put to the minister. You are saying it is advice to government. You know that is not a recognised public interest ground. I am asking you which public interest ground you are pointing to.

Ms Halton—I will take advice from the minister as to whether she wishes to provide that information.

Senator CORMANN—That is a fair point. Is specific legislation required to implement informed financial consent, or are there other ways it can be implemented?

Ms Shakespeare—We have been working with the industry over a number of years to improve rates of informed financial consent and that is obviously without legislation.

Senator CORMANN—You have done various surveys and you have worked with the AMA, but has that only had limited success? Can you tell us of your most recent surveys? How has compliance with informed financial consent been tracking over the last five or six years based on your surveys?

Ms Shakespeare—The most recent survey conducted by the government was in 2007. That was conducted by Ipsos. It found that in 17 per cent of privately insured hospital episodes patients experienced a surprise medical gap. Previously the government conducted a survey through Ipsos in 2006 that showed a similar rate. I think it was slightly lower—16 per cent.

Senator CORMANN—Have there been any further surveys since the election of the new government?

Ms Shakespeare—There have not been any surveys commissioned from Ipsos, no.

Senator CORMANN—Have there been any other surveys?

Ms Shakespeare—I am aware of other surveys that have been conducted by, for instance, Medibank Private.

Senator CORMANN—Are you considering the research conducted by Medibank Private as part of this process?

Ms Shakespeare—Yes, we are.

Senator CORMANN—Can I ask a few questions of PHIAC?

Ms Shakespeare—Yes.

Senator CORMANN—Mr Groenewegen, are you looking after the shop?

Mr Groenewegen—I am. Mr Gath, the usual witness at these proceedings, is overseas on official business.

Senator CORMANN—When we last met we were talking about how health fund financial viability, and in particular net operating margins, have been tracking from the March 2008 to the March 2009 quarter and they roughly halved, did they not?

Mr Groenewegen—We do not prefer to look at quarter to quarter measurements on net margins because they can be volatile, particularly around the March and June quarters.

Senator CORMANN—If you compare March to March then would you not be comparing apples with apples? They would be similar each year, would they not?

Mr Groenewegen—If you measured the years ending March then that would be a valid comparison, yes.

Senator CORMANN—Can you talk us through it? Since March 2007 all the way through to September 2009, which is the most recent quarter, but that has not been released yet, has it?

Mr Groenewegen—No.

Senator CORMANN—The most recent quarter is June 2009. How have net margins been tracking?

Mr Groenewegen—Net margin for the industry in the 12 months ending June 2009 was 3.2 per cent.

Senator CORMANN—How does that compare to June 2008?

Mr Groenewegen—June 2008 was 4.3 per cent.

Senator CORMANN—And June 2007?

Mr Groenewegen—It was 5.6 per cent.

Senator CORMANN—It is fair to say that it is trending down.

Mr Groenewegen—It is.

Senator CORMANN—You would have overheard my conversation with the department about the proportion of the Australian population with private health insurance. Do you report private health insurance coverage as a percentage of the population?

Mr Groenewegen—We do.

Senator CORMANN—There are no plans to change that moving forward?

Mr Groenewegen—No.

Senator CORMANN—Why is that a relevant indicator?

Mr Groenewegen—It is relevant because people see it as a relevant measure of the number of people in private health insurance. It is not the only measure; it is one of two principles.

Senator CORMANN—The percentage essentially adjusts for population growth. If you just look at the number in isolation of a percentage, you do not have an immediate adjustment for population growth. The percentage achieves that, does it not?

Mr Groenewegen—I am not quite sure how to respond, except to say that when we calculate our percentages we take into account population growth.

Senator CORMANN—If you look at the number of people that are privately insured at any one point in time as a proportion of the population, that is a percentage, is it not?

Mr Groenewegen—Yes. It can be expressed as such.

Senator CORMANN—If you express it as a percentage you clearly see the proportion of the Australian population that is privately insured. What happens to that percentage as the population goes up and the number stays static?

Mr Groenewegen—It goes down.

Senator CORMANN—Thank you. I have a few questions in relation to the Medibank conversion process. You were actively involved in this. Can you talk us through the involvement of PHIAC in that process?

Mr Groenewegen—PHIAC is involved under section 126.42 of the Private Health Insurance Act which governs the conversion of private health insurers to for-profit if they apply to become for-profit. There are a number of steps that are required under the relevant section, the principal one being that the council determines on an application whether or not the application involves a demutualisation of the insurer.

Senator CORMANN—On what basis did you come to the conclusion that it did not involve a demutualisation of the insurer?

Mr Groenewegen—The council had regard to a number of criteria with respect to the concept of demutualisation that had been referenced either by courts or in publications of ASIC, who also deal with demutualisations. Some of those criteria that the council had regard to were whether or not each policyholder was insured and insurer; whether or not an insured person must be a member of the organisation; whether or not the organisation, in effect, changes to be owned by one person and becomes owned by another group of people; whether or not the policyholders had rights in relation to the governance of the organisation; whether or not policyholders were entitled to dividends out of the organisation—that is probably more a test of whether or not it is a for-profit mutual as such—and whether or not policyholders, on winding up of an organisation, would be eligible to any surplus after the winding up.

Senator CORMANN—You came to the conclusion that none of that applied?

Mr Groenewegen—In consideration of these factors and other information the council concluded that the application to convert would not, in substance, be a demutualisation.

Senator CORMANN—In that context, Mr Savvides, the managing director of Medibank Private, told us that the regulatory capital adequacy requirements for Medibank as a for-profit are lower than they were for Medibank as a not-for-profit, or indeed in the more general sense that the capital adequacy requirements for for-profits are lower than those for not-for-profits.

Mr Groenewegen—That is true.

Senator CORMANN—Can you talk us through that?

Mr Groenewegen—The capital requirements are based on risk and the possibility of adverse experience of a health insurer. If a for-profit health insurer suffers an adverse

experience then there would be a lesser gain or an increased loss. If you work that through tax effects, it effectively means that they might be entitled to receive either a future income tax benefit—an asset, a receivable—or they would be liable to pay less tax. It is recognition of the tax effect of a for-profit insurer.

Senator CORMANN—In order to maintain the minimum regulatory requirements and sufficient reserves to cater for future clients, does that mean that any future rate change application can be lower—that is, that it does not have to be as high as it otherwise would have had to have been?

Mr Groenewegen—My experience is that rate change applications are based much more on the experience of utilisation and cost growth rather than on the capital position.

Senator CORMANN—Is that because everybody has got a pretty safe capital position?

Mr Groenewegen—Each insurer in the industry satisfies its minimum capital requirements, yes.

Senator CORMANN—In terms of the net margins tracking down, obviously what you have given me before is an industry average which went from 5.0+ down to 3.2. Presumably some are doing better than others.

Mr Groenewegen—Yes.

Senator CORMANN—That usually would be the case. Are you concerned about the way net margins are tracking for any particular funds? I am not asking you to name anybody. I would like to know if the trend is such that you are concerned about the financial viability of any of the registered funds out there.

Mr Groenewegen—As they all meet their minimum capital requirements we are not more than usually concerned—can I use that expression?

Senator CORMANN—Yes.

Mr Groenewegen—It is my job to be sceptical. In any given year, in any premium round, there are some insurers that ask for a larger increase than others because they need it.

Senator CORMANN—The investment environment is starting to relax a bit again. There was the potential for a perfect storm, was there not? Investment income was going down significantly and quite a lot of the funds have reported significant downturns, obviously, in investment income. Net margins are trending down. When would you start to be concerned?

Mr Groenewegen—I think we have been. I would think that the level of anxiety that we have as a regulator of the industry is probably slightly less than it was about this time last year and early this year.

Senator CORMANN—Not that you let on about that when I asked you these questions this time last year. I am pleased that you are slightly less anxious now; that is good.

Just going back to the Medibank Private conversion, the public consultation process that you ran was really quite short, was it not? It was less than two weeks. Is that usual?

Mr Groenewegen—There is no 'usual' in this case, it being the first.

Senator CORMANN—There had been some other conversions.

Mr Groenewegen—There had.

Senator CORMANN—It has been the first government owned one, because there is only one.

Mr Groenewegen—It was the first conversion where demutualisation was not essentially offered within the application. It is the first time the council had to consider whether to go through a full consideration of whether or not—

Senator CORMANN—Medibank approached you and they said, 'We want to convert into a for-profit fund, but we want to do it on the basis that there is no demutualisation.' You had to assess whether or not demutualisation should happen. Clearly there are a lot of people other than Medibank—and the government, for that matter—that potentially have an interest in this. There are 3.5 million policyholders with Medibank that would have an interest in this. Were you pre-empting the acceptance of the Medibank Private proposition that demutualisation was not going to be the way they wanted to go?

Mr Groenewegen—The difference is not that Medibank Private would say that it was not a demutualisation but that they had not said that it was.

Senator CORMANN—Medibank said what?

Mr Groenewegen—It is not that they said that it was not; it is not that they put a position absolutely that it was not. It is that they did not offer the conclusion that it was.

Senator CORMANN—They did not offer the conclusion that it was but you as PHIAC had to make an assessment as to whether or not it was not. It is fair to say that there are potentially 3.5 million policyholders who have an interest in the decision that you are making because, if you had come to the conclusion that it was a demutualization, a lot of them might have been able to make a bit of money out of this. You have read out the consideration: dividend payments and surplus revenues, et cetera. In that context was it not unusual that it was a consultation period of less than two weeks?

Mr Groenewegen—It was two weeks, which was about half the time the council had available to it to make the decision. The council had 30 days to determine that firstly and then there was a demutualisation—

Senator CORMANN—Is that a legal requirement?

Mr Groenewegen—The council must determine the application for demutualisation within 30 days.

Senator CORMANN—How many submissions did you receive in that time frame?

Mr Groenewegen—Eight.

Senator CORMANN—Did you advertise for submissions?

Mr Groenewegen—Yes, we did.

Senator CORMANN—In the *Fin Review*—

Mr Groenewegen—In all major city and national newspapers.

Senator CORMANN—In the *West Australian*?

Mr Groenewegen—Yes.

Senator CORMANN—Can you give us a bit of the flavour of those eight submissions? Presumably Medibank would have made a submission. Did the government make a submission?

Mr Groenewegen—No.

Senator CORMANN—No? The government did not make a submission?

Mr Groenewegen—No.

Senator CORMANN—Who made submissions?

Mr Groenewegen—Policyholders.

Senator CORMANN—Those eight submissions were all submissions from policyholders?

Mr Groenewegen—That is correct.

Senator CORMANN—Out of 3.5 million policyholders, eight of them made a submission. What was the nature of their submissions?

Mr Groenewegen—I think I can probably best summarise them as, 'I think I should get some money.'

Senator CORMANN—All eight of them were like that? They were like, 'I have an entitlement as a policyholder'? Essentially you wrote back to all of them to say, 'We have considered your views but we do not agree'?

Mr Groenewegen—That is correct.

Senator CORMANN—Is there a reason why the submissions were not made available on PHIAC's website?

Mr Groenewegen—I am not sure that they could have been or should have been.

Senator CORMANN—Normally—

Mr Groenewegen—They go to inform the council's decision.

Senator CORMANN—When you normally conduct reviews you do not publish submissions on your website?

Mr Groenewegen—No.

Senator CORMANN—That is good to know. In your call for submissions what is it that you asked for, roughly, in broad terms?

Mr Groenewegen—In our submissions?

Ms Halton—We will get you that on notice.

Senator CORMANN—Were there any issues raised other than the demutualisation issues that you already mentioned?

Mr Groenewegen—I am sorry, in the—

Senator CORMANN—Did the eight people who wrote to you all exclusively write, 'We should get some money out of this,' or did they raise other issues?

Mr Groenewegen—I will take that on notice.

Senator CORMANN—Once you finalised your consideration of this did your report go to the government or did you just make a decision—'This is it'—and you are now happy for the conversion to proceed and have notified Medibank?

Mr Groenewegen—We notified a number of agencies—the tax office, the secretary and the minister amongst them.

CHAIR—Thank you very much to the witnesses.

[4.37 pm]

CHAIR—We now move to outcome 2, Access to pharmaceutical services.

Ms Halton—Can I clarify that advice that was given to Senator Fifield as to the role of senators in the Local Sporting Champions program? Just so that we are absolutely clear, I suspect the officer may have given the senator—who was very pleased about this—a slightly bum steer, if I can use the technical—

CHAIR—It is a sporting term.

Ms Halton—Local Sporting Champions grants are allocated to MPs in the House of Representatives. Senators can and would be encouraged to refer applications for local sporting champion grants within their state or territory to the appropriate MP. MPs can also choose to involve senators in the assessment process. So I apologise for that slight bum steer. Can I also just go to the question that we were asked at the beginning of the day, because I have asked for some advice internally about this matter as to the date of annual reports. What I can tell you is that since 1998-99—in other words since the report tabled in 1999—the reports have been tabled on somewhere between 21 October and the end of October. There was one that was tabled on 1 November—and that was clearly an aberration—but they have all been tabled basically at the end of October—

CHAIR—We remember that one. It caused some discussion.

Ms Halton—I think it might have done. The reality is, however, that supplementary estimates hearing dates have moved and that is why the report historically has been available. For the same year, 1999, the estimates hearing date was on 1 December. The following year it was 22 November. In 2002 it was 21 November. In 2003 it was 5 November. In 2005 it was 2 November, et cetera, and we are now in October.

CHAIR—Senator, does that actually meet your needs or do you want that response in writing? You asked about annual reports. Ms Halton has just gone through that. You are okay with that, so it will not be on notice now.

Senator CORMANN—My first question is in relation to the 2008-09 budget measure of more efficient arrangements for chemotherapy drugs. Originally that was supposed to take effect on 1 July 2009. It was deferred in the 2009-10 budget to 1 September 2009. Recently, there was an announcement by the minister that it will now be linked with the fifth community pharmacy agreement. Can you just confirm for us exactly what the time lines for this are going to be moving forward?

Ms Campion—No implementation date has yet been specified for the measure. The minister's announcement stated that we would be talking about these issues as part of the fifth agreement. That announcement did not specify a new implementation date, so that announcement will occur sometime in the future.

Senator CORMANN—But when you say it will be as part of the fifth community pharmacy agreement, when at the earliest do you expect that to come into effect?

Ms Campion—The current agreement expires on 30 June 2010 and, all things being equal, the next agreement will commence on 1 July 2010. That does not necessarily mean that the measure would be delayed that long; it will depend on whether we are able to resolve the issues around the measure. If we are able to do that earlier then the government may decide to commence the measure at some earlier point.

Senator CORMANN—You mentioned that there were issues needing to be resolved. Clearly, if you are going to have discussions as part of the fifth community pharmacy agreement then I would have thought those discussions would take place for as long as it takes to finalise the fifth community pharmacy agreement. What is the incentive for anybody who is going to be negatively impacted by this to facilitate agreement earlier?

Ms Halton—That is a matter for further discussions between us and the guild.

Senator CORMANN—Just between you and the guild?

Ms Halton—The agreement is between the government and the guild.

Senator CORMANN—In terms of the chemotherapy measure the guild is an important stakeholder, but it is just one stakeholder. There is obviously a range of other stakeholders involved in all of this. Can you just talk us through some of the issues that you are still trying to resolve?

Ms Campion—The majority of the outstanding issues in relation to the measure in some way or another relate to remuneration either in terms of delivery fees, supply chain fees or the amount that we pay pharmacists for preparing and supplying infusions. That was one of the reasons why a decision was made to incorporate ongoing discussions as part of the fifth agreement. Most of the outstanding issues are, as I said, in that sort of area. They relate to how much we pay for certain activities associated with preparing chemotherapy infusions.

Senator CORMANN—Looking just at the core of what the initiative was at the time, are you still looking at pressing ahead with the proposition of funding chemotherapy drugs on a per milligram basis, based on dosage rather than based on phials? Or have you moved away from that and are exploring alternative ways of achieving efficiencies but without actually having the negative impacts on patients that would otherwise have happened?

Ms Campion—The intent will still be to achieve efficiencies in the system and therefore for taxpayers to receive the benefits of those efficiencies to pay less for chemotherapy medicines. There are other options that are being put forward. We do have a proposal that has been presented to government by a group of stakeholders—

Senator CORMANN—I have recently read a copy of it thanks to four folders of documents that arrived in my office.

Senator Ludwig—Be careful what you wish for.

Senator CORMANN—No, this is provided by government as a result of an order of the Senate, so it was not inappropriately received.

Senator Ludwig—Be careful what you wish for.

Senator CORMANN—That is right.

Ms Campion—We will be discussing that proposal as part of the negotiation process.

Senator CORMANN—If I can summarise: you are still pursuing efficiencies, which of course is very sensible—everybody supports pursuing efficiencies—but you are no longer going down the track of wanting to implement a funding arrangement that is based on a per milligram rebate system. You are looking at alternative ways. Is that a fair way of summarising it?

Ms Campion—No.

Ms Halton—We have not made any decisions about that. We have a number of propositions that you are aware of, but there is not a decision in respect of them and we have to have these negotiations.

Senator CORMANN—I have to say that I congratulate the government for this. I have been a bit concerned about this measure, as you would appreciate. I initially asked some candid questions but it is sensible that the government has decided to defer implementation of this until we can make sure that whatever efficiencies are pursued are done in a way that does not ultimately harm patients. I do congratulate the government on that. In relation to the Fifth Community Pharmacy Agreement, what progress has been made on negotiating that?

Ms Halton—There is not yet any formal negotiation on that.

Senator CORMANN—They have not started yet?

Ms Halton—No.

Senator CORMANN—When do you expect them to start?

Ms Halton—That will be a matter for the minister.

Senator CORMANN—We heard earlier that it runs out on 30 June 2010. How long do these negotiations usually take? How long did it take to negotiate the Fourth Agreement?

Ms Halton—The use of the word 'usually' is probably not something I would have chosen. I think 'variable' would be the right description. Sometimes they take a very long time and others times they do not.

Senator CORMANN—Given that we are looking at the Fifth Agreement, presumably there is a first, second, third and fourth. What was the experience of negotiations for the first, second, third and fourth community pharmacy agreements?

Ms Halton—We will take that on notice.

Senator CORMANN—Is there nobody here who was involved in the negotiations on any of those agreements?

Ms Halton—Regrettably, yes, I was.

Senator CORMANN—That is what I thought. So I am sure you would be able to give me some indication. Perhaps the first one is too far away, but what about the fourth and fifth?

Ms Halton—Regrettably I was around then, too, I am loathe to say.

Senator CORMANN—You are a great source of information.

Ms Halton—That is not my reputation.

Senator CORMANN—Can you give us an indication? Is it like a week? I suspect not. Is it a year? I hope not.

Ms Halton—There is a difference between the amount of time one spends talking to the other side and the lapse of time. The last agreement did take us a while.

Senator CORMANN—How long?

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

Senator CORMANN—Roughly? Two months, five months, 12 months, two years?

Ms Halton—No, it did not take two years. It was about nine months, a bit under a year.

Senator CORMANN—Nine months?

Ms Halton—Yes.

Senator CORMANN—You tell me that I should not use the word 'usual', but what happens if you do not reach agreement by 30 June 2010?

Ms Halton—There are a number of options, including extending the current agreement.

Senator CORMANN—Has that happened in the past?

Ms Halton—Yes.

Senator CORMANN—It is a matter for the minister as to when you start having meetings. Is the minister involved in those discussions?

Ms Halton—The minister will choose herself whether or not to be involved in some or all of those meetings. Again, that is a matter—

Senator CORMANN—At the risk of using the word 'usual' again, is it sort of usual for these sorts of discussions to involve the minister?

Ms Halton—Of course I could suggest that you could inquire of former Minister Abbott, who was the minister at that time. I think what you would find in his case—and of course this is where this is ultimately a matter for ministers themselves to decide—he participated in some of those discussions.

Senator CORMANN—I am sure that with something of this importance the Pharmacy Guild would make it their business to get an opportunity to have a discussion with the minister. But we are not talking here about the actual day-to-day negotiation process; I would be very surprised if any minister was involved in that. The way it would usually work I assume is that you are given a framework within which to negotiate and then the department and relevant officers of the department sit down with the Pharmacy Guild and work through the detail.

Ms Halton—Yes. Certainly in the past there has been a higher level discussion, if I can put it that way, between the principals of the guild and government principals and the line-by-line detail has been worked through by officers. But again, as this has not started I cannot characterise to you what will happen on this occasion.

Senator CORMANN—But in essence what you are telling me is that you are waiting for the minister to essentially make the starting shot and say, 'Off you go and negotiate; start now', before you get underway.

Ms Halton—It is a matter for the minister, absolutely, because whatever the position is the minister's position; that is correct.

Senator CORMANN—Are there any specific issues that are going to be on the table given the experience with the Fourth Community Pharmacist Agreement?

Ms Halton—Again, that is a matter for the minister in terms of what matters the government and she wish to pursue under the agreement. As it has not yet commenced I cannot answer that question.

Senator CORMANN—Excellent. What is the average time taken for the listing of a drug that meets the cabinet threshold from the time of PBAC approval to the time of listing?

Mr Stuart—While we might be able to provide you with data on an average, it is also something which is quite highly variable.

Senator CORMANN—What would drive variability?

Ms Halton—We should acknowledge at this particular point that Mr Stuart has been in the job about three minutes so his grasp of what might be those factors may be best described as a little sketchy as yet. I am sure he will come to grips with it very soon. And if he is wrong I am going to take great delight in telling him that later.

CHAIR—When was that round of changes made? We were looking at the list and there seems to have been quite a distinctive change around the first assistant secretaries in particular.

Ms Halton—There are only two at this particular moment. Mr Stuart made the mistake of going away on holidays for a rather long period—

CHAIR—That is always an error.

Ms Halton—It was a serious error because he was away for some months. He had a particularly nice time and I decided to upset him when he came back.

CHAIR—Mr Stuart has just gone into the job this month?

Ms Halton—Yes.

CHAIR—And that was Ms Podesta going into—

Ms Halton—That is correct.

Mr Stuart—The average time taken to list high-cost drugs on the PBS—this is drugs over $10 million—from a PBAC recommendation to listing is at about 10 months.

Senator CORMANN—I am sorry if I am jumping around. It is just that I have issues in a particular order. Perhaps I am not being consistent with the way things are structured within the department. But as I understand it they are all under Outcome 2. The Productivity Commission's *Annual Review of Regulatory Burdens on Business* recommended the removal of the PBS authority system. I assume you would be familiar with that? And of course that is a system which requires doctors to obtain telephone authority from Medicare Australia to prescribe certain PBS medicines and those requests are never rejected. What is happening in relation to that? Are there any active proposals to implement that Productivity Commission review recommendation?

Ms Santiago—As you would be aware, as part of the PBS reforms the streamlined authorities arrangements were introduced, which meant that a designated list of medicines was changed so that prescribers no longer have to ring Medicare Australia for the approval.

Senator CORMANN—Has this actually already been removed?

Ms Santiago—For a subset of the items.

Senator CORMANN—What is the purpose of the PBS authority system?

Ms Halton—Can I make a comment about this? When we actually negotiated the PBS reforms we had put to us some concerns amongst prescribers in relation to that particular system. The countervailing concern from inside government was, notwithstanding your point about the times at which they were refused, that there certainly has been a view that it makes people think before they prescribe as to whether the prescription is actually really necessary. The obverse of this would be that there would be a financial impact if you removed the authority's arrangements. What we agreed to do as part of reform was to look at the list and agree which ones we thought were low risk and to then monitor that. Notwithstanding the fact that that report in terms of regulatory arrangements has made a recommendation, we still have a commitment to look at authorities in an ongoing way, and that will certainly be the case.

Senator CORMANN—What you are saying is let us make it harder, let us put a little hurdle into the process so we can slow down the flood of relevant requests. Is that the theory behind it?

Ms Halton—The authorities have been in place for quite a long time. They were introduced precisely to make people pause and think before they wrote a script, to be absolutely confident that that script was necessary.

Senator CORMANN—As I understand it, doctors are going to spend between four and 10 minutes on the telephone waiting to get the authority. As I understand it, requests are never rejected. Are you aware of any circumstances where a request has been rejected?

Ms Halton—I do not know about that. We would have to take that on notice.

Senator CORMANN—I hear what you are saying. Essentially what you are saying is that this is a deterrent. Even though we never reject it, and doctors have not figured out that we never reject it, it sort of stops them from putting in a request that is not justified. Is there any evidence that that is how it works? I understand that that might have been the idea behind it when it was introduced, but is there any evidence that that is—

Ms Halton—Precisely as I have indicated, one of the things we agreed as part of the PBS reforms was that we would relax the authority arrangements in a number of areas and then we would look at that over a period. It is fair to say that our colleagues in the department of finance get themselves quite worked up about the notion of taking off authorities because they believe it will cause—

Senator CORMANN—Hang on. Is it not the Department of Finance and Deregulation?

Ms Halton—There is an interesting contradiction there.

Senator CORMANN—How many—

Ms Halton—You can go to their estimates and ask them if you like.

Senator CORMANN—It is the Department of Finance and Deregulation.

Ms Halton—You might be right.

Senator CORMANN—I think that is a statement of fact. How many requests for authority are received each year, do you know?

Ms Halton—Again, Medicare Australia administer this.

Senator CORMANN—You say you are reviewing it. When did you remove the requirement for requests for the PBS authorities? When did you actually remove the subset of items as you mentioned? When was that?

Ms Santiago—I believe that was in August 2007.

Senator CORMANN—So it has been going for two years. Have you done any formal assessment of how that has been working? Has there been a significant increase in applications since then?

Ms Santiago—The department established a group to monitor the impact of this particular measure. We monitored streamlined authorities over a period of 12 months. That report was concluded after the 12 months. The general finding was that removing the requirement to contact Medicare Australia had not changed prescribing behaviour.

Senator CORMANN—It had not changed prescribing behaviour?

Ms Santiago—No.

Senator CORMANN—That sounds to me like evidence that the authority system is not actually the deterrent that people might have thought it was.

Ms Halton—In respect of those items.

Senator CORMANN—Do you think that the behaviour would be different with other items?

Ms Halton—To be honest I have not had a look at it. The issue in respect of that recommendation will have to be considered.

Senator CORMANN—Are ADHD drugs something I can talk about under access to pharmaceuticals?

Ms Halton—It depends on what the issue is.

Senator CORMANN—I am sort of keen to just understand what is happening. Obviously there have been some very concerning TGA reports recently about incidents of psychotic episodes amongst kids that have been treated with ADHD drugs. The minister, before she was the minister, was quite outspoken about the need for treatment guidelines, the previous guidelines having lapsed at the end of 2005. I am just wondering where—

Ms Halton—The guidelines are an NHMRC issue.

Senator CORMANN—Aren't they a health department issue as well?

Ms Halton—Yes, but they are being done by the NHMRC.

Senator CORMANN—They are being finally ticked off by the NHMRC?

Ms Halton—No, they are being developed by the NHMRC.

Senator CORMANN—Is there a current policy in relation to pharmacies and supermarkets?

Ms Halton—We do not have them.

Senator CORMANN—Have there been any approaches to the department by supermarket chains since November 2007 to have them?

Ms Halton—Not that I am aware of. I am certainly aware before that of occasional approaches et cetera, but I have not had any approaches recently. I do not know whether anyone else has.

Ms Campion—No, we are not aware of any.

Senator CORMANN—Do I talk about swine flu vaccines in this area? Which area is that?

Ms Halton—We have actually already dealt with pandemic under biosecurity. It depends on what the question is.

Senator CORMANN—I asked some questions at the last Senate estimates about the Life Saving Drugs Program. I thought I would follow up on a few of those. In relation to Gaucher disease, there have been significant stock outages of the treatments for Gaucher disease and Fabry's disease as a result of manufacturing issues with the supplier of the only approved treatments for these diseases. Essentially there have been some manufacturing issues.

Ms Halton—Yes.

Senator CORMANN—How are you dealing with that?

Mr Stuart—We are aware that there have been manufacturing issues in a particular plant overseas. I will ask Mr O'Connor-Cox, the responsible branch head, to talk a little bit about the committee that we have that is advising and the process for rationing and providing access to those drugs.

Mr O'Connor-Cox—On 16 June the company that supplies those drugs under the program notified the department of shortages that will be affecting the global supply of Fabrazyme and Cerezyme due to the detection of a virus in one of its facilities. The department, from 1 August 2009, has implemented rationing strategies for Cerezyme and Fabrazyme as recommended by our advisory committees, the Gaucher and Fabry Disease Advisory Committees. These dosing strategies included reducing dosages and temporary

cessation of therapy from Cerezyme. This was based on a clinical severity hierarchy. The committee has also recommended reduced dosages of Fabrazyme. This was in response to information provided by Genzyme that the supply of Cerezyme would be reduced to 60 per cent of usual patient dosages and 80 per cent of usual patient of Fabrazyme until October 2009. On 11 August 2009 Genzyme revised down their estimates of their ability to meet underlying global demand for the—

Senator CORMANN—So, revised down further?

Mr O'Connor-Cox—Yes, on 11 August. And they revised down the estimates for Cerezyme to 20 per cent of usual patient dosages until the end of 2009. On 23 September they revised down the estimate of Fabrazyme to 30 per cent of usual patient dosages.

Senator CORMANN—That sounds to me like a pretty serious situation. Certainly, the advice that I have had is that the shortage is likely to go well into the new year, which is a period of six months and perhaps longer where patients suffering from these relevant diseases essentially have to cope with a significant reduction in treatment dosages. Have you investigated alternative options for treatment?

Mr Stuart—It might be helpful if I ask Dr John Primrose to talk about this. This is a serious issue.

Senator CORMANN—Yes, I know. I am not being flippant about it.

Mr Stuart—No. Neither are we. He might talk a bit about the health impacts, which are not initially as marked as you might expect—Mr Primrose has briefed me on this already—and the sorts of strategies being recommended by the committee to deal with the issue.

Senator CORMANN—That would be great.

Dr Primrose—The situation with Fabry disease is less serious than with Gaucher disease, because there is an alternative supply of enzyme available using another isomer of agalsidase, which is called Replagal. So, if the doctor is concerned about his or her patient who has Fabry disease, Replagal is an alternative, although the doctor would need to establish the patient on a new dosage of that agent. The worry about Fabry disease, as I say, is not as great. For Gaucher disease there is no alternative enzyme therapy available on the market at present. The Gaucher committee is made up of doctors who are very experienced in the management of this condition. The management of the condition is aided considerably by the fact that we have a biochemical marker of disease activity called chitotriosidase. This applies to most patients with Gaucher disease. If there is increasing disease activity the chitotriosidase level goes up and so you can follow the patients. Although it sounds quite serious that we are reducing the dosage of Cerezyme for many of these patients and giving some patients drug holidays, it should be pointed out that this disease is generally one that takes a long time to develop. The abnormal enzyme function means that the abnormal substrate, or chemical, that causes the problems of the disease does accumulate over years, and so with this reduction in drug supply it is likely that substrate again will accumulate gradually for most patients.

Senator CORMANN—That is not a good thing, though, is it?

Dr Primrose—No, but it has to reach a certain level of accumulation before it starts to give problems with bones, liver, spleen and bone marrow.

Senator CORMANN—Given that you now have to ration supply essentially of these drugs, do you prioritise supply according to certain clinical criteria?

Dr Primrose—Yes. The committee looked at the patients case by case and made a decision as to what level the enzyme should be maintained at and which patients should go on drug holidays, so it was individualised. Obviously, the patients who were seen to have the more active disease will continue on a dose that is close to their previous dose level. The patients who have been in longstanding remission with respect to their disease are allowed to have a drug holiday. In addition, we can keep a close eye on these patients with monthly full blood counts and we also have less frequent magnetic resonance imaging of the liver, spleen and bones, which is covered by Medicare.

Senator CORMANN—The reason I am asking some of these questions is that in Europe the TGA has approved, in some circumstances, Miglustat for use in mild to moderate Gaucher disease type 1 patients. Bear with me with the names; I am sure you know what I am talking about. Why are we not going down that path? The TGA approved it but PBAC has not let it through the system.

Dr Primrose—I could tell you a bit about that, although some of it is in the province of TGA. Miglustat is a—

Senator CORMANN—But TGA has approved it, has it not?

Dr Primrose—Yes, I will tell you more information about that. Miglustat is an agent that reduces this substrate, or abnormal chemical, so it is less likely to cause damage. It is not enzyme replacement therapy and so it is not directly replaceable for Cerezyme. The Therapeutic Goods Administration has looked at the available data for Miglustat and they recommended that it be used only in patients with mild to moderate Gaucher disease where enzyme replacement therapy is not a therapeutic option. They made it a very relatively small group of Gaucher type 1 patients. The PBAC looked at that recommendation and, of course, the data from the trials. They recommended that Miglustat was the best treatment that could be made available for patients who fitted into that category, in particular people who have severe needle phobia that does not respond to psychological counselling, for people who have severe hypersensitivity to Cerezyme that cannot be managed with usual medications, and for people with very poor venous access, because this obviously has to be given by the infusion and some people who have a central line get recurrent episodes of septicaemia, so you cannot leave the central line in. For that group of patients Miglustat is a good therapeutic option but, of course, most of the patients on the program have their enzyme therapy without ill-effects so they do not really fit into that category.

Senator CORMANN—Sure, but where I am coming from—and you have described this in your earlier remarks—is that there are clearly different degrees of severity. What you are saying is that for the ones at the lower end of severity, because it takes a while to accumulate, a drug holiday can be quite appropriate. Obviously it goes up in terms of levels of severity. If I look at the European guidelines on this, in the context of this rationing, they have essentially prescribed that infants, children and adolescents should receive Cerezyme at a reduced dose, though no patient should be treated at a dose lower than 15 units per kilogram of bodyweight every two weeks, or alternative treatment should be considered in adult patients. But in

Europe they say for adult patients without severe life-threatening disease progression, Miglustat should be considered as an alternative treatment. Why are we not considering it for that category of patients in Australia given that there is a worldwide shortage and given that there is a need to ration but perhaps also find other ways to deal with what is still a developing situation? There have been three or four downward revisions in terms of world supply. Are we at least looking at these things?

Mr Stuart—Miglustat has been made available quite urgently in Australia. It has been subsidised on the PBS from 1 September 2009 as an alternative therapy for Gaucher disease. Targeted letters are being sent to treating doctors of patients with the disease under the Lifesaving Drugs Program to advise them that the drug is available. In respect of those patients that Dr Primrose outlined—those with poor venous access, hypersensitivity and/or needle phobia—it is the Therapeutic Goods Administration that regulates the indications in Australia, not the Pharmaceutical Benefits Scheme.

Senator CORMANN—I am pleased to hear that it has been offered as an option and subsidised as an option as of 1 September to targeted patients.

Mr Stuart—Sorry, I said the PBS; it is the Lifesaving Drugs Program.

Senator CORMANN—My understanding is that PBAC in its recommendation of 8 March 2009 is the one that has provided the limitations to patients with poor venous access, severe needle phobia and hypersensitivity. Are you saying that that is a direct translation of what came from the TGA?

Dr Primrose—That is correct. The PBAC considered Miglustat initially for PBS listing. They saw that there was a clinical need for the drug for patients who could not have enzyme replacement therapy. There was evidence of some effectiveness in that situation, but the drug was not cost-effective so it could not be listed on the PBS, but the PBAC did recommend that it be listed on the Lifesaving Drugs Program under these conditions. It was simply a matter of translating the approved indication from the TGA into guidelines that clinicians could use. Those guidelines have been incorporated by the Gaucher disease advisory committee and to the Gaucher disease treatment guidelines.

Senator CORMANN—What we are doing here in relation to this treatment is not consistent with what is done in other parts of the world, is it?

Dr Primrose—In terms of the rationing?

Senator CORMANN—In terms of the limitations applied to the use of this drug?

Dr Primrose—That would be a matter for the Therapeutic Goods Administration. It determines the approved indications for drugs in Australia, and Miglustat falls under that.

Senator CORMANN—I do not want to use the word ‘crisis’, but there clearly is an issue where supply could continue down. That has been the experience over the last three or four months. This is now a health portfolio matter, Ms Halton. In a circumstance such as this, what is required for TGA, PBAC and the Lifesaving Drugs Program to sit down and reassess these things, given what is happening in other parts of the world in response to this situation? Who takes the initiative for that?

Ms Halton—Dr Hammett can take you through the details in relation to the listing process and the application from a sponsor, as you well understand. I cannot comment about what the sponsor sought in this area, because I am just not familiar with it. The question of, in fact, special access, which I think is a scheme you would also be familiar with in terms of clinicians' capacity to use product—the issue here will be the subsidy questions.

Senator CORMANN—The subsidy; that is right.

Ms Halton—Yes, exactly. The bottom line is that we are highly conscious of this as an issue and it is being monitored very carefully and on a regular basis. I would not rule anything in or anything out.

Senator CORMANN—What sorts of numbers are we talking about? How many patients in Australia have Gaucher disease type 1?

Dr Primrose—I refer to Mr O'Connor-Cox for the numbers on the program, which would be a subset of the people with Gaucher disease.

Mr O'Connor-Cox—There are currently 70 patients with Gaucher disease.

Senator CORMANN—On the program or with Gaucher disease?

Mr O'Connor-Cox—On the program.

Senator CORMANN—When you say 'on the program', is that the current program in the context of rationing or is that what would be your normal program?

Mr O'Connor-Cox—Both.

Senator CORMANN—So, 70 is the total number of people. Of those 70, how many are currently not getting access to any treatment? How many of them are on a drug holiday?

Ms Halton—While Mr O'Connor-Cox is finding the relevant piece of information, I think the other thing to remember is we are working very closely with the advisory groups on managing this situation and the dialogue that we are having with them is attempting to manage both needs and expectations in a way that is collaborative. That is the important thing; that will be the way we continue to work on this.

Senator CORMANN—That is good.

Mr O'Connor-Cox—The information I have here is that 40 per cent of patients—those with the least severe conditions—are receiving no subsidised therapy until normal supply resumes.

Senator CORMANN—That is 28 patients?

Mr Stuart—Forty per cent of 70.

Ms Halton—Twenty-eight; he is right.

Senator CORMANN—But at this stage we do not have any indication as to when normal supply will resume.

Mr O'Connor-Cox—The information that we received from Genzyme is that normal supply will resume in January 2010.

Senator CORMANN—There are no issues if those 28 patients continue to be on a drug holiday until January 2010; there are no clinical issues?

Dr Primrose—I could not give you a guarantee of that, but we have advised the treating doctors, who are all specialists, to review these patients on a monthly basis and do the chitotriosidase level for most of them where it is appropriate on a monthly basis, and the blood count on a monthly basis, to continue with the normal program of magnetic resonance imaging. We are confident that if a patient starts to get into trouble we will pick it up early.

Senator CORMANN—Then you would reprioritise.

Dr Primrose—Yes, that is right, and perhaps ask Genzyme if they have any strategic reserve that we could get access to.

Ms Halton—This is one of the challenges in this area, which I am sure you appreciate. It is the catch-22, if you like. It is great that someone has developed a therapy in this area for a group of people who otherwise would not be facing great prospects, let us be honest. I do not know whether you have ever seen some of the photographs of the longer term consequences—they are not good. But we are held a bit hostage to the fact that there is one producer. As to the way we are managing this—which I am comfortable is being managed as carefully and as sensitively as it can be, and exactly as Dr Primrose says—I am absolutely confident the clinicians will stick up the flag if there is an issue for any one of those individuals.

Senator CORMANN—Thank you very much.

CHAIR—Senator Siewert may want to go back over some of the issues with the pharmaceutical agreement, as she was caught up in another inquiry. We will see where that goes.

Senator SIEWERT—I do want to cover the Fifth Community Pharmacy Agreement. I apologise, I was off harassing Resources about oil.

Ms Halton—We may say we have already answered that question.

Senator SIEWERT—I appreciate that we have now been talking about the Fifth Community Pharmacy Agreement for some estimates. I am firstly seeking an update, which you may have already provided to Senator Cormann, around where negotiations are up to.

Ms Halton—We have already covered that.

Senator SIEWERT—I will chase that down. Did we cover the issues around the reviews that were supposed to be undertaken as part of the fourth agreement process?

Ms Campion—No.

Senator SIEWERT—I am aware that I have asked about this before and some of them were still being undertaken and some of them, I think from memory, had not been commenced. I am seeking an update on where those reviews are now.

Ms Campion—As we mentioned previously, the agreement and associated documentation specify 11 reviews and we have reached agreement with the Pharmacy Guild that four of those reviews are no longer required, because they have been overtaken by events. Four other

reviews were identified as priority reviews. Of those, one, the collection and recording of PBS prescriptions priced below the general patient co-payment, has been completed.

Senator SIEWERT—Has it been released?

Ms Campion—No, it has not. It is with the minister for a decision as to whether she would like that released.

Senator SIEWERT—Is it best to ask this at the end of you going to the list or now?

Ms Campion—No, you can do it now.

Senator SIEWERT—When did that go to the minister?

Ms Campion—I do not have that information here.

Mr Stuart—I need to correct that answer. It has not gone to the minister at this stage. It is being consulted on with the Pharmacy Guild, and we are still preparing to provide advice to the minister on that.

Senator SIEWERT—Will you be consulting with other stakeholders on that as well? You have done the review and you are consulting with the guild, which is the subject of this. I can appreciate why you would, but there is also a number of stakeholders who would be vitally interested in that information as well.

Ms Campion—The consultation with the guild was about agreement to publicly release the report, because there is a range of protocols around how we conduct the reviews. But more generally, and in a lot of the other reviews, there is actually general consultation. People are invited, if they have an interest, to participate in the reviews.

Senator SIEWERT—In terms of that one, it has not gone to the minister, but it is expected to be with the minister shortly?

Ms Campion—That is correct.

Senator SIEWERT—The minister will then make a determination about whether it will be publicly released?

Mr Stuart—That is correct.

Senator SIEWERT—Thank you.

Ms Campion—One of the other reviews that has been going for a while now is looking at PBS supply arrangements in residential aged care facilities and private hospitals. That one is nearing completion. Another one is looking at some of our special supply arrangements under section 100 of the act. That one is under way. The fourth priority review was the review of the pharmacy location laws, which has not yet commenced.

Senator SIEWERT—When is it likely that that one will commence?

Ms Campion—We have been out to tender and we are in the process of assessing the tenders that we received. It is not too far away.

Senator SIEWERT—As to the other two that are underway, you said earlier that it is normal to carry out stakeholder consultation as part of those reviews. I presume that with both

there will be, but particularly with section 100 there will be extensive consultation, particularly with Aboriginal communities.

Ms Campion—There is widespread consultation. Discussion papers have been released and people have been invited to make submissions. There are also workshops being conducted in different locations.

Senator SIEWERT—So that accounts for eight of the 11.

Ms Campion—That is right.

Senator SIEWERT—What is happening with the other three?

Ms Campion—There are two others that are being conducted at the same time. One is about staged supply where for certain medicines pharmacists provide the medicine in stages rather than all at once. The other one is looking at the impact on community pharmacy when drugs are recalled. They have commenced very recently. The final one is looking at what is called concessional entitlement validation payments to pharmacies. That is another one which has been completed quite some time ago early on in the agreement, because of PBS reform and moving to PBS online, which has incorporated into it an online entitlement-checking system. That review was completed around the time of the PBS reform.

Senator SIEWERT—Presumably that was released? I must admit I am not familiar with it.

Ms Kunca—There was actually no formal review conducted as such and so there is no report for that particular review.

Senator SIEWERT—Was that just input into the PBS process?

Ms Kunca—It was superseded.

Senator SIEWERT—Because the arrangements had changed?

Ms Kunca—Yes, that is right.

Senator SIEWERT—I would like to follow up questions that I put on notice last time. I noticed that the inquiry has now commenced on the location of pharmacies, but I asked whether the department considered that there were too many pharmacies. The answer that you gave me related to the fact that before pharmacists are approved to supply PBS medicines they must comply with Medicare Australia, which refers the application to the Australian Community Pharmacy Authority to assess the application against the pharmacy location rules. I am finding that a little complicated. Are you able to explain that for me? Before they are approved to dispense PBS medicines they have to be approved by the authority and once they are approved they are automatically able to supply medicines; is that the case?

Ms Campion—The authority makes a recommendation to the delegate at Medicare Australia and then the delegate at Medicare Australia issues the approval. The authority is just a recommending body.

Senator SIEWERT—Once they recommend and Medicare gives it a tick, it then becomes automatic that they become eligible for PBS?

Ms Campion—To supply PBS medicines, yes.

Senator SIEWERT—I do not want to make you repeat what you told Senator Cormann in terms of the fifth agreement, so I will catch up on that. In answer to my questions earlier, you pointed out, under the Health Act, the authorisation for the agreement process. You pointed out that under the legislation it states 'the Pharmacy Guild of Australia or another pharmacists organisation that represents a majority of approved pharmacists'. Does that mean that you can only negotiate with one body?

Ms Campion—In effect, yes. There can only be one body that represents the majority of approved pharmacists.

Senator SIEWERT—What happens if you are not a member of the guild? I am sorry if I am being a bit thick.

Ms Campion—In terms of how your interests are represented?

Senator SIEWERT—Yes.

Ms Campion—Essentially the government can only negotiate with in this instance the guild, because the guild represents the majority of approved pharmacists. As we have said earlier, that does not prevent our having discussions with other groups that may be interested in pharmacy issues. As Mr Deller indicated in previous hearings, people have approached us and wanted to talk to us about those issues. We have accepted their invitations to meet and talk, and we will continue to do so.

Senator SIEWERT—The agreement is between the guild and the government?

Ms Campion—Yes.

Senator SIEWERT—I suspect that I will run out of time so I will have to put some more questions on notice. I am particularly interested in Indigenous communities. I appreciate the information you provided around section 100 and the further payments. What happens in respect of the specific issue of Aboriginal communities? Very serious issues have been presented to me and other senators around the provision of pharmaceuticals and medicines to Aboriginal communities, particularly remote communities. I must admit that I have heard about this even in metropolitan areas. There are still some significant issues. How are they going to be dealt with in the fifth agreement and who officially represents their interests? I would put to you, without wishing to put the Pharmacy Guild's nose out of joint, that I do not know that they are necessarily the right body to represent that community of interest.

Ms Campion—Obviously we cannot comment around how the government may want to conduct the negotiations on the agreement. I can say that we have programs that are run in remote Aboriginal communities that are not part of the agreement. They are run separately. We do have programs within the agreement that are providing services to Aboriginal communities and assisting with access to pharmaceuticals. Those programs are being evaluated as part of this agreement. As part of those evaluations we are making sure that the affected stakeholders are involved in those evaluations, and the outcomes of those evaluations will feed into how we design the next agreement. The guild and the government both have an interest in making sure that anything we decide to carry forward is improved upon and based on outcomes of the evaluations. One of the reviews that I mentioned before, the section 100 review, is looking at the remote Aboriginal program as well. There will be a range of

information around its distinct programs, both within and outside of the agreement, whereby that information will feed into the next agreement.

Senator SIEWERT—I have some fairly detailed questions that I will put on notice, but is it possible that further refinement of the model could be included in a new agreement such that there is a revised way of providing pharmaceuticals and medicines to Aboriginal communities, if a different model could be developed that delivered better outcomes?

Mr Stuart—I think you are wanting us to jump to some answers here.

Senator SIEWERT—No. Is there room within the fifth agreement to look at alternative models to those that have been used to date?

Ms Campion—As I said earlier, we cannot comment on what may or may not be in the agreement. Given that we have programs running at the moment, both within and outside of the agreement, those ones that are within the agreement are being evaluated and reviewed with the view in mind that if they are not meeting their intended objectives they may need to be refined and modified.

I would also mention that another program outside of the agreement that will start on 1 July next year is the PBS component of the Closing the Gap package. That is outside of the agreement and that will be providing co-payment relief for Aboriginal and Torres Strait Islander people in non-remote parts of Australia.

Senator SIEWERT—Can you remind me how much funding there is for that program?

Mr Stuart—While Ms Campion finds her place, I just want to correct an answer that we gave earlier. Streamlined authorities were introduced on 1 July 2007. I believe we said August.

Senator SIEWERT—Thank you.

Ms Campion—To provide that other answer, Senator Siewert, there is around $88 million for the PBS component of the Closing the Gap package.

Senator SIEWERT—Over how many years?

Ms Campion—Four years.

Senator SIEWERT—Thank you.

Senator ADAMS—I would like to ask a question about the impact of PBS restrictions on access to breast cancer therapy. The drug I am concerned about is Tykerb, which is used for HER2+ advanced metastatic breast cancer. It was listed on the PBS in May 2008 for patients whose disease had progressed despite treatment with other therapies, including Herceptin. There seems to be a very small uptake of this drug because of some prescribing restriction placed upon access. Could you explain that for me?

Dr Primrose—Lapatinib (Tykerb) is a drug that belongs to the group called tyrosine kinase inhibitors. It is used specifically for HER2+ metastatic breast cancer, which would be about 25 per cent of all cases of metastatic breast cancer. It is a minority of cases. Usually HER2+ breast cancer is a more aggressive disease and it occurs in younger women. It is a significant concern despite the minority number of cases.

The PBS restriction for Lapatinib is for patients with HER2+ metastatic breast cancer who failed therapy with Herceptin or Trastuzumab. Normally Herceptin is given in combination with a taxane drug, which could be Paclitaxel or Docetaxel, if a patient with breast cancer represents with metastatic or widespread disease. The data that we looked at related to patients who had progressive disease on the combination of Trastuzumab and a taxane, and in this case there was good evidence of response to Lapatinib plus another chemotherapy agent called Capecitabine.

The PBS restriction for Lapatinib specifies that Trastuzumab must be discontinued because the patient has progressive disease, and the PBAC did not see any data relating to the combination of Lapatinib plus Trastuzumab. That is the rationale for the current restriction. It is thought that some medical oncologists may feel that there is a role in continuing Trastuzumab in patients who have progressive metastatic disease, but the evidence for that is inconclusive and it certainly has not been reviewed by the PBAC. It is most unlikely that that use would be cost-effective, because currently Trastuzumab for metastatic breast cancer is subsidised on the Herceptin program and that program was set up because Herceptin was not deemed to be cost-effective by the PBAC when it initially reviewed that drug early in the 2000s. I cannot remember the exact year.

Senator ADAMS—Will this particular drug be reviewed again as to its use?

Dr Primrose—It is likely that additional indications will become available for Lapatinib, because the clinical trials program with that drug is continuing. That would, of course, be contingent on the Therapeutic Goods Administration widening the approved indications for the drug. The PBAC is always happy to consider applications made by sponsors and it also considers advice from expert groups, such as the Medical Oncology Group of Australia. I do believe this issue will be discussed at a meeting that certain members of the PBAC and the department will be having with the Medical Oncology Group and other interested groups on 13 November.

Senator ADAMS—Thank you. I will look forward to hearing the result of that at the next estimates.

CHAIR—I thank the officers from Outcome 2.

[5.39 pm]

CHAIR—We are now on Outcome 6, Rural health. Senator Williams has some questions.

Senator WILLIAMS—You might be able to answer this or you might have to take it on notice. I would like to know how much is spent per capita on rural and remote area health as compared to urban areas. Would it be possible to get that sort of detail or is that too much out of left field?

Ms Bennett—That is a very complex question because many of the programs that deliver services to rural and remote people are, in fact, mixed in mainstream health programs. Most of the health delivery that people get is not actually from a targeted identified rural health program. For example, with respect to access to pharmaceuticals, we would not necessarily be able to tell the location of individuals who got those as part of their healthcare delivery. To some extent we can identify MBS usage by rural location, but again it will not necessarily

give you the level of detail you want because people access services in many different locations, depending on the severity of illness and whether they travel or not. It is a complex answer. What we could give you, though, is the detail of the funding provided from every Commonwealth specific targeted rural program where we are responsible for the delivery and the funding.

Senator WILLIAMS—Would that not be a lot of trouble for you?

Ms Bennett—No, we can do that without too much trouble.

Senator WILLIAMS—I would appreciate that. I knew it was a difficult question. I was just trying to see whether regional Australia was getting its fair share of the cake seeing they build the cake.

Ms Bennett—I forgot to mention that much of the service delivery that rural people get is of course state funded and based as well. That is another complexity to it.

Senator WILLIAMS—You mentioned programs that are specifically targeted for rural and remote Australia. Can you give us a briefing on those programs?

Ms Bennett—Again, there are many. We can provide you with some overall detail.

Senator WILLIAMS—You can take it on notice.

Ms Bennett—I will take it on notice. We could be here for quite some time answering that.

Senator WILLIAMS—As to the workers who deliver rural programs, do you have trouble attracting enough workers to carry out the delivery of those rural programs? Is it always a problem?

Ms Bennett—No, it is not always a problem, but again it varies across the workforce and across the country. We have areas of workforce shortage in Australia that are metropolitan ones, but of course overall on average they are worse the more remote you go. Again, it depends on whether it is GP, specialist or allied health. The picture, once again, is that there is not a straightforward answer, but overall access is more difficult to health professionals in the more remote locations.

Senator WILLIAMS—I would say the lack of GP numbers would be the biggest complaint in many rural and regional areas.

Ms Bennett—That is an issue that is before the government.

Senator WILLIAMS—Dentistry is as well. Are the RRMA scholarships improving the flow of doctors to regional Australia; that is, from people who have progressed through the RRMA scholarship scheme?

Ms Bennett—That is not an issue under our outcome.

Senator WILLIAMS—I was just referring to workers in rural health. Do incentives have to be provided to attract workers to regional areas? I know that local government in some cases offers free housing, for example. It might be a building for a surgery or perhaps a free vehicle and so on. Is that common practice throughout many areas?

Ms Bennett—There are those sorts of incentives provided by local government and others. The government has introduced a range of incentives. I do not wish to confuse you, but most

of our rural workforce incentives and programs are actually an outcome 12 issue, which is not one that is before the committee's hearing today. We do provide a range of incentives to attract and retain the workforce.

Senator WILLIAMS—With regard to overseas doctors and dentists that are coming to Australia, I am concerned as to the ratio and how many are going out to those regional areas. Are they staying in the cities or are they helping to fill the gap to provide those essential medical services in the regional areas?

Ms Bennett—By and large, the programs that we monitor and implement are designed to ensure that overseas trained doctors are attracted and are required to work in the more rural and remote areas. Through being able to control their access to Medicare we have the capacity to ensure that they work in districts of workforce shortage and that they work in the more rural and remote areas. Yes, that is one of the important levers that we use. As part of the reforms introduced in the last budget we have introduced a notion of scaling that requirement so that from July next year overseas trained doctors will have to work a lower number of years in the most remote locations compared with the less remote rural regions. We do use that lever of ensuring that overseas trained doctors do help address our workforce shortages.

Senator WILLIAMS—In relation to those areas with large Indigenous communities—if I can put it that way—are we filling the gaps there in many of those areas that are in desperate need of medical and professional help?

Ms Bennett—To be honest, that is a question that touches across OATSI programs and workforce programs, and people are not in the room to answer those questions today. Obviously many of those communities that you are referring to are located in the more remote areas, and overall the focus of all of the new initiatives introduced in the last budget was to significantly increase the incentives to a range of professionals to attract them to those areas, including into areas that have large Indigenous populations. That is the general thrust of the most recent budgetary reforms.

Senator WILLIAMS—Thank you.

CHAIR—Senator Adams.

Senator ADAMS—Firstly, with respect to the Rural Women's GP Service, could you tell us how successful that is at the moment and how it is going?

Mr Andreatta—For the 12 months for 2008-09 we had 18,200 services provided through that program. That is a six per cent increase on the previous year.

Senator ADAMS—That was the reason I was asking. I had a fair idea that it started to increase, which is very good for rural women. They are using the service. Has the funding been increased for the Royal Flying Doctor Service program? I have not quite got to that in my book.

Mr Andreatta—Currently the funding is from 2007 to 2011. That is locked in. It was $247 million. There has been no change to that agreement.

Ms Bennett—That agreement substantially increased the funding over the previous four-year period. There was a large increase, but we are now in that funding period.

Senator ADAMS—Are the states that are involved with the Royal Flying Doctor Service increasing their funding as well?

Mr Andreatta—The Australian government funds the RFDS for traditional services. They are the air evacuation, clinics and consultations. The states and the Northern Territory fund the RFDS and other providers of aeromedical services for the hospital to hospital transfers. In that respect they have separate contracts with the RFDS and other providers and then they complement the Australian government program that we are funding.

Senator ADAMS—Does the Regional Health Services Program finish at the end of December?

Ms Bennett—The Regional Health Services Program is one of the programs that was reviewed as part of the overall review of rural health programs. It will form part of a new consolidated program that consolidates regional health services, the MAHS program, the multipurpose centres program and the Building Healthy Communities program. Regional Health Services is the key one and it will be amalgamated into one new rural primary health program. It continues. The funding levels continue, but it is amalgamated with other programs into a more flexible program that will be delivered to the same communities, but allowing a little more flexibility and a little less reporting burden to the auspice organisation.

Senator ADAMS—I am very happy to hear the 'flexibility' word, plus less red tape; I think people will be very pleased with that.

Ms Bennett—People have been given a period of extension of current arrangements, but that is not because it is going to end then. It is to allow time to do the new program guidelines and get things set up for the new consolidated program.

Senator ADAMS—Has the Medical Specialist Outreach Assistance Program increased as well, as far as people accessing the service?

Mr Andreatta—I can tell you that for the 2008-09 year we have had 1,430 services delivered. What I cannot tell you at the moment is how that compares. We have an issue with the data that we have sourced and we are trying to confirm that that is an accurate figure. I do think the level of service is being maintained from last year.

Senator ADAMS—Can you take that on notice?

Mr Andreatta—I will.

Senator ADAMS—Are you able to attract specialists to become involved with the service or are there fewer specialists making themselves available?

Mr Andreatta—There has not been a problem to date in attracting the relevant specialists. Each jurisdiction or each auspicing organisation sources the local providers and to date we have had no feedback that there has been an issue there.

Senator ADAMS—I will start with the Patient Assisted Travel Scheme. I note that the Health Commission, when it handed down its report, actually mentioned it and had a recommendation, which I was delighted about. It is fine to have a recommendation, but where have we gone since then?

Ms Halton—As I have indicated, that report is being consulted on at the moment. The government will be considering those consultations, the reports, and some discussions with the states and territories in the run into the COAG meeting about March of next year.

Senator ADAMS—That issue keeps coming up wherever we go to hold inquiries. It does not matter which inquiry it is.

Ms Halton—We agree.

Senator ADAMS—I will bring one up in here.

Ms Halton—You know our view on this issue.

Senator ADAMS—I do know your view. I thought I would just raise the issue and hope that I was in the right section this time.

Senator BACK—My concern particularly was addressed, and that was the length of time that doctors coming into Australia spend in rural communities before they are able to go to the major regional or metropolitan cities.

CHAIR—Senator Back, we did not list workforce for this evening, so we will put something on notice for you. We could hold a briefing, if that would be useful for you.

Senator BACK—It certainly would.

CHAIR—That is often something we do, so we will arrange that and put a request in to get a briefing for you. I know that Senator Fielding had questions.

Senator McEWEN—I wanted to ask about the National Rural and Remote Health Infrastructure Program. Could you give us an update on how much infrastructure investment has actually been provided since the program was announced last year?

Mr Andreatta—There have been two rounds of the program completed. In funding round 1 we had 202 applications worth $60 million and on 28 January the minister announced 53 successful projects amounting to $11.8 million.

Senator McEWEN—Are they spread widely throughout Australia?

Mr Andreatta—Yes, they are. There was a media release that listed those locations. I could certainly provide you with that on notice if you wish.

Senator McEWEN—That was the first round?

Mr Andreatta—It was the first round. At the same time this year in the 2009-10 budget there were an additional 17 applications funded worth $4.7 million. In round 2 we had 168 applications worth $45.8 million. On 18 June Minister Snowdon announced 27 successful projects to be funded worth approximately $5 million. We currently have round 3 underway. We have received 238 applications worth $68.5 million. There has been no announcement yet of the successful applicants, but we are expecting that to happen shortly.

Senator McEWEN—Are some of the applicants in round 3 repeat applicants?

Mr Andreatta—I could not tell you that. I could certainly take that on notice.

Senator McEWEN—Was the maximum amount of allocations $500,000; is that right?

Mr Andreatta—That is correct.

Senator FIELDING—I would like to chat about a hospital in Victoria, the Warrnambool hospital, if I can. It is about MRI machines.

Ms Halton—It is not under this program.

CHAIR—Do you have any other questions?

Senator FIELDING—No.

CHAIR— I believe that concludes question under Outcome 6, so thank you to the officers from Outcome 6. Now we move to Outcome 7 which is Hearing Services.

[5.58 pm]

Hearing Services

Senator WILLIAMS—The statistics that have been publicised show that one in six Australians suffer from some sort of hearing damage or hearing loss and that may go down to one in four. What actions are you putting in place to prevent this, or do you have any plans to restrict or stop the flow of the amount of people experiencing hearing loss or who are going to suffer hearing loss because, with the population growth to 30 million people by the year 2025, we could be looking at seven and half million Australians with hearing problems?

Ms Ward—The Hearing Services program has three components. One of the components is a voucher component; it is a demand driven program for those with a hearing loss who are eligible under the program. But there is also a Hearing Loss Prevention program which funds research into preventable hearing loss as well as projects that would promote actions that would avoid hearing loss for example through noise damage.

Senator WILLIAMS—The prevention instead of cure sort of attack?

Ms Ward—Yes.

Senator WILLIAMS—What age group do you target that at? Is it all ages or do you particularly target the young?

Ms Ward—Young people, Aboriginal people and workforce age people, because most damage is done through ageing but also through noise.

Senator WILLIAMS—Exactly, especially when we look at some of the MP3s and people who are walking down the street and you can easily hear five metres behind them.

Ms Ward—That is right. In relation to the National Acoustic Laboratories there are a number of projects—six research projects—under the Hearing Loss Prevention program that was announced last year and three more projects this year in the prevention component. Some of those are through the National Acoustic Laboratories and they are particularly looking at young people and the sort of noise exposures that they have through personal instruments for playing music and that sort of thing.

Senator WILLIAMS—These include nightclubs and bars. The music noise to me is—

Ms Murnane—True. The symphony orchestra and the opera orchestra now do occupational safety work with them. Now you notice that when a particular movement or part of a movement that a particular instrument plays is finished they will actually leave. That is part of their protection and that came from research that was done by NAL. NAL has done a

lot of research on the devices like Walkmans and iPods as to what the damage is. I cannot remember the figures, but they have established that the hearing of people now in their mid-20s is much more damaged than it was 15 years ago. There is a lot of work. This is not the Commonwealth's role, but another important aspect of prevention is the screening of newborn children, and that is undertaken by the states and territories.

Senator WILLIAMS—I believe some states have got a lot of room for improvement to lift their game as far as the hearing test for infants is concerned.

Ms Murnane—There is always further to go.

Senator WILLIAMS—How do you sell a message especially to younger people that the noise is damaging to their hearing and it will no doubt have an effect on them especially later on in life? How do we get that message through? Whether it be loud music in motor vehicles or the MP3s, to me it just appears to be cool to have everything turned up very loud. How do we turn this around?

Ms Ward—There was the Hearing Awareness Week work where the head of NAL spoke and got quite a bit of media coverage, but some of the research that NAL is doing is also directed to how do you get the message across to adolescents. They have got some research into school based programs that you could roll out as well.

Senator WILLIAMS—Because we should have seen some reduction in hearing loss from farm machinery. In my early days on tractors they were extremely noisy; the later ones now are very well lined, insulated, comfortable et cetera and much, much quieter. The exposure to a lot of farm machinery and chainsaws would be a bit better these days so you would hope that the statistics would be starting to improve. In fact they are looking as though they are going to get far worse.

Ms Murnane—We could get the latest figures from the National Acoustic Laboratories. That is part of Australian Hearing, not part of this portfolio. It is part of Senator Ludwig's portfolio—

Ms Halton—He has moved on to other things.

Ms Murnane—I do apologise. I thought that they were actually registering an improvement on occupational deafness.

Senator WILLIAMS—You would certainly hope so because of the awareness of it; with the earplugs at work and the earmuffs and quieter machines et cetera, you would hope it was improving. The point I am making is that if the workplace is improving as far as hearing loss is concerned and yet the average for Australia is getting far worse—of course, the percentage of elderly people is growing in number—but it is frightening to see that if the numbers go down to one in four, which is what I am looking at and what I have heard about, then we are in for a serious problem with a serious cost attached to it. How do you train the young ones especially to look after their ears and not expose themselves to high decibel noise of 100, or even 110?

Senator Ludwig—If you do have an interest in this area there is a lot of work Australian Hearing is doing with the acoustics laboratory. They have a Hearing Week where they try to provide more insight, particularly for the young, around iPods and the like. They also come to

parliament. I think they have been to parliament during Hearing Week as well with a whole range of demonstrations. Australian Hearing is in the Human Services portfolio, but I have no doubt that they have already appeared—in fact I do not think they appeared before this committee this time—but of course you are still able to put questions on notice to them.

Alternatively I am sure you could go through the minister's office to contact Australian Hearing. They would be only too happy to assist you in providing some information. They have been doing a lot in this area, particularly the National Acoustic Laboratories. I know there is a renowned professor who works there who has been taking an extraordinary interest, particularly in relation to the young adults right through to babies. One of the important things is to pick up on hearing loss very early. That means that you can provide some assistance, because otherwise it will affect their learning abilities as they develop and their developmental stages may not keep pace because of their hearing impairment.

On Friday, I think we are also going to deal with the NTER, the Northern Territory Emergency Response, but a range of Indigenous issues also arise particularly around ensuring that even in classrooms people can hear so that they can provide an environment where they can learn. A lot of work has gone on. This is only from memory of some of the briefs I have read in this area. Certainly there are things like hearing loops in schools for teachers to assist in amplification of voice, but you would be surprised that there are also things like ensuring that if you get a common cold it gets treated very early because if it continued on, particularly among young infants, it could lead to scarring of the ear, which means that there is a degradation of hearing or hearing loss as a consequence, and that can be permanent. What that means is that as people develop into preschool, grade 1 and grade 2 it may not be picked up that a significant hearing loss has already commenced from things such as common colds that have continued on with runny noses and the like. So it is quite an extraordinary area to look at. But there is a lot of work being done, particularly through the National Acoustic Laboratories. It is worth a visit as well to see some of the exciting work that they are doing.

Ms Ward—WorkSafe is also doing some research under the Hearing Loss Prevention program on enablers and barriers in the workplace to avoiding noise hazards, including headsets and why people take them off and why they keep using them and that sort of thing to try to encourage better uptake of those protections.

Senator WILLIAMS—I will close by saying that with some precaution and some education so much of this can be prevented, especially for young ones, from causing so much damage to their hearing. No doubt you have 16-year-olds who, because of the huge amount of noise they are putting up with, have got as much damage to their ears these days as the average 60-year-old.

Senator ADAMS—As you are aware there is a Senate inquiry into hearing services at the moment. As we have been moving around the state probably one of the biggest issues is the fact that, with the Hearing Services, once a person with a hearing problem turns 21 they are then out of the service. A lot of these people have other disabilities; they are not just hearing impaired. Could you explain why they can no longer access Hearing Services programs? The figure quoted at the moment is that there are possibly 700 people in the category of having turned 21 who are affected at present and who are not able to access hearing aids because of their financial constraints and other issues.

Ms Ward—The criteria for eligibility were established in the legislation in 1997. It has likely to have remained the same since the program was first started in 1947, and that was targeting veterans and children because of the great impact on children of speech development in educational opportunities, et cetera. The more significant change from the eligibility criteria was including some categories for Aboriginal and Torres Strait Islander people in 2005-06. So, successive governments have decided that the eligibility criteria which were set out in the legislation continue to be the group, the cohort, that they want to provide service to under the Hearing Services program.

Senator ADAMS—Has the department had any requests or issues from people having problems and asking is there any way that this could be extended?

Ms Ward—We do get ministerial correspondence from people in that regard. As I understand it, over the years the department has provided advice to government about eligibility issues and the government has not changed its position on eligibility criteria.

Senator ADAMS—I cannot say what our recommendations will be yet. That particular issue is becoming a little bit repetitive.

Senator Ludwig—Have you been to the National Acoustic Laboratories?

Senator ADAMS—It is on our list. No, we have—

Senator Ludwig—and then had a briefing from Australian Hearing?

Senator ADAMS—I went to the Hearing Services demonstration that they had in Parliament House a while ago which was—

Senator Ludwig—There is a range of out-services that Australian Hearing also provides. They go to a range of community groups and the like. There is a particular Indigenous one out of Sydney. If you have got time, depending on how long the committee is examining the issue, it is worth examining some of the work they do, or get them to take you through some of the outreach work and then some of the work that they have also assisted in, particularly around the research work that they have done. It is a very interesting field and I am sure you would want to have it contained within your report.

Senator ADAMS—Thank you, because members of this committee are also involved with Indigenous issues on other committees, as we have moved around the Indigenous communities we have seen the schools that have their own acoustic rooms or the teachers have got their amplifiers and it is just amazing to see the difference in the children because they do not want to wear hearing aids. if we can somehow do something through our committee it would be very good.

There has been another suggestion that perhaps Hearing Services should move to disability services. I know it might be a policy thing, but it is a fact that most of these people, upon reaching 21, have a disability as well and hearing is just part of it. Is somebody with a hearing disability really a different category of person? This seems to be a bit confusing, especially as we have heard the evidence from Ms Murnane that we are going to have more and more young people being affected. When listening to people driving past and the booming that is going on in the car I sort of look at them and wonder what is going to happen to them later.

Ms Halton—You are asking for an opinion really—

Senator ADAMS—I suppose I am, too.

Ms Halton—I am not familiar with the history in terms of what has been put where and why. I think you would have to remind yourself that, firstly in relation to hearing, in a number of cases there are interventions which are categorically health interventions, such as cochlear implants, et cetera. So you just have to think about that. In the way that the treatment and the appliance is managed there probably is a distinction perhaps between some of the disability services—certainly in my experience of them—but there is obviously a series of philosophical arguments you could mount on several sides of this debate, some of which I think Ms Murnane and I historically would have more than some familiarity with. But I would point to the health side of a number of these things.

Senator ADAMS—The next thing that was raised was mental health issues associated with hearing. A number of children are having problems with mental health. Because they cannot hear they are getting aggressive. They just cannot really cope with their situation. Do you have any comment about that?

Ms Ward—The Hearing Services program would look at anybody with comorbidities like that as being a complex client. Part of the service that is provided is about rehabilitation and some of that is around coping with the hearing loss, not just devices but also communication strategies and a follow-up on those matters as well. I guess from the other side of things mental health services need to be aware of a comorbidity with hearing, such as depression and that sort of thing that can be associated with a hearing loss, especially acquired hearing loss.

Senator ADAMS—As far as the newborns are concerned I note that on 29 June this year the Minister for Health and Ageing and the Parliamentary Secretary for Disabilities put out a media release about hearing screening for all Australian babies saying:

> The Australian government will seek a commitment from states and territories to deliver newborn hearing screening for all Australian babies from 1 January 2011.

Could you comment on that particular commitment? Has any communication on that started with the states and territories?

Ms Ward—The states and territories have given a commitment to have a national neonatal screening program by the end of 2010, with services commencing more uniformly from 2011. There is a subcommittee of the health ministers' conference that is a screening subcommittee. They have a working group. They are looking at the whole screening pathway from the initial screening to follow-up services and a registered national database and work is well underway on that work, including standards for screening and services. The preliminary screening is a state responsibility but it was getting all governments to work together with that common aim.

Senator ADAMS—This is just a quote from specific issues affecting Indigenous communities—and I have touched on it—saying traditional hearing aids are often culturally not accepted in Indigenous communities. It says:

> The use of classroom amplification systems and good acoustic design would address the hearing needs of many Indigenous children. However, there is no single authority, state or federal, education or health, that has responsibility to ensure that classrooms with a high proportion of Indigenous children have been acoustically treated or had classroom systems installed.

What they are saying is that there is a sort of collective, whether it is health, education or hearing, but whose responsibility it would be to fund something like that?

Ms Ward—It is in the education sector.

Senator Ludwig—What you are actually then talking about is where there has already been hearing loss. Prevention is just as important, particularly in Indigenous communities. That is where I was going earlier—

Senator ADAMS—That is what I thought you were talking about.

Senator Ludwig—One of the people you may want to talk to in your travels is Pat Lock, who is one of the Indigenous elders in Liverpool and who holds a very good relationship with Australian Hearing, to address some of these issues. Australian Hearing has worked in the issues that arise in Indigenous communities to try to look at how you can provide prevention. There is a whole range of issues there. I do not want to take up your time by going through them, but I would encourage you to have a look at their annual reports as well. I think there is some good work there available for the committee.

Senator ADAMS—I come to the patient assisted travel system for people with children having to travel to Hearing Services. They are not eligible. I do not know where we go with that one. That is coming up quite a lot. It is a specialist appointment really and it surely is a medical health issue, but for some reason they are excluded. That has come up from a number of our submissions, especially from the rural areas.

Ms Halton—I have to admit I did not know that.

Senator ADAMS—They are not included and really and truly I think they should be.

Ms Halton—That is very useful. Thank you, Senator.

CHAIR—I thank the officers from Hearing Services.

Proceedings suspended from 6.21 pm to 7.31 pm

CHAIR—We will reconvene and we will go into outcome 10. It is our intention to start with health system capacity and quality and go into e-health.

Senator BOYCE—I was wanting to start with the 2009-12 strategic plan for the National E-Health Transition Authority: 'coordinate the priorities for e-health solutions and promises, accelerate the adoption of e-health through increasing awareness, lead the progression of e-health in Australia'. None of these involves an activity that relates to patients. Can you talk me through how long it will actually be before we implement any of these strategies?

Ms Forman—This is the NEHTA strategic plan that was released quite recently?

Senator BOYCE—That is right, yes—2009-12.

Ms Forman—NEHTA has developed that strategic plan to fit within the National E-Health Strategy. It is actually articulating all the work that NEHTA is doing. Within each of those key priority areas that NEHTA has identified it is actually doing quite a lot of work that relates to clinicians and healthcare providers.

Senator BOYCE—Can you tell me what those are?

Ms Forman—It is developing four key packages—e-referrals, e-medications, e-pathology and secure messaging. All of those have been consulted on with clinicians and healthcare providers.

Senator BOYCE—They are also the same sorts of initiatives that have been around almost since 2004. What has actually happened?

Ms Forman—On those?

Senator BOYCE—Yes.

Ms Forman—The secure messaging specifications and standards have been completed. NEHTA has taken those right through the development stage and completed and agreed those. They have now been provided to Standards Australia to finalise the process. We are expecting those to probably be published at the end of the year, but they are available now for software providers to put into the—

Senator BOYCE—Was that not the case in June? Were they not being trialled with software providers in June?

Ms Forman—Now they are finalised and agreed. The e-referral package is almost completed and I think the e-medications package has been released for consultation.

Senator BOYCE—I asked for a list at the last estimates on the outcomes that were to be completed and implemented between June and December. Could we go through that list. In June you were going to have the clinical terminology completed; 99 per cent of the TGA registrable products would be in an Australian medicines terminology.

Ms Forman—That is correct. That has been completed and it has since been superseded by version 2.2, which was released to the public on 24 August this year.

Senator BOYCE—What does version 2.2 do?

Ms Forman—It includes all of those things. It is just the most recent update.

Senator BOYCE—Is it more than 99 per cent now?

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

Senator BOYCE—If you could just explain to me what the difference between version 1 and version 2 is on notice, that would be good. Who is actually using this clinical terminology?

Ms Forman—I will have to take that on notice. I am not aware of a list of organisations.

Senator BOYCE—You cannot tell me what sorts of organisations are using it?

Ms Forman—It is available now for use.

Senator BOYCE—On your website it is publicly available?

Ms Forman—That is right.

Senator BOYCE—But you do not know who is accessing it and for what?

Ms Forman—No.

Senator BOYCE—Would you anticipate knowing that?

Ms Forman—NEHTA would certainly get a feel from its consultations and the work that it is doing with the range of providers where the AMT is getting picked up.

Senator BOYCE—Could you tell me on notice how many organisations have accessed it or are currently using it—whatever useful information you can give me about the actual use of the clinical terminology?

Ms Forman—Yes.

Senator BOYCE—In July you were going to have an electronic discharge summary nationally endorsed and released.

Ms Forman—That has been completed. A nationally representative core discharge summary was publicly released on 22 July 2009.

Senator BOYCE—Again, who is using that?

Ms Forman—Once again, I do not have that information on hand.

Senator BOYCE—Is it being used?

Ms Forman—It is a NEHTA product. I do not have the information about where it is being used.

Ms Halton—It is probably important to understand that all the states and territories have a commitment to using NEHTA products. Because of the process that they have of refreshing legacy systems and putting in new developments, these things are picked up at varying stages. I will use an historical example, and that would be the common medication chart. We developed a common medication chart. To begin with, that common medication chart appeared nowhere, but as people refreshed their medication charts it is now used almost universally and indeed the private sector has picked it up as well. In this area, because the states are committed to using these things what happens is that as their systems are developed and as they change various things they will pick up these things.

Senator BOYCE—What I need to know is the level of that usage that is actually occurring.

Ms Halton—Because this is actually undertaken by states and territories we will only be able to tell you anecdotally because we do not know—and there is no mechanism for us to find out—exactly how much penetration there is.

Senator BOYCE—How will the department ever assess how well the National E-Health Strategy is working?

Ms Halton—Essentially, if and when we end up with the electronic health record, the completeness of that record and its capacity across jurisdictions will only be realised if indeed the states and territories are rolling out all these various elements.

Senator BOYCE—You will measure its success by lack of failure, is that how it will work? How will you measure its success?

Ms Halton—If and when the electronic health record itself is actually funded there will no doubt be put in place a series of quite hard quantitative measures, but in the shorter term in this area we are reliant on the states.

Senator BOYCE—If I could just, in this case, go through it. Conformance, compliance and accreditation was due in July. Has that occurred?

Ms Forman—It has. The concept of how a national certification authority for e-health related software will function has been prepared and significant consultations commenced with government and industry around the concept.

Senator BOYCE—That is not in use yet, but you are consulting about whether the conformance, compliance and accreditation—the governance package—is suitable?

Ms Forman—That is correct.

Senator BOYCE—When would you expect to finish that?

Ms Forman—NEHTA has presented it to the stakeholders reference forum and to a number of nationally recognised organisations, such as the joint accreditations scheme. It has also been presented in outline as part of the practice incentives program working group that NEHTA has established. It will lead to a fully fledged concept of operations. We do not have a specific date when that will be completed, but it will be when those processes are done.

Senator BOYCE—Clinical terminology was going to be completed by November. Is that on schedule? That is the first consolidated version of SNOMED CT 2. Do I have the acronym right?

CHAIR—Well done.

Ms Forman—That is right. That is still on schedule for delivery in November.

Senator BOYCE—Who will use that once it is delivered? How will people access that one?

Ms Forman—That will be released as a NEHTA product again.

Senator BOYCE—That is the version 2 you were talking about, was it, or not?

Ms Forman—I do not actually have a version. It was the first consolidated version, I think.

Ms Halton—Yes, there probably is not version 2. I cannot remember the version we were up to.

Senator BOYCE—For December you have secure messaging. I am sorry, I am just trying to rush through these because we are going to run out of time. Secure messaging will be in December?

Ms Forman—That is right. The NT secure messaging is proceeding according to schedule and will be going live in December in phase 1 of the NT upgrade project.

Senator BOYCE—And we have yet another clinical terminology due in December, which will be the release of the live technical demonstration. I am going to the end of the list at the moment. That is due in December: 'Release of a live technical demonstration to show the healthcare community the benefits of SNOMED CT 2 and the Australian medicines terminology.' I am glad I am not going, but I am sure there are a lot of people who will find it absolutely fascinating.

Ms Forman—The SNOMED CT 2 and AMT were both demonstrated at the medications safety committee of New South Wales in August 2009 and also at the Health Informatics Conference 2009 in Canberra.

Senator BOYCE—So this live technical demonstration has been done a couple of times already. So we are ahead of schedule with that one, are we?

Ms Forman—Indeed.

Senator BOYCE—Could you give me the same information for supply chain, referrals, electronic transfer of prescription, e-health engagement and communications, which were due in December? Then I will go back to the one that is probably the big one, unique healthcare identification, which is also due in December.

Ms Halton—Unique healthcare identifier. Let us be clear about this. This is the notion of a number that each individual will have. It is under the rubric of being able to be identified, but the particular product is a unique healthcare identifier for each individual.

Senator BOYCE—Can I just read here what it said in the information that I was given at the last estimates:

> The individual healthcare identifier and healthcare provider identifiers for individuals and organisations will be designed, developed and delivered as per the contract arrangement with Medicare Australia.

That was to happen by December.

Ms Halton—I met with the CEO of Medicare Australia, in fact, yesterday or the day before, and it is on track.

Senator BOYCE—When will people actually begin to have individual healthcare identifiers?

Ms Halton—It depends on which jurisdiction they are in when it is going to be rolled out, but the capacity will be there from December.

Senator BOYCE—Where would you expect it to be rolled out first?

Ms Halton—I do not know. I will have to take that on notice.

Senator BOYCE—Is there a schedule for the rolling out of it?

Ms Halton—It is partly a question of each jurisdiction and what they are doing.

Senator BOYCE—Each state. There is certainly a perception—I think you agree—out there, particularly within the community I think you referred to at one stage as computer geeks.

Ms Halton—Yes. Indeed, I got myself an entire slagging-off in the computer pages of a certain newspaper because I think I used the terms ‘propeller head’ and ‘geeks’, which somehow they found less than flattering.

Senator BOYCE—I am sure that was not how it was intended.

Ms Halton—Indeed, that would be right.

Senator BOYCE—However, this community is feeling a little irritated by what they see as a lack of progress in this area. The view has been put to me that this authority was established

in 2004 and the budget has been more than $200 million over that length of time. Is that the correct figure?

Ms Halton—I will take the quantum on notice because I do not have it to hand. I think people actually, if you do not mind me saying, just need to calm down a bit about this. What we are trying to do here—

Senator BOYCE—I think they have a sense that they have calmed down for several years.

Ms Halton—Actually, I think they are being unreasonable. What they actually want is a significant investment from government now to have everything happen instantly. The bottom line is we are trying to build a reasonable national system that will enable private investment and private engagement. The work that NEHTA is doing—all of the work that is on the delivery schedule for basically the end of this calendar year, and is on schedule—is as good as you will get around the globe. Genuinely I think that. Okay, they might want several billion dollars more. That is fine as an ambition. But in terms of taking relevant, logical, ordered steps towards this e-world I think actually we are not doing too badly.

Senator BOYCE—Can you supply on notice a schedule of who would be rolling this out when, or is that not yet available?

Ms Halton—As I said, what you have here with this list of things that NEHTA is developing and delivering, which is what they have been asked to do, are the enablers. They are the things about ensuring that we do not have six or eight railway gauges in this country in respect of electronic health. That is the crucial point. None of us—and let us be really clear about this—none of us wants a world where what we have stored in terms of our medical records is controlled by a proprietary product in a doctor's surgery or something else. We want interoperability and the ability to say, 'Are you Senator Boyce?' such that no-one can steal your identity or misconnect a record about you.

Senator BOYCE—I do not think anyone has any concerns or problems with the idea that this should be a very secure exercise.

Ms Halton—This is not just about security, and security is absolutely fundamental. It is also about ensuring that there are not islands of information over here that somebody owns and islands of information over here that somebody else owns, and any notion of basically connecting those two up, which would be in your interests medically, is either controlled and charged for privately by somebody or is just not able to happen.

Senator BOYCE—Now we have a trial exchange of electronic prescriptions between GPs and community pharmacies planned. Can you tell me about that? How will it be trialled? Who will it be trialled with? Will real data be exchanged during this exercise?

Ms Forman—This is one of the NEHTA deliverables?

Senator BOYCE—Yes. 'NEHTA will be releasing specifications to support the trial exchange.'

Ms Forman—That is right. The draft business and technical specifications were completed in September 2009, while the final specifications can be delivered in December.

Senator BOYCE—What can be delivered in December?

Ms Forman—The final specifications. The draft ones have been released. The final can be delivered in December. Extension to the original consultation period for the specifications is proposed to allow NEHTA to incorporate more comprehensive consultation.

Senator BOYCE—To when?

Ms Forman—That consultation is planned to be completed in February 2010. This change still awaits decision. It has not been approved at this stage.

Senator BOYCE—By? Who would need to approve that?

Ms Forman—NEHTA's board.

Senator BOYCE—That is going out to 2010 for the specifications. When would the trial be?

Ms Forman—Once the specifications are finalised.

Senator BOYCE—After February 2010.

Ms Forman—Yes.

Senator BOYCE—You might need to take this on notice, but how would that trial be conducted? Who would be involved? Would real data be used? What are the protocols around advising people that real data is being used or would this simply be organisation to organisation? Would individuals be aware that their prescriptions are being handled in this way?

Ms Forman—We will take that one on notice.

Senator BOYCE—At the last estimates I was told that all of this data may not necessarily be held within Australia. Where else are we looking at that it might be held?

Ms Halton—Sorry, Senator?

Senator BOYCE—We were told that with regard to all Australian health and personal data there was no guarantee that it would be stored within the Australian jurisdiction. That was a misreading of *Hansard*?

Ms Halton—I think so.

Senator BOYCE—Can you guarantee that it will all be held within Australia?

Ms Halton—That is an issue—absolutely. I do not think there has been a dialogue about that, has there?

Ms Forman—No, not to my knowledge.

Senator BOYCE—You would guarantee that it would be held in Australia?

Ms Halton—I think we would have a very strong preference that that be the case, but I do not even think this is an issue that has been put forward at this particular moment.

Ms Huxtable—I think in response to that question what the response actually said was that during the planning phase of the IEHR implementation all Australian governments will identify the appropriate storage location, which suggests that that is a decision yet to be taken and will be taken at a point that the IEHR is actually being rolled out.

Ms Halton—Let us be clear about this. Certainly I have a very clear view about what I think about that, but it has not gotten to the point that anyone has put that issue to governments for a decision.

Ms Huxtable—It may have been a misreading.

Ms Halton—Yes, of the response.

Senator BOYCE—You are basically saying that it does not need a guarantee because it is so much of a given that—

Ms Halton—It has to be decided.

Senator BOYCE—That might have been where I thought we got the fact that there was no guarantee.

Senator BOYCE—There was an interview recently with the relatively new chief executive of NEHTA, Peter Fleming, saying that people would have an option to choose health records from a range of sources and their medical information would be stored in a number of locations. How will people be aware of who has got what, where and when?

Ms Halton—This is one of the issues that has to be worked through. Think about what happens to us at the moment in terms of paper records. If I think about the GP that I currently go to and the GP that I used to go to, the assorted specialists that I have been to over the years, all of them have a paper record about me, which probably sits in an open-ended file somewhere behind a receptionist.

Senator BOYCE—Or it has been sent off to an archive somewhere.

Ms Halton—Indeed. It is most likely that there is an electronic component of a record. I do not know about you, but when I go to a GP now she sits there, taps away and puts in assorted details about me. That is then stored, I assume, on a server in her practice. We know that information is stored in our world that is both paper and electronic. We are working on the basis that an electronic health record will be, in the first instance, a summary of key and highly relevant information. It is unlikely, in our view, that there will be one place where that summary will be. It is more likely that it will be drawn from a number of places and it may well be that you will have a capacity, certainly in the medium term, to opt where that is stored.

Senator BOYCE—What might some of those locations be?

Senator Ludwig—Conceptually it is modelled on either a single big database or what I think is being described as a distributed database. As to where the information might be stored, for argument's sake I will use me as an example. I might go to two or three different doctors.

Senator BOYCE—I hope you are not ordering pseudoephedrine.

Senator Ludwig—No. That would be new. For argument's sake, over time your family might go to a different doctor—all of those things—which means that ultimately the providers may store the information in various locations. Therefore, you get the distribution.

Senator BOYCE—The concern is that there is the perception that information held in a computer is far more easily transferred than information held in, as you said, musty old paper records. That may or may not be true, but that is certainly the perception.

Ms Halton—I am not convinced about that.

Senator Ludwig—I do not accept that. One of the things that you have always to recall is that dusty old files can get lost or be misplaced.

Senator BOYCE—They can be thrown on rubbish tips.

Senator Ludwig—I know that doctors take privacy very seriously. A whole range of practices, particularly modern professional practices, put in place significant privacy controls to ensure that their records are maintained with a high level of security.

Senator BOYCE—The question that people are putting to me is: when will we see the first trial of electronic transfer of prescriptions or electronic use of data between GPs and specialists for referrals, for example? We do not have a date on that and are we no closer to a date on that?

Ms Halton—That is not true. Essentially what we are doing is moving to point to point first in this world. It is more likely that we will go to point to point on the moving of pathology, radiology and prescriptions in the first instance. To be fair, the point-to-point GP to specialist is more difficult because specialists are not as connected as some of the others. That is not true with pathology and radiology. It is just a different industry.

Senator BOYCE—Or pharmacy.

Ms Halton—That is not a specialty. That is a different profession. What you are going to see here is a point-to-point communication about moving referrals and test results backwards and forwards in the first instance. That, together with the basic things about name, date, age, blood type, immunisations and so on, will form, I think in the first instance, the core of someone's electronic health record.

Senator BOYCE—There is one thing I wanted to check with you. We talked last time about the appointment of David Gonski as the independent chair. You subsequently talked about an independent member on the board. Who is that?

Ms Bennett—We do have that.

Senator BOYCE—From my reading, all the other members were senior executives within state or, in your own case, federal health departments.

Ms Forman—Lynda O'Grady was appointed as an independent adviser to the board in February 2009.

Senator BOYCE—Was she appointed as an adviser?

Ms Forman—An independent adviser.

Senator BOYCE—She is not actually a board member?

Ms Halton—No. What you have is the CEOs of the state, territory and federal departments with an independent chair and then the advisory position.

Senator BOYCE—I am happy to hand over to someone else.

CHAIR—I thank officers from E-Health. We will now go to the National Breast and Ovarian Cancer Centre.

[7.58 pm]

National Breast and Ovarian Cancer Centre

CHAIR—Senator Adams.

Senator ADAMS—Thank you. Dr Zorbas, it is very nice to see you.

Ms Halton—Can I just observe: she is actually not wearing pink but salmon.

Senator ADAMS—Not yet—that is next week.

CHAIR—It is actually Carers Week this week, Ms Halton.

Ms Halton—Can I observe that Senator Moore is not wearing the colour purple, and I am really disconcerted. Some people are wearing pink. I have spoken at a breast cancer function and done the pink thing, so I have turned to red.

CHAIR—I am building up.

Senator ADAMS—Next week is Breast Cancer Week.

Ms Halton—I do have to observe that Dr Zorbas is not wearing pink.

Dr Zorbas—I am working up to it.

Ms Halton—I do think that Senator Cormann and his colleagues ought to be roundly castigated for not turning up in pink ties.

Senator CORMANN—I look nice in pink; you'd be surprised.

Senator WILLIAMS—A pink shirt could be worse.

Ms Halton—I have seen Senator Ronaldson and, you are right; it is a very bad shade of pink on him, but put that to one side. I spoke at a function in Canberra last week for the Expand network of EAs. There were 320 people and we raised over $16,000 for breast cancer. There were a truckload of secretaries—male—all wearing the most hideous pink ties I have ever seen, with the exception of Martin Parkinson, who told me he had pink undies. Just so Hansard got that!

Senator CORMANN—Too much information. I did not think that you were normally one to give too much information.

Ms Halton—Only when it is a certain quality of information.

Senator CORMANN—I think you should have claimed public interest immunity on this one.

Ms Halton—Anyway, it is salmon, so she only just qualifies.

Senator ADAMS—Dr Zorbas, could you tell me how long the National Breast and Ovarian Cancer Centre has been in existence? I know that ovarian has come in recently, but how long has it been? It seems like years so I thought I had better check.

Dr Zorbas—The National Breast Cancer Centre, as it was, was initially established in 1995 and we were given the additional remit of ovarian cancer in the year 2001. Next year we are celebrating 15 years in existence.

Senator ADAMS—We will talk about national breast and ovarian cancer funding. A lot of your projects are funded by grants, are they? How does that work?

Dr Zorbas—The majority of our funding comes from the federal government. We also have some funding that comes from external sources—corporates and the National Breast Cancer Foundation. We have a small amount in donations and also some government grants that are time limited, which we may apply for, or from other agencies. At the moment approximately two-thirds of our funding is core government funding.

Senator ADAMS—The core government funding started in 2001. Has that risen with all of the extra activity that you have done over those years?

Dr Zorbas—Our funding level has been increased a little with indexation. We are now funded at around $3.3 million per year by the federal government. That comes to us as two allocations—core funding and an additional $800,000 announced in October 2008 by the Prime Minister. That allows an additional $800,000 per year on top of base funding that was around $2.2 million to $2.3 million. With indexation it is now around $3.3 million a year that we are getting and that is fairly stable to the end of our funding agreement, which is 2011.

Senator ADAMS—That was the next question I wanted to ask, because I thought it all looked very stable and I just could not work out whether you were getting a funding increase.

Dr Zorbas—This current funding agreement is a four-year agreement—2007 to 2011.

Senator ADAMS—Can you give us an idea of how the work of the centre has increased since you have been the National Breast and Ovarian Cancer Centre?

Dr Zorbas—As I said, we have fairly stable funding and we work within that budget to identify projects that will improve outcomes for people with both breast and ovarian cancer. The projects that we undertake are for clinical education and clinical information to guide practice and for consumer information. We also use evidence to inform policy and health service delivery. They are the key areas that we have worked in and we do that across both breast and ovarian cancer. We do not differentiate our funding or our staffing in relation to those programs of work in breast and ovarian cancer. We have a staff that works across those areas. For example, this financial year, 15 of 34 projects have relevance to ovarian cancer.

Senator ADAMS—What breakthroughs have you had with ovarian cancer as far as your research goes?

Dr Zorbas—We obviously do not undertake any desktop research, but one of the key areas that we are currently working on is undertaking some work with the Queensland Institute of Medical Research looking at the actual pathways to diagnosis of women who have had ovarian cancer. That is looking at about 1,500 women who were diagnosed with ovarian cancer in this country, and now looking at the management pathways of those women once they were diagnosed. That is a very big undertaking of work across Australia, looking at what is happening on the ground that we can report on in terms of which symptoms are most prevalent for those women who have reported symptoms with ovarian cancer, the pathways, how many medical professionals they saw before they were diagnosed, what tests were undertaken and what management they received.

Another important piece of work for us was conducting a forum that looked at the screening issue for ovarian cancer. This was very topical. Women were demanding tests of their general practitioners without evidence on which to base that testing, in particular CA125. We brought together the ovarian cancer stakeholders, in terms of gynae-oncologists, medical oncologists, general practitioners, the department and other cancer organisations. Together we looked at the evidence and developed a population based screening statement, which was published in the *Australian and New Zealand Journal of Obstetrics and Gynaecology* this month and that position statement has been adopted and endorsed by all of those organisations. We now have a national position statement on ovarian cancer screening. I think we are giving really clear advice that is evidence based to all levels of the community and to assist in policy making in this country on ovarian cancer.

Senator ADAMS—With respect to the first trial of 15,000 across Australia, were you involving the divisions of general practice?

Dr Zorbas—That is the 1,500?

Senator ADAMS—As far as prediagnosis with the symptoms.

Dr Zorbas—That is looking at the pathways, looking at their medical records and getting data from their records. That has required quite a lot of resources in terms of ethics approval across every state and territory. It should give us actual data from those patient records on which we can provide information about the care that is provided to women in this country.

Senator ADAMS—Will that go back to GPs once it is finalised?

Dr Zorbas—Yes. All the work that we do has an arm of explaining the outcomes to general practice. For example, with the screening statement that I talked about, we developed additional information for general practitioners to assist them in discussions with consumers. It was for women in their offices so that they could translate that evidence based information into a meaningful conversation with patients across the desk.

Senator ADAMS—What will the actual screening tool be?

Dr Zorbas—Unfortunately, there is no evidence that any test or combination of tests is effective in ovarian cancer detection at an early stage at this point in time. It is important that women have that clear advice so that they are not undertaking tests that could give them false positives and false negatives. Even in higher risk populations of women we are now revising the information that has been provided as part of our guides, on the basis of the evidence.

Senator ADAMS—A number of women have heard on the grapevine that all of a sudden there is this miraculous test that can be done for them.

Dr Zorbas—Yes. It is very misleading.

Senator ADAMS—It is. What is the latest research that you are doing on breast cancer?

Dr Zorbas—Where do we start? One of the key things we are launching next Monday—Australia's Breast Cancer Day—is a statistical report, which we have developed in collaboration with the Australian Institute of Health and Welfare. That will have the latest statistics and most up-to-date data on breast cancer—incidence, mortality, survival, prevalence—and looking at differences by socioeconomic group, Indigenous status, age and

geography. It will look at the burden of disease and some costs in relation to breast cancer treatment.

Ms Halton—At the risk of putting words in Dr Zorbas's mouth, and given the time of year, it is really important to put on the record again that early diagnosis for people is the best protection that people have. If you are diagnosed early there is a 98 per cent chance of being at five-year survival.

Dr Zorbas—That is correct; when it is very early.

Ms Halton—The bottom line is—given the month that we are in and next week—reiterating that regular check-ups, knowing your own body and having a check-up if anything looks amiss is so important for women.

Senator ADAMS—As a breast cancer survivor, I think the message should go out to them as well that anything that is a little odd, no matter what it is, go back and check.

Ms Halton—Absolutely.

Senator ADAMS—I know we have discussed the bone scan before, but it is just so important. Women tend to think: 'Oh, no, it's all right. Just getting old.'

Ms Halton—Or 'I'll soldier on.'

Senator ADAMS—They just keep going and then it is too late.

Dr Zorbas—You are absolutely right. There are a couple of areas that we are looking at. One is: what are the risk reduction strategies that women can undertake, even after they have been diagnosed with breast cancer in relation to a secondary, and what are the symptoms that they should be reporting? We do know that most of the secondaries are actually found by patients themselves and not by the regular check-ups. They are in between normal screening or diagnostic episodes.

Senator ADAMS—The messages have to be a lot stronger than they are at the moment.

Ms Halton—I agree with that.

Senator ADAMS—Thank you. That is very good. Your organisation has grown so much. How many researchers do you have now?

Dr Zorbas—We have a staff of 34 full-time equivalents at the moment. We have a breadth of expertise represented on that staffing, which allows us to take up the full program of work that we have underway. You may also be interested in the CD that we launched last week, which looks at the other aspect of our work, providing not only improvements in outcomes in terms of survival but also quality of life. That is a CD for men who support women going through the breast cancer diagnosis. It was extremely well received.

Senator ADAMS—I am sure the committee would be happy to have a copy of that.

CHAIR—Yes, thank you.

[8.12 pm]

Cancer Australia

CHAIR—Welcome. Senator Adams has some questions.

Senator ADAMS—I will follow the same line of questioning. When did Cancer Australia begin, what have been the changes and what have you done in that time? You have certainly expanded. I remember when you first came and were just settling down. Professor, I think you had been in the job for two months when you came to your first Senate estimates. Could you give us a brief overview of where Cancer Australia is at today?

Prof. Currow—Cancer Australia turned three in real terms just a few weeks ago, so I am delighted to report that we are out of the terrible twos.

Ms Halton—That means he is overconfident!

Senator ADAMS—I do not think so.

Prof. Currow—It means I can walk.

Ms Halton—And not dribble at the same time!

Prof. Currow—That is correct. In that time we have had a very busy program of work in engaging collaboratively with organisations across the country whose interest is cancer control. As an agency of our size, we have to work collaboratively and those relationships have been formalised with a number of national organisations. We have had a strong focus on consumer engagement throughout our time. That includes having consumers on all of our advisory groups and reference groups. All of our assessment panels have trained consumers as members.

As you would be aware, there is currently a call out for consumers who want to apply to work with Cancer Australia. Through the generosity of the Cancer Council of New South Wales, we have trained another cohort of consumers in research application evaluation this year. We had a very strong response to our advertisements for that. In ensuring that we are addressing the needs of the whole community, our advertisements this year are specifically seeking to target people from Aboriginal and Torres Strait Islander backgrounds. We already have three such people on our advisory groups. We are also distributing that call for applications through the Federation of Ethnic Communities Councils of Australia so that we can reach into communities where we know that cancer outcomes are worse than we would like to see.

In service delivery and service improvement we have been working with the states and territories over the life of Cancer Australia. That work has been particularly to look at how we can streamline service delivery by better linking regional and rural centres with metropolitan centres. The first two years of that program came to an end in June 2009. We have had external evaluation of that program and I am delighted with the speed with which we have been able to demonstrate change in service delivery as a result of that program. For example, in your state of Western Australia, Senator, the pilot program, run jointly between Cancer Australia and the Department of Health in Western Australia, was to better link Albany and the region with Perth. At the end of two years the figures are really quite encouraging. The increase in referrals for radiotherapy was of the order of 25 per cent within that two-year period, and there was a decrease of 30 per cent in people who needed to travel for their chemotherapy. That has been achieved by ensuring that we better create and support multidisciplinary teams. There is now a team working in Albany and linking into major

metropolitan centres in Perth. We have seen similar stories repeated across the country in that particular program.

Together with that we have worked on education of health professionals, including primary care and general practitioners, as well as specialists. As we have flagged before, there is now a national curriculum to prepare the nursing workforce for cancer care at several levels: the skills that we would expect of every nurse, together with the skills that we would expect of a specialist nurse, and indeed the skills that can take people through to nurse practitioner status.

In working as to primary care we have joined with the Cancer Institute NSW to look at the architecture of their web based information for medical practitioners and nurses. They have recently launched their website, which has specific resources for primary care in a way that was not available before the relationship with Cancer Australia.

We have also worked with the college of physicians and the college of radiologists, which includes the radiation oncologists, the Australian College of Rural and Remote Medicine, and the college of general practice on developing new resources to ensure that we have a workforce right across the country. This is particularly to reach into regional and rural Australia to ensure that those practitioners who have more than their share of cancer clinical service provision are adequately prepared and supported in that role. That has been an exciting development.

With regard to our website, we have worked with the Office of Postgraduate Medical Education and a consortium they put together through the University of Sydney. That group, most importantly, have a website called Cancer Learning, which is to support all practitioners who encounter cancer—allied health practitioners, nurses and doctors, whether they are specialists or generalists. Encouragingly, we are seeing an uptake of that website. Importantly, the group from the University of Sydney and their consortium have worked very hard to ensure the continued currency of that website, and I am delighted to see the uptake figures improving in that area.

As to research, the government asked us to take leadership to bring together both the research-funding community and the researchers themselves. To date we have had two full rounds of competitive grant applications. The first stage of those grant applications go through the National Health and Medical Research Council assessment and then come out for additional assessment against priorities that have been set to ensure: that the questions being addressed have importance in practice or policy terms; that they are collaborating with the researchers who are working in the same or in similar areas across the country and indeed around the world; and that they are adequately engaging consumers at the same time.

That program will have its third round of successful applicants announced in the next few weeks by the minister. It has been really gratifying to see how well the research community has responded. We have had nine funding partners this year, which has more than doubled the appropriated money for Cancer Australia in that area. Importantly, we have had fundable applications against every single priority that has been put forward. The research community has responded incredibly well.

Together with that we are supporting the cooperative oncology groups. There are 13 such groups. When Cancer Australia was formed there were only 10. Now for the first time one of

those includes prostate and other urological cancers. We have a new primary care cooperative group, which has been formed this year. It is gratifying to see the progress as that group reaches out nationally to ensure that the important role that primary care has in cancer control is recognised but, much more importantly, that they are able to take that work forward and improve the quality of care that is offered and through that decrease the impact of cancer across our community.

The University of Sydney has a chair in Cancer Quality of Life for the first time as part of our program. We are bringing together key national resources for researchers in cancer particularly around biostatistics, pharmacoeconomics and health economics so that, particularly in the area of clinical trials, if those trials are positive they will have an economic evaluation that will allow them to move more rapidly through the process of registration and importantly subsidy application through the Pharmaceutical Benefits Advisory Committee. At the end of our first three years—

Senator CORMANN—This is a very comprehensive answer.

Prof. Currow—The only thing I have not mentioned is something very close to the senator's heart, which is the National Centre for Gynecological Cancers.

Senator CORMANN—There is more.

Ms Halton—It is alleged, Senator, that he has not drawn breath yet.

Senator CORMANN—I have got to say I am very impressed.

Prof. Currow—The national centre is working closely to—

Ms Halton—That was a hint, David.

Prof. Currow—I would hate for it to be lost.

Senator CORMANN—No, you should take the opportunity. It is important information.

CHAIR—Professor, I want to check who has got questions, given that we are running out of time. We will go to Senator Adams.

Senator ADAMS—Thank you very much, Professor, for that. That is great. Because of time constraints, we are going to have to move on to something else now. I will talk to you later.

Ms Halton—Senator, I will tell you at another time—it will be off the record—the story about a former officer of the department who only needed to be asked a question and could then start and literally talk for an hour without drawing breath—precisely to waste time. I am looking at Mary and she knows exactly who I am talking about. With this particular officer it was precisely to waste time.

Prof. Currow—I would hate that to be associated with what I have just said.

Ms Halton—Not at all. Professor Currow's answer was all quality input.

Senator CORMANN—Ms Halton, one day we should ask your officers just to read all their briefing notes.

Ms Halton—Would that include the background section?

CHAIR—Senator Siewert, do you have some questions?

Senator SIEWERT—I want to follow up the issue of bowel cancer. Where are we at with the screening program? Is there any work that you have you been doing on following that up? Is that the next outcome?

Prof. Currow—The screening group is in the next outcome.

Senator SIEWERT—I will ask then.

CHAIR—Thank you very much. It is probably time for this committee to have another briefing from your organisation to follow up the ongoing issues, and we do appreciate your attendance this afternoon.

[8.25 pm]

National Health and Medical Research Council

CHAIR—Welcome. I apologise that there will be limited time, but there are people who have some questions for you.

Senator CORMANN—Is this the area to ask the question about the clinical guidelines for ADHD drugs?

Ms Halton—Yes.

Senator CORMANN—The minister, when in opposition, was quite keen to see those clinical guidelines finalised. You would be well aware of the reports coming from the TGA last week about 30 children with severe psychotic episodes as a result of treatment with ADHD drugs. Can you update us as to where all of that is at?

Prof. Anderson—The guidelines that are being developed by the Royal Australasian College of Physicians came to our council for routine endorsement in March last year. Council said that they wanted further work on them in a sort of peer review way. They were referred back to RACP. Unfortunately, soon after we became aware that one of the authors—in fact, an author of 80 of 900 papers upon which the guidelines were based—was under investigation for having transgressed the National Institute of Health—our sister organisation in the United State—conflict of interest guidelines. We immediately wrote to his employer and in fact to the US Congress, which is also doing an investigation. We were told by his employer at that time that the investigation is likely to take several months. It is about six months since we wrote and we have since written back to clarify it. In the meantime the NHMRC looked again at the guidelines and said they were quite clear that they should not be issued by the NHMRC while this uncertainty over 80 of the 900 references existed. The author is being investigated basically for research misconduct.

There is little we can do at this stage until we find out what the outcome of that investigation is. If he is exonerated then things can go ahead very quickly. If he is not and if there is a pall cast over those 80 papers, then that part of the guidelines will have to be redone. That is the council's view. Unfortunately, this is right in the area that you mentioned. This is pharmacological treatment of ADHD. This is a very unexpected hiccup in the process. We did ask our council's advice on this less than a month ago—I think it was two weeks ago—and

they were quite clear that they would not support the issuing of these guidelines until this matter had been cleared up.

Senator CORMANN—The effect of this is that we have not had any current guidelines in place since the end of 2005. You would appreciate that, with reports like the one last week coming from the TGA, there is a level of concern among parents. From what you are telling me you have not really got a time line within which—it may or may not go quickly—this could be resolved.

Prof. Anderson—That is right. Although taking guidelines through the NHMRC is voluntary so one option—

Senator CORMANN—Could the minister issue the guidelines?

Prof. Anderson—No, but the RACP could decide to do so.

Senator CORMANN—But you would be concerned that they could be based on tainted research?

Prof. Anderson—We absolutely would—in the crucial area of the guidelines.

Senator CORMANN—I understand your dilemma, but obviously there is—

Prof. Anderson—I understand the dilemma you raise, too, and am very aware of it. We are certainly doing all we can to make sure that as soon as this is clarified we are able to move.

CHAIR—I think we will have to put the rest of the questions to the agency on notice. I think there are a couple. I do apologise for the limited time. We appreciate your and your officers' attendance. Next time we will give you more time. That is all the time we have for outcome 10.

[8.30 pm]

CHAIR—We now move back to outcome 3, Access to medical services.

Senator FIELDING—My questions relate to MRI machines. In particular, it was to do with an article that was in the *Warrnambool Standard* last Thursday about cancer patients in Warrnambool and surrounding districts such as Hamilton, Portland and Mount Gambier being forced to travel for hours to other regional centres because of red tape getting in the way of the South West Healthcare's Warrnambool Hospital being granted a licence for an MRI machine. I do not know whether you are familiar with the story but it was in the *Warrnambool Standard* last Thursday. Are you familiar with the story at all?

Mr Kingdon—Yes, I have read the article.

Senator FIELDING—Is it true that Warrnambool Hospital is actually willing to fund the purchase of the MRI machine themselves and that the only thing holding them up from getting it is the granting of the MRI licence, which would cost the department nothing to issue? I am happy for you to respond to that, because it just does not seem right to me.

Mr Kingdon—MRI is usually provided by public or private providers. They usually provide the capital for them and the federal government provides access to the MBS on a limited basis. This is for private patients, of course. This gives access to the scheduled items. It is referred to as a licence, but it is actually an access to it. It is controlled and determined by

the government-of-the-day as to how many they will be issuing. We had around 15 with the new government. We were just in the process of finalising that. At this stage that is all that is available. There was an earlier review of diagnostic imaging and subsequently a cabinet decision that was announced in the budget saying that there would be a further review of diagnostic imaging and in that review the question of access to MBS for MRI would be looked at.

Senator FIELDING—That is good background. I appreciate that. Has the minister's office had any contact with a delegation from Warrnambool over this issue?

Senator Ludwig—I do not know. I can certainly take it on notice to see whether or not the Warrnambool people have contacted the minister's office.

Senator FIELDING—I will go a bit further, but I would appreciate it if you could confirm that on notice. From what I understand, a delegation from Warrnambool met with the minister's adviser on this issue last week and was told that they had a very strong case. Obviously this is hearsay so you would have to confirm this. But the key to it was they would have to wait two years for a review to be completed. Can anyone explain to me why it would take two years? Can you explain why the department is saying it is two years?

Mr Kingdon—That was part of the budget decision—that there would be a report back to cabinet, which would then be available for consideration in the 2011-12 budget. That was announced at the time of those reviews as to the timing. The stakeholders are aware of the timelines for that.

Senator FIELDING—Given that other regional hospitals in Victoria, such as Bairnsdale, Sale, Traralgon, Bendigo, Ballarat, Wodonga and Shepparton all have MRI machines yet Warrnambool, which is one of the few regional centres that has a 24/7 oncology services, two resident medical oncologists, advanced surgery and is the regional trauma centre, does not have a machine. Can you explain to me what criteria the department uses to decide where they will grant a licence?

Mr Kingdon—The department did not decide the locations. They were actually decisions made by the government prior to the election and they therefore became election commitments.

Senator FIELDING—That does not sound very good, does it? That does not sound like a rigorous and proper process at all to me.

Mr Kingdon—I cannot comment on that.

Senator FIELDING—No. Let us go on a bit further. Is it not true that it is costing Australian taxpayers thousands of dollars more because cancer patients need to be transported by ambulance to, say, Geelong, which costs $2,500 for every trip, or have their travel expenses reimbursed under the Isolated Patients Travel and Accommodation Assistance Scheme? Wouldn't the granting of a licence to Warrnambool Hospital save the government and taxpayers thousands of dollars, given the hospital is happy to fund the MRI machine themselves? They are going somewhere else to get MRI scans. Would it not save the government money?

Senator Ludwig—I was not there when the adviser advised on Warrnambool, but I think on the basis that there have been some discussions already with the minister's office it might be worth while for me to take it on notice and we can perhaps get some clarity around what the—

Senator FIELDING—But the question still stands. Would it not be saving the Australian taxpayers thousands of dollars, because if you eventually have to pay the travelling costs—

Senator Ludwig—It is difficult to make that statement without knowing all of the issues that may surround it as to the costs of the MRI, the nature and number of patients that are involved and a whole range of other things. I think the statement as a bold statement is not one that you could make. But in the interests of ensuring that we do get accuracy around this issue, I have indicated that it is best I think that we take it on notice.

Senator FIELDING—But the issue is around making patients travel and picking up the cost for that travel. It has to cost money.

Ms Halton—Let us be clear. If this is a public hospital, a public hospital can buy and operate an MRI any time it wants to. The issue here is if they want to privately bill. The fact they may be prepared to buy it is great. The issue here is actually the private billing side, and that is what is managed quite tightly. I think we just need to be clear about what in fact it is they are asking for. Because if it is a public machine and is operated for public patients they can do what they like.

Senator Ludwig—In the interests of clarity, do you know whether it is a private machine they are seeking to purchase or whether it is one for the hospital?

Ms Halton—It is not a matter for us unless they want it to operate privately, to put it at its absolute bluntest, so that it is not for public patients but for private patients; otherwise it is not a matter for the Commonwealth.

Senator FIELDING—I think it could be used for both, which they can be, from my understanding. They can be used for both.

Ms Halton—Yes. With privately operated machines there is a clear limit to the number of those machines and where they are located. But for publicly operated machines, go for your life.

Senator FIELDING—Are you aware of what is available in Warrnambool at all? I understand patients have to travel a long way?

Mr Kingdon—There is no MRI. The nearest would be Geelong or Ballarat.

Senator FIELDING—That is correct. It seems odd to me that we are forcing people to travel, yet we have a hospital that is willing to pick up a machine and there is a restriction on the licence. Why is there a restriction on the licence?

Senator Ludwig—As I said, I do not know whether you can make that bold statement. When you say 'you', I presume you mean the government. But as I have indicated, and I think for the safety of both the question and to ensure that we get an accurate response we will take it on notice. You can continue to make statements, but let us look at the facts of the matter. We already know on record tonight that there are both private machines, which can be purchased,

and the government then regulates where they are located. We already understand it is a public hospital for public patients. If I am correct, there does not seem to be a restriction on MRI placement. If it were Warrnambool Hospital seeking to add an MRI in their hospital as a publicly funded MRI to ensure that it treats patients and it prevents them from needing to travel, and all of the positive things around that, that is a different issue from one where a hospital is seeking to maximise the use with private capacity. We can all differentiate between what might be regarded as Warrnambool Hospital seeking a public good, but let us look at the facts about what it is that they are actually seeking and on what basis they are seeking it and then look at the costs that are associated with it. That way you can make the statement I think that you might want to make, ultimately, if you are right, but let us make sure we are right about this.

Senator FIELDING—You will take that on notice?

Senator Ludwig—I have clearly said I will take it on notice.

Ms Halton—Just for the record so we can be clear; I am advised that any MRI which is able to privately bill will cost the Commonwealth, the public taxpayer, nationally $1.2 million. That is our estimate of the billing.

Senator FIELDING—You first said you were aware of the issue right up front.

Ms Halton—Because it has been in the paper.

Senator FIELDING—Is there anything you want to say to that at all, because the claims being made there are pretty serious?

Senator Ludwig—That is why the taxpayer wanted to have a look at the issue. I have not seen the article and usually I ask for the article before I comment. In this instance I have given some latitude, but I think it is important to make sure that we do get the facts right. I have not seen the article; I do not know the nature of what the issue is. We do know, obviously from your questioning, that it is about an MRI. We have undertaken to take the issue on notice and then we will see if we can provide all of the facts around it.

Senator FIELDING—Coming back to the licences, is there anything changed in how licences going forward are going to be allocated? In other words I think the previous way they have been allocated is—

Mr Kingdon—That is the review—

Senator FIELDING—When is that due?

Mr Kingdon—The review is in the process of starting but it will not report until the budget of 2011-12.

Senator FIELDING—Is there a name to this review?

Mr Kingdon—It is called the Diagnostics Imaging Review.

Senator FIELDING—Is there a terms of reference to the review?

Mr Kingdon—They are being drafted at the moment and the minister will be putting those out and she will be seeking a public comment. There will be quite a lot of discussion around many of the features of that review.

Senator FIELDING—Thank you.

Senator BOYCE—On 1 November there will be an incentive for bulk billing of MBS for hospital diagnostic imaging; is that correct?

Mr Kingdon—It could be hospital or private, but it is where it is relating to an MBS item which is for a private patient.

Senator BOYCE—What prompted this incentive payment?

Mr Kingdon—It was a cabinet decision following a review of diagnostic imaging and it was seen—

Senator BOYCE—What have you projected would be the result of that incentive payment? What are you expecting to achieve?

Mr Kingdon—We are expecting to see bulk billing remain, if not slightly increase, for diagnostic imaging, which runs quite low.

Senator BOYCE—It is one of the lower ones, is it not?

Mr Kingdon—It is one of the lower ones; about 62 per cent—71 per cent for bulk billing for diagnostic radiology.

Senator BOYCE—That has been falling, has it?

Mr Kingdon—Slightly. In fact it has moved; it seems to have plateaued.

Senator BOYCE—What are you anticipating will be the effect of—

Mr Kingdon—We are not anticipating any great increase. The government was given considerable advice from the profession that they felt there was a need for some increase in fees and that was seen to be the most appropriate.

Senator BOYCE—What are you expecting as a cost on this for this 2009-10 year, for the part year and the full year?

Mr Kingdon—It is $600 million over four years.

Senator BOYCE—That is for three-and-three-quarter calendar years, so to speak, is it, or three and a bit more?

Mr Kingdon—Yes. It will take us out to 2012-13.

Senator BOYCE—How many services would that be, even if you just want to give it to me on an annual basis?

Mr Kingdon—I do not think I have that. We will have to take that on notice.

Senator BOYCE—If you could give me perhaps the previous 12 months before the incentive comes in, and then the anticipated take-up in the following four years of services that would be performed. Is this in diagnostic imaging?

Senator WILLIAMS—Yes. Just adding on from Senator Boyce there, on the figures I have for the area in which I live in northern New South Wales, the gap for a patient undergoing a CT scan has increased from $90 in 2007 to $110 last December. That gap is increasing dramatically because there has been no increase in the Medicare rebate on that. Are you saying that this is an issue that they are certainly looking at?

Mr Kingdon—Being a bulk billing incentive, it will not change the gap. Hopefully, it will encourage more bulk billing in that area and therefore the average gap may come down, if you follow how you would work an average out on that, but if a patient is paying a gap now and the provider chooses not to bulk bill, then they will still pay a gap. We are hoping that there will be more discrimination about the patients who are bulk billed and that that will benefit patients. This is the intention of the measure, to flow to patients.

Senator BOYCE—I have a question on the removal of the MBS items, which I think arthritis organisations have done a great job of making sure that every senator knew about. The items 50124 and 50125 did attract a rebate of about $25; that was for a joint injection or aspiration for someone with rheumatoid arthritis, caused by arthritis or a joint injury. How did it come about that this was simply taken off the website or ceased to be an item without any consultation at all?

Mr Kingdon—This was a budget measure and so it is difficult with many budget measures for consultation to occur. The decision was taken because it was seen to be, in most instances, a minor procedure that should form part of a consultation, just as when you go and see your GP and you have your blood pressure taken we do not have a separate item for your blood pressure to be taken. The intention here was to align that with the consultation. We have had representations from a number of groups who have pointed out that they do have particular concerns with particular issues of this and the minister has undertaken that these will be looked at. We are in the process of looking at those to see—

Senator CORMANN—But have you increased the rebate on any other item to include it in?

Mr Kingdon—No, it was regarded as part and parcel of a normal—

Senator BOYCE—But it has to be performed by a specialist?

Mr Kingdon—Not necessarily. In fact quite a large number—

Senator BOYCE—Rheumatologists are generally the physicians who perform it.

Mr Kingdon—No, in fact, it is not. The biggest users are radiologists and then vocationally registered—

Senator BOYCE—Who use it in conjunction with an x-ray?

Mr Kingdon—Usually ultrasound.

Senator BOYCE—Could we have some data on that, please?

Mr Kingdon—Then you have vocationally registered GPs who are actually—in fact Ms Robertson has got the numbers for you.

Ms Robertson—In the 2008 calendar year there were 169,457 services provided by diagnostic radiology specialists. In that same period a vocationally registered GP provided 115,778 services and I think you could add to that fellows of the College of GPs and they provided an additional 67,870 services. Predominantly, it is done by GPs and radiologists.

Mr Kingdon—Rheumatologists came out at 54,721, so in fact they were the smallest user of the professional groups.

Senator BOYCE—Nevertheless, most of the correspondence that we have received has been from people who are concerned about its use for people suffering from arthritis. What is the review going to encompass?

Mr Kingdon—We are going to look to see if there are circumstances where it is not reasonable to have accepted that the procedure was minor. An example of it that has been given to us by the rheumatologists—which I have some sympathy for—is where they do an aspiration that may take 20 minutes. That clearly was not intended and that is something that the minister wants to have reviewed.

Senator BOYCE—Do you have a timeline on the review?

Mr Kingdon—We have not got a particular timeline but we are working on that.

Senator CORMANN—I have got a series of questions in relation to the cataract rebate. I note the government has tabled the General Medical Services Table in the House of Representatives, pressing ahead with the 50 per cent cut to the three rebate items for cataract surgery: 42699, 42701 and 42702, the main one being, of course, 42702. Before we get into it, can you just explain to me the services that are covered by the fee rebate under MBS item 42702?

Ms Robertson—It is the professional time that is actually provided by the ophthalmologist in providing that service. If you are looking at the cost of the lens, the cost of nursing staff and the cost of any consumables that are used in providing that procedure, those are not funded through the MBS fee. Generally those costs for private services are funded through private health insurers, as I am sure you would be aware.

Senator CORMANN—When you say 'professional time', it is not just the surgery itself; it is also to a certain degree some post-operative services, as well.

Ms Robertson—Normal aftercare is included in the fee, yes.

Senator CORMANN—I am advised that you have got the surgery—lens extraction and lens insertion—and then you have got up to 21 days of post-operative care which on average I am told includes two additional consultations which are equivalent to item 105 consultations, even though they are not claimed or billed as such. Is that an appropriate way of describing it? Is that an appropriate reflection of what happens?

Ms Robertson—I would not say it is an equivalent service to an item 105, which is a subsequent consultation for a specialist.

Senator CORMANN—It is not a subsequent consultation for a specialist?

Ms Robertson—It is an aftercare consultation and usually it would occur the day—

Senator CORMANN—Aftercare and subsequent are a bit different?

Ms Robertson—Yes, they are different procedures because really the day following surgery someone would present for a follow-up. They might just check to see how the patient is going and if there is any discomfort, pain or what have you. Then I think there is generally another follow-up, say a week later, to see how the patient is going and sometimes that can be a quick consultation. There is always provision where it does not fall within what we consider

to be a normal aftercare consultation for practitioners to state that the service is not normal aftercare, in which case a further consultation and Medicare benefit would be payable.

Senator CORMANN—I am not going to go into the semantics of 'subsequent' or 'aftercare'. I have just got to go through a whole heap of questions. In answer to a question on notice—it is No. 2045—you indicated that the MBS fee for cataract surgery was determined, and I am quoting here, 'At a time when the procedure took longer.' When was that time? What was the date when the MBS fee was first determined?

Ms Robertson—Certainly before I was even working for the government.

Senator CORMANN—But the thing is you have made the statement and the minister has made the statement that when this was first put in place it took longer and the time that was mentioned was 45 minutes. What is your reference time?

Ms Robertson—I will just get the question number again, if you would not mind.

Senator CORMANN—Question No. 2045.

Ms Robertson—I do not think that computes with what I have got there.

Senator CORMANN—I will send you a copy of it. There you go. It is actually Senator Ludwig who presented it on behalf of—

Ms Robertson—If I could have a look at it I have probably got it in my folder, but I can just talk to you in general terms. I have seen material within the department that says that in the nineties the cataract surgery procedure took around one hour; I have seen material in the later nineties which said that that had reduced to 45 minutes and most recently I have seen information which says that that has gone down to between 15 and 20 minutes.

Senator CORMANN—You have seen material; that is not all that specific. Has this MBS fee rebate for this type of surgery ever been cut before?

Ms Robertson—Yes, it has.

Senator CORMANN—When was that and by how much?

Ms Robertson—In 1987—that was a long time ago—the fees were reduced for the separate items as they were then. There were two separate items; one was for lens extraction and the other item was for a lens insertion.

Senator CORMANN—These separate items still exist.

Ms Robertson—Yes, they do, but there is also one where the procedure is done at the same time and usually we say that if you are doing a single procedure then you would just do the lens extraction, but if you are doing both—

Senator CORMANN—I know this. By how much has it been reduced?

Ms Robertson—Back then, at the same time that other ophthalmology services were increased by six per cent, that one was reduced by 30 per cent.

Senator CORMANN—An ophthalmologist will tell you that, because it was due for a CPI increase, that in effect it was reduced by 32 per cent then. Has it been reduced again since then?

Ms Robertson—Yes, it has. In 1996 as part of a budget measure there were many services reduced at that time and cataracts was decreased by 10 per cent.

Senator CORMANN—I have given you a copy of your answer there in front of you. When it was first introduced as an item the surgery took 45 minutes.

Ms Robertson—Yes.

Senator CORMANN—In 1987, which presumably was after it was first introduced because you cannot cut a rebate that has not been introduced yet, it was reduced by 30 per cent. In 1996 it was reduced by a further 10 per cent, so what would justify a further 50 per cent cut on top of that?

Ms Robertson—A 50 per cent decrease in the time taken to perform the procedure.

Senator CORMANN—In what way? Since 1996 when we have had the most recent decrease there has been a 50 per cent decrease in the time taken to perform the procedure, has there?

Ms Robertson—By saying that you assume that at the time that decrease was undertaken in 1996 that the service was valued at the price that was paid at the time.

Senator CORMANN—How long did a cataract procedure take to perform in 1996?

Ms Robertson—I am not sure. I do not have that information with me. I would have to go back and check our records.

Senator Ludwig—Do you accept the proposition that if the time does, in fact, decrease that the rate should decrease? It is a reasonable proposition.

Senator CORMANN—It is not as simple as that, trust me. I have got to go through a whole series of questions and at the end we can have the conversation and we will have the conversation in the Senate next week if you want. What advances in technology and efficiency gains have occurred since the most recent cut to MBS cataract rebates in 1996 to justify a further 50 per cent reduction? Now, you have said a further reduction in time, but you cannot properly—

Ms Robertson—There have been myriad technological advancements during that time but at the end of the day it all translates into how long it takes to do the procedure.

Senator CORMANN—What sort of CPI adjustments have been applied to these particular MBS fee rebate items for relevant items for cataract surgery over the period since the 1987 cut? Was it adjusted by general CPI, above CPI, below CPI or health CPI? What has been the adjustment in that period?

Ms Robertson—None of the items in the MBS are indexed by CPI, because obviously there is a—

Senator CORMANN—Is that right?

Ms Robertson—And I can tell you why. That is because part of what people pay out of their pockets goes into calculating the CPI, so it would be a bit like double dipping if you did it that way.

Senator CORMANN—What has happened to the rebate, then, since 1987?

Ms Robertson—It has been indexed every year by the index that we index all items under the MBS with, on 1 November every year.

Senator CORMANN—So, since 1987, what percentage would that be?

Ms Robertson—It would be around two per cent.

Senator CORMANN—Around two per cent per annum?

Ms Robertson—Yes. Sometimes it is more; sometimes it is less.

Senator CORMANN—Which of course over that period would be well and truly below CPI, and so—

Ms Robertson—That is if you say that CPI is an appropriate measure, Senator.

Senator CORMANN—Well, CPI is a cost-of-living measure. Doctors who perform certain procedures live in the real world and they face a whole series of costs as they perform surgery. When reflections have been made about revenue and income and everything else, what I noticed is that these items have been reduced by 30 per cent, by 10 per cent, and there have been increases in the rebate over a 20-year period that have been well below CPI. So in real terms there has been a significant reduction in the rebate, even before the application of this 50 per cent rebate. But we will just carry on.

Senator Ludwig—Would you say that would hold for all types of increases across the board or just particularly this issue?

Senator CORMANN—I am focusing on the cataract rebate at the moment, Minister—

Senator Ludwig—Wages, housing costs, all sorts of things. If you follow that logic—

Senator CORMANN—If you look at the answers that I have—

Senator Ludwig—No, I think I can make a comment in relation to this, because the witness is answering the question and you are then overlaying that with another proposition, and I am rejecting that proposition. The fact is that you are trying to use the CPI, which has been indicated to not be a relevant measure. You know—

Senator CORMANN—You say that, Minister. We can have that argument in the Senate next week.

Senator Ludwig—You know that there is an indexation process in place that has been accepted across the board for implementing these increases. That has been—

Senator CORMANN—That is your position, Minister.

Senator Ludwig—It was also the previous government's position, surprisingly enough!

Senator CORMANN—We did not cut the rebate by 50 per cent.

Senator Ludwig—Surprisingly enough, it was your government's position as well.

Senator CORMANN—We did not cut the cataract rebate by 50 per cent. Minister, in the interests of time—

CHAIR—Senator Cormann.

Senator Ludwig—But ideally with the increases.

CHAIR—Senator Cormann and Minister, I would prefer it if both of you would just finish your sentences and not talk over each other, because Hansard cannot get it. Minister, have you completed your statement in response?

Senator Ludwig—Thank you, Chair.

Senator CORMANN—Thank you, Madam Chair. Now, if you look at the answers to the Medicare rebate questions I put on notice in the Senate, which I have just tabled—I would appreciate if I could get them back afterwards—one of the questions asks how many of the MBS funded cataract procedures take less than 15 minutes, between 15 and 20 minutes, and 20 minutes or more, and your answer was that you cannot really tell. That is right, isn't it?

Ms Robertson—We do not collect the time for the procedure, no.

Senator CORMANN—Okay. Are you aware of a recent AMA survey of ophthalmologists in which a sample group of 334 specialists participated which indicates that over 70 per cent of all ophthalmologists who perform cataract surgery take between 25 and 40 minutes?

Ms Robertson—I am aware of that survey.

Senator CORMANN—Do you care to comment on that survey?

Ms Robertson—No.

Senator CORMANN—Okay. You are presumably aware that a majority of senators have indicated that they will move to disallow that particular rebate cut in the Senate?

Ms Robertson—I am aware of that.

Senator CORMANN—What will be the effect of that?

Ms Robertson—If you disallow the item in the Senate?

Senator CORMANN—Yes.

Ms Robertson—I think that it would revert back to the previous rebate.

Senator CORMANN—Thank you very much for that. How many cataracts operations are there per annum across Australia and across both private and public hospitals?

Ms Robertson—How many?

Senator CORMANN—Yes.

Ms Robertson—In the 2007-08 financial year, there were 187,912 procedures provided; of those, 131,675 were undertaken in the private sector and 56,237 were undertaken in the public sector.

Senator CORMANN—The overwhelming majority of cataract procedures are performed in the private system.

Ms Robertson—About 70 per cent, yes.

Senator CORMANN—So those who have their cataract surgery performed in the public hospital system moving forward will continue to access the service for free, won't they?

Ms Robertson—For those who are public patients, yes.

Senator CORMANN—Those who access the service as public patients in public hospitals will continue to access the service for free despite this change in the MBS rebate. Are you aware that the New South Wales health department on its website, in the section 'Cost of care in New South Wales hospitals', lists the cost of cataract surgery at $3,579?

Ms Robertson—I am sure that that would be a complete figure.

Senator CORMANN—Yes, it is.

Ms Robertson—That would include everything.

Senator CORMANN—It essentially includes the professional services, accommodation, theatre, lens et cetera. I invite you to verify the figure on the New South Wales health department website. The MBS rebate at present is $626. In the answer that I referred you to, you indicated to me that private health funds pay a rebate of about $1,700 on average for accommodation, theatre, lens et cetera and I have verified with industry sources that that is indeed an accurate average. That brings me to $2,326 for this procedure in the private system versus $3½ thousand for that surgery in the public system.

Ms Robertson—What you are not counting on top of that would be the additional 25 per cent that is paid by the private fund in relation to the gap as well as any amount that would be paid over and above that as part of gap cover arrangements that somebody might have with their private fund, as well as any out-of-pocket costs that might go on top of that.

Senator CORMANN—That is not quite right. It might be right in a small minority of cases, but 85 per cent of this sort of surgery in the private system comes under the no-gap arrangements, which means patients at present do not pay out-of-pocket expenses. The $1,700 covers the health fund rebate above the MBS rebate, so—

Ms Halton—Sorry, did I miss something, Senator? I thought you talked about the New South Wales health department price, not the private sector price.

Senator CORMANN—I am talking about two different prices—I am comparing.

Ms Halton—But the price you just quoted and what I thought the answer was—

Ms Robertson—It is apples and oranges, Senator.

Ms Halton—It is apples and oranges.

Senator CORMANN—It is not quite apples and oranges. The point I am making here is that—

Senator Ludwig—Bananas and pears?

Ms Halton—We have a fruit salad going here!

Senator CORMANN—This is actually a pretty serious issue here. I do not think it is a matter for laughing.

Senator Ludwig—I think that in some respects you are completely right: it is a serious issue. What I think is that a lot of the facts have not been put on the table in respect of this. Looking at the two sources that I have, the Fred Hollows Foundation states that cataracts—though not all cataracts—can now be removed in a straightforward, 20-minute operation and done under local anaesthetic. Similarly, the Australian—

Senator CORMANN—You have no government data to substantiate that.

Senator Ludwig—Let me finish. You have had your turn. The Australian Institute of Eye Surgery indicates that cataract surgery usually lasts less than 20 minutes and is often performed using anaesthetic eye drops without the need without the need for injection. But the government has also acknowledged that in some cases the procedures can be more complex and take more time. That is why we are introducing a new high-value MBS item with a schedule fee of $850. But if you look at the savings that—

Senator CORMANN—I am really pleased that you are reading your briefing note, Minister.

Senator Ludwig—It seems to me that you can read your briefing and I can try to correct the record, so that is what I am seeking to do to ensure that we have accurate information on the record. But I do not want to take up your time.

Senator CORMANN—Thank you. Let us go back to the cost in the public system. We have agreed that if you are admitted as a public patient in New South Wales hospitals the cost of cataract surgery including professional services, accommodation, theatre and auxiliary fees is $3,579.

Ms Halton—Let us be clear: you say you have read this on a website. We have not seen it. It is your assertion, so I am not agreeing with it or not agreeing with it, but we have not seen it.

Senator Ludwig—Perhaps you can use the clerks. I think that is the usual process to adopt.

Senator CORMANN—I will pass you the document I am quoting from. I do not make these things up. If we accept the $3,579 figure for the cost of cataract surgery in a New South Wales public hospital for public patients, through this cut the Commonwealth is seeking to save $313 per procedure and essentially force people into the public system, where the same procedure is going to cost the taxpayers $3½ thousand. How is that good health economics?

Ms Robertson—I think that you are actually mixing up some of those numbers, because on top of the $1,700 that is paid by the private fund, of which that $3½ thousand that you quoted—

Senator CORMANN—The $3½ thousand is the public system.

Ms Robertson—is a component, on average you are looking at about $1,265. That is the average fee charged for a cataract procedure by a private ophthalmologist.

Senator CORMANN—That is right.

Ms Robertson—Okay. If you add that $1,265 to the $1,700 then you get close to $3,000. That figure with regard to public sector surgery—who knows what is included in that? It could be costs to transport surgeons from Sydney to the outback; who knows?

Senator CORMANN—You are reducing the rebate by $300, which will increase out-of-pocket expenses for patients. Incidentally, Medibank Private, the government owned health fund, have made it very clear publicly and again here at estimates that, because their private health rebate funding formula is linked to the MBS, their rebates will automatically reduce by

$290 as a consequence of the cut, so we are talking about an additional out-of-pocket expense of $600. Do you concede that, for some people, that will make access to this procedure unaffordable and that some people will be forced to shift into the public system, where your $300 saving for the Commonwealth will translate into a $3½ thousand expense for the state public health system?

Ms Robertson—No, I do not accept that, because it depends on a multitude of factors—

Senator CORMANN—Which part don't you accept?

Ms Robertson—The fact of the matter is that you are saying that Medibank Private are going to reduce what they pay—

Senator CORMANN—I am not saying that.

Ms Robertson—Well, you are saying that Medibank Private have said that they are going to reduce what they pay on top of the Medicare rebate because it is linked to the Medicare rebate. With regard to their gap arrangements, the no-gap and the known gap arrangements, that would really depend on whether or not the individual ophthalmologist for that individual patient is going to accept that as full reimbursement for the service provided. We cannot predict what ophthalmologists are going to do in response to this.

Senator CORMANN—Do you anticipate a drop in demand for these services in the private sector? In terms of your modelling of MBS item No. 42702, are you expecting a drop in the utilisation of that item?

Ms Robertson—The thing with this procedure, Senator, is that the demand is relatively inelastic, and that is one of the reasons why we have the out-of-pocket costs that we do.

Senator CORMANN—Do you expect that any of the specialists will reduce their fees?

Ms Robertson—I cannot predict that. I would hope that they would. Given that the time taken to perform the procedure is now half the time it took in the 1990s, you would hope that they would pass some of that on to their patients.

Senator CORMANN—Are you able to direct specialists in terms of the fees they charge patients?

Ms Robertson—No, we are not.

Senator CORMANN—Has any ophthalmologist given you an indication that they will reduce their fees as a result of this reduction in the rebate?

Ms Robertson—No.

Senator CORMANN—Do you concede that there will be an impact on people when they are faced with additional out-of-pocket expenses?

Ms Robertson—No.

Senator CORMANN—You do not concede—

Ms Robertson—No.

Senator CORMANN—that there will be an impact on people facing additional out-of-pocket expenses?

Ms Robertson—No, because it depends on the ophthalmologist's fee.

Ms Halton—Senator, let us be really clear about this. There are changes in medical practice and technology over time. If we are unable to change rebates based on improved efficiency in medical practice, basically what we do is factor in for evermore increasing inefficiency in an economy. That means that we cannot then arguably fund new technologies and new treatments. That is the equation we are talking about here. Let us not mince words about this. The bottom line is that, just as in pathology, things have gone from being done by human beings doing single tests, all looked at under slides with microscopes, to being automated. The reality is that there are changes in technology in this area which are well acknowledged by the profession, and the bottom line is, if we are unable to reflect that in the time and therefore the rebate, we cannot actually then fund other things that we should be funding. That is the simple equation there.

Senator CORMANN—Thank you, Ms Halton, and if it had not been reduced twice by 30 per cent and 10 per cent and increased below CPI then you would have—

Ms Halton—Let us be clear about this as well. The last time, on your contention, not ours, was well over 10 years ago, and the bottom line here is—

Senator CORMANN—Hang on; Ms Robertson said that it had been reduced by 10 per cent in 1996—

Ms Halton—Yes, 10 years ago.

Senator CORMANN—Yes, 1996. That is what I am saying.

Ms Halton—Yes. My point is that that is well over 10 years ago and things have moved on.

Senator CORMANN—When the item was first introduced, the procedure allegedly took 45 minutes. Since then there have been two reductions in the rebate—one of them significant, 30 per cent, and another 10 per cent on top of that. Anyway, I have got to rush through this.

CHAIR—Senator Cormann, you can have only two more minutes at the most.

Senator CORMANN—Okay, I have two minutes. New complex item No. 42718: when exactly was the decision made to introduce new MBS item No. 42718?

Ms Robertson—That was announced in the budget.

Senator CORMANN—That was actually a budget announcement?

Ms Robertson—Yes.

Senator CORMANN—How many services per annum do you anticipate will be claimed under MBS item No. 42718?

Ms Robertson—I do not actually have that information here with me, Senator. I would have to take that on notice.

Senator CORMANN—How would you assess that, given that you do not have access through the MBS to data which indicates the number of services that take more than 40 minutes?

Ms Robertson—Whenever we are costing our procedures, we gain information from a range of different sources. There are some procedures that are funded through the Commonwealth via other programs. We can look at the correlation with anaesthetic time units taken for the procedure and we make an estimate on that basis.

Senator CORMANN—Did you speak to the state governments before this was announced in the budget or have you spoken to them since this was announced in the budget?

Ms Robertson—I have spoken to some colleagues in the state health departments, yes.

Senator CORMANN—Have any of them expressed concerns about cost-shifting?

Ms Robertson—No.

Senator CORMANN—How many ophthalmologists did the department consult to determine the revised MBS rebate for cataract procedures?

Mr Kingdon—I will take this. It was a budget decision, Senator. But since then the minister invited the ophthalmologists to put alternative views up if they felt that this was an incorrect approach, and they have failed to really negotiate or discuss any alternative—which is really in contrast to what happened with assisted reproductive technology, where we did have a very productive negotiation with the people there—

Ms Halton—There was a bad pun in there—a bad, bad pun.

Senator CORMANN—Don't go there—honestly, don't!

Mr Kingdon—and we did come up with a solution that suited everybody. I think it is quite disappointing that we have not had that engagement, which we were quite willing to have, with the ophthalmologists.

Senator CORMANN—I think it is a different circumstance, but I will not waste time on that. This is my last question. How many private ophthalmologists are contracted to public hospitals on rates that are tied to MBS rebates; and are these public hospital arrangements expected to be affected by the MBS funding cut for cataract surgery?

Ms Robertson—That is a question that you would have to ask of the states and territories, Senator. We do not have that information.

Senator CORMANN—Thank you very much.

CHAIR—Senator Siewert.

Senator SIEWERT—I want to ask a question following up on Senator Cormann's question about the new complex MBS item number. I think you said that you did not have on you the information about what it would cover.

Ms Robertson—No, I do have the item descriptor with me, Senator. It states:

COMPLEX LENS EXTRACTION AND INSERTION OF ARTIFICIAL LENS, with a surgical procedure time of 40 minutes or more, excluding surgery performed for the correction of refractive error except for—

a word that I really do not want to pronounce right now because I do not know how!—

greater than 3 dioptres following the removal of cataract in the first eye.

Ms Halton—Would you like to spell it?

Ms Robertson—A-N-I-S-O-M-E-T-R-O-P-I-A. How would I say that, Brian?

Dr Richards—Anisometropia.

Ms Robertson—Anisometropia.

Ms Halton—That was for the benefit of Hansard—the spelling.

Senator SIEWERT—I want to move on to a completely different item—that is, midwives and their eligibility for MBS access. We figured that it was appropriate to ask these questions here.

Ms Halton—It depends what the question is. Before you move on, I thought that Senator Cormann might spend some time this evening on this particular item and that we were going to be asked a question on the campaign we are doing on eye health, so I brought a certain little takeaway for all the senators on the committee because we are running a campaign on eye disease at the moment. I would like to table these brochures but I may not have enough. This is a genuine public health campaign. I have to tell you that any officer who has sat next to me has tried to nick these and if I do not have enough we will make good in due course.

Senator SIEWERT—How many of the currently practicing midwives do you estimate will be eligible for MBS access?

Mr Kingdon—It is expected that 700 midwives will be eligible and participating by 2012-13 in terms of the take-up of the item.

Senator SIEWERT—Is it a requirement that the MBS eligible midwives will have to have backup from a private obstetrician?

Mr Woodley—The government's stated intention is that midwives will be required to work collaboratively with a broad health team.

Senator SIEWERT—I think we are struggling at the moment with the definition of collaborative. I know there is a process in place and I have another question about that in a minute. Does that mean there will have to be backup from a private obstetrician?

Mr Woodley—These are the issues we are grappling with right at this very moment in close consultation with a range of stakeholders—midwives, doctors, obstetricians and consumers.

Senator SIEWERT—I realise you have the consultation process going and the steering committee. Maybe I should ask for a few more clarifications and you can tell me if it is being included in the consultation process and if it is not, why not. Have you given much thought to how that will operate in both a public system and a private system if you are requiring that backup?

Mr Woodley—Yes, we are certainly alive to the issue of pathways for women who choose to engage with a midwife through this experience. The intention is not to design arrangements that would preclude a woman choosing to use the public health system at any point whether it is through antenatal, intrapartum or postnatal care and that subject to the services being available a woman should be able to stitch together a mix of care that suits her circumstances.

Senator SIEWERT—That is being considered as part of the consultation process.

Mr Woodley—Absolutely.

Senator SIEWERT—In the announcement that was made around the exemption for the requirements under NRAS it was announced that Victoria would be leading the consultation process after that. Is the consultation process for the collaborative model now coming under that process that is being led by Victoria or will that still be a separate process?

Mr Woodley—We are dealing with the process of collaboration in a couple of contexts. I can only speak about the way we are dealing with it in relation to access to MBS, not in relation to eligibility.

Senator SIEWERT—So as far as you are concerned in terms of access to MBS—and I will not get you to go through it again because I am aware of time—as we have discussed previously in a particular Senate inquiry that process is still being undertaken and is still under the department?

Mr Woodley—Yes, it is.

Senator SIEWERT—I suspect you are not going to be able answer some of the other questions I have around the interaction and backup with private obstetricians because you are still developing the collaborative care model, but I am interested in one particular issue if you can clarify it now. Is it envisaged that if a midwife does not have that backup from a private obstetrician that they will not be able to carry out a home birth?

Mr Woodley—The issue in home births is really around indemnity. That is a sphere I cannot comment on. I am sorry.

Senator SIEWERT—I appreciate I might be making it difficult here but it is all tied up. If they cannot get indemnity insurance does that mean they will lose their eligibility?

Ms Halton—These officers cannot answer that question because they are able to answer in respect of the MBS only. The minister put out a release and there was one put out after health ministers which we might forward on to you.

Senator SIEWERT—I have seen that and that is why I am asking these questions because, with all due respect, it is as clear as mud. I am not trying to be rude. I know that this is a difficult area but that is why we are asking these questions, because coming from that process it is not clear where to from here. I have been given some detail and it is still not clear.

Ms Halton—And there is quite a detailed consultation process going on. The Chief Nursing and Midwifery Officer is a major player in that discussion and the essential message is that people will have to have appropriate professional backup and a plan in respect of any confinement in the event that that does not go as anticipated. What we might do is take that on notice. Once that work is perhaps a little more complete we can give you a briefing if that is preferred. That might be the way to do it, actually.

Senator SIEWERT—That would really be appreciated.

Ms Halton—I am sure that the minister would have no objection to there being a proper briefing on this in due course.

Senator ADAMS—Ms Halton, you were discussing the committee which has the Chief Nurse and Midwifery Officer on it. Is there anyone on that committee who is a home birth midwife?

Ms Halton—I cannot remember the list of the names. I suspect that there is at least somebody who has practised in that area, but I have not brought that list with me.

Senator ADAMS—Could we have that?

Ms Halton—Of course you could.

Senator ABETZ—Is this where I ask about Medicare? Is this the right area?

Ms Halton—That is primary care. What did you want to know?

Senator ABETZ—The Medicare call centre is administering the pink batt system.

Mr Kingdon—No, you have missed it.

Senator ABETZ—That is very unfortunate. The Medicare call centre in Hobart is dealing with it.

Ms Halton—The Medicare call centre is not us. If you are talking about Medicare Australia, that is the Department of Human Services.

Senator ABETZ—That is most unfortunate. Let's go on to NICNAS. Is that here or is that the next item?

Ms Halton—I think that is program 14.

Mr Kingdon—You are not having a good evening.

Senator ABETZ—No, I am not. It is most unfortunate when advice is sought on these things and you are told throughout the course of two days as to when the issue will be raised. It has been done and I have learned about midwives and all sorts of things tonight. It has not been wasted time, and I have had a great chat with Senator Carol Brown.

CHAIR—Thank you to the officers from outcome 3.

Proceedings suspended from 9.30 pm to 9.34 pm

CHAIR—Senator Abetz has some questions on the National Industrial Chemicals Notification and Assessment Scheme.

Senator ABETZ—The member for Cook has raised a couple of issue with me. Bunnings currently sells a brand of paint called Nippon Paint. I understand from my constituent that these paints contain chemicals that are not available to be imported into Australia. This prevents, or so it would appear, Australian paint manufacturers from competing against this imported product. What role does NICNAS have in relation to the regulation of those paint additive chemicals?

Dr Healy—The scheme is a notification scheme—a chemical entity based scheme—so that chemicals that are used in Australia have to be on the national inventory or, in general, if they are not on the national inventory, they need to be notified and assessed by NICNAS before they are used.

Senator ABETZ—That is if you want to import that chemical. What about if that chemical might be only a very small component of another substance, as with what is in a pot of paint? Does one have to then notify your organisation about that chemical being in that product?

Dr Healy—For paint I would expect yes. Under the NICNAS legislation, what are called articles are excluded from the legislation. So there are circumstances in which an article may contain chemicals that are imported that, if manufactured in Australia, would not have to be notified. There is a difference in relation to articles, but for paint I would be expecting that the constituents would be notified to us.

Senator ABETZ—Sorry if I am a bit obtuse, but would you expect the importer of these Nippon paints to notify you that the paint has this particular constituent in it?

Dr Healy—That is right. And, if you would like to pass me the details, we would be happy to follow up the specifics.

Senator ABETZ—I will go back to my good friend the member for Cook and he can pass it on to his constituent and we will follow it through. The second issue that the member for Cook has raised with me is that supposedly NICNAS has not accredited cornstarch chemicals. The interest of the constituent is that that means that cornstarch bags, which would be a viable alternative, of course, to plastic bags, are not currently available in Australia. What do we know about that?

Dr Healy—This would be an industrial use. I neglected to say earlier that NICNAS covers chemicals that have an industrial use. In a bag it would be an industrial use. A bag is an article. If the bag is manufactured in Australia, then the chemicals would have to be notified to NICNAS and assessed. If it is imported it probably would not have to be.

Senator ABETZ—Are cornstarch chemicals currently under assessment for accreditation? Where are we at?

Dr Healy—I can't you give you the specifics about whether we have received a request to look at that particular chemical, but we can follow that up. The system works by the company or the person who wants to introduce the chemical providing NICNAS essentially with a technical dossier to enable us to undertake the assessment. There is an inventory as well. It has something like 38,000 chemicals on it, so we would also need to check whether cornstarch, or some variant of it, is already on the inventory.

Senator ABETZ—Without testing the patience of the committee too far, did you say in one of your answers that it had to be for industrial use?

Dr Healy—That is right.

Senator ABETZ—What about a pot of paint that is sold retail at Bunnings, which is the example I was given? Is that covered by the definition of industrial?

Dr Healy—That is right.

Senator ABETZ—Would the cornstarch bags that would be used by shoppers also fall within that definition of industrial?

Dr Healy—Yes, that is correct.

Senator ABETZ—Chair, I will communicate with the member for Cook and suggest that he might send a slab or some other appropriate form of reward to the committee for its forbearance.

CHAIR—We could not accept that under our entitlements, Senator! Thank you very much, Dr Healy.

Senator ABETZ—Thank you very much, Dr Healy. It is much appreciated.

CHAIR—We are going to population health, which is outcome 1. I propose to start with the TGA, then go on to FSANZ and then go to general questions.

[9.41 pm]

Therapeutic Goods Administration

Senator BOYCE—I have a series of questions relating to the Federal Court agreement and the mediated settlement against the Commonwealth of $55 million in favour of Mr Jim Selim for the role that TGA played in the licence suspension, product recall and closure of Pan Pharmaceuticals, which was the company he founded. The key defendants from TGA in the case were Mr Terry Slater, who was then the head of TGA, and Ms Rita Maclachlan, a senior executive with TGA. What action, if any, was taken by the TGA against Mr Slater and Ms Maclachlan following the Commonwealth consent to judgment on those charges of negligence and misfeasance?

Ms Halton—I would like to say right here and now that there are still legal proceedings underway in respect of this matter, and I do not believe it is proper that we answer questions in respect of individual officers or indeed in terms of the technical detail of the case.

Senator BOYCE—But it is in respect of the matter and not in respect of these particular people.

Ms Halton—That is not what you just said. You actually talked about what action has been taken 'in respect of'.

Senator BOYCE—But the ongoing case is not related to these individuals.

Ms Halton—No, but the actions that may or may not have been taken by individuals, and any other actions in respect of those individuals, are all relevant to the case.

Senator BOYCE—So you are not able to tell me what, if anything, was done, what action was taken by the TGA or by the department regarding those two officers at the time?

Ms Halton—I can tell you. When you say 'at the time'—

Senator BOYCE—I mean when the settlement was done.

Ms Halton—One of those individuals was no longer an officer; therefore, I have no jurisdiction in respect of that person. In any event, these matters are still the subject of quite seriously contested legal action.

Senator BOYCE—Okay. Is the department, and the TGA, aware of a not-for-profit company called Research Infrastructure Support Services Ltd?

Dr Hammett—I personally am not aware of that company. If you can provide me with further information, I can make inquiries about it.

Senator BOYCE—I do not have that. The website page is here, but I can quote to you from their annual report of 30 September 2008, where Mr Slater is noted as the chairman of Research Infrastructure Support Services Ltd.

Ms Halton—That is not a matter we can comment on.

Senator BOYCE—Would you also not be aware that RISS is a not-for-profit company that was set up in July 2007 to assist companies to obtain good manufacturing practice licences from the TGA?

Ms Halton—What is the point of this question, Senator? You are talking about an individual who is not an officer of the Commonwealth who is allegedly undertaking private activity. That is not a matter that we can make any comment about.

Senator BOYCE—I am surprised, though, that there is not knowledge of a company that is specifically established for the purpose of assisting companies to obtain good manufacturing practice licences from TGA.

Ms Halton—There are any number of people who offer services in that respect. I would not expect TGA—

Senator BOYCE—Do you have a register of companies that do that? How do you interface with these companies, Dr Hammett?

Dr Hammett—There are regulatory affairs companies in all parts of the therapeutic products industry related to—

Senator BOYCE—This one particularly functions in the cellular therapies area.

Dr Hammett—We do not have a register of regulatory affairs companies or consultants; that is beyond the purposes of the Therapeutic Goods Act.

Ms Halton—And let's be clear: when the TGA go out to do inspections and assessments in respect of GMP they look at the evidence in front of them. Does the company actually pass or not?

Senator BOYCE—Ms Rita Maclachlan is listed as a member of the RISS's expert advisory committee in that 30 September 2008 annual report. Was Ms Maclachlan an employee of the TGA at 30 September 2008?

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

Senator BOYCE—So you do not know whether she worked for you then?

Senator Ludwig—I think we said we would take it on notice.

Ms Halton—We will take it on notice.

Senator BOYCE—I understand that she no longer works for the TGA; could you please advise me at what date she left the TGA's employment.

Ms Halton—I will take advice as to whether I am empowered to provide individual details in terms of retirements and/or other things. If I am able to answer that question, I will do so.

Senator BOYCE—Particularly if she was employed by TGA at 30 September 2008.

Ms Halton—I will take it on notice. If I am able to answer it, I will.

Senator BOYCE—In general, if an employee of the TGA wants to work on the board or as an outside expert for a company that has dealings with the TGA, do they have to seek approval from anyone?

Dr Hammett—The TGA has very strict probity and conflict of interest guidelines. Certainly we would expect any of our officers undertaking activity in any company that had direct relationships with the TGA to declare that and seek approval for that involvement.

Senator BOYCE—Who would they have to seek that approval from?

Dr Hammett—In the first instance from me, but, in a matter of that nature, I would refer it to the secretary for her consideration.

Senator BOYCE—And you would be the ultimate arbiter, Ms Halton? Could you advise me if that procedure was followed in the case of Ms Maclachlan?

Ms Halton—No, but we have already indicated that we will have to find out what the circumstances were at the particular date that you have given.

Senator BOYCE—And you would advise me if that has occurred?

Ms Halton—If I am able to do so, yes, I will.

Senator BOYCE—Does the TGA have input into the selection of grant recipients under the Department of Innovation, Industry, Science and Research's program the National Collaborative Research Infrastructure Strategy, NCRIS?

Dr Hammett—At times we may be asked for comment on research grants, but we have no direct oversight or any role in the selection of grants.

Senator BOYCE—Would you explain a little further what you mean by 'comment'.

Dr Hammett—Because the TGA is largely a scientific organisation and has scientific technical expertise, at times various academic groups, for instance, that might be applying to research funding may well seek the TGA's approval to access data that might be available. For instance, a university that is studying the safety of a particular medicine might be interested in getting data from the ADRAC database. The TGA, having received a request to that effect, may well provide information that is publicly available as part of that research effort.

Senator BOYCE—Would you be able to tell me then, Dr Hammett, whether any comment was sought from the TGA in relation to a $7½ million grant over four years that was given to RISS in 2008?

Dr Hammett—I would have to take that on notice. I have no knowledge of that whatsoever, but I will make inquiries for you.

Senator BOYCE—You will probably want to take the next question on notice as well: what was Ms Maclachlan's role with the TGA at the time that that grant was awarded to RISS?

Dr Hammett—Thank you, Senator; we will take that on notice.

Senator BOYCE—I have a couple of others. Mr Pio Cesarin, who was another defendant named in the case against Mr Selim and Pan Pharmaceuticals, has recently been appointed as the head of the TGA's Office of Prescription Medicines. Is that correct?

Dr Hammett—Mr Cesarin is currently the acting head of the Office of Prescription Medicines.

Senator BOYCE—Briefly, what are the tasks of that office?

Dr Hammett—That office evaluates applications for prescription medicines to be included on the Australian Register of Therapeutic Goods.

Senator BOYCE—Is it normal practice for a qualified medical practitioner to be in that role? Has a non medical practitioner been appointed to the head of the Office of Prescription Medicines before?

Dr Hammett—Again, I will have to take that on notice, because I am not sure whether in the distant past it has always been a medical practitioner. The previous incumbent in that role was a medical practitioner who had been in the role for a decade, so in the recent past it has certainly been a medical practitioner. The office is staffed with large numbers of medical practitioners, who are delegated with decision-making responsibilities around those prescription medicines.

Senator BOYCE—Thank you.**CHAIR**—There being no further questions for the TGA, I thank you very much.

[9.52]

Food Standards Australia New Zealand

CHAIR—I intend to start with Senator Siewert, and I know that Senator Colbeck and maybe Senator Back.

Senator SIEWERT—I would like to ask, firstly, about the presence of novel DNA and protein in highly processed oils. I know I have asked a series of questions several times around this issue. Since I last asked, have you done any testing of food oils in Australia for the presence of novel DNA and proteins—either yourselves or with other organisations?

Dr Brent—The answer is no, we do not do testing of novel DNA and protein. What we do is we get information from a variety of scientific sources in order to do our risk assessments before we amend the food standards code and approve a GM food.

Senator SIEWERT—Okay. I am aware that we have had discussions about this before, but there is literature that does assert that DNA and proteins can survive the processing used to produce them.

Dr Brent—There is a range of literature, some of it good, some of it not so good. I think the literature that you are referring to perhaps belongs in the not-so-good category. There are some studies that show that fragments of DNA can survive in the gut, but in terms of the overall science we do not think that is an issue at all. There is no safety issue with that occurring.

Senator SIEWERT—So it is still the FSANZ position that there is no safety issue associated with highly processed oils?

Dr Brent—Yes, it is the FSANZ position—and, I think it is fair to say, it is also the overwhelming international consensus of scientific opinion amongst regulators around the

world and international bodies like the WHO, FAO, Codex and OECD. So I think we are in good company.

Senator SIEWERT—In an Australian context, now that there is GE canola and in fact cotton being grown commercially in New South Wales and Victoria, have you reconsidered this concept, given that we are now likely to be producing oils that may have been contaminated with GE products?

Dr Brent—I am not quite sure I understand your question. Did you say 'reconsider the concept'?

Senator SIEWERT—Have you looked at the possibility of contamination occurring through the increased growth of GE commercial crops in Australia?

Dr Brent—I suspect that that could be a question to ask the OGTR, if you are talking about contamination of crops growing.

Senator SIEWERT—No, I am talking about the possibility of the contamination of food.

Dr Brent—I do not think it is an issue anyway, because the crops that are growing in Australia—for example, the cotton and the canola—we have already approved for food use.

Senator SIEWERT—What about for testing? You still do not think you need to be testing oils?

Dr Brent—Testing for?

Senator SIEWERT—For the presence of novel DNA.

Dr Brent—Again, I am not sure testing of DNA is an issue for FSANZ. The enforcement of the standard is the mandate of the jurisdiction, so the state and territory health departments are the areas that enforce those standards. But I cannot think of a reason why you would go out testing for GM crops or GM foods that have already been approved. They have been approved as safe for human consumption.

Senator SIEWERT—If there is increased processing now of Australian crops into oils, there is a greater likelihood that they have been contaminated with GE. I presume you are saying that, because you believe that DNA does not survive through the processing, you do not believe that is a relevant point.

Dr Brent—I would have to clarify. Maybe I will rephrase your question. I think what you are saying is that non-GM crops could be contaminated with DNA or protein from GM. Is that the question?

Senator SIEWERT—Yes.

Dr Brent—Again, that is possible, but I think it is more of an OGTR question.

Senator SIEWERT—Through the food supply chain, you mean?

Dr Brent—The growing of the crops, for example, is definitely an OGTR area. In the food chain, as I said, those GM events have been approved as safe for human consumption. So if they are found in non-GM oils, for example, and they are contaminating them, there is no safety issue. It is an issue, perhaps, for labelling.

Senator SIEWERT—That is an issue around labelling?

Dr Brent—Yes.

Senator SIEWERT—Have you been asked to consider that?

Dr Brent—We have not been asked to consider it. I think the labelling issue, again, is an enforcement issue. There is a labelling standard in the Food Standards Code—standard 1.5.2—and there is a section on labelling. You only have to label if you can detect DNA or protein in the final food or if there has been a significant change in the composition of the GM food. As you know, there is also a threshold for contamination. It is a one per cent threshold, so if you are below that in terms of contamination then you do not have to label it.

Senator SIEWERT—I want to move on to the issue around the genetically engineered triffid flax seed. Are you aware of that issue?

Dr Brent—I would probably have to take it on notice, unless you can explain it a little more.

Senator SIEWERT—There are concerns that cereals, bakery products and mixtures, nuts and seed products have been contaminated in 28 countries by an unapproved and untested GE flax variety, which is called CDC Triffid, from Canada. Are you aware of that issue?

Dr Brent—Senator, I would have to take it on notice. I am not aware of that issue.

Senator SIEWERT—Okay. I have a series of questions around that issue, so I will put those on notice. There is no point in me wasting time going through them if you are not aware of the issue, which is fair enough—I do not expect you to be aware of everything. I will put them on notice.

Dr Brent—Thank you.

Senator COLBECK—On to food labelling: Minister Burke, the Minister for Agriculture, Fisheries and Forestry, indicated in January that the accelerator pedal is down with respect to country-of-origin labelling. In July, the Parliamentary Secretary for Health indicated that the latest review of food-labelling laws will not be ready for consideration by state and territory governments until at least the middle of 2010. Is that still the program?

Ms Jonasson—COAG has asked that the ministerial council undertake a review of food-labelling law and policy. At this stage the deadline for the ministerial council to report back to COAG is July next year.

Senator COLBECK—So that is still the time frame. What work are FSANZ doing at the moment, and what stage in the process are you up to?

Ms Jonasson—FSANZ actually are not involved in that. It is a process that is being run through the Australia and New Zealand Food Regulation Ministerial Council. The ministerial council are setting up a panel and appointing a chair and have some terms of reference that they are developing. They will be, obviously, consulting with FSANZ as they will be with the general public and a whole range of other interested stakeholders, but it is a process that is being run by the ministerial council.

Senator COLBECK—So FSANZ has no involvement in that process at all?

Ms Jonasson—They will have involvement. They will be consulted and asked to provide information, as other stakeholders will.

Senator COLBECK—Is that going to involve country-of-origin labelling to any extent that you are aware of?

Ms Jonasson—I believe that is an issue that Minister Burke has asked to be considered by that review.

Senator COLBECK—I will use that as segue into yesterday's announcement in relation to allowing beef from BSE infected countries into Australia. Is that process likely to impinge on the ministerial council process at all?

Ms Jonasson—No. There is no change to the food standard in the Food Standards Code, and we do not believe that there is any sort of process that is related to the ministerial council that would change.

Senator COLBECK—Even though the joint statement between Ministers Crean, Burke and Roxon talks of potential changes to the food-labelling laws to deal with—or am I misleading you? No, I am sorry; it is an interview Minister Burke did today with Leon Byner which said that there would have to be changes in the law to identify beef from country of origin. So that is not going to be something that would be part of this process?

Mr McCutcheon—I guess the announcement made by the government yesterday did not specifically talk about labelling. It certainly specifically talked about, in the FSANZ context, the risk assessment exercise or process we have to undertake. In respect of any flow-on changes to labelling, that is not something we have been made aware of, but we are certainly happy to pursue that after these hearings.

Senator COLBECK—I know I have you at a disadvantage because I have a transcript of the interview and you do not.

Senator Ludwig—I was going to ask you, if you wanted to be reasonable, to make copy of it and make it available for witnesses to see.

Senator COLBECK—I am more than happy to make a copy of it available, Minister. I am happy to do that. To quote from the transcript, Mr Byner says to Minister Burke:

Are you going to make sure that the food, you and I have talked about food labelling before, given all these things going on, the customer has got to know where this is from, what's in it, how far away are we from these good labelling laws that give people informed choice?

Minister Burke says:

… this is something that I'm talking with … Mark Butler about when we've been continuing the talks today because there is a new element of it that we now need to get fixed and I'm glad you've raised it.

He says:

If you look at the fishing industry—

mentioning the labelling laws for fresh fish, and says:

We don't have that for red meat at the moment and that is something that we do now have to look at.

If the secretariat want to get a copy of this, I am happy to table a copy; it is a transcript.

Senator Ludwig—That would be helpful. I suspect that the answer is that it will be taken on notice, to have a look at what the issue is.

Senator COLBECK—Okay. Is the joint statement available to witnesses at the table? Do you have the joint ministerial statement that was issued yesterday?

Ms Halton—The press release?

Senator COLBECK—Yes.

Mr McCutcheon—Yes.

Senator COLBECK—I just want to run through a few items in that and if you have got that in front of you it would make it easier for us to refer to as we go through. Can I first ask: by what process will this change in the importation be allowed? Will it be done by regulation?

Mr McCutcheon—It will be given effect under the Imported Food Inspection Scheme administered by the Australian Quarantine and Inspection Service, and regulations under the legislation.

Senator COLBECK—So that would be a new regulation?

Mr McCutcheon—It will be under the—I think it is the Imported Food Control Act.

Senator COLBECK—Okay. We have got AQIS coming back before us next Friday, so we can check that then. But my perception was that it was going to be by regulation. We can deal with that by virtue of what process we go through. Can you tell me which agency played the lead role in this process. Obviously, Health were part of the process, but was there a lead agency with respect to negotiations on this change?

Ms Halton—When you say 'negotiations', what do you mean?

Senator COLBECK—You have got a joint statement from the Minister for Trade, the minister for agriculture and the minister for health; was there a lead agency in this process of changing the regulations to import beef from countries that have BSE?

Ms Halton—I can say it was not us, Senator.

Senator COLBECK—Okay. If I can deal with it by process of elimination, that is one way to deal with it! So it was not Health. That is fine by me.

Ms Halton—Yes. I cannot say who it was but I can tell you it was not us.

Senator COLBECK—If I get enough denials then I can start to narrow it down!

Ms Halton—I do not know what you do if everyone says no! But we are first; I can tell you it was not us.

Senator COLBECK—Well, you are in front so far.

Ms Halton—Excellent!

Senator COLBECK—In the second paragraph of the press release, it says:

Professor Mathews' report concludes that the risk to human health from imported beef remains extremely low, provided the appropriate risk mitigation strategies are put in place.

Can you tell us what those are and if there are any protocols. We may have gone over this a bit this morning, so tell me if you have. And can we have access to the protocols.

Mr McCutcheon—Sure. In general terms, Senator, the risk mitigation areas that would certainly be important to ensure a safe food supply would be around the feed supply system in

countries that make an application to export, the on-farm or production systems that are in place and then, finally, the processing of meat or the abattoir systems that are in place. They are the three key areas where a range of risk mitigation measures would be important. Then there are two key areas within those: firstly, making sure there are extremely stringent measures around feed, which transmits this prion through meat and bonemeal and the like; and, secondly, once animals are in the processing environment, making sure that all of what we call the specified risk material that can carry the prion is removed and also that there is no scope at all for cross-contamination with that material. So in a general sense they are the areas where fairly stringent risk mitigation measures would have to be put in place.

Senator COLBECK—Are there any specifications, for example, about cattle age and things of that nature?

Mr McCutcheon—There certainly would be for some specified risk materials—

Senator COLBECK—My understanding is that that is a protocol that has been in place in some other jurisdictions.

Mr McCutcheon—This is well known—this is an international definition, I guess. But we are talking about risk materials of tonsils and distal ileum from bovine animals of any age—brains, eyes, spinal cord, skull, and vertebral column of bovine animals over 30 months of age. They are what they call the specified risk materials.

Senator COLBECK—In the statement it says—and you may not be able to answer this because it might have come from a different agency and, as I said, we will deal with them later—that a number of countries have requested access. Are you aware of which countries they may be?

Mr McCutcheon—No, I am not, Senator.

Senator COLBECK—The statement goes on to say that these countries will be required to undergo a rigorous risk assessment led by Food Standards Australia New Zealand to ensure that they have robust systems in place to prevent the BSE agent from entering the human food chain. So you would receive a reference from Biosecurity Australia or someone of that nature to undertake those risk assessments?

Mr McCutcheon—I guess this is very early days. The announcement was made yesterday so FSANZ itself has a fair bit of work in front of it to do this.

Senator COLBECK—The excitement levels are still very high.

Mr McCutcheon—Essentially the process is that a country would apply for an assessment to the Australian BSE Food Safety Assessment Committee. That is a committee that will be run by FSANZ because our role is to do the risk assessment. That risk assessment would then be undertaken by that committee. In terms of which countries might well apply, that will be very much demand driven, I guess, but the fact is that any country that wants to export here will need to go through that process.

Senator COLBECK—So you do not know what the formation of that committee will be at this stage? What role, for example, would Biosecurity Australia have? Forgive me for calling them just that—their name is changing and—

Mr McCutcheon—The focus of the committee will be on food safety. It will not be on biosecurity. We would expect to have experts on that committee in the area of food safety. We would expect some animal health experts on that committee because this is essentially a veterinary public health issue that we would have to look at, but the focus is on food safety.

Senator COLBECK—But while there are obviously human health concerns, there are also a number of other concerns, which is why, obviously, you have got three portfolios involved—trade and agriculture. I think that the most heightened level of excitement that I can understand at this point in time comes from the beef industry and, having been through numerous import risk assessment processes through various incarnations of the biosecurity organisation, one of the real issues that comes out of that process is about how these assessments are conducted: what the checking processes are and, most importantly, what happens once the trade starts. We all know that when you know that there is going to be an assessment process, or an inspection process occurs, you make sure that everything is tickety-boo for that process. But then after that is done and you are approved and everybody goes away, that is when things start going pear shaped, and that has been a major concern in a number of Biosecurity cases coming through. I do not need to go through them all, but there remains an enormous amount of concern within the cattle industry about the potential impacts on their markets. That is why my concern at this stage in proceedings is about what role Biosecurity might play. You have said that animal health will be part of it but that process has not been finalised yet.

Mr McCutcheon—No, it has not. Just to be clear, when you say that animal health will be part of it, we will need an animal health expert on the committee, because, in addressing the food safety risks, part of this disease requires veterinary public health skills, so we need that. I cannot answer the questions on the biosecurity issues and how they would be managed. That is a separate agency. But certainly from the food safety point of view and managing the risks for the human population, once we recommend to AQIS that, yes, we believe the risks are okay to be managed, AQIS would make that final determination and put in place the appropriate risk management systems. After that, countries would be required to submit surveillance results and information on feed controls and changes to be epidemiological situation for the preceding calendar year by 31 January each year for a review by the Australian BSE food safety assessment committee. Every 12 months there will be a re-look at the situation for those countries that would be granted access.

Senator COLBECK—Based on a report submitted by that country.

Mr McCutcheon—That is correct—yes.

Senator COLBECK—There would be no visits or inspections as part of that process?

Mr McCutcheon—Under the new policy that was announced, there is scope for in-country inspections, but they will very much depend on, I guess, whether the information that we at FSANZ or the assessment committee has is sufficient. If we have any concerns or doubts about that, we have the scope to be able to ask for an in-country inspection.

Senator COLBECK—Have the protocols been developed yet for this process?

Mr McCutcheon—No.

Senator COLBECK—The statement says:

Countries looking to export their beef to Australia must meet rigorous requirements to ensure that beef products entering Australia are BSE free and we will not compromise on this.

But we have not yet developed those protocols and requirements.

Mr McCutcheon—No, that is right. The first step for us at FSANZ would be to develop the methodology for doing the risk assessment. That is the priority for now.

Senator COLBECK—When you go on to say that you will need reporting processes to demonstrate the controls are implemented and monitored, that is the annual process that you talked about?

Mr McCutcheon—Correct.

Senator COLBECK—But you are saying that there will be capacity to go in and do in-country monitoring checks if that is deemed necessary?

Mr McCutcheon—There is certainly capacity in the risk assessment process for FSANZ and the committee itself to do in-country inspections if we believe that is necessary. That might be triggered by a number of reasons—for example, we are not satisfied with the information we have or there are gaps in the data; the country might have had a reported BSE case within the last two years. There are a number of considerations we would look at, but there is certainly scope in the risk assessment process for us to ask for an in-country inspection. I guess that would flow on. Once a country does have access and we get their annual report, if there are concerns raised again and we believe an in-country inspection is needed to address those issues, then we certainly have the scope to be able to do that.

Senator COLBECK—Are you aware of any discussions that we have had with our key export markets? That would not be something that you would have been involved with in this portfolio—

Mr McCutcheon—No.

Senator COLBECK—I will pester someone else about that. Countries that are currently importing into the country under this protocol will also be required to go through this risk assessment process?

Mr McCutcheon—That is correct.

Senator COLBECK—Do we have a list of those countries that currently do that? You might have to take that on notice.

Mr McCutcheon—That is probably an issue better directed at DAFF or AQIS, who look after the border.

Senator COLBECK—I am just going to the report. In the implications of the science, it talks about imports from controlled risk or negligible risk countries with appropriate certification. Obviously, we do not have any use for that at this stage because we have not gone down that track. There is a note at the bottom of page 7 in the report that says: 'Negligible risk does not imply zero risk, it is simply implies that the risk in every question is very small in comparison with the other risks that people assume in everyday life. An estimate of the absolute risk to Australians from UK imports is quantified in table 4 and found to be

200 million times less than the risk from road accidents.' Who made the calculation? How did that risk analysis come into force?

Mr McCutcheon—Was that quoting from the consultant's report?

Senator COLBECK—It is note 7 on page 7 at the bottom of the report as I have it printed out. I have heard many times that risk is negligible; I have very rarely seen it quantified like that.

Mr McCutcheon—I think we would have to take that question on notice.

Ms Halton—Yes, we will.

Senator COLBECK—I would be fascinated to know where it comes from and how it is justified. Senator Back?

Senator BACK—You're not wanting me to answer the question, I hope, Senator Colbeck.

Senator COLBECK—If you want to have a crack at it, that is fine by me. But I am happy to have the committee take it on notice.

Senator BACK—I want to go back, Mr McCutcheon, to the risk assessment process for countries that are known to have, or have had, BSE. As part of that risk assessment process, do you believe it is reasonable to require those countries to have what we in Australia know as the National Livestock Identification System—in other words, a process where in the event, however unlikely, that we do have a positive case we can actually identify the farm of origin and possibly the herd from which that animal came?

Mr McCutcheon—I could not say yes or no to that question because clearly that is something we will be looking at during the risk assessment process. But what I could say is that it is one component of many measures that a country would need to have in place to control their BSE risk. A livestock identification system does not of itself guarantee disease freedom, but it certainly does help in the tracing animals where that is necessary. From an Australian point of view, I think we would say that we recognise that not all other countries have a system that is as comprehensive as the NLIS but that they may well have systems that are appropriate for their circumstances and that give an equivalent outcome. That is something we would look at in the risk assessment process itself.

Senator BACK—Because, as Senator Adams has correctly said, we can do that for something like wool where there is no risk to human health. Even given the very low levels, we would surely plead for the capacity to be able to trace back to a farm of origin in a circumstance like this.

Mr McCutcheon—Certainly, traceability of cattle is an important component of the risk assessment process that we will be looking at, and that is something we will examine closely with all the countries that want to make an application.

Ms Halton—Can I just make an observation, Senator. You went to footnote 7 and particularly the issue in respect of the '40 million times less than'. If you actually go to table 4, which is referenced in footnote 7, you will actually find the logic set out for those numbers. So the rationale for that is actually printed at table 4.

Senator COLBECK—I have been through a heap of risk assessment processes. I have never seen anyone be brave enough to put a number to something like that before.

Ms Halton—Well, there you go.

Senator BOYCE—Mr McCutcheon, I have some questions regarding bisphenol A—which we will refer to as BPA from here on in. In the last estimates you advised that the use of BPA in plastic products such as baby bottles was considered safe by FSANZ and that that followed some 2008 reviews in Europe. Is FSANZ aware that one of the makers of bisphenol A, Sunoco, is now refusing to sell the chemical to companies for use in food and water containers for children younger than three saying, basically, that they cannot be sure of the compound's safety.

Dr Brent—No, we are not aware that that company is now saying they cannot be certain of the safety of BPA.

Senator BOYCE—There has been a media release put out by their head of marketing claiming that they are not prepared to sell the chemical for use in products used by children under three.

Dr Brent—I cannot comment, Senator, I have not seen the media release and I am not aware of the issue that this company is raising about the safety of BPA.

Mr McCutcheon—Certainly, we will chase up the media release and have a look at it.

Senator BOYCE—That raises the question of how would you become aware of an issue such as this?

Dr Brent—In general what I can say is that the safety of BPA has been looked at comprehensively and, as you probably know, has been looked at by the US FDA, the European Food Safety Authority, Health Canada's Food Directorate and also by FSANZ. We are all in agreement that at the levels that we are being exposed to from BPA leaching from polycarbonate bottles, and this includes babies, there is no human health and safety issue at those levels.

Senator BOYCE—I have also been provided with some information—and you may well be right, Dr Brent, that it is not really about the safety of the product—and am advised that several US states, Canada and Denmark have taken action to ban BPA from babies' bottles. Are you aware of those actions?

Dr Brent—Yes, we are, Senator. In the case of Canada, for example, their risk assessors were very, very clear that at the levels they are being exposed to, including kiddies, there is no safety issue. But the politicians in Canada made a different decision which did not harmonise with the risk assessment.

Senator BOYCE—Is there likely to be any review of the use of BPA by FSANZ in the near future? You consider it a closed issue unless startling new evidence emerges?

Ms Halton—In relation to this press release, and from what you have said, if in fact they are saying any product that might be used by an under three-year-old, then this is not just a FSANZ issue. We would like to have a look at the press release.

Senator BOYCE—The concern particularly is its use in babies' bottles.

Ms Halton—I understand that but I think we need to have a look at the press release and then we follow it up.

Senator BOYCE—I will get it provided to you tomorrow morning.

Ms Halton—Thank you.

Senator BOYCE—The other question I have is regarding the mandatory addition of folic acid to bread, which I think was recommended as well by the CMO, to reduce incidents of neural tube birth defects such as spina bifida. We were in the process of signing a joint agreement with New Zealand but I understand that New Zealand has since withdrawn. This move came into effect in Australia about one month ago, which will add two to three parts per million to bread. New Zealand has deferred a decision until at least 2012. Are you able to tell us what that is based on?

Mr McCutcheon—It is essentially a decision by the New Zealand government. I should make it clear that the New Zealand proposed standard was a New Zealand only standard and was one that they developed themselves. It was their decision and it is not for us to comment on why they made that decision.

Senator BOYCE—We have had some concerns raised by millers and others suggesting that there are technical difficulties in delivering the correct dosage of folic acid to flour, there are costs of up to $250,000 or more for quite small millers to put in the equipment needed to do it, and they claim that deterioration in the life of the folic acid on the shelf could create doubt about the dosage that you would receive when you ate the break. Could I have comments from FSANZ on those issues please?

Ms Fisher—These issues were brought up by the millers during the standards development process. We did canvass them exhaustively. They did develop a set of costings about what they foresaw as being the impacts on large and small millers. We had two different consultants' reports testing those figures. We also sent one of our staff members overseas to have a look at fortification systems in larger and small mills in Canada and the United States, where fortification with folic acid has been taking place for more than a decade now. All of the evidence pointed to much lower costs. Some of the costs the millers were saying were required were not actually a requirement under the standard and we did not feel were needed to meet the range that was set and required in the standard.

The other issue you raised was degradation and the impacts on shelf life et cetera. We took that into account in calculating the addition of the level that was to be added and we took into account the range of shelf life that you might expect from the addition at the mill to it being consumed by the consumer after purchasing bread or bread mix through the supermarket. I forgot the other issue you raised? Was it the technical feasibility of achieving the range?

Senator BOYCE—Yes, the ability of getting a consistent dosage in the bread.

Ms Fisher—Again, this was a very difficult issue that we looked at very extensively. A major part of the trip to the US and Canada was to look at how all of those millers with all their different milling systems and their sophisticated and unsophisticated processes managed to deal with that and what kinds of ranges they were able to achieve. Our conclusion was that that range was achievable.

We also put considerable effort into working with industry and the Commonwealth, states and territories around how monitoring of the addition of folic acid would occur, what kind of testing would be used, what kinds of sampling strategies would be appropriate and so on. That work is continuing. We understand from talking to a couple of the larger millers recently that they are finding that they are dosing within the required range. We do not believe it is difficult for small millers to achieve if they do put the emphasis into testing their processes and putting in their sampling and monitoring approaches.

Senator BOYCE—What would you perceive to be the average cost of this?

Ms Fisher—I guess it depends on the type of milling operation.

Senator BOYCE—What about for a small miller? Are you able to give me a quick figure or is it better to put this question on notice?

Ms Fisher—If their process is set up so that all they need to do is buy a microdosing piece of equipment and add that in, then that equipment can be purchased second-hand for as little as US$3,500. The more expensive newer microdosing pieces of equipment cost around $10,500 to $11,500. If the mill needs to do some process re-engineering and build extra rooms to change their process line then there will be more costs incurred. It will very much be a mill by mill situation.

Senator BOYCE—Is there any public health risk from receiving an excessive dose of folic acid in your bread?

Dr Brent—There have been a lot of studies done on the positive and negative effects on health of folic acid, both voluntary and mandatory. Our summary of all of the data leads us to conclude that what we are doing—fortifying flour for bread making—is safe for the whole of the population.

Senator BOYCE—Thank you.

CHAIR—Thank you. That is all we have for FSANZ.

[10.35 pm]

Department of Health and Ageing

CHAIR—We will now move to the screening programs in population health.

Senator ADAMS—Has any of the money for the digital mammography equipment been expended and what states have got their machines?

Ms Koukari—None of those funds have been expended yet. We have been doing work with the states and territories on scoping the requirements of each of the states and territories in terms of digital mammography equipment and agreed at a meeting last week, I think it was, on a way forward that we are now going to put to the minister for consideration. That includes looking at things like where there is the greatest need in the states and territories, whether their equipment is now so outdated that there are no parts available to fix things. That will be the first consideration.

We are also making sure that we create the greatest efficiencies we can through purchasing arrangements, particularly for things not necessarily related to the equipment but around the software licensing, data standardisation and maintenance of equipment, which actually chews

up quite a lot of the costs and in fact costs more than the equipment itself. They are the things we are looking at.

We are certainly looking to expend that first $10 million by the end of this financial year. But, as I said, it will be for areas of need. One of the things we are scoping is where those areas are and who needs the equipment first.

Senator ADAMS—The whole $120 million that has been set aside has not been used this year. Will it still be kept? It won't disappear, will it?

Ms Koukari—That is right. $10 million was set aside for this first year. It was a scoping year. The money will start rolling out in force next year.

Senator ADAMS—How many machines approximately will be purchased for that money?

Ms Koukari—It is difficult to say at this stage because it will depend on what price we are able to achieve in the market and also what the needs are of the states and territories. It is not just about equipment; it is about the licensing. It is not just about the machines that take the mammograms but also about the software that transfers the digital data from the film-taking equipment to the software. It is how you transfer it so that it is readable. They are called PACS machines. They are transfer data systems. As the secretary was saying before, it is about interoperability and ensuring that we have interoperability of systems between the states and territories so that we can ensure that, if there is some spare capacity in one of the states or territories, we can transfer films quite easily because the machines can talk to each other. That is the other part of it. We have been taking some time to make sure that we get the right equipment and that it is going to talk to each other.

Senator ADAMS—What qualifications will the operator need? The same as they have had for the normal mammograms?

Ms Koukari—Yes, it will be the same. The machinery is very similar. In fact, some of the things that will be no longer required is processing that currently is undertaken by the radiographers on site. Processing of those types of things will no longer be required on site. I am sorry, Professor, I should have deferred to you. The reading will be very similar. It will just be on a different thing. Some things will be slightly different in terms of the way that the workstations are set up for people to do reading but the qualifications are essentially the same and what they are looking for will be the same.

Prof. Bishop—One of the advantages of this particular system is that you can often check at the time that the woman is there whether you have a good image, so that saves time. You can also get the images properly stored through the PACS, the storage system. You can also manipulate the image better at the time of reading so that you can see through some of the density, particularly with younger women. That is shown to be more effective in a reading sense for younger women compared to older women. While the overall results are very similar to the old analog system, for some subsets, such as younger women, it is actually a more effective measure. It is also much more convenient, because it does not require the woman to re-visit if the image turns out to be a bad image once it is processed through an old analog system. So it is more convenient for the woman trying to get the screen.

Senator ADAMS—As far as radiation goes, I gather it is a lot less radiation is emitted.

Prof. Bishop—It is a much more modern machine, which is obviously state of the art in terms of radiation dose. On all accounts, it is a win.

Senator ADAMS—As far as transport to rural areas in the van, are there any problems?

Ms Koukari—No, not at all. In fact, some of the states have already started working on fitting out their vans with the digital mammography equipment. Victoria has entered into an arrangement with one of the Commonwealth departments, the name of which escapes me, around broadband technology and using the high-speed technology for transferring images from the mobile vans so that they can be read almost immediately. As Professor Bishop noted, if there is a need for a second mammogram if something is not clear or if they need an extra view or something like that, the woman does not have to come right back to an assessment centre. They can do it where they are, so there is no step down from that service.

Senator ADAMS—That is good. I will look forward to talking to you at the next estimates to see where we are. The sooner that we get rid of the old machines the better. As far as radiologists go, there has obviously been quite a problem with the recruitment and retention of radiologists by BreastScreen Australia during the past 10 years. Could you tell me what has been done to try and recruit and to try and encourage people to take up that field of work.

Ms Koukari—That is a matter that essentially the states and territories have been managing, because they are the service delivers. But one of the projects that was undertaken as part of the BreastScreen Australia evaluation was looking at workforce capacity over time, the current workforce that we have and what we will need into the future to maintain the same participation rate that we have now or indeed even perhaps to increase it. Some of the things that came out of that were not just about recruitment and retention of radiologists. In fact, while there is a shortage of radiologists, it is really radiographers that are much of an issue. Some of the things that were suggested as part of that report include looking at things around workforce practices and workforce planning, having more things like job share arrangements, using rosters more effectively and those types of things. We need to see whether we can make a difference to capacity not just by having more staff but by using them much more flexible. They are some of the things that we have looked at. But I know that individual states and territories have also got arrangements in place to recruit to their services. Sometimes that is through overseas recruitment, but quite often it is by entering into arrangements with tertiary institutions with fellowships in hospitals and those types of things.

Senator ADAMS—With the increase, I am delighted that the age range has been expanded. That is something that I have been working for for a while, so I am very pleased about that.

Ms Koukari—There has been no decision made on that as yet, though.

Senator ADAMS—Hopefully there will. How is the workforce going to cope with the extra people?

Ms Koukari—As I said, part of the evaluation looked at workforce capacity over time and what would be required to meet the needs in different scenarios, which included if the age group was expanded downwards or upwards, if we increased participation and if we stayed at the same rate. It has been considered in that context. But until we have decisions it is a bit

hard to tell what we can do into the future. It is something that I know states and territories want to work quite closely together on to resolve.

Senator ADAMS—I have a question on breast screening, and it is a worry. Some of the alternative breast screening that is going on with heat mammography—

Ms Koukari—Thermography.

Senator ADAMS—Could you make a comment about that. The reason that I am asking is that in Western Australia this is happening quite a lot. People are accessing that service rather than going to breast screening, because one hurts and the other does not. I am quite concerned about the take-up of it.

Prof. Bishop—I will answer that. What evidence there is around thermography has been reviewed, and there is clearly a lot of evidence around mammographic screening augmented by ultrasound as required. There is no good evidence in terms of comparison with that gold standard and thermography. So the evidence base on which the claims are made that it is an alternative is in fact lacking. Obviously, everyone will continue to watch this. It may be an area that develops in terms of its technology and its ability. But at the moment all the randomised trials and all the evidence fits clearly with the gold standard that we are dealing with. The addition recently of MRI being used as the next step for high-risk women is also important. That is something that has been recognised. But thermography has an insufficient evidence base to recommend it.

Senator ADAMS—Thank you very much. I wanted to get that on the record.

[10.46 pm]

CHAIR—We thank the officers from population health. We know that there are going to be many questions on notice in that area, as it is such a large one. We will now move to outcome 5, primary care.

Ms Halton—On indulgence, given that the good Mr Humphries is going to run or amble away from us—I do not know what it is that you are doing, Elton—in keeping with our normal tradition, we have been debating where you are going. You can share that with us later if you like off *Hansard*. But some of us have a vision of you lying beside some river a bit like something out of the *Wind in the Willows* and take it very easy. What we have is the usual health show bag to farewell you from our presence. I have been told that you may be temporarily incapacitated, but it will encourage you to get moving, Elton. There are other nice things in here. I will not go on, but you get the general flavour. From the department, I thank you for all of the service that you have done us over the years. I will pass this via Leonie. I am not tabling it for everyone else; it is just for you.

Senator ADAMS—On the GP clinics, could you tell me how they are progressing and how many we have in place at the moment.

Ms Bennett—The program is well on track. We have 26 of the first 31 superclinics with the funding agreements executed to date. The first clinic is fully operation in Ballan, Victoria. It opened on 14 September. We have just been told today that it has been operating now for five weeks and in that time it has seen 4,500 people, which we think is terrific, including 3,000 GP visits in that five-week period. That is going very well indeed. We have five other

superclinics that are delivering their first and early services. They are in the Blue Mountains, the North Central Coast, southern Lake Macquarie, Devonport and Palmerston in the Northern Territory. Construction is underway at a further eight sites. Consultations and processes of negotiation are continuing with six of the sites that are not yet fully under funding agreements. So considerable progress is being made.

Senator ADAMS—Can you give us an indication of the services that are being provided at Ballan and the number of staff?

Ms Bennett—Ballan is offering a range of services for people with chronic disease. It has a lot of services focusing on people with heart disease, diabetes and asthma. There are privately practising GPs, practice nurses, dentists and a range of visiting specialists, including physicians and others. So quite a broad range of services are already being delivered. As I said, 4½ thousand services have been delivered in the first five weeks of operation.

Senator ADAMS—Does it have a pharmacy, physio and radiology attached anywhere with it, as a one-stop shop for everything?

Ms Bennett—It has got audiology, physiotherapy, podiatry, dietetics, nutrition, psychology, a range of mental health services, occupational therapy and pathology. But there is no exact pharmacy on the premises.

Senator BOYCE—Could I follow up on Ballan. The community of Ballan raised $900,000 and put that with the Rudd government's $1.4 million contribution, I understand, to get the superclinic up and happening. Was the $900,000 a requirement before the superclinic became operational?

Ms Bennett—No, Senator, that is not a funding requirement.

Senator BOYCE—Are any other communities doing the same thing?

Ms Taylor—Various clinics have private investment in them. I could not give you the exact amounts but certainly they are not the only ones that have private investment in the actual service.

Senator BOYCE—I understood from the media reports that I read that this was not so much private investment as community investment. Fundraising activity by the community itself had raised $900,000.

Ms Taylor—I could not tell you that specifically off the top of my head.

Senator BOYCE—Would that $900,000 mean there are extra services in this superclinic over and above what the government was intending to provide?

Ms Taylor—I would assume that it would have funded additional infrastructure there, yes.

Senator BOYCE—Could you take that on notice to tell me what extra infrastructure was provided with the $900,000?

Ms Taylor—Yes.

Senator BOYCE—Just going back, you said that five superclinics were partially operational; is that correct?

Ms Bennett—That is right. They have commenced delivering services. It is a mixture of whether they are, for example, building on to existing premises or just starting part of the service where they can while renovations are taking place—that sort of mix of things are happening.

Senator BOYCE—On notice, could you tell us or tell me where and what services they do provide and when they would be fully operational?

Ms Bennett—We are happy to take that on notice.

Senator BOYCE—How many superclinics will be open and fully operational by the end of 2009?

Ms Bennett—By the end of this year, 26. Ballan will be fully operational by the end of this year. Others are coming on, as I said, early stage, then most of the rest throughout next year. There are a range of reasons for that, mainly to do with the capacity to secure a block of land suitable for the site. In some cases be there have been extensive periods required for planning approval. In other cases it takes a long while—not necessarily to be considered delayed, but part of what was always anticipated is the time it takes to get a workforce ready to undertake major construction in some of these areas. So it takes a good while to build a substantial piece of infrastructure.

Senator BOYCE—How many would be fully operational by the end of 2010—calendar or financial year; just nominate which it is, I do not mind.

Ms Taylor—By the end of 2010, in terms of construction to be completed and with the doors open, we are anticipating 11 services.

Senator BOYCE—Some fully and some partially operational?

Ms Bennett—Yes, that is right.

Senator BOYCE—Do you know how many would be fully operational?

Ms Taylor—No, I cannot give you that detail at the moment. We do not have service plans for all of the clinics at the moment. They are due as a milestone to the actual contracts.

Senator BOYCE—We are not getting up to 20 very fast.

CHAIR—On behalf of Senator Furner, who cannot be with us, he particularly wanted to have a question about the Strathpine centre. Can you give us any information specifically about that one?

Ms Taylor—We certainly can. The service model in the Strathpine superclinic is anticipated around multidisciplinary integrated patient care and it will have services including GPs, nurses and allied health professionals and that will include physiotherapy, exercise physiology, audiology, dieticians and a diabetes educator. They are also looking at psychology, visiting medical specialists, an Aboriginal health worker, pathology and x-ray. There is a pharmacy that is intended to be located adjacent to the facility. A range of chronic disease management clinics will be the services. The construction of the Strathpine service is well advanced. The ground floor is complete and ready for fit-out. The first floor is currently under construction and an additional car park has almost been completed. So Strathpine is

well on the way. That is likely to be the next service that will be operational early to mid next year.

Senator BOYCE—Could I also ask about one of the Queensland centres—the superclinic that was promised for Bundaberg in 2007. There was a statement on 18 September from the department saying that the assessment process had not been concluded and no decision had been made on the operators for that clinic. Can you tell me why that has not happened? I understand the early consultations have happened.

Ms Bennett—No suitable applicant was found as a result of the invitation to tender for that particular site.

Senator BOYCE—Are you able to give me the number of applicants that did apply?

Ms Bennett—No, I do not think so.

Senator BOYCE—Because it is confidential or because you would need to take it on notice?

Ms Bennett—No, we do not normally give the detail of the number or privacy considerations around who applicants were.

Senator BOYCE—I was not asking for the details of who they were. I was asking how many.

Ms Bennett—But it could, depending on the number—

Senator BOYCE—If the answer is one, I realise that that might be a problem.

Ms Bennett—Exactly, and even if it is only a very small number it could also be an issue around privacy of applicants or nonapplicants.

Senator BOYCE—That is exactly my issue. Was there no suitable applicant because there was no applicant?

Ms Taylor—No, there were applicants.

Senator BOYCE—Perhaps if you could take it on notice and see what other information you can give me. Bundaberg Plaza has recently announced that it will be turning its shopping centre into a health complex and that this has been supported by the Queensland state government and that it will be providing all the sorts of services you would expect to get from a GP superclinic. Are you aware of this announcement?

Ms Taylor—We are aware of that announcement.

Senator BOYCE—What effect does that have on your planning around a superclinic?

Ms Taylor—The commitment to the superclinic in Bundaberg remains at this point, so it has not had any impact at all on the commitment.

Senator BOYCE—So you are anticipating that Bundaberg would get two major health complexes in the next how long?

Ms Taylor—I cannot give you a time frame for Bundaberg.

Senator BOYCE—You do not know?

Ms Taylor—Because we have not got a suitable—

Senator BOYCE—When would you review that decision? Have you reviewed your decision around Bundaberg in light of the Queensland government/Bundaberg Plaza decision?

Ms Bennett—No, Senator.

Senator BOYCE—So you really do not know whether it is still needed in Bundaberg or not?

Ms Bennett—Our task is to implement the election commitment of the government, which included the establishment of a GP superclinic in Bundaberg, and that is the task that we are forging ahead with.

Senator BOYCE—So the department would not have the wherewithal or the means to cancel a superclinic?

Ms Bennett—It would be a decision of government to not proceed with the superclinic that was part of a previous election commitment. It would not be a decision that we in the superclinic area would take.

Senator BOYCE—I will put my questions about practice incentive programs on notice.

CHAIR—Thank you. That completes the hearing for today. Thank you to the officers of Primary Care, who got the last position this evening. I thank all the officers for their contributions.

Senator BOYCE—On behalf of coalition members of this committee, past and present, I add our thanks to Elton Humphries, given that this is his last health estimates function.

Committee adjourned at 11 pm