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Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

ESTIMATES

(Budget Estimates)

THURSDAY, 3 JUNE 2010

CANBERRA

BY AUTHORITY OF THE SENATE

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SENATE COMMUNITY AFFAIRS

LEGISLATION COMMITTEE

Thursday, 3 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, Back, Boyce, Brandis, Carol Brown, Fierravanti-Wells, Fisher, Furner, Humphries, Ludlam, Lundy, Milne, Moore, Parry, Ryan, Siewert and Xenophon

Committee met at 9.01 am

HEALTH AND AGEING PORTFOLIO

In Attendance

Senator Ludwig, Special Minister of State

Department of Health and Ageing
Whole of portfolio
Executive
Ms Jane Halton, Secretary
Ms Rosemary Huxtable, 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, Assistant Secretary 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
Mr 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

Department of Health and Ageing

CHAIR (Senator Moore)—The Senate Community Affairs Legislation Committee is continuing the budget estimates for the Health and Ageing portfolio. I welcome back the minister, Senator the Hon. Joseph Ludwig; the departmental secretary, Ms Jane Halton; and departmental officers for the programs that we are covering today. The committee will now continue with the program as circulated, so we are going to start this morning with outcome 14.

Senator FIERRAVANTI-WELLS—I would like to follow up on some of the issues pertaining to the flu vaccine. The Commonwealth does not fund the vaccine for children under 15. Basically the states do that in their own immunisation programs. Is that the case?

Prof. Bishop—It is only the case in one state, which is Western Australia. It has a particular program for children under five with seasonal flu vaccine. Otherwise, the government provides, in the normal course of events, a free vaccine for children and adults who have underlying medical conditions. There are a series of other conditions which are picked up on the free government program, and that includes pregnant women, Indigenous above the age of 15 and people above the age of 65.

Senator FIERRAVANTI-WELLS—I think you are aware of articles such as 'Parents warned over flu vaccine', which was in the *Australian* of 2 June. I have assiduously brought with me copies of that article, but you are aware of the press that under-fives should not be given the seasonal flu injection because it can trigger febrile fits at nine times the expected rate, aren't you?

Prof. Bishop—Yes, I am aware of that.

Senator FIERRAVANTI-WELLS—Are you monitoring the condition of these children?

Prof. Bishop—This result mentioned in the media was the result of a release that the government had put out in relation to this. From 22 April, I was made aware that there was an increased incidence of young children under the age of five presenting to emergency departments in Western Australia with febrile convulsions. We made a decision at that time to suspend the program for that age group until a further investigation could be undertaken. We have undertaken a fairly thorough investigation, including reviewing all the case record notes from Western Australia. When I say 'we', this is an investigation done by the TGA and by ATAGI, which is the Australian Technical Advisory Group on Immunisation, our normal government advisory group for immunisation issues.

As a result of that, we have good epidemiological evidence that there is a higher rate than expected of this complication, given that fever is often a situation in little children that results in a fit. Normally, in the course of events through a flu season, for example, a number of children will come into emergency departments having had a fit from an infection, and that is the normal cause of this sort of problem. But there is a low incidence of fever following vaccination of any sort. It is usually less than one in a thousand. When it is less than one in a thousand, then occasionally we see them, as we do vaccination. Most paediatricians regard it as a benign condition where children fully recover, although it frightens the parents—and rightly so. What I am saying is that there is a normal rate, and it is usually less than one in a thousand for vaccines. What we were noting was a higher rate than we expected, so we did an investigation on it.

Senator FIERRAVANTI-WELLS—There has been talk about these—basically, in my poor medical terms—three vaccines rolled into one. These children were given a vaccine that actually had three components to it. Is that the best way to describe it?

Prof. Bishop—Yes, that has been the practice for the last 40 years. Every year, the WHO in the Northern Hemisphere, the WHO collaborating centre and the WHO in the Southern Hemisphere decide what are the components of the seasonal flu vaccine for that year. It normally covers a flu A and a flu B, and often it contains another flu, H3N2. These are the common strains that circulate in the world and those three components are usually put into a seasonal vaccine. The H1N1 component has been there for many years; it just does not happen to be the swine flu component. It changes by minor genetic differences. For many years we have cycled different strains through this process, and it changes about once every year or two years. For H1N1s, it changes about once every 10 years, on average. We can see that, in fact, it is normal practice to include three antigens together.

Senator FIERRAVANTI-WELLS—And this was the first time to include the swine flu component?

Prof. Bishop—That is correct.

Senator FIERRAVANTI-WELLS—And we are the first in the world to have done this?

Prof. Bishop—We are.

Senator FIERRAVANTI-WELLS—And can I just ask who made that decision? Where was the decision made to combine the three to include the swine flu vaccine?

Prof. Bishop—There is normally a recommendation from WHO as a result of a meeting that occurs in Melbourne. I think that was in September. Subsequently it goes to a committee within the TGA for further consideration.

Senator FIERRAVANTI-WELLS—But who initiated the original proposal to combine the three components, the swine flu plus two?

Prof. Bishop—It is a normal decision taken every year in around September in the Southern Hemisphere, through a collaboration through the WHO. Then an Australian government committee would consider that recommendation.

Senator FIERRAVANTI-WELLS—So every year it comes around, and we think, 'What are the three components'—I am trying to simplify it.

Prof. Bishop—Yes. We ask: 'What are the circulating strains this year? What is likely to infect Australia?' This is all based on the next flu season, so we are looking at the circulating strains in the world at the time.

Senator FIERRAVANTI-WELLS—This was the first time that the swine flu vaccine was included. Were there any concerns? What sort of clinical assessment is done before something like this occurs? The point I am trying to get at, as you can understand, is: is the inclusion of the swine flu component a potential cause of what we have seen? It seems to be the differing component this year, so I am just trying to explore whether the inclusion of the swine flu component may be a contributor to what these children are suffering at the moment.

Prof. Bishop—Let us just take a step back, if we may, just to understand how we could come to a conclusion like that.

Senator FIERRAVANTI-WELLS—I am not making that conclusion.

Prof. Bishop—No, I am just trying to answer it.

Senator FIERRAVANTI-WELLS—I am just exploring the possibility of it.

Prof. Bishop—Yes. Just recall a couple of things. One is that we do have fairly extensive information on the single monovalent swine flu vaccine and we do know, and we have said, that it does not cause febrile convulsions to the level that we have seen. Secondly, it clearly has been used in millions of people now around the world, including many, many young children. The second thing is that there is another component that changed at the same time. It is a new H3N2. The third thing is that with the other vaccines that include H1N1, namely, the Influvac, we have 3,250 cases that have been vaccinated in Western Australia and there have been no convulsions. It does not mean that we cannot be 100 per cent that that is the case. The numbers are not the same as the swine flu numbers, where millions have been vaccinated and we have got very solid data, but it is sitting at the same level, in terms of the likelihood of febrile convulsions.

What we have said is we want to do some biological tests to understand the biology of it. We understand the epidemiology and we have identified the signal, but now we are doing a whole lot of fairly sophisticated work on the biology. What that has been so far is, firstly, we have looked at the vaccine. We have looked to see, with electron microscopy, whether there are whole bits of virus in the vaccine, whether there are fragments in there—and there are not—and whether there are endotoxins, which might contribute to a fever, in other words, a substance that causes fever. We have done that through high performance liquid chromatography, which is the usual way you would do that. We have looked at the flu vaccine manufacturing process, and the TGA have been out to the CSL plant. There is nothing in the GMP—

Senator FIERRAVANTI-WELLS—They made all three of the components for this year's?

Prof. Bishop—I am talking about the vaccine, which is produced by CSL, which is the Fluvax vaccine. There are other vaccines on the market where we have not seen this.

Senator FIERRAVANTI-WELLS—I appreciate that.

Prof. Bishop—They did make it.

Senator FIERRAVANTI-WELLS—What I am trying to say, in simple terms, is that there are three components to this year's vaccine, one is swine and there are these other two, and that was all made by CSL?

Prof. Bishop—That is correct. The other thing about that is that there is ongoing work. We have collaborated with the US Centres for Disease Control in Atlanta, and there are a number of other tests that we can do. Some of this testing has been under the auspices of a TGA expert committee and they are providing some advice about this. We have been talking to the CDC about what other investigation can be done. I would have to say the biology is not clear about why this is occurring. It is not as straightforward as, 'It is because we put in H1N1'—why aren't we showing this in other vaccines at this point that have H1N1? Also, there is another new component. We do not understand what the biological difference is at this point. I would say it is an open story, in terms of what the biology is.

Senator FIERRAVANTI-WELLS—What I am getting at is, obviously, this vaccine has gone out there on the market. You have had this reaction. Who was responsible, ultimately? The process started with the WHO and then there is a process, but somebody must have ultimately authorised it. Take me through that process. Ultimately, who made the decision that this year the vaccine would be a swine flu plus two other components? Who ultimately ticked off on those three components?

Prof. Bishop—Ultimately, medicines are allowed to become public through being registered and agreed to by the TGA. The TGA obviously authorises it. By the way, this is all for the Southern Hemisphere. The agreement has been for South America, South Africa, New Zealand and Australia. All of the countries of the Southern Hemisphere have agreed.

Senator FIERRAVANTI-WELLS—Have any countries had these problems? Have they started using the vaccine?

Prof. Bishop—A smaller vaccination program occurred in New Zealand with the CSL product and they have seen a small number of febrile convulsions, but they were not able to pick up a signal with the small program they have got. They have not seen a signal. They have also been using the other vaccines and we hope that their ongoing vaccination program with the other vaccines will also provide data for us, and they have agreed to collaborate.

Senator FIERRAVANTI-WELLS—What is the situation now? Whilst it is Southern Hemisphere, we are the ones that have basically seen the problems?

Prof. Bishop—We are the ones that have detected it.

Senator FIERRAVANTI-WELLS—What is the advice that we are now giving to parents in relation to this year's flu vaccination?

Prof. Bishop—I think we are taking a precautionary approach on this and I think that is a sensible thing. The free program, under the Australian government NIP program, has specified that seasonal flu vaccines are to be used for children with underlying medical conditions. That is the position that we have got to. What we have said is, for healthy young children under five, we would not be recommending the seasonal flu this year because of this complication, because the lower numbers with the other vaccines does not give us a degree of surety that we know everything about this at this point. It is a precautionary approach. For

normal healthy children, the Panvax H1N1 monovalent vaccine is still available. Given that the Northern Hemisphere was mainly H1N1, it is a reasonable consideration to think, 'This year, for healthy young children under five, the Panvax, or H1N1, vaccine could be given.'

Otherwise, apart from the healthy children, for children with underlying medical conditions we are suggesting this is a decision to be made by the doctor with the parents, in full understanding, now we know the side effects. There are three possibilities there to consider. There are another two vaccines which have not shown the signal, namely, Influvac and Vaxigrip, and there is also the pandemic H1N1 vaccine, which is available anyway for the most likely circulating virus this year. We have children with underlying medical conditions well covered.

Just to give you an understanding of that, if you have got a child with cystic fibrosis or severe asthma, those children cannot afford to get the flu. It will make their condition deteriorate. You have got to balance the risk of the flu, with all of the complications of flu, and they can be severe in children with underlying medical conditions, against a complication—even if it is a higher rate, and we do not think it is for the other vaccines—let us say of a fever, which can be spotted and dealt with and then is a condition which has normally got no ongoing consequence. That is why it is a medical decision, at the end of the day, about the severity of the underlying conditions versus the side effects that we have now very well documented through our investigation. That is the way medicine works. It usually is a balance of risk and benefits and that is where we are up to with that recommendation.

Senator FIERRAVANTI-WELLS—As at the last hearing we had 21 million doses of the swine flu vaccine. I understand that we have only really used up 7 million of those doses. Is that still the case?

Prof. Bishop—I think we have put out close to 9 million now.

Senator FIERRAVANTI-WELLS—So we had 21 million and we have used up 9 million. On the last occasion we were told, in answer to a question on notice, that the life of the undistributed vaccine would begin expiring at the end of July. Has CSL applied for an extension to extend the shelf life of the vaccine?

Prof. Bishop—I am not aware of what CSL has done about that.

Dr Hammett—We have not received an application for an extension of shelf life for the CSL vaccine at this stage.

Senator FIERRAVANTI-WELLS—Does that mean that if you do not receive an application to extend the shelf life, we have got 11 million doses of flu vaccine which was purchased, and I understand there is an indemnity in relation to vaccines, if that is how I understand Budget Paper No. 1. Is that the case?

Ms Murnane—The indemnity lasted until registration. This is a registered vaccine, so CSL, as the manufacturer of the swine flu vaccine, will no longer have a full indemnity from the government.

Senator FIERRAVANTI-WELLS—Okay. So if we have got 11 million doses of swine flu vaccine just sitting there due to expire at the end of July 2010, if the TGA does not give them

an extension—correct me if I am wrong—then 11 million does of swine flu vaccine is just useless.

Prof. Bishop—Just to give you a feeling for that, I think the expiry is not just on one date, because the manufacture occurs over time, so there is a staged process with respect to that expiry. We received our last doses, I believe, in December or January, so I think there is an issue of a rolling expiration.

Senator FIERRAVANTI-WELLS—Even accepting that, we have got about 11 million doses, or 10 million—there might be a variation. But we have got millions of doses worth millions and millions of dollars, because, if I understand correctly, just on memory, it was about $120 million that we expended—

Ms Murnane—Yes, in round figures.

Senator FIERRAVANTI-WELLS—in relation to purchasing 21 million doses of the vaccine. My question is: has the swine flu been included in this year's components as a way of getting rid of the doses that have just been sitting there, because, if they do not, then that is millions of dollars just down the drain. I am putting that question because, I think if you look at it, we have bought all these millions of doses of the swine flu—Minister Roxon created this situation; there was a pandemic—and we are now left with all these doses that—

Senator Ludwig—I do not think Minister Roxon created a pandemic.

Senator FIERRAVANTI-WELLS—Let me withdraw that. We had a situation where Minister Roxon was out there and all this happened last year; we bought 21 million doses of vaccine, but now we have got millions of doses that if we do not—

Senator Ludwig—I would really like to just slow you down a fraction. Is there a question in here or are you making a broad unsubstantiated statement about the pandemic? In that instance, I would rather hear from Professor Bishop about the circumstances which led up to it just to put it in context and why there was a purchase of 20 million doses.

Senator FIERRAVANTI-WELLS—No. We canvassed that last time.

Senator Ludwig—I thought we had.

Senator FIERRAVANTI-WELLS—That is not the object of my question.

Senator Ludwig—Sorry.

Senator FIERRAVANTI-WELLS—The object of my question is: we have got 11 million doses sitting there about to expire in July, August, September this year and then, suddenly, we are the only country in the world that has included the swine flu vaccine in this year's flu vaccine. Are we doing so to use up these doses?

Prof. Bishop—There are a few things there. We are not—

Senator FIERRAVANTI-WELLS—We are not?

Prof. Bishop—Every country in the Southern Hemisphere is including the swine flu. You cannot use up one vaccine by producing the other. These are separate activities. So the swine flu component of the seasonal flu vaccine has got nothing to do with the H1N1. They are separate.

Senator FIERRAVANTI-WELLS—So those 21 million doses—

Prof. Bishop—It cannot—just to understand that. Then, the second thing is that, really, the situation, as you are aware, is that the decision to order the doses was taken at the time of the upswing of the pandemic. Our expert advice said, 'Because this is a new virus, we anticipate you will need two doses for every person in Australia.' At that time, when the decisions were being made, essentially it was unknown what the clinical course of this pandemic would be. So it was a prudent course, at that time, based on expert advice, to get sufficient doses. It turns out, of course, that once the clinical trials were done—and, remember, the clinical trials did not report until September, well after all of the contracts—all of those decisions had to be made much earlier in order to get the vaccine in sufficient time. That time line is quite important.

The point I was making on the biological side is that the experts were saying, 'Because it is a new virus, you need two doses to cover people.' As it turned out, the clinical trials were unusual. They were unusual in a couple of ways. First of all, this vaccine caused a high degree of immunity. That is unusual. As I think Senator Back knows, this is an unusual situation for seasonal vaccines, that they should produce such a high degree of immunity. So it was unusual, and it was lucky in a way. Also, as you know, the TGA recommended two doses for children. So I guess the experts got it half right. They have got it half right by telling us you need two doses for everybody. The swine flu vaccine turned out to be very potent, and that is very helpful to get immunity, but more so than perhaps we have seen regularly. As a result of the decision made some months prior to that, when the clinical trials were reported, which I mentioned was mid-September, we were then in a position where, obviously, for most people, most adults, one dose would be sufficient. That is the rationale. You can think, in retrospect: what else could have been done? In the face of the first pandemic for 40 years, without knowing the clinical situation we know now, I think it was the right decision at the time to protect the population. I still think it was the right decision at the time.

Senator FIERRAVANTI-WELLS—Professor, can I just clear this up. On the last occasion there was some question about the contract. I raised issues about a contract to CSL for some clinical trials, and that contract, I think, was around November, whereas the rollout had been before that. Ms Halton, I think on that occasion you told me there had been some sort of glitch in the computer system, and that was going to be taken on notice. Is that the case?

Ms Murnane—I do not recall that. The clinical trials actually began before the release of the vaccine in Australia.

Senator FIERRAVANTI-WELLS—Ms Murnane, there was a contract to CSL where we were paying them—November, December, January. I raised it specifically at February estimates, and I raised it in the context of: why are we doing clinical trials after it has been rolled out and paying CSL?

Ms Halton—No. It was an accounting issue. Colleagues can talk to you about that.

Ms Bryant—You did raise that issue and, on checking the information you gave us on that occasion, we found there was an error in the data that had been lodged on the AusTender site. That has since been corrected. The commencement date for the clinical trials contract was

incorrectly recorded in AusTender as 1 December 2009. That has been amended to show a contract commencement date of 5 June 2009.

Senator FIERRAVANTI-WELLS—Your internal documentation backed that up?

Ms Bryant—Yes, it will. Although on the front page, I think it does not alter the way AusTender has set it up. When you go to the subsequent pages you will see the amendments that have been made to the site—corrected in the light of the issues you raised.

Senator FIERRAVANTI-WELLS—Thank you. I wanted to correct that because that was raised on the last occasion.

Ms Bryant—Yes, certainly.

Senator FIERRAVANTI-WELLS—That was the point I was making, Ms Murnane.

Ms Murnane—I do recall.

Senator FIERRAVANTI-WELLS—Thank you. I did not make the allegation just out of the air, Ms Murnane.

Ms Murnane—No. I was not—

Senator FIERRAVANTI-WELLS—I did have my facts correct. After the swine flu pandemic, I understand, at the last occasion it was indicated that there would be a review undertaken in regard to how the Commonwealth and the various states responded, and I think there was going to be a COAG pandemic influenza group, which was to meet in February. What was the outcome of that? Was that the only review that was undertaken?

Prof. Bishop—There has been a whole series of reviews. What we have done is worked with the groups that came together during the pandemic that provided support. We have had a review from our GP round table, for example, which puts together all the issues that the general practitioners discovered—things that went well, things that did not; that sort of thing. We also had a meeting which included all of the expert specialists. These are the intensive care specialists and the respiratory physicians and others who assisted us during the process. We have also had discussion with the chief health officers. The CDNA network approach group have also met and provided some ongoing feedback. This work is still ongoing. In other words, we have identified some issues. There is some ongoing work. There will be some documentation coming forward in relation to that. But this is also helping the Australian Health Protection Committee to determine how things were handled, in retrospect what could have been done better, what went well and, obviously, what we want to support more completely as a successful approach.

Senator FIERRAVANTI-WELLS—So at the end of all this, do we know how many people all up were infected with swine flu?

Prof. Bishop—We have to say we do not. We know how many people reported. I will just clarify what I am talking about here. It is to do with testing. In the early phase of our pandemic, what we did is we tried to case manage and find everybody. Once we realised that it was spreading through the community, we changed our phase to this new protect phase, and what that meant is we focussed down on the vulnerable. So we were only testing those with deteriorating flu, severe flu, and those in high-risk groups that were likely to have a bad

outcome. We stopped testing the rest of the population. It went through the population without us wanting to test it, and that is the normal approach that one takes from a public health perspective, so this would be best practice, really.

So we cannot say exactly, but I can tell you something about what happened with the first wave, and we know from London and Manchester that between 15 and 25 per cent of the population were infected in those cities towards the end of their winter. We have some preliminary information from Australia from the various states, and if I could just, without actually going into all the data, fairly summarise it for you. Somewhere between 15 and 25 per cent of the population were infected, but it is very age dependent. So it happens in toddlers that around two to nine per cent were infected. For school-aged children, which are the super spreaders, it is much higher, it is around 30-35 per cent. For the elderly, who may have had some degree of cellular immunity or some other degree of immunity from previous pandemics or epidemics we do not understand, probably swine flu—

Senator FIERRAVANTI-WELLS—That is one of the advantages of getting older. You do build up some immunity.

Prof. Bishop—That is right. Those people over the age of 65, essentially, had a low infection rate. Trying to put all that together for you in an overall understanding, given the geographical differences as well, around 20 per cent, let us say, would be a reasonable figure to aim for, based on all of that data. That is what happened, but that—

Senator FIERRAVANTI-WELLS—But we do not know that. That is just—

Prof. Bishop—They are serological surveys, which are accurate, but they have got to be all put together into a picture, which I have just tried to do for you.

Senator FIERRAVANTI-WELLS—All right.

Senator BACK—And the mortality—

Prof. Bishop—I am sorry?

Senator FIERRAVANTI-WELLS—I was going to ask that. Senator Back said, 'How many died?' Sorry, you stated in medical terms of 'mortality rates.' I was just going to say, 'How many people died?'

Prof. Bishop—Again, what we have done is we have identified 191 individuals who we know had H1N1 where there is a reasonable consideration that it was contributing to their death, but remembering some of those may well have died of other things.

Senator FIERRAVANTI-WELLS—Other complications.

Prof. Bishop—Then there are other people that we probably did not know about, based on what I have just told you about this broad population thing, and that is just inevitable. So what we look at are the broad statistics of pneumonia and influenza deaths in the community, and there is a statistic that we follow on that, and that was lower than the previous year, although not hugely substantially so. Normally, the figure bandied about that you know about, which varies from year to year, is around 2,000 to 3,000 deaths from influenza and pneumonia influenza every year, and this was probably lower than that, based on that, but it was not 191; it was a number which was somewhere between 1,000 and 2,000.

Senator FIERRAVANTI-WELLS—Okay. In the end, there was a level of hospitalisation. As I understood the evidence given on the last occasion—and I think, Ms Murnane, you indicated that you were about to, on that Friday, attend the COAG pandemic influenza group meeting, which I do not know if you attended—part of it was going to be the impact on the hospitals and whether there was going to be some evaluation in terms of the hospital response following the pandemic.

Ms Murnane—Yes. There was a meeting that the Department of Prime Minister and Cabinet convened of all the states and territories and the Commonwealth, in which the states and territories and I, on behalf of the Commonwealth, spoke of our experiences, highlighted some of the main issues that were unexpected and that we had to draw into the domain of expectation in the rewriting of the plan. Among those was the use of ICU and the use of ECMO—and Professor Bishop is better to describe that than I, so Jim, you might just come in and—

Prof. Bishop—Yes. The story of the epidemic is essentially that of a reasonably high infectivity—it spreads around reasonably easily, is what I am saying. It affected younger people than traditional flu, and the median age of death was 53, compared to 83 normally, and it had a higher rate of hospitalisation than with normal flu. Particularly we are concerned about the hospitalisation into intensive care that was over 700 cases, and we collaborated with the intensive care research network to get that information, and that was a great collaboration, I think. The issue is not so much just the deaths; it is the morbidity component as well, which is really important, and in the younger people.

Senator FIERRAVANTI-WELLS—Can I just summarise it: what went well, and what did not go well, what could have been done better, and what were the lessons learned? If you could just give us that overview.

Prof. Bishop—We were still getting a lot of information together, but I think it is quite clear what went well is all of the planning that went into pandemic planning over the years, and I am not a party to that; I can just admire it, remembering that this is the second pandemic plan that we worked off. It also had been exercised through operation Cumpston, which I think was a very useful exercise to get some of the logistics done. So that worked very well. I think the Australian Health Protection Committee worked extremely well under the leadership of Deputy Secretary Murnane. I think that showed leadership, and although sometimes the media might have played up differences, in fact, almost all decisions were joint decisions, collaborative decisions where people were working very collectively around the jurisdictions with the Commonwealth. When the chips are down, people actually often put aside some of the issues, and actually, people worked extremely well. I think the Australian Health Protection Committee worked very well.

The pre-planning and the information that we got from overseas was critical to us, because while we had a lag period between when the epidemic was affecting the Northern Hemisphere and when the first case came to Australia, that seven-week period was critical because we could find out about the biology, who was affected, who were most vulnerable, and what the outputs were looking like. We were starting to see the ICU story straight away. We understood the indigenous issue straight away from Canada. We started to understand that the death rates were much less in the US than they were in Mexico, so we understood it might be quite

different to what a pandemic with a high death rate might look like, so we may have to consider how our plan would be flexible. All of that set us up so that by 6 June, with a meeting which we had of the chief health officers, we were able to give chapter and verse about what the virus was doing and how it would affect this country. That was a critical meeting to provide some additional flexibility into our plan, which allowed us then to be positioned exactly where the biology was. That was an important step for us, that the plan was there as a backup and we could just add to it based on what we were actually seeing, and that is a huge thing.

The other clear message is that, of course, viruses do not behave appropriately. They attack different geographical areas differently. So we had one area of the country—and this is a lesson—which was in a different position than other parts of the country It probably was always thus and it was thus at the end. So that is why the serology, as I mentioned before, is quite patchy, but it also means that the health authorities locally must be able to react as they see fit in their jurisdiction as well.

Senator FIERRAVANTI-WELLS—I hear all that. What you are saying to me is that everything went well and there were no problems? Is that—

Prof. Bishop—No, I have not said that. I am just saying what—

Senator FIERRAVANTI-WELLS—I asked you what went well and what did not go well, and I am waiting for the second part of your answer.

Ms Murnane—Senator, I might come in here. I think that there were some problems that we are—

Senator FIERRAVANTI-WELLS—What are they? That is what I would like to know. You have said that it would be evaluated and that you would come back. Now is the opportunity, Ms Murnane—

Ms Murnane—And we are drawing—

Senator FIERRAVANTI-WELLS—so tell me what did not go well.

Ms Murnane—What did not go according to plan stemmed in large part from the fact that the virus behaved differently from the pandemic we prepared for, as the director-general of the World Health Organisation said on one occasion that history had misled us or we let ourselves be misled by history. Our pandemic plan and the pandemic plan of other countries, including the WHO plan, was predicated on a much more virulent pandemic. In fact, though, it was better that we had to step down than step up, and what Professor Bishop said about the plan was right. The plan was a guide. One of the things that, in a sense, went wrong was that we could not follow the plan according to Hoyle. We had to, in the course of managing the emergency, modify the plan, which we did. We modified the plan during the course of the emergency in three ways.

One way was that we introduced a new phase: protect. That allowed more flexibility across Australia. This was related to the fact that the virus does not behave itself according to categorisation. The virus basically presents differently and involves differently in different states of Australia. That did mean that there were some issues across states and there was some publicity in national and state media around different phenomena in different states, and

the imputation was at times that some states were not doing as well as they should have been. That actually was not right. The phenomena was that the virus started in one place, became very intense, moved very fast. We had to respond to that, and we did with the phase protect, which was nutted out between the chief medical officer and the chief health officers.

We had anticipated that there was going to be an issue about school closures, but we had not anticipated how complex that was going to be and the extent to which the issue of school closures was going to flow into wider economic and social consequences. So, in the next plan, we have to draw from the knowledge we gained in this experience and go into more detail about this. The idea of the plan is that we will have in some ways pre-digested some of the problems and be ready for them. I am being very frank here: we had not fully anticipated the issue that could arise with cruise ships, and so in the course of managing the emergency we developed a special annex on how to deal with cruise ships that we worked out with all the states and territories and also with the CEO and executives of the main cruise ship company that was active in Australia during that season.

The third area that I wanted to draw attention to that next time we will anticipate and be more ready for is the disproportionate impact on Indigenous people. We got very early warning of this, that this was happening in Canada. Quite early, before we had the first case in Australia, we made some arrangements and we did develop, again in the course of managing the emergency, a special annex on Indigenous. All of these things will be brought into our new plan, but one of the precepts of planning, and what we have to be more ready for next time, is that we will have to depart from that plan, because in the situation we plan for, nature is not going to follow our categorisation and our framework exactly. But looking back on it, I think that we were agile enough to be able to respond and adapt in the course of the emergency.

Senator FIERRAVANTI-WELLS—As part of the analysis, what about the response of our public hospital system and those reports where everything else had to shut down whilst we dealt with potential swine flu? There were some reports at the time in the newspapers. I think we even canvassed it on the last occasion.

Prof. Bishop—What we found really was that, because it was rolling around quickly and transmitting quickly through the community, there would be one hospital where, for a week, they would have significant stress and they may have had to cancel some elective surgery, but then it would roll on and there would be another area. Because remember the intensity of the peak is around three to four weeks, so for that three or four week period it will roll around as that peak moves around the community. So there was not wholesale shut-down of elective surgery. There was stress, there was a lot of work in emergency departments, but I would say it was coped for around the system as the infection moved—remembering it is that short time frame that we have to deal with.

One of the things to plan for for the future is: what if that time frame were blown out and it was not three to four weeks but that intensive period went on with a more virulent virus for a longer period of time? How would we deal with that? Those are the sorts of things we are considering.

Senator FIERRAVANTI-WELLS—And just to conclude, the 11 million doses that will effectively just expire in July: is that likely what is going to happen?

Prof. Bishop—The first thing I would say is the vaccine is still being used. There has been continual take-up. There was a blip down in the—

Senator FIERRAVANTI-WELLS—Yes.

Prof. Bishop—But we have a winter in front of us. We have some question marks about some categories of use of the trivalent vaccine, so the alternative is the Panvax vaccine, so we think we are in a good situation to have the availability we do. I think we are in the middle of the start-up of a flu season with this vaccine available with this, most likely, the virus. I just think it is a little bit premature to say, 'Well, it is useless.'

Senator FIERRAVANTI-WELLS—But chances are, after this flu season, whatever is left over will just have to be ditched, I suppose.

Prof. Bishop—I do not think a decision has been made.

Senator FIERRAVANTI-WELLS—Sorry?

Ms Murnane—Could I come in here for a moment?

Senator FIERRAVANTI-WELLS—Sorry, I did not hear what the professor said.

Prof. Bishop—I am not sure that a decision has been made.

Senator FIERRAVANTI-WELLS—I am just asking is that the likely situation, that those millions of doses will just be ditched?

CHAIR—Senator, I think the answer has been given. Ms Murnane.

Ms Murnane—Could I just put a perspective on this. It is actually more like 10 million that we will have left over, and it may be less than that because of the continuing take-up of the H1N109 vaccine.

Senator FIERRAVANTI-WELLS—I thought I said nine or 10 million.

Ms Murnane—More like 10 million left over. What I am doing there in getting to that 10—and I have just been looking at my notes—is that, if you remember, Australia donated 2½ million doses to the World Health Organisation, and those are now being distributed. If we look back—and I refer back to what Professor Bishop said earlier—we ordered sufficient vaccine for one dose for half the Australian population. It turned out that—

Prof. Bishop—One course.

Ms Murnane—One course.

Prof. Bishop—Two doses, yes.

Senator FIERRAVANTI-WELLS—For 21 million. That is what I was told last time.

Prof. Bishop—Yes, one course.

Senator FIERRAVANTI-WELLS—21 million population, I thought that the object of the exercise—was that not the gist of the question?

Prof. Bishop—The object of the exercise was to cover half the population.

Senator FIERRAVANTI-WELLS—All right. Okay.

Prof. Bishop—Because we thought we needed two doses.

Ms Murnane—Now, it turned out that we did not need two doses; we only needed one dose.

Senator FIERRAVANTI-WELLS—My question—

Ms Murnane—So we will still have—

Senator FIERRAVANTI-WELLS—still remains: what is going to happen to those 10 million—

Ms Murnane—We will still have vaccine that is left over. We have explored a number of possibilities of countries that might want that vaccine, and no country yet has indicated that they want it, but we would be prepared, should other countries like to make use of that vaccine, to make it available. As Professor Bishop said, as the vaccine came in tranches, it will similarly expire in tranches.

Senator FIERRAVANTI-WELLS—I appreciate that, but what happens at the expiry date of this vaccine? It is no longer valid. You have got 10 million doses out there. If we do not offload them to other countries, then that is 10 million doses that are just going to be ditched. That is my question. I am just asking for a simple answer. What happens at the expiry date?

Ms Halton—We cannot give you that answer yet, because the bottom line is there is a whole series of unknowns in this equation. We do not know what the manufacturer is going to do in terms of applying for an extension. We do not yet know how much is going to continue to be rolled out. We actually cannot answer a hypothetical on this.

Senator FIERRAVANTI-WELLS—Okay.

Senator BACK—I wonder if I could pick up on the point of the learnings from last year. There was concern, I recall, Professor Bishop, of the communication between the chief health officers in the different states in terms of actions that might or might not be taken. As a result of the 2009 experience, have your standard operating procedures changed to give you a greater degree of control in the event that there is not cooperation between the chief medical officers in each state? For example, movement of people was one, if you recall, Ms Murnane, as a result of the cruise ship situation.

Prof. Bishop—We are looking to capture hearts and minds rather than control, if you know what I mean. I think the idea would be to get a strong consensus so that the chief health officers work off the same evidence base and therefore will work together. That is really—

Senator BACK—My question really is: do you have that consensus?

Prof. Bishop—Yes, I think we do. I think the latest events with respect to the issue in Western Australia is a good example where in fact there has been a high level of collaboration and agreement about the approach, and very much support for the investigation done by TGA and ATAGI in relation to getting the evidence that we required to make the right policy setting or approach.

I think that the exercise of the pandemic and the exercise that we have dealt with since has actually brought the group well together, and the way that we work now is by easy

cooperation and easy communication, and that has been a very collective activity. I would say that has been one of the positives of this whole thing, that we do get much better collaboration.

Senator BACK—Of the pandemic. Can I go back to the question of the H1N1 vaccine unused and ask Dr Hammett: what would be the circumstances under which TGA may consider extending the shelf life of those vaccines that are currently in storage unused?

Dr Hammett—Just to preface that, there are well-established processes, not just for pandemic vaccine but for all medicines if, for any reason, the manufacturer believes that the shelf life can be extended. For instance, if they have improved a step in their manufacturing process, they can apply for an extension of that shelf life, and that application is made to the TGA. Our scientists at the TGA assess the rationale for the application and whether there is sufficient scientific information to support it. Indeed, they may well conduct, within our laboratories, additional testing to ensure that the vaccine remains both safe and efficacious, that if it was going to have a shelf life extension it would still work and it would work in the same way that the vaccine was intended at the point of registration. We will go through that same rigorous scientific assessment if we receive such an application.

Senator BACK—Thank you. Can I ask, coming out of the Northern Hemisphere winter, what the experience has been in 2010 with this particular virus?

Prof. Bishop—Yes. Perhaps I can just start off there, shall I? The experience in North America was illustrated to us in some discussions with the department of health in Washington DC. Essentially what happened was that the normal start of the flu season occurred in the United States, there was a fairly usual uptake of flu throughout the community but then, surprisingly, halfway through the normal epidemiological curve, the epidemic or the activity ceased.

At the same time as that was happening, two other things were occurring, first of all from the first wave and then from the subsequent second wave. I would say the experience is about 90 per cent of the influenza under the age of 65 was swine flu. But it was an unusual epidemiological curve in that it had the normal upswing, but then stopped halfway through in the middle and then rapidly declined, and has been at low levels since.

A couple of things could be in play here, and we do not know exactly and we are getting advice from the CDC and others about this. I was speaking to the assistant secretary of state for the US last week in Geneva about this, and the theories are, of course, that it has got to a level of natural immunity in the community from the first and second wave at the same time they were rolling out their vaccine program. The obvious conclusion is not that the virus has changed in its transmissibility or anything but, rather, that the immunity, both vaccine and natural, has come to play. We are very hopeful that this country this year will have a very low level of influenza A activity. I think it is quite likely, but that is just a guess at this point.

Senator BACK—In those countries where mortality rates were high, Mexico and others, has that been a similar pattern, that there seems to have been a natural immunity built up in the wider community this year?

Prof. Bishop—It was similar in some of the other Northern Hemisphere developed countries. Mexico, Venezuela and Argentina are really countries that are quite informative. The death rates in South America were very high.

Senator BACK—In 2009?

Prof. Bishop—Yes. While we were having 191 that we identified, and I said a few more probably from our broader statistics, nevertheless they had hundreds. I think it shows the value of, obviously, a good health system as part of dealing with something like this.

Senator BACK—Certainly. Can I just go back to the vaccine production, and you can correct me if I am wrong, but my understanding, Ms Murnane, was that Australia was required to take its full 21 million doses when ordered where other countries were able to roll back their orders. The figures that have been given to me were that Britain originally ordered 90 million doses from CSL but were able to roll that back to a figure less than that. Am I correct in that information?

Ms Murnane—I cannot comment on the UK. Most of their supplies I thought came from GSK and Baxter, not from CSL, so I do not know what arrangement they had with CSL.

Senator BACK—I wonder could you take on notice whether in fact that is the case. The countries that I was informed of were France, the US, Germany and the UK, that all had placed orders and all were able to roll back their orders contingent on the pandemic having effectively concluded in those countries. Is it possible to get some further information on that?

Ms Bryant—Perhaps I can help here. We do not know what the content of the US and UK contracts was, but we surmise that, in effect, what they had in them was either a stop work or a termination for convenience clause. Our contract similarly contained a termination for convenience clause.

Senator BACK—Right.

Ms Bryant—It is just that in order to exercise the right to terminate for convenience, there are only certain points in the decision-making process where that was possible to happen. The first opportunity would probably have arisen about June, and at that point we had in fact just placed the order very early on—

Senator BACK—Just got underway.

Ms Bryant—and we still did not have trial information or any knowledge about the number of doses that would be required. We still expected we would need two doses to cover about half of the population. The next opportunity probably would have arisen around September, and at that point certainly we had some inkling that, at least in adults, one dose would be required. But at that point in the process CSL had in fact already completed all of their manufacture of the bulk product and were beginning on packing and filling. So had we exercised a termination for convenience clause, we would still have been liable to pay CSL essentially the bulk of the purchase price.

Senator BACK—By that stage you had purchased and they had produced.

Ms Bryant—Yes.

Senator BACK—And the 21 million were in some form of production.

Ms Bryant—Quite.

Prof. Bishop—There are two sides of this, too, which you would be aware of. You want rapid production. In fact, we want to make it shorter. We want to make it a few weeks rather than a couple of months. So, when you get into that, then the ability to actually intervene becomes harder. The whole of the world is now trying to make this production line shorter for obvious reasons. That is part of the dilemma here.

Senator BACK—I think you said, Ms Murnane, that we did in fact make two million or a couple of million doses available to World Health for the region?

Ms Murnane—We did. It was $2½ million.

Senator BACK—Australia gifted that, presumably?

Ms Murnane—Yes. CSL also made a gift to the WHO, and other countries made gifts to the WHO, including the US. In relation to the vaccine, I just say again that our order, actually, was modest and, at the time we made the order, which was to cover half the population, we thought we may need to make a further order.

Senator BACK—Absolutely.

Ms Murnane—We negotiated, and I still think we negotiated, a very good deal. I cannot comment on the circumstances of other countries, but what I can say is this: when we started to roll out our vaccine, we had requests from a number of other very large countries either to donate or sell them some of our vaccine, or to allow CSL to supply them before they supplied us. You are trying to see into the future. You do not have a clear line of vision. At the time in which we negotiated that contract, the Director-General of the WHO had declared worldwide pandemic. She had said that, while it was not virulent yet, it could mutate at any stage, it was a true pandemic, it had at least two of the features of a pandemic and the whole world had to prepare for it. That is what we did. It could have turned out the opposite. As Professor Bishop said in relation to hospitals and ICU, if in fact it had been more virulent, we would have been in difficulty.

Senator BACK—We would have been looking for more—absolutely.

Ms Murnane—If it had been more virulent, after you use up all the potency of the other parts of your armoury, both pharmaceutical and non-pharmaceutical, the only real protection is vaccine.

Senator BACK—Yes.

Ms Murnane—What we are trying to do is to shorten the space.

Senator BACK—Exactly. I will go back now to some questions that were asked earlier with regard to the seasonal flu for this year, Professor Bishop. I think you said that there were 3,250 children under the age of five vaccinated in WA. Was that correct?

Prof. Bishop—That is correct, yes.

Senator BACK—I have a number of 251 who had adverse reactions. Is that of that group of 3,250?

Prof. Bishop—No. I am sorry. I was quoting two different groups.

Senator BACK—Right.

Prof. Bishop—There is a group that have got the flu vaccine, and they were subject to an epidemiological study by ATAGI and an investigation by the TGA. We are saying that the rate of febrile convulsions there is around nine per thousand. In addition to that, a separate group of children, the group that I mentioned, the 3,250, were treated with the Influvac vaccine.

Senator BACK—Influvac has just the one—

Prof. Bishop—No, it has got three components.

Senator BACK—Influvac has the three?

Prof. Bishop—Including the H1N1 component, which I mentioned to the other senator. In fact, in WA at this point we have not had a convulsion from that vaccine. There has been a small number of convulsions in other states, but the point is that it is within the range that you would expect for a seasonal flu and it is quite a different experience to the Fluvax.

Senator BACK—Were the 251 adverse reactions from the combined three-in-one vaccine or were they from a different, single-virus vaccine?

Prof. Bishop—In relation to our releases on seasonal flu, it is all the triple antigen vaccine that we are talking about there.

Senator BACK—Yes.

Prof. Bishop—We have a done a comparison there with Panvax, which is sitting below the rate that you would expect for a seasonal flue. But it is all triple antigen.

Senator BACK—You mentioned earlier that 22 April was the first time you were made aware of this spike.

Prof. Bishop—Yes, I was called. That is right.

Senator BACK—Do we have any understanding at all, leading up to that, as to what the incidence was of these adverse reactions?

Prof. Bishop—The TGA have done an evaluation of all of these. Can I just preface this by saying that the way we have gone about this is that, first of all, we took the view that we needed to put down a moratorium until we understood. There are large numbers being bandied around in the media and other places about how many children were affected, so we thought the first thing was to actually get hold of the case record forms of those that we had been recommended as having this complication and go through them in detail. As a result of that investigation, we have got down to 59 the number that we have identified that clearly have had a febrile convulsion. It is thought quite likely that essentially two-thirds of those are due to the vaccine, but other factors are also likely to have contributed to a third of those. That is the normal way that we would investigate something like this. Let us say that 59—

Senator BACK—Of the 250?

Prof. Bishop—of all the numbers you have heard, are the ones with the febrile convulsions that have been verified with review of all the clinical data by the TGA. That is the number that we think is the right number and that is the number that the ATAGI group use. The

number is one that they use for their epidemiological review of the likelihood of this convulsion.

Senator BACK—In arrears, were general practitioners asked to go back and review their records and actually make contributions, where they may not earlier have done so? It is not compulsory, is it, for a GP to record or to report?

Prof. Bishop—As you know, when we first put the moratorium, we made a general request that everyone first of all update the vaccine register. There is a register that they can enter their data into. We also asked for all adverse events to be reported to the TGA because at the time we were notified of this, on the 22nd, most of those adverse events had not reached the TGA and the TGA did not have these cases in their documentation. We went through an exercise where we asked all the chief health officers, and WA in particular, to make sure that they identified all the cases, got the case record forms and reported all the adverse reactions. Then I went to the GP roundtable and asked that all the GPs update all their registers.

In addition to that, we did some modelling work and we also worked with the children's hospital in Perth and with the three children's hospitals in New South Wales. That included contacting parents, understanding whether they had had fever and getting a very good picture of what was going on with the children's hospitals. That is preliminary data which I have not mentioned here, but essentially that gives us a very good picture of the fact that this is a real signal.

Senator BACK—Do you have any comprehension at all as to why there seemed to be this spike in Western Australia, as opposed to the other states?

Prof. Bishop—The data from ATAGI would suggest that the rates are about similar in other states. It is just that the volume of vaccination is higher in WA because the program specifically targeted this age group. There are children in the other states, but the volume did not occur as quickly. Also, it is more scattered, so you would not see it all coming to one children's hospital. I think it was fortuitous, in a way, that in WA they were able to pick up the signal based on the way the program was structured, but it really is the same rate in other states. We have not got full data on other states—we are still going through that—but the data that we have got so far would suggest it is the same rate.

Senator BACK—In the five or six weeks since the ban has been placed on the vaccination in children under the age of five, have you seen a spike in the incidence of influenza in that age group?

Prof. Bishop—There are two things that happen. I think you should be aware that when we put the moratorium on the children under five, the spike that was in the emergency departments at the children's hospital in Perth disappeared. It went up when the vaccination started; it went down when it was stopped. That is very good circumstantial evidence. Fortunately, the rates of infection with influenza around the country are quite low. We have got respiratory syncytial virus, but we have not yet seen the spike of Influenza A. I am just hoping that it is all going to be damped down. Nevertheless, in WA it is not spiking at the moment.

Senator BACK—When you introduce a new three-in-one vaccine, would it be normal that the first 100 or 200 children to be vaccinated would be the subject of a higher degree of

scrutiny than would be the case once they have been examined and the vaccine has been found not to have had a higher level of adverse reaction than normal?

Prof. Bishop—With vaccines there are a whole range of potential side effects that one could consider focussing on. I am happy to say that vaccines, in general, have a really good, solid safety record compared to pharmaceuticals and other things that we need to use. It is a very good public health and safety method. But, having said that, I think that obviously this is a spike. This is not something that had been considered before. It is an observation, which is the way medicine progresses. But, having gone through this, obviously we will need to consider the experience we have just had for next year. Traditionally, for the last forty years, that has not been the case for seasonal flu, but we have now had an experience, and obviously we will be seeking advice about what the process should be for the next season.

Senator BACK—Sure. It has been reported to me that there is a shortage of influenza vaccine available for the adult community this year. I have heard several cases—in fact, I have spoken to chemists who have said to me that they have not been able to get supplies of flu vaccine, particularly if they are having it purchased for themselves and paid for through their private health cover. Is that the case? Is there a shortage of influenza vaccine?

Prof. Bishop—Let us be precise about this, just so that we are clear. The government expanded the seasonal flu program last year by increasing the number of people that are in the vulnerable group. The government program is targeted very much towards the vulnerable group, and it has expanded, and that is a good thing because the vulnerable people are those who have the worst outcomes from flu. This was telegraphed many months ago by the minister, and then the commercial companies—the manufacturers—make up their own mind about what should be the commercial supply for chemists. We do not determine that. That is a commercial decision, where they can sell the product or not outside the government program. They have to then work out how much they should supply to the commercial product, independent of government. Government does not control that.

Senator BACK—But what they supply to government would have priority in their production lines to what they then decide to produce commercially.

Prof. Bishop—But they can make their own decision. They can extend their production line.

Senator BACK—Sure.

Prof. Bishop—But there are a couple of factors here. One is that the H3N2 component was a low-yielding component, and that has resulted in the manufacture being late by a few weeks. There was also the issue of supplies coming from external, which was affected by the volcano, actually, in Iceland. There are issues like that. And then there is also the issue that all the interest in flu, and even adverse interest like the children's issue, has actually heightened the community awareness of the importance of vaccine, in fact, positively, and so we have seen both commercial and the government supplies actually being more sought after this year. So I am very pleased, in a way, that in fact we have got a much higher level of vaccination in our community from both these programs than we have ever seen. So that is a good thing, but the fact is it has put pressure on the system, not because there is not as much as last year—there is more than last year—it is just that the public are more interested than they have been.

These are the issues. There are new suppliers coming into, I understand—and this is not our remit. There will be new commercial suppliers coming in, particularly from the Sanofi product, and so within a few weeks, we are told at least, that—

Senator BACK—We would expect that shortfall to be fixed.

Prof. Bishop—That is just not information that we actually have.

Senator BACK—Thank you.

Ms Halton—But Senator, I think it is important to put on the record that there have been more doses distributed already in Australia at this point in the season than were in the entire 2009 season. The manufacturers predict exactly how much is needed in the private market, and the reality is this year the private market has demanded a lot more.

Senator BACK—It is amazing the impact of a pandemic on awareness in the community. If I can move, then, please, to an area of great interest to me, and that is the area of One Health, and I think, Ms Murnane, we seem to have had some success between us in our efforts, and I notice that with regard to the development of a vaccine in animals for Hendra, that the federal government has joined the State Government of Queensland in contributing each $300,000 to the $330,000 that CSIRO have provided for that vaccine. Has the department made a contribution, or has it been from this department that the $300,000 has been allocated by the federal government?

Ms Murnane—We are having some discussions with the Department of Agriculture, Fisheries and Forestry about the One Health dimension about this.

Senator BACK—Excellent.

Ms Murnane—That is the case at the moment.

Senator BACK—So do we know from which vote or budget allocation that $300,000 will be allocated, or is it being spread between—

Ms Halton—It is a commitment made in the portfolio. They have now approached us. They have only just done that, and obviously, we are in discussion with them, so we cannot provide any further detail, other than to say obviously, we are aware of the commitment and we are working with them.

Senator BACK—I wonder if you can tell me what has been the outcome or what is the nature of those discussions with the other departments in relation to the One Health approach.

Ms Murnane—This particular issue is recent, like a matter of days. So I cannot add anything material to what the secretary has said there. This is something we will talk to them about, and we are very, very acutely aware of the fact that this is a zoonotic disease, and that has an enormously high fatality rate in humans, and we are also aware of the dangers posed by other viruses in this family of viruses.

Senator BACK—Yes. The minister would be aware of the discussions that we have had in the past surrounding the decision to cease the funding for the biosecurity CRC for new and emerging diseases. Has there been any decision taken following the CRC being closed to develop a more permanent centre for the study of new and infectious diseases?

Ms Halton—CRC policy obviously is not a policy for this portfolio, so—

Senator BACK—No, I made that observation. That discussion is now in the past. I am seeking the future—

Ms Halton—No, that is right, and so there probably is not anything materially we can say further to that. Obviously, we are very interested in this area. It is something which is quite important and material to what we do, but more than that, we probably cannot comment.

Senator BACK—The department would be consulted, presumably, in the event that there was a move to a more permanent centre?

Ms Halton—We would hope so.

Senator BACK—Have those discussions commenced, or are they advanced, or are, in fact, those discussions on the table?

Ms Murnane—There is a centre that is funded by the University of Sydney, and Professor Bishop and I have had a number of discussions—and will continue to do so—with the director of that centre, Professor Tania Sorrell, and we just do have a lot on our plates and have had this year, but we hope to be talking more to them and to other universities that are engaged in research into zoonotic diseases. We are aware that we need to consolidate a strategy on diseases that are in or could come into Northern Australia. That strategy needs to have a pre-border as well as a post-border dimension, and that is something that we need to be in partnership with other Commonwealth departments, with state departments, both health and agricultural, and with the university sector.

Senator BACK—So I hear you telling me that the One Health approach really has currency and has—

Ms Murnane—Absolutely.

Senator BACK—Good.

Ms Murnane—The concept has. What lands where in terms of the funding of a particular centre, that is something we cannot talk about, and as secretary said, the decisions on that CRC were not made in our portfolio, and we were not consulted.

Senator BACK—No, we have gone through that in the past. My final question relates back to Hendra. The experimental human monoclonal antibody: I understand the members of the family associated with the gelding that had to be put down a couple of weeks ago on the Sunshine Coast have been treated. Are you able to give us any idea at all of the process of the use of this antibody and the extent to which it may or may not be likely to have some impact with humans?

Prof. Bishop—I think this is all experimental work, and therefore it is a bit premature to try to come to a conclusion. But, as you know, in these situations the use of antibody or immunoglobulin and those sorts of treatments may be helpful, so we will wait on the results of the clinical work. To add to Ms Murnane's last answer, we do know that there is a lot of academic interest in this One Health area so I am quite hopeful we will get high quality work done. You are aware of the Peter Doherty Centre being formed around the Parkville site—

Senator BACK—I am.

Prof. Bishop—and also the group in Sydney. I am aware of other academics that are very enthusiastic about this issue. Out of the scientific academics, supported by the proper processes of peer-reviewed support through the research activities, we will see continuing ongoing work so I am quite optimistic about it.

Senator BACK—Thank you. Thank you, Chair.

CHAIR—Thank you. Senator Adams.

Senator ADAMS—I would like to ask some questions about tuberculosis in Papua New Guinea and Saibai Island. Having recently spent some time on Saibai Island at the medical centre, I was quite concerned about the number of TB cases that were coming over from Papua New Guinea and, of course, only being two nautical miles away, that is very, very close proximity. I realise that that is the Queensland government's issue, but in these cases how is the process followed through so that the Commonwealth are aware of just what is happening and have those cases increased in the past year?

Ms Holden—We are aware of the cases. As you indicated, it is an issue that Queensland Health is managing, but we work jointly with Queensland Health through the Torres Strait cross-borders health issues committee. Through that committee, we do a lot of work between the Australian government, Queensland government and governments within Papua New Guinea to look at the issue of TB and how we manage that and look for better ways to improve communication between Australia and PNG so the cases from PNG nationals coming over can be managed better.

There has been an increase. I do not have numbers with me available at the moment. There has been an increase in the number of TB cases that Queensland Health are seeing. There is a joint project between Australia and PNG at the moment around TB to help better identify the number of cases of TB with in the Western Province and more broadly around the management and identification of TB within the Western Province of PNG and PNG as a whole. That project has been going for the last year. There have been a number of delays with the project from the Papua New Guinea side in terms of the need to build the capacity of PNG to identify TB and to have appropriate treatment, so we are continuing to work with them around that.

Senator ADAMS—The numbers and the way they turn up to the medical centre is of concern to me. It just really worries me that they are then transferred down to the hospital on Thursday Island. Would you be able to take on notice the increase that has arisen?

Ms Holden—Certainly.

Senator ADAMS—Thank you very much. I have some questions on the seasonal flu vaccine rollout. Firstly, I would like an explanation of how the tendering and distribution process for the seasonal flu vaccine is done under the National Immunisation Program.

Ms J Bryant—How it is done?

Senator ADAMS—Yes, the tendering process for it.

Ms J Bryant—The Commonwealth does the tendering for influenza vaccines, as opposed to other vaccines, the majority of which are still purchased directly by the states and territories under their own tenders. The Commonwealth has tendered for the flu vaccine for a number of

years now and I think initially prior to 2004. We have recently conducted one complete tender in respect of the new at-risk cohort, the expanded group that is now eligible under the National Immunisation Program. That tender has been finalised, the contracts have been let and the supplies are flowing this season. As was identified in the earlier discussion, there is an increased number of doses being supplied both under the National Immunisation Program and in the private market this year following that.

We are currently in the process of conducting a further tender. This tender is for the whole market. The first tender was just to expand the eligible cohorts. This one is now to sign entirely new contracts for the supply of both seasonal and future pandemic vaccines. It has been advertised. There was an open tender process. Submissions have been received and the committee is evaluating those, but given it is still not a finalised tender there is a limit to how much more I can say about that.

Senator ADAMS—When do you think it will be finalised?

Ms J Bryant—The existing supply deeds finish in November 2010. It would be our objective to have the new contracts in place in advance of that to allow for that changeover time.

Senator ADAMS—How many doses of seasonal flu vaccine were provided under the PBS and the National Immunisation Program last year?

Ms J Bryant—I might have to check those numbers. My memory is that about 860,000 doses were supplied under the PBS last year and that it is something of the order of 3½ million under the National Immunisation Program, but I would be happy to take it on notice to confirm those figures for you.

Senator ADAMS—Thank you very much for that. Was it a government decision to remove the seasonal flu vaccine from the PBS?

Ms J Bryant—The Pharmaceutical Benefits Advisory Committee considers any application to expand vaccines provided under the National Immunisation Program. The Pharmaceutical Benefits Advisory Committee, under the National Health Act, is required to consider whether it is cost-effective to do so and to make a recommendation on which vaccines should be included under the immunisation program. That same committee obviously makes recommendations in respect of the Pharmaceutical Benefits Scheme. The PBAC considered the application to expand the eligible cohort under the Immunisation Program. It made a recommendation to expand availability under the National Immunisation Program and basically to move the entire cohort that had previously received private prescriptions under the Pharmaceutical Benefits Scheme under the National Immunisation Program. That recommendation was accepted by government, and that is what has occurred.

Senator ADAMS—What were the conditions to access the seasonal flu vaccine on the PBS previously? What conditions did you have to meet to be able to do that?

Ms J Bryant—The vaccine was available under the Pharmaceutical Benefits Scheme basically for any individual who was at risk or had conditions predisposing them to severe influenza, for people aged six months and older. Previously, in 2009 and earlier, under the National Immunisation Program those eligible were individuals 65 years of age and older, and

Aboriginal and Torres Strait Islander people aged 15 and over, I think. Under the Pharmaceutical Benefits Scheme, people who had conditions predisposing them to severe influenza who were not in those Indigenous or over-65 cohorts—and they include people with things like cardiac disease, chronic respiratory conditions and so on—were all eligible. Those people and, additionally, pregnant women are now all eligible under the National Immunisation Program for free vaccine.

Senator ADAMS—You are guaranteeing that all those patients that were previously able to access the vaccine can now do it, with an expanded cohort?

Ms J Bryant—The eligibility for flu vaccine is a medically based one, and the medical criteria that apply are exactly the same as they were last year.

Senator ADAMS—No-one is going to miss out because of the change. That is really what I am asking.

Ms J Bryant—That is correct, and the judgment is, of course, always one for individual medical practitioners.

Senator ADAMS—I have just had a constituent who tried to get her vaccine. She had a prescription and went to the local chemist. The local chemist said, 'I'm sorry—I can't give it to you because you're not in that particular cohort of people,' and they were desperately short so did not have it. That is another question which I think Senator Back touched on: why there was a shortage and why it was not available for someone with a prescription to actually get the flu vaccine.

Ms J Bryant—I think that may be an issue where the doctor may have formed a view that the individual did not qualify on age grounds or have medical conditions which in the medical practitioner's view would predispose the individual to severe outcomes from influenza. If the doctor reached that medical judgment, they may still have issued the patient with a private prescription. They would take that prescription to the pharmacist and, if that particular pharmacist had not received their private market supplies, they may have been unable to fill the prescription. But I think that that would be the only basis that—

Senator ADAMS—It seems strange because every year she has been able to get it with a prescription, but now she turns up to the chemist and, she says here:

The local chemist brought to my attention there are only two suppliers. One has said they are not producing any more for this year and I believe this to be CSL. The other cannot keep up with the demand on the public system.

Ms J Bryant—I think that is a supply issue rather than an eligibility issue. The eligibility is exactly the same and Senator Back did touch on the supply issues in the private market, which are expected to ease, as we discussed earlier this morning, in the next couple of weeks as more supplies come in. I think Professor Bishop has identified the Sanofi product that will come in. There will be more supplies on the market.

Senator ADAMS—Is there any reason why this pharmacist would not have been able to get stock?

Ms J Bryant—Because, as we identified earlier in the discussion, demand is up overall. In the global supply chain what happens is that both pharmacists and the National Immunisation

Program coordinators in each jurisdiction forecast what they expect the demand will be next season. In October 2009, pharmacists and the immunisation program coordinators tell the pharmaceutical companies what they anticipate their ordering pattern will be. Last year, we ordered an expanded amount of stock for the immunisation program. We have already identified this morning that suppliers in the private market, pharmacists and others were clearly ordering more than last year as well. Once the global manufacturing process is locked in from about October—about six months before the season starts—it is very hard for manufacturing companies to then insert additional orders and manufacture more, because their manufacturing capacity is finite.

For a series of reasons, this year, as Professor Bishop has already identified, one of the strains in the seasonal influenza vaccine was a very slow growing strain. That made production slow. Some companies, I understand, started manufacture a little late because they had been manufacturing for the Northern Hemisphere for the monovalent pandemic vaccine. In addition, more recently the Icelandic volcano has disrupted international flights into Australia which were carrying private market supplies of influenza vaccine. The combination of all of these things has meant that private market supplies have arrived in Australia a little late. We know that at least Sanofi will have more supplies in coming weeks, and that is why we expect shortages to ease.

Senator ADAMS—Okay. Thanks very much.

CHAIR—That is the end of outcome 14. Thank you to the officers. We will break until 10.45 and come back with outcome 3, Access to medical services.

Proceedings suspended from 10.35 am to 10.47 am

CHAIR—We will reconvene. Thank you very much. Ms Halton, have you got any updates?

Ms Halton—Yes. At the extreme risk of being murdered—

CHAIR—Ms Halton, from behind or in front, or from the side?

Ms Halton—I should make the point that, whilst he is not wearing his party shoes or his party frock, it is Mr Learmonth's birthday today.

Mr Learmonth—I think from the side was the answer.

CHAIR—From the side?

Senator FIERRAVANTI-WELLS—Is he below or over 50?

Ms Halton—He is well below. He has not hit that.

Mr Learmonth—Forty-seven.

Ms Halton—Yes. I just should acknowledge that he is here on his birthday. Happy birthday, David.

CHAIR—Thank you, Ms Halton. We would like to acknowledge Mr Learmonth's seniority. That is really important.

Senator FIERRAVANTI-WELLS—What a wonderful way to spend one's 47th birthday.

Mr Learmonth—It rolls around every year like this.

CHAIR—We want to acknowledge Mr Learmonth's birthday.

Mr Learmonth—Thank you.

CHAIR—We are now moving into outcome 3, access to medical services. Senator Siewert has some questions. I know Senator Fierravanti-Wells and maybe Senator Adams have questions, and Senator Milne is coming in later with some questions about medical imaging. Senator Milne is in the room. I did not realise.

Senator SIEWERT—Can I ask midwife questions? Is this where I ask them?

Mr Bartlett—Yes.

Senator SIEWERT—Thank you. First off, I want to ask about the regulations and where they are at, and do we expect to see them before the end of this sitting in June?

Mr Bartlett—The regulations, as they currently stand, are being finalised. You should see them shortly, as I understand it.

Senator SIEWERT—Okay. We can expect to see them in the June sitting. Is that correct?

Mr Bartlett—That is my understanding.

Senator SIEWERT—Thank you. I want to go to insurance issues. As I understand it, the MIGA website has on it some detail around complying with the Australian College of Midwives national midwifery guidelines. In that, it also refers to not being able to meet your obligations as per appendix A of the guidelines, which talks about when a woman chooses to be outside the recommended guidelines. As I understand it, a midwife is then exempt from any ongoing issues that are caused by the patient choosing not to go with the guidelines. However, it appears as if the insurer is saying, 'You're not exempt.' Has this issue been referred to you and is that, in fact, the case?

Ms Hancock—Yes, that issue has been raised with us. Your understanding is not quite correct. Would you mind if I just explained what the situation is both with the college guidelines and the policy?

Senator SIEWERT—Yes, that would be appreciated. That is why I asked: to find out what is correct, what is not and what you are doing about it.

Ms Hancock—There is a general requirement with all professional indemnity insurance of this nature for the practitioner to comply with the relevant guidelines. In this case, given these are midwives, the Australian College of Midwives professional guidelines are the appropriate ones. Those guidelines have an appendix, known as appendix A, which is essentially guidelines to a midwife about what their response should be, should the woman that they are treating decline a recommendation that the midwife has made about a clinical pathway that they think the woman should take. Generally, it is referral to a treatment by an obstetrician. It includes, for example, instructions around proper documentation of the discussions with the woman that they are treating, so that the written records are complete.

The professional indemnity insurance policy is for those midwives who are working in collaborative arrangements. There is an obvious logical inconsistency between a requirement to work in a collaborate arrangement and a guideline which essentially allows a midwife to document where they are basically going outside a collaborative arrangement. So the purpose

of the reference to 'excluding appendix A' in the professional indemnity insurance is to make it clear that, if you are in a situation where appendix A applies, then your collaborative arrangement may no longer be operational, because of the wishes of the patient. And it may still be, depending on the facts of the case, that a woman has chosen to refuse a midwife's recommendation but the midwife is still working collaboratively with the medical professional. For example, they could be having a conversation with the relevant obstetrician. But the overriding requirement for the insurance is that the midwife is acting in a collaborative arrangement.

So, if a midwife finds themselves in a situation where collaboration is no longer part of the picture, then the consequence is that their insurance policy may not cover them. Once again, it depends on the circumstances of the case. The conversations that we have been having with the privately practising midwives who have raised this issue with us are principally around the need for midwives to have an initial conversation with a woman that they are proposing to treat which makes it clear that they are working in a collaborative arrangement and about what that means in terms of the woman's treatment, so that these things are not happening as a surprise at the last minute.

There are two consequences if a midwife does find themselves in a situation where the appendix A guidelines apply. One is that the insurance may not cover them, depending on the circumstances. The other consequence of insurance possibly not applying is that that may be a breach of the registration requirements, because it is a registration requirement in national law that professional indemnity insurance be in force.

Senator SIEWERT—Okay. Thank you for that. I have a number of questions leading off from that. I will go back to the collaborative arrangements. Where the midwife is still talking to the obstetrician, for example—and, in effect, keeping that collaboration—but the patient may not want to be involved in that, does that count as collaboration for the needs of the insurance and registration process?

Ms Hancock—It is possible it may. It really would depend on what was actually happening at the time.

Senator SIEWERT—Okay. The problem with this is that the midwife is left in a situation where he or she—mainly it is a she—does not know whether they are covered by it, so you can understand why they are gravely concerned about this, because they are left in a high degree of uncertainty. What are you doing to try and get rid of some of that uncertainty?

Ms Hancock—We are still in discussions with the midwives who have raised this with us about the scenarios, I guess, where this might arise. One issue to consider is that, if the woman is indicating a refusal to follow a recommended course of action in an intrapartum situation, it is either in a hospital—and hospitals have protocols about what should happen in those circumstances and the hospital protocols would normally apply—or in a home birth situation and, of course, because of the exemption under the national law, that is not an insured course of care anyway, so there is, in effect, no change from the situation that applied.

Senator SIEWERT—Okay. Thank you. If a patient decides they are not going to take the recommendations—and so the insurance may or may not be valid—and a midwife decides they can no longer provide care, have there been situations developing where the midwife has

then said, 'Well, I cannot provide the care,' and then the patient has nowhere to go? Have you come across those situations yet?

Ms Hancock—No. there have been a number of hypothetical scenarios raised with us about circumstances where this might arise. Midwives are principally concerned, obviously, about their duty of care to a patient who may have no immediate alternative pathway, and I guess our response to that is: if a midwife chooses to continue caring for a patient, that may or may not be an issue which would eventually come to the attention of the Nursing and Midwifery Board, which is the body that takes an interest in the extent to which a midwife is acting in accordance with their conditions of registration. Obviously, questions about what sort of response would the board take are, I guess, most appropriately directed to the board rather than the department. That said, we are, of course, liaising with the board about these issues.

Senator SIEWERT—Okay. Can I just move onto this issue about collaborative arrangements? I have received a number of emails—and I am sure you have received letters—around the issue about refusal of doctors to enter into collaborative arrangements. Has that issue been raised with you?

Ms Hancock—Not recently. It had been in previous months, but not of recent times.

Senator SIEWERT—Okay. I had an email about four weeks ago, detailing a specific case about refusal for collaborative arrangements. It was from a patient, and it said that she had been unable to find somebody to provide care because there had been a refusal by doctors to enter into collaborative arrangements. Have you had one as recent as that?

Ms Hancock—Possibly. We have had a number of contacts from midwives about a whole range of issues to do with—

Senator SIEWERT—Okay. So what has been happening with that process, where there appears to be a lack of willingness by some in the medical profession to enter into collaborative arrangements, which I must say is what midwives fear?

Mr Bartlett—The nature of collaborative arrangements will be defined in the regulations, and I think that is going to be the mechanism by which that situation will be addressed.

Senator SIEWERT—Which we will see shortly?

Senator ADAMS—Shortly or soon or—

Senator SIEWERT—This is where they have just said—sorry, I am not trying to be—

Senator ADAMS—June.

Senator SIEWERT—We were just told we will see them in June for the June sitting. Are you able to answer a few questions around the nature of the collaborative arrangements, or do I take, Mr Bartlett, from your answer, I have to wait for the regulations?

Mr Bartlett—I think you have to wait for the regulations.

Senator SIEWERT—I appreciate that you have said they are in the nature of the regulations. However, I doubt that in the regulations you are going to be going outside of what you have already said and what we have covered in previous discussions. I would suggest to you that the issues that I have just raised, in terms of people in the medical profession being

unwilling to enter into collaborative arrangements, is still going to be there. My question still stands, in terms of what evaluation process are you putting in place to actually look at whether collaborative arrangements are being entered into, and whether they are effective or not? Sorry, I know that is a three-part question. What action are you taking to address this issue that is already starting to emerge, regardless of the regulations?

Mr Bartlett—The nature of collaboration and defining collaborative arrangements will be part of the regulations. In terms of how that works and what flows from it, that is also an outcome of that process, and we will obviously be looking to ensure that it works.

Senator SIEWERT—Have you got an evaluation process in place?

Mr Woodley—I think, under outcome 5, there are arrangements to evaluate the program as a whole, not specifically the collaborative arrangements aspect of it. I am afraid I do not have any more details than that, but perhaps we could ask our colleagues to get you that information. If I could just add a further comment as well. We have had very many and extensive discussions with midwives, with consumers and with medical groups around the issue of collaboration. Those people representing medical groups have put a contrary view to us. I know there is anecdotal evidence that isolated doctors may have indicated some reluctance to collaborate, but that is certainly not what we have been told by those in authority within the medical community.

Senator SIEWERT—Those in authority may or may not be the ones that are entering into collaborative arrangements. Outcome 5, we have missed, was yesterday, so I will put the questions on notice, therefore, around what evaluation process they are putting in place. I am quite happy to do that. Thank you. When midwives are actually visiting hospitals, is it your understanding that they have to get permission every time they visit or seek visiting rights every time they visit a hospital?

Mr Bartlett—It is outside our area, but my understanding is that any visiting medical practitioner has to have visiting rights to visit a hospital. Midwives, I assume, would be—

Senator SIEWERT—Is it generally granted on a wider basis than every time you go in?

Mr Bartlett—Yes, it is generally granted on a wider basis than having to be requested for each visit.

Senator SIEWERT—Have you had concerns raised with you that midwives may be required to get it every time they visit?

Mr Bartlett—No, we have not, but, again, I think the issue that we have got here is that you are taking into areas that are outside this outcome.

Senator SIEWERT—I can chase that elsewhere. Thank you.

CHAIR—Which outcome is it?

Mr Bartlett—Thirteen. Acute care.

Senator SIEWERT—I have missed that one, too. That will go on notice. Thank you. I am finished in that particular area. I do have others in this area.

CHAIR—Anything else in that area? Senator Adams.

Senator ADAMS—What budgetary impact will these new arrangements have on the legislation that was originally imposed? Is there any problem there, as far as the extra things you have had to do?

Mr Bartlett—My understanding is it will have no budgetary impact.

Senator ADAMS—Thank you.

CHAIR—Any more questions under 3.1, Medicare services?

Senator FIERRAVANTI-WELLS—Just on the Medicare teen dental, how many patients have accessed this scheme?

Ms Hancock—The total number of patients who have received a benefit under the scheme since 1 July 2008 is 624,883 patients.

Senator FIERRAVANTI-WELLS—How many patients were originally budgeted for the scheme?

Ms Hancock—I do not have the number of patients with me. We did originally estimate an uptake percentage of the 1.3 million vouchers that are sent out each calendar year, which was—no, I do not have the original uptake percentage figures with me. I do have the revised ones.

Senator FIERRAVANTI-WELLS—All right. You will take the actual number and the percentage on notice?

Ms Hancock—Yes.

Senator FIERRAVANTI-WELLS—What has been the total Commonwealth funding for teen dental vouchers to date?

Ms Hancock—The total Commonwealth expenditure to date is $121,528,694.

Senator FIERRAVANTI-WELLS—What happens if the dentist charges less than the amount provided for in the voucher for the preventative check. In that case, does Medicare pay less, does the patient pocket the difference or does the dentist pocket the difference?

Ms Hancock—The rules provide that the benefit is the amount of the charge.

Senator FIERRAVANTI-WELLS—I do not have any more questions on the Medicare teen dental.

CHAIR—Anything else in 3.1?

Senator FIERRAVANTI-WELLS—I do. I have got a couple of other areas. Just on the chronic disease dental scheme, how many patients have accessed benefits under this chronic disease dental scheme to date?

Ms Hancock—From 1 November 2007 to 30 April this year, 414,137 patients.

Senator FIERRAVANTI-WELLS—Also in 3.1, can you provide an update on the government's reconsideration of an item number for joint injections?

Mr Bartlett—I can do that. We have had a number of discussions with the Rheumatology Association as part of finalising their application for some new items.

Senator FIERRAVANTI-WELLS—I have a vested interest in this. Sorry, my knees may give up one day.

Mr Bartlett—They initially submitted an application at the end of January. It needed some further work. That discussion was held with them. We got a revised application at the end of April and that is being processed at the moment.

Senator FIERRAVANTI-WELLS—When is it expected that the item number will be issued for joint injections?

Mr Bartlett—The difficulty is that it is going through a new process as part of the Quality Framework initiative that was announced in the budget before the last one. It is the first application to go through that process. We anticipate it will take three to four months.

Senator FIERRAVANTI-WELLS—With some teething problems, yes.

Mr Bartlett—But it is a little difficult to be certain about that, given the fact it is a new process.

Senator FIERRAVANTI-WELLS—In about three or four months?

Mr Bartlett—In three or four months we will be in a position to advise the minister.

Senator FIERRAVANTI-WELLS—Then we do not know when thereafter?

Mr Bartlett—No.

Senator FIERRAVANTI-WELLS—Okay.

CHAIR—Thanks. Any more in 3.1?

Senator FIERRAVANTI-WELLS—I do not have any more in 3.1.

Senator SIEWERT—I do.

CHAIR—3.1?

Senator SIEWERT—Yes, missed ones. I am sorry to be boring and go back to issues around midwife services. Have you heard of the situation where people are being refused or where midwives are not able to book clients in for blood tests and ultrasound scans because their GP has been told by the insurance company they cannot provide care to a woman who is not booked into a hospital or who has a private obstetrician—in other words, women who are choosing home births. Has the issue of people not being able to access that end of the services been raised with you?

Ms Hancock—I do not recall that specific issue being raised with us, no.

Senator SIEWERT—It has certainly been raised with me. You are saying it has not been raised with you?

Ms Hancock—No. We had a general question raised with us, going back about six months, concerning the extent to which medical indemnity insurers would cover their doctor members if they were working collaboratively with midwives, but we have not had any specific issues raised with us since that time.

Senator SIEWERT—This is actually people being able to access other services like blood tests, ultrasounds et cetera. People can still access that part of the service, can't they, if they are choosing a home birth?

Ms Hancock—I am not aware of any reason why they would not be able to.

Mr Bartlett—We will have to take that on notice.

Senator SIEWERT—That would be appreciated. Thank you. I am happy to provide you with some more detail.

Ms Halton—I think it will be good if you could. Are you talking about outpatient services?

Senator SIEWERT—Yes.

Ms Halton—So refusal to deliver on an outpatient basis.

Senator SIEWERT—No. It is just when they are trying to access basic medical tests and ultrasounds.

Ms Halton—But most people would have those tests done at a private provider.

Senator SIEWERT—Yes.

Ms Halton—I think if you have got some details it will be good to know what they are.

Senator SIEWERT—I can provide you with the detail. There are two points. Is it an issue and it has not been raised with you to date?

Mr Bartlett—It has not been raised with us to date.

Senator SIEWERT—Okay. I would like to follow that up.

Ms Halton—Yes, because I certainly have not heard of that.

Senator SIEWERT—You do not think it is a problem?

Ms Halton—It has not been raised with me.

Senator SIEWERT—Thank you. We will follow it up.

[11.12 am]

CHAIR—Any further questions on 3.2? I know there are some under 3.3, Diagnostic imaging services. Senator Fierravanti-Wells, I know that Senator Ryan has one here. Is it okay if he starts?

Senator FIERRAVANTI-WELLS—Yes, go for it.

Senator RYAN—At the last or second last estimates we discussed the issue of your review into the issuing of MRI licences and I wanted to follow up some issues around that. Some of these issues—this is about Warrnambool Hospital—also relate to the provision of a cancer centre in Warrnambool Hospital. The two issues are linked, but if you need to refer me to it later on when that outcome comes up, please feel free. What is the status of the review into new MRI licences?

Mr Bartlett—There is not a review into new MRI licences. There is a review of diagnostic imaging, whose terms of reference include a review of MR, which is looking at a range of issues including licensing. That review is scheduled—

Senator RYAN—A range of issues including?

Mr Bartlett—Including MR licensing, eligibility, availability. That review is due to report to government and be dealt with as part of the 2011-12 budget.

Senator RYAN—When is the report due to government?

Mr Bartlett—It has to be done in time to be considered as part of that budget process, so it is going to be late this year or early next year.

Senator RYAN—Has the minister received any interim reports from the group undertaking the review?

Mr Bartlett—A discussion paper about the review was released early this year. Submissions closed on 30 April. A number of people sought extensions. We have received, I think, 33 submissions. We are in the process of going through those. There is a diagnostic imagining review consultative committee that is scheduled to meet next week to discuss those submissions with a range of stakeholders. But the review is certainly not in a position to be making interim outcomes about—

Senator RYAN—No. I appreciate that. When did the review commence?

Mr Bartlett—It was announced in the budget before last.

Senator RYAN—So it was 2008-09.

Mr Bartlett—That is right.

Senator RYAN—Have there been any new licences granted for Medicare funded MRI machines since the review was announced?

Mr Bartlett—To my knowledge, none. I will check that and confirm it.

Senator RYAN—If that was different, I would appreciate being informed. I am talking about since the announcement of the review.

Mr Bartlett—Senator, we have just had it confirmed: there have been no new ones.

Senator RYAN—Thank you. The minister received a letter from a Mr Dan Tehan. The letter was sent on 4 February, and it might have popped up in discussion in the last estimates. It contained a petition signed by a number of people, including doctors, in Warrnambool about access to MRI facilities, given some of the unique problems Warrnambool has. There has been no response to that yet. Do you have anything to say to that, Minister?

Senator Ludwig—What I might do is just take it on notice and see what Minister Roxon can find out for you.

Senator RYAN—I would appreciate an explanation as to why, although Mr Dan Tehan happens to be the Liberal candidate for Wannon, filing a petition of doctors and others from the Warrnambool community does not seem to warrant a response in what is now over four months.

Senator Ludwig—We will see what we can do in the short time we have available to see if we can find a response.

Senator RYAN—I would appreciate that. In finance and public accounts estimates last week, we were informed that the visitation program of the minister and the Prime Minister to various hospitals around Australia was in fact coordinated by the department of health, not the Department of the Prime Minister and Cabinet.

CHAIR—We had an extensive discussion about that issue yesterday. Keep going. I just wanted to let you know we did talk about it a lot.

Senator RYAN—Sorry.

Senator Ludwig—That was confirmed yesterday, I think.

Senator RYAN—My question was—and I am assuming you cannot roll them off the top of your head—whether or not you either had already taken on notice or could take on notice a list of the hospitals to which such visits were coordinated?

CHAIR—I am sure Senator Fierravanti-Wells asked that question.

Senator FIERRAVANTI-WELLS—Sorry, the question?

Senator Ludwig—The list of hospitals which the Prime Minister visited.

Senator FIERRAVANTI-WELLS—I asked for details of all the visits.

Senator RYAN—Including by the health minister?

Senator FIERRAVANTI-WELLS—Yes, the health minister and the Prime Minister.

Senator RYAN—And if there were any criteria for making such determinations?

CHAIR—That was part of the question.

Senator FIERRAVANTI-WELLS—Yes, who determined where you would go. There were 103 visits, I think.

Senator RYAN—Yes. Is there a particular reason why the minister—in response to this particular issue, Chair, since I am asking it here—has not visited the hospital in Warrnambool? There have been numerous requests from local media, from the letter that has not been responded to at this point, and from local doctors.

Mr Bartlett—I could not comment on that.

CHAIR—The officers were looking into that.

Senator RYAN—I am asking the minister this question.

Senator Ludwig—I see. I am not familiar with any of the correspondence. I can certainly take it on notice and see what the response from Minister Roxon is. Clearly I have not had any representation on a visitation by the Prime Minister to Warrnambool, but I will certainly take it on notice and have a look at the correspondence.

Senator RYAN—Sure. That is all I have on that issue, Chair.

CHAIR—Thank you. Any more questions under 3.3, Diagnostic imaging services?

Senator ADAMS—I have under 3.3—

Senator FIERRAVANTI-WELLS—Senator Adams definitely has questions.

Senator ADAMS—if it is applicable to here.

CHAIR—We will find out.

Senator ADAMS—Yes, we will find out. It is about the digital mammography for breast cancer and also about the new thermal mammography group. It is a new therapy that has unfortunately been advertised as an alternative to mammography. I am just wondering what the status of that is. It is causing huge problems in Western Australia. Can I talk about the digital mammography first. Is that here or does it come somewhere else?

Mr Bartlett—It comes here, if we can help.

Senator ADAMS—All right. The rollout of the new machines: how far has that got? I did ask this question last time.

Mr Bartlett—In terms of rollout of equipment like digital mammography, they are decisions made in terms of MBS funding by individual providers.

Mr Learmonth—That is outcome 1, that is BreastScreen.

Senator ADAMS—For later. I thought I was probably going with it. Thank you. That one is on notice. That is coming up.

Senator SIEWERT—I just want to pick up on the PET issue. I do have a range of other ones that I will be kind enough to put on notice, but there are two that I specifically want to ask now. We have been talking about the review, but is the process of moving PET items to the DIST regulations going to result in any delay or diminished patient access to PET services while that is occurring?

Mr Bartlett—No, it should not result in that.

Senator SIEWERT—There is a guarantee it will not or it should not?

Mr Bartlett—To the extent I can give a guarantee, there is a guarantee it will not.

Senator SIEWERT—Thank you. What process is going to be followed to deal with the items that are currently under consideration by MSAC?

Mr Bartlett—MSAC will go through it and will make recommendations to government, or to the minister, and the minister will consider those. I should qualify the previous answer by saying that if MSAC recommends, as a result of its analysis, that particular items are not clinically effective or cost effective, then there will be a reduction in access because, essentially, it will have recommended that that item should not be listed.

Senator SIEWERT—But that would be through that process, not because of the new process?

Mr Bartlett—No.

Senator SIEWERT—Thank you. Because of time, I will put the other questions on notice.

CHAIR—We will be requiring to do 3.3 again when Senator Milne returns, but we will go to 3.4 rather than wasting time. Senator Fierravanti-Wells.

Senator FIERRAVANTI-WELLS—I would just like to ask some pathology questions. In the 2009 budget, the government announced the removal of the cap on collection centre numbers for pathology providers. Has the department undertaken modelling on the impact of this change on MBS outlays and, if so, what did that show?

Mr Bartlett—The work that we have done on the uncapping of collection centres suggests that any impact it has will be on the issue area of market share rather than on the issue of demand.

Senator FIERRAVANTI-WELLS—There might have been shifting between different providers rather than the actual number? There has been no number?

Mr Bartlett—It is not anticipated it will lead to an increase in demand.

Senator FIERRAVANTI-WELLS—So there will be no effect on the collection centres and the referral processes?

Mr Bartlett—There may be more collection centres open; there may be less, but I assume there will probably be more, based on the feedback that we are getting, but it is not anticipated that that will lead to extra demand.

Senator FIERRAVANTI-WELLS—Do you have any data on the effect this may have on the rent for the collection centres or on the referral processes?

Mr Bartlett—Not at this stage.

Senator FIERRAVANTI-WELLS—Do you receive complaints about access to pathology services?

Mr Bartlett—In very small number.

Senator FIERRAVANTI-WELLS—How many is 'small'? Just give me some ideas.

Mr Bartlett—We would have to take that on notice.

Senator FIERRAVANTI-WELLS—If you could.

Mr Bartlett—My sense is it is less than one a week, but we can verify that.

Senator FIERRAVANTI-WELLS—If you could take that on notice, that would be good. Thank you. What are the current rates of bulk-billing for pathology, as compared to other medical specialities?

Mr Bartlett—For the March quarter of 2010, the bulk-billing rate was 85 per cent. The overall bulk-billing rate is 74.5 per cent of all Medicare services.

Senator FIERRAVANTI-WELLS—Just compare that 85 per cent with, say, other medical specialities up and around that area; is it the area that has the highest level?

Mr Bartlett—It has the highest level of bulk-billing, as I understand it.

Senator FIERRAVANTI-WELLS—Followed by?

Mr Bartlett—Optometry has an undertaking where all services are provided bulk-billed, so it is 100 per cent but, within what you would call the 'medical' area, it is the highest of the bulked.

Senator FIERRAVANTI-WELLS—Can you provide an update on any procedures to be implemented that would allow doctors to track tests and results as a result of removing practice-specific referrals for pathology requests.

Mr Bartlett—There is no intent, as I understand it, to introduce anything. The e-health changes that are talked about will obviously improve that. There are a range of things that are

coming that will improve that, but I think that what we are talking about at the moment is status quo.

Senator FIERRAVANTI-WELLS—Status quo. How many pathology providers are operating in Australia?

Mr Bartlett—I would have to take that on notice. I think the thing is there are a lot of pathologists; there are a number of corporate providers.

Senator FIERRAVANTI-WELLS—Yes.

Mr Bartlett—It would help if you told us which you want.

Senator FIERRAVANTI-WELLS—I may just put a little bit more detailed questions about that on notice. Thanks.

CHAIR—This is your area, Senator Abetz. Senator Fierravanti-Wells, you have finished on pathology?

Senator FIERRAVANTI-WELLS—I have finished there.

Mr Bartlett—I just should come back and clarify something I just said to you.

Senator FIERRAVANTI-WELLS—Sure.

Mr Bartlett—Optometry has a bulk-billing rate of 96.7 per cent; not 100 per cent.

CHAIR—Not 100 per cent, Mr Bartlett; I am disappointed. We will go to Senator Abetz and his question and then back to you Senator Adams.

Senator ABETZ—Thank you very much, and I hope I am in the right area. I never seem to be in the right area in this committee, but we tend to get there eventually. I understand that the 2009 budget announced the removal on the restrictions on the number of ACCs, which are approved collection centres.

Ms Halton—That is what the senator was just asking about.

Senator ABETZ—Yes. Do we know how many extra collection centres there are now?

Mr Bartlett—Not as yet.

Senator ABETZ—When will that come in?

Mr Bartlett—It takes effect on 1 July.

Senator ABETZ—2010?

Mr Bartlett—That is right.

Senator ABETZ—Have we done any estimates, modelling or whatever as to how many more collection centres there may be?

Mr Bartlett—No.

Senator ABETZ—No feedback from the sector as to how many centres there may be?

Mr Bartlett—There has been a range of feedback from the sector about the impact of changing collection centres. Some people are very supportive of it; some people have concerns about it.

Senator ABETZ—The suggestion has been put to me that the more collection centres you have—and some companies are trying to put them into GP clinics, some into pharmacies et cetera—if you have a whole conglomerate of collection centres around the place, the chances are the overheads and costs will increase and, therefore, to make it all work, there will be a driver to increase the number of pathological services to pay for these increased overheads. Was that considered at the time of this announcement?

Ms Halton—Pathology services perhaps, not pathological services. Maybe, but let us go with pathology, shall we?

Senator ABETZ—I am a novice in this area, I fully agree. Thank you for correcting me.

Mr Bartlett—A number of the things that you have described already occur. There are now pathology collection centres in GP premises. The assumptions that have been made as part of this measure are that it will have an impact in terms of who gets the business, not that it will have an impact on the volume of demand.

Senator ABETZ—That is your assessment?

Mr Bartlett—A series of claims were made to a KPMG review of collection centres, which undertaken in 2006, that some of the circumstances that people are now saying will occur are already occurring. We have got no evidence that they are occurring now and no evidence to suggest that they will now start to occur.

Senator ABETZ—It has been suggested to me that somewhere between $200 million and $400 million extra may need to be outlaid in relation to pathology MBS payments. That is not the department's view?

Mr Bartlett—That is not the department's view.

Senator ABETZ—I suppose in two years time, hopefully, I will not be on this side of the table to ask whether or not your predictions are right. Can I ask you, Minister: is this an example of the government believing that the market ought to rip by completely deregulating it? Is this the government's commitment to letting the market rip and relying on market forces? It sounds very neoliberal to me and I was wondering whether this policy was made before or after the Prime Minister's scribblings in *The Monthly*?

Senator Ludwig—I reject the contention contained within your question. What I can do is have a look at the—

Senator ABETZ—What—that it was scribbling by the Prime Minister?

Senator Ludwig—I think all of the things that you have included within the question. The basic question is: what is the underpinning policy in relation to the collections, and I will seek an answer from the minister, who may be able to assist.

Senator ABETZ—As I understand it, in February 1992, there were 2,246 collection centres and then there was restriction placed and, by February 1995, there were only 1,037. That reduced the rate of growth from 13 per cent per annum in 1991 to an annual growth rate of six per cent. It constrained or halved the growth rate. That is what has been put to me. Now, if we are going to let the market rip, why would we not be going back to those sorts of increases in the growth rate as we experienced before the regulation was in place?

Mr Bartlett—The information that we have got says that there were a number of changes made in the period that was described. Collection centre restrictions were one and only one.

Senator ABETZ—Yes. The others were?

Mr Bartlett—There was a memorandum of understanding entered into that essentially put a cap on outlays. There were other changes made. I would have to come back to you with the history.

Senator ABETZ—That would have been a while ago, so you would want to take that on notice and I fully understand.

Mr Bartlett—I would prefer to.

Senator ABETZ—Thank you.

Senator ADAMS—The government is currently undertaking a detailed review of pathology funding arrangements and the aim of this is to ensure that the government is paying the right amount to support access for patients to quality pathology services. However, it seems unlikely that a review of this size and complexity would be instigated without an expectation that it should result in significant cuts to current expenditure. The question is given the review has commissioned a report by PricewaterhouseCoopers that identifies Australia as spending less on pathology than almost any other country investigated. Is the minister prepared to give an undertaking that cuts will not be made unless there is clear objective evidence of areas where the amount being paid currently is too high? Does that need to be taken on notice?

CHAIR—Senator Ludwig could not answer on behalf of the other minister, but it is clearly a ministerial question.

Senator Ludwig—The difficulty always is that we would, I would imagine, wait for the review to be finalised before the minister would be able to provide what the review contains and indicate what parts of that review, if not all of it, may be agreed to. I am only second guessing at this point. At this point, I would say it is a very hypothetical question. What I can do is ask Minister Roxon if she can provide additional information to you in relation to this. The guarantee, of course, we can give in this area is that we have spent a considerable amount of time, energy and money improving right across all the health services. Those are our bona fides to date.

Senator ADAMS—All right. Thank you. The department discussion paper stated that a key task of the review was to provide detailed options for implementing tendering for selected pathology services, and it also included the following statement:

> Although cost would be the main consideration in a competitive tender process, aspects of quality, such as predicted turn-around times for providing test results and the level of patient access achieved at that cost could also be used as criteria for selecting one provider over another.

In most tender processes, cost is seen as only one consideration in recognition of the fact that the cheapest is not often the best, and that this is especially relevant in an area such as healthcare. This is, once again, seeking a commitment that, firstly, quality will not be subordinate to cost when it comes to a tender selection process and, secondly, objective

measures of quality will be included in any tender analysis and management process. My question is: are those issues being taken up within the tender process?

Mr Bartlett—There is no tender process as yet, but I also have to say that that quote has been taken out of context in the sense that the paper itself acknowledges the importance of quality in pathology and the high level of quality that exists in the Australian pathology sector. That is obviously integral to any pathology arrangements that are had, whether they are done through an agreement, through the current arrangements, through a tender, or through whatever occurs.

Senator ADAMS—Thank you. Will the tendering of pathology services result in reduced choices for patients? How will the government ensure that patient choice is maintained and we do not end up with a monopoly or duopoly situation that drives up costs in years to come?

Mr Bartlett—A number of the areas that have been talked about, such as collection centres and pathology requesting, have been intended to improve competition in the pathology sector. Tenders can have a variety of results. We are not at the stage of having a tender yet, but it is unlikely that an outcome that had a single provider would be seen as a good outcome for the government or for patients.

Senator ADAMS—What attention has been given in the review to the role of pathology testing in preventative health initiatives, such as monitoring of cholesterol to help prevent heart attacks?

Mr Bartlett—It is acknowledged that it is an important part of pathology's contribution to health care.

Senator ADAMS—All right. I note the review will not examine issues relating to demand for pathology services except where relevant to considering how services are funded, yet demand for all medical services is increasing as the population is ageing, and more people are living with chronic diseases. How can the minister ensure that the review does not just tell half of the story?

Mr Bartlett—There is another measure dealing with demand. The National Prescribing Service was contracted, as a result of a budget initiative from the budget before last, to look at demand issues. To the extent that we can avoid the pathology review overlapping unnecessarily with that, that is what that restriction is about, but, clearly, you cannot separate demand from funding. One of the key drivers of growth in pathology outlays is growth in demand. It is an integral part of the review. The way that is expressed is intended to ensure that there is a link, and an effective link, with the NPS arrangements, rather than the review, in a sense, operating in isolation from that initiative.

Senator ADAMS—Okay. Thanks.

CHAIR—That is 3.4. We will move on to the Professional Services Review Agency.

[11.39 am]

Professional Services Review Agency

Senator FIERRAVANTI-WELLS—Good morning. Dr Webber, I would like to start off by asking some questions in relation to an article which was in the *Australian* on 10 May. I have got a copy of it here for you; I came prepared today.

Dr Webber—Yes, I have scanned that article.

Senator FIERRAVANTI-WELLS—I would like to take you through some of the aspects of it. It is a rather drastic measure, I would have thought, that is driving the doctors to day-long boycotts of bulk-billing, and it is described there as a:

… hawkish attitude towards doctors who claim longer consultations—an approach they say contradicts the federal government's encouragement of more preventive care.

Did this meeting occur between senior figures of the AMA with your organisation?

Dr Webber—Yes, we did meet. I cannot tell you the date off-hand, but we did meet.

Senator FIERRAVANTI-WELLS—All right. Without obviously going through the detail of it, can you tell us about the nature of those discussions, and perhaps the outcome of that meeting?

Dr Webber—The discussions were based around the complaints that the doctors had raised, and I must say that the doctors have been somewhat paranoid in their reaction to this issue. Medicare provides items for standard, long and prolonged consultations, the item descriptors for which are fairly specific and fairly well defined. In the vast majority of cases, doctors have no trouble in understanding what is required of them.

Senator FIERRAVANTI-WELLS—That is level A, level B—

Dr Webber—A, B, C and D. Yes.

Senator FIERRAVANTI-WELLS—I do not have that in front of me, but A is?

Dr Webber—A is a very brief consultation.

Senator FIERRAVANTI-WELLS—That is what—five minutes or less?

Dr Webber—Yes. Level B is the standard consultation that the majority of people will use most of the time, and that is a limited consultation—for a fairly straightforward, simple condition—lasting less than 20 minutes.

Senator FIERRAVANTI-WELLS—Then you have got 20 to 40, and then D is 40 plus.

Dr Webber—That is right. The confusion has arisen in many doctors' minds because there are two aspects to the item descriptor for these items. One is content and one is time. That is where a lot of the problems have arisen for doctors, in that some doctors have not realised that both components of the descriptor must be met. So that there must be a complex interaction, and that is defined in the descriptor, and also the time component.

One of the problems where doctors were falling into difficulty, when examined by PSR's peer review committees, was that they were only billing according to time and not complexity, and that is where some of this confusion arose. To go back to your original question, the discussions with the AMA were around explaining that conundrum that doctors

were finding. The changes to the primary care items have simplified the descriptor and made life a lot easier, but they came in on 1 May.

Senator FIERRAVANTI-WELLS—Do I read into that that there has to be a bit more education of our doctors? And is it your responsibility to set out the parameters, and then the AMA's responsibility to inform their doctors better?

Dr Webber—These items have been around a long time.

Senator FIERRAVANTI-WELLS—Obviously some are still having a problem.

Dr Webber—They are still having a problem and, yes, it is about education. It is not our role to educate. Bu there is ample information out there. There is the MBS book, and there is the department's website, Medicare's website, that really spell out these difficulties quite well. Doctors should take note of these things. But it is certainly not our role to educate doctors.

Senator FIERRAVANTI-WELLS—The third paragraph of that article says:

Doctors have complained that Medicare and the PSR decline to advise them whether a particular service qualifies as a longer consultation—which attract a higher Medicare rebate—yet are quick to grill doctors who appear to be claiming significantly more such items than average.

How many complaints have you had in relation to that?

Dr Webber—Directly to PSR, probably in the order of four or five.

Senator FIERRAVANTI-WELLS—Are you aware of complaints that may have been made to Medicare?

Dr Webber—I am not privy to that.

Senator FIERRAVANTI-WELLS—So you think that that criticism is not justified in the situation?

Dr Webber—Medicare and ourselves are not in a position to tell doctors how to practise medicine. Each consultation, by the nature of a consultation, is very different, whereas an audit process can pick up problems with the consultation, and that is a peer process. Remember that the peer-review process that PSR goes through has two components. The first component is that a committee has to be satisfied that the item descriptor was met. So you cannot charge for a broken leg if you have treated a broken arm.

Senator FIERRAVANTI-WELLS—The content and time components.

Dr Webber—All of those components, yes. The second component in assessing a service is: would this service be acceptable to the general body of that person's peers? That encompasses the appropriateness of the clinical content. So there are those two aspects that we, in PSR, look at when we are auditing somebody. For that reason, it is not up to us to advise people if a particular item may or may not be qualified.

Senator FIERRAVANTI-WELLS—So, to that extent, the comment about grilling doctors who appear to be claiming significantly more than the average is not justified? I am trying to break this down, because the article seems to infer that there is a real issue out there in relation to this. Leaving aside some journalistic licence, it is actually quite strident in its comments, because, if there is no agreement reached, non-cooperation with the Medicare system will likely have its own repercussions.

Dr Webber—Medicare can only assess statistical data, and over the years it has certainly been found that if there is an abnormal pattern of billing—be it excessive long consultations at quite significant variance from peers—then it is reasonable to have a look at what is going on. There is often a perfectly good explanation for that particular practice. A particular practitioner may have a particular interest in counselling or some other issue. However, what we have found at PSR is that, of the people that Medicare has sent with these statistical profiles, 85 per cent of people sent to us have a case to answer and we only are able to dismiss approximately 15 per cent of cases sent to us.

Senator FIERRAVANTI-WELLS—In terms of the statistics, I will have to go to Medicare to get those statistics.

Dr Webber—Yes, you will.

Senator FIERRAVANTI-WELLS—I can only ask you, from your perspective, the number of reviews that are finalised, which is in the budget papers.

Dr Webber—That is right.

Senator FIERRAVANTI-WELLS—So Medicare sends you a complaint about a particular doctor; you investigate; you then go through your procedures—some take longer, some take shorter—and then you finalise them. They are the statistics that appear. For example, in 2009-10, you finalised 95—that is your deliverables. Then, this year, you are talking about 2011 of 60.

Dr Webber—Yes. To put that in context: on average, Medicare intervene directly with a doctor in approximately 600 cases a year, and if there is an abnormal profile the Medicare adviser will go and visit the doctor to seek an explanation. If there is not an explanation, that doctor is given time to adjust their profile. It is only if there is no explanation and no change in behaviour that anyone is ever sent to me. On average, over the years we have got about 10 per cent of those people that Medicare intervene with, so we are dealing with a very select group of practitioners.

Senator FIERRAVANTI-WELLS—The article goes on to say that doctors have:

… stopped providing Level C consultations … due to concerns they would be penalised by the PSR for not complying with the criteria.

But those are the sorts of statistics that Medicare should be able to give me.

Dr Webber—They should be able to give you that.

Senator FIERRAVANTI-WELLS—The observation quoted at the end of this—and that was really what I was going to ask you on, if you are able to proffer a comment—is:

"… Nicola Roxon has been quoted quite a few times trying to encourage longer consultations, but then she has Medicare and the PSR on the tail of anyone who does lots of them—it's a mixed message."

Dr Webber—We would encourage a longer consultation if the quality is there. I think everyone would agree that in a complex clinical situation a longer consultation is certainly desirable and necessary. I do not think anyone is disputing that or, indeed, discouraging longer consultations. The problem for doctors that we see is that they are claiming these benefits

very inappropriately—for instance, claiming a longer consultation for a sore throat. That is not a complex interaction.

Ms Halton—If I can just make the observation: as Dr Webber has indicated, you are talking about 600 cases. The statement in here that says that:

> … she has Medicare and the PSR on the tail of anyone who does lots of them …

is clearly bunkum.

Senator FIERRAVANTI-WELLS—I wanted to put it into context, Ms Halton. That is why I said at the beginning that, from a statistical perspective—

Ms Halton—Exactly.

Senator FIERRAVANTI-WELLS—Regarding the tone of the article, I wanted to put it into perspective and actually understand the nature of the problem, but I will get some more statistics from Medicare in relation to that. Just before I leave that, just on those figures, in terms of the number of reviews finalised—that is, 95—do I take it then that in some you establish a committee? Talk me through those three.

Dr Webber—The figures are confusing if you are looking at them year on year.

Senator FIERRAVANTI-WELLS—Yes.

Dr Webber—They are. On average, over the last five years, I have dismissed 15 per cent of referrals, having examined the issues. I have sent approximately 35 per cent to a committee and negotiated a settlement with the remaining 50 per cent. That is roughly the historical average over the 15 years or so that the PRS has been in existence. The other thing is that our process is very long and very convoluted with all the various steps. It will often take 24-30 months to complete from whoa to go. That is why the figures do not often line up year on year.

Senator FIERRAVANTI-WELLS—Do you have lots of lawyers in your organisation? Sorry, I should not have said that. I was having a go at myself as well. Just give me a bit of a breakdown of the nature of the sorts of cases. We are going through, obviously, more serious and less serious. Are those 95 basically consultation based?

Dr Webber—No, it is a variety of things.

Senator FIERRAVANTI-WELLS—A variety of things? Give me a bit of a flavour.

Dr Webber—To give you a flavour, there are certainly consultation issues, with long and prolonged consultations. Other issues include, for instance, chronic disease management items; the GP management plan; team care arrangements seem to have been difficult for practitioners to get right; skin lesions; inappropriate use of skin items; flaps. More recently, you will have noticed some publicity about the inappropriate use of CT scans. The other big issue that is about 15 per cent of the caseload is the inappropriate prescribing of benzodiazepine drugs and narcotics. So it is a mixed bag.

Senator FIERRAVANTI-WELLS—Just as an aside, do you have many aged-care related complaints?

Dr Webber—We do see doctors who have been referred by Medicare for their use of the nursing home visiting items and so forth—is that what you mean?

Senator FIERRAVANTI-WELLS—Yes, that is the sort of thing.

Dr Webber—I must admit, most of the people we see have been okay in that area when we have looked at what they have done. There have been a few problems, but I have been pleasantly surprised. The standard of care from the doctors that we have seen has been quite good.

Senator FIERRAVANTI-WELLS—I have one more question. You answered a question on notice in relation to workplace bullying—E10 309, on an alleged grievance. Are you aware of that?

Dr Webber—Yes, I am.

Senator FIERRAVANTI-WELLS—You note there that the complainant and the officer subject to the matter were advised of the resolution of the grievance. Nobody changed jobs. No-one left PSR. That was one instance, but is this an increasing area that you are doing work in? Are you seeing more workplace bullying?

Dr Webber—No.

Senator FIERRAVANTI-WELLS—This was just a one-off rather than a trend?

Dr Webber—Not a trend—no.

Senator FIERRAVANTI-WELLS—Okay. Thank you.

CHAIR—Thank you. I would think that Senator Milne's questions will now need to go on notice and we will be able to move on to the next item, which is outcome 11. I thank the officers from outcome 3. Outcome 11—mental health. We are going to start with mental health.

Senator FIERRAVANTI-WELLS—How many early psychosis prevention and intervention centres will be provided with the funding allocated under the COAG agreement?

Ms Harman—The Commonwealth's contribution is $25.5 million over four years. I believe Ms Huxtable gave evidence yesterday that we are seeking matching funding from interested states and territories. We are costing it on the basis of there being four sites around Australia.

Senator FIERRAVANTI-WELLS—Four sites?

Ms Harman—That is correct.

Senator FIERRAVANTI-WELLS—Where will they be located?

Ms Harman—That is going to be decided through consultation with states and territories.

Senator FIERRAVANTI-WELLS—As part of that COAG agreement, is that referred to in the agreement in the appendices as to the timelines, or is this part of the end of 2010?

Ms Huxtable—They are all in the red book.

Senator FIERRAVANTI-WELLS—Over the weekend, Ms Huxtable, I will re-read my red book.

Ms Huxtable—Whether I can actually find it in this long list—

Senator FIERRAVANTI-WELLS—I have been looking at the appendices to the agreement, Ms Huxtable.

Ms Huxtable—There is the communique, and the agreement really needs to be seen as a job lot.

Senator FIERRAVANTI-WELLS—Yes, I know.

Ms Huxtable—But the red book is a good reference, in terms of when things will come on board. 1 January 2011 is the implementation date for the additional EPPIC sites.

Ms Harman—There will be a period of consultation with states and territories to seek interest and a contribution.

Senator BOYCE—Has the government decided which states yet?

Ms Harman—No, that will be part of those discussions with states.

Senator FIERRAVANTI-WELLS—Depending on who is interested. You are virtually inviting those states who may be interested in matching funding. Presumably, those states that come on board with matching funding will likely be the states that get a location, Is that correct?

Ms Huxtable—We will need to obviously make an assessment, depending on how many states are interested, with the money that is available. If we get to the happy situation where we have got more states interested than money, then we would need to look at prioritisation of their various capacities.

Senator BOYCE—When is the needs assessment done, in terms of those locations?

Ms Huxtable—The needs assessment will be part of the discussion with states and territories.

Senator BOYCE—Do you have the quantum of unmet need in this area?

Ms Krestensen—The intent of this measure is an expansion of access to the EPPIC model. It is not looking at addressing a deficit or rolling out a service in a way which would achieve national rollout. It is expanding the model, dipping a toe in the water, in sites other than where it is available in Victoria at the moment.

Senator BOYCE—Yes, but surely the expansion was based on a perceived need. What is that need?

Ms Harman—There is a high prevalence of mental health disorders in young people and about 25 per cent of young people aged 16 to 24 years experience a problem in any one year. I understand that about one per cent of these young people could have a form of psychosis. I cannot give you the exact numbers, in terms of how that translates to individuals, but those are the kind of—

Senator BOYCE—If we, on that basis, assumed that one per cent of the population between 16 and 24?

Ms Harman—One per cent of those people within that age group, in any one year, may experience some form of psychosis. So it is 25 per cent of young people 16 to 24. Of that group, about one per cent might experience psychosis.

Senator FIERRAVANTI-WELLS—I guess the point that Senator Boyce is making is that there must have been some assumptions made in relation to this extra funding. You have told us that there are going to be four sites, so that is only four physical locations. How many people do you anticipate will benefit from the centres? How many people do you think will actually benefit from this measure?

Ms Harman—We believe that, over that four-year period, up to 3,500 young people.

Senator FIERRAVANTI-WELLS—We are really talking about limited location and, in the big picture of the issue, a very small number of people. That is the point that Senator Boyce is really getting at. There are various people out there talking about mental health and all those needs. It seems to me that, given the billions that are being spent in all sorts of areas, when you look at this sort of measure and $25 million over four years for four sites to deal with this problem and you put it into context, it is not a lot.

Ms Harman—The $25.5 million, as we have previously said, will be hopefully matched through interest from states and territories. It may be that we end up having a huge amount of interest from states and territories, in which case the Commonwealth's funding might be stretched even further.

Senator BOYCE—If the states put in more than 50 per cent. Is that what you are saying?

Ms Harman—No, if more than four states and territories come on board.

Senator FIERRAVANTI-WELLS—To get a total of 50. Is that what you are aiming at?

Ms Harman—As I said, we need to go and have those discussions with states and territories. We want to make the Commonwealth's contribution go as far as it can, but how many sites we end up with will be determined by those discussions with states and territories. Just in terms of the broader issue that you have raised, clearly there is a lot of discussion about the need to service people better who have severe mental illness. The Commonwealth has indicated its strong interest in doing better for that group of people.

Senator BOYCE—But, as you would know, both Professor McGorry and Professor Ian Hickie have suggested that the dollars do not match that statement.

Ms Harman—Yes, we are aware of those statements. As I said, mental health and mental health reform writ large is very much on COAG's mind. We have work to do, on COAG's instructions, with our state and territory colleagues, to go back to COAG in 2011 on broader reforms to mental health. That will look at roles and responsibilities as well.

Senator FIERRAVANTI-WELLS—But there is nothing substantial in relation to mental health in the current plan. You are talking about more youth-friendly services, expanding the measure that we are talking about at the moment, some money for additional mental health and some flexibility in packages. That is not a lot for a problem that the Prime Minister and others seems to have said is another one of these priorities for us in this country. If it really is a priority, that sort of money is not really addressing the problem.

CHAIR—That is a question for the minister, not for the officers.

Senator FIERRAVANTI-WELLS—I appreciate that and I take the opportunity to get a comment from the minister. As Senator Boyce has been saying, this is another one of the

Prime Minister's 'high priorities' but, when push came to shove in the grand hospital plan, there is very little there. In fact, it is miniscule in relation to mental health. Does that mean that we are going to see more on mental health, or is this it for the foreseeable future?

Ms Harman—As I said, the Commonwealth will lead some work to take back to COAG in 2011 on health reform for mental health.

Senator FIERRAVANTI-WELLS—In other words, the Commonwealth is proposing more mental health programs and you are looking at that, and then you are going to go to the states for matching funding?

Ms Harman—No.

Senator FIERRAVANTI-WELLS—The Prime Minister said, 'We're going to do things on mental health.' I am trying to understand what it is that is going to be done and when it is going to be done.

Senator Ludwig—If you look at the funding for health specific programs, it will double over the next four years, compared to the last four years of the previous government, which is $1.1 billion over 2010-11 to 2013-14, compared to $516.5 million from 2004-05 to 2007-08. There is also significant funding for psychological services subsidised through Medicare and the Pharmaceutical Benefits Scheme. I just do not think you can take it in isolation, either. Of course, as part of the health reform, the government is investing $175.8 million, including $123.2 million in new funding for—and I think you have heard me say this in the Senate—up to 30 headspace services, which is extra funding for the existing 30 headspace sites and expansion of telephone and web-based services. There is $25.5 million of four years to expand the early psychosis prevention and intervention centre model, $13 million to employ 136 mental health nurses and $58.5 million to deliver care packages to better support up to 25,000 people with a severe mental illness. That is just an overview, but if you want to drill down into any of those, I am sure the officials might be able to add to that, or, alternatively, take some of that on notice.

Senator BOYCE—Perhaps you could tell us which of those are new programs in the past three years?

Senator Ludwig—The $175.8 million, including $123.2 million in new funding is what I said, which was the $78.8 million for up to 30 headspace services and the $25 million for the early psychosis prevention and intervention centre model, the extra mental health nurses and the care package to better support people with severe mental illness.

Senator BOYCE—But these are primarily an expansion of existing programs, are they not?

Senator Ludwig—You asked me whether it was new money; I said yes.

Senator BOYCE—No, I said 'new programs'.

Senator Ludwig—There are the headspace services, the early psychosis centres and extra mental health nurses, and they all provide additional services in this area. Of course, that is on top of what we already do in terms of the psychological services funded through Medicare and the Pharmaceutical Benefits Scheme. The general funding for mental health specific programs will double over the next four years compared to the previous four years. I am

really just dealing with the broad issue that it seems to be a flavour from your side of the bench that this government is not doing anything in mental health. I just wanted to set the record straight that this government does take it very seriously, is committing money to this area and, within the broader area of health, has continued to act in this area.

Senator FIERRAVANTI-WELLS—If that were the case, why are Professor McGorry and Professor Hickie so stridently complaining in this area. They are obviously pointing out needs, and they are very stridently critical of the government for what the government is not doing in this area, Minister. If you were actually doing a good job in this area, Professor McGorry and Professor Hickie probably would not be out there so stridently criticising you. That is the point we are trying to make.

Senator Ludwig—I understand the point you are trying to make, and I understand that they are very strong advocates in this area. What I have outlined is what the government's response is in this area, and it is not insignificant. This government takes this area very seriously. It does listen to the strong advocates in the area, but it also has to deal with all the areas of health, and it is confident that it has been able to demonstrate the seriousness of its commitment to this area.

Ms Halton—Can I add that COAG explicitly agreed that this was an area which would come in for detailed and careful consideration in the next 12 months.

Senator BOYCE—What is your reaction, then, to the claim of Professor McGorry that only three per cent of people with mental health problems are being serviced under the current funding that will be in place?

Senator Ludwig—Sensibly, Professor McGorry is entitled to his own views, but of course more can be done. There is no argument that you cannot do more. We have done a lot to date. That is the subtle point I am trying to get across to the committee. What the secretary has outlined is that there is more work to be done through COAG as well. Everybody recognises that. It is a challenge. This government is committed to it and is working its way through it. It is not going to be done overnight.

Senator BOYCE—Dr Lesley Russell, who is a former health adviser, has said that there is only $31.4 million of new funding, once you get past the glossy brochure, and that building the foundations for mental better health care is a hollow claim. Is there only $31.4 million in new funding, or is there much more?

Senator Ludwig—I think I have outlined what the funding is more broadly and I ask the officials to provide any additional information, if not here at the table then on notice. As I have indicated, I do not know how she has constructed these figures. I can only provide information about our figures.

Ms Halton—The $31 million figure is not a figure we understand. It is not correct, but we do not know where it has come from. It is absolutely not correct.

Senator BOYCE—So what is the new funding?

Ms Harman—It is $123.2 million over four years.

Ms Halton—That is the dedicated funding and, as I think has been pointed out in the public arena on a number of occasions, there are a number of other elements to the package

which, it is our expectation, will provide direct assistance. We discussed yesterday, for example, the subacute beds. Explicitly, one of the targets is those subacute beds.

Senator BOYCE—Your figure, Ms Harman, is a net figure?

Ms Halton—Yes.

Ms Harman—That is right.

Senator SIEWERT—Can you break it down, because I am interested in the additional funding, for example, for headspace. There is some existing funding for headspace. How much is new funding and how much would be a simple continuation of that program? So it is new funding, but how much of that would apply if you were taking the funding from, say, the last two years and you needed to continue the funding?

Ms Halton—The $123 million enables new headspace sites. The continuation of the existing ones is in one bucket; new ones are in this bucket.

Senator SIEWERT—So the $123 million does not include any of the existing funding for existing headspace sites?

Ms Halton—No. It is not a double-count.

Senator SIEWERT—So how much of the $123 million is for new headspace?

Ms Harman—New funding for headspace is $78.8 million.

Senator BOYCE—That is for new headspaces?

Ms Halton—Absolutely correct.

Ms Harman—It will also provide some additional funding to the existing sites, and enhance web and telephone based services for young people as well. Those are the three components of that new money that amounts to $78.8 million.

Senator BOYCE—How much of it will actually be spent on new services—not expanded services in existing locations but in developing new services in new locations?

Ms Krestensen—Just to give you a concrete example of that, in the final year of 2013-14 when it is fully ramped up and all the new sites are operational, there will be a total of about $41 million going for the youth mental health initiative for headspace. At the moment, about $17 million a year goes to headspace. There will be an additional just over $24 million in that final year, bringing the total to over $41 million. Of the $24 million in that final year, approximately $20 million will be dedicated to headspace sites. That will be, as you have suggested, a combination of the full rollout of the additional up to 30 sites and also the extra funding for the existing sites. We do not want to compromise headspace's ability to negotiate the level of funding with those sites, because we anticipate that, whereas in the past headspace has taken a very uniform approach to funding all sites exactly the same regardless of demand and regardless of location, they might want to have a more tailored approach this time. We have actually built into the funding the expectation, for example, that there will be 10 super sites, some of which might exist, some of which might be new, which will get an higher elevated level of funding to cope with the fact that they have got high levels of demand or that they are in areas of lower capacity. I hope that gives a concrete idea that about $20 million in

that final year will go for headspace sites. The balance will go for things like headspace administration, telephone and web based support and evaluation.

Senator SIEWERT—Of the $123 million, we have $78 million for headspace. We have got the EPPIC sites of—

Ms Harman—It is $25.5 million. Would you like me to run through the elements?

Senator SIEWERT—Yes.

Ms Harman—There is $123.2 million in total. Of that new funding there is $78.8 million for headspace and $25.5 million for expanding EPPIC.

Senator SIEWERT—Okay. None of that is going on any existing services.

Ms Harman—That is correct.

Senator SIEWERT—So it is new.

Ms Harman—There is also $13 million to expand the Mental Health Nurse Incentive Program and new money of $5.9 million as a contribution towards the flexible care packages, which will be delivered through the ATAPS program, and those will be targeted at people with more severe illness.

Senator SIEWERT—That is expanding the existing program?

Ms Harman—No, that is a new measure. The flexible care packages measure totals $58.5 million, of which new money is $5.9 million.

Senator SIEWERT—Sorry, that is what I mean. So that is expanding the existing program.

Ms Harman—It will be auspiced, if you like, through the existing ATAPS program but it is a new measure, because it is targeting a specific group.

Senator SIEWERT—Okay. It is a new measure in the exiting ATAPS program.

Ms Harman—That is exactly right.

Ms Huxtable—It is a different model. It has different rules et cetera.

Senator SIEWERT—Yes. And the $13 million is the mental health nurses, and that is new money as well.

Senator FIERRAVANTI-WELLS—Is there any capital funding in this?

Ms Krestensen—There is no capital funding.

Senator FIERRAVANTI-WELLS—So all the new services will be run out of existing services?

Ms Harman—Of the headspace expansion, there will be up to 30 new sites around Australia. That funding will be provided through the headspace company and they will manage that funding.

Senator FIERRAVANTI-WELLS—In other words, it is establishment—there is no separate money for building and bricks and mortar?

Ms Harman—It includes the establishment and operating costs, yes.

Senator FIERRAVANTI-WELLS—If establishment includes a new site, then out of that also has to come the building costs for new premises or anything like that?

Ms Harman—Our experience through headspace has been that new sites have not necessarily been built. They have been linked into existing buildings.

Senator FIERRAVANTI-WELLS—But with these new early psychosis prevention and intervention centres, if there is going to be any building, it has to come out of that $25 million.

Ms Krestensen—There will be set-up and operational costs associated with finding premises to rent and recruiting staff and so forth. That is correct.

Senator SIEWERT—As to this issue around the percentage of funding and the recommendation in the select committee report that mental health funding, as part of the overall health budget, be moved up to around 12 per cent, have you got a plan to move the level of health funding up to that higher percentage of the overall health budget?

Ms Harman—As the minister said, there will be $1.1 billion spent over the next four years on specific mental health programs. That is almost a doubling of the previous four-year period. There will be a detailed exercise that we go through over the next 12 months to take further advice to COAG on further initiatives in mental health, and those will be matters for government, in terms of what investments come out of that.

Senator SIEWERT—I hear what you are saying, in terms of there being an improvement in mental health funding, but my argument is that a doubling of not a lot is still not a lot. In terms of the recognition—and it has been recognised certainly through the select committee report and internationally—is it recognised that a higher level of percentage is ultimately required to effectively address the issue of mental health?

Ms Hart—There is actually some dispute around ideas about the right level of funding for mental health, or for many other conditions. The discussion in the literature and through the World Health Organisation sources means that it is difficult to make international comparisons. The latest data indicates that spending on mental health since about 1992, when the mental health strategy began, is greater than seven per cent of total health spending. Comparisons have been made with, for example, the Netherlands and the USA. The difficulty, though, with international comparisons is an apples and apples problem. Some countries would, for example, count drug and alcohol expenditure as part of mental health expenditure. Other countries, I understand, might also count intellectual disability.

The academic literature has pointed out that until there is a consistent typology about what is counted and how that is defined, there is not a sound and valid basis for comparing across different countries and for making that international comparison. There is also quite a lively debate in the literature about what the right level of spending is, given need, because there is a gross estimate of spending and we have several reports that track that and publish that regularly. There is also an important discussion about the level and mix of services. As with overall health expenditure, some countries spend at a higher level than others, but it always needs, I think, to be looked at in the context of what are the type of services and the range and mix of services. With things like the recent investment in early intervention services, there is a

balance there between intervening early prevention services, early treatment, and the balance between that and longer-term treatment for the management of people with chronic disorders.

Senator BOYCE—There is this complete disconnect between what experts in the mental health field are saying and what the government is saying. You would be aware of Professor John Mendoza?

Ms Harman—Yes, I am.

Senator BOYCE—He has been involved in the minister's advisory council on the topic of mental health, is that correct?

Ms Harman—That is correct.

Senator BOYCE—What position did he have there?

Ms Harman—He is the chair of that council.

Senator BOYCE—A media release which he has issued today says:

An analysis of government funding for mental health shows a fall in 2010-11 for the first time in more than a decade …

'This coming financial year total spending on mental health will fall to below less than 6% of all health funding. This is largely due to the failure of the Rudd Government to invest any significant new money in mental health' …

'This fall in investment simply beggars belief when we have more evidence today from the Institute for Health and Welfare showing that Australia's prisons are the repositories of the mentally ill, the drug and alcohol-addicted, and the under-educated' …

He points out that:

… people with serious mental illnesses have a mortality rate 2.5 times the general population, and yet the Rudd Government has ignored the advice of its own advisory groups on this issue' …

'The Prime Minister has clearly decided there are no votes in mental health despite the fact that 45% of Australians experience a mental disorder some time in their lives.

How do the comments not just from the Australian of the Year, Professor McGorry, and Dr Ian Hickie, from the Mental Health Council, who obviously are very senior people in this area, but also from the chair of the minister's own advisory council gel with what you are telling us here?

Ms Halton—You are asking for an opinion. I have to make the obvious statement that I have not seen the document from which you read and I cannot make any comment on it.

Senator BOYCE—No, it has been released today.

Ms Halton—And therefore you cannot expect me to make any comment as to whether it is accurate or not. I will make the point to you, though, that if your reading of it was correct, I should remind you that, in terms of expenditure on prisons in respect of health, that is a matter for state governments and I cannot make any comment in relation to that level of expenditure. I have no idea what that is a reference to, but that is a matter of fact. As to your asking for us to comment on people's comments, manifestly we cannot do that. The officers have outlined to you the investments that are being made. I should make the point to you that it is a statistical artefact to start comparing percentage growth as against total of expenditure. The

bottom line is there is more being spent on mental health under this government. As to the particular analysis done in that document, which I have not seen, I cannot comment.

Senator BOYCE—Perhaps you would like to, Minister?

Senator Ludwig—I had already gone through effectively a short version of the PBS and where the government has indicated $123.2 million in new funding. We had already indicated that we would be funding double over the next four years compared to the previous government, which is $1.1 billion over 2010-11 to 2013-14, compared to the previous government's expenditure of $516.5 million. I have not seen the article, obviously, either, nor the context upon which it is based. I can say that in this area there are strong advocates for more funding for mental health. I have indicated that the government already recognises that more can be done. We are working through COAG. We have spent, and are spending, new money in this area—significant new money; more than the previous government spent. I have not seen the figures that you have cited, and nor can I say with any veracity whether they are correct.

Senator BOYCE—I was not asking for comments on the accuracy of the figures, per se. I will assume that Professor Mendoza knows how to add up. What I was asking for is your explanation of the disconnect between your views on mental health funding, the government's views on mental health funding, and the sector's views on mental health funding?

CHAIR—Senator, that point has been made twice so far in previous evidence. There is no value at this time in continuing. It is half past 12 and we are going to break and come back at 1.30.

Senator Ludwig—Thank you, Chair. I will finish it then.

CHAIR—Yes, absolutely.

Proceedings suspended from 12.31 pm to 1.29 pm

Senator BACK—I would like to pick up a couple of points which confused me during the last period of questions. With regard to the budget, the government has announced a $175.8 million package of which, I understand from the minister's press release, $78.8 million is for headspace, $25.5 million is for early psychosis prevention intervention, $13 million is for mental health nurses over two years and $58.5 million is for care packaged and unspecified funding. Am I correct in that assumption?

Ms Harman—That is correct.

Senator BACK—These were federal government commitments under COAG, were they not?

Ms Harman—No, these are all new measures.

Senator BACK—So none of those were COAG commitments; they are all new measures?

Ms Harman—They are all new measures.

Senator BACK—So the $175.8 million is all new money?

Ms Harman—No, there is $123.2 million of new money and those were new measures announced at COAG in April.

Senator BACK—That was what I said—those were COAG measures announced in April.

Ms Harman—Yes.

Senator BACK—So the balance of them, which is new money in this budget, is how much?

Ms Harman—It is $123.2 million.

Senator BACK—That was announced in April for COAG. I am asking whether the difference between that figure and the $175.8 million is the new allocation announced in the budget for the first time.

Ms Harman—The difference between $175.8 million and the new funding of $123.2 million is derived from $52.6 million in offsetting from the Better Access measure.

Senator BACK—I am not clear. The earlier figure, the $123.2 million was announced as part of the federal government's COAG commitment back in April?

Ms Harman—That is correct.

Senator BACK—Okay and then in the budget they announced $175.8 million which includes the April announcement?

Ms Huxtable—If you look at the communique from COAG on 20 April, what that said—and there is little bit of change around the margin of those figures because of out-turn in the figures for the budget—is that the Commonwealth will provide $174 million to improve our mental health system including $115 million in new funding. There is a little bit of variation, as often happens, because the numbers need to be out-turned, but basically the communique flagged exactly the figures that were then appropriated in the budget context.

Senator BACK—Where is the $59 million, being the difference between $174 million and $115 million, allocated? Is that the $58.5 million for care package?

Ms Huxtable—Yes, that is correct and in the communique it was flagged that there would be some redirection of moneys in the order of that $58 million. The nature of that redirection was announced in the budget context.

Senator BACK—What is the total expenditure for 2009-10 on mental health?

Ms Huxtable—My colleague will need to help me answer that. I would like to correct the record because I said $58 million and I should have said $52.7 million, I have just been advised.

Senator FIERRAVANTI-WELLS—You consulted your red book.

Ms Huxtable—I did not consult my red book. I consulted my colleague on this occasion.

Senator BACK—What is the allocation in 2009-10? Is the $175.8 million that we have just talked about over the out years or is it for 2010-11?

Ms Huxtable—No, that is a four-year figure.

Senator BACK—Is it possible to take on notice, because I know time is limited, what the actual annual division of those figures will be?

Ms Huxtable—Yes, and that is in the red book so we can look it up.

Senator FIERRAVANTI-WELLS—Get a spare copy, Senator Back, then we'll have three spare copies.

Senator BACK—I'll read it on the plane. My second question is regarding the $1.63 million for 1,316 new subacute beds by 2013-14. I understand that that was to support rehabilitation, palliative care and mental health services including residential and community based services. What is the break-up between those four areas: palliative, rehabilitation, geriatric and mental health?

Ms Huxtable—The way in which that money is allocated is through the states and territories. For the various target groups who could benefit from those moneys as identified in the documents that you have read out there are no specific applications across those components. The idea would be that states and territories will have flexibility in terms of how those moneys are allocated, but the expectation of COAG is that those target groups will benefit across those areas that you read out.

Senator BACK—But you do not have any direction as to the break-up of that $1.63 million amongst those four groups?

Ms Huxtable—Not in the way that you are asking, where you actually say, 'This amount is for this target group and this amount is for that target group.' But in the agreement with states and territories through the National Partnership Agreement that will transmit that money there will be specific reference to those target groups as benefiting.

Senator BACK—Through COAG, have states committed? Or, what expectations or anticipation does the federal government have of what the states and territories are likely to commit? I ask because in the Western Australian budget just brought down there is a figure for mental health of $506.5 million for 2009, 2010 and 2011 to be allocated through the new Mental Health Commission and a further $29 million over four years for 10 new acute mental health beds. Is that the sort of expenditure you are expecting other states and territories to commit per capita?

Ms Huxtable—No. It is really a matter for individual governments to make their budgetary decisions around what they wish to commit to mental health.

Senator BACK—So there has not been any commitment by premiers, chief ministers and the Prime Minister as part of COAG? The figure of $1.63 million is a very modest figure, is it not?

Ms Huxtable—It is billion—$1.63 billion.

Senator BACK—Yes. You are right. Will that be divided through the states and territories for allocation according to their priorities?

Ms Huxtable—Allocation for those priorities that have been identified by COAG and which all states and territories, with the exception of WA, have agreed through the National Health and Hospitals Network Agreement.

Senator BACK—This is the GST?

Ms Huxtable—The agreement covers a range of individual measures, some of which are directed through states and territories and some of which are not. The sub-acute measure, as

described in the communique, is clear about the expectations as to how that money will be allocated. There will be a national partnership agreement which will set out the expectation about the number of services that will be delivered year on year for each state and territory.

Senator BACK—Given the brevity of time, I will just ask a couple of questions on Better Access and the removal or flagged removal of specialist mental health social workers from the Better Access program. Why are social workers to be removed from the program, and is this part of an evaluation by the department? If so, has that evaluation been completed, and could you give me some guidance as to what led to that decision for the mental health social workers to be excluded?

Ms Harman—We know that fee-for-service interventions do not work particularly well for people with severe illness. The government took a decision that it wanted to, in the context of the COAG agreement, do more for people with severe illness who are being treated in primary care. It identified a package with a total value of $58.5 million to introduce a new measure to be delivered initially through the ATAPS service stream to target people with severe illness and introduce better care packages for them that go to clinical and non-clinical needs as well as packages of care that will meet their ongoing needs.

To answer your question about whether or not this decision was part of an evaluation of Better Access, the evaluation of Better Access is an ongoing evaluation that will report to government at the end of this calendar year. The government took this decision in the context of knowing that it wanted to do better for people with severe illness.

Senator BOYCE—Perhaps we can go back to the basic funding of Better Access. The previous government had $500 million in there—is that correct? And it has gone up now to $1.1 billion?

Ms Hart—The latest figures show that from the start of the Better Access initiative in November 2006 and the end of April—the latest figures I have available—for 12.8 million mental health services there have been total gross payments of $1.3 billion.

Senator BOYCE—Is this a capped program?

Ms Hart—It is an entitlement program, so it operates along similar lines to other MBS items.

Senator BOYCE—So if people go to their doctors, they are entitled to a plan et cetera.

Ms Hart—It is not an unlimited entitlement in that there is a capping of the number of sessions that are available to a client of the Better Access initiative over a calendar year.

Senator BOYCE—Is it unlimited in terms of the number of people who may choose to access it if they believe they have a mental health problem?

Ms Hart—If the general practitioner has made an assessment and diagnosed them as having one of the mental disorders that the initiative covers then, potentially, they are eligible for referral to allied health services under the scheme.

Senator BOYCE—My figures for the period from the start of the program in 2006 through to December 2009 say that there were roughly 1.9 million GP mental health consultations. Is that correct? Are you able to give me figures for the period since December 2009?

Ms Hart—I believe we have those. The current figure of GP mental health treatment plans as at the end of March is 1,902,669.

Senator BOYCE—When is this up to?

Ms Hart—This is from the beginning of the scheme up to the end of March.

Senator BOYCE—Rather than run through it now, could you give me on notice the whole list up to the end of March 2010 with the number of consultations and psychological assessments under the item numbers. Is that possible?

Ms Hart—Yes, we are happy to do that.

Senator BOYCE—Do the psychological assessments and therapy for a mental disorder include sessions that would have been conducted by a mental health social worker under the guidance of a psychologist or is it just strictly with psychologists?

Ms Hart—To clarify, do you mean of the count I just gave you?

Senator BOYCE—Is item 80010 just for people who see clinical psychologists?

Ms Hart—The item you just referred to is one of several items for clinical psychology.

Senator BOYCE—Is it just for clinical psychology?

Ms Hart—It is just for clinical psychology.

Senator BOYCE—Are you able to tell us how many services by mental health social workers were conducted in the period up until March 2010?

Ms Hart—The number of services provided by social workers under the Better Access initiative to the end of March 2010 were 331,770.

Senator BOYCE—So there were 3.3 million services. Is that correct?

Ms Hart—No, there were 331,770.

Senator BOYCE—We have talked before at length about funding but, really, the fact that the funding has doubled into the Better Access program has been simply because of the popularity of the program hasn't it? The government has simply met the costs of the program; they have not put new money in or expanded the services available under the program in any way, have they?

Ms Hart—The services available under the program are the same as when the program commenced over that time period—is that your question?

Senator BOYCE—Yes, because it seems to me to be a little duplicitous of the government to claim that they are putting new money into mental health when in fact all they are doing is paying their bills that this very popular program has created. You would be aware that mental health social workers and others in the mental health sector are of the view that they have been cut out of the Medicare rebate system simply to save money on this program.

CHAIR—I am concerned by the term 'duplicitous'.

Senator BOYCE—I did say 'somewhat', but I am more than happy to withdraw that term and suggest we go back to things like 'hollow claims' and 'gilding the lily', which were being used earlier and not by me.

CHAIR—You can keep them.

Senator Ludwig—Senator Boyce is wrong. It is on top of significant funding of psychological services subsidised through Medicare and the Pharmaceutical Benefits Scheme. It is on top of those. It is, as part of the health reform, investing $175.8 million, including $123.2 million in new funding. I know we have said this three to four times today, but that is in the PBS. That is what it is. If you do not agree with it, you can hold your view but I take issue with you if you say that it is not correct.

Senator BOYCE—But the bulk of the funding is in Better Access and Better Access has increased because more people want to use it not because you are funding expansion of the services available under Better Access. Minister, that is my point.

Senator Ludwig—That is a different point than you were making early.

Senator BOYCE—No, I do not think it is.

Senator Ludwig—We can always differ on degrees on this issue. But it is new funding, and that is the point I have been making. It will mean up to 30 additional headspace services.

Senator BOYCE—Yes, but they are not under the Better Access program, are they?

Senator Ludwig—It will include over four years to expand the early psychosis prevention—

Senator BOYCE—Chair, we have heard this list.

Senator Ludwig—Yes, but it seems to me that you take issue with it and you say there is no new funding when there is.

Senator BOYCE—I was remonstrated earlier for asking this question several times. I hope you give your view of the answer not repetitiously either, Minister.

CHAIR—Senator, I am going to take exception. You were not remonstrated. I pointed out that that argument had been stated several times. You have made a comment about access with Better Access and interpretation of the funding. The officers and the minister have responded to that. Is there another point you wish to make other than stating your point of view?

Senator BOYCE—I was asking the departmental officers if they were aware of the view within the mental health social workers field and the mental health sector that the fact that they have been defunded or taken out of the Medicare rebate system is simply a way to try to save money on the Better Access program.

Ms Hart—We are very well aware of their views. The department has been working very closely with the CEOs of both the Australian Association of Social Workers and the occupational therapists.

Senator BOYCE—What are you hoping to achieve?

Ms Hart—In terms of the discussion about the opportunities for their participation, social workers and OTs are already integral providers of ATAPS, access to allied psychological services, under the existing program. They will be an important part of the service provider landscape under the new ATAPS measure which is focused on people with severe mental illness. We would see both those professional groups as having important skills and

experience to bring to the treatment under the flexible care packages under the new ATAPS measure.

Senator BOYCE—How will their services be costed within the flexible care packages, as you stated?

Ms Hart—I will need to refer that to my colleague to talk about the costing of that.

Senator BACK—There is 331,000 to the end of the third quarter, so 440,000 to the end of the financial year would be a reasonable assumption. With the specialist mental health workers now being denied access to the program where will those people get their treatment and at what cost in comparison to what the costs have been using the specialist mental health workers? Or have I missed the point completely?

Ms Huxtable—Just before Ms Hart responds to that, the figures we read out before were from the commencement of the program until March I think.

Senator BACK—I see, so they were not for the financial year.

Ms Huxtable—So you cannot extrapolate that annual figures.

Senator BACK—Whatever that figure is—it probably becomes 360,000-odd by the end of the financial year—where will those people be treated and at what cost differential to the current service?

Ms Hart—Those people will continue to have access to clinical psychologists and psychologists under the Better Access initiative. I guess it is important to point out that more than 95 per cent of providers under Better Access are encompassed by clinical psychologists and psychologists, so they will continue to be eligible and be able to access those services. I am not able to speculate about the costs associated with that.

Senator BOYCE—If we could get the costs that consumers will pay or are likely to pay and what sort of subsidy consumers will receive for mental health social workers and OT services through the flexible care packages first please.

Ms Krestensen—Under the ATAPS program there are very small, if any, copayments. Copayments of between zero and $30 are generally paid for ATAP services, which to date have targeted people with mild to moderate disorders. Given they are provided through fundholding arrangements, which often involve salaried providers of care or people employed on a sessional basis, there is less of an impetus to have copayments than in general, but the cost to consumers has been kept very low under the ATAPS program.

Senator BOYCE—'Very low' means less than $5 or less than $10?

Ms Krestensen—Under $30 in general. I think the average is $5. A lot of services are provided without any copayment at all under ATAPS.

Senator FIERRAVANTI-WELLS—I, like other senators, have been inundated with correspondence from people. Lynne in Ryde in New South Wales writes:

From 1 July my clients will no longer be able to claim back their one-on-one sessions referred from GPs. I cannot begin to tell you what is going to happen. A lot of my clients are people who are on pensions like disability pensions and aged care pensions. There is no way they can afford to go and spend money on counselling, so I bulk bill them.

Without counselling my clients are helpless. A lot of these people do not have family and, unless we can go in there and assess them and work with the GPs, nothing happens. In aged care there is so little funding for people with mental disorders. It is just not there.

When you make that sort of comment, how do I respond to Lynne from Ryde who asked me specifically to put this question to you?

Ms Krestensen—Just to be clear, 89 per cent of all ATAP services have no charge at all; only 11 per cent of ATAP services to date have had some level of copayment.

Senator BOYCE—What is the criteria for whether there is a cost?

Ms Krestensen—There is no criteria as such.

Senator BOYCE—Just whether the therapist chooses to—

Ms Krestensen—That is correct. There are arrangements negotiated between divisions and between the providers of services. But in general because ATAPS has tended to target hard to reach groups, many of whom do have problems paying for services—two-thirds of people who access ATAPS are on low incomes—there has been a very strong trend towards no or very low copayments under the ATAPS program.

Senator FIERRAVANTI-WELLS—Clearly there is a concern. The concern of Lynne from Ryde is echoed in just about every one of the lists that I have in front of me. I am not going to go through it. Obviously there is a problem there. We are talking about people who are on very low incomes and you have not communicated properly because these people are basically all giving us the same sort of circumstances. It varies from area to area—Michelle from Milton, Ken from Riverina, Diane from Leichhardt, Pete from Neutral Bay; the list goes on and on. Our questions are very legitimate. These people want an answer. They have specifically written to us before estimates so we could ask you these questions so you can provide answers to them.

Ms Harman—If I can just clarify that the department is aware of the very strong representations from OTs and social workers. As Ms Hart said, we have been involved in discussion with both of those groups. The government took a decision, which it announced on 19 May, to defer the implementation of the new care packages and to defer the associated changes to the MBS items for OTs and social workers until 1 April 2011. That will give us time to work with OTs and social workers. Those processes are already starting.

Senator FIERRAVANTI-WELLS—Did you consult with them beforehand? Why didn't you consult with them beforehand? Did you go out and consult? Is this another example where somebody makes a decision and then they realise—

Senator BOYCE—I do not think it is the departmental officers we should be talking to about this, Senator Fierravanti-Wells.

Senator FIERRAVANTI-WELLS—That is the point. Is this another example of somebody having a thought bubble in the Prime Minister's office or somewhere else? Nobody bothers to—

Senator Ludwig—Is there a question at the end of this?

Senator FIERRAVANTI-WELLS—My question is: was there any consultation with industry before you embarked on this measure or was this simply a budget measure where you realised you had to find some money?

Senator Ludwig—You have asked the question; you should let the officer respond.

CHAIR—Can I just remind senators again that it is not very useful to have a couple of people speaking at the same time. I am not quite sure what Hansard has picked up after that last session there. I hope you got something there, guys. Anyway, there was going to be an answer to the question that Senator Fierravanti-Wells asked.

Ms Harman—The department did not consult with social workers and OTs before the government's decision.

Senator FIERRAVANTI-WELLS—Isn't that interesting. Why didn't you consult first? Everybody is talking about mental health and the needs of mental health. You go and undertake a measure like this and you do not even bother to talk to the very people who are going to be affected by this.

Senator Ludwig—You have asked why they did not consult. You should then let the officer respond to that question.

Senator FIERRAVANTI-WELLS—Well give me a reason. Give me a valid reason.

Senator Ludwig—The officers will respond if they can. If not, they will take it on notice.

Ms Halton—We will take this on notice, but the reality is that the government took a series of decisions. That is a matter for the government in terms of the decisions taken. Indeed, the government did actually discuss a number of things to do with this particular program with the committee, which you were referring to earlier in terms of its views, that is chaired by Mr Mendoza.

Senator SIEWERT—Now that the changes have been put off until April, as I understand it, the evaluation that has not yet been completed will be completed by then. In fact, it is due to be completed later this year I understand.

Ms Harman—That is correct. It is due to report to the department by the end of this calendar year.

Senator SIEWERT—One of the things I could never understand was why you made this decision on Better Access before the report was finalised.

Ms Halton—It is not our decision; it is a decision of government.

Senator SIEWERT—Okay. Why was the decision made when you have got an evaluation there? As I understand it from the feedback I have had from social workers, they see beneficial effects. You could say, 'Of course they are going to say that,' but the fact is that you are doing an evaluation to see whether or not it is useful. What is going to happen now? You have got the evaluation process that is coming by the end of this calendar year. You are not implementing this until next year. What happens if the evaluation says this is a really cost-effective program that the community likes? Are you still going to go ahead and make the changes or are you going to reconsider it in light of that report?

Ms Halton—That is a question you have to put to the minister. We cannot answer that.

Senator SIEWERT—Minister?

Senator Ludwig—I am happy to take it on notice.

Senator FIERRAVANTI-WELLS—Given Minister Roxon's form, the answer is yes. We will probably have another backflip.

Senator Ludwig—That is a comment not a question.

CHAIR—If you want to throw in those comments, Senator Fierravanti-Wells, it is your time to keep on with the process.

Senator FIERRAVANTI-WELLS—That is fine. If we choose to occupy our time in that way then that is our prerogative.

CHAIR—Then we will just do away with bothering with officials or questions because we will just be able to have a speech. Those comments are not favourable.

Senator SIEWERT—I am presuming the government was aware there was an evaluation process being undertaken at the time they made the decision?

Ms Harman—Yes.

Senator SIEWERT—We have been talking about the flexible packages. I would suggest that the flexible packages are not going to use the same number of social workers and OTs, for example. There is not enough funding in those packages to replace the funding and the process in the Better Access package. So all the issues that we have been hearing about in terms of disrupting people's practices et cetera—not all of those are going to be dealt with through transferring across to the flexible packages, are they?

Ms Krestensen—Putting it another way, I think not all occupational therapists and social workers might choose to move across to deliver flexible packages. But we are certainly already working with the divisions of general practice who provide ATAPS services to remind them that we think that, for ATAPS, a broad based team, including a team of occupational therapists, mental health nurses and social workers, is very important to meet the challenges ahead. There certainly will be opportunities for employment for occupational therapists and social workers in ATAPS, and we are certainly working with the professional associations in the design of the program of the flexible packages to maximise those opportunities. They certainly will be key players. They will not be the sole players as the providers of those packages. There will also be psychologists and various other players. The links to psychiatrists and the Mental Health Nurse Incentive Program will also be important, but there will certainly be expanded work opportunities under that measure. The funding for that measure is greater than the funding that has been removed from the Better Access program.

Senator BOYCE—For the same bit of services?

Senator SIEWERT—No. They are different services. In terms of the number of people who are supported through the Better Access program and the transfer of the funding from that program to ATAPS, what is the number of people that will be able to be supported and seen through the ATAPS program? My follow-up question is: what is the cost of the services that OTs and social workers provide compared to the cost that we would be paying for psychologists through the ATAPS program?

Ms Krestensen—The way that providers are paid through ATAPS is really negotiated between individual divisions and the providers who work within those divisions. We do not set set amounts for them to pay psychologists and social workers. It is not quite as structurally straightforward as it is in the Better Access program, with the set rebates. But to answer the first part of your question, we are anticipating that up to 25,000 people with severe mental illness will be supported through the new flexible packages over a four-year period.

Senator SIEWERT—How many people are you anticipating will not be able to access services through the Better Access program?

Ms Krestensen—I do not have that information with me. It is a bit of a complicated answer, in the sense that some people who would have seen a social worker or occupational therapist would instead be seen by a psychologist. I think we might have to take that one on notice.

Senator SIEWERT—If you could take it on notice, that would be appreciated. The next point is: what is the cost differential between seeing a social worker and seeing a psychologist? Under the Better Access program you still do the rebates with the set prices. If you move from there to the ATAPS program, what is the cost differential there?

Ms Krestensen—I think we will take that one on notice, but just to reiterate what I said before: there are not set amounts that we pay for particular types of services.

Senator SIEWERT—Point taken. Then how do you know you are getting better value for the service that certain people will require if they shift across to ATAPS? How do you know that you are getting better professional service for the same amount of money?

Ms Krestensen—I guess the intent was not so much that we were going to be getting value for money but it was the mix of services. Better Access and, to date, ATAPS itself have focused on a very straightforward, structured six plus six sessions of psychological care. Someone with severe mental illness, the sector has been telling us, needs a different mix of services—they need psychological services, case management and broader social support, linking into other services. So a broader range of providers are best able to meet those services. Under Better Access, under Medicare, it is very hard to encourage a structured and balanced approach to packaging the care of an individual. Under ATAPS, there is capacity to purchase these packages through fund-holding arrangements.

Senator SIEWERT—Certainly from my perspective I do not actually see one replacing the other. I am not suggesting that we do not need the additional services that you are funding. I am concerned about taking money out and changing the circumstances under Better Access. I appreciate that people need other services but for those who have been able to access services and meet their needs under Better Access where do they go now if funding is coming out of that program?

Ms Hart—Maybe I can add to Ms Krestensen's answer. As you rightly say, we are looking at two groups. For the people who have the high-prevalence disorders that Better Access is designed for—anxiety and depression—they will still be able to access the Better Access initiative and be referred to the clinical psychologists and psychologists under the program because, as has been pointed out here, it is not a capped expenditure program. It is a question

of fulfilling eligibility requirements. Those people with high-prevalence or common disorders will continue to be able to see those two groups of allied health professionals.

Senator SIEWERT—What happens here—does the waiting list grow? Money is coming out of that program. Do the waiting lists grow?

Ms Hart—With any program there are always some workforce constraints but what we have done in tandem with the Better Access program is put in place a number of workforce measures to grow that workforce. They are the backbone of Better Access. The psychologist workforce obviously plays a critical role in public specialised mental health services, in the ATAPS program for mental health, and in rural and remote services. There are a number of measures that I could outline for you that are focused on increasing the supply of that workforce.

Senator SIEWERT—I appreciate the issue about it not being capped but there is a certain amount of money allocated for Better Access. What happens when the money runs out?

Ms Hart—As a special appropriation it is appropriated as the eligible client base grows and outlays grow—unless I am missing your point?

Senator SIEWERT—You have taken the funding away. There is a funding cut there for Better Access, isn't there?

Ms Hart—Yes, the offset that has been used to support the new ATAPS measures?

Senator SIEWERT—Yes.

Ms Huxtable—It is a change to the projection of the forward estimates for that program, basically. That program will continue to grow but compared to how it would have been projected to grow in the forward estimates it will now grow at a lesser rate. Does that make sense?

Senator SIEWERT—Yes, it does. So I am right: there is money coming out of it. Perhaps we can solve this by asking: how many people are using it now? How many people are you estimating will use it now that the funding has been reduced? It is not growing at the same rate.

Ms Huxtable—There will be more people.

Ms Halton—It actually may grow at the same rate but it is off a lower base.

Senator SIEWERT—I thought I was just about there then!

Ms Halton—No, because you can expect the growth to be the same and it is on a slightly lower base.

Senator SIEWERT—Exactly. There was funding to provide for this many people and now there is funding for this many people?

Ms Halton—But it still grows.

Senator SIEWERT—Yes, it still grows but less people will be able to access those services because the funding projection has shrunk.

Ms Huxtable—The range of services that are available changes.

Ms Halton—It is not because you have cut the funds. Basically, because it is a standing appropriation whoever is eligible under the circumstances that the eligibility is defined as can access the service but because there is a change in the group of eligible providers they can continue to provide, as the officers have told you, under this other part of the program. It actually means that the base reduces; it does not change the expected slope of growth.

Senator SIEWERT—So you will flip people over. Instead of staying in Better Access you will flip them over into ATAPS?

Ms Halton—Many of them.

Senator SIEWERT—That is how you are dealing with those, is it?

Ms Halton—Many of them. And the issue is who is going to provide that and how they are reimbursed for that provision. As the officers have said, and as I made comment earlier about some of the discussions they have been had with people in the sector, the complaint about some parts of Better Access has been that notion of more packaged-up, integrated into other parts of service systems, et cetera. That is what this does.

Senator SIEWERT—Yes, and I have heard some complaints too. My question is about how you are dealing with those complaints. I am not convinced that cutting OTs and social workers out of providing services in that area is the best way to fix the issues that have been identified. Why was the decision made? What advice did you have that the way to fix that was to cut OTs and social workers out of that program?

Senator Ludwig—I do not think that is quite right, but what I can add is—

Senator SIEWERT—What bit is not quite right?

Senator Ludwig—To the extent that:

Following the budget last week, the Government has had constructive discussions with the Australian Association of Social Workers—

Senator SIEWERT—With all due respect, Minister, that was afterwards.

Senator Ludwig—I will come to the answer, but I thought I would put it in perspective first.

Senator SIEWERT—I did know that.

Senator Ludwig—It continues:

and Occupational Therapy Australia on how to best introduce coordinated mental health care packages for people with … mental illness in primary care and better use of fee-for-service … items.

That is the aim. We need to talk with them constructively about how to achieve that.

These packages of care will provide—

And again this is the aim—

more integrated care focused on each patient's individual mental health care needs, compared to current fee-for-service …

Senator SIEWERT—But you are talking about a different group of patients there.

Senator Ludwig—Our focus is ensuring that there is a better outcome for individuals around individual packages designed to assist them. If you are focusing on the OTs, with respect, you are focusing on the wrong path. It is about focusing on the outcome for the patient. That is the government's responsibility.

Senator SIEWERT—For a lot of these people you are talking about a different group of patients. As I said, I do not have a problem with the flexible packages. What I do have a problem with is whether the people who are currently accessing Better Access with the help of social workers and OTs will be just as well off and just as supported through the new approach. A lot of those people were getting a lot of support from social workers and OTs. I am not saying that any of the rest of it is not good.

Senator Ludwig—I understand.

Senator SIEWERT—That is why I want to know who made the decision. Was there a conscious decision to move the focus from those people that can get good support to those people that need more support? Was that the decision that was made?

Senator Ludwig—What we intend to do is:

In collaboration with social workers, occupational therapists and current service providers, the Government will also seek to ensure current mental health programs better use the skills of these highly qualified professionals. These programs include Access to Allied Psychological Services and the Mental Health Services in Rural and Remote Areas program.

The Government is currently evaluating the provision of the mental health services through the Medicare Benefits Schedule under the Better Access program.

As part of this, the Government will work closely with social workers and occupational therapists, as well as clinical and registered psychologists, to examine further ways to provide coordinated care to those most in need.

We are looking at the same issue, but I think from a slightly different perspective.

Senator SIEWERT—It is almost like the horse has bolted and with all due respect—

Senator Ludwig—Unfortunately because of the way budgets are done that is what we are provided with.

Senator SIEWERT—In certain respects I understand that, but you are going through an evaluation process and you have made a decision. As I said publicly, I am glad that the implementation has been put back, but you made that decision after the horse had bolted.

Senator Ludwig—What we have said is:

To ensure that in future the Better Access reforms are informed by the evaluation—

So I think they have to be informed by the evaluation—

Senator SIEWERT—I agree with you.

Senator Ludwig—

—and the detailed design of care packages can be developed in consultation with professional groups …

So it is along that continuum. To do that:

the Government will defer …

and I think that has been announced—

the introduction of the care packages and any associated changes to fee-for-service Medicare arrangements until 1 April 2011.

So we will have time to ensure that we do it in a systematic way and the current arrangements will continue until that time. You will have evaluation and based on that evaluation, with input from the professionals, care packages will be designed that will provide a better outcome for patients.

Senator SIEWERT—I will bite one more time. That takes me back to the question that I started with, which was this. What happens if the evaluation shows that the current program is effective in certain areas, bearing in mind what Ms Halton said around the other issues that we talked about? What happens if the evaluation shows that and shows that perhaps some of those resources should not have been shifted?

Senator Ludwig—We can address that question in the future.

Senator SIEWERT—Once we have seen the evaluation.

Senator Ludwig—That is right. When you talk about the cost I am advised that the revised implementation strategy will be cost neutral over the forward estimates and over the four years from 1 April 2011. It is anticipated that 25,000 people with severe mental illness will benefit from the new flexible packages.

Senator SIEWERT—What do you mean by cost neutral? Is it for better access across the programs because money is being shifted from one program to another?

Senator BOYCE—One is capped and one is uncapped.

Senator SIEWERT—Is that what you mean about cost neutral?

Ms Huxtable—I think the minister is referring to the decision to defer implementation to 1 April, which is cost neutral, because both elements of the measure are deferred.

Senator SIEWERT—Okay, that is clear, thank you.

Senator BOYCE—Isn't it true, Minister, that what this does is shift people out of an uncapped, a better access program, into a capped program, the ATAPS flexible program, where not everyone can access it because there is a level of unmet need?

Senator Ludwig—My understanding of it is about commitment to reforming Australia's mental health system so that it does provide better integrated care. You can talk about capped and uncapped provision but ultimately you actually have to focus on what you are going to deliver and to whom.

Senator BOYCE—Exactly, how many and whom?

Senator Ludwig—We are not talking numbers for numbers sake. It is actually about integrated care.

Senator Boyce interjecting—

Senator Ludwig—Well, that is what you just said, I am sorry, Senator Boyce. It is about ensuring that we have better integrated care for those most in need in our community. It is not just simply saying that everybody gets a standardised service where you tick off and get one per person. You said more people, unfortunately.

Ms Halton—Our experience is very much that fee-for-service medicine does not always necessarily provide the best care in every circumstance. This is a mixture now of the two.

Senator BOYCE—I find that somewhat startling as an explanation of a system which we all know has vast amounts of unmet need in it and, from my perspective, what this will do is move people from an uncapped program into a capped program. If you can guarantee to us that this will not affect patients and their carers—

Ms Halton—Let us be very clear. It moves no patient anyplace. A patient can continue to receive a service under ATAPS, if they choose, under the providers who are eligible. A patient can choose to receive this kind of service if they are eligible. It removes no patient from anywhere. We have made no change to patient eligibility at all.

Senator BOYCE—If they can afford it would be the other point, I think, Ms Halton.

Ms Halton—I think the officers have already gone through with you, Senator, what the level of co-payments are and they are very small.

Senator SIEWERT—In relation to the issue around eligibility there have been no changes to eligibility for any of those programs?

Ms Halton—No.

Senator SIEWERT—Who did you consult when these changes were made in the advisory committees?

Ms Halton—What we said was that there had been a number of views put to us at length and over a long period about the operation of ATAPS.

Senator SIEWERT—You did not actually seek advice about changing access.

Ms Halton—Sorry, a Better Access.

Senator BOYCE—I thought I understood you said that the National Mental Health Advisory Council advised you around these changes to ATAPS.

Ms Halton—They have made a lot of commentary in relation to Better Access.

Senator BOYCE—Better Access, but what about ATAPS. I understood that is what you had said earlier.

Ms Krestensen—We reviewed ATAPS over the last couple of years and we had an advisory group for the ATAPS program.

Senator BOYCE—A separate advisory group.

Ms Krestensen—Yes, a separate advisory group. There was a very strong view, particularly amongst consumer reps at that table, that ATAPS was not as it was structured to meet the needs of people with severe mental illness and that more flexible approaches to care were needed. That was some of the thinking that led to the design of the flexible care packages.

Senator JOYCE—I am just trying to clarify something I thought you had said earlier, Ms Halton, when you said that the National Mental Health Advisory Council had advised you.

Ms Halton—I think I just said advisory group and that is where the confusion has come from.

Senator FURNER—As a result of the proposals, has there been any effect on rural and remote areas?

Ms Krestensen—Ms Hart has the rural and remote program but I can start off before she leads in. ATAPS has a very good track record in terms of its reach into rural and remote areas. As high as 45 per cent of services provided through ATAPS to date have been provided in rural areas and it is anticipated that, with the new packages, they will also have the capacity to provide services to consumers who live in a broad range of geographical areas.

Ms Hart—I can add that, where there are providers in rural and remote settings under Better Access, service is provided there. We appreciate the limitations of fee-for-service medicine and we have a complementary program that I also have responsibility for, called Mental Health Services in Rural and Remote Areas, which employs a range of allied health practitioners to provide services in those areas where access to MBS funded services are low.

Senator FURNER—I understand that, overall, there are something like 1,200 social workers and 320 occupational therapists throughout Australia. Are you able to identify how many of those people might be in rural and remote areas?

Ms Harman—I think the figures you are referring to are the numbers of OTs and social workers who are currently registered with Medicare Australia to provide Better Access services.

Senator FURNER—That is correct.

Ms Hart—I do not have a breakdown of those by rural and remote classifications, but I would be happy to take the question on notice.

Senator FURNER—Thank you.

Senator SIEWERT—Ms Hart, we started to go through the training and workforce development issues and you did offer to put the information on notice, I think. Could I ask for that information on notice, because I would like to have it.

Ms Hart—Yes, I am happy to do that.

Senator ADAMS—How much funding has been put aside for suicide prevention and what programs are there?

Ms Krestensen—This financial year, $22 million has been allocated under the National Suicide Prevention Strategy.

Senator ADAMS—What has been funded with that money?

Ms Krestensen—The funding has been directed at a number of levels. The fundamental layer is investment in key infrastructure, in things like the National Centre of Excellence in Suicide Prevention, which is based at the Australian Institute of Suicide Research and Prevention, located at Griffith University, in Queensland. That centre provides advice on

research-promising models of what works in terms of suicide prevention. We also invest in funding at an infrastructure level for the Life Communications Project, which promotes information and things like the life framework to a broad range of parties within the community.

At the national level we fund a broad range of public health initiatives which target suicide prevention at the population health level. These are things like the Mindframe program, which targets working with the needy to promote help-seeking behaviour, and responsible de-stigmatised messages around mental health and suicide prevention are funded through that. The MindMatters program for schools, which, again, targets help-seeking behaviour and promotes resilience in secondary school children, is also partly funded from the suicide prevention program.

At the local level, we are investing in quite a broad range of small community projects, most of which commenced in 2006 through a broad open tender process. Those projects generally have a focus on addressing the needs of high-risk groups such as Indigenous Australians, people in rural Australia, men and others who are at greater risk of suicide. Finally, the fourth level of broad activity is our work across governments, with the states and territories, on alignment under the National Suicide Prevention Strategy.

Senator ADAMS—Is there any funding for guidelines and a national accreditation body which could monitor and accredit training providers, services and programs? Has any thought been given to that as something that could help?

Ms Krestensen—Just to be clear: do you mean an accreditation body that would accredit suicide prevention projects and activities?

Senator ADAMS—That is correct.

Ms Krestensen—Not that I am aware of. The national centre of excellence is probably the best placed organisation that would have evidence on what works, but I am not aware of any approaches towards credentialing organisations undertaking work in suicide prevention.

Senator ADAMS—Suicide Prevention Australia has a recommendation about that. I was at the launch of their front-line suicide prevention the other day and it was something that arose there so I thought I would ask if there was anything like that and put it on the record that that might be something to look at.

Ms Krestensen—We are in discussions with states and territories about the best approaches to front-line training to improve the capacity to identify and respond to individuals at risk of suicide. We did an audit through the Hunter Institute of Mental Health of a broad range of front-line training for suicide prevention and front-line training to promote mental health first aid. A part of that exercise did try to identify what the broad competencies might be, which would inform the approaches to future front-line training. Whilst there has been some work, we have not gone as far as SPA might suggest we need to go. I will take your question on notice.

Senator ADAMS—One other thing that has arisen is the problem associated with the media, how they report suicide and the number of suicides that go unreported. The road toll has a terrific advertisement through the program that they do there. Have you looked at any

way that suicide can be put forward by the media to let people know it is a far greater issue? I know it is a very delicate issue but it really is something we should all be responsible for and be able to help people. Is there a way to somehow make the community aware without frightening them?

Ms Krestensen—It is a sensitive issue and it is something that the media Mindframe group has been working on with the media and a broad range of parties for many years. There was a media monitoring study done for us by the University of Melbourne which compared the reporting by the media on suicide and mental health issues from about 2000 with how they were reporting on those issues in 2007-08. There was shown to be a marked increase in reporting on suicidality and mental illness but also a marked improvement in the quality of reporting—for example, more reporting of Lifeline's phone number, more reporting on the importance of help-seeking and less stigmatised reporting on suicide and mental illness. So there are some signs of good progress in that area. Through exercises like the program run by the Hunter Institute which works with undergraduate journalist education authorities to embed into their curricula a process to better understand suicide prevention and mental illness. Some of those exercises do seem to be getting some traction in improved reporting—more reporting but more responsible reporting. But I take your point that there is still some way to go and a lot of sensitivities to navigate to get it right.

Senator SIEWERT—I would like to ask about the issue of providing funding and programs for suicide prevention for the LGBTI community. There has been some criticism that the strategy does not adequately address or provide resources for the issues specific to the LGBTI community. Could you articulate those, and whether they are going to be picked up in the next round?

Ms Harman—We will have to take that on notice.

Senator SIEWERT—That would be appreciated.

CHAIR—That completes item 11; there are some questions on notice. The next outcome is outcome 10, Health system capacity and quality.

Senator ABETZ—Chair, can you assist us? I know Senator Humphries and I have similar questions about the ACT and Tasmania.

Unidentified speaker—In which area?

Senator ABETZ—The Cancer Australia agency.

Senator FIERRAVANTI-WELLS—I suggest that we deal with the agencies first, and then that way we can—

Senator BOYCE—Chronic disease and the agencies go together.

Senator Ludwig—It would seem sensible to do the agencies first.

[2.31 pm]

CHAIR—We will start with Cancer Australia and then go to NBOCC and then the National Health and Medical Research Council. So we will start with Cancer Australia. Welcome, Dr Ramadge, we have not had you here, so it is lovely to see you.

Dr Ramadge—Thank you.

Senator HUMPHRIES—I wanted to ask about the new cancer facility at the Canberra Hospital. I understand the facility will be—

CHAIR—That is the department, not Cancer Australia.

Senator HUMPHRIES—Sorry. It is the department that answers those questions?

Ms Halton—Yes.

CHAIR—The officer who is going to answer questions on cancer is here, so we may as well do that. Doctor Ramadge, there may be some crossover, and we will go to you as soon as these questions finish. Senator Humphries, we will try again.

Senator HUMPHRIES—The new cancer clinic at the Canberra Hospital is costing $27 million. Is that correct?

Ms Harman—It was confirmed in the 2009-10 budget that $27.9 million would be allocated to build that new centre.

Senator HUMPHRIES—And that funding is carried over at the moment? It has not changed in the present budget?

Ms Harman—That is correct.

Senator HUMPHRIES—I understand the facility on the campus of the Canberra Hospital was originally planned to be a five-storey building, a new building on that campus. Is that correct?

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

Senator HUMPHRIES—All right. I also understand that the building, as originally proposed, was five storeys. It has now been reduced in size to four storeys, and that of those four storeys, only two are to be fitted out and made operational under the $27.9 million budget. Can you confirm whether that is the case?

Mr Morris—That is a matter of detail I would need to take on notice.

Senator HUMPHRIES—I would appreciate if you did that. I understand that the facility will be, in those circumstances, not significantly different in size and scope to the present cancer facilities available on the campus of the Canberra Hospital. Are you able to indicate whether you have any appreciation of whether that is the case not?

Mr Morris—No, I am sorry, I cannot. I would also need to take that on notice.

Senator HUMPHRIES—I would also like to know, if indeed it is not significantly larger than the hospital's present facilities, why the existing facility is being replaced by a new one no larger in size and with apparently no greater capacity. I would appreciate knowing what the other two floors of the building are to be used for. Since the Commonwealth's money is building the entire building, as I understand it, I would like to know what else is happening with the other two floors. I understand that Lismore is to receive a facility of a similar nature costing $30 million. I would like to know what the differences are between the scoping capacity of those two buildings so that a comparison can be made between, for example, the number of medical practitioners that are hosted by each building and the number of facilities

and the patient throughput that is possible between those two buildings please, as a means of comparison.

Mr Morris—I should also take that on notice.

Senator HUMPHRIES—I had some other questions on a different area, but I am happy to defer to Senator Abetz.

CHAIR—All right. Senator Abetz, you have some issues about cancer?

Senator ABETZ—Thank you, Chair. I have an interest in matters Tasmanian. I was wondering if you could advise us about the—what do I call it?—'deal' or 'agreement' that was struck whereby Tasmania was given $18 million for cancer, which was announced in recent times.

Mr Morris—The Tasmanian government, following the recent state election, was invited to resubmit its application for a regional cancer centre. The resubmitted application was for a bid of $18 million. It was assessed by the independent Health and Hospitals Fund advisory board in accordance with the legislation, the Nation-building Funds Act. It was assessed as eligible against the criteria of the act. The board recommended to the minister that it was eligible for funding. The government then chose to fund at the applied level.

Senator ABETZ—All right. Can you tell us why they were invited to resubmit?

Mr Morris—The invitation was a matter between the two ministers offices, not between the departments, but I can comment that the original application, while a very good application, was proportionately very far in excess of the population representation of Tasmania vis-a-vis the share of funds that would have been applied.

Senator ABETZ—Can we confirm that Tasmania's got the highest cancer rate of any state or territory?

Ms Harman—Yes.

Senator ABETZ—And Tasmania has a population of about 500,000. Are we agreed on that?

Mr Morris—Yes.

Senator ABETZ—Can you tell us what the population of Nowra is, for example?

Ms Halton—No, Senator.

Mr Morris—No.

Senator ABETZ—You cannot, Secretary, I accept that. But I wonder if Mr Morris can.

Ms Halton—No, Mr Morris is not employed nor is he required to answer questions which are beyond the scope of this portfolio. A vast grasp of the geographical divisions of this country is not part of his employment, and therefore I am not going to allow him to answer questions about the size of Nowra.

Senator ABETZ—Unfortunately, Ms Halton, he just told us that the amount allocated to Tasmania was based on population—

Ms Halton—Of the state.

Senator ABETZ—and he agreed that the population of Tasmania was 500,000. You allowed him to answer that question but we now have a—

Ms Halton—Of the state.

Senator ABETZ—So your officials only have knowledge of state? All right, take it on notice then: what is the population of Nowra and why were they granted $23 million as opposed to Tasmania, with a population of 500,000 and the highest cancer rate in the nation, which was given $18 million? Can you confirm for me that in fact early in 2010 the state government put in an application for $47 million worth of funding?

Mr Morris—Yes, I can.

Senator ABETZ—Would that funding have included a private involvement as well? So it was a joint public and private approach to the federal government for funding?

Mr Morris—Yes, it was.

Senator ABETZ—And that $47 million, had it been granted, would have driven a further $13 million out of the state and private sectors. That is also correct, isn't it, for a total package of $60 million?

Mr Morris—Yes, that is correct.

Senator ABETZ—Was it not the fact that it was the federal minister's office that went to Tasmania and said, 'You are not going to get that money. You have got to put in a bid that is reduced to $18 million of federal funding'?

Mr Morris—I cannot speculate on discussions between the two ministers' offices.

Senator ABETZ—I accept that, but you are telling us that it was not the department that made that approach to Tasmania?

Mr Morris—That is correct.

Senator ABETZ—I then ask you to take on notice: how much time was Tasmania given from the request to put in a revised application to the date that that revised application had to be back in Canberra?

Mr Morris—I do not think I could obtain that information because the department did not generate the request.

Senator ABETZ—All right. Minister, could you please take it on notice—

Senator Ludwig—I will. It sounds like those two questions are directed to this office. I will take those on notice: the two parts, the time that revised application was sought—that was first issue—

Senator ABETZ—And how much time was given—

Senator Ludwig—and how much time was given.

Senator ABETZ—I understand it was a 48-hour turnaround that was given to Tasmania in relation to the request for the revised application and by the time the application had to be put in. I am somewhat exercised about it because the initial application, that seemed to have been accepted, included involvement of the Cancer Council Tasmania and Calvary Hospital. With

the revised application—and please take this on notice as well, Minister—neither the Cancer Council nor Calvary Hospital were advised and at the end of the day were completely cut out of the new lot of funding, which is now down to $18 million. As a result, Tasmania is going to lose out on what would have been an excellent public, private and volunteer partnership between public hospital, private hospital and the Cancer Council for a state that has the highest rate of cancer.

Senator Ludwig—So the part that you want me to seek information on from the minister's office relates to whether or not the Cancer Council and the Calvary Hospital were advised?

Senator ABETZ—I am sure that they will say that it went to the state government and it was solely the state government's responsibility in cutting the other two out—but I am predicting an answer here.

Senator Ludwig—I will see what I can do.

Senator ABETZ—It was somewhat disingenuous, wasn't it, for Minister Roxon to say that in relation to this application Tasmania got everything it asked for when we know Tasmania asked for $47 million, were then told that they were not going to get it and to put in a revised application for $18 million. They did that. They got $18 million and then Ms Roxon said at a press conference that Tasmania got exactly what they asked for. I would suggest, Minister, that is somewhat disingenuous and I would like an explanation out of the minister's office. Take that on notice and I will leave it at that.

Senator ADAMS—My question is to do with the National Breast and Ovarian Cancer Centre. It states here:

The Australian Government supports the early detection of breast cancer through funding from the Health and Hospitals Fund, for the national roll-out of digital mammography technology in BreastScreen Australia services.

That came up in 10.1, but I was wondering whether it should be under the next outcome, population health.

Ms Huxtable—I understand it is outcome 1.

Senator ADAMS—I will go on and ask the question. That might be the simpler way to go with this. The PBS states:

In 2010-11, the Department will support states and territories to purchase and install new digital technology to provide improved diagnostic services to patients.

Western Australia have got this digital mammography service, but with the agreement the way it is are they going to continue to be funded for that service? What will happen if there is no agreement?

CHAIR—I think that goes across a couple of outcomes.

Senator ADAMS—It does, but it is here on page 286, which is outcome 10.1.

Ms Harman—Sorry, Senator. That is a question in outcome 1 and I do not think we have anyone here who can answer that.

Ms Huxtable—Can we come back to it under outcome 1, which is the next outcome?

Senator ADAMS—Yes, that is fine.

Senator FIERRAVANTI-WELLS—Program 10.1 talks about improving the management of chronic diseases such as asthma, diabetes, cardiovascular disease and musculoskeletal disorders. In relation to the treatment of diabetes, I think this program is administered in another area, but did you prepare estimates that underpin this program?

Ms Huxtable—The voluntary enrolment program?

Senator FIERRAVANTI-WELLS—Yes, the voluntary enrolment.

Ms Huxtable—There are estimates. I am not sure whether I can find them. It is under outcome 5, which we did yesterday, but I will see if I can lay my hands on them.

Senator FIERRAVANTI-WELLS—I just thought that the questions on diabetes might go here because this area deals with improving disease management. There is overlap.

Ms Huxtable—The new voluntary enrolment program is managed under the primary care division, and those officers are not here, unfortunately.

Senator FIERRAVANTI-WELLS—Would you like me to put these questions on notice?

Ms Huxtable—If it is in regard to that voluntary enrolment program. There are a number of other diabetes measures that this outcome does cover with which we can discuss.

Senator FIERRAVANTI-WELLS—This is in relation to the number of patients with diabetes currently registered with their local practice. That one probably does go to the administration rather than the conduct of a review of current primary care patients with diabetes. That would all go under outcome 5?

CHAIR—Put them on notice, Senator.

Senator FIERRAVANTI-WELLS—Yes, I will put them on notice. I have one more question. How will you measure the success of this voluntary enrolment initiative? Will that come back to this program where you look at how you are treating this disease?

Ms Huxtable—There will be evaluation criteria in regard to that program, but one of the key elements of that program is having performance measures that are part of what practices could expect to be achieving for their population with diabetes. While the details of those measures will need to be developed with the stakeholders, one of the obvious ones is in relation to HbA1c measures. There are effectively performance payments or reward payments that relate to what is happening within a practice in terms of the management of those patients. So not only will there be an evaluation of the effectiveness of the program but it will have as part of its design an ongoing performance element to which payments will be attached.

Senator FIERRAVANTI-WELLS—For example, one provider who we called made the comment that at the first consultation you will come on in, and then your other consultations will be free. It is an encouragement to get people to come to a particular practice and then stay with that practice for other things. Is that the sort of thing you mean?

Ms Huxtable—No. I am actually thinking about the program as it will work for the needs of patients with diabetes—the diabetes related needs of those patients.

Senator FIERRAVANTI-WELLS—Where diabetes is the principal problem that they have?

Ms Huxtable—Yes. So there is a stream of money per patient that goes to the practice, but on top of that there are performance payments across the practice's population of patients with diabetes. We would be looking at the outcomes they are achieving across a broad range. As I said, we still need to do significant consultation on this measure. It does not come into effect until 1 July 2012, so we will be working closely with the stakeholders on how best to embed this.

Senator FIERRAVANTI-WELLS—I will put those questions under outcome 5. Thank you.

Senator ADAMS—On page 285 of outcome 10 there is a comment that the government will 'continue to assist Breast Cancer Network Australia in the provision of information and support to people with breast cancer through funding to produce, promote and disseminate breast cancer resources'. Could you tell me how much that funding is and how long it is for?

Ms Appleyard—Breast Cancer Network Australia currently receives approximately $218,000—in 2009-10—to produce the My Journey Kit. You will be aware that the kit is designed to support people initially diagnosed with breast cancer. The four-year funding for that program is $876,000, commencing in 2008-09, with the fourth year of the program being 2011-12.

Senator FURNER—I just want to take a look at the Regional Cancer Centre program funding that Queensland was a recipient of during the budget announcements. Could you explain where the funding will be going and what the additional services will be and also provide some idea of the implementation time line of that funding?

Mr Morris—The Regional Cancer Centre funding for Queensland will total $171 million over the next four years. It will go to the Townsville and Mt Isa Integrated Regional Cancer Service, to the Toowoomba and South-West Queensland Integrated Cancer Service, to the enhancement of the service capability of the St Andrews Cancer Treatment Centre at Toowoomba, and to the central integrated regional cancer services at Rockhampton, Bundaberg and Hervey Bay.

Senator FURNER—Do you have a time frame for the implementation of that?

Mr Morris—The time frame for roll out will be over the coming four years. Do you want the centres read out jurisdiction by jurisdiction?

Senator ADAMS—Western Australia, and then the further question is: does that funding continue if the agreement is not signed?

Mr Morris—There are two centres funded for Western Australia. One is a statewide network of services termed Strengthening Cancer Services in Regional Western Australia. Facilities are allocated to Albany, Northam, Narrogin, Geraldton and Kalgoorlie. There is also funding for the South-West Health Campus Comprehensive Cancer Centre at Bunbury. That is a sum of funding of $45.57 million over four years for the two centres.

Senator ADAMS—If Western Australia does not sign up to the agreement, will that funding continue?

Mr Morris—Yes. This is quite independent.

Senator ADAMS—It is quite independent of it? Good.

Senator HUMPHRIES—I want to ask about the national health priority areas. I am trying to find a place where I can see how much is being spent from the federal budget on each of those national health priority areas.

Ms Harman—We need to take that on notice because there are a range of programs across many outcomes that would address each of those eight priority areas.

Senator HUMPHRIES—Could I have both a projection of what is intended to be spent over the forward estimates and what has been spent in each of this and the previous two financial years, please.

Ms Harman—Certainly.

Senator HUMPHRIES—A global figure would be useful, but if it is possible to break it up into what has been spent on things like direct Medicare funding, PBS funding and support for the states with respect to those priority areas, that would be useful. Can you tell me whether there are action plans in place in each of those priority areas.

Ms Harman—I will have to take that on notice as well.

Senator HUMPHRIES—Could you direct me to where those action plans are, if there are such action plans. There are some other questions, which I will place on notice. Mr Morris was answering questions before about the ACT cancer centre. There is another aspect to that which you might be able to help me with. Do you know which company has been given the contract to build the ACT cancer centre?

Mr Morris—I would also need to take that on notice. Sorry to take all this on notice, but there are 35 major projects funded under round 1.

Senator HUMPHRIES—Okay. I understand that the company which has received the contract to build the ACT cancer centre is not the same company which is doing the other general upgrade of the Canberra Hospital campus. I am just wondering why the decision was made not to have the same builder build all the facilities at the one time. You might want to take that on notice.

Mr Morris—That is an issue for the ACT administration. It is not an issue that concerns us.

Senator HUMPHRIES—Okay. Thank you.

[2.58 pm]

CHAIR—We will move to 10.2, which is e-health.

Senator BOYCE—Ms Thompson, I am not quite sure who to direct questions to, but I am sure you will tell me if I have not got it right. The funding for e-health in the last budget was $467 million over two years, which is much less than was anticipated by the industry. Given the low amount of funding and some terminology used during the budget and consequently by Minister Roxon, there appears to be quite a lot of confusion in the market. I will go through and ask you to explain some of the terms that seem to be being used at the moment.

'Personally controlled identifier', or 'electric health records systems', is a term that is being used by both the Treasurer and the health minister. This has been interpreted in some areas to mean that people would be required to keep these records on a USB and take it with them wherever they went. Could you explain to me exactly what is meant by a 'personally controlled electronic health record system'?

Ms Thompson—Yes. The concept of a personally controlled electronic health record is about the fact that only people who wish to use it will use it into the future. What goes into that record and who is allowed to access it, in terms of other health providers that they may be involved with, will be within their control. That is the concept. There is certainly no expectation that people will carry around their health records on a USB stick.

Senator BOYCE—Where will I go to decide that I want to have an electronic health record if I am a consumer of health services in Australia, which is pretty much everyone? How will that be accessed by me or by others?

Ms Thompson—The concept is that, if you have chosen to establish a health record, once the enablers are in place for you to do that you will actually be able to access it on a portal, similar to what you do with internet access for other information systems.

Senator BOYCE—Who else will be able to access it?

Ms Thompson—If you have chosen to be part of the system then it will be those people you have authorised to access it—so, health providers.

Senator BOYCE—Can I do this from my home computer?

Ms Thompson—Potentially, yes.

Senator BOYCE—What do you mean by 'potentially'?

Ms Thompson—We have not yet built it all.

Senator BOYCE—Would the intention be that I would be able to do this from my home computer or from a computer in a library—or whatever else?

Ms Thompson—Yes.

Senator BOYCE—Medicare will give everyone a health care identifier number; is that correct?

Ms Thompson—That is correct—if the legislation is passed to allow that.

Senator BOYCE—We are coming to that. We are assuming at the moment that the system is (a) going to be passed and (b) going to happen, which are probably some pretty big assumptions to make—but never mind. So the number is given, but whether I use that identifier number will be entirely up to me.

Ms Thompson—Whether you use it to attach a health record will be completely up to you as an individual.

Senator BOYCE—Who else will use it if I do not?

Ms Thompson—Use the number?

Senator BOYCE—Yes.

Ms Thompson—The number will potentially be used by health providers in terms of your individual records with those providers, but the electronic health record that we are talking about is about the ability to connect information from various health providers.

Senator BOYCE—But, irrespective of whether I have chosen to create a collated health record for myself, other health providers, who also have different identifier numbers, will be able to use my number to put in their information about what their dealings with me may have been. Is that correct?

Ms Thompson—That is right, in a similar way to the fact that they identify patients at the moment through perhaps an individual set of numbers. The concept is that there will be one health identifier, which will ensure over time that the potential for mistakes in exchanging health information will be reduced because you will have a unique identifier number.

Senator BOYCE—The other area which has had people very exercised—and this also came out of the fact that there was surprisingly little funding for the healthcare identifier legislation—was a concern that commercial companies would run the identifier system. Are you aware of those concerns?

Ms Thompson—Firstly, the amount that was announced in the budget is actually quite in line with the beginnings of the initiative. It is absolutely consistent—

Senator BOYCE—I was going to ask you to talk me through what you were going to spend that money on but—

Ms Thompson—It is consistent with the agreement by health ministers about how to go forward in terms of a business case around—

Senator BOYCE—Consistent with what, sorry?

Ms Thompson—It is consistent with things that have gone forward to the health ministers to discuss the e-health strategy more broadly. In fact, it is an implementation strategy that reduces the risk around such a large IT change because we can test the infrastructure that we are developing and ensure that it is actually robust before further development.

Senator BOYCE—So we are talking about small steps.

Ms Thompson—It is incremental steps, I think, as opposed to small steps.

Senator BOYCE—Can we go back to my point about the concern about who exactly would be running the health records system. There has been some concern expressed—I do not know if you are aware of it.

Ms Thompson—I am sorry—

Senator BOYCE—You are not. I could perhaps give you a copy of this. It appeared in the *Australian* on 12 May and the title of the article is: 'Will e-health records be outsourced to Google, Microsoft?'

Ms Thompson—Yes, I am aware of that article; thank you.

Senator BOYCE—You are aware of that article.

Ms Thompson—I was not sure about what you were referring to. I think that is the issue that you raised earlier about how you would access your record. The whole way forward here

is about building the infrastructure that will ensure that the portals that are used to go in and get a record, attach information to it and are used over time are secure. In fact there is certainly no intention for the record to be free for anyone to use. That is not part of the architecture at all.

Senator BOYCE—So we will not have Facebook identifiers in the health area?

Ms Thompson—No, absolutely not.

Senator BOYCE—That is good to hear because there was some confusion. When you look at the article, it says:

Will it be the private sector, Medicare, or some other government body—

running the proposed electronic health records system? You are confirming that Medicare will develop the system.

Ms Thompson—No: I confirmed that Medicare would develop the number, and we are in the early stages of the next phase of implementation, so we have to think through all those next steps. Obviously we have done some thinking already, but in terms of how we build the infrastructure that is still being mapped out.

Senator BOYCE—I am not sure who might answer this next question but I know that the coalition had anticipated seeing the health identifiers legislation back in the Senate during the last sitting and it was not. Someone here might be able to tell me when it is intended that it be introduced.

CHAIR—Senator, that is definitely a question for the government. Minister, you may wish to answer that.

Senator BOYCE—That is why I was addressing the question very broadly.

Senator Ludwig—I just do not have that list in front of me nor do I know whether I would share it. I will take it on notice and get back to you.

Senator BOYCE—If the legislation were not passed before 30 June—or 1 July; let us be completely accurate—what would be the effect on the scheme?

Senator Ludwig—In part that is a question which is predicated on an event that has not happened yet. Can I say that—

Senator BOYCE—Given there are two weeks of sittings—

Senator Ludwig—we are optimistic in having it introduced into the Senate in the next sitting week and of course calling on the opposition, minor parties and Independents to support what is a very good initiative from this government to build a new health system. I am sure we can garner your support, Senator Boyce.

Senator BOYCE—Indeed. Does the legislation need to passed for the system to function?

Ms Thompson—The health identifier system will not come into effect if the legislation does not pass.

Senator CAROL BROWN—Are you able to give me some information about the introduction of personally controlled electronic health records?

Mr Thompson—Yes, they are very related issues. The health identifier is an enabler of the next stage of the development of the personally controlled electronic health records system. The identifier in itself is a number that will attach to people's records and will allow for unique identification so that we reduce the risk of error relating to information not being available because you cannot backtrack and find the right person's records. In addition to that, the personally controlled electronic health record is about what you might attach to that record in an electronic space. So you might attach immunisation records, and you might attach allergies and medications—things like that—over time. That is what we are seeking to develop as the next stage in the electronic health strategy.

Senator CAROL BROWN—Thank you.

Senator BOYCE—I am not sure who I should direct this question to, but you are presumably aware, Ms Thompson, that the coalition members of the Community Affairs Committee who inquired into this legislation were somewhat concerned about privacy issues and about function creep. The minister appears to have accepted a number of the recommendations from coalition members in the report. I am quoting from a media release of hers of 2 June 2010 titled 'Health care identifies', where she said:

… the Government has considered recommendations by coalition members of the Senate Community Affairs Committee and the changes specifically address two of these recommendations.

The first proposed change will give increased parliamentary oversight of the Healthcare Identifiers Service, ensuring that any change to Medicare Australia's role can only be made through legislation.

As of late last night, that was the only information we had in regard to that. Are you able to explain how that will be achieved?

Mr Thompson—I might ask my colleague, Ms Forman, to address that issue.

Ms Forman—This goes back to the issue of the ability to change the operator in the regulations, and there were some of the concerns around that. Basically all this means is that it would require a change to the legislation if in future there was a desire to change the Healthcare Identifiers Service from Medicare.

Senator BOYCE—That will be an amendment the government will propose to the legislation. Is that correct?

Ms Forman—That is what the minister's press release indicates.

Senator BOYCE—Okay. The second proposed change:

… will create more flexible arrangements for review of the assignment of identifiers to some healthcare providers.

Is this specifically aimed at that situation where you had information providers within the healthcare system who did not have identifies?

Ms Forman—This particular amendment that is being referred to use around the right of review for a healthcare provider who applied to Medicare who was not covered under the national registration arrangements. They have to apply directly to Medicare to get a healthcare provider identifier number. In the earlier version of the regulations, there was no right of review for those particular providers. The regulations now include a right of review so that if

they are not comfortable with that result they get from Medicare they can appeal that and have reviewed.

Senator BOYCE—There were six—or seven, depending on how you counted them—recommendations put by the coalition. We would certainly be looking at other areas here, because, as I said earlier, this is all about protecting privacy and stopping function creep. I have a couple of questions regarding what happens on 1 July—what is the actual action that will happen on 1 July and how the $467 million is to be allocated over those two years. Would that be a problem for the rest of the committee?

CHAIR—I am just looking at timing. We are going at 3.45 to the agencies, so we have half an hour for the rest of these areas. I just want to be fair to all the senators. For the rest of the area, Senator Fierravanti-Wells, do you have any questions?

Senator FIERRAVANTI-WELLS—Would questions about the national health survey be in public health 1.6 or 10.3 here?

Ms Halton—Public health.

Senator FIERRAVANTI-WELLS—Thank you.

CHAIR—Are there questions about the Western Australian drug service and naltrexone?

Ms Halton—I have talked to Senator Abetz about that issue. I do not know whether he has any more questions.

CHAIR—I think he has more. That is in this area, is it not?

Ms Halton—It is in population health.

CHAIR—That is fine. We have a question on infrastructure from Senator Brown. Senator Boyce, that means you—and others—probably have until at least half past three on this issue of e-health.

Senator BOYCE—I could do this until 10 o'clock tonight, but I will not.

CHAIR—I know you could, but we will go to 3.30 on this area. You and Senator Furner both have questions.

Senator ADAMS—I have some questions on this too.

Senator BOYCE—Can we look at the budget allocation for this and how it is to be spent? What happens on 1 July, presuming the legislation is passed?

Ms Thompson—I might deal with the second question first, if that is all right. Presuming that it passes, we will then be authorising Medicare Australia to implement the system that they have built. In the first instance that is an allocation of numbers. I might ask Ms Forman to give you some detail around that.

Senator BOYCE—Is the system built?

Ms Thompson—Yes.

Senator BOYCE—And operational?

Ms Thompson—It is not operational until it is authorised, but it is ready to go.

Senator BOYCE—We have talked in the past about doing tests, have we not, and they were—I forget the term—virtual tests or something. Can you tell us where you are up to now, Ms Forman?

Ms Forman—As you know, the system has been built by Medicare Australia. They are under contract to NEHTA to build that system. The build is substantially advanced. I think we discussed that testing at this stage could only be on non-live data, so there would need to be live testing of data following the legislation coming in. The capacity of the system from 1 July would be that it would be able to issue healthcare provider individual numbers and those would actually be issued as part of the national registration process for providers that are registered under the AHPRA legislation. The internal allocation of healthcare identifier numbers to individuals would actually happen within Medicare itself to all those individuals who currently have a Medicare number or a DVA number.

Senator BOYCE—I might just work backwards there. Is there anyone or any significant group who does not have a Medicare number or DVA number that might use health or medical services?

Ms Forman—There is a very small proportion of the population that do not have a Medicare number or a DVA number. There are some members of the defence personnel, for example, who have been continually covered under the defence scheme and so have not required a Medicare number. There are also temporary residents, visitors to Australia. I am not sure of any other scenarios, but there are a small number who might not be allocated one.

Senator BOYCE—Assuming the legislation is passed within the next two weeks, then Medicare will do some live trials. Is that right?

Ms Forman—The regulations would also need to go through their process, which I think would not be until the end of June.

Senator BOYCE—So the time to do some live trials between when the regulations pass and when the button gets pressed on 1 July is what?

Ms Forman—I am confident that Medicare Australia will not press the button to allocate those numbers until they are confident that the results will be accurate, safe and secure.

Senator BOYCE—In which case the rollout is highly unlikely to start on 1 July. Is that the situation?

Ms Forman—I would have to take advice from Medicare Australia on that.

Senator BOYCE—Has the department—or the government; I am not sure who the signatory would be—signed the contract to provide the system with Medicare?

Ms Forman—The contract to provide the system is between NEHTA and Medicare Australia. NEHTA is actually funded by COAG to build and operate the healthcare identifier service.

Senator BOYCE—Is it signed?

Ms Forman—The contact for the ongoing operation following the legislation will not actually be signed until the legislation is passed. But there is a contract currently in place until 30 June.

Senator BOYCE—I presume there is an unsigned contract somewhere—

Ms Forman—That is my understanding.

Senator BOYCE—That people are hoping to date 1 July or something. Is that correct?

Ms Forman—That is my understanding—that a contract is being negotiated.

Senator BOYCE—You would appreciate that there is ongoing concern within the industry around the lack of live testing, the huge number of systems that the different information management systems that health providers use, and bringing this all together. What can you tell them to reassure the industry and others?

Ms Forman—Medicare Australia has been working closely with the industry and making available specifications for the system. We have also been working quite closely with the industry around the regulations, how they work and technical options that will be available for vendors to meet all the various ways that they deliver services to healthcare providers.

Senator BOYCE—Plenty of medical systems information system organisations have said that with a new rollout like this they would expect maybe six months of live testing to make sure the system is debugged properly and that it is functioning properly. There has been no live testing with this and yet it is due to come in in about three weeks time. Are there concerns about how it can integrate with the large number of management systems that are used by health providers already and that there have been no coordinating programs or software developed in that space up to date, how could all this happen on 1 July? That is the ongoing concern.

Ms Thompson—Senator, perhaps I could add something. In March this year, Medicare Australia made access available to the HI service IT test environment—

Senator BOYCE—That was after last estimates—

Ms Thompson—Yes—which allows clinical IT and software providers to test their interoperability. They have to sign a developers agreement in order to start that process. To date we understand that three have signed.

Senator BOYCE—Three out of how many potentials?

Ms Thompson—I could not answer the potential number, I am sorry. But the fact is that there is a process in place for the software industry to engage in the development of this project. We understand that Medicare has been very keen to engage with the industry to ensure that they do understand what their concerns might be.

Senator BOYCE—Do you get feedback on that?

Ms Thompson—Do you mean in terms of formal feedback?

Senator BOYCE—Either formal or informal, in terms of what the developers are saying about their work.

Ms Forman—There is not a formal process to obtain that feedback. However, we have ongoing discussions with Medicare and NEHTA almost daily around the developments of their whole work program, and we understand that they speak with the industry regularly. We are also often in attendance at meetings where all parties are present, and we are confident

that we, Medicare and NEHTA and are all engaging with the industry around this initiative. It is a huge and complex initiative and it is absolutely essential for the development of e-health in Australia.

Senator FIERRAVANTI-WELLS—How much has been spent—and I think you will have to take this on notice—in total by the Commonwealth since 1993 on e-health initiatives? I think it was referred to in the hearing but I do not think we got an exact figure.

Ms Thompson—I think we will have to take that on notice.

Senator FIERRAVANTI-WELLS—I appreciate that. Could you also take on notice how much has been spent by the state and territory governments since 1993 on e-health?

Ms Halton—No, Senator, we cannot take that on notice. We cannot answer questions on behalf of the state governments.

Senator FIERRAVANTI-WELLS—All right. If you do have any information that refers to state and territory government spending on e-health, could you provide that on notice? Can you provide a breakdown of the expenditure year by year?

Ms Thompson—Since 1993?

Senator FIERRAVANTI-WELLS—Yes, since 1993, year by year—thank you. How much did NEHTA ask for in their business case for patient controlled e-health records?

Ms Thompson—There is no NEHTA business case for patient controlled e-health records.

Senator FIERRAVANTI-WELLS—Has the government estimated how much will be required for the promotion of health identifiers if the legislation does go through?

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

Senator FIERRAVANTI-WELLS—Have you done any preparatory work in terms of any communication or moneys expended in communication and, if so, when the approval, if you have gone through—

Ms Halton—No—

Senator FIERRAVANTI-WELLS—Yesterday we went through that process.

Ms Halton—No, there is no campaign or anything of that sort in this area.

Senator FIERRAVANTI-WELLS—There is nothing like that?

Ms Halton—No.

Ms Huxtable—On the HI service there is an implementation and communication plan which NEHTA has just posted on their website. I think that went up yesterday. But it is not—

Senator FIERRAVANTI-WELLS—No, yesterday we went through the committee that you have to go through.

Ms Halton—No.

Senator FIERRAVANTI-WELLS—There has been $218 million allocated to e-health—50 per cent from the Commonwealth and 50 per cent from the states. Can you break down this amount to show what it will be spent on?

Ms Huxtable—That was a COAG commitment in2008 and there is a National Partnership Agreement on E-Health which goes to that.

Ms Forman—The national partnership agreement shows the funding—

Senator FIERRAVANTI-WELLS—The national partnership agreement shows the breakdown of that funding, does it?

Ms Forman—No, it shows the funding by year. But it does not—

Ms Huxtable—Sorry, Senator, what are you seeking a breakdown of?

Senator FIERRAVANTI-WELLS—A breakdown of what it has it has actually been spent on.

Ms Huxtable—We would have to speak to NEHTA on that. We will take that on notice and see what we can get for you.

Senator FIERRAVANTI-WELLS—Okay. On the $466 million under COAG provided over two years to establish the national components for a secure national system as part of the plan, what will that be spent on? There is only a global figure of $466.7 million. Can you break that down to separate line items or will it be paid in total to NEHTA?

Ms Huxtable—On page 126 there is a year-by-year breakdown, but that probably does not go as far as you would like.

Senator FIERRAVANTI-WELLS—No, I do not think we are going to be successful by looking at that. I do not have that one flagged.

Ms Thompson—With regard to the government's announcement of $466.7 million, I cannot give that to you line by line. We certainly have ideas about how it needs to be broken up in terms of governance, infrastructure and funding for different elements of it such as the tools that might need to be deployed and the lead implementation sites that may need to be contracted to trial the infrastructure and architecture that we are going to design. The detail of that I would have to take on notice.

Senator FIERRAVANTI-WELLS—All right. As part of the COAG agreement, is there a component where the states will make any contribution?

Ms Huxtable—The expectation is that there will be additional costs for the states to connect their systems to the national EHR system. The estimate of that cost, which I think appears in the red book, is an additional $286 million, but that also recognises that there is significant state investment in their own IT systems that are already on foot. That would be expected to continue over the coming years. We are talking about quite a long period of time in that regard.

Senator FIERRAVANTI-WELLS—I have some other questions on e-health. We can put those on notice.

Senator FURNER—When was NEHTA established? Was it 2005?

Ms Thompson—Yes.

Senator FURNER—Who was the minister for health at the time of its commencement?

Ms Halton—It was Minister Abbott, as he was then.

Senator FURNER—Senator Carol Brown has asked you some questions about personally controlled e-health records. Are you familiar with a report called *Optimising e-health value using an investment model to build a foundation for program success*? I have a copy here if you are unfamiliar with it.

Ms Huxtable—Is that a recent report?

Senator FURNER—Yes. I will table it.

CHAIR—I think that will be useful.

Senator FURNER—The report says:

Investment in comprehensive e-health programs can lead to substantial savings in annual national healthcare expenditures (in the case of Australia, this will equate to a conservatively estimated AU$7.6 billion in 2020 alone …

Furthermore, it indicates savings in lives and in our health systems: an avoidance of 'an estimated 5,000 deaths annually once the system is in full operation', the avoidance of '2 million primary care and outpatient visits', the avoidance of '2 million primary care and outpatient visits, 500,000 emergency department visits, and 310,000 hospital admissions' per year. Additionally, I have seen a report—

CHAIR—Do you have a question?

Senator FURNER—I am getting to that. Back in March 2005, Tony Abbott said that NEHTA would identify the various steps necessary to get us to an integrated IT based national health information system. Furthermore, he went on to say, this was important because he believed upwards of 3,000 people a year died prematurely because of inadequate information and record keeping. We could avoid quite a few of these unnecessary deaths if we have an integrated record system. Can you identify whether you concur with both the figures in the report I have handed up and the comments that I have just indicated from Mr Abbott? Is that a savings figure for deaths and our health systems?

CHAIR—It is difficult for the officers to respond to your question when they have just got a copy of the report.

Ms Thompson—I can respond generally. This report and many others recognised the importance of e-health. It is internationally recognised that an electronically connected health record does mitigate many of the issues that you have spoken about. There is no doubt that the clinics and the professions believe that this is essential. They believe it because they can see the history of errors that happen across the health sector in its various forms in both the acute sector and primary care. So there is no doubt that there is pretty universal understanding and the view that electronic health is the way forward in terms of really mitigating some of these adverse events.

Ms Halton—I can confirm that this report did indicate that if it extrapolated the RAND study, for example, by 2020 you could expect to avoid 10,418 deaths. That is the one figure I can find in here which I can confirm. I also found $7.6 billion.

Senator FURNER—What is happening in other countries with respect to the issue of e-health? What are we seeing in other progressive countries?

Ms Thompson—There are certainly a number of countries that are progressing their e-health systems. We know of several, such as Denmark and the UK, that are advanced in this regard, but all around the world countries are looking at e-health as a way of creating not only better and safer health but also efficiencies in the dollars that the health sector costs.

Senator FURNER—What, therefore, would be the case if there were any threats of not implementing the e-health system as it stands?

Ms Thompson—I think the feedback from the professions is probably the most relevant here. The announcement about the next stage of the personally controlled electronic health record was universally welcomed by the professions. Everyone sees it as the next step forward because of the understanding of how important it is for the future of the provision of a health system that is built for this century. I believe there would be great disappointment in the sector if we did not proceed with this.

Senator FURNER—Would it be fair to suggest that the issues associated with deaths, underreporting, overreporting and all those sorts of things that we have identified would continue as a result of opposing the introduction of an e-health system.

Ms Thompson—I know there are many factors to that issue, but not proceeding with a system that connects the health sector and ensures that people's records are accurate and available when they are needed would certainly be a detriment to the health system altogether.

Senator FURNER—Thank you.

Senator ADAMS—My first question regards the update to the National Palliative Care Strategy. I note that that is to be handed to the Australian Health Ministers Advisory Council in October 2010. Are you up to date with that? Will that happen?

Ms Koukari—We have received a draft of the updated strategies. They have been through the process of consulting with individual stakeholders and doing reference groups and information gathering. We have a draft that has gone out again for consultation. Those consultation comments have come back. There is going to be a meeting of the palliative care intergovernmental forum in the middle of July, where we will discuss it. Then it will go from there up through the Australian Health Ministers Advisory Council process. So it is on track to happen before the end of this year.

Senator ADAMS—Will it be made public later?

Ms Koukari—Yes.

Senator ADAMS—When do you think that might happen?

Ms Podesta—That is a little bit hard.

Senator ADAMS—Once again the palliative care services provided through this program with the National Health and Hospitals Network Agreement, with capital funding over the next four years for 286 subacute beds or beds equivalent in multipurpose services, how is that going to go as far as Western Australia goes?

Ms Podesta—The subacute beds that will be made available through multipurpose services will be made available to states and territories.

Senator ADAMS—All the states and territories?

Ms Podesta—I believe so.

Senator ADAMS—How will they be allocated? Is there a certain number per state? Have you any idea about the allocation? Are they applied for, like residential aged-care beds?

Ms Podesta—No, the multiservice program with the states and territories is a process of discussion and negotiation because we have responsibilities for putting funding into those services. But we will make available to states and territories capital funding for 286 subacute beds and it will be through negotiation with other governments the location and commencement of those services. They may not all choose to take up the opportunities.

Senator ADAMS—I am thinking of the way the multipurpose aged-care beds are allocated. That was the reason for my question, to see whether there was going to be some sort of system like that.

Ms Podesta—It will be a similar process. The MPS beds are not through the aged-care allocation rounds, they are done through discussions and negotiations with the states and territories now.

Senator ADAMS—I realise that, but so many used to be allocated to the MPSs and then it was worked out where they went from there. That was the reason for my question. Thank you.

CHAIR—I suggest we go into the agencies, complete those and then return.

Senator FIERRAVANTI-WELLS—That is a good idea.

CHAIR—Thank you so much, palliative care. We will go into the agencies. We expect we will have some time at the end of the session to go back to infrastructure.

[3.42 pm]

Cancer Australia

Senator ADAMS—Firstly, when Cancer Australia first started they had groups of different organisations involved in cancer. As you have moved on through the years of Cancer Australia being established, have you had any new organisations associated with cancer join or become involved with Cancer Australia?

Dr Ramadge—We continually look to engage a range of organisations in cancer control across Australia. Depending on the work we do, we do engage with different agencies at different times. Many of the agencies and organisations that we began to work with when we were established we continue to work with, particularly the Cancer Councils. But as our work has evolved and as we have gained new programs, we have engaged more and different organisations. For instance, with the lung program that we now have that was founded in the 2009-10 budget we have started to work with the Australian Lung Foundation, whom we had not been working with at the beginning. So it really depends on the work we are doing. All I can say is that we continue to grow in terms of our partnerships and the collaborations. In our research program our partnerships have increased. We now have 11 partners in that program. In the consumer grants program there are now eight partners whereas we started with none and gradually built that up.

Senator ADAMS—Have you extended or expanded the membership of your consumer advisory committee or just kept it the same?

Dr Ramadge—Our advisory group has stayed at the same number of members, but the number of consumers whom we have recruited to work with Cancer Australia has increased. That has increased to 50 now. We have in the last month had a workshop for new consumers to work with Cancer Australia. There were 29 new consumers at that workshop.

Senator ADAMS—Do those consumers apply? Do you advertise the position?

Dr Ramadge—Yes we do. There are three methods that we use. One of them is to advertise in the paper. Another is to go to consumer organisations and seek nominations. The other method is through direct sourcing of people we know have expressed an interest through our website or other means. Then there is a selection panel. People who are interested put in an application and then there is a selection panel to work through those applications and identify the people who will become part of the work that we do.

Senator ADAMS—I notice that you have more funding allocated this year to work with consumers. Could you just tell us what you think you are going to do in that respect?

Dr Ramadge—It is the same amount of money but it is continuing.

Senator ADAMS—It is continuing. That is probably an important thing.

Dr Ramadge—The consumer grants program will continue. There are two parts to that grants program. One of them is in partnership with the cancer councils and other organisations to build sustainability into those support groups and the work that those partnerships engage in. The other part is directly to organisations that might apply. The other part of that work is supporting the work of ACT Online, which will be a consumer portal that defines, categorises and explains clinical trials to consumers. So it will be a portal specifically around clinical trials that are occurring. It will be continually updated and it will be specifically for consumers so they can look on that portal to identify any clinical trials that they might be interested in or to find out more about a clinical trial that their doctor may have mentioned to them.

Senator ADAMS—Could you just explain what the CanNET program does please?

Dr Ramadge—That started when we were established essentially. The measure started before we were established, it transferred to Cancer Australia and we initiated the CanNET project. That is a partnership with each jurisdiction to establish formal links between regional cancer services and metropolitan services. It is underpinned by a number of principles that were developed through the managed clinical networks in the UK that have proved very successful. So there is a strong evidence base to support that work. Essentially it is to provide quality and effective cancer services in regional areas for people from those areas. As I said, each jurisdiction has been participating in that and in this last budget the allocation was continued. So we have resumed that work with each of the jurisdictions to build on the initial work that they started.

Each project in the jurisdictions is slightly different, but they are each based on the principles that underpin that work. For instance, in Western Australia in that first round they sought to improve the links between Albany and Perth. So they just focused solely on Albany. As a result of the 2½ years initial work in CanNET, they are actually developed very strong formal links with Perth which they had not had before. Their clinicians in Albany were much

better supported by their specialists in Perth. There was access to multidisciplinary teams in Perth that had not happened before and the evaluation demonstrated there was a 30 per cent less travel for patients for chemotherapy services from the other the region. Western Australia focused solely on that area to build a strong model that worked and in doing so they then had the intention of rolling it out to other regional areas, which they are starting to do now. So that was just an example of—

Senator ADAMS—Yes, thanks for that. That is very close to where I come from so I did know about that, thank you.

CHAIR—Thank you, Dr Ramadge.

[3.51 pm]

National Breast and Ovarian Cancer Centre

Senator ADAMS—Welcome, Dr Zorbas. How many staff do you now have employed with your organisation?

Dr Zorbas—We now have 34 full-time equivalent staff at the centre. Three of those staff are project staff that are time limited specifically for work in a project for supporting women in rural areas. They started with the centre last year.

Senator ADAMS—We will come back to that particular project. Approximately how many researchers do you have at the present time?

Dr Zorbas—We do not have researchers as such employed within the centre, but the skill base of the staff is quite broad and includes epidemiology, project management, communication skills, policy, medical expertise et cetera. We do not have staff that are researchers as such. We work very closely with researchers in our advisory groups and we are obviously very reliant on the published research to inform the evidence base for our work.

Senator ADAMS—And those researchers are able to obtain grants from other areas and then work with you in a collaborative way.

Dr Zorbas—Yes, very much so.

Senator ADAMS—Okay. Let us move to the rural program now.

Dr Zorbas—Yes. That is a very exciting program. It is the result of some funding that was received from the Commonwealth specifically to support and extend opportunities for support for women in rural areas diagnosed with breast cancer. It is an initiative that we are undertaking collaboratively with the Breast Cancer Network Australia and it is a two-year program of work, 2009-2011, with each of those organisations receiving approximately $1.35 million over the two-year period.

The start-up phase has really been very productive and we are now into implementation. Both agencies are collaborating in terms of joint meetings and supporting each other where possible. In terms of the work that has been undertaken by National Breast and Ovarian Cancer Centre we are very pleased that on 1 June, just two days ago, three specific online breast cancer education lectures—modules that are hosted on the Australian College of Rural and Remote Medicine website—have now been launched, and there are approximately 8,000 members of that college so we anticipate that they will be widely used in terms of resources.

We also will be developing two Rural Health Education Foundation broadcasts. The reach here is to an estimated 660 satellite sites across Australia. In addition we are holding more intimate virtual classrooms—approximately 14 of these—which will be far more interactive than the modules. These will be starting in late June and the first of these will focus on breast cancer and family history. These are particular streams of work that will inform rural health professionals about all aspects of the care and support of women with breast cancer.

A second stream is looking particularly at linking women who have to travel some distance from home for some time for treatment, particularly radiotherapy, with their families. We are using web cam technology, and the pilot phase of that project is currently underway. We feel particularly pleased about being able to do something that is very practical and supportive for women—to help them connect—particularly those who have young children at home. So we are very excited about that particular project. It is currently being trialled in three locations in three states.

Senator ADAMS—Which locations?

Dr Zorbas—The Royal Brisbane and Women's Hospital, the Bendigo Radiotherapy Centre at Peter MacCallum, and the Southern Adelaide Health Service. They are the trial sites at this point.

In addition to that, we have a stream which is focusing on improving the knowledge and skills of Aboriginal and Torres Strait Islander women and the health workers who work with them. We had the first summit, which was held in Darwin just two weeks ago, which was an extraordinary success. We had 52 participants who registered and, in fact, closer to 60 actually attended, which is apparently unheard of. You usually have a dropout rate for such activities. It was an all-day summit. People arrived early and wanted to stay on. There was at lot of connectivity. People came from many miles to attend the summit. Some were people who had never travelled out of their communities before. So it was a really rewarding experience and much learning was exchanged. There were women who had breast cancer, Indigenous health workers, remote area nurses and the elders of the communities, of course, who most importantly will take those messages back to communities.

One other aspect of work within that Indigenous area is developing a breast cancer module which will assist in training health workers in breast cancer. That module has already received in-principle endorsement by the Aboriginal and Torres Strait Islander Health Registered Training Organisation Network. Again, that is something that will have real application on the ground.

Senator ADAMS—Thank you for that. That is very good. Just on Breast Cancer Network Australia, could you give us a few words about your partnership with them and the work that you do in the way that you collaborate.

Dr Zorbas—Yes, absolutely. The Breast Cancer Network Australia is a key partner for us. Obviously this program is one area in which we are collaborating very closely. But in addition to that consumers form a very important part of our work, not only informing every aspect of our activities but in a very meaningful way having a place in all our working groups. Breast Cancer Network Australia is our source agency for the consumers who represent consumer

views on each of our working groups. We currently have around 35 consumers involved in our work.

Obviously Breast Cancer Network Australia is represented on our board with Lyn Swinburne. We undertake regular meetings of CEOs and chairs of the organisations to identify ways in which we can collaborate productively and present to the community the importance of the different aspects of the work that we do. We also have joint meetings with the National Breast Cancer Foundation and more recently with the McGrath Foundation as well so that we can identify ways in which we can collaborate and not duplicate work and so we can support each other's activities.

Senator ADAMS—I have one last question on ovarian cancer. I have been reading about some of the work that has come to fruition; could you just give us a brief statement on the work you are doing there.

Dr Zorbas—Yes, absolutely. One of the key resources that we launched in February this year, which was Ovarian Cancer Awareness Month, was an online tool for familial risk assessment for women with breast or ovarian cancer. This is primarily for use by health professionals and general practitioners in particular. We are delighted to report that we have had 11,000 hits to that particular site since that launch, so we are obviously filling a very important need there.

We are currently undertaking systematic reviews of the evidence in three areas of work in ovarian cancer. These topic areas have been identified through our advisory group structure. They are the management of women at high risk of ovarian cancer, the follow-up care of women with ovarian cancer and the use of radical upper abdominal surgery in ovarian cancer.

We have undertaken a number of educational activities, particularly with general practitioners, in relation to the appropriate referral of women with symptoms that could be ovarian cancer. So far this year we have had approximately 2,400 GPs attend those seminars across Australia. Very importantly, we published a report on Ovarian Cancer Awareness Day which is a statistical review of data around ovarian cancer. This was very important to bring a spotlight to the poor survival for women who are diagnosed and to look at changes over time. This report was also developed into more user-friendly, online resource that provides the data and information around ovarian cancer. It is called *Report to the nation: ovarian cancer*.

We have developed an online resource about menopause in younger women with ovarian cancer. This is a much neglected area, we felt, in terms of the young age of many people who receive ovariectomy and are plunged into premature menopause because of the treatment. This provides an evidence base around some strategies for them.

We have developed a position statement on population based screening. This was an area was particularly misunderstood by many people who were looking for a way to identify the early stages of ovarian cancer. At this time the evidence suggests that there is no screening test or any particular test that is effective in identifying the disease in its early stages. So it is providing not only that information that is supported by all the key cancer agencies but also developing that information into a resource that GPs could use in consultation with women who are asking to have those particular tests.

Senator ADAMS—Thank you very much for that.

CHAIR—Thank you very much, Dr Zorbas. The next agency is the NHMRC.

[4.03 pm]

National Health and Medical Research Council

CHAIR—Good afternoon, Professor. Questions, Senator Abetz.

Senator ABETZ—I have questions about the document that the NHMRC produced called *A new food guidance system for Australia: foundation and total diets*. In the preparation of that, was any advice or guidance sought from the Department of Agriculture, Fisheries and Forestry?

Prof. Anderson—I may have to take that on notice. This is a guideline being developed under our act, funded through the department, which had an expert writing group developing it in our normal way. Then, again as is required by the act and as is our normal procedure, it is put out for comment so that all, in this case many, interested parties have the opportunity to have their say. It comes back, we consider it further and consider every piece of advice and submissions as part of that public consultation, and then make a decision as to whether it is ready to take to our council for endorsement or it needs to go out again.

That is not going to your specific question, but generally we are very keen on this method to make sure that the many interested parties have an opportunity. I do not know whether Dr Morris can provide further information.

Senator ABETZ—Before that, if I could ask this. If you could provide us, please, with a list to whom you sent the draft and from whom you got responses, that would be helpful.

Prof. Anderson—We can certainly do that.

Senator ABETZ—So I have asked about that and that of course will be one of those. Just in case you do know, did you ask the Department of the Environment, Water, Heritage and the Arts for comment on this? It is simply to say that I am—

Prof. Anderson—I cannot say, except to say that we do advertise that it is available. We advertise that it is available.

—**Senator ABETZ**—So you advertise generally that it is available for comment?

Prof. Anderson—Yes.

Senator ABETZ—That is as opposed to sending it out to specific people or organisations?

Dr Morris—We generally do both. We put an ad in a newspaper, we put it on the website and we also send it to key stakeholders that we think have an interest in the issue.

Senator ABETZ—Having defined it as such, could you please provide me with a list of the key stakeholders to whom you sent the draft and then a list of those that responded, not only the key stakeholders but any from the advertising. That would be very helpful, and thank you for clearing that up. Are you aware of the concerns of the seafood industry about the draft guidelines which recommend that Australians eat seafood just once a week?

Prof. Anderson—Yes, we are certainly aware and very pleased that the industry have brought their concerns directly to us. They are certainly being taken fully into consideration as we take the feedback from them and everybody else to revise the guidelines.

Senator ABETZ—What I would like to know if you are able to tell us—and the question you have taken on notice may tell us this anyway but if you can tell us now that would be good—is this. Which government agencies or officials did the NHMRC consult with about sustainability of stocks, which is apparently being used to influence the draft dietary guidelines?

Prof. Anderson—I think we should take that on notice except to say that the views in the draft came from the wide expertise of the writing group doing the guidelines and their knowledge, experience and understanding of the literature. But can I reassure you that it is very common in our processes that the initial draft that is developed and goes out to consultation has gaps and interpretations of literature that need to be changed. That will certainly be taken very seriously.

Senator ABETZ—Can I ask whether you were consulted or received advice from any non-government agencies. The chances are that you would have done so, I would imagine.

Prof. Anderson—Only through the membership of the writing group, the individuals there. I do not believe that we sought advice.

Senator ABETZ—But from the public advertising, for example, you may have received some advice from an environmental group?

Prof. Anderson—Yes. The public consultation has only closed relatively recently.

Dr Morris—We have had on our website essentially a blog and a way of getting feedback so we can look to see who has made submissions through that process as well.

Senator ABETZ—Would it be the advice of the NHMRC for people to in fact eat more than just one meal of fish a week if there were not any sustainability issues involved?

Prof. Anderson—I think I will wait until the expert group has looked at the feedback and made a final recommendation to our council and our council has considered it and made its recommendation to me. I think behind your question is the well-known beneficial effects of seafood. What we need to do—as a boring, evidence based organisation!—is take all the evidence on board. I can assure you that our council insist that whatever the final guidelines say are based on such evidence.

Senator ABETZ—So this is still in a draft stage?

Prof. Anderson—Absolutely.

Senator ABETZ—Thank you for that.

Prof. Anderson—It has got a little way to travel.

Senator ABETZ—I am asking these questions, I suppose, in partnership with my colleague Senator Richard Colbeck, who is a shadow parliamentary secretary, but also in my capacity as a 'clapped-out' fisheries minister from the previous government that spent a lot of money on developing in this country a sustainable seafood industry, which has in fact received worldwide accolades for its sustainability. I never thought I would get an environmental group saying that I had done a good job, but there you go. It is recognised, even by UN bodies—and often I do not put much store in them either so we have this amazing agreement in relation to Australia's fisheries—and those are its wild sea fisheries and

of course more and more today in Australia and indeed around the world we are farming fish. It would be most disappointing to me, personally, and also to the seafood industry—and, if I might say, this is important to the health of the nation—if people were dissuaded from consuming fish because they thought that there were some sustainability issues surrounding the fish that they ate. So, without taking up anymore of the committee's time, can I put in a very strong plea as to those aspects—and I have highlighted four separate parts of this document—and to the issue of environmental sustainability that arises. If I might I will suggest—with my non-scientific background—that it is ill advised. At the end of the day, I dare say, your expertise is in health and not necessarily the environmental management of sea fisheries. If you were to go down that track, it would be helpful—without telling you how to suck eggs—if you were to consult with the Department of Agriculture, Fisheries and Forestry and indeed DEWHA in relation to that issue. I will leave it at that.

Senator FIERRAVANTI-WELLS—Having a look at your funding—and this is on page 743 of the budget paper—do I detect, Professor, that your total resourcing has gone down from 1.7 to 1.4?

Prof. Anderson—If I may, would you reidentify the line that you mentioned?

Senator FIERRAVANTI-WELLS—It looks from those figures on page 743 that the funding for grants has decreased. That is what I am trying to have a look at. I just want you to tell me if that is the case. From my reading it seems to be that the columns as to 2009-10, as against 2010-11, are greater, so the funding has gone down.

Dr Morris—For 2009-10 it was $703,065,000. If you look to the left, at 2010-11, it is $715,479,000.

Prof. Anderson—So it is up marginally.

Senator FIERRAVANTI-WELLS—So what about your total resourcing? You get funding from other different sources. So your total resourcing has gone from 1.7 to 1.4. That is the figure further down.

Prof. Anderson—I see. We would probably need to take the exact details on notice. The Medical Research Endowment Account that supports our research funding is an unusual account and the expenditure has a number of different components.

Senator FIERRAVANTI-WELLS—I was just not sure whether your funding available for grants has been reduced.

Prof. Anderson—The answer to that is no.

Senator FIERRAVANTI-WELLS—I have a copy of a press release from Minister Roxon dated 8 July—and I am happy to give you a copy of this—which I think picks up some comments you, Professor Bishop, made in passing in relation to the pandemic issue. I am particularly going to focus on some research projects. This morning you made mention of research, but I am particularly going to ask those questions here. The media release talks about 'H1N1 medical research projects fast-tracked'. What was that research that you did? The release refers to 41 medical research projects. Can you tell me a bit about that?

Prof. Anderson—This was a call for research during the early stage of the H1N1 pandemic when we were really unclear about how dangerous it was and where it was going to

go. We had, from memory, around 100 applications across some specified areas—and they are in that press release, actually. We required applicants to put an application in in very short notice. I think it was three weeks or something like that. We then ran peer review with US, New Zealand and Singapore experts to help make sure we were not having too many conflicts of interest, because many Australians in this area applied. We then rolled out those grants very quickly following the minister's announcement. They were all one-year grants specifically targeted at the H1N1 pandemic that was occurring at the time. One of the conditions of the grant was that they came and reported to us—people from the department, including the Chief Medical Officer—in December, so that we could get early feedback from the research that was done to feed into any policy changes that might have needed to be done. The grants themselves were mostly for one year. So they will finish at the end of this month.

Senator FIERRAVANTI-WELLS—Was it $7 million extra or was the work that you did absorbed in your existing funds?

Prof. Anderson—It was absorbed.

Senator FIERRAVANTI-WELLS—What did it cost all up?

Prof. Anderson—It was just short of $7 million, as I remember.

Senator FIERRAVANTI-WELLS—So $7 million was taken out of or redirected from your other operations to run over here and quickly do this research and put out these grants to do these projects fairly quickly?

Prof. Anderson—There are I suppose two parts of it—

Senator FIERRAVANTI-WELLS—I am trying to simplify it.

Prof. Anderson—We do have a budget line that our research committee advises on and then council recommends and considers for urgent calls for research and targeted calls for research. This funding was taken from that funding line.

Senator FIERRAVANTI-WELLS—But no extra money was given to you. Some of these projects have not even reported. They were given for a purpose but they have not—

Prof. Anderson—No, they have all reported. They all reported in December.

Senator FIERRAVANTI-WELLS—All these projects were asked for urgently in July—and it was clear that we had to do something. In the end, what practical things did you get out of this that contributed to the way that we better handled the reaction to the flu issue?

Prof. Anderson—We could provide that in more detail should you be interested, but the research was focused on the virus itself so that some of our best virologists could look at the propensity for it to change in dangerous ways versus non-dangerous ways. There was the clinic research—I did hear some of the comments Professor Bishop was making earlier today about the clinic process. We learnt from that. Then there were the public health measures research. I cannot pull down the main findings from the top of my head but they were to do with population behaviour and strategies to ensure appropriate public health policy and processes around that. I should also add that all the state chief health officers, who are members of our council, were also at that workshop in December, and heard from the researchers directly what had been found.

Senator FIERRAVANTI-WELLS—I am trying to fix the timeline. This was urgently rolled out in July. You said they did not report until December. This money was used to fund a series of grants for something that was urgent in July but they did not report until December. I am trying to understand what the urgency was there. Was it just because we had to appear to be doing something, or did we actually use the research in December? The pandemic was at a particular point in time. The research was delivered at the end of the year. How could it have fed into what we were doing at that time?

Prof. Anderson—H1N1 has not gone away, of course. Research always takes time and all these projects would also have required ethics approval. We did say at the time that the importance of doing the research this year during the southern hemisphere epidemic would mean that by the time we were facing the subsequent year we would have a stronger research background about the virus.

Prof. Bishop—I think it is important to understand that at the time of this rapid research opportunity there were a number of questions that were unclear, and still are unclear, and one is: how dangerous can this virus get? In other words, if, as I mentioned this morning, this virus became suddenly more virulent because of genetic change it could be twice or three times more virulent, conceivably. It was relevant to know some of the biological work on the amount of drift, the genomics and other things in relation to this virus as quickly as possible and is still relevant. The other thing is that we know a lot more about some of the public health modelling, which enabled us to understand what effect our vaccines would have—all relevant. These calls for research at the time of public health crises of various sorts is a good model. It does take time; you are not going to get the result the next day. Talking to the US team, they were envious of the particular approach. They thought it was a good approach. I think that is what our assessment would be as well.

Senator FIERRAVANTI-WELLS—I am not doubting the value of the research. My point is that this was pitched as some fast-track quick thing that the minister can stand up and announce on 8 July to appear to be doing something. I am not doubting the validity of the research—that is why I asked the question in those terms. This media release is quite deceptive because it gives the impression of being fast tracked. I have some questions on infrastructure. Thank you.

CHAIR—We have some questions on infrastructure. We will cease this at 4.30 pm and have a 10-minute break, but we will use the last five minutes. I know Senator Carol Brown has a question on infrastructure, which she may want to put on notice, as does Senator Fierravanti-Wells. We will get the officers up here first.

Senator FIERRAVANTI-WELLS—I want to ask about funding for the cancer centres which was part of the monies coming out of the health infrastructure fund. There are 20 projects and of the $560 million allocated for regional cancer centres how much remains unallocated?

Mr Morris—Current we have $499 million allocated to the regional cancer centre round that has been announced progressively over the last several weeks. The ACT Cancer Centre, which was announced as part of round 1, represents a further $28 million.

Senator FIERRAVANTI-WELLS—How many are actually operational? I will not bring my map of where the 20 are.

Mr Morris—None are operational.

Senator FIERRAVANTI-WELLS—How many localities in total applied to have regional cancer facilities funded?

Mr Morris—There were 37 applications, one was noncompliant, so 36 were assessed by the Health and Hospitals Fund Advisory Board.

Senator FIERRAVANTI-WELLS—As far as the guiding principles for locations in regional cancer centre, it is the case that Australian Standard geographical classification remoteness areas apply?

Mr Morris—Yes.

Senator FIERRAVANTI-WELLS—One of the projects being funded is the Central Coast Regional Cancer Centre at Gosford. Is that correct?

Mr Morris—That is correct.

Senator FIERRAVANTI-WELLS—How much has been spent on that project? Interestingly that sits in the federal seat of Robertson.

Mr Morris—We spent $28.59 million.

Senator FIERRAVANTI-WELLS—Was that when the Prime Minister visited there with Ms Neal for the photograph at the Gosford Hospital in April 2010. Is that the case?

Mr Morris—Yes, it was announced on 14 April.

Senator FIERRAVANTI-WELLS—Can you tell me what the remote classification is for Gosford?

Mr Morris—Gosford is RA1 but that regional cancer centre is intended to take catchment area from RA2.

Senator FIERRAVANTI-WELLS—It does not actually meet the guidelines.

Mr Morris—It does meet the guidelines which provide explicitly for the circumstance where the most efficient way to provide services to regional patients is to anchor the service in a RA1 area serving a catchment area outside of that RA1 area.

Senator FIERRAVANTI-WELLS—Could you provide me with details of that catchment area? Please take it on notice if you do not have the detail now. It is interesting to note the area that you have said the Gosford catchment covers, and to note why some other area, which is in and would fit that remote classification, would not have covered?

Mr Morris—I will answer that in two parts. First, in terms of Gosford the areas that will be forming the catchment area include McMasters Beach, Patonga and Brisbane Waters from Gosford out west to Peats Ridge, Somersby, Mangrove Mountain and Wisemans Ferry, north of Wyong including Morisset, Cooranbong and Dora Creek and the lower Lake Macquarie areas. To answer your second part, the Health and Hospitals Fund Advisory Board was not in the business of making comparisons between project A and project B. They assessed each project individually on its own merit.

Senator FIERRAVANTI-WELLS—I appreciate that but for most of those areas, if you are looking at a location that probably was more remote, why didn't you choose further north, which would have been a bit more central rather than Gosford? That is my point.

Mr Morris—The board had to assess the applications that were put to it, and the meritorious—

Senator FIERRAVANTI-WELLS—Because Robertson is of one colour the more likely location would have perhaps been—

CHAIR—Senator!

Senator FIERRAVANTI-WELLS—I withdraw that. I do have—

CHAIR—No, I am sorry.

Senator FIERRAVANTI-WELLS—No more questions?

CHAIR—They will have to go on notice. I apologise, but the time has been preset. Senator Brown had a question about Launceston hospital that she is going to put on notice as well. Thank you very much to the officers. That ends outcome No. 10.

Proceedings suspended from 4.30 pm to 4.43 pm

Food Standards Australia New Zealand

CHAIR—I welcome the officers from FSANZ.

Senator SIEWERT—I will firstly ask about the issue of BPA and where we are up to with any reassessment of the standards for BPA in Australia?

Dr Brent—We are certainly receptive of concerns that consumers have about the presence of chemicals in food, particularly BPA. We can certainly empathise with those concerns. We have done an enormous amount of work on BPA, and continue to do so, with the research that is going on. We have networks with our colleagues in other regulatory agencies both within Australia and internationally. We are aware of surveys that have been done in Canada recently and also in the USA, mainly looking at BPA levels in canned foods.

We are aware, for example, that industry all over the world has taken action to either restrict or take BPA out completely from infant formula and also from polycarbonate baby bottles that hold the infant formula. There is a lot of research going on and a lot of debate going on on that research. As I said we are connected with our colleagues, particularly in the US FDA, and we are already privy to some of the results on the research that they have been doing at the National Institute of Environmental Health Sciences in the USA and in the FDA. Having summed up at the moment the current available information on the research our view is still that there is very unlikely to be any human health and safety problem at the levels that we are currently being exposed to, particularly in infants and young children.

Senator SIEWERT—In terms of the results that you have received from the US FDA what are those results showing? Are you able to tell us that?

Dr Brent—We have received these results from our networks in the US FDA. We are aware that they have done three studies. One study is on the pharmacokinetics of BPA in rats and humans. Another two studies are on the behavioural effects of BPA at very low doses in

rats and also in monkeys. We do not have the results in monkeys but we know that there are no behavioural effects in rats. The pharmacokinetic effects show that in a rat 99 per cent of a dose of BPA is conjugated by the liver which only leaves one per cent of the free BPA to act. In the human 99.9 per cent of a dose of BPA is conjugated by the liver and that leaves less than 0.1 per cent of a dose.

Senator SIEWERT—Do we know what impact that 0.1 per cent can have?

Dr Brent—I think that is the subject of some of those other researches that are going on at the NIEHS. If you, for example, look at the level of BPA that might be contained in a polycarbonate bottle that has infant formula in it, say 10 parts per billion, 0.1 per cent of that is down to 10 parts per trillion. That is one with 12 noughts after it so that is a very very small amount. We are also working very closely with industry here in Australia and we have had meetings with the AFGC and also with the Packaging Council of Australia and various manufacturers of canned foods and infant formula. We also know that the ACCC have done a study in polycarbonate baby bottles where the infant formula has been prepared according to the instructions on the can. This is right across all of the main brands of infant formula in Australia and we have found none.

Senator SIEWERT—In bottles manufactured in Australia?

Dr Brent—Not bottles, this is the infant formula manufacturers. The infant formula, as you know, goes into the bottle and then you analyse the infant formula to see if any BPA has leached out of the bottle into the infant formula. In those researches the limit of quantification was 10 parts per billion and none was found. The limit of detection of that assay was 0.5 of a part per billion. None was found.

Senator SIEWERT—Is that for all the formulas that are used in Australia?

Dr Brent—The main brands, yes.

Senator SIEWERT—Not all of them?

Dr Brent—It is the main brands—I would have to take on notice whether it was all of them.

Senator SIEWERT—You said you were working with other regulatory agencies, or liaising with other regulatory agencies. Have any more regulatory agencies banned the use of it in their countries?

Dr Brent—Recently the French government, the French Senate, voted to put on a temporary ban of BPA in products used for infants under three years, and also Denmark has a similar ban. These are temporary bans that are pending more research, particularly the research coming out of the US. The European Food Safety Authority is also poised to make another opinion on BPA, and of course you know that Canada has already put a ban on the use of products containing BPA for children, again, less than three years old.

Senator SIEWERT—When you say you are receptive to concerns, what is your process from here in terms of time lines and any further decisions you may make?

Dr Brent—At the moment we are tracking the research that is going on overseas. We are working closely with our regulatory partners within Australia; in fact, we called a meeting

earlier this year of all of the regulators involved in, for example, babies' bottles. The regulators at that meeting were NICNAS, TGA, ACCC, APVMA and ourselves, and we came out with a joint view on the safety of BPA at the levels we are currently being exposed to. That joint view is that we currently do not think there are any human health and safety problems at the levels we are being exposed to, including children. We resolved to work together in the future; we resolved to try to do joint surveys. As I have said, ACCC have already done their own survey and supplied that to us. We are also working closely with industry to try to find whether we can get any newer current levels of BPA particularly in the infant formula type products. We very recently also commissioned our own survey, so this is a specific, targeted survey of BPA in a range of products, not just polycarbonate bottles but also canned foods and other food packaging chemicals. The results of that survey we would hope to get by the end of July, say, and then we would hope to have the exposure modelling done by October.

Senator SIEWERT—Will those two surveys be publicly released?

Dr Brent—Certainly the survey on the BPA in canned foods and so on, and also the other chemicals that migrate from packaging, would be.

Senator SIEWERT—I realise the ACCC survey is not your survey, but is that publicly available?

Dr Brent—It has not been made publicly available so far. It is certainly known, now, that it has been done.

Senator SIEWERT—When was that survey done?

Dr Brent—It was done earlier this year—about two or three months ago.

Senator SIEWERT—I realise it is not necessarily up to you, but do you know if it is going to be made available? I realise it is not your survey

Dr Brent—It is not our survey, so we do not know.

Senator SIEWERT—I will need to chase the ACCC to get them to release it.

Senator FIERRAVANTI-WELLS—Yesterday I tried to get some answers to questions to the accreditation agency in relation to food standards in nursing homes, but I did not seem to get very far. I do not know if any of you followed that. Whilst I appreciate issues about contamination of food that may go in to aged-care homes, what is your role in terms of food standards? The agency could not explain this to me although they talked about what they do. Where do I go to find information about food standards in nursing homes?

Ms Fisher—We have a food standard that requires people serving food to vulnerable populations to have food safety management programs. That is in our Food Standards Code. Nursing homes are identified as one of the vulnerable population target groups.

Senator FIERRAVANTI-WELLS—Do you make the rules determining food in relation to nutrition and those sorts of things as well?

Ms Fisher—No, our requirement is around providers like nursing homes having food safety programs that make the food suitable and safe for the recipients.

Senator FIERRAVANTI-WELLS—Drill down into that and tell me a little bit more. How do you determine that?

Ms Fisher—Our standard does not determine it. It is left up to the jurisdictions, the enforcement agencies at the state and territory level, to determine within their jurisdiction what elements they require in a food safety program.

Senator FIERRAVANTI-WELLS—In other words, what food can and cannot be served in nursing homes?

Ms Fisher—It does not go to the nutritional profile; it goes to food safety and suitability.

Senator FIERRAVANTI-WELLS—What do you mean by 'suitability'? Please explain that. You can see the reason I am asking this question. You would have seen reports like this in the newspapers and I am sure that you would have been just as alarmed as everybody else, so tell me about food suitability.

Senator Ludwig—I am not sure that the officer was able to identify what it was that you were waving around, although I understand the officer has an awareness of it. I worry about identification for the *Hansard*.

Senator FIERRAVANTI-WELLS—For the purposes of the *Hansard*, I am referring to a report in the *Sunday Telegraph* on 30 May 2010 on page 1 and continued on page 14.

Ms Fisher—An example might be that you would need to be aware whether any particular residents have allergen problems. If they are allergic to, say, dairy products then that is the kind of thing that goes to food safety. That is quite different to the nutrition and quality of food unrelated to safety, which is not our province.

Senator FIERRAVANTI-WELLS—Whose province is it? Much was made yesterday of nutrition. We hear about nutrition, standards and those sorts of things. I notice it says that you help develop, review and maintain standards of food. Help me out on this.

Ms Halton—As we said yesterday, FSANZ have a responsibility under their legislation for standards in relation to the safe production of food and they have standards which go to, for example, what restaurants do, and we have just discussed vulnerable populations. It is not their responsibility to worry about nutrition in terms of what is presented to you on the plate. As we said yesterday, the question of nutrition and hydration—as in whether you get enough vitamin B, protein and I could go on—is a matter for the agency. The question of what you have put on the plate in front of you and whether it was prepared and handled safely comes down to the macro work that is done here, but the monitoring of enforcement of the standard that says, 'Is that piece of potato, fish or whatever actually produced in a manner consistent with and is therefore safe' is a matter for the states and territories.

Senator FIERRAVANTI-WELLS—Thank you, Ms Halton. Given the assertions made in the newspaper article, it would be really helpful if somebody could produce a list for me of the state and federal—and Ms Halton is probably going to say, 'We don't worry about the states,' but I am sure it is in the purview of the Department of Health and Ageing—legislation that nursing homes have to comply with not only in terms of the food that they serve, the food that comes into the nursing homes, but also the food in my example where residents with

dementia go on an outing—have the dignity of an outing—and buy themselves an ice-cream from McDonald's.

Senator Ludwig—Chair, the witnesses can only really answer in the area of their competence. They can provide how their legislation applies to a nursing home only. For the broader question, Health could I suspect take on notice what legislation, including regulations, they have which applies to nursing homes, although I expect it goes without saying that that would be available on the web. There would be state and local council regulations, which I am sure are outside their area of responsibility. In relation to your requirement for them to gather all sources, what happens if they leave one out? With respect, I am not sure it is a question that can be asked of this officer.

Senator FIERRAVANTI-WELLS—Minister, the secretary of the department is sitting there. I appreciate that in so far as FSANZ is concerned—can you tell me your awareness of the legislative framework?—but I would have thought the secretary of the department could provide me with a list of all regulations, both state and federal, that affect food both served in nursing homes and when residents go out of nursing homes.

Ms Halton—You mention a particular case in relation to a group of residents and McDonald's ice-creams. What I said to you yesterday was: if you can give us a few details, I am happy to have a look at that and answer you in that context. I think the point the minister makes is that we cannot undertake a broad research service in terms of everything to do with this domain. I am happy to find the piece of work that was done by the BRCWG in relation to regulations and the Productivity Commission piece in this respect. We will give you something, but I need to see the details of the particular case you are talking about in order to inform that answer.

Senator FIERRAVANTI-WELLS—But, ultimately, your agency is responsible for the accreditation of these two nursing homes—the report of which is in this newspaper—

Ms Halton—Indeed—

Senator FIERRAVANTI-WELLS—because they receive Commonwealth funding.

Ms Halton—In terms of our legislation, and we covered all of that at some length yesterday. As I said at the time in relation to the other issue—and we seem to be conflating now the issue of food that you raised yesterday, which went to ice-creams and what people are allowed to take into places, which is I think a perfectly reasonable question to ask, and now that article—

Senator FIERRAVANTI-WELLS—It was not just that if you were listening yesterday. Other providers have said to me that they have stopped serving certain foods because they are no longer allowed to. It was not just one incident. I think it is really unfair to trivialise this—if that is what you are doing. Just because residents who have dementia are taken out to McDonald's once a week to get an ice-cream—

Senator Ludwig—I think it is also unfair to characterise it as—

Senator FIERRAVANTI-WELLS—In so far as the secretary may have made some inference of trivialisation—

Senator Ludwig—I do not think that was the case.

Senator LUNDY—It was you making that inference.

Senator FIERRAVANTI-WELLS—In so far as any attempt to trivialise the examples I am using, I find that offensive.

CHAIR—Senator, there was no attempt to trivialise. I do think asking whether the secretary was listening was inappropriate and crossed the line. Basically my understanding is that you have an issue about which you are concerned, quite rightly. The department—

Senator FIERRAVANTI-WELLS—Well, I will go back to the agency then.

CHAIR—Senator, do I have to keep reminding you that when I am speaking I do not appreciate being talked over. The department will take the concerns raised by Senator Fierravanti-Wells and will provide an answer as much as they possibly can on notice. There probably will be a necessity for more discussion, but they have taken the issue on notice. Is that right?

Ms Halton—Indeed. As I said, we would like to be provided with the examples of what people believe they can and cannot do. The particular example used yesterday by the senator was in relation to McDonald's, but all of the examples she has will assist us in understanding what potential misunderstanding there is. If there is a real issue, we will get to the bottom of it.

Senator FIERRAVANTI-WELLS—I did not use the names of the nursing homes for the very reason that the department did not want to disclose the two nursing homes run by Bupa and Domain for privacy reasons. That is why I have not gone into the details on the record.

CHAIR—Senator, we have the issue and the concerns you have raised over two days on the record now. We have to move on because the time for FSANZ is over.

Ms Halton—It has been a longstanding practice in this committee, as you know well, that if a senator has a particular concern about issues in respect of an individual facility we do not read that name into the record but we ensure that that name is provided to us and we treat that in a manner which is appropriate given privacy and issues under the legislation.

CHAIR—I am sorry there are many questions you will have to take on notice. There is a great deal of interest in your agency. Next time we will have to give you more time. I thank the officers from FSANZ.

[5.07 pm]

Australian Radiation Protection and Nuclear Safety Agency

CHAIR—I welcome officers from ARPANSA.

Senator LUDLAM—I do not know whether you would have had time to review the session I had with ANSTO a couple of days ago in which I referred to a report that ARPANSA undertook into an incident that occurred at the radioisotope production facility at Lucas Heights on 28 August 2008. Can you confirm for us whether your case on that incident is closed or you are still working with ANSTO or ARI?

Dr Larsson—The inspection report has been finalised. The observations that have been made have been transmitted to ANSTO. As far as we understand, there is work being

undertaken in ANSTO, and was already when the report was finalised, in order to implement the recommendations that we made.

Senator LUDLAM—It is a pretty strongly worded report. The radioisotope production facility was described as being a research grade facility—and ANSTO have not denied that that is the case—rather than a commercial grade or industrial production grade facility. What does that actually mean in practice? What are the key differences between a research grade facility and a place where you would normally do commercial production?

Dr Larsson—I think there has been a transition at ANSTO from the research activities, which was one of the original basis for ANSTO research. We now have commercial production of certain radiopharmaceuticals. They largely make use of the same equipment that has already been in place. There have been modifications but, as you would have noticed in the inspection report, there were some modifications that were missing in some places. As far as I have been informed, these areas have not been rectified. This reflects that the production facility was really intended for other purposes than it has subsequently been used for. The modifications have been made but it seems also from the observations that inspectors made that they were overlooked in a few cases.

Senator LUDLAM—Before we move on, is it your understanding that there are a number of measures arising as result of your report that are still ongoing; or is it your understanding that ANSTO has completed everything that you suggested they do?

Dr Larsson—Those measures are still ongoing because we still have had discussions about what we in broad terms relate to as the safety culture within ANSTO.

Senator LUDLAM—Culture, I guess, is one thing and facilities is the other. Still on facilities: are you confident that if ANSTO undertake all of your recommendations and give them effect that they will effectively have made a transition into a commercial-grade lab or will there still be some deficiencies, do you think?

Dr Larsson—I think it is very difficult to answer that question because it goes very much into the details of the different facilities but I think that I can be reasonably assured that the safety culture and the operations as such as well as the equipment are suited for the purpose and can be operated safely. Whether they are operated safely is a question of our inspection of the safety culture.

Senator LUDLAM—I will come to that in a moment. You made some very strongly worded comments that go to the issue of culture of safety—that there were management lapses; there were people in hot areas who had not had the appropriate radiation safety training; and there were incidents and accidents that went misreported for a period of hours and so on. What does it take to change the culture and create a culture of safety in an institution like that?

Dr Larsson—It takes managerial action and managerial responsibility and it takes information and education for the staff. There are actually protocols that you can follow here. There are internationally agreed guidelines. It is not only a question of ticking the boxes that you have done this and that; it is also a question of changing the frame of mind and of fostering a culture where if you have observations that are concerned about safety that there is no culture of punishment; and that it is possible to bring those forward to management and be

confident that whatever you bring forward to management will also be dealt with in the appropriate manner and the corrective changes will be made.

Senator LUDLAM—Let us go to that specifically. Mr David Reid was a health and safety officer. He was the one who initially raised the concerns about the safety of that facility. For his trouble, he was suspended indefinitely. He still has not retuned to his previous role despite his comments having been vindicated by ANSTO again on the record earlier this week. Given his treatment, how confident are you that the current process of internal review does ensure protection of whistleblowers?

Dr Larsson—If we comment on Mr Reid's witnessing about what has been going on, I think that there are more issues to that than only the comments that he had made about the safety culture, so I would be uncomfortable outside that. The information that was received from Mr Reid has formed a basis for much of the retrospective analysis that we have been doing at the radiopharmaceuticals production facility. I had a meeting with Mr Reid and I informed him that whatever information he had that he thought would be of interest for the regulatory authority, he should come forward with it. I also informed him that the information that he had already come forward with was part of the investigations that we have been doing and are continuing with.

Senator LUDLAM—Exactly. Nobody has disputed the fact that he has raised—and I think ANSTO, without wanting to verbal their evidence the other day, acknowledged that the information that he provided was extremely valuable in improving not just the facilities but the safety culture and yet he is still suspended. He has not returned to work. What are we able to do about a culture that really should ensure the protection of people who do blow the whistle when these sorts of things occur?

Dr Larsson—We cannot comment on that. I am sorry because I think there are wider issues as well and I do not want to go into that.

Senator LUDLAM—ABC ran a piece which I am presuming you would be aware of, I think, on *Lateline*. They reported that one of the employees involved had an elevated white blood cell count, which would be consistent with a radiation dose above normal. Do you have any idea where that information came from or have you seen that claim corroborated anywhere?

Dr Larsson—The only thing I can tell you is that we have not been able to verify that information. We also have the dose records for the staff, and those records would not indicate that the white blood cell count of anyone having been exposed to that level would be affected.

Senator LUDLAM—Maybe I should ask the ABC. Do you have ongoing contact with that individual? Do you have any updated information on the welfare of the individual, whom I am not going to name in this session?

Ms Evans—Are you talking about the individual with the alleged raised white blood cell count?

Senator LUDLAM—Yes.

Ms Evans—The only contact we continue to have with those staff is as part of our ongoing inspections. That means they are part of the cohort of people whom we are asking questions

about the work practices. As our CEO has indicated, we could not find any evidence which verified that from the point of view of an elevated dose. One of the things we were very painstaking about was that, because we were investigating incidents that occurred some time in the past, that we were investigating based on recollections, we were very meticulous about trying to find extraneous confirmatory evidence where we could.

Senator LUDLAM—Blood tests from 2008 and that kind of thing.

Ms Evans—I would have to take that on notice. I am not aware as to whether or not blood tests were involved. I will take that question on notice and let you know what kind of evidence we examined.

Senator LUDLAM—I would appreciate information on what kind of evidence you sought to obtain and what you were able to examine.

Ms Evans—Certainly.

Senator LUDLAM—How often are ANSTO's facilities—not just the hot cell area but the facilities in total—investigated by ARPANSA?

Ms Evans—We have a planned inspection program for all the facilities at ANSTO. On average, under the planned inspection program, we would visit those facilities every quarter. We are also in receipt of quarterly reports from each licence holder, and in each of those quarterly reports there is an account of incidents and a whole range of things. We also are in receipt every quarter of dose records and discharges from ANSTO. As a total picture each quarter we have a number of different aspects that all go to the current state of safety at the facility. But of course from time to time we may in fact become aware of information that requires immediate action or inspection.

Senator LUDLAM—As in this case.

Ms Evans—Yes.

Senator LUDLAM—It is my understanding that you folk are entitled to undertake spot checks without giving ANSTO any notice at all. Can you confirm that?

Dr Larsson—That is correct.

Senator LUDLAM—How often do you do that sort of thing?

Ms Evans—With regard to our unannounced inspection program across the facilities, we would do between 15 and 20 per year. All of these are set out in our quarterly reports to the parliament.

Senator LUDLAM—On those occasions do you have unaccompanied access to all the facilities, except, I presume, the highly secure ones? Are you allowed to roam around at will?

Dr Larsson—Yes, we do.

Senator LUDLAM—In the case of the 15 to 20 per year, is it described in your quarterly or annual reports what areas you do not have unaccompanied access to?

Ms Evans—I do not think it is set out explicitly, but the one area that we do not have unaccompanied access to is any area that is also subject to safeguards legislation. You might be aware that, under our act, we are also subject to that legislation. For instance, nobody has

unaccompanied access to the vault where the fuel is kept. Apart from that, we have unaccompanied access.

Senator LUDLAM—You mentioned before that ANSTO issues you with quarterly reports on their emissions. Can you summarise, as part of routine emissions into the air and water, what kind of inventories there are of radioisotopes that are emitted into the environment by that facility as a whole.

Dr Larsson—We will have to take the details of that, the specifics, on notice. I would like to inform you that the limits are derived on the basis of very strict dose limitations.

Senator LUDLAM—I am sure they are, but I am interested in the actual volumes, not so much what the regulations say.

Dr Larsson—The question is about volumes?

Senator LUDLAM—Volumes by radioisotope—what are they actually emitting into the air and into the water?

Dr Larsson—Activity?

Senator LUDLAM—Yes, rather than volume, you are quite correct. Is that reported by you quarterly, or on any other basis? Where do I go to look?

Ms Evans—Yes, that is reported in our quarterly reports to the parliament as well as our annual report. But we can also give you a breakdown, if you would like, on a particular basis for the last 12 months, or perhaps we can clarify with you over which periods of time you are interested.

Senator LUDLAM—A breakdown by radioisotope over a period of 12 months would be great, if that does not require a huge amount of homework.

Dr Larsson—We can provide you with that. Would that also be for liquid discharges and—

Senator LUDLAM—Yes, that is right, thank you. Can you describe for us—and I do not know whether this is folklore or not—whether there is an exclusion zone surrounding the Lucas Heights facility within which you are not allowed to produce food?

Ms Evans—Senator, just to clarify, are you talking about the 1½ a kilometre buffer zone?

Senator LUDLAM—So the buffer zone is where you cannot live, I take it. There are no houses within 1½ kilometre of the facility.

Ms Evans—Yes, that is my understanding. But as to the specific question about the production of food, I would have to take that on notice.

Senator LUDLAM—I would appreciate that. My understanding is that there is a larger zone than 1½ kilometres where horticulture is not permitted. I am just seeking some confirmation of whether that is the case.

Ms Evans—We will take that question on notice.

Senator FIERRAVANTI-WELLS—I have a question about the health implications of the full-body airport scanners. You would recall that Minister Albanese on 9 February in a joint press conference with the Prime Minister stated:

… we'll be having full consultation and involvement with the Privacy Commissioner, with other organisations, as we did, indeed, for the trial, including looking at health issues, and making sure that all of those issues are dealt with.

I understood that the government advised that they would be looking at the health implications. Can you provide an update on what that investigation was? Were you involved in that investigation?

Dr Larsson—I would have to say that I am not quite aware of which investigation you are referring to.

Senator FIERRAVANTI-WELLS—That is why I am asking. Have you been involved with any investigation or any consultation in relation to the full-body airport scanners?

Dr Larsson—I can tell you what we have been involved in. We issued a licence for a trial, which was issued to the department of infrastructure—

Senator FIERRAVANTI-WELLS—Sorry, the licence for the trial was issued to—

Dr Larsson—If I recall correctly, to the department of infrastructure. We have had subsequent meetings with department of infrastructure. We have also explained the situation with regard to licensing. In the case that these ionising airport scanners—the ones referred to is back-scatter scanners—are to be licensed, that would require a licence from ARPANSA. In that case ARPANSA, would take into account that the activity, as such, is justified from the point of view of doing more good than harm, and also that we have an optimisation of the radiation so that doses are kept as low as reasonably achievable. We would also, as a part of that, request to have the information on the results of the trials that we had issued a licence for.

Senator FIERRAVANTI-WELLS—So you have not actually provided any advice, as such, on the health implications of the use of the body scanners?

Dr Larsson—I think that the health implications are fairly well known. They are probably known by the department of infrastructure. There are three different types of whole body scanners that can be used. One type is using ionising radiation and the two others are using radio frequency radiation, and they are of active and passive types. I think they are fairly well characterised. There is also information available on our website, where anyone can see the information on the health implications that are known.

Senator FIERRAVANTI-WELLS—But, insofar as your formal advice has been given, it has only been in relation to the licensing parameters?

Dr Larsson—We have not formulated any formal advice on this issue.

Senator FIERRAVANTI-WELLS—So it has really been only informal advice?

Dr Larsson—There have been informal discussions.

Senator FIERRAVANTI-WELLS—Informal discussions, not written advice?

Dr Larsson—Not written advice, no.

Senator FIERRAVANTI-WELLS—You said your website contains information on this. So you are aware that individuals will be exposed to radiation from these types of machines,

and you have said that all three types of machines expose people to some form of radiation. What are the levels of radiation?

Dr Larsson—The levels of radiation are very low. If we were to talk about so-called back-scatter scanners, the radiation dose from one scan is in the order of 0.1 microSievert, which is a very low dose. It might be relevant to compare that dose with the average dose that you get at cruising altitude when you are flying, which is in the order of 5 microSieverts per hour; this would correspond to one to two minutes of flying, so it is a very low dose.

Senator FIERRAVANTI-WELLS—Are there any particular concerns, if I could put it that way, or any greater effect that this could have on, say, groups of people, like young children or pregnant women?

Dr Larsson—Not that go beyond what we know about the effects of radiation in general. This is not a special type of radiation that these machines emit. So it would be a very minor contribution to the radiation dose to the population in general, and even for very frequent flyers this contribution would be very small.

Senator FIERRAVANTI-WELLS—Are you aware of other jurisdictions that may have considered health implications of these multiview machines?

Dr Larsson—We know that, internationally, there is a debate going on. We know that we already have these types of scanners installed in several airports in the US. We know that there is a debate going on within many of the European countries, and the whole issue of so-called non-medical imaging is something that is being debated in Europe and also internationally. This is part of the IAEA basic safety standards and the European basic safety standards. And the basic principles of radiation protection apply—that is, that the use of radiation should be justified and that you should keep the doses as low as reasonably achievable.

Senator FIERRAVANTI-WELLS—Are you aware whether any overseas jurisdictions have indicated that they will not introduce the scanners, on the basis of negative health issues?

Dr Larsson—I am aware of discussions in some European countries, but I am not aware of any regulatory decisions not to introduce such scanners.

Senator FIERRAVANTI-WELLS—If you could provide some information in relation to those countries that would be helpful. Thank you.

CHAIR—Thank you very much to the officers from ARPANSA.

[5.29 pm]

Therapeutic Goods Administration

CHAIR—We will now move to the Therapeutic Goods Administration. Senator Xenophon, you are up first.

Senator XENOPHON—Dr Hammett, I have so little time and so many questions, so let me start off by saying: regarding the recall of the LCS Duofix femoral component that the TGA has stated in response to questions placed on notice by me in February that:

As result of the increasing reports received in 2009 an investigation was undertaken by the product manufacturer which led to the subsequent recall of the product.

My question is: why did the TGA rely on the manufacturer to initiate an investigation and why did the TGA not conduct its own investigation?

Ms Halton—That was almost an *Alvin and the Chipmunks* performance it was so fast.

Senator XENOPHON—I have not seen the movie.

Ms Halton—That was impressive.

CHAIR—Dr Hammett, did you get the question?

Dr Hammett—Yes, I think I did. It was about the LCS Duofix femoral component—

Senator XENOPHON—It was quick because I know that Dr Hammett can absorb things very quickly.

Dr Hammett—Thanks.

Senator XENOPHON—It is a compliment.

Dr Hammett—As we have indicated to you in questions on notice, there was found to be a problem with that particular orthopaedic prosthesis. As is the usual practice for medicine companies, medical device companies and other companies involved in therapeutic supply, if there is a problem with their product it is normal and expected that they will conduct an investigation. Where the TGA is also made aware of specific problems with a product we will also conduct an investigation and may well seek the advice of expert committees and advisers who have particular knowledge of—

Senator XENOPHON—Would you agree that it is preferable that the TGA either conducts the investigation or outsources it to an independent body rather than the manufacturer as a general principle?

Dr Hammett—I do not think they are actually mutually exclusive. I would certainly agree with the premise that it is important that there is an independent scientific regulatory agency such as the TGA to ensure the safety and efficacy of the products that are available for as the Australian people. That is certainly the case. A balance that needs to be struck between having that independent scientific body that can investigate issues and at the same time allowing appropriately well-defined investigations to occur in other settings as well. There are standards about how an investigation into a product issue should be conducted, whether it is by industry or by the TGA.

Senator XENOPHON—In terms of how an investigation is conducted and by whom, are these protocols that have been developed by the TGA?

Dr Hammett—They are in fact usually internationally harmonised protocols.

Senator XENOPHON—And that is what the TGA relies on?

Dr Hammett—The TGA relies on its assessment of the significance of the particular safety issue to determine whether the product remains acceptable to safety.

Senator XENOPHON—In terms of the international protocols you referred to, are they what the TGA receives guidance from?

Dr Hammett—We have within the agency well-established protocols for investigations as well. We have standard operating procedures for how we would conduct an investigation.

Senator XENOPHON—Could you provide those protocols on notice?

Dr Hammett—Yes, we could.

Senator XENOPHON—Thank you. I will just move on. You also stated in response to my question on notice about high revision rate for the device that:

The TGA first became aware of these revision rates when Johnson & Johnson Medical Pty Ltd contacted the TGA in July 2009 with concerns raised by hospitals in Australia over current batches of the LCS Duofix femoral component.

My question is: why were hospitals reporting to the manufacturer and not the TGA?

Dr Hammett—In Australia we operate reporting systems for adverse events for all types of therapeutic products. As I think we have discussed previously, there are obligations that apply to manufacturers of products to report problems to us. There are stated time frames for that. In addition, there are mechanisms by which anyone—you, I, the hospital or the treating clinician—can report such events to the TGA. That can occur via telephone, on our website, by email or by written communication. So all of those avenues for reporting are open. How an individual chooses to report a particular incident is not a matter that the TGA can actually control.

Senator XENOPHON—Can I just go to another issue, although I will put some further questions on notice in relation to that. In terms of the PIP breast implant recall earlier this year, can you provide information on the investigation and when it might be completed?

Dr Hammett—My understanding—and Dr Kelly, who heads our office of devices, may come in on this—is that the recall followed an initial investigation in France or an initial visit by the French regulator to the company that manufactures the product. That company has in fact ceased to trade. The investigation in France is continuing and we have effected a recall of those products in Australia and have commenced our own investigation into those products. I have to say that, at present, our investigation does not demonstrate any problems with the product that has been supplied in Australia, but we are seeking further information.

Senator XENOPHON—It has been reported that these implants may be more likely to rupture because the company was using a different type of gel from the one it was authorised to use. Is that correct?

Dr Hammett—I think it is correct to say that it has been reported as such. I am not sure the report is correct.

Senator XENOPHON—That was the question.

Dr Hammett—The breast implants and what they are filled with has been assessed by the TGA and, at present, we have no information suggesting that they have been filled with something other than what was authorised in Australia. But we are looking into that further.

Senator XENOPHON—So you are satisfied that the type of gel these implants were filled with in Australia was the type of gel that was authorised for use? Has that been tested?

Dr Hammett—We are still conducting our investigation, but we have, for instance, looked at whether there is any evidence that the implants supplied in Australia do not conform with the standards for rupture that are required of those implants. We have not found any evidence

of that. It appears as though these implants do not have a higher rupture characteristic than would be expected. Clearly there are reports in the media arising from France and it may well be that what was authorised for use in those products in France historically many years ago may not have been what was authorised for use in Australia.

Senator XENOPHON—Wasn't there a suggestion that there was a fraud committed by the company in France in terms of the type of gel that it used compared to the gel it was authorised to use in terms of the French market?

Dr Hammett—I am unaware of any such suggestion.

Senator XENOPHON—So independent test have been performed by the TGA in relation to these implants?

Dr Hammett—Yes. Dr Kelly might want to expand on that testing.

Dr Kelly—Further to Dr Hammett's comments, we have done the physical stress testing, the rupture testing, that Dr Hammett mentioned and that all seems to comply with standards. We have measured the cytotoxicity of the gel in the implants and that has passed all of the standard testing as well.

Senator XENOPHON—Is it the same gel that was initially approved in the ones that you have tested?

Dr Kelly—That testing is underway at the moment.

Senator XENOPHON—Okay. Could you take that on notice as to whether it is the same gel that was approved initially and anything that arises out of that?

Dr Kelly—Sure.

Senator XENOPHON—Before these gels were approved, were they independently tested or did you rely on the manufacturer's testing?

Dr Kelly—In fact, in this case the TGA undertook its own audit of the manufacturing facility and reviewed all of the documentation provided by the manufacturer.

Senator XENOPHON—Did that audit include independent testing of the gels?

Dr Kelly—It is not normal to test samples as part of an approval process for any therapeutic goods. Vaccines may be the only exception.

Senator XENOPHON—So there is no suggestion of TGA pursuing legal action against Medical Vision Australia or PIP, the company that was the manufacturer?

Dr Hammett—Our investigation is still continuing and I would not like to comment on what options are available.

Senator XENOPHON—I have been approached in relation to the issue of the reprocessing of single-use devices such as heart catheters. I recently had a discussion with a senior Canadian cardiologist who told me of his hospital's experiences of re-using catheters that were originally designed for single use. As I understand it, under the guidelines of the TGA, any company that wants to sell reprocessed single-use devices will have to prove that they can stand up to multiple use. Is that the case?

Dr Hammett—That is correct.

Senator XENOPHON—Can you outline how they will be required to do this and whether there is an application for the re-use of devices that were designed for single used?

Dr Hammett—Yes, this is a longstanding issue in the medical device industry. Indeed, it has been subject to many years of consultation and discussion. From the point of view of the TGA, our concern is that, if devices are to be reused, they should be appropriately safe and efficacious—indeed, they should be as good as the device that was first produced. In order to ensure that, if a product is reprocessed, it does in fact perform the way it was intended to, there are requirements for companies to reprocess with, for instance, good manufacturing standards. So there are provisions for reuse, but I have to say it is a process that has not been widely used in the Australian context. I would be interested to hear the views of your Canadian friend.

Senator XENOPHON—Dr Larry Sterns is a cardiologist, head of the electrophysiology division at the Vancouver Island Health Authority. In information he provided to me he said:

> Since we started using the reprocessed catheters, we have run into many quality problems, especially with the more complex tearable catheters. The problems are twofold. Firstly the physical characteristics of the catheters are much worse than the original catheters and, secondly, the electrical performance was very flawed …

He goes on to say that it could lead to an ablation taking place with the wrong information, which could have quite catastrophic consequences. So, in any proposal before the TGA in relation to the reuse of single-use catheters, will there be independent testing? Will you be looking at the international experience with respect to this?

Dr Hammett—I am delighted that you have got those views in the *Hansard*, because those views are very similar to the views shared within the TGA. We want to ensure that all those devices performed safely and as they were intended to. One of the criteria for ensuring that a reprocessing facility is able to operate as such is that they can demonstrate that those devices actually do what they were intended to do initially.

Senator XENOPHON—Would the views of Dr Sterns and others who have had poor experiences with single-use catheters being reused be taken into account? For instance, would you seek out the evidence or advice from hospitals around the world?

Dr Hammett—Certainly, those sorts of views have been sought out in previous consultation. Interestingly, there are eminent cardiologists in other parts of the world, and indeed in this country, who have different views. But those views are sought as part of the consultation, and there was extensive consultation in previous years that has produced a position where reuse of devices is not completely outlawed. But, to actually do it, a reprocessing facility has to demonstrate that they can do it safely and effectively.

Senator XENOPHON—Does the TGA consider what implications this would have, for instance, for patient consent—in other words, will patients be informed if their doctor is using a reprocessed device? Would that be one of the conditions the TGA could apply if it considered that it was, on the face of it, safe to—

Dr Hammett—I might throw that one to Dr Kelly, because I do not want to give you—

Dr Kelly—Senator, it is most likely in that circumstance that there would be a labelling requirement, that that device was a reprocessed device. Then it would be for the physician using that device to—

Senator XENOPHON—Not for the TGA to say, 'You should advise patients as part of any patient consent'?

Dr Kelly—The TGA would control the labelling requirements but we would not usually go so far as to dictate what the physician should say to a patient.

Senator XENOPHON—You could, though, couldn't you? You have the power to do so?

Dr Hammett—I think it goes to a broader question about professional competence and integrity. We would expect that clinicians, when they are using any device, to explain all the risks and potential benefits of that device with the patients. If there are specific risks associated with use of a reprocessed device, again, part of the informed consent process puts an onus on clinicians to explain the risks of that product. Indeed, our labelling requirements are there to remind the clinician—who in fact is the one who sees those labels rather than the patient—that they should be considering that in the advice they are giving as part of the informed consent.

Senator XENOPHON—I have two more questions on this issue. Is there an application before you for the reuse of single-use devices at the moment?

Dr Hammett—We would not receive an application for the reuse of a single-use device. What we may receive is an application for a facility to obtain GMP accreditation to be such a facility but it is not our usual practice to comment on individual applications before the TGA for commercial reasons.

Senator XENOPHON—I see. Another angle on this is: are patients afforded the same protection by way of product liability if a product fails to perform in subsequent reuse? As I understand it, the product liability insurance of the primary manufacturer will not apply in these instances. Is that a factor that the TGA would consider?

Dr Hammett—I might have to take that on notice. I'm afraid I am not a lawyer but we can certainly look it up.

Senator XENOPHON—I am and I do not have the answer. What is the TGA's position on the safety of exporting used catheters and other devices and importing them again? In order words, if they are reprocessed overseas do you apply the same quality control standards to those single-use devices—being sterilised or whatever—for subsequent use?

Dr Hammett—We would require the same standards of good manufacturing practice and, indeed, the same standards of labelling and informed consent.

Senator XENOPHON—Does that mean you would go over there? Would you have an independent assessment of the overseas processing device?

Dr Hammett—Yes, we would go and audit that facility to make sure it complied with the standards of good manufacturing practice. As you are aware, there are a large number of medical device manufacturers around the world and we have a limited team of auditors but

we do travel overseas. We are one of the few regulatory agencies for therapeutics in the world that actively conducts international audits and we would do that.

Senator XENOPHON—As someone who has had the odd cardiac catheter stuck in, I would prefer a single-use device. But you can understand why most consumers would be quite nervous about such a proposal?

Dr Hammett—Yes. Again, I think there is a balance here. There are clinicians who will argue that it is quite safe if you reprocess according to good manufacturing standards and if the devices can be enabled to perform exactly as they did initially. In that setting there may be an appropriate use of those devices, while being mindful of the constant need to ensure that healthcare dollars are used in the most effective way to produce the best health outcomes for the community. If the same health outcomes can be produced through reused products, and that can be demonstrated, then in certain clinical settings it may be an acceptable outcome.

Senator XENOPHON—Assuming there is no catastrophic outcome?

Dr Hammett—Absolutely. We would want that device to perform exactly as the initial device.

CHAIR—Senator Xenophon, you have got questions on notice that will go to the TGA as well?

Senator XENOPHON—Yes.

Senator ADAMS—I would just like to ask questions about the equipment used by some of the complementary medicine providers for breast scanning. This is creating quite a stir in Western Australia at the moment. The equipment involves thermography or electrical impedance. It has been advertised as an alternative to mammograms. It is creating quite a stir because there are a number of women who think that they do not have to go through the pain of their mammograms and therefore they are going to this. Do the devices that are used go to TGA? Are they equipment that you look at before or approve?

Dr Hammett—In general terms we might approve a device like a thermal scanner. Unless it was supported by appropriate evidence, we certainly would not be supporting the use of that device for the diagnosis or screening of breast cancer. Dr Kelly will correct me if I am wrong but to my knowledge we have not approved any such devices for the screening or diagnosis of breast cancer. That being the case—

Ms Halton—It then becomes an issue of professional practice. As you would well know, we have a technology assessment process for what we will reimburse.

Senator ADAMS—It is not reimbursed. It is not on the Medicare list.

Ms Halton—Precisely. That means that it has gone through none of the normal processes. Then it does come down to an issue about professional registration and all the things that that entails.

Dr Hammett—And certainly, if there are such devices, making claims around that as part of their registration process with the TGA, we would be reviewing those claims, and I am aware—

Senator ADAMS—No, they have not said that. I am just asking because BreastScreen WA has put out quite a lot of media about it. They are very concerned. They have now started to move to the regional areas where you can only get your mammograms when BreastScreen come around with their bus. This is what is concerning them—that people are going and having what they think is equivalent to a mammogram and it is not. My concern is whether the equipment has to be approved anywhere for them to use it.

Dr Hammett—Yes, the device would have to be approved by the TGA to be used lawfully, but for that purpose is another question. I will certainly undertake to—

Senator ADAMS—They are calling it scanning. They are not saying it is mammography—it is actually breast scanning.

Dr Hammett—I will take this issue on notice and we will go back and have a look at our register and see if there are such devices that—

Senator ADAMS—Dr Liz Wylie, who is the director of BreastScreen WA, would be able to help you with the evidence.

Dr Hammett—Thanks.

Senator ADAMS—The other one I have just had given to me is in the *Australian Doctor* of 28 May 2010. I will table it, but it is 'Dodgy devices to face new TGA regulations'. So once again this is an in vitro diagnostic device that apparently is not really quite up to standard. When legislation changes I guess they will have to provide clinical evidence to you to be able to have that approved.

Dr Hammett—I am not aware of the specifics of the article that you are talking about but I am aware that we are introducing new regulatory frameworks for in vitro diagnostic devices. They come into operation on 1 July 2010 and that is to fill a regulatory gap in the therapeutic goods area where we are enhancing the regulatory requirements to try and improve health outcomes.

Senator ADAMS—Good. Thank you.

Prof. Bishop—In relation to thermography, the gold standard is mammography based on large clinical trials, as you know. That same clinical evidence is not there with respect to screening activity for thermographic devices and certainly BreastScreen Australia is not in favour of considering these as screening devices or even diagnostic devices that can be relied upon. So I think that evidence is pretty straightforward.

Senator ADAMS—It really does concern me that people think that they can go and have this done and that it is the same as having a mammogram, because it is not. But misleading advertising can do that, and that is really what has happened.

CHAIR—Thank you very much to the officers of the TGA.

[5.53 pm]

CHAIR—We will now move on to outcome 1, Population health.

Senator FIERRAVANTI-WELLS—Thank you. I want to start in 1.1 about the diabetes initiative. At page 62 of the yellow book it says that you will be working with the Australian General Practice Network to boost uptake of the diabetes initiative and then in the next

paragraph you talk about, as part of the hospital networks plan, the initiative there in relation to reducing the risk of diabetes and that the two will be integrated together. You talk about boosting the uptake but do you have a target built in there?

Mr Kennedy—Is this the target for the new initiative or for the lifestyle modification program?

Senator FIERRAVANTI-WELLS—I guess in the end it is to help treat people with diabetes. So if you could give me the breakdown—

Ms Huxtable—Before Mr Kennedy starts, with regard to the voluntary enrolment measure, which we referred to before, I think I already took on notice giving some further advice on that with regard to the numbers. Mr Kennedy could certainly speak to the lifestyle diabetes modification program and provide information on that.

Mr Kennedy—I understand there was a target, which was in the PBS as well.

Senator FIERRAVANTI-WELLS—If you could take that on notice, that would be fine.

Mr Kennedy—I will take it on notice but I might be able to find it while we are talking.

Senator FIERRAVANTI-WELLS—As part of the uptake, are we going to see—particularly as far as the voluntary part is concerned—case management plans to try to get people involved in taking up this program?

Ms Huxtable—You are talking about two different things. You are aware of that, though, aren't you?

Senator FIERRAVANTI-WELLS—I am. What I am trying to get to, Ms Huxtable, I kind of alluded to it yesterday but would now like to ask a more direct question. With the GP superclinics—and I know it traverses the GP superclinics but just bear with me over this—there is obviously now going to be encouragement given to people as far as care management plans for diabetes. One of the superclinics that I raised yesterday was the Nelson Bay Plaza one. You may have heard me say that on Tuesdays to Thursdays between 1 pm and 4 pm, they would accept locals only and one problem. In other words, you walk in for minor ailments like a sore throat. That is bulk-billed. All other appointments are not bulk billed. The information I have received is that, if you accept a care management plan for diabetes, the first visit is charged and all subsequent appointments are bulk billed. So I read that as meaning that that is a kind of encouragement to try to get people to get involved—by saying 'We'll charge you the first one but the subsequent appointments are bulk billed.' Are you aware that that is happening?

Ms Huxtable—I was not aware of that particular example, and I think we talked about that yesterday.

Senator FIERRAVANTI-WELLS—Yes. Let me just ask you in general terms. Are we aware that there are creative things happening in the general practice network to try to encourage people to take up this offer?

Ms Huxtable—This would go to the particular charging practices of individual general practices, which is really a matter for them. There are measures that governments put in place from time to time to encourage certain things. For example, some years ago now—probably

around 2005—there were bulk-billing incentives introduced to encourage practices to bulk bill. However, what individual practices choose to do is really a matter for them in this area. I do not want to not answer the question but, with regard to this measure, as noted in the PBS, there is an existing lifestyle modification diabetes program that is managed through the divisions of general practice, which Mr Kennedy can talk about in more detail. A new voluntary enrolment measure has been announced as part of the recent budget. Clearly, the intention will be to get those two things working together so that there is a pathway and effective communication between divisions of general practice regarding evolving into Medicare locals in time and what is actually happening at the practice level. So we are trying to get integration in that regard.

On that diabetes and lifestyle modification program, there have been some changes to that program in recent times, which Mr Kennedy can speak to, basically to boost uptake. I think there were some issues around the way in which the funding was rolled out to divisions of general practice in respect of that measure. He can correct me on the absolute detail, because I am not familiar with it, but that was done quite recently and I think we are already seeing positive results from that changed set of arrangements.

Senator FIERRAVANTI-WELLS—Thank you for that. That answered my question. Are you aware of reports about the GP superclinic at Port Stephens, which was also referred to yesterday, or whether there has been any criticism levelled at it for forcing patients to sign 'coercive' contracts over whether they will be bulk-billed? I want to show you a copy of this document that has been given to me. I will give Ms Huxtable a copy of it. I would like to read it, Ms Huxtable, and if you could have a look at it as well. It is off a website and it looks like there is an Australian government logo—

Ms Huxtable—It is very hard to read, isn't it? My eyesight is not as good as yours, clearly.

Senator FIERRAVANTI-WELLS—It has a little Australian government logo up in the top corner but it is called 6 Minutes. There is an article that says:

'Coercive' contracts to join Super Clinic

Patients at the Port Stephens Super Clinic, which opened recently with $2.5 million of government funding, are asked to sign an agreement stating that "Bulk billing, if offered, is a privilege which may be withdrawn if I do not reasonably participate in the management of my health."

The document seen by 6minutes also stipulates that the clinic will not give test results over the phone, instead opting to bulk bill all appointments "dealing only with test results", such as—

and it goes on. It continues:

Patients must also agree to give all health care providers at the clinic access to their medical records—

and then it talks a bit about that. It also says:

Doctors Action founder Dr Adrian Sheen says the agreement amounted to a contract that was coercive and not in the best interests of patients.

He raises certain privacy issues and he says:

"You don't know who the receptionist is in a small town, do you? You walk into a clinic, you have a sore throat, and they want to know whether you're bisexual," he tells 6minutes—

because they wanted to ask your marital status and other things. So the question I am asking is: is this true? Are you aware of this?

Ms Huxtable—As I said, I am not aware of this. This is really a matter that is not in this outcome. It is under outcome 5.

Senator FIERRAVANTI-WELLS—I appreciate that, but as you can see—

Ms Huxtable—This is something that has obviously been posted on the internet. I have no idea what veracity it has.

Senator FIERRAVANTI-WELLS—Sure.

Ms Huxtable—We are very happy to take it on notice and find out more information about this. However, I would reiterate what I said previously—that it is historically the case that governments do not get involved in determining how doctors charge and what charging arrangements apply. We are certainly very happy to get more information for you in regard to this. I would just point out, too, that the logo, I believe, looks like an advertising bubble in respect of Medicare Australia.

Senator FIERRAVANTI-WELLS—Yes, I think so.

Ms Huxtable—So I do not think this is actually an Australian government website, if that is what was implied.

Senator FIERRAVANTI-WELLS—No, it is definitely not.

CHAIR—Senator, can we get back to this program?

Senator FIERRAVANTI-WELLS—We are, because my concern is about the Australian General Practice Network. The object of this exercise is to get people taking this up and getting more involved, but are we going to start seeing a coordinated approach? I appreciate the comments you have just made, Ms Huxtable, but if part of that is going to be some sort of practice that will employ these coercive type contracts then I would have thought that was not the intention, certainly not in the spirit of what I have heard about what these management plans are going to be—certainly not from what I have heard you say over the last couple of days.

Senator Ludwig—You have used the words 'coercive contract'. I am sure you mean 'alleged coercive contract'.

Senator FIERRAVANTI-WELLS—Alleged coercive contract—thank you—with 'coercive' in inverted commas.

Ms Huxtable—Clearly, as I said earlier today, the design of the voluntary enrolment measure is in the public domain, there will be a period of consultation and it does not come into effect until 1 July 2012. We are very interested to engage actively with stakeholders around that measure. So, whatever this particular example is, it really has nothing to do with the measure that has just been announced in the budget.

Senator FIERRAVANTI-WELLS—Insofar as it looks at practices of superclinics I hope that you will at least take that on notice. I just want to move to the national health survey, which I think is 1.6. I understand that 50,000 Australians will be selected by the bureau to be surveyed. You have contracted this out to the bureau?

Mr Smyth—We signed a memorandum of understanding on 31 March with the Australian Bureau of Statistics for the conduct of the Australian Health Survey.

Senator FIERRAVANTI-WELLS—I understand this is a regular thing, but this time there will be additional questions in the survey?

Mr Smyth—That is correct. The survey actually has four component parts to it: the Australian Health Survey, which is the existing household survey, that has been undertaken for a number of years now; and the National Aboriginal and Torres Strait Islander Health Survey, which is the existing Indigenous household survey. Then there are two new components: the National Nutrition and Physical Activity Survey; and the National Health Measures Survey, which is the pathology collection component of the survey.

Senator FIERRAVANTI-WELLS—People will be asked what they eat and drink and how much physical activity they are involved in?

Mr Smyth—Correct.

Senator FIERRAVANTI-WELLS—They will also be measured and weighed—I hope they do not pick me as one of those 50,000—and blood and urine tests have also been added to this survey.

Mr Smyth—That is right.

Senator FIERRAVANTI-WELLS—Answering the questions is compulsory?

Mr Smyth—The survey will be conducted under the Census Act. Issues relating to the nature of the questions that are going to be asked should be referred to the Australian Bureau of Statistics because they are actually undertaking the survey. I can talk broadly in terms of what the component parts of the survey are and how the survey will work, but questions as to the conduct of the survey are an ABS responsibility.

Senator FIERRAVANTI-WELLS—I appreciate the conduct of that but it is your National Health Survey and the people who participate are required to answer, except for, I understand, the weigh-in and providing the blood and urine tests is voluntary.

Mr Smyth—That is correct.

Senator FIERRAVANTI-WELLS—You have defined the parameters, so the survey and the answering of the questions is compulsory.

Mr Smyth—The survey is conducted, as I said, under the Census Act. The elements of that and the questions relating to it are best answered by the Australian Bureau of Statistics.

Senator FIERRAVANTI-WELLS—People can be fined $110 a day if they do not participate. As you are aware, that has received media coverage and caused disquiet for some members of the community. Are you aware of some of the media articles around that?

Mr Smyth—I am aware of some of the media articles.

Senator FIERRAVANTI-WELLS—Are you aware of the article in the *Daily Telegraph* by Sue Dunlevy on 19 May 2010?

Mr Smyth—Yes.

Senator FIERRAVANTI-WELLS—How will Australian citizens who are involved in the survey be informed of this, in particular that some parts of it are compulsory and some parts of it are voluntary?

Ms Halton—The person who goes to collect the information will be very clear about which elements of this are a matter of discretion and which are covered in the ways that you have outlined.

Senator FIERRAVANTI-WELLS—I just asked whether there would be some information. There is obviously disquiet. This article does talk about the concerns out there about this. To ally those concerns. is some sort of information available?

Ms Halton—To get into the detail of this, I think it would be good for you to direct those questions to the ABS, as I have just said to Senator Ludwig. They are on at 9.30 tonight, as it happens.

Senator FIERRAVANTI-WELLS—You would like me to exit from here and go to ABS?

Ms Halton—No, no.

Senator FIERRAVANTI-WELLS—That was a nice, polite way of putting it.

Ms Halton—I was just thinking how it would improve the evening of somebody I know well.

Senator FIERRAVANTI-WELLS—Thank you. I will take that as a compliment from you.

Ms Halton—It was very much a compliment. The person I am thinking of would not be impressed to know I have made that suggestion. The reality is that the Australian Bureau of Statistics have been doing health related surveys for many years. For my sins, even I worked in the ABS a long, long time ago. The ABS has been conducting health surveys since 1977, with over 290,000 participants. The arrangements that you have outlined have been ever thus.

Senator FIERRAVANTI-WELLS—My question is: has anybody been fined for not participating?

Mr Smyth—I am not aware of it, but I think that is a question that is best directed to the Australian Bureau of Statistics.

Ms Halton—My advice is no, but again I invite you to ask that question of them.

Senator FIERRAVANTI-WELLS—Since the department has commissioned the ABS to do this yet again, have you made that inquiry?

Ms Halton—As it happens, I have.

Senator FIERRAVANTI-WELLS—And?

Ms Halton—My informant told me that no-one had been fined.

Senator FIERRAVANTI-WELLS—Thank you. We will see what happens this time if people do not give their weight or their measurements. I live in fear that somebody will ask me to participate in this!

Ms Halton—Don't you worry; you're not the only one who has that fear. I should also make the point that the media coverage of this is best described as unfortunate. My understanding is that somebody from the Bureau of Statistics did talk at some length about a whole series of things to do with the survey and, probably unwisely, provided information which was then selected out for a level of scrutiny and amplification. As I have pointed out already, this has been going on since 1977. This is not unusual. In fact, the one component of this which you could regard as being new and different is explicitly voluntary. I think it is regrettable—and I thank you for your interest in this—that people have been unnecessarily alarmed and led to believe that this is exceptional, because it is not.

Prof. Bishop—I will just make one obvious medical point, if I may, and that is that this country is really facing a huge difficulty with obesity and lack of physical activity, and here is an ability for us to measure and to understand the extent of the problem and therefore people's habits—

Senator FIERRAVANTI-WELLS—Are you saying this, Professor, because you saw me go and get another Tim Tam? Is that why you are stressing this point? I am starting to feel somewhat guilty here!

Prof. Bishop—No. I just think it is worth putting on the record that this really is a major health issue for us.

Senator FIERRAVANTI-WELLS—Of course, seriously.

Prof. Bishop—To get clear measurement of it and to get some clear basis on which we can work is terribly important for the future health of the country.

Senator ADAMS—I have some questions on bowel cancer screening. Could you provide an update on the National Bowel Cancer Screening Program and the problems that you had with the kits earlier on? Where are we at with that?

Mr Smyth—The remediation of the National Bowel Cancer Screening Program recommenced on 2 November 2009. Since that time, approximately 382,329 kits have been issued to participants and, of that number, 132,000 have returned samples for analysis. Approximately 130,000 replacement kits were issued to those participants who had received a negative result from the modified kit, and 98,000 of those have been returned for analysis.

Senator ADAMS—Have they been analysed yet?

Mr Smyth—As you can imagine, there is ongoing analysis. As part of the remediation process the country was divided into a number of areas in terms of the mean temperature at a particular point in time. Some areas were classified as hot zones, and they are the people who have now finally received all of those replacement remediation kits. So everyone who had been affected by the modified kit has now received a replacement kit through the program.

Senator ADAMS—There has been quite a lot of comment in the newspapers as to whether any consideration has been given to extending the program to a lower age group.

Mr Smyth—That is really a decision of government.

Senator ADAMS—So there is nothing being done?

Mr Smyth—In 2008, when phase 2 of the program came in, the 50-year age cohort was added to the program. So it is now 50-, 55- and 65- year age groups.

Senator ADAMS—Can you give me a breakdown of the results for the 50 and 55 age groups in relation to the numbers that have to go on for further testing?

Mr Smyth—I think we will have to take on notice as to the age breakdown of particular participants.

Senator ADAMS—I am just interested.

Mr Smyth—We have group figures for the entire program but I do not have with me those that are broken down by age categories.

Senator ADAMS—I am specifically interested in the younger age group to see whether the test has picked up many people. The program has obviously expanded; how much do you expect that will cost? Also, I have been trying to find the date for how far the program will go. I think 2011 was the original date.

Mr Smyth—At this stage, the program will terminate as at 30 June 2011. It will screen people who reach those age cohorts up until the end of December 2010—that is, it will reach those cohorts at the end of December but the screening will obviously continue after that, with the analysis of samples and the sending out of those kits.

Senator ADAMS—So, really, no more funding has been committed to a further program after this cohort of people have been screened?

Mr Smyth—That is correct.

Senator ADAMS—That is bit frightening, especially with the number of positives you have had back. How many schools have participated in the Stephanie Alexander Kitchen Garden Foundation program?

CHAIR—That officer is just on her way, Senator.

Mr Smyth—We currently have 88 schools across Australia participating in the program. There was participation by 41 schools in phase 1 of the program and 47 in phase 2. On 17 May, I think, Minister Roxon announced the launch of phase 3 of the program and called for applications from schools across Australia.

Senator ADAMS—Do you have as many participating as you originally expected?

Ms Quigley—The first two rounds were not as high as we had originally anticipated, but we have just extended our eligibility for round 3 so we expect that they will be increased during rounds 3 and 4.

Senator ADAMS—How much funding has been provided to the schools under the program to date?

Mr Smyth—To date, $5.38 million has been provided to the 88 schools that are funded under the program.

Senator FIERRAVANTI-WELLS—Did you tell us how many you expected to participate?

Mr Smyth—Across the four phases of the program it is expected that up to 190 schools will participate across Australia.

Senator FIERRAVANTI-WELLS—Not a lot of schools.

Senator ADAMS—What was the original budgeted amount for the program?

Mr Smyth—I think that the original budgeted amount was $12.8 million.

Senator ADAMS—Have any students participated in the program from independent or religious affiliated schools?

Mr Smyth—Not to date, but the eligibility criteria that have just been revised now allow for government schools with a primary enrolment, special schools with a primary curriculum and non-government schools that receive additional support through the Smarter Schools—Low Socio-Economic Status School Communities National Partnership. That is broadening the arrangements out to allow those schools that qualify in that area, so that they can be non-government schools as well.

Senator FIERRAVANTI-WELLS—I am sure they will be encouraged now that they see the Prime Minister taking up gardening at The Lodge as well. I am sure that all the schools will be encouraged to go out there and garden themselves—most commendable.

I just want to ask some questions on HIV-AIDS and the reports about the HIV infected man who has potentially infected hundreds of women in Australia. My concern is that it raises questions about action right across the federal authorities. I note that the Queensland branch of the Australian Medical Association has called for urgent action on a national register of people with notifiable diseases. What is very concerning is that this fellow came to the attention of South Australian medical authorities in 1997 and Queensland authorities in 2009—that is a truncated summary. Is any action being considered along the lines that the AMA has suggested?

Ms J Bryant—In short, no. If I could explain to you how our arrangements work: the Commonwealth role in this sphere is one of monitoring and evaluation. Public health responses on the ground are normally managed by states and territories; it is not the Commonwealth's role to directly manage them on the ground. What would normally happen in a state or territory is that where an individual attends a medical practitioner and is diagnosed with a notifiable disease, that GP or medical practitioner would notify the state health authority of the notifiable condition. That record and information would be kept in the jurisdiction. De-identified information, if you like, is then passed to the Commonwealth for The National Notifiable Diseases Surveillance System so we get aggregated data for monitoring and evaluation purposes, and for targeting preventative action at a national level and so on.

Where an individual exhibits problematic behaviour—for example, a person becomes infected and reports to the state health authority that they believe they were infected by someone who has misled them about their status—then the state health authority would normally investigate. If that person were found to be exhibiting problematic behaviour, or there was evidence that there was a pattern of behaviour that was undesirable and they were infecting others, then the state health authority, under public health legislation, has a series of

escalating steps that they can take. They could counsel and educate the person, first up, and sanctions under their legislation would extend to confining them if appropriate or to criminal sanctions and so on.

Senator FIERRAVANTI-WELLS—I appreciate that, but I asked it in the context where, apparently, the federal parliamentary secretary, Mr Butler, recently urged the states to talk to the Commonwealth about dealing with these matters. I really wanted to know what action had been taken.

Ms J Bryant—These matters have come up from time to time for a number of years. This is not the first instance. They have been reported in a number of jurisdictions over time. This matter has been considered jointly by the Commonwealth and states on several occasions in the past. There are some guidelines called *Management of people with HIV infection who knowingly risk infecting others* which have been endorsed by the Australian Health Ministers Conference. They form a set of coordinated Commonwealth and state approaches to the management of individuals. They include protocols for information sharing across jurisdictions where, for example, an individual known to be exhibiting problematic behaviour moves from one jurisdiction to another. So they do include protocols for the transfer of information in that circumstance.

To go to your question about registers before, the article which I saw from the Queensland AMA contained a suggestion that there should be a register which records the number of occasions on which an individual attends their medical practitioner and their compliance with treatment. I think that goes well beyond, in terms of the bounds of privacy, what would normally be the type of information that would be appropriate to record in a register. There are no plans or intentions to have such a register.

Senator FIERRAVANTI-WELLS—Thank you. I now have a question about the deadly stomach bug that was reported in a private hospital in Melbourne. Three people at a private hospital in Melbourne were confirmed last week to have been infected with—Professor Bishop, you will probably help me on this—

Prof. Bishop—*Clostridium difficile*.

Senator FIERRAVANTI-WELLS—Yes. It is only the second time that it has been reported in Australia. Professor Riley from the University of Western Australia said that it is a matter 'of huge concern' and that the bug is particularly fatal for older people and is resistant and extremely virulent. Professor Bishop, is there a level of concern about these confirmed cases? I understand Professor Riley has been tracking the bug for years, and he says that we should be extremely concerned. What would be your response to that? Are we prepared?

Prof. Bishop—We are prepared. Everyone is aware of the information from overseas. We are fortunate in this country that, while everyone has been alert, prepared and able to diagnose this, we have not had very much activity yet. It is very fortunate that there have been appropriate activity and actions taken by the health authorities in that particular private hospital, that the issue is being confined and that appropriate case ascertainment and containment have occurred. That would be our normal approach. When we are faced with an issue it is a matter of early identification, diagnosis, containment and containment of contacts. That occurred, so the system worked well. All of the health authorities in each of the states are

well aware of the issue and everyone is on alert for these things. So our surveillance program has worked well and our identification diagnosis programs continue to work, but of course we have concerns.

Senator FIERRAVANTI-WELLS—I have one last question in relation to the illicit drugs campaign. From Budget Paper No. 2 on page 210 it looks like there has been $4 million taken out of that program. What is the current focus of the campaign and how has the focus changed as described in the budget paper? From where will the money be cut to provide the $4 million in savings?

Ms Palmer—The overall aim of the campaign is to contribute to the work of the previous national drug campaign to reduce the uptake of ecstasy, methamphetamines, cannabis and other illicit drugs amongst young Australians by raising awareness of the harms associated with drug use and encouraging and supporting the decision not to use. It also encourages young people who use these illicit drugs to reconsider their use and directs them to relevant support, counselling and treatment services.

Senator FIERRAVANTI-WELLS—So where has the focus changed? The budget paper says 'changing the focus of campaign activities'.

Mr Cotterell—The focus of the campaign changed this year. Previously, it was heavily focused on ice but also on methamphetamines and cannabis. In response to indications of an increase in the use of ecstasy, the campaign was adjusted to increasingly focus on the use of that drug.

Senator FIERRAVANTI-WELLS—The third part of the question, which has not been addressed by either of you is: where will money be cut to provide the $4 million in savings?

Mr Cotterell—This campaign has been running in one form or another since 2001. The evaluation of the last phase of the campaign found that a very high level of awareness was being maintained through lesser media buys. So what will happen is that there will be fewer broadcast activities and more targeted activities in the campaign and that will reduce the cost.

Senator FIERRAVANTI-WELLS—So we have more drugs being used, a high level of awareness and you are cutting the expenditure.

Mr Cotterell—No. Overall, rates of drug use are coming down. In relation to ecstasy only there has been an increase, so we have shifted the focus onto ecstasy. The evaluations have shown that it is possible to maintain the high level of awareness with a lower level of investment in media buy.

Senator FIERRAVANTI-WELLS—Using other means?

Mr Cotterell—That is right: using more targeted media buys.

Senator FIERRAVANTI-WELLS—Such as?

Ms Palmer—Putting the media in places where the users are much more likely to be. Instead of having to buy a lot of mainstream media, we are actually targeting more specific messages in places where people are most likely to have that initiation conversation about taking a drug. We are doing more things in nightclubs, for instance, as opposed to putting print ads in general newspapers.

Senator FIERRAVANTI-WELLS—Soon we will have tweets on these things. I was about to say that soon the Prime Minister will start tweeting everybody about illicit drug use.

CHAIR—It was good that you did not say that.

Proceedings suspended from 6.33 pm to 7.34 pm

CHAIR—We will move to outcome 12, Health workforce capacity.

Senator ABETZ—I was just going to say 'I have a few questions' but I have been told there are not necessarily time restraints, so thank you for that. Can it be confirmed to me that general practice doctors in designated rural areas can currently claim a Medicare rebate item for services provided by general practice nurses—and do not tell me I am in the wrong area.

Senator FURNER—I have a feeling!

Senator ABETZ—I do this on a regular basis with this committee, Mark.

Ms K Flanagan—I have a sinking feeling that you may be in the wrong area.

Senator ABETZ—Are there any people here that might be able to assist without stretching the friendship too far?

CHAIR—Is it possible to hear the questions? You just made a statement about—

Senator ABETZ—No, I asked the question whether it is correct, because if that is incorrect, then of course I would have difficulty in pursuing other questions.

Senator Ludwig—I thought that was the case.

Senator ABETZ—That is why I asked that question.

Ms K Flanagan—It is outcome 3.

Senator ABETZ—Just so I understand this, what heading are we operating under?

CHAIR—Workforce capacity. Outcome 3 is access to medical services. That is where the Practice Nurse Program fits.

Senator ABETZ—So it is access to medical services, but getting practice nurses is not part of the medical workforce? All right. That is an interesting delineation.

CHAIR—Do you have any other questions?

Senator ABETZ—If we are talking about workforce, can I ask about how we get more nurses?

CHAIR—I think you could ask that. The program is for extending the nurse workforce.

Senator ABETZ—Let's approach it with extending the nurse workforce.

CHAIR—Go that way, Senator. Well done!

Senator ABETZ—In that context, can I re-ask my question? Is it correct that general practice doctors in designated rural areas can currently claim a Medicare rebate for services provided by general practice nurses?

Ms Halton—No, Senator, you cannot ask that question here because that is in relation to benefits. We can talk here about workforce programs—the training of, the numbers of et cetera.

Senator ABETZ—The idea of getting more numbers into—

Ms Halton—No, anything that is a benefit related question is under program 3.

Senator ABETZ—Right, but do you know the answer to the question?

Ms Halton—Not in detail with these officers, no.

Senator ABETZ—I am not asking for detail. It is a pretty general, basic question, and I think we all know that the answer is yes.

Ms Halton—Put the question again, Senator.

Senator ABETZ—Is it correct that general practice doctors in designated rural areas can currently claim a Medicare rebate or item for services provided by general practice nurses?

Ms Halton—It is the case that, in all areas of the country, for certain functions there are 'for and on behalf of' items which a doctor can claim when the function undertaken is performed by a nurse.

Senator ABETZ—Do we know how Tasmania is designated for this purpose?

Ms Halton—I do not think this is a rural item.

Ms Huxtable—It is across the country. It is not related to specific areas.

Senator ABETZ—How much is the rebate per payment and in total?

CHAIR—That is where you cannot ask those questions.

Senator ABETZ—All right. We will take that on notice. Can you also take on notice how much was claimed in total in relation to procedures undertaken by nurses in Tasmania in the last financial year.

Ms Halton—For and on behalf of nurses?

Senator ABETZ—Yes, and what is the estimated total value of the new payment to Tasmania, because that will have an impact on the number of nurses that will ultimately be employed? Did the department do any modelling in relation to these new arrangements in relation to Tasmania, because the public argument by the doctors is that Tasmania will be substantially worse off under these new arrangements and therefore we will have fewer nurses participating in the health workforce. This sort of delineation is interesting and we sought very good advice in relation to this.

CHAIR—Senator, I am sorry, you did not ask me.

Senator ABETZ—Chair, I am sure that you would have gone elsewhere for that advice.

CHAIR—Yes, that is right.

Senator ABETZ—And you would have been giving me the same advice.

CHAIR—Every now and then I go on my own way.

Senator ABETZ—I will put all those on notice.

CHAIR—Thank you very much.We are glad you came in.

Senator ABETZ—I am always happy to visit. At least I have kept my record, haven't I, in asking in the wrong area of this committee? But if you can get me the answers on that because

I think there might be a genuine issue in Tasmania. If I may quickly have the benefit of a little statement: rather than a one-size-fits-all approach, if consideration could be given to various geographic areas and an understanding of what happens in other places, then we might be able to get a better health outcome for Australians. I will leave it at that.

Senator Ludwig—For the record, I will take that on notice and seek advice from the minister's office.

Senator ABETZ—Thank you.

Senator FIERRAVANTI-WELLS—I want to ask about the Bringing Nurses Back program. The funding has been redirected into the budget to support other measures. There has obviously been a decision to shut down that program. Have you done some evaluation of it as to why it did not achieve the targets that had been set?

Ms Jolly—There has not been an evaluation formally of that program. We have spoken at previous estimates about the targets for the program and the numbers of nurses that have been returned under the program. That is clearly part of the information that would have been in front of people as they have made decisions.

Senator FIERRAVANTI-WELLS—Why weren't you able to achieve those targets? You must have considered that in terms of thinking, 'Look, this isn't working. We're going to move the moneys elsewhere.'

Ms Jolly—There were a range of changes to the program as it rolled out and as we have spoken about previously, but ultimately a decision was taken to redirect the funds to other measures.

Senator FIERRAVANTI-WELLS—What is going to work now that did not work before, in practical terms rather than the esoteric objectives of the program?

Ms Jolly—I can point you to the new range of measures that were announced in the recent budget in the nursing area. We have a nurse locum scheme which will assist rural nurses to attend CPD. One of the issues for nurses working in rural areas is the ability to take leave to undertake the training that they would like to do.

Senator FIERRAVANTI-WELLS—That is a new concept?

Ms Jolly—That is a new measure. That is a new program. That is certainly one of the new initiatives announced recently. I understand that there was some discussion earlier around aged care. A lot of the new programs are specifically in the aged-care area.

Senator FIERRAVANTI-WELLS—I am interested to know what did not work before and how these programs are different to what did not work before.

Ms Jolly—I certainly cannot comment specifically on the aged-care initiatives. The programs that are in place are focused on the education, training and upskilling of nurses and providing career paths and career choices for nurses as they take decisions about how they spend their time in their career. If you look through all of the measures across the nursing area, that is really a flavour of the measures about providing choices and options for nurses, where and when they work, and supporting them in their education and training pathways in parallel.

Senator FIERRAVANTI-WELLS—Does that include any element of bringing retired nurses back in?

Ms Jolly—Not in the new elements, no.

Senator FIERRAVANTI-WELLS—So encouraging nurses who had left the profession back into the workforce did not work.

Ms Jolly—There had been a range of those sorts of programs in various places, both at Commonwealth and state level, over a number of years, so nurses who had retired or had done other things had come back in. There are re-entry scholarships for nurses who still wish to take that path, but largely the focus of the new measures is around career development, support and education and training.

Senator FIERRAVANTI-WELLS—Broadly speaking, have you examined the sort of nurse profile across Australia, in terms of resetting targets, and the current nurse profile? What I mean by that is the number of nurses that are working in the system now that are from overseas—most of them would be here on 457 visas—as opposed to those who are Australian citizens. Do you have a feel for that profile?

Ms Jolly—We certainly have some information and I could take that on notice and get you some information about those figures. There is an AIHW study which looks at the nursing workforce that we rely on in most of our analyses. There is also information that we get from other portfolios that would collect that data on overseas trained and visa status issues.

Senator FIERRAVANTI-WELLS—Thank you.

Senator ADAMS—I would like to ask about some numbers. I suppose I had better do rural health first and then do the ordinary things after that. Could you give me an indication of how popular the General Practice Rural Incentives Program is, where it is actually going and when it finishes, please?

Mr Andreatta—The General Practice Rural Incentives Program is due to commence on 1 July this year. It was a budget measure of 2009-10. It is on track to be commenced on that date.

Senator ADAMS—I do not have my 2009-10 budget paper with me. How long is it due to go? Is there funding for three years?

Mr Andreatta—There will be four years of funding. I will check the exact figure. It is $75 million over four years.

Senator ADAMS—Could you tell me basically what the incentives are that are being offered?

Mr Andreatta—The program is a consolidation of two existing programs—the Rural Retention Program, which was for general practitioners, and the Registrars Rural Incentive Payment Scheme, which was incentives for registrars. From 1 July, the new program will provide GPs and registrars a relocation incentive grant, as well as retention payments for years of service at that location.

Senator ADAMS—The reason I ask the question is that, coming from rural Western Australia and knowing what our local governments have to do to support a GP in a town, as

an incentive most of them are paying packages of well over $500,000. I was hoping that that program might help out a little bit, but it does not look like they are going to get any relief because, being a community obligation for them, they have to provide a doctor in the town, if they can do it.

Mr Andreatta—The new payments have increased significantly from the old schemes. For the relocation incentives, for example, if a doctor was transferring from a major city, which is RA1 in our classification system, to a very remote area, RA5, they would receive a relocation grant of $120,000; for retention grants, an example is, from an outer regional area, RA3, for a period of five years, up to $18,000 per annum. So the benefits under this new program are very attractive.

Senator ADAMS—They certainly are. Their package includes a house, a car, usually living rent-free, plus their clinic and consumables. So they can just walk in and start. If that is on top of that, I am wondering if there is going to be any relief for local government with it. I guess there will not be, sadly.

Senator Ludwig—I will take it on notice.

Senator ADAMS—Could you step me through the Rural Procedural Grants Program, please.

Mr Andreatta—This is a program that provides two components of payments. There is a grant payment for up to two weeks training and a grant for the cost of up to three days training, to a maximum of $6,000 per GP each financial year. The two colleges—the College of General Practice and the Rural College—administer that program. I can give you some figures on uptake. For the year up to 30 April, we had 1,679 participants in that program.

Senator ADAMS—How long is this program funded for?

Mr Andreatta—It is $21 million over the four years.

Senator ADAMS—When did that start?

Mr Andreatta—It started in 2009-10.

Senator ADAMS—Sorry about this, but I do not have my budget paper from then. I should know it. Obviously that is a very popular program, and I can certainly understand why. Our rural GPs are having to upskill themselves very rapidly to deal with community expectations.

Mr Andreatta—I would like to correct that last statement. It actually commenced in 2003-04.

Senator ADAMS—Right.

Mr Andreatta—There have been some improvements to the program over a number of years, and it has been running for six years.

Senator ADAMS—When is it funded to? When is it going to stop or be reconsidered?

Mr Andreatta—In 2013-14.

Senator ADAMS—That is good to know. It is very difficult in a lot of areas to get locums, so would the Rural Locum Relief program and the uptake—

Mr Andreatta—Is it the rural GP locum program that you are referring to?

Senator ADAMS—That is right, yes.

Mr Andreatta—That is a new program that commenced in November of last year. It provides locum services and subsidies to rural GPs. We have the rural workforce agencies administering that program. They provide a brokerage service that links GPs with locums. On top of that, there are subsidies for the cost of the locums, so the GPs are subsidised.

Senator ADAMS—So they are subsidised then?

Mr Andreatta—They are.

Senator ADAMS—Are they subsidised according to remoteness of the area? How does that work?

Mr Andreatta—How it works is that locum fees are $500 per day. For locum travel time, there is a maximum of $500 per placement up to a maximum of $2,000.

Senator ADAMS—That is actually the subsidy for them?

Mr Andreatta—Correct. The other part is the brokerage—linking the GP with a suitable locum.

Senator ADAMS—What has the uptake been on that? I think that figure is rather low.

Mr Andreatta—Our target was 42 for the financial year just gone. As of 30 April, we had 35 placements filled.

Senator ADAMS—That is not too bad. I know some GPs have been so desperate that they have had to pay whatever has been asked for, which has been exorbitant. Whether that is enough to prevent that, I do not know. They will probably have to do a big top-up. I would now like to move on to the Rural Health Multidisciplinary Training program. You probably have the groupings there, but I will read them out for the benefit of Hansard: Rural Clinical Schools program, University Departments of Rural Health program, Dental Training Expanding Rural Placements program, Rural Undergraduate Support and Coordination program, and the John Flynn Placement program. Could I have a breakdown of how well those programs are going, when they started and when they are funded to.

Mr Hallinan—Those programs started at a range of times over the last 10 years or thereabouts. They are currently funded in 2009-10 at $116.8 million and in 2010-11 at $122.4 million. There is currently no termination date for the programs, so they are an ongoing status in the budget books.

Senator ADAMS—Who is overseeing the John Flynn Placement Program?

Mr Hallinan—ACCRM.

Senator ADAMS—That was one that the National Rural Health Alliance did at one stage. I know because I was involved with that a long time ago. There is quite a lot of uptake there. One that I would like to ask about is the Dental Training Expanding Rural Placements program. Was there much uptake for that?

Mr Hallinan—There are six universities participating in that program. Around 30 full-time equivalent students are placed in expanded rural placement settings per annum.

Senator ADAMS—As part of their training, is it a compulsory component that they have to go and spend time in a rural area?

Mr Hallinan—No.

Ms Jolly—It would be a voluntary option for students, as it is across the other programs. Whilst the university would have a target, individuals would select. In fact, our experience with all of these programs is that we have more students who would like to do them than the places that are available.

Senator ADAMS—As far as where they stay—and I know that accommodation has been a problem, especially in some of the smaller towns—is there any subsidy for accommodation for them?

Mr Hallinan—There is no specific subsidy for accommodation. However, through the program, universities do sometimes provide accommodation facilities for students.

Senator ADAMS—This has always been a problem for medical students. They are actually given a subsidy and funded, and they are given accommodation. But it has always been difficult for nursing students and allied health students because they have not been able to gain the same sort of subsidy for that. That was the reason for asking that, just to see if anything has been done in that respect. It is very difficult to get decent accommodation in a rural community, especially in the north-west of WA. If you can find a room in a place like Karratha or Port Hedland, you would be very lucky and you would be paying probably in excess of $600 a week. So it is really difficult. Is there any way that that might be considered at some stage?

Mr Hallinan—Through the amalgamation of the programs under the Rural Health Multidisciplinary Training program, there is a new stream of funding which is called the Rural Education Infrastructure Development Pool. Participating universities were able to apply for funding for expanding their programs or providing accommodation where it was necessary through the REID Pool this year.

Senator ADAMS—I will have to check up on that and see how they are getting on. Thank you for that. Now we come to your program for recruitment and coordination of, and support and assistance for, overseas trained doctors. Could you run me through what you are actually doing under that program to assist foreign trained or overseas trained doctors?

Mr Andreatta—You are talking about the International Recruitment Strategy. Its aim is to increase the supply of appropriately qualified overseas trained doctors and place them in districts of workforce shortage around Australia. We have engaged the Rural Health Workforce Australia to administer that program. I can give you some figures. The number of OTDs working in Australia since 2004 has more than doubled—from 2,500 in 2004 to approximately 6,000 as at 31 December 2009. The rural workforce agency in each jurisdiction has a responsibility to target and recruit overseas trained doctors and place them in appropriate settings, in districts of workforce shortage.

Senator ADAMS—Talking about appropriate settings, once again, with my background and where I come from, I believe we have had a number of overseas trained doctors sent to inappropriate areas. Going out to the far edges of the wheat belt in Western Australia when

you are used to living in a very large city is quite frightening. It does not just affect the GP; it affects their family as well. It is very hard for them to acclimatise. We have had a number that just have not been able to do it. Then, with the outer metropolitan areas being declared areas of unmet need by the minister, we have lost a lot of doctors. Instead of ending up in the rural areas, they have gone back to the outer fringes of the city.

Mr Andreatta—Part of the role of the Rural Health Workforce Agency role, as well as that of the Divisions of General Practice, is to support overseas trained doctors in location, both in setting them up in practice and looking at their family situation to ensure they are living appropriately in the location and they have the housing they need. There is funding allocated for that support.

Senator ADAMS—I know that the support agencies do a very good job. But it is sometimes very difficult, especially if the doctor is very quietly spoken. A lot of elderly people live in rural areas and they cannot always understand what is being said. It can really get difficult. But it is a fact that you have somebody there that is qualified, that you can utilise.

Senator FURNER—What is the retention rate? Do you have those figures as an example of what Senator Adams is referring to?

Mr Andreatta—The OTDs in those centres would be there for the 10-year moratorium. I do not have figures to indicate the retention. I could take that on notice.

Senator FURNER—Thanks.

Senator ADAMS—What happens if they just cannot cope, if it is for the good of the family and the community that they have to be relocated somewhere? What happens to such doctors? Are they able to be relocated somewhere without being penalised? What is the situation?

Mr Andreatta—The workforce agency would deal with that situation and relocate if appropriate. If that were the option available to them, they would.

Senator FURNER—While Mr Andreatta is at the table, to save him coming back again, I have one specific parochial question on Queensland. Mr Andreatta, you spoke earlier about the retention and relocation incentives. Are you able to outline some of the towns in Queensland that will have access to those for the first time?

Mr Andreatta—I can give you the headcount for Queensland.

Senator FURNER—That will help.

Mr Andreatta—You are talking 386 GPs that will receive the incentive in newly eligible areas, and we believe the uptake figure for Queensland will grow to 689.

Senator FURNER—When do you envisage it will reach 689?

Mr Andreatta—It would be over the four years.

Senator FURNER—Thank you.

CHAIR—Mr Andreatta, can you get on notice which places those are likely to be? I do not want to get 300 names tonight.

Mr Andreatta—I will take that on notice.

CHAIR—It would be very nice on notice and it would not surprise me if other states did not want the same sorts of statistics.

Senator ADAMS—I was about to say, if they are getting those numbers, I may as well get ours.

CHAIR—Can we get numbers for all those areas across the country.

Senator ADAMS—Yes, could you go through Western Australia as well?

Mr Andreatta—Certainly.

Senator Ludwig—I think I will make a move, Chair.

CHAIR—Thank you very much, Minister. Senator Adams, where do you want to go now?

Senator ADAMS—The Rural Australia Medical Undergraduate Scholarship scheme. I have to brush up on these things so I know where they are going. How much is, and what is the term of, the funding for the undergraduate scheme? And, in terms of the uptake, are you oversubscribed?

Mr Hallinan—Funding for the RAMUS scheme in 2008-09 was $6.289 million; in 2009-10 is $6.417 million; and in 2010-11 will be $6.509 million. The program currently provides 573 scholarships worth $10,000 per year. Since the program began in 2000, 1,544 scholarships have been awarded and 872 scholars have graduated from medicine.

Senator ADAMS—Are you still getting more people wanting to take up that scheme than you have places for?

Mr Hallinan—Yes—140 new scholarship places will be awarded this year, and there have been 684 applications.

Senator ADAMS—So nothing has changed—it has been like that since it started. That is very good to hear. Now I am thinking about the teaching side. What about the bonded scholarships—can you tell us about those?

Mr Hallinan—Yes.

Senator ADAMS—That is the rural bonded support scheme.

Mr Hallinan—Under the Medical Rural Bonded Scholarship Scheme there is, in 2009-10, $11,615,000; in 2010-11, $11,798,000; in 2011-12, $11,986,000; and in 2012-13, $12,177,000.

Senator ADAMS—With that one, would you know how many people have pulled out and had to pay their bond back, because they are bonded for 10 years? Is that still the case with this one?

Mr Hallinan—The bonding for the program is six years. In total, there have been 43 withdrawals from the program: 28 of those have been without penalty; seven have been in breach of the contract with no penalties applied; two have been in breach of the contract with a financial penalty applied; four are in breach at the moment, but are currently awaiting determination; and two have been terminated from the program or from the field of study.

Senator ADAMS—Regarding those that are in breach but have not had to pay anything back, what would be the reason for that?

Mr Hallinan—Usually it is personal circumstances, such as sickness or an inability to continue studies.

Senator ADAMS—As far as take-up of that scholarship is concerned, is it very popular or is it not as popular as the other?

Mr Hallinan—It is oversubscribed.

Senator ADAMS—Oversubscribed again? I know there was some doubt about it when it first started. They were a bit worried about the bonding, as to whether people would be able to stick to it or not. I have got the Bonded Medical Places Scheme and the bonded support scheme. Can you answer for that, rather than having you all shifted around again?

Mr Hallinan—I can do that.

Senator ADAMS—Thank you.

Mr Hallinan—There is no specific funding available under the Bonded Medical Places Scheme. Twenty-five per cent of all commencing Commonwealth supported medical places are bonded for a period of return of service once graduates have received their qualification.

Senator ADAMS—And the Bonded Medical Places Support Scheme?

Mr Hallinan—The Bonded Medical Places Support Scheme has been merged with the Medical Rural Bonded Scholarship Support Scheme. That happened in the last budget. That scheme continues and it is currently administered by ACCRM.

Senator ADAMS—Good. Now we get to the National Rural Locum program. Is that something that you can deal with or will someone else have to deal with that?

Mr Hallinan—I am not sure what that is.

Senator ADAMS—The National Rural Locum program. I do not know what the difference is with it.

Ms Jolly—There is a general practice locum scheme that we have already discussed and there is also the new rural locum scheme, the nursing scheme.

Senator ADAMS—I am going off page 238 of the budget statement book. It is just called the National Rural Locum program. But I have still got some education questions, so you are going to have to come back.

CHAIR—Have you got the question, Mr Andreatta?

Mr Andreatta—The program you refer to, the National Rural Locum program, is a new program that is consolidating two existing locum programs: the Specialist Obstetrician Locum Scheme and the General Practitioner Anaesthetists Locum Scheme.

Senator ADAMS—I wondered where they had gone. So that is where they have gone. Gee, that is tricky! That is very sneaky!

Mr Andreatta—That is right. They are being consolidated on 1 July. At the moment, they are two separate locum schemes, as I mentioned, operating as per the program guidelines.

Senator ADAMS—How long is that funded for under its new banner?

Mr Andreatta—I do not have that figure on me. I could take that on notice.

Senator ADAMS—I am interested in the number of applications for that particular program, as in how many people want to come out to the bush with our unfortunately diminished obstetric services.

Mr Andreatta—Certainly, I could give you some uptake figures for the number of placements for both the SOLS and the GPALS as at 31 March this year. In the specialist obstetrician program we had 45 placements; in the GP obstetricians scheme we had 12; and in the GP anaesthetists scheme we had three.

Senator ADAMS—Will they go on now into this new program? Will that continue through?

Mr Andreatta—Correct. I think the consolidation is in name only. They will still operate as separate programs.

Senator ADAMS—What are the numbers that you have worked your budget on for that program?

Mr Andreatta—The performance targets for the new program are you after?

Senator ADAMS—That is right, yes. I guess that is the way to put it.

Mr Andreatta—Regarding the targets for the specialist obstetricians in 2010-11, we are looking at 90 placements, and that is 717 days of placement; for GP obstetricians, 25 placements and 350 days of placement.

Senator ADAMS—What is the interest? As the program is just starting, have the applications gone out?

Mr Andreatta—It is a little early to tell at this stage on whether we will meet the targets, but we are very confident that we will. They are schemes that are very well utilised and over time we believe that they will increase in demand.

Senator ADAMS—I certainly hope they do, because rural areas need them and, unfortunately, for a GP with those skills; we are just not getting them back, which is a shame.

CHAIR—Senator Adams, how are you going?

Senator ADAMS—I am going all right. Seeing as I have said I am going to do education, I suppose I had better.

CHAIR—Yes, and Senator Furner has some questions before we go to the agencies. So what have you got?

Senator ADAMS—It is just a continuing education and training support program that has combined four different programs—that is all. So who can deal with that one? It is the Consolidation of Continuing Education and Training Support for Rural Health, and it incorporates the Rural Health Support, Education and Training program; the Rural Health Education Foundation; Rural Advanced Specialist Training Support; and the Support Scheme for Rural Specialists. Seeing as that program has been combined, when does it start, or has it started?

Mr Hallinan—It has started. I will just give you a quick run-down of the changes. The Rural Health Education Foundation funding continues.The other funding has been merged into two streams: stream 1 provides continuing professional development training to medical specialists in rural and remote locations; and stream 2 provides continuing professional development funding for allied health professionals, nurses, general practitioners, and Aboriginal and Torres Strait Islander health workers.

Senator ADAMS—Has that been oversubscribed? Have you called nominations or applications for it yet, or for either of those two streams?

Mr Hallinan—They are administered by two auspicing bodies. Stream 1 funding is auspiced by the Committee of Presidents of Medical Colleges and stream 2 funding by the National Rural Health Alliance.

Senator ADAMS—Yes, I thought that may have been where that was. Do nurse practitioners come into this area?

Ms Jolly—Yes.

Senator ADAMS—How many scholarships are offered to nurse practitioners? Have we got any stream that accommodates nurse practitioners?

Ms Jolly—Yes. Thirty-four nurse practitioners have been awarded scholarships.

Senator ADAMS—What are those scholarships worth?

Ms Jolly—Up to $15,000 per annum.

Senator ADAMS—And the guidelines for those? Is there any specific area they have to work in or can they name what they want to do? How do they work?

Ms Jolly—The particular area is not specified at the moment. But, of course, there are some additional projects in aged care that you may have heard about today that were announced as part of the budget.

Senator ADAMS—I did. Yes, I was aware of those. Are they part of this particular package?

Ms Jolly—They are complementary to this. They are a different program but in the same—

Senator ADAMS—How many places are there in the aged-care one?

Ms Jolly—I would need to take that on notice.

Senator ADAMS—Are these scholarships offered once a year or twice a year? How does one apply for them?

Ms Jolly—They are an annual round.

Senator ADAMS—The reason I am asking is that universities usually have two intakes a year. So one lot go through, and then the next lot have to wait until the next round comes along?

Ms Jolly—Yes.

Senator ADAMS—That is fine. I think I had better stop.

CHAIR—Thank you, Senator. Senator Furner.

Senator FURNER—Thank you. Are you able to detail the number of GPs and specialists that will be trained by the government's health workforce initiatives?

Ms Jolly—In the latest round of measures that were announced in the budget, the general practice training program will be increased to 1,200 places per annum from 2014, so it builds incrementally from now until 2014. There are additional places for junior doctors to undertake a training rotation in general practice and that program also grows—in fact more than doubles—to 975 places in 2012. The other medical specialist training program that we have has also increased. I will ask Mr Hallinan to give you the figures on that particular program.

Mr Hallinan—That program will increase to around 900 places per annum by 2014.

Senator FURNER—What additional support will be provided to allied health workers?

Ms Jolly—In the recent budget there are additional rural allied health scholarships that have been funded. There will be an additional 100 every year. They are to undertake clinical training in a rural location for allied health students. Also, there is an allied health locum scheme that, similar to the nursing locum scheme, will assist health professionals working in a rural and remote areas to undertake continuing professional development.

Senator FURNER—Thanks for that.

CHAIR—That is it?

Senator FURNER—Yes, thanks.

CHAIR—Thank you. Senator Fierravanti-Wells.

Senator FIERRAVANTI-WELLS—I would like to ask some questions in relation to the agency Health Workforce Australia but, before I do, there are some other questions that I am going to ask which also tie in with the department. Is it appropriate, Madam Chair, to call the agency and then, as required, an officer from the department could—

CHAIR—It may be easier, if it is linking across there, if we get the agency at the table and we can go from there.

Senator FIERRAVANTI-WELLS—Thank you.

[8.26 pm]

Health Workforce Australia

CHAIR—Welcome, Mr Cormack. Senator Fierravanti-Wells.

Senator FIERRAVANTI-WELLS—Thank you. I have got a media release from the minister, dated 11 February. The release talks about $1.6 billion in workforce investment and the government has committed $1.1 billion to the partnership and $500 million will come from the states. What component of that $1.6 billion is just the agency? If I read the budget papers correctly, the agency is not directly appropriated. Appropriations are made to the department, which are being paid to the agency and considered departmental for all purposes. I am trying to work out this $1.6 billion. It is not actually in their moneys. Can somebody help me out here?

Mr Cormack—The $1.6 billion that is referred to in the media release is the amount specified in the national partnership agreement that was signed in 2008. I will have to take on

notice the specific figure, but approximately $500 million of that is existing efforts and contributions by state and territory governments, which brings the quantum back to $1.1 billion over four years. From that, there is a component which is allocated to postgraduate GP training, which was in the $1.1 billion Commonwealth funding, and that has been allocated, as I am advised, to GPET. Broadly speaking, the balance is what is allocated to Health Workforce Australia over the four-year period.

Senator FIERRAVANTI-WELLS—I am just trying to understand. You have got a workforce responsibility in the department. You will now have a workforce element in this agency and then you have got the General Practice Education and Training program. Can somebody explain the roles of the three and their relationship to each other? It seems to me that there will be at least some overlap and there will certainly be interaction.

Ms K Flanagan—First of all, as Mr Cormack has indicated, there are a range of functions that are set out that are expected of the Health Workforce agency. One of the biggest is to provide additional Commonwealth money to enhance undergraduate training. There are also functions around looking at workforce planning and trying to forecast what sort of workforce supply we may need into the future.

Senator FIERRAVANTI-WELLS—General Practice Education and Training told us they do not actually do the training; they just coordinate the training. They, effectively, procure and do that. Then you currently have Health Workforce Australia, which will actually do training? When I say 'training' I mean it in its broadest sense, so not just facilitate it but actually do it.

Ms K Flanagan—Health Workforce Australia has a significant grant program to enhance training opportunities for undergraduates. GPET delivers training places for postgraduate GP training. There are other functions expected of Health Workforce Australia, such as perhaps looking at simulated learning environments and other ways of providing training. GPET, of course, is specific to GP training, but Health Workforce Australia is responsible for undergraduate training—not only for medical undergraduates but also for allied health professionals and nurses. There are three or four other things that Health Workforce Australia is responsible for.

You just heard Senator Adams running through a range of programs—for example, establishing rural clinical schools, dental schools et cetera. The department administers a range of programs, which are mainly postgraduate but can be undergraduate in terms of capital investments into, as I say, things like rural clinical schools. If it would help, we could do you a bit of a map.

Senator FIERRAVANTI-WELLS—Yes, I am into maps!

Ms K Flanagan—But we would need to do that on notice.

Senator FIERRAVANTI-WELLS—If you could do that, I would appreciate it, because I think there are noodles, and I have not quite worked it out.

Ms K Flanagan—I do not know that they are noodles.

Senator FIERRAVANTI-WELLS—There will be lots of lines going everywhere, I think. So the actual amount is really the money that is there allocated for the training, and included in that figure of $1.1 billion are obviously the costs of the agency.

Ms K Flanagan—Yes.

Senator FIERRAVANTI-WELLS—It has obviously just been established. What is your operating budget, Mr Cormack?

Mr Cormack—The core operating costs of the agency for 2009-10 are $12.5 million, then $30 million the subsequent year and $35 million in 2012-13.

Senator FIERRAVANTI-WELLS—I am just trying to find the page.

Mr Cormack—That is the core agency funding. With reference to the portfolio budget statement, it is on page 673. You can see the expenses there, 'Total for program 1.1'.

Senator FIERRAVANTI-WELLS—Yes.

Mr Cormack—The amounts that I mentioned before were the specific subcomponents to operate the agency. The funding outlined there in table 2.1.1 is the annual expenses budget.

Senator FIERRAVANTI-WELLS—I note that in 2009-10 there are five staff and in 2010-11 you go up to 96.

Mr Cormack—Yes.

Senator FIERRAVANTI-WELLS—Where are you at now with staffing?

Mr Cormack—We are in the middle of a large-scale national recruitment program. We have been advertising across the country over the last few weeks, and we expect to be building up to that number early in the new financial year. We are seeking up to 120 staff over time, but we will be building up, starting with our senior staff and then a group below that level.

Senator FIERRAVANTI-WELLS—I have noticed a number of advertisements, not only in the newspapers but on the web. I have an advertisement here of 15 May, which I assume was put in newspapers around Australia, and it is for what I take to be five senior executive positions. Are they the only senior executive positions or will there be more?

Mr Cormack—They are the five senior executive positions that we are looking for.

Senator FIERRAVANTI-WELLS—Then there are some more advertisements—Job Online, for example—for policy roles. How many do you envisage there?

Mr Cormack—In time we envisage that there will be up to 120 staff in the agency. There will be an executive group consisting of me, plus five initially, and then the balance of that 120 will be predominantly policy program management and a small component of administrative staff, plus a pool of research and data analysts.

Senator FIERRAVANTI-WELLS—I noticed an advertisement for policy roles, multiple positions. How many are you filling at the moment?

Mr Cormack—The agency has been up and running for four months. We are simultaneously recruiting the executive staff and, at the same time, recruiting a round of positions, such as those you have outlined, to enable the executive staff on appointment to have a pool of staff available for the midyear start.

Senator FIERRAVANTI-WELLS—I appreciate that. You have advertised for multiple roles. I just want to know how many positions. It says 'various divisions' and gives a salary figure—

Mr Cormack—I will take that on notice.

Senator FIERRAVANTI-WELLS—I notice that they are all based in Adelaide.

Mr Cormack—That is correct.

Senator FIERRAVANTI-WELLS—Why was a decision made to base this national agency in Adelaide?

Ms Halton—It was a decision of the ministerial council.

Senator FIERRAVANTI-WELLS—Is there any particular reason why?

Ms Halton—That was what the ministers agreed. The Australian Health Ministers Conference agreed that this agency will be located in Adelaide.

Senator FIERRAVANTI-WELLS—I note Professor Bishop has gone.

Ms Halton—He has vaporised, I am afraid. If we need medical assistance for Senator Boyce, I can find someone else; don't you worry!

Senator FIERRAVANTI-WELLS—That is all right. I went to a conference once where somebody was speaking and they asked, 'Is there a doctor in the house?' and Dr Wooldridge walked in. That was when he was health minister, so I thought that was quite amusing.

Ms Halton—I do not know that Dr Wooldridge has actually practised medicine much recently.

Senator FIERRAVANTI-WELLS—He certainly had his bag with him. Jim McGinty, a former Labor health minister in Western Australia, is the chair. He is over in WA, I think, so did that contribute to the decision to locate the agency in Adelaide?

Ms Halton—No, that was a decision made well after the location was established.

Senator FIERRAVANTI-WELLS—Mr Cormack, we have some policy roles and we have some financial roles. How many of those positions do we have?

Mr Cormack—We do not have any on board at the moment. We are using contracted staff to perform those functions.

Senator FIERRAVANTI-WELLS—You are advertising for finance roles. How many are you filling as part of this—

Mr Cormack—Initially we would be looking for three finance staff.

Senator FIERRAVANTI-WELLS—Then you are advertising for project officers and managers, with salary ranges of $61,000 to $117,000, or thereabouts. How many project officers and managers will you be bringing on board?

Mr Cormack—We have not specified the precise number out of the total staff of 120. We will be developing a more detailed staff profile as the executive staff are appointed, to line up with our work program.

Senator FIERRAVANTI-WELLS—The applications for all of them close on 4 June. When people apply, they will want to know how many positions are available.

Mr Cormack—We have included within there a general expression of interest, because, as I mentioned, we are looking for up to 120 staff over time. We have not specified the precise numbers in each category beyond the executive group, but we are very keen to progress the work plan, and to do that we will to have as many staff on board as possible.

Senator FIERRAVANTI-WELLS—You have also advertised for data analysts roles. Do you know how many of those positions there are?

Mr Cormack—I have not determined a final number.

Senator FIERRAVANTI-WELLS—Do you think that some of the workforce will come over from the department of health? Is it anticipated that the department of health might lose some staff, given there is an overlap of roles? Ms Flanagan, as you are going to provide to me, there are certainly areas of overlap.

Ms K Flanagan—I do not know that we would agree that there are areas of overlap. We will give you the map. But certainly there would be no reason why, if staff in the department were interested in applying for the jobs, they would not be able to do so.

Senator FIERRAVANTI-WELLS—The point I am making, Ms Flanagan, is that you have got a large bureaucracy in the department. Senator Adams took us through just some of the workforce areas. You have myriad people in the department already involved in workforce areas. Is there any duplication in what you are doing as a consequence of setting up a whole new bureaucracy which is going to do workforce?

Ms K Flanagan—We do not believe so. The agency is in its infancy. We will be working very closely with it. I have indicated that there is a delineation between the sorts of programs that the department delivers and the sorts of programs that Health Workforce delivers. But, clearly, work that Health Workforce does, for example, around workforce planning will be very valuable to the department and we will be looking to Health Workforce Australia to share that with us.

Senator FIERRAVANTI-WELLS—The point I am trying to make is: what work is not being done in the department that is now necessitating an enormous bureaucracy being set up, another level of bureaucracy, which is going to have a budget of—sorry, what did you say, Mr Cormack?

Mr Cormack—The budget for 2010-11 is $243 million.

Senator FIERRAVANTI-WELLS—One hundred and twenty people, so—

Ms K Flanagan—That is the total budget. You are possibly after the administrative budget to run the agency.

Senator FIERRAVANTI-WELLS—That is what I thought Mr Cormack—

Mr Cormack—No, I was referring to the total budget of the agency, which includes a very significant grants program.

Senator FIERRAVANTI-WELLS—Okay. And what was the actual running cost of the agency?

Mr Cormack—The core agency allocation in 2010-11 is $30 million.

Senator FIERRAVANTI-WELLS—So, Ms Flanagan, what deficiency do you have in the department that you have not been able to meet over the last three years that now necessitates the establishment of a new bureaucracy of over 100 people which costs $30 million a year to run?

CHAIR—Senator, I am sure the officer will answer in the best way that she can, but I think the phrasing of that question was not an appropriate question to officers of the department.

Senator FIERRAVANTI-WELLS—Let me rephrase it.

CHAIR—Okay, give it a go.

Senator FIERRAVANTI-WELLS—Clearly there is a perceived void that needs to be filled in this area. What is not being done in the department now that necessitates the establishment of a new bureaucracy of over 100 people on a budget of $30 million?

Ms Halton—I will take that question, if I might. We have had a major problem with workforce in this country. It is well acknowledged by, I had thought, both sides of politics. We have a significant shortage of nurses. We have had major problems with doctors. I could go on via professions. Why is this so? If you look at what is required to deliver a workforce, we have been fractured across state lines and we have been fractured across the Commonwealth and the states because of the different roles that different parties play. The blunt reality is that, if we had not done something about creating an integrated national approach to workforce, frankly, when all of us get there, there will not be enough care in acute care, subacute care, ambulatory care, primary care and, dare I say, residential care.

What governments of all persuasions across the country have done is to have a very serious look at how we are going to rectify this significant problem. It was agreed—and I think this is absolutely the right decision—that we need a singular, solitary focus on making sure we deliver the workforce necessary. The new National Registration and Accreditation Scheme—commenced, I might add, under the last government—is a key plank in this and the reality is that this agency, which is a creature of all governments, is absolutely fundamental to creating a better workforce environment for the delivery of health and aged care.

Senator FIERRAVANTI-WELLS—Ms Halton, do I take from that that there is absolutely going to be no duplication of efforts; that this agency, together with your department and General Practice Education and Training, will not result in additional unnecessary bureaucracy?

Ms Halton—Absolutely.

Senator FIERRAVANTI-WELLS—You give that guarantee?

Ms Halton—Absolutely. I can tell you right now, Senator, if there is any suspicion or problem in respect of potential duplication, I will be the first one, if it is pointed out to me, to root it out. We are not interested in duplicatory functions. In fact, the whole point about this agency is that it is meant to actually reduce duplication.

Senator FIERRAVANTI-WELLS—That was my point. Is there going to be any reduction in your staff numbers, Ms Halton?

Ms Halton—If you look at the budget appropriations you will see that the staffing appropriation in my department, notwithstanding the significant additional functions coming out of COAG, remains about static. In fact, if it had not been for the COAG initiatives we would have dropped quite significantly this year.

Senator FIERRAVANTI-WELLS—Ms Halton, that is all very well. With our $30 million a year and our 100 extra bureaucrats, what practical targets is this agency setting itself? I do not see anything practical in terms of numbers or what this is actually going to do. I appreciate that bureaucracy and setting up new bureaucracies has become a feature in recent years, but the establishment of another new bureaucracy does not of itself create a practical outcome. What is the practical outcome? When are we going to start seeing the first practical outcomes of this investment?

Ms Halton—I am very happy for Mr Cormack to outline to you precisely what he is going to deliver, because I can assure you that you are not the only person interested in that: I am, all my colleagues are, and I know all the ministers are.

CHAIR—Mr Cormack, before you answer—Senator, how much longer are you going to be?

Senator ADAMS—Can I just—

CHAIR—Sure.

Senator ADAMS—I can just use quarter of an hour for rural health, so I think this is terribly important because—

CHAIR—Senator, that is fine. We will do that. I was aiming for rural health being only about half an hour, but after we have finished this one we are having a 10-minute break so that we can get ready for the last one. I just wanted to get a sense of time for the officers.

Senator FIERRAVANTI-WELLS—We will be on time. In fact, I will probably be another five minutes or so, and then Senator Adams.

CHAIR—That is fine. It was just to get an idea. Thank you, Mr Cormack.

Mr Cormack—Thank you, Senator. Just to focus on the key deliverables of the agency, in the National Partnership Agreement there is a table which identifies, between 2005 and 2010, a 70 per cent increase in nursing commencements at university and a 50 per cent increase in the placement requirements in the clinical training sector; for doctors, a 61 per cent increase, and a 65 per cent increase in clinical training requirements in the sector.

Senator FIERRAVANTI-WELLS—Sorry, this is page six hundred and—

Mr Cormack—No. I am referring to the National Partnership Agreement. I am just trying to give you some background there.

Senator FIERRAVANTI-WELLS—Sorry. I was just looking at the budget papers. I do not have the agreement.

Mr Cormack—Between 2005 and 2010, that is the sort of increase in undergraduate places that are coming through the system. In order to be able to respond to that, because that requires additional hands-on staff in those training environments, over the next three years we will be allocating $139 million in 2010-11, $142 million in 2011-12 and $143 million to support the front-line doctors, nurses, allied health, pharmacy and physio, who are receiving training in the clinical training environments, hospitals, primary care and community settings.

On top of that, we will also recognise the additional burden that this places on other health professionals who have to train 60 per cent or 70 per cent more students than they did before. We will be allocating $6 million in 2010-11, $8 million in 2011-12 and $10 million in 2012-13 to improve the quality, consistency, tools and support that are available to train health professionals in the future.

Ms Halton—Can I put this in non-bureaucratic language. What this agency is going to do is make sure that all of the people coming out of institutions who need it get clinical training that is relevant to the way they will need to practise their profession in the future. That means not just mostly in a hospital; it means in a private hospital, in a public hospital, in a community based setting, in a rural environment and in a metropolitan area with disadvantaged people et cetera. It means that we will have the right number of those people in the right places. It also means that we will be confident that they will have the skills to deliver the kind of care that we are talking about in all the other reforms: integrated care, working in teams et cetera. Their job is to make sure that, as these numbers come through, they get all of that skill and, furthermore, that the people working in hospitals, private and public, and in general practice—working wherever—actually have the capacity to deliver that training, to help those people become fully functioning members of the medical profession, the nursing profession et cetera. That is their job.

Senator FIERRAVANTI-WELLS—That is fine. I have taken all that on board, Ms Halton, and I hope that this promise does come to fruition. I saw another advertisement for a tender for mapping clinical training to support growth. Are you aware of that? It was in the papers on 22 May. Mr Cormack, can you explain what this actually means?

Mr Cormack—Yes, I can. It is a request for tender. What it is doing is ensuring that the money that is being spent, which I outlined in my previous statement, is being put to good effect—that is, we are able to demonstrate growth in the numbers of students, in the numbers of placements that are out there. Consistent with what Ms Halton said, we are also looking to expand the settings in which our health professional students are trained. To do that, we are asking for the assistance of consultants to map out the new places across the country that could take on additional students if the right incentives and the right conditions were offered, and also to assist us with supporting clinical trainers at a regional level through looking at regional training networks which bring together the higher education sector and the clinical training providers to be able to better plan and better support the delivery of good-quality training to health professionals.

Senator FIERRAVANTI-WELLS—This tender says:

… undertake an extensive and detailed Australia-wide consultation and information gathering process across the health and education sectors.

This project will establish an evidence base to inform decisions—

and it talks about COAG. Is HWA seeking advice based on data and information collected from the field? I am sorry; this just does not make sense. In plain English, you are just setting up a bureaucracy of over 100 people—$30 million—and now you are going to go out to a tender for consultants to gather more information. I do not quite understand. This is just bureaucracy on top of bureaucracy, Mr Cormack.

Mr Cormack—The purpose of the consultancy is to make sure that public funds are invested wisely and that we are able to deliver the training outcomes that are being purchased with the funding I described before.

Senator FIERRAVANTI-WELLS—So you are going to outsource that to another organisation? You have money that supposedly you are going to use for training and you have a bureaucracy that has been established to do that. That is what I understand you saying to me you are going to do. The bulk of your money will be in grants. Then you are going to—what?—outsource this to entity X that wins this tender. I do not understand.

Mr Cormack—We are working towards a timetable where we need to have a lot of additional clinical training capacity in place for the commencement of the 2011 academic year. We are a start-up organisation, as we have indicated before, but we need a lot of good foundation work done very quickly, and the most efficient and time-effective way of doing that is to seek external assistance to get that work done.

Senator FIERRAVANTI-WELLS—In other words, at the same time as you are setting up your bureaucracy and you are working towards your 96 bureaucrats, you are effectively going to get some other organisation to fill the gap—is that what you are doing?

Mr Cormack—No. They are assisting us to deliver the clinical training program funding quickly and effectively to enable a commencement in the beginning of the 2011 academic year.

Senator FIERRAVANTI-WELLS—I am sorry, Mr Cormack, I think it is just bureaucracy on bureaucracy, but we will see if you actually deliver what you say you are going to deliver. You are also going to bring in—what?—expert committees. I assume this is the consultants. Are there other consultants on the horizon, other than this tender in this financial year?

Mr Cormack—This is the biggest consultancy that we are running at the moment.

Senator FIERRAVANTI-WELLS—I am glad to hear that. What about expert committees that you will seek? On the website it says that you are going to establish some expert committees, so where do they come into the picture? Maybe you should draw a diagram for me as well.

Mr Cormack—I would happy to do that.

Senator FIERRAVANTI-WELLS—I would be very interested to see what your structure is now and what you anticipate it is going to be after you have put in 96 staff—all these SES positions, all these policy-whatever other positions, all the expert committees and all the consultants you intend to employ.

Senator Ludwig—I am sure there is an organisational chart that the witness can provide.

Senator FIERRAVANTI-WELLS—I was not able to find it, Minister, but I think I will leave it there; thank you.

Senator ADAMS—Congratulations on your appointment since I saw you last.

Senator FIERRAVANTI-WELLS—He is really looking forward to it, I can tell.

Senator ADAMS—Yes. Being a Western Australian and this is an Australian-wide program, my first question is: what is going to happen if Western Australia do not sign up?

Ms K Flanagan—Sign up to the new national partnership?

Senator ADAMS—Yes.

Ms K Flanagan—The programs that are going to be administered by HWA, the extra $1.1 billion that the Commonwealth has committed to deliver through the agency, will not be affected, as we understand it, if WA does not sign the agreement.

Senator ADAMS—That is a relief. I am wondering about NRAS? How are they going to fit into the scheme? Do they run parallel with you or are they part of your overarching—

Ms Halton—It is part of the general strategy, but obviously it is not run out of Health Workforce Australia.

Senator ADAMS—No.

Ms Halton—The national registration and accreditation arrangements are set up as a national entity as against all the individual state entities that used to exist—and obviously very much controlled by the professions in terms of the committees et cetera.

Senator ADAMS—That is right, but I am just looking at the workforce. There would have to be quite a lot of communication, wouldn't there, with them too?

Ms Halton—Absolutely.

Senator ADAMS—Mr Cormack, how do you see that fitting in?

Mr Cormack—We will be working very closely with NRAS. In fact, the collection of information about the regulated health professions will form part of our research basis. There will be a lot more information collected about doctors and nurses and allied health professionals that will enable us to plan workforce requirements for the future much more consistently than we have been able to do in the past.

Senator ADAMS—Coming back to the local hospital networks and Medicare Locals and how all of that fits together, will you be helping them with the training of the workforce for those specific areas? How is that going to work and what communication would you have with that?

Mr Cormack—Our job is to work across Commonwealth, state and territory governments. We report to health ministers, and we will be providing them with the information about the workforce that they need for the future and the training that is required to support that workforce into the future. We will need to take into account any changes that the national reform program throws up in terms of how we plan for workforce reform into the future.

Ms Halton—If I can expand on that a little bit, the reality is, with the new structures like the hospital networks and Medical Locals, that we know we are going to have to expand

training in each of those domains. For example, one of the things that this particular tender here is going to do is work out where we can actually do that training. As Medicare Locals become established, it will give us a good place to go and talk about—for example, with primary care—how it is we can actually roll out training which will be relevant to the workforce of the future.

Senator ADAMS—I am getting a bit like Senator Fierravanti-Wells, needing to get a map because it is difficult. On the shortage of the workforce at the moment, what would be the main five areas you have now identified where we are desperately short?

Mr Cormack—The main areas of shortage have already been summarised previously, but we are really talking about nurses in particular. They would be the single biggest group, with roughly a third of the health professional workforce. Clearly there are very specific shortages there. There are growing shortages in a number of the allied health disciplines of physiotherapy and psychology—they are certainly areas of pressure—as well as specific shortages of medical professions in certain rural and remote areas. They are the ones that are clearly the priorities that we are looking at, but we have more work to do on further planning.

Senator ADAMS—Radiographers seem to be very scarce at the moment as well. Are they anywhere on your list?

Mr Cormack—Yes, they certainly are.

Senator ADAMS—They are a smaller group but they are very essential people.

CHAIR—That concludes outcome 12. Thank you to the officers and also Health Workforce Australia. I am sure you will be back to see us again, Mr Cormack.

Proceedings suspended from 9.04 pm to 9.14 pm

CHAIR—We are going into outcome 6. Senator Adams and Senator Siewert both have some questions. Senator Adams.

Senator ADAMS—I will be good and stay on outcome 6. Firstly, would someone like to tell me how much funding the Royal Flying Doctor Service are getting and how long that funding goes for?

Mr Andreatta—The current agreement with the RFDS is $247 million and that funding ceases at the end of this financial year.

Senator ADAMS—Then what happens? Have we got any forward estimates on that?

Mr Andreatta—At the moment we are in negotiations with the RFDS. We are negotiating a new contract for the next period.

Senator ADAMS—When that contract is let, how long is the period? Is it four years? How long does it go on?

Mr Andreatta—At this stage it is three years, but that is not yet locked in. There is consideration of a four-year contract as well. That will be part of the negotiations over the next few months.

Senator ADAMS—When do you expect to have those? If the funding is running out at the end of this financial—

Mr Andreatta—I beg your pardon—the following financial year, July 2011.

Senator ADAMS—That is all right. I was starting to think: 'Goodness, that is not too good.'

Mr Andreatta—We have 12 months to renegotiate the new contract.

Senator ADAMS—That is all right. Can someone help me with The Rural Women's GP Service, please?

Mr Andreatta—Again, that is administered by the RFDS. I can give you some update figures on the usage of that.

Senator ADAMS—Yes, that would be good.

Mr Andreatta—In 2009-10, the budgeted figure was 168 operational locations. Those are visits by the female GPs. As at 11 May 2010, we have had 165 visits. In terms of the number of patients seen by those female GPs, our budget was 17,500 and, in the first six months of the reporting period, there have been 9,535 consultations or patients seen.

Senator ADAMS—As far as the availability of female GPs, is there any problem getting people to be part of the program?

Mr Andreatta—No. I do not believe the RFDS has a problem sourcing female GPs to undertake this type of work. I think there is a waiting list to actually undertake that work.

Senator ADAMS—That is good. What about the Rural Primary Health Services program?

Mr Andreatta—That is a new program and it is a consolidation of four existing programs.

Senator ADAMS—Which ones?

Mr Andreatta—The Regional Health Services program; the More Allied Health Services program; the Multipurpose Centre program; and Building Healthy Communities in Remote Australia.

Senator ADAMS—They have all been rolled into that particular one?

Mr Andreatta—Correct. That started 1 January 2010. I am pleased to say that we have executed 172 contracts out of the 173, and that will cover the delivery of services to 1,700 remote communities.

Senator ADAMS—That is good. How do regions or areas apply for that? Is there an application process? How do they find out about it?

Mr Andreatta—The program is restricted to locations in RA2 to RA5—so the current classification from regional out to the most remote. I might pass this over to my colleague, Mr Cameron, who has the details.

Mr Cameron—The consolidation of the four programs into one was essentially to pull a common funding framework across all four. What we did not do as part of that consolidation was open it up to new entrants, so existing auspice organisations are the ones that are funded. But that does not mean that new services cannot be adopted by those auspice organisations in the local area.

Senator ADAMS—So it is still open for those bodies to take on?

Mr Cameron—To amend or change or take on new health services, yes.

Senator ADAMS—That clarifies it. I had been worried about just where that was going and I can see now where it was. That is good. As far as the funding goes, you are saying you have 172 out of 173 up and running. Is that correct?

Mr Andreatta—Just a correction: 171 out of 172.

Senator ADAMS—Is there any scope for new ones in the future? Is there any sort of future planning with the existing ones? The service can go in, but would there be any more communities that would be eligible to—

Mr Andreatta—At this stage the funding agreements are 3½ years—so to 30 June 2013.

Senator ADAMS—That will then be thrown open to any communities to apply within that area?

Mr Andreatta—A decision is yet to be made on how future funding agreements will be met once these ones expire. Presumably, one option will be to have an open, competitive expression of interest arrangement.

Senator ADAMS—Will this program be evaluated before 2013? Do you evaluate how these communities have coped with the program and if they have fulfilled the guidelines?

Mr Andreatta—As part of their contractual arrangements they are required to report to the department on progress and the activities that they undertake, on a six-monthly basis.

Senator ADAMS—I will not complicate things with the question that I was going to ask. We will go to the Medical Specialist Outreach Assistance Program. It is in outcome 6. Could you help me with that—as to how it is going—and then I would like to ask about the Patient Assisted Travel Scheme; people being able to utilise that to visit the specialist who might have come out once and then they go to the city to see the specialist again. Could you tell me how popular that is and are you having any difficulty getting specialists to take up the program?

Mr Andreatta—I might pass this over to Mr Cameron.

Mr Cameron—The MSOAP is going well. The core MSOAP, noting that there have been a couple of expansions of the program in recent years, this year has planned for 1,651 services to be delivered—that is, outreach services to locations, not to be confused with individual interactions with patients. That is an increase of a couple of hundred services at this stage, assuming the full year's information pans out the same as the first six months, which we are very pleased about. The budget for the core MSOAP is approximately $19 million each year.

Senator ADAMS—You are not having problems to date getting specialists to take it up?

Mr Cameron—Not in any uniform pattern. From time to time, for a number of reasons, there will be people that cannot make a planned visit, but generally, no.

Senator ADAMS—The way the Patient Assisted Travel Scheme works is that often specialists come out to an area and see the patients and then they are not visiting again for another month and the patient has to either go up for surgery or go back for further consultation within that month. Have you had any sort of feedback on that as to people not being able to access it?

Mr Andreatta—Are you talking about accessing PATS?

Senator ADAMS—Yes, the Patient Assisted Travel Scheme.

Mr Andreatta—You would be aware that the jurisdictions have responsibility for administering and delivering the PATS arrangements. From the Commonwealth's point of view, we are involved at the moment with the states and territories through the Rural Health Standing Committee to look at PATS arrangements across all jurisdictions, with a view to putting forward to AHMAC later this year some options on how it might be made more consistent and potentially higher—

Senator ADAMS—Thank goodness for that. It would be very useful if that happened. I have written down the 'local hospital networks and the Medicare Locals and thinking about boundaries'. Probably one of the biggest issues, as far as a national focus is concerned, is to get some consistency with state boundaries so that people who are living right on the edge of one state boundary can access specialist services much closer to home in the next state.

Mr Andreatta—Certainly the cross-border issue is one of the main issues in the discussions in that standing committee and we are looking at ways to solve that.

Senator ADAMS—I hope you are utilising this committee's report.

Mr Andreatta—We are.

Senator ADAMS—And the recommendations.

Mr Andreatta—Absolutely.

Senator ADAMS—Just to remind you. I have one more, the National Rural and Remote Health Infrastructure Program.

Mr Andreatta—With that program to date, three funding rounds have been conducted and in those funding rounds we have generated over 600 applications seeking approximately $170 million worth of grants. We are currently in the fourth round stage. It closed on 29 January 2010. We had 302 applications and they were worth $87 million. We are currently going through the assessment process for those 302 applications and we expect an announcement very shortly.

Senator ADAMS—All right, we will go back to 'very shortly' and 'soon'. How long is 'very shortly'?

Mr Andreatta—We believe—and ultimately it will be for the minister to decide—that this month an announcement will be made.

Senator ADAMS—That is very good, and it will be very good news for a few people that I know that have been pestering me saying, 'What's happening?'

Senator SIEWERT—I want to ask some general questions. How are these programs going to fit in with the new process in terms of local hospital area networks and the new Medicare Locals? Is it business as usual or is there a process where you are starting to integrate some of these programs and coordinate them through the new process?

Mr Andreatta—It is a bit early to tell what will happen with these programs with the introduction of the two networks. The first 15 Medicare Local networks will not commence

until next year and I am not sure of the date for the commencement of the local hospital networks.

Senator SIEWERT—Yes, that is a bit further down the track.

Mr Andreatta—During the development of those two networks, I expect to be discussing how our rural programs would fit in there, but at this stage it is business as usual for us.

Senator SIEWERT—Do you expect that the funding for the programs is going to remain the same, so those programs will still exist but they will be coordinated in a different manner?

Ms Thompson—I think one of the positives that will come out of the introduction of Medicare Locals in regard to rural and remote communities is the ability to understand the needs and the required services in those local areas. We think that will work very well into the whole range of services that Rural Health provides at the moment.

Senator SIEWERT—Can you explain how you envisage the situation is going to be different to what it is now with Medicare Locals in terms of looking at what services are needed?

Ms Thompson—As I think was discussed yesterday, the whole concept of performance data and information will be available through Medicare Locals.

Senator SIEWERT—So you are going to use that?

Ms Thompson—Yes. It should fit very well into our understanding of what is needed in a rural or remote community. We believe it is positive and fits very well into the strategic framework of the rural health initiatives and the primary care strategy.

Senator SIEWERT—I am a little bit concerned that we do not lose the value of the programs that are running at the moment but that we do build the Medicare Locals process and the local health network process, so that we are value adding and do not end up with a nil sum gain in rural areas.

Ms Thompson—Yes, I understand. The representatives of rural organisations are fundamental to our consultation process around the introduction of Medicare Locals to ensure that we get that feedback and to ensure that it is more than a zero sum gain.

Senator SIEWERT—Thanks. Obviously it is early thinking. I will continue to follow that up because I think it is important that we add value to what we already have.

CHAIR—Thank you, Senator Siewert. That concludes questioning in outcome 6. Thank you to the officers.

[9.33 pm]

We will now go to outcome 15, Sport performance and participation. Welcome, Mr Miller, and officers from the Sports Commission. Senator Fierravanti-Wells.

Senator FIERRAVANTI-WELLS—In relation to the Commonwealth Games to be held in New Delhi, is there a contingency plan to keep our athletes in Singapore, because of security concerns in New Delhi, and fly them in and out for events?

Mr Miller—I am not aware of any of those arrangements that are being made by the Commonwealth Games Association.

Senator FIERRAVANTI-WELLS—Those arrangements would be made by the Commonwealth Games Association?

Mr Miller—Yes.

Senator FIERRAVANTI-WELLS—Would they be in consultation with you?

Mr Miller—No, they would not be in consultation with us, although we are working across the Australian government to support the Australian Commonwealth Games Association in respect of security issues that might be related to the upcoming games.

Senator FIERRAVANTI-WELLS—You have obviously had discussions pertaining to a range of matters, including security.

Mr Miller—We are working with the Commonwealth Games Association on making sure they have adequate security measures in place and that they are in a position to make the most informed decision about whether to send the team.

Senator FIERRAVANTI-WELLS—Has there been any discussion about a contingency plan?

Mr Miller—I am not privy to any of the discussions about a contingency plan.

Senator FIERRAVANTI-WELLS—Minister, is there such a contingency plan?

Senator Ludwig—I can certainly take that on notice, but it would seem to be outside the general work of the Sports Commission.

Ms Halton—Mr Rowe, can give you a little information.

Mr Rowe—The issue of security for the Australian team is really a matter for the Department of Foreign Affairs and Trade and the Attorney-General's Department. As Mr Miller has just said, he is assisting those departments by communicating messages and information about security, but the security issues themselves are not matters that are dealt with in the portfolio.

Senator FIERRAVANTI-WELLS—Minister, given the particular circumstances here, could you take on notice whether there is a contingency plan to accommodate our athletes in Singapore and fly them in and out because of concerns in relation to security.

Senator Ludwig—Just so that no-one mistakes the question, I do not know of any. The security of athletes attending the 2010 Delhi Commonwealth Games is of course in everybody's mind. It is of paramount importance to the Australian government. The Department of Foreign Affairs and Trade, though, would deal with current travel warnings and those types of things.

The Australian Commonwealth Games Association, as the organisers of the 2010 Games, would be the organisation which would discuss the safety and security of athletes. While the decision on whether Australia will participate in the Delhi Commonwealth Games is made by the Australian Commonwealth Games Association, it is not the Australian government. The Department of Foreign Affairs and Trade works closely with the Commonwealth Games Association and national sporting organisations to help Australian athletes make informed decisions about their overseas travel plans.

The Australian government will continue to monitor the security situation in India and work with the Australian Commonwealth Games Association. It seems that the question you are asking is not really one for the Australian government; it would be one that you could put to the Australian Commonwealth Games Association.

Senator FIERRAVANTI-WELLS—I will rephrase my question. Is the government aware of a contingency plan? Given the government's involvement—

Senator Ludwig—Where is the source of that story?

Senator FIERRAVANTI-WELLS—I am just asking whether you are aware.

Senator Ludwig—Did you make it up?

Senator FIERRAVANTI-WELLS—No, I did not make it up.

Senator Ludwig—I was just wondering if there was a source.

Senator FIERRAVANTI-WELLS—You have taken it on notice. If you are not aware, that is it, end of story. How many schools and out-of-school-hours care services are delivering the Active After-school Communities program?

Mr Miller—The number of schools is around 3,250, but I will get the exact number for you.

Senator FIERRAVANTI-WELLS—Do you have a breakdown of that by state?

Mr Miller—We will take that on notice.

Senator FIERRAVANTI-WELLS—Do you have it broken down by areas?

Mr Miller—We can get all of that data. I do not have that information with me.

Senator FIERRAVANTI-WELLS—By electorates?

Mr Miller—I am sure we could provide that information.

Senator FIERRAVANTI-WELLS—In relation to this program, I notice that it says in the agency budget papers at page 553, 'Increase opportunities to participate in sport'. Mr Miller, you were not here but Professor Bishop earlier today spoke in particular about issues dealing with obesity and how it was a very important health issue. I understand this program was introduced in about 2004 and has become very popular. Could you then explain to me why in 2009 the number of schools is 3,250 and in 2010 it is 3,270 but then that is it—the program seems to end. The program is ending?

Mr Miller—No, the program is not being terminated. In fact, consistent with the recommendations in the Crawford review report, the government is reviewing where it takes the program.

Senator FIERRAVANTI-WELLS—What are the options?

Mr Miller—In fact, the program is funded until 31 December this year.

Senator FIERRAVANTI-WELLS—So the intention is not to abolish it?

Mr Miller—That is a matter for the government.

Senator FIERRAVANTI-WELLS—Right. It certainly was a measure that was supported, I understand, in 2007. So at this point in time it is in limbo and we do not know where it is—

Senator Ludwig—No, it is not in limbo. The Active After-school Communities program is currently funded until 31 December 2010, so that does not put it in limbo and it is in line with the school calendar year. There has been no decision to end the program. The government is continuing to review the program in line with the Independent Sport Panel's recommendations to do so. So there was an Independent Sports Panel, they made a recommendation and we are undertaking that process.

Senator FIERRAVANTI-WELLS—The footnote says, 'The government is considering the future of this program,' which implies that one option could be to abolish it.

Senator Ludwig—That is not the advice that I have at this point. What I have said is that, clearly, it is funded until 31 December 2010, and the government is continuing to review the program in line with the Independent Sports Panel's recommendation.

Senator FIERRAVANTI-WELLS—Okay. We might move on to the FIFA World Cup in South Africa and your involvement in that. On the last occasion when we were here, on 10 February, I asked some questions in relation to the bid, and I think Mr Eccles was with us.

Ms Halton—And he is again tonight.

Senator FIERRAVANTI-WELLS—He is again? Mr Eccles, there you are at the end.

Ms Halton—That cheerful little football enthusiast down the end of the table.

Senator FIERRAVANTI-WELLS—On the last occasion we were talking about the bid and the commitment to the bid. Can you tell me how many employees of the department are attending the World Cup in South Africa?

Ms Halton—This is a sad number.

Mr Eccles—At this stage there is the potential for one.

Senator FIERRAVANTI-WELLS—One, okay.

Ms Halton—Do you want to ask who that might be, Senator?

Senator FIERRAVANTI-WELLS—I do not think I need to ask.

Ms Halton—He has got his football boots strapped on as we speak.

Senator FIERRAVANTI-WELLS—How many employees of the Australian Sports Commission will be attending?

Mr Miller—None.

Senator FIERRAVANTI-WELLS—On the last occasion, Ms Halton, you told us how committed the Prime Minister was in supporting and making a bid for the World Cup.

Ms Halton—Yes.

Senator FIERRAVANTI-WELLS—I would assume that the Prime Minister will be attending the World Cup. Is that the case?

Ms Halton—I cannot possibly answer for the Prime Minister.

Senator FIERRAVANTI-WELLS—Senator Ludwig?

Senator Ludwig—I do not know, Senator Fierravanti-Wells. I can inquire on your behalf.

Senator FIERRAVANTI-WELLS—I would have thought that, since the Prime Minister is so assiduously chasing his bid for a seat on the UN Security Council, this would be a very good opportunity for him—

CHAIR—It is very late to be making comments.

Senator Ludwig—That is not the circumstance. You have made a statement that is unsupported. Is there a question there?

Senator FIERRAVANTI-WELLS—I have just noticed the commitment that the government has made of $400 million in foreign aid to Africa by 2015. Given recent press statements, I would have thought that this could be a great opportunity for the Prime Minister to do a Quentin Bryce and visit Africa.

Senator Ludwig—Is there a question?

Senator FIERRAVANTI-WELLS—Will you take on notice whether the Prime Minister is going?

Senator Ludwig—I already have.

Senator FIERRAVANTI-WELLS—Thank you. I was going to ask whether the Prime Minister was going to be wearing a tracksuit, as Prime Ministers normally do, but I will not pursue that one.

Senator LUNDY—You are trying to score a point and it is not working!

Senator FIERRAVANTI-WELLS—I want to ask a question in relation to the minister's international travel since December 2007. Senator Mason has asked—and I will put these on notice for him—

Senator Ludwig—They may have to go to PM&C, if they were talking about—

Ms Halton—International travel, because we do not—

Senator Ludwig—the Prime Minister's travel.

Senator FIERRAVANTI-WELLS—No, these are talking about the Minister for Sport.

Senator Ludwig—I have got you.

Ms Halton—We are not responsible for international travel for our ministers.

Senator Ludwig—Yes. Those questions would normally be asked of PM&C or Finance.

Ms Halton—Finance.

Senator FIERRAVANTI-WELLS—All right. I will get Senator Mason to put those questions—

Senator LUNDY—Put them on notice, please.

Senator FIERRAVANTI-WELLS—There is a list of programs here that I have. Senator Mason wanted me to ask these questions in relation to total funding for a series of programs—over the forward estimates—and whether that was funding involving multiple governments

and, if so, what the federal government's contribution was. Is it better if I just simply tender that list and then you can take that on notice?

Ms Halton—I think so.

Senator FIERRAVANTI-WELLS—Could you also take on notice: if is funded by multiple federal government departments, what is this department's funding contribution?

Ms Halton—Yes, happy to do that.

Senator FIERRAVANTI-WELLS—And what is the number of staff positions allocated to the program et cetera. I will put those questions on notice. On the last occasion, I asked whether Mr Harvey and Mr Dixon had been engaged in relation to the bid for the World Cup in 2018 or 2022. The answer provides those details. Are Mr Dixon and Mr Harvey still engaged in any way with the commission?

Ms Halton—They were not engaged with the commission. They were engaged in assisting the government—

Senator FIERRAVANTI-WELLS—Sorry, I beg your pardon. I meant are they engaged with the department?

Ms Halton—Yes, they are.

Senator FIERRAVANTI-WELLS—They are still engaged with the department?

Ms Halton—Yes, they are, because the bid is still ongoing.

Senator FIERRAVANTI-WELLS—Could you take on notice the outline of what they are doing and the cost of their contract?

Ms Halton—Sure.

Senator FIERRAVANTI-WELLS—Thank you very much.

Ms Halton—I think, as I indicated last time, Mr Dixon is pro bono, obviously other than expenses, but I am happy to do that.

Senator FIERRAVANTI-WELLS—I may have a couple more questions, but perhaps if Senator Lundy—

CHAIR—Senator Lundy.

Senator LUNDY—Thank you, Chair. Can the Sports Commission outline what the government is doing to support the next generation of Australian Olympic champions, particularly with respect to the talent identification program?

Mr Miller—Yes. There is a doubling of effort proposed as part of the 'pathways to success' response to the Crawford review in respect of talent identification and development and the additional money that has been granted. That will be tendered, in addition to a review of the program and how it works within sporting organisations.

To broaden it beyond talent identification, though, I think it is also important to recognise that the government is doing a lot in respect of doubling its Local Sporting Champions program, which does provide an opportunity for particularly regional young Australians to grow their sporting prowess through attending various competitions domestically.

Senator LUNDY—Just going into a bit more detail about the talent identification program, how many sports now run a formal talent ID program?

Mr Miller—I am advised that there are 13.

Senator LUNDY—In terms of doubling that effort, does it mean that more sports are going to have talent ID programs or that you will expand the reach of those that already exist?

Mr Miller—We are still very much in the early and formative days of developing the absolute precise responses, but our early thinking is that we will be doubling the number of sports that would be involved in NTID, as we call it, to around 25, and they would have the opportunity to employ developmental staff et cetera within those national sporting bodies.

Senator LUNDY—Some years ago there was quite a bit of discussion about some of the benefits of talent identifying across sports, particularly looking at young people who may be excelling in one sport that lends itself to strong attributes in another. Is that being developed as part of this or has that developed over the last couple of years?

Mr Miller—I might ask one of my directors to add to it. I must say, one of the pleasing things that I have experienced in the 12 months I have been in this job is to see a number of examples where that exact thing has happened. I would particularly cite Carly Light, who won the Australian road cycling championships, who talent-transferred into cycling about 18 months before from equestrian. That is an example of where sports have benefited. Obviously some of the Winter Olympians as well have come out of other sports and gone on to great things, but I do not have any other details in respect of the numbers of athletes involved that are in that talent-transfer space.

Senator LUNDY—Will those talent ID programs continue to be run with a combination of the national sporting organisation, the state institutes and the Australian Institute of Sport providing support through testing, lab work et cetera?

Ms J Flanagan—Yes, all of those players are very integral to the talent identification pathway. The partnership that is being strengthened between the institutes will ensure that the pathways are as robust as they can be in that respect.

Senator LUNDY—Can you describe the changes resulting from the Crawford review and the government's response to how we are supporting Olympic athletes?

Ms J Flanagan—As a result of the Crawford review and the government's response to that review, there are a range of measures that are being developed and will be implemented to support our athletes in high performance across all areas, including Olympic sports. In particular, we will bolster the direct athlete support to the top athletes and filter that down further into the development pathway. We will be providing more support to recruit and retain our best coaches. Of course, the talent identification pathway is critical. Additionally, we will be providing more support to the daily training environment, through our service providers in sports science medicine, and also athlete career and education, particularly for further development of the athlete wellbeing area.

Senator LUNDY—What is the overall increase in this year's budget to this important task?

Ms J Flanagan—For the high-performance component?

Senator LUNDY—Yes.

Ms J Flanagan—It is $30 million.

Senator LUNDY—How does that compare to the existing budget? What is the existing budget? I am trying to get the detail of the magnitude of the increase.

Mr Miller—The current budget is $159 million; so about 25 per cent.

Senator LUNDY—Significant. Very good.

Ms J Flanagan—Sorry, there is one other thing I did not mention. We are also providing more support for international competition for our athletes.

Senator LUNDY—Getting teams overseas?

Ms J Flanagan—Sending teams overseas, as well as strengthening our domestic national league competitions.

Senator LUNDY—What is going into the domestic national league competitions?

Ms J Flanagan—We will be providing support to two new sports on the Olympic agenda—rugby sevens and golf—and also bolstering support, particularly for our women's national leagues, in a number of our sports.

Senator LUNDY—How will that support be provided?

Ms J Flanagan—Through additional revenue to market and brand the events, and obviously media coverage as well where possible.

Senator LUNDY—Do you envisage that that would result in a form of subsidisation of the media coverage of national competitions for women?

Ms J Flanagan—Yes.

Senator LUNDY—Similar to previous funding?

Ms J Flanagan—Obviously we have to consider the quantum, but we will try and allocate as a priority where we think it will have the most benefit for the sports.

Senator LUNDY—If a national women's league believed they had a good case to approach the government for support, what would the process be?

Ms J Flanagan—With the new funding, we will be looking at a process whereby sports across the board will be able to put in a bid to access that funding, and we will assess it against a range of criteria, including their overall sports planning—the whole strategic planning.

Senator LUNDY—So you look at their strategic plan as a sport as well?

Ms J Flanagan—Yes.

Senator LUNDY—Is there a figure on the pool of funding that would be available for that purpose?

Ms J Flanagan—No. We are still working that out as we allocate the money.

Senator LUNDY—While we are on the issue of women's sport, there have been some good results lately.

Mr Miller—You were not thinking of the Matildas, were you?

Senator LUNDY—I know. I am going to go straight there. The Southern Stars and the Matildas, of course.

Senator FIERRAVANTI-WELLS—Regrettably not in the not in the parliamentary arena, Senator Lundy.

Senator LUNDY—What's that?

Senator FIERRAVANTI-WELLS—Our women's parliamentary teams.

Senator LUNDY—Yes, but you do not play soccer. We do quite well in that department.

Ms Halton—I was going to ask last night, at the women's thing down at the National Library, but I did not get the chance because we only had 10 minutes each—and now you have given me the opportunity—'What is wrong with this photo?' And the answer is: 'It's not on the front page.'

Senator LUNDY—It is on page 3.

CHAIR—That's right. Exactly. Absolutely. If it had been a male sport, it would have been on the front page!

Ms Halton—It was not on the back page of the sports page and it was not on the front page. It was on page 62 in the *Tele*, so it is not even on the front or the back, which is where it should have been.

Senator LUNDY—It should. In fact, I understand this was the subject of a report commissioned by the department with regard to the portrayal of women's sport in Australia. Ms Halton, perhaps you would care to outline some of the main findings of that committee, seeing you have begun that task already. You are quite right.

Ms Halton—My colleagues can do that. I have calmed down now, but I was quite irritated by that.

Senator LUNDY—It is a worthy observation to make, because of course one of the findings was that women's sport still receives less than 10 per cent.

Ms Halton—Exactly.

Senator LUNDY—In some cases very small percentages of the proportion of coverage. We have already talked a little bit about a policy that will help change this by getting more women's sport out there.

Ms Halton—Yes.

Senator LUNDY—What other things can be done from a public policy perspective, recognising of course that we are dealing with the free market and the media and various editorial decisions about what subject matter is covered and what is not? How will you make a difference?

Mr Miller—We have had that report that you alluded to.

Senator LUNDY—What is its proper title?

Mr Miller—It is *Towards a level playing field: sport and gender in Australian media*. We have a workshop scheduled in July, as a part of our Sporting Futures conference on the Gold Coast, to start to work through what practical things might be done to progress that report.

It is not just the media issue. As you would be aware, in the response to the Crawford review, there have been a range of initiatives promulgated in respect of advancing the cause of women in sport, particularly looking not just to improve the media coverage but to establish a new register of women in sport and to increase the leadership grants available for women. It is recognised that one of the ways we need to push that agenda is to get more women into senior roles in national sporting bodies, so there is a lot of focus there. The government also intends to establish a women in sports awards program. There are a range of things that the government is proposing to do to advance in a more generic sense the role of women's sport. But it is early days in terms of some of the practical things in responding to the *Towards a level playing field* report.

Senator LUNDY—Does the Australian Sports Commission monitor the television ratings of women's sport that is actually covered and broadcast on free-to-air TV?

Ms J Flanagan—No, we do not. However, having undertaken this research recently, we will be putting in place a mechanism to do more regular ongoing monitoring. We now have a great platform and the methodology to do that and we will ensure that that happens.

Senator LUNDY—That is excellent news. Will it be an annual survey?

Ms J Flanagan—Biennial.

Senator LUNDY—Excellent.

Mr Miller—The other thing I think is worth noting is that many national sporting organisations are taking up these issues in a proactive way and looking at how they can grow their businesses by increasing women's participation in their sports. That is evident in some of their planning.

Senator LUNDY—Do you compile statistics of the proportion of women in the sports that the ASC provides funding for, that sort of thing—a gender based statistical analysis or trend growth?

Ms J Flanagan—In terms of actual senior management positions and board membership we do. In terms of participation rates, we rely on the sports to actually—

Senator LUNDY—This takes us to an interesting area, doesn't it?

Ms J Flanagan—Yes, it does.

Senator LUNDY—Let's go there. What can the Sports Commission do to get a more accurate picture of the participation levels across all age groups in the respective sports?

Ms J Flanagan—We are currently reviewing how we collect our statistical data for participation rates and we are working with our system partners in the state departments of sport and recreation and also the Australian Bureau of Statistics to look at a more robust methodology around collecting that data.

Senator LUNDY—You have anticipated where I was going next. Is it the Sports Commission's role, or is it a role, because of the broader health implications of physical

activity, better associated with another area of the health department in conjunction with stats, and how does sports participation relate to the physical activity population analysis, which I know we have struggled with as a statistical dataset for many years now as well?

Ms Halton—We had that conversation earlier on, Senator. I think you were here when we discussed the health survey. I was talking about my informant who I had been talking to about that particular survey. I know that that informant and my colleague Mr Miller here were having a conversation about exactly this issue today. The good thing is that the Bureau of Statistics is looking very much at how it can—I think the jargon would be—'increase its footprint', which in this context is particularly relevant: to look at both the health data and the sports data. There is a job of work to be done with the states in making sure that that is connected and unified and all the rest of it. But I can assure you that that is something that is being very actively looked at.

Senator LUNDY—That is good to hear. I certainly have an appreciation of the complexity of it. So much of Australians' participation is not necessarily through organised sport anyway.

Ms Halton—Exactly.

Senator LUNDY—It is often swimming, walking or tennis that is not through a club.

Ms Halton—That is right.

Mr Miller—Could I add to the secretary's comments. As she pointed out, there was some active discussion with state departments of sport and rec today. The other thing to note is that the government's response to Crawford also envisages a new national sport and active recreation policy framework. One of the issues in that policy framework is clarifying the definitions around participation. That will be participation, obviously, in the active recreation space as well as the sports space. Existing datasets are fairly limited, certainly from our perspective, and that has been the subject of the work that we are doing within government with our colleagues in the Department of Health and Ageing, but also with the Australian Bureau of Statistics so that we do get more robust measures going forward.

Senator LUNDY—Thank you. You mentioned earlier the Local Sporting Champions program and an increase in numbers. Can you tell me how many people have benefited from that program and the level of investment that is now being made. What it is being lifted up to?

Mr Miller—It is my understanding that since the inception in 2008-09 the Local Sporting Champions program has provided financial support to almost 3,000 applicants. The investment, as a part of the 'pathways to success' response, will see a doubling of the amount of funding available under the program to $3.2 million per year—up from $1.6 million, I can only assume.

Ms J Flanagan—That is right.

Senator LUNDY—I presume this excellent decision has been based on the strong demand for the program. Will that mean that you are able to give bigger grants to young people looking for this assistance or will just more people receive the assistance? Is there a maximum to the grant?

Mr Miller—Yes, there is. The program does not envisage increased quantums per individual or team. It just envisages more people getting access to the funds.

Senator LUNDY—More people being supported, yes.

Ms J Flanagan—There is so much unmet demand for it.

Senator LUNDY—Did the program reach its cap? Was it fully expended and the demand was still there?

Ms J Flanagan—Yes, in the last financial year.

Senator LUNDY—Excellent. Just for the sake of completeness, can you give a brief outline to the committee about the purpose of that local sporting heroes grant and what it assists athletes to do.

Ms J Flanagan—It assists athletes to attend under-age competitions, at state or national level, and it can assist with paying for accommodation, any of the team or individual fees or transport, that sort of thing. It has been very well received by local families all around Australia. $500 makes a big difference to families and $3,000 for the teams also goes a long way.

Mr Miller—Could I add that the program this year is going to be expanded to include coaches, umpires and referees, not just athletes.

Senator LUNDY—Really?

Mr Miller—Yes.

Senator LUNDY—That is terrific. I know people personally whose kids have not been able to participate because of their socioeconomic circumstances. So, for what it is worth at that anecdotal level, this is making a real difference to whether or not kids, once selected in a team, are actually able to follow through and participate. What is the government doing with regard to asking athletes to give back to sport whilst they are on scholarships? So many athletes do. I know many who spend a huge amount of time in schools, in the community, working with disadvantaged kids et cetera, but what is built into the program of your scholarship athletes in this regard?

Ms J Flanagan—What we are instigating is, through their personal development training with the Athlete Career and Education program, a coaching and officiating training program. Some of the athletes will already have that, but if they do not they will be asked to participate in that and, as part of their community service requirements, to give back at a particular point in time to local community clubs in some shape or form.

Senator LUNDY—How do you monitor that? How do you keep an eye on that? How do you manage that?

Ms J Flanagan—We have got a very good education program with our athletes. They are very well attuned to participating in that from a personal development perspective and they are very keen to help, even in community service type arrangements—going out to disadvantaged areas et cetera. It is more about just fitting it in with their scheduling and making sure that we are realistic about what they can achieve, but they are very focused on, where possible, giving back. They understand what that means.

Senator LUNDY—What sort of response do you get from athletes? The ones I know do this sort of thing anyway, but I would imagine it is pretty positive.

Ms J Flanagan—It is very positive, and it is very positive for communities to see it. It is just a great thing for some of our top athletes and developing athletes to be out there at grassroots level or in the local community helping out.

Senator LUNDY—That is good. Going back to women's sport, did the Sports Commission participate in the international women's sport congress in Sydney recently?

Ms J Flanagan—Yes, it did. We were part of the organising group. We also gave a number of presentations as part of the conference and convened a number of side workshops.

Senator LUNDY—What was the take-out for the Sports Commission of that congress? Given that only occurs every 10 years or so and we were lucky enough to have one here in Australia, what is the legacy it is going to leave in the eyes of the Sports Commission?

Ms J Flanagan—One of the biggest legacies is the networking and the links that are made, nationally and internationally, between women in leadership positions and women looking to attain leadership positions and play a role in sport. What they learnt from each other was quite significant—the good as well as the bad—and already the communication channels have really opened up. From an Australian point of view, the access for Australian women to that level of conference has been very well received.

Senator LUNDY—Excellent. Going back to the direct athlete support, how many athletes are currently receiving direct athlete support and do you have any idea of changes to that as that program expands?

Ms J Flanagan—There are around 445 currently receiving support and that will increase to just over 620. The quantum of funding they receive will increase as well.

Senator LUNDY—By how much? I know it varies.

Ms J Flanagan—It does vary. Because sports allocate that, accordingly we are working on that.

Senator LUNDY—Yes. That is a significant percentage increase again. It is about another 30 per cent.

Mr Miller—Whilst the precise quantums are yet to be established, we can say that in the government's response to Crawford it is envisaged that top three ranked athletes get significant increases in support, and the support is broader in that it goes to supporting, at some level, top eight or top 10 athletes.

Ms J Flanagan—And also, below that, some of our emerging athletes, our developing athletes.

Senator LUNDY—Refresh my memory. One of the issues with direct athlete support was that there was not enough funding to go around necessarily beyond the top athlete or the top two, so the policy change here is that the top three will get that support?

Ms J Flanagan—They will get the top level. There is further support to the top 10 and then there is more support down below that.

Senator LUNDY—The Crawford review and the positive response by the government placed an emphasis on supporting participation in sport, so not elite pathways but development pathways. How is that—making participation in a sport for fun and physical

activity sustainable—manifesting itself as far as the actual policy or program by the Sports Commission?

Mr Miller—It is early days, but the primary way we will be pushing forward is in partnership with the state departments of sport and rec. In round figures, about $18 million per annum of the increased funding is directed towards improving participation. That is going to be across a range of areas, but the primary strategy is to get national sporting organisations to embed participation plans as part of their overall strategic planning for their sport and then to work through their state bodies down to the clubs to strengthen across the entire pathway. The key focus is strategic investment through the national sporting organisations to get them attuned to the notion of having strategic participation plans as well as high-performance plans. To date, they have tended to focus more on the high performance.

Senator LUNDY—I am very pleased to hear that. From a public policy perspective, it has been a long time coming. I think it comes down to providing the leadership and emphasis on the value of participation per se and I would like to commend you for that direction. I think it was a great outcome of the review.

Mr Miller—Thank you.

Ms J Flanagan—Additionally, embedded within that are a number of strategies for particular population groups and also for children, particularly with our sport and education strategy which we are supporting DoHA and DEEWR in developing, and also our volunteer strategy and social inclusion strategy.

Senator LUNDY—What about Indigenous participation in sport?

Ms J Flanagan—That falls into the social inclusion strategy. We are currently, with our partners in DoHA and the states, looking at the whole Indigenous sport and active recreation area to ensure that we can provide a better coordinated and aligned support mechanism for Indigenous people.

Senator LUNDY—Is there a program or a source of grants within the Sports Commission for the kinds of programs that evolve out of communities, prove to be successful, might not necessarily be effectively replicated everywhere, but are working for that community? How do you support those kinds of almost one-off success stories, whether they are in Indigenous communities or others?

Ms J Flanagan—At the local level that does fall into the realm of the states. However, what we are trying to do in a better partnership model with the states is have a repository of case studies and things that are working well so that we can use that when we are advising and working with our sports on how to best get community outcomes.

Senator LUNDY—Finally—because I could just keep asking questions all night, but I should defer to my colleagues—on facilities funding: I know there is facilities funding that comes from a range of sources. Is the Sports Commission involved in facilities funding at all?

Mr Rowe—The management of facilities funding is handled by the department rather than the commission.

Senator LUNDY—That is what I thought. Is there facilities funding allocated in this budget?

Mr Rowe—No, Senator.

Senator LUNDY—Thank you.

CHAIR—Thank you. Senator Fierravanti-Wells.

Senator FIERRAVANTI-WELLS—Thank you. Mr Eccles, I am curious: what happens after July? Does that mean that you hang up your boots and Ms Halton finds another job for you somewhere?

Ms Halton—I will find him another job, Senator. Don't you worry about that!

Senator FIERRAVANTI-WELLS—Okay.

Mr Eccles—But my boots will remain well and truly secured until 2 December at least. On 2 December, FIFA will make the call as to the successful bidding nations for 2018 and 2022.

Senator FIERRAVANTI-WELLS—So your role of football World Cup task force is not just what is happening now?

Mr Eccles—No. The football World Cup that is being played in South Africa over the next month or so is separate to the bidding process that Football Federation Australia is going through. They are bidding for either the 2018 or the 2022 world cup, and that decision will be made in early December.

Senator FIERRAVANTI-WELLS—What other major sporting events is the Sports Commission attending or participating in over the next 12 months?

Mr Miller—My understanding is that it would be normal for the commission to attend the Commonwealth Games in Delhi. That would be the only event that I would—

Senator FIERRAVANTI-WELLS—How many people will be going from the commission? What is the contingent?

Mr Miller—No decision has been made. It will be one or two at the most.

Senator FIERRAVANTI-WELLS—If I have understood it, Mr Miller, your average staffing level for 2009-10 is 744.

Mr Miller—What page are you referring to?

Senator FIERRAVANTI-WELLS—I am on page 548.

Mr Miller—Yes.

Senator FIERRAVANTI-WELLS—That goes down to 639.

Mr Miller—Yes.

Senator FIERRAVANTI-WELLS—Could you explain that drop to me.

Mr Miller—That drop reflects the half-year impact of the loss of staff from the AASC program. The AASC program—the Active After-school Communities program—has only been funded until December, so half of the year's FTE is reflected in that drop.

Senator FIERRAVANTI-WELLS—I understand. Your departmental expenses are $60 million or thereabouts.

Mr Miller—No, it is more than that. It is about $248 million.

Senator FIERRAVANTI-WELLS—That has gone up from $223 million in 2009.

Mr Miller—Yes.

Senator FIERRAVANTI-WELLS—I noticed in your last annual report that there is a section on grants. There is what I assume is a domestic component, an Australian component, and then there is an overseas component. Could you tell me what your overseas component is.

Mr Miller—I will get one of my directors that has responsibility for this program to talk to it, but primarily I think the question you are asking relates to the work that we do in conjunction with AusAID and our Australian Sports Outreach Program, where we deliver sports development activities in a range of international jurisdictions.

Senator FIERRAVANTI-WELLS—Has that been happening for some years?

Mr Miller—My understanding is that that is the case, but Mr Nance will be able to provide further commentary on that.

Mr Nance—Yes. The Australian Sports Outreach Program has effectively been doubled in the last couple of years in terms of its reach. It is up to around $4 million a year. It reaches out into a number of countries in the Pacific region, Southern Africa and the Caribbean.

Senator FIERRAVANTI-WELLS—Under the heading 'Increase opportunities to participate in sport' at page 551, I got the impression from questions that you answered for Senator Lundy that the establishment of women in sport awards was a new initiative for the next financial period.

Mr Miller—Correct.

Senator FIERRAVANTI-WELLS—Do I assume that 'Strategic partnerships established with key stakeholders to plan and implement community sports development programs in the Pacific, Asia, Southern Africa and Caribbean regions' falls into that same category?

Mr Miller—Being new?

Senator FIERRAVANTI-WELLS—Yes.

Mr Miller—My understanding is that they are existing programs and we will continue to deliver those programs.

Senator FIERRAVANTI-WELLS—So there has been an increase in funding? You have gone from what to what?

Mr Miller—There is no increase in funding for that particular program for 2010-11.

Senator FIERRAVANTI-WELLS—So why are there increased opportunities? I am trying to understand whether we have more partnerships with the Pacific, Asia, Southern Africa and Caribbean regions.

Mr Miller—I cannot see where it says 'increased opportunities'.

Senator FIERRAVANTI-WELLS—At the bottom, in the last box on the left-hand side.

Mr Miller—It says:

Agreements in place within agreed timeframes with partner countries in regions—

Senator FIERRAVANTI-WELLS—Just left of that. I got the impression from what you said to Senator Lundy before that these are increased opportunities and that was a new program—and 'strategic partnerships' underneath it. Are you saying they are new—

Ms Halton—No.

Mr Miller—No, they are ongoing.

Senator FIERRAVANTI-WELLS—partnerships or the extension of an existing partnership?

Mr Miller—They are continuing.

Senator FIERRAVANTI-WELLS—So where is the increase?

Mr Miller—The establishment of women in sport awards is a new initiative. It says:

National sporting organisations implement inclusion—

Senator FIERRAVANTI-WELLS—I can read that, Mr Miller, but I want to know where the increase is in the 'strategic partnerships established', which is in that fourth box at the bottom. What is the component of increase there? What extra things are we doing in the Pacific, Asia, Southern Africa and Caribbean regions that warrant them to be included in 'increase opportunities'?

Mr Nance—The programs take a period of time to establish. Some of them were started four years ago, and they are ongoing. As the funding was increased in previous years, the cut-in to develop the programs occurs over a period of time. So in this next year there will be increased opportunities for those existing programs as they roll out.

Senator FIERRAVANTI-WELLS—What extra are we actually doing on the ground? I am interested in the areas.

Mr Nance—What extra are we doing on the ground?

Senator FIERRAVANTI-WELLS—Yes. What does it actually mean?

Mr Nance—The increase in funding in previous financial years has basically doubled the amount of money available and doubled the reach into the Pacific countries. You are dealing with a small number of countries to start off with, three or four, and it is now reaching into six or seven. The countries that you are looking at are small Pacific island nations: Kiribati, Nauru, Samoa.

Senator FIERRAVANTI-WELLS—What about Asia?

Mr Nance—India came in last year, late in the piece—South Asia. There are no specific Asian countries targeted in the program.

Senator FIERRAVANTI-WELLS—What about Southern Africa?

Mr Nance—In Southern Africa there is one program in South Africa, working in a township there. It is a small-scale program that has been around for several years.

Senator FIERRAVANTI-WELLS—And in the Caribbean?

Mr Nance—That is a similar program with a partner agency in Trinidad. It works through an NGO there and has remained constant for a number of years.

Senator FIERRAVANTI-WELLS—In terms of your departmental expenses, could you tell me what component of that is travel?

Mr Miller—I will have to take that on notice.

Senator FIERRAVANTI-WELLS—Thank you. I think that covers my questions, thank you.

CHAIR—Thank you very much. Thank you to the officers from outcome 15. We appreciate your time. Thank you, Ms Halton, for your staff and their activities for the last two days. Happy birthday, Mr Learmonth! Thank you, Minister.

Senator Ludwig—Thank you, Chair, and thank you, committee members.

CHAIR—Thank you, Hansard. We now stand adjourned until tomorrow at 8.30 when we do Indigenous programs.

Committee adjourned at 10.28 pm