COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

ESTIMATES

(Budget Estimates)

WEDNESDAY, 2 JUNE 2010

C A N B E R R A

BY AUTHORITY OF THE SENATE

THIS TRANSCRIPT HAS BEEN PREPARED BY AN EXTERNAL PROVIDER

INTERNET

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

The internet address is:

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

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

SENATE COMMUNITY AFFAIRS

LEGISLATION COMMITTEE

Wednesday, 2 June 2010

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, 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, Boyce, Brandis, Carol Brown, Fierravanti-Wells, Furner, Humphries, Marshall, Moore, Parry, Ryan, Siewert and Xenophon

Committee met at 9.00 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, 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 Officer
Mr Graeme Head, Deputy Secretary

Business Group

Ms Margaret Lyons, Chief Operating Officer
Mr Malcolm Bowditch, Acting Chief Financial Officer
Ms Samantha Palmer, General Manager, Communication and People Strategy
Ms Tracey Frey, Assistant Secretary, People Branch
Mr Joseph Colbert, Assistant Secretary, Corporate Support Branch
Ms Patricia O'Farrell, Assistant Secretary, Legal Services Branch
Mr Gary Davies, Assistant Secretary, IT Solutions Development Branch

Ms Kerrie Reyn, Assistant Secretary, IT Service, Support and Strategy Branch
Mr Adam Davey, Acting Assistant Secretary, Communications Branch
Mr Gary Aisbitt, Principal Client and Technical Services Adviser
Mr Christopher Payne, Acting Assistant Secretary, Corporate Support Branch

Portfolio Strategies Division

Mr Peter Morris, First Assistant Secretary
Mr Klaus Klauke, Acting Assistant Secretary, International Strategies Branch
Mr Greg Coombs, Assistant Secretary, Economic and Statistical Analysis Branch
Mr Michael Culhane, Assistant Secretary, Budget Branch
Ms Sue Campion, Assistant Secretary, Policy Strategies Branch
Ms Carolyn Driessen, Assistant Secretary, Ministerial and Parliamentary Support Branch

Health Reform Taskforce

Ms Megan Morris, First Assistant Secretary
Mr Alan Singh, Assistant Secretary, Health Reform Taskforce

Audit and Fraud Control

Mr Colin Cronin, Assistant Secretary, Audit and Fraud Control Branch

Outcome 1—Population health

Population Health Division

Mr Nathan Smyth, Acting First Assistant Secretary
Ms Janet Quigley, Assistant Secretary, Healthy Living Branch
Mr Damian Coburn, Assistant Secretary, Population Health Strategy Unit
Ms Melinda Bromley, Assistant Secretary, Population Health Programs Branch
Mr Bill Rowe, General Manager, Sport Branch
Ms Natasha Cole, Assistant Secretary, Sport Branch

Regulatory Policy and Governance Division

Ms Mary McDonald, First Assistant Secretary
Ms Teressa Ward, Assistant Secretary, Office of Hearing Services
Ms Donna Burton, Assistant Secretary, Blood, Organ and Regulatory Policy Branch
Ms Alice Creelman, Assistant Secretary, Governance, Safety and Quality Branch
Ms Kylie Jonasson, Assistant Secretary, Research, Regulation and Food Branch
Ms Anne Kingdon, Director, Governance, Safety and Quality Branch

Mental Health and Chronic Disease Division

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

Therapeutic Goods Administration
Dr Rohan Hammett, National Manager
Dr Ruth Lopert, Principal Medical Adviser
Mr Charles Maskell-Knight, Principal Adviser, Regulatory Reform
Ms Jenny Hefford, Chief Regulatory Officer
Ms Kim Loveday, Chief Operating Officer
Ms Philippa Horner, Principal Legal Adviser
Mr Craig Jordan, Chief Financial Officer
Dr Larry Kelly, Head, Office of Devices, Blood and Tissues
Mr Michel Lok, Head, Office of Manufacturing Quality
Australian Institute of Health and Welfare
Dr Ken Tallis, Acting Director
Mr Andrew Kettle, Head, Business Group
Ms Alison Verhoeven, Head, Governance and Communications Group
National Industrial Chemicals Notification and Assessment Scheme
Dr Marion Healy, Director, National Industrial Chemicals Notification and Assessment Scheme
Food Standards Australia New Zealand
Mr Steve McCutcheon, Chief Executive Officer
Ms Melanie Fisher, General Manager, Food Standards (Canberra)
Dr Paul Brent, Chief Scientist
Dr Andrew Bartholomaeus, General Manager, Risk Assessment
Mr Dean Stockwell, General Manager, Food Standards (Wellington)
Mr Cain Sibley, Acting General Counsel
Australian Radiation Protection and Nuclear Safety Agency
Dr Carl-Magnus Larsson, Chief Executive Officer, Australian Radiation Protection and Nuclear Safety Agency
Ms Rhonda Evans, Director, Regulatory and Policy Branch, Australian Radiation Protection and Nuclear Safety Agency
Mr George Savvides, Chief Financial Officer, Australian Radiation Protection and Nuclear Safety Agency
Office of the Gene Technology Regulator
Dr Joe Smith, Gene Technology Regulator, Office of the Gene Technology Regulator
Dr Michael Dornbusch, Branch Head, Office of the Gene Technology Regulator
Mr Greg Barber, Branch Head, Office of the Gene Technology Regulator
Outcome 2—Access to pharmaceutical services
Pharmaceutical Benefits Division
Mr Andrew Stuart, First Assistant Secretary, Pharmaceutical Benefits Division
Mr Kim Bessell, Principle Pharmacy Adviser, Pharmaceutical Benefits Division
Ms Felicity McNeill, Assistant Secretary, Pharmaceutical Evaluation Branch
Dr John Primrose, Medical Officer, Pharmaceutical Evaluation Branch
Ms Andrea Kunca, Assistant Secretary, Community Pharmacy Branch
Ms Adriana Platona, Assistant Secretary, Policy and Analysis Branch
Ms Linda Jackson, Assistant Secretary, Access and Systems Branch

Outcome 3—Access to medical services

Medical Benefits Division

Mr Richard Bartlett, Acting First Assistant Secretary
Ms Samantha Robertson, Assistant Secretary, Medicare Benefits Branch
Mr Peter Woodley, Assistant Secretary, Medicare Financing and Analysis Branch
Ms Jackie Stuart-Smith, Acting Assistant Secretary, Diagnostic Services Branch
Mr Brian Richards, Executive Manager, Health Technology and Medical Services 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

Ms Lesley Podesta, First Assistant Secretary
Dr David Cullen, Assistant Secretary, Policy and Evaluation Branch
Ms Bernadette Walker, Acting Assistant Secretary, Residential Program Management Branch
Ms Samantha Robertson, Assistant Secretary, Residential Program Management Branch
Ms Tracy Mackey, Assistant Secretary, Community Programs and Carers Branch
Mr Keith Tracey-Patte, Assistant Secretary, Budget Finance and Information Branch
Ms Andriana Koukari, 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, Assistant Secretary, Compliance Branch

Aged Care Standards and Accreditation Agency

Mr Mark Brandon, Chief Executive Officer, Aged Care Standards and Accreditation Agency
Mr Ross Bushrod, General Manager, Operations
Mr Chris Falvey, General Manager, Corporate Affairs and Human Resources
Mrs Victoria Crawford, General Manager, Accreditation

Outcome 5—Primary care

Primary and Ambulatory Care Division

Ms Raelene Thompson, First Assistant Secretary
Mr Lou Andreatta, Principal Adviser, Office of Rural Health
Mr Rob Cameron, Assistant Secretary, Rural Health Services and Policy
Ms Liz Forman, Assistant Secretary, eHealth Branch
Mr Mark Booth, Assistant Secretary, Workforce Distribution Branch
Mr David Dennis, Assistant Secretary, Policy Development Branch
Ms Tuija Harms, Assistant Secretary, Practice Support
Ms Sharon McCarter, Assistant Secretary, eHealth Systems Branch
Ms Vicki Murphy, Assistant Secretary, Service Access Programs Branch
Ms Meredeth Taylor, Assistant Secretary, GP Super Clinics Branch

General Practice Education and Training

Mr Erich Janssen, Chief Executive Officer

Mr Rodger Coote, National General Manager, Program Improvement and Workforce Branch

Outcome 6—Rural health

Primary and Ambulatory Care Division

See Outcome 5

Outcome 7—Hearing services

Regulatory Policy and Governance Division

See Outcome 1

Outcome 8—Indigenous health

Office for Aboriginal and Torres Strait Islander Health

Ms Linda Powell, First Assistant Secretary, Office for Aboriginal and Torres Strait Islander Health

Ms Rachel Balmanno, Assistant Secretary, Policy and Budget Branch

Dr Geetha Isaac-Toua, Senior Medical Officer, Public Health Advisory Unit

Mr Garry Fisk, Assistant Secretary, Performance and Quality Branch

Ms Tarja Saastamoinen, Assistant Secretary, Family Health and Wellbeing Branch

Ms Alison Killen, Assistant Secretary, Better Health Care Branch

Mr Craig Ritchie, Assistant Secretary, Remote Health Services Delivery Branch

Ms Joan Corbett, Assistant Secretary, Program and Planning Branch

Ms Kathleen Finn, Director, Program and Planning Branch

Outcome 9—Private health

Private Health Insurance Administration Council

Mr Paul Groenewegen, Acting CEO, Private Health Insurance Administration Council

Private Health Insurance Ombudsman

Ms Samantha Gavel, Private Health Insurance Ombudsman

Outcome 10—Health system capacity and quality

Primary and Ambulatory Care

See Outcome 5

Regulatory Policy and Governance Division

See Outcome 1

Mental Health and Chronic Disease Division

See Outcome 1

National Breast and Ovarian Cancer Centre

Dr Helen Zorbas, Chief Executive Officer

Cancer Australia

Dr Joanne Ramadge, Acting Chief Executive Officer

National Health and Medical Research Council

Professor Warwick Anderson, Chief Executive Officer

Dr Clive Morris, Deputy Head

Outcome 11—Mental health

Mental Health and Chronic Disease Division

See Outcome 1

Outcome 12—Health workforce capacity
Health Workforce Division
Ms Maria Jolly, Acting First Assistant Secretary
Mr David Hallinan, Assistant Secretary, Medical Education and Training Branch
Ms Paula Sheehan, Acting Assistant Secretary, Nursing, Allied and Indigenous Workforce Branch
Ms Louise Morgan, Acting Assistant Secretary, Nursing, Allied and Indigenous Workforce Branch
Ms Gay Santiago, Assistant Secretary, Workforce Development Branch
Ms Kerry Flanagan, First Assistant Secretary, Health Workforce Division
Mr Mark Cormack, Chief Executive Officer, Health Workforce Division
Outcome 13—Acute care
Acute Care Division
Mr Tony Kingdon, First Assistant Secretary, Acute Care Division
Ms Veronica Hancock, Assistant Secretary, Hospital Development, Indemnity and Dental Branch
Dr David Martin, Acting Assistant Secretary, Health Services and Information Branch
Mr Peter Broadhead, Assistant Secretary, Partnership Agreement Branch
Ms Gail Yapp, Assistant Secretary, Acute Care Strategies Branch
Ms Penny Shakespeare, Private Health Insurance Branch
Dr Andrew Singer, Principal Medical Adviser
National Blood Authority
Dr Alison Turner, General Manager and CEO
Australian Organ and Tissue Donation and Transplant Authority
Ms Elizabeth Cain, Acting Chief Executive Officer
Ms Judy Harrison, Acting Chief Finance Officer
Ms Elizabeth Flynn, Acting General Manager
Dr Gerry O'Callaghan, National Medical Director
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 Holden, Assistant Secretary, Health Protection Policy Branch
Ms Sally Goodspeed, Assistant Secretary, Surveillance Branch
Dr Gary Lum, Assistant Secretary, Health Emergency Management Branch
Mr Graeme Barden, Assistant Secretary, Office of Chemical Safety and Environmental Health
Ms Julianne Quaine, Assistant Secretary, Immunisation Branch
Dr Bernie Towler, Medical Officer, Office of Health Protection
Outcome 15—Sport
Population Health Division
See Outcome 1
Football World Cub Bid Taskforce
Mr Jaye Smith, Acting Assistant Secretary, Football World Cup Bid Taskforce

Australian Sports Commission

Mr Matt Miller, Chief Executive Officer, Australian Sports Commission
Professor Peter Fricker, Director, Australian Institute of Sport
Ms Judy Flanagan, Acting Director, Assisting the CEO
Ms Christine Magner, Director, Corporate Services
Ms Nadine Cohen, Assistant Director, Sport Performance and Development Division
Mr Steve Jones, Director, Commercial and Facilities
Mr Laurie Daly, Chief Financial Officer
Ms Wenda Donaldson, Acting Director, Community Sport
Mr Greg Nance, Director, Sport Performance and Development Division

CHAIR(**Senator Moore**)—I declare open this hearing of the Senate Community Affairs Legislation Committee to consider the proposed expenditure for 2010-11 for the portfolio of Health and Ageing. The committee must report to the Senate on 22 June and it has set 30 July as the date by which answers to questions on notice are to be returned. Officers and senators are familiar with the rules of the Senate governing estimates hearings. If you need assistance, the secretariat would be very happy to help you. I particularly draw attention to the 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 document 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—As we know, officers who are called upon for the first time to answer a question should state their name and position for the *Hansard* record and witnesses should speak clearly into the microphone. It is also important that the name plates that you have can be clearly seen by Hansard as well. Sometimes they get hidden by the jugs. Please make sure all mobile phones are turned off. I welcome the minister, Senator the Hon. Joseph Ludwig; the departmental secretary, good morning Ms Halton; and the officers. Minister, would you like to make an opening statement?

Senator Ludwig—No, thank you.

CHAIR—Ms Halton, would you like to make an opening statement?

Ms Halton—Not so much an opening statement; one question and then just a point of clarification in relation to the program, if that is all right?

CHAIR—Sure.

Ms Halton—The first question, which we do not have to take the answer to now, is: I am just cognisant of the fact that nearly every portfolio agency has been requested this time. That may indeed be the case. I would just like some clarification because, obviously, if people do not have to travel to Canberra et cetera, it would be good to know that. If I can just put that question on the record.

CHAIR—Yes.

Ms Halton—The second observation is that there are multiple components to health reform. I should say that the officers are prepared on the basis that they will answer questions about the specifics under the specific program. If there are any overarching questions, they probably should sit under 13 or whole of portfolio.

CHAIR—Sure.

Ms Halton—That is the first thing this morning anyway. In terms of our preparation, our observation of this would be questions in the macro, probably Whole of Portfolio or 13, and then for the item by item stuff we have got people prepared to answer under the relevant programs.

CHAIR—That was how I would see it working. Certainly, if we have issues where questions come up but the appropriate officers are not here, we will put them on notice. Also, it will be an extraordinarily tight time frame to make sure that these people all get a chance in questions, and I intend sticking to the program.

Ms Halton—Thank you.

CHAIR—We also will be going to run through areas hopefully under subsections, going through subsection by subsection.

Ms Halton—Certainly.

CHAIR—Given that, we will start with questions on whole of portfolio and corporate matters. I believe Senator Fierravanti-Wells is starting?

Senator FIERRAVANTI-WELLS—Thank you, Madam Chair. Ms Halton, I would like to start off by asking about the outstanding questions on notice. My office has been assiduously asking for questions, particularly in relation to the GP super clinics, and those questions still remain unanswered. Some of them were actually asked on 10 February, and some of them were actually put on notice on 23 February. It is now four months. Can you tell me when I am going to get these answers, given that we are there now? Where are they?

Ms Halton—I will ask the officers concerned to answer the specifics of the questions. Can I just make the observation—and I am sorry that they are not here—that the reality is we had a 50 per cent increase in the number of questions this last time, nine hundred and something. My colleagues can tell you exactly the number. I am sorry that these ones are late, but they can give you the specifics.

Mr Morris—The complexity of questions in this particular case was extraordinary. We had 425 questions received in 938 parts. We have returned 416 of those 425 questions, which represents 98 per cent. We apologise for the outstanding two per cent. We are working to get those in as quickly as possible.

Senator FIERRAVANTI-WELLS—Ms Halton, the concern that I have is that the questions that I am specifically seeking are about the GP super clinics. If there is one thing in the portfolio that the Prime Minister and the minister have well and truly put out there, it is GP super clinics. If we can see a press release on every little item pertaining to GP super clinics, then I cannot understand why your department cannot answer four or five specific questions about GP super clinics. They are the questions I specifically have been asking about and they are the outstanding ones that I am particularly interested in. You can go out and put out a press release every minute on whatever is happening, on every little thing that is progressing on this issue, but you cannot answer my questions.

CHAIR—The officers do not put out the press releases. The issue of press releases is with the minister. That would be for the minister.

Senator FIERRAVANTI-WELLS—I appreciate that. Let me just ask my question: where are the questions now? Are they with you, Ms Halton, or are they with the minister's office for clearance?

Mr Morris—They are with the minister's office.

Senator FIERRAVANTI-WELLS—How long have they been in the minister's office?

Ms Driessen—I would have to take the specific dates on notice, but they were questions that did require revisiting after the budget announcements, in terms of making sure that they were up to date and still comprehensively answered.

Senator FIERRAVANTI-WELLS—The budget has come and gone, but the questions are still sitting. My question to you is when did they first go to the minister? Obviously they went to the minister in one format and then, after the budget, they had to be revisited. Is that the situation?

Ms Driessen—They needed to be updated.

Senator FIERRAVANTI-WELLS—All right. When did they go to the minister's office for the revisiting?

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

Senator FIERRAVANTI-WELLS—I would have thought that since my office has made repeated requests, Ms Halton, about these questions, it should be foremost in your mind. I cannot think of the times that we have approached the committee. I have no doubts that the committee has, in turn, approached the department, asking for these questions. Hello! Must be uppermost in your mind! I cannot understand why you have to take this on notice.

Senator Ludwig—Chair, I have just spoken to the secretary. I understand there are about eight; we will not be specific—we have indicated two per cent. Some of them clearly do relate to the GP super clinics. I will have a look today. I will ask the minister's office to see what we can do so that if not all of the answers then part of the answers, or a better explanation than what we are currently providing, is provided and we can give you an opportunity tomorrow to ask questions in relation to that information. With your kind permission, Chair, I am happy to adjust the program to suit that. If there is a problem in terms of resources or issues like that, then I will come back with an explanation.

Senator FIERRAVANTI-WELLS—We have a very tight timetable. If our questioning goes over until tomorrow, then tomorrow's program gets mucked up. We are on at four o'clock on primary care. I would appreciate it if the answers to these questions were provided to me by lunchtime. If you can put out the sort of material that you are putting out on GP super clinics, then my questions can jolly well be answered because the questions that I have asked no doubt involve information that is there. I appreciate—as the press releases are saying, like this one of 25 May, *Roxon super-clinic sensitive*—the minister might be sensitive about the super clinics; I appreciate that, with only 2½ actually operational, my questions go to the very core of another area where this government is failing but, in fairness, I want those answers and I expect to have them by 12.30 today.

CHAIR—Senator—

Senator FIERRAVANTI-WELLS—No, Senator Moore.

CHAIR—Senator, when I actually speak, you do not talk across the chair.

Senator FIERRAVANTI-WELLS—I do not want you tomorrow to then say, ‘Senator, we do not have time to ask questions on this because the program has been reorganised.’

CHAIR—Senator, you have not been in this committee very long. That is not a process we follow in this committee. We are very fair and give people open access to ask their questions. The minister has now provided a response. You have made clear what your needs are. We will consider at lunch time what is happening with those questions. If there is a need to restructure the program to allow you to have questions on the super clinics, it will occur, but just appreciate that we do try, in this committee, to be as fair as possible. Your experience is not with us so, in terms of process, I would appreciate it if we could just continue now. You have made your point, and we will continue with the questions. Will the minister be able to get an update at lunchtime about the status of those questions?

Ms Halton—We will.

Senator FIERRAVANTI-WELLS—I would like to start, if I can, Ms Halton, on your media release subscription system. Just following on from what you said in your opening statement about hospital reform, I intend to deal with overall questions on the big picture in relation to hospital reform here, but I will deal with the specifics in acute care. So we will deal with that component of it.

Regarding this media subscriptions program, my office and the staff in my office have had an inordinate amount of problems in relation to getting what appears to be a simple subscription to the health media from your department. One of my staff, Mrs Brown, has applied about 10 times and gone on and off, on and off, on and off. Another one of my staff members has applied about three times. Despite repeated efforts, they keep going on and they keep coming off. So, my question, Ms Halton—and this is what concerns me—is: has there been blatant discrimination? If every member of the public is entitled to get subscription, what is the problem and why have my staff encountered so many problems in getting access to what appears should be a very, very simple process?

Ms Palmer—I spent some time speaking to one of your staff about the email subscription service and we did check into the service to make sure that the two staff in your office were subscribed. The process is a manual process, where we add people’s email addresses and we take them off. What happens to emails after they leave our department’s servers is impossible for us to control. We know from experience, from some of our other subscribers, that sometimes ISPs and particular software systems will identify our emails as spam emails and sometimes they get stopped, and that can create some problems for people trying to receive the emails.

In terms of how we add people onto and take them off the email system, it is a very straightforward process. It is done on a daily basis. We cannot find any explicable reason as to why the staff have had problems. At this stage, it might be that those problems are occurring on the other side of the wall, once the emails leave our system.

Senator FIERRAVANTI-WELLS—I did not want to talk about blatant discrimination, because it is either that or somebody is manually taking my staff on and off, or, alternatively, there is some sort of problem with your system.

Ms Halton—No. Let's be clear about this. What the officer is telling you is that we have the records to demonstrate that your staff have been added to this list and that the emails leave our system. We can demonstrate that. So it is not necessarily a problem with our system, and what the officer is explaining to you is that it is certainly the case sometimes that other people have problems getting things through their firewall. So I do not think you should make an assertion that indeed people have been in any sense discriminated against, because it is absolutely a provable fact that people were added to lists and that they are on lists. This has been explained. As you know well, we know your staff, but this has been explained to them.

Senator FIERRAVANTI-WELLS—Ms Halton, thank you for that. My concern in raising it is that the department has problems in getting simple health media subscription emails out there to members of the general public, in a department that is now professing to run e-health and all sorts of other national GP call centres and that sort of thing. If you cannot get a simple media subscription system going, how are you going to deal with much bigger issues, Ms Palmer? That is my concern. That is why I am raising it.

Ms Halton—I frankly think that that is a stretch. The bottom line here is, as we have indicated, these emails leave our system. We can demonstrate that. It is true, as we all know, in this world that sometimes other people's systems identify emails as spam. We all have these systems in place to protect us from the enormous amount of cyber-garbage running around in the world. The bottom line is this has no relationship whatsoever to the implementation of programs such as e-health.

Senator FIERRAVANTI-WELLS—Ms Halton, I will wait with bated breath when I subscribe to your system and see if I have to wait 10 times and have my name removed 10 times and then have it put back on.

Ms Halton—No—

Senator FIERRAVANTI-WELLS—I will try that, and next time when I come along I can tell you the progress of my own experience.

Ms Halton—I have to reiterate on the record that your officers have not had their names removed 10 times.

Senator FIERRAVANTI-WELLS—No. Ms Halton, I appreciate what you are saying, but the point is: what is wrong with the system? If my staff have to go through this, what about an ordinary member of the public who wants to know about all your grand plans in health, who wants to subscribe, who wants to know about health issues? Does that mean they have to go through that? My staff have persisted. That is my point, Ms Halton. If there is a problem with the system, a glitch with the system, what are you doing to rectify it?

Ms Halton—There is not a glitch with the system, and maybe what the public do is they change their internet service provider if they are having that much trouble getting stuff through their firewall—

Senator FIERRAVANTI-WELLS—But we are trying to do it through Parliament House.

Ms Halton—or they read the website.

Senator Ludwig—Chair, we seem to have gone around this mulberry bush a couple of times now. I accept that there is a problem. I do not know where the problem lies. The department has undertaken to look to see whether or not it lies with them and, if it does not lie with them, then it must lie somewhere else, and the department will get back to us in respect of that issue.

CHAIR—Minister, I accept that, but it is up to Senator Fierravanti-Wells to frame her questions.

Senator FIERRAVANTI-WELLS—Senator Moore, the reason for pursuing this is that we are talking about Parliament House to Health. That is what we are talking about. We are talking about APH addresses. If there is a problem with APH addresses being firewalled, or some sort of a problem, we have a problem. Do you understand what I am saying, Ms Halton?

Senator Ludwig—Chair, on that basis, if it does come up as an APH problem—

CHAIR—It is your responsibility.

Senator Ludwig—I will then take it on notice and have a look at it. If the department of health advises me it is not their issue, I am quite happy—and I am sure my advisers are watching—to note this and examine the issue because Senator Fierravanti-Wells is right: it is important that information about health be communicated to APH addresses.

CHAIR—Senator, we have the Special Minister of State on the job.

Senator FIERRAVANTI-WELLS—Thank you. When it is the Special Minister of State, then at least perhaps things may happen. I might just move on. Ms Halton, I am not sure if you were aware of some of the questions that were asked of Prime Minster and Cabinet the other evening in estimates for Finance and Deregulation. Are you aware of that?

Ms Halton—I might have some familiarity with some of them, but do not assume anything. Perhaps you can tell me if there is a particular reference you are making.

Senator FIERRAVANTI-WELLS—I am asking in particular if you followed the questioning that I made of officers of Prime Minister and Cabinet, including Ms Cass, Dr Grimes and Mr Rimmer on 25 May. It is from page 96 to about page 109 in the transcript. The questioning was in relation to the big picture of the hospital reform process.

Ms Halton—We have some familiarity with what was asked.

Senator FIERRAVANTI-WELLS—Good. One of the issues that troubled me during that questioning was how it all fits in together. It was very clear from the evidence that was given by Mr Rimmer and others that you have a unit in the Prime Minister’s office which—

Ms Halton—Office or department, sorry?

Senator FIERRAVANTI-WELLS—Department, sorry—the Department of the Prime Minister and Cabinet. I will just get that chart in front of me. It deals with Health and Ageing. Then we have another section that deals with health reform, and now we have Mr Beresford, who is supposed to be, according to the evidence that has been given and certainly some of the reports, the sort of fixer on health. I am interested to know, Ms Halton, with the whole

department and the thousands of bureaucrats that you have, why you need this unit. What is the interaction between your department and this unit?

Ms Halton—I am not actually conscious of a unit and, as you would well understand, administrative arrangements in the Prime Minister's department are not in my area of responsibility and I am loath to comment on any other department's administrative structures or arrangements. What I can tell you is the arrangements in relation to health reform in my department, and I am very happy to do that. You are probably aware of—and if you are not, I can outline to you the establishment of a transition office in my department, and I see, coming to the table, Graham Head, who I should introduce to the committee. He has joined my department. He is formally a director-general from New South Wales. He has joined my department as the deputy secretary, but he is currently the acting CEO of the transition office.

The transition office has responsibility for coordinating all of the implementation of health reform. It is responsible for ensuring that, firstly, the program is delivered, it is delivered in an appropriate way—that is, properly coordinated on time, on budget et cetera. So whilst you refer to a structure in the Prime Minister's department, I have to say I am not familiar with that precise structure. I am familiar, historically—because, of course, I was in Prime Minister and Cabinet as the deputy secretary—with the health branch, which has been a feature of that department for literally as long as I can remember, but in terms of some of the other structures, I cannot say that I can comment particularly.

Senator FIERRAVANTI-WELLS—All right. In the Prime Minister's department under the domestic policy section—and Dr Grimes gave evidence the other evening—you have a social policy division, which has a first assistant secretary, Ms Cass, who has health and ageing, and she also now has a newly-formed section called health reform, which she told us was established in about September last year. Are you aware of that?

Ms Halton—I would not say I was aware of a group called health reform but there was a small group of officers who worked with quite a large group of officers from my department, together with officials from the Treasury and officials from the finance department, on health reform. So if she says it is a discrete group, that is hers to describe, but we certainly are aware of a group of officers who are tasked in respect of health reform, yes.

Senator FIERRAVANTI-WELLS—Okay. And you are also aware of the unit called strategic policy and implementation, the deputy secretary, Mr Rimmer, who, beneath him, has the strategic policy and implementation, Mr Beresford, and also strategic policy and implementation, Mr Flintoff.

Ms Halton—As I say, I am not aware of the subsidiary structures under Mr Rimmer, but certainly I am aware of Mr Rimmer, yes.

Senator FIERRAVANTI-WELLS—Okay. The reason I ask this, Ms Halton, was because of the evidence that Mr Rimmer gave. In fairness, I should ask you some of those questions because it seemed, in summary of their evidence, that health reform is being driven out of the Prime Minister's department. That is the upshot of the evidence that Mr Rimmer was giving, and there is the appointment of Mr Beresford and Mr Flintoff in April to effectively fix and drive this reform. I ask this: if they are driving it, what is your department doing? Is yours a subsidiary role or a—

Ms Halton—I do not think I would agree with that characterisation, and I am not actually sure, based on what I understood was said in those estimates, that that was necessarily a reflection of what Mr Rimmer said. I will go back and review the transcript. I have to say that is not my understanding of what he said, but perhaps I missed a nuance that was perhaps more evident if you had been here. I am not actually even conscious that I have met Mr Flintoff, so to say that he is driving health reform is, perhaps, news to me. As to Mr Beresford, he certainly has something to do with the strategic review which is just an administrative review of the portfolio, but that is as an officer who is participating with a series of others, and particularly with my acting deputy secretary responsible in this area, he is, I think, maybe a division head. So no, I am not conscious that Mr Beresford is driving this.

Senator FIERRAVANTI-WELLS—All right. In fairness, then, I would like to take you then through the various parts of that evidence—

Ms Halton—Sure.

Senator FIERRAVANTI-WELLS—and just ask you from your perspective. So Ms Cass has got these two sections called health and ageing, and now health reform. What interaction do you have with that area of the Prime Minister’s department?

Ms Halton—Personally, none, but my officers—

Senator FIERRAVANTI-WELLS—When I say you, I assume the department.

Ms Halton—Okay. I will not use the royal we. Again, this has been ever thus. In terms of the health branch, I can tell you that if there is a day without phone calls between that branch and my department, I would be surprised. It was certainly that way when I was deputy secretary in Prime Minister’s department, and it is certainly my understanding that that level of connection continues. I should make the observation that, indeed, a number of those officers are actually former officers of my department.

Similarly, that was the case in my day, that there is a fair level of interchange between the senior officers in that area and my department. This is not uncommon. In terms of the smaller group who have worked with us on health reform, again—in fact, on various occasions we had, for example, Treasury officers physically sitting with us. I had officers physically sitting over there. There was a great level of interchange, basically because the work was so mutually interdependent. In terms of the reform group, Ms Huxtable I think would have been in daily contact with people in that—

Ms Huxtable—Yes.

Ms Halton—part of Prime Minister and Cabinet.

Senator FIERRAVANTI-WELLS—Dr Grimes said—and I will just quote this:

> Our work on health reform is ongoing. It is a major area of public policy and has been for some time. It is something we have been involved in on an ongoing basis.

It was also clear from what Ms Cass said that they did—and it is from their documents, and I would appreciate, perhaps, if you, over the morning break, just go over and have a quick look at that evidence. But from your perspective, can I just summarise by saying that the Department of Health and Ageing had carriage of the Bennett process, if I can put it that way—

Ms Halton—Correct.

Senator FIERRAVANTI-WELLS—and you provided the secretariat to the Bennett—

Ms Halton—Correct.

Senator FIERRAVANTI-WELLS—Right. And so we now have two distinct processes. We have the Bennett process, and that ended, and then we have the next process, which was the consultation process and the 100 or the 103 visits to the hospitals—

Ms Halton—Correct.

Senator FIERRAVANTI-WELLS—and the gowns and the beds and the photographs. Right. Okay. I tried to drill down to actually understand who did what on a day-to-day basis, and I started to ask questions in relation to these 100 or 103 visits. I think I have been corrected there. It is about 103.

Ms Halton—Yes.

Senator FIERRAVANTI-WELLS—I wanted to ask who determined where those visits were to be. Who had carriage of those? So let me just start by asking the first question. Who managed this process? PM&C say you managed it.

Ms Halton—Correct.

Senator FIERRAVANTI-WELLS—Because I was particularly asking about the 21 visits that the Prime Minister did, and I was trying to find out who managed those, who decided where the Prime Minister would go on those 21, and I was told to just come to you, so I am coming to you.

Ms Halton—Yes, we managed all of those, and I think it is fair to say that there was a genuine attempt to ensure that those consultations were widely distributed geographically. My understanding is that in terms of setting a broad program, then it was a question of—and I use the ministerial team in a large sense to include the Prime Minister—who was available in terms of those consultations, but I can ask Ms Morris if she would like to add to that.

Ms Morris—In regard to management of the consultations, yes, it was done by a branch within my taskforce, the communications branch. There were 26 sites announced by the Prime Minister when he launched the final report of the National Health and Hospital Reform Commission. Those sites were expanded over time and ended up with 103 consultations, as you rightly said, and it was an ongoing process of negotiation with our minister's office as to availability of what Ms Halton described as the broad ministerial team, and trying to link that with other visits that the Prime Minister, the minister and other ministers within the portfolio were making. We tried, to the extent we could, to work consultations into non-sitting periods to maximise the availability of senior members of the government. But it was an ongoing process, dealing directly with our office regarding availability because public servants cannot actually determine on which days senior members of government may or may or not be available.

Senator FIERRAVANTI-WELLS—My question is: who determined the hundred? Who determined where? Who came up with the list? How were they chosen?

Ms Morris—It was an ongoing process of feedback with our minister's office, who presumably spoke to the Prime Minister's office, but we did not deal directly with the Prime Minister's office. Sometimes people would propose that, if possible, could the minister or the Prime Minister come? Some of the consultations coincided with other major meetings of interest groups. Sometimes they were special interest group meetings brought together. For instance, there a mental health consultation organised in Canberra. Most of them occurred in hospitals, as they provided appropriate facilities.

Senator FIERRAVANTI-WELLS—Ms Morris, my question is very specific. Who determined—

Ms Morris—I doubt that there was any one person I could say, 'Joe Bloggs told us exactly when and where.' There was constant feedback between us and our office, and our office was in constant touch with the Prime Minister's office. There were regular updates on availability and possible sites.

Senator FIERRAVANTI-WELLS—Somebody other than the department determined the location of the hundred?

Ms Morris—Usually, yes.

Senator FIERRAVANTI-WELLS—Okay. Usually the minister for health or the Prime Minister's office?

Ms Halton—We cannot comment on that.

Ms Morris—I cannot comment on that. I deal with my office. I did not deal directly with the Prime Minister's office.

Senator FIERRAVANTI-WELLS—All right. Were you given any specific instructions in relation to where these visits were supposed to be?

Ms Morris—Yes.

Senator FIERRAVANTI-WELLS—All right. Could you tell us what those instructions were?

Ms Morris—As I said, there were regular updates on the availability of ministers and the Prime Minister, and sites. We would then contact the hospital, the whatever, to see if such a day was doable. It was a changing story, week by week, depending on availability of senior members of government, who have other priorities on at the time.

Senator FIERRAVANTI-WELLS—Did you keep a board in your office, a map of Australia?

Ms Morris—We kept a running spreadsheet.

Senator FIERRAVANTI-WELLS—I am interested in understanding how these consultations were chosen, and also who attended. Who determined the guest list about who attended?

Ms Morris—The guest list was determined by us, in close consultation with both the minister's office but also our state officers, who knew the local stakeholders much better than we did. We tried to be as inclusive as possible. Most of them were held in hospitals because

they provided an appropriate venue, but the invitation list went well beyond clinicians and staff at the hospital. Sometimes consultations would have a specific focus. I gave, as an example, the mental health consultation in Canberra.

Senator FIERRAVANTI-WELLS—The department of health determined who was to be invited?

Ms Morris—Yes.

Senator FIERRAVANTI-WELLS—Did you vet those lists?

Ms Morris—I did, personally, yes.

Senator FIERRAVANTI-WELLS—Okay. Did people have to register? It is a bit like the community cabinet. Do you have to register name, rank and serial number?

Ms Morris—Not quite name, rank and serial number.

Senator Ludwig—That is not the way we do it at community cabinet, Senator Fierravanti-Wells. If you had attended, you would know.

Senator FIERRAVANTI-WELLS—I do not think if I had attended at the Binalong one I would have been very welcome, Senator Ludwig.

Senator Ludwig—You were always welcome. I write to you, I think, and ask you to come along and let you know that it is on.

Senator FIERRAVANTI-WELLS—I will remember that next time. I shall register for a question as well.

Senator Ludwig—Only too happy. You can come and visit me.

Ms Morris—We did have guest lists and RSVPs were required. No-one was ever turned away from the door. We did, on the odd occasion, have people turn up who were interested in attending and they were allowed in. I think there was only one instance where people were not accepted, and that was when an invitation was sent to an organisation and they wanted to bring along—I cannot remember the number—seven or nine people and there just was not room, because each venue had different seating capacity. We tried to monitor how many invites were issued, watch the RSVPs and be as inclusive as possible. We also worked very closely with state departments of health, wherever there was a consultation.

Senator FIERRAVANTI-WELLS—From the sounds of things, and certainly from some of the answers to the questions on notice, there was specific allocation for signage, consultation, the lanyards, the insertion of cards. It was quite a detailed process. It certainly would have avoided a Gordon Brown-type situation. I am sure you did not have any unwanted people. The question I am really asking is: was this just stage-managed? How did you come to your list of people?

Ms Halton—Can I just underscore what Ms Morris has said. Essentially, our state officers, as people on the ground, who, particularly in that more local area arrangement, have a better grasp than we do from Canberra of who the stakeholders are, were actually asked to give us a list, then people approached us about coming. It is a question of, with the state health departments, who also have a group of stakeholders sometimes we do not deal with as directly, with our state officers and then people approaching us, compiling a list and inviting,

as Ms Morris said, not so many people that you cannot actually get a seat, but enough people who are going to be interested to attend.

Senator FIERRAVANTI-WELLS—Ms Halton, I will leave it there, but I would ask, if you could take on notice if you could provide a list of all the people who attended each of those consultations, please?

Ms Halton—There may be a privacy issue about that. If we can, we will, but I will have to take advice about whether I can give you that, in terms of privacy.

Ms Morris—What I can do, I have a list here of the type of people who were asked. I am very happy to read that through. This was basically our checklist for the range of people who would be asked, if you are interested.

Senator FIERRAVANTI-WELLS—You spent $14,000 on display signage for the consultation events, $10,000 on lanyards and inserting cards. You have obviously got lists, so it would not be very hard to produce them.

Ms Halton—No, we have got lists. As I said, if I can provide them to you without it being a breach of privacy, I just want to take advice. I do not want to say I am going to give it to you and then discover I have got a privacy problem.

Senator FIERRAVANTI-WELLS—Subject to privacy, I see no reason why we should not have them. There was a television camera at every consultation, the Prime Minister in his coat.

Ms Halton—I agree with you entirely. I am just saying that I do not want to give you an undertaking which subsequently, for some reason, I cannot. But if we can, we will.

Ms Morris—For the record, would you like the list of the type of groups that were asked and the range of individuals?

Senator FIERRAVANTI-WELLS—No, I want a list of all the people who attended.

Ms Morris—Local members were asked in each area, for instance.

Senator FIERRAVANTI-WELLS—I appreciate that, but if you have got 103 consultations, you have been able to provide on questions on notice the fact that you spent the money that you spent, and the fact that you spent such and such on lanyards, which means obviously you put cards in, you did all that. You know who attended.

Ms Halton—Yes, we do.

Senator FIERRAVANTI-WELLS—You have obviously got a list. You just press print and that list should come out in some format, subject to what Ms Halton says about privacy principles, to have a look.

CHAIR—Is this the community members that went? Who are you after?

Senator FIERRAVANTI-WELLS—No, this is the Prime Minister's 103—Minister Roxon and the Prime Minister did their tour with their road shows. I would like to understand who participated in those consultations at those road shows.

Senator SIEWERT—It is up to the government to say, but if I went to one of those road shows as a Joe Blow, I might not want people to be putting me on a list to circulate to people.

Ms Halton—That is my concern.

Senator Ludwig—Chair, I raise the issue of privacy to the secretary because it is an area that I look after and have ministerial responsibility for. I am sure, if the lists can be provided, they will be provided, but I always, in abundant caution, put a caveat around privacy issues just to ensure that the department is not committing to something which would breach the Privacy Act.

Senator FIERRAVANTI-WELLS—I am happy with that. That is not a problem. We will move on.

Ms Halton—What I will have to do, particularly here, is just check what undertakings were given to people. I just need to go back and look at all those details, and we will.

CHAIR—Ms Halton, as you know, we have had a similar issue in previous questions in previous types of consultations. I think we have got the answer from the department. Senator Fierravanti-Wells, your next area?

Senator FIERRAVANTI-WELLS—My next series of questions are in relation to the three booklets *Taking preventative action*, *Building a 21st century primary health care system* and *A National Health and Hospitals Network for Australia's future*. Mr Rimmer seemed somewhat reluctant to tell me who actually signed off on these documents. Could you enlighten me on who had the final sign-off for these documents?

CHAIR—Ms Halton, do you know the documents?

Ms Halton—Intimately, I regret to say. In terms of signing them off for the physical print run, as the department commissioning them we actually signed them and sent them to the printer.

Senator FIERRAVANTI-WELLS—You paid for them?

Ms Halton—Yes.

Senator FIERRAVANTI-WELLS—But my question is: who had the final sign-off on the content?

Ms Halton—We obviously received clearance from our minister's office when they were happy with the final drafts.

Senator FIERRAVANTI-WELLS—Do I take from your answer that the final signoff on the content was from Minister Roxon?

Ms Halton—Her office are the ones who authorised to push-print.

Senator FIERRAVANTI-WELLS—Are you aware whether there had been consultation with the Prime Minister's office in relation to the sign-off of these documents?

Ms Halton—My understanding is that there was some discussion with the Prime Minister's office. As to the nature of those discussions, I am not aware of that.

Senator FIERRAVANTI-WELLS—So we do not know whether the minister's office was told, 'Yes, you can go with it.' So we do not actually know who had the final sign-off of the content, in terms of whether it was Minister Roxon or the Prime Minister.

Ms Halton—My understanding is that, because these documents were around in government pretty broadly, there would have been wide reading amongst the interested ministerial team. It would be my expectation that advisors in a number of places would have seen that document. I am not privy to the traffic inside Parliament House as to how those documents were circulated and/or commented on. It is not my job to know that. My job was to ensure that when we push-printed we were authorised to do so.

Senator FIERRAVANTI-WELLS—I guess it goes to the question of who is driving this. That is really the question I am getting to. Is this being driven out of the Prime Minister's department and the department of health is just doing the legwork and the donkey work on this, or are you actually driving the agenda? That is what I am trying to find out, and Mr Rimmer was not very clear with me the other evening. That is why I have come to you. One assumes that, as the Department of Health and Ageing, you would be driving this. I do not know who is driving this. I am trying to get clarity on it, so I have come to you.

Ms Halton—You probably well understand I am not used to being in the position of merely doing donkey work. It is not my reputation. I can assure you that the department has had a very significant, ongoing policy role in all of this, driving it. To say that the minister is intimately acquainted and has driven every single element of this reform does not quite give it the justice it deserves. Not surprisingly, when you are talking an investment of this significant size, the Prime Minister—and I think this is quite evident in the number of consultations he has done and the interest he has taken in the policy matter and, indeed, in the comments from the community—has himself been intimately involved in this, as indeed has the minister for finance, as indeed has the Treasurer, as indeed has the Deputy Prime Minister.

Senator FIERRAVANTI-WELLS—Sorry, I do not have a clean copy here with me, but there was an article in the *Australian Financial Review* of 23 March.

Ms Halton—Was that the front-page article?

Senator FIERRAVANTI-WELLS—Yes, it was the front—

Ms Halton—I think I might know that one!

Senator FIERRAVANTI-WELLS—Yes, I thought you might know it, which is why I am asking the question. The article's headline is 'Rudd goes downtown for health fixer' and says:

The Rudd government has … turned to a management consultant to implement its centrepiece health reform as part of a broader strategy to recruit private sector talent into the bureaucracy.

Tim Beresford, a former corporate lawyer and Westpac executive with over 15 years' experience in banking and mergers and acquisitions—

which surprised me somewhat, because I am not sure how much banking mergers and acquisitions have to do with health reform, but leaving that aside—

has taken on a senior role in Mr Rudd's department that will focus on implementing the proposed national hospitals network.

Because the article says 'Rudd goes downtown for health fixer', it sort of reminds me of some—anyway, I will not go there.

Senator Ludwig—Chair, the usual position that I have adopted in this committee and others is that, if information is going to be put to the witness, then the witness has an

opportunity of looking at that document. I understand that the secretary has indicated that she has some familiarity with the document, so I did not want to interrupt the flow of Senator Fierravanti-Wells's questioning but I remind that it is usual practice to do that. In the previous committees both sides of politics have acknowledged that is a fair thing to do for the witness.

Senator FIERRAVANTI-WELLS—I did come with copies of some articles but not a copy of this one.

Senator Ludwig—I thought that might be the case.

Senator FIERRAVANTI-WELLS—That is why I prefaced my comments by asking Ms Halton if she was aware of it. She is indeed, because it was page 1 of the *Australian Financial Review*. That is the reason I ask these questions. Understandably, Ms Halton, I am trying to understand who is driving this.

Ms Halton—Indeed. Mr Rimmer made some remark about that being a little—I cannot quite remember the language, because as I say, I have only seen it once—either 'overblown' or something synonym for that, in terms of what he said to you about that article. I make two observations about that: (1) I have met Mr Beresford twice or maybe three times—if he were genuinely driving this, I think I might have seen him more often—and (2) he is a division head in the Department of Prime Minister and Cabinet. In my experience, prime ministers themselves personally do not go out looking for division heads. It is a bit of a waste of their time. Whilst he is no doubt an important officer who the department of Prime Minister have chosen to recruit for his skills and capacities, the work on driving this reform's implementation is going to sit very clearly in the transition office in my portfolio. But, exactly as has been the case in developing the policy in the run-in to the decisions and the COAG agreement, it will be absolutely in consultation and close collaboration with our colleagues in Prime Minister and Cabinet, the Treasury and the department of finance.

Senator FIERRAVANTI-WELLS—Ms Halton, I would now like to go to the COAG process. I also asked Mr Rimmer about that process. You had the communique in December last year and then there were a series of meetings. Did you attend those meetings?

Ms Halton—It depends on which meetings. There were many, many meetings about all sorts of things. Can you be specific about which—

Senator FIERRAVANTI-WELLS—There were a series of meetings that occurred. I asked Mr Rimmer about the meetings after that communique in December 2009, when the communique promised the grand plan. Mr Rimmer said:

> … the Prime Minister wrote to state premiers and he proposed the establishment of a health reform working group. I chaired that group, alongside representatives from the Commonwealth—from both the Department of the Treasury and the Department of Health and Ageing. States were invited to nominate … That group held four formal meetings, the first of which was on 5 February 2010.

Did you attend meetings of that health reform working group, the first of which was on 5 February 2010?

Ms Halton—No. That group was established as a deputy group. Certainly my deputy secretary, Ms Huxtable, attended that group, but I did not.

Senator FIERRAVANTI-WELLS—What input did the department of health have into the Prime Minister's Press Club speech on 3 March 2010?

Ms Halton—It depends on what you mean by 'input'. Obviously we are not responsible for writing the Prime Minister's speeches. That has never been part of our duty statement. But, in terms of the policy content, which obviously was a decision of government, the policy work in relation to—and I think you also went to the Department of Finance and asked them in relation to their role, and they said they costed policies at various points. The polices that they were costing were policies that we were preparing.

Senator FIERRAVANTI-WELLS—The Prime Minister gave a speech at the National Press club on 3 March 2010. In particular he talked about the local hospital networks:

For the first time, local hospital networks run by local health financial and managerial professionals, rather than state or, for that matter, federal bureaucrats, will be put in charge of running the hospital system.

What sort of input, if any, did the department of health have in relation to those comments and any other comments in the Prime Minister's speech of 3 March?

Ms Halton—As I have said to you, we did not script any of the Prime Minister's comments, because we do not write his speeches; but, in terms of the policy that was reflected in that speech, we wrote those submissions in respect of the policy.

Senator FIERRAVANTI-WELLS—The Prime Minister made much of this 'federally funded, locally managed'. How locally managed are these local health networks?

Ms Halton—The geography of the local hospital networks will be agreed in discussion with the states and, as I think we have also indicated, wherever possible—it may not be 100 per cent possible—we would like the Medicare local boundaries to be coincident in order that those regions can start to work in a more integrated way across primary and acute care. So the management structures, which you have broadly outlined, which were reflected in the Prime Minister's Press Club speech, were obviously subsequently discussed at COAG and were agreed. The process of formulating those local hospital networks is something which is now being discussed with the states and with others along with the management arrangements for the governing councils which will be part of that and which will have control of the operation of those local hospital networks.

Senator FIERRAVANTI-WELLS—At the time when the Prime Minister made his speech, were you aware of or were you able to quantify the number of local networks? You must have some idea. Did you?

Ms Halton—I think the Prime Minister did indicate a number. I would have to go back and refresh my memory as to the precise number. I think it was in the order of a range. Ms Huxtable might be able to jog my memory.

Senator FIERRAVANTI-WELLS—Mr Rimmer told us 100. Would that be correct?

Ms Halton—In fact I was going to say to you I thought it was somewhere between 100 and 120, but one never wishes to be imprecise when talking to estimates. Certainly there was discussion at COAG in relation to the number. I do think it is important to note that there was not a precise number agreed. In fact, what needs to be done is, as I have said, look at the

geography in order that the structure of these best meets local needs as well as, as I have said, coincides wherever possible with Medicare locals.

Senator FIERRAVANTI-WELLS—I take you now to the detail of the local hospital networks and how local 'local' is. Perhaps the Prime Minister's meaning of local does not necessarily coincide with my meaning of local, and I would like to delve into this if I can. At page 14 of the National Health and Hospitals Network Agreement—which was, after all, the document that was agreed to by the states except Western Australia as a consequence of the COAG meeting—you are aware of the detail of that agreement?

Ms Halton—I do not have it in front of me, but I think my colleagues do have it in front of them. Yes.

Ms Huxtable—Page 14.

Senator FIERRAVANTI-WELLS—It says at page 14:

LHNs will have the following governance structure:

It then goes on about:

a. a professional Governing Council and Chief Executive Officer (CEO), responsible for:

et cetera. Then it sets out (i) to (v). And then it says:

Governing Councils will comprise members with an appropriate mix of skills and expertise to oversee and provide guidance to large and complex organisations, including:

i. health management, business management and financial management;

ii. clinical expertise, external to the LHN wherever practical;

iii. cross-membership with local PHCOs wherever possible;

et cetera. My question is, when I read:

ii. clinical expertise external to the LHN wherever practical ;

that means, does it not, that the doctors that the Prime Minister was referring to in his Press Club speeches as being 'run by local health' et cetera, are going to come from outside the local health network wherever practical?

Ms Halton—It does not, actually.

Senator FIERRAVANTI-WELLS—That is what is says.

Ms Halton—Yes. It is important to read the words in the context of the way they are going to be implemented, and perhaps I can give you some detail on that. We need to make a distinction at this point about Victoria. We will put WA to one side. Essentially, Victoria already has arrangements in relation to clinical engagement and those arrangements have been in place for some time and it is not our immediate intention to change those arrangements. What I can tell you is that elsewhere the local clinical community will be asked to nominate somebody to participate in the governing council.

We are all mindful of issues in respect of conflict of interest, but they will be asked to nominate representatives for that governing council and, ideally, it is better to have somebody who does not have a conflict of interest. The overarching principle here is that it should be the

best person for the job, but it may well be that the best person for the job, indeed, is a local clinician. Certainly that is the way this will be implemented.

Senator FIERRAVANTI-WELLS—Ms Halton, this is an agreement. I spent 20 years as a lawyer before. That is what it says here. It says:

> ii. clinical expertise, external to the LHN wherever practical;

You have two statements here—one by the Prime Minister at the Press Club, one written in agreement which the states have agreed to—in direct contradiction of each other. Three guesses as to which one I believe.

Ms Halton—No, sorry. Let us be clear: those are not in direct contradiction with each other. The bottom line is there is, rightly, in the formal drafting of this an acknowledgement inter alia of a potential for conflict of interest. I can tell you how the overarching principle is to be implemented with absolute confidence—and, indeed, this was also reflected in the speech, as I understand it, though I have not seen the precise text, that was given last week which goes to the detail—and that is that, mindful of issues in respect of conflict of interest, the local clinical community will be asked to nominate people who could be part of the local governing council. That is very consistent with, exactly as you say, the overarching ethos—if I can describe it in that way—of the reform.

Senator FIERRAVANTI-WELLS—But this Prime Minister has made so much of local hospital networks 'run by' local health. You see them in the advertisements now. Those advertisements refer to 'run locally'. They have spent so much money on advertising. That is false. Take my local hospital network in the Illawarra, for example—there will be one down there in the Illawarra. What, effectively, this says is that the clinical expertise for the local hospital network that will be based around the Illawarra will not come from the Illawarra; it will come from outside the Illawarra.

Ms Halton—With respect to your 20 years as a lawyer, I have nearly 30 years as a bureaucrat and I can tell you how this will be implemented, and it will be—

Senator FIERRAVANTI-WELLS—That is not what the agreement says, Ms Halton.

Ms Halton—I am telling you how it is to be implemented.

Senator FIERRAVANTI-WELLS—Ms Halton, if that is how it is going to be, perhaps you should have written the agreement, because that is not what is in the agreement. If this is the agreement that the states have signed up to, is there going to be a second agreement, a modified agreement?

Ms Halton—No.

Senator FIERRAVANTI-WELLS—The point is: what is in the agreement and what the states have signed up to, except Western Australia, is a document that says that the clinical expertise will come from outside the Local Hospital Network wherever practicable.

Ms Halton—With respect, my observation is that actually the clinical community will not give a rat's about formal agreements or otherwise. What they will care about is how this is implemented and what they will care about is the arrangements as I have outlined to you, which will be how this will be implemented.

Senator FIERRAVANTI-WELLS—With due respect, the agreement specifies, virtually down to the letter, the obligations of the states in relation to this agreement, and I would have thought that state bureaucracies are going to follow to the letter what they are required to do, presumably under eventual legislation that is going to be established to give effect to this agreement. I would have thought that the parameters of this agreement are going to carry much more weight, Ms Halton, than your interpretation of what potentially might be the situation.

Ms Halton—I can tell you with absolute confidence that my, as you describe it, interpretation—indeed, let us put it more broadly: the approach to implementation of this has not just been my whim or whimsy but has been discussed between myself and the others, just to confirm that this is indeed how it will be implemented.

Senator FIERRAVANTI-WELLS—When the Prime Minister gave his speech to the AMA the other evening, he suddenly plucked out another $58 million. Could you first of all tell me where that $58 million that the Prime Minister indicated at the AMA conference on 28 May is coming from? What outcome is that coming from? Where is the money for this additional $58 million coming from?

Ms Halton—It will come from an appropriation. I will have to take some advice on which program, because I cannot say that I can answer that immediately. It is outcome 13, we think.

Senator FIERRAVANTI-WELLS—But it is not in the budget.

Ms Halton—It is.

Senator FIERRAVANTI-WELLS—It is in the budget?

Ms Halton—Yes.

Senator FIERRAVANTI-WELLS—Whereabouts in 13 is it?

CHAIR—Ms Halton, is it better to answer this question here or in outcome 13?

Ms Halton—Outcome 13.

Senator FIERRAVANTI-WELLS—All right.

Ms Halton—We will come to it and we will—

Senator FIERRAVANTI-WELLS—We will deal with it in outcome 13, but my point here is that, in what the Prime Minister outlined of these lead clinicians groups, the language is not directive. There is no mention of variation in this speech of the agreement that the states agreed to, in relation to the clinical expertise being external to the Local Hospital Network. That is my point. Even after the Prime Minister gave his speech to the AMA, there is nothing concrete in this speech that I see that varies the agreement with the states. That is the point.

Ms Halton—As I pointed out to you, there is no need to vary this agreement with the states. The arrangements, as I have outlined to you, are how this is to be implemented, and this is the way it will be implemented.

Senator FIERRAVANTI-WELLS—If that was the way it was going to be implemented, why wasn't it written in the agreement?

Ms Halton—I cannot answer that. I was not there.

Senator FIERRAVANTI-WELLS—That is my point. Clearly, if a document in black and white says one thing, what you are saying to me is that the implementation and giving effect to this agreement will be in a way that is not necessarily written into the agreement. I mean, this agreement goes on and on and on.

Ms Halton—I am sorry. The reality here is the way this is being implemented is consistent with this agreement. This agreement acknowledges, inter alia, as I have already indicated, that there are potentially conflict of interest issues, but, as I have already indicated to you, everybody wants the best people for the job. Yes, we probably will ask the local clinical community. We will ask them to nominate people. If they can find somebody who they are comfortable with who does not actually work in the facility, that is a good thing, but it may be that the best person for the job does work there, in which case other conflict of interest arrangements are going to have to be used to manage that. That is consistent with this agreement. If you actually read down (a)(i) through—I cannot actually read this without glasses on, but if you go to (b), you did not get all the way down to (v), where it says ‘where appropriate, other skills and experience’. The bottom line is that this agreement actually enables you to put anybody we think is appropriate on these governing councils. I take your point that, if you read narrowly, you could misinterpret (ii) in the way that you are, and I understand your narrow reading of this—

Senator FIERRAVANTI-WELLS—I am reading what is there. I am not misinterpreting.

Ms Halton—but the bottom line—

Senator FIERRAVANTI-WELLS—Ms Halton, I would ask you to withdraw that. I am not misinterpreting; I am reading what is there.

Ms Halton—When I hear you, it sounds to me like a misinterpretation. If you say your interpretation is legitimate, I accept that is your opinion. What I am saying to you is that, if you look at governing councils (i) through (v) which says ‘where appropriate, other skills and experience’. I have explained to you how this is to be implemented. I have explained to you that this is a conversation I have had with my state colleagues. I have explained to you that there is a distinction with Victoria because there are already these arrangements in place. I actually do not know I can say much more to satisfy you, Senator. This is how it will be.

Senator FIERRAVANTI-WELLS—But that flies directly in the face—how can you say and promise in advertisements ‘run locally’, ‘run by’? ‘Run by’ means overall control of local health, financial and—this is what the Prime Minister is saying.

Ms Halton—Yes, but that is—

Senator FIERRAVANTI-WELLS—‘Run by locals.’

Ms Halton—And that is absolutely correct. We are talking about a governing council that will have a number of people on it who will have sufficient skills and experience, business acumen, financial management capability et cetera, who actually do run those services locally.

Senator FIERRAVANTI-WELLS—But the doctors will not be local. The doctors will not be local, Ms Halton.

Ms Halton—Well, Senator—

Senator FIERRAVANTI-WELLS—I mean, isn't this just an attempt to just buy off—has somebody in the AMA finally worked out what was actually in this agreement and the Prime Minister goes on last week and—is this just this latest speech about saying, 'Oh, yes, we are going to give you more input'? It just seems to me like just buying them off.

Ms Halton—I think Ms Morris has already indicated the local clinician networks were always a feature of this package. The money is appropriated in the budget. This is not something that is a change, in any way, shape, or form. The bottom line is this was always part of the package. The way we have been describing this publicly has remained consistent. It has not varied and it is how it will be implemented.

Senator FIERRAVANTI-WELLS—Well, we will beg to differ on that, Ms Halton, but perhaps I might just move on at this point to the Yourhealth website. In an answer to a question on notice, No. 242, you mentioned that you have final clearance, it is indicated, on the Yourhealth website. I asked the question as to whether it was the minister or the secretary, and the answer is that you have final say on this website.

Ms Halton—I will have to get someone to show the question to me. Okay. I have the question in front of me.

Senator FIERRAVANTI-WELLS—You finally clear all the information posted on that website?

Ms Halton—It is delegated to the first assistant secretary, health reform taskforce, but it is a departmental decision, and therefore, as the department secretary—as is the case with a number of pieces of legislation—I am technically the decision maker. But this is a delegated decision.

Senator FIERRAVANTI-WELLS—So Ms Morris clears it and then it comes up to you and you tick off on it?

Ms Halton—No. It is a delegated decision. I do not fetter the delegate. The delegate exercises that responsibility.

Senator FIERRAVANTI-WELLS—That means, therefore, that part B should really say 'the secretary but on delegation'.

Ms Halton—I will accept that it is probably a truncated answer.

Senator FIERRAVANTI-WELLS—All right. On that website there is this thing called 'quick polls' on how people have voted. What are these polls used for?

Ms Morris—The website, as a whole, was used as part of the consultation process on health reform. There was a variety of means of communicating with the public and allowing the public to communicate with us. 'Quick polls' was just one of many tools that was used throughout the course of the consultation. The answers were collected, collated and fed, in a broad sense, into policy development.

Senator FIERRAVANTI-WELLS—When were these quick polls set up?

Ms Morris—I cannot give you dates on which they were set up, but the website was launched, I think, in August last year and the quick polls started not too long after it was

launched. I am sorry I cannot tell you exactly how many different polls there were, but there were different topics that were posted up over the course of the consultation period.

Senator FIERRAVANTI-WELLS—You see, Ms Morris, I tried to find some information on that launch, but, interestingly, I can find all sorts of things on both Minister Roxon's website and the Prime Minister's website, but I cannot actually find anything, or any speech, in relation to the launch of your health website.

Ms Halton—It was not launched.

Ms Morris—'Launch' would be the wrong term. It went 'live'—that would be the right term, I think.

Senator FIERRAVANTI-WELLS—Did it? I see. It went live, and did the Prime Minister—

Ms Morris—27 July.

Senator FIERRAVANTI-WELLS—officiate at the going live?

Ms Morris—No.

Senator FIERRAVANTI-WELLS—He did not.

Ms Morris—It was a departmental website.

Ms Singh—And it was 27 July that it went live.

Ms Halton—I confess at the outset, as I probably should, that I do not Twitter and nor do I Facebook.

Senator FIERRAVANTI-WELLS—You and I share that, Ms Halton. Today's Twitterers will aspire to all sorts of things tomorrow.

Ms Halton—Yes.

Senator FIERRAVANTI-WELLS—Senator Ludwig, do you Twitter?

Senator Ludwig—No, I do not.

Ms Halton—It may be a demographic thing we are talking here.

Senator Ludwig—I think it is age related.

Ms Halton—Age related, that is right. However, one of the things that we know about communications is that there is an expectation—I see Senator Moore laughing; she is, regrettably, I suspect, in the same demographic as the rest of us—which I am aware of, in an intellectual sense, that other people prefer to communicate using a variety of different means. I can see Ms Bleeser laughing. I bet she Twitters. No, she does not.

Senator SIEWERT—All right. Hands up anyone here who Twitters.

Ms Halton—Senator Siewert, don't you?

Senator SIEWERT—Apparently some people do send little messages to me, but I do not.

Ms Halton—I was confident. Okay. Let us ask the question: who Twitters amongst the officers? Yes, the IT guy Twitters, and Learmonth, apparently, but he is under 50 as well. Anyway, the point being that we acknowledge our collective demographic is not necessarily

the dominant demographic anymore. Advice from our communications people, and our IT guy and others, is that when one, these days, attempts to communicate with people, one has to have a variety of, I think the language is, channels. This was a departmental website which basically enabled people to come back to us and give us information about the reform process. It was not launched by the PM, the minister or anybody else.

Senator FIERRAVANTI-WELLS—That is very interesting, Ms Halton, because, in the break, I will get you a copy of an article, *Policy by the seat of their pants. It's got to be bad*, by Nick Miller, 22 February 2010, which has this picture of the Prime Minister in the dark with:

Prime Minister Kevin Rudd at the launch of the yourhealth.gov.au website. Was the government making it up as it went along. Photo: Glen McCurtayne.

This followed the rather interesting article which I read called *Yes Minister meets Alice in Wonderland*, the other article which I am sure somebody has read in your department, of 21 February 2010, which recounts Mr Peterson's time as a speechwriter in your department.

Ms Halton—I am happy to go through that with you line by line if you really want.

Senator FIERRAVANTI-WELLS—Ms Halton, the point I am particularly interested in is that you have just said to me the Prime Minister did not launch it.

Ms Halton—No. I want to make a distinction. He did launch the consultations, and I think that might be where there is some confusion.

Ms Morris—That is right.

Senator FIERRAVANTI-WELLS—That is the photo. I will get you a copy of this.

Ms Halton—Yes.

Senator FIERRAVANTI-WELLS—I took that off the website yesterday evening.

Ms Halton—Yes, and we might be—

Senator FIERRAVANTI-WELLS—There is a photograph. This Prime Minister does like being in photographs. There it is on the www.yourhealth.gov.au website.

Ms Halton—Yes. As I say, it might be that we are talking at cross-purposes here. Certainly he launched the consultation process. We may be talking at cross-purposes here. He did not flick the switch on the website, but he launched the consultations, yes.

Senator FIERRAVANTI-WELLS—In that case—

CHAIR—Senator, if you are going to be referring in detail to that document—

Senator FIERRAVANTI-WELLS—I will. I will get copies for Ms Halton.

CHAIR—Rather than waving it.

Senator FIERRAVANTI-WELLS—I do not have a colour printer, so I cannot do it in colour, but I will get it for you in black and white, Ms Halton.

CHAIR—We just need it tabled if you are going to quote from it.

Senator FIERRAVANTI-WELLS—I will. I will not do it at this point until I have got copies of them.

CHAIR—That will be useful.

Senator FIERRAVANTI-WELLS—I am interested in these quick polls. At what point were they used for the hospital planning?

Ms Halton—Sorry?

Senator FIERRAVANTI-WELLS—We talked about these quick polls before. I got a little bit sidetracked in relation to the stunning photo of the Prime Minister on the yourHealth website.

Ms Halton—Was the question: how were they used?

Ms Morris—On an ongoing basis.

Senator FIERRAVANTI-WELLS—On an ongoing basis?

Ms Morris—Along with any other comments made on the website or submissions to the website.

Senator FIERRAVANTI-WELLS—Were they used to develop specific aspects of the hospital plan?

Ms Halton—We will have to go back and have a look to answer that specifically. The reality is, as I have indicated, it was important for us to understand not just the bureaucracy's view about what was needed in health reform, not just individuals who came to consultations. Remembering that what we are doing here is we are taking the Health and Hospitals Reform Commission report, the prevention task force report and the *GP Strategy*. All of those documents provide a very large number of proposals in relation to things that should change.

It was important that we actually get wide-ranging input as to what people thought about those ideas or, indeed, things that they thought had been missed, and getting that input in order to balance the policy advice that we gave about what should be done and what should not be done, what order they should be done in et cetera. It was in that context. To say that any one particular thing caused a cataclysmic shift, I think, is a little much. I would have to go back and have a look to give you specific examples, and I am happy to do that.

Senator FIERRAVANTI-WELLS—I am interested, because these polls are so statistically insignificant that if you did rely on any of these polls to decide policy or to at least develop any aspect of policy then I would have thought there was some gross dereliction. This one says:

> Does Australia need a sustained awareness strategy to increase the community's awareness of mental health and reduce the stigma of mental illness?

Ninety-eight per cent said yes, but it was 98 per cent of 48 people. The point I am making is that those are very, very low figures.

Ms Halton—Yes, indeed.

Senator FIERRAVANTI-WELLS—It is actually interesting because Mr Miller, in his article, actually refers to staff being encouraged to generate some of the poll information. I ask the question—

Ms Halton—That is absolutely not true.

CHAIR—Senator, you are actually quoting from—

Senator FIERRAVANTI-WELLS—What I am asking you is: did—

CHAIR—You are quoting from the article again without tabling the document.

Senator FIERRAVANTI-WELLS—I will get a copy of that.

CHAIR—I remind you, Senator—

Senator FIERRAVANTI-WELLS—Perhaps, Ms Halton, you can give us an assurance that—

CHAIR—Senator, I am speaking. I am asking you a question and you just kept on with your comment.

Senator FIERRAVANTI-WELLS—Sorry.

CHAIR—We only have another half an hour on this process.

Senator FIERRAVANTI-WELLS—I have finished now.

CHAIR—There are other senators wanting to ask questions in this area.

Senator FIERRAVANTI-WELLS—I will come back to this in the IT section. Thank you.

CHAIR—Ms Halton, we have had a question about asking questions about the membership of the proposed new boards. Is that best handled here or under acute care?

Ms Halton—Either.

CHAIR—In the interests of time, we will go to your questions, Senator Adams, in acute care. Senator Siewert.

Senator SIEWERT—Thank you. I am not sure if this is the right place to ask this question. It may be in acute care, but you will let us know. I am interested in this issue around Western Australia not signing up to the reform process. Is that one I can ask now?

Ms Halton—Yes.

Senator SIEWERT—What is the contingency approach if Western Australia does not sign up to the health plan? I am obviously particularly interested to see if Western Australia is going to get the same level of funding or what we are going to miss out on.

Ms Huxtable—There are ongoing discussions occurring with WA, so it is probably a little premature to talk about contingencies. However, you will be aware that there are two types of moneys, I guess, flowing through the health reform proposals. There are certain moneys that flow direct to the states and would be subject to national partnership agreements, and in the absence of WA signing up to the reform plan, clearly, we are unable to finalise national partnership agreements with WA. However, there is a range of other moneys which go to primary care reform and other matters—mental health, for example—that would not be delivered through the states and territories. Certainly we are continuing to actively engage with WA about how those proposals would roll out within WA. WA is part of the Commonwealth-state group that has been formed to take forward implementation. There are a number of processes that are in place. One relates to the Health Reform Implementation

Group, which has representatives of central agencies, health departments and treasuries from all states and territories, and Western Australian officials are part of those processes.

There are very much discussions ongoing with them in regard to details of specific measures and implementation issues. Side by side with that, I am aware that there are other discussions that have occurred with WA in regard to broader issues that were issues of importance to them in regard to the health reform plan more broadly.

Senator SIEWERT—I have a series of questions. I might as well start where you have just finished: those ongoing discussions about broader issues. Are you able to share with us what those issues are?

Ms Huxtable—At the time of the COAG decision, the WA government made fairly clear what its concerns were and what the impediments were to it signing up. They are basically—

Senator SIEWERT—They are the issues that are the ongoing—

Ms Huxtable—They are the issues that were being discussed. I would be speculating somewhat, because I am not personally involved in those discussions, but I do understand that there has been a number of discussions that have occurred with WA officials predominantly through central agencies. That is my understanding.

Senator SIEWERT—Thank you. I want to go back to this issue of the two streams of money, and the other moneys. Are we talking about the primary care, the mental health money?

Ms Huxtable—Yes.

Senator SIEWERT—Are there any other buckets that come in there? Is additional funding for aged care, sub-acute care—those additional elements—classed under other money?

Ms Huxtable—I would probably need to take those in turn. The elements that specifically relate to moneys that flow through the states go to the emergency department measure, the elective surgery measure, the sub-acute investment, and then there is capital money flexible funding associated with those elements. They are predominantly the elements that would be managed through national partnership agreements with the states. There are roles and responsibilities in respect of aged care. You would be aware that Victoria is not part of the HACC arrangements; they were excluded from that in the agreement. I think the position of WA in that regard would probably not be on the table at this point in time. However, there are a range of other investments that go to direct Commonwealth moneys that would benefit the citizens of a state or territory, and that includes the GP and primary care initiatives.

Senator SIEWERT—The Medicare Locals.

Ms Huxtable—Yes.

Senator SIEWERT—Okay.

Ms Huxtable—There is money for after-hours changes, so there is a number of moneys that are made available through Medicare Locals. There is also the GP superclinics money and the infrastructure money that is part of the GP superclinics initiative. There is also the diabetes measure. If you look at the red book—and I am not sure if you have it there—all of

the various measures are listed by type policy stream, if you like. There are a number of discrete aged-care measures that are listed in that book. There are also a number of workforce measures and initiatives in the area of mental health.

Senator SIEWERT—So all of the mental health initiatives—the additional funding for mental health?

Ms Huxtable—The exception probably is the EPIC initiative, because if you recall, the EPIC initiative was a Commonwealth contribution seeking state contributions in respect of the sites that might form the new EPIC sites. So that one is probably a little less clear. There is not one per state, that is right. No doubt we will get into this under outcome 11, I think it is, but we anticipate that there is probably sufficient funding for around four EPIC sites. But that will very much depend on the interest of states and territories. In any calculation, there will not be an EPIC site in every state and territory, I would not expect.

Senator SIEWERT—Okay. Thank you. So WA can access those. Under the other initiatives that come under the money that goes direct to the states, from a Western Australian perspective, how much are we going to miss out on if WA does not sign up? Have you done any calculations? There was originally a figure of $350 million floating around.

CHAIR—'We' being WA?

Senator SIEWERT—Yes. I am putting my Western Australian hat on. How much are Western Australians missing out on?

Ms Huxtable—In terms of those programs that I spoke of which would be subject to national partnership agreements, the amount of moneys that would be allocated to WA is in the order of $350 million. I am not sure exactly what the $350 million is that you have referred to, because there are lots of numbers, but my advice is that it is in the order of that amount of money.

Senator SIEWERT—So the amount of WA would get, if there were an agreement reached for those other initiatives we have discussed, would be $350 million?

Ms Huxtable—To put it another way, if WA had signed up in April to the COAG agreement, then the allocation of funding by state and territory flowing from that agreement through national partnerships for WA is in the order of $350 million.

Senator SIEWERT—Okay. And if we do not sign up, do other states get the money?

Ms Huxtable—There has been no decision about what may occur if WA does not sign up, precisely because I think there are still discussions occurring with WA. So it would be premature to be making decisions about what might happen.

Senator SIEWERT—Okay. Is there a deadline on the negotiations?

Ms Huxtable—Not that I am aware of.

Senator SIEWERT—Okay, so there is an ongoing process of negotiations. If, in a couple of months, the rest of the process—which we will go into a bit more detail, I presume, under each of the programs—continues and the rest of the reform rolls out while you negotiate with Western Australia, we will have to play catch-up from a Western Australian perspective?

Ms Huxtable—We will just continue, obviously, to implement the reforms according to the timelines that are in the public domain. In parallel, I am sure there will be discussions continuing with WA.

Senator SIEWERT—Thank you. Is it best to talk about the specific programs here, or will we deal with them as we come to the programs?

CHAIR—I would imagine to the programs, because it would make more sense that way.

Senator SIEWERT—Okay, I won't chase the sub-acute care.

Ms Halton—If we can deal with that on the program structure, Senator, it might be best, if that is okay.

Senator SIEWERT—Yes, that is all right.

CHAIR—Senator Furner, you have general questions.

Senator FURNER—Thank you. Can you disclose the figures for your annual staff turnover?

Ms Lyons—For the current financial year to date, the staff turnover is running at about 7.7 per cent.

Senator FURNER—What does that relate to in heads?

Ms Lyons—It is 348.

Senator FURNER—Overall, how many staff are employed by DoHA?

Ms Lyons—As at the end of April, 5,165 is the head count.

Senator FURNER—No doubt you would be aware of the opposition's announcement, or position, based on a staff freeze over two years, using their figure of 6,000 public servants. What would that do in relation to DoHA's capacity to honour its statutory functions as a department?

Ms Lyons—It would very much depend on what the nature of the freeze was, but the statutory obligations would always be a priority within the department.

Senator FURNER—The nature of the freeze is quite simply no staff to be replaced over two years, at least. Once again, their figures are, at this stage, indicating that will be about 6,000 across the whole of government. How difficult will it to be to function as a department in relation to honouring your statutory obligations?

Ms Halton—Our job is always to ensure that we deliver our statutory obligations, and that is what we would do.

Senator FURNER—What areas in DoHA would be cut, in relation to that proposition? That is based on your figures of 348 staff on current figures. Taking that out of the system, what would that do in regards to areas of cuts through DoHA?

Ms Halton—That is a hypothetical which I do not think I am in a position to answer. It would depend on the circumstances at the time and it would depend on where attrition came from, and we would have to have a look at it.

Senator FURNER—What are the possibilities you may want to consider? Would it be a position of changing staffing arrangements? A suggestion might be to look at non-permanent staff. Would that be a proposition to consider?

Ms Halton—No, this is where, as Ms Lyons says, it depends on the actual terms of the freeze. Without the actual terms of a freeze, I think it is very difficult to speculate, other than to say that my portfolio obligation as secretary is to ensure that my statutory obligations are delivered, and that is what I would do.

Senator BOYCE—Has the two per cent efficiency dividend affected your staffing levels?

Ms Halton—It always does. Efficiency dividends were ever thus—as long as I can remember, the entire time I have been secretary, they have affected our staffing levels.

Senator BOYCE—Negatively, or decreased them?

Ms Halton—Yes. Exactly.

Senator SIEWERT—I want to go back to the issue of the health reform process and specifically ask about the different bodies' instructions that are being set up through this process and how the specific involvement of consumer health advocates is being included and how they are being resourced. Has that been given any consideration yet?

Ms Halton—The short answer to that is not yet. In fact, I was asked this question in a stakeholder briefing yesterday in Brisbane about consumers. What I said was I cannot give any specifics, because we are working through exactly how this is to occur, other than to say that we are very, very conscious of the need to ensure consumer voice is present and part of this. That is an undertaking I am more than happy to give, but I cannot give you the specifics because we are not at that point yet.

Senator SIEWERT—Are you able to give a commitment that there will be some resources available once you have established the process? Will there be resources available to assist with the representation?

Ms Halton—That will be a decision for government. It is not within my gift to make that commitment, but I can say that consumers are very much part of the policy thinking. I cannot give you a financial commitment because it is not within my gift.

Senator ADAMS—I would like to continue on health reform, drilling back down into rural hospitals and how the networks are going to work in respect of case mix funding. Coming from Western Australia, you are fully aware of our rural hospitals and how many we have, and most of them are very small. How are they going to fit into the overall pattern?

Ms Huxtable—You would be aware of the large number of hospitals across Australia. There are around 160 large hospitals in metropolitan areas or large regional centres. The expectation is that in the order of that number would be completely funded using activity-based funding in respect of their patient services. There will then be those at the other end of the spectrum which are very small hospitals, which would be, we anticipate, entirely funded through community service obligation block funding. That has been made very clear in the publications and in the Prime Minister's statements. In reality, there is probably a mix in the middle. It would be a matter for the Independent Hospital Pricing Authority to provided

advice as to the way in which those hospitals are funded, but there will be hospitals that will be funded using a mix of ABF and a mix of CSO funding mechanisms.

For example, you could have a rural hospital that is required to maintain an ICU or a trauma centre, or the like, depending on its location, where there would not be the patient numbers to justify an ABF funding stream in respect of that activity. That could be funded using a block arrangement, but other activity in the hospital could be funded using the ABF arrangement. It is very much in the gift of the Independent Hospital Pricing Authority to work through the methodologies and the treatment of individual hospitals, and how the funding streams flow for those individual hospitals. I think one of the important things to note is that while there are around that 165 hospitals in metropolitan and large regional centres, they are delivering around 90 per cent of public hospital services, so it is where the bulk of the activity lies and they would be funded using ABF.

Senator ADAMS—It is very important that the community obligation be recognised in the rural areas. I would like to ask who is going to decide how these networks are set up and what hospitals are under which networks?

Ms Huxtable—That is probably two questions there. One is about the establishment of the networks themselves. In the agreement, while the states are responsible for managing the local hospital networks, the decisions about the boundaries in respect of those networks are matters that would be discussed between, first, ministers and agreed. I think that is to happen before the end of this calendar year, one of the issues being that the agreement is seeking as much alignment as possible with the primary health care organisations as well, so you can get a good integration of care and effective clinical pathways across the two sectors.

In terms of the calculation of the CSOs, that would be a matter for the Independent Hospital Pricing Authority. As to the CSO work, I would say—and I am not actually responsible for acute care division, so someone can jump up and bash me if I get this wrong—the CSO work was initially agreed in 2008 COAG, in decisions that were taken at that time to move to ABF costing models that needed to be done in respect of community service obligations. That work has been on foot from that point and is continuing and now being accelerated to prepare for the Independent Hospital Pricing Authority taking over the function in respect of methodologies around case mix.

Senator ADAMS—As far as Medicare goes, would the boundaries for rural and remote be associated with the networks?

Ms Huxtable—The intention is to get as much alignment as possible, but it is not always going to be the case. I expect that that will be able to be achieved. With the local hospital networks, there will be many instances where there is a geographic focus to those networks, but clearly there will also need to be arrangements in place for more specialised services—children's hospitals, for example—where it might not be appropriate to have a regional hospital network. In fact, it might be more appropriate to have a hospital network of one. So there will be times when that coincidence is not going to make sense. But, in reality, there is work that needs to be done both with the states and with the broader community around boundaries, on both the primary healthcare org side and on the local hospital network side,

and we are beginning those processes now. All the boundaries need to be basically agreed by the end of the calendar year.

Senator ADAMS—Despite the fact that Western Australia has not signed the agreement, is it going to be included in this large overall plan of how the networks are set up?

Ms Huxtable—As I said in response to Senator Siewert, WA is definitely at the table and part of the discussions around health reform implementation, so those discussions are occurring without prejudice, from their perspective, and so they are very much part of the way forward. I do not know that we are really at a stage to say, in respect of local hospital networks, what might occur in WA. With Medicare Locals, there are clearly a number of funding streams that will be going to primary care that will go through the Medicare Local structure, so I expect that WA will be quite interested in being part of discussions around Medicare Locals and Medicare Local boundaries, but probably it is a little bit early in the process to say, and I would not want to speak on their behalf, clearly, about what their view is.

Ms Halton—If we are unable to achieve an agreement with them at the point at which we are setting boundaries for Medicare Locals, it would be my hope that we would do that in a sufficiently informed way. One is hopeful that we will get an agreement with them; therefore, you would not want to put in place arrangements on Medicare Locals which actually then are not congruent at some later point. This is very much a matter that we would be looking to discuss with them, ideally, to ensure that we are positioned to implement in WA when we can actually reach an agreement.

Senator ADAMS—WA are already moving with their board structures now and this is starting to confuse the general public. To follow on from Senator Siewert, the idea of local network boards immediately sent flashing signs: 'Right. We are going back to our old hospital system.' Local communities think that they are going to get their boards back again, to continue to have their budget and continue as they used to. So that message really needs to be sent out loud and clear that this is a change, because rural communities are certainly fired up in Western Australia, thinking that they are going back to what they had before. There is a lot of confusion, and now if the Western Australian department goes forward with their strategic structure, as they are looking at with the metropolitan split and then the country split, it really is becoming confusing. I do not think the media are really across exactly what is happening, so I would plead with you that somehow we get the clear message out there that this is not like it was.

Ms Halton—Yes. Certainly we will endeavour to work with our colleagues in Western Australia.

Senator ADAMS—The multipurpose service situation: are they going to remain? Are they part of the new plan?

Ms Halton—Absolutely. In fact, there was an additional investment in multipurpose services as part of the COAG agreement to actually expand the number of multipurpose services. Like you, Senator, we are big fans.

Senator ADAMS—Good. Thank you.

CHAIR—You can table the document and then we are moving to AIHW.

Senator FIERRAVANTI-WELLS—Can I just table these documents? Two articles: one is *Yes Minister meets Alice in Wonderland*, and the other one is *Policy by the seat of their pants*. That is the photograph, Ms Halton, I was telling you about. It is in colour, so you will be able to match the logos. There are a couple of things. One is that the second article, the Nick Miller article, makes reference to—the website was actually blank—a conversation that he had with the minister's office. I would appreciate if you could verify whether that was actually the case, in the sense that, when it was actually launched by the Prime Minister, the website was actually blank. The other thing is that this article refers to the previous one Les Patterson—sorry, Myles Peterson. Sorry. Freudian slip there.

Ms Halton—Actually, that might be closer to the truth when it comes to fiction and drama, actually.

Senator FIERRAVANTI-WELLS—That may be the case, Ms Halton, but I would appreciate, given the assertions that have been made in that article, if you could go through it and counter what you perceive is misinformation or information that is not correct in both articles, and if you could take that on notice, I would be really—

Senator Ludwig—I normally would not intrude on that. I am not sure, in terms of the analysis required, that the secretary would be able to do that. What I could suggest as an alternative, although it may not be as convenient for you, is that if there are matters that you then highlight or indicate, I am sure the secretary could give a general analysis of it.

Senator FIERRAVANTI-WELLS—If you want me to highlight the areas that you want comment on—

Senator Ludwig—That you think are in contention, and perhaps put them on notice in question and answer format. I just worry that what we are getting into is an inquiry process, rather than an estimates process.

Senator FIERRAVANTI-WELLS—That is fine. As Senator Ludwig says, I will have formal leave to table, but I will give them as questions on notice and highlight the sections which I would like the secretary to make a comment on. Is that acceptable?

Senator Ludwig—If that seems reasonable to you, chair.

Senator FIERRAVANTI-WELLS—In terms of veracity or otherwise of the assertions that are made.

Senator Ludwig—I am only looking for a reasonable process that would not put the department—

CHAIR—Thank you, Senator. That was an extraordinarily long piece of tabling, and now we will move to AIHW.

[10.47 am]

Australian Institute of Health and Welfare

CHAIR—I welcome officers from AIHW to the table. Dr Tallis, have you been with us before?

Dr Tallis—I have not. I have attended as an observer.

CHAIR—I did not think so. I believe Senator Boyce has a question, as does Senator Fierravanti-Wells.

Senator BOYCE—Thank you. Dr Tallis, Ms Lynelle Moon, as acting director of AIHW, yesterday launched the 'go for red' program. Why does the institute currently have an acting director?

Dr Tallis—Our substantive director, Dr Penny Allbon, is on leave at the moment. Ms Moon is, in fact, the acting head of our health group.

Senator BOYCE—You are Ms Allbon at the moment, are you?

Dr Tallis—I masquerade as her, yes, to the best of my ability.

Senator BOYCE—My initial questions are follow-up questions from last estimates in regard to the collection of data around alcohol and drug information in Queensland. Apparently someone had been appointed to do something about that. Can you update me on that situation please?

Dr Tallis—Yes, there is still work being done in Queensland in collaboration with us on looking at the data supply arrangements. That has not yet concluded, so we do not yet have Queensland in the mix for that reporting. We hope that that will be possible. There is a fair amount of technical work to be done on being able to bring this up from the alcohol and drug treatment services, but it will be a little while in the future.

Senator BOYCE—Fair amount of technical work? What does that mean?

Dr Tallis—This is the issue: are we able to obtain consistent data elements from the drug treatment services in Queensland such that when they are brought together with those from the other states we can do valid comparisons across the jurisdictions? That requires a good deal of data development. The alcohol and drug treatment services, where established, are jurisdictional ventures, and therefore they have their own service delivery models and what have you. It follows from that that they also have their own data content. Our process in all of what we call our national minimum data sets is that we enter into negotiations on an agreed set of data items that will be reported into the NMDS and that require two sorts of work. One is the work at the national level that establishes those common definitions, and the other is the work at the local level that allows the service delivery agencies to distil those items and roll them up in a consistent way, and that is going forward.

Senator BOYCE—Is the alcohol and other drugs area the only area where you do not have satisfactory data input from Queensland?

Dr Tallis—I believe that is the case. We have in the order of 22 or 25 NMDSs and, on my understanding, that is the only one in which Queensland does not report. I can validate that for you, if you like.

Senator BOYCE—The other question I had, and you will probably need to take this on notice, or you may be able to answer it, is: are you able to provide me with a list of states that do not contribute to other NMDSs?

Dr Tallis—Yes, we can certainly do that. It is a rather rare occurrence. Generally speaking, the hacking out of the NMDS specification is done through a careful process under the

MINCOs, the committees that sit under that. It is usually the case that, once you have agreed on a specification, the states then verify that they are able to report against it. We can certainly provide that list. It is well known; in fact, it is visible in all our publications, and we will do that for you.

Senator BOYCE—The other question I have relates to how this will affect the health and hospital reforms package that the government is currently looking at. Is the institute involved in ensuring that, as the changes are put in place, the data is collected in such a way that it will be nationally comparative?

Dr Tallis—There are two aspects to that. There are some information requirements and agencies that are set up specifically under the reform package. Those arrangements are being negotiated among the governments and under the carriage of the department. Certainly, with any change in administrative or service delivery arrangements in health, we do, indeed, in cooperation with the jurisdictions, look at what that will imply for the data that can be coming out of the service delivery agencies in the NMDSs. That is absolutely right; we would be doing that work continuously through the reform package.

Senator BOYCE—Where is that work at, at the moment?

Dr Tallis—At the moment, the reform package has been announced in its broad, conceptual terms. We are certainly thinking inside the institute about the implications in principle of that, but it is really when the delivery models, financing arrangements and what have you are in place that we can then do an assessment, in a technical manner about what that implies for the 'data supply chain', as we call it. Most of that work is in our future.

Senator BOYCE—Would you think that that assessment will use the resources of the AIHW in a very large way or will it be a relatively small project for you?

Dr Tallis—It will be an important project for us. The actual call on resources will depend, I think, on the amount of change that happens back at the data supply origin. It is also fair to say that a good deal of the work is done by the institute in collaboration with the jurisdictions at these committees. All of us—all the eight states and territories, the Commonwealth, we and the Australian Bureau of Statistics—all contribute work to that. We have certainly planned for a good deal of thinking about the future data supply chain in our own work program. We have recognised that in the draft work program we are going to take to our board. Quantification, I cannot tell you. I am not trying to be vague, but we just do not know until we see what happens with the data origin.

Senator BOYCE—Do you have any extra resources required now to undertake that work?

Dr Tallis—For the exploratory work, we are able to travel with the resources we have available. If there were an implication of, say, a major new data collection that might come to us, or a major revamp of data items or lodging in our metadata repository, METeOR, then we would need to look at what resourcing would be required. We do not have an appropriation bid in for that at the moment, nor have we any particular funding stream under contract for that at the moment.

Senator BOYCE—Just briefly because I mentioned it, AIHW, yesterday, was involved in the launch of the Go Red for Women. I notice Ms Halton is a day behind here, wearing her red!

Ms Halton—I know. I am sorry!

Senator BOYCE—The campaign looks at women and heart disease. Could you just very briefly outline for us what the communication of those findings will be now?

Dr Tallis—Yes. As is typical of our reports, we issue, first of all, a range of media releases and briefing and what have you. That report, I should say, has generated a great deal of interest.

Senator BOYCE—As I think many of your surveys and reports do.

Dr Tallis—Yes, it is kind of you to say so. The follow-up procedure to the release of the report is that we then have a range of information packages that go into our other compendium publications, for example. Things are built into presentations. Our staff are very active in distilling from our publications and doing presentations at conferences and departmental fora and so on. That report, in particular—which is one of the prettiest, I think, that we have put out for a while—will appear in those guises as well. It was not available, I think, in time for incorporation in the next issue of *Australia's health*, our flagship, which comes out in just a couple of weeks, but certainly future issues would incorporate the information out of that report.

Senator BOYCE—There is also an ongoing discussion around collection of health data for Indigenous Australians—

Dr Tallis—Indeed.

Senator BOYCE—based on the fact that we are focussing on closing the gap.

Dr Tallis—Yes.

Senator BOYCE—Could you tell me just a little about the institute's work in trying to make sense of the data, so to speak?

Dr Tallis—Absolutely. It is a major focus for us. In fact, we have established a whole group, one of whose major responsibilities is looking after Indigenous health and welfare statistics and information. We have a number of efforts. We do mount particular data collections in this field. Our most important work is probably trying to ensure that Aboriginal and Torres Strait Islander people are identified appropriately in all of our data collections, so that we are able, for any health and welfare report, to do a slice, which identifies Indigenous people and compares them with non-Indigenous people and tracks the trends in Indigenous health services to Indigenous people. That is a major exercise because what it implies is trying to ensure that, at every point of health service deliver, in this instance there is standard way of ascertaining who is Aboriginal not Aboriginal is applied—that is a respectful way of asking people themselves to say how they go, according to the standard ABS question—and then seeing that that rolls up into all of the national reporting.

That has been a huge investment for us and for other agencies. We have issued, rather recently, guidelines on how that should be done, and we have an active campaign to ensure

that that occurs throughout health service delivery, so that the statistics we have in the future are better than those we have at the moment. There has been, I think it is true to say, great progress in getting better and better Indigenous identification in data. We are able to do analyses and do reporting today that, even five or six years ago, we would simply have been silent on.

Senator BOYCE—Could you on notice, perhaps, just quantify some of those ‘progresses’, for want of a better word, that you have made? On notice, that would be good.

Dr Tallis—Yes; we would be very happy to. It probably will not be in the manner of quantification, because it is qualitative improvement, but we can certainly point you to both the activities we have in train and the improvements that we have been able to put into our main reports, as well as the Indigenous-specific reports.

Senator BOYCE—Thank you.

Senator FIERRAVANTI-WELLS—There has been constant commentary by the Prime Minister about this alleged decrease of $1 billion of public hospital spending under the coalition government. At the last estimates, I asked some specific questions in relation to funding. Thank you for your answers because your answers totally contradict the assertions that the Prime Minister has been making. For the record, can I ask you to confirm that Australian government funding of public health expenditure, in your answer to question 407, was $545 million in 2001 to 2005-06. I have got that from your answer. The most important figure that I would like you to reaffirm for the record is that funding of public hospitals in 1997-98 was $5.9 billion and in 2007-08 was $12 billion?

Dr Tallis—I do not have those figures in my head, but I would be very happy to go back to our table and confirm them.

Senator FIERRAVANTI-WELLS—You have produced this. I am asking you—

Dr Tallis—I do not have the document in front of me.

Senator FIERRAVANTI-WELLS—No. The reason I put these on the record is that the Prime Minister constantly goes on about public hospital funding decreasing by a billion dollars, but your figures contradict that assertion and show up the falsity of what the Prime Minister is actually saying. You do not have to comment, but I am making that comment.

CHAIR—Thank you. I take that as a statement. We are taking a break and we will come back with questions under outcome 13, Acute care.

Proceedings suspended from 11.00 am to 11.13 am

CHAIR—We will now resume with questions in outcome 13. My proposal is that we have 40 minutes under general questions on acute care, and then 20 minutes each under National Blood Authority and Australian Organ and Tissue Donation Transplantation Authority.

Senator FIERRAVANTI-WELLS—Just to be clear, Madam Chair, we will be dealing with all of outcome 13. Most of my questions in 13 are more about the hospital side of it.

CHAIR—Yes.

Senator FIERRAVANTI-WELLS—Thank you. You are aware of some of the questions, Ms Halton. I think you mentioned earlier questions that I asked of finance. I asked some questions in relation to finance.

Ms Halton—In general, yes.

Senator FIERRAVANTI-WELLS—To sum it up, they said to me, 'Well, look, we did costings based on assumptions and those are the assumptions that came from the Department of Health and Ageing.' Let us look at some of these programs. The $1.6 billion that is set out there in the budget papers for the acute hospital beds, Finance said to me that they did costings for $800 million of that. Did Health and Ageing do the costings for the rest of it?

Ms Halton—The costings for that particular measure were actually costings agreed with the states. Finance had costed part of the initiative, and the part of the initiative that was announced prior to COAG, and, as you know, there was an additional element agreed at COAG. The overall position was agreed at COAG.

Senator FIERRAVANTI-WELLS—There was $800 million agreed to before COAG, which was presumably based on X number of beds. Of that, 1,316 beds that were in the budget papers, I assume—correct me if I am wrong—that $800 million of that was done in costings by finance presumably for a number of beds.

Ms Halton—Correct.

Senator FIERRAVANTI-WELLS—Can you tell me what the figure was?

Ms Halton—I will have to take it on notice, actually, I think, because you are going back now through several iterations. What I can tell you, though, and maybe this will help, when we had the conversation with our state colleagues at COAG—and you would probably understand that the use of sub-acute beds varies quite significantly from lower care cost beds in the community right through to very intensive rehabilitation kinds of beds. So the cost of a bed varies pretty substantially, depending on the nature of the bed. In the negotiations with the states in relation to the beds that were agreed, the 1,316 beds, the costings that were agreed in respect to those beds were in relation to a particular model which was negotiated and agreed with the states at COAG.

Senator FIERRAVANTI-WELLS—What were the assumptions that underlay the costing that, ultimately, Finance did for $800 million of a portion of that 1,316 sub-acute beds?

Ms Halton—I will take that on notice, because we will not have that with us.

Senator FIERRAVANTI-WELLS—All right. I assume that the assumptions that I have asked Finance to provide would be the same assumptions that you provided to Health and Ageing. If I ask you for assumptions, the two things should marry?

Ms Halton—I would hope so.

Senator FIERRAVANTI-WELLS—I would hope so, too, Ms Halton. Let's say for assumption's sake the figure that was in your costing was 650—half—does that mean that then the balance, the other 650 beds and the other $860 million was an assumption that was made, as you said, through the process, was that just then a replica of what finance had costed?

Ms Halton—No.

Senator FIERRAVANTI-WELLS—Okay. So somebody did maybe a back of the envelope type calculation, or would it have been a bit more technical than just simply doubling the figures?

Ms Halton—In terms of COAG?

Senator FIERRAVANTI-WELLS—Yes.

Ms Halton—No. It was more technical than that because, as I have said to you, there is a variation across the nature of these beds, sub-acute beds. There was a process of looking to see what the nature of those cost variations were across the states, and it was on that basis that the agreement was struck, so, actually looking to see across all of the states for types of beds, what actual cost they were incurring.

Senator FIERRAVANTI-WELLS—Is the calculation that you would have looked at right across Australia, except WA, and then looked at—

Ms Halton—No, that is including WA.

Senator FIERRAVANTI-WELLS—Okay. So you looked at the marginal recurrent costs, and put a whole series of factors into a formula that then resulted in you being able to say that $1.6 billion over four years will deliver 1,316 subacute beds?

Ms Halton—A minimum of, yes.

Senator FIERRAVANTI-WELLS—And have you got a breakdown of where those 1,316 are? I have not seen, or perhaps I have not—

Ms Halton—We will have to take it on notice.

Senator FIERRAVANTI-WELLS—I could not find it anywhere—

Ms Halton—We will give it to you.

Senator FIERRAVANTI-WELLS—as to where they are.

Ms Halton—We have got it. We will give it to you on notice.

Senator FIERRAVANTI-WELLS—Sorry, Ms Huxtable. Did I miss it somewhere or—

Ms Huxtable—No.

Senator FIERRAVANTI-WELLS—It is not anywhere in the published material.

Ms Huxtable—I am saying that we can certainly provide the breakdown by state and territory.

Senator FIERRAVANTI-WELLS—Thank you. Obviously that has to take into account a mix of country and city beds, the different categories of subacute and those diverse parameters. All right. Could you provide to me the assumptions and also the breakdown of those 1,316. Again, with the emergency department beds, the 251.4, is that a similar process, Ms Halton?

Ms Huxtable—Yes.

Senator FIERRAVANTI-WELLS—Bearing in mind that, as I understand it, it is the one figure. It was not an addition, unless Finance did not mention that to me. It was not a two-part question.

Ms Huxtable—I think there are two types of issues here that we are talking about. One is the way in which the communique refers to the numbers of additional services that could be provided for the funding that is being provided. I might have missed the particular bit where you were talking about—

Senator FIERRAVANTI-WELLS—Sorry, I withdraw that question. You are correct.

Ms Huxtable—Yes. Can I just say, though, that the second thing that you are talking about in respect of subacute is actually the numbers that the states agree will be delivered as a part of a national partnership agreement, so they become tied to delivering this number of beds, and I think you made a comment about marginal. I know that we have been through this before in another place, but the 1,316 subacute care beds are fully funded by the Commonwealth over the forward estimates period. So it was very important, in discussions with states and territories, that we were all very clear that the moneys that were being made available were sufficient to fully fund the mix of subacute care services that would need to be delivered, as you say rightly, in various locations et cetera across that forward estimates period.

Senator FIERRAVANTI-WELLS—For the emergency departments and improving access to elective surgery, are there underlying assumptions as to targets and that sort of thing? Is that something built into the figure of $251 million, and the figures that are in boosting elective surgery capacity, and the $652 million over four years to reduce the waiting times? In effect, I mean the figures you see when you sort of run down the budget at a glance. Sorry, I have made it a little bit bigger, but it is a bit small, I have to say.

Ms Huxtable—I was going to say it is good; you can read it.

Ms Halton—Yes, we are back to that age reference.

Senator FIERRAVANTI-WELLS—Ms Halton, I think you might next year—

Ms Halton—I cannot read it either, if it makes you feel better.

Senator FIERRAVANTI-WELLS—So I assume that apart from the acute beds, there are certain assumptions built in in relation to these measures. Do those assumptions actually include numbers?

Ms Flanagan—I think that for elective surgery and emergency departments there are a number of funding streams. There is capital and facilitation funding, and also reward funding. It was a negotiated process, but we are going to hold the states to the arrangement. Just as Ms Huxtable has talked about the number of beds in subacute, there are targets that have been set for emergency departments around four hour access, and also for elective surgery, in that 95 per cent of people will receive their elective surgery within clinically recommended times. So the totality of the money flowing into the system for emergency departments and elective surgery is expected to reflect that—and we will hold the states to actually deliver on those targets.

Senator FIERRAVANTI-WELLS—We have a hearing coming up on this next week, so I will not delve into too much more, but suffice to say we will drill down into that. On page 357 of this document, it has got as part of the qualitative deliverables in health reform, elective surgery data reported. Ms Flanagan, that is the sort of stuff that you are talking about, in terms of—

Ms Huxtable—I think there are two elements to this, again. In the national partnership agreement which will oversight the elective surgery measure and the emergency department measure, there will be specific targets that form part of those national partnerships—for example, showing that states are making progress toward reaching that 95 per cent target in respect of elective surgery. This goes more to information that is made available in respect of elective surgery that is occurring within states and territories, so I think this is something that would be coincident with but side by side with national partnership agreements.

Senator FIERRAVANTI-WELLS—And also underneath that, there is the release of average cost of procedures in public and private hospital activity. Presumably you are already collecting that sort of data.

Ms Huxtable—That is right.

Senator FIERRAVANTI-WELLS—Is it envisaged that you are going to release that next year, and the data that you are now collecting is the data that underlies the assumptions that you used in the hospital reform?

Ms Flanagan—The data that we will need to collect around this is also critical for the new performance authority and the independent hospitals pricing authority to do its work. So, very clearly, we are asking the states to provide more data, and consistent data, so that that can actually be provided to those authorities as well.

Senator FIERRAVANTI-WELLS—I asked Finance questions about the independent pricing authority and the national funding authority. That is probably best dealt with when we cover those things next week, and it might be easier to drill down into a bit more detail in relation to that next week.

Ms Huxtable—Wherever you wish to ask questions.

Senator FIERRAVANTI-WELLS—I will do that next week, Ms Huxtable. I might just move, if I may, to the $29 million that is going to be used for the advertising campaign. I just saw the global figure, but can you break down the various elements of this campaign? In other words, how much is going to be spent on advertising by television, radio and newspapers?

Ms Huxtable—Ms Palmer can do that when she gets her folder out.

Ms Palmer—I can give you a breakdown for the activity on air.

Senator FIERRAVANTI-WELLS—Yes.

Ms Palmer—We have $3.92 million for television advertisements, $1.09 million for radio advertisements, $0.98 million for newspaper placements, $1.17 million for internet advertising and internet search advertising. There is $0.28 million for non-English-speaking background/Aboriginal/Torres Strait Islander people advertising and print handicapped

material, and there is $0.09 million for the cost of despatching the advertising to be placed. That comes to a total advertising or media placement for this financial year of $7.4 million.

Senator FIERRAVANTI-WELLS—Okay. So you have got $18.3 million to be spent 2010-11; and over the forward estimates, $1.1 million in 2011-12, obviously after the election campaign; for 2012-13, only $0.2 million, and then no spending on 2013-14. Given that some aspects of this go up to 2020, various aspects of this reform are spread over quite a number of years into the future, it is interesting that you are basically going to stop any advertising or any information distribution after 2012, notwithstanding that the operation of this plan will supposedly go into the future.

Ms Palmer—The aim of the campaign is to ensure that the Australian public are informed of the Australian government's health reform plan and what it will mean for the health and hospital system and for Australians.

Ms Huxtable—Just to add to that, as you would be aware, there are various elements of the reforms which have already begun, and certainly are rolling out from 1 July 2010.

Senator FIERRAVANTI-WELLS—Sorry. You are reading from?

Ms Huxtable—If you look at page 124 of the red book, that has actually got the key delivery milestones that are set out in there. As you would be aware, the tobacco excise increase took effect from 30 April 2010, but there is also a variety of measures—some payments being made now, others occurring in the second half of this calendar year—and a range of things that are coming on line, obviously, over the coming years. Just to add to Ms Palmer's response in respect of the purposes of the campaign, there is also a purpose to direct people to where they can find more information in respect of individual measures because, as you would be aware, this is a very complex reform landscape with a lot of individual measures, so it is important that people know where they can get more information. Certainly the feedback that we have been getting for some time—and it really mirrors some of the points that Senator Adams was making—is that people are very keen to know more and understand more about specific reforms and what it might mean for them. In that environment, it is important that there be that more detailed information, which is through the website.

Senator FIERRAVANTI-WELLS—Ms Huxtable, the inference—and correct me if I am wrong—it says 30 April tobacco excise increased: is that inferring that that is where the money is coming from for this?

Ms Huxtable—No. Are you on page 124?

Senator FIERRAVANTI-WELLS—I am.

Ms Huxtable—All this is a summary of what the key milestones are against all the various elements of the campaign. Clearly, the tobacco excise is part of the preventive health elements of the reform plan.

Senator FIERRAVANTI-WELLS—Okay. I shall keep that to the side. What other products are going to be produced under this allocation? Are we going to have more merchandise, or that sort of thing? Ms Halton is familiar with golf balls. Are we going to see little golf balls?

Ms Palmer—We are not planning any golf balls.

Senator FIERRAVANTI-WELLS—No golf balls?

Ms Palmer—No. We are planning a number of information products to assist consumers, but also help professionals and stakeholders. At the moment we are, for instance, working on, and have, fact sheets, brochures. We have our website which we will be continually updating and adding material to as a core information platform for the campaign. Obviously, with advertising, you cannot put a lot of very detailed information into a 30- or a 60-second television advertisement, as, of course, you would know. The website gives us a platform to put a lot more detail and to also put the source documents as well. A key component of the advertising is to enable people to really understand where they can go to get that extra level of information.

Senator FIERRAVANTI-WELLS—In terms of the TV ads, does this mean we are going to see Dr Rudd in the white coat and sitting on the edge of people's beds? Is that the sort of stuff that we are going to be subjected to?

Ms Palmer—The TV ads need to comply with the government's advertising guidelines.

Senator FIERRAVANTI-WELLS—Yes, Ms Palmer, we know all about that.

Ms Palmer—One of those guidelines is very clear about there being no party-political content.

Senator FIERRAVANTI-WELLS—We have heard that one before. I am asking you are we going to see Dr Rudd in the white coat like we normally see him?

Ms Palmer—No.

Senator FIERRAVANTI-WELLS—No posters, nothing like that?

Ms Palmer—No.

Senator FIERRAVANTI-WELLS—I am comforted that our television screens will not be inundated with Dr Rudd. What about the website? I assume there is a website.

Ms Palmer—Yes. It is the yourHealth website. We have continued that website through.

Senator FIERRAVANTI-WELLS—We have continued the yourHealth website. Okay. And how much is that costing?

Ms Palmer—In terms of the costing for the campaign? The website is updated by staff internally to the department. We have made a small allowance for website development and maintenance. This year, the allowance was $0.2 million, and for the 2010-11 year it is 0.6, and for the following two years after that it is also $0.6 million.

Senator FIERRAVANTI-WELLS—Over what period will this advertising campaign be spread?

Ms Palmer—We currently have, within our costings, advertising to occur in the 2009-10 and the 2010-11 years.

Senator FIERRAVANTI-WELLS—All right. Let me just say insofar as it started a few weeks ago, the ink was barely dry on the COAG agreement.

Ms Palmer—13 May is the date it started.

Senator FIERRAVANTI-WELLS—For those ads to have been ready by that date, when were they commissioned?

Ms Palmer—I can take you through the time line.

Senator FIERRAVANTI-WELLS—Yes, please.

Ms Palmer—We had authority to work on a campaign in mid-March. We had approval from the minister to develop a campaign on 19 March. Four creative agencies were invited to tender then and creative Q and A sessions were held with those agencies. We did this work in close consultation with the Department of Finance and Deregulation, who manage the guidelines, and they participated in this process. We engaged a research company to undertake concept testing and do benchmark research on 23 March this year. The creative tender closed, then we went to pitch concept testing. We ran 12 groups from 26 to 27 March. We also did some benchmark research on 26 to 30 March. The creative agency was appointed on 30 March as a result of the testing activity.

Senator FIERRAVANTI-WELLS—Who was that?

Ms Palmer—JWT is the agency that was appointed. We updated the minister on the progress of the campaign and we appeared before the independent campaign committee on 7 April. We had a second round of concept testing. We did eight groups at that point on 28 and 29 April. We updated the ICC on the progress on 21 April and 28 April. We did another round of testing on 5 May. The ICC considered the campaign and materials then. On the 6th and the 11th we received information from them regarding the compliance with the guidelines. On the 11th certification of the campaign was done on that day. The minister approved the launch of the campaign on 12 May. The campaign started appearing on the 13th.

Senator FIERRAVANTI-WELLS—That is right, well in advance of any agreement with the states. When did this whole concept—

Ms Huxtable—Sorry, Senator. COAG was on 19 and 20 April.

Senator FIERRAVANTI-WELLS—Yes, I appreciate that. I am going to ask Ms Palmer now—

Ms Huxtable—I will butt out.

Senator FIERRAVANTI-WELLS—I appreciate we are all a bit sensitive about advertising at the moment.

CHAIR—Senator, that is a comment. You can go ahead with your questions.

Senator FIERRAVANTI-WELLS—Can I take you back, Ms Palmer? Presumably the department started the process as far as this campaign is concerned, the advertising process?

Ms Palmer—We started the process when we had authority to do so.

Senator FIERRAVANTI-WELLS—And you told me that you had authority back in March.

Ms Palmer—Yes.

Senator FIERRAVANTI-WELLS—What work was done before March to gain that authority?

Ms Palmer—We started work on the campaign when we had authority to do so.

Senator FIERRAVANTI-WELLS—Right. There must have been some preparatory work. What was the date you gave me, mid-March?

Ms Palmer—Yes.

Senator FIERRAVANTI-WELLS—Who gave you that authority?

Ms Palmer—It was a government decision.

Senator FIERRAVANTI-WELLS—The minister communicated via a minute, or something like that? What was the form of that authority?

Ms Palmer—We acted with cabinet authority.

Senator FIERRAVANTI-WELLS—Okay. Ms Halton, what happened? The minister told you that you now had authority to engage in an advertising campaign?

Ms Halton—We had cabinet authority.

Senator FIERRAVANTI-WELLS—Okay. That starts in mid-March. So the campaign that is now being run is like this? This is the sort of stuff that is now being put in the papers. The authority to run this was given in mid-March?

Ms Palmer—The authority to develop a communication campaign.

Senator FIERRAVANTI-WELLS—The authority to develop the communication started in mid-March—and that is before COAG, before the budget, before any major decisions in relation to reform.

Ms Palmer—The campaign was about explaining the government's health reform plan.

Senator FIERRAVANTI-WELLS—All you had, presumably, until March was this document here. Did you start with that?

Ms Huxtable—No, this document was released on 3 March, I believe.

Senator FIERRAVANTI-WELLS—Sorry. Okay. All you were doing was about to sell this?

Ms Palmer—Explaining the government's health reform plan.

Senator FIERRAVANTI-WELLS—Okay. You were effectively allocated $29.5 million, or got authority, to sell this blue document?

Ms Palmer—To explain the health reform plan.

Senator FIERRAVANTI-WELLS—To explain what is in this blue document.

Ms Halton—Let us be clear. We had authority to commence the development of a campaign to explain health reform. Your point in relation to the release of that document is accurate, in terms of the timetable. The campaign itself was not finished and put into the public arena until after we had the COAG agreement.

Senator FIERRAVANTI-WELLS—My point to you is that you have obviously sought authority way in advance of what actually ultimately appears in the newspapers. Do you see my point?

Ms Halton—No, actually, I do not see your point.

CHAIR—You have a point of order, Senator Furner?

Senator FURNER—The senator has held up three pieces of material, two in booklets and one in a newspaper article. I imagine Hansard is having great difficulty in understanding what the reference is.

CHAIR—Thank you for your point of order.

Senator FIERRAVANTI-WELLS—Senator Furner, if you were listening before, we did hold it up. It was identified.

CHAIR—Excuse me, Senator. That was a point of order to the chair. We are trying to make this as smooth as we can. It was a point of order to the chair. In response to that, Hansard was aware of what was going on. Senator Fierravanti-Wells, the words will appear. The witnesses said that they did recognise the advertisements, so there was no need for tabling. Senator Fierravanti-Wells, you have about three more minutes before I give it to other questions in this section. Thank you for your point of order, Senator Furner.

Senator FIERRAVANTI-WELLS—In other words, we are out seeing advertisements like this, the process for which commenced way in anticipation of any health reform being agreed to with the states. It really would not have mattered what was agreed to at COAG because you had already started developing a campaign back in March-April.

Ms Halton—No, let us be very clear about this. The campaign, and the advertising, which involves the expenditure of significant amounts of money, was something that occurred once we had the COAG agreement, but—as Ms Palmer has taken you through line by line the processes that we have gone through to understand what people’s understanding about health is and about health reform, and the process of how you actually communicate that—this was not resolved until after COAG.

Senator FIERRAVANTI-WELLS—All right. My question is: what did you do before COAG and what did you do after COAG?

Ms Halton—I think Ms Palmer has already taken you through precisely that time line.

Senator FIERRAVANTI-WELLS—She has given me some sort of technical—I think it would be useful, Ms Palmer, if that was broken down to a more retail message, if I can put it that way. You mentioned ICC. If you could break that down, that would be very helpful. Obviously, there were initial preparations for the advertising campaigns. What was ordered or decided to be initiated before COAG and after COAG?

Ms Halton—Whilst you might be interested in a ‘retail story’ about this—

Senator FIERRAVANTI-WELLS—So will some of our listeners, Ms Halton—

Ms Halton—the bottom line is that this is a—

Senator FIERRAVANTI-WELLS—rather than bureaucratic mumbo-jumbo.

Ms Halton—It is not bureaucratic.

CHAIR—I am sorry. Can I just stop you for a moment?

Ms Halton—Thank you.

CHAIR—We cannot have two speakers talking over each other for Hansard. Senator, you had your question. Ms Halton is responding. This is the last question and we will have to go on to other questions. Ms Halton, you have a response for Senator Fierravanti-Wells?

Ms Halton—Thank you. What Ms Palmer has done is outline to you the process of development and testing of people's understanding and how one best and most effectively communicates, getting a baseline in terms of people's understanding, and then the development work that goes into any form of campaign, which ensures that the campaign achieves its objectives in relation to effective communication. I can tell you that what she has done is outline that in precisely the terms which are used right across the industry by people who understand how campaigns are developed. And then, ultimately inside government, it is decided that moneys will be spent. It is quite consistent with how this subject matter is treated right across government and has been forever, as long as I can remember.

Senator FIERRAVANTI-WELLS—All right. In that case, can you provide to me what was shown to the Independent Communications Committee on 7 April and what was shown to the communications committee on 21 April. What would have happened to this material had most states not signed up to the Rudd plan? Would it have just been dumped?

Ms Halton—There are two answers to that, the first of which is that I am not sure but I will find this out, as I have a suspicion that the information may be cabinet-in-confidence. If it is not, certainly it can be provided, but I do have to clarify that. Secondly, the latter question is a hypothetical and I therefore cannot answer it.

CHAIR—Thank you. Senator Brown and then Senator Siewert.

Senator CAROL BROWN—Just on that, was the process that you undertook for this campaign any different than previous campaigns that you have produced? Have you put some work in before you have—

Ms Halton—There are new guidelines, as you are probably well aware. Is it different to previously? Yes, it is, because of the change in the guidelines. In terms of the material elements of it, how we go about these things, no, it is no different.

Senator CAROL BROWN—So what has been told to us today is pretty much the same as what was normally done. Can you highlight the differences for me?

Ms Palmer—Yes. It is pretty much exactly the same process, in terms of pitching, getting agencies to provide creative, testing the creative to identify which creative is going to be most effective in achieving the communication objective, then refining that creative over multiple concept testings. For instance, with our sexual transmitted infections campaign, which was launched this year, we appeared before the previous committee, which was the interdepartmental communication committee, which included the review body, the ANAO. We appeared before them five times. By coincidence, we appeared before the new committee the same number of times on this campaign. We had to do more testing for the STIs, a much more difficult and subtle campaign, but we continue to refine communication materials in the

same way as we have done and to engage with the independent review body throughout the process so that they are very familiar with it and can provide their feedback along the way.

Senator CAROL BROWN—So nothing unusual?

Ms Palmer—Nothing unusual at all.

Senator SIEWERT—I want to ask some questions around the new bodies that are being established. Should I ask that in terms of the independent pricing authority? In terms of the processes that will be undertaken, setting the efficient pricing, that will be established through that process. That is correct, isn't it?

Ms Halton—Yes.

Senator SIEWERT—Is that going to be subject to review? If there is a disagreement over the price that has been set by the authority, what happens? I am predicting that there may be.

Ms Huxtable—I am just reminding myself. There is a section in the agreement that goes to the operation of the IPA, which has quite a lot of detail in it about the expectation of how the IPA will work. As usual, I cannot find exactly the bit that I want, but my recollection is that parties can make submissions to the IPA in respect of efficient price matters—so the states and the Commonwealth—but the IPA is the binding decision maker.

Senator SIEWERT—Sorry, I missed that.

Ms Halton—The independent pricing authority is independent, literally, and it has the capacity to determine what the price is. There is a provision in the agreement where it says, essentially, that the Commonwealth health minister and Treasurer have a reserve power in exceptional circumstances. I will just read you the part that comes from the agreement. It says: 'The Commonwealth health minister and Treasurer should only exercise the reserve power when the Prime Minister and the first ministers of four states and territories, including at least three states, have agreed, prior to the exercise of their reserve power, to tabling any direction or decision in the Commonwealth parliament.' The pricing authority is independent. It will be enshrined in legislation, so that will be available for scrutiny if that legislation passes, obviously. The notion of what any reserve power would be was explicitly agreed as part of COAG.

Senator SIEWERT—So that is a reserve. In terms of the internal process of the way the authority would run, is there a process whereby somebody can ask for a review prior to that, or is the only review process those reserve powers?

Ms Halton—There is nothing that I am conscious of in the agreement that goes to that issue. You probably fully understand that we are working through the precise detail of this with our state and territory colleagues at the moment, so I cannot answer that question in the negative or the affirmative at this point. And understanding, as you will, that the pricing authority will have a constant process of interaction with all of the parties engaged in this, not just states, territories and departments of state, but also hospitals and others.

Senator SIEWERT—I appreciate that, but you can also appreciate that, while it will be a process of consultation, that is different to a formal process whereby someone can trigger a review or ask for a review. If I understand correctly, what you are saying is that that has not been worked out yet. My question is: is that part of the discussions? Is what will be the review

process for the authority outside of the reserve powers? I understand the issue around reserve powers, but that seems to me a pretty extreme use—

Ms Halton—Yes.

Senator SIEWERT—That would be an extreme process to use those powers, which you are not going to want to do if there is a state or even a local hospital network, for that matter, questioning or seeking a review. So is that process part of the discussions?

Ms Halton—It will need to be part of the discussions.

Senator SIEWERT—Thank you. The process around the issue of making binding determinations about cost shifting and border issues in health and hospital systems: what precisely does that mean, and does it involve penalties? Cross-border is not such an issue in Western Australia, I have got to admit, but the cost-shifting issues are. When it says 'making binding agreements' what does that mean and will there be penalties involved?

Ms Halton—Binding agreements usually involve, in this respect, money.

Senator SIEWERT—Yes, exactly.

Ms Huxtable—In the agreement itself, it refers to the binding determination powers of the IPA, but also says 'with a view to resolving issues in a definitive, lasting and nationally consistent manner'. So I think that probably gives us some clue as to the sorts of determinations they may make. It also notes here, though, that mechanisms in respect of the binding nature of the determinations will need to be agreed by COAG in 2010-11. Again, that is one of the issues that, at the next layer of detail, will need to be worked through in terms of their operating guidance.

Senator SIEWERT—I have heard statements like 'making final decisions' et cetera before, but I have not seen that that has stopped cost shifting so far. What overall provision are you making to ensure that data collection is consistent across the states and the territories? The issue around data is relevant to this issue and it is relevant to the performance authority and, I would have thought, the Australian Commission on Safety and Quality in Health Care.

Ms Halton—Essentially, exactly as you say, what we have to do is ensure that data that is collected is collected on standard definitions and is consistent. In some areas that will be very easy to achieve and in other areas there will be quite a bit of development work that will be needed. If I give you, as an example, the safety and quality commission, there was a safety and quality commission meeting only held in the last week where, in fact, this issue was discussed and indeed the private sector were explicitly saying they want to be collecting and providing data on exactly the same basis as the public sector. So I think there is a great acknowledgement across all domains that what we now need to do is ensure that the way we collect data and are then able to analyse it is completely consistent. But there are a lot of legacy systems out there in terms of how data is currently managed, and in some cases that will take us a little while to sort out.

Senator SIEWERT—Okay. Is there one approach that has been taken for this whole process now, so that there are not individual negotiations going on over the data for each of the authorities, for example, and there is a consistent approach across all the states for all the data?

Ms Huxtable—For the data that is required to establish the national efficient price, there are clauses in the agreement about the need in the agreement that states will provide data according to the national classification systems. In respect of the performance authority I believe—and I could take it on notice and look for it—that there are similarly commitments made about the provision of data in a consistent way. There will be some core data that is common, but it will not necessarily be common across the two bodies when the pricing authority is very much focused on determining the national efficient price. The performance authority would be very much focused on what is actually happening within a local hospital network area in terms of the health outcomes in that area, so there will be different types of data. I am sure there will be a common set—and my colleagues who understand these matters more than me will be able to jump in, if you wish—but there will also be some more specific things that go into each of those governance bodies.

Senator SIEWERT—Thank you.

Ms Flanagan—Senator, I might just add that in the 2008 COAG agreement there was agreement to a work plan to come up with nationally consistent data definitions, certainly for hospital episodes of care, and also, I think, a performance framework that was also agreed at that time. One would imagine that those bodies of work that are currently underway would be handed over or form the basis of the work that the new authorities will undertake.

Senator SIEWERT—Thank you. What has been the progress made in those two areas?

Ms Flanagan—Mr Martin might be able to give some more detail.

Dr Martin—The progress is according to the plan that was published in the national partnership agreement, or what we sometimes refer to as the 2008 COAG ABF agreement. Progress is, I understand, proceeding according to plan, and the rollout of that planned nationally consistent data development has informed the timetabling of the movement through state-specific prices to efficient prices. So that nationally consistent data will form the base upon which efficient pricing is to be built when that comes.

Senator SIEWERT—Okay.

CHAIR—Senator, I am going to have to step in and move to the other agencies.

Senator SIEWERT—Okay. One more question on that. Can I just clarify: what you are saying is that you are on schedule for the time table that was set out in the partnership agreement?

Dr Martin—So I am informed, yes.

Senator SIEWERT—Okay. Thank you.

Ms Huxtable—Just before we finish, the reference on the performance authority is D6 in the agreement, which is on page 35.

Senator SIEWERT—Thank you.

CHAIR—We have now got 15 minutes each for the National Blood Authority and the Australian Organ and Tissue Donation and Transplantation Authority. Thank you, officers from acute care. Senator Carol Brown has questions for acute care which she will put on

notice with a reference to Tasmania—I do apologise, Senator Brown—and there are questions on notice from Senator Adams from Western Australia.

[12 pm]

National Blood Authority

CHAIR—Welcome to the officers from the NBA. Senator Siewert has some questions.

Senator SIEWERT—This is a bit of a general question. Did you see the Australia Institute report that was released relatively recently about the impact of climate change on blood supply?

Dr Turner—Not specifically. We are aware, though, that if climate changes there is a likelihood of us getting more viral diseases transmitted in the northern part of Australia, which will impact on some of what we can do with blood collected in those areas. So we are aware of the general principles, but I have not read that specific report.

Senator SIEWERT—It makes quite interesting reading in terms of looking at some of the case studies and raises, I think, some very interesting questions. I realise you cannot answer any questions about the report because you have not read it, but you said you are aware of the issues around climate change and I am wondering what actions you are taking to address that specific issue.

Dr Turner—In terms of change in the climate, unfortunately, we are unable to do anything! Sorry, I am being flippant.

Senator SIEWERT—I meant in terms of blood supply.

Dr Turner—The NBA has a very active horizon-scanning program which looks at all the emerging potential threats to the blood supply—of which, of course, climate change is one. But there are also viruses which just arise spontaneously throughout the world which would have nothing to do with climate change. We keep a very active eye on those and see how other blood services are responding and how the technology can respond. We are very active in looking at that, together with the Red Cross, which obviously has to take appropriate actions. We will then do what we can to mitigate those risks if we think the blood supply is under threat.

Senator SIEWERT—I appreciate, of course, that you would be watching for viruses. It seems to me, with climate change, and from what I understand there is indication already, that some diseases are spreading further south—for example, encephalitis—

Dr Turner—And dengue.

Senator SIEWERT—dengue, et cetera.

Dr Turner—Yes, absolutely.

Senator SIEWERT—So, instead of it just being that we may need an emergency response because we are dealing with a particular virus in a particular circumstance in a one-off situation, my understanding is that, with the disease vectors changing and moving further south, we are going to be having on ongoing issue, rather than perhaps responding to particular occurrences of a particular virus at any one time.

Dr Turner—Yes, I think that is correct. For example, in respect to dengue, which does appear—although somebody may correct me—to be moving slightly south, the Red Cross Blood Service is unable to use fresh blood that they collect in those areas. They can, however, use the plasma collected in those areas because the risk mitigation measures that are used in the production of plasma products mean that any virus that is in there would be destroyed. So there is no risk there. As things change, we do change the practices that the blood service has in response to that.

Senator SIEWERT—Thank you for that; I appreciate that explanation. It will have an impact, though, on available blood. You can deal with it in terms of generating certain blood products, but it may have an impact in some localities on blood supply. Is that a correct understanding?

Dr Turner—That is correct, although the blood supply is managed at a national level. So as we are unable, for whatever reason, to collect fresh blood in one area, the system will compensate by collecting blood in other areas. At this point in time, we and the Red Cross have had no problems in dealing with the shortages because of that.

Senator SIEWERT—Okay. But you may need to deal with it in the future in terms of looking at overall national supply.

Dr Turner—Absolutely, and those things are very closely monitored.

Senator SIEWERT—Thank you.

CHAIR—Are there any further questions to the National Blood Authority? There being none, thank you very much.

Dr Turner—You are welcome.

[12.04 pm]

Australian Organ and Tissue Donation and Transplant Authority

CHAIR—We will now move on to the organ transplant agency. Ms Halton, because I allocated time because we had these agencies called, there could be some capacity at the end, if we do not go for the full time with the organ transplant authority, to recall some questions on item 13 generally, if the officers are available. I do apologise; there is not much you can do when you have got agencies—you cannot give them less than 15 minutes.

Ms Halton—Indeed. If those officers have not escaped the building we will restrain them.

CHAIR—It may not come, Ms Halton, but we will see.

Ms Halton—No. If they are still here they will be restrained.

Senator FIERRAVANTI-WELLS—On organ donations, I have questions now, but if we talking about filling time, I am sure I can do that, Senator Moore.

CHAIR—We all have capacities! For the Australian Organ and Tissue Donation and Transplantation Authority I know there are questions from Senator Fierravanti-Wells, Senator Brown perhaps, and Senator Siewert. We will start with Senator Fierravanti-Wells.

Senator FIERRAVANTI-WELLS—I understand that there was a recent article—and I have a copy of it, Ms Halton—which says, ‘Karen Murphy steps down as CEO of Australian

Organ and Tissue Authority amid tax office, police investigation'; it is an article by Steve Lewis.

CHAIR—Do the officers have a copy of that?

Senator FIERRAVANTI-WELLS—I have a copy for them. It sets the background for some of the questions that I am going to ask. Are you aware of code of conduct investigations?

Ms Halton—I am not aware of code of conduct investigations. I am just reading this. Does it say 'code of conduct'? I do not think it does.

Senator FIERRAVANTI-WELLS—No. I am just asking you whether you are aware if there any code of conduct inquiries as a consequence of these allegations in the paper.

Ms Halton—Can you be clear about what you mean—in relation to whom, and what code of conduct?

Senator FIERRAVANTI-WELLS—Ms Halton, there is an article in the press that says a former CEO has stepped down amid tax office and police investigations.

Ms Halton—Yes.

Senator FIERRAVANTI-WELLS—Are you aware of any inquiries that were made in relation to irregularities or otherwise pertaining to Ms Murphy?

Ms Halton—Yes.

Senator FIERRAVANTI-WELLS—And by—

Ms Halton—But let us be clear: 'code of conduct' has a particular meaning in relation to legislation, and my answer to that question is no.

Senator FIERRAVANTI-WELLS—All right. So in relation to the particular meaning of 'code of conduct' the answer is no—

Ms Halton—Correct.

Senator FIERRAVANTI-WELLS—but there were other inquiries that were made.

Ms Halton—There were some broader discussions with the authority in relation to a whole series of things about management and, in the course of that, some other questions were raised.

Senator FIERRAVANTI-WELLS—All right. Thank you. At the time of the commencement of the authority, if my memory serves me correctly, on the last occasion at estimates Ms Murphy said she was the only person who was actually there in the authority—I will withdraw that. What were then the processes for hiring and firing staff on the commencement of the authority?

Ms Halton—There are a series of public service processes, which I think you are probably fairly well familiar with, which were followed.

Senator FIERRAVANTI-WELLS—Okay. How many staff were there when the authority was established?

Ms Halton—As in all places, zero on the moment it was established, and a number shortly thereafter; I could take that on notice.

Senator FIERRAVANTI-WELLS—Yes, please, because that was the point I was making: I think, on the last occasion, Ms Murphy said she was the sole one. Were any members of the executive seconded from the department?

Ms Halton—Of the executive? It depends on what you mean by ‘executive’. In terms of our executive, no.

Senator FIERRAVANTI-WELLS—The question is in relation to the executive.

Ms Halton—Were staff seconded? Yes, they were.

Senator FIERRAVANTI-WELLS—Of the executive of the authority—I am asking whether any were seconded from the department.

Ms Halton—Yes, I believe there were.

Senator FIERRAVANTI-WELLS—Okay. How many staff are there now?

Ms Halton—At the authority? I will ask the acting CEO to answer that.

Ms Cain—As at 31 May, there are 32.6 full-time equivalent staff at the authority.

Senator FIERRAVANTI-WELLS—Are there any on secondment?

Ms Cain—Secondment from?

Senator FIERRAVANTI-WELLS—Secondment from the department. Anyway, take that on notice.

Ms Cain—No. There are other staff on secondment from a variety of agencies. There is a mixture of staff seconded from the Department of Health and Ageing. The way the authority has staffed up, including prior to my appointment as acting CEO, was through, generally, merit-based recruitment processes as per the Australian public sector requirements. So staff from the Department of Health and Ageing would have had every opportunity to have worked in the authority if they had wished.

Senator FIERRAVANTI-WELLS—How many staff have left since the authority was set up?

Ms Halton—Are you asking about turnover or are you asking about aggregate? Can we be a bit clearer?

Senator FIERRAVANTI-WELLS—Staff that have actually left the authority. It has had a high—

Ms Halton—The number of individuals?

Senator FIERRAVANTI-WELLS—Yes.

Ms Cain—I would take that on notice.

Senator FIERRAVANTI-WELLS—And could you also take on notice how many of these were resignations and how many of these were people who were actually fired? If you could do that.

Ms Cain—Yes.

Senator FIERRAVANTI-WELLS—Can you advise why there appear to have been no permanent appointments to positions of authority in the sense of at least the executive? There seems to be a preponderance of acting. Is there a reason for that?

Ms Cain—I think that the decisions made in relation to using non-ongoing staff would not be unusual for a start-up agency. The nature of the work of any new entity changes over the first couple of years of the entity's existence. For example, at the moment, we are going through a process of increasing the number of staff that are focused on delivering the nine measures of the government's reform package so that we have appropriately skilled staff in place to deliver on eye and tissue reform, on supporting the 159 doctors and nurses that are operating across the 76 public hospitals so that we have good, skilled staff in relation to activity-based funding and things of that nature.

In that respect, we are currently changing the staffing mix so that we have fewer administrative focused staff and more skilled staff. In the first year of the operation of any new entity, I would have expected to have seen a higher level of administrative staff, but you would not have wanted to appoint them permanently because you would recognise that your skills need would change over a period of time.

Senator FIERRAVANTI-WELLS—You have an acting financial officer at the moment.

Ms Cain—We do.

Senator FIERRAVANTI-WELLS—When did the chief financial officer leave?

Ms Cain—The chief financial officer resigned in late March. I would have to take the exact date on notice.

Senator FIERRAVANTI-WELLS—Thank you. What were the circumstances surrounding his departure?

Ms Cain—He wrote a letter of resignation to me.

Senator FIERRAVANTI-WELLS—Were there any accusations of wrongdoing?

CHAIR—Senator, it is unusual to get into such detail about individuals, and I am conscious of privacy issues, but the officers will be able to determine what they can and cannot say.

Senator FIERRAVANTI-WELLS—Subject to privacy requirements could you take that on notice? Can I just then move to whether any reviews or audits have been undertaken at the authority?

Ms Cain—We undertake ongoing reviews of authority business on a number of fronts. Since I commenced with the authority on 17 March, we have maintained ongoing review of progress against the nine measures in the Australian government's reform package. It is pleasing to see that each of those nine measures are on track and delivering well. We are cautiously optimistic about the level of donation rates in Australian in 2010 as a result of the reform measures, so we are keeping those under ongoing review.

We keep the HR and financial practices within the authority under ongoing review and, for example, provide training and up-skilling to staff where we decide that that is necessary. We

go through usual external review processes. At the moment, the Australian National Audit Office is having a look at some of the financial and process issues within the authority. So, yes, we have a range of review processes ongoing.

Senator FIERRAVANTI-WELLS—When you joined in March, were you aware of any audits that had been undertaken prior to your arrival?

Ms Cain—I am not aware of any audits undertaken by the ANAO prior to my arrival, no.

Senator FIERRAVANTI-WELLS—I asked are you aware of any internal audits.

Ms Cain—I am sorry, internal audits. I misunderstood. The authority did have an internal audit process which revolved around the authority's internal audit committee appointed under the Financial Management and Accountability Act, and I am aware of the internal authority audit processes that would revolve around that, yes.

Senator FIERRAVANTI-WELLS—So there is an internal audit, and you said that you are not aware of any ANAO audit. You are not aware or there has not been an ANAO audit done?

Ms Cain—Other than the financial statements last year which the ANAO reviewed and signed off on, I am not aware of any other audit that the ANAO has undertaken, other than the one that is underway now.

Senator FIERRAVANTI-WELLS—Would you like to take that on notice and make sure that you check your records in relation to that?

Ms Cain—No. That is fine. I do not need to take that on notice. The ANAO has signed off on the financial statements and is currently undergoing an audit, but that is the extent of the ANAO activities.

Senator FIERRAVANTI-WELLS—Sorry. Take me back again. The ANAO has undertaken a financial audit, and that is the extent of it.

Ms Cain—They have signed off on the financial statements at the end of last financial year, and they are currently going through an audit process which is ongoing.

Senator FIERRAVANTI-WELLS—So there is an ANAO audit.

Ms Cain—Currently. That is right, yes.

Senator FIERRAVANTI-WELLS—All right. Do you have an indication from ANAO as to when that is going to be completed?

Ms Cain—I expect a report at the June audit committee. Whether that will be a final report or not, I do not know.

Senator FIERRAVANTI-WELLS—Are there any investigations currently under way into any type of fraud or misappropriation of funds?

Ms Cain—In relation to administered dollars, I have looked at all of the expenditure over the current financial year. The answer is no.

Senator FIERRAVANTI-WELLS—Assuming the ANAO have signed off on the findings, are you aware whether that was qualified in any way?

Ms Cain—It was not qualified.

Senator FIERRAVANTI-WELLS—So, presumably, the ANAO was happy with its financial audit of the authority.

Ms Halton—We cannot speak for the ANAO. We can just say what the outcome was.

Senator FIERRAVANTI-WELLS—Certainly.

CHAIR—I would like to move to other questioners. We are running out of time.

Senator FIERRAVANTI-WELLS—All right. Just going back to the departure of the chief financial officer, are you aware whether this had anything to do with Ms Murphy's departure?

Ms Cain—No.

Senator FIERRAVANTI-WELLS—Ms Halton, were you aware of these audits? Have you been following them as well?

Ms Halton—The ANAO audit?

Senator FIERRAVANTI-WELLS—Yes.

Ms Halton—In the abstract, yes, but obviously I am not involved in the day-to-day detail.

Senator FIERRAVANTI-WELLS—All right. The authority commissioned both its internal audit process and the ANAO is the routine one.

Ms Halton—No. The ANAO one is not routine. There is a routine to ANAO coming in, but there is a distinction we need to make between the routine process of signing off financial statements on an annual basis versus ANAO audits, which, whilst at one level abstractly you can describe them as routine, are not an everyday occurrence, if that does not mix too many metaphors.

Senator FIERRAVANTI-WELLS—Okay. I just have a couple of questions on the DonorTrac system.

CHAIR—Senator, you are going to have to put them on notice while I move to Senator Siewert.

Senator FIERRAVANTI-WELLS—I just have one question.

CHAIR—No. You have had more than the share in terms of this segment.

Senator SIEWERT—Obviously the objective of the exercise is to increase donations. I would like to get some up-to-date figures, please, on where we are in this year compared to last with the increase in donations.

Ms Cain—Certainly. As at 31 May 2010, we had 118 donations in Australia. This is the highest end of May result in Australia in a decade. The previous highest as at end of May result was 102 donations in 2008. The year-to-date figures for 2010 have exceeded the figures at any point in the trend year to date of any other year in the last decade. We are cautiously optimistic that the combined measures of the additional 159 new doctors and nurses in the 76 public hospitals, together with the awareness campaign that started a couple of months ago,

will have really good results for the remainder of the year, in terms of increased organ donation rates.

Senator SIEWERT—Thank you. Are there specific areas where you have seen a significant increase? In other words, is that donation rate consistent across the states?

Ms Cain—As you would probably recall, South Australia, for example, has always had high organ donation rates compared to other jurisdictions, but this year New South Wales has increased its numbers quite significantly. I believe that they had 12 donations in May?

Dr O'Callaghan—In May of this year.

Ms Cain—Which is a significant increase for New South Wales over the same month in any of the last 10 years.

Senator SIEWERT—Are you able to provide a breakdown of each state, comparing each state from, say, the 2008 figures that you quoted to the 2010 figures?

Ms Cain—We can do that.

Senator SIEWERT—Is there any state that particularly stands out? Because we have got limited time, I will not get you to go through each state now, but is there a state that is not improving in particular?

Ms Cain—No, I think that there is an improvement.

Senator SIEWERT—Consistent across the borders?

Ms Cain—You would not want to be looking month to month, because the numbers are relatively small overall, but I think that, largely, the trends are positive across all of the jurisdictions.

Dr O'Callaghan—There is evidence from all states and territories of improvements in performance of specific organisations, evidence of donations occurring in organisations or hospitals where there have not been donations either for a very long time or before, and there is evidence of an increase in particular pathways to organ donation which are more complicated or are, in fact, in new practices. I think sometimes the state to state comparison, because it contains averages of small numbers of hospitals in particular states, does not reflect the improvements that are occurring in specific hospitals right across the country.

Senator SIEWERT—Thank you.

CHAIR—Senator Fierravanti-Wells, you have got another chance.

Senator FIERRAVANTI-WELLS—I was just going to ask some questions on the DonorTrac system. Are there plans to shelve it?

Ms Cain—What we are going through at the moment is a very usual process of writing business specifications, which any organisation would do for any new IT system, developing a budget and determining what is the most appropriate product to support the business process. There are, for example, off-the-shelf products from the United States that we are having a look at which may be more cost-effective than building an Australian specific system, while still achieving the same sort of exchange of information. So we are just going through the business process at the moment.

Senator FIERRAVANTI-WELLS—I understood that the program was to be up and running by early 2010, so does that mean that you have decided to shelve that program and now go into a new IT system and possibly buy some American product off the shelf?

Ms Cain—No, it is—

Senator FIERRAVANTI-WELLS—Could you just explain.

Ms Cain—Yes, sure. It simply means that some good developmental work was done on a system called DonorTrac. That information is now available to the authority. It is appropriate for the authority to go through the normal due diligence transparent process of assessing the efficacy of that system and its cost-effectiveness against any other product. It is just about testing the market and making sure that there is an appropriate contestability.

Senator FIERRAVANTI-WELLS—It appears to have received widespread support amongst surgeons.

Ms Cain—It certainly has its supporters, and it also has some people who have highlighted where they think that off-the-shelf products might be more effective. Yes, it would be correct to say that there is a diverse range of views in relation to that system.

Senator FIERRAVANTI-WELLS—Okay. So it has been tested. Why do you say that the American off-the-shelf product is preferable ?

Ms Cain—I did not say that—

Senator FIERRAVANTI-WELLS—I see. It is one of the options being considered.

Ms Cain—It is one of the options; that is right.

Senator FIERRAVANTI-WELLS—Okay.

Ms Cain—And it is appropriate to consider whether it is more efficient or cost-effective or has other benefits compared to developing a purpose-built system, which would need to be maintained and therefore have costs of an ongoing nature. So we are just weighing it up in a transparent manner.

Senator FIERRAVANTI-WELLS—When is it proposed to roll it out?

Ms Cain—It is not proposed to roll DonorTrac out or any other system out—

Senator FIERRAVANTI-WELLS—Your new system. If you are going to change from one to the other—

Ms Cain—Just to be clear, it is not about changing from one to another. There was no endorsement by the authority of DonorTrac. No budget has been set aside for DonorTrac. What needs to happen is a system of developing business specifications and going through a budgeting process and determining what the appropriate system is to support Australian clinicians in the Australian environment, and that is the process we are going through at the moment.

Senator FIERRAVANTI-WELLS—And I understand there were some recommendations of the expert advisory group. What were those recommendations, and—

Ms Cain—I am sorry, which expert advisory group and recommendations in relation to what?

Senator FIERRAVANTI-WELLS—I understand that there was an expert advisory group established to recommend the best option for implementation in Australia.

Ms Cain—I am not aware of an expert advisory committee established for that purpose.

Senator FIERRAVANTI-WELLS—All right. I might put some further questions on notice. Thank you.

Senator CAROL BROWN—I wanted to get some information about the public awareness program, DonateLife Family, and how that is going.

Ms Cain—It is going very well.

Senator CAROL BROWN—Has there been an increase in people signing up as organ donors?

Ms Cain—What we have done is develop that campaign on the basis of extensive research that has been conducted over the last couple of years, including some very precise benchmarking research that was done immediately before the campaign started. As you know, the campaign is all about encouraging people to have the really important conversation with their family about their intention to donate, because at the end of life it is the family that are going to be asked to give the final okay for donation. Understanding what the current trends are within the Australian community around family understanding of the decision to donate is what we have done in terms of establishing our benchmark.

What we are hoping to do is lift the consent rate in the first couple of months of the campaign from around 58 per cent to 65 per cent. That is quite an ambitious target, but the national advertising campaign has been incredibly well researched and we should set stretch targets where we are reasonably confident of being able to meet them. We will have the first tracking research results by the end of June, but already we have some quite remarkable indications that the conversation we are hoping that Australian families will start having is actually occurring. The campaign commenced about two weeks ago, and before that date we had around 300 Facebook friends that were engaged actively in a conversation about the conversations they were in turn having with their families. As of yesterday, there were over 6,000 people actively participating in some level of conversation on Facebook. To have people not just aware of the ad and aware of the messages but then translating into action on things like Facebook is a very positive early indicator, but until we get the research results at the end of June we will not have a final, definitive view about how we are really going.

Senator CAROL BROWN—So you do not have information about how many people have signed up to be organ donors.

Ms Cain—The thing that the advertising campaign is trying to do is not to increase registration rates but to increase family awareness of each other’s wishes, in terms of donation, because after somebody dies it is their family that will be asked to give the final consent to the donation, and so it is—

Senator CAROL BROWN—I understand that, but for me, I think it is a little bit linked, because we all know that in the Australian community the number of people who support organ donation is quite high. About 80 per cent of people actually support organ donations. But then we have that trouble about the consent, and that is where the awareness campaign

comes in. Also, linked to that, if my partner had that discussion with me and said, ‘I have decided to do this and this is what I want you to do if something unfortunate happens,’ then he would sign up as well. Do you also track the people that sign up?

Ms Halton—I think this is a really important point, because it is great if people sign up because it means there is some objective evidence, and sometimes families need to know that they did sign up, even if they have had the conversation. But actually the act of signing up itself is not what we are targeting here, and quite deliberately so, because all the evidence says that it is the conversation that occurs, as you say, if there has been a tragic event. That is the crucial point.

In fact, what you do not want to do is to direct people’s action into the process of filling in a form. If there is only one action they take, you want that action to be for them to say to their loved ones, ‘Did I mention this? Take the lot, because it is no use to me,’ which is what I have said to my loved ones. If there is going to be one action people take, there is a danger. We know that in social marketing if you use a call to action which is ‘do something’ about whatever, people are likely to take one step. If the call to action gets them to register, that is not what we need. What we actually need is exactly as you say—to translate that 80 per cent response, ‘Yes, of course, okay,’ which is what people think, into an environment where their family members are confident about that. That comes from the conversation, and that is what the call to action is.

Senator CAROL BROWN—Thank you, Ms Halton. I understood that the first time. Do you monitor how many people sign up? Do you do that work?

Ms Cain—Medicare Australia maintains that—

Senator CAROL BROWN—I know they run the system, but do you—

Ms Cain—and we maintain a dialogue with them. What we are working on—and we can share the results; we will be making the results publicly available—and what we are particularly interested in monitoring is the consent rate at the point of a loved one dying. We are looking at what the family consent rate is and we have set those targets that I mentioned earlier.

Senator CAROL BROWN—Of those 218 as of 31 May, how many people did that assist?

Ms Cain—What I can tell you is the results as at the end of April in terms of transplants. As at the end of April, 88 donations had happened in the first four months of 210 resulting in 251 transplants. I should add that that is solid organ transplants and solid organ donations; that is not counting eyes and tissues. That is an average of around about 3.5 transplants per donor, which is an improvement on many of the previous results. So the donation rates are up and we are optimistic about the number of transplants that are resulting from each donation.

Senator CAROL BROWN—Thank you, Ms Cain.

CHAIR—Thank you very much, Ms Halton, and thank you to the officers for outcome 13. We will now suspend until 1.30, when we are going to come back with aged care. Ms Halton, I believe all questions on notice have now been received, so we have them all. Thank you very much.

Proceedings suspended from 12.33 pm to 1.31 pm

CHAIR—We will now go into consideration of outcome No. 4, Aged care.

Senator FIERRAVANTI-WELLS—I am.

CHAIR—Are you able to go through by each of the programs?

Senator FIERRAVANTI-WELLS—I will try. In fact I have organised my material to do that.

CHAIR—We will start with program 4.1, the aged care assessment team.

Senator FIERRAVANTI-WELLS—Ms Halton and minister, I think you would be aware of the article on the front page of the *Sunday Telegraph* entitled 'This is how we care for the aged'. Ms Halton, are you aware of that article?

Ms Halton—Yes.

Senator FIERRAVANTI-WELLS—So you do not need a copy?

Ms Halton—I do not have one with me and I cannot say that I have memorised every single word of it.

Senator FIERRAVANTI-WELLS—My comments will be more general. Do we have the names of the nursing homes being talked about? The article refers to two organisations. It does not refer to the names of the nursing homes in question.

Ms Smith—You are correct. The article refers to the names of the two approved provider groups. As soon as we saw the article in question we looked at the department's records and talked to the providers in question. We were able to identify the names of the two homes involved.

Senator FIERRAVANTI-WELLS—Do we have the names of the two homes involved?

Senator Ludwig—Do we want to read that into the record? There would be a public interest reason.

Ms Smith—It is protected information under the Aged Care Act. I cannot release that information.

Senator FIERRAVANTI-WELLS—I appreciate that. Have these nursing homes been sanctioned before?

Ms Smith—No, they have not.

Senator FIERRAVANTI-WELLS—For ease of reference I will refer to this way: one is under Bupa Aged Care and the other is under Domain Principal Group.

Ms Smith—Yes.

Senator FIERRAVANTI-WELLS—For the purposes of our discussion this afternoon I will just refer to them as Bupa and Domain, because that is information in the public domain.

Senator Ludwig—Thank you.

Senator FIERRAVANTI-WELLS—So neither of these two homes have been sanctioned?

Ms Smith—That is correct.

Senator FIERRAVANTI-WELLS—Did Ms Squires have a police check?

Ms Smith—Both providers were able to verify the identity of the home by checking their volunteer register. Ms Squires used her correct name and police checks were obtained.

Senator FIERRAVANTI-WELLS—When were these homes last visited by the agency, or when did they last receive a visit?

Ms Smith—The department visited the homes on Sunday afternoon, but in respect of their previous accreditation visits you would need to check that with the accreditation agency.

Senator FIERRAVANTI-WELLS—During the course of your investigation, I would assume an investigation has been undertaken, commenced.

Ms Smith—We initiated an own motion investigation as soon as we were aware of the issues in the media article.

Senator FIERRAVANTI-WELLS—What action has now been taken by the minister since the department became aware?

Ms Smith—The minister, I think you would be aware, put out a press release on Sunday. The department has commenced an investigation and the accreditation agency commenced review audits at both homes on Monday morning.

Senator FIERRAVANTI-WELLS—At the last election the incoming government indicated that they would be undertaking 7,000 unannounced visits, and there is material in relation to unannounced visits, so can you tell me how many unannounced visits either of these two homes have had since 2007?

Ms Smith—Unannounced visits are in the agency’s domain, so they would have to talk to you about their accreditation visits in respect of those homes.

Senator FIERRAVANTI-WELLS—Okay, I will ask the agency. Have you received any complaints about either of these two homes?

Ms Smith—We have received complaints, over what time period are you talking about?

Senator FIERRAVANTI-WELLS—Let us start with from since 2007?

Ms Smith—We have received complaints about both homes since 2007.

Senator FIERRAVANTI-WELLS—Can you tell me when those complaints were recived?

Ms Smith—I do not have a complete list of every complaint at both homes.

Senator FIERRAVANTI-WELLS—I would assume that since this happened on Sunday, the department would have made it their business and the minister would have it her business to find out as much as possible about these two nursing homes, and I am surprised you do not have this information with you today. I would have thought you would know I would ask questions about it.

Ms Smith—I can tell you numbers, but I cannot tell you—

Senator FIERRAVANTI-WELLS—The nature of the complaints.

Ms Smith—The nature of every instance.

Senator FIERRAVANTI-WELLS—That is fine.

Ms Smith—Since 1 May 2007, which is when the Complaints Investigation Scheme was introduced, we have received 10 contacts in respect of the Bupa home, and then, in respect of the other home, 27.

Senator FIERRAVANTI-WELLS—And in relation to those complaints, what action has been taken? You do not have any information at all about these complaints?

Ms Smith—We have investigated those complaints. In respect of the Bupa home, we have finalised nine of those, and the one remaining is actually the own motion investigation initiated by the department over the weekend.

Senator FIERRAVANTI-WELLS—In relation to Domain?

Ms Smith—In relation to the other one, we have finalised 24 of them.

Senator FIERRAVANTI-WELLS—Were the complaints found to have been valid?

Ms Smith—We had some in which the information was validated and some in which it was not. I would have to take that on notice in respect of each of the homes.

Senator FIERRAVANTI-WELLS—So you have obviously got some details about the complaints against these two nursing homes, but you do not have the nature of those complaints?

Ms Smith—I do not have exhaustive detail on each. I have summary information with me today.

Senator FIERRAVANTI-WELLS—You might like to give us the information that you have in relation to each of those nursing homes.

Ms Smith—In respect of the Bupa home we have had two finalised contacts in the most recent 12-month period: one in September 2009 and one in February 2009. The one in September 2009 was a report of a missing resident. That resident was located within 24 hours and there was no breach of the approved provider’s responsibilities identified. The February 2009 complaint was an alleged assault of a resident by another resident. The scheme conducted an unannounced site visit and our investigation did not identify a breach of the approved provider’s responsibility.

Senator FIERRAVANTI-WELLS—Let us take the Bupa ones. Turning to the matters and allegations raised in relation to Bupa, of the 10 you have given me, were any of those the subject of a similar complaint?

Ms Smith—I do not believe so, but I would need to check.

Senator FIERRAVANTI-WELLS—None of the complaints since 1 May 2007 relate to similar allegations to what is alleged in the *Sunday Telegraph*?

Ms Smith—Not that I believe, but I would need to check.

Senator FIERRAVANTI-WELLS—You do not have as much detail.

Ms Smith—I do not have as much detail on the older complaints with me today.

Senator FIERRAVANTI-WELLS—Let us go to the Domain ones and similarly the nature of the complaints in relation to Domain.

Ms Smith—We have three contacts currently under investigation. There is one from February relating to alleged poor clinical care in respect of an infection stemming from inadequate monitoring of diabetes. That contact is currently under investigation. The resident in question has been discharged from the home and is now in Brisbane. In May 2010 we had a contact about alleged unreasonable use of force by a staff member on a resident and we are currently investigating that. Then we have the current own-motion investigation that we commenced on the weekend. Those are the three contacts that are currently under investigation. I think it is worth, in relation to this home, putting a little bit of background on the record. This Domain home has a fairly challenging resident profile.

Senator FIERRAVANTI-WELLS—I was about to ask you that. How many?

Ms Smith—There are a number of residents who would be younger than the typical resident population; more males than females; and people with alcohol-related brain damage or who have been homeless for much of their lives, or have some other acquired brain injury. That makes it a fairly challenging environment.

Senator FIERRAVANTI-WELLS—What is the ratio? Give me a bit more of a profile. High, low: all high care?

Ms Smith—It is a high-care facility, and it has got a much younger profile. In terms of the three domains of the aged-care funding instrument, a lot of the residents have got high ratings in the behaviour domain but low ratings in the complex health care domain, so these are not people who are frail and needing a lot of clinical support but people who have got very complex behaviour.

Senator FIERRAVANTI-WELLS—How many people are there in the nursing home?

Ms Smith—I think there are 55 there currently.

Senator FIERRAVANTI-WELLS—So there are 55 at Domain. How many are at the Bupa facility?

Ms Smith—It is a 90-bed facility with 89 residents there at the moment.

Senator FIERRAVANTI-WELLS—What is the staff profile of each of these nursing homes?

Ms Smith—I do not have that information with me.

Senator FIERRAVANTI-WELLS—Is that part of the information that you will have available as part of their records?

Ms Smith—As part of an investigation, we would look at the staffing profile on the rosters because that is one of the issues that are alleged to have been impacting on care.

Senator FIERRAVANTI-WELLS—Obviously this story has generated a lot of media interest, both written media and radio. What about the department? Have you received any complaints or, as a consequence of this story, had people contacting the department with similar stories?

Ms Smith—I think there may have been a couple of inquiries to our New South Wales office following the story, but I would have to check actual numbers and whether people were

particularly referencing the article as having prompted their call or whether they were just ringing generally. I would have to take that on notice.

Senator FIERRAVANTI-WELLS—So you have two nursing homes, both of which have a fairly consistent history of some complaints—

Ms Smith—In relation to the first home, I think 10 in a three-year period is not particularly remarkable.

Senator FIERRAVANTI-WELLS—What is the average number of complaints?

Ms Smith—I would have to take that on notice, but certainly 10 in a three-year period, with only two in the last 12 months, is at the low end. The other home, as I have noted, has a particularly challenging resident profile, so I think it is fair to say that there is a history there, but I do not think that is a fair statement in relation to the first home.

Senator FIERRAVANTI-WELLS—In relation to those visits, I will deal with the accreditation agency.

Ms Smith—The department took this article extremely seriously.

Senator FIERRAVANTI-WELLS—I would hope it did.

Ms Smith—As soon as we read the article we were working to identify the homes and ensure that an investigation was commenced as soon as possible. Without in any way wanting to diminish the seriousness of some of the issues raised in the article, I think there are some issues there where there may be a lack of experience with nursing homes. For example, there was a picture of pureed food there. It was described as slop in the headline, but it is actually a reality that, for residents with swallowing difficulties, it would be dangerous for them to eat other than pureed food. There was a mix of information in that article, some of which is a feature of nursing homes and what is required to care for residents of particular types, and some of which are very serious allegations about care.

Senator FIERRAVANTI-WELLS—Yes, I am aware of that. On the topic of food, what is the situation now in terms of monitoring of food to residents? What regulation and guidelines have the department or its agencies imposed in relation to food in nursing homes?

Ms Smith—There is an accreditation standard that relates to food and nutrition and that is monitored by the accreditation agency as part of its processes. Residents and their families also have the capacity to complain through the Complaints Investigation Scheme if they are concerned about food and nutrition. We are certainly very acutely aware that that is a critical issue for residents. I think with the increasing frailty of many residents and the sort of diagnoses they have, lack of appetite can be a feature of those conditions, and it is really important that homes understand how to keep adequate nutrition up to residents.

Senator FIERRAVANTI-WELLS—As far as the department is concerned, were there some reports in relation to—particularly in New South Wales—the New South Wales Foods and Standards Agency being involved, are you aware of—

Ms Smith—I am not exactly sure what you are referring to?

Senator FIERRAVANTI-WELLS—In relation to the more detailed questions about food, is that something that you have some input in, or is that something I should purely just ask the agency?

Ms Smith—The department has a role in terms of promotion of good practice around a range of issues relating to good quality care, including food and nutrition. We also will investigate complaints where they relate to food. In terms of the accreditation standards and what is found in monitoring of homes, that would be a question for the agency.

Senator FIERRAVANTI-WELLS—All right, what about pets in nursing homes, is that something that comes within your domain?

Ms Smith—Do you mean where the people are prevented from having pets or allowed to have pets?

Senator FIERRAVANTI-WELLS—Just in terms of access to nursing homes by volunteers with pets, is that a program that you—

Ms Smith—I am certainly aware that some nursing homes have pets as therapy programs as do hospitals, I think that can be quite a valuable addition to the range of activities a nursing home has for residents. I am not aware of any particular program that is causing concern though.

Senator FIERRAVANTI-WELLS—As I have been sitting here, I have just received an email, and I would just like to share this since we are following up this story that was in the *Telegraph* the other day, and it says:

Dear Senator, I can tell you from experience that a lot of nursing homes are bad, not only do they exploit the patients, they exploit the staff. A lot of staff are from non-English speaking backgrounds and their lack of English causes a lot of communication problems, lack of care.

She refers to her grandmother being in a place in New South Wales for respite and surgery. and she is blind, bedridden et cetera. This sort of commentary—and I ask this in the context of—in the last few days after this story, there has been on some of the talkback radio programs an enormous amount of interest and people calling in with story upon story, upon story, about difficulties in nursing homes. You obviously paint your picture of what the situation is, but clearly there are a range of problems out there. The fact that this can happen is indicative of a far greater problem in the system.

Ms Smith—We have taken the issues raised in that article very seriously, we have got an investigation underway. The government has also made a recent investment in the Complaints Investigation Scheme to improve its capacity to investigate complaints, so I think it is demonstrably an issue that has been taken very seriously.

Senator FIERRAVANTI-WELLS—But what about the underlying problems that the industry is facing, and there is review upon review, upon review, that has been done in this area, in particular since 2007 and yet the same problems seem to be emerging. The fact that we do see this sort of story, doesn't that raise alarm bells about an industry in crisis and the more systemic problems that are in the industry that need to be addressed so that these sort of stories do not appear in the newspapers?

Ms Halton—Senator, you are asking the officer for an opinion, which she is obviously not going to give because that would not be appropriate. I should make the point that there were a number of measures taken in the budget in respect of aged care but the Productivity Commission, as you are aware, is also examining aged care. I think it remains for us, firstly, to wait while those measures are implemented and, secondly, while the Productivity Commission does its wholesale review, to think about where the future of aged care is going. But the officer obviously cannot answer a hypothetical or speculative question about opinion.

Senator FIERRAVANTI-WELLS—So did the Senate Standing Committee on Finance and Public Administration's *Inquiry into residential and community aged care in Australia* examine ageing. So did the Productivity Commission's 2009 *Annual review of regulatory burdens on business: social and economic infrastructure services*; so did the Auditor General's Audit Report No. 40 2008-09: *Planning and allocating aged care places and capital grants*; so did the Productivity Commission paper *Trends in aged care services: some implications*; so has COAG; so have other internal reviews of the department that have not been released. How many more? Surely all these reviews that have been conducted on aged care must have given the department and the minister some inkling of the myriad of problems in this sector.

Ms Halton—The minister herself has received a small number of reviews. A number of those 'reviews' that you have referred to are in fact things that have been undertaken in respect of, for example, the deregulation agenda. I do not think it is appropriate to lump all of those together and say they are all wholesale reviews of aged care, because they are not. In fact, a number of things in the budget have responded to matters that have been raised but, precisely because of the interactive nature of a number of these issues, that is why the Productivity Commission is doing a top-to-bottom review of the program and the system.

Senator FIERRAVANTI-WELLS—Perhaps I can take you to the Productivity Commission and the terms of reference. I think you will see in box 1 of the Productivity Commission's issues paper that they recently put out that it starts with a whole series of quotes from the so-called small number of reviews—you are trying to dismiss them as a small number of reviews; I think it is more than a small number of reviews. Anyway, there are quotes from a number of reviews that have already been undertaken in relation to aged care. The Productivity Commission's first sentence—and I am sure you have read that document—says that major reform is required. It then quotes six or seven paragraphs from six or seven different reviews where, effectively, there are strident comments about the need for major reform of the sector. The point is that, yes, the Productivity Commission is doing this, but it seems to me that stuff is just going to be shuffled over to the Productivity Commission for yet another review when you already have a whole series of reviews which this government has not even bothered to respond to. Its response is to have another review.

Senator Ludwig—It is set out on the Productivity Commission's website:

In undertaking the inquiry, the Commission will develop options for further structural reform of the aged care system …

I think it is entirely appropriate that the Productivity Commission undertake this work. I think it is also appropriate that we look to see what the outcome of that is. I think it is correct to also say that the reviews you have mentioned are not all reviews as such. The Auditor-General,

COAG and the particular Senate committee inquiries are of a different character and I recognise that.

I think it is also fair to say that the government is reforming the aged care system. We have, I am advised, looked in the budget at how we can do that. In 2010-11 there will be $730 million more funding for aged care than if Mr Abbott had remained the minister. To date the minister has been engaged, particularly in that last one you mentioned in relation to the report in the paper. There is an aged care complaints investigation scheme in place. I think you are well aware of that.

I think it is also worth mentioning that if there are issues that surround us—for instance, if residents, relatives of residents, visitors, staff or volunteers in aged care facilities—have concerns about the operation of aged care facilities there is a complaints number they can contact. For those who may be listening it is 1800 550 552. It is one of those areas for which you can provide a complaints mechanism. It is effective. These steps were taken shortly after the paper produced that article. The aged care complaints body visited the site and I am advised that the independent Aged Care Standards and Accreditation Agency has commenced a full audit. So there is a process in place for dealing with current issues and dealing with the way forward. It is a challenging area. I think everyone accepts that. This government is taking it very seriously.

Senator FIERRAVANTI-WELLS—Then can you explain to me why it took from August last year until April this year for the terms of reference of that Productivity Commission to be announced.

Senator Ludwig—I can take that on notice. I am not sure of the process involved in that—unless the department has an overview of how that comes about.

Ms Halton—They are obviously released by the Treasury but, more importantly in this particular case, they were released as we followed discussions at COAG on a couple of issues in respect of aged care. There is nothing more I can say on that.

Senator FIERRAVANTI-WELLS—Some issues have been raised with me in relation to building codes and layers of duplication. Is there some intention to review building codes as part of concerns that providers have raised in relation to duplication and layers of codes to achieve accreditation?

Ms Smith—I think you might be referring to the building certification requirements. It was a recommendation of the Productivity Commission in relation to the regulatory burden report that we should examine incorporating the privacy and space requirements which are currently in the certification instrument into the Building Code of Australia. The government has accepted that recommendation and we are currently consulting with the Australian Building Codes Board with a view to incorporating the privacy and space requirements that are currently in a separate instrument into that. That is in direct response to the feedback the industry has provided.

Senator FIERRAVANTI-WELLS—Can you tell me where and how the extra funds allocated in the budget in relation to accreditation will be spent?

Ms Smith—There is an element of the complaints investigation scheme that provides additional funding for the accreditation agency. That is in recognition of the fact that, of the complaints the department examines, some will end up being an individual issue that only affects one individual, but some will raise a systemic question. The department in its usual way of investigating complaints will make referrals to the agency where we believe there is a systemic dimension to the concerns being raised. In line with the projected increase in complaints which we are seeing for a number of reasons—ageing of the population, increase in number of places and a general increasing community expectation, I think, about their right to complain—we have also projected an increase in activity for the agency. That is reflected in the budget papers.

Senator FIERRAVANTI-WELLS—You have allocated extra money for benchmarking. How will this be conducted? Are you going to directly fund providers?

Ms Smith—That is a question for my colleague.

Ms Podesta—In the budget the government provided $7 million for a benchmarking tool and business advisory services so that aged care providers can compare and improve their business practices. All of the residential aged care providers will be included in the benchmarking survey and it will use the data that is currently provided. This will enable each aged care facility to benchmark their operations against best practice and improve the quality and efficiency of their care delivery to residents.

Senator FIERRAVANTI-WELLS—In other words, you will also use this to track financial performance? Is that the intention?

Dr Cullen—We already track financial performance through the general purpose financial statements. The benchmarking study is done at a different level. Typically, the benchmarking study will be not at the level of the approved provider but at the level of the aged care home. It would also be done at a lower level of cost centres. You would collect costs separately on catering versus laundry versus utilities, et cetera and thereby allow providers to compare themselves to other aged care homes with similar resident mixes in order to see how their costs compare to others.

Senator FIERRAVANTI-WELLS—What is the timeframe for this?

Dr Cullen—It is an ongoing process. At the moment we are in the process of setting up a reference group, with the industry, of providers who would help us in the design of this but over the next 12 months we would hope to establish the benchmarking site. The intention at the moment is to have a web based site whereby providers can enter their data and at the same time select a group of peers and compare themselves to those peers on any sort of analysis that they want to. We would hope to have that benchmarking service up and running by the end of the financial year.

Senator FIERRAVANTI-WELLS—So that it is really for their own benchmarking against industry rather than any attempt to assist in the reduction of red tape?

Ms Podesta—Precisely. It is genuinely about business efficiency, recognising that it is in the interests of the approved provider to be as efficient as possible.

Senator FIERRAVANTI-WELLS—I just want to ask a couple of questions about the aged care assessment. How will this system continue if Western Australia does not sign up to the health plan? I noticed one of the provisions is that you are going to take over the aged care assessment. What happens if Western Australia does not sign up?

Ms Podesta—We are currently negotiating an implementation plan with each state and territory for the next two years—that includes the Western Australian government. This is part of the current national partnership on health services. We will have negotiations with those parts of the country who have signed up for the COAG reforms about how the assessment program will link into the unified aged care services as they are built. Western Australia currently takes responsibility with us for aged care assessment and at this stage they will be supported through the next two years once they have signed the implementation plan to go with the national partnership agreement.

Senator FIERRAVANTI-WELLS—In the budget allocated over forward estimates for aged care assessments it is actually a global figure. Can you break that down into the funding for each of the states or have I missed it? Where can I get that information?

Dr Cullen—You can find a notional breakdown in budget paper No. 3. Because it is a national partnership agreement, the notional state breakdowns are provided there. I say 'notional' because the forward estimates are driven by population parameters and can change.

Senator FIERRAVANTI-WELLS—One of the criticisms has been the inconsistency of the ACAT assessment across Australia. One assessment in one state or one location within a state may be different to another. Firstly, how is your takeover going to rectify those issues and secondly how do you build into that—is it a stock amount per ACAT team, or how have you assessed the budget in relation to those teams?

Ms Podesta—As part of the implementation plan negotiations and in the lead-up to the renegotiation of the implementation plan, we have been working closely with our colleagues in the states and territories to get agreement about new key performance indicators on timeliness, consistency and quality of their aged-care assessments. That is consistent with the previous COAG decision of 2006 to ensure that we have more consistent and timely arrangements with our states and territories. The new implementation plan will have new agreed key performance indicators for the transition period with the states and territories.

Senator FIERRAVANTI-WELLS—Have you, as part of that, made any assumptions in relation to the cost of each of these assessment teams and the variation of costs across Australia? What I am getting at is that the cost of running a team in one location may be different to another. Is that budget being determined based on the individual needs in a particular area as opposed to the other?

Ms Mackey—Part of the negotiations that are happening at the moment with states and territories around the new implementation plan for the aged-care assessment program looks at the transition period that will be required over the next couple of years and the information we need to make sure that we build a robust funding model for the future, including what the appropriate price might be for a comprehensive assessment.

Senator FIERRAVANTI-WELLS—And built into that, will there be some performance indicators? One of the concerns that I hear all the time is the delays to get an assessment. Are you going to build into that some more stringent time lines?

Ms Mackey—As Ms Podesta has indicated, in the current arrangements and in the implementation plan that is currently being negotiated there are key performance indicators which particularly go to timeliness. We will certainly be interested in making sure that there is a continued effort in improving timeliness.

Senator FIERRAVANTI-WELLS—You are going to set a time such as assessements within six weeks or five weeks or something like that?

Ms Mackey—We already have those arrangements.

Senator FIERRAVANTI-WELLS—Yes, I know, but they do not always work.

Senator CAROL BROWN—You could always have a little bit more time to indicate how the changes are going to be better than the current assessment process. How will the changes be more advantageous for the industry and the clientele?

Ms Podesta—I think that is the right question. There are many parts of the age care assessment program which are phenomenally positive and, as a system of assessment, it is quite robust. There are certainly things that could be done to improve that. I think that is about national consistency and better training for staff, and better information for carers and for people who are being assessed, and then later follow-up for people. We will certainly be focussing on making sure that the work force have the right sort of training to be able to undertake that but that there are incentives to have a timely response around assessment needs.

One of the things it is important to note is that we have particularly focused on improving response for highest need. That is as it should be. So the vast majority of people assessed as urgent cases are assessed within two days—48 hours is the benchmark for priority one cases. There has been an improvement in the way the teams do that. That is the important part of it. There are a range of other things that can be done to improve the way we undertake assessment nationally, and they are around issues of cultural appropriateness, ensuring that the communication is done properly and consistently, that we have fair access to assessment services and that people understand what the assessment means for them in terms of the plans that they need to make about their life.

Senator FIERRAVANTI-WELLS—One of the complaints raised with me is the discrepancy between the assessment done by ACAT and the assessment done by the registered aged-care faculty for ACFI purposes. Do you monitor the discrepancy rates or discrepancies between those two? Obviously you have to do it on a person-by-person basis, but the discrepancy between the ACAT assessment and the subsequent assessment that may be done by the registered aged-care facility is one of the things that is constantly raised with me.

Ms Podesta—I think you are asking a question that has been a particular focus in the work we are doing under the aged-care funding instrument review. I guess you are thinking particularly here about residential care—is that right?

Senator FIERRAVANTI-WELLS—Yes.

Ms Podesta—So in the time lag that can sometimes happen between the time that someone has an ACAT assessment and when they enter a residential aged-care facility, has their condition changed? Or in the ACFI assessment that is made by the approved provider when they enter the home or place, what they identify as their needs and what is the mechanism. We have particularly been examining that issue. I will ask my colleague, because it has been part of the review, to particularly focus on that issue.

Senator FIERRAVANTI-WELLS—Thank you.

Ms Murnane—They actually serve a different purpose—a complimentary purpose, but different. The assessment team assesses that they are eligible for residential aged care. Nursing homes or aged-care homes will ask them, 'What category do you think?' They may say, but they do not do the detailed observation on needs for assistance that the home will then do over a two- or three-week period.

Senator FIERRAVANTI-WELLS—I appreciate that, but the issue is that when you have somebody who gets assessed there are certain expectations. It is not just the one person, it is usually a family or loved ones around, and there are certain expectations. Then of course you go to the provider, and often if there is a discrepancy it leads to potentially some tension. I appreciate that it is for different purposes and there are different tools. Nevertheless, there are still overlapping components, and that is what I was really getting to.

Dr Cullen—You will recall that on 1 January the Quality of Care Amendment Principles 2009 changed the definition of high and low in the ACFI in order to address this issue. That has been very successful in addressing this issue. Prior to the introduction of the ACFI, the rate of disagreement between ACATs and the then RCS assessment was 7.9 per cent. After the introduction of the ACFI in January this year, if we had kept the first definition of the ACFI the rate of disagreement would have been 15.1 per cent. Instead, under the new definition, the rate of disagreement was 8.4 per cent—in other words, exactly the same as it was under the RCS. So the changes made in January have resolved the issue back to the level of disagreement which is absolutely to be expected. Over 12 years of the RCS our experience was that about 8 per cent of cases would be in disagreement.

Senator SIEWERT—What was the date that the calculation was done of 8 per cent?

Dr Cullen—January 2010.

Senator SIEWERT—To when?

Dr Cullen—The month of January.

Senator SIEWERT—It was just the month of January?

Dr Cullen—In the month of January 2008, under the old system, it was 7.9 per cent. In the month of January 2010, under the new system, it was 8.4 per cent.

Senator SIEWERT—Have you done an average across a further time line than that?

Ms Podesta—No. We can take it on notice.

Dr Cullen—We could take that on notice, but the number of entries in January would be statistically significant. I would not have any doubt that that number would stand.

Ms Podesta—We will take it on notice, but because the number of entries were about the same they are statistically pretty valid. We will certainly give you the additional information.

Senator FIERRAVANTI-WELLS—Thank you. I am sure this and many other things are contained in the ACFI review, which we are still waiting for with bated breath.

Ms Podesta—Senator, the ACFI review is absolutely on track.

Senator FIERRAVANTI-WELLS—Good, I am waiting with bated breath.

Ms Podesta—All of the submissions have been published, the first part of the analysis has been published, the discussion paper is out.

Senator FIERRAVANTI-WELLS—I will wait for the final.

Ms Podesta—ACFI review reference groups have been meeting regularly and working with us.

Senator FIERRAVANTI-WELLS—I want to ask about the allocation for the one-stop shops. There is a budget allocation for one-stop shops, but not total, and the number expected and the location. Can you enlighten me on that please?

Ms Podesta—The government has committed $36.8 million over four years to streamline the front end of age care. The introduction of the one-stop shop and the locations will be linked with the local hospital networks. As such, we will be working with our colleagues on the appropriate location sites. I think indicated this previously in the briefing.

Ms Halton—Senator, I really think it is important to underscore what we are trying to do here. We all know, because we have either had family members in these circumstances or people tell us about it, that people expand a huge amount of shoe leather trying to work out how to get round the age care system and how to find a service. This is very much about providing a coherent, integrated place that people can go for that advice. And as Ms Podesta says, it is really imperative that this is integrated in the health reforms and that it is part of a coherent regional presence, which we did talk about first thing this morning.

Senator FIERRAVANTI-WELLS—In the appendices to the national hospitals agreement that we were discussing this morning, is the time line for this to happen contained in one of those appendices? I might have missed it. Or is it just to be determined?

Ms Podesta—No, there is a transition process. We will be progressively, over the next year, identifying locations and establishing one-stop shop outlets and services progressively as we finalise arrangements around transition, and then the Home and Community Care program will be building on the services that one-stop shops will be providing and the system that will underpin them. It will be a progressive rollout of the services of the one-stop shops, and progressive rollout of—some will be, as I think we have previously indicated, using the capital and stock of existing infrastructure, some will be new services and new sites. We will also have telephony and internet services that will underpin the one-stop shop services.

Senator FIERRAVANTI-WELLS—I want to go to the tender process for the ACAT reform changes. How will that tender process work? Will there be a tender process?

Ms Mackey—In terms of procurement for one-stop shops?

Senator FIERRAVANTI-WELLS—No, not about procurement. I have finished on one-stop shops; I want to go back and ask about the ACAT reform and the changes you are going to make. Does that involve a tender process?

Ms Mackey—The current provision of the ACAT program does not involve a tender process. It is service delivery through the state and territory governments.

Senator FIERRAVANTI-WELLS—So it is really just going to be a takeover federally?

Ms Mackey—In terms of the future of the Aged Care Assessment Program and how we make sure that comprehensive assessment is part of the front-end of age care, and linking in and part of the delivery of one-stop shops, that is what we will be working through over the next little while as part of the transition process. So there have been no decisions on future tendering of procurement or how those services might be delivered.

Senator FIERRAVANTI-WELLS—Okay. But if I understood Ms Podesta in a previous briefing, there will be potentially some sort of tendering process where some entity, not necessarily state government entity, will run this?

Ms Podesta—I think there is going to be a range of options that we will need to examine. We spoke previously, and the budget measure makes clear, the one-stop shops will be in a position to purchase some complex assessments. So there will be at least one feature of the system which provides for some funds to be able to purchase.

In relation to what the infrastructure is around the Aged Care Assessment Program, we have made a very strong commitment that we want to continue and build on the solid infrastructure that exists within the Aged Care Assessment Program. We went recently to the Aged Care Assessment Program conference and spoke with a very large number of staff and made a real commitment to staff that we are incredibly proud of what the program is able to deliver for older Australians. It is not our intention to start as if that does not exist; that would be ridiculous. This is about taking the best features of the Aged Care Assessment Program and looking to see what is going to make the most sense for people as they enter through one door, for how they enter into that system, and how the aged-care assessments can be done as quickly and comprehensively and, most importantly, with the highest quality. That is absolutely critical. We are not interested in going down the path of looking at how we can do it as fast and cheaply as possible. The critical question is to get the assessment done appropriately and to get it right so that people's needs are identified and then they are supported and referred to the right services.

Senator FIERRAVANTI-WELLS—And not have to wait four, five or six weeks to do it. Chair, I want to move now from 4.1 to 4.2.

[2. 26pm]

CHAIR—We can go back to 4.1 if we have time and Senator Adams finds she has some questions. We will move now to 4.2, Aged care workforce.

Senator FIERRAVANTI-WELLS—At page 164 of the big yellow book, there is a reference at the bottom of the page to the aged-care workforce and reform of the system. It says that you will introduce new programs and restructure and expand existing programs et

cetera. Which programs will be restructured and why are they being restructured? Will some be discontinued?

Ms Nicholls—In terms of restructuring the existing workforce programs, we currently have a number of workforce programs which have developed over time from 2002. Those programs were not necessarily logically integrated together. What we have taken the opportunity to do is restructure those programs into four major funding streams. We will have a focus on vocational education and training and a focus on training for nurses, enrolled nurses and registered nurses and postgraduate training. They are measures that we have already been doing and that have been part of the existing programs. We are also bringing in some new measures which are more about promoting professional practice and training. In particular, we are bringing in some initiatives to support clinical placements for student nurses to ensure that they have better quality clinical experiences during their training period.

Senator FIERRAVANTI-WELLS—This is at the top of page 165? If we look at 164 and 165 that might make it easier to both of us.

Ms Smith—The top of page 165 talks about the new programs. What Ms Nicholls is describing is the new elements of the restructured programs.

Ms Nicholls—In terms of the new elements of the old programs, we are looking at clinical placements so that student nurses will have better, positive and quality clinical placements in aged-care facilities. That will encourage them to look at aged care as a future career choice. We are looking at strategies to establish graduate placement programs for graduate nurses. When nurses graduate, they generally like to have a year which is perhaps more supportive than your normal employment. Certainly in the public health system they run graduate programs whereby students have access to additional training and support and access to clinical expertise and mentoring so that they can solidify their practical skills in their day-to-day delivery of care. So we are looking at trying to develop that for the aged-care sector as well. We are also looking at the establishment of a number of teaching nursing homes. Underpinning the concept of teaching nursing homes is the idea that it is partly about addressing workforce issues in terms of providing an environment which supports and promotes the development of good quality clinical skills.

Senator FIERRAVANTI-WELLS—Any sites identified there?

Ms Nicholls—No, not at this stage. The other aspect of teaching nursing homes is promoting quality in terms of good quality clinical practice. One of the key elements is that it promotes the links between the aged-care sector, between universities and education institutions, and between research areas. We would also be looking for links with the local hospital networks.

Senator FIERRAVANTI-WELLS—I did ask for a list of all the elements of each of the programs and the answer that I got for program 4.2 simply says ‘aged-care workforce programs.’ It did not actually list the programs. Could you please list the programs for me and tell me how much is allocated to each of them now and how much will be allocated to them under their restructured form? Ms Murnane, we were talking about the current programs which are being restructured and Ms Nicholls was telling me about a series of programs that are now going to be restructured. That is what she just said to me.

Ms Nicholls—I was talking about the new elements that would be available under the restructured program.

Senator FIERRAVANTI-WELLS—Okay, but it is still a program that has a name and has been existing for a number of years.

Ms Smith—I think program 4.2 is the broad program name but within that, incrementally over time, there have been different programs introduced—support for aged-care training, more aged-care nurses et cetera.

Senator FIERRAVANTI-WELLS—I appreciate that. I have asked on a number of occasions for that to be detailed to me and all I have got in the latest iteration is ‘aged-care workforce programs’. It would really have helped me if somebody had listed them all for me. It would make it so much easier.

Ms Murnane—We can do that straightaway.

Senator FIERRAVANTI-WELLS—I have asked. This is now the second time. I actually asked Minister Evans and I did ask at a briefing.

Ms Murnane—We will have it to you after dinner.

Senator FIERRAVANTI-WELLS—Perhaps it is third time lucky.

CHAIR—Senator Fierravanti-Wells, Ms Murnane is in the middle of making a comment.

Ms Murnane—I was saying that the restructuring is in large part a replacement of new elements using the same bundle of money. So we will give you all those new elements with a full description and with the amount of money assigned to each of them. We will compile that and get it to you after dinner.

Senator FIERRAVANTI-WELLS—Old program and new program. That would be helpful. If you could, put the amounts of money next to each of those.

Ms Smith—As you have indicated, the material at the top of page 165 of the PBS is new programs to be introduced. There is the aged-care education and training incentives program, which is to encourage aged-care workers to up skill. That includes support for getting certificate training, enrolled nurse training and registered nurse training. There is also the building nursing careers program, which is an additional 600 fully funded enrolled nursing places and 300 undergraduate nursing scholarships. Lastly, the aged care nurse practitioners program, where we are hoping to encourage models of practice using nurse practitioners, which I think the sector is pretty exited about.

Senator FIERRAVANTI-WELLS—Can I just ask in relation to the teaching nursing homes: did you mention earlier how many you are intending to establish or do you not know yet?

Ms Nicholls—We do not know yet.

Senator FIERRAVANTI-WELLS—We have seen the program to bring nurses back into the workforce. I take it that is now going to be scrapped. It was not very successful. I think you had 139 of the projected 1,000. Is that the case?

Ms Smith—That program has been ceased and the funding has been redirected to other priorities. When the program closed on 11 May, 150 nurses had returned to aged care.

Senator FIERRAVANTI-WELLS—So, 150 of the projected 1,000. How much money was left over?

Ms Smith—There was $4.2 million.

Senator FIERRAVANTI-WELLS—And that has been redirected into the new initiatives or restructuring.

Ms Smith—Into allowing new initiatives to be delivered within the previous funding envelope.

Senator FIERRAVANTI-WELLS—The first category that Ms Halton was talking about?

Ms Smith—Yes.

Senator FIERRAVANTI-WELLS—How many on-the-ground nurses it is anticipated that these programs will collectively deliver? This is a very much a concern of many providers. The workforce issue is one that is always raised with me.

Ms Nicholls—Overall, we anticipate that we will be able to fund more than 31,000 aged-care training places and also provide more than 1,000 clinical and graduate placements. The 31,000 aged-care training placements include short-course and certificate level training for personal care workers as well as training for enrolled nurses and scholarships for registered nurses and postgraduate scholarships.

Senator FIERRAVANTI-WELLS—Over what period of time?

Ms Nicholls—Over four years.

Senator FIERRAVANTI-WELLS—They are all of the questions I have in relation to 4.2, Chair.

CHAIR—Does anybody else have questions on 4.2, which is Workforce? There being none, we will go on to 4.3, which is Ageing Information and Support.

Senator FIERRAVANTI-WELLS—Can you tell me a little bit about the Community Visitors Scheme?

Ms Smith—That program has been in place for a number of years—many, many years. I do not know, Secretary, whether you can add anything. It is from well before my time, anyway.

Ms Halton—I think it might date back to Ms Murnane’s time. Does it not?

Ms Murnane—I think so, yes.

Ms Smith—It is a program that provides for visitors to go to homes to visit socially isolated residents who, without the help of a community visitor, would not be receiving the sort of support that we know is important to the resident. It is a program that has done some really important things over many years and continues to be an important feature of what we do to support residents.

Senator FIERRAVANTI-WELLS—That is the generality of it. How does it actually operate? What is the nitty-gritty of it? Do you give out money to organisations? How does it work?

Ms Smith—We provide funding to auspices which are located in each state and territory organisation, and then those auspices recruit volunteers, who are then matched with particular homes and particular residents in their local area.

Senator FIERRAVANTI-WELLS—So you simply give them money. How much is the program?

Ms Smith—It is just over $9 million. We are just verifying the exact amount. It is $9.3 million.

Senator FIERRAVANTI-WELLS—Looking at the deliverables, is there a target number of visitors to nursing homes per annum? How do you measure its success?

CHAIR—What is the evaluation method?

Senator FIERRAVANTI-WELLS—Yes.

Ms Veneros—Measures for the program involve training that is provided to visitors. Sorry, I need to find my brief.

Ms Smith—We have a target of 7,500 volunteers recruited to run the program.

Senator FIERRAVANTI-WELLS—That is your target. How many actual volunteers do you have?

Ms Smith—We have achieved our target.

Senator FIERRAVANTI-WELLS—I was just looking for those figures in the documents but I have not been able to find them.

Ms Smith—We can certainly give you some more information on notice.

Senator FIERRAVANTI-WELLS—If you could take it on notice. You said it is $9 million, but I cannot see the budget allocation over the four years. It is not specified.

Ms Podesta—The budget measure includes the advocacy services as well. You have asked specific questions about the visitor program part of that. The budget measure is the visitors and the advocacy services.

Senator FIERRAVANTI-WELLS—Which page is it on?

Ms Podesta—I do not know which page it is.

Ms Smith—We do not publish the forward estimates at the element of subprogram.

Senator FIERRAVANTI-WELLS—Can you take that on notice?

Ms Smith—We will take it on notice for you.

Senator FIERRAVANTI-WELLS—Is this where Ms Noeline Brown's activities are funded as well? Last time there was some issue about what she had been up to. I notice that the website was immediately updated. Has she been earning her keep?

Ms Podesta—It is a very successful program. Is there any specific question you have?

Senator FIERRAVANTI-WELLS—Is she basically doing the same as she was doing before?

Ms Podesta—This year Ms Brown participated in and led 12 events up until 10 May. She has another 28 events scheduled to December. She is a very active, extraordinarily positive attendee and promoter of active and positive ageing.

Senator FIERRAVANTI-WELLS—Who initiates her activities?

Ms Koukari—Organisations contact the department. We have a specific phone line to contact Ms Brown and request her presence at various events.

Senator FIERRAVANTI-WELLS—So she comes and goes a lot.

Ms Podesta—I would just like to put on the record our apologies that the website had not been updated. It was not that the ambassador had not done the work. We had a staff member who was ill and therefore it had fallen behind. We apologise for that and we have made it a priority.

Senator FIERRAVANTI-WELLS—That is fine.

[2.43 pm]

CHAIR—We move now to 4.4, community care.

Senator SIEWERT—When should I ask about indexation? Have I missed that?

CHAIR—You can ask about that now.

Senator SIEWERT—It is a bit unclear which program item it sits in. An indexation announcement was made last Friday. Is that correct?

Ms Podesta—Indexation was announced last week, yes.

Senator SIEWERT—And the amount is 1.7?

Mr Cullen—Yes.

Senator SIEWERT—That is lower than last year, which was 1.9. That is correct, isn't it?

Dr Cullen—Yes, last year the indexation rate was 1.9. Perhaps I could give some background. It is complex.

Senator SIEWERT—That would be appreciated.

Dr Cullen—Providers receive income from both residents and the Commonwealth. Resident fees and charges in general move in line with the pension, in other words they are in general indexed with average weekly earnings. That is about 30 per cent of the income of providers. Those fees in fact have tended to grow faster than that because a lot of that income comes from bonds which had been growing at a much faster rate. From government funding there are two sorts of government funding: care funding and accommodation funding. Care funding is indexed on 1 July each year. It is indexed by a wage cost index and this year that number was 1.7 per cent. Accommodation funding is indexed in March and September each year and is indexed by CPI. So providers have a complex range of income, some of which is indexed by average weekly earnings, some which is indexed by CPI and some which is indexed by the wage cost index of 1.7 per cent.

Why the 1.7 per cent this year compared to the 1.9? The index is a combination of movements in the consumer price index and movements in the minimum wage. Because the CPI was trending lower this year than last year, CPI in this period was at 2.4 per cent compared to 4.4 per cent the previous year, and the index is therefore lower. It is important to understand when looking at what providers receive that indexation is only one measure by which their funding increases. If you look on average over the last three years, funding has increased on average over those three years by 5.2 per cent per year. That is on a per resident basis, so this takes out all the growth in places. This is just for each resident on average 5.2 per cent a year. Historically—

Senator SIEWERT—Can I just stop you there. The 5.2 per cent is if you combine indexation and the increases in accommodation.

Dr Cullen—No, sorry, I am now just looking at the government funding.

Senator SIEWERT—Okay. So when you say it has increased by 5.2 per cent, this is an increase in actual government funding.

Dr Cullen—Government funding per resident has increased by 5.2 per cent per year on average for the last three years.

Senator SIEWERT—Does that include the conditional adjustment payments?

Dr Cullen—No, it does not. It includes one year of the conditional adjustment payment.

Senator FIERRAVANTI-WELLS—Just as a clarification, you are talking about the average figure now. Is that that $40,550—

Dr Cullen—Correct. I am saying that the average payment per resident this year will be $43,789 compared to $37,618 in 2007-08. Over those three years this is a 16.4 per cent increase, or 5.2 per cent per year.

Senator BOYCE—Is that because of the indexation or because of the high and low care mix as well?

Dr Cullen—There are three factors that affect that. One is indexation, one is what we call frailty drift, that the population has become frailer, and the other is new policy. New policy tends to put more money into the system. Historically all of our analysis shows that frailty drift adds about one per cent per year to the cost of delivering care, so we would tend to discount that 5.2 per cent by one per cent and say that in real terms for a resident of exactly the same frailty providers have been receiving 4.2 per cent additional per year. That is the real price increase that they have received, most of that through ACFI in the last three years, the introduction of the ACFI and ACFI grandparenting and also the operation of ACFI has delivered significantly more funding than the RCS. So over the last three years in constant frailty terms we have seen an average increase of 4.2 per cent compared over the same period with a CPI increase on average of 2.3 per cent.

Senator FIERRAVANTI-WELLS—I am sure Dr Cullen is the only person in Australia who actually understands this.

Senator SIEWERT—As I hear it I understand it.

Senator BOYCE—He does not understand it the way the operators understand it.

Ms Podesta—I think it is fair to say that we have tried to provide this information so that everyone can understand it. We understand that providers will always seek to maximise their case but we also I think it is important to put on the record that the indexation measure is one part of the increase. The ACFI changes are, for example, particularly significant for providers. We would be very happy to talk through with you the changes that have resulted as a result of ACFI. We have published this. It is on our website. ACFI has provided for providers approximately 2.9 per cent in real terms increase in funding.

Dr Cullen—I am sorry if my explanation was confusing.

Senator BOYCE—I am not disputing your information at all, Dr Cullen. I am simply pointing out that the aged care operators come to a different conclusion looking at the same data.

Senator FIERRAVANTI-WELLS—It is a bit like Ms Halton and I earlier this morning. We came to different conclusions about the same data, but we allow that to happen don't we, Ms Halton?

Ms Podesta—Aged care is complex but we try also to be very fair. We have no reason to argue a case that is not correct. These are the facts of what the increase in the funding has been.

Senator SIEWERT—I could go down that line, but I am not going to because I have a whole series of other questions I want to ask. Going back to the increase in the accommodation CPI in March can you remind me what that figure was?

Dr Cullen—I cannot, Senator. It is a complex situation at the moment because the accommodation supplement when it was introduced some years ago was jumped up to the level of $26.88 and then it was kept constant at that level. I think it would be best if I took on notice an explanation on how the accommodation charge has been moving.

Senator SIEWERT—You said accommodation CPIs March and September, so I was just wanting to know—

Dr Cullen—It is on March and September and therefore over the year it would increase by 2½ per cent on average. At the moment because of government decisions it is moving faster than CPI because the maximum accommodation charge is moving from $26.88 to $32.38 over the next year and a half in six-month steps. There is a government decision in place which is moving the maximum at faster than CPI. I would like to take that on notice.

Senator SIEWERT—If you could take that on notice that would be great. In terms of the indexation then going on to where I am supposed to be which is community care, is the indexation that applies for community care going to be 1.7?

Dr Cullen—I should reflect that all the data I gave up until now was for residential care.

Senator SIEWERT—Yes.

Dr Cullen—Subsidies for community care would increase by about 1.7 per cent.

Senator SIEWERT—Okay, so the same indexation is applying for community care.

Ms Podesta—However, it is important to note that there has also been a new budget measure which will increase the viability payment for community care. About 400 eligible

aged care providers for community care will receive an increase in their viability supplement as well.

Senator SIEWERT—Which ones are the eligible ones?

Dr Cullen—Rural and remote community care providers.

Senator SIEWERT—It is just the rural and remote ones?

Dr Cullen—Correct.

Ms Podesta—The viability supplement is around where there is a recognition of particular markets that are harder to service.

Senator SIEWERT—How much was that?

Dr Cullen—It is a $10.1 million over four-year measure which increases the viability supplement by 40 per cent.

Ms Podesta—And it will be eligible to about 400 community care providers.

Senator SIEWERT—That was the figure that I missed, sorry. In terms of the new process for HACC services, is it okay if we move on to that?

Ms Podesta—Do you want to talk about HACC as a result of the COAG decision or HACC as in business as usual HACC?

Senator SIEWERT—As in post the new process because I want to get my head around how that is going to operate. I know that I should get my head around how Victoria is going to operate but I am a West Australian so—

Ms Podesta—Do you want to know about HACC in Western Australia?

Senator SIEWERT—No, HACC in general, and I know that is complicated because of the agreement with Victoria. Can we go through how community care and HACC services are going to be delivered and the overall funding and where you are at with the states. Am I making sense?

Ms Podesta—There are three questions. Can we start with the first one. You want to know what the decision is with regard to HACC?

Senator SIEWERT—Where we are up to in implementing the decision.

Ms Podesta—On 20 April COAG agreed to transfer to the Commonwealth current resourcing for aged-care services, including Home and Community Care, in all states except for Victoria and Western Australia. That is the first decision that has been made. We have one year left of the current triennial agreement between the Commonwealth—

Senator SIEWERT—This is 2011?

Ms Podesta—Correct. So the current triennial agreement will continue until that time. After that time the responsibility will move to the Commonwealth for this program.

Senator SIEWERT—For all HACC services for aged care—that is including community care packages?

Ms Podesta—We already have responsibility for the packages.

Senator SIEWERT—Yes, so now is it all going to be delivered as one—

Ms Podesta—That will be the ultimate objective.

Ms Mackey—There is a staged process around the transition for HACC. The first stage of that process is the Commonwealth 100 per cent funding HACC services for older people. The second stage of it is a year later, where the Commonwealth takes responsibility for direct contracting of those services that are currently in the HACC space.

Senator SIEWERT—Except Victoria and WA?

Ms Mackey—Except Victoria and WA; I am talking about those other jurisdictions.

Ms Podesta—So we will have in Victoria a separate national partnership agreement to deliver HACC and, subject to negotiations with Western Australia, we would anticipate that something similar would happen in Western Australia. But with respect to the Western Australian decision, as you know—it has been discussed today—there is still no final landing place.

Senator SIEWERT—The way you are envisaging the West Australian process, the idea is that the services for aged care would still be delivered in the same way but by the state rather than the Commonwealth?

Ms Podesta—We would anticipate that that would be the case. The overriding objective from our point of view is no disruption in service delivery to the client. Obviously there would need to be negotiations and discussions about the logistics and the operations. But the overriding issue from our point of view is that there is no disruption to services. We are absolutely committed to making sure that the services on the ground are delivered, the arrangements at a government level about who administers the contracts and who pays for what need to be finalised. But we have no intention whatsoever that there will be a disruption of services to people in those states where there still needs to be some finalisation about the arrangements.

Senator SIEWERT—In terms of what I see as a bit of an artificial barrier between HACC services and packages, is the idea that the same rules will apply for both? Am I asking too difficult questions here?

Ms Podesta—No. I think you are asking the question which possibly is part of the reason why we are moving towards a unified aged-care system.

Senator SIEWERT—Exactly. That is why I am asking: is that actually what is going to happen?

Ms Podesta—There is a strong motivation to ensure a seamless transition for the client, and this is all about building an aged-care system so that the older Australian is assessed appropriately, the right services are made available to them if it is at the point in their life where it is a relatively low-level community intervention—buy your shoes or paint your roof, those things for daily life—then identifying the types of movements through the aged-care system progressively as people's needs change. That is our vision. We do not expect that will happen in the first two years. It is going to be about a system build. But that is what the intention is—to have a one-stop shop where people enter into the system and, to a large degree, are case managed through as their needs change.

Senator SIEWERT—I am sorry I am jumping around in linking the issues. You were saying that not in the first year of the new process but in the second year of the new process the Commonwealth will take over contracting. Did I understand that correctly?

Ms Podesta—That is right. The responsibility will become the Commonwealth's.

Senator SIEWERT—So the service providers will just deal with the Commonwealth from that point—

Ms Mackey—We anticipate.

Senator SIEWERT—Okay, I will get to what 'anticipate' means in a minute. For all community aged care services other than for WA and Victoria—

Ms Podesta—All services funded under the Home and Community Care Program, the community packages—

Senator SIEWERT—This includes—I just want to be clear—the current community care packages?

Ms Podesta—The community aged care packages.

Senator SIEWERT—I want to be clear that I am understanding—

Ms Podesta—Is it true that it is possible that there will still be, for example, state government entities that are contracted by the Commonwealth to deliver things? Absolutely. We do not anticipate that what will happen is that, because you are a state government with a contract to do certain things on behalf of the Commonwealth now, we will say, 'You no longer do that.' That is not our intention at all. In fact, depending on how we work out the process of having HACC delivered, it might well be that we negotiate some parts of it or that we contract some of the states to do some bits of it. If, for example—and if the point of your question is this—a state government is currently contracted to deliver community care packages, we do not anticipate changing that around, unless their performance is terrible.

Senator SIEWERT—I want to understand how the administration is going to work with current service providers who deal with both the state and the Commonwealth. The idea is that they will be dealing with only the Commonwealth.

Ms Mackey—It will only be for older people in terms of the Commonwealth funding. At the moment, HACC providers use a range of funding sources. Some of those funding sources come from other Commonwealth agencies and some of them come from other funding streams in states and territories, outside of the HACC stream.

Senator SIEWERT—That is where I was coming from. In terms of these boundaries—they are real, not artificial—there are different costs and different payments made under HACC from those made under the age care packages at the moment. That will disappear?

Ms Podesta—Over time. We recognise that this will be a very significant period of adjustment and transition. The idea is to move towards a nationally consistent fees and charging arrangement. But obviously we will look sensibly at what the impact is on local arrangements and on people. The idea is to move towards a fair and reasonable system.

Senator SIEWERT—Who will be doing that? We went through this morning and talked about who sets it for the hospital process. Who will be setting the fair and reasonable prices?

Ms Podesta—The Commonwealth will have responsibility for aged care.

Senator SIEWERT—Which body will be doing it? We are putting in place an independent body who will be setting the efficient prices—

Ms Halton—For the efficient price as described in relation to acute care.

Senator SIEWERT—I know. I am asking: who will be making those sorts of decisions for the aged care sector and for the community care?

Ms Halton—This will be done in the department.

Senator SIEWERT—It will be the department. So you are not going to move to some sort of independent process similar to that of acute care?

Ms Halton—There has been no decision to do that. I have not heard any suggestion that we should do that. No.

Senator SIEWERT—Obviously that is a pretty significant issue. We have just been talking about it in relation to residential care. It is an issue for community care as well.

Ms Halton—Yes.

Senator SIEWERT—There has been no decision made or—

Ms Halton—And no discussion of.

Senator SIEWERT—Is there going to be a discussion of how that happens?

Ms Halton—I am not anticipating that there will be a similar separate body, if that is the question. The bottom line is that, as we get into the detail of rolling out all these arrangements, there will have to be quite specific considerations made about a number of things, but I am not anticipating any particular change to the way we tend to manage these things in the department.

Senator SIEWERT—I realise that we are getting short of time so I will put some questions on notice. In terms of Western Australia, and I appreciate that you are a bit stuck because the negotiations are still ongoing, what is the worst-case scenario? I say that in terms of not seeing much improvement in the system in Western Australia. Is it the status quo? Is that likely to be the case? So you have still got the current system operating? Is that what we may end up with in WA?

Ms Podesta—In regard to Home and Community Care?

Senator SIEWERT—Yes.

Ms Mackey—In terms of the current HACC program, the Commonwealth has already been working closely with the states and territories on a range of improvement measures. In terms of Western Australia in particular, they have been looking at a wellness focus, which I am sure you are familiar with. So there have been some improvements in the program in that state in particular. No matter what the arrangements look like in the future, the Commonwealth, with it still contributing funds to the HACC program, would be seeking to continue to move forward with those processes that we have already been working on in partnership with the states and territories.

Ms Podesta—If it is the case that a state is outside the common arrangements and we have a specific national partnership agreement, then the Commonwealth will still maintain its very keen interest in improved outcomes and high levels of accountability.

Senator SIEWERT—Sorry, I phrased that badly. It was not a judgment on the services that are delivered, because I know they are good services that are delivered. It was more a case that we are still going to have the aged-care packages through the Commonwealth and we are going to have HACC through the states so we are still going to have what I see as being an artificial boundary and the complications between HACC services and what people can get and the aged-care packages.

Senator BOYCE—The line down the middle of the one-stop shop?

Senator SIEWERT—Yes. That is what I mean about the worst-case scenario. We have still got those two essentially 'separate' but not separate systems. So that is what we are going to end up with potentially.

Ms Podesta—The Commonwealth strongly supports a national aged-care system, and we can see the benefits for consumers. No matter what decisions our governments make, we will continue to work towards much harmonisation around the new arrangements.

Senator SIEWERT—That was a very diplomatic answer.

CHAIR—Senator Fierravanti-Wells, do you have anything under 4.4?

Senator FIERRAVANTI-WELLS—In the interests of time I will put questions in relation to 4.5 and 4.6 on notice. Then I thought we could move to 4.7. I think 4.7 and 4.8 and the agency are really where the rest of the questions are.

CHAIR—As everyone is agreed, we are happy to be in your hands. We are still on 4.4 at this stage and then we will go to 4.7.

Senator SIEWERT—Chair, can I ask about one key area?

CHAIR—Of course you can.

Senator SIEWERT—Are the DVA programs remaining completely separate to this process?

Ms Halton—DVA will continue their arrangement, yes.

Senator SIEWERT—I just wanted to double-check. Thank you, Ms Halton.

CHAIR—We will move on.

Senator FIERRAVANTI-WELLS—I want to ask a few questions on the Transition Care Program. This was much vaunted by your policy minister in June 2007. I refer to *New Directions for Older Australians: improving the transition between hospital and aged care.* There was much ado in that document about moving people out of hospitals and into aged-care facilities and also discussion about transition care. I will deal with transition first—the promise of 2000 transition places by 2011-12. I understand—and correct me if my statistics are wrong—that, by 30 June 2009, 698 had been allocated but only 228 were operational.

Ms Podesta—As of 1 April 2010 the rollout of the transition care places is exactly on track, as agreed with the states and territories. There are 84 operational transition care services and, as of 1 April, there are 2,698 operational transition care places.

Senator FIERRAVANTI-WELLS—As at 3 February, when we were last at estimates, we were still talking 228 operational. Do I understand from that that, as at 1 April, we have now gone from 228 to 698 operational?

Ms Podesta—2,698 operational transition care places.

Senator FIERRAVANTI-WELLS—I know. There were 2,000 before the previous election. I am only talking about the new ones.

Ms Podesta—698 new ones. If you are talking about the additional transition care places—

Senator FIERRAVANTI-WELLS—Yes. Where are they? Can I find out where they are? Do you have a list of those?

Ms Walker—I am just having a look for those at the moment. We may have them by state.

Senator FIERRAVANTI-WELLS—It would be helpful if you could take that on notice and provide a breakdown of them as to where they are.

Ms Walker—Certainly.

Senator FIERRAVANTI-WELLS—In terms of cost of transition care per day, interestingly, in your document reference was made to the figures that were done by Labor before the election:

The average cost per day of an acute public hospital bed is about $967, whereas the average cost for a residential aged care bed is just over $100 a day.

Can I ask this in the context of the decision that was made at the last election to redirect funding of $276.4 million over three years from high-care residential aged-care places to provide care in the long-stay older patients measure.

Ms Podesta—I am just checking so that I do not get this wrong. Would you like me to comment on the COAG decision in regard to the long-stay older patients measure? That is what you would like me to comment on. That is quite different to transition care.

Senator FIERRAVANTI-WELLS—I appreciate that; I will come to that. There are two parts. Let me finish off the first part. Under your transition care, what is your cost of transition? What are you assessing the cost of transition at, per day?

Ms Podesta—Transition care funding is provided in the form of flexible care subsidy under the Aged Care Act. It is provided on a flat rate per occupied place per day. For the four years, until 2012, each state and territory is paid at a different subsidy rate, which factors in a number of existing jointly-funded places and the rollout of new fully-funded places. That reflects the different take-up rates. In terms of funding rates there is no distinction between jointly funded and fully funded. All places are still jointly funded. However, we do have different daily subsidy rates per state and territory in 2009-10. Would you like me to tell you those different rates?

Senator FIERRAVANTI-WELLS—Yes, I want those.

Ms Podesta—For New South Wales, the Commonwealth daily subsidy rate for transition care is $137. 57 per day; in Victoria it is $138.27; in Queensland it is $140.26; in South Australia it is $138.67; in Western Australia it is $141.87; in Tasmania it is $140.09; in the Northern Territory it is $161.57; and in the Australian Capital Territory it is $128.14 per day.

Senator FIERRAVANTI-WELLS—Can you tell me the percentage of patients that are returning home—first of all, the number of patients.

Ms Podesta—Forty-five per cent of care recipients returned home from the transition care, and 60 per cent of care recipients have a higher level of functioning on exit than on entry. That is the current release; in 89 there were slightly different figures. Actually, I beg your pardon, Senator; may I just correct that. That was the target—60 per cent to have a higher level of functioning and 45 per cent to return home. In fact, 60.3 per cent had a higher level of functioning and 49.7 per cent returned home. So we have exceeded the target that was set. I apologise for that.

Senator FIERRAVANTI-WELLS—I have more questions on transition, but I will put those on notice. I do not have any more questions in program 4.7, so unless my colleagues have—

[3.15 pm]

CHAIR—We will go to program 4.8. I know a few people have questions in 4.8, so I suggest we go to Senator Siewert first to have two questions. We are sharing it around because we have 15 minutes before we go to the agency.

Senator SIEWERT—Does this count as one of my questions? Can I ask about young people in nursing homes here?

CHAIR—That is one! No, it does not count.

Ms Podesta—It depends on what the question is. I think we have had this conversation. We do not have responsibility for the young persons in nursing homes measure, but we do have some information.

Senator SIEWERT—Yes, we ran out of time yesterday.

Ms Podesta—What would you like to know? We will see if we can—

Senator SIEWERT—There has been some recent publicity around the issue of the number of people that have been moved out of nursing homes. If it is not appropriate to ask it here, I will put my questions on notice.

Ms Podesta—No, we can give you the data that we have.

Senator SIEWERT—That would be appreciated if you could.

Ms Podesta—I will just ask Professor Cullen to get his running shoes on and pull open his 'impossible' folder.

Senator SIEWERT—It is all a plot! I have a series of questions here. I will put the majority of them on notice, but if you could give us some of the data—

Ms Podesta—I have the briefing. What is the first question?

Senator SIEWERT—How many young people, out of the total in the program, have been moved out of nursing homes?

Ms Podesta—The number of young people under 50 in permanent residential care has decreased from 1,196 to 809. That is a decrease of 32.4 per cent.

Senator SIEWERT—And that is over the period of the program?

Ms Podesta—From 1988-89 to 2008-09.

Senator SIEWERT—Sorry—19—

Ms Podesta—Sorry; it is 1998-99 to 2008-09.

Senator BOYCE—That is people moving from nursing homes to other accommodation—is that right?

Ms Podesta—No, it is a number of—

Dr Cullen—Senator, you are asking about the YPIRAC program, which is managed by FaHCSIA. We are going to have to take it on notice.

Ms Podesta—We cannot answer the questions.

Dr Cullen—We cannot give you the answer. We can give you answers as to how many people there are in, and that number is going down, but we cannot tell you why they are moving out.

Senator SIEWERT—That is fine; I appreciate that.

Ms Podesta—My answer was in terms of the number of people—

Senator BOYCE—Yes, I was wondering if it included people who died and exited for other reasons.

Senator SIEWERT—So the 2008-09 figure is the number under 50 that are currently in residential facilities?

Dr Cullen—Correct.

Ms Podesta—That is correct, but we cannot give you the details about YPIRAC.

Senator SIEWERT—That is fine; I appreciate that. I was trying my luck.

Ms Podesta—I think we have answered your questions now, Senator.

Senator SIEWERT—Yes, thanks. I will put the rest on notice in terms of the program itself and an explanation of the program itself. Is it here that I ask about the current Aged Care Approvals Round?

Ms Podesta—You may.

Senator SIEWERT—There has not yet been an announcement of the current ACAR, has there?

Ms Podesta—No, of course not. The current invitation to apply for places was advertised on 30 January, and we do not anticipate that we will announce the results until October. That is the normal time frame.

Senator SIEWERT—Are you able to tell me the number of applications, or the response, you have had?

Ms Podesta—We are still assessing applications. One of the difficulties is that it is in a tender like process. It is difficult to give you information midway through a process. More than 12,000 places were advertised and, without being able to tell you whether every one of these applications conforms, we have had about 57,000 applications for places.

Senator FURNER—I understand, on information I have been provided, that some aged-care providers have raised difficulties in accessing GP services. Can you explain what the government is doing in supporting access for aged-care residents, please?

Ms Podesta—This is one of the budget measures, Senator.

Senator FURNER—Really!

Ms Podesta—There has been a new budget measure announced about improving access to general practice and primary health care. This will not actually be delivered through the aged-care part of the department, but, of course, we take a great interest in this activity, so we can give you broad information—my colleagues from the primary care division can probably give you very specific information. The measure is to provide a 50 per cent increase in the payment for GPs who provide at least 60 attendances to old people in aged-care homes. That fee will increase from $1,000 to $1,500 a year. The measure also more than doubles the payment to GPs who provide at least at 140 attendances to older people in aged-care homes—from $1,500 to $3,500 a year. These increased financial incentives are expected to support over the four years about 105,000 extra GP services for older people in aged-care facilities. We anticipate that about 1,200 extra GPs will receive the incentive payments. Just over 4,000 GPs currently receive those payments.

CHAIR—So further questions about that issue should come under primary care.

Ms Podesta—Yes—questions about the detail of these programs.

Senator BOYCE—Ms Podesta, estimates would not be complete without a question regarding the Evans Head nursing home—

CHAIR—Oh, Senator!

Senator SIEWERT—I wish we had bingo—how many out there would have just won something?

Senator BOYCE—Would you please tell me how long this has been—

Senator FIERRAVANTI-WELLS—If it was in the minister’s own electorate, she would have sorted it out by now.

Ms Halton—Oh, that is not fair, Senator.

Senator BOYCE—For how many years has this approval been on foot, and what progress, if any, has been made?

Ms Halton—I am obliged to point out that this is a bipartisan issue—

CHAIR—Through how many government—

Senator BOYCE—I have been asking questions about it since I arrived here, Ms Halton, in which case it was the government—

Ms Podesta—The pre-provider was allocated its initial low-care places in 2001 and additional low-care places in 2005.

Senator BOYCE—What has been the progress?

Ms Podesta—On 9 March, the council commenced a selective tender process to remediate the contaminated land at the site. This tender process closed on 8 April, and council is currently assessing the tenders. Council have informed us that they expect to award the tender—

Senator BOYCE—When?

Ms Podesta—this month. The remediation works are expected to commence in July 2010—I am thinking about putting on gumboots and going and seeing this myself, I have to tell you—and reach completion by November 2010.

Senator BOYCE—Is the department aware that the land that was initially proposed for a nursing home, including 13 housing blocks, is now available for sale? This land is not subject to native title claim and it is not contaminated.

Ms Podesta—We understand that they are building in co-location of independent living units adjoining the site of the aged-care facility. There is a business decision to do that.

Senator BOYCE—I will put other questions on notice, Chair.

Senator FIERRAVANTI-WELLS—I want to ask some questions about unallocated bed licences. The figures I have for last year are that 14,105 residential care places were allocated as at 30 June but they were not operational. Can you tell me whether that is the total number of allocated places that are not operational?

Ms Walker—Was your question about the number of aged-care places that had been allocated as at 30 June 2009?

Senator FIERRAVANTI-WELLS—How many licences are there that have been allocated to providers but are still not operational—the total number?

Ms Walker—As at 30 June 2009, there were 20,805 residential places that had been allocated that were in the process of being built.

Senator FIERRAVANTI-WELLS—And that includes some off-line ones? What are those off-line ones?

Ms Walker—Off-line places are still regarded as operational.

Senator FIERRAVANTI-WELLS—So they are in your 20,000?

Ms Walker—No.

Senator FIERRAVANTI-WELLS—They are in addition to that. Okay.

Ms Podesta—I think it is important to note that that is a consistent figure with the last five stocktakes.

Senator FIERRAVANTI-WELLS—Ms Podesta, I am not questioning it. I just asked the number; that is all. I did not need a justification for it; I just wanted the number. How many bed approvals are more than five years outstanding and hence not operational? How many are more than five years outstanding?

Ms Walker—As at 30 June 2009, we had 880 that were more than five years old, and I believe we have provided that response in a question on notice.

Senator BOYCE—Do you update those figures at all?

Ms Walker—We do it in the stocktake, which will be completed after 30 June 2010.

Ms Podesta—It used to be the case that it was done in a random process. It was impossible to see a trend. It is now done each year at the same time. That is why we can make some analysis of the trend of how we are going with our places.

Senator FIERRAVANTI-WELLS—Ms Podesta, I am conscious of the time. I need the number of bed licences that have been handed back since 2007 and I would also like a breakdown by planning regions of where those bed licences have been handed back and how many of those bed licences have been reallocated, firstly, for residential and, secondly, for community care places. Can you take that on notice?

Ms Podesta—We will take it on notice.

Senator FIERRAVANTI-WELLS—Thank you. Could you tell me about the cost-of-care study that was undertaken by Grant Thornton. The Grant Thornton company, I understand, presented the minister and the finance minister with the report on 14 October. Where is that cost-of-care study and is it going to be released?

Dr Cullen—It is not a government study, as I understand.

Senator FIERRAVANTI-WELLS—It is not a government study? So it is a Grant Thornton study. I will put that one on notice and ask you more specific details. Could you tell me about the zero-interest loans. There was $300 million in the first round. Now you have extended it. You have changed the criteria, with another $300 million. How many were allocated in the first round and how many signed agreements are there? In other words, what is the value of those allocated and how many signed agreements are there as part of the first tranche?

Ms Podesta—As at 28 April, we have executed 27 of the 40 loans offered through the first round. That totals more than $78 million to create 752 residential places and 77 community care places.

Senator FIERRAVANTI-WELLS—Could you take on notice where they are, please—what planning region they are in.

Ms Podesta—Certainly. Offers are made and loans are executed when approved providers meet milestones. It is important to note, I think, that it is not that we just have not done it; it is that an offer has not been made. As an approved provider meets the milestones agreed in the negotiations, then we execute the loan and make the funds available.

Senator FIERRAVANTI-WELLS—Okay. You have changed the criteria and extended it out to 22 years in the expectation of how much greater uptake?

Ms Podesta—The government has made a decision to have a new form of zero-real-interest loans. It was a budget measure. We anticipate that we will deliver 2,500 more aged-care places as a result of the expansion of the zero-real-interest loans program.

Senator FIERRAVANTI-WELLS—When is the 2009-10 ACA round to be announced?

Ms Podesta—We anticipate that, in line with every other year, it would be around October, closing in March.

CHAIR—It is now 3.30. Do you want to put them on notice?

Senator FIERRAVANTI-WELLS—Yes, I will put the rest of those on notice.

CHAIR—We thank the officers from the department in outcome 4.

[3.30 pm]

Aged Care and Standards and Accreditation Agency

CHAIR—I welcome officers of the agency. You see: this time we did get to you. I know Senator Fierravanti-Wells has some questions. Other people may as well, but we will go straight into it. Would you like to start, Senator?

Senator FIERRAVANTI-WELLS—Thank you. You were present when I asked questions in relation to the two nursing homes that were the subject of these reports. When was the Bupa one last accredited?

Mr Brandon—The Bupa home was last accredited in September 2009.

Senator FIERRAVANTI-WELLS—And what about Domain?

Mr Brandon—Domain was last accredited, a site audit was conducted, in September 2009.

Senator FIERRAVANTI-WELLS—So both in September 2009?

Mr Brandon—Correct.

Senator FIERRAVANTI-WELLS—Since then, have you undertaken visits to them?

Mr Brandon—We have.

Senator FIERRAVANTI-WELLS—How many in relation to each?

Mr Brandon—We undertook a visit to the Domain home in March of this year and we undertook visits to the Bupa home in April of this year.

Senator FIERRAVANTI-WELLS—With regard to the allegations that were contained in the *Daily Telegraph* article, did any of the matters in relation to either or both of those homes come to your attention? Did you become aware of or see any of that?

Mr Brandon—No. The concerns raised in the media report had not been reported to us, nor did we have any evidence of them at the time. I should say to you that in looking at the media report on Sunday I think I shared everyone else's concern about those reports. Quite early on Sunday I created review audit teams to ensure that we were out there quite early to understand and to see what was actually happening in those homes. You would also appreciate that, as a statutory decision maker in relation to accreditation, I am required to deal with the

facts, so it is very important to us that the teams we sent out there actually ascertained what was really going on in those homes.

Senator FIERRAVANTI-WELLS—I understand that. In terms of unannounced visits since, there was an announcement made that this government would undertake 7,000 unannounced visits. Are you meeting that target? You obviously go in for accreditation purposes but what about unannounced visits? What is your rate in relation to those?

Mr Brandon—My understanding is that the government announcement reflected previous announcements that each home would receive at least one unannounced visit per year. We have previously achieved at least one unannounced visit per year to each home and we will do so again this year.

Senator FIERRAVANTI-WELLS—That is 2,795 nursing homes, roughly, so that is 2½ visits over the year I suppose. Some get more; some get less.

Mr Brandon—That is true. As you would be aware, accreditation has a cycle. The workload is not flat. Over the three-year cycle, in some years 1,500 homes will get a full site audit. The cycle directs our workloads.

Senator FIERRAVANTI-WELLS—You may have heard earlier some questions in relation to accreditation standards for food. Can you tell us a little bit more about that. I would like to ask you some questions about some of the circumstances that have been put to me and ask you to comment on them. I read some time ago about the involvement of the New South Wales food standards. Can you shed any light on that or is there some involvement by state bodies in terms of food standards in nursing homes?

Mr Brandon—Yes, there is. I can tell you that the residential aged-care accreditation standards that we use relate to nutrition and hydration, but the issue of food also covers a number of other areas, such as regulatory compliance, which I think goes to your topic. In the last financial year we identified 40 homes with noncompliance in nutrition and hydration and in the year to date we have identified 19. Those are the numbers. That is about nutrition and hydration. In fact, as I said, the food area covers other parts. My colleague Ms Crawford is the expert on—

Ms Crawford—Food!

Mr Brandon—She is more expert than I am on the particular assessment arrangements.

Ms Crawford—In terms of your question about state involvement in food regulation, there is a food safety regulation act in New South Wales. Indeed, there are Australia-New Zealand standards that all states comply with, but are administered by each state. The residential aged-care homes come under those acts. In terms of food safety, hazards in the preparation of food, premises and equipment, those standards do not really go to nutrition and hydration, although there are aspects of the standards that deal with the food that should be prepared and provided to vulnerable persons.

Senator FIERRAVANTI-WELLS—Let me just put a circumstance to you. I visited one nursing home where they told me that they used to take the residents on a trip once a week and they would stop at McDonald's and get an ice cream. They now tell me that they cannot stop at McDonald's. That is, they can stop at McDonald's but only those people who are able

to go in and get their own ice cream at McDonald's can partake in this. Those who are not capable of actually going into McDonald's to purchase their ice cream cannot partake of McDonald's icecream. Can you shed some light on that?

Ms Crawford—Only to the extent that that viewpoint or application is not part of the accreditation standards. It would seem to me that it is an interpretation somebody has based on the section of that act on food for vulnerable persons. It is not something that we—

Senator FIERRAVANTI-WELLS—Gosh, I am really vulnerable; I eat so many of them! So, in other words—

Ms Halton—We would quite like the details of that. If you would like to give us those details separately, I would be grateful.

Senator FIERRAVANTI-WELLS—I will give you the details, but I want to understand the framework of the food standards because this is a registered nursing home with some patients suffering from dementia. I want to understand who regulates what they can and cannot eat. That is the question I want to understand, Ms Crawford.

Mr Brandon—Maybe I could contribute to this. No-one actually regulates what they can and cannot do eat. In terms of standards there are a whole lot of assessments which would include infection control. In fact, your scenario would include choices and decision making and a whole range of standards. I think Ms Halton has got it absolutely right. If we have all of the circumstances we would then be in a position to ask, 'Does this meet the standards generally?' I am speculating but I think the picture you paint could—and I stress 'could'—cover a raft of standards. In fact, in some ways you might say it has little to do with food per se but is more about a range of other things such as privacy and dignity, choices and decision making. It goes, fundamentally, to the value base and how the nursing home works with, treats or deals with its residents.

Senator FIERRAVANTI-WELLS—I hear that, but look at this article. Who is responsible? There is obviously an issue about nutrition. Ms Halton made the comment that some people who cannot eat properly have to have their food mashed. I would like to understand who regulates foods, and who is responsible for this in nursing homes that receive subsidies from the Commonwealth government.

Ms Halton—We should be really clear about this. As we know, Food Standards Australia is in the portfolio and I chair the Commonwealth-state regulatory committee in relation to food. For issues in respect of the safety of food hygiene and things of that sort there is a national code. But the delivery of the specific regulatory side of safety, which can go to storage, preparation, et cetera, is a matter to be administered locally, that is, not by the Commonwealth and not by this agency. Nutrition and hydration concern adequate food appropriately provided. Some people need things which are easy to swallow. These are things we have already discussed in these estimates. As Mr Brandon said, there are issues in respect of choice. This particular case sounds as if someone has got the wrong end of the stick. But we need the details so we can have a look at it.

Senator FIERRAVANTI-WELLS—For example, somebody wants to bring food to a resident in a nursing home. What are the rules in relation to that?

Mrs Crawford—There are no rules as such within the accreditation standards. As Mr Brandon said, things like choice and even cultural issues come into it. If the food is brought in and it is handled appropriately, then there would be no issues. Homes would have systems in place for that to occur.

Senator FIERRAVANTI-WELLS—Here is a question. I go and visit a person in a nursing home. I bring them a birthday cake or something that I have made myself. This is a situation that happened to me recently. This resident said, ‘Oh no, we are not allowed to take food from outside.’ I thought perhaps it was the way I made the tiramisu—my mother made it. It was a distinct impression for this resident, whose faculties were 100 per cent, that she could not take this food because the nursing home did not allow them to have food brought in from outside. My question is: in those circumstances do I have to go to the front desk when I arrive at that nursing home and say, ‘I’ve got a birthday cake for Mrs Bloggs, can I bring it into the nursing home?’ That is what I would like to understand.

Mrs Crawford—There is not requirement for that to occur. An individual home may make such a rule. If our assessors were then assessing that home and were aware of that rule, they would certainly ask questions about the choice the residents have. But there are safety issues around food that may be prepared externally, particularly if it is cooked food. Perhaps questions could be raised about the temperature it has been kept at, in order to ensure the residents are safe.

Senator FIERRAVANTI-WELLS—Who determines whether that food can be brought into that nursing home?

Mrs Crawford—It is not a matter of who determines it. It is going to be individual cases each time. There is no rule that says that food cannot be brought into a home.

Senator FIERRAVANTI-WELLS—It is just that I have had other instances. For example, other places have said, ‘We can’t give them strawberries or lettuces any more because of food standards.’ This is the sort of thing that is being told to me. I see these sorts of reports in the paper and you say to me, ‘Look, you can serve anything.’ I go out into the field and I get told that you cannot give residents in nursing homes certain things. There is a discrepancy.

Mr Brandon—We did not say that you can serve anything. In fact, that would be quite irresponsible of us. What we said is that there are a whole range of standards. There is a general perspective about the home-like environment. But, in deciding how these things happen, there are standards about taking into account and respecting cultural differences. We did not say you can give them anything.

Senator FIERRAVANTI-WELLS—I will not press the point. Can you provide for me anything related to food standards applicable to residential nursing homes that the Commonwealth provides funding to? Do you understand my question?

Mr Brandon—I understand your question, but I think it is outside my remit.

Senator FIERRAVANTI-WELLS—Who do I go to? Who is going to give me this information? You say that they do not serve just anything, but somebody should be able to answer this question.

Mr Brandon—I can tell you what we look at when we assess the accreditation standards which have any link to nutrition and hydration, any link to food. I can ask other people about the relevant statutes. I am happy to do that. But I cannot guarantee that it is the world's best information because that is not our area of expertise. We assess performance against the standards which take into account nutrition and hydration, as I said earlier. There are a lot of other links to other standards.

Senator FIERRAVANTI-WELLS—I am no clearer on the issue than I was. What is the highest number of complaints made about a nursing home in the last three years in New South Wales?

Mr Brandon—You would have to ask that question of the Department of Health and Ageing. We do not action complaints.

Senator FIERRAVANTI-WELLS—I was told that I could ask you.

Ms Smith—The department administers the complaints investigation scheme. I would have to take on notice the question about the highest number of complaints received about a New South Wales home.

Senator FIERRAVANTI-WELLS—Could you do that and give me the details of that? What about the total number of complaints made against nursing homes in New South Wales in the past three years? Could you take that on notice as well?

Ms Smith—Absolutely.

Senator FIERRAVANTI-WELLS—Could you tell me how many have been investigated and the outcome of those investigations. Could you also tell me about the spot checks, the unannounced visits, in the last three years and the procedures that you normally follow in relation to those spot checks. Clearly, the nursing homes are not warned when you make an unannounced visit. I presume you just turn up at nine o'clock in the morning or one o'clock in the afternoon and say, 'I'm here'?

Ms Smith—Unannounced visits are done by both the department and the agency. The department does unannounced visits in respect of complaints. The agency does—

Senator FIERRAVANTI-WELLS—Then can I ask the question for both—for the agency and for the department.

Mr Brandon—I can confirm that they are truly unannounced.

Senator FIERRAVANTI-WELLS—Where are we at with the accreditation review?

Ms Smith—The department is taking the lead on the accreditation reviews, but we are working very closely with our colleagues in the agency. There are two reviews. One is a review of the accreditation standards and one is a review of the processes that underpin the standards. I gave you a bit of a brief on both at the last hearing. In respect of the accreditation standards, we have engaged PricewaterhouseCoopers to assist the department in undertaking the review. We are also working with the technical reference group. As I said, the agency and the department are closely cooperating on that piece of work. We expect to have a draft set of standards available in the next month or so that will then be the basis of consultation with the sector and piloting later in the year.

Senator FIERRAVANTI-WELLS—There were some reports, which you would be aware of, in relation to malnutrition levels in nursing homes. The last one came out from a Melbourne university.

Ms Smith—There have been a couple of university studies that have been published in the media.

Senator FIERRAVANTI-WELLS—You have taken those on board? You are obviously aware of them. What action have you taken? Have you followed up? Have you taken any action in relation to those reports?

Ms Smith—When we see a report like that, staff in the department—principally our senior nurse adviser—review the study in question. We take that information into account as part of the work we are doing in other areas.

Senator FIERRAVANTI-WELLS—From recollection, that Melbourne report—I think it was Melbourne university or one of the Melbourne universities that did it—was quite explicit in terms of levels of malnutrition in nursing homes. They were very serious circumstances. Obviously, Mrs Crawford is concerned about nutrition; it is clearly an issue for you. Do you measure nutrition levels as part of the accreditation process, Mr Brandon?

Mr Brandon—No, we do not measure nutrition levels. We look at the standards which we expect will stop malnutrition actually happening. In relation to your question about the research project out of Melbourne, we too have reviewed that report and others and what we do is look at the issues that they have raised and then introduced it into our assessment methodology, because that is where a lot of the learning comes from.

Senator FIERRAVANTI-WELLS—When you say you introduce it into your assessment methodology, do you mean you decree that ‘these are the foods that are required to reach a certain nutritional level’?

Mr Brandon—No. When I say we put it into our assessment methodology, I mean that we look at what they are saying are problems, and that gives us hints to look for where those problems are, if they exist in the broad. One of the things that came out of, I think, the Melbourne one that you raised with me last time, was that it was a very small number of homes, and the challenge for us is to ascertain whether the results of that small survey roll out across the sector, given that the sector is very diverse with 2,800 homes.

Senator FIERRAVANTI-WELLS—Mr Brandon, when you walk into a nursing home, like you walked into Domain and Bupa in March and April, how do you ascertain that the residents are receiving the requisite nutrition, apart from looking at them? What do you actually do, Mrs Crawford?

Mrs Crawford—We do a variety of things.

Senator FIERRAVANTI-WELLS—Because that is obviously what is being complained about in the papers here. What are you actually doing to make sure that stories like this do not appear in the newspaper?

Mrs Crawford—In terms of assessing the accreditation standards, nutrition and hydration is about residents receiving adequate nutrition and hydration. That is the expected outcome. We look at whether or not homes are undertaking assessments of residents when they come

into the home to ascertain whether at that point they are suffering from malnutrition, because some residents come into a home already suffering.

Senator FIERRAVANTI-WELLS—Yes, I appreciate that.

Mrs Crawford—Then, in terms of ensuring that those residents who are either already suffering malnutrition or at risk of malnutrition are looked after, we look at what food program they may have in place. But that is also coupled with: what does this resident really want; what are the preferences for that resident? We talk to residents, because we want to see whether or not they are satisfied with the meals they receive and with their input into the types of menus that are available. We look at the variety of food that is on the menu. We observe food actually being served to residents and how residents are assisted if they cannot feed themselves. We look at weight loss—and weight gain—so that we can then track what is happening to a resident who is suffering weight loss: has the home realised this, have they referred that to the resident's GP, has the GP had any input into what should be done with that resident? Are the residents on supplements? How frequently are drinks made available to residents? How easy is it for residents to get additional food and drink when they require it, or do they have to just wait for someone to come along and give it to them? If they say they are unable to access water et cetera themselves because they are too frail, then we look at how frequently the staff are offering them additional drinks. It is a range of activities; it is not just a one-off.

Senator FIERRAVANTI-WELLS—I appreciate that, Mrs Crawford, and may I hope that next time we do not have another story like this one to begin our estimates. That is enough. I do not have any more questions.

CHAIR—Any other questions under accreditation? Senator Adams.

Senator ADAMS—I would like to ask a question about increasing business efficiency in the new provider benchmarking system. Is that going to be linked to accreditation standards?

CHAIR—Thank you to the officers of the agency. Dr Cullen, could you please answer Senator Adams's question.

Senator ADAMS—It is not linked at all?

Dr Cullen—No, it is not linked to accreditation. It is not about quality of care; it is about business practices.

Senator ADAMS—I would have thought that, with a benchmark, surely your accreditation standards people will have to look at that as well.

Ms Podesta—This is a tool that will be available for the aged-care provider to use to benchmark themselves against other like businesses, to be able to identify their costs, to compare themselves with other like businesses and to identify opportunities for efficiencies and improvements. It is not linked to their accreditation standards; it is linked to their capacity to manage effectively and efficiently within their envelope of money. They may choose to use the information that they gather from that exercise to contribute to the documentation they provide as part of accreditation, but that is not the intention. This is absolutely a service being made available to the industry as part of ongoing efforts to improve efficiency.

The other part of the measure is about not just the benchmarking tool but business advisory services that providers will be able to work with to improve the efficiency of their businesses. It is not meant to be in any way a punitive measure; it is meant to give them an opportunity to improve and increase their own efficiency. We think it is in everyone’s interests that aged-care providers operate efficiently.

Senator ADAMS—I am not disputing that one bit. I think it is very important too, but that particular issue is a benchmark. Surely accreditation people can use that to see where things are going.

Dr Cullen—Fundamentally, accreditation is about the quality of the care delivered. This benchmarking survey is not about the quality of the care but about the cost of delivery of the care.

Senator ADAMS—Surely there has to be a tie-up with it. You are running two things side by side. There must be some alignment that crosses over. We are only going back a few years to when accreditation first started in an aged-care facility, and I was involved with that. That was part of the business side of the accreditation. They looked at it to see how they were performing, what they were doing and what could be done better. Is this not an opportunity to improve that?

Ms Podesta—I think many approved providers will take the opportunity to use that data to improve their own activity and operation and to make themselves more efficient, but the department does not intend to use the benchmarking tool as a formal part of the accreditation process.

Senator ADAMS—That is the answer. Thank you.

CHAIR—I thank the officers from outcome 4, Aged Care. We will now take a 10-minute break. We will come back on outcome 5, Primary care.

Proceedings suspended from 3.59 pm to 4.10 pm

CHAIR—We will reconvene in outcome 5, primary care. Senator Fierravanti-Wells, have you given me any idea about the time for the agency yet?

Senator FIERRAVANTI-WELLS—I think it will just be 15 minutes at the end.

CHAIR—On that basis, we have got two hours. I suggest that we do the first hour and three-quarters on primary care, working as closely as we can through the dot points. But we are very flexible. We can spend the last 15 minutes on the general practice education and training agencies. Senator Fierravanti-Wells, do you have questions on 5.1, primary care education and training?

Senator FIERRAVANTI-WELLS—Ms Halton, what is the Grant Saves exercise?

Ms Halton—Can you give me more information? What are you reading from? That might help me.

Senator FIERRAVANTI-WELLS—I am reading from a document and I am asking you about an exercise referred to therein as ‘Grant Saves’. Does that ring a bell?

Ms Halton—Not in those terms.

Senator FIERRAVANTI-WELLS—I might ask it in other terms. At page 32 of the yellow book, you will see in the middle of the page that it says ‘Department of Health and Ageing Grant Programs – Reprioritisation’. You have got a series of programs in various areas. There are three here, 5.1, 5.2 and 5.3, which are clearly savings measures or moneys that are being shifted or moved around. Specifically in relation to 5.1, 5.2 and 5.3, what are those figures and what does that ‘reprioritisation’ mean?

Ms Halton—We can go through those in the individual programs—I am happy to do that—but you would be familiar with the notion that in each budget sometimes moneys are underexpended or whatever, so—

Senator FIERRAVANTI-WELLS—I appreciate that. I am interested in the actual program. Let us start from the beginning. At 1.1 there is obviously going to be $80,000, $162,000, $249,000 and $252,000 taken out. It goes down the line. I would like to know those programs that are going to have moneys moved and where those moneys are moving to. I will start with that question in relation to 5.1, 5.2 and 5.3. In 5.1 moneys are being reprioritised. Can you tell me what that is in 5.1? It is primary care education and training.

Ms Halton—I have been advised that we are going to have to go through the folders if we are going to go through this line by line and actually sort a couple of things out, so can we come back to this?

Senator FIERRAVANTI-WELLS—I am happy for you to take the table and then give me the answer on notice if you would. I would like to know where the money has been taken out of and where it has been redirected to or whether it has been taken out because it has been discontinued. It is very difficult to understand what it is from that perspective. I have one other question. I am going to start questions on GP superclinics but before I do that—that being an area where the government has obviously made a series of commitments—and of course there were election commitments that we talked about earlier in the day, Ms Halton, does the department provide the minister with regular updates on the progress of key initiatives including election commitments?

Ms Halton—The department provides updates on things that we are doing, programs that are being implemented et cetera. I would not describe them as being ‘election commitments’ but certainly with the programs we are implementing we would advise as to progress.

Senator FIERRAVANTI-WELLS—You are saying that you do not provide regular updates in relation to key initiatives including election commitments.

Ms Halton—No, there are updates in relation to progress writ large.

Senator FIERRAVANTI-WELLS—Which do include election commitments.

Ms Halton—Which include anything that we are working on which by definition can well include election commitments.

Senator FIERRAVANTI-WELLS—Obviously. Are these provided on the minister’s request or is it a report provided on a regular basis.

Ms Halton—It is regular.

Senator FIERRAVANTI-WELLS—Is that weekly, fortnightly?

Ms Halton—We will have to check that. It is fortnightly.

Senator FIERRAVANTI-WELLS—In the most recent report does it stipulate the election commitments that are partly or wholly incomplete and the reasons for that?

Ms Halton—No, and I do not have it with me. It would stipulate progress against timetables in relation to everything that we are working on.

Senator FIERRAVANTI-WELLS—That would, of course, by implication include whether you have partly or wholly completed what you promised that you would do. I would assume it would contain time lines, Ms Halton.

Ms Halton—It is a project planning arrangement.

Senator FIERRAVANTI-WELLS—I might move to one of those spectacular commitments that you made on GP clinics, Minister, and spend some time on those if I may. We now have 2½ which are fully running.

Ms Thompson—We have three fully up and running.

A document was then shown—

Senator FIERRAVANTI-WELLS—If you could assist me, Ms Thompson, I have gone to your website and on your website you have this coloured map. I have enlarged it so that we can see it, but I think it is pretty self-explanatory—

CHAIR—Is that from the website?

Senator FIERRAVANTI-WELLS—It is—and I have enlarged it. Ms Thompson, do you recognise the map?

Ms Thompson—Yes.

Senator FIERRAVANTI-WELLS—This comes from your website. In fact, I had this printed off yesterday evening. This says: ‘GP Super Clinic Locations (as that November 2009)’. So anybody looking at this on your website would think, ‘Isn’t that wonderful. We’ve got all these GPs superclinic locations.’ That is the inference from that document, is it not?

Ms Thompson—I am sorry, I cannot comment on that. I would not make that inference.

Senator FIERRAVANTI-WELLS—If I look at this map, it is not unreasonable to assume—

Senator Ludwig—Chair, it would depend on what else is on the website and what the underlying annotations are in relation to the website. I am just discerning whether there is actually a question in relation to that other than a statement which the witness is required to provide an opinion on. The witness is not in a position to provide an opinion on it. If there is a question that can be more usefully put then I am comfortable with that.

CHAIR—Senator Fierravanti-Wells, you are moving to a question?

Senator FIERRAVANTI-WELLS—I am, because other material on the website, Minister, says:

Welcome to the Australian Government’s GP Super Clinics Program.

And of course it tells us that you have

... committed $275.2 million over five years ... to establish GP Super Clinics in 36 localities across Australia.

It talks about the additional ones et cetera.

On this site you will find a wide range of up-to-date information about the Australian Government's GP Super Clinics Program, including information specific to each—

Then it goes on about each of them. My point is: when you read that and you go into the website, the inference here is that these superclinics are up there running already, because it actually says 'Super Clinic Locations'. It does not say 'Proposed GP Super Clinic Locations'; it actually says 'GP Super Clinic Locations'. It is certainly not being accurate because we only have 2½ actually up and running and that can actually said to be operational. Why are you leaving on the website something that is clearly trying to infer that these superclinics are all up and running when clearly they are not?

Ms Thompson—In fact there are three up and running, there are eight delivering early services and there are 17 that have commenced construction. I would also comment that you cannot necessarily read things on the website out of context. You need to read everything that is on the website, which gives a full outline of the program, including all the criteria for establishment. I can go through all of the locations and give you an update, if you would like.

Senator FIERRAVANTI-WELLS—I have looked at the questions that you have provided and I have also taken the liberty of having a look at the website. What I would like to do is take some of these, if I may, and just go into some of the detail that is available, because what seems to be mostly available on the website is really just the consultations that you have undertaken.

For example, if I look at 'GP Super Clinics' then 'Victoria', there are minutes there: 'Summary of local information and consultation meeting'; I do not actually have information on when the proposed ones in Victoria—which are supposed to be in Ballan in Ballarat, Bendigo, Berwick, Geelong, Portland, South Morang, Wallan and Wodonga—will be up and running. Let us look at them.

Senator Ludwig—Looking at the website—

Senator FIERRAVANTI-WELLS—So you have gone there, too, Senator Ludwig!

Senator Ludwig—Certainly, because I can, but what it says is:

On this site you will find a wide range of up-to-date information about the Australian Government's GP Super Clinics Program, including information specific to each of the 36 GP Super Clinics localities.

I have just taken a part of that. You can then go to 'GP Super Clinic Locations' and it then says:

GP Super Clinics have been announced in 36 localities—

so there is nothing misleading about that—

across Australia, as shown in the map below—

and obviously on the map they are highlighted. You can then go to particular localities and, if you go to localities, you can then see where they have got further and better information about

the types of clinics in, for instance, Queensland. It then gives you detailed information about where you can update the information.

In ‘New South Wales’, if we can use that as an example, it says:

The Commonwealth has committed to establishing nine GP Super Clinics in New South Wales at the following locations—

and then it goes through the locations. So it does not say that they are established or up and running; it says ‘The Commonwealth has committed to establishing’. If you go through it, it then says:

Funding agreements have been executed with—

and goes through the various places; I will use that general statement. It then gives you phone numbers and contact details. Down the bottom it says:

The details of the Commonwealth’s funding, including the engagement approach, is outlined in the table below.

So you then see, ‘Blue Mountains’, ‘Up to $5.0 million’, ‘Commonwealth led Invitation to Apply process’, and ‘Date of Local Information & Consultation Session,’ so that if you are interested in that particular one you can go to the summary of outcomes. I am providing additional comment to the chair in relation to the question to assist people, but I do not support the argument in the question put by Senator Fierravanti-Wells that the site is misleading in any way.

CHAIR—Thank you, Minister; that was an extensive response. But I am just wondering if Senator Fierravanti-Wells—

Senator FIERRAVANTI-WELLS—This is going to be another case where Senator Ludwig’s interpretation is different from mine. It is just that when you read ‘GP Super Clinic Locations’, this document suggests, or one would assume, that those locations are actually up and running. I will not go through each of them, but I will go to some of them.

Ballan was the first one to be opened, and during the consultations with the community the health priorities raised included:

- GP services (including access to a female GP);
- After hours services;
- Maternity services;
- Mental health services;
- Dental services;
- Pharmacy services;
- Practice nurse services; and
- Youth support services.

Which of these services are being supplied at that clinic?

Ms Thompson—The Ballan GP superclinic was opened in September 2009. It offers chronic disease management services focusing on heart disease, diabetes and asthma. For the first time, there is a female GP in the town; there are practice nurses; there are dentists, for the

first time, both private and public; and visiting specialists—for example, an occupational physician. There is also a range of allied health services: audiology, physiotherapy, podiatry, dietetics and nutrition, psychology, mental health services, occupational therapy and pathology. There have been over 29,000 presentations, including over 10,000 allied health presentations, to date.

Senator FIERRAVANTI-WELLS—Are there pharmacy services there?

Ms Thompson—There is an existing pharmacy very close by.

Senator BOYCE—What about dental services?

Ms Halton—There are also dental services—and it is not just dental services. I have actually visited this particular clinic, so I am quite familiar with it. When I visited, which was a couple of months ago, not only had they managed to attract a dentist—I think it was for four days a week; I could be corrected on that—but they had also managed to attract an orthodontist to come and practice in the town. I think it was for about one day a week.

Senator FIERRAVANTI-WELLS—Ms Halton, I am impressed that you got to go rather than the Prime Minister. This must have been one that just slipped his mind and he could not quite be there. He must not have been available on that day.

Ms Halton—I cannot comment on that, Senator, but I can tell you that I thought it was a particularly good centre. I was very pleased to have the opportunity to talk to staff when I went.

Senator FIERRAVANTI-WELLS—That is very good to hear because, given the number that you promised and given that this is the first one to open of the 36 that you have promised, it has taken a very long time. Anyway, it is good to see that at least the first ones are up and running. Are these services available full time or only at particular times?

Ms Thompson—That general practitioners are full time. I would have to check on the rest.

Senator FIERRAVANTI-WELLS—Right.

Ms Halton—Again, I can provide information here. As I said, there are a range of services and, certainly on the day that I went, the physiotherapist was there, the psychologist was there, the social work was in play, the GPs were practising and there were practice nurses. I met all of these people, and they were actually quite surprised that the dentist was working there four days a week. I do not think they expected that level of service. I think they were also genuinely pleased that the orthodontist chose to visit one day a week. So I think the expectation was not that every single one of these services would be full time; there is not enough business, if I can put it that way. But what it does—and what the advantage of these facilities is—is it provides a venue not only for people to practise there permanently if that is appropriate for them but also for them to accommodate visiting practitioners and indeed train students in a variety of health and related professions.

Senator FIERRAVANTI-WELLS—This one I am holding up refers to itself as the Ballan community centre. Are the GP superclinics supposed to be named superclinics, or they can just choose whatever name they want to go by?

Ms Thompson—We certainly like them to use the GP superclinic as part of their name.

Senator FIERRAVANTI-WELLS—But there is no obligation to do so?

Ms Taylor—The names of the clinics do vary, but essentially we ask them to identify that they are part of the GP superclinic network. So they do have various names.

Senator FIERRAVANTI-WELLS—Okay, but as part of their funding they are not required to be called 'superclinic'?

Ms Taylor—They are required to identify that the Commonwealth has contributed to that clinic and identify themselves as part of the network.

Senator FIERRAVANTI-WELLS—Like a plaque on the wall or a sign on the front?

Ms Taylor—Yes.

Senator FIERRAVANTI-WELLS—What happens after hours? Do people go to the hospital?

Ms Taylor—I am just checking the after-hours arrangements at that superclinic. They operate from 8.30 am to 6.30 pm, Monday to Friday, and 9 am until 1 pm on Saturday. They have an after-hours roster with an on-call doctor who provides overnight coverage. That is part of an established roster arrangement with the hospital.

Senator FIERRAVANTI-WELLS—So they do not go to the hospital? Out of hours they are referred to another doctor. Is that how it works? One of the stated aims of these GP clinics is to take pressure off the local hospital. That is why I am asking what the arrangements are.

Ms Taylor—They participate in an after-hours roster to cover the after-hours period.

Senator FIERRAVANTI-WELLS—I will put some other questions in relation to each of the other clinics, but I have some questions about Portland. Senator Ryan, do you have some questions about Portland?

CHAIR—Senator Furner has a question about one of the clinics, if that can come in now.

Senator FIERRAVANTI-WELLS—I am going to do it state by state, Chair. I just thought that might be an ordered way of doing it.

CHAIR—Sure. You are in Victoria now?

Senator FIERRAVANTI-WELLS—I am doing Victoria now.

CHAIR—That is fine. We will get to Queensland—

Senator FIERRAVANTI-WELLS—That might make it easier, rather than going all over the place.

CHAIR—No worries. Senator Ryan on Victoria?

Senator RYAN—I have some questions around the contract with the Portland superclinic. To whom does Anne Thorpe, who I understand is listed as director of GP superclinics, report?

Ms Thompson—She reports to Meredeth Taylor.

Senator RYAN—Are you aware that on 19 May—the time, I have been informed, was 9.36 am—an email went from a person in that area to the CEO of the community health group that was signing the agreement with Portland, which indicated that the department would like the attached agreement signed by lunchtime?

Ms Thompson—I am aware of an email. I do not believe it said that.

CHAIR—Do you have a copy of the email?

Senator RYAN—I do. It has my notes on it. I am not sure if I particularly wish to table it, for that reason.

Ms Thompson—Sorry, Senator Ryan. Meredeth has just corrected me and she says it did say that.

Senator RYAN—It did. That makes it easier.

CHAIR—Do the officers have a copy of the email? If Senator Ryan is going to be referring to it, it might be useful—

Senator RYAN—That is the only fact I needed to establish. The email said that the department would like a contract signed by lunchtime today, that day being Wednesday 19 May. I am assuming that that was not the first time that the Portland group had seen a copy of the contract.

Ms Thompson—In fact, there had been numerous emails and telephone exchanges over several months in relation to the negotiations around the signing of the agreement which is, as you can understand, absolutely what we would do in all contract negotiations.

Senator RYAN—Was that the first time they had seen the final version of the contract? These contracts, I understand, would have iterations—hence the process you have outlined. Was that the first time they had seen the final contract, which I understand is now signed?

Ms Taylor—That was, indeed, the final, but there had been various iterations up to that point. There was very little in that contract, as I understand it, that was any different to iterations that they had seen for quite some time.

Senator RYAN—But that was the final contract.

Ms Taylor—As I understand it, yes.

Senator RYAN—And there had been changes since the previous version they had seen.

Ms Taylor—We sent them a previous version and my understanding is we had a conversation about one or two minor changes. We sent that contract back with those minor changes included in it.

Senator RYAN—When did that conversation take place?

Ms Taylor—Which conversation?

Senator RYAN—You said you had a conversation in this process. Immediately before this contract was sent you said you had a conversation with Portland group—I assume it was with the CEO but I am not going to put names to it—some minor changes were made and it went back to them for their final signature. When did that conversation take place?

Ms Taylor—I do not have that exact detail with me at the moment.

Senator RYAN—Could you take that on notice, please.

Ms Taylor—I can take that on notice.

Senator RYAN—Can you indicate whether it would have been days or weeks, when that final conversation took place?

Ms Taylor—As I said, there were several exchanges of contracts prior to that period—

Senator RYAN—I understand that. I am trying to chase down the time between the penultimate contract, your conversations and the verbal agreement on minor changes, and when they saw the final contract.

Ms Taylor—I will endeavour to provide you dates and times.

Senator RYAN—How many contracts have been signed for GP superclinics across Australia?

Ms Thompson—There are 36 signed.

Senator RYAN—That correlates with the 36 announced. That was mentioned earlier. Are they the same 36?

Ms Thompson—There is one extra, which is the Wallan superclinic, which has not signed, as yet. It is the same 36, but there is one that is unsigned. The signing of it, we hope, will be very soon.

Senator RYAN—The Portland one is obviously signed as well.

Ms Thompson—Yes.

Senator RYAN—Was the Portland one signed that day, before lunchtime?

Ms Taylor—I do not remember the exact time.

Ms Thompson—We will have to take that on notice. We do not have the exact time with us.

Senator RYAN—Was it signed that day?

Ms Thompson—It was signed on the 19th.

Senator RYAN—For the other contracts that you have signed, were there similar requests with respect to the timeliness of the signatures?

Ms Taylor—We work closely with the funding recipients right through those processes and that would not be an unusual request to us, for funding agreements to be signed within a particular time frame, given that we have been working with the organisations to those particular time frames. There are no surprises with this. We worked consistently and over a period of time with all of the funding recipients.

Senator RYAN—I am not disagreeing that this would be a very iterative process. How much is the Portland superclinic worth roughly?

Ms Taylor—I think it is $4.9 million.

Senator RYAN—Are you aware of whether the group, Portland District Health, had the opportunity to have a board meeting to discuss and agree to sign off on the contract prior to your request?

Ms Taylor—I am not aware of that. We deal with a particular person in the organisation, and their internal workings are a matter for their organisation.

Senator RYAN—I will come to that. This is over $4 million, and if I am generous and assume lunchtime is one o'clock, they have had less than 3½ hours to sign it. Is that typical of the time line allowed? If I sat here and asked you about every other contract, would that seem atypical or typical? Would they be given less than half a day to sign a contract?

Ms Taylor—Out of context, that seems a rather interesting question to ask. As I said, it is an iterative process in every case that we have had. I could not put my hand on my heart and say every funding organisation had had days and weeks and months to look at every single contract, but—

Senator RYAN—With all due respect, I think I have made my point—that is, that 3½ hours is not the same as days, weeks or months; it is less than half a day.

Ms Taylor—And I would make the point that they had seen various iterations that were very similar to that final funding agreement well prior to that time frame.

Ms Huxtable—Senator, there were a number of times that funding agreements went to and fro from us to that organisation over several months.

Senator RYAN—Who instructed this officer, who reports to Ms Anne Thorpe, to ask for this agreement to be signed by lunchtime?

Ms Thompson—I am not aware of the exact exchange of information between officers but, as Ms Taylor has said, this was an iterative process. This was the last stage of it, and that was the process that was in place.

Senator RYAN—I am getting to the point: someone made a decision to say this had to be signed by lunchtime. What I would like to know is who made that decision and who directed this officer, or was it this officer's personal decision—and I doubt that. This is a pretty specific and strict request, so who made the decision to direct the officer to have it signed by lunchtime?

CHAIR—Senator, it is most unusual in these estimates to come down to individual personal responsibility. I am happy for the department officers to respond, but what tends to happen is that the branch in which it takes place takes responsibility. It is not our practice to say, 'Claire Moore sent that email.' It is not what we do in this process.

Senator RYAN—On certain occasions, Chair—

CHAIR—Not in this estimates committee.

Senator RYAN—Can I finish my sentence? I am getting to the point—I am happy if a branch takes responsibility. So it was a branch decision?

Ms Thompson—It is part of the division that I am responsible for and I take responsibility for all of the decisions within my division.

Senator RYAN—What I am trying to chase down here is this: given the time line, an interesting request—were you directed by anyone or was it a branch decision for which you are taking responsibility, to use the words that you have just used?

Ms Thompson—I was not directed by anyone in relation to the Portland funding agreement.

Senator FURNER—Senator Ryan, do you support the Portland superclinic at all?

Senator RYAN—I did not think this was a forum for questioning senators, Senator Furner.

Senator FURNER—No, it was just an observation. You seem critical of—

Senator BOYCE—Point of order, Chair. I thought we were asking questions of the department.

CHAIR—Senator Boyce, I accept your point of order. Senator Ryan is in the midst of his questions.

Senator RYAN—Subsequent to the signing of the contract, was there any discussion with people in your branch? I will come to the minister's office soon and I understand, Senator Stephens, that you probably will have to take that on notice. So were there any discussions between members of the department and Mr O'Neill or Mr Govanstone about the media commentary that subsequently appeared about the signing of the superclinic contract?

CHAIR—For the information of the committee, I take it Mr O'Neill—

Senator RYAN—Sorry, Mr O'Neill is the CEO and Mr Govanstone is the chairman.

CHAIR—Sure. I just thought it was important that that be said.

Senator RYAN—My apologies.

CHAIR—That is fine.

Ms Thompson—I certainly have not spoken to Mr O'Neill. I understand Ms Taylor has and he rang to express his concern that he had been characterised in the media in the way that he had been. He expressed to us, and he subsequently stated in the media, that he had not been put under any pressure in relation to the signing of the agreement.

Senator RYAN—I am aware of his statement to the media. I am also aware of the original email that he sent. This is the point that I am going to. Were the discussions you had with Mr O'Neill initiated by him?

Ms Taylor—The initial discussions, yes. They were initiated by him.

Senator RYAN—And they were regarding the initial media commentary?

Ms Taylor—Yes.

Senator RYAN—And the way it was characterised seconds ago is the way you would characterise the conversation?

Ms Taylor—Yes.

Senator RYAN—Senator Stephens, can I ask you to take on notice whether there were any discussions between the minister's office and the CEO or chairman—so Mr O'Neill or Mr Govanstone—regarding the media that appeared subsequent to the signing of the Portland GP superclinic agreement and what the nature of those conversations was.

Senator Stephens—Certainly.

Senator RYAN—That is all I have on this issue, Chair.

Senator FIERRAVANTI-WELLS—In relation to the material, it is not clear from the website about each of these superclinics. It talks about a lot of information but it does not actually give me when a superclinic will be operational. Can I go through the Victorian ones and ask if you can tell me when it is anticipated that each of them will be fully operational. Is Ballan East fully operational?

Ms Taylor—Yes.

Senator FIERRAVANTI-WELLS—And what about Bendigo?

Ms Taylor—At this stage we believe Bendigo will be completed around mid-2011.

Senator FIERRAVANTI-WELLS—Berwick?

Ms Taylor—Same time frame: mid-2011.

Senator FIERRAVANTI-WELLS—Geelong?

Ms Taylor—With Geelong we anticipate late this year, 2010.

Senator FIERRAVANTI-WELLS—After what Senator Ryan said, when you said you anticipated that it would be operational—

Ms Taylor—We believe—

Senator FIERRAVANTI-WELLS—When I say 'operational' I mean fully operational—

Senator BOYCE—So patients walking in the door and seeing people who actually work there.

Senator FIERRAVANTI-WELLS—That is right.

Ms Taylor—We believe Portland will be completed by late 2011.

Senator BOYCE—Does that mean operational, Ms Taylor?

Ms Taylor—As close to as possible. It might take them a day or a week to wrap up getting the services in there. We see it as one and the same date.

Senator FIERRAVANTI-WELLS—I am assuming that this is operational—as you said, operating with patients.

Senator BOYCE—I did check what the definition of 'fully operational' was at last estimates.

Senator FIERRAVANTI-WELLS—Did you?

Senator BOYCE—Yes, just to be sure that we were talking about the same thing when we say that.

Senator FIERRAVANTI-WELLS—So we are all talking about patients walking in the door. South Morang?

Ms Taylor—Late 2011.

Senator FIERRAVANTI-WELLS—Wallan?

Ms Taylor—At this point we believe Wallan will be operational also by that date. We have not signed the funding agreement yet with Wallan. But we have been working with them on

the funding agreement and we have been working on a timetable for that clinic being operational by late 2011.

Senator FIERRAVANTI-WELLS—Wodonga?

Ms Taylor—Early 2012.

Senator FIERRAVANTI-WELLS—To be clear, 'fully operational' means patients walking in the door, everything done and everybody on staff, give or take one day.

Ms Taylor—That is our expectation.

Senator FIERRAVANTI-WELLS—I will leave Victoria if I may and move over to Queensland. We have got Strathpine.

Ms Taylor—Which is opened.

Senator FIERRAVANTI-WELLS—Yes, and the health priorities raised during consultations there included Aboriginal and Torres Strait Islander health services, outreach services such as mobile dental and care for the aged, and visiting specialists and services from GP clinics including oncology and radiology. Which of these services are currently being supplied at Strathpine?

Ms Thompson—The Strathpine clinic, as you know, opened in January this year. It offers services in general practice. It has allied health professionals and an Indigenous health nurse. The services include diabetes education, dietetics, physiotherapy, exercise physiology, x-ray, audiometry, psychology, podiatry and mental health. It operates seven days a week. It is open from Monday to Friday from 8 am until 7 pm and Saturdays and Sundays from 9 am until 5 pm. It will bulk-bill all MBS services. There have been over 17,000 presentations to date, including 3,950 allied health nurse and specialist presentations.

Senator FIERRAVANTI-WELLS—There is bulk-billing with a current Medicare card?

Ms Thompson—Yes.

Senator FIERRAVANTI-WELLS—Home visits?

Ms Thompson—No.

Senator BOYCE—Are you able to tell us how many services for Indigenous people have been offered?

Ms Taylor—No, I do not have that degree of detail.

Senator BOYCE—How will you know that it is meeting the needs of the Indigenous community in the area?

Ms Taylor—There is Indigenous representation on their community consultation group, which is an ongoing group that services the clinic, and we expect to get ongoing feedback from that Indigenous local community through those processes.

Senator BOYCE—Is this an individual or a representative organisation?

Ms Taylor—It is an individual that represents the local community.

Senator FURNER—Is the name of the organisation the Bunya—

Ms Taylor—That is right. It is representation from the local Indigenous community.

Senator BOYCE—Is there a dental service offered there?

Ms Taylor—I do not believe there is at this point. They are negotiating to bring that dental service on-stream.

Senator BOYCE—That would be mobile or someone actually working in the—

Ms Taylor—I do not believe it would necessarily be mobile; I believe it would be located within the clinic.

Senator FIERRAVANTI-WELLS—Are there visits to nursing homes?

Ms Taylor—I am not aware that they specifically do visits to the aged-care facilities in the local area.

Senator FIERRAVANTI-WELLS—That was one of the priorities identified. You are not aware whether that is happening?

Ms Taylor—No, I am not aware whether that is happening.

Senator FIERRAVANTI-WELLS—Perhaps you could take that on notice. Is Strathpine considered a district of workforce shortage?

Ms Taylor—Not currently.

Senator FIERRAVANTI-WELLS—Have any of the medical authorities required any of the doctors at this clinic to be supervised by another doctor or placed conditions on their registration?

Ms Taylor—I am not aware that that is the case.

Senator FIERRAVANTI-WELLS—Could you take that on notice and, if so, who provides that supervision or what the conditions of their registration are; on what dates and times is that supervision provided; and are any of the doctors working at that clinic subject to a 10-year Medicare moratorium? Further, what exemptions have been granted, if any? Are any of the doctors at this clinic practising there for a special purpose activity?

Ms Taylor—I am not aware of that; again, we will check that.

Senator FIERRAVANTI-WELLS—Are there any overseas trained doctors employed at the clinic who have been registered as medical practitioners in Australia for less than 10 years? Do any of them have any exemptions under the Health Insurance Act? Have other GP practices within the Strathpine area sought Medicare provider numbers for overseas trained doctors who do not meet the 19AB exemptions? Can you also tell me, if there were any such requests, how many, when and what the results have been?

Ms Thompson—We will have to take that on notice.

Senator FIERRAVANTI-WELLS—Can you tell me if there has been any special treatment given to this superclinic—anything outside the ordinary?

Ms Taylor—Not that I am aware of. Not from our perspective, no. I am not sure what you mean by any ‘special treatment’. We will check the exemptions.

Senator FIERRAVANTI-WELLS—That would be helpful.

CHAIR—I am sorry to interrupt, Senator Fierravanti-Wells, but Senator Furner has a question about the Strathpine clinic in Queensland.

Senator FIERRAVANTI-WELLS—By all means. Jump in. I have finished with Strathpine. I was going to move on to Logan. So by all means go ahead, Senator Furner.

Senator FURNER—Thank you. Senator Fierravanti-Wells has covered most of the questions I was going to ask. Nevertheless I still have a couple of questions.

Senator FIERRAVANTI-WELLS—You can agree with me, Senator Furner. Senator Cameron does every so often.

Senator FURNER—I agree wholeheartedly with the success of the superclinics, particularly the one at Strathpine. It has been an amazing achievement. Ms Taylor, firstly, it was opened on 29 January, well ahead of schedule. Was there any particular reason why that was the case?

Senator BOYCE—Which schedule was that, Senator Furrner?

Senator FURNER—Ignore the interjections, Ms Taylor.

Ms Taylor—A large part of the reason was that it was an existing building, so it was a clinic that needed minimal refurbishment to have it up and running, in terms of the physical premises. It was a fairly straightforward transaction. As I understand it there were also fairly straightforward council requirements that were met. I could not say that for all the sites.

Senator FURNER—Is that consistent with some of the proposed superclinics—for example, those sites displayed on the map on your website?

Ms Taylor—There is a great variation. Some of them require land to be purchased right back at the beginning of the process; others will simply be a refurbishment of an existing building. Although I say ‘simply’, sometimes it is on a major scale as well and takes significant time. But there is a variety across the spectrum of the land and building arrangements that will be in place for the clinics.

Ms Thompson—Senator, if I could just add: this is a capital infrastructure program and that is why it is a five-year program. It does have to take into account the process of building or refurbishing, including planning permits, architectural design, building workforce—and, at the end of all that, the actual GP and allied health workforce. So there are many steps in this process to ensure we get the superclinic up to meet the needs as identified in the area.

Senator FURNER—Of course, that varies from location to location, depending on the state of the building that requires refurbishment or expansion.

Ms Thompson—Yes, that is right. In addition to that, the consultation process around superclinics was very important to ensure that we understood the service provision in the first place. All of those consultations took time, but they were very important in determining that need.

Senator FURNER—With respect to the Indigenous elders, I am quite familiar with the Bunyabilla group and I know they are extremely impressed with the interaction—the clinic and the ease of transportation—

Senator BOYCE—Are you able to table those documents in regard to that, Senator Furner?

Senator FURNER—access to the shopping vicinities. I am wondering what feedback you have received from, for example, Bunyabilla.

Ms Taylor—We have not spoken directly to that service but we are aware, as I said, that that service is represented in the clinic's community consultation process. So we will seek some of that feedback and I am sure we will have buckets of feedback on this particular issue, because Indigenous health services were not something easily accessed prior to the advent of the Strathpine superclinic.

Senator FURNER—There is a medical library upstairs as well, as I understand.

Ms Taylor—There is. That is right. That is accessible.

Senator FURNER—Is there any feedback on how that is being used by the community—whether practitioners in the area or students are taking up that opportunity?

Ms Taylor—Again, we do not have specific information on that, but it is something we can chase up.

Senator FURNER—I have some questions that deal with GP superclinics in general, which I can leave for later.

CHAIR—Do you want to finish Queensland first, Senator Fierravanti-Wells? Go north to Logan, and then we will get the general questions.

Senator FIERRAVANTI-WELLS—I also have some general questions at the end, so I wonder whether—

CHAIR—I am in your hands. It is your time.

Senator FIERRAVANTI-WELLS—Okay. I would like to go to Logan, if I can. First of all, can I go through the list of the GP superclinics in Queensland and ask when they will be fully operational. We will start with Brisbane Southside—the Logan one.

Ms Taylor—There are two parts to Brisbane Southside—there are both the Annerley site and the Logan site. The Annerley site should be operational around September this year. The Logan site will be somewhat later—late 2011.

Senator FIERRAVANTI-WELLS—Bundaberg?

Ms Taylor—For Bundaberg, we are looking at a time frame of early 2012.

Senator FIERRAVANTI-WELLS—Cairns?

Ms Taylor—Cairns, again, is one of those sites that have a number of parts to them. Cairns should be operational by mid to late 2011. There is a component of the Cairns superclinic that is currently operational, providing GP, nursing and mental health services at their Woree spoke.

Senator FIERRAVANTI-WELLS—Yes, but it is not fully operational in the sense that—

Ms Taylor—It is fully operational at that spoke, but no; it is part of the bigger superclinic, yes.

Senator FIERRAVANTI-WELLS—Can I just understand this. I know that Senator Boyce traversed this on the last occasion, but can you delineate what you mean by ‘fully operational’. I know that we have gone through this but, for the record, what does ‘fully operational’ mean to you?

Ms Taylor—I did say that the Cairns superclinic will be fully operational by mid to late 2011, so we are not claiming that it is fully operational now. That is certainly not the intent of my previous comment. The time frame for Cairns to be fully operational—all the parts of that particular model to be up and operating—is mid to late 2011.

Senator FIERRAVANTI-WELLS—What about Gladstone?

Ms Taylor—For Gladstone we are running on a time frame of mid to late 2011.

Senator FIERRAVANTI-WELLS—Ipswich?

Ms Taylor—Ipswich will be fully operational by early 2012.

Senator FIERRAVANTI-WELLS—What about Mount Isa?

Ms Thompson—I can speak to that. With Mount Isa we are not sure. We have some issues with their capacity to get up and running, and we are considering some options around that one at the moment.

Senator FIERRAVANTI-WELLS—So you do not know about that one.

Ms Thompson—No.

Senator FIERRAVANTI-WELLS—Redcliffe?

Ms Taylor—Redcliffe is mid-2011.

Senator FIERRAVANTI-WELLS—We know about Strathpine. Townsville?

Ms Taylor—Townsville is late 2011.

Senator FIERRAVANTI-WELLS—I want to go now, if I can, to the Logan one. The GP Super Clinics National Program Guide states:

GP Super Clinics must complement and enhance existing health services—

and they should—

… be a supported addition to the local community.

Does the Brisbane Southside clinic at Logan meet those criteria?

Ms Taylor—As far as I am aware, yes.

Senator FIERRAVANTI-WELLS—So can a tenderer—in this case, the University of Queensland—change its plans or models from its tender application after winning the tender?

Ms Taylor—It can moderate its plans, depending on whether the original site is still available. Sometimes sites are sold out from underneath our funding recipients. Sometimes the tenancy arrangements might change. So we need to be a little flexible around what we consider to be a major change as opposed to a minor change in clinic locations.

Senator FIERRAVANTI-WELLS—All right. So what guarantee does the government have that it gets what it tenders for?

Ms Taylor—I am not sure what you mean in that regard.

Senator FIERRAVANTI-WELLS—In this case, the site of the Logan clinic, there is an issue because the original proposal was to put it on one side—are you aware of this or familiar with this?

Ms Taylor—I understand that there is now a proposal to potentially put it across the road from the original site.

Senator FIERRAVANTI-WELLS—Yes, that is my point. One would think that that is a major change. In other words—

Ms Taylor—I do not necessarily agree with that assessment, that moving it from one side of the road to the other is a major change.

Senator FIERRAVANTI-WELLS—Oh. Well, it does, depending on whether the facilities that are available on one side are the same as those you originally tendered for on the other side. That was why I asked the question. Anyway, you had a site originally set out in the tender process. Was the site that was outlined in the tender process the Meadowbrook village shopping centre?

Ms Taylor—As I understand it, it did include the Meadowbrook Medical Centre, not necessarily the Meadowbrook shopping centre.

Senator FIERRAVANTI-WELLS—Okay. And the new site that the University of Queensland has successfully tendered for is across the road?

Ms Taylor—I understand that those arrangements are in process.

Senator FIERRAVANTI-WELLS—Right. The Meadowbrook village shopping centre already contained a general practice, Medihealth pharmacy and pathology practice, so it fitted the bill for your complementing and enhancing existing health services and being supportive of the local community.

Ms Taylor—Yes, but I do not understand why a clinic located on the other side of the road cannot equally provide those services.

Senator FIERRAVANTI-WELLS—No, I am trying to get to another issue. You accept one tender and then there is a substantial variation of that tender, and I am asking you what your position is in relation to acceptance of that major variation. In this case, you have moved from one concept, where you have got an established set of services on one side, to the University of Queensland winning the tender and shifting operations to the other side of the road. That is the point that I am trying to make.

Ms Thompson—Senator, perhaps I could comment on that. I think, with any capital program, this sort of thing can happen and does happen. What we do when these things happen is ensure that the criteria that applied in the first place are still met, and those criteria are around the delivery of services to the community as assessed through the consultation process. We will always ensure that that fundamental objective of the program is met.

Senator FIERRAVANTI-WELLS—As I understand it, you had a group of doctors wanting to set up—they had the original idea. The doctors went to the University of Queensland. The University of Queensland, as I understand it, relied on their experience; they

described it as an ‘established capability in establishing, developing and operating multidisciplinary medical centres’. After the University of Queensland won the tender, they basically dropped the doctors and the pharmacy, the original set-up. That is it, in a nutshell. So I am asking you: is that a part that you as the Commonwealth, from your perspective, are not interested in?

Ms Thompson—As I said, we will ensure that the criteria that need to be met are met and that the objective of the program is achieved—and that is the objective of the program.

Senator FIERRAVANTI-WELLS—The University of Queensland say, ‘Our site is part of an established shopping complex which already contains a medical practice, pharmacy and pathology service,’ and indicate that in the adjacent shops they could provide tenancy operations for other health services, and you award a tender on that basis. When that materially changes, I do not understand why you do not revisit that. Do you see the point that I am trying to make?

Ms Thompson—As I said, Senator, we do revisit and we ensure that the criteria that need to be met are met and that the objective of the program is met. That is what you do whenever circumstances change in terms of a contract arrangement. That is what you do.

Senator FIERRAVANTI-WELLS—All right. Now we have a situation where you have got a GP superclinic on one side of the road the tender process for which was built on, if I can use those words, the parameters of the experience and established capability of the doctors that are now operating across the road.

Ms Thompson—I am sorry, I did not hear your question.

Senator FIERRAVANTI-WELLS—At the moment you have got a situation where you have got doctors who are operating in the Meadowbrook Village shopping centre. You have got a practice that is operating there. That was the basis upon which the university originally built its tender. All of a sudden now the university has decided they are going to set up operations across the road, forget the doctors that they originally partnered with and now set up in competition across the road. So the GP superclinic is being funded across the road. My question is, surely there is some concern on the part of the Commonwealth in relation to those doctors whose goodwill, if I can put it in those broad terms, was utilised to form the basis of the original tender?

CHAIR—We have actually gone through this and I think the point is on the table, the issue you are raising. I would think that the officers could take that on notice, look at the consideration and give a briefing to Senator Fierravanti-Wells about this particular issue. I just do not sense we are moving forward on it.

Senator FIERRAVANTI-WELLS—I will stop it there, but you take my point. Is it going to be a process where if you cannot get a superclinic up for some reason, suddenly midstream you change your contractual arrangements? If we have seen it here, are we going to see it in other GP superclinic proposed locations?

CHAIR—When we get the briefing we will be able to see and you will be able to go from that point.

Senator Stephens—Chair, can I make the point that in relation to Senator Fierravanti-Wells's questions on this issue I think there are some assumptions that are underpinning those questions that perhaps may not be exactly as she perceives them to be.

CHAIR—Perhaps that sometimes happens, Minister, but Senator Fierravanti-Wells has put her issues on the table, the concerns she has. Now we will see what comes back in terms of information.

Senator FIERRAVANTI-WELLS—I may provide, subject to what I can, separately documents to the department.

Ms Halton—That would be very helpful.

Senator FIERRAVANTI-WELLS—Now that you have got this here at Logan, they have advertised—

CHAIR—We are still in Logan, are we?

Senator FIERRAVANTI-WELLS—We are. There is another aspect to this that I would like to traverse. I find in the *Australian Financial Review* on 23-26 April an advertisement for the chief executive officer of the University of Queensland GP superclinics, which I read with some interest. We actually managed to get a recruitment package for this position, which runs to nigh on 20 pages. In this package is an absolutely fascinating little diagram. I will hold it up—

Senator Stephens—The officers cannot see that.

CHAIR—Would you like to pass that to the officers?

Senator FIERRAVANTI-WELLS—Let me just tell you it says: superclinic steering committee. This was a real noodle. I will provide you with a copy of this because I really want to understand, if this is the way every superclinic is going to be run, no wonder this is bureaucracy gone absolutely mad. Over here on this diagram you have got local reference groups. I do not know what those local reference groups are. You have got Ipswich, Annerley and Logan, and then you have got some letters under here which I am not sure what they mean. Then you have got a board of the superclinic, which I assume is part of the requirements. Is that the case for superclinics? Could somebody enlighten me as to whether they are required to have that?

Ms Thompson—They certainly have to have appropriate governance arrangements.

Senator FIERRAVANTI-WELLS—So you have 'Board of UQ GP Superclinic Pty Ltd, 1 and 2', obviously. Underneath that you have a CEO and a practice management company, then you have clinical model working groups, and then on this side of the equation you have a superclinic advisory committee and UQ faculty representatives. I will give you a copy of this. But if this is what is required for the CEO to run this superclinic it really is bureaucracy gone absolutely mad.

Senator Stephens—Senator, can I just say in response that, given the corporate governance requirements of companies in Australia, that is actually quite straightforward.

Senator FIERRAVANTI-WELLS—Are you saying that every GP superclinic will have that sort of structure? Is that what you are saying?

Senator Stephens—No, I am not saying that at all. I am saying that you see there that you have some companies limited by guarantee and therefore they have some requirements around that. The fact that it is associated with the university means that there are some requirements around that. I imagine that each GP superclinic has its own structure that recognises who the affiliated partners are.

Senator FIERRAVANTI-WELLS—Further in this document it has 'Proposed organisational GP superclinic structures': board of directors, CEO, business development manager—again, I will provide a copy of this. My question to you is: what is this structure typical of? Is it typical of just this GP superclinic or is it typical of what you are going to require for all GP superclinics? That is really my question.

Ms Thompson—I haven't ever seen that document, so I cannot comment on it except to say that appropriate governance arrangements based around the GP superclinic at an individual level are things that we are interested in and pay attention to to ensure that the objective of the program is achieved. But it is quite right to say that each of these superclinics will have a governance structure that is applicable to their particular company structure or program activity, depending on where they are from.

Senator FIERRAVANTI-WELLS—This document contains not just the structure. This is 20 pages of 'this is what you have to do' et cetera. I will give you a copy of this but I really would appreciate it if you could tell me if this is what every GP superclinic is going to be doing and requiring—that is, if this is the norm or if the University of Queensland is just going outside it.

Ms Thompson—We could certainly provide the types of governance arrangements around the superclinics that are being developed or are currently operating, if that would be useful.

CHAIR—So you are going to exchange documents then? Senator Fierravanti-Wells, you will provide the information you have—

Senator FIERRAVANTI-WELLS—I will.

CHAIR—and then on notice, Ms Thompson, you will take that as part of the information you will get back to us. Thank you.

Senator FIERRAVANTI-WELLS—I have two short questions. Have the doctors involved in the Mount Isa clinic claimed that the clinic in that city cannot be built for the money allocated under this scheme?

Ms Thompson—We certainly have had advice that they do not believe they can proceed at this stage and we are working on options around that.

Senator FIERRAVANTI-WELLS—This is the one that you mentioned to me earlier—

Ms Thompson—Yes.

Senator FIERRAVANTI-WELLS—in that you are not sure what the options are and you are looking at other options?

Ms Thompson—We are considering options.

Senator FIERRAVANTI-WELLS—Could you take on notice to give me some information in relation to those options. Then there is the Bundaberg clinic. You told me it is going to be fully operational in early 2012. So what is the status of the clinic at Bundaberg?

Ms Thompson—I am sorry, Senator?

Senator FIERRAVANTI-WELLS—Earlier, when I ask the question about clinics being fully operational, I was told that Bundaberg would be fully operational in early 2012. My question is: what is the status of that clinic now?

Ms Taylor—For the Bundaberg superclinic, the funding agreement was signed in April this year. Land settlement is currently under way.

Senator FIERRAVANTI-WELLS—All right. I have finished Queensland, Madam Chair, and I was going to move on to New South Wales.

CHAIR—It may be useful then for Senator Furner to have his general questions—

Senator FURNER—I admit I am very patient, Chair.

CHAIR—I am just concerned that we have only another 25 minutes in this area before we get on to the agency. Is there anyone else who has any other issues in primary care that they would like to cover?

Senator FIERRAVANTI-WELLS—I will ask if you could, in relation to each—I am just conscious of time; if I can I will come back—give me, like you have for the other GP superclinics, details of when they will become fully operational in New South Wales and the other ones that I did not cover.

Ms Taylor—Yes.

Senator FIERRAVANTI-WELLS—Can you tell me about the Port Stephens facility in New South Wales? Again, with the services that were indicated would be available—diabetes services and increased access to X-ray services—are these available and are they full-time or part-time?

Ms Thompson—Yes. Port Stephens superclinic opened on 3 May this year. It operates Mondays, Wednesdays and Fridays between 8 am and 4 pm; Tuesdays and Thursdays between 12 noon and 8 pm; and Sundays from 10 am to 4 pm. It also provides a specific service to residential aged-care facilities on Tuesday and Thursday mornings. There are four GPs—two female—two practice nurses, a practice manager, and a range of allied health professionals including a psychologist, or psychologist services, diabetes educator, dietician, physiotherapist, podiatrist, pharmacists—in particular for medication reviews, and a visiting medical specialist—a geriatrician.

Senator FIERRAVANTI-WELLS—And do they bulk bill?

Ms Taylor—They do bulk bill a range of services, yes.

Senator FIERRAVANTI-WELLS—I would like to ask some questions about Warnervale.

CHAIR—Which state are we in?

Senator FIERRAVANTI-WELLS—New South Wales.

CHAIR—Okay. I had just lost where we were.

Senator FIERRAVANTI-WELLS—It opened in October 2009 but according to Minister Roxon’s press release it is only a temporary clinic until there is a permanent site in 2011. Is that the case?

Ms Taylor—That is correct. Early 2012—

Senator FIERRAVANTI-WELLS—Sorry?

Ms Taylor—Early 2012 is the expected completion date.

Senator FIERRAVANTI-WELLS—So the minister said early 2012. It has one full-time GP—is that the case? What is the GP situation there?

Ms Taylor—Yes, I understand they have at least one GP there.

Senator FIERRAVANTI-WELLS—Does it have bulk billing?

Ms Taylor—It does provide bulk-billed services, as far as I understand.

Senator FIERRAVANTI-WELLS—What about nursing home visits?

Ms Taylor—I do not believe they do nursing home visits specifically.

Senator FIERRAVANTI-WELLS—Okay. I found a position advertised for a general practitioner for that practice, and I am happy to provide you with a copy of it. It says, ‘There is no requirement for the GP to perform visits to aged-care facilities or nursing home visits.’ My question is: is this the situation with GP superclinics? I thought that was going to be one of the features of it. The government has made much in its announcement recently about encouraging GP visits to nursing homes. Indeed, Ms Podesta herself mentioned earlier, I think, 105,000 extra visits to nursing homes. It is interesting to see that at one of your GP superclinics it is almost there as an attraction for that prospective general practitioner that there is no requirement for GPs to perform visits to aged-care facilities or do nursing homes visits. I find it somewhat troubling that on the one hand the government is supposedly pumping money in to get GPs to visit nursing homes and here we have a GP superclinic that is basically saying they are not required to go and visit nursing homes.

Ms Halton—I cannot comment about the specifics, other than to say that we are very clear about our requirement in relation to a greater level of attendance at nursing homes. I do not know the details of the ad and I think it would be inappropriate for me to comment.

Senator FIERRAVANTI-WELLS—I will provide it. The point I am trying to make is about whether this is a feature of GP superclinics. I would appreciate it if you would look at this advertisement. We have just heard Ms Podesta’s evidence. There is a big fanfare about getting GPs to nursing homes. We know GPs do not want to go to nursing homes. It is almost as if it is being touted as a positive to the job that they do not have to go to nursing homes. I will leave it at that. I will provide the document to you, if you could take that one on board.

Ms Halton—Yes, but I might just make a comment. I cannot leave that sitting there, Senator. The bottom line is that saying GPs do not want to visit nursing homes is a comment that a number of people in the medical profession would regard as something that could not be let go without comment. We know of many practitioners who devote a significant proportion of their practice time to that. We think we need more of that, and that is what these arrangements are on about. I will look at this advertisement. I do not know, for example, how

this particular service is structured. We know that in some services they may have a GP who focuses on adolescent health, for example. There are areas that people specialise in within general practice. So I think we need to have a bit more information before we leap to conclusions.

I would be quite clear that our expectation is that, particularly working with Medicare locals, GP superclinics would be part of providing a holistic service to people in that community, and that includes Australians who are resident in residential care.

Senator FIERRAVANTI-WELLS—Okay. Just one question in relation to Nelson Bay Plaza GP superclinic. I have been given various opening hours. They are very disparate: Wednesday, Friday, 8 am to 4 pm; Monday, Tuesday, Thursday, 8 am to 8 pm; Saturday, not open. And for Tuesdays and Thursdays, interestingly, it has: '1 pm to 4 pm: locals only, one problem. Walk in for minor ailments—example, sore throats'. Does that mean that at some GP superclinics we are going to start delineating when people can come in? It seems strange that you can only have locals with one problem. Is that a new feature or just particular to Nelson Bay? Have you come across it?

Ms Thompson—I am sorry Senator, I missed the beginning of the question. Where was that information from?

Senator FIERRAVANTI-WELLS—What I am saying is that an inquiry was made at this Nelson Bay Plaza superclinic and the advice is that on Tuesdays to Thursdays, 1 to 4 pm, it is: 'Locals only, one problem. Walk in for minor ailments'. Is that a common feature of what we are going to start seeing at superclinics, that you will only be treated if you are a local with one problem?

Ms Thompson—I would have to check what is going on there.

Senator FIERRAVANTI-WELLS—Fine. I will not go through the other states. I want to ask some questions in relation to the budget allocation of $355 million—3.5, 5.2—for an additional 23 GP superclinics and for 425 grants to GP practices. To describe it in a shorthand form, we have seen superclinics mark 1, which is the 36 or 37; then we have another 23, which is mark 2; then there is this new phase, which is these 425 grants to GP practices. I note that that is at page 214 of the yellow book. Could you tell me a bit about these? I cannot help but think that we have got 2½ fully operational and we are still in the first phase of superclinics and now we are talking about 425. We cannot even get through mark 1, let alone now the grand plan for mark 3.

Ms Thompson—The 425 relates to the number of grants, and I can detail those for you. The objective of that program is to upgrade and extend general practice, primary care or community health services, and Aboriginal medical services, to improve their facilities to allow them to expand the services to their communities. That is the objective of the program. We believe that that will give greater flexibility in service provision and allow and attract allied health professionals to GP practices.

Senator FIERRAVANTI-WELLS—At page 214 of the budget papers, as you go through it goes into the establishment of Medicare Locals—and we will come to that. You explain in the budget papers what Medicare Locals are going to do. It is very clear that you have introduced this new coordinated diabetes care program where, basically, you are going to

allocate certain amount of money, if I understand, to a person who has got diabetes, and the figure I have heard is $1,200, but I am not sure if that is the case. Is that your understanding?

Ms Thompson—That is right. I can verify that.

Senator FIERRAVANTI-WELLS—That also means that that $1,200 not just includes that person's diabetes care, but is everything else as well. Is that the case?

Ms Thompson—The new initiative relates to those people who choose to sign up to a practice that has agreed to deliver a coordinated approach to the care of people's diabetes. There will be up to $1,200. Some of that will go to the practice and some will be a flexible pool that eventually will be held by Medicare Locals to deliver allied health services as required. The idea behind this is to create a greater engagement between the person, the patient, and the general practice and all the allied health services that they may need to deliver their care.

Senator FIERRAVANTI-WELLS—But does it also not take away choice of GP, because if you want diabetes care you have got to go to that doctor—you are allocated that doctor?

Ms Thompson—It is a voluntary enrolment.

Ms Huxtable—The patient voluntarily enrols with the general practice for the purpose of getting their care from the general practice. And, adding to Ms Thompson's comments, there is also funding under this initiative that goes to general practice in respect of how their diabetes population are faring, and their performance payments that relate to that we expect on average to be just over $10,000 per practice. So there are a number of components of funding. There is the $1,200 per patient, which was referenced earlier, some of which goes to the general practice. There are also reward based payments that go to the practice as well.

Senator FIERRAVANTI-WELLS—So you are going to set up these Medicare Locals. How will they be formed?

Ms Huxtable—The Medicare Locals will evolve from divisions of general practice. However they will be much broader than divisions of general practice currently are. They will embrace a wider set of health professions within a local area and will have responsibilities to report on the health of our local communities. There is a range of elements that are in the 'red book' that I am sure you are all familiar with. The concept of Medicare Locals is grounded very much in both the considerations of the National Health and Hospital Reform Commission, but also in the primary care strategy which was also announced in final form on 11 May, and is really about having a much better regional focus on primary care provision complementing local hospital networks.

Senator FIERRAVANTI-WELLS—They will not actually be involved in patient care though, will they? They will just coordinate patient care; they will not actually see the patients themselves?

Ms Huxtable—There is a variety of measures in the budget papers, where there are moneys earmarked for Medicare Locals. Some of that relates to after-hours provision. There is the allied health funding which Ms Thompson has already referred to. There is also funding as part of that aged care measure. They will have a role in coordinating the provision of services. I think we need to be reasonably flexible as to the types of things that Medicare

Locals will do because the whole point of this is to have primary health care organisations that are responsive to local communities. So we do not want to be too prescriptive around what their various functions are.

I think it is true to say that, on the whole, their role is to really understand what the needs of their local communities are, where there are gaps and where there are people who are vulnerable and disadvantaged who are falling through those gaps, and act to fill gaps in service delivery.

Senator FIERRAVANTI-WELLS—They will interact with the GPs. How will they know about patients and their needs? They are not actually treating patients themselves. Are they just going to be directing patients around their local area?

Ms Huxtable—They will be expected and be funded to have considerable information about what is going on in their local area in terms of the demographics of the population and the health outcomes that population is experiencing, and they will be identifying where there may be gaps or variations from what would be expected to be normal practice—I think there are many examples we could give in that regard—and they will be working closely with the local community and with the network of providers to put in place arrangements to fill those gaps.

Senator FIERRAVANTI-WELLS—There is really not a lot of detail about this yet. Where is the nitty-gritty about where they are going to be and the areas they are going to cover? We do not have any of that detail yet. It is just conceptually up there, despite what is in the red book.

Ms Huxtable—I was about to cite the red book. There is a significant amont of information not only in the red book but in the National Health and Hospitals Network Agreement.

Senator FIERRAVANTI-WELLS—I know, but we have not delineated the parameters of where they are, the area they are going to cover.

Ms Huxtable—That is right.

Senator FIERRAVANTI-WELLS—Is that going to be done in conjunction with the local health networks by the end of the year?

Ms Huxtable—That is correct. I think one of the important things here is the need to be very aware of what the circumstances of local communities are, what the catchment areas are and what the hospitals look like in those areas, and to work with stakeholders around defining these boundaries. I do not think they are the sorts of things that really can or should be imposed from a central place.

Senator FIERRAVANTI-WELLS—At page 225 you talk about the improvement of primary care. We were talking earlier about diabetes and the $1,200 that flows from that if patients go to a certain practice. I notice at page 225 that you are now talking about coronary disease, chronic obstructive pulmonary disease and improved access to others. Does that mean that we are looking at diabetes today but we are also looking at a series of other diseases further down the track that are going to be under the same formula, if I can put it that way?

Ms Huxtable—The reference on page 225 is to a quite specific program—the Australian Primary Care Collaboratives program. I am probably not the best person to question about the detail of that program.

Senator FIERRAVANTI-WELLS—Ms Halton, you obviously have experience with the British National Health Service.

Ms Huxtable—In fact, I was born under it.

Senator FIERRAVANTI-WELLS—I know. That makes me think that what we are starting to see sounds remarkably like a shift in that direction—towards a British national health service. We are bringing in these local networks, and this and that, which are not really local. It is almost as if people are going to be directed; that it is going to be: ‘You will go to this doctor and go to that doctor.’ Is this what we are starting to see?

Ms Halton—No.

Senator FIERRAVANTI-WELLS—A categoric assurance that we are not moving down that route?

Ms Halton—Absolutely.

Senator FIERRAVANTI-WELLS—I will put further questions on notice.

Senator SIEWERT—I am interested in how Medicare Locals are going to interact and evolve from the divisions of general practice. There are going to be fewer Medicare Locals than divisions of general practice. That is correct, is it not?

Ms Huxtable—I think that has been the expectation, but until those boundaries have been finalised I could not say that definitively.

Senator SIEWERT—In terms of how you are currently interacting with the divisions of general practice about how they will evolve into the new being, how is that proceeding? I am particularly keen on understanding then how it is going to happen in WA, where this is going to be funded, as I understand it from our discussion this morning, but the other issues around health reform are not going to be. There may be a different relationship between Medicare Locals and any of the local health networks.

Ms Huxtable—There are a number of questions there.

Senator SIEWERT—I know, sorry.

Ms Huxtable—I might try and take them in turn, if I can. In terms of Medicare Locals and divisions of general practice, really the foundation thinking around the primary healthcare organisation structures goes back to the Primary Health Care Strategy, which was developed with input from an external reference group. There has certainly been wide discussion in the sector about the value of primary healthcare organisations as a means to better coordinate, fill gaps and really address that issue about the MBS being good at the sort of transactional based service but not so good at managing long-term chronic disease.

For the Divisions of General Practice Network, there are absolutely no surprises in this. In fact, I know they have been doing quite a lot of thinking themselves about what it means for them, and we will obviously continue talking to them around this, but not only them. There are clearly a range of other primary healthcare providers who have an active interest in

Medicare Locals. What is also in play here is the Commonwealth taking 100 per cent funding and policy responsibility for state based primary care services and, again, bringing those primary care services into the rubric of the Medicare Locals sort of planning environment, if you like. I am not sure if that has completely answered your question in regard to the divisions, but there is definitely an active dialogue with the divisions and with other primary healthcare providers now that we are moving to the next six months, which will really be bedding down the arrangements for Medicare Locals at their boundaries and also the process to select the first tranche of Medicare Locals, which is due to come on board in July next year.

Senator SIEWERT—I want to pursue that a little bit more in a minute. I know I asked a multipronged question. What about the issues around WA?

Ms Huxtable—Firstly I would say, as I did this morning, that discussions with WA are continuing, so I do not think that we can speak too definitively about where that might end. I think it is quite hypothetical to talk about a circumstance where there might be different arrangements in WA to the rest of the country, because those discussions are continuing, as I understand it. However—we may be going back a little bit on what was said this morning—the place of Medicare Locals in WA, I think, is a matter that really needs to continue to be discussed between governments.

Senator SIEWERT—Does that mean that there is a potential case where in WA we are not involved in the first tranche?

Ms Huxtable—That is hard to say, and I think it is a two-way discussion. I have not personally had discussions with WA about Medicare Locals and about what it might mean in WA, so I cannot say to you that they have firm views about those organisations, where they might be and how they might align with local hospital networks and the like. It is probably just a little early to say how that whole thing might proceed. Meanwhile, there are these parallel discussions occurring.

Senator SIEWERT—Okay. In your discussions with Senator Fierravanti-Wells, you were talking about the identification of gaps that are not picked up through the MBS process, and you just mentioned that again. My take on where we are at with some of the divisions of general practice is that there is a great deal of variety across Australia. Some seem to me to be more engaged in certain issues—for example, mental health. My observation is that that is not necessarily just based on there being a greater need in certain areas for mental health; it also depends on the level of engagement of some of the people involved. It seems to be a bit hit and miss. I am only picking on mental health as a particular example. How are you going to monitor and ensure that all the gaps are being met so you do not get what seems to me to be the somewhat more haphazard approach that we have got through some of the divisions of general practice at the moment?

Ms Huxtable—The *Building healthy communities* report and the role of the Performance Authority is important.

Senator SIEWERT—Sorry?

Ms Huxtable—The *Building healthy communities* reports are referenced in the Health and Hospitals Network Agreement. So one of the key things here is to have greater transparency about what is happening in a local community and having an organisational structure that has

a specific responsibility to understand the needs of the population, what is happening for that population, how that population is faring against other similar populations. So the National Performance Authority, at the most high level—

Senator SIEWERT—Which WA is out of.

Ms Huxtable—Well, as I said, discussions are continuing. The role of the National Performance Authority and the role of the Medicare Locals with respect to those *Building healthy communities* reports are important points of transparency and accountability about what is happening in local communities. Where gaps have been identified, through those open processes, then very much the expectation would be that the Medicare Locals act and show that they are doing work to fill those gaps, and also that the local hospital networks are. Often what we are talking about here is where people are falling through the gaps—they are leaving hospital and going nowhere, information is not being passed or whatever the case may be. We have had some other discussions about this a few weeks ago.

The other issue is about the funding streams that are available for Medical Locals. They will, in part, drive the early prioritisation of their work. So after-hours is one area that has been identified. Allied health services in respect of diabetes and the aged care money are others. There is also the ATAPS money with respect to people with severe and persistent mental illness that will be going out through divisions but moving into Medicare Locals as they come on line.

Senator SIEWERT—I will put some more questions on notice.

CHAIR—Thank you to the officers from that outcome.

[5.47 pm]

General Practice Education and Training Ltd

CHAIR—Welcome to the officers of the agency.

Senator FIERRAVANTI-WELLS—There is a lot in the hospital plan and the network documents relating to workforce. I am interested to know what part you will play in relation to those programs and where, specifically, you will be assisting and how you will be assisting in relation to delivering some of those workforce outcomes.

Mr Janssen—The annual intake for general practice trainees or registrars is increasing to 900 next year, and going up from there to 1,200 by 2013. Those registrars are distributed across Australia into training localities based on a range of workforce related needs factors. We look at the available data on the distribution of general practices. We look at data on areas of workforce shortage, available training capacity and a range of other factors that determine the distribution. The objective is to distribute the trainee workforce—who, as they go into practices, provide services—to respond to those needs. Under the contractual arrangements we have for distribution, no less than 50 per cent of all training across the program is required to take place in areas outside of the major capital cities—in RA2 to RA5 localities. So the program is very much focused on addressing workforce requirements for the general practice community needs.

Senator FIERRAVANTI-WELLS—In the budget statements it says:

As part of the *National Health and Hospitals Network Agreement* and to address the current shortage of GPs across Australia, the Government will increase prevocational placements from 380 in 2010 to 975 in the 2014 training year, and the available number of vocational training places from 700 in 2010 to 1,200 in the 2014 training year.

Is that what you have just mentioned?

Mr Janssen—I referred specifically to the distribution of general practice registrars—the vocational trainees—but we are taking a similar approach to the distribution of the additional placements in the prevocational program. These are doctors that have not yet chosen a specialty for training and, as a part of their prevocational experience, have an opportunity under this program—in increasing numbers now—to rotate into a general practice placement that is supervised for a short period.

Senator FIERRAVANTI-WELLS—So you do not actually do the training; you just organise and coordinate it.

Mr Janssen—We coordinate it and contract with regional training providers, and they in turn have relationships with general practices that are accredited to take trainees, registrars and prevocational doctors.

Senator FIERRAVANTI-WELLS—Were you consulted in relation to the assumptions that were made in relation to the hospitals network plan?

Mr Janssen—In relation to the distribution or the numbers of registrars, we are in continuous dialogue with the department over what we see as the numbers that could be accommodated coming into the system, the rate of growth that could be sustained and, overall, the final numbers. So, to that extent, yes, we are involved quite closely with the ultimate policy decisions that are made around the numbers. We certainly have input, and we are very pleased with the increases that have been announced. We believe they are sustainable in terms of creating the placements that are required going forward over the period of time.

Senator FIERRAVANTI-WELLS—It is a substantial jump if I look at page 55 onwards, given some of the difficulties that we have had. Without going into specifics, I think that the general anecdotal evidence is that there are difficulties in this area. I am interested to see the considerable jump there. It is more than a doubling and a half of general practice placements for prevocational doctors—380 to 975. That is a sizeable jump. Do you honestly think that that is going to be doable?

Mr Janssen—As part of our response to those decisions, we have undertaken an audit, firstly, of expected demand from junior doctors for these placements in the next year. That really is based on the number of junior doctors in the hospital system that will be released by their hospitals to undertake these terms. We have also, through our training providers, looked at potential training capacity—what is available there in terms of placements for them—both from practices that are already accredited for the purpose and from other ones that could be brought on between now and the beginning of next year to accommodate the growth. We think it is achievable. It is a real challenge for us, and we are working with some of the accreditation bodies in the various jurisdictions that accredit prevocational training places to streamline their processes. That is happening. The biggest growth area, in fact, will be in New South Wales—

Senator FIERRAVANTI-WELLS—I was about to ask about New South Wales.

Mr Janssen—which has not participated in the program in a significant way in the past. We are working very closely with the Department of Health there, the accreditation bodies and the providers to ensure that we can roll out the program.

Senator FIERRAVANTI-WELLS—I wonder if you could take that on notice and provide to me the basis of those assumptions. It does seem quite a sizeable jump. I would be interested to know the basis of those assumptions.

Mr Janssen—The assumptions behind?

Senator FIERRAVANTI-WELLS—The assumptions behind that. On page 655 of the yellow document there is 'Program 1.1: Deliverables' and 'Minimum number of places available' and for 2010 we are talking about 380 and then in 2011 we are talking about 910 and then 975 thereafter. So I would like to understand the assumptions that underlie those figures.

Mr Janssen—I think that would be a question better directed to the department that is actually responsible for the policy and ultimately the final figures that are put into the PBS.

Senator FIERRAVANTI-WELLS—So in terms of when you say it is achievable, the department makes the assumptions and says, 'We want to deliver from 380 to 910,' and then your job is to go out there and do it.

Mr Janssen—Exactly right, although we do have input, as I indicated earlier, on the broader question of what is a sustainable rate of growth in the various programs. But, as for the final figures, these are matters that have been determined within the relevant policy areas of the department.

Senator FIERRAVANTI-WELLS—And how much of that increase is actually New South Wales generated?

Mr Janssen—We are expecting at the end, when we get to 975 funded placements, around 30 to 35 per cent of those being located in New South Wales simply because that is where 30 to 35 per cent of the population and the doctors in fact are. So we are trying to move to a rational distribution of those places across Australia.

Senator FIERRAVANTI-WELLS—In terms of those regional training providers, you think that the structure is sufficient to be able to meet those needs out there?

Mr Janssen—On the basis of the audits that we have undertaken through those providers, the information is that we should be able to meet the demand for those places—the demand that is likely to be evidenced from the hospital doctors next year—and place them in practices that are accredited for the purpose.

Senator FIERRAVANTI-WELLS—What sort of working relationship do you have particularly with the regional medical schools? There are about nine of them around. Do you have a relationship with them? Do you do any work with them?

Mr Janssen—These are the rural medical ones?

Senator FIERRAVANTI-WELLS—Yes.

Mr Janssen—Yes, we do. We have a number of interactions with them. The university medical schools are in fact on our board; they have a nominee on the board. One of our advisory committees—particularly the one around this program, prevocational training—has a nominee from a rural clinical school, in this case out of Western Australia, so there is an interaction and, importantly, there are interactions at the regional level between our training providers and the local medical schools and the rural clinical schools.

CHAIR—That concludes our questions as to outcome 5, Primary care. As always there will be significant questions on notice. We will now move to outcome 9, Private health.

[6.01 pm]

Private Health Insurance Administration Council

Senator FIERRAVANTI-WELLS—There has been quite a bit of discussion this year about private health insurance and I would like to ask about the viability of the industry. There are about 11 million Australians with private health insurance. Does the council keep statistics?

Mr Groenewegen—We do keep and publish a range of statistics.

Senator FIERRAVANTI-WELLS—Tell me a little bit about the state of the industry. There has been the discussion earlier this year about the government's proposed changes to private health insurance and the consequential effects of those three bills that were before the Senate, which I am sure you were aware of. In the statistics you keep or monitor, were you aware of any shift or movement in relation to numbers and memberships?

Mr Groenewegen—I think the best way to answer that question might be just a look at membership over the last 12 months or so. Our last published statistics in terms of the proportion of population covered showed that 44.5 per cent of the population held hospital cover. That was a slight increase from the same time 12 months ago, when it was 44.4. That was an increase of just over 200,000 people.

Senator FIERRAVANTI-WELLS—You keep the statistics but do you also have a role in terms of the qualitative analysis of that increase? In other words, do you monitor motivation or why people choose to take up or discard their private health insurance?

Mr Groenewegen—No, we do not have statistics or any surveys that go toward motivations of people.

Senator FIERRAVANTI-WELLS—Is that something that just the insurers themselves keep a very close eye on?

Mr Groenewegen—I believe that insurers themselves monitor membership and membership satisfaction. I do not know of any study into what is driving people to take out health insurance or otherwise.

Senator FIERRAVANTI-WELLS—So, every time there is a debate about private health insurance, are there blips? Do memberships go up? Do memberships go down? For example, during the period when we had the recent debate in relation to private health insurance, did you notice a shift in the number of people that had private health insurance?

Mr Groenewegen—Our statistics are collected quarterly and are just in terms of totals; we just collect the number of people in. They are not disaggregated sufficiently for us to be able to form a view.

Senator FIERRAVANTI-WELLS—All right. For which quarter is the last set of statistics that you have?

Mr Groenewegen—It is for the March 2010 quarter.

Senator FIERRAVANTI-WELLS—Could you give me the last four quarters.

Mr Groenewegen—The last four quarters in terms of percentage of people covered?

Senator FIERRAVANTI-WELLS—Yes, or even numbers if you do not mind.

Mr Groenewegen—In terms of numbers, in March 2010 there were 9.913 million people with hospital cover; in December 2009 there were 9.866 million people; in September 2009 there were 9.821 million; in June 2009 there were 9.745 million; and in March 2009 there were 9.702 million.

Senator FIERRAVANTI-WELLS—You just keep statistics? You do not know where those people are? Is it purely the private health insurers themselves that have a breakdown of where their members are—for example, the 44.5 per cent who have hospital cover? In terms of the location of those people who hold private health insurance, is that information that is held purely within the purview of the insurers themselves or is that the sort of statistical information that you have access to?

Mr Groenewegen—We publish coverage statistics by state.

Senator FIERRAVANTI-WELLS—By state only?

Mr Groenewegen—By state.

Senator FIERRAVANTI-WELLS—You do not break that down to regions or anything like that?

Mr Groenewegen—No, we do not.

Senator FIERRAVANTI-WELLS—So, in terms of various electorates or particular areas, regions or anything like that, that is information that is purely in the purview of the insurers themselves, and at that level they presumably only have information on the people that insure with them. For example, if I take insurer A or insurer B, they will know where the people insured with them are located; they would not know where the people who are insured with another company are.

Mr Groenewegen—That is correct.

Senator FIERRAVANTI-WELLS—Thank you.

CHAIR—Thank you very much.

[6.08 pm]

Private Health Insurance Ombudsman

Senator FIERRAVANTI-WELLS—Can you tell me your statistics in terms of complaints about private health insurance? I know you publish material on complaint-handling activities. Tell me a little bit and give me some statistics in relation to levels of complaints.

Ms Gavel—I have brought some figures along—not for the full financial year, because it has not finished yet.

Senator FIERRAVANTI-WELLS—Thank you.

Ms Gavel—These figures are from 1 July last year to 14 May this year. We have had 2,035 complaints so far. For the same period the year before, it was 2,038, so it is fairly similar.

Senator FIERRAVANTI-WELLS—Tell me a bit about the nature of these complaints. Are they the kind that says, 'My private health insurance is charging me too much'? What is the nature of the complaint?

Ms Gavel—We tend to get similar sorts of issues coming through each year, which is not surprising, and I would say that the funds would get the same sorts of issues as well. The most complained about issue concerns the level of benefit that people receive from their insurer. That can be anything from what they get back for their dental claim through to what they get back for their hospital claim.

Other areas where we receive complaints concern information that people read in the brochure or get over the phone through the call centre. There are membership complaints, often to do with arrears of membership. We get complaints about waiting periods, the 12-month waiting period for pre-existing ailments. Interestingly, complaints about premiums and cost are not a significant issue for the office.

Senator FIERRAVANTI-WELLS—Considering that 9.1 million people have got private health insurance, 2,000 complaints a year is not a lot of complaints.

Ms Gavel—No, that is right.

Senator FIERRAVANTI-WELLS—Is there any group in particular in that cohort of 2,000—in terms of age? Is that something that you—

Ms Gavel—We do not actually record the age of the complainant. But my guess, from looking at our stats and the sorts of complaints we get, is that we get complaints across the whole spectrum, so across all insured.

Senator FIERRAVANTI-WELLS—If the insurance industry wanted to start offering new products or new services to their membership, is there a role that you play in terms of the efficacy or otherwise of those services? Do you have a role in that sense?

Ms Gavel—I do not really have a role with new products that insurers might bring to market. But I would certainly have a role through the complaints to my office in giving feedback to funds if issues arose with new covers that came in.

Senator FIERRAVANTI-WELLS—All right. So if an insurance company decided to go out into the marketplace with a series of new products, your involvement would only be after

a particular period of time that the product had been in operation in the marketplace, then if there were complaints in relation to it that is when you would become involved?

Ms Gavel—That is right. I also have a role in taking up issues with insurers if, for example, a product came out that appeared to be confusing, I would not have to have a complaint to talk to the insurer about that product.

Senator FIERRAVANTI-WELLS—So particularly if you are dealing with, say, a more vulnerable cohort of persons, then you would take that upon yourself to look at that from that sort of qualitative assessment if you became aware of that?

Ms Gavel—Yes, that is right. But usually, the sorts of issues that I take up with insurers are things that come to the office through complaints.

Senator FIERRAVANTI-WELLS—Then what happens? You get complaints and if there is a spate of certain complaints then you take that up with the insurance industry or the insurer? Do you deal with them one on one?

Ms Gavel—Yes, that is right.

Senator FIERRAVANTI-WELLS—Or if you have got a spate of certain issues—premiums go up, for instance—then you will end up having a bit of a spate of complaints about premiums and that sort of thing. Is that normal?

Ms Gavel—I do not have a role in the premium process itself—

Senator FIERRAVANTI-WELLS—I know you do not. But if you had a series of complaints and you noticed that there was a trend and there were a number of complaints in relation to a particular insurance aspect, then you would deal with that, rather than one on one, by getting all the insurers together?

Ms Gavel—It depends, because the complaints to my office can show a systemic issue with one fund or across a number of funds. So it depends on what the issue is. And it does not necessarily have to be a large number of complaints either. It could just be that there are a small number of complaints but they raise a particular issue that needs to be taken to the fund.

Senator FIERRAVANTI-WELLS—Okay. Thank you. I have no further questions, Chair.

CHAIR—On that basis, we will suspend for the dinner break. When we come back will have questions on private health to the department.

Proceedings suspended from 6.15 pm to 7.30 pm

CHAIR—Welcome. We will go back into the last half-hour of outcome 9, where we have questions for the department. I know that Senator Fierravanti-Wells and Senator Siewert both have questions.

Senator FIERRAVANTI-WELLS—Does Senator Siewert want to start off?

CHAIR—That is fine.

Senator SIEWERT—It will shock you to find out that I actually have a specific question about the budget papers.

Senator BOYCE—Oh, Senator Siewert!

Senator SIEWERT—I was just getting in first before the chair did. In the budget papers in the forward estimates for the private health insurance rebates it says there will be $4.456 billion in 2010-11, $3.51 billion in 2011-12 and so on, and then under ‘Trends in the major components of medical services and benefits sub-function expenses’ the figures are different. I want to know why they are different—or are we misreading the papers? This is Budget Paper No. 1.

CHAIR—Do you know which page it is?

Senator SIEWERT—Basically, the forward estimates are different to the trends that you are predicting in some of the other expenses.

Ms Shakespeare—We might have to take that question on notice. I am not sure that I have the figures in front of me.

Senator SIEWERT—That would be appreciated. I am purely after the explanation for the discrepancy. What is the reason for the two different sets of figures?

Ms Halton—We will give you the details on notice.

Senator SIEWERT—Thank you. You might need to take this one on notice also: can you tell me whether, in the current figures, you are factoring in the means testing of the rebate?

Ms Shakespeare—I can answer that question. Over the forward estimates period there has been a change in the start date for the means testing of the rebate from 1 July 2010 to 1 July 2011, so that has had an impact on the expenditure figures over those years.

Senator SIEWERT—In light of that, if you could take the other question on notice, that would be appreciated. Thank you.

Senator FIERRAVANTI-WELLS—What proportion of the budgeted expenditure on health does the private health insurance rebate represent? Is that a figure that is readily available?

Mr Kingdon—We will have to take that question on notice.

Senator FIERRAVANTI-WELLS—In Budget Paper No. 1, page 6-19, in the middle of the page at table 8.1 it shows that the expenditure on the private health insurance rebate is projected to decrease. We are looking at $4,513 million for 2009-10 and $4,641 million for 2010-11, and then it goes down to $3,781 million over the forward estimates. I assume that excludes potential growth in premiums.

Mr Kingdon—It includes the rebate change, which, as Ms Shakespeare explained, is estimated to take effect from 2011-12. So you have that reduction that will flow through in those subsequent years.

Senator FIERRAVANTI-WELLS—I appreciate that, but doesn’t that assume that the legislation will pass?

Mr Kingdon—That is the assumption that has been made in the budget.

Senator FIERRAVANTI-WELLS—Even though it was rejected? All right. Have you done calculations on the assumption that it does not pass?

Mr Kingdon—We have not projected forward estimates on that basis.

Senator FIERRAVANTI-WELLS—I would have thought that would be a prudent contingency, Mr Kingdon.

Mr Kingdon—If it were something that was going to take effect next financial year—

Senator FIERRAVANTI-WELLS—I take your point.

Mr Kingdon—it would still be the same.

Senator FIERRAVANTI-WELLS—Next year, of course, it will still be the same. But you must have an idea of what the figure will be if the legislation does not pass.

Mr Kingdon—We do not, but it would not be unreasonable to project the $4.6 billion with a small amount of growth through there.

Senator FIERRAVANTI-WELLS—It would probably stay at $4.7 billion or something.

Mr Kingdon—It could, but we do not have the figure and we have not had cause to estimate it.

Senator FIERRAVANTI-WELLS—Looking above that table, it says:

Medicare expenses are the major driver of growth ... expected to increase in real terms by 10.1 per cent over the forward estimates period, or by an average annual increase of 3.3 per cent.

According to the papers, MBS expenditure is also growing. I am trying to work out that percentage in figures. Can you help me there, Mr Kingdon?

Mr Kingdon—You are trying to find out percentage growth of?

Senator FIERRAVANTI-WELLS—Of MBS expenditure.

Mr Kingdon—It is really outside this outcome. That is outcome 3. You should be able to ask that question there and they will have an answer for you.

Senator FIERRAVANTI-WELLS—Okay. On the previous page of the budget paper, 6-18, it looks at the general administration expenses in health growing and it goes from $1.6 billion to $1.9 billion to $2.3 billion, and then the projections are going higher.

Mr Kingdon—I do not think we can hold private health accountable for that.

Senator FIERRAVANTI-WELLS—Again, that is for tomorrow.

Mr Kingdon—That is general administration, which I think is different. It is a departmental lift.

Senator FIERRAVANTI-WELLS—On page 273 of the yellow book, , under the main heading ‘Major activities’ and the subheading ‘Ensure the sustainability of the private health insurance rebate’, it says:

Private health insurance rebate funding is the fastest growing component of Australian Government health expenditure.

What data do you have that shows, even including premium growth, that the rebate expenditure is growing? Is that within your purview, Mr Kingdon? What underlies that comment? Can you assist me with that? If you can provide it, I would like a percentage expenditure of that rebate.

Ms Shakespeare—This is drawn from the most recent Treasury *Intergenerational report* modelling.

Senator FIERRAVANTI-WELLS—That statement is taken straight out of the *Intergenerational report*. Is that what you are saying?

Ms Shakespeare—That is what the *Intergenerational report* showed: that this was the fastest growing component of health expenditure.

Senator FIERRAVANTI-WELLS—Just help me out: did they put a percentage on that? I have a figure of 10.4. Is that your understanding? Is that correct?

Ms Shakespeare—We would have to take that on notice.

Senator FIERRAVANTI-WELLS—Thank you. I might move on to the aggregate value of procedures performed in the private hospital system. Do you have a value as to that? Is that something that you can assist with or estimate?

Mr Kingdon—Unfortunately, we will have to take those on notice because the private hospital data is collected in the outcome 13 activity.

Senator FIERRAVANTI-WELLS—So this is what was referred to earlier in outcome 13, the National Hospital Cost Data Collection 2010, which will then be released by June 2011.

Mr Kingdon—No. There is separate data that is collected for private hospitals.

Ms Shakespeare—There is Hospital Casemix Protocol data and also the Private Hospital Data Bureau data, so there are a couple of datasets. I think they are also included in the admitted patients dataset.

Senator FIERRAVANTI-WELLS—When will you next do that calculation?

Ms Shakespeare—We would have to take that on notice and check with the people that collect the data in the department.

Senator FIERRAVANTI-WELLS—Are you saying I should have asked this in outcome 13?

Mr Kingdon—Correct.

Senator FIERRAVANTI-WELLS—Okay. Again for outcome 13 there is the proportions of procedures that would be currently performed in the private system. Is that something that you can assist me with?

Mr Kingdon—It sits there primarily because we could give you a figure on private health but that does not necessarily equate to the total amount of activity in a private hospital. You may well have some activity that has been purchased by the public sector in a private hospital. You may have activity that does not attract a private health benefit. We could not give you a full picture but you would get it from that total data that is collected from private hospitals.

Senator FIERRAVANTI-WELLS—For every person who exits private health insurance what is the expected marginal cost to the public system? Is that the sort of data that you are able to assist with?

Mr Kingdon—I am sorry, we would have to take that on notice too.

Senator FIERRAVANTI-WELLS—You can assist me, but you will have to take it on notice?

Mr Kingdon—I think we can. I am not sure we can, but I will take it on notice to see what we can provide you there. I cannot guarantee it. I really do not know one way or the other.

Senator FIERRAVANTI-WELLS—Is there a marginal saving? Obviously, there is a saving to the Commonwealth and the state governments for each person who accesses benefits under the private health system and does not rely on public hospital services. Is that marginal saving quantifiable?

Ms Shakespeare—It depends on which government you are looking at. If the Commonwealth is purely what you are looking at, they probably fund a bit more for private patients.

Senator FIERRAVANTI-WELLS—Yes. If you are looking at New South Wales; I understand.

Ms Shakespeare—If you are looking at costs across government, that is something that we could estimate, but it is a quite complicated modelling exercise because we have to look at numbers of people who actually attend hospital. Just because somebody leaves private health insurance does not mean they are going to necessarily need hospital services. You have to discount your figures to actually relate to the numbers of people that use hospital services.

Senator FIERRAVANTI-WELLS—So any marginal saving calculation would have to be dependent on whatever assumption you put in there. If you have X number of people exiting the private health system, assuming 20 per cent, then there would have to be a series of assumptions—is that what you are saying?—before you could actually tell me a figure.

Ms Shakespeare—That is right.

Mr Kingdon—It begs the question whether there is a saving if you put it in the context of whole of government, because you have so many factors coming into play as to what role the government plays in either a private or a public system: whether it is a state or Commonwealth contribution, whether it is a rebate—there are tax savings if someone uses their tax rebate. It is a very complicated set of calculations. If there are some available we will happily provide them to you, but I am not sure that we have all that.

Senator FIERRAVANTI-WELLS—Do you have statistics in terms of the average amount spent on public hospital services by both the Commonwealth and state governments for each Australian who does not have private health insurance?

Mr Kingdon—No, I do not have that information.

Senator FIERRAVANTI-WELLS—Is that something that is within your purview?

Ms Halton—I would be surprised if that were available anywhere. I am happy to look.

Senator FIERRAVANTI-WELLS—I am just asking. I suppose my question should have been: is that a figure that is available anywhere?

Ms Halton—Not that I am aware of.

Senator FIERRAVANTI-WELLS—What about the average amount spent by the Commonwealth government for the private health insurance rebate for each person with private health insurance?

Ms Shakespeare—We could work that out for you, because we know what the total expenditure on the rebate is and we know how many people have private health insurance. But we do not have it and, without a calculator, I cannot do that for you now.

Senator FIERRAVANTI-WELLS—Could you take that on notice. The yellow-cover budget paper says on page 273:

Means testing the rebate will help rebalance the affordability of private health insurance to the Government. In 2010-11, the Department will support the Government to implement means testing.

How much is this means testing the private health insurance now projected to save the government, given the calculations are looking at 2010?

Ms Shakespeare—The estimated saving over the forward estimates period is still $2 billion.

Senator FIERRAVANTI-WELLS—Where is that figure in the documents?

Ms Shakespeare—That is in the budget papers for 2009-10. The detail of the savings was set out in the budget papers.

Senator FIERRAVANTI-WELLS—What changes will the government be making to the proposed thresholds for the means testing since the bills were last defeated in the Senate?

Mr Kingdon—I do not think it is our position to speculate.

Senator FIERRAVANTI-WELLS—Are you doing any work in relation to that?

Ms Shakespeare—There will be indexation of the thresholds. Under the draft legislation put forward by the government they were to be indexed by average weekly ordinary time earnings; so, as the measure will not start until later on, the tiers will change due to indexation.

Senator FIERRAVANTI-WELLS—That is a mechanical change?

Ms Shakespeare—Yes.

Senator FIERRAVANTI-WELLS—If the legislation were to be introduced, that would be the only change. Is that what you are saying, Ms Shakespeare?

Ms Shakespeare—Yes.

Senator FIERRAVANTI-WELLS—How were the thresholds for the rebate means testing decided upon? What economic data or evidence was used to set those thresholds?

Ms Shakespeare—The bottom of the first tier is tied to the income rate at which the Medicare levy surcharge applies, and the other income thresholds were set having regard to numbers of people within tax brackets and an assessment of what income level—when the Medicare levy surcharge is operating in conjunction with a step-down in the rebate—would encourage the maximum number of people to remain in private health insurance.

Senator FIERRAVANTI-WELLS—But to set those thresholds you would have made a series of assumptions.

Ms Flanagan—This work was mainly done by Treasury, because it was necessary to rely on tax data and they hold tax data.

Senator FIERRAVANTI-WELLS—Ms Flanagan, did you provide any input to Treasury in relation to this? What you are saying is that Treasury made the assumptions at a point that it was feasible to make those different cut-offs, if I can put it that way.

Ms Flanagan—Yes. It had the data on which it could do the modelling.

Senator FIERRAVANTI-WELLS—Paraphrasing, you simply said, 'Look, give us three levels,' and they came back and this was their suggestion.

Ms Flanagan—I think it was more interactive than that.

Senator FIERRAVANTI-WELLS—I appreciate there must have been dialogue, Ms Flanagan, but the main determinant was Treasury.

Ms Flanagan—They certainly had the data on which the modelling could be done.

Senator FIERRAVANTI-WELLS—When this was considered, were various alternatives canvassed?

Ms Flanagan—With any development of policy, various things are looked at. That was part of the policy-making process.

Senator FIERRAVANTI-WELLS—When was advice first provided on proposals to means test the private health insurance rebates?

Ms Flanagan—I think we would need to take that on notice, if we have not already answered that before.

Ms Shakespeare—Yes, we have answered that at previous estimates, and we would have to go back and check the dates. I do not remember at this point.

Senator FIERRAVANTI-WELLS—I do not have my folder with me, but there were various points at which public indications were given by the government that there were not going to be changes to the rebate, but at the same time there was work being done by Treasury and the department, and it is clearly on public record that this was happening. I am really interested to know when that advice was first provided. If an answer has already been provided, could you simply direct me to where it is.

During the course of the debate, Senator Ludwig made some comments about people who might be affected by these changes. Can you provide an update on the number of individuals that the government's proposed changes will impact upon?

Ms Shakespeare—The means testing proposal?

Senator FIERRAVANTI-WELLS—Yes.

Ms Shakespeare—The current estimate of people impacted is 2.3 million. That is all insured people, including dependants.

Senator FIERRAVANTI-WELLS—At the moment we have got about 9.1 million—

Ms Shakespeare—It is 9.91 million.

Senator FIERRAVANTI-WELLS—people who have private health insurance. So, of those, 2.3 million will be affected in the broader sense. Is that what you said, Ms Shakespeare?

Ms Shakespeare—Yes, 2.3 million insured people rather than policies.

Senator FIERRAVANTI-WELLS—Thank you. The budget papers also state that:

> Private health insurance rebate funding is the fastest growing component of Australian Government health expenditure.

To make that claim, what is the annual growth rate that you are assuming for private health insurance coverage? Are you assuming static or an increase?

Ms Shakespeare—We do not make assumptions regarding the growth rate in participation. Under the budget papers, we aim to ensure maintenance of the number of people with private health insurance, but there are no targets for growth.

Senator FIERRAVANTI-WELLS—Are you making any assumptions of what the growth rate for private health insurance coverage will be with the means testing? Does it follow from your previous answer that you assume it will stay static at 9.1?

Ms Shakespeare—It is 9.91 million at the moment. Private health insurance has continued to grow in terms of numbers, but it is fairly stable in terms of the participation rate. I do not think there is a particular amount of evidence to suggest that it is going to grow at a particular rate or that the means testing of the rebate would have any particular impact. The government has made some estimates of the numbers of people that would drop out if means testing were introduced but they are very small numbers.

Senator FIERRAVANTI-WELLS—That appears to contradict some of the reports that we have seen from other areas and other stakeholders in the industry. Has the department commissioned or undertaken in the last 12 months any work on a new private health insurance model?

Ms Shakespeare—Yes, it has. We are currently building a new PHI economic model.

Senator FIERRAVANTI-WELLS—What is the basis for the new model? Are there any preliminary results?

Ms Shakespeare—We have not finished developing the new model. It is to allow us to model more policy variables into the future. That is not being driven by any particular project or policy. It is to allow us to provide advice to government about the impacts of policy changes on private health insurance participation and expenditure.

Senator FIERRAVANTI-WELLS—Can you give us an example of what you mean by that?

Ms Shakespeare—I will not speculate on possible changes the government might want to make. For instance, say you were to look at the impact of changing variables around lifetime health cover—for example, if lifetime health cover started at an earlier age rather than at age 30—and what impact that would have on participation. It is modelling those sorts of changes to policy levers.

Senator FIERRAVANTI-WELLS—I previously asked some questions of the agencies. That sort of variable could be, for example, if new products came into the private insurance

industry and we suddenly saw those sorts of changes and there was an uptake. For example, if there were a major change for new areas of private health insurance coverage, would that be the sort of variable that you are talking about?

Ms Shakespeare—We would not be able to model things at a product level. This is fairly high level modelling across the insured population and it is mostly aimed at looking at government policy changes and how they would impact on the insured population.

Senator FIERRAVANTI-WELLS—So it is not only how you put the variable in but the variable itself?

Ms Shakespeare—Yes.

Senator FIERRAVANTI-WELLS—Thank you, Madam Chair. I do not have any further questions in relation to that outcome.

CHAIR—I will just check whether anyone has anything else under private health.

Senator BOYCE—I would like to ask one, if we have got the time.

CHAIR—Yes, we have got time for one question, Senator Boyce.

Senator BOYCE—I was late arriving at this session, so I am rather hoping that it may have been covered. Is the department aware of cuts in private health insurance funding for gastric banding? Has that been covered?

CHAIR—It has not been covered.

Ms Shakespeare—Insurers are free to change the benefits covered under their policies to exclude particular services. Those are commercial decisions made by individual insurers. In general, we are aware that some insurers are excluding gastric banding services from some of their policies.

Senator BOYCE—Has there been any departmental action? Are you aware of cases that have been taken to the Private Health Insurance Ombudsman?

Ms Shakespeare—No, I am not, I am afraid.

Senator BOYCE—From the department's perspective, has there been any reaction to this change?

Ms Shakespeare—I am not aware of any reaction from consumers. It might be a question that you could put to the Ombudsman to see if she has received any complaints about limits on those services. Generally, insurers do provide a wide range of products and many consumers want to buy products that have exclusions for particular types of services that are more expensive.

Senator BOYCE—However, changes to available benefits without considerable notice are the concern here.

Ms Shakespeare—Under section 93 of the Private Health Insurance Act insurers may not make detrimental changes to policies without providing reasonable notice to members. Generally that is at least 60 days.

Senator BOYCE—Yes. Thank you.

CHAIR—Thank you very much. We thank the officers from outcome 9 and now we are going to move to outcome 2, Access to Pharmaceutical Services.

[8.01 pm]

Pharmaceutical Benefits Division

CHAIR—Senator Fierravanti-Wells, have you got your questions under 2.1 and 2.2?

Senator FIERRAVANTI-WELLS—I have for under 2.1.

Senator BOYCE—Sorry, but I need to know where mine go.

CHAIR—Why don't we start on 2.1 and then if you have got questions, Senator Boyce, we will put them and find out where they fit in?

Senator BOYCE—No, sorry, mine are under 2.1. They are around the pharmacy agreement.

Senator SIEWERT—I have got PBS stuff. I presume that is in.

CHAIR—Mr Learmonth, which one does the pharmacy agreement fit under?

Senator BOYCE—Is the agreement under 2.1? That was the assumption I was making.

Mr Stuart—It is in outcome 2 and we can call it 2.1, if you like.

CHAIR—We will call it 2.1. Mr Stuart, we are trying to be disciplined here. I know that is difficult for you to understand after working with us for so many years, but we are trying very hard to go in the order 2.1, 2.2 and 2.3. So we will start off on 2.1.

Mr Stuart—Outcome 2.1 is community pharmacy and 2.2 is pharmaceuticals. We can do the agreement under 2.1 and then medicines pricing under 2.2.

CHAIR—Okay, who wants to kick off on 2.1?

Senator BOYCE—I think my questions probably go backwards and forwards between the two, but why don't I just start and see what happens?

CHAIR—Why don't you start and then, if we are on an issue that you also want to question, please just jump in so we do not digress.

Senator BOYCE—My first question is to confirm with you some information that was given during Senate estimates on Monday evening by Minister Carr in regard to the relative shares of the market held by the companies within the organisations of Medicines Australia and the generic medicines organisation. Senator Carr said that Medicines Australia had 50 member companies that accounted for 85 per cent of the total cost of PBS medicine and nearly 60 per cent of sales of off-patent medicines annually.

Mr Learmonth—That would equate with our figures as well. We might have put it at 86 per cent, but what is one percent?

Senator BOYCE—Eighty-six per cent was your figure, was it?

Mr Learmonth—Yes, the MA proportion of the PBS, but what is one per cent?

Senator BOYCE—Can you give me the equivalent percentages for GMiA?

Mr Learmonth—GMiA has, I think, about five companies versus MA's 50, and they account, I think, for about 34 per cent of the off-patent market.

Senator BOYCE—Thirty-four percent of the off-patent market?

Mr Learmonth—There is a balance of companies which are not members of either GMiA or Medicines Australia.

Senator BOYCE—That is right. What about the percentage of the total cost of PBS medicines?

Mr Learmonth—Medicines Australia has about 86 per cent of PBS.

Senator BOYCE—So we are safe to assume that the majority of the other 14 per cent would be GMiA members?

Mr Learmonth—Probably most, bearing in mind that there are some companies which are members of neither.

Senator BOYCE—Yes, but the vast majority of that 14 per cent.

Mr Learmonth—Sure.

Senator BOYCE—There is one other figure I wanted to verify. The industry has 5,000 employees and exports $470 million worth of manufactured pharmaceuticals each year, or currently—last year.

Ms Platona—Those are the figures that you have quoted. They are from the GMiA website. They are the only figures that we are aware of.

Senator BOYCE—That you have about the value of the GMiA?

Ms Platona—Five thousand employees and about 1,700 in manufacturing.

Mr Learmonth—We would have no independent verification of that.

Senator BOYCE—Going to the memorandum of understanding that was signed in regard to the 2010 budget, it was exclusively between Medicines Australia and the health department. Is that correct?

Mr Learmonth—And the government.

Senator BOYCE—The government, not the health department.

Mr Learmonth—Yes. That is correct.

Senator BOYCE—Yes, okay. There was obviously concern from GMiA on this issue and given that they, as you pointed out, account for around 14 per cent of sales of the total PBS and 34 per cent of off-patent medicines, why were they not included in the discussions with the government on the memorandum of understanding?

Mr Learmonth—The memorandum of understanding grew out of discussions with Medicines Australia. Equally, we had numbers of discussions over time with GMiA about what might be possible in this space and, as it turned out, the policy propositions that GMiA was putting forward—and stuck to for the duration of all of those discussions—were not things that I think the government was prepared to contemplate. Thus, whilst an agreement ended up being possible with Medicines Australia in terms of an exchange of propositions

and, whilst we had significant senior pretty regular discussions with GMiA on potential policy matters, there were not the same prospects for an agreement with them. But, clearly, we were talking often and on policy.

Senator BOYCE—So the intention originally had been to have two memoranda or a memorandum with those two organisations?

Mr Learmonth—I do not know that there was any particular intent up-front about a memorandum of understanding. Certainly there was an intent to have discussions with the sector in its various forms about ways in which we could improve sustainability of the Pharmaceutical Benefits Scheme. We had long and fruitful discussions with Medicines Australia and an MOU, a memorandum of understanding or agreement, was the product of that. With GMiA that was not the case.

Senator BOYCE—Will those discussions with GMiA resume, or is that simply a part of the individual—

Mr Learmonth—They have never stopped. We have policy discussions with all of the elements of that sector regularly, whether it be through formal structures such as the Access to Medicines Working Group or informal consultations. Indeed, Mr Stuart and I met recently with Martin Cross, who is the new head of GMiA, and talked not only about what had transpired but about GMiA's desire to engage regularly with us in the future. So they certainly have not stopped. Policy discussions are a pretty regular feature in that sector.

Senator BOYCE—The government have said that they will be saving $1.9 billion over five years as a result of the MOU with Medicines Australia. Is that correct?

Mr Stuart—Yes.

Senator BOYCE—What is the cost of implementing the MOU going to be? Who should I be directing this to? Mr Stuart, is it?

Mr Stuart—Yes. I believe the budget papers show some implementation costs in relation to the MOU. We are just looking for them.

Ms McNeill—The cost of implementing this measure is $8.64 million.

Senator BOYCE—Could you tell me what that is to cover, please, Ms McNeill?

Ms McNeill—That is related to staffing for implementing the measure, as well as the cost of implementing price disclosure—advice for that—and the calculation work that is undertaken to implement price disclosure.

Senator BOYCE—The $8.64 million is over the five years?

Ms McNeill—Yes.

Senator BOYCE—Does it include administrative costs?

Mr Stuart—They are administrative costs.

Senator BOYCE—So we do not have any separation of implementation and administration costs? Is that correct?

Mr Stuart—We would not characterise them differently.

Senator BOYCE—You are not going to be implementing for five years, are you?

Mr Stuart—Yes, we are.

Senator BOYCE—I think we might be using different meanings for the word 'implementing'. 'Development costs' perhaps is what I am looking at.

Mr Stuart—Often when we have implementation costs for things, we have more implementation money earlier in the implementation period and then it tapers down over a period of time.

Senator BOYCE—Because there are start-up costs, for want of a better word.

Mr Stuart—That is right. That is certainly also the case here. So this funding for the department to implement is front-end loaded to some degree and then tapers out over the five-year period.

Senator BOYCE—Do we have annual figures for those five years, Ms McNeill?

Ms McNeill—Yes. In 2010-11, the costs are approximately $3.6 million and then we taper down in the out years to approximately $1.4 million, $1.2 million and $1.2 million again.

Senator BOYCE—I was unable to find those in the budget papers, but you tell me they are there. Are they?

Ms McNeill—It is rounded up at the total level. In the budget papers it allows for the save as well as the costs.

Senator BOYCE—I am sorry, I am having trouble hearing you, Ms McNeill. We are probably a good pair.

Mr Stuart—Felicity is saying that they are not separately shown in the budget papers.

Senator BOYCE—We are saying that we have $1.9 billion in savings over five years, but is the $8.6 million actually offset against that? Is that a net saving or a gross saving?

Mr Stuart—That is a gross saving.

Senator BOYCE—What would the net saving be, Mr Stuart?

Mr Stuart—It is $1.9 billion minus $9 million.

Ms McNeill—Yes.

Senator BOYCE—That is going to be the only cost that you are aware of?

Mr Stuart—Yes.

Senator BOYCE—You would be aware of some of the issues that GMiA have raised, suggesting that there will be other costs in the system with movement between generic medicine and non-generic prescribing?

Mr Learmonth—I am not sure what you mean. Things in the nature of what is prescribed and dispensed would not count as a cost in any event. It would go to the level of PBS outlays and savings achieved.

Senator BOYCE—I am sorry?

Mr Learmonth—Things that related to what was prescribed or dispensed, if there was any shift or any claim of any shift, would not go to implementation or administration costs anyway.

Senator BOYCE—No, but if they—

Mr Learmonth—They would go to the level of outlays for the PBS portfolio.

Senator BOYCE—But if the outcome, as GMiA perceive it to be, is an increase in costs, some companies going offshore and less competition within the market, would that not affect the PBS?

Mr Stuart—We have no reason to believe that any of those effects are likely to happen as a result of this policy. There is, generally, in the pharmaceutical market a process of consolidation going on—and there has been for a number of years—driven internationally. This is international consolidation. But we have good reasons, I think, to believe that the impact on investment and the impact on jobs of this policy will be very low. I can set out for you the reasons for that.

Senator BOYCE—I would be very appreciative if you would, Mr Stuart.

Mr Stuart—There are really three reasons for thinking that. The first is that we are now providing a period of stable pricing policy, so the government has now committed to refrain from introducing new policies to generate price related savings from the PBS for the next four years. This will deliver stability in medicine pricing for all players in the market, whether they are members of Medicines Australia or GMiA or any other body.

Senator BOYCE—I suspect that would be disputed too. But anyway, go on, Mr Stuart.

Mr Stuart—A commitment for no new policy in the pricing area is a general commitment. It is not specific to one series of companies.

Senator SIEWERT—The way that the generics also make money is by bringing in substitutes that are low in cost. Doesn’t this now preclude them from doing that?

Mr Learmonth—On the contrary, Senator.

Mr Stuart—Not at all.

Mr Learmonth—It relies on it.

Senator SIEWERT—How?

Mr Learmonth—It relies on the entry of generics and competition in the market, which reduces price and which is caught within price disclosure. One of the reasons that we have difficulty understanding some of the claimed impacts on companies is that, unlike most other ways in which one might save money, price disclosure is a price taker and not a price setter. We do not determine arbitrarily a range of cuts. It is simply a process whereby the price we pay reflects what those companies themselves charge down the supply chain.

Mr Stuart—There is significant discounting of medicines in the Australian market by all companies, particularly for the off-patent sector. What they do is they sell their medicines to pharmacies at a discount in order to try to get those pharmacies to stock their medicines in preference to other suppliers. Both generic manufacturers and manufacturers of previously

on-patent drugs do that, and they are trying to sell their drugs by giving discounts. What price disclosure does is to ask all companies in the off-patent sector to tell us what they are actually selling their drugs for in that market and then we lower the price that the government pays for the drugs to the average of the disclosed price.

What we are doing is finding out the price that drugs are actually being sold for in the marketplace and then we are lowering the government price. We are not artificially lowering the price further than the market price and, therefore, we cannot see where the impact is on the bottom line for companies, unless they are selling their drugs at a significant premium to pharmacists, above what other suppliers are selling. We do not think we are taking cuts out of the earnings of pharmaceutical companies. That is the second reason that we do not think that this has a very significant impact on jobs.

The third reason is that there is a very significant growing market for generic drugs in Australia. The PBS is continuing to grow; it will reach $9 billion next year. Growth each year is expected to continue to be between six and 10 per cent, perhaps around eight per cent. The sector is growing faster than the economy as a whole and the share of off-patent drugs in that market is actually growing. Over the last four years, the proportion of off-patent drugs out of the total PBS has grown from about 27 per cent to about 34 per cent.

Senator BOYCE—That is over four years, though.

Mr Stuart—Over four years, from 27 to 34 per cent, so from a bit over a quarter to over a third. There are a significant number of drugs coming off patent over the next few years; about 19 medicines that currently cost the PBS about $2.3 billion a year are coming off patent.

Mr Learmonth—Some of the so-called ‘blockbuster’ drugs.

Mr Stuart—Atorvastatin and olanzapine are both coming off patent in 2012, so we see significant market opportunities for growth in this marketplace for the generic sector.

Senator BOYCE—Going back to your second point, Mr Stuart, the averaging is of off-patent medicines only?

Mr Learmonth—It is the weighted average disclosed price for a particular medicine.

Senator BOYCE—I am sorry?

Mr Learmonth—It is the weighted average disclosed price for a particular off-patent medicine.

Senator BOYCE—For an off-patent medicine?

Mr Learmonth—Off patent, yes.

Ms Halton—These are medicines where there is competition.

Senator BOYCE—Yes.

Ms Halton—If there is more than one medicine in the category then there can be competition. There is a distinction here between generics, off patent, and things where there may be a price discount, so we need to not confuse that.

Senator BOYCE—But if we have the weighted average of generics, is there not an incentive then for companies that have off-patent medicines in the same bundle to encourage pharmacists to prescribe those medicines?

Mr Stuart—I think the secretary was trying to say—

Ms Halton—That was not a compliment, Senator. I will speak to him later!

Senator BOYCE—No, I thought it was aimed at me, Ms Halton, not you.

Ms Halton—No, I think it was aimed at me.

Mr Stuart—Certainly not. The secretary has already very capably explained that generic medicines are a subcomponent of what we call ‘off patent’. Off-patent medicines include medicines that were once on patent, sold by the former patent holder, and then there are generic entrants that compete with those. They are selling basically the same molecule in the marketplace and the PBS is remunerating them at the same price, so they are competing together in the marketplace.

Mr Learmonth—But your proposition is basically right, Senator, and the system relies on that. The companies that compete for a particular molecule down the supply chain do so, largely, by providing discounts down that supply chain in order to gain market share and encourage selling at the retail end. Price disclosure merely allows the taxpayer to take a slice of that.

Ms Halton—It is important to understand that the changes that we are making basically expand and bring forward the changes that we made under a former government in relation to pharmaceutical reform. All it does is bring that disclosure into an earlier part of the cycle and, essentially, what that is doing is ensuring that the taxpayer actually gets the benefit of what is, effectively, a commodity price in a commodity market.

Senator BOYCE—I am trying to understand how, apart from perhaps trying to somehow extend a patent, a company with a patented medicine might feel encouraged to keep that medicine from becoming a generic medicine. Do you know what I mean?

Ms Halton—Yes. But you cannot, really.

Senator BOYCE—It is possible to perhaps fiddle with the molecule.

Ms Halton—Okay, but put to one side the notion of patent evergreening, which I think is a whole separate area about patent law and a whole series of other things. In some cases, what the originators do is bring onto the market basically pseudogenerics, so they bring on another brand of the same molecule and they bring it on before the patent expires. And this is why I was making that other distinction: we move it into F2 because, effectively, there are now two brands of the particular molecule and we say for all intents and purposes, therefore, that this is no longer a product where there should not be any competition. But you cannot bring a generic on until that patent expires. As soon as you get to that point, it is a commodity market.

Senator BOYCE—Yes, I appreciate that, but the concern that has been raised with me is ways by which companies with patented medicines, and therefore non-competitive medicines, might seek to exploit the fact that they have preferential treatment in terms of payments and a

memorandum of understanding over and above companies that simply rely on generic medicines.

Ms Halton—I am absolutely confident that the fact that there is an agreement and these changes are in place makes no difference to that equation. Essentially, the bottom line here is that the behaviour you are talking about does not change.

Mr Stuart—There is nothing in the MOU that gives an advantage to the on-patent sector. We have been extremely careful throughout this entire process to treat equally companies that sell off-patent medicines, whether they be selling generics or formerly patented medicines. We want to treat them very even-handedly.

Senator SIEWERT—The MOU, if I understand it correctly, says that government will not be putting in any more measures for four years on price reductions, other than through the mechanism you have just described. Why was this approach taken rather than, say, any potential mandatory pricing mechanism for off patent?

Mr Stuart—There are some small additional mandatory price reductions being implemented at the same time, but price disclosure is the preferred policy because it is the policy that says that the government is not arbitrarily cutting deeper than the market can bear. All that this is doing is allowing the taxpayer to gain a benefit from the existing competition in the marketplace.

Ms Halton—This was preferred because (1) the government was very interested in certainty in relation to the savings that were able to be achieved through this measure—there are very significant savings; (2) the bottom line is that, if there is more competition out there in the market, we will actually reap the benefit of that, so it is very significant potentially; and (3) importantly, the industry agree that this is a fair thing to do.

Senator BOYCE—Part of the industry does, anyway.

Ms Halton—The MOU originally.

Senator SIEWERT—Medicines Australia may well agree to it—they see it as fair—if in fact it saves them from other mechanisms that could actually result in more savings. Did you look at other mechanisms that are used internationally, such as a mandatory pricing approach, a tendering approach? Where they are used in other countries, as I understand it, there has been a substantial reduction in the cost of medicines.

Ms Halton—Both under the former government and under this government, this is a program which has had more scrutiny than I think most of us could understand.

Senator BOYCE—But, given its size, that is quite reasonable.

Ms Halton—Totally. As I think I am on the record as saying here, the very first outlays review I ever did as an officer in the finance department was of the PBS. At that point we were about to crack the $1 billion mark and everyone was having hysterics, so it just shows you how long ago it was. The bottom line is that we have looked at all of those kinds of things in considerable detail, taking account of the way our market works, taking account of our approach to pricing, cost-benefit analysis et cetera, and taking account of what we have done in terms of implementing the F1 and F2 arrangements and the savings measures that were put

in place under the former government. This was absolutely considered to be the best approach.

Senator SIEWERT—You have just mentioned the previous round of reforms that were made. Are the savings that were announced as being made, the $1.9 billion, purely from this approach or is it combining some of the previous reform?

Ms Halton—Just this one. This is on top of the previous one.

Senator SIEWERT—As I understand it from our discussions previously and other comments that have been made, some of those reforms are actually only just starting to have an effect now. Is that a correct understanding?

Mr Learmonth—It is, insofar as price disclosure took a while to ramp up, which is why in these reforms there is really nothing qualitatively that has been changed in the policy at all that was introduced before. It has merely been accelerated, in a way. It is true that there was always going to be a progressive ramp-up of the savings that would be attributed to PBS reform, principally deriving from price disclosure. It is also true that there have been a variety of estimates—I think we have talked about this before—of what those savings might be. In the minister’s report to parliament earlier this year those savings were quantified and, among other things, the conclusion was reached that, despite the savings being higher than were anticipated at the time, the level of outlays in the PBS were still going to be higher than the level that was predicted before the reforms were in place. It is a very strongly growing program; hence the imperative to look for a further stage in sustainability.

Senator SIEWERT—I am not arguing the point in terms of the need to find savings. I am asking about the approach that was taken.

Mr Learmonth—More of the same, in essence.

Senator SIEWERT—To be clear, the $1.9 billion is on top of the previous savings.

Mr Learmonth—Yes.

Senator SIEWERT—Thank you. Sorry, Senator Boyce.

Senator BOYCE—That is all right. Following up on comments by Ms Halton and Mr Stuart, is the department confident that nothing will come out of this memorandum of understanding that will decrease the market entry of generic medicines or the competitiveness, the wish to compete, in the generic field?

Mr Learmonth—We are very confident. We do not distinguish in the off patent between generic and originator off patent in the commodity market. As an adjunct, the campaign in relation to confidence in generics ought to help sustain generic take-up and see further increases in the generic market share within the off-patent market that Mr Stuart talked about before.

Senator BOYCE—Sorry, can I go back and ask one question that I meant to ask you earlier, Mr Learmonth. You spoke about talking to all of the stakeholders in the market. Are there any other significant stakeholders outside the companies represented by Medicines Australia and GMiA?

Mr Learmonth—We talk to a range of stakeholders generally—in particular in this area, AusBiotech, Consumers Health Forum and others—in relation to this particular exercise of PBS reform mark 2. Principally we had been speaking to Medicines Australia and GMiA.

Senator BOYCE—As the manufacturers of pharmaceuticals.

Mr Learmonth—Pretty much, yes.

Senator BOYCE—Given that you have you said you are very confident that the market for generics will continue to be highly competitive—in fact, more competitive—how will you be monitoring that? What will you be doing? How will you ascertain that this is the case?

Ms Halton—We said that we had to look at what is actually being prescribed.

Mr Learmonth—We will know that from prescribing data. As the secretary said, we will know—

Ms Halton—Dispensed, I should say.

Senator BOYCE—So you will use your current monitoring framework?

Mr Learmonth—We will use a range of sources. I think there are other industry sources, too, which go to market share between sectors and so on. We will use whatever data we can. We provided data earlier in relation to market share in various dimensions and we will look to see how those figures evolve over time.

Senator FIERRAVANTI-WELLS—Just on that question—sorry, Mr Learmonth, you may have answered it before—as a rule of thumb, generally what proportion of patients choose a cheaper generic rather than the prescribed brand at the pharmacy level?

Mr Learmonth—That was the figure that Mr Stuart talked about before, which is the proportion of scripts on the off-patent side which are manufactured by generics as opposed to originator brands. That is currently just under 33.8 per cent in 2008-09, which has grown from 27 per cent in 2005-06.

Senator FIERRAVANTI-WELLS—About a third.

Mr Learmonth—Yes.

Senator BOYCE—So 33.8 per cent—

Mr Learmonth—In 2008-09.

Senator BOYCE—for off patent.

Mr Learmonth—That is the generic manufacturers' share of off patent.

Senator BOYCE—What is the off-patent share, so to speak? No? It does not matter.

Mr Learmonth—No, you've got me on that one!

Senator BOYCE—There is a working group, isn't there, that will be monitoring the implementation of the MOU and the impact on PBS? Is that right?

Mr Stuart—In response to your previous question, roughly a third of the PBS is in the off-patent sector.

Senator BOYCE—But haven't we got 33.8 per cent in generic?

Mr Stuart—A third by value.

Senator BOYCE—And yours was by prescription. Is that right?

Mr Learmonth—Mine was of all off-patent scripts. About a third of those scripts are dispensed using drugs manufactured by a generic manufacturer as opposed to originator.

Mr Stuart—What I am saying is that, of the total PBS, which includes both on patent and off patent, the off-patent sector is about one-third of the PBS. So they are different one-thirds.

Senator BOYCE—Has a working group been set up to monitor the implementation of the MOU and its impact on PBS expenditure?

Mr Learmonth—The monitoring of how the reform has progressed will undoubtedly be a topic of consultation with the sector, even with Medicines Australia through the Access to Medicines Working Group, and through ongoing dialogue with GMiA. Ahead of monitoring the impacts, of course, we are currently engaged in consultation with those groups about the administration and the rollout of the measures. Mr Stuart has been involved in a number of those discussions. They are actively involved even now in designing the rollout in detail.

Senator BOYCE—Who are the members of the AMWG?

Mr Learmonth—The Access to Medicines Working Group is essentially the department and Medicines Australia. It is co-chaired by me and Will Delaat.

Senator BOYCE—This has been specifically established for the memorandum.

Mr Learmonth—Yes, it is longstanding.

Senator BOYCE—Longstanding?

Mr Learmonth—There are a couple of things, one of which is that both Will and I have been very conscious about regularly meeting with other stakeholders and talking to them about the Access to Medicines Working Group agenda and how it is going, so we talk with a variety of players. As I have also said to Martin Cross at GMiA—most recently a couple of weeks ago—our door is always open and we are always ready and willing to have ongoing discussion on matters of policy and program administration. We are well engaged with all the players.

Senator BOYCE—I am wondering why you have a longstanding working group that involves one major player and no-one else.

Mr Learmonth—The genesis was a decision of the previous government that set it up in particular circumstances, and it has a life. But, as I said, we engage with all of the stakeholders. Will and I meet regularly with the other groups to talk about the agenda and what we are doing. In any event, we have other policy discussions with those other stakeholders—GMiA, AusBiotech and others. Whether or not it is labelled under a particular formally constituted group, with terms of reference, we do have pretty regular and productive policy discussions.

Senator BOYCE—It is also about the perception of those groups as to whether they are as included as they might be.

Mr Learmonth—The message we have been giving them is that they are as included in policy discussions with us as they wish to be.

Mr Stuart—We are about to embark on some focused consultation in relation to implementation, which will certainly include all of the groups that are affected.

Senator BOYCE—Implementation of the memorandum, you mean?

Mr Stuart—Implementation of the pricing changes.

Senator BOYCE—When will that be happening, Mr Stuart?

Mr Stuart—We are trying to organise our first roundtable discussion for Tuesday of next week.

Senator BOYCE—That will be a fairly short process.

Mr Stuart—It will be a focused process to discuss implementation issues. The time line there will be related to the implementation time line that we discussed earlier.

Senator BOYCE—There will be stakeholders other than Medicines Australia at those discussions?

Mr Stuart—Absolutely. GMiA and AusBiotech will there, and also the wholesalers.

Senator BOYCE—Getting back to the question of the 33.8 per cent of generic off-patent medicines under the PBS, are there any plans to use tools other than the current query from the pharmacist to encourage consumers to ask for generics?

Mr Stuart—Yes. A part of the budget announcement was for a new generic medicines campaign, which is going to be rolled out through the National Prescribing Service at a cost of $10 million over four years, basically pointing out to consumers that generic medicines are an equal choice.

Senator BOYCE—There is no suggestion that GPs might be required in any way to consider the issue of generic medicine when prescribing?

Mr Stuart—No, there is nothing in the MOU or in the reforms—

Senator BOYCE—No, I realise that, but—

Mr Stuart—that impacts on the capacity of prescribers to prescribe what they think is the most appropriate medicine for their patient.

Senator BOYCE—All right. I could ask lots more questions, Chair, but I am happy to stop there.

CHAIR—Senator Siewert.

Senator SIEWERT—Thank you. I want to go back to the issue of price disclosure and clarify the issue around the $1.9 billion and all the measures under the previous reform that relate to price disclosure as well. How do you calculate what is coming out of this reform and what is coming out of the last reform?

Mr Learmonth—What came out of the previous reform is already reflected in forward estimates where there are a series of assumptions about what the individual measures would actually achieve.

Senator SIEWERT—It is the series of assumptions, isn't it, that is the—

Mr Learmonth—Yes, and this time around it was a very similar exercise. It was essentially changing those parameters, knowing what we know about volumes of the different medicines being dispensed and so on, and seeing what that did to the forward estimates at the other end and understanding what the difference was.

Senator SIEWERT—There are various savings made against certain clauses in the MOU, aren't there? Where do we find the specific information about which measure produces which savings?

Mr Learmonth—I think that is actually aggregated in the budget.

Senator SIEWERT—It is aggregated?

Mr Learmonth—It is aggregated, yes.

Senator SIEWERT—Is it easily possible to get the breakdown of the savings against the specific measures?

Mr Stuart—The budget reported $1.9 billion.

Senator SIEWERT—Yes.

Mr Stuart—That is the level at which the government's accounts are published and there is no further published source in relation to a breakdown of that.

Senator SIEWERT—Why is that?

Mr Learmonth—I think it has ever been thus.

Senator SIEWERT—So we just believe that you have added all the figures up and it is $1.9 billion. We cannot scrutinise them any more than that?

Ms Halton—No. We have added them up and the Department of Finance and Deregulation have checked them.

Senator SIEWERT—So the community cannot check it? A generic company cannot check it?

Ms Halton—But you will be able to check it, because you will be able to see what the outcome is against the forward estimates. This goes to the model which actually drives the forward estimates and this is a conversation we have been having in this committee for as long as I can remember. We do not disclose or discuss how the model actually works.

Senator SIEWERT—I am not asking you to give me the model. I am asking you to give me the savings against each of the particular measures that you articulate in the MOU. I do not need the model. I just need you to tell me how much each individual measure is.

Ms Halton—What I am saying is that it is not published by the government and we are not in a position to release that.

Senator SIEWERT—Can you see why the generic companies are complaining because you are not prepared to give that sort of information out?

Ms Halton—As the officers have already indicated, the bottom line is that there is nothing in those components which go one way or the other to the generic companies' issues.

Senator SIEWERT—They think there is.

Ms Halton—I know they do, but—

CHAIR—Senator, I think the only way you can proceed is to go straight to the minister. The officers cannot do any more.

Senator SIEWERT—I do not think Senator Boyce covered the issue around the F1 patents.

Senator BOYCE—I am glad you are going to talk about that.

Senator SIEWERT—Yes. There are claims by the GMiA that some of the clauses in the MOU may drive up the costs of F1 patent medicines.

Ms Halton—Given that the prices of F1 patent medicines—or shall we just say 'F1 medicines' because we do not, as I say, make a distinction—

Senator SIEWERT—Yes.

Ms Halton—F1 medicine pricing is determined by the PBAC's cost-effectiveness analysis and then by price negotiations. There is nothing in this which will actually affect that.

Senator BOYCE—But isn't the F1 taking a larger and larger percentage of the PBS?

Mr Learmonth—Whatever share of the PBS it takes is a product of what happens to prices in the off-patent market and a product of what new medicines come on to F1.

Ms Halton—That is right. If you believe the drug companies, they say that the pipeline coming in is actually shrinking. You can believe that or not—

Senator BOYCE—Sorry, the pipeline?

Ms Halton—The pipeline.

Senator SIEWERT—The number coming on is—

Mr Learmonth—The originator companies say that the pipeline is shrinking. They have got blockbusters coming off patent—

Ms Halton—Yes.

Mr Learmonth—about to go generic and they have nothing in the pipeline to replace them.

Ms Halton—You can believe that or not.

Senator BOYCE—So in the future this will be the case?

Mr Learmonth—In the near future. That is what they claim.

Senator BOYCE—Good-o, if that is what they claim.

Ms Halton—That is what they claim.

Senator BOYCE—Sorry, Senator Siewert.

Senator SIEWERT—I have finished on that lot.

Senator BOYCE—Could I just ask one or two more in this area?

CHAIR—Sure.

Senator BOYCE—Is it right that under the memorandum the number of items covered by price disclosure will go to 1,600? Is that correct?

Mr Stuart—Yes—that is, brands of medicines.

Senator BOYCE—So you have 1,600—

Mr Stuart—Brands of different medicines, that is right.

Senator BOYCE—Is that 1,600 medicines?

Mr Stuart—No, it is 1,600 brands. There could be one medicine for which there are 20 brands.

Senator BOYCE—Twenty brands.

Mr Stuart—This is the total number of brands that will be subject to disclosure.

Senator BOYCE—So 1,600 items. You have about 160 at the moment. Is that correct?

Mr Learmonth—That is correct.

Senator BOYCE—We have a tenfold increase there. What is the intention in terms of dealing with that administratively?

Mr Learmonth—I guess hence those administration costs.

Mr Stuart—Yes, exactly—hence the administration costs.

Senator BOYCE—But what is that administration going to look like?

Mr Stuart—We will have four quarterly periods of data collection and data provision that will come in. We have a number of months to prepare for this, because the first data collection period begins in October.

Ms McNeill—The first data is due in January 2011.

Mr Stuart—The first data begins to be collected from October of this year.

Senator BOYCE—Yes.

Mr Stuart—We are starting our discussions with representatives, hopefully on Tuesday of next week, to talk about the logistics for this with all involved.

Senator BOYCE—How often will they have to report—monthly or quarterly?

Mr Stuart—They will report quarterly, and we want to discuss with them in what manner it will be the most efficient for them.

Senator BOYCE—Will they have to continue to do any monthly data reporting?

Ms McNeill—Are you talking about how often they report to us or how often they collect their data?

Senator BOYCE—No, how they report to you.

Ms McNeill—They do report to us quarterly at the moment.

Senator BOYCE—I want to go back to this area of competitiveness. It has been put to me that, because there is an automatic reduction in the PBS list price when you get a second drug

coming in, that may lead to uncompetitive behaviour in the generic market. The example that has been given is that patent AU597784—

Ms Halton—I know it well!

Senator BOYCE—Yes, I thought you would—Clopidogrel.

Mr Learmonth—Clopidogrel, yes.

Ms McNeill—Clopidogrel.

Senator BOYCE—Clopidogrel. Thank you—I think.

Mr Stuart—It is one of the ones that helps us unclog the arteries.

Senator FIERRAVANTI-WELLS—Particularly if you are a heavy smoker.

Senator BOYCE—I do not know that there is anyone here who fits that category, Senator Fierravanti-Wells. Because of the challenge to that patent and it being declared invalid, there was allegedly a saving—and I will ask you to confirm or deny this—of $70 million to the PBS because it came off patent three years early. The suggestion is that those sorts of challenges would not be made by generics companies in the future if a second drug coming into the market meant that everyone got paid less.

Mr Stuart—I have had this argument put to me. I think the beginning point here is that it is in the interests of patent holders to protect their patent for as long as possible—

Senator BOYCE—That is why you have a patent, isn't it?

Mr Stuart—irrespective of what government policy does. There is an argument from the generic sector, when we take a price reduction when a generic enters, that that sharpens the incentive for the originator maker to fight to hold the patent for as long as possible. That may or may not be the case, but it does not change the fact that they had an incentive before to hang onto the patent for as long as possible, to keep the market to themselves, and if there is a price reduction associated with that, whether as a result of competition or as a result of price reduction, they are going to have to share their market. It is perhaps slightly a matter of degree, but I do not see that it changes the equation all that much.

Senator BOYCE—I was looking at it from the other perspective, which is: what is in it for a generic manufacturer to challenge a patent if they do not perceive that there is a good profit to be made in that area?

Ms Halton—Let us be clear about this. We are not just talking about an Australian market.

Senator BOYCE—I realise that.

Ms Halton—This is a global market.

Senator BOYCE—They are currently our top exporters, which was a discussion that was had with the department of industry and innovation.

Ms Halton—But this is a global market. If there are patents to be challenged, the equation that you do about whether or not you are going to challenge a patent is one you do in terms of the global market. You do not take a decision about whether you are going to challenge a patent based on a very narrow, dare I say, Australian-centric perspective.

Senator BOYCE—Yes.

Ms Halton—The bottom line is that the generic market is a global commodity market, and we have historically paid too much for those products.

Senator BOYCE—Some would argue that we continue to.

Ms Halton—That is precisely the point about this policy. What it actually enables is genuine competition on price in the commodity market and that competition is to the benefit of the taxpayer, which is as it should be. What that does is enable us to invest the health dollar in the most effective place we can put it, which could be a number of different places, but it certainly should not be invested in a product that we can buy for a cheaper price. We know that the price disclosure arrangements and the competition in the market—because this has been demonstrated to us by how it was operating—drive down the price.

So it is actually neutral. You are going to make your decision about whether you challenge a patent or not based on that global position. Once that patent has been challenged, every generic manufacturer is in the same category. They have to decide whether they are going to enter that market based on how much market share they can get and what they think the price they are going to get for it is, and they have to take account of competition in making that decision. This does not change any of that.

Senator BOYCE—Thanks, Chair.

Senator FIERRAVANTI-WELLS—Dealing with pharmacy and pharmaceutical awareness, on how many occasions this year has the minister agreed, under discretionary power, to consider a pharmacy location?

Mr Stuart—The minister has agreed to consider the use of her discretion on two occasions and both were this year.

Senator FIERRAVANTI-WELLS—Did she approve a pharmacy location on both occasions?

Mr Stuart—On both occasions that she agreed to exercise her discretion, she approved a pharmacy.

Senator FIERRAVANTI-WELLS—You must have been a lawyer in a previous life, Mr Stuart!

Mr Learmonth—That’s a terrible thing to say to an economist!

Senator FIERRAVANTI-WELLS—Isn’t it just? Cruel cut! It is my way of getting back at people who make dreadful comments about lawyers. In relation to medication review, is that something within this—

Mr Stuart—Yes, it is.

Senator FIERRAVANTI-WELLS—Periodically we do medication reviews. How often do we do them, Mr Stuart?

Mr Stuart—Now I am completely unsure what you mean, I am sorry, Senator.

Senator FIERRAVANTI-WELLS—Like medication reviews. I asked this question now, but perhaps I should have asked it in—

Mr Learmonth—Are you talking about home medication reviews under Community Pharmacy or residential—

Senator FIERRAVANTI-WELLS—I am talking about home and aged care.

Mr Stuart—Yes, that is Community Pharmacy.

Senator FIERRAVANTI-WELLS—Statistics that have been put to me about some people, particularly older people, is that they sometimes have eight, nine—what is the average medication statistic—medications that they may take. I think you know what I am referring to.

Mr Stuart—Yes, absolutely. Polypharmacy. A number of older people do use a number of medications. And we do have review programs, one in respect of people in the community and the other in respect of people in aged-care homes. What specifically can we help you with?

Senator FIERRAVANTI-WELLS—I am really asking for information, Mr Stuart. Could you provide me with this review? Are these reviews periodically published?

Mr Stuart—The reviews are of the medications used by individuals, and so the outcomes are to improve the medication use of those individuals. It is that kind of review.

Mr Learmonth—It is not of medicines. This is a review by a pharmacist in consultation with that person's doctor about whether or not there are unintended interactions or if there is some more optimal—

Senator FIERRAVANTI-WELLS—Mr Learmonth, let me rephrase my question. Is there some work that you do as part of usage of drugs in this country in terms of looking at overuse of medication—that sort of work. I am really asking the question in general terms, because I have had said to me that sometimes, particularly when we are looking at older people, there are—

Mr Learmonth—I do not think we do, specifically. I think there are some academics in particular in the field who—

Senator FIERRAVANTI-WELLS—Perhaps you could take on notice to find out if there is some work that may have been done in relation to that sort of medication review. I know that you entered into specifics with Senator Boyce, but picking up on that question, Mr Learmonth, that I asked you before—the proportion of patients choosing a cheaper generic—you mentioned to me this figure of 33 per cent. Is it possible to suggest that there is evidence of brand loyalty in the prescribing habits of doctors, or is that just anecdotal? Is there any work that has been specifically done in relation to that?

Mr Learmonth—I cannot say that I am aware of any.

Senator FIERRAVANTI-WELLS—I am just asking in general terms. What about work such as when drugs come off patent? That is an imperfect situation for both doctors and patients. They are unlikely to substitute for a generic, or there is a smaller proportion substituting for generic. Have you done any work in relation to that sort of stuff?

Mr Stuart—We have not specifically done that. Patents, on day one of generic entry, will have all of the market, and then the generic entrants are fighting for market share.

Mr Learmonth—I think it is less about the prescriber and more about the pharmacist and the way the generic manufacturers will encourage and provide incentives to pharmacists in the dispensing process to offer a generic to a customer.

Senator FIERRAVANTI-WELLS—So it is possible that we may see consolidation. It is very difficult to say, because you do not know what percentage goes off immediately when the drugs come off patent. It is really a matter of choice. You can only monitor what happens in relation to—

Mr Learmonth—That is right. Equally, that share of the generic sector has been growing slowly but steadily over the last few years.

Senator FIERRAVANTI-WELLS—In terms of the bigger picture, if you have specialist generic companies—and I know both senators asked questions about generic companies and their operation—and if they do exit and we do see a reduction in terms of generic usage—this degree of consolidation—obviously it is going to have a price impact. Is that the sort of thing that you have factored in, or have you just factored in a static?

Mr Learmonth—As we were saying earlier, we do not expect that sort of outcome, for the simple reason that the real core of this is price disclosure. As I said, it is a price-taker, not a price-setter. We do not determine a price at which a medicine will be sold. We follow the price that the manufacturers sell it down the supply chain and we take a share for the taxpayer out of the discounts that they are offering down the supply chain. So we do not force a price. We take their price, or some portion thereof.

Mr Stuart—There is no change in price and there is no change in volume, so we do not see the impact.

Senator FIERRAVANTI-WELLS—I take that point. In terms of the new PBS pricing reforms, what effect, if any, will they have on community pharmacies?

Ms Halton—They will not have any particular effect. The reality is that pharmacy had this discussed with them in the run-up to doing the agreement. They no doubt will receive fewer discounts informally through companies because, with the earlier advent of price disclosure, there is room for that to happen, but that has all been factored in as part of these arrangements.

Senator FIERRAVANTI-WELLS—There has been some extra funding provided to community pharmacies as a result of these changes. Why has that been provided?

Mr Stuart—An additional amount of $277 million has been provided into community pharmacy in the form of programs and services for patients. That is transitional funding in response to the PBS savings and that is going to go into patient services.

Senator FIERRAVANTI-WELLS—Can you take that on notice and give me some further details in relation to the services that you envisage that $277 million will fund.

Mr Stuart—For that funding? Absolutely.

Senator FIERRAVANTI-WELLS—Thank you. Is the department aware of, or is it considering, a communications campaign to promote the government’s PBS and MBS

changes for midwives and nurse practitioners? This is where Australian nurses were extended access to the program.

Mr Learmonth—We know the measure.

Senator FIERRAVANTI-WELLS—Has the department proposed or discussed a communications campaign with the minister or the minister's office?

Ms Halton—Not that I am aware of.

Mr Learmonth—Not that we are aware of, no.

Senator FIERRAVANTI-WELLS—Has there been any discussion about a communications campaign within the department?

Ms Halton—Not that I am aware of.

Senator FIERRAVANTI-WELLS—Professor Bishop, because you have been sitting there all day—

Ms Halton—Are you going to make his evening?

Senator FIERRAVANTI-WELLS—I am actually going to ask this question: at page 11, at the bottom of the page of this document—this is the yellow book—there are the funding arrangements. It arose in relation to the chemo medicines. This is the measure that has been revised to eliminate excess wastage by the dispensing of whole vials and requiring individual patient's dosages to be vial sizes. Are we looking at vial sizes just in relation to chemotherapy or is that generally looking at dosages of other things as well?

Prof. Bishop—Just chemotherapy.

Senator FIERRAVANTI-WELLS—The reason I ask, Professor, is that on the last occasion we had this discussion about the flu vaccine—and I will come to that at a later time. As I discussed this with various people, one person said to me that they observed, when they went to get their flu vaccine, that the dosage was actually quite large—it was for five doses. Is that the case? Do you understand the question?

Prof. Bishop—I do understand the question. The multi-dose vials were for the Panvax and not the seasonal flu. So we are talking about the Panvax?

Senator FIERRAVANTI-WELLS—Yes.

Prof. Bishop—That was deliberately done as part of the broad planning which would normally occur in pandemic planning, because it is to do with getting sufficient quantities out fast enough. The usual arrangement is that doctors are asked to batch their patients, so that in fact there are a number of patients who would be available at any one time for the use of a multi-dose vial.

We worked with the College of General Practitioners and the AMA to develop a guideline so that we would, firstly, have safe use and, secondly, there would be minimal wastage. Where we know about wastage—and in a couple of states we have good data on this—it is around 10 per cent, which is what the world average would be.

I should make the case that the United States rolls out seasonal flu vaccine every year in multi-dose vials and gives something like 100 million doses per year by that methodology.

They waste about 10 per cent through that method, but because of the large numbers that can be vaccinated in a mass-population situation, it is the optimal way to do that.

Senator FIERRAVANTI-WELLS—Normally it is one single dosage?

Prof. Bishop—It can be a single dose, but we cannot do that for large vaccinations.

Senator FIERRAVANTI-WELLS—That is what I mean. The norm is a single dose.

Prof. Bishop—It is normally a single-dose syringe.

Senator FIERRAVANTI-WELLS—What has happened with the chemo is not something that we are looking to do with other drugs or medicines?

Prof. Bishop—The difficulty with chemo is that you do not want to have the degree of wastage which occurs because of adjusting the size of the dose individually per patient; it is adjusted for the body weight and the surface area. It is a metre-square dosage, which is different from person to person. Chemotherapy drugs are quite expensive products, so the normal way that a large throughput program would use a particular drug would be that there would be many patients who would have that requirement.

Senator FIERRAVANTI-WELLS—Thank you. I have some questions on program 2.3, Chair, and then that would finish—

CHAIR—Where does the pharmacy agreement come in?

Mr Learmonth—It is now at 2.2.

CHAIR—Senator Siewert does have some questions on the pharmacy agreement.

Senator SIEWERT—I did have one more question on this. Are we in 2.2 now?

CHAIR—We are.

Senator SIEWERT—I have one more question about generics. How do our rates compare to other countries in the use of generics?

Mr Stuart—They vary wildly country by country. There are some we are above and there are some we are below.

Senator SIEWERT—Are you saying we are average? What about some of the countries like the Netherlands, Canada and the UK that have some stronger measures in place on price control et cetera?

Ms Platona—They are higher in generic usage in countries like Germany and the Netherlands because they have specific mandatory brand substitution policies and also other policies in place that mandate the use of a cheaper drug first.

Mr Stuart—So we are talking about tendering, for example.

Senator SIEWERT—Which is going back to the issue—

Senator BOYCE—Tendering to the equivalent of the PBS?

Mr Learmonth—For example.

Mr Stuart—To the government scheme, yes. They also have different financing mechanisms to what we have. They tend to have insurance based models, so we could have a discussion about the applicability of those policies to Australia.

Senator SIEWERT—They were the policies that you canvassed earlier, not specifically but in terms of saying you had reviewed them?

Ms Halton—Correct.

Senator SIEWERT—Thank you. Can we go on to the pharmacy agreement?

CHAIR—Yes.

Senator SIEWERT—Sorry.

Ms Halton—This is the jack-in-the-box impersonation: backwards and forwards.

Senator SIEWERT—Thank you. At the last estimates the government was very significantly progressed on the Fifth Community Pharmacy Agreement. Could you update us first on the progress on that?

Mr Stuart—We have now agreed the fifth pharmacy agreement between the government and the guild. It has been signed both by the guild and by the minister, and the agreement was placed on the website. I believe that happened on budget night.

Senator SIEWERT—With all the other things, I missed that one on budget night. Thank you. We did discuss part of it last time and I would like to follow up, please, the process for some of the ongoing issues arising out of the fifth pharmacy agreement in terms of the patient services charter and how you intend implementing that particular element of that.

Mr Stuart—First of all, we are very pleased about that initiative as part of the agreement. It was something that was brought to the table, amongst others, by the Consumer Health Forum, so we are very pleased to have been able to negotiate it.

Ms Kunca—At this point we are busily establishing the government's arrangements under the fifth agreement. What we are proposing to do is to have a meeting of the agreement consultative committee on 16 June. How we are going to progress with implementing particular aspects of the agreement, in particular the programs, will be discussed at that point.

Senator SIEWERT—Regarding the decisions about how consumers will be engaged in that process: will you start the initial discussions on that through that meeting that you have just described?

Ms Kunca—That is correct, yes.

Senator SIEWERT—I presume—since, Mr Stuart, you did make mention of the Consumer Health Forum being involved in the discussions—that you will be engaging them and other consumers heavily in the process of that development. Is that a safe assumption to make?

Mr Stuart—Yes, we will. There is a new governance structure in place for the fifth agreement, which also includes a program reference group, which will also now include consumer representation.

Senator SIEWERT—How will they be resourced? Will there be a process of helping them participate in the process?

Mr Stuart—We provide support to consumer organisations to attend meetings and so forth, yes.

Senator SIEWERT—That is what I was looking for, thank you. We have had discussions previously about the previous agreement and the various evaluation mechanisms and the public availability of data. What mechanisms are going to be put in place in terms of evaluation, the evaluation program, and how much of that will be publicly available?

Mr Stuart—Are we talking about the fifth agreement now?

Senator SIEWERT—Sorry, for the fifth, yes. I have got over the fourth one now.

Mr Stuart—We are nearly over it too. There is a clause in the fifth agreement which provides for evaluation of the agreement to take place well ahead of the completion of the agreement and in preparation for—

Senator SIEWERT—The next one.

Mr Stuart—the beginning of negotiating towards the sixth. The mechanisms for evaluation and the definition of data collection and so forth all need to commence now, in discussion with both the agreement consultative committee between the department and the guild and with the program reference group that I mentioned, which has a much broader skills base and expertise, as well as consumer involvement.

Senator SIEWERT—In terms of the way the next agreement is developed—I am already thinking ahead—will it be on the table more, to allow that to occur a bit more publicly? Certainly from the perspective I had, from the outside looking in, there seemed to be fairly secret negotiations between the Pharmacy Guild and the government. Is it intended that there would be a process developed fairly early on in terms of how the ongoing negotiation occurs?

Mr Stuart—It would be fair to say that that will be a matter for the government of the day.

Senator SIEWERT—Point taken. However, the evaluation process is intended to include various stakeholders upfront, I gather, from what you have just said.

Mr Stuart—Yes, there are a range of stakeholders represented on the programs reference group that will be involved in assisting to define the evaluation process and the data requirements.

Senator SIEWERT—Have there been resources defined for how much the evaluation will cost? In other words, is there costing for the evaluation process?

Ms Kunca—Not at this point, because it is all individual and we have to look at which things we are going to evaluate. Then we can work out the extent of the costings.

Senator SIEWERT—How does that work in terms of the departmental budgeting? Will that be a budget item for future budgets?

Mr Stuart—No. We have some departmental costs for the implementation of the fifth agreement.

Senator SIEWERT—That it will come out of?

Mr Stuart—Yes.

Senator SIEWERT—I beg your pardon. That is what I was looking for: how that will be resourced. So there is allocation of resources, a pool that you can take from, to do the evaluation?

Mr Stuart—Yes, that is right.

Senator SIEWERT—Am I allowed to ask how much that is?

Mr Stuart—What we can tell you is the total made available for the Department of Health and Ageing over the period of the agreement.

Senator SIEWERT—That would be appreciated, thank you. I will take what I can get.

Mr Bessell—We will take that on notice.

Senator SIEWERT—Okay. I was so close!

Mr Stuart—We will be able to tell you very soon on notice.

Senator SIEWERT—Thank you. That would be appreciated.

Mr Stuart—Sorry to flip-flop on that one.

Senator SIEWERT—I have another couple of questions that I think go back into the area that Senator Fierravanti-Wells touched on. It is probably a question of ignorance on my part, but I am going to ask it anyway. I have a specific question about a country town pharmacy. I understood that that would be a WA matter. How does the Commonwealth interact with the state around specific registering of pharmacies? Sorry if I am displaying my ignorance.

Mr Stuart—That is fine. The registration of pharmacists is a role for the states. The Department of Health and Ageing manages policy. There is the ACPA, which manages the implementation of location rules. Apart from remuneration for pharmacists for professional services and the management of the location rules, all of the other matters of regulation in relation to pharmacy belong in the state and territory bailiwick.

Senator SIEWERT—Location belongs with you though?

Mr Stuart—Location rules belong.

Senator SIEWERT—Location rules but not implementation of the location rules?

Ms Kunca—Technically, the implementation of the location rules is something between the department and Medicare Australia. The department manages the Australian Community Pharmacy Authority secretariat. It puts the applications to the authority for consideration. Then those recommendations from the authority go to Medicare Australia for a final decision about the approval of where to establish a pharmacy that can dispense PBS medicines.

Senator SIEWERT—Okay.

Mr Stuart—Someone wishing to establish a new pharmacy in a town is something that the department and Medicare Australia have some purview over. Allegations that a pharmacist is not appropriately delivering services is a state matter.

Senator SIEWERT—That is a state matter?

Mr Stuart—It is a state matter.

Senator SIEWERT—I will not go into specific issues. If a pharmacy in a specific town, a fairly small town, was sold, could that pharmacist almost immediately open a new one in the same town?

Ms Kunca—It depends on the rules and the particular circumstances, but it is possible.

Senator SIEWERT—It would probably be best if I wrote a letter about a particular issue that has been raised with me, rather than discussing the matter here.

Mr Learmonth—It seems quite complex actually—

Senator SIEWERT—Yes, which is why I am struggling a bit with it. It relates to service for the community; a lot of community complaints around delivery of service et cetera. Should I write to the department, firstly, and then you can direct me to where I should go?

Mr Stuart—Yes.

CHAIR—Have you finished with the pharmacy agreement?

Senator SIEWERT—I have finished with the pharmacy agreement, but I still have some more pharmaceutical questions.

CHAIR—Yes. We are just going into another program. Senator Boyce.

Senator BOYCE—I have some that are—

CHAIR—Which program?

Senator BOYCE—They relate to the Pharmaceutical Industry Working Group, but I think Senator Fierravanti-Wells had one question she wanted to ask first.

Senator FIERRAVANTI-WELLS—I want to canvass some issues in the access to lifesaving medicines, program 2.3, so I guess I will just have to wait.

CHAIR—No. I am unsure whether we have completed 2.2. I thought we may have completed 2.2.

Senator SIEWERT—I have some questions that I was chasing last time around Indigenous access. Will I ask that on Friday?

CHAIR—Yes.

Senator SIEWERT—I will do that on Friday. That is fine.

CHAIR—I am going to move to 2.3, Senator Fierravanti-Wells.

[9.23 pm]

Senator FIERRAVANTI-WELLS—Mr Stuart, you are probably familiar with the case of the funding for Soliris through the Life Saving Drugs Program. I have been approached by the PNH Support Association of Australia in relation to funding and the listing of this under the PBS. I understand that in January the department wrote to the pharmaceutical company about the funding of Soliris as part of the 2010-11 budget process. You are aware of that?

Mr Stuart—Yes, we are aware of the letter.

Senator FIERRAVANTI-WELLS—I understand that there has been some history, because it goes back to September 2009, when the association wrote to the minister

requesting that the matter be dealt with and resolved in a timely manner. Apparently the minister gave assurances—and I quote: ‘endeavour to ensure that these matters are resolved in a timely manner’. It appears that then there was a consideration by the PBAC who, I understand, recommended that the drug be funded. Is that your understanding, Mr Stuart?

Mr Stuart—I would not say that the recommendation was quite as strong as that. I think the recommendation—if Linda could find the words—was something to the effect that the government consider the funding under the program.

Senator FIERRAVANTI-WELLS—I understand that this drug is used by a very small number of sufferers and 35 per cent of sufferers will die within five years of diagnosis. It is a very difficult circumstance. I have a copy of some correspondence from you, Mr Stuart, dated 10 May, that was forwarded to Professor Sansom of the PBAC. It relates to the changes of the funding criteria and conditions for the Life Saving Drugs Program.

Mr Stuart—Yes.

Senator FIERRAVANTI-WELLS—The changes were effective from 10 May and the pharmaceutical company was advised in relation to that. I understand that the minister then put out a press release on 20 May, where she said that the government was not able to fund the drug through the Life Saving Drugs Program in the 2010-11 budget. The concern that I have—and it has been raised with me—is that, in effect, this drug has gone through the process under a set of rules where, conditional or otherwise, there has been a determination, or at least some sort of positive indication, and now the government has decided not to fund it. That means they have to start from scratch. Where does that leave the patient group in relation to these new rules?

Mr Stuart—The role of the PBAC is advisory to government, so it was, I think, always obvious to all concerned that, while advice had been given which was in some measure supportive, it was subject to government decision making in the budget context. The minister has asked the PBAC to engage further with the sponsor of Soliris, Alexion, and to have a discussion with them—these discussions have already commenced and are ongoing—about the evidence and whether there is further evidence now available to address some of the areas of uncertainty that were noted in the PBAC’s original advice. The chair of the PBAC, Lloyd Sansom, has already met with the sponsor, and they have begun discussing the kind of evidence which would now be helpful to address those areas of uncertainty. I do not think it means going back to square one.

Senator FIERRAVANTI-WELLS—That was the gist of my question, Mr Stuart. Is this a sort of deviation of the process, rather than a start from scratch?

Mr Stuart—We think so. The minister has asked the PBAC for urgent further advice. It could be considered by the PBAC again as early as July or August, depending on the nature of the evidence which the company is able to, and wishes to, bring forward.

Senator FIERRAVANTI-WELLS—I understand there was some media coverage in relation to this, and you are probably aware of some of those media reports. After rejection, do I take it then that it was on 20 May that the minister asked for further advice? Do we know of a potential date when this matter might be concluded, Mr Stuart?

Mr Stuart—Not with certainty. I want to say that the word ‘rejection’ is not being used. The minister is seeking further advice. The timetable is more dependent on what the nature of the evidence that is able to be marshalled is and the time that it takes for that evidence to be brought forward. Then, of course, it will require fresh government consideration.

Senator FIERRAVANTI-WELLS—I raise this in the context of the request that has been put to me. Obviously we are dealing with a small group of people who are in dire circumstances—I think that is what the statistics are telling us. I do not need to go into the details of the condition, so I might just leave it on that basis, Mr Stuart, and review progress.

Senator ABETZ—I wrote to the minister on 22 March 2010 in relation to one Dr George O’Neil and the naltrexone program in Western Australia. I got a relatively timely response on 16 April, telling me that my letter had been sent to the department. Allow me to briefly read my letter into the record: ‘It would be appreciated, subject to your agreement of course, if it could be arranged for Dr O’Neil and myself to liaise with the appropriate officials of your department to ascertain what the roadblocks are to support for such a program ...You can be assured I am not raising this in a partisan manner and was disappointed that the government of which I was a part did not pursue this matter to a greater degree.’

Seventy days later, we are still unable in a non-partisan way to get an appointment with the department over this issue. You might not want to trust me, but I can assure you that I want to pursue this issue in a non-partisan way, and we have had to wait 70 days without an appointment being made. What is the roadblock to getting an appointment?

Ms Halton—With whom has an appointment been sought?

Senator ABETZ—With the department.

Ms Halton—The department is a large place. Can you give me a particular indication of who has been approached for an appointment?

Senator ABETZ—It is in relation to the roadblock, and I am sure that the department would be aware of the difficulties in getting funding for Dr O’Neil’s naltrexone program.

Ms Halton—If I can make a point about this, Senator, you are talking to people from the Pharmaceutical Benefits Scheme. It should be quite clear that anybody who wishes to receive funding under the Pharmaceutical Benefits Scheme, as a sponsor of a drug, makes an application to the PBAC.

Senator ABETZ—Ms Halton, I think that is fair, and chances are that I have raised that question at the wrong time. The department can simply deal with that aspect of my inquiry on notice. I probably should have brought that up under ‘general’ or something like that. Can you take that on notice, Ms Halton?

Ms Halton—I am not quite sure what I am taking on notice. You say that there has been a request for a meeting.

Senator ABETZ—I have written to the minister seeking an appointment with the department, in as non-partisan a way as possible, to deal with this issue and it has taken more than 70 days now.

Ms Halton—No-one has approached me. I have had no approach from anybody representing yourself or anybody else seeking an appointment. This is why I am curious.

Senator ABETZ—On 22 March 2010 I wrote to the minister, ministerial liaison and support section. One PJ Moore wrote to me on 13 April, saying: 'I am writing to acknowledge receipt of your representation to the minister. Minister Roxon has forwarded your correspondence to the department for further attention.' Since that date I have heard nothing. Let's leave it there. Take it on notice.

Ms Halton—I am going to be clear about this. If you wish to make an appointment with the department, you are at liberty to approach my office in order to have that happen, but the bottom line is that no-one has approached me for an appointment. I am happy to take a request for an appointment, but you need to approach me.

Senator ABETZ—Imagine if I were to approach you direct. The minister and other people would be upset. That is why I wrote to the minister asking her to facilitate that, so that all the protocols were properly gone through step by step. I repeat again, I am not doing this in any partisan manner. In fact, Senator Siewert and I have got a unity ticket on this one, which I think indicates how this does transcend political boundaries. I will leave it on notice.

Senator Ludwig—I was going to raise it higher than on notice. Chair, can I cut to the chase and accept that as a request for an appointment? The secretary will then seek to find time with the relevant officials. Senator Abetz is probably in town tomorrow, so the earlier the better.

Ms Halton—Except that we will be here all day.

Senator ABETZ—The next sitting fortnight, if that could be facilitated, would be helpful.

Ms Halton—Senator, you are absolutely right if you have made an approach to the minister's office. That is absolutely protocol. I will seek some advice from the minister's office, because it is again protocol, as you know, that a member of the government or the government's staff should attend any such meeting. I have not actually seen this correspondence. I will endeavour to find a copy. You talk about a roadblock. I am not quite sure what 'a roadblock' means, so I need to be more acquainted with the particular problem.

Senator ABETZ—With great respect, I think there are people in your department who would have a fairly substantial file on the discussions and liaisons with Dr George O'Neil and the wonderful program that he runs.

Ms Halton—But that has been in the context of his issues with the Therapeutic Goods Administration in relation to his use of products. Those issues are resolved. I am not aware that there is any other issue on foot with Dr O'Neil.

Senator ABETZ—When were those issues resolved?

Ms Halton—Some time ago.

CHAIR—Senator, we have the approach now. There will be contact about having a meeting.

Ms Halton—But let's be clear about this. In terms of his regulatory arrangements, which was a matter of some considerable concern, those issues have been resolved.

Senator ABETZ—I met with Dr O'Neil whilst I was in Western Australia a fortnight or so ago and I did not have the impression that matters had been resolved. If we can have a meeting and see what has and has not been resolved, that will be great. I will leave it at that. Do the officials at the table accept the efficacy of the Fresh Start service and that it has a success rate 12 times greater than other good methodologies to take people off opiates.

Ms Halton—The officers at the table are not in a position to make any remarks about that. These are the people who run the Pharmaceutical Benefits Scheme. They have no particular knowledge of or expertise in pharmacotherapies in respect to addictions.

CHAIR—Wrong outcome.

Ms Halton—Wrong outcome.

Senator ABETZ—Where should it have been raised?

Ms Halton—We are happy to take it on notice.

Senator BOYCE—Is Professor Bishop aware of this area at all?

Ms Halton—I do not think Professor Bishop, in his time in the department, has had the opportunity to become familiar with some of the issues to do with Dr O'Neil. I think it would be best that we had a meeting to discuss it.

CHAIR—Senator, I think we have gone as far as we can go in this outcome.

Senator SIEWERT—What outcome would it have been?

CHAIR—Population health.

Senator ABETZ—Population health, tomorrow? By tomorrow you might be able to tell me whether we have that appointment. That would be great.

CHAIR—That might be the right place to discuss the issue.

Senator ABETZ—There was some liaison and I thought this was the place. My apologies.

Senator BOYCE—Who is the departmental representative in the Pharmaceutical Industry Working Group?

Mr Learmonth—In the Pharmaceutical Industry Working Group it is the ministers—Minister Roxon and Minister Carr.

Senator BOYCE—I thought it was government and industry representatives and, 'key leaders of originator and generic pharmaceutical manufacturers, biotechnology companies, over the counter and complementary medicine companies and research institutions and the Chief Executive Officer of the National Health and Medical Research Council.' Is there no-one from the department?

Mr Learmonth—The department attends.

Ms Halton—Attends, but not on it.

Senator BOYCE—So you attend in, what, a support role for the minister?

Mr Learmonth—To support the minister, yes.

Senator BOYCE—Do you provide secretariat services to the group?

Mr Learmonth—The secretariat is provided by Mr Carr’s department.

Senator BOYCE—How often does the group meet?

Ms Platona—The last meeting—

Ms Halton—Irregularly. Biannual. I mean—

Senator BOYCE—Sorry, when was the last meeting?

Ms Platona—The last meeting was 11 September 2009.

Senator BOYCE—The Department of Innovation, Industry, Science and Research website says:

The Pharmaceutical Industry Working Group will:

- Provide a forum for the key players to articulate their views on issues affecting industry development and consult with Government on possible policy options
- Discuss identified constraints/impediments to the industry’s competitiveness and expansion ...

What discussions were had with the working group on the memorandum of understanding in the last pharmacy agreement?

Mr Learmonth—None, Senator.

Senator BOYCE—Why was that, Mr Learmonth?

Mr Learmonth—The MOU grew out of discussions with Medicines Australia. It was an agreement between Medicines Australia and the government.

Senator BOYCE—It affects industry development and it is a policy option, isn’t it?

Mr Learmonth—I do not know that it affects industry development. The industry development aspect of PIWG—

Senator BOYCE—There will be no effect on industry development from the current PBS changes?

Mr Learmonth—The industry development focus within the Pharmaceutical Industry Working Group is more on industry assistance, R&D tax concessions, things of that nature. It is things that are more aligned to the industry portfolio, hence their secretariat support of that group.

Senator BOYCE—Things like ‘policy certainty to continue manufacture and supply of important drugs to Australia and to undertake investment in development, manufacture and export activities’ would seem to be something that the PBS has the ability to effect, is it not, or changes to the PBS have the facility to effect?

Mr Learmonth—The discussion was had between Medicines Australia and government. The government considered that was the appropriate venue and way in which to conduct that discussion and to reach agreement with the industry.

Senator BOYCE—Ms Platona, who called the last meeting, or who normally calls meetings, of the working group?

Ms Platona—I think the suggestion for a meeting is jointly agreed upon by the two ministers, as needed.

Senator BOYCE—They are ad hoc meetings?

Mr Learmonth—The industry department has carriage. They are the secretariat, so the organisation of meetings would be—

Senator BOYCE—They would be the ones who would suggest a meeting?

Mr Learmonth—I am sure that industry would have a voice in that, too. I suspect there is an interchange initially between industry, in whatever form, and the industry department and there would be an attempt to set up a meeting, given the availability of the two ministers.

Senator BOYCE—Where would I get a list of either the individuals or the organisations represented on the working group?

CHAIR—Senator Boyce, I think we have established that the secretariat is with another department, so these questions should be going to Innovation, Industry, Science and Research.

Senator BOYCE—We will accept that the minister, in estimates a couple of nights ago, did not seem entirely confident about this group—

Mr Learmonth—We are, Senator.

Senator BOYCE—and appeared not to have called many meetings.

CHAIR—We can be certain that this group says it is with Innovation.

Senator BOYCE—All right. I will continue to be somewhat surprised that a group with that membership and that title had no input whatsoever into what was a fairly major PBS reform that has been introduced in the last budget, and leave it at that, Chair.

Senator ADAMS—I have a question one about a drug called Vidaza. It apparently went through the PBAC for reimbursement with the PBS in September 2009. I have had a query from several constituents as to what progress has been made with that particular drug.

Mr Stuart—Yes, Vidaza. Azacitidine is the molecule.

Senator BOYCE—Yes, I know. I was trying to dodge having to say that!

Mr Stuart—I thought I would have a go at it for the mutual entertainment.

Ms McNeill—Just to clarify, azacitidine was originally considered by the PBAC in September 2009, but its decision was not finalised until December 2009.

Senator BOYCE—Is it available now, or what is happening?

Mr Stuart—No. We have now completed a period of price negotiation with the company and it is now essentially waiting for government decision.

Senator BOYCE—Is that going to be soon, shortly, or some time?

Mr Stuart—From the department's point of view, it is one of our very small number of next most urgent things that we are working on. But, of course, the government decision-making timetable is a matter for the government and I do not think I can promise a particular timetable. It is something that we are now trying very hard to push forward as quickly as possible.

Chair, I have an answer to a previous question. Senator Siewert asked about the departmental funds for the implementation of the Fifth Community Pharmacy Agreement. The answer is $6.6 million in departmental funds over the five years of the agreement.

Senator SIEWERT—That is much appreciated. Thanks.

CHAIR—We thank the officers from outcome 2. We will take a very short break and then we will go into the last one, outcome 7, Hearing services.

Proceedings suspended from 9.47 pm to 9.58 pm

CHAIR—This is the last outcome for the day, outcome 7. I know Senator Fierravanti-Wells wishes to start. We have questions from Senator Siewert and, I believe, Senator Adams, and maybe others. But they are the definite three that we have. Senator Fierravanti-Wells.

Senator FIERRAVANTI-WELLS—Thank you. We had the hearing on Hearing Australia recently. I would like to follow up on some of the issues that were raised there and ask whether the waiting times to obtain a Hearing Services voucher have changed, or are they still taking a minimum of four weeks to process the voucher applications?

Ms Ward—We have returned to a 14-day processing time, which is our service target, from 21 May.

Senator FIERRAVANTI-WELLS—When my office called the service provider to organise an appointment, the advice was that it would take more like six to eight weeks to receive the voucher, and it was suggested that an appointment be made six to eight weeks in advance to ensure that another voucher was received. The advice to my staff member was that, without the voucher, that person could not be seen.

Ms Ward—That would be the case: they would need their voucher to be seen. But we do update our website regularly on what the processing time is. It might have been that the service provider, when they talked to the client, was basing that on what they had seen previously on the website, but we had moved, from a time earlier in the year when we had longer waiting times, towards shorter waiting times, and we reached the 14-day mark on the 21st.

Senator FIERRAVANTI-WELLS—So you are saying that there are no issues in relation to this service?

Ms Ward—No, generally not.

Senator FIERRAVANTI-WELLS—Another service provider had a similar story, but said we could pay $75, the consultation fee without the voucher, and attend an appointment much sooner. Those are two instances where we have done our own investigation. I know that we discussed this last time, but two on the same day is a bit of a problem. How many providers are out there?

Ms Ward—How many service providers?

Senator FIERRAVANTI-WELLS—Yes.

Ms Ward—There are 206 contracted service providers.

Senator FIERRAVANTI-WELLS—I take your point, but certainly the two that we rang clearly believed that there was still a six- to eight-week wait. You are saying 14 days.

Ms Ward—I should clarify.

Senator FIERRAVANTI-WELLS—Or four weeks to process the voucher application. You are saying two weeks; they have been told four weeks.

Ms Ward—That is from the time we receive it to the time we dispatch it.

Senator FIERRAVANTI-WELLS—Yes, okay.

Ms Ward—So there might be up to three to five days either side of that when the person posts it to us and when we post it back out to them.

Senator FIERRAVANTI-WELLS—All right. On the last occasion we asked about waiting times and the 1800 number. Are you still having problems with that number? I think we went through all that last time, but I am just asking whether—

Ms Ward—I understand that in May the wait time on the call line dropped. I have times up to April when the average time was up to 16 minutes.

Senator FIERRAVANTI-WELLS—Let's try over the last day or so—an answering queue between 12.30 and 2.30 advising that you will experience delay. A call was made outside those times and the queue said there was a 15-minute wait. That is another aspect which we canvassed in detail last time and, clearly, there are still problems with this as well. This call could have been made by any other person. What is your answer in response to that? It is still quite a long wait. Do callers pay for the call?

Ms Ward—No, it is an 1800 number. But, yes, you are right, that person was waiting. It depends on what time of the day you ring how long the wait might be.

Senator FIERRAVANTI-WELLS—It said, 'Answering queue between 12.30 and 2.30'. A call was made outside that time and the queue said that there was a 15-minute wait. If you have to wait 15 minutes outside 12.30 to 2.30, how long are you going to be waiting between 12.30 and 2.30? There is clearly a problem with this service. We raised it at the hearing, but what has been done about it? Have you taken any action at all since the matter was raised?

Ms Ward—We have. We got someone off supplementation from the department in March and we have increased the number of people that are in the call centre and in the applications team. We have done over 3,000 more calls this year to the end of April than we did to the end of April last year, so the overall volume of calls being answered is greater.

Senator FIERRAVANTI-WELLS—I appreciate that, but these were the things that we specifically addressed on the last occasion. You say to me that the minimum time to process the voucher applications is 14 days; I am being told it is four weeks. So my point remains: what action have you taken in relation to the waiting times to obtain a voucher?

Ms Ward—We have increased the number of staff that are processing.

Senator FIERRAVANTI-WELLS—Perhaps you need to give that a little bit more consideration, because I hope I do not have to come back to the next estimates still with four weeks. I can assure you that I will be monitoring it regularly between now and the next estimates and I will be quite systematic in doing that. There are a lot of people who count, and

a lot of them are older people, so I think it is grossly unfair that they have to wait such long times.

I might move on to the budget measure. At the hearing we canvassed the $34 million cut that was set out in last year's budget hearing services and the change of the hearing threshold and investment in preventative health, the environment health program and further efficiencies. So you are introducing this minimum level of hearing from 1 July. On the last occasion we canvassed the number of people who were affected. Who made the decision about this threshold?

Ms Ward—I think we did provide an answer to a question on notice on this matter.

Senator FIERRAVANTI-WELLS—No. The answers that you provided were in relation to the hearing threshold.

Ms Ward—We did, yes.

Senator FIERRAVANTI-WELLS—The consequences of the introduction—it pertains to the percentage of clients, rather than the threshold issue. In any case, where was the decision made in relation to the threshold?

Ms Ward—That was question No. 4 from 19 March, in *Hansard*, CA 48.

Senator FIERRAVANTI-WELLS—Question No. 4, okay.

Ms Ward—Yes. We said there that our clinicians, our audiologists that are employed in the office, determine threshold based on evidence provided in audiological professional literature and that it is widely accepted in the audiological profession internationally that 25-decibel hearing loss indicates a mild loss and internationally most government funding hearing programs have implemented minimum hearing loss thresholds. Comparatively, Australia's is less stringent. For example, in Quebec it is 35 decibels, in the Netherlands it is 35 decibels, and in the UK it is equivalent, with 25 decibels.

Senator FIERRAVANTI-WELLS—Is that literature based on clinical decisions?

Ms Ward—Yes, it is in the audiological literature.

Senator FIERRAVANTI-WELLS—Was there any clinical assessment done here in Australia?

Ms Ward—It was done by our own clinicians, our audiologists.

Senator FIERRAVANTI-WELLS—Again, after conversations with a service provider, they were not aware of the budget measure, which takes effect on 1 July, that a minimum hearing loss is required before a hearing device is fitted. How are you communicating with providers? There are, you said, about 206 providers. How are you communicating with them to make them aware of the change which is going to take effect on 1 July?

Ms Ward—We have had a consultation process that had representatives of the provider industry body, the professional bodies and consumer groups.

We consulted with them on the threshold and the criteria for exemptions. We have done quite a lot of work with them and have identified four criteria for exemptions, which have been supported by the stakeholder group. That has been approved. We are rolling out for the

rest of this month a communication strategy with the entire stakeholder group that will have guidelines, an e-bulletin setting out all the requirements, and questions and answers. They will be based on a website as well as sent to providers and there will be a capacity on that website to ask specific questions.

Senator FIERRAVANTI-WELLS—You said communication material was going out this month?

Ms Ward—In the next few days, yes.

Senator FIERRAVANTI-WELLS—We are in June. This is going to take effect on 1 July. Haven’t you left your run a bit late?

Ms Ward—Our guidelines and so on have been canvassed with all the stakeholder groups and the representative bodies and they have them.

Senator FIERRAVANTI-WELLS—Clearly one provider that was communicated with did not know. There are only 206 of them. Did you think about writing direct to them?

Ms Ward—We are doing that now that we have the guidelines. We have the exemption criteria approved. We needed to have them approved in order to inform people about what they were.

Senator FIERRAVANTI-WELLS—You had to have your communication material approved?

Ms Ward—No, we just had to have the exemptions policy approved.

Senator FIERRAVANTI-WELLS—Sorry.

Ms Ward—And the legislative instruments drafted as well.

Senator FIERRAVANTI-WELLS—You are confident that all those people who are no longer eligible to be covered—I think you were talking about three per cent. I think at the hearing we canvassed the number of people that we are potentially talking about. You are confident that your communication strategy will be sufficient to make people aware, bearing in mind that a lot of these people are older Australians. What sorts of efforts will you make? Will you go through the consumer groups? Will you put information out to seniors publications and those sorts of things?

Ms Ward—Yes.

Senator FIERRAVANTI-WELLS—You are sending this material out now. Will there be a transition period for somebody or will it be straight by 1 July?

Ms Ward—It is implemented on 1 July, but the exemption criteria which were canvassed with all the stakeholder groups, we believe, cover everyone with a clinical need that anyone can anticipate, including people who currently have a hearing device and may have 23-decibel-or-less hearing, who are using their device and who can demonstrate that. Those people would still be eligible.

Senator FIERRAVANTI-WELLS—Have you revised the number of people that will now become ineligible from 1 July or does that figure remain? I know you provided it at the hearing. How many people are we talking about that will become ineligible from 1 July?

Ms Ward—It will be hard to say because of the number of exemption categories that there are. We will have to wait and see who falls out of that, given the exemptions.

Senator FIERRAVANTI-WELLS—So you should be able to see fairly soon after 1 July.

Ms Ward—And we will be monitoring that as well—carefully.

Senator FIERRAVANTI-WELLS—By the time you answer questions on notice, you might be able to give me at least some early indication of that.

Ms Ward—Yes.

Senator FIERRAVANTI-WELLS—I have one last question in relation to answers to questions on notice. One of the things that was raised at the hearing was that a number of men tend to put the hearing devices in the drawer and not use them. I note with some interest that the answer was that gender had no significant effect on the degree of benefit obtained from hearing aids, so it is all anecdotal, I take it, that older men are not very good with hearing aids. I do not mean anything, Senator Ludwig!

Senator Ludwig—I was not going to buy into it. I was just thinking about it.

Senator FIERRAVANTI-WELLS—It became a point at the hearing. Obviously, people putting their hearing devices in their drawers does not depend on whether they are older males or older females.

Senator ADAMS—No, a lot of women do it.

Senator SIEWERT—A lot of women do, but men in particular do it.

Senator FIERRAVANTI-WELLS—Thank you.

Ms Halton—I think we are in dangerous territory here!

Senator SIEWERT—It is too early to explore the government's response to the hearing report, but one area that I do want to explore is the issue around additional funding assistance for early intervention, in particular for children. Has that issue been raised with you? Everybody was universally supportive of our program for under-21-year-olds and was not critical of the program itself but did raise the issue of specific funding for early intervention. I am wondering if that has been raised with you and whether you have given any consideration to how you would assist additional funding for the early intervention, in particular with development of language skills? You know the issues.

Ms Ward—Yes. Beyond the sort of early intervention through device and rehabilitation that we fund through the HSP and other sorts of early intervention?

Senator SIEWERT—Yes, I beg your pardon. In terms of the support, I am talking about the language development skills and those sorts of things.

Ms Ward—Yes, language development and so on. It has been raised with us and I see it in the Senate recommendations. Those sorts of early interventions tend to be funded by FaHCSIA and by states and territories with DEEWR. We have conveyed the recommendations, the background information and the things that have been raised with us to those two organisations as part of developing our response.

Senator SIEWERT—You have not looked at providing it from some of the funding sources for the services that are provided as part of the hearing program?

Ms Ward—No, it does not fall within our legislative base to provide that sort of thing.

Senator SIEWERT—In other words, you would need legislative reform. It is the same sort of issue—the sound fields issue—and the issue that we have raised in the committee report of only being able to fund devices and not sound fields, and that would require legislative reform. Does that fall into the same sort of area: to be able to fund those sorts of support services, you would need to change the legislation?

Ms Ward—There is legislative support for it in other portfolios, so what we need to do is work across portfolios to see that we have something seamless. We do the sort of tertiary end of it. Others are doing early interventions for people with disabilities; or in education.

Senator SIEWERT—So that is recognised as an area of need?

Ms Ward—Yes.

Senator SIEWERT—Thank you.

Senator ADAMS—I come back to a recommendation that the committee made on patient assisted travel and whether people going for audiology tests or treatment were going to be eligible. It was something that you said you would get back to me about in this lot of estimates.

Ms Ward—I just have to look for my bit. I know that we have contacted another portfolio on that topic.

Senator ADAMS—Ms Halton, I am on my favourite topic: asking about patient assisted travel for people going for audiology tests and treatment, as in ENT.

Ms Ward—Typically, I cannot get my hands on it now, but we have noted that as being one of the recommendations. We have contacted a range of other portfolios that are also responsible for recommendations to raise with them these issues and we will follow up on the answers. If I can find which one, I will tell you.

Senator ADAMS—All right. So long as you have not forgotten about it.

Ms Ward—No. We have identified all of the recommendations and where the responsibility may lie, then have contacted those other agencies so that we can get a comprehensive response.

Senator ADAMS—Thank you. I will ask you next time what the result is.

CHAIR—No further questions in outcome 7? Yes, Ms Murnane?

Ms Murnane—I ask your indulgence so that I can table an answer to a question that Senator Fierravanti-Wells had earlier today on aged-care workforce programs.

CHAIR—Yes.

Ms Murnane—I have the answer to that.

CHAIR—Thank you, Ms Murnane.

Ms Murnane—We will distribute it, if that is okay.

CHAIR—That would be lovely. Thank you very much. I take it that is the end. I would like to thank the officers from outcome 7 and Ms Halton. That ends today. Thank you to your staff and minister. We will now stand adjourned until tomorrow morning at nine when we start with outcome 14.

Committee adjourned at 10.20 pm