COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

ESTIMATES

(Budget Estimates)

THURSDAY, 3 JUNE 2004

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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Thursday, 3 June 2004

Members: Senator Knowles *(Chair)*, Senator Greig *(Deputy Chair)*, Senators Barnett, Denman, Humphries and McLucas

Senators in attendance: Senators Allison, Barnett, Cherry, Crossin, Forshaw, Humphries, Knowles, McLucas, Moore, Payne, Webber and Wong

Committee met at 9.03 a.m.

HEALTH AND AGEING PORTFOLIO

Consideration resumed from 2 June 2004

In Attendance

Senator Ian Campbell, Minister for Local Government, Territories and Roads

Department of Health and Ageing

Whole of Portfolio

Executive

Ms Jane Halton, Secretary
Mr Philip Davies, Deputy Secretary
Ms Mary Murnane, Deputy Secretary
Professor John Horvath, Chief Medical Officer

Business Group

Ms Alison Larkins, Acting Chief Operating Officer, Business Group
Mr Stephen Sheehan, Chief Financial Officer, Finance Branch
Ms Eija Seittenranta, Chief Information Officer, Technology Group
Ms Wynne Hannon, General Counsel, Legal Services Branch
Ms Michelle Baxter, Assistant Secretary, Legal Services Branch

Portfolio Strategies Division

Mr David Webster, First Assistant Secretary, Portfolio Strategies Division
Mr Greg Roche, Assistant Secretary, Parliamentary and Portfolio Agencies Branch
Ms Shirley Browne, Director, Parliamentary and CSSS Section
Mr Jamie Clout, Assistant Secretary, Budget Branch

Audit and Fraud Control

Mr Phillip Jones, Assistant Secretary, Audit and Fraud Control Branch

Outcome 1 - Population Health and Safety

Population Health Division

Mr Andrew Stuart, First Assistant Secretary, Population Health Division
Prof John Mathews, Medical and Scientific Director, Population Health Division
Dr Tom Ioannou, Assistant Secretary, Strategic Planning Branch
Ms Sarah Major, Assistant Secretary, Food and Environmental Health Branch
Ms Lesley Podesta, Assistant Secretary, Communicable Diseases Branch

Ms Jenny Hefford, Assistant Secretary, Drug Strategy Branch
Ms Carolyn Smith, Assistant Secretary, Targeted Prevention Programs Branch

Primary Care Division

Mr David Learmonth, First Assistant Secretary
Mr Richard Eccles, Assistant Secretary, Budget and Performance Branch
Ms Leonie Smith, Assistant Secretary, General Practice Programs Branch
Ms Lisa McGlynn, Assistant Secretary, Primary Care Programs Branch
Ms Judy Daniel, Assistant Secretary, Primary Care Policy Branch

Therapeutic Goods Administration

Mr Terry Slater, National Manager
Dr John McEwen, Principal Medical Adviser
Dr Leonie Hunt, Director, Drug Safety and Evaluation Branch
Dr Larry Kelly, Acting Director, TGA Laboratories
Mr Pio Cesarin, Director, Non-Prescription Medicines Branch
Ms Rita Maclachlan, Director, Office of Devices, Blood and Tissues
Dr Fiona Cumming, Principal Scientific Adviser, Trans Tasman and Business Management
Dr David Briggs, Acting Director, Office of Complementary Medicines
Dr Margaret Hartley, Director, Office of Chemical Safety
Dr Sue Meek, Gene Technology Regulator
Ms Elizabeth Flynn, Assistant Secretary, Policy and Compliance Branch, Office of the Gene Technology Regulator
Mr Jonathan Benyei, Assistant Secretary, Evaluation Branch, Office of the Gene Technology Regulator
Ms Ngaire Bryan, Executive Director, Trans Tasman and Business Management Group
Ms Christianna Cobbold, Director, Trans Tasman Group
Mr Michel Lok, Chief Finance Officer, Therapeutic Goods Administration
Ms Terry Lee, Director, Legal Services Group
Mr Tony Gould, GMP Auditor, Office of Devices, Blood and Tissues
Dr Albert Farrugia, Manager, Blood and Tissues Unit, Office of Devices, Blood and Tissues
Mr Stephen Howells, Section Head, Surveillance Section, Trans Tasman and Business Management Group

Food Standards Australia New Zealand

Mr Graham Peachey, Chief Executive Officer, Food Standards Australia New Zealand
Dr Marion Healy, Chief Scientist, Food Standards Australia New Zealand
Ms Claire Pontin, General Manager, Office of Safety and Services, Food Standards Australia New Zealand
Ms Melanie Fisher, General Manager, Office of Food Standards, Food Standards Australia New Zealand
Mr John Fladun, General Counsel, Office of Legal Counsel, Food Standards Australia New Zealand
Mr Paul Brent, Section Manager, Product Safety Standards, Food Standards Australia New Zealand

Mr Steve Crossley, Section Manager, Modelling, Evaluation and Surveillance, Food Standards Australia New Zealand

Australian Radiation Protection and Nuclear Safety Agency

Dr John Loy, Chief Executive Officer, Australian Radiation Protection and Nuclear Safety Agency

Outcome 2 - Access to Medicare

Medical and Pharmaceutical Services Division

Ms Judy Blazow, First Assistant Secretary
Ms Rosemary Huxtable, Assistant Secretary, Medicare Benefits Branch
Dr Jane Cook, Senior Medical Adviser, Medicare Benefits Branch
Ms Joan Corbett, Assistant Secretary, Pharmaceutical Benefits Branch
Ms Ruth Lopert, Medical Adviser, Pharmaceutical Benefits Branch
Mr Chris Sheedy, Assistant Secretary, Diagnostics and Technology Branch
Mr Tony Kingdon, National Manager, Office of Hearing Services
Mr Allan Rennie, Assistant Secretary, Pharmaceutical Access and Quality Branch

Acute Care Division

Dr Louise Morauta, First Assistant Secretary, Acute Care Division
Ms Linda Addison, Assistant Secretary, Private Health Insurance Branch
Mr Charles Maskell-Knight, Principal Adviser, Medical Indemnity Branch
Ms Alex Rankin, Assistant Secretary, Acute Care Strategies Branch
Mr Mike Clarke, Acting Assistant Secretary, Acute Care Development Branch
Dr Bernie Towler, Medical Adviser, Acute Care Division

Primary Care Division

See Outcome 1

Health Insurance Commission

Mr Jeff Whalan, Managing Director
Mr James Kelaher, Deputy Managing Director
Mr Geoff Leeper, National Manager, Operations
Mr David Hancock, Manager, PBS Branch, Program Management Division
Mr Lou Andreatta, Manager, Medicare Reform Taskforce, Program Management Division
Mr John Trabinger, Manager, Medicare Branch, Program Management Division
Dr Janet Mould, General Manager, Program Review Division
Mr John Lee, Chief Finance Officer, Finance and Planning Division
Ms Ellen Dunne, General Manager, Program Management Division
Dr Brian Richards, Chief Information Officer
Ms Lynne O'Brien, Manager, Pharmaceutical Benefits Scheme Initiatives, Program Review Division
Ms Gabrielle Davidson, Manager, Privacy Branch, Office of the Chief Information Officer
Mr Peter McMahon, Manager, Business Relations and Development, ECLIPSE, Business Improvement Division

Outcome 3 - Enhanced Quality of Life for Older Australians

Ageing and Aged Care Division

Mr Nick Mersiades, First Assistant Secretary, Ageing and Aged Care Division
Mr Mark Thomann, Assistant Secretary, Office for an Ageing Australia

Mr Warwick Bruen, Assistant Secretary, Community Care Branch
Mr Stephen Dellar, Assistant Secretary, Residential Program Management Branch
Ms Virginia Hart, Assistant Secretary, Policy and Evaluation Branch
Dr David Cullen, Executive Director, Policy and Evaluation Branch
Ms Jane Bailey, Assistant Secretary, Quality Outcomes Branch

Information and Communications Division

Dr Robert Wooding, First Assistant Secretary, Information and Communications Division

Aged Care Standards and Accreditation Agency

Mr Mark Brandon, Chief Executive Officer
Mr Ross Bushrod, General Manager, Accreditation

Outcome 4 - Quality Health Care

Acute Care Division

See Outcome 2

Primary Care Division

See Outcome 2

National Blood Authority

Dr Alison Turner, General Manager
Mr Peter Degraaff, Branch Manager, Contract Management and Supply Planning
Ms Stephanie Gunn, Branch Manager, Policy, Planning and Corporate Services

Outcome 5 - Rural Health Care

Health Services Improvement Division

Mr Bob Wells, First Assistant Secretary
Dr Vin McLoughlin, Assistant Secretary, Safety and Quality Branch
Mr Dermot Casey, Assistant Secretary, Health Priorities and Suicide Prevention Branch
Mr Brett Lennon, Assistant Secretary, Health Workforce Branch
Ms Jan Bennett, Assistant Secretary, Rural Health and Palliative Care Branch

Outcome 6 - Hearing Services

Australian Hearing Services

Ms Anthea Green, Managing Director

Outcome 7 - Aboriginal and Torres Strait Islander Health

Office of Aboriginal and Torres Strait Island Health

Ms Helen Evans, First Assistant Secretary
Dr Patricia Fagan, Senior Medical Adviser, Office for Aboriginal and Torres Strait Islander Health
Mr Peter Broadhead, Assistant Secretary, Program Planning and Development Branch
Ms Yael Cass, Assistant Secretary, Workforce, Information and Policy Branch
Ms Mary McDonald, Assistant Secretary, Primary Health Care Review
Ms Joy Savage, Assistant Secretary, Health and Community Strategies Branch

Outcome 8 - Choice through Private Health Insurance

Acute Care Division

See Outcome 2

Medibank Private

Mr George Savvides, Managing Director
Mr Pat McKinney, General Manager Sales and Retail, Medibank Private

Ms Sarah Bussey, General Counsel, Medibank Private

Private Health Insurance Ombudsman

Mr John Powlay, Private Health Insurance Ombudsman

Private Health Insurance Administration Council

Mrs Gayle Ginnane, Chief Executive Officer
Mr Paul Collins, Manager Reinsurance and Statistics
Mr Paul Groenewegen, Manager Prudential Reporting

Outcome 9 - Health Investment

Health Services Improvement Division

See Outcome 5

Office of the National Health and Medical Research Council

Professor Alan Pettigrew, Chief Executive Officer
Ms Cathy Clutton, Acting Executive Director, Centre for Health Advice, Policy and Ethics
Ms Suzanne Northcott, Executive Director, Centre for Research Management and Policy
Dr Clive Morris, Executive Director, Centre for Compliance and Evaluation
Mr Tony Krizan, Acting Executive Director, Centre for Corporate Operations

Information and Communication Division

See Outcome 3

CHAIR—Good morning, everyone. It is such a long time since we have seen each other but lovely to welcome you back here! I declare open the public hearing of the Senate Community Affairs Legislation Committee considering the budget estimates. The committee now will continue examination of the Health and Ageing portfolio. I welcome back Senator Campbell, representing the Minister for Health and Ageing, and Ms Halton and the officers of the Department of Health and Ageing. The committee has completed Medibank Private, corporate matters, outcomes 2 and 3 and has commenced outcome 1. We will now continue with outcome 1, Population health and safety, followed by questions relating to outcomes 4, 5 and 9, which are grouped together. Outcomes 7, 6 and 8 will follow.

Ms Halton—Could we revisit an issue that came up yesterday? I said I would come back to you as soon as I had the advice from the lawyers. You will recall that we had various versions of logos being bandied around yesterday and a discussion about when they were or were not allowed to be used. I said that I thought a number of these things were not copyright but that I would confirm my understanding with the lawyers. I have a piece of legal advice on that. I am happy to table it in just a moment, but it might be useful if I run through the issues. Essentially, the term 'Medicare' is specified in the Health Insurance Commission Act 1973, and the act provides for offences in relation to the use of 'Medicare' or a prescribed symbol, which of course is the well-known green label. Essentially, the offence specified in paragraph 41C(1)(a) of the act is in connection with 'a business, trade, profession or occupation'. The lawyers' advice says:

> In our view this is use in business or trade, or delivery of professional services or other services. It is a use which seeks to make a connection between medicare and goods or services provided. It is true that being a Member of Parliament is an occupation. But in our view use in a political statement is not caught by paragraph (a).

It later cites an issue in respect of political communication, which was a High Court decision that basically said that use in a political communication is legitimate.

CHAIR—Even though it could make it appear as though it is an official document from Medicare, when it is in fact quite misleading?

Ms Halton—I am happy to table this, then everyone can scrutinise it. In relation to issues such as trademarks, the advice says:

7. We understand that there may be relevant trade marks registered on behalf of the Commonwealth or a relevant agency.

8. However a trade mark is defined in s.17 of the *Trade Marks Act 1995* as a 'sign used, or intended to be used, to distinguish goods or services dealt with or provided in the course of trade by a person from goods or services so dealt with or provided by any other person'. The principal infringement of a registered trade mark in the Act is the use as a trade mark of a sign that is substantially identical to, or deceptively similar to, the trade mark in relation to goods or services in respect of which the trade mark is registered (s.120). Use by Members of Parliament or political parties to make a political statement is not use as a trade mark, as that term is defined, nor is it use in relation to goods or services. At any rate there are a range of uses of a trade mark which are not infringements, within which use by Members of Parliament or political parties to make political statements may fall (s.122).

I think the pithy take out of this is: use for political purposes is okay. But I am happy to table this. I should also pass on that the lawyers made an observation that it is possible to argue copyright in relation to works of art, but the lawyers did not think MedicarePlus constituted a work of art.

Senator Ian Campbell—I am sure that will be very offensive to a graphic artist somewhere.

Ms Halton—We are happy to table that.

Senator McLUCAS—Where is that legal advice from?

Ms Halton—It is from the AGS.

Senator McLUCAS—Before we go any further, I would like some clarification about which outcomes certain matters should come under. I was going to do this yesterday but I forgot. Is the Red Tape Task Force in outcome 4?

Ms Halton—I thought we might do it under outcome 2, to be honest, but I am sure we can manage to accommodate discussion on the Red Tape Task Force when it suits you. I can find the relevant officers.

Senator McLUCAS—Let us put it in outcome 4.

Ms Halton—Yes. It is just that that involves the primary care people who were here yesterday for outcome 2, but if you want to ask questions on that I will get them back.

Senator McLUCAS—We will do it at the beginning of outcome 4. Is more doctors for outer metropolitan areas under outcome 9, 4 or 2?

Ms Halton—Let us come back to that one.

Senator McLUCAS—This is an issue that we have not asked questions about before. It is around a 50 per cent FBT subsidy that is paid to community health organisations, particularly Indigenous organisations, to attract doctors to their area.

Ms Halton—Outcome 5, more doctors, is where we should take that.

Senator McLUCAS—An issue has just been put into my pack. It has to do with statistics on caesarean sections by hospital. Would that have been covered in outcome 2, and is it possible to revisit that?

Ms Halton—We can revisit that. It would have been outcome 2. If you would like to give us an indication of the specifics, I can bring back the one person who is relevant.

Senator McLUCAS—I would like to know—and it is probably Ms Smith who knows this information—does the department collect data by hospital in terms of caesarean as opposed to natural births?

Ms Halton—We do not collect data. We only receive data on these issues from the states. My understanding is that we do not go down to hospital level. In fact, that is the stuff that goes to the AIHW. I will see if I can get the answer to that, and if you want more I will get someone else back.

Senator McLUCAS—Thank you. I want to know whether we have the ability to collect the data. If we do, can we have an understanding of whether there are any differences between groups and types of hospitals in terms of caesarean rates—interventions—as opposed to natural birthing rates?

Ms Halton—I know information about basically those procedural issues is received by the AIHW. I do not know whether we get the data tapes. I think the answer down to that level is no, but let me confirm that.

Senator McLUCAS—Thank you. I will go now to outcome 1 on the Australian Health Disaster Management Policy Committee and issues around disaster management. A fact sheet that accompanies the budget papers states:

The Australian Government will review the adequacy of the current legislation and the need for further legislation to cover areas such as health protection, disease detection and reporting and the regulation of laboratories holding high-risk biological materials.

Can the department give the committee some information about what changes to the legislation may be envisaged?

Ms Murnane—We cannot give you any information in an exact sense yet, but what we are aware of is that while there is state public health legislation and while there is national quarantine legislation, from which the Chief Medical Officer, currently Professor Horvath, derives his powers—which are very wide—in the event of an epidemic there are things that have emerged recently that certainly merit inspection and assessment on whether or not we need to have some national coordination powers. There are a number of particular areas specified there; one is surveillance. We do have—and we have been talking about this recently—a national disease surveillance system that has been built on very good cooperation between the Commonwealth and the states. We have money in the biosecurity area of the budget now to improve that surveillance system and to turn it into a real-time system. The government has given us money to explore whether we need to embed that in statute somehow. Then there is the issue of laboratories—the role of laboratories and the inspection of laboratories—which, of course, contain a lot of hazardous material. We are more acutely aware of those sorts of things now.

Senator McLUCAS—Are the laboratories currently being inspected and regulated by the states?

Ms Murnane—Yes, to an extent, although it is a question of coordination, of knowing what is happening, of knowing where capacity is in case we need to quickly mobilise resources in the event of some sort of either natural or terrorist catalysed catastrophe.

Senator McLUCAS—These are laboratories that are producing medications that we would need in such an event, or that may hold potentially dangerous—

Ms Murnane—Yes, they are producing medications. However, I think what is more pertinent is the testing and diagnostic capacities of those laboratories, which would be very important in relation to infectious disease and also with regard to terrorist attack with a biological agent.

Senator McLUCAS—Is the issue that we do not really have a register of where they are and what capacity they have?

Ms Murnane—We do know where the public health laboratories are and we do have a pretty good idea of what their capabilities are. What we are talking about is having a real-time idea—basically putting what, to date, has been done very well on a semiformal, or informal, cooperative basis between the Commonwealth and the states on to a more formal basis. This is something we want to explore, and we are going to use the AHD-MPC as a forum to discuss and scope the issues. We have identified here what may be a need.

Senator McLUCAS—What is the time frame in which you are proposing to do this piece of work?

Ms Murnane—We are having a meeting of the AHD-MPC on 9 July, and an initial discussion of this will be on the agenda for that meeting.

Senator McLUCAS—Is this the first time this issue has been brought to the attention of—

Ms Murnane—No, that would be wrong. Since the AHD-MPC was formed we have been discussing issues around public health laboratories. I mentioned surveillance earlier. Surveillance and public health laboratories are not separate channels; they are intertwined, because one of the sources of critical information for any surveillance system is information that is available to laboratories, which regularly test samples that are delivered to them by hospitals and by GPs.

Senator McLUCAS—Do you imagine that the Quarantine Act is the appropriate piece of legislation to be amended to deliver what you are proposing?

Ms Murnane—I do not want to jump too far ahead. What I am saying is that we are now looking closely at the legislative basis that we have for these sorts of things in an environment that has changed substantially. I might say that governments all over the world—including the US, Canada and the UK—are doing the same thing now. I think it is prudent and responsible for us to assure ourselves and, most importantly, be able to assure the government—and this is what they have asked us for—that our legislation is suited to the times, and that is what we are doing.

Senator McLUCAS—Can you give me some information about the secure information sharing network? It talks about the development of a web based outbreak reporting system. Can you give me some understanding of what a web based outbreak reporting system is?

Ms Murnane—Again, I will not talk in technical terms, but this is, in a sense, another way of describing the real-time system I talked about. We would be asking state public health authorities to post information onto a system that would come into a central point in the Australian government that they got from laboratories, emergency departments and from sentinel GPs. The information they gave us would be the raw data and their analysis of that information. The important thing is not only to post the information in a sense that is timely but also to then analyse patterns so that we can be alerted early to what might be an unusual pattern. It could either be some naturally caused event that we need to respond to from a public health point of view, or it might even be something that comes from a malign source. Again, this is something that countries to which we compare ourselves are also doing. In other words, we are keeping up with the needs of the times.

Senator McLUCAS—What do we have now to give us that sort of national information?

Ms Murnane—What we have now is a National Notifiable Diseases Surveillance System that we keep in Canberra. It is based on information we receive from the states and territories. We collate that information, post it back to the authorities and use it for analysis and policy development. That is very much supplemented by real-time information that comes via telecommunication links and email. For example, in the SARS outbreak, and when we were monitoring whether there were any cases of avian flu in Australia, we were not relying on information that had a lag. We were basically getting real-time information, sometimes by email. What we want is the economy of being able to have a system that presents the information to us so that it can be readily analysed and discussed, and response can be decided.

Professor Horvath has just reminded me that another aspect of surveillance that is primarily being undertaken by the Department of Agriculture, Fisheries and Forestry is animal surveillance, because the emerging infectious diseases that are presenting such challenges to us now have animal hosts. So we are working closely with the Department of Agriculture, Fisheries and Forestry to make sure that we are able to link the two systems. We also have a food surveillance system that we fund—OzFoodNet—and that surveys food-borne illnesses in Australia and enables a quick response to them.

Senator McLUCAS—That describes a naturally caused event. How do you imagine that information that is from an event that is not a terrorist event can be included into that collection side of the continuum?

Ms Murnane—The web based system would, as I said, capture information that was reported by emergency departments, sentinel GPs—and we would hope to expand the range of sentinel GPs—and laboratories, both public and private. Some of that information would fall into the category of complete diagnoses and what are currently in the states' lists of notifiable diseases, but some of it would be more in the nature of symptoms, so that patterns would be detected. This requires a lot of skill in conceptualising because you can very easily capture so much information—you have so much noise—that the volume of information you

have outweighs the capacity to analyse it. We will be spending a lot of time with experts in the state and territories, with our own experts and with academic experts and will take into account what the Centre for Disease Control and the World Health Organisation say so we can identify what symptoms or incidents we will post, so that we do not get so much information we are not able to meaningfully analyse and detect patterns.

Senator McLUCAS—Can we talk now about avian flu and the purchase of the medication to do with that? In the budget we have $133.6 million allocated for avian flu measures and, of that, $127.6 million is for 2003-04. Can you give me an understanding of the intent of that allocation of funds?

Mr Stuart—Certainly. The specific intent of those funds is to meet the risk or the contingency of an outbreak of pandemic influenza which might be created out of the avian flu currently circulating in Asia or other outbreaks in other countries. It is do deal with avian flu if it threatens to become a national pandemic within Australia's borders. So the primary purpose of the expenditure is to stockpile anti-viral drugs which would help to keep essential services operating, under conditions of a pandemic flu.

Senator McLUCAS—We talked before about stockpiles and what they are and whether they are virtual or real. Is this a real stockpile or a virtual stockpile?

Mr Stuart—It is a real stockpile of anti-virals. Not all are necessarily in one place. But they are certainly held within the country for a contingency.

Senator McLUCAS—How many essential personnel would be covered by that allocation?

Mr Stuart—The actual use of the stockpile in a particular situation would be governed by discussions and consultation with NIPAC and our state and territory colleagues. So it depends on the nature of the viral attack. As to the balance between prevention and use for cure, with prevention, for example, we would want to be protecting health workers, people transporting essential supplies of food and medication, police and essential utilities like power and water, to make sure that people keep turning up for work under conditions of a pandemic flu.

Senator McLUCAS—Has the tender for the anti-viral medication been awarded?

Mr Stuart—This was not a tender process; this was a direct purchase from the supplier of the product that the department has determined is the best fit for the purpose.

Senator McLUCAS—What have we purchased?

Mr Stuart—We have purchased an oral antiviral.

Senator McLUCAS—From what company?

Ms Murnane—We prefer not to provide a lot of detail on these sorts of purchases. Australia and other countries look at detailed information about what is in their stockpile as something that falls into the category of 'security'—it is information that may be misused. But, if you like, Professor Horvath can talk to you about the clinical underpinnings of the decision we made.

Prof. Horvath—I will give you a little background to the decisions. As Ms Murnane has indicated, through our links with the other portfolios it became obvious late last year that avian flu was spreading throughout Asia. By early this year, about a third of the world had

very high density avian flu—most probably 200 million birds were affected and at least 100 million had to be culled. With such an unprecedented large volume of avian flu, the World Health Organisation were of the opinion—and so advised—that there was now an unprecedented risk of a world pandemic. If that were to occur, the expert advice we had was that, due to the infectivity of this epidemic, Australia was facing the potential of somewhere around 58,000 patients needing hospitalisation, 13,000 deaths and about one million consultations on an ambulant basis—and that is within the first eight to 10 weeks. That is a huge potential impact on the Australian public.

The WHO called together a consultation on 16 to 18 March. As a result of that consultation a number of recommendations were made. First, it was reconfirmed at that consultation that the world was at an unprecedented high risk of pandemic and that, at that stage, there was no apparent sign that it would abate. There had been a number of people in Vietnam and Thailand in particular who had been inflicted with this avian flu, though it had not yet converted to human pandemic status. The mortality was very high. When it infected humans, the virus caused a very nasty and quick death. As a result of this we consulted very widely, both nationally and internationally, and took into account the recommendations from WHO as to the most appropriate antiviral. It was on the basis of the WHO consultations and international and local consultations that advice was given to the department as to their choice of oral antiviral. To complicate the matter further, in their recommendations the WHO said:

> Stockpiling of drugs in advance is currently the only way to ensure sufficient supplies at the start of a pandemic. Governments with adequate resources should consider pursuing this option as a precautionary measure.

Because of the cost and the lack of availability of these drugs, there is a real issue in getting adequate supplies. The second issue, which involves the use of vaccine and was discussed at length at the WHO consultation, is that the time between an epidemic appearing and adequate supplies of vaccine becoming available can be anywhere up to six to 12 months, as there is a worldwide shortage of capacity for vaccine production. I am happy to expand further.

Senator McLUCAS—Given your comments, Ms Murnane, I might take some advice before I pursue questioning, and come back to that. I suggest that we now deal with OGTR, FSANZ and TGA.

CHAIR—Senator Payne has some questions on the HIV programs.

Senator McLUCAS—In outcome 1?

Senator PAYNE—I am not sure to whom I should direct this, but I wanted to make some inquiries about the status of the fourth national strategy on HIV-AIDS.

Ms Podesta—The minister has extended the existing strategies until the end of the year while MACASHH, the ministerial advisory committee, continues its work on the development of the new strategy.

Senator PAYNE—MACASHH and, I assume, the department?

Ms Podesta—The department assists MACASHH in the development of a strategy.

Senator PAYNE—So MACASHH is doing it by itself, basically?

Ms Podesta—MACASHH has a responsibility for the development of a strategy, and the department assists.

Senator PAYNE—What is their program for the development of the fifth national strategy?

Ms Podesta—The working groups—the subcommittees that comprise the process—are busily working on the development of the detail of those strategies. There is a range of drafting groups from the policy areas that are participating and we expect that in the next week draft strategy papers that have resulted from the work of the working parties and the assisting consultants will be available to be circulated to the MACASHH members and to all the working groups meetings for comment and input.

Senator PAYNE—So next week draft strategy papers will be available for circulation. What is the consultation process from there?

Ms Podesta—The consultation process is that MACASHH members will comment on the first draft, and we anticipate that there will be finalised consultation drafts available in mid to late June both on the department's web site and through peak bodies such as the Communicable Diseases Network Australia and all of the organisations that have an interest in the development of the strategy. So there is an absolute period of input, discussion et cetera.

Senator PAYNE—In the development of the fourth national strategy—certainly in the city of Sydney—public meetings were held, convened by the department on occasion and obviously through the peak bodies as well. Is that process going to be followed again?

Ms Podesta—I believe that MACASHH is considering a range of public consultation mechanisms.

Senator PAYNE—When might they come to review their public consultation mechanisms?

Ms Podesta—There is a MACASHH meeting this month, and part of the discussion at the MACASHH meeting is the process for public consultation to finalise that.

Senator PAYNE—Is that the second meeting of MACASHH since they were formed?

Ms Podesta—It is the second meeting of the full MACASHH. MACASHH subcommittees and chairs have held a range of meetings since the appointment of the committee and subcommittee members.

Senator PAYNE—If the drawing together of the fifth national strategy is the responsibility of MACASHH, with assistance from the department obviously, how are they going about engaging other Commonwealth departments in that process? How do they have the authority and capacity to do that?

Ms Podesta—As part of their terms of reference, they have a responsibility to liaise widely, and as part of the process they will be engaging with other Commonwealth departments, the drafts will be circulated and comments will be received.

Senator PAYNE—What input will AusAID have?

Ms Podesta—AusAID are one of the key stakeholders in the development of the strategy. They will certainly be asked to participate in the consultation process.

Senator PAYNE—You might want to look at the *Hansard* from AusAID estimates yesterday. There appeared to be some divergence of views amongst officers about what level of involvement they had and what capacity they had to be involved in this process. I think the government's response to the 2002 reviews of the national HIV-AIDS and hepatitis C strategies and strategic research processes indicated, as you said, the importance of the involvement of our international agencies and fora. Is there going to be any discussion by or presentation from Australia at the ministerial meeting in Bangkok in July about the development of the fifth national strategy?

Ms Murnane—It is planned for the chair of MACASHH, Dr Wooldridge, to attend. We have not spoken to him yet about what he will be talking about precisely, but I am sure he will be collecting information and thinking about using that opportunity to think about the fifth strategy and what could go into deliberations that he will be conducting around it.

Senator PAYNE—Will your department be involved at all in the ministerial meeting or in support for the ministerial meeting in Bangkok?

Ms Murnane—A departmental officer will attend the meeting with Dr Wooldridge.

Senator PAYNE—The second meeting of MACASHH was this month. What has the meeting program of the subcommittees been like?

Ms Podesta—The subcommittees have been meeting as required. Would you like me to give you a list of the times that they have met? They are meeting regularly, as required. We are providing assistance and support to the subcommittees to be able to undertake their work.

Senator PAYNE—Having been reformed after the review process, all of the subcommittees have fairly different membership from their predecessor committees in some way. What is the department's observation about how that is working?

Ms Podesta—We have been very pleased with the work of the committees so far. There is a broad range of skills and experience on the subcommittees and MACASHH, and people have certainly expressed a large degree of enthusiasm and commitment to the work.

Senator PAYNE—Is there a representative from a HIV-AIDS community based organisation on MACASHH?

Ms Podesta—The membership of MACASHH is a broad-ranging one. MACASHH is supported by three subcommittees. I do not know the status of people in that sense.

Senator PAYNE—No, I said HIV-AIDS community based organisations.

Ms Podesta—No.

Senator PAYNE—Notwithstanding your observation, is there on MACASHH a representation of people living with HIV-AIDS who are directly connected to the PLWHA organisations?

Ms Podesta—No. There are on the HIV subcommittee.

Senator PAYNE—Is there a person who is directly linked to the HIV-AIDS response in the community from the part of the community who has been—in Australia, at least—most overwhelmingly affected by HIV-AIDS, the gay community?

Ms Podesta—As I said, I do not know people's status. Certainly there is Professor Frank Bowden, who is a very well respected expert on HIV-AIDS. He is a member of MACASHH and he also chairs the HIV-AIDS and STI subcommittee.

Senator PAYNE—Through the various incarnations of the overarching committee ANCAHRD, IGCAHRD and the organisations in between, is this the first time there has not been someone from the HIV-AIDS community sector represented on the overarching committee since about 1989?

Ms Podesta—MACASHH is a different committee to ANCAHRD. MACASHH brings together overarching advice on a range of strategies—the hepatitis C strategy, the Indigenous strategy, the HIV and the STI strategy. So it is difficult to compare ANCAHRD with MACASHH, in that sense, and the membership is different.

Senator PAYNE—How does that accord with our support for the UNGASS declaration from 2001, which said that states should at the national level:

By 2003, ensure the development and implementation of multisectoral national strategies … for combating HIV/AIDS that … involve partnerships with civil society and … the full participation of people living with HIV/AIDS, those in vulnerable groups and people mostly at risk …

How does not having a person from those particular groups on MACASHH accord with our support of that declaration?

Mr Stuart—MACASHH, and its subcommittees, is drawing very widely in its work from discussions with other groups and, as Ms Podesta has pointed out, the HIV subcommittee is, itself, quite broadly represented. So I do not think that the government, in making its decisions about who will be on these committees, is going to be in any difficulty with that resolution.

Senator PAYNE—When you say that the HIV subcommittee is 'quite broadly represented', what do you mean?

Ms Podesta—The membership of the HIV subcommittee is—as is the hepatitis C subcommittee, as is the Indigenous Australian sexual health committee—representative of a broad range of stakeholders of the communities of the treatment areas or the research areas.

Senator PAYNE—So if I were to seek your advice on the particular activities and responsibilities of individual members of MACASHH and the subcommittees, would you be able to tell me what their particular role is?

Ms Podesta—I would be able to tell you the qualifications and background that they bring to the subcommittees.

Senator PAYNE—That is good and, helpfully, your web site has provided me with all of that information as well in relation to their backgrounds. What I am interested in is their particular contribution on HIV-AIDS, sexual health and hepatitis—those being the areas of engagement. However, if what you are going to tell me is what I can read on the web site, then it probably will not take us very far.

Ms Podesta—It is what I am going to be able to tell you.

Senator PAYNE—I thought so.

[9.49 a.m.]

Office of the Gene Technology Regulator

Senator CHERRY—Have the submissions from state governments in response to the commercial release of GE canola been publicly released?

Dr Meek—No, they have not.

Senator CHERRY—Would you be happy to release those to the committee?

Dr Meek—That is something that is not up to me to decide. The arrangement that we have with the states and territories is that they provide information to us that we take into account in the risk assessment and risk management plan that we prepare in relation to commercial release applications and we summarise the information that we receive and the issues that have been raised in the context of the finalised version of the risk assessment and risk management plan, so that information is already in the public domain.

Senator CHERRY—In a summary version?

Dr Meek—Yes, that is correct.

Senator CHERRY—Would you be able to check with the state governments whether they are happy for the actual submissions to be released as well and let the committee know?

Dr Meek—Yes.

Senator CHERRY—In previous testimony to this committee you indicated that the responsibility for assessing herbicides and herbicide regimes was the responsibility of APVM. Would you agree that the herbicides that one uses on a herbicide tolerant crop will be the direct result of the type of GE plant that is being cultivated?

Dr Meek—Yes.

Senator CHERRY—Would you agree that the herbicide used on HTGE volunteers would be the direct result of the type of HTGE plant that has been growing?

Dr Meek—Yes.

Senator CHERRY—Would you agree also that the herbicide regime adopted in order to deal with volunteers and any emergent resistance would be the direct result of the type of HT plant being cultivated?

Dr Meek—Yes.

Senator CHERRY—In the Gene Technology Act—and I know that we have had this discussion before—section 3 requires you to assess the risks posed 'by or as a result of gene technology', and section 51 goes on to talk about the matters to be taken into account in assessing risk, including risks posed by dealings including cultivation, propagation et cetera. Would you agree that herbicide regimes that are used on GE plants volunteers and in field weeds are the result of that GE technology?

Dr Meek—They are.

Senator CHERRY—What then is the legal basis for concluding that herbicide resistance issues and related herbicide management issues do not relate to the environment and safety issues surrounding the intentional release of GMOs?

Dr Meek—That is not the legal basis that we have placed it on. The issue is the jurisdiction of the respective acts that the different regulatory agencies operate under. We have said very clearly that there are issues related to the use of herbicides in the environment that need to be assessed, and the appropriate authority for that is the Australian Pesticides Veterinary Medicines Authority, the APVMA. So what we have in the integrated regulatory framework in Australia is a set of legislation which is designed quite deliberately to work cooperatively and collaboratively. The Office of the Gene Technology Regulator has a scope of responsibilities; however, where there is a pre-existing statutory product approval authority such as the APVMA with its legislation in place, then our legislation does not override it.

As we said very clearly in the risk assessment and risk management plan that we put out in relation to this, we recognise that it is an issue. This issue will be assessed by the APVMA—the Australian Pesticides and Veterinary Medicines Authority—and we work closely in looking at that. We determined that it was something that the APVMA would be dealing with. As you may be aware, Senator, they put in place some quite rigorous processes in order to monitor, examine and look at the impacts of the introduction of GM canola in relation to the herbicide use.

Senator CHERRY—And you are satisfied that those arrangements that have been put in place to look at the use satisfy the requirement under your act to look at the risks posed as a result of gene technology?

Dr Meek—As I said, the way in which the act was crafted was one which would not duplicate existing statutory responsibilities. Therefore, we are working collaboratively to achieve that end.

Senator CHERRY—But, as a general rule, is it not true that the APVMA's role stops with the selling of herbicides?

Dr Meek—No.

Senator CHERRY—What are the processes which have satisfied you that the APVMA will be looking at the issues that result from a change in herbicide use?

Dr Meek—There are a number of matters that I have taken into account. Firstly, as I said, we have worked quite closely and cooperatively with the APVMA in our parallel assessments of two applications. You may recall, Senator, that the approval I give is in relation to the release of the genetically modified organism into the environment. The APVMA is responsible for the regulation of herbicide use—or, indeed, much broader than that obviously—in Australia. So there are two different statutory responsibilities.

We have discussed intensively in that regard what the two evaluations were leading to in terms of the conditions that we may or may not apply. We also, as part of the process of evaluating both the Monsanto and Bayer applications, looked at the proposals that the companies were making in terms of managing these issues. In that context, we noted that, in the licence that was issued to the companies in order to enable them to apply herbicides to

GM canola, which is what they had to do—we look at the crop and releasing it into the environment and the APVMA looks at the application of the herbicide to a GM crop—there were a range of conditions that the APVMA have now put in place.

Senator CHERRY—Will they be considering the likely changes in herbicide use over time as a result of planting the GM canola?

Dr Meek—That is my understanding. These questions actually relate to the regulatory activities of another organisation, and I suggest that you talk to them.

Senator CHERRY—My submission is that they also relate to you in that you have the overriding responsibility to look at results. You say that you have a cooperative relationship in place but, if there are any gaps, I think your overriding responsibility would come into play.

Dr Meek—As I said, it is an integrated regulatory framework. I do not have an overriding thing. But, yes, they are working complementarily. Indeed, as I have said, my understanding is that that will happen.

Senator CHERRY—But, under section 3, you are required to assess all risks posed by or as a result of gene technology.

Dr Meek—Yes.

Senator CHERRY—To me, that is a fairly overriding responsibility.

Dr Meek—In relation to their impacts on environmental and human health and safety. As I said earlier, the intention—very much so—in the design of the act was to have these systems working in cooperation with each other.

Senator CHERRY—Are you familiar with last year's US department of agriculture's Benbrook study which looks at the impacts of genetically engineered crops and pesticide use in the United States over the first eight years?

Dr Meek—There has been a range of studies. I cannot at the moment conjure that one to mind, but I can tell you that there are many studies on herbicide use—some of which have conflicting results.

Senator CHERRY—Certainly this particular one indicated that, over time, herbicide use is likely to increase on herbicide tolerant GE plants. I am just wondering whether OGTR has evaluated this new information in light of its approvals on the canola varieties.

Dr Meek—As I said, the issue would probably be one for the APVMA in that context. The APVMA, as you may or may not be aware, has a review program in relation to herbicide resistance management. I think that there are very much processes in place that, if new evidence comes to light, the appropriate regulatory authority could look at that issue.

Senator CHERRY—But isn't it correct that most conditions relating to herbicide use, including type and quantities, will reside in crop management plans?

Dr Meek—And the crop management plan is part of the licence condition that has been imposed by the APVMA.

Senator CHERRY—That is right. So their crop management plan is different from the one which you recommended?

Dr Meek—We have not recommended a crop management plan.

Senator CHERRY—Do you think they are a good idea?

Dr Meek—Of course.

Senator CHERRY—Will those crop management plans be enforceable under any regulatory system that you are aware of?

Dr Meek—As I have just said to you, that is part of the APVMA's conditions.

Senator CHERRY—Right. You received copies of the crop management plans of Bayer and Monsanto as part of the risk assessment process. Were those crop management plans released to the public?

Dr Meek—At the time there was a problem in the sense that the companies were having difficulty finalising their crop management plans as they did not know what licence conditions might be imposed by either OGTR or APVMA. However, subsequent to the finalisation of the decisions by OGTR and APVMA, my understanding is that that information was made available on the web sites of the companies.

Senator CHERRY—From the APVMA?

Dr Meek—No, from the companies themselves.

Senator CHERRY—I will check that.

Dr Meek—I will stress that it is my understanding that that is what has happened.

Senator CHERRY—If that has not happened would you be concerned?

Dr Meek—As I said, the issue to do with the regulation of the use of herbicides was one related to the APVMA's conditions. The conclusion that we came to in relation to the assessments of both the Bayer and the Monsanto canola was that it was as safe to humans and the environment as conventional canola. So we have only imposed oversight conditions rather than any detailed ones.

Senator CHERRY—You were asked questions back in November relating to seed purity and mixing. You replied to a question from Senator Heffernan, relating to the mixing of GE and non-GE seeds in the field and the impact of spraying Roundup on new canola plants, with the comment that 'a lot hinges on those crop management plans.' What was the basis for not imposing them as conditions but allowing them to be implemented by industry on a voluntary basis?

Dr Meek—I think I have just said to you that the conditions imposed by the APVMA did actually require some element of that to be done.

Senator CHERRY—So it is back to them again. Are you familiar with the CSIRO project about ecological implications of GMOs?

Dr Meek—Yes, I am.

Senator CHERRY—What communications did OGTR have with CSIRO in respect to that project in relation to both design and implementation?

Dr Meek—We were not directly involved in the design of the program. However, we have quite close contact with the researcher involved in it. We maintain an ongoing dialogue. The gentleman in question is a well-known expert in the area of risk analysis and so he is a valued colleague, if you like, in the scientific context. In that context, we have had seminars internally in OGTR on the way in which the results of that study came out.

Senator CHERRY—Did you see or comment on draft reports?

Dr Meek—We did see a draft.

Senator CHERRY—Did you correspond with CSIRO in relation to any of the findings or conclusions of those various reports?

Dr Meek—Not to my recollection. As I said, we were already aware of the contents.

Senator CHERRY—Is OGTR aware of any reasons why the various components of the project promised were not undertaken, such as the risk assessments, up to landscape scale, of direct and indirect ecological impacts of BT cotton, legumes with high sulphur and protein and herbicide tolerant canola, which were due to be completed last year?

Dr Meek—No.

Senator CHERRY—Are you concerned that those components were not completed?

Dr Meek—It was not our project. I am not in a position to comment on that.

Senator CHERRY—Do you think they are things that, in terms of your ongoing research regulation, should be looked at?

Dr Meek—We have a joint research group that is made up of Environment Australia, us, CSIRO and Agriculture, Forestry and Fisheries. We are constantly reviewing areas of research that may be of interest across those agencies, as well as our own internal requirements in that regard.

Senator CHERRY—One of the documents produced as part of that CSIRO project was a paper on best practice risk management, *Best practice ecological risk assessment for genetically modified organisms* by Keith Hayes. The report made a number of recommendations for best practice risk management. Are you familiar with that particular report?

Dr Meek—Yes.

Senator CHERRY—Do you agree with its conclusions and recommendations?

Dr Meek—Perhaps the issue there is that this was a study of hazard identification—that was the focus of that research. Hazard identification is only one element of the work that we do in terms of the risk assessment process. You may be familiar with the fact that it is a two-stage process: you identify hazards and then you look at what the potential impact of those hazards might be and the likelihood that they will occur. The study only did a very early stage on a very broad basis of a wide range of hazard identification issues. That is a useful methodology. We are at the present time looking at our own risk analysis framework, which is the document that we have as our public interface, if you like, about how we conduct risk assessments in the OGTR. That is information that we would take into account in the review of our own risk analysis framework.

Senator CHERRY—What is the time line for that review?

Dr Meek—We are looking at having a draft out for public consultation around midyear.

Senator CHERRY—And, before you implement that, you are saying that it would go through a public consultative phase?

Dr Meek—Absolutely.

Senator CHERRY—The report recommends that:

Monitoring strategies should include a statement of objectives, precise descriptions of the design of experiments, data that will be collected and the methods of analysis to test for statistical significance and the power of the test procedures.

To what extent has this occurred with the field trials approved by OGTR?

Dr Meek—When we have research programs associated with the OGTR, we are usually heavily involved in the design of those studies. Obviously, if they are studies that were undertaken and come to us as data that we were not involved in, then there will be a different level of integration with what we might have wanted and what was actually given. But the way in which we undertake our review of data that is provided to us as part of the application package is that we look very closely at the experimental design in such a way as to determine whether we believe that the research is valid.

Senator CHERRY—So you would be fairly confident that your analysis and monitoring of field trials would be consistent with those recommendations?

Dr Meek—Just to clarify, are you talking about the monitoring that we conduct on field trials, or are you talking about the research that we look at in the context of making decisions? I am not quite sure what you are looking for.

Senator CHERRY—At this stage I am looking at the monitoring of field trials. Obviously, the result of that monitoring of field trials would relate to the information that you subsequently rely on.

Dr Meek—Yes.

Senator CHERRY—So my question is: would the monitoring in terms of the information you accept as reasonable as a result of those field trials comply with that recommendation about monitoring strategies, including objectives, precise descriptions of the design, data to be collected and statistical significance?

Dr Meek—There is a bit of a difference here, I think.

Senator CHERRY—Yes, I accept that.

Dr Meek—What you are talking about is the design of an experimental study, whereas our monitoring activities relate to actually visiting sites where either a crop is growing or there is a post-harvest situation. So it is about looking on the ground as to whether there is compliance with licence conditions or whether there are any anomalies, if anything. So we are really talking about two different issues here.

Senator CHERRY—In terms of approving a field trial, I would have thought that you would want to ensure that that field trial was going to produce something useful and statistically significant.

Dr Meek—Field trials can be undertaken for many purposes. The only data that we would be interested in, in terms of field trials, is where we have said that we believe that there is data that we require—to validate the assumptions that we have made in the context of the risk assessment—or we have flagged to companies that we believe that there is additional research that is required. In the situation where we have imposed a research condition as part of the licence conditions, then we would expect to be involved in the design of that research. Where there is research that is ongoing and is of interest to the applicant—whether it is strain selection or a whole host of other things that the field trial could be conducted for—then it is very much up to the licence holder as to whether they have designed their experiments appropriately to get the results that they need. Obviously what we are interested in is the integrity of the data that relates to our decisions in relation to the risks to human health and safety or the environment.

Senator CHERRY—Would you be fairly comfortable that the monitoring requirements on the Bayer and Monsanto commercial canola release licences actually fulfil these conditions and recommendations?

Dr Meek—As I mentioned a little while ago, the conditions in relation to the commercial release for Bayer and Monsanto are actually general oversight conditions, where the company is basically providing information on the number of plantings that it may have put in place. There is also the standard condition that companies have, which is to advise us of issues that they may become aware of that are unexpected. The major imposition of requirements really relates to the licence conditions that were imposed by the APVMA.

Senator McLUCAS—Could you give me an understanding of the role of the Gene Technology Technical Advisory Committee?

Dr Meek—Certainly. The legislation establishes three statutory committees—one on technical matters, one on ethical matters and one on community consultative matters. The Gene Technology Technical Advisory Committee is made up of a range of experts in a number of different fields. The act stipulates what the fields need to be. The technical advisory committee provides advice on applications that come to me. We would refer, for example, intentional release applications to the Gene Technology Technical Advisory Committee. It is one of a range of prescribed agencies that I am required to consult twice in the assessment of intentional release applications—once on the application in relation to matters that I need to take into account in preparing a risk assessment and risk management plan and once when that plan has been prepared. When the plan has been prepared we go back to all of the prescribed agencies, including GTTAC, to get advice and comment on the RARMP itself. We may also seek information from GTTAC in relation to licences for dealings that do not involve an intentional release to the environment, and if I have any other matters I can ask them. Obviously, they are people who are very highly skilled, and they can provide other sorts of advice too.

Senator McLUCAS—How is the committee appointed?

Dr Meek—Nominations have to be put forward. We are actually in the process of reappointing all of our advisory committees. I can run you through the process that is involved. That might be helpful.

Senator McLUCAS—Yes.

Dr Meek—We have advertised for people to nominate themselves. We have sent out an invitation for a whole range of interested organisations, numbering some 400 or so, from across the spectrum of views in relation to GMOs to nominate people. They will then be short-listed by a committee comprising representatives from state and territory governments. The short list for that will be prepared and forwarded to the parliamentary secretary for health, to whom matters in relation to the TGA et cetera have been delegated. The agreement of the states is required in order to make appointments to the committees.

Senator McLUCAS—You said that you manage three committees, which include the technical advisory committee and the ethics committee. What is the third one?

Dr Meek—It is the community consultation committee.

Senator McLUCAS—It seems to me from what you are saying that the work of the technical advisory committee is very much based on responding to applications. Do they also have a role to provide you with more strategic advice, or is that in the purview of the ethics and community consultation committees?

Dr Meek—The way the committees are established is that the committees can provide advice on request either to me or to the ministerial council. In practice, it is a pretty free-flowing relationship. They are people whose opinions I value very highly.

Senator McLUCAS—In terms of the GM debate, about which a broad range of views is held, how do those people in the community who are opposed to the use of genetically modified material in Australia—the planning of it, the importation of it and everything—get a chance to advise you within the structures that you have?

Dr Meek—The community consultative committee has been set up quite deliberately to reflect a range of views—that was a quite conscious decision. So there is a representative forum in that context. Indeed, many of those people are active in the community and therefore they channel those views. That is one way. The other opportunity for the expression of views is obviously that we consult very widely in relation to the applications for intentional release, so there is certainly an opportunity to express views there. However, it is fair to say that, if there are issues brought up that are outside the scope of legislation, I do not have any ability to do anything about that. I am responsible for administering the scheme that was put in place by the government.

Senator McLUCAS—Is the community consultative committee also being rolled over?

Dr Meek—Yes, basically it is a term of appointment issue. The process that I described earlier has been undergone for all three committees.

Senator McLUCAS—When will those committees be in place?

Dr Meek—The term of the current committees expires in October this year. Obviously there are processes to go through, but our intention is to have them in place by that stage.

Senator McLUCAS—Who finally ticks off on the membership of those committees?

Dr Meek—The minister.

Senator McLUCAS—I have questions about the application for a trial release of fowl adenovirus vaccine vectors. What is the time frame? When was that application made?

Dr Meek—A decision, did you say?

Senator McLUCAS—Has it been approved?

Dr Meek—No.

Senator McLUCAS—Where are we up to in the process?

Dr Meek—At the moment we are in a situation where we have received the applications. We have gone back to the applicants and asked for a significant amount of other information. The clock has stopped on those applications until we receive that information.

Senator McLUCAS—Have you received the institutional biosafety approval—is that the right language?

Dr Meek—The institutional biosafety committees are an instrument of the organisations that submit applications. They are a group of people who do a preliminary vetting of applications that are submitted to us. They are not an approval body, per se, in relation to things like licence applications. They have an internal view as to the status of an application in terms of its completeness and so on, but the actual assessment is done entirely within the Office of the Gene Technology Regulator.

Senator McLUCAS—That information is provided in support of the application?

Dr Meek—It is not really a support; it is basically a way of ensuring that the organisation is aware of the submissions that are going to the office. The IBCs have a range of roles in the implementation of the regulatory system, and their role varies depending on the nature of the application that is going forward. With very low-risk dealings such as exempt dealings, they basically just keep a record of what is going on, which is reported in the annual report. For notifiable low-risk dealings, which is the next level up, the IBCs are required to notify us within 14 days of receipt that they have a given a tick to that. But anything higher than that—dealings not involving intentional release or dealings involving intentional release where there are licence applications—they are essentially forwarding to us for our consideration. It is not a support in that sense.

Senator McLUCAS—Is who has produced the various pieces of research relevant to your decision making process? Do you actually consider that this application is coming from entity A and these other pieces of work have been potentially done by the organisations that are associated with that applicant? Do you look at that?

Dr Meek—In the research that we look at, we do not confine ourselves simply to what might be provided by the applicants. Whenever we receive an organism to look at for the first time, irrespective of how much it is genetically modified, we put together a document, which is essentially a major literature review—we call these our biology and ecology documents—which forms a base of information about those organisms. In relation to research about the genetic modification itself, we would certainly look at the information that we receive from

the applicant in their package, which, as you say, may be research done by them or by someone else. We would critically review any of that research and, as part of our process, we would search the literature for other information that might be relevant in that regard.

Senator McLUCAS—The last set of questions goes to how we sit internationally with similar regulatory regimes in other countries. What relationship does your office have with other international protocols or agreements? How do we sit in the world?

Dr Meek—That is quite a complex question. The first thing I would say is that each regulatory system in each country has its own nuances. Some are significantly different. In Australia we have taken the decision that we have a regulatory system that is triggered by whether or not the gene technology is used. Other regulatory systems are broader than that. For example, New Zealand's regulations are based on novel organisms. When an organism per se has been introduced into New Zealand for the first time, irrespective of whether it has been genetically modified, their legislation comes into effect. There are different things in different countries. However, there are things that all regulatory bodies need to do in terms of assessing applications, identifying the hazards and looking at the risks that might be posed. In that context, we have common areas of interest, even though our regulatory systems might have a different basis. For that reason, we have an agreement with New Zealand, for example, which we have just put together, for the exchange of information that might be relevant.

We have a range of informal contacts with other regulatory agencies around the world—in particular, we have had quite a bit of exchange with the US and Canada. In addition to that, the office participates, where we feel it is appropriate, in workshops under the auspices of international agencies where people are looking at standard setting. An example of that would be that the OECD has a 'harmonisation on regulatory frameworks workshop'. In fact, there is a meeting next week that one of our officers will be going to. We take the lead for the Australian government in participating in that workshop. It varies. Sometimes we are asked to make presentations where people want to understand our regulatory system. There are a range of different things we do to build relationships and exchange information in various places.

Senator McLUCAS—In this question I am asking for your opinion, so you do not have to answer if you do not want to. Do you see the international structure of regulation of GM as not quite robust yet? It is new, the regulation in each country is different and no international group exists that has been established through the WHO, for instance.

Dr Meek—There are certainly a range of activities at the international level that endeavour to look at what the common baselines might be. I see no evidence to say that the systems are not working efficiently and effectively in the countries they are responsible for. I believe that, whilst it is certainly evolving in terms of gene technology, the methodologies of risk assessment are available internationally now, and I think it is a matter of adaptation in many ways. It is certainly evolving but I do not think there is any reason to be alarmed that countries are not fulfilling their obligations and requirements.

Senator McLUCAS—I suppose it is the information sharing and international discussion. But I just cannot see an entity that is tasked with that.

Dr Meek—Because it is a research area in that sense it is different to some other areas. But because it is a research area it actually follows the sorts of methodologies that allow for

international dialogue in many areas that are related to research. As I said, there are many opportunities for the informal exchange of information in that context. I would also say that particularly for Australia, where we have circumstances which are unique environmentally and climatically and so forth, a far greater emphasis in terms of the information that we need to think about is within the country. It is of interest to us to know what the experience of people has been elsewhere but we have also got to bring it back to the Australian situation, too.

Senator McLUCAS—Thank you.

Senator CHERRY—I want to come back to the role of your organisation versus that of the APVMA. On its web site it states:

The Australian Pesticides and Veterinary Medicines Authority (APVMA) is an Australian government authority responsible for the assessment and registration of pesticides and veterinary medicines and for their regulation up to and including the point of retail sale.

Its governing act, the Agricultural and Veterinary Chemicals Act 1994, has no provisions in it relating to genetically modified plants or the assessment of herbicide use on GM plants. Are you absolutely confident that the issues of changes to crop usage, crop systems and potential biodiversity as a result of changes to herbicide are fully picked up by the APVMA and there is not a part of your responsibility that is not being covered in the current arrangements?

Dr Meek—You need to bear in mind that the issue of herbicide use is far broader than GM crops.

Senator CHERRY—I accept that.

Dr Meek—The actual proportion of use of herbicides on GM crops as opposed to the vast majority of use in the non-GM environment—

Senator CHERRY—But where the genetic modification relates to herbicide tolerance then obviously it is the key reason for the pick-up of that genetic modification of that particular plant. The crop system changes and the results of that, to use the wording of the act, flow from the fact of that herbicide resistance. I am just not confident that there is not a crack between your two regulators.

Dr Meek—I would say that there would be more of a risk if I had to look in isolation at the use of glyphosate on GM crops in the Australian system. It is extremely important that the APVMA looks at the use of herbicides and at any change that might come up on a whole of sector basis. There could be, for example, a non-GM herbicide tolerant variety which would not be covered by the Gene Technology Act that the APVMA should be able to look at. There is a higher level of assurance of the continued efficacy of the use of various herbicides by looking at whole of sector use than there is by, if you like, trying to look down the wrong end of the telescope at what minor perturbations might arise from the use of GM crops. My view is that it is far more appropriate that the APVMA continues to look at this on a whole of sector basis—including at changes that may or may not occur as a result of the introduction of GM crops into the agricultural farming system—rather than to try and look at it from my end. That is very much why the legislation was crafted in the way that it was.

Senator CHERRY—The last time we met we talked about the British farm scale evaluations and you said essentially they were not relevant to Australia because they were about herbicide regimes and weed issues in the UK which were not particularly relevant to Australia. I am paraphrasing, and I apologise for that. The CSIRO review of those farm scale evaluations found that the studies were relevant in that 'significant changes in farming systems are likely to change the biota associated with farms'. I think that is from October 2003. Do you consider the environmental impacts associated with changed farming practices to be within your jurisdiction?

Dr Meek—If they relate to changed farming practices that may have an impact on human health and safety or the environment, yes.

Senator CHERRY—The CSIRO review found that the British evaluations were relevant, too, on the basis that farm scale evaluation 'clearly shows the interdependence of different groups of organisms within farm-land ecosystems'. Would you agree that that sort of approach is also relevant to the Australian situation?

Dr Meek—The issue that is at point here—and in fact it is what the CSIRO says—is that while it is certainly true that there is an interdependence the reason why it was significant in the UK situation was that the organisms that were interdependent were actually remnant native vegetation, whereas in Australia the organisms that would be affected in that context are actually introduced weeds that it would actually be a good thing to get rid of in the Australian environment. So there is a very different implication to those two statements.

Senator CHERRY—How much study has been done in Australia on those interdependent biodiversity questions?

Dr Meek—As I have said to you before, the issue is that the weeds in the Australian system are not native vegetation. The issue of whether or not they should or should not be eradicated really does not come up, because it is regarded as a good thing to get rid of exotic weeds that have been introduced into the Australian environment.

Senator CHERRY—You have indicated that, as part of the GE canola approvals, you looked at 400 papers and you suspect there would be peer-reviewed biodiversity studies amongst those. You were asked to take that question on notice. Have you found any Australian based peer-reviewed biodiversity studies on some of these issues?

Dr Meek—I think you sent us a supplementary question on that.

Senator CHERRY—Yes.

Dr Meek—I think we advised you that we were not aware of any in that context.

Senator CHERRY—Do you think the whole issue of whether changes to cropping systems will impact on biodiversity in Australia is an important area of research that needs to be opened out a little further?

Dr Meek—Again, it comes back to the rather interesting issue that cropping systems, in general, do have an impact on the environment. That is a much bigger question than gene technology. I think it is a much broader debate and it is not one that can be driven from the question of whether or not you adopt genetically modified crops. It is a much bigger question. You may be aware that Lord Robert May, in the UK, made this very point in relation to the

UK farm scale evaluations. He said to forget what the impact of herbicide use on GM crops might be and whether it is different to non-GM crops. He said that, as a broader community, we need to make a decision about the sorts of farming situations that we want. To some extent, the situation is the same here—my responsibility is to look at the impacts on human health and safety in the environment.

Senator CHERRY—Have you had any discussions with the relevant agencies or APVMA about joint collaborative research to explore some of these issues?

Dr Meek—No.

Senator CHERRY—I might have to leave it there, Chair, because I have another meeting. I will put some questions on notice. I thank the committee for their indulgence.

CHAIR—Thank you.

[10.33 a.m.]

Therapeutic Goods Adminstration

Senator FORSHAW—I have a few questions as a follow-up to our last estimates hearings regarding the ongoing issues surrounding Pan Pharmaceuticals. Could you tell us where the potential legal action against Pan or Mr Selim or anyone else is up to?

Mr Slater—The issue around whether charges are laid against Pan, Pan directors or Mr Selim, the executive director, is a matter for the DPP. We have provided a great deal of material for the DPP to assess in relation to some of the matters that we are investigating. There are other matters that we are still in the process of investigating.

Senator FORSHAW—It seems to be taking quite some time. I appreciate that you said the final decision is in the hands of the DPP but do have you any idea when that decision is likely to be made?

Mr Slater—No. It is a matter for the DPP. I could only speculate.

Senator FORSHAW—So the TGA has not been given any indication as to when a decision might be made?

Mr Slater—I would be offering only an opinion on that.

Senator FORSHAW—You said you are still investigating matters. How intensive is that? I would assume that by now you would have provided the DPP—and had already done so, I think, at the time of the last estimates—a fair amount, if not most, of the information that would be required to make a decision about prosecution. Is the DPP waiting on the TGA for more material?

Mr Slater—For some matters the DPP has the final brief of evidence as a result of the investigations that we have undertaken. For other matters those investigations are ongoing.

Senator FORSHAW—Yes, but can you be more specific? How much more work would you estimate needs to be done? How much more time is required before you can say, 'It is now up to the DPP'?

Mr Slater—On those matters that the DPP has the final brief on, that is an issue for them to make a decision about—whether they take the matters forward for prosecution. For those

other matters that we are investigating, it would be in the realm of speculation for me to say when they would be closed, but we are applying a great deal of effort to those. They are complex matters. They involve other countries. I do not think I should give you an off the top of the head view about that—it would be pure speculation.

Senator FORSHAW—As far as the TGA is concerned, in relation to at least some potential prosecution on some matters the TGA has provided all of the information. I know you cannot answer this, but it would seem from what you are saying that the DPP could well be in a position to make a decision about commencing legal action on some matters, and further decisions might be taken afterwards. It is not going to be one whole prosecution decision, if you like.

Mr Slater—No, there is more than one matter involved. It is up to the DPP as to how these matters are taken forward when we finish our investigations.

Senator FORSHAW—Can you give us as much information as you can about just what resources are being committed to the investigation and provision of information to the DPP? By resources I mean number of officers, and I would also like to know what costs to date have been incurred by the TGA in that respect.

Mr Slater—I will ask Michael Lok to come and talk about the costs, but let me say that we have our own investigators who have been working on this case. The DPP has also provided resources to assist us in those investigations. Mr Lok will give you some advice about the current cost of the investigations to date.

Senator FORSHAW—Just before we go to Mr Lok, has the TGA scaled back the level of its use of resources on this matter?

Mr Slater—Not to my knowledge. As we finish one matter or close the brief of evidence as a result of our investigation and pass that across to the DPP, we are of course able to apply those resources to the further matters that are under investigation. As I said, some of those matters are very complex and they are intricate. They involve other countries and we are dependent, of course, on the availability of those players in finalising the matters.

Senator FORSHAW—Are you able to say how many personnel—how many officers within the TGA—are dedicated to this task?

Mr Slater—I need to take that on notice. It really comes to the fact that any one of the investigation team—which could potentially number as many as 10 in the TGA—could be involved at any one point in time. Therefore, the overall cost probably gives you a better indication of the resources that we have applied.

Senator FORSHAW—Thank you. Mr Lok, would you tell us about the costs.

Mr Lok—The total cost for the surveillance and investigation activities incurred to date—since the licence suspension in April last year—is $822,000.

Senator FORSHAW—Is that TGA costs?

Mr Lok—Yes.

Senator FORSHAW—Mr Slater, you said that there are other agencies involved and that the DPP has provided resources. I appreciate that it goes beyond the area of the TGA, but I

would like to get an idea of the total costs that have been expended on this investigation, including the resources from any other agencies or departments. Could you take that on notice for me?

Mr Slater—Yes.

Senator FORSHAW—Tell me who in addition to the TGA is involved. We have the DPP. Are there any other agencies? What about the Australian Government Solicitor, for instance?

Mr Slater—There is bound to be legal advice in there. I would also estimate that there would be some AFP involvement at different points along the way.

Senator FORSHAW—Would their costs be met by the TGA?

Mr Slater—No.

Senator FORSHAW—Please give us the overall information about the total cost to the Commonwealth since this matter started in regard to those investigations. Has any money been recouped so far by the TGA in respect of this matter?

Mr Slater—Do you mean from the liquidators and—

Senator FORSHAW—From the liquidators or anywhere else. The liquidators are obviously the source.

Mr Lok—The TGA has recouped a dividend, which was announced by the liquidator last month. The liquidator accepted a proportion of the TGA claim, and we have received $8,144 as a dividend.

Senator FORSHAW—What was the claim?

Mr Lok—The total claim was approximately $17,288,000.

Senator FORSHAW—That was the claim, and you have received $8,000-odd. What does that represent as a dividend? It is pretty small.

Mr Lok—It is small. The bulk of the claim that was made against the Pan Pharmaceuticals group was assessed by the liquidator and, on advice from the Australian Government Solicitor, we have not been able to pursue the bulk of that claim.

Senator FORSHAW—So that is a final dividend payment in respect of that total claim—

Mr Lok—Of the residual. It is not the final dividend on the residual.

Senator FORSHAW—A $17 million claim has been made, and you have received $8,000-odd. What hope is there of recovering any more, firstly from the liquidator?

Mr Lok—First of all, the level of claim by a range of creditors and suppliers was well in excess of the resources and assets of the actual corporation.

Senator FORSHAW—I was aware of that.

Mr Lok—The liquidator estimated a dividend of perhaps 25 per cent. That is subject to the liquidator's decision on whether or not to pursue former directors and officers.

Senator FORSHAW—So whether or not the TGA recovers any more money is dependent on action to be taken against former directors and other persons that action may be able to be taken against?

Mr Lok—That is partly correct, although the bulk of the claim is unable to be pursued through the liquidator.

Senator FORSHAW—Yet—because the assets are not there?

Mr Lok—No. It is because the TGA, unless it has under its legislation specific authority to seek recovery of those costs, is unable to pursue those costs.

Senator FORSHAW—Could you give me, on notice, a more detailed explanation of what you have just said?

Mr Lok—Certainly.

Senator FORSHAW—I do not want to spend time now going through the legal machinations of that. Arising out of this, isn't there a TGA debt to the Department of Health and Ageing?

Mr Lok—That is correct. There was a debt, and it has now been fully paid back.

Senator FORSHAW—How much was that?

Mr Lok—It was an outstanding amount of $14.2 million.

Senator FORSHAW—Where were the funds found to pay that back?

Mr Lok—The funds were appropriated to the TGA in the additional estimates.

Senator FORSHAW—The funds were given to the TGA, in the additional appropriation, in order to pay back the Department of Health and Ageing?

Mr Lok—That is correct.

Senator FORSHAW—Lucky you. Have any previous directors or owners of Pan applied for or obtained licences to manufacture or import therapeutic goods?

Mr Slater—Subsequent to the Pan suspension?

Senator FORSHAW—Yes.

Mr Slater—Not to our knowledge.

Senator FORSHAW—Are you able to check and confirm that?

Mr Slater—Yes, we will check and confirm that.

Senator FORSHAW—Can you give me an update on progress in the matter of the Trans-Tasman Regulatory Authority?

Mr Slater—The Australian and New Zealand governments signed a treaty last December to establish a single agency to regulate therapeutic products in both countries. The legislation to enable that treaty to be implemented is under development and, all things being as they are, we expect to introduce that in the Spring sittings.

Senator FORSHAW—In terms of the overall budget allocation for the TGA, there are a couple of references in the PBS that I am interested in. Firstly, there are the actual amounts at page 79. As I read the figures, total revenue from government and other sources increased from $141,408,000 in 2003-04 to $147,030,00 in 2004-05. So somewhere you have had an increase of almost $6 million in the budget estimate for your revenue. Is that correct?

Mr Slater—I would love the TGA to have $141 million at its disposal, but that is the total figure for all those regulatory agencies. Going to the point of your question, we have applied an indexation factor to most of our fees and charges, except for an adjustment in prescription medicines, which is the result of discussions with the industry about rebalancing where the incidence of certain charges fall.

Senator FORSHAW—I apologise for that: it is all under the heading of TGA, but there are figures in there for the Office of the Gene Technology Regulator, NICNAS and so on. What, if any, is the additional appropriation for the TGA for next year?

Mr Lok—If you look at that table, there is actually a decline in the TGA appropriation from $6.246 million to $5.82 million.

Senator FORSHAW—So that is to the TGA special.

Mr Lok—That is the appropriations.

Senator FORSHAW—Okay. What is the estimate for the total revenue for the TGA for next year, as compared with the current year? I find it a bit confusing to understand what the TGA gets out of it.

Mr Lok—The very first line on that page for that table represents the total TGA revenue, inclusive of any appropriation amounts.

Senator FORSHAW—That is from $67,589,000 to $70,325,000.

Mr Lok—That is correct.

Senator FORSHAW—So there is still an increase of around $2½ million.

Mr Lok—That is correct.

Senator FORSHAW—Okay. I apologise for misreading that. How is that going to be spent? The only reference I can find in the PBS is to this new policy advisory role, and I am not sure whether that is an additional measure.

Mr Slater—Can I just draw out the question? Are you talking about the additional $2½ to $3 million?

Senator FORSHAW—Yes.

Mr Slater—That reflects an indexation amount.

Senator FORSHAW—That is what I thought it must have been, because there are no other measures in there.

Mr Slater—Except for that adjustment I mentioned in relation to prescription medicines.

Senator FORSHAW—Can you tell me anything about the measure that is noted at page 73 of the PBS. It says:

The Government will provide $2.4 million over two years to establish a therapeutic products policy advisory role within the Department of Health and Ageing ...

Ms Halton—Allow me to answer that question, if you will.

Senator FORSHAW—Yes. Is that separate from the trans-Tasman agency that is to be established?

Ms Halton—Yes. This is essentially a bit like when we established FSANZ. At the moment we have a kind of combination of policy adviser and regulator in the one body. When the trans-Tasman agency is established, we will separate that regulatory role. There will still be a need inside government and inside the department to provide policy advice on these sorts of issues. So, just as we have had to create a policy advising capacity in the population health area in relation to food, we are going to have to create a policy advising role in relation to these issues inside the department. Effectively, what we are seeing is a slight separation of the roles now. The practical reality is that these people talk all the time, as our food policy people talk to the FSANZ people, but this enables us to separate that advice.

Senator FORSHAW—I am advised that the TGA management are advising employees or the union that there is a Department of Employment and Workplace Relations policy that statutory agencies do not become attached to the maternity leave act schedule—that that has to be dealt with through certified agreements. Is this true?

Mr Slater—My understanding of this matter is that there are no new agencies to be added to the maternity leave provisions. This is a new agency—

Senator FORSHAW—The trans-Tasman one?

Mr Slater—The trans-Tasman agency. Hence, to preserve those conditions of service that are available to officers of the department, they are included in the certified agreement, which will come across with the TGA and the other parts of the group that will form the new agency on 1 July 2005. It will reflect those provisions that are in the certified agreement, including the maternity leave provisions.

Senator FORSHAW—How are the maternity leave provisions reflected now for TGA personnel?

Ms Bryan—The maternity leave act provisions apply to TGA employees in the same way as they apply to the rest of the APS.

Senator FORSHAW—So what you are saying is that, because the new agency is not in the schedule to the legislation, the position is that it must be covered by a certified agreement.

Ms Bryan—That is right. The advice we have from DIR is that, because the new agency will be employed outside the Public Service Act employment scope, the provisions of the maternity leave act will not automatically apply. It has been government policy for some time, I understand, for new agencies not to be prescribed for that purpose. We will ensure that that entitlement continues through the mechanism of the certified agreement process.

Senator FORSHAW—So the employees of the TGA at the moment are within the APS—

Ms Bryan—That is right.

Senator FORSHAW—and after the new agency is established you are saying they will not be APS.

Ms Bryan—They will not be employed under the Public Service Act.

Senator FORSHAW—Is there a policy document where this is laid out?

Ms Bryan—We have not been given that policy document, no.

Senator FORSHAW—How is the expert committee that was established going?

Mr Slater—The expert committee report, as you know, was handed down in October. The government gave an extended period of consultation for interested parties and stakeholders to input the process. That consultation period ended around mid-February. The government response is now at a point of near finalisation, and we expect that to be available in the next month or so.

Senator FORSHAW—So what is going to come out in the next month: a final report?

Mr Slater—The government's response to the expert committee's report.

Senator FORSHAW—Can you give me an update on the costs associated with the expert committee process?

Dr Briggs—The expert committee on complementary medicines in the health system has been completed. Their duties have finished, with the production of their report. The additional expenses that are being incurred are a result of the meetings of the interdepartmental committee to consider the government draft response to the recommendations of the expert committee report.

Senator FORSHAW—Who is actually meeting the costs of the expert committee on the preparation of that report and the subsequent work that is being done?

Mr Slater—The TGA.

Senator FORSHAW—Will it recover or seek to recover any of that cost?

Mr Slater—I should say that the TGA is meeting those costs, but those other departments that input the process will meet their own costs, of course. But the cost of taking this expert committee process to conclusion is being met by the TGA.

Senator FORSHAW—You can take this on notice: are you able to give me a breakdown of all of the costs?

Mr Slater—We will give you a total picture of the costs.

Senator FORSHAW—I would like it broken down into where it has been attributed to.

Mr Slater—Into the various stages, yes.

Senator FORSHAW—And what is able to be recovered and what is not. From your earlier answer, I take it there is no extra funding in the budget for the implementation of any recommendations that may come out of the expert committee's report and the government's response to it.

Mr Slater—If there are matters for appropriation, they would be taken forward through the budgetary process. If there are matters that go to existing programs that are provided by governments, where funds may be available they could be funded out of those existing programs.

Senator FORSHAW—But at this stage there is no extra funding.

Mr Slater—There is no additional funding at this point in time.

Senator FORSHAW—That concludes my questions on the TGA.

[10.59 a.m.]

Food Standards Australia New Zealand

Senator McLUCAS—I have two issues I want to traverse with FSANZ. The first one is children's baby food. I have been advised, and I do not know if it is correct, that FSANZ is considering new draft labelling requirements. Is that happening?

Mr Peachey—Yes, we are. We are trying to bring those into line with what is accepted international practice at the moment.

Senator McLUCAS—What process have you undergone to get to the point you are at at the moment?

Mr Peachey—As I understand it, we have raised a proposal and that will run through its usual course—two rounds of public consultation—and then the board will make a decision, once it is completed.

Senator McLUCAS—Sorry, there is a proposal for—

Mr Peachey—The proposal is to amend the Food Standards Code to bring it into line with what is happening elsewhere. I think the issue is around age—whether it is four-plus months or around six months or whatever. I think what we are trying to do through that process is address the issue and bring some consistency between our standard and what is happening elsewhere. It is under way.

Senator McLUCAS—It is the issue of solid food at four months or six months.

Mr Peachey—Yes.

Senator McLUCAS—Have you come to the point of making a recommendation?

Mr Peachey—We have not made a recommendation yet. The proposal just canvasses the issues. Having said that, we are obviously mindful of what government policy is elsewhere. From my understanding, the NHMRC has a position on this, and it is the older age—six months.

Senator McLUCAS—I am just trying to understand the process, because there is a lot of community interest in what FSANZ will do in terms of labelling. What happens next?

Dr Healy—We have already raised a proposal, which is part of the legal mechanism for considering an amendment to the Food Standards Code. The first step in that process is to release what we would call an initial assessment report, which is a document that canvasses the issues. The document is talking about the various advantages and disadvantages of changing the labelling requirements. The document was released about mid last year for public consultation. A number of views were received and we are currently doing the internal work to consider those views and consider the issue further. We have not yet come to a view; it is expected that we will do so in the second half of this year, at least in draft form. The process that we go through is that there will be a recommendation to the FSANZ board, who will come to a position. There will be another round of public consultation on that draft position, and then probably in early 2005 we will consider the public submissions and come to a final view.

Senator McLUCAS—How do you involve the states? Is it just part of the normal consultation? I understand that Queensland Health have produced guidelines regarding optimal infant nutrition, which go to the point that Mr Peachey made—that breast-feeding to six months is the most appropriate and six months is the point at which to introduce solid food. How do you make sure that the states' views are considered in that process?

Mr Peachey—We have a very close working relationship with the states. We certainly notify them of any proposals we are working on. We involve them wherever we can. There is a committee structure that promotes that sort of cooperation. Speaking hypothetically, if one of the states wanted to get more closely involved in our process, we would be inviting them along to our expert committees and panels, so in that regard it is very open and certainly very inclusive of state views.

Senator McLUCAS—Thank you. Maximum residue levels and the difference between what is allowable for adult consumption and what should be allowable for consumption by a child—could you give me some background to that issue and how FSANZ deals with it.

Dr Healy—The FSANZ role in looking at maximum residue limits is to look at the residues that are permitted to remain in food—recognising that there are other agencies that have other responsibilities in the regulatory arrangements for maximum residue limits. In a process sense, the majority of the health and safety issues are looked at by the TGA as part of the process that the APVMA goes through in considering the maximum residue limits. The responsibility of FSANZ is to set the limit in food. In doing so, we would undertake a dietary modelling exercise, which looks at potential exposure and different population subgroups.

Senator McLUCAS—How do you consider in this process the question of what might happen if a child were to consume this food? How is that considered in the process? Do you use the lowest level of tolerance?

Dr Healy—In a general sense, we are looking across population subgroups and we are looking at the consumption patterns for different groups. Of course, children are always an issue because they have a lower body weight; so proportionally their exposure is going to be greater, so that has to be taken into account. Generally, the reference health standards, which are the acceptable daily intakes, are set so that they are suitable for the whole population.

Senator McLUCAS—Thank you. Just finally, vannamei prawns and nitrofurans: we have talked about this issue in this committee before. Is there anything you can update the committee on? Have you had to test foods?

Mr Peachey—I can give you an idea of what testing is done. Last time, I think we spoke about who does what and we explained that there was a relationship between FSANZ and AQIS. They do it on our behalf, and we provide the risk assessment for them. This is data from AQIS: testing on prawns for nitrofuran started in December 2003 and seven failures were detected from 116 tests since then. In November 2003 we advised AQIS to inspect imported prawns for nitrofuran, so there was a continuing discussion with AQIS, and we sought to have it categorised as a risk food, in accordance with their inspection arrangements, which upped the level of inspections.

Senator McLUCAS—What level of inspections are carried out now, Mr Peachey?

Mr Peachey—As a risk food, they are inspected at 25 per cent. This is a performance based inspection arrangement. If certain consignments turn up and there are no residues found, it drops back to another level. So it is a performance based testing scheme.

Senator McLUCAS—But it is still classified as a risk food?

Dr Healy—If I could clarify: there is some confusion about uncooked and cooked product and the inspection rate. The inspection rate for uncooked prawns, specifically for nitrofurans, is 10 per cent. That is regarded as an active surveillance rate. The routine rate would be five per cent. Because of the concerns around nitrofurans, we ask that the inspection rate be a little bit higher. The inspection rate for cooked prawns is higher again, but that is for a different reason.

Senator McLUCAS—What is that reason?

Dr Healy—Microbiological contamination.

Senator McLUCAS—That is the 25 per cent rate that Mr Peachey advised?

Mr Peachey—Yes.

Senator McLUCAS—When did we start the 10 per cent inspection regime?

Dr Healy—In November 2003.

Senator McLUCAS—And that has been maintained. And that figure of seven positive readings out of 116: what date is that up to?

Mr Peachey—The information I have before me is that it is from December 2003 until now.

Senator McLUCAS—It is current.

Mr Peachey—Yes.

Senator McLUCAS—What is the classification higher than 'risk food'?

Dr Healy—That would be the highest classification. It is a three-tier system.

Senator McLUCAS—Your risk analysis says that a 10 per cent inspection rate is enough to identify when the product is contaminated?

Dr Healy—Our risk assessment, which is based on public health and safety grounds, says that the risk to public health from nitrofurans is very low. The inspection rate is more a compliance issue than a public health and safety issue.

Senator McLUCAS—Are you aware that there have been discussions between CSIRO and prawn producers in Asia to find a masking measure that would mask the identification of—

Mr Peachey—No, we are not aware of that.

Senator McLUCAS—You are not aware of that? It has been in the media. What would that mean in terms of your assessment process?

Dr Healy—In terms of our assessment of public health and safety, it has no impact because the assessment is for nitrofuran itself. It then becomes a question of an ability to ensure compliance with the requirements.

Senator McLUCAS—On what basis does FSANZ assess that nitrofurans are not a problem for human health and safety?

Dr Healy—We have taken into account the available toxicological information, including the evaluation that was undertaken by the international expert body that sits under the World Health Organisation. We have also taken into account the levels of nitrofuran residues—and I should make that clear: it is nitrofuran residues—that have been found in prawns in the Australian food supply.

Senator McLUCAS—I will leave it there, thank you.

[11.12 a.m.]

Australian Radiation Protection and Nuclear Safety Agency

CHAIR—We will now move to ARPANSA.

Senator WONG—With regard to the budget appropriation for ARPANSA, I notice there is a reduction from the 2003-04 appropriation of just over $2 million—is that right?

Dr Loy—Yes.

Senator WONG—It is on page 79 of the PBS.

Dr Loy—It arises from a number of factors and, if you like, our base appropriation has not changed, other than through indexation factors. 2003-04 was a bumpy year in some respects in that we did receive one-off funding for specific purposes, including restructuring of, I think, $1.8 million. There was also in the 2003-04 appropriation some funds for the part payment of our 2002-03 insurance premium and also additional funding for our 2003-04 insurance premium. All in all, if you compare like with like, our basic funding has been actually increased in 2004-05 by the new policy measure that is described in the papers. It is a one-off effect of some one-off funding in 2003-04, both for specific purposes of addressing some issues in our structure, plus some ins and outs because of the insurance funding.

Senator WONG—What was the new measure?

Dr Loy—Under 'Investing in Australia's Security' on page 70 there is 'Radioactive material security and emergency response capability'.

Senator WONG—You said your base-level funding had not changed other than indexation. What is the base-level funding?

Dr Loy—It is of the order of the total you see on page 79. The base funding that you can compare from year to year is that 21.4 less the 1.3 of new funding. As I said, in 2003-04 we received one-off funds.

Senator WONG—Was any component of the one-off funds in 2003-04 to take into account your activities in relation to the radioactive waste disposal facility in South Australia?

Dr Loy—No. The major component, as I said, was specifically directed to some restructuring of the organisation. It was also in recognition that in fact we had, if you like, spent more than anticipated on the assessment of the replacement reactor construction licence.

Senator WONG—Can we turn now to a number of the reports which I think have been finalised since we last spoke at the last estimates. The first is the international peer review of

the International Atomic Energy Agency. The report was somewhat critical of the way DEST had structured its application in that DEST has submitted a single application to cover siting, design ,construction and operation. In the International Atomic Energy Agency report they make the point that international best practice would generally have each of those steps as a separate and individual licensing step. I questioned DEST on this matter yesterday. Have you received the letter yet from them on this issue?

Dr Loy—No, I have not.

Senator WONG—I understand from their evidence that they are proposing to indicate to you that, notwithstanding these criticisms, they are not going to restructure their application.

Dr Loy—Following the IAEA peer review report I wrote to Dr Harmer, transmitting the report and asking for the department's response. I said, 'I am not limiting your response in any way but here are things that seem to me to be important in the review.' Specifically in relation to their recommendations about the stepwise approach, or a step by step approach, I said:

In the light of these recommendations I would be glad if you would confirm whether you wish to proceed with the current application for the three conducts or would now wish to proceed only with an application for a licence to prepare the site. Should you wish to continue with the current application for all three conducts, I would be glad if you brought forward suggestions for how a step-by-step approach might still be accommodated within the context of your present application.

Senator WONG—That seems to be a pretty reasonable letter. Is it of concern to you that DEST appear to be saying, 'This may be international best practice but we are not going to do it that way'?

Dr Loy—I will have to see what they say and assess it when they bring forward the arguments they have for that position.

Senator WONG—But you would concede that this report provides pretty cogent reasons why there should be a stepped licensing process as opposed to a one-stop shop licence application?

Dr Loy—It certainly contends, argues, that a step by step approach is international best practice. That does not necessarily mean that that cannot be made consistent with a three-step single application. But I have asked, as you would have noted, in that letter for DEST to bring forward its views about how its single application, if it proceeds with that, could be made consistent with that step by step approach. I assume they will do that and I will examine that argument when I receive it.

Senator WONG—Given the public concern about this facility, though, wouldn't international best practice be something that the public ought to receive?

Dr Loy—I do not think it is a matter where you can say that a particular report has said X and therefore that is the end of the matter. The report has said what it has said. I have put it to DEST. I have asked them to say whether they wish to continue with the single application and, if they do, how they argue that it can be made consistent with the step by step approach. I will wait and see what it is they say in response to that.

Senator WONG—I will just note that a similar criticism was also made by Professor Ian Lowe, so it is not only the International Atomic Energy Agency that has made this criticism but the independent expert who I understand you requested assistance from. He made a similar criticism of the one-stop shop application or all in one application.

Dr Loy—I believe so. Again, I have transmitted that to the department and they will no doubt respond to it.

Senator WONG—Dr Perkins from DEST last night seemed to suggest that DEST's view was that this application was different—'We were different,' I think was the phrase used; I might be corrected by *Hansard*—and that somehow this facility was different and therefore it did not need to go through the international best practice process of a stepped licensing regime. Is that a concern for you?

Dr Loy—Two comments. First, they have talked of a step by step approach. That is not necessarily the same as a step by step licensing application. The single application and the step by step approach may be able to be made consistent, and that is what I have asked them to examine. Second, I cannot really conduct an assessment on the basis of reports of Dr Perkins's testimony.

Senator WONG—No, I do not expect you to do that. I am sure you will hear from them shortly. The report also recommends that you develop a guidance document specifically for radioactive waste disposal. Are you doing that?

Dr Loy—No. I have said that, first of all, the basic regulatory guidance seems to me to be provided in the NHMRC code of practice. Where that needs to be supplemented or updated I have referred to the IAEA safety requirements documents on near-surface disposal and on predisposal management of radioactive waste and a safety guide, which is a lower level of document on safety assessment for near-surface disposal, and the ICRP publication on radiation protection recommendations as applied to disposal of long-lived solid radioactive waste.

In addition, the other point I have made is that, at the end of the day, consideration of international best practice needs to be looked at by the applicant and arguments made to me about it. I have described what I think it means in the decision on the replacement reactor construction licence, and that was also the subject of consideration by Justice Beaumont in the Greenpeace appeal. So there is plenty of material around for them to be able to look at and frame their application and argue for international best practice in relation to what it is they are putting forward. So I do not think any additional guidance from me is warranted.

Senator WONG—Their evidence last night was that they have written to you saying they think you have enough material before you to deal with it. But you obviously have not received that letter as yet.

Dr Loy—No, I have not.

Senator WONG—I will turn now to Professor Lowe's report. Do you have a copy of that with you?

Dr Loy—Yes, I have.

Senator WONG—Just to clarify, you requested that Professor Lowe and—was it a Professor Jack?

Dr Loy—Mr George Jack.

Senator WONG—Mr Jack assist you in providing some, I suppose, external advice regarding this application. Is that correct?

Dr Loy—Their specific role was to assist me in the public forum that took place in Adelaide at the end of February, to hear the submissions made in that forum, to question the people who made submissions and then to write me a report on their own views and observations arising from the forum.

Senator WONG—I congratulate you on organising the forum. I think it is a pity that ARPANSA rather than the government has conducted such a forum which enabled members of the public to put their views, I think, very clearly about this issue.

Dr Loy—Thank you.

Senator WONG—Turning to Professor Lowe's criticisms, I do not think it is overstating it to say that he is quite heavily critical of the application; in fact, he describes it as being so clearly deficient in a number of areas that it would be very difficult for the regulator to accede to the department's request for a single-step approval. He comments on the first page: 'If the regulator does not reject the proposal, I believe he should certainly require the proponent to provide much more satisfactory assurances than have been given in the licence application and in evidence at the public forum.' They are fairly weighty criticisms of this application.

Dr Loy—Yes, he is certainly critical of it; there is no question.

Senator WONG—As a result of this, do you retain serious concerns about this application?

Dr Loy—I do not think it is my role to have concerns or not have concerns. It is my role to assess the information that is put before me and then ultimately to proceed to a decision on the basis laid out in the ARPANS Act and to justify that decision. The stage that we have reached in the process is that the department has made an application and there has been substantial criticism of it by the peer review and by the public forum and the reports arising from that. I have put all that information to the department and asked them to respond. I will receive their response and, once I have their full response, I will proceed to assess it against the requirements of the act.

Senator WONG—Can you remind me of when you wrote to the department subsequent to the forum and the IAEA review in the terms you have just outlined?

Dr Loy—There has been a series of letters. March was my writing to Dr Harmer month. As each thing was completed I wrote him a letter saying, 'Good news, here's another report and I'd be happy to receive'—

Senator WONG—Good news: here's another report that says your licence application is pretty poor!

Dr Loy—I was being flippant.

Senator WONG—Are you able to provide the committee with the letters to Dr Harmer in relation to the public forum, Professor Lowe's report and the International Atomic Energy Agency report?

Dr Loy—Yes, I am happy to do that. I should clarify that the most substantive letter is the one in relation to the IAEA peer report where I felt moved to indicate some things that I thought it was important he should respond to, without limiting his ability to respond to every word if he wished. The other letters are more straightforward, simply forwarding the reports and asking for any response. But I am happy to make them available to the committee.

Senator WONG—Thank you. Professor Lowe in his report questions the DEST assertion that disposal of the waste in a purpose-built national repository will reduce the cumulative risks of storing wastes leading to the conclusion that the community and the environment will benefit. He states: 'The basis for this assertion is shaky. It is by no means clear what the exact scale of the current problem is.' Later on that page he goes on to talk about the failure of the government, or DEST, to do any rough risk calculation which could actually justify the claim that the repository will reduce the cumulative risk to the community. Doesn't what Professor Lowe is saying challenge the entire basis of the government's application for a single repository?

Dr Loy—Not necessarily. Presumably you argue for a repository on the basis that it is better than what you have now.

Senator WONG—But I think his point is that we do not know what we have now because the inventory of where the current waste is stored is extremely incomplete. So it is not possible to do a risk comparison between a single storage place and where it is currently stored.

Dr Loy—I do not think that is altogether fair. Certainly, as you get further down into the detail, no doubt there will be new issues that arise and changes to what we know about the inventory, and that is inevitable. But the idea of a repository is to deal with the waste, to finally put it in a repository and thereafter, ultimately after the period of institutional control, walk away. The alternative of doing nothing does not seem to me to be viable because that leaves waste in an unconditioned state available to the environment in all sorts of ways. Is there another way of moving to condition waste at particular sites and then storing it at sites, and is that better than a repository? I think most countries that have examined that issue have come to the conclusion that a repository is a better approach. It is true that has not been particularly quantified in the Australian argument and maybe it can be. But my view would be that it is not sensible to simply leave the waste where it is with nothing being done to it, and therefore either a repository or some form of managed storage is essential. They may be the two things that need to be compared.

Senator WONG—And that has not been done yet?

Dr Loy—Only, I think, in terms of general argument.

Senator WONG—Rhetorical argument.

Dr Loy—I have never seen somebody who has done a particularly quantified analysis of it; that is true.

Senator WONG—I will turn now to Professor Johnston's submission to the forum and Professor Lowe's analysis of that. I understand that Professor Johnston worked with DEST on the clean-up of the weapons test site at Maralinga and he was particularly critical of DEST's capacity to manage contractors. The importance of that submission and that evidence is that the licence application that is currently before you essentially contracts out the operation of the repository to the private sector—that is, the non-government sector. Professor Johnston cited quite a number of significant and glaring problems with DEST's management of contractors at Maralinga and concluded from that that the applicant had not demonstrated a capacity for effective control of the proposed repository. I note that Professor Lowe refers to the fact that DEST did not accept Professor Johnston's criticism but advanced no refutation of his argument. Would you agree with both Professor Lowe and Professor Johnston that ensuring that DEST can actually effectively manage and control a facility is a precondition for a licence being granted in this area?

Dr Loy—Yes.

Senator WONG—Do you have concerns as a result of DEST's failure to refute Professor Johnston's criticisms?

Dr Loy—I think Professor Lowe made that observation, if you like, on the day. Again, that is something that the department can respond to in more consideration in their response to the issues in the forum. In my letter about the IAEA peer review I did refer to their comments about the heavy reliance on contractors, making it difficult to deliver an integrated program and provide continuity; and I asked that the department should consider a model in which a greater degree of expert knowledge is maintained within the department to develop the fundamentals of the safety case for the repository, and then to apply the safety case to the ongoing development and management of the repository through contract management. I said the department must be able to demonstrate that, in fact as well as formality, it would have effective control of the repository and would take responsibility for its safety.

Senator WONG—This government seems to have a predilection for contracting out, from detention centres to nuclear facilities.

Dr Loy—I think the only sensible way to run the repository is by a contracting-out process. I do not think it is necessarily sensible, at least in the Australian context, for a government department to actually do that. But I guess the issue is the degree of technical expertise that needs to reside in the managing department of the contract.

Senator WONG—On that point, Professor Johnston, who worked on Maralinga with DEST—

Dr Loy—I think I need to clarify that Professor Johnston actually worked for the Maralinga Tjarutja, the Aboriginal community.

Senator WONG—Yes, but he was involved in hands-on work. He had some intimate knowledge of DEST's activities and management of contractors during the Maralinga clean-up. Would you agree with that?

Dr Loy—Yes, indeed.

Senator WONG—His submission is highly critical of DEST's capacity to manage contractors, given the technical issues you have raised.

Dr Loy—His submission is. I have received a submission from Dr Keith Lokan, who argues that that is not a valid view, based on Maralinga experience. People can look at that history and come to different conclusions. I would like to take the opportunity of emphasising also that Professor Johnston's view was that, despite his issues about the contract management, nonetheless the Maralinga clean-up project was successful.

Senator WONG—I turn now to the overriding of state laws. I am not going to ask you about the compulsory acquisition of the land. One of the issues that has been discussed by, I think, both the IAEA and Professor Lowe is the legislation that the South Australian parliament has passed prohibiting the transport of radioactive waste into the state and also the report of the New South Wales committee which recommends similar legislation be passed in New South Wales. If those laws were valid, were not voided by any contrary law of the Commonwealth, they would prevent the movement of waste from Lucas Heights to the proposed repository. Have you turned your mind to that issue?

Dr Loy—Not in the sense of considering it as an issue in relation to whether or not to issue a licence for the repository. I am certainly aware that the Australian government has advice that provided the activities were undertaken by the Commonwealth and under an ARPANSA licence, that would be overriding of the state law. But that is not an issue that has been a matter that I personally have considered in my role.

Senator WONG—So the Australian government have advice that they can override the state law via the existence, amongst other things, of an ARPANSA licence?

Dr Loy—That is my understanding, yes.

Senator WONG—When were you advised about that?

Dr Loy—This would be more than a year ago, I think.

Senator WONG—So not only will they override state laws in respect of the acquisition of land but also in relation to the transport of waste.

Dr Loy—I think that is a comment of yours.

Senator WONG—Is that your understanding of the situation? Professor Lowe says that this is something you ought to get qualified legal opinion about. That is obviously only his opinion; I accept that. But he makes the point that the approval of the proposal raises this legal issue. You have said that the Commonwealth government has advice on this issue. I presume what you are saying from that is that you do not need to obtain your own advice. Is that right?

Dr Loy—I actually am not convinced as yet that this is a matter that I need to consider.

Senator WONG—Because it is a political decision, ultimately?

Dr Loy—That is correct. In a sense, my job is to say that the repository, if it goes ahead, must operate safely and it must do this to operate safely. If, in the event, it does not go ahead because of legal or political decisions, that is not my issue.

Senator WONG—I turn now to two final issues. The first is costings. DEST seem unable to provide me with an estimate of how much the facility will cost the taxpayer in the first year or two. The best they could do was to give me some estimates of a user charge per cubic metre which I think was $1,000 per cubic metre, but they indicated that that would not cover the totality of the cost. Do you have costings or have you been provided with evidence which tells us, essentially, how much public money will be spent on the facility should the application proceed?

Dr Loy—No.

Senator WONG—So no-one in government can actually tell us what this is going to cost the taxpayer?

Dr Loy—I think the intention is to operate it on a cost recovery basis.

Senator WONG—But the vast majority of the waste is Commonwealth waste?

Dr Loy—Yes.

Senator WONG—So even if it is charged on a cost recovery basis they are still transactions within government? It is still taxpayers' money, isn't it?

Dr Loy—Yes, and operations of Commonwealth agencies that are using radiation sources and nuclear facilities, and it is proper that the cost of disposal of their waste be part of their costs. As part of my assessment of the department's ability to effectively run the repository, I certainly need to be assured that they can do it on a financial basis. To that extent, it is a matter that needs to be addressed.

Senator WONG—What does that mean? You will ask them to provide some costings or funding options?

Dr Loy—I need to be assured that the money to operate the repository safely will be available. In terms of the way governments work, of course, I cannot see a fund extending between now and the crack of doom, but at least some commitments in terms of government appropriation and expenditure need to be there.

Senator WONG—So have you sought that?

Dr Loy—I have not addressed that specific issue at this time, no.

Senator WONG—When do you propose to do that?

Dr Loy—That could be something that I would address as part of my assessment and, perhaps, in a question to DEST seeking their response.

Senator WONG—I hope they can give you more than they gave me last night.

Dr Loy—I am sure they will.

Senator WONG—I am sure they will, too. Finally, I turn to the Indigenous issues. I think we were both there for the section of the public forum when there was a presentation by some Indigenous women and men. Professor Lowe makes the comment that the submission made by those Indigenous people was in direct conflict with the presentation of DEST. DEST told the hearing that the Indigenous people had given their permission, whereas the view that was

put by the Indigenous representatives was either they had not given permission or if some people had given permission they had done so under duress. Is that a concern for you?

Dr Loy—I have written to DEST asking them to clarify it. The reason I have done that is that since it was raised in the public forum, essentially in public submissions, I believe I have to take into account and at least clarify the factual situation. Whether it is relevant to my decision making might be more arguable, and that is something that I have not yet fully turned my mind to.

Senator WONG—With respect to the time frame, do you have any inkling of how much longer this process will take?

Dr Loy—April has passed.

Senator WONG—Yes, I have worked that out.

Dr Loy—I think the short answer is no. In response to my letter, Dr Harmer said, 'We'll write to you soon on other issues raised in your letters.' One specific thing that did arise from their response to the peer review report and other things is some more work on the site characterisation so that will be carried out. I am not sure quite when that is happening.

Senator WONG—The additional ground water work was a condition of the EIS approval.

Dr Loy—Yes, that is right.

Senator WONG—Which has been around for two years now, I think, or a year and a half.

Dr Loy—There were also some remarks in the peer review report about characterisation of the materials that would be used for the barriers and so on. Of course, there have been observations that the hydrogeological characterisation of the site is not sufficient. That work will be carried out, and I am not sure when and how long that will take. All I can say is that the ball is now largely back in the department's court, and in due course they will make further submissions.

Senator WONG—They seem to think they can deal with all the concerns in the IAEA report, the EIS condition, Professor Lowe's report and your correspondence arising out of those matters in a time frame of between three and five months, I think their evidence was. Does that seem somewhat optimistic to you?

Dr Loy—I think three months might be optimistic; five months sounds within the ballpark of realism.

Senator WONG—And then how long do you think you will take to determine the matter, given the additional evidence?

Dr Loy—I guess that depends on their response. I have certainly committed myself to putting their response out publicly and seeking further public submissions so that process would take, say, a couple of months at best.

Senator WONG—On notice, could you get me the correspondence from you to Dr Harmer on the issues that I previously iterated? I can go through them again, if you want but it is, essentially, the reports that we have been discussing and also—

Dr Loy—I am happy to provide you with everything I have written to Dr Harmer. I guess his correspondence back is his property, in a sense, but I am happy to ask the department to make it available.

Senator WONG—I would ask also for his responses to that. If there is a difficulty with that, I will pursue it through the other committee.

Senator FORSHAW—Dr Loy, would you give me a quick report on the current development of the nuclear reactor at Lucas Heights in relation to ARPANSA's approval process. The reactor is under construction. Can you give me a rundown of where that is up to and what is happening in regard to ARPANSA's future role?

Dr Loy—We are still in the process of approving some final requests for approval for the construction of systems important for safety, and they include items like the fuel and parts of the cold neutron source. That latter thing is a pretty complex beast and we have sought assistance from some German consultants to help us with that. We are also looking at the final acceptance testing for many of the instrumentation and control systems that operate the reactor protection systems. All of these are very important and major items but, if you like, they are starting to be at the end of the chain of items. Most of the other matters that we have before us are relatively small. The next stage of our involvement will be when they make an application for a licence to operate.

Senator FORSHAW—I want to come to that. Could you expand a bit on the issue with the fuel? What precisely is happening in terms of ARPANSA's licence for the fuel?

Dr Loy—Any part of the reactor that has a role that is important for safety has to come to me for approval for construction and installation et cetera. Obviously it is very important for safety that the fuel is properly manufactured and constructed. So we are examining the proposal for the fuel type and the manufacturing process for the fuel which, for the initial cores, is by the atomic energy agency, CNEA, in Argentina. The issues go to the nature of the fuel, but the nature of the fuel is pretty well established—it is used in lots of other reactors—so that does not seem to be a major issue. The other issue we want to be satisfied about is the specific manufacturing process by CNEA in Argentina. Some of my people will be visiting there shortly to follow that up.

Senator FORSHAW—When you are talking about the fuel, are you referring to the licensing of the fuel for the operation of the new reactor on an ongoing basis or are there different stages in the initial start-up of the reactor and its permanent running? I recall—without going into detail—issues about what could possibly happen in terms of accessing fuel for the first year or two of operation. There was some question mark about whether it would be available.

Dr Loy—As I understand it, the proposal before us is for fuel for—and here my memory goes a little awry—either the first two cores in the reactor or the first two years of operation—I cannot remember which, but I will clarify it for you later—and for a particular manufacturer of that fuel. That is all we are approving at this time. In due course, if the reactor is in operation and they have a proposal to change the manufacturer or the fuel, they will have to come to us for approval.

Senator FORSHAW—That is my recollection too. At this stage it is sort of an initial licence. Do you know when an application for a licence to operate is likely to be lodged? What is your expectation?

Dr Loy—The last time I spoke to the then Acting Executive Director of ANSTO he was optimistic that it would be in September of this year, but I have not heard anything subsequently. As far as I am concerned it is up to them to come forward with an application when they are ready.

Senator FORSHAW—I appreciate that there is the infrastructure side of it and also the ongoing installation of systems and so on, but when is the construction phase of the project likely to be finished? How far away is it, to your knowledge?

Dr Loy—I am really the wrong person to ask.

Senator FORSHAW—I appreciate that it is an issue for ANSTO as well, but you keep a very close watching eye on this. The reason for asking that is in relation to the processing of the licence to operate. What is your expectation?

Dr Loy—It is important to be aware that the licence to construct the reactor goes up to the point of and includes cold commissioning—that is, commissioning the plant without nuclear fuel in it. Loading of nuclear fuel requires the licence to operate.

Senator FORSHAW—Yes.

Dr Loy—My understanding is that ANSTO will be making their application prior to commencing the cold commissioning. But their application will argue that the results of the cold commissioning of this system will be X, Y and Z. Obviously, I will have to see that actually happen, and for X, Y and Z to be achieved, before I could go to a licence to operate. So the licence to operate process will be extended because it will have to await this cold commissioning process, which clearly would mark the end of the construction period.

Senator FORSHAW—How long does the cold commissioning process take?

Dr Loy—It would take a couple of months.

Senator FORSHAW—Okay. I am just trying to get an idea of how close to the point of the actual physical construction and installation of systems ANSTO will be when they lodge their application for a licence to operate. That raises the issue of, once they lodge a licence to operate, whether or not ARPANSA is in a position to assess that licence application at that time or whether you need to wait for some period of time for other work to be finished.

Dr Loy—We would be in a position to assess it in the sense that it will say, 'The plant as built is like this, and it is expected to perform like this'—and this will be tested in the cold commissioning—and argue that, on the basis of these expectations, it will be able to safely operate. But, very obviously also, those expectations need to be borne out by the results of the cold commissioning test.

Senator FORSHAW—Would you be able to consider that licence to operate before you have finalised the issues regarding the other licences that you are examining at the moment—regarding the fuel safety, for instance—the ones you mentioned earlier?

Dr Loy—No. They would not, in my view, be able to come forward with an application to operate before our final approvals on all of the systems are given.

Senator FORSHAW—That is what I wanted to ascertain. In the event that ANSTO lodges an application around September or thereabouts for a licence to operate, can you tell me, with respect to the progress on the nuclear waste store, what you will be looking for in considering that licence to operate?

Dr Loy—I have said many times that I will be looking for progress, such that I can be convinced that there will be a store.

Senator FORSHAW—I am aware of what you have said in the past, Dr Loy, as you are, and this is what I want to go to. You have made statements on a number of occasions in previous estimates regarding how you will need to be satisfied in terms of progress on the decisions regarding the waste store before you could grant a licence to operate. Can you tell me what progress has been made in that regard to date?

Dr Loy—I cannot, really; that is in the hands of DEST, and I am not aware of where they are up to.

Senator FORSHAW—They are not keeping you informed of the work they are doing or what is happening in regard to resolving that issue—to your satisfaction?

Dr Loy—No, but at this point I would not necessarily expect them to do that. It is not an issue before me.

Senator FORSHAW—It will become an issue fairly soon. If an application for a licence to operate is made, you will have to make that assessment, and that appears not to be that far away.

Dr Loy—Yes, but my decision to grant it might be somewhat further away.

Senator FORSHAW—This is what I am trying to ascertain.

Dr Loy—I will certainly be asking for information about the progress with the store.

Senator FORSHAW—Have you asked for any information at all to date about that?

Dr Loy—Not at this point.

Senator FORSHAW—Will you wait until an application for a licence to operate is made before you seek information on that aspect?

Dr Loy—Yes.

Senator FORSHAW—In June last year, in answer to a question from Senator Carr, you said:

... I believe I would need to be satisfied that there were steps being taken that would satisfy me that there will be a store for the spent fuel waste product when it returns from conditioning overseas from the replacement reactor. So it is not that a store will actually be in existence but that there will be sufficient steps taken to satisfy me that one will be in place.

Senator Carr then asked:

So you are looking for a serious proposition that the store will be up and running?

Dr Loy —Yes.

Are you aware of any serious proposition that a store will be up and running?

Dr Loy—I am certainly aware, as I am sure you are, that DEST has had a process for examining and assessing sites on Commonwealth land for a store and has published some papers setting out the criteria that they saw as important for the siting. I am aware of that.

Senator FORSHAW—At this point of time, would you say that that represents sufficient progress from your perspective?

Dr Loy—I think you are asking me to anticipate a decision that I do not have to make at this point.

Senator FORSHAW—I am sorry, I am not trying to ask you that.

Dr Loy—But if you want me to cut through: no.

Senator FORSHAW—You do not think sufficient progress has been made?

Dr Loy—No, I do not, but it does not have to have been made yet.

Senator FORSHAW—In the context of the point where you make the decision, I understand that, but progress is one of these things that is measured over time as well. I particularly want to take you to some comments you made in a submission to the Senate inquiry. I am quoting from the report of the select committee in May 2001, which I had the privilege of chairing. On page 208, paragraph 79 of chapter 9 of the committee report, which quotes from the submission, says:

At the time of a decision on that licence—

that is, a licence to operate—

Dr Loy advised that:

- the arrangements for reprocessing of its spent fuel would need to be entirely firm;
- with regard to the ILW store, there would need to be substantial and evident progress—such as the features of the design settled, siting criteria established and a strategy and timetable in place for a site(s)—that it was moving forward with clear paths to its future establishment and the CEO could be satisfied that a store will exist.

Does that continue to be your position in regard to the progress that would need to be made at the time you considered the licence to operate?

Dr Loy—Yes. I think it is rather nicely put.

Senator FORSHAW—It is well put. It may not be strong enough in some people's view, but it is very well put.

Dr Loy—That was my thinking at that point, and it remains my thinking, but the qualification I have of it overall is that of course I have to consider what is put before me in a licensing decision, and people may put arguments that differ from that position. If you ask me what I think, that is a statement of it.

Senator FORSHAW—Are you aware of whether the features of the design are settled at this point in time?

Dr Loy—I think the work that DEST have done has described that in at least a broad outline in terms of some of the discussions papers they have released and the work of their store advisory committee.

Senator FORSHAW—Have the siting criteria been established?

Dr Loy—I think that is part of the DEST discussion papers and the advice coming from the store advisory committee. As I understand it, the process is then to put those criteria over the map of Commonwealth land in Australia and see what turns up.

Senator FORSHAW—Could you also deal with the other aspect, which is the arrangements for the reprocessing of the spent fuel. In your words, they would need to be entirely firm. Can you shed any light on that aspect of the process?

Dr Loy—I guess in the light of a few more years experience, the only change I would make to that is that I would not necessarily use the word 'reprocessing'. That is certainly one way of achieving a good waste product from the spent fuel, but it may not necessarily be a reprocessing activity. It could be more a conditioning activity. But, whatever, there needs to be something very firm for the management of the spent fuel.

Senator FORSHAW—Is your ability to make that decision affected by the fact that you would be looking at a licence for the initial fuel and then there would have to be a subsequent application for approval for the use of the fuel on an ongoing basis?

Dr Loy—To some degree they are independent arguments. In terms of the here and now, we are looking at the safety of the specific fuel proposed and its manufacture. There is a subsequent argument about how that fuel is dealt with when it becomes spent fuel, but that is not what we are looking at now.

Senator FORSHAW—I understand that, but does what happens to the first batch of fuel involve a separate consideration from what happens to the subsequent fuel?

Dr Loy—It may do.

Senator FORSHAW—I hope you understand what I am getting at here. You have said you have to be satisfied about what arrangements are in place for the reprocessing of the spent fuel, that that has to be firm, and we know what happens with the fuel rods from the existing reactor. Does the fact that there are two phases of the supply and use of fuel complicate your assessment in order to be able to grant a licence to operate?

Dr Loy—It might do that. That is an issue that you would certainly have to look at in the context of the licence to operate.

Senator FORSHAW—Right through this process you have utilised, obviously, the services of experts and the IAEA in terms of examining various stages of the project. Will the IAEA be involved in the examination of an application for a licence to operate?

Dr Loy—I would anticipate doing that, yes.

Senator FORSHAW—What about other agencies, experts or consultants? I appreciate you may not have made that decision yet but is that a likely course?

Dr Loy—I think it is likely, yes. In some cases we will be moving over well-trodden ground. We might have needed seismic experts in the construction licence but may not need

them in the operating licence. The issues in the operating licence about the organisation, how it is structured, the roles and responsibilities of individual operators and so on are probably going to loom much larger than they did in the earlier stage and we might involve other expertise in the assessment of that.

Senator FORSHAW—I assume that the assessing of a licence to operate would have regard to international best practice and benchmarks?

Dr Loy—My act requires that I take into account international best practice in radiation protection and nuclear safety.

Senator FORSHAW—I just wanted to have confirmed that on the record again. Is there any form of an auditing process in regard to the consideration by ARPANSA of various applications for licences?

Dr Loy—I am not entirely sure I understand the question.

Senator FORSHAW—You receive an application for a licence to construct and to do all sorts of other things and then to operate, and you make that assessment using the expertise of ARPANSA and whatever other government agencies and international experts, the IAEA and so on. Once you have come to a view, is that then subject to—auditing might be the wrong word—any assessment from another body or agency before you actually issue the licence?

Dr Loy—No.

Senator FORSHAW—Peer review might be another word that comes in here.

Dr Loy—Yes. No, we have not used a peer review process at the stage of, if you like, a peer review of my decision before it is made. I guess we have taken the view that there is sufficient external input into the analysis and assessments and, of course, ultimately appeal processes on the decision as to not warrant a peer review prior to that.

Senator FORSHAW—Do you envisage any form of public submission or consultation when it comes to dealing with the application for a licence to operate?

Dr Loy—Certainly. I think I have established the benchmarks for that in relation to major licence decisions. I would certainly be expecting a couple of rounds of public submissions and some form of public forum. Quite how to make that work in the context of this licence is something we will have to cogitate upon. I have made that rod for my back and I will have to continue to beat myself with it, if that is the metaphor.

Senator FORSHAW—Rods can be very dangerous things in the nuclear industry.

Ms Halton—I do not think rods are technically used for beating oneself in that metaphor but, anyway, we will talk to Dr Loy about that later.

Senator FORSHAW—I was thinking more in terms of—

Ms Halton—Yes, I know what you were thinking!

Senator FORSHAW—I thought it was a very good pun, but. Congratulations, Dr Loy. You have now put me right off my track.

Ms Halton—That worked, then!

Senator FORSHAW—What do you expect would be the period of time that might be needed to be assess a licence to operate? I appreciate that you cannot give me a hard and fast answer on that, but do you have some concept of how long it would take?

Dr Loy—On a planning basis I would be thinking of something like the same amount of time as for the construction licence, which ended up being a bit over 10 months. I would expect a similar amount of time to that. But, ultimately, I am dependent on not only the quality of the application and so on but also, finally, the carrying out of the cold commissioning tests.

Senator FORSHAW—So if the application for the licence to operate was lodged in September this year you are looking at a period through to July next year.

Dr Loy—Yes, something of that order.

Senator FORSHAW—When does the licence for the existing HIFAR reactor expire?

Dr Loy—It does not expire. But I have a condition on it that says if ANSTO wishes to operate it past a certain date—my mind is saying 31 January 2006 but I will have to check the date as I could be wrong; it is around then—they have to come to me with a proposal for my approval.

Senator FORSHAW—Thank you, Dr Loy.

[12.17 p.m.]

CHAIR—We will move back to population health.

Senator McLUCAS—We are travelling a little bit behind now. It is no reflection on anyone else but we will try and get population health done by probably an hour after we resume after lunch. I will go now to the question of avian flu, as we were discussing prior to moving to the agencies. Ms Murnane, you seemed to be indicating to me that it was probably not in the national interest or probably not good for national security, I think, to go that far, for me to name the drugs that we are talking about. Can you indicate why that is the case?

Ms Murnane—The more information that is available generally on how much of a particular drug we have and where it is stored has a potential to allow those who do not wish us well to identify where they might act. So we have taken the line that we are not going to talk about manufacturers either, because once you start to talk about the manufacturer or the supplier that we are purchasing from you set up a reference point for a further line of inquiry.

Senator McLUCAS—Has that advice been given to the minister?

Ms Murnane—It has. Indeed, the previous minister, Senator Patterson, took that line at the budget estimates last year when she was asked about the drugs we had purchased and the manufacturer of those drugs.

Senator McLUCAS—But it did not stop Minister Abbott naming the drug in a newspaper article recently.

Ms Murnane—I am not aware of the newspaper article you are talking about, but we have always said—and at the outset—that antivirals were part of the stockpile. We have not, though, gone into more detail than that.

Senator McLUCAS—But Minister Abbott has actually named the drug in an article in the newspaper recently. How does that jeopardise our national security?

Ms Murnane—I am not saying there is a direct causal line. I am saying that it is not useful and it could assist those who do not wish us well—who wish us ill—for there to be information around and publicly available about these things. That is a line that other countries take too.

Senator McLUCAS—I will take that advice, Ms Murnane; I accept what you are telling me. It is a shame that the minister did not take that advice as well. But I do want to go to the questions of the process by which the selection of the particular drug was made. Professor Horvath, you did explain that there was an advice from the World Health Organisation which Australia has taken. Does that advice actually name the drug that we should purchase?

Prof. Horvath—There are four potential antiviral drugs currently available, and what we had to assess was their efficacy and their appropriateness, based on the best available information. We took advice from a large number of sources in order to make that decision. They included the World Health Organisation's consultation, which advised on one of the antiviral agents in preference over the other three.

Senator McLUCAS—So the World Health Organisation actually names the particular manufacturer and the drug?

Prof. Horvath—Correct. We took advice from what other countries of a similar nature to our own were stockpiling, and my counterparts and senior health advisers gave us, in strictest confidence, advice as to what they currently held and what they were planning to hold. And we took advice from other local experts as well as departmental officers, and also looked at the literature. As you can imagine, there is not a lot of literature but very good quality scientific papers that give us further guidance as to the appropriate drugs for this particular episode.

Mr Stuart—Could I just clarify the record. The WHO advice very clearly named the drug but not the proprietary brand name or the particular make-up.

Senator McLUCAS—Okay. The antivirals are a group of drugs?

Prof. Horvath—They are a group of drugs.

Senator McLUCAS—Of which I think you were telling me there are four brand names? Can we use that language?

Prof. Horvath—Not so much brand names. There are four compounds. But it just so happens they are each made by a single manufacturer—they are differing, but there is only one of each. So antiviral A is manufactured by only one manufacturer.

Senator McLUCAS—I understand.

Prof. Horvath—Of any of those antivirals, there are not competing manufacturers making the same product.

Senator McLUCAS—If we can talk about Vioxx and Celebrex, for example—a very similar drug made by two different—

Prof. Horvath—Correct.

Senator McLUCAS—I've got it. Who made the final decision to purchase the drug that we purchase?

Prof. Horvath—I will have to seek some technical advice as to who makes decisions. I do not think CMOs make any decisions, Senator.

Senator McLUCAS—Don't you? That is a shame.

Mr Stuart—The department made that decision.

Senator McLUCAS—And you make a decision or does the minister finally make that decision? Is it an internal decision?

Mr Stuart—The decision about the particular product was included as part and parcel of the advice given to government about the purchase.

Senator McLUCAS—Is cost a consideration in making the decision?

Mr Stuart—Cost was not a consideration in making the decision. Nevertheless, we are satisfied that we have extremely good value for money in relation to the purchase.

Senator McLUCAS—I thought you might say that. I imagine availability would be a consideration.

Prof. Horvath—Clinically it was absolutely a consideration because we were in a period of heightened threat—and it remains so. We are in a competitive environment, as the ability of manufacturers to ramp-up volumes of these compounds is very limited, as was again shown at the WHO. So, once a decision was made, being able to secure the compound was important.

Senator McLUCAS—Is the purchase now complete?

Mr Stuart—We have an agreement with the manufacturer which is binding. Although we have not yet signed a final contract we have an agreed heads of agreement, which has enabled manufacture urgently to have commenced for the Australian market. We have specific requirements for our market through the TGA. We have done enough to secure the supply.

Senator McLUCAS—I dare say that that agreement goes to the question of when it will be delivered.

Mr Stuart—Yes.

Senator McLUCAS—Is that very soon?

Mr Stuart—Yes, it is very soon.

Senator McLUCAS—Okay, I will leave it at that. Professor Horvath, I suppose this goes to the question of efficacy. Is it within your responsibilities to consider what side-effects the drug may have and also the question—not quite related to efficacy—of drug resistance and, especially in these types of drugs, the development of drug resistance?

Prof. Horvath—Fortunately, I have the support of an excellent team within the department and also some external experts. I suppose it is my responsibility to put all this together. Efficacy is considered, side-effects are considered and what to do in the case of any particular side-effects is considered. That is a normal clinical decision. I must say I took a purely clinical approach, choosing a compound that had the highest potential efficacy and the lowest potential for resistance—with the body of knowledge that we are aware of—and what to do if

there were side-effects. If there are side-effects, we do a risk-benefit analysis on the alternative situations. In fact, one of the drugs excluded had already been demonstrated to show very high resistance to the current threat from avian flu. With regard to all those issues, with the best available advice within and without the department, my role is to put it together.

Senator McLUCAS—Thank you. I want to ask some more questions about drug stockpiles. There was a budget allocation of $11.3 million in 2002-03 for chemical antidotes and vaccines, and I understand that some antiviral drugs were purchased as part of that stockpile.

Ms Murnane—That is correct.

Senator McLUCAS—What knowledge do we have now that may have changed the decision that we made then to the decision we have made now?

Ms Murnane—Then we were stockpiling antivirals in respect of a general preparation in anticipation for what might be an influenza pandemic. The recent purchase was agreed in the knowledge of the strain that was most likely to be present in a pandemic virus or we knew was present if the avian influenza virus pandemic basically itself became efficiently and sustainably transmitted in human beings. We knew that the antiviral that was going to work best in that circumstance was the one we purchased. There was also more knowledge available to us of side-effects and limitations of another different drug, as Professor Horvath has said.

Mr Stuart—There is benefit in diversity in the stockpile, and we think there is a benefit in having that diversity. The recent decision is very much about horses for courses in the specific context that Ms Murnane has outlined.

Senator McLUCAS—So the stockpile that we purchased in 2002-03: do we still have that?

Ms Murnane—Yes.

Mr Stuart—Absolutely, yes.

Senator McLUCAS—But drugs have lives, don't they?

Ms Podesta—There is a rotation arrangement in place for most of the drugs.

Senator McLUCAS—The National Medicines Stockpile, which is different again, I understand—

Ms Murnane—No, it is not.

Senator McLUCAS—Is that the proper name for it?

Ms Murnane—Yes, it is the National Medicines Stockpile.

Mr Stuart—It is the same stockpile; it is just referred to or referenced by a different name in a different measure, I think.

Senator McLUCAS—You are just doing it to confuse me. There has been an allocation of $15.3 million for this year. What types of medicines and vaccines and antidotes will be purchased as part of that?

Ms Podesta—The measure this year supplements the existing stocks held within the health system. That will allow us to purchase additional stocks of antibiotics, antiviral drugs, chemical antidotes and a new reserve supply of personal protective equipment for health care workers and border control staff.

Senator McLUCAS—That is an increased allocation. Is that because we are purchasing more or because what we are buying is more expensive?

Ms Podesta—I am sorry; I did not hear you. I apologise.

Senator McLUCAS—It is a higher allocation than previously. Is that because we are purchasing more or what we are buying is actually more expensive?

Ms Podesta—We will be purchasing additional stocks.

Senator McLUCAS—Extending what we have in the stockpile?

Ms Podesta—It will extend what we have in the stockpile.

Senator McLUCAS—You have given us evidence before about who would use these drugs, should they be required, and that is different from the previous discussion we have had about the antivirals, I think. Who else now would be covered if required, or is it the same list of people that we spoke about earlier?

Ms Podesta—The stockpile is available to allow a rapid response by Australian health authorities in the event of a chemical, biological, radiological or terrorist event. So the stockpile, depending on the nature of the situation, will be deployed and be able to be used, depending on the nature of the situation, for either treatment or prevention.

Mr Stuart—Just to round that out a little more, it gets back to a discussion we were having a little earlier. If a particular virus is very dangerous but slow to spread, we would want to be protecting the staff that were working directly with the people identified. We would be wanting to provide prophylaxis or prevention to the contacts of the people identified. We would be using the antiviral—it is a wonderfully flexible drug which is useful both for prevention and for cure, and we would be wanting to provide it to people who were infected. In the case of a much wider spread, much faster spreading virus which was already well throughout the country or potentially well throughout the country, we would be concentrating on keeping essential people at the workplace. So it depends on the situation.

Senator McLUCAS—The relationship with the public hospitals within the planning that you are doing: what funds does the Commonwealth have to support the activities that the public hospital sector would have to deliver, should such an event occur?

Mr Stuart—The framework that we work under is that states and their hospitals are responsible for the first line of response to health emergencies in Australia. The stockpile provides assistance when there are particular things which are scarce or which in the ordinary course of events would not be held in large volumes by particular jurisdictions. It provides a capacity to respond. The government provides funding to state and territory hospital systems through the health care agreements.

Senator McLUCAS—Sorry, Mr Stuart, I am a bit worried about the time; is the answer nothing?

Mr Stuart—No—and in situations such as Bali, for example, which is a recent and reasonable example, the Commonwealth becomes involved in assisting at a national level to coordinate the efforts of states and territories to share burdens across borders, which in national emergencies they have proven to be very willing to do.

Senator McLUCAS—Yes, I am aware of that. But there has been some analysis in some of the states that I have read commentary about that talks about just the enormous financial strain and potential inability of those state hospitals to play the part that they want to play because of lack of funds. Is there any allocation in the current budget that acknowledges that reality?

Ms Murnane—We have recently, with the states, completed the first ever survey of Australia's capability to deal with a catastrophe, whatever the cause. All the states and territories collaborated in this and we looked not only at hospital beds; we looked at respirators, at operating theatres. We will look more intensively than we have so far at expertise. The Chief Medical Officer, Professor Horvath, has instigated a clinical forum from which we gather advice of front-line clinicians.

What we have found—and again these are details that for the same reasons I alluded to before we do not want to put around in neon lights—is that Australia's capacity to respond to a disaster of the types that have occurred is a reasonable one, is adequate. It would involve beyond a certain scale which differs on the size of the state—there would be a national response required, and that would mean, as Mr Stuart said, a transfer of patients, expertise, resources across borders. I am not saying that we are complacent. There are always going to be deficits identified that can be filled. But we are looking very collaboratively and constructively at doing that.

Senator McLUCAS—Thank you, Ms Murnane. That is very important information, but the bottom line is that there will be a cost and some of the states are still concerned. I am pleased that there is at least discussion occurring around how practically it will occur and finally then how you fund it. Turning to pneumococcal vaccine, can you remind me when ATAGI recommended that pneumococcal vaccine should be provided through the process, please?

Mr Stuart—It was during the year 2002.

Senator McLUCAS—That advice goes to the minister, doesn't it? Is that the process?

Mr Stuart—It was November 2002. ATAGI has a dual role. It advises the National Health and Medical Research Council and also the minister.

Senator McLUCAS—What does the NHMRC do with that advice?

Mr Stuart—They publish it in a document. They endorse the advice and then they publish it in a document, which is the national schedule of vaccines.

Senator McLUCAS—That is what NHMRC does. When ATAGI makes a recommendation to the minister—let us say for one that has been successfully funded—the minister then takes that process to cabinet. Is that correct?

Mr Stuart—That is correct.

Senator McLUCAS—Is that contingent on NHMRC endorsing and then publishing the finding?

Ms Podesta—The minister takes into account in regard to NHMRC's public consultations, as we have discussed previously, any decision about the standard vaccination schedule.

Senator McLUCAS—Why were pneumococcal, polio and chicken pox not included in the 2004-05 budget?

Mr Stuart—I think that goes to a process of government decision making. The government decided not to include those obviously in the budget and is still considering those matters.

Senator McLUCAS—When was the decision made to go ahead with negotiations to purchase the vaccines? They were announced by the minister on 13 May.

Mr Stuart—I am sorry; what is the reference to 13 May?

Senator McLUCAS—The minister announced on 13 May that there would be negotiations undertaken to purchase the vaccines.

Mr Stuart—It was either on that day or very shortly before. You are testing my memory. I do not have that with me.

Ms Murnane—It was before.

Senator McLUCAS—How long before?

Ms Murnane—It is hard to pinpoint here a particular date. There had been discussions in the department and discussions between the department and the minister about negotiations with the manufacturer, and they had been ongoing.

Senator McLUCAS—I dare say, for a long time.

Ms Murnane—Yes, for a long time.

Senator McLUCAS—Probably 2002.

Ms Murnane—No, I would not say that; there were more intensive discussions than that. The date that we actually started what we would call formal discussions with the manufacturer was the Monday before the budget, which I think was 10 May.

Mr Stuart—Yes, that is right.

Senator McLUCAS—So the minister advises the department to start negotiations with the producer of the vaccine; that is the trigger.

Ms Murnane—Yes. Before you actually start a formal process there is a lot of thought and discussion about how you approach that. The formal start with the manufacturer was 10 May.

Senator McLUCAS—Who is doing those negotiations? Not who personally but—

Ms Murnane—Officers of the department.

Mr Stuart—Senior officers of the department.

Senator McLUCAS—Do personnel from the Prime Minister's office or the minister's office become involved in those negotiations?

Ms Murnane—No.

Mr Stuart—Not in the negotiations.

Senator McLUCAS—It is directly done between department and supplier?

Mr Stuart—Yes.

Senator McLUCAS—Are we negotiating with more than one company?

Mr Stuart—There is only one maker of a suitable pneumococcal vaccine for children.

Senator McLUCAS—When is it expected that those negotiations will conclude?

Mr Stuart—Fairly soon but I could not put a particular date on it because there are two parties involved in the negotiation.

Senator McLUCAS—Why didn't negotiations on this particular pneumococcal vaccine include a discussion about including chicken pox and injected polio vaccine?

Mr Stuart—This particular product has a particular maker. We were asked to negotiate with the particular maker about the particular product. The government has not asked the department to at this stage price beyond information already available the other vaccines. But it should be noted that there are a number of such vaccines in different combinations and a number of makers in relation to the other vaccines.

Senator McLUCAS—In terms of oral polio, has Australia been advised that we could face a supply problem in terms of oral polio?

Ms Podesta—Not to our knowledge.

Mr Stuart—It is not at front of mind but we cannot say definitely; not without going further.

Senator McLUCAS—Also on notice, could you advise the committee how much the price of oral polio vaccine has risen since September 2002, which is the time when I thought the recommendation was received to switch to injected polio vaccine. Take that on notice.

Mr Stuart—We will take that on notice.

Ms Murnane—I have just confirmed this with the director of that section: we have had no advice at all that there is any threat to the oral polio vaccine or that there is any shortage. There is no shortage at the moment. We have no advice that there is any shortage imminent.

Senator McLUCAS—You would be aware that there is an international discussion about the appropriate use of oral as opposed to injected polio?

Ms Murnane—Yes.

Senator McLUCAS—The discussion is around countries such as ours taking the lead to move to injected polio because of the cost differential and the need for oral polio to be provided to Third World countries. That is a very big ethical debate and it needs to be considered.

Ms Murnane—That particular connection is something that is new to me. I do not know if it has been made.

Mr Stuart—There is a somewhat different connection being made by the WHO which the UK has been considering. WHO advice is that countries should consider retaining the use of oral vaccine until such time as the disease has been eradicated. So there are clearly some differing schools of though.

Senator McLUCAS—This is probably venturing away from estimates questions but if you have any references you could advise me to look at on that matter, I would appreciate it.

Mr Stuart—Okay.

Senator McLUCAS—Moving very quickly: the childhood immunisation register is substantially less than last year. Is there an explanation as to why you needed less money or why less money has been allocated?

Mr Stuart—Could you quote a source for that, the source of the information? Is it in the budget papers?

Senator McLUCAS—The budget papers.

Mr Stuart—All right, I think Ms Podesta is well informed.

Ms Podesta—It is because of the change of childhood 18-month DTPa. There were fewer administrative requirements, but also it was a forecasted cost and the actual expenses in maintaining the ACIR, Australian childhood immunisation register, were less than were required.

Senator McLUCAS—Funds allocated for last year were not all spent: that is what you are telling me?

Ms Podesta—It was a forecasted amount in the budget, and the actual expenditure was less than what was forecast.

Senator McLUCAS—By about $3 million, is that right?

Ms Podesta—I do not have the papers in front of me.

Senator McLUCAS—If that is not right, could you write me a note to that effect?

Ms Podesta—Certainly, Senator.

Senator McLUCAS—Thank you. One issue we might be able to do, Chair, and then break for a half an hour for lunch.

CHAIR—I Beg your pardon?

Senator McLUCAS—I thought we might do one more issue and then break for lunch for half an hour and then come back at 1.30, how about that?

CHAIR—Half an hour I think is a little impractical for all the officers to be actually able to get down to the canteen, line up, get lunch and be back. That is the only problem.

Senator McLUCAS—That is fair enough.

CHAIR—I think that is fair to say isn't it? It is very difficult. I think three quarters of an hour would be really minimum for you to be able to do that.

Senator Ian Campbell—I would agree to that if we could finish before dinner.

CHAIR—I understand what you are saying, Senator, but I just think it is a little—

Senator McLUCAS—Thank you. I did not—

Senator Ian Campbell—What about no lunch and finish before dinner and have a really—

Senator McLUCAS—I think my union might have something to say about that.

Senator Ian Campbell—You can have a really long dinner.

CHAIR—If we can break as close to one as possible.

Senator McLUCAS—There was a national vision forum held in Canberra in March, and I understand the minister spoke at that forum—

Ms Halton—I beg your pardon?

Senator McLUCAS—A national vision forum was held by Vision 2020 in March here, and the minister spoke at that forum: is there someone who can answer questions to that effect?

Ms Halton—We actually cannot speak in relation to the minister's diary. We think probably that is not correct, but we are not the custodians of the minister's diary, so what he did and did not attend—

Senator McLUCAS—Maybe that is just a statement of fact.

Ms Halton—Okay.

Senator McLUCAS—I understand there is a relationship between Vision 2020 and the department which I am advised precluded the shadow minister from being able to speak at that function. Can you give me some information about why that was the case?

Mr Stuart—The person in our department who is best informed on this is actually part of the aged care outcome. We could take this one on notice I think.

Senator McLUCAS—I suppose the question I am asking is does the department have contractual arrangements with various people, as has been described to me, that would limit the ability for an organisation to invite, let us say, the shadow minister?

Ms Halton—I have to say I find this surprising.

Senator McLUCAS—I did too.

Ms Halton—Yes, and we will have to go and check. Can you be any more specific about relationship? I am actually not aware that there is 'a relationship'.

Senator Ian Campbell—Are we talking about a function that we believe the minister did not speak at?

Senator McLUCAS—I am advised he did. I was not there. I cannot confirm that.

Ms Halton—Senator, can you give us more information?

Senator McLUCAS—It was a national vision forum. The purpose was to develop a paper with key stakeholders to enable input from community and eye health sector to further develop the National Vision 2020 plan. I am advised that the minister was invited to speak at that forum. When the shadow minister offered to provide an alternative point of view, the

people advised that this was not possible 'due to our sponsorship arrangements with the Department of Health and Ageing, we are under contractual arrangements which limit our usual flexibility.'

Ms Halton—I will find out about this. Sometimes bodies like this ask us to assist them if they are conducting a national consultation on something which is relevant to our portfolio. This is clearly relevant to our portfolio. Sometimes we provide assistance, and it is conceivable we provided them with some assistance. I would be heartily surprised if there were anything in the way that this was constructed that would in any sense constrain somebody as to whom they might see as a relevant stakeholder. I will come back to you on that but I would be heartily surprised. What is more, I would not agree with it.

Ms Murnane—I have never known anything like that. I have never known anybody to suggest that they might do that and I have certainly never known us to even think of requiring it. No minister has ever suggested to us that we should, but we will check the facts.

Senator McLUCAS—The other concern I have is that it is somehow implicit in the contract or in the sponsorship arrangement. I am concerned that there has been a misconstruing because of the language of that contract—if in fact there is a contract.

Senator Ian Campbell—It may well have been that the person putting the conference together—which is a booming industry in this country, as you would probably know—was making excuses and passing the blame to someone.

Senator McLUCAS—That is what I am trying to ascertain.

Ms Halton—We will look at that as a matter of priority. But as I said, I would be heartily surprised, and not happy, if that were to be—

Senator McLUCAS—It would be appreciated if you could give us some more information.

Ms Halton—Can I raise one issue?

CHAIR—Certainly, Ms Halton.

Ms Halton—I have to apologise to the senator. When Gail Finlay gave you some figures yesterday in relation to calls to the Medicare information line—I think you might recall she was somewhat under the weather—she read you one category; she did not give you the total figure and I need to do that. Had she given you the total figure, rather than the subcategory from which she was reading, she would have given you a total of 6,280 calls to 1 June. I note in passing, as we are now one day beyond when she actually provided you with evidence, that yesterday that line received 3,236 calls. That gives a total, to date, of 9,517. In other words, yesterday there was a 50 per cent increase in the calls in a single day. Senator McLucas, I have a feeling it might have been you, but I stand to be corrected, who asked about how many complaints there had been.

Senator McLUCAS—I think it was.

Ms Halton—Again, she read you the subcategory total. To 1 June—and this is therefore relevant to that 6,280 figure I just gave you—there were 12 complaints regarding the booklet and 30 complaints regarding the campaign in general. I think you were talking about your

staff having failed in their duty, as I recall the conversation now. I think you are allowed to give them a marshmallow. And there were 37 complaints regarding the underlying policy. That gives a total of 79 complaints, or a 1.26 percentage complaint rate across 6,280 calls. I apologise for that.

Senator McLUCAS—The officer used the term 'campaign calls', and that was the 600-odd that she was referring to.

Ms Halton—They clearly separate into various categories. I do not have those, I am sorry, but this is within the total of categories in relation to this issue.

Senator McLUCAS—It could be useful if you could provide us—

Ms Halton—The categories?

Senator McLUCAS—There is obviously a set of categories and a spreadsheet. If it is possible maybe we could get a copy of that?

Ms Halton—I will see what I can get.

Senator McLUCAS—Up until 30 June.

Ms Halton—Let me see what I can get by this afternoon.

CHAIR—You mean 31 May?

Senator McLUCAS—Yes, May.

Ms Halton—I will see what I can get by this afternoon.

Senator McLUCAS—The 3,236 calls that came in yesterday is because the mail-out has actually hit?

Ms Halton—Presumably, yes.

Proceedings suspended from 12.59 p.m. to 1.50 p.m.

Senator McLUCAS—Has the department developed a plan to address the issue of obesity?

Mr Stuart—The government has cooperated with states and territories and experts on the National Obesity Task Force to develop a plan to tackle obesity in childhood. That plan went to health ministers jointly and was agreed by them. That was a plan about a range of activities that it would be good to do. That plan is now being turned into an action plan, with priorities attached to it—how those things would be taken forward with a view to the next meeting of the National Obesity Task Force. The Obesity Task Force has also been asked to come back to ministers with a similar plan in relation to adult obesity.

Senator McLUCAS—And when will that meeting be held?

Mr Stuart—The next meeting of the National Obesity Task Force is scheduled for 17 June.

Senator McLUCAS—Was there a consideration of the need for funding for that action plan in the lead-up to the budget?

Mr Stuart—The action plan is a plan that covers a range of activity, some already under way in some places and some not. Governments often work together to produce strategies which do not have dedicated funding immediately applied to them but which are statements of

intent or plans for further work, and it has been of that nature. Very many of the activities which are mentioned in the plan are under way in some jurisdictions, in some places. A number of them are the responsibility of states and territories—for example, through schools, child-care arrangements, community organisations and so on. So there has been no dedicated particular funding for that strategy in the budget.

Senator McLUCAS—You talked about the development of an action plan. How did you describe the previous document?

Mr Stuart—The report of the National Obesity Task Force, *Healthy weight 2008*, contained a statement of strategic intent, goals and a description of desirable action areas but without going into who should do what, for what cost and in what time frame.

Senator McLUCAS—So the purpose of the action plan is to allocate those tasks and to work out what the costs might be?

Mr Stuart—It is to be clearer about which are the priorities for urgent, medium and longer term action and how those things are best taken forward.

Senator McLUCAS—Is the document *Healthy weight 2008* in the public domain?

Mr Stuart—Yes, it is; it is on the department's web site.

Senator McLUCAS—Thank you. Will the action plan also be promulgated publicly?

Mr Stuart—I think that, once it has been to ministers and ministers have agreed it, it will be made available.

Senator McLUCAS—Have funds been provided in the forward estimates to support the costs required for that action plan?

Mr Stuart—The government forward estimates already contain funding for a range of activities which the Commonwealth manages, which are directed towards obesity prevention, promotion of healthy lifestyle, standards for physical activity and guidelines or advice about nutrition. So there is a range of activity already under way which is contained in the forward estimates.

Senator McLUCAS—Rather than get you to explain all of the different activities that the department is doing and what money is involved, I wonder if you could provide me a list on notice of what current expenditures support the intent of the *Healthy weight 2008* document and its subsequent action plan. Is that reasonable—could you do that?

Mr Stuart—Yes.

Senator McLUCAS—Thank you. I understand that in 1995 there was a National Nutrition Survey. I am not sure about this—is that an ongoing survey that has occurred over time?

Mr Stuart—My understanding of the National Nutrition Survey of 1995 is that it included Commonwealth funding and funding from states. There might have been other parties involved as well.

Dr Ioannou—There were a number of stakeholders. The Australian Bureau of Statistics conducted the survey on behalf of the Australian government with financial assistance from a range of agencies: the Australia New Zealand Food Authority of that time; the Institute of

Health and Welfare; the New Zealand Ministry of Health, which obviously has an interest through the Australia and New Zealand food regulatory arrangements; state and territory health departments, except from the Northern Territory; the Department of Veterans' Affairs; and the National Heart Foundation. It was a broad-ranging effort.

Senator McLUCAS—Was that the first time that the survey had occurred?

Dr Ioannou—I am not certain. I do not think we can answer that question just now. We could return on that point.

Senator McLUCAS—Was there a recommendation or an indication in that 1995 survey that a repeat event should occur? Was it a longitudinal type of methodology?

Ms Halton—My understanding of that survey is that it was conducted by the ABS using its standard sampling methodology to make sure that it was representative of the Australian community. You would know that the ABS have—and these days it is slightly more reduced—an ongoing program of surveys. There are a number of other surveys that it has done historically and intermittently. We will check on whether this one has been done before. I have a feeling something has been done on nutrition before—whether it was in the context of a health survey or not we need to take some advice on. The ABS, other than the way it runs its panels around, for example, employment, where it rotates the same sample through for a period of months before rolling out the sample, is not historically a body that has done a lot of longitudinal studies. It is not like following the same cohort, which is what you would expect, in a longitudinal sense.

Senator McLUCAS—Maybe I used the term 'longitudinal' incorrectly. I meant a survey repeated over a period of time that would inform of changed eating patterns in Australia.

Mr Stuart—There was no provision made for that.

Senator McLUCAS—Has there been any consideration of repeating that survey by the department?

Mr Stuart—The department was involved in a cross Commonwealth-state group, the Strategic Inter-Governmental Nutrition Alliance, which has been exploring the logistics and business case for mounting another such survey across governments. We are part of that thinking process.

Senator McLUCAS—Is it proposed that you will use a similar sort of methodology to that of the 1995 survey?

Mr Stuart—Yes, a broadly similar methodology. There is discussion about the breadth of it and the inclusion of physical activity. There are differing points of view about what you would include if you were going into the field to do such a thing. The department is part of a state-Commonwealth jurisdictional discussion of those issues.

Senator McLUCAS—Of the need for information to inform policy development, I suppose.

Mr Stuart—No; if governments made a decision to do such a thing, what you would want to collect.

Senator McLUCAS—I understand that. When are those discussions expected to come to a point of decision?

Mr Stuart—There has been a particular step taken which is a consultancy which was let recently to develop the thinking on that to produce a paper, a business case, and that consultancy I think is yet to—

Dr Ioannou—I has not been let at the moment; we are in the middle of the tender process.

Ms Halton—I come back to the question you asked before lunch about Vision 2020. I have an email from the senior officer in charge of the part of the department that provided the sponsorship and I have also been provided with a copy of the contract. The email from the Assistant Secretary—it attaches the agreement—says: 'It is a standard departmental sponsorship agreement to support the forum.' I have just had a look at it and it certainly looks to me like the standard agreement. It confirms that Minister Abbott did not speak at this forum and it says: 'To my knowledge there was never any discussion between us and Vision 2020 about an opposition spokesperson and the agreement did not preclude Vision 2020 from inviting anyone they chose to invite to speak.'

I have just read through the original letter of offer to the organisation where we go into surprisingly remarkable detail in relation to the size of the logo, acknowledging the sponsorship, just making sure the Australian Government is getting full value and what we were expecting by way of product and the timing in which that product has to be received. We get invoices and there is the fact that they have to be insured—I could go on—but in terms of any detail in here that indicates that we can in any sense veto whom they could or could not invite, no, categorically not.

Senator McLUCAS—It is a contract. You may not be able to do this but in the interests of transparency can that be tabled?

Ms Halton—It is a copy of the letter of offer from the senior officer. I do not think there is a problem with tabling that. My understanding is that this is what was signed, together with an attachment which goes to the general condition, so I would be happy for you to have a copy of that.

Senator McLUCAS—What was the value of the sponsorship?

Ms Halton—Twenty thousand dollars but I think it is important to understand that this covered a couple of things: to assist in (a) conducting a survey of community and eye health sector stakeholders to help identify key issues, achievements, directions for the future, potential areas of focus and priorities and possible models for a national plan; (b) providing a discussion paper based on findings of the survey; (c) the aforementioned forum conducting a national vision forum with Vision 2020 Australia partners, key non-government stakeholders and agencies and Australian state, and territory government agencies; and (d) preparing a paper outlining the outcomes of the forum and recommendations to be forwarded to the department for consideration.

Mr Stuart—You raised the issue of OPV prices. I draw your attention to an answer to a previous question on notice which I have here and which I can make available, otherwise I can provide you the reference.

Senator McLUCAS—Just tell me the number.

Mr Stuart—It is EO3-114 of 5 November 2003.

Senator McLUCAS—Has there been any change to the information in that answer?

Mr Stuart—No, it is still current.

Senator McLUCAS—I understand that public health outcome funding agreements are to replace a range of individual agreements. Could you give me some background to them briefly?

Mr Stuart—In brief, we have had two previous public health outcomes funding agreements: one for a short period—two years sticks in my mind—and there was a more fully fledged arrangement for five years with the states and territories. That arrangement has included funding for a range of population health activity for which the Australian government has provided part funding to the states for activities such as breast screening and cervical screening. The immunisation program has previously been included, as well as programs relating to HIV and substance abuse issues. I will stop there and you can say what you want to follow up.

Senator McLUCAS—Okay, that was a great explanation. When does the current agreement expire?

Mr Stuart—The current agreement is due to expire on 30 June this year.

Senator McLUCAS—And what has the department undertaken in order to renegotiate these agreements?

Mr Stuart—The minister has now made an offer to the states and territories in writing setting out the terms of an offer from the Australian government, which is based on an Australian government decision.

Senator McLUCAS—When was that offer made?

Dr Ioannou—On 29 April.

Senator McLUCAS—Do you usually have a series of negotiations and discussions between the states or has the Commonwealth just said, 'This is the offer'? What is the usual way of undertaking the sorts of bilateral arrangements?

Mr Stuart—There is a process of discussion. In this case, I think this process began in about the middle of last year, but I stand to be corrected. When we undertook, cooperatively with the states and territories, a review of the previous agreements, including providing the states with opportunities to tell us about what they found beneficial and problematic about the previous agreements and how they might be improved.

Senator McLUCAS—And when was that review completed?

Mr Stuart—The review was undertaken during October of last year.

Senator McLUCAS—And then what happened to that document? Was it sent back to the states for their comment or did it become an internal department document?

Mr Stuart—Yes, it was provided back to the states and territories for their comment.

Senator McLUCAS—And that was in October last year.

Mr Stuart—Yes.

Senator McLUCAS—What happened then?

Mr Stuart—Then Australian government officials took their learning from that process. There was a process of discussion inside the Australian government agencies, and advice was provided to the Commonwealth government about options for the construction of a future public health outcome funding agreement. There is now a three-step cabinet agreement requirement for all significant agreements with states. All significant agreements are going through that process. The process includes an initial approach to cabinet by the minister to set out the broad approach to be taken. A second approach to cabinet sets forward the proposed offer. Then, ultimately, a third approach reports on the negotiations and gains agreement to the final Australian government position. We are between the second and third of those processes and in discussion with the states territories. The processes were that the minister wrote to his state and territory counterparts, and the department wrote very shortly afterwards, with more detail, to our counterparts in the states and territories and then we organised a workshop in Melbourne to have a discussion with them, essentially to make sure everyone had a common understanding of the facts in relation to the offer.

Senator McLUCAS—Is there an opportunity for negotiation after the offer from the minister to the states?

Mr Stuart—We are now in that process with the states.

Senator McLUCAS—But the question is: is the offer a final offer or does a process of discussion then ensue? I dare say that the states say: 'We haven't got enough money; we would like some more.' What happens now?

Mr Stuart—The states are responding to the offer. We are in discussion with officials. Some ministers have written. That is an ongoing negotiation process.

Senator McLUCAS—Have the states expressed concerns to the Commonwealth about the timing of the offer?

Mr Stuart—Yes, they have. We have been taking that concern on board.

Dr Ioannou—Officials at our multilateral meeting in Melbourne certainly made the point that they would obviously have preferred to have more time. We said we would take that on board and see what we could do about that. In correspondence to our minister, at least two ministers from other states have indicated that this may be a concern.

Senator McLUCAS—Dr Iannou, you said the Commonwealth was going to take that advice on board. You cannot invent time, so what are you going to do?

Dr Ioannou—We are in the process of advising the minister on his options in that regard, and he is considering what he will now say to his state and territory counterparts.

Senator McLUCAS—Is there an opportunity to extend the current agreement for a period of time in order for fuller negotiations to occur?

Mr Stuart—There may be. That is under consideration.

Senator McLUCAS—You would be aware that, given the nature of the work that is being done, a lot of this money is eventually used by community based organisations. Is the Commonwealth aware that ongoing funding is necessary for the longevity of these organisations?

Mr Stuart—Some of the funding is passed on to community organisations by the states and territories, and other parts of the funding are used by state and territory regional health structures. We are certainly aware that there is a need to provide ongoing funding to groups, and that is certainly a context in which this discussion and advice is being taken.

Senator McLUCAS—Is the learning from this that we actually started the negotiations too late?

Ms Halton—There is always a range of factors that determine when things actually happen. We acknowledge that timing can be a constraint but, as Mr Stuart indicated, we are in discussions with the minister about where we go next.

Senator McLUCAS—What additional funds have been allocated in the budget and in forward estimates for these agreements, other than basic indexing?

Mr Stuart—The minister has been successful in being able to offer the entire existing forward estimates plus indexation to the states and territories and, in addition, has included funding for family planning as part of the broadbanded agreements. Immunisation agreements, which were previously a part of the public health outcome funding agreements, are being taken to one side for separate negotiation as agreements in themselves—and for good, clear reasons.

Senator McLUCAS—I will come back to that.

Mr Stuart—The rationale here is that the offer to the states is for a fully broadbanded public health outcome funding agreement in which there is considerably increased flexibility of states and territories to spend according to need within the funds provided. The immunisation program would not be appropriate for that kind of arrangement because, essentially, the funding for the immunisation program is given by the number of people requiring immunisation—by the number of shots and so on—so it is a different kind of thing.

Senator McLUCAS—What you are saying is that, within the agreement, the Commonwealth does not tag certain moneys for certain programs?

Mr Stuart—This is a key change from the last agreement in which the Australian government has responded to the consultations that were had—the discussions with states and territories. They made the argument that there were important flexibilities, that there were synergies between different parts of the activity and that it was not useful for the Australian government to dictate exactly what proportion of the funds were spent on what activity.

Senator McLUCAS—In a broad sense, has there been any growth in the funds that were allocated last financial year, subtracting immunisation, for this year and the out years?

Mr Stuart—The growth is the funding that was already in forward estimates, based on growth through indexation.

Senator McLUCAS—So it is indexation and that is all—there is no new money, so to speak?

Mr Stuart—No. There are forward estimates, which include indexation.

Senator McLUCAS—Is the immunisation program going to be negotiated separately but in a similar way to the agreements we are talking about?

Mr Stuart—Yes. There is no change in the immunisation program linked to this accounting change. We are negotiating the immunisation agreements in parallel with the PHOFAs, in much the same way as we would have before. But, instead of the immunisation being a fixed component within the PHOFAs, they are now a similar component just outside the PHOFAs.

Senator McLUCAS—The negotiations are occurring at the same time?

Mr Stuart—Yes, in parallel, involving a number of the same people, both at the Australian government and state ends.

Senator McLUCAS—Is the time frame for the immunisation agreements the same as the time frame for the PHOFAs?

Mr Stuart—Yes.

Senator McLUCAS—You referred earlier to family planning services. Do they sit under the National Women's Health Program?

Mr Stuart—Family planning is part of outcome 1. Mr Eccles might be able to elucidate further.

Mr Eccles—The Family Planning Program comes from a separate program that is under outcome 1.

Senator McLUCAS—So is not part of the public health outcome funding agreements?

Mr Eccles—The offer to the states provides for the funding currently going to the state family planning organisations, to be put into the PHOFA bucket, in recognition of the expanded scope of the PHOFAs to incorporate sexual and reproductive health.

Dr Ioannou—I think the issue here is that that is the future intention. At present, however, funding for South Australia and the ACT is provided through the PHOFA mechanism but it is provided separately with the other states—directly to the other states.

Senator McLUCAS—Why is it different for South Australia and the ACT?

Mr Stuart—This is an anomaly that grew up in the context of the last round of PHOFA negotiations where an offer was made to states and territories which some states accepted and others did not. That is my understanding.

Mr Eccles—So at present we have the hybrid model with funding for sexual and reproductive health services in South Australia and the ACT contained in the PHOFAs. Funding for the other organisations is through direct contract with the Australian government.

Mr Stuart—So there is an anomalous situation which the new PHOFAs provide an opportunity to resolve.

Senator McLUCAS—What has been the response from the two groups of states—let us put it that way—to including family planning in the PHOFAs?

Mr Eccles—There has been almost no reaction. They have not got back to us formally on that. The reaction from the states where it is currently under the PHOFA—South Australia and the ACT—indicates that it is working well.

Senator McLUCAS—Mr Stuart, you described how funds will not be tagged, are the family planning funds going to be tagged within the agreement?

Mr Stuart—As we discussed earlier, under the existing PHOFAs the states and territories make grant to particular organisations. On the funding for family planning, if the states accept the offer for it to be rolled into the PHOFAs, it will become a part of the broadband arrangements. The states and territories will then be responsible in the future for decision making about the use of the family planning organisations to support either the current activity or expanded activity or different activity.

Senator McLUCAS—Has there been growth with the funds allocated for family planning services? Is it just with indexation? What is the state of those moneys?

Mr Eccles—The funding that will go into the PHOFA pool for a particular state will be that funding that is provided to that state in the current financial year plus indexation.

Senator McLUCAS—So there is no loss of funds to Family Planning Australia?

Mr Eccles—Not to the state organisations, that is right.

Senator McLUCAS—Just for my understanding, Mr Stuart, I wonder if it is possible to do a disaggregation of those funds—this might be tricky—by state and by program for the 2003-04 year and the 2004-05 year from the budget papers. That would then identify where the immunisation money has come out and where the family planning money has gone in.

Dr Ioannou—There are substantial elements of the current PHOFA agreements which are in fact broadbanded. We are moving to a situation where we remove the anomalies and ensure that the entire funding pool is broadbanded. It would be difficult to disaggregate—

Mr Stuart—We could set this out for you at a high level. Essentially, we could produce a small table which shows last year's PHOFAs, last year's total family planning funding and last year's immunisation funding.

Senator McLUCAS—Which is a part of PHOFA.

Mr Stuart—The current year.

Senator McLUCAS—Yes.

Mr Stuart—And next year's. You would be able to see this year's total and next year's total are the same plus indexation and that the forward estimates are being fully expended and those three elements are in the mix.

Senator McLUCAS—Right. Thinking about how you achieve your objectives, if moneys from the Commonwealth were to be allocated to, let us say, the breast screening program, which is identified nationally, how would you track that money once you got to a position where the PHOFA allows the state to expend that money within their parameters?

Mr Stuart—The government's concern will be about performance in relation to an agreed set of indicators. BreastScreen is a pretty good example there, because it is a fairly straightforward matter to measure—we are reporting on this now—the proportion of the target group which is being assisted through breast screening on the regular cycle.

Senator McLUCAS—It is through the outcomes?

Mr Stuart—Through the reporting on the outcomes.

Senator McLUCAS—If you could do that for me, that would be very useful.

Mr Stuart—Certainly.

Senator McLUCAS—Hepatitis C, please.

Mr Stuart—How can we help you on hepatitis C?

Senator McLUCAS—I understand that the section of the department that is focused on hepatitis C has gone through another restructure, and I have been advised—and I do not know if it is true—that that has happened on a number of occasions recently.

Mr Stuart—I suppose this is in the administrative sense, but we are close to completing another look at the division structure and we will be ready to move into our new alignment hopefully on Monday.

Senator McLUCAS—Are you aware of the concern that has been expressed by the community about the frequency of movement in the staffing of people who are tasked to work on hepatitis C?

Mr Stuart—In this case, the particular staff are going to remain with the program. In having another look at the division structure, we have been able to add another branch and another branch head to the structure, which is actually going to enable us to focus better on the range of activities that we now have. The rule in the reorganisation is that staff follow the function that they are currently engaged in, so there is not expected to be any change in the staffing dealing with hepatitis C as a result.

Senator McLUCAS—That is comforting. I understand that when funded organisations are wanting to publish documents there is a departmental approval process for that to occur—is that correct?

Mr Stuart—This depends on the nature of the documents and whether they are part of agreements held with the department.

Senator McLUCAS—The hepatitis C council have, I understand, documents that they are wanting to publish which are part of a contract that they have with the department of health.

Mr Stuart—We have relationships with a range of organisations in which we use organisations which are close to particular communities to help us target information and messages to those communities. Those communications are part of specific contracts that they have with the department for funding.

Ms Murnane—We would be able to talk about this meaningfully if we knew the document you were talking about.

Senator McLUCAS—I do not have the document, I am sorry.

Mr Stuart—The hepatitis C council is certainly an organisation that we fund to produce materials.

Senator McLUCAS—Has there been any delay in the approval process for publications by not only the hepatitis C council but other organisations that are funded under the hepatitis C strategy?

Mr Stuart—On occasions, yes.

Senator McLUCAS—Could I get a list of the period of time that each approval process had to go through, including ones that are not complete?

Mr Stuart—We should be able to make that available. This is in relation to hepatitis C in particular?

Senator McLUCAS—Hepatitis C.

Mr Stuart—Yes, we will be able to provide that on notice but not immediately.

Senator McLUCAS—Of course.

Mr Stuart—The issue is that, where the Australian government pays for particular material to be produced under agreements, then a responsibility falls on the department to ensure that it is epidemiologically sound, that it is safe from a health perspective, that it is in line with government policy—

Ms Podesta—and that it meets censorship laws and that it meets all other state or Commonwealth laws.

Mr Stuart—So sometimes that process takes a little time and then the to-ing and fro-ing with the funded organisation can take a little time, so that puts it into context, but we can provide the information.

Senator McLUCAS—If you can provide that, it will start the conversation and we can progress it from there. I understand the second national hepatitis strategy was delayed for six months. Can you give me an indication of why that occurred?

Ms Podesta—Certainly. As discussed previously in regard to the strategies MACASHH, the overarching ministerial advisory committee, has a subcommittee on hepatitis. As there was a request for an extension of time for the HIV strategy, it was agreed that all three strategies would be given additional time, because there are very strong interconnections between the three strategies.

Senator McLUCAS—The review identified discrimination as a key issue for people who are infected with hepatitis C. What is the proposal to deal with discrimination?

Mr Stuart—It is true that the review did highlight that issue. The entire review now becomes an input into the considerations of the new MACASHH and the particular HIV subgroup that is working to it.

Ms Podesta—One of the things that the review indicated is that access and equity are achieved when the programs and services are designed in a way to accommodate the very diverse group of people within the community who may be affected by hepatitis C. One of the critical factors built into the review and into the development of the strategy process is the

involvement of people in the affected communities. Discrimination will be one of the issues that are addressed as part of the process of consultation identification of matters of discrimination.

Senator McLUCAS—The point I am making is not just about assisting the victims of discrimination. Wasn't the review recommending that we needed a national awareness campaign so that people who are discriminating, hopefully, will stop doing it?

Ms Podesta—There is a range of issues being considered in the review which include issues to do with work force awareness by all sectors of the community, health promotion and information about treatment and care. There are a range of factors that will be considered in the strategy.

Senator McLUCAS—When is the strategy going to be complete?

Ms Podesta—The existing hepatitis strategy has been extended, as have the other two, until 31 December. As I indicated in the discussion regarding the HIV strategy, there is a similar time frame in terms of consultation for the first draft with affected community groups, with stakeholders, with other government agencies et cetera.

Mr Stuart—Against the background of that, the 2003-04 federal budget allocated $15.9 million over four years for the hepatitis C education prevention initiative, which is an initiative undertaken at the national, state and territory levels. The Australian government provides funds to the states and territories through this initiative for particular targeted programs and education.

Senator McLUCAS—That is the existing funding; there is no growth in that funding?

Mr Stuart—Yes, it is. It does address issues of discrimination amongst other issues.

Senator McLUCAS—That money in many respects operates the hep C councils in most states?

Ms Podesta—That is one of the functions, yes.

Senator McLUCAS—A point that has been made to me is that, currently, we are not running a national awareness campaign. Whilst there is a whole range of work that is being done, the review suggested that we needed another piece of work to deal with the issue of discrimination. Having gone through the current inquiry that the Senate standing committee is doing into hepatitis C, it has become extremely evident to me that this is absolutely required, not only for those who have hepatitis C through the blood supply but also for those who have got it in a range of other ways. The money that is being allocated now will continue the existing range of services. The request is for more. I cannot see in the budget where it might be. I think you are telling me that there is not any more than is what is currently being allocated.

Ms Podesta—Certainly MACASHH and the subcommittee have discussed awareness programs. The strategy certainly will be able to address the identification of awareness. The strategy is not a funding document; it is a high-level guidance which identifies directions and policy. Therefore, it is something for further consideration after the strategy is discussed, endorsed, agreed and adopted by government.

Mr Leeper—Senator McLucas, yesterday you asked some questions about Medicare offices: locations and criteria for establishing them. I have some documentation I am happy to table. That includes a listing of all the current Medicare office locations Australia-wide. It locates those then on a map of Australia. It also provides an indication of where we have what we call Easyclaim facilities, which are telephone or facsimile based claiming points, where there is not a Medicare office. It also includes the criteria that we use to look at establishing Medicare office outlets. Finally, in relation to the two new offices in Victoria that are being set up, there is an indication of the set-up and ongoing costs for those two sites. Yesterday you were asking what we are doing to ensure that as many families registered for the safety net as possible. I can now advise you that this morning the Minister for Health and Ageing announced that the vast majority—in fact, more than 90 per cent—of Medicare offices will be open on Saturday mornings through June to support that.

Senator McLUCAS—Is that a paid advertisement, Mr Leeper?

Mr Leeper—You were asking me yesterday and I am advising the committee of what we are doing to make sure that people can register. Starting this Saturday and all through June we will be open from nine until 12.30.

[2.37 p.m.]

ACTING CHAIR (**Senator Humphries**)—We will proceed now to outcomes 4, 5 and 9, which we will deal with together. Outcome 4 is Quality health care.

Senator McLUCAS—I want to go to the question of the plasma fractionation agreement with CSL. Could you give me the background to the ANAO report dealing with the agreement between health and CSL about plasma fractionation?

Dr Morauta—What exactly would you like to know about it? The report has been made and it is in the public arena. It was also considered by the JCPAA.

Senator McLUCAS—Is it true that the guidelines on competitive tendering and contracting were not followed in coming to that agreement?

Dr Morauta—No, that is not the view of this department.

Senator McLUCAS—Is that the view of ANAO?

Dr Morauta—No, I think they received some advice from Finance and I think the only recommendation in the report was to amend the guidelines to avoid any obscurity in their intention on that point. It looks as if where the ANAO came out was that it was a good idea to adjust the Finance guidelines to address this point, and I believe that recommendation was accepted by Finance.

Senator McLUCAS—It was more about advice to Finance rather than Health?

Dr Morauta—That was actually the only recommendation of the report.

Senator McLUCAS—Has the department or, in fact, the National Blood Authority been approached by any United States based company interested in supplying blood plasma products to Australia?

Dr Turner—Yes, certainly the National Blood Authority has had approaches from companies other than CSL who are interested in supplying blood products in Australia.

Senator McLUCAS—I understand that we have had a policy for some time of being self-sufficient in fresh blood products. Can you explain the policy position of the NBA on blood plasma products?

Dr Turner—The NBA itself does not have a policy. The policy is that of governments. The NBA's role is to implement blood policy on behalf of the nation. That is a joint policy which is agreed by health ministers, so obviously the Commonwealth and the states contribute to that policy, and the policy is for self-sufficiency. Certainly Australia is self-sufficient in fresh blood products. With regard to fractionated and recombinant products, there are some products which are imported from overseas but in the main the products are supplied by CSL.

Senator McLUCAS—How is the contractual arrangement to occur to bring products in from overseas?

Dr Turner—The NBA's new authority has inherited a number of contracts which were negotiated principally by the department of health before, so for a specific product, whether it is a recombinant factor VII or whatever, the NBA's approach, which would have been consistent with the department of health's previous approach, would be to go to the market and see who was able to supply. If there was a number of suppliers in the market, then we would go out for a tender on those products. But for some of the products, for example the recombinant factor VII, there is only one supplier, so then it would be a case of negotiating the best deal we could to recognise Australian priorities. Those are price, security, supply, meeting regulatory standards and a number of other issues. That process would involve an evaluation which would take all those factors into consideration. I should point out that the National Blood Authority has yet to negotiate wholly, because we are new, a new contract for blood. Those are the processes we will be following in developing our contracts.

Senator McLUCAS—Mr Davies, you are reported in this document that I am reading as saying at the March hearing that current government policy on self-sufficiency restricts the ability of overseas players to enter the Australian market. Is that the view that you expressed then?

Mr Davies—If that is what I said, then, yes, that is still the case.

Senator McLUCAS—Do you mean in terms of fresh blood products or fractionated blood or recombinant factor VII?

Mr Davies—In terms of all three. The policy is that wherever possible we should use—although recombinants not so—products based on blood, human blood derived products, or fresh blood. The policy is still for self-sufficiency except in the case, as Dr Turner has just said, where there are some products that are not available in the domestic market.

Senator McLUCAS—The fact that we are actually contemplating changing our position on self-sufficiency seems like a policy shift, from my perspective. I recognise that you are not the policy maker, Mr Davies, but I am interested in the context of that comment.

Dr Morauta—I would like to take you to the government's position as expressed in the side letter to the US FTA, where both the concept of tender processes for plasma fractionation services and self-sufficiency are set side by side. The context in which they could be set side by side is that one possibility that could be contemplated is that Australian plasma is sent

overseas for fractionation but is still Australian plasma. It does not rule out that possibility if you stick with the self-sufficiency arrangement, which is what is protected in the US FTA side letter.

Senator McLUCAS—If that option were to be considered, how would Australia ensure the safety of the product once it had been overseas and returned to Australia?

Dr Morauta—These options have not been fully explored by government, because they are part of the review that follows the US FTA. But the same letter provides for the regulation of blood product by a country that is a party to this arrangement. In this case, I imagine the government would be looking for the same level of regulation as is provided through the Therapeutic Goods Administration at the moment. That is the sort of thing that is contemplated by this letter, but it is not spelt out in detail and the work of the review has not been done yet.

Mr Davies—I stress that we are in the realm of the hypothetical here. Toll fractionation—sending the plasma offshore to be fractionated and the resultant product being reimported—does not happen at the moment.

Dr Morauta—The side letter says that a party may require any producer to fulfil the requirements necessary for ensuring safety, quality and efficacy.

Senator McLUCAS—Still on blood, I would like to move to BSE—mad cow disease. We are one of only, I think, four countries in the world that are BSE free. That partly relates to the safety of our blood supply. When did the policy shift to self-sufficiency solely within fresh blood products occur?

Mr Davies—I am not sure which policy shift you are referring to. I am not aware that there has been one.

Dr Turner—That is absolutely correct. All the fresh blood product that Australia purchases through our arrangements is supplied by the Australian Red Cross and it is from Australian plasma, donated by Australian donors. So we are entirely self-sufficient in fresh blood product.

Senator McLUCAS—There was a policy—and I am trying to remember when it was—that all blood products, fresh or not, were to be provided from within Australia. There has been a shift that allows that plasma products do not have to be provided from Australian blood. I am trying to identify when that shift occurred.

Dr Morauta—We have done quite a detailed answer. Self-sufficiency—and I think we have answered this in a previous question—has to be thought of in three layers. Firstly, there is very fresh blood—stuff that has to be used very quickly and moved around—and that has always been and continues to be self-sufficient. Then there are a set of things that are manufactured from blood, which are basically the plasma derived products, and they are largely self-sufficient. But, if I can find the question on notice, I will tell you the particular exceptions where we do not have the capacity to manufacture some of that, where we run temporary shortages and bring in other product, or where there are particular cases. Finally, there are a group of products that are entirely synthetic and have largely been sourced overseas from the beginning—it is just the mass-manufactured stuff.

Mr Davies—To my knowledge those three categories and the balance between them has not changed significantly other than in line with changing patterns of utilisation.

Senator McLUCAS—I have a document here, and although I have to say I do not know the context that it has been presented in it is from the National Blood Authority and it says 'Self sufficiency redefined as self sufficiency in fresh blood product'. It is from that document that I am trying to work out when the policy shift occurred. It is an overhead slide.

Dr Turner—I am sorry; I am not aware of the document that you are referring to. I am happy to look at it and see if we can give you some context for it if that will help.

Senator McLUCAS—Thank you. I would like to get some understanding of when this policy shift occurred.

Mr Davies—I am sorry, Senator, but whatever its source that document is not a description of the status quo.

Ms Halton—If that is an overhead slide it is quite conceivable that someone has been unsolicitous with their use of language. But, exactly as has just been explained to you, it is not our understanding that there has been a shift. If someone has used that at some point we would like to see it, and I am sure Dr Turner will follow it up, because that is not the understanding of any of the senior people here.

Dr Turner—The government's policy is quite clear at this stage. Whilst there is certainly debate about it, the policy has not been changed.

Senator McLUCAS—In terms of both fresh blood product and plasma product?

Dr Turner—That is correct.

Senator McLUCAS—That is interesting. You may want to look at the ARCBS submission to the hep C inquiry.

Dr Turner—I am certainly aware there is debate about it. I have not heard of debate about fresh blood products.

Senator McLUCAS—No, it is not about fresh blood product at all. Where is the department's thinking on the cost and efficacy questions around the use of recombinant products?

Dr Morauta—Through the blood arrangements the government already fund roughly 42 per cent of the population of people with haemophilia to use recombinant product. There are a set of priorities which were set by government some years ago as to how these products, which are not available to everybody, should be made available. For example, children and people without viral infection are given priority access to those products. And so naturally, over time, as those children grow into teenagers and use more of a product, more of the recombinant product is used by those patients.

Senator McLUCAS—Does their budget allocation reflect that?

Dr Morauta—There is a natural growth in it year on year and that has been happening for some years now.

Senator McLUCAS—Thank you. That is all I have to do on outcome 4.

CHAIR—Thank you very much.

Ms Halton—Before we go, you asked for information about vaginal and caesarean deliveries and hospitals et cetera. I have a piece of paper which I am happy to table which tells you what we can and cannot tell you and what we know.

CHAIR—Thank you.

Proceedings suspended from 2.54 p.m. to 3.08 p.m.

CHAIR—I believe we have a clarifying statement on a previous answer to be put at the moment.

Dr Turner—I was just referring to a suggestion that the NBA had in some way implied that self-sufficiency in Australia's policy had changed. I discussed that with Senator McLucas. What she was referring to was a slide that we had presented saying what was happening internationally with regard to the self-sufficiency policy. There are a number of countries—and a classic would be Britain—where they have said to me that they have now redefined 'self-sufficiency' to mean self-sufficiency in fresh blood products and that they in fact import all the rest. So that slide, in a sense, was unfortunately given to you out of context. We have never ever suggested that the policy has been changed in Australia.

Senator McLUCAS—Just to reconfirm: Australia's policy is for self-sufficiency in all blood products, with the exception of the recombinants.

Dr Turner—When we run out, or if we have a supply shortage—absolutely, yes.

CHAIR—Thank you very much.

[15.09 pm]

CHAIR—We will now move on to outcome 5, the regional health services programs.

Senator McLUCAS—There was a recent ANAO report into the Regional Health Services Program. I understand that the department has agreed with the recommendations of that report to investigate, essentially, the underspending in the program. Could the committee be updated on what the department has found.

Mr Wells—There were underspends in previous years, as identified in the report. For the current financial year—2003-04—our expectation is that the program will be fully spent. We estimate that that will continue into future years—that is, that the program expenditure will be fully expended.

Senator McLUCAS—Did the department identify why the underspending was occurring?

Mr Wells—The underspends were part of the early development of the program. This program relies essentially on local communities bringing forward proposals for funding which meet their particular community requirements. In the early stages considerable work was done with the communities to work through how they would identify the requirements, formulate their submissions et cetera. The take-up was slower than perhaps had been anticipated when the program was first devised but that has now caught up. We are now in a situation where we are fully meeting the funding parameters.

Senator McLUCAS—I understand that $6.6 million was underspent.

Mr Wells—That was the total underspend over the period.

Senator McLUCAS—What happened to that money?

Mr Wells—That money was not spent in the years it was allocated. It was therefore returned to revenue.

Senator McLUCAS—The report also found that the Regional and Health Services Program guide was—in their words, I think—out of date, not accurate and not being used by the staff.

Mr Wells—That is right. That has since been revised in consultation with our state and territory offices and a new guide has been in place for about a month. That was finalised in May.

Senator McLUCAS—Is adherence to the guide occurring? I suppose you cannot really assess that in a month, can you?

Mr Wells—No. But, as I say, this was worked up with our staff involved in managing the program so we expect it is more user friendly and will, therefore, be of more use to them.

Senator McLUCAS—Who uses the guide? Does the staff use it to assess the applications? Can you give me an understanding of the guide?

Mr Wells—The guide is for the staff who are actually involved in working up their proposals with local communities and then in managing the program for those organisations that are funded. It is their handbook for running the program.

Senator McLUCAS—Is it an internal document?

Mr Wells—It is an internal document, yes.

Senator McLUCAS—I have some questions around the rural health strategy. On page 189 of the PBS, there is an allocation of $830.2 million over four years. Could you give us a breakdown of those funds?

Mr Wells—As part of the review of the programs in the lead-up to this year's budget and as part of streamlining the program and giving us more flexibility in managing the funds, it is now a one-line appropriation for a range of programs, which includes rural health services and others. There is now more flexibility in moving across the various elements of the program. There is not a budget breakdown of the various elements. A lot of the money is already committed in terms of continued funding for programs that already exist. In terms of the new money, if you like, and the opportunities for further funding, we will be looking across the various programs that are covered under this to see where we can best make the investment in terms of need and availability of services et cetera.

Senator McLUCAS—Is it possible to give me a list of the former programs that that money used to fund?

Mr Wells—Yes, it is. We will provide that. It is a long list—

Senator McLUCAS—I can imagine.

Mr Wells—with about 20 or so programs. It is probably best if we get you that list this afternoon.

Senator McLUCAS—I am trying to identify within that large amount of money what is new money and what is ongoing commitments in the forward estimates from the last budget. Do you understand what I am asking?

Mr Wells—Yes, I understand. The program itself is essentially a renewal of programs that were originally funded from four years ago that we reviewed and continued funding. We have linked into that general bucket of funding a couple of other programs—for example, the program which provides support for local communities to give help to people to better self-manage their conditions and that sort of thing. So a couple of other programs have actually been brought in but they are essentially ongoing programs.

Senator McLUCAS—When you say a couple of programs have been brought in, were they pre-existing programs?

Mr Wells—They were pre-existing programs, yes.

Senator McLUCAS—So this is just an amalgamation of a range of other programs?

Mr Wells—It is an amalgamation and a streamlining of programs that were funded from an earlier budget and that have now got a more flexible funding base.

Senator McLUCAS—Now they are all in one big bucket, how does the department decide where moneys are going to go from year to year?

Mr Wells—As I said, a lot of that will already be committed to services that are already being funded. We are not de-funding any service. With any new money—that is, in the sense of services which drop out or funding which has not yet been committed—we will be looking to fund the type of service which best fits the need. It might be an expanded specialist service, another local community regional health service or whatever. We would be able to take a more flexible approach to that. There will not be defined buckets. A lot of the money is precommitted from programs that are already being funded.

Senator McLUCAS—I am just trying to understand how the community would work out where moneys are travelling. Whilst you are saying it is not being de-funded, you are suggesting that government could decide that the priority shifts and money will be moved from one program to another within that overall program. I am just trying to work out how we understand that.

Mr Wells—Let me give you an example. Part of the program is to fund support for specialists in rural areas. That part of the program has been managed through the Committee of Presidents of Medical Colleges, which is the peak body of the specialist medical colleges. From time to time they will come to us and say, 'We think we should actually do more of this sort of support rather than that sort of support.' We would look at that proposal on its merits. That would presumably result in a shift of resources from type A to type B type support. That is the sort of thing I am talking about. But the quantum of funding for support for specialists probably will not vary much. It will wrap up in real terms but it will not occupy a larger proportion of the total than it has previously. Within that proportion there might well be different activities undertaken, largely on the advice of the professions.

Senator McLUCAS—I am trying to understand the rationale for putting all of those programs into one. I think you are telling me that there will not be movement between support for specialist services and some other program.

Mr Wells—I am suggesting it could be at the margin, whereas under the previous arrangement the barriers were fairly rigid. You then did get underspends in some elements of the program where there was slower take-up, whereas now, if there were, for example, some drop-off in one area for whatever reason, we would not necessarily be locked into a situation where we could not put that funding into another area.

Senator McLUCAS—I am starting to understand the rationale. We will not lose it out of rural health essentially. That is the purpose of putting it into one program.

Mr Wells—That is right—to give us the flexibility when circumstances change, essentially.

Senator McLUCAS—There must be a notional allocation to the 20 or so programs for this coming financial year.

Mr Wells—We will get you that list. We will try to get you that before we close this evening.

Senator McLUCAS—Has the work been done on forward estimates programming across those 20 or so subsets of the overall strategy?

Mr Wells—Some of that would be for ongoing services. That would be in the estimates.

Senator McLUCAS—If we could do a break-up according to the program across the out years, that would be useful.

Mr Wells—We will get you a list with the estimated break-up for this year.

Senator McLUCAS—Thank you. The regional health strategy was reviewed, I understand, in 2003. It says so in the PBS. Was that review report made public?

Mr Wells—No. There were several reviews because of the number of programs. They were seen as part of the budget process and budget documentation. It is not intended to release them.

Senator McLUCAS—Was their purpose standard reviewing?

Mr Wells—There is a standard review process for which the terms of reference are determined by the Minister for Finance and Administration. We followed those. The process leads to informing the government in its deliberations in the budget process.

Senator ALLISON—I want to raise some questions on that point. As I understand it, there was a report last month which actually made seven recommendations with regard to the multipurpose services program and the regional health services program.

Mr Wells—That was the Auditor-General's report, I think.

Senator ALLISON—Can I ask some questions about that?

Mr Wells—Of course.

Senator ALLISON—As I understand it, the audit found that a third of the MPS funding agreements had been extended with almost half of those agreements expiring in or before

2001, which suggests that they may well be implementing out-of-date services that do not meet community expectations. That was the general finding of that review. What steps have been taken to make sure that that is not the case?

Mr Wells—My reading of the audit was not that the services were necessarily not meeting community needs; it was that the form of some of the agreements were longstanding and the form of the agreement was perhaps not consistent with what might be regarded as best practice in terms of articulating service outcomes and performance measures. That is what we are working on now. We are revising all the agreements state by state because these agreements are bilateral agreements between us and the jurisdiction in which the service is provided. We are working through those now. We expect to have all those agreements renewed in a modified form within the next six to 12 months.

Senator ALLISON—Is it just the agreement which will be modified, not the service itself?

Mr Wells—Not the services, that is right, unless the community come forward. Generally, the Auditor found that the problem was not the service provision; the problem was in the form of the agreement and whether it actually provided the best way of determining performance outcomes et cetera. We have accepted that our agreements do need upgrading and we are in the process of doing that.

Senator ALLISON—The audit also found a significant underspend in the rural health program and found that that had increased by 9.6 per cent from the previous year of 2001-02—$6.6 million was not spent over that two-year period from 2001 to 2003. What has been done so far to investigate that underspending? How do you intend to see that that is not repeated down the track?

Mr Wells—We agree that the underspend was an underspend. That is a matter of fact and record. We have worked on that. As indicated earlier, with regard to the program expenditure for the current financial year we expect all the funds to be spent and it is our estimate that that will continue to be the case in future years. The underspend was actually a factor of commencing the program and a slower take-up than had originally been anticipated. We have worked through those issues and we are now on a track where we expect the moneys will be fully expended each year.

Senator ALLISON—The Audit Office was critical of your lack of analysis of that underspend either in the first or in the second year. Is that all it came down to? How do you respond to that criticism?

Mr Wells—That was our response to the Audit Office. Both in the discussions during the audit and in our written responses we acknowledged the underspend and we acknowledged our analysis of that. I do not think the Audit Office has disagreed with our analysis that the underspend was because there was a lot of developmental work in communities in working up their proposals, identifying their needs et cetera. That process took longer than might have been anticipated when the program was first devised. We have worked through that phase and we are now in a situation where we are expending the money as it is allocated.

Senator ALLISON—So it was just a phase, all of those proposals around the country are now up to speed and that will not happen again—is that what you are saying?

Mr Wells—Yes, that is right. Once they get up and running, unless a problem develops in a particular service, the expenditure flows on a regular basis against performance reports they give us.

Senator ALLISON—I think it was also the case that there was criticism of the very high proportion of one-off spending programs. Do you accept that that is an issue? Is that something the department is concerned about?

Mr Wells—With this program now, most of the expenditure goes to services which are meeting community needs on a continuing basis. I do not think that is currently a criticism of the way the program operates.

Senator ALLISON—That is generally understood, is it? In the next budget we can expect to see those programs funded again?

Mr Wells—That is right, yes, unless a particular program dissolves for some reason in a community. There is no de-funding of them. They are not funded for a fixed term, in a pilot sense, with someone then worrying about what happens; they are funded as ongoing community services, as long as they continue to meet the need for the services.

Senator ALLISON—All of them are for this coming budget session?

Mr Wells—That is correct.

Senator McLUCAS—I was wanting to get some data on rural and remote doctors. I wonder if I could go through the questions. They might be best provided on notice. Essentially what I am trying to ascertain is what has happened since 2000-01. Is it possible to provide us with the numbers of doctors who were in rural and remote areas—and I suppose that is divined more by RRMA 3 to 7—in that year and then for the years following that?

Mr Wells—We will take that on notice.

Senator McLUCAS—Can you also turn that into full-time equivalent doctors?

Mr Wells—Yes.

Senator McLUCAS—Can you also do the separation between how many were GPs and how many were specialists?

Mr Eccles—I suspect so. We certainly can do the other things but I will take that other one on notice as well.

Mr Wells—Our figures will be stronger for GPs. We will have some figures on specialists but some specialists in rural and remote areas are actually salaried doctors of state governments, for example, and we would not necessarily have those figures. So, yes, but perhaps with a qualifier.

Mr Eccles—A lot of that information is on our web site but we will certainly get that for you as well.

Senator McLUCAS—Essentially what I am looking for is what has happened since 2000-01.

Mr Eccles—To the last data year?

Senator McLUCAS—To the last data year, in full-time equivalents, in actual bodies.

Mr Eccles—A head count?

Senator McLUCAS—A head count.

Mr Eccles—FWEs.

Senator McLUCAS—You call them FWEs?

Mr Wells—FTEs.

Mr Eccles—Full-time workload equivalents.

Senator McLUCAS—Then the GP and specialist separation.

Mr Eccles—If we can, yes.

Senator McLUCAS—By doing that we will be able to ascertain the number of doctors that have been attracted to rural and remote areas over that period. Can you also identify for us the number who have physically left? Is that possible?

Mr Eccles—I need to take that on notice. That would require a different sort of analysis to just pure numbers—

Senator McLUCAS—Exactly.

Mr Eccles—It would be attributing to individuals. I will take that one on notice and see if we can do that.

Senator McLUCAS—I do not know if you are aware of this, but there has been a report by the New South Wales Rural Doctors Network, who are predicting undersupply of doctors in rural areas if people simply actually work fewer hours. Some of the evidence we had during the Medicare inquiry talked about the hours that rural GPS work. You would think they would want to have a bit of a break, given the hours that they are working.

Mr Wells—In terms of your last question about those who have left, I am not sure whether we would have that information, but the figures of the Australian Medical Workforce Advisory Committee—AMWAC—suggest a net increase over four years to about 2002-03 of around 11 per cent. I suspect that would include their best estimate of losses, but I do not think anyone has ever counted them. I have never seen a figure which says, 'Here is the number who have left, here is the number who have come, and here is the net result.' I think there are some estimates involved in reaching those figures.

Senator McLUCAS—In the AMWAC figures?

Mr Wells—Yes.

Senator McLUCAS—I would like to talk about the More Doctors for Outer Metropolitan Areas program. That was announced in 2002-03 budget, I think—

Mr Wells—Yes, I think so.

Senator McLUCAS—Can you tell me how many doctors have been attracted into outer metropolitan areas with incentives from that program?

Mr Lennon—There are different incentives available under the More Doctors for Outer Metropolitan Areas measure. Perhaps the main one is the relocation incentive grant that provides funding of up to $30,000 for doctors who move from better supplied inner

metropolitan areas to more poorly supplied outer metropolitan areas. As of 1 May 2004, 160 doctors have taken up a relocation assistance grant. Of those 160 doctors, 100 have already physically relocated and the bulk of the rest will be shortly relocating. There is also another element of the program to do with doing placement for GP registrars, which I will ask my colleague to talk about.

Ms Smith—We are confirming the number. I think there are around 60 GP registrar placements, but we will need to confirm that number for you.

Mr Lennon—I should add that in terms of the objectives of the program, which were to get 150 doctors under the program over a period of four years, the 160 that we have achieved has been achieved in 12 months and so the objectives of the program have basically been achieved in 12 months.

Mr Wells—I might add that there is also a retention element of this Our estimate is that around 30 doctors have taken advantage of that. That is 30 doctors who were there who might otherwise have left who have taken advantage of the retention measures and are still there.

Senator McLUCAS—What was the incentive for retention? I cannot recall it?

Mr Wells—There are several programs and if they enrol in an accredited program which would make them eligible for doing the College of General Practitioners exam for fellowship they can go access the higher rebate.

Senator McLUCAS—That was the VR question, thank you. Can you turn that amount of 160 doctors into full-time equivalent doctors, Mr Lennon?

Mr Lennon—I cannot turn that into full-time equivalent doctors on the spot, but I would be happy to take that question on notice.

Senator McLUCAS—We are trying to ascertain whether or not people are working full time or part time.

Mr Lennon—I understand the question. Some of them will be working part time and some will be working full time.

Senator McLUCAS—Is the amount of money allocated differentiated if the person is intending to work full time or part time?

Mr Lennon—Yes, it is differentiated. It is a pro rata payment, depending on the hours that you work. You get the full payment if you work full time, and part thereof if you work part time. I should also say that there is differentiation in the relocation incentive grant, depending on whether you are moving to establish a new practice, in which case you get up to $30,000, or moving to be part of an existing practice, in which case you get up to $20,000.

Senator McLUCAS—Were all of those doctors GPs, or were some specialists included in that 160?

Mr Lennon—The great bulk of the doctors were GPs. There were a few specialists, but the overwhelming majority were general practitioners.

Senator McLUCAS—Can you give me, on notice, the separation between those two groups?

Mr Wells—It is not in my brief here, so we will take it on notice.

Senator McLUCAS—Thank you. You have provided an answer to question E03-123 from last estimates. Is there a time frame from the point at which a doctor agrees to relocate to when they have to do it? When is the payment made?

Mr Lennon—It is expected that they will relocate within three months of the agreement starting. The payments are staggered, such that the doctor only gets the full payment some time after the agreement is made.

Senator McLUCAS—Have there been any instances where payments have been made and, for unknown reasons, the doctor has not finally relocated?

Mr Lennon—Yes, there have, but they have been only a handful.

Senator McLUCAS—What happens in that circumstance?

Mr Lennon—We are in the process of instituting action to get back the money that has been paid.

Senator McLUCAS—Is that difficult?

Mr Lennon—As I say, there has been only a handful of cases. I do not see why it would be particularly difficult because the terms of the funding agreement are quite clear.

Senator McLUCAS—How long do they have to stay in that area?

Mr Lennon—For those doctors who have relocated to an existing practice, to get the full payment they have to stay for a minimum of two years. For those doctors who are relocating to establish a new practice, to get the $30,000 grant they have to stay for a minimum of three years.

Senator McLUCAS—Do the doctors have to relocate from an inner metropolitan area to an outer metropolitan area?

Mr Lennon—In general, that is correct.

Senator McLUCAS—Have there been other doctors who have relocated from other geographical areas?

Mr Lennon—In general, doctors are only able to relocate from inner to outer metropolitan areas. For example, a doctor could not relocate from a regional rural area to an outer metropolitan area. That is not permitted under the program. The objective of the program is a distributional objective to get doctors from better supplied inner metropolitan areas to more poorly supplied outer metropolitan areas. It is not to get doctors from regional and rural areas that might be experiencing work force shortages, into outer metropolitan areas that might be experiencing work force shortages.

Senator McLUCAS—Is it possible to receive the grant if you are moving from one outer metropolitan area to another?

Mr Lennon—Not in general, no. In general, you would be moving from one area of work force shortage to another, given the fact that we work off national averages and that probably a significant majority of outer metropolitan areas would have doctor to population ratios that are worse than the national average.

Senator McLUCAS—What I am trying to ascertain is that the program does not encourage doctors to move to get $30,000.

Mr Lennon—We also have a net benefit test which we apply—that is, if a doctor were moving from an inner metropolitan area which had a workforce shortage to an outer metropolitan area that had a workforce shortage we generally would not allow it, because there is no net benefit.

Senator McLUCAS—In a situation where a doctor starts under the program working part time and then wishes to extend their hours, what do you do?

Mr Lennon—For doctors who, for example, started in an outer metropolitan area and may only be working one day a week and then decide to work say five days a week, we will pay a grant in recognition of the fact that they have substantially upped their hours. Similarly, if a doctor moved from an inner metropolitan area to an outer metropolitan area and started off at one day week, we would pay them pro rata, and if they upped their hours there would be provision to increase the incentive payments.

Senator McLUCAS—How do you monitor that? People's lives change. How do you monitor someone's hours of work?

Mr Lennon—We know where doctors are and what their service levels are on the basis of Medicare statistics, which are kept in the department. We are able to monitor that.

Senator McLUCAS—It is simply by the number of consultations that they are doing?

Mr Lennon—Yes, the service level as revealed in their Medicare statistics.

Senator McLUCAS—Does the contract—and I suppose it is a contract—between the doctor and the department describe hours of work, or number of consultations?

Mr Lennon—My recollection—and I am just going on memory here—is that it is described in terms of numbers of days, in terms of proportion of full-time equivalent work. If it is 20 per cent of a full-time equivalent, for example—

Senator McLUCAS—But the measure is number of consultations?

Mr Lennon—Yes.

Senator McLUCAS—Do you see a conflict—

Mr Lennon—Or number of services. I would have to take on notice precisely what is in the contract, as you would appreciate.

Senator McLUCAS—I just see potentially that the measure of the performance is not necessarily equal to what the contract says it should be.

Mr Lennon—I do not see that that is the case.

Senator McLUCAS—I am just thinking that, if someone is doing lots of long consultations, that will look different on the books than someone who is providing an enormous number of very short consultations. That may be clinically okay; I am just trying to understand the measure.

Mr Wells—The Medicare billing would be a trigger for inquiry rather than being the absolute measure. If there were a significant, say, decline—that would be the one I guess that

would be of most interest; if they increased, that would be a bonus—that would be a trigger, and we would then talk to the doctor. If it were a change of profile then that might be something we could allow for, but if it were, in fact, a reduction in hours worked, then that would bring in contractual issues.

Senator McLUCAS—Has that occurred at all to this point in time?

Mr Lennon—I am aware that there have been a few situations, and they would only be a handful, where doctors have not met the terms of the contract, but my understanding is it is more that they have not relocated than that they have said that they will work a certain number of hours and then they have not. To be sure of that, I would have to go and check every individual contract.

Senator McLUCAS—I am not asking you to do that. What do you do in circumstances where something absolutely unforeseen occurs—for example, the doctor gets sick?

Mr Wells—That is what I mean by a trigger. If there were a sudden drop-off, we would talk to the doctor. It could well be that there has been some crisis in their life or some problem at the practice that was beyond their control. That is how we would approach it, but I am unaware of any cases. None have been brought to my attention.

Mr Lennon—We seek to operate the provision flexibly and to look at it on a case-by-case basis.

Senator McLUCAS—With those numbers you can do that. Could you provide me on notice, Mr Lennon, the criteria by which you decide which outer metropolitan areas actually meet the area of need criteria, or is that something you can tell me about straightaway?

Mr Lennon—It is basically those parts of an outer metropolitan area where the full-time equivalent doctor to population ratio is worse than the national average, and the national average is one full time equivalent doctor to 1,404 people.

Senator McLUCAS—That is pretty well everywhere, isn't it?

Mr Lennon—No, it is not everywhere. Off the top of my head it is around about 80 per cent of the population in outer metropolitan areas—that is my recollection. There are maps which we provide on the website of all of the areas which are eligible for the More Doctors for Outer Metropolitan Areas measure so that doctors thinking about moving have easy access to the span of locations to which they can move.

Senator McLUCAS—Is it possible to identify by state and territory the number of doctors who have relocated under this program?

Mr Lennon—Yes, it is.

Senator McLUCAS—Could you provide that on notice?

Ms L. Smith—Just confirming that number of GP registrar placements: there were 54 placements under the program in 2003. The 2004 data is not yet available. We will get that report pretty soon, I think.

[3.47 p.m.]

Senator McLUCAS—Ms Halton, I had some questions on the Red Tape Taskforce review, which I think you did advise me actually come under outcome 4—Quality Health Care. Are those people still here?

Ms Halton—Yes.

Senator McLUCAS—The Red Tape Task Force has, I understand, completed its report. Is that correct?

Mr Learmonth—This was not a report per se, there has been a summary of the consultations that were undertaken in connection with Red Tape, which was concluded in November last year.

Senator McLUCAS—Has that summary been made public?

Mr Learmonth—I believe it is on our web site.

Senator McLUCAS—I understand there are going to be changes to the way that PIP and EPC are going to be administered. Could you give the committee some information about how that is going to occur?

Mr Learmonth—There are essentially three stages to that. In the short term there is some simplification to the administrative requirements around PIP which maintain the integrity of the programs and which are designed to make them a little easier. There is, secondly, the creation of two new PIP items for GP managed complex care, together with a practice nurse and multidisciplinary care assessment. Finally, there is a second-stage review of PIP and EPC which will be undertaken over the remainder of this year.

Senator McLUCAS—Thinking about it from the point of view of a GP, I can see that there is some simplification in the administration. Can you give me a practical example? What is it going to do?

Ms L. Smith—Some of the short-term changes that we are talking about, and that were agreed to by general practice groups, include consolidating the tiers. At the moment with the PIP payments for IMIT, for example, you have several tiers, you need to meet one, then the second, then the third. There is going to be a consolidation of those tiers. As well as that, administrative arrangements for registration with the Health Insurance Commission will be simplified. Information going back to practices will be simplified and improved as well. Those are some of the short-term changes that will be made.

Senator McLUCAS—What sort of information going back to a practice? Is this information from the department or from the HIC?

Ms L. Smith—It is from the Health Insurance Commission and it is about the payments, what they are being received for, the level of payment and the activity that it relates to.

Senator McLUCAS—It is just the reporting style; is that correct?

Ms L. Smith—I think it is probably the reporting style but we will confirm that.

Senator McLUCAS—You talked about a consolidation of the tiers in the IMIT program. When does the payment get made? I thought they were being paid progressively under IMIT.

Ms L. Smith—Do you mean once the tiers are consolidated?

Senator McLUCAS— Yes.

Ms L. Smith—The payments will obviously need to be reconstructed once the tiers have been collapsed.

Senator McLUCAS—I am just wondering what triggers the payment if you collapse the reporting benchmarks.

Ms L. Smith—There will be a single payment for basic IT infrastructure and information gathering by general practitioners but there will be an advance payment as well for people who have a much more advanced electronic infrastructure. I will just see if I have got that in here. I have not, so I will have to take that on notice.

Senator McLUCAS—Mr Learmonth, what has been the response from general practitioners to this action plan, if we can call it that?

Mr Learmonth—I have only seen one that I can recall, which was a press release from ADGP issued shortly after the minister's letter of 12 May, which was I think very positive.

Senator McLUCAS—They can see that red tape and administrivia will be removed out of their work program.

Mr Learmonth—It would be for them to reflect on their press statement. I think they thought that there was an action plan that was consistent with the consultation that had happened last year, that was tackling those areas they thought were of significance in an appropriate way and that there was both a short- and long-term aspect to it.

CHAIR—Are there any more questions on outcome 5?

Senator McLUCAS—I am just checking. I have got some other questions that Ms Smith might be able to help me with about the work force. It is the question of headcount as opposed to full-time equivalent doctors. I understand that in the 12 months in the lead-up to December 2003, the number of GPs dropped by five per cent from 21,750 in December 2002 to 27,673.

Mr Eccles—Could you give me the reference for those figures? They do not seem to match the figures I have here.

Senator McLUCAS—No, I cannot.

Mr Eccles—It has been suggested that they may be HIC headcount figures.

Senator McLUCAS—They are HIC, yes. How do you actually collect those statistics? You get lots of different spin, if you can put it that way, on how many doctors in fact there are.

Mr Eccles—I do not want to talk about how the HIC derive their headcount figures because I know there are some issues—for example, they exclude GPs who have billed less than $1,000 in the past year or something along those lines. But I can talk to you about the basic assumptions that go into the different methodologies headcount.

Ms Halton—We need to be clear: that is earned from Medicare.

Mr Eccles—That is right.

Ms Halton—There may be salaried doctors out there working for AMSs and people of that sort. This is a large group but it is a subgroup.

Mr Eccles—The GP headcount figures that we utilise is a count of all GPs who have provided at least one Medicare service during the period of time—that is, the number of GPs who at some point in time would access Medicare. The full time equivalent is an alternative measure to headcount because it measures the number of doctors working full time and the partial contribution of part-time doctors. Then there is a third measure, which is full-time workload equivalent, which almost takes that FTE figure one step further and takes into account the fact that, even though some people would be considered full time, there is a fair bit of variation. The workload equivalent figure is the figure that reflects most accurately the amount of work and the throughput that a doctor is realising.

Senator McLUCAS—It has been suggested that the number of GPs practising has increased by 350 in the first three months of 2004, and that is attributed to the minister. Can you give me an understanding of where that comes from?

Mr Eccles—I do not know off the top of my head but we could check. I suspect it might be the HIC headcount statistics, which are the most up-to-date, publicly accessible statistics on headcount.

Senator McLUCAS—That will just tell you the number of individuals. Is that the number of individual doctors who have started practising who were not practising at the beginning of the year?

Ms L. Smith—I think you would need to talk to the Health Insurance Commission about the methodology they use to calculate those numbers. It is a bit different from that which we use in Health.

Senator McLUCAS—How long does it take, Mr Eccles, for you to get your data? How recent is the information that you have about the FTE doctors?

Mr Eccles—We collate and publish that information on the web site annually. We can do a snapshot. I do not know how long it takes to do a snapshot. We publish it annually on the basis that to do smaller time frames sometimes can be misleading because there are seasonal issues and there are GPs going in and out of the system. A year average is probably the most appropriate way to determine medium- to long-term trends.

Senator McLUCAS—When do you publish those?

Mr Eccles—In August each year. We will do the analysis in July.

[3.58 p.m.]

Senator McLUCAS—I want to ask some questions on the General Practice Partnership Advisory Council. What outcome is that?

Mr Eccles—We can take them under outcome 4, Quality health care.

Senator McLUCAS—Mr Learmonth, I understand that the council has been disbanded. Is that correct?

Mr Learmonth—It has reached the end of its program of work, yes.

Senator McLUCAS—Given that, what was its work program?

Mr Learmonth—That goes back a little before my time. My understanding is that their principle role was to advise on the implementation of the general practice strategy. That having reached its conclusion, the reason for which it was established had been fulfilled.

Senator McLUCAS—Who was on the council?

Mr Learmonth—It was a significant list. I would have to take that on notice.

Senator McLUCAS—Not individuals, but was it a representational council?

Mr Learmonth—No, it was not in the sense that the individuals represented the organisations to which they belonged. It was a collection of individuals, if you like.

Senator McLUCAS—How were they appointed to the council?

Mr Learmonth—I believe by the minister at the time.

Senator McLUCAS—I have an article here from one of the medical media. I do not know which one it is. It just says, 'four groups' nominees on the GPRG'. It is just interesting that they use the term nominee, but that may be incorrect.

Mr Davies—Was that the GPRG? That is a different group. The GPRG is made up of people acting in a representational role for various GP bodies, and that has not been disbanded.

Senator McLUCAS—That is right.

Mr Learmonth—Indeed it is not a creation of government; it is their own group that has come together.

Senator McLUCAS—That is their own representative body. They were expressing concern in this about the dissolution of the advisory council, which does not seem to fit with the idea that the work was actually finished. That is an ongoing matter. I will leave that issue.

CHAIR—There being no more questions on outcomes 4 or 5, thank you very much to those involved thus far.

[4.01 p.m.]

CHAIR—We are now addressing outcome 9, Health investment.

Senator McLUCAS—I want to ask some questions about an allocation on page 253 of the PBS that identifies $3 million which will go to the Menzies Foundation to support innovative health research. What was the basis of that funding allocation?

Mr Wells—That was a government decision. The funding for that was provided in the additional estimates bills.

Senator McLUCAS—Did they apply for the funds?

Mr Wells—It was a government decision to provide them with the grant.

Senator McLUCAS—So they did not apply for the funds.

Senator Ian Campbell—The officer did not say that.

Mr Wells—I said it was a government decision to provide the foundation with a grant. That decision was given effect through the additional estimates.

Senator McLUCAS—What is the purpose of this allocation of $3 million?

Mr Wells—The Menzies Foundation provides a number of funding mechanisms. For example, it provides some core funding for the two Menzies research institutes—the one in Darwin and the one based in Hobart. It provides a number of scholarships. It funds seminars and that sort of activity. It is a not-for-profit trust.

Senator McLUCAS—So it was purely a government decision. Would the department be aware of any other organisations of a similar nature who have sought this level of funding?

Mr Wells—I am only aware of that one in our portfolio.

Senator ALLISON—What research will it do?

Mr Wells—It does not do research itself; it is a foundation. From the income it generates from its trust it funds things like giving money to the two Menzies research institutes—the one in Darwin and the one in Hobart. It funds a number of scholarships for researchers. I understand it funds seminars, conferences and that sort of thing, generally in the field of health and medical research.

Senator ALLISON—Specifically with this $3 million what sort of research or scholarships will it fund?

Mr Wells—It was a grant to the foundation; it is not tied to any particular scholarship or whatever. It was a grant to the foundation, and the purpose of the foundation is set out in their incorporation document.

Senator ALLISON—So they could use it for anything? They could use it for putting up a new building?

Mr Wells—They can use it for the purposes of the foundation.

Senator ALLISON—Which could include putting up a building?

Mr Wells—That is probably a technical question. The purpose of the foundation is set out in their incorporation. The purpose of the foundation does not say that they are in the building industry. It sets out their role in relation to funding scholarships—the sorts of things I have described. It would be a matter for the foundation to determine whether building a new building was appropriate within the construct of their foundation charter.

Senator ALLISON—But there is nothing in the agreement with the Menzies Foundation that would preclude the money being spent for such a purpose?

Mr Wells—The money was allocated for the purposes of the foundation.

Senator ALLISON—That was not what I asked you.

Mr Wells—The government gave the grant to the foundation for the purposes of the foundation. I cannot answer the question.

Senator ALLISON—I asked you: did the terms of that grant preclude the money being spent on such things as a building?

Mr Wells—The grant, by definition, could only be spent on activities which are legitimately within the purpose of the foundation. I am not in a position to advise on that.

Senator ALLISON—Would putting up a building be legitimate?

Mr Wells—I cannot answer that.

Ms Halton—We cannot answer the question.

Senator Ian Campbell—We can ask the foundation. I am happy to ask for more detail, but the work at the centres that this $3 million goes to support includes research into diabetes; heart and renal disease; maternal and child health; infectious diseases such as malaria; sudden infant death syndrome; cancer; and multiple sclerosis. The purpose of the grant is to ensure that the foundation continues its outstanding work and maintains its international reputation for excellence in health and medical research. It is pretty clear what the government's intention is.

I will look into the issue of building; it is a fair question. But I would not have thought, without going into the detail, that research institutes do need accommodation. I doubt, from reading this, that it is supposed to go into a building, but I certainly would not have thought that it would preclude a research institute who had employed some more researchers to look into sudden infant death syndrome, malaria or anything else putting a roof over their heads to put in their desks, chairs and a computer and some other stuff. But I think it is a fair question and I will be happy to get an answer from the minister for you.

Senator ALLISON—I would have to say it is a bit unusual for the government to simply give a grant with no sense of what that money is going to be used for. Would that be fair to say? You have said so yourself, Mr Wells.

Senator Ian Campbell—The federal government puts more money into medical research than any other government in the history of Australia. I am sure some of that money goes towards funding a variety of needs of research organisations. We spend an enormous amount of money on construction of buildings for the CSIRO.

Senator ALLISON—I am not saying that the constructing of buildings is necessarily not the right thing to do; I am just trying to see if there are any constraints whatsoever on what the money can be used for. Is there a report that the Menzies Foundation prepares?

Mr Wells—The Menzies Foundation provides an annual report, as it is required to do under its charter.

Senator ALLISON—Would it identify what that $3 million was spent on?

Mr Wells—The annual report for that grant I expect will not be until next year, so I would not be able to say at this stage what they will have spent the money on. But I reiterate that the condition of the grant, if you like, is that it has to be for the purposes of the foundation.

Senator ALLISON—I am sure that is given.

Senator McLUCAS—In the PBS it says that the money is provided to support innovative health research. How do you identify what is innovative? I dare say that that is the performance indicator for the $3 million.

Mr Wells—The Menzies Foundation, as I said, funds other people to do the research. It is not itself a research institute.

Senator McLUCAS—I am aware of that.

Mr Wells—Each of the main recipients of their funding, which are the two Menzies research institutes—the one in Darwin and the one in Hobart—has a good track record. The one in Hobart, for example, was responsible for a lot of the work around identifying the causes of SIDS, sudden infant death syndrome, and the one in Darwin has done a lot of groundbreaking work in relation to Aboriginal health. I think on any judgment those two institutes do groundbreaking research.

Senator McLUCAS—So do many others.

Mr Wells—And a lot of it is internationally groundbreaking.

Senator Ian Campbell—I note from searching through their web site that they funded, for example, late last year a lecture by Dr Donald McKay from the National Institutes of Health in the USA, internationally recognised as a world leader—and I am sure this will not appeal to Senator Harradine—in stem cell research, especially in the nervous system and pancreas. They sponsored this lecture at the National Stem Cell Centre's free public lecture series being held in conjunction with the first National Stem Cell Centre scientific conference. If anyone were to give the Menzies Foundation work on medical research an even cursory glance, they would find why they have the reputation as a world-leading research centre.

Senator McLUCAS—I am sure there are lots of organisations that would love to get $3 million to do innovative health research. I just cannot see how this allocation of this money fits with the broad strategic health research work that is happening across a range of organisations, and hopefully with some strategic oversight from the department. You just put $3 million aside and say, 'They'll do something innovative.' It is a bit of a hope. That is probably directed at the minister more than the officers.

Senator Ian Campbell—Do you have an objection to us funding the Menzies Foundation?

Senator McLUCAS—Research funding should be done—

Senator Ian Campbell—Is it because it is called Menzies? If it were called the Curtin foundation would it be all right?

Senator McLUCAS—Surely it should be done on a competitive basis.

Senator Ian Campbell—It is a non-political organisation; it has an independent board.

Senator McLUCAS—Surely all research funding should be done on a competitive basis. All of our research funding pretty well across Australia is done in that way. For the government to decide they are going to give $3 million to anybody—

Senator Ian Campbell—This is a foundation that funds research on a competitive basis.

Senator McLUCAS—without any competition I think begs the question.

Senator Ian Campbell—So you would stop the funding to the Menzies Foundation?

Senator McLUCAS—I might give it to the Whitlam foundation!

Senator Ian Campbell—Exactly. Now we know. Now at least we have your cards on the table.

Senator McLUCAS—I mean, really!

Senator Ian Campbell—It is not a political organisation. There are lots of things called Menzies that are not political.

Senator McLUCAS—Why didn't the government decide to develop—

Senator Ian Campbell—I think you might be confusing it with the Menzies Institute, which is attached to the Liberal Party. This organisation has no attachment to the Liberal Party.

Senator McLUCAS—That is not the point I am making. The point I am making is that any allocation—

Senator Ian Campbell—You said you would fund it if it were called the Whitlam foundation.

Senator McLUCAS—That was a joke, Minister.

Senator Ian Campbell—What is your objection to the Menzies Foundation?

Senator McLUCAS—That it is not competitive.

Senator Ian Campbell—Have you studied what the Menzies Foundation does?

Senator McLUCAS—No, I have not. But I have ascertained that it is not a competitive funding round.

Senator Ian Campbell—I suggest to you that you go to its web site and have a good look, as I have just done. It is a very impressive organisation.

Senator McLUCAS—It sounds like it.

Senator Ian Campbell—It does very good work.

Senator McLUCAS—But it is not competitive.

ACTING CHAIR (**Senator Humphries**)—Senator McLucas, could we return to questions rather than an exchange across the chamber. I am sure we can do that in the Senate chamber itself. Are there any further questions of these witnesses?

Senator McLUCAS—Not on that matter.

ACTING CHAIR—Are there other questions on outcome 9?

Senator McLUCAS—Yes. These are questions that we were going to go to yesterday to do with the bonded medical students. Have all the bonded medical student places been filled?

Mr Wells—Yes.

Senator McLUCAS—I am not unsurprised to hear that. Are you aware of some commentary from the Australian Medical Students Association, who have been saying that parents of several students who have been successful in getting some of these bonded scholarships say they intend to buy them out at the completion of their degree? What will that

do to the program and do you have any knowledge about how many of these places are going to be bought out in that way?

Mr Wells—No, we do not, because this is the first year. The first intake was this year, and those students have at least four years to go before they complete their degree—some have longer, depending on which university they attend. The provisions are that in accepting a bonded place the students enter into a contract with the department. The penalties in that for default on the bonding requirement are that they repay the amount the government invested. The cost of a medical school place is approximately $21,000 per annum, and about $6,000 of that is met through the HECS payment, which the student meets eventually. So $15,000 is notionally the government's contribution.

So the contract requires that they pay that back and that they pay it back with interest. The repayment is calculated on the basis of CPI over the period compounded for the number of years. So the amount of repayment for an individual, if they were to go down that course, would depend on the length of the course and whether they had served out some of the bonding—therefore they would be on a pro rata repayment. But it is a substantial amount whichever way you look at it. Of course the intent of the program is for students to get a place when they would not otherwise have got a place, because these are additionally funded places in the system. The expectation is that they will ultimately return to the community some of the investment the community has made in them, in areas where the community most needs their services.

Senator McLUCAS—Have you had any complaints from either students or their parents talking around the question that there is a two-type entry point now, and that those students who got the bonded places are feeling somewhat lesser as a result of that?

Mr Wells—They still have a place, and the universities have assured us that there is no dilution of the standard.

Senator McLUCAS—I agree with that.

Mr Wells—The universities have always maintained that they could take many more students from the pool of candidates, so it is not a question of those students being somehow of a lower standard. They have a place but the place they have just happens to have a bonding requirement, because that was the condition on which the government decided to fund those places.

Senator McLUCAS—You said all places had been filled. There were 10 or 12 places that were allocated last year to a Gold Coast institution, and then they were given to Brisbane—is that right?

Mr Wells—As part of the 234 new places funded in last year's budget, these all had a bonding requirement.

Senator McLUCAS—Outside of those 234? Is that where the 10 go to Griffith?

Mr Wells—Of the 234, notionally 50 were set aside for Griffith. Griffith is still going through the process of getting accreditation and does not expect to take students until 2005. For 2004, those 50 places were distributed to the University of Queensland and to James Cook University. I think there were 40 to UQ and 10 to James Cook. So that group of students

who started this year will in fact stay on at UQ and James Cook. Next year those 50 places will revert, assuming Griffith gets accreditation and takes students, and be the core of Griffith's places for its medical school.

Senator McLUCAS—Did JCU take up those 10 extras?

Mr Wells—Yes.

Senator McLUCAS—When did they take them up?

Mr Wells—The students are there.

Senator McLUCAS—When did they agree to take up those extra 10?

Mr Wells—Late last year. I would have to take on notice exactly when. Both University of Queensland and Griffith formally agreed to take those places under those conditions.

Senator McLUCAS—I will follow that up as well. There are 10 doctors floating around somewhere that I still have not pinned down.

Mr Wells—Ten doctors? Ten students.

Senator McLUCAS—Would-be doctors. I move now to overseas trained doctors. How many OTDs are we currently attracting into Australia? There is a range of different ways we are attracting doctors into Australia. Do you keep data on that?

Mr Lennon—Yes, we do. The data which the Commonwealth holds for overseas trained doctors is mainly for those who are Medicare claiming, so they are in the Medicare system. Overseas trained doctors can work either in the Medicare system or in the public hospital system, or they can work in some combination thereof. We hold good data on the Medicare claiming doctors but we do not have good data on the doctors who are in the public hospital system only. For 2002-03 there were approximately 1,500 exemptions issued for overseas trained doctors to operate through the Medicare provider number arrangements in Australia. That would include new doctors and doctors whose visas or Medicare approvals had run out and who were renewing those approvals.

Senator McLUCAS—How many doctors did we lose from Australia in that same period?

Mr Lennon—I do not have statistics on that but there would be some proportion of overseas trained doctors who would be temporary, who come here for a period of time and who then move on. That has always been the way it is. But in terms of the growth pattern we have been successful in attracting increasing numbers of overseas trained doctors into the system over time.

Mr Wells—That is a very difficult figure to ascertain because if, say, an Australian trained doctor decides to go overseas to a country where there is no visa that movement does not necessarily record that that is a doctor gone to another country. There is a tradition in Australia particularly of junior doctors going to other countries for a period of time to get some extra training, experience or whatever and then coming back to Australia. Even if we did count all the ones who left, which we cannot, it would not necessarily be the case that they are lost because they go for a specific purpose and then come back. The actual loss is a very difficult figure to estimate.

Senator McLUCAS—How would we know that the government has met its target of 750 full-time equivalent OTDs?

Mr Wells—We count the ones that come in. Of those who come in on temporary arrangements, as Mr Lennon said, many will access a Medicare provider number so our department has that data. Those who come in to work in the public hospital system exclusively have to get a visa. We have arrangements with Immigration to get regular figures on the visas.

Senator McLUCAS—I still do not know how we are going to know that we have 750 more doctors in Australia than we currently are achieving. I accept your point that we cannot count the ones who are going out.

Mr Wells—We know some who are going out. For example, we know the ones who are here on a visa, whose visa expires and who then decide not to renew. We can count those ones. What I am saying is that we cannot count the Australians who, for whatever reason, go out short-term or long-term.

Mr Lennon—As well as the macro measures of what is happening with overseas trained doctors, we also have micro measures. For example, we are implementing an international recruitment strategy for overseas trained doctors and we will know precisely how many of those doctors we secure, precisely where they will be and what Medicare claiming activity they will have.

Senator McLUCAS—When were doctors added on to the skilled occupation list for migrants?

Mr Lennon—In May 2004; last month.

Senator McLUCAS—Why did it take so long? We have known we have been short of doctors for a long time.

Mr Wells—There is some difficulty in defining 'doctor' for the purposes of the skilled occupation list. It is perhaps more difficult to define than, say, plumbers or electricians. It was part of the package; the government decided we would extend the maximum visa period from two to four years and also include doctors on the skilled occupation list. That policy decision was taken last year. Since then the process has been sorting out the definition and the processes that Immigration have to go through to get the relevant gazetting, or whatever it is they have to do.

Mr Lennon—It was announced in November 2003 as part of the enhanced Medicare package and it was implemented in May 2004.

Senator McLUCAS—We have known for a very long time that we have been short of doctors. I am just surprised that we had to have an announcement to put it on the list. I am not trying to make a political point; it is just a matter of why it was not on the list for five years.

Mr Wells—I understand that point, but that was in fact what happened.

Senator McLUCAS—I understand that Indigenous health workers are also on the skilled migration list. Is that correct?

Mr Wells—I will have to take that on notice. I am not aware of all the occupations on the list.

Senator McLUCAS—I would be interested to know what opportunity we have to attract Indigenous health workers from overseas to Australia, if in fact that is true.

Mr Wells—I will take it on notice.

Senator McLUCAS—Thank you. What is the overseas recruitment process that is being undertaken as part of the program?

Mr Lennon—As part of the overall program, a menu of strategies has been put in place for overseas trained doctors. There is an international recruitment strategy being undertaken by the Australian government. To put that strategy into effect, we went out and did a tender process and engaged a number of experienced recruiters of overseas trained doctors. That process started as of February-March of this year. We have now got 11 international recruiters in place actively working to recruit overseas trained doctors.

Senator McLUCAS—And the contracts run for 12 months?

Mr Lennon—The contracts run for varying periods of up to 12 months, yes. We want to take the opportunity to have a look to see how our recruiters perform against the contract and then reassess, but I think they would run for a period of up to 12 months or thereabouts. But we will obviously be looking to review the process after a suitable time.

Senator McLUCAS—What is the nature of the contracts? How are payments made to recruiters?

Mr Lennon—Payments are made to the recruiters on the basis of having doctors placed in an area of work force shortage and claiming against Medicare. Once that happens, once the process has been completed and they are on the ground, are claiming against Medicare and are in a designated area of work force shortage, as approved by the department, they will be paid an amount.

Senator McLUCAS—Is that amount public?

Mr Lennon—No.

Senator McLUCAS—Can it be?

Mr Lennon—No, it cannot be.

Mr Wells—It varies.

Senator McLUCAS—It varies?

Mr Wells—It varies depending on how well we negotiated with different parties. Some of them are bigger than others and it does vary. We negotiate with them and they give us their best commercial price, presumably.

Senator McLUCAS—Can you tell me the cost of all of the 11 contracts then? That way you are not losing any advantage.

Mr Lennon—The cost will entirely depend on how successful our recruiters are. It will depend on how many doctors they put on the ground and on the Medicare billing. We would expect that the cost to 30 June 2004 will be under $500,000, because they have just started

with the process, but we expect it will build up to several million next year. But the great bulk of the cost of the overseas trained doctor measure will in fact be the extra Medicare benefits outlays, which will flow from the fact that we will have a significant number of extra doctors providing services in areas that need them.

Senator McLUCAS—So $500,000 for this current year?

Mr Wells—We think it will be less, but that is our current estimate: up to $500,000.

Senator McLUCAS—And some million—

Mr Wells—Next year, 2004-05.

Senator McLUCAS—I understand there is a loophole that allows medical graduates who are born overseas but trained in Australia access to provider numbers and work unsupervised in areas of work force shortage without completing any vocational training—is that true?

Mr Wells—That is a matter that has been brought to our attention by the College of General Practitioners. We are preparing advice for the minister about that issue and what options there might be to change the situation, or indeed whether it is a problem.

Senator McLUCAS—It is under consideration?

Mr Wells—It is indeed. I am corrected there. I understand the minister has actually made a decision on that.

Mr Lennon—He has made a decision. The problem I have is not whether the minister has made a decision on the matter but whether or not it has been publicly announced, so I will have to get back to you.

Senator McLUCAS—You do not want to make a ministerial announcement here tonight—I can understand that.

Ms Halton—It is considered unwise.

Senator McLUCAS—I am happy at this point to put the rest of the questions that I have—and there are not very many—on notice for outcomes 4, 5 and 9, and hand over to outcome 7.

Senator ALLISON—I am not finished with outcome 9. I wanted to raise some questions under health investment to do with smoking programs.

Ms Halton—That falls under outcome 1, Population health and safety.

Senator ALLISON—What about the drug strategy?

Ms Halton—That again falls under population health, which we did last night.

ACTING CHAIR (Senator Humphries)—Are there any further questions on outcome 9?

Ms Halton—This is Bob Wells's last appearance. He actually thought he was escaping a moment ago, and he got called back. This is a very important decision now. Bob is actually retiring—this is it for him, no more estimates. So we have to be really certain that we are going to move on.

Senator McLUCAS—Thank you, Mr Wells, for the information that you have provided to committee in the time that I have been here and much longer. Good luck in your retirement.

Mr Wells—Thank you very much, Senator.

[4.34 p.m.]

ACTING CHAIR—We now move to outcome 7, Aboriginal and Torres Strait Islander Health.

Senator CROSSIN—I want to start with questions on cancer mortality for Indigenous Australians. I am not sure if you are aware of a recent article in the *Medical Journal of Australia* entitled 'Long term trends in cancer mortality for Indigenous Australians in the Northern Territory'. It highlighted that cancers that affected Indigenous Australians to a greater extent than other Australians are largely preventable. Do you have the figures for the smoking rates amongst Indigenous Australians?

Dr Fagan—I can look up the precise figure, but in the Indigenous component of the National Health Survey 2002, the smoking rates are approximately double. It is close to 50 per cent for Indigenous Australians and close to 25 per cent for non-Indigenous Australians.

Ms Halton—No, it is less than that. For non-Indigenous Australians it is under 20 per cent.

Dr Fagan—But in that survey the figures were approximately double.

Senator CROSSIN—Do you have a breakdown of the rates? Can you give me the figure for the Northern Territory Indigenous Australians?

Dr Fagan—I cannot answer that. No, not in the Northern Territory.

Senator CROSSIN—So you do not have a breakdown state by state?

Dr Fagan—I do not think we have. We could take that on notice.

Senator CROSSIN—You have to take on notice the smoking rates for NT Indigenous Australians. Is that right?

Dr Fagan—Yes.

Senator CROSSIN—Can you tell me what Quit programs are available for Indigenous people?

Dr Fagan—Quit programs used in the sense of early intervention to address smoking as a risk factor?

Senator CROSSIN—Yes.

Dr Fagan—The population and health division is the key funder of tobacco control strategies in general, as I am sure you understand. Through the primary health care services that we fund and our work in maternal and child health as well as chronic disease, we attempt to increase the capacity of the primary healthcare interventions in relation to tobacco cessation. The population and health division has funded what is called the Centre for Excellence in Indigenous Tobacco Control through the University of Melbourne, which is establishing itself at the moment. A key objective of that centre is to become a sustainable national centre for excellence in Indigenous tobacco control. It has initially taken on the role of being a clearing house for information and improving the Indigenous health work force capacity to respond. It is also developing a toolbox that will be accessible to primary healthcare service providers to develop programs that are locally relevant, which will be Quit programs.

Ms Evans—With regard to your specific question about figures, we could take it on notice. I am not sure whether figures are available, but we do not have them on hand. We will consult with our colleagues.

Senator CROSSIN—No, I did not ask about figures. With regard to the centre for excellence you are talking about, Ms Fagan, when is that due to begin operation in terms of its outcomes you have outlined?

Dr Fagan—Those are the projects that it is currently pursuing. It has been in operation since the beginning of this year.

Senator CROSSIN—Are there any particular Quit programs targeted at Indigenous Australians?

Dr Fagan—As Ms Evans just said, we would have to take that specific question on notice.

Senator CROSSIN—It is not something you do in collaboration with your population and health people?

Ms Evans—No, it is not. I would have to take questions about Quit programs on notice.

Senator ALLISON—Surely this is an issue that has one of the most serious impacts on the health of Indigenous people—and yet we do not know if there is a program that is specifically targeted to Indigenous people?

Ms Evans—I do not know the figures on the Quit programs.

Senator CROSSIN—I did not ask for the figures. I just asked whether there were any particular programs targeted at Indigenous people.

Ms Halton—We will get the details. As you know, the population health people are not here, but I am aware that there is a particular program, which, as I understand it, targets Aboriginal health workers in particular. There is certainly one initiative I can think of off the top of my head, and there may well be more. But we will make a phone call and find out the information from the relevant officers who are back in the department.

Senator CROSSIN—I actually want to find out whether there are any specific programs for Indigenous people. What is the percentage of Indigenous women who may have received a pap smear in the past two years?

Dr Fagan—We do not have national data on that. There are state based registers, but they do not necessarily identify Aboriginal and Torres Strait Islander women. We do have regional data. In fact, we have regional data from Queensland, which was published just last year. The rates are lower than for mainstream Queensland women. I would have to put my finger on the precise figure in that article, but I think it was around 40 per cent, whereas it was close to 60-plus per cent for the rest of Queensland women in the late 1990s.

Senator CROSSIN—Is there any way you can ascertain the data from the states? Do you have no national snapshot of the percentage of Indigenous women accessing this service?

Dr Fagan—It is my understanding that most of the state based registers do not have an Indigenous identifier. I think that the Northern Territory may. Queensland does not. The process of identification requires identification at the time of collection of the smear, recording that onto the pathology form and carrying that over to the register. At the moment,

the most reliable data that we have comes from the kind of peer reviewed article that I mentioned in connection with Queensland. In fact, the report I referred to previously was based on identifying women from discrete Indigenous communities, where the proportion—

Senator CROSSIN—What data are you able to get your hands on at a national level, to understand what is happening in this area?

Dr Fagan—There is no national data on cervical screening.

Senator CROSSIN—Are you telling me that you would be able to ring the Northern Territory and they could tell you what percentage of women are accessing pap smears, or are you saying that Queensland has that kind of information and Western Australian does not? What is happening around the country?

Dr Fagan—Could you repeat that question?

Senator CROSSIN—What is happening around the country in terms of Indigenous women accessing and having a pap smear?

Dr Fagan—In terms of the data available?

Senator CROSSIN—Who is collecting data and who is not? What do you know about the situation? What is a snapshot of this situation? You have told me that in Queensland the rates are much lower. What is happening everywhere else?

Dr Fagan—There are unpublished reports from the Northern Territory which suggest that the rates have certainly improved in recent times. This has also been reflected in a non-significant drop in cervical cancer mortality from the Northern Territory, but this is, as yet, not published data. It is in report form at the moment. There is enormous effort going towards improving Indigenous women's access to cervical screening, through work force development, education campaigns and enhancing primary health care.

Senator CROSSIN—That might be my next question, but I just want to know if you can tell me what happens state by state. What is happening in Queensland? Do they or do they not collect data?

Dr Fagan—They collect data, but the data is not state based data. The data will be local health service based data.

Senator CROSSIN—By region and by town?

Dr Fagan—Outside the urban areas, it will be by health service. In urban areas, it will still only be by health service. On the state based register, the last time I checked there was no identifier.

Senator CROSSIN—Has the Commonwealth ever asked Queensland for the figures?

Dr Fagan—In relation to Indigenous women?

Senator CROSSIN—Yes.

Dr Fagan—Not to my knowledge. As I said before, it would be quite difficult to get accurate data, because it requires the identification of women at the point of collection of the Pap smear—and for that then to be carried right through to the register.

Senator CROSSIN—And no-one bothers to do that in Queensland—or anywhere in the country for that matter?

Dr Fagan—We encourage clinicians to identify Aboriginal and Torres Strait Islander people among their patients, for a number of reasons. Queensland Health Pathology Services, the last time I looked at their form, had an opportunity for a doctor to identify their patient. But that is the extent to which it goes.

Senator CROSSIN—What is happening in the Northern Territory?

Dr Fagan—I have not worked in the Northern Territory, but it is my understanding that in the Northern Territory there is an identifier on the register, but I would have to check it to be certain.

Senator CROSSIN—Western Australia?

Dr Fagan—I would have to take the question on notice but, to my knowledge, there is no other state that identifies on the state based register that a woman is Indigenous on the cervical screening register. But we can take this on notice, and I will check for you.

Senator CROSSIN—So what is the level of follow-up? If you do not know how many Indigenous women are actually accessing Pap smears or are on the register, what level of follow-up is there? How do you get a snapshot of what the situation is and whether or not you need to run programs to encourage women to have Pap smears?

Dr Fagan—As I am sure you are aware, it is acknowledged that increasing Aboriginal and Torres Strait Islander women's participation in cervical screening is an important issue. Cervical cancer mortality rates are greater, so there is a considerable effort at the local and regional level to improve women's access to women's screening services.

Senator CROSSIN—So what is being done to get more Indigenous women to have Pap smears?

Dr Fagan—The Department of Health and Ageing funds the Rural and Remote Women's Health Program, which is run through the RFDS, to increase the access of rural and remote women, Indigenous and non-Indigenous, to female general practitioners. That has made a difference.

Senator CROSSIN—Wait a minute: there are two or three of those female practitioners in the Territory. What is being done to encourage more Indigenous women to get Pap smears where there is no access to a female doctor, for example?

Dr Fagan—There are numerous initiatives, at the local and at the regional level—initiatives which attempt to provide a female provider—

Senator CROSSIN—Which initiatives does the Commonwealth fund?

Dr Fagan—The RFDS Rural and Remote Women's Health Program is one initiative the Commonwealth funds. It is my understanding that we also contribute through PHOFAs to state based initiatives which are around work force initiatives to improve women's access to women's screening services.

Ms Evans—The registers are a state government responsibility. We can certainly get you information on that. At the individual service level, there is enormous effort. The Population

Health Division manages the National Cervical Screening Program. Perhaps we could take it on notice and give you a fuller briefing. I do not think we are actually able to provide you with the sort of information that you are looking for.

Senator CROSSIN—Has the Commonwealth given any consideration to perhaps tying any sort of funding to a requirement that states or territories keep this sort of data on record? You are saying that it is up to the states and territories, but have you done anything about trying to make it compulsory for states to do that? Has there been any consideration given to the idea that you might say, for instance, 'All right: as of 1 July we want all states to keep on their cervical register data on the number of Indigenous women who have Pap smears'?

Ms Evans—I am not aware of that. Once again, this is a question that we can take on notice and talk to our colleagues who run the Cervical Screening Program about.

Senator CROSSIN—Can you tell me what percentage of the Indigenous population is hepatitis B positive?

Dr Fagan—We would have to take that on notice.

Ms Evans—I think that would have similar issues in terms of identification and the completeness of the coverage.

Senator CROSSIN—Can you tell me what percentage of the Indigenous population has been vaccinated against hep B?

Dr Fagan—Of the adult population, we would have to take that question on notice to give you a precise figure. There has been a vaccination program in childhood since the late 1980s for a Aboriginal and Torres Strait Islander Australians.

Senator CROSSIN—Would you expect that 100 per cent have been vaccinated?

Dr Fagan—No, I would not.

Senator CROSSIN—Or 70 per cent?

Dr Fagan—We can provide you with the information.

Senator CROSSIN—So you are going to take those three questions on notice for me?

Dr Fagan—Yes.

Senator CROSSIN—Can I ask you about the Aboriginal and Torres Strait Islander People's Complementary Action Plan 2003-06?

Ms Evans—I am sorry to do this, but that is run under the National Drug Strategy. We have to take those questions on notice.

Senator CROSSIN—We just assumed, as it was an Aboriginal and Torres Strait Islander action plan, that you might have some involvement or a collaborative involvement in that.

Ms Evans—We do have some involvement. I guess we could try to take your questions. But, as we have said before, each of the divisions have responsibility for Aboriginal programs and population health.

Senator CROSSIN—You do not have a role in overseeing some of those?

Ms Evans—We work collaboratively with them, yes.

Senator CROSSIN—You might be able to answer the questions then. What funds has the government committed to implement the National Drug Strategy?

Ms Halton—That really is a question for program 1. I am sorry. As Ms Evans has indicated, each of the divisions in the department has a responsibility to run its own Indigenous programs. That is a level of detail that really the program 1 people would be required to answer.

Senator ALLISON—I might chip in here and ask about specific programs, if that is all right. Are there any programs under way for addressing otitis media, particularly for children?

Ms Savage—Yes, we have a hearing program, we have developed a number of free sources and we provide funding for 30 hearing health workers in communities across Australia to conduct screening for zeros to five-year-olds.

Senator ALLISON—How many children does one health worker need to get through with that number?

Ms Savage—The health worker usually works as part of a team within the primary health care setting. Depending on their region of coverage that optimal number would differ. They would also work with other local service providers to reach their particular coverage area.

Senator ALLISON—Does that mean all children have now been screened by these hearing health workers?

Ms Savage—No, we would not be able to say that all Aboriginal children have been screened.

Senator ALLISON—What percentage, then?

Ms Savage—We do not have a national repository of information which would enable us to give you a percentage of all the children zero to five who have been screened. In some states and territories hearing screening is done as part of school programs. We would be unable to give you a percentage figure of the total.

Senator ALLISON—Is there a projection of how many next year, the following year and so on? How can we judge whether 30 hearing health workers will be able to reach all Indigenous children?

Ms Savage—Because of the nature of the local and regional service provision, that would be something that would be worked out in the context of a health plan or the linkages between the range of providers to establish their own targets.

Senator ALLISON—Let me put the question another way. Why was the number of 30 chosen? Is 30 enough and how do you know that it is enough.

Ms Savage—That goes back to the historical basis of the program. It was decided, in consultation with partners to the Aboriginal and Torres Strait Islander health framework agreements—in particular the partnerships with the community control sector; state and territory health departments; ATSIC; and the Commonwealth, to locate Aboriginal hearing health workers at sites that were nominally providing a range of child and maternal health services, so that they could actually be integrated into that provision, both locally and

reaching out more regionally. So it was actually decided in consultation with partners at the state level.

Senator ALLISON—Is that because the states are also contributing to the funds for these health workers?

Ms Savage—No, they are not contributing to the funds. That is funded solely by—

Senator ALLISON—So the states said, 'We only need 30, don't give us any more than that'?

Ms Evans—No, that was not the situation. The 30 are located in the services we fund. The states also have a fairly major role in running community health services and clinics, particularly in remote areas, and they have responsibility for the screening in the services they run.

Senator ALLISON—So how do you determine which the Commonwealth will fund hearing health workers for and which they will not fund for?

Ms Evans—As Ms Savage said, and as I understand it—and this goes back a bit in history—the hearing health workers are based in the community controlled health services that the Commonwealth funds, based on services that have a particular focus on child and maternal health. So they are services that were chosen because they were already established and had a focus on child and maternal health programs.

Senator ALLISON—Is it possible to tell the committee how much unmet need there is, despite these 30 workers and those that are provided in the state-run clinics? Has there been an estimate made of the adequacy of those services? If not, what is the extent of the shortfall? Could you take that on notice?

Ms Evans—We will take that on notice. I want to correct the record in terms of national smoking rate figures. The data from the *National Drug Strategy Household Survey 2001* indicates the overall population smoking prevalence rate is 19.5 per cent and the rate for Indigenous Australians is 45 per cent. As Dr Fagan said it is nearly—

Ms Halton—It is over double. The next survey is being conducted in 2004, so we will have updated data.

Senator ALLISON—Is there a specific program that is running at present to eliminate scabies?

Ms Savage—We are not specifically funding scabies programs, but the Aboriginal primary health care services that we do fund may well be engaged in scabies programs at the local level.

Senator ALLISON—But you are not aware of the extent or success of them?

Ms Evans—What Ms Savage is saying is that it is the responsibility of a primary health care service and the health staff there, doctors, nurses and health workers, to respond to scabies and treat it, as they have patients in the clinic. There is not a specific scabies program. Having said that, we have been involved in discussions about a much broader approach to scabies across the Top End in the Northern Territory. I do not know whether Dr Fagan wants to comment briefly on that.

Dr Fagan—Scabies is an example of an infection that requires both a regional and coordinated response, as well as a local primary health care response. In the Top End, partly attempting to address the issues of mobility, there has been considerable work in recent years to develop very strong community responses to scabies and skin sores. This has developed into what has been called the Healthy Skin Program. There are number of entities contributing to this program. We are currently considering contributing to the development of community workers who will be working on this program.

Senator ALLISON—When will a decision be made about that contribution?

Ms Savage—That should be made fairly shortly.

Senator ALLISON—Do we have some idea of how many children and how many adults are affected by scabies at the present time? What is the trend?

Dr Fagan—The rates fluctuate, but it is a significant issue among children and adults in many communities across Northern Australia, and it requires a concerted response.

Senator ALLISON—In your view, is there a concerted response?

Dr Fagan—Yes. There are many challenges in addressing the issue. There are underlying issues—environmental issues—which contribute to it. We need to have a well-informed and responsive primary health care work force and we need to work closely with the community to make it a high priority. Certainly, through the work on the Healthy Skin Program in northern Australia, there are some successes and it is very positive.

Senator ALLISON—The education committee, when it was doing its Indigenous inquiry, found a number of schools that had terrific programs to eliminate scabies—simple programs that worked—but they do not seem to have been picked up elsewhere. Why do you think that might be?

Dr Fagan—I am not sure what you are referring to, so I cannot answer.

Senator ALLISON—Okay. Is it the case that scabies is largely responsible for the very high rates of rheumatic heart disease among Indigenous Australians, which are six to eight times that of non-Indigenous Australians?

Dr Fagan—Traditionally it has been considered that rheumatic fever—and therefore rheumatic heart disease, which is a complication of rheumatic fever—is association with strep pharyngitis. But the evidence is increasing that it may be associated with pyoderma or skin sores resulting from scabies.

Senator ALLISON—Has there been any cost-benefit analysis done of the benefits of preventing scabies vis-a-vis dealing with the more major health problems that result from those sorts of diseases?

Dr Fagan—Not that I am aware of.

Senator ALLISON—But it would not surprise you if I put the proposition to you that it would be better to supply plenty of people with the ointment for scabies than to mop up the rheumatic heart disease problems at a later stage.

Dr Fagan—I would agree.

Senator ALLISON—How are diabetes programs going?

Ms Savage—We consider diabetes to be one of a number of conditions that fall within the chronic disease category.

Dr Fagan—We address diabetes as a preventable chronic disease, as part of our approach to chronic disease. We consider it a core and very important part of the way we attempt to enhance the way the primary health care services that we fund operate. We work quite closely with the services that we fund to embed a systematic approach to the early detection and management of chronic disease, using quality improvement as the underlying principle.

Senator ALLISON—With that systematic approach have you built in some objectives, some targets, and, if so, is there a time line for reducing the incidence of diabetes? How do you measure the success of this program?

Senator CROSSIN—How many Indigenous people have diabetes?

Dr Fagan—Again, the rates vary. I am answering your question, Senator Crossin.

Senator CROSSIN—They are a bit related, really.

Dr Fagan—The rates from the Torres Strait, in a community survey done in the late 1990s, were 24 per cent in those aged greater than 15. But the national figure that is reported varies regionally between 10 and 30 per cent, which is much higher than in the mainstream. The approach that we take at the primary health care level is to attempt to address risk factors and to attempt to enhance our capacity to diagnose diabetes and other chronic diseases early and to prevent complications. In order to do that, you need to have a systematic approach and you need a multidisciplinary team.

Senator ALLISON—When do you know you have reached the objectives that you have set for the systematic approach?

Dr Fagan—I suppose we begin at the beginning. At the moment we are trying to ensure that the work force is equipped to provide good quality care, ensure that—

Senator ALLISON—And are they?

Dr Fagan—I do not think there is a simple answer to that question. There are always a lot of challenges in recruiting and retaining a health work force that needs to have an extraordinary range of skills and often lives in remote settings. We always have challenges in recruiting and retaining a health work force to address such complex issues as these chronic diseases, but that is what we try to work with our services to ensure. In terms of early detection, we work with the services to develop their own benchmarks in screening and we ensure that evidence based protocols are in place around the management of those who are diagnosed with chronic disease. So it is a matter for services to work towards their own targets for clinical care processes in order to improve intermediate outcomes.

Senator ALLISON—Do they report on those targets and the extent to which they have achieved them?

Dr Fagan—We have been working on this project for the last 18 months, so we are about at the stage that I am talking to. In a few years time we may be able to report the targets of the nature that you are referring to.

Ms Evans—Senator, in relation to your earlier comment, can I just add that one of the big challenges is early identification of diabetes and then treatment of it. I think the introduction of the Indigenous health check MBS item, which went on the schedule in May this year, is one of the initiatives we hope will make a difference, because part of that health check will cover testing for diabetes et cetera. You may be aware that part of the issue we have is that sometimes people have diabetes that is untreated for a long time, and the complications that go with it are fairly advanced by the time it is diagnosed. So there is a big emphasis on early identification and then, as Dr Fagan said, treatment. The obvious first step is to identify early, but then appropriate treatment and ongoing management is another issue. These continuous improvement projects are working towards that.

Senator ALLISON—I think we are persuaded about that. We like the idea of a systematic approach and early intervention and treatment. It sounds terrific, but the data would suggest that there has been no progress.

Ms Evans—These initiatives are quite new. We are concerned, and there is a huge concern, about the very high rates of chronic disease, particularly diabetes, then the consequences of that and untreated diabetes. So we are really trying to put a strong focus on early identification and treatment.

Senator ALLISON—The real question is: are there enough resources going into this? Professor Deeble offered the view recently that $300 million a year was needed—$250 million in primary care and $50 million in preventive care. Do you agree with those figures? Is that the sort of scale of effort that is required?

Ms Evans—I think quantum is always a difficult thing to agree on. There is always room for more. I think that funding for Indigenous health has increased significantly since 1996; it has almost doubled. There was further growth in this budget, and there is always capacity for more. That is a decision for government. There is also an issue around the capacity of the sector to make use of it, too. There is an issue around the work force and being able to recruit and retain nurses, doctors and health workers. So, while more resources can be used, there is a finite capacity to take on and make best use of those resources over time. It has been tiered in, which I think is a good approach.

Senator ALLISON—What do you say to the criticism that there is no system in place that ensures that enough money is spent where it is needed?

Ms Evans—I am not sure where that comes from. One of the things we have tried to do—

Senator ALLISON—It comes from the Fred Hollows Foundation documents and fact sheets on Indigenous education.

Ms Evans—One of the things we have tried to do over the last six to eight years is to do a systematic assessment, region by region, in collaboration with our state health colleagues, to get a good handle on what resources are there and, therefore, to get a better handle on where the major gaps are in relation to health services for Aboriginal and Torres Strait Islander people. We are progressively and more systematically putting in resources where there is the greatest need.

Senator ALLISON—So you would expect to see some results from this over the next few years. When can we look to some success in this area?

Ms Evans—In fact, in relation to some areas that we have targeted as being high priorities and have put resources in, we already have some data that a difference has been made at the local level, and that information should be progressively becoming available.

Senator ALLISON—A paper that appeared in the *Medical Journal of Australia* quite recently, and it was also the subject of an ABC radio program, made the accusation that health care provision for Indigenous people included institutional racism. Have you had a chance to look at that article and can you advise the committee whether or not you think that is accurate?

Ms Evans—I have had a brief look at the article, but I have not studied it in depth. I really do not feel in a position to comment on it at this point in time.

Senator ALLISON—What about the case study that was cited? I am sorry, I do not have the name of it, but I think it was a service in Western Australia which had overspent its budget by 10 per cent because of an enormous increase in the number of people seeking services and, ultimately, it was closed down. Do you know of any instances of that? Is that commonplace? Are we scrutinising services to such an extent that we remove programs that are successful?

Ms Evans—I am not familiar with that particular example. There is an issue about services living within their budgets. While I think there is, undoubtedly, unmet need in many places, like all of us, services—be they national or local—really need to live within the budgets they have. In terms of just good management of program, one of the messages that we have to give to the services we fund is that, while there may be unmet need—and we appreciate that—they have to live within the budgets they have, and then, based on information, we will negotiate when new money becomes available as to whether there is additional funding to expand their services.

Senator ALLISON—Perhaps you could you take that on notice. You could have a look at that paper and give a response to the specific service that was cited.

Ms Evans—Yes.

Senator ALLISON—It would be interesting to know whether there were others in this category. It would be a great shame if a service was closed down just because it overspent its budget by 10 per cent, given that overspend is common in our public hospitals in city areas, in particular.

Ms Halton—I have a little trouble believing that story, if indeed it is true. There might have been something else going on, but we will be very happy to have a look at that and come back to you.

Senator ALLISON—Thank you. Is the provision of dental services to Indigenous communities something the Commonwealth has an interest in? The dental health area is another area of far poorer health outcomes for children and adults. Does the Commonwealth have any specific programs?

Ms Evans—You may be aware that the Commonwealth government's position on dental services is that that is a state responsibility.

Senator ALLISON—So you have no interest in oral health for Indigenous people?

Ms Evans—A number of the Aboriginal medical services that were transferred across to the Health portfolio from ATSIC in the mid-nineties had dental services and we have continued to support and fund those dental services. So there are a number of medical services we fund that have dental services. That is the extent of our involvement in the provision of dental services for Indigenous people.

Senator ALLISON—So what is the annual budget for dental services for Indigenous people?

Ms Evans—There is not a specific budget because it is part of their core funding. It came across as part of their core funding and has continued in that base. In services where they had that dental service and the clinics have been rebuilt or the services upgraded, we have provided funding for the upgrading of the dental equipment as well. So it is considered part of the program, but we do not have a separate figure because it is part of their core funding.

Senator ALLISON—Are there any Commonwealth efforts going into supporting Indigenous undergraduates in dental courses or any efforts being made to recruit Indigenous people into dental health?

Ms Cass—Under our work force program we provide a series of scholarships for Aboriginal and Torres Strait Islander people undertaking health courses. They have focused to date on medicine, nursing, a range of allied health services and Aboriginal health worker courses. Dental scholarships have not been provided to date, but that principally reflects both the people who are applying and some of the key work force gaps for the services that we fund.

Senator ALLISON—So how many Indigenous dentists are we likely to see over the next few years?

Ms Cass—My understanding is that there are very few; I think there are three Indigenous dentists nationally. I cannot foreshadow what the planning is.

Senator ALLISON—How many are in training at the present time?

Ms Cass—I do not know how many are in training. We can that find out.

Senator ALLISON—Thank you. As I understand it, there were significant delays in implementing the Primary Health Care Access Program because of problems reaching agreement with the states. Can you comment on that program? Is it now up and running successfully or are there still delays with the money flowing through?

Mr Broadhead—I think it is fair to say that we have had some long discussions with our state and territory colleagues. But this year we have cut to the chase and have been successful in funding a wide range of initiatives across the country as a whole. This year we have funded from the PHCAP program increases in services and/or facilities in all states and territories. I have to say that technically we have got over that line at this stage because there has only been a very small—

Senator ALLISON—So what were the issues? What were the barriers to reaching agreement?

Mr Broadhead—I am not sure that I can give you an exact answer to that, because to some degree you would have to ask the states and territories.

Senator ALLISON—They might say the Commonwealth held them up.

Mr Broadhead—They might—it would not be the first time. We were, for example, asking them to commit to documenting their existing levels of resources and ensuring that they maintained those existing levels of resources. You can imagine that that was the subject of some discussion, as to whether or not they wanted to go to that level of detail, do it and commit at that level. That would be one example of a sticking point. There are others. I would suggest, although I do not want to be unkind to my state and territory colleagues, that in some instances it was marginal to their overall business, so they did not give a great deal of attention to what we were proposing. They were not motivated to respond quickly to what we were asking of them. As I said, I do not think I can give an exact answer as to why each state and territory took the position that it did—

Senator ALLISON—Which was the worst state?

Mr Broadhead—but in general we were struggling to get them to agree to what we wanted them to agree to.

Senator ALLISON—Which were the slower states? In which state were the biggest problems in reaching agreement?

Ms Halton—Maybe shaming is not something that we would be keen to get into. The reality is that we had different issues in every single state. To say that one was quantifiably worse than another is not a fair reflection. Mr Broadhead can disagree with me.

Mr Broadhead—No, I will not do that.

Senator ALLISON—It is a fair question.

Senator CROSSIN—In DEST they were happy to tell us who the recalcitrant states are.

Ms Halton—We could send them on a tact and diplomacy course, if you like.

Senator ALLISON—I think it is a fair question, given that this program has been delayed as a result of it. I am entitled to ask: who and why?

Mr Broadhead—Another example of where there were delays is that initially we were requiring what we call regional planning to have been completed. PHCAP was actually funded initially on a couple of different measures. The first measure in 1999 applied only to those jurisdictions which had completed their regional planning. I use the term 'jurisdiction' a little bit loosely because half of the Northern Territory made it across that requirement, but the other half did not, so it was really 2½ jurisdictions, and those were South Australia, Queensland and Central Australia. You could say, I suppose, that the others were stragglers in that sense. Those 2½ jurisdictions made the cut; the others had not completed their regional planning and therefore did not.

In the 2001 budget further funds were made available from this year—so they were voted in in the 2001 budget and became available this financial year—and that was for the remaining five jurisdictions. I say there were five jurisdictions, but it was the top half of the NT, plus the remaining states and territories, apart from South Australia and Queensland. We

were approaching those states and territories in the second round, and knowing that the funds were not available until some time after the budget measure meant that they were not necessarily rushing into our arms to do deals for money that was not yet available. Work was undertaken, but I do not have the scale to measure the reluctance or the speed of travel of a state in these respects.

Senator ALLISON—What about the funding that was not spent prior to September 2001, when I gather all of the states and territories came on board? Was that put back into the program? And when will that spent?

Mr Broadhead—There has been no money lost to this program at any stage that I am aware of.

Ms Evans—That is true—no money lost.

Mr Broadhead—It predates my involvement, but I do not believe that any money has ever been lost to the program. The money that was available in that first round rose over time to, I think, $33½ million last year. I say that carefully because we had some capital rephases from 2002-03 into 2003-04 and 2004-05, and some of the money we rephased with respect to capital projects was for capital projects funded out of PHCAP. I do not have the exact amount, but the allocation initially was $33½ million. We have never lost any funds from that allocation. It has all been allocated and spent, with the exception of the money that was rephased from 2002-03 into 2003-04 and 2004-05. It was not lost; it was just rephased in terms of when it was to be spent.

Ms Evans—There is sometimes a bit of misunderstanding. The bulk of the first round of PHCAP money went to provide ongoing resourcing for four coordinated care trial sites. They were time limited trials. A significant amount of that money went to provide ongoing funding for those four sites, so they could be ongoing services.

Mr Broadhead—I should have mentioned that the first round was for places where regional planning had been completed and for former coordinated care trials. I should have been more precise.

Senator CROSSIN—Let us stay with PHCAP. On page 209 of the PBS it says that in respect of PHCAP the government will embrace a more streamlined approach to services expansion. What does 'a more streamlined approach' mean in 2004-05?

Mr Broadhead—It means that we have been less strict in some of the requirements that we have made in terms of reaching agreements with states and territories around particular aspects of the program and we have instituted a process whereby we have funded 155 initiatives this year out of 210 proposals that came forward for services and facilities expansion. In the past we made it a condition precedent that we have a signed memorandum of understanding with the state or territory with respect to the program. We have, however, settled for agreement minister-to-minister on the principles of the program, which is underpinned also by the framework agreements which are not specific to this program but which have existed for some time. Therefore, we have proceeded with initiatives funded from the program in those jurisdictions.

Ms Halton—I will make a comment about this. Honestly, I was concerned that we were going a bit too slow over some things that could be—

Senator CROSSIN—You would not have been alone there.

Ms Halton—regarded as being bureaucratic Is and Ts when in fact there was a need to get on and do some delivery. What I think I might have said, possibly sometimes in slightly more colourful language, was that I would be keen to meet the requirements of accountability while getting on and doing some delivery.

Senator CROSSIN—How is all this different from your approach in 2003-04?

Mr Broadhead—In a sense it will not be. It is a continuation of what we have begun this year.

Senator CROSSIN—But you are talking about a more streamlined approach. What is going to be more streamlined next year in comparison to this year?

Ms Halton—I think those words basically reflect what we started doing partway through the year, so it is basically a change on the last PBS. The last PBS was essentially a reflection of what had sometimes been a slightly sluggish bureaucratic process. We have attempted to remove the blockages.

Senator CROSSIN—Are you telling me you are a bit more flexible or accommodating?

Ms Halton—As Mr Broadhead has just indicated, we have already started being more flexible and accommodating.

Mr Broadhead—To be fair, we have come clean in this PBS on the changes we have already initiated this year.

Senator CROSSIN—What actual benchmarks have been established to demonstrate the effectiveness of the streamlining?

Mr Broadhead—In the short run, our measures of effectiveness are the degree to which we are successfully funding the purpose of the program, which is increased access.

Senator CROSSIN—Would how fast you are funding it perhaps be a measure?

Ms Halton—There is a good benchmark; it is called satisfaction of the secretary.

Mr Broadhead—I have not actually taken that measure yet.

Senator CROSSIN—I am not going there! I just want to hear in perhaps the next six months that at least one Indigenous person has finally got a Panadol out of this money. I continually hear that that is not happening. Is a measure of effectiveness how fast funding is going to get out there on the ground?

Mr Broadhead—No. The measure of effectiveness, in my view, is the additional services available to Aboriginal and Torres Strait Islander people.

Ms Halton—On the ground.

Mr Broadhead—It is not simply about spending money; it is about spending money so that increased access to services is achieved.

Ms Halton—And we get deliverables.

Senator CROSSIN—How is that going to be accelerated in the next year when it has been sluggish in the last five?

Mr Broadhead—In the work we have done this year we have already provided funds for over 100 new health service delivery staff. That includes 24 additional GPs, 22 additional nurses and more than 65 additional Aboriginal health workers. We have also funded 44 capital projects to increase or upgrade facilities and so on. We have measures now of the funds that we have allocated and the additional services that we expect to achieve by having done that.

Ms Evans—The services that have expanded and are delivered on the ground has to be the benchmark. Getting money out the door is hazardous because you can get money out the door in all sorts of ways but it may not necessarily make a difference. We cannot take our eye off the ball of expanding services on the ground being our measure.

Senator CROSSIN—That is true, but surely that has been an objective—

Ms Evans—It has, that is right.

Senator CROSSIN—for six years now?

Mr Broadhead—The objective is to spend the money well.

Senator CROSSIN—We can sit around forever and talk about how that is going to happen. At some stage, someone has to write a cheque and bank it.

Mr Broadhead—We are doing it. We are not sitting around and talking; we are doing it.

Senator CROSSIN—Can you provide me with a disaggregation of the PHCAP funding for 2004-05 by state and territory?

Mr Broadhead—Yes.

Ms Evans—For 2004-05? Not yet.

Mr Broadhead—Not right here and now, but we can take it on notice—

Ms Evans—No, we are working on that at the moment. We will take it on notice.

Mr Broadhead—and provide you with a breakdown of what will have been funded that was not previously there, if you like.

Senator CROSSIN—All right.

Ms Evans—Let me clarify that: you are asking for next year—2004-05—for the new growth money, aren't you?

Senator CROSSIN—Yes.

Ms Evans—We are actually still working on that, but when it is done we will provide it to you.

Senator CROSSIN—Has all or any of the unspent PHCAP funding been rephased to 2004-05 in future years?

Ms Evans—We expect that all funds will be committed. Some will need to be rephased because some of it is in capital, and capital, as you know, spreads out over two, three or sometimes even four years, so some of it will be rephased. But it is our understanding and intention that it will be all committed.

Senator CROSSIN—Will there be any unspent PHCAP funds, come 30 June?

Ms Evans—That is not our intention, no.

Mr Broadhead—No.

Senator CROSSIN—Is that a categorical no? Will they all be spent on 30 June?

Ms Evans—Yes.

Mr Broadhead—It is in the future, so I do not know how categorical we can be, but it is certainly our intention.

Ms Evans—I guess the reason that—

Senator CROSSIN—You are not expecting that there will be an underspend of PHCAP funds?

Ms Evans—No, I am not. The reason I am hesitating is that, as you know, when you have large sums of money and you have accrual accounting, you are never quite sure that there is not something around the margins that did not actually get locked in, so that is why I am being very cautious.

Ms Halton—If we come back next time and we have $10,000 sitting there, we would not want you to castigate the officers because accrual accounting caught them out.

Senator CROSSIN—It will be all right; we will be sitting with you next time we are back here. Is any rephasing represented in the additional $40 million allocation shown on page 217 of the PBS?

Ms Evans—No, that is new money.

Ms Halton—No, it is all new.

Senator CROSSIN—On page 38 of the PBS is 20 per cent of the additional $10 million in PHCAP expenditure for 2004-05.

Ms Evans—Is this page 38, outcome 7?

Senator CROSSIN—Yes. Is that to be expended on departmental expenses? Is that correct?

Ms Evans—Yes. The $2 million is for departmental expenses.

Senator CROSSIN—It is $10 million, isn't it?

Ms Evans—It is $10 million, but it is made up of $2 million departmental and $8 million administered.

Senator CROSSIN—Administered is the program—

Ms Evans—It administers program money that goes—

Ms Halton—That is the panadol.

Senator CROSSIN—Yes. So $2 million is actually allocated in departmental expenditure?

Ms Evans—Yes.

Senator CROSSIN—That is the explanation for that. Do you have an update of the table of expenditures on PHCAP by state and territory for 2003-04? I think last year you gave me the anticipated expenditure. I am just wondering if you now have a reconciliation of that.

Mr Broadhead—We do. I have been having a look at it and I am not sure how easily understood it will be, because it itemises at a very low level—

Senator CROSSIN—What does that mean?

Mr Broadhead—and just has entries like 'capital' and 'new services'. We do have an update of that table which I can provide you with now, if you like.

Senator CROSSIN—Does that table also have the estimate and the actual in it?

Ms Evans—We will not have the actual until the end of the financial year.

Mr Broadhead—No, it does not have the actual because the year is not complete.

Ms Evans—We can certainly undertake to provide that to you but, if you want the estimated and the actual, you will need to wait until after the end of the financial year, when we have the wash-up of that.

Senator CROSSIN—All right, we can do that. What is the total allocation this financial year for PHCAP?

Mr Broadhead—Independent of any rephases, it is $54.7 million in total. I say independent of rephases because, as I said, you could regard some of what we have rephrased from 2002-03 into 2003-04 and 2004-05 for capital as being PHCAP. But, keeping it simple, it is $54.7 million.

Senator CROSSIN—What is the forward estimate for 2005-06?

Mr Broadhead—The figure I have before me is $59.2 million for 2005-06, but I am wondering whether that includes the budget measure.

Ms Evans—Can we take that one on notice just to make sure we give you the right figures?

Senator CROSSIN—Yes. Was there an imperative driven by the Commonwealth to ensure that all allocated PHCAP funds were expended by the end of this financial year?

Ms Evans—It is always our intention to make sure that all funds we have are expended.

Senator CROSSIN—Has the demand to expend funds overridden any existing consultative processes?

Mr Broadhead—No. I presume your question relates to the streamlined approach that we have taken to allocating PHCAP funds?

Senator CROSSIN—It is perhaps mixed up in people's perceptions that that is what is happening.

Mr Broadhead—One of the things that we do in terms of our allocations is consult with what we call forums, or partnerships—the name varies from state to state or territory to territory. We have forums and/or partnerships in every state and territory and, in fact, two in Queensland, for reasons I will come back to.

Senator CROSSIN—Have you funded some of those initiatives without consulting those forums?

Mr Broadhead—No.

Senator CROSSIN—Why would there be a perception that existing consultative processes have been overridden?

Mr Broadhead—I do not know what is in people's minds when they say 'existing consultative processes'. There may be things that people felt were desirable which we have not proceeded with, but, in terms of our commitments to consultation through framework agreements we have put all the proposals through. Indeed, in some cases that have been approved, some of the proposals that came to us were generated by members of those forums. They took a lead role in generating some of those. So we have taken things through the forums. I suspect another possible source of the comment may be that, in some instances, we did not necessarily do exactly as the forum wanted us to do or as a particular member of the forum wanted us to do. There may be some tension arising from the fact that, while we consulted forums, we did not always act absolutely in accord with the particular preferences of one or other member. They may be regarding that as a breach of consultation, but I do not believe that is the case.

Senator CROSSIN—Have there been other years where there have been unspent funds?

Ms Evans—No, we have never had unspent funds.

Senator CROSSIN—If you had unspent funds would they be rolled over, or returned to consolidated revenue?

Ms Evans—It would depend on our negotiations with the Department of Finance and Administration. If that had been the case, we would have attempted to negotiate a rollover, and the decision about rollovers rests with the Minister for Finance and Administration.

Senator CROSSIN—So you are telling me that there were no unspent funds in 2003 from PHCAP?

Ms Evans—That is correct. There were some rollovers, but that is to do with capital. You might recall that we discussed last time that there has been a change in the accounting procedures. My colleague Ms McDonald is the authority on this. Previously, once there was a contract to build, that money was then allocated there and did not appear on our bottom line. With the change in accounting requirements, we have to show it all under the appropriations. As you know, these projects are often over two or three years and therefore only the money expensed in that financial year can show and we have to actually technically rollover the remaining capital. So you will see some changes, but that is to do with capital.

Senator CROSSIN—So if staff housing, clinic renovations or IT are on the books to be done and they are not quite done by the end of the financial year, you just roll the money over?

Ms Evans—Yes.

Senator CROSSIN—So you do not bring that money forward and allocate it to design? You do not say to them, 'You were going to have your clinic renovated and it was going to be

$2 million, but here's the end of the year, it hasn't quite happened, but you can have your $2 million anyway'?

Ms Evans—No, our capital works program is managed by Ove Arup. We do not hand the capital money up front to an organisation—that is correct.

Ms Halton—It is contrary to Finance rules.

Senator CROSSIN—Who did you say your capital works program was managed by?

Ms Evans—Ove Arup.

Mr Broadhead—They are our program manager, so we contract with Ove Arup to oversee the implementation of our capital program.

Senator CROSSIN—How do they allocate the funds? Do they drip-feed them or do they pay out on completion of projects? How does that happen?

Mr Broadhead—The funds are drawn down on the basis of milestones. Depending on the project, there will be a number of milestones through it and as those milestones are met, stages of construction for example, then payments will be made. There will also be a period after construction is completed when there is a defects period. In some instances, there may be some payments that rely on completion of the defects period. The central answer is that it is related to project milestones and the money is drawn down as those milestones are completed.

Senator CROSSIN—There has been a claim that, as of December last year, PHCAP was a long way from realising its aims of improving primary health care where it is most needed. What is your response to that?

Ms Evans—The aims of PHCAP are essentially to strengthen primary health care services for Aboriginal people on the ground and to do that in a collaborative way. We are working collaboratively with states and territories and with the community control sector. It is a long-term project and, while there have been unavoidable delays, there has also been a lot of progress. It was never going to happen overnight. There was a review of the Aboriginal health program carried out last year by Associate Professor Judith Dwyer. Her conclusion was that the approach and frameworks that we had in place and the progress we had made was good. We have got a way to go, but she felt that we were well on the way.

Senator CROSSIN—Where is the rollout of PHCAP up to?

Ms Evans—That is not a simple question to answer.

Senator CROSSIN—How many zones are there around the country?

Mr Broadhead—Off the top of my head I could not tell you how many zones there are.

Senator CROSSIN—We have 21 in the Northern Territory—is that correct?

Mr Broadhead—Yes.

Senator CROSSIN—How many of those zones would you say are rolled out then around the country? Are any of them fully rolled out at this stage?

Ms Evans—We will have to take that on notice.

Mr Broadhead—There is an issue that if you divide the entire country up into a series of zones, the funds that we have available would not provide funding in all those zones to the same level. It is a simply a fact of the level of the appropriation.

Senator CROSSIN—I am not asking about funding to the zones. I am asking whether there are any zones that are fully operational at this stage.

Mr Broadhead—I would have to say that we have not done the calculation going back to see, as an outcome of the things that we have funded recently in a full year, what that would bring zones up to. We did, as part of the funding, ensure that we did not exceed the intended allocation, so that was one of the things we considered in funding proposals. We could come back to you and give you a figure.

Ms Halton—Let us actually do the quantification of that rather than give you our perception. I do think it is worth underscoring though what Ms Evans just said. Because everyone wanted to know whether we were actually achieving anything with PHCAP and the roll-out et cetera, the review was a very—

Senator CROSSIN—Who commissioned that review?

Ms Halton—The Australian government, but it was commissioned through the department.

Senator CROSSIN—Who conducted it?

Ms Halton—Associate Professor Judith Dwyer.

Senator CROSSIN—Was it an independent assessment?

Ms Halton—Yes.

Senator CROSSIN—Did she win the contract to review it through a tender process or was she asked by the government to do that?

Ms Evans—No, it was done through a tender process.

Senator CROSSIN—Was she just commissioned to do it?

Ms Evans—Yes.

Ms Halton—That review will be released so you will be able to read it and make your own assessment. I think our view is that PHCAP has made a quantifiable difference in a number of areas. We would think that in due course the roll-out of PHCAP will continue and build on the changes and the improvements which Professor Dwyer documents in her review. We will very happily go back and do the statistical analysis we were just talking about.

Senator CROSSIN—When are you planning to release that evaluation.

Ms Evans—It is currently being prepared for publication at the moment. Professor Dwyer's report plus six consultancies that fed into that report are all being prepared for publication. The most recent information I have is that we hope it will be actually printed and available by the beginning of July.

Senator CROSSIN—Tell me about the six consultancies.

Ms Evans—I might ask Mary McDonald to answer that—she managed this and she has those at her fingertips. I would like to say also that there is a perception being developed in the community that we have PHCAP and we have the rest of the Aboriginal health program—actually it is the whole Indigenous health program that we run with all the components that we are really working on in terms of strengthening Aboriginal and Torres Strait Islander people's access to health services.

Ms McDonald—The review that was conducted for the government had Associate Professor Judith Dwyer from La Trobe University pulling together the main review document, but her work was informed by six other consultancies as well as the use of the department's program material. She also used material from a whole range of reviews, evaluations and parliamentary inquiries that have been held over the last eight years or so. So it was a fairly substantial piece of work. Out of the other six consultancies, two of them were economic consultancies and one of them was a cost-effectiveness model looking at primary health care and the impacts that primary health care has both on overall system costs as well as on people's wellbeing, measured in terms of disability adjusted life years.

Senator CROSSIN—Who did that and how much did it cost?

Ms McDonald—I would have to take the cost on notice. It was undertaken by an economics unit in the Northern Territory Department of Health and Community Services in conjunction with Carol Beaver, who was working for the World Health Organisation and doing similar work in the Pacific.

Senator CROSSIN—Perhaps you could provide me with a list of the consultancies, what they did and the cost of them?

Ms Evans—Yes.

Ms McDonald—Yes.

Senator CROSSIN—So what was the total cost of conducting this review?

Ms Evans—We will provide that with the information on the consultancies.

Senator CROSSIN—You do not have that with you?

Ms Evans—No.

Senator CROSSIN—Did the costs come out of the PHCAP funds?

Ms Evans—The cost came out of program funds, yes.

Senator CROSSIN—But did it come out of the PHCAP allocation?

Ms Evans—We actually have one appropriation and it came out of the program appropriation.

Senator CROSSIN—Is PHCAP not a distinct and separate program?

Ms Evans—It is part of the overall program, and in fact we have a single line appropriation.

Ms McDonald—There are two parts of the PHCAP allocation. The major part of it is a services component, and that is the part that we have been talking about: services on the ground.

Senator CROSSIN—Where do I find those figures or that split in the PBS then?

Ms McDonald—I am not sure if they are separately distinguished in the PBS. There is a separate part which is called national infrastructure which used to be separated out. A small component is put into that. That is for work force measures such as scholarships and training programs. It is for things that are not necessarily direct service delivery but improve the quality.

Senator CROSSIN—I am assuming that those are not part of the PHCAP funding though—work force services, scholarships et cetera?

Ms McDonald—They were part of the original budget measure.

Senator CROSSIN—Of the PHCAP budget measure?

Ms Evans—Yes.

Senator CROSSIN—What about this allocation though?

Ms Evans—Yes, also. The funding has always had a direct service funding component and a component that underpins it. You cannot run services without a work force; you need the data and the planning and a focus on a particular target: a health strategy such as for child and maternal health programs or chronic disease—the sorts of initiatives we were talking about earlier.

Senator CROSSIN—I refer to page 38 and to, under 'Aboriginal and Torres Strait Islander Health', the administrative amount of $8 million. Are you saying that includes PHCAP and a range of other programs as well?

Ms Evans—Yes, it includes service delivery and work force and data. It always has.

Senator CROSSIN—Okay. You have given me a quote of around $52 million for PHCAP for the coming year but I do not specifically see this in the PBS as a line item for PHCAP. Is that correct?

Ms Evans—That is right.

Mr Broadhead—We do not get a breakdown of our appropriation. Our appropriation is one line. This measure is essentially one line, although it identifies the departmental versus the administered, and within the administered there is no breakdown given.

Senator CROSSIN—So there is no discrete, separate, program labelled the Primary Health Care Access Program?

Mr Broadhead—In terms of our appropriation, no. In terms of the way we manage what we do, yes.

Senator CROSSIN—So the money for these consultancies and the review came out of which area?

Mr Broadhead—It came out of our overall appropriation.

Senator CROSSIN—It came out of outcome 7's appropriation?

Mr Broadhead—Yes, it came out of outcome 7's overall appropriation.

Senator CROSSIN—I will be interested to see the cost of it. Your budget papers, at page 28, indicate that 0.8 per cent of the health budget will be spent on Indigenous health—is that correct?

Mr Broadhead—Are you talking about the outcome 7 proportion?

Senator CROSSIN—Yes.

Ms Halton—Remember, Senator—and this follows from the conversation we had earlier on—that, while this is outcome 7, it does not include the moneys in, for example, aged care or population health—

Mr Broadhead—Or in MBS and PBS.

Ms Halton—Yes, exactly, program 2—and I could go on. So it is just the money allocated to this particular program.

Senator CROSSIN—So with outcome 7, that 0.8 per cent would include the money for PHCAP—is that correct?

Ms Halton—Yes.

Senator CROSSIN—Can you tell me if that is an increase or a decrease from previous years?

Ms Halton—As a proportion of the portfolio?

Senator CROSSIN—Yes.

Ms Halton—Or of the amount?

Senator CROSSIN—Yes.

Ms Halton—The amount has increased.

Senator CROSSIN—No, the proportion.

Mr Broadhead—I could not tell you year on year but overall, given that the specific programs for Aboriginal and Torres Strait Islander health have doubled and the portfolio itself, to my knowledge, has not doubled, outcome 7 would be increasing faster.

Senator CROSSIN—Perhaps you might take it on notice.

Ms Halton—Yes, we will take it on notice. My expectation is that outcome 7, in conjunction with a number of the other outcomes, will have declined as a proportion of the overall portfolio because of the significant investment in two things: the moneys going into strengthening the Medicare program and also the significant injection in relation to medical indemnity. In terms of the relative balance across the portfolio, you will find that the balance of outcome 2 will have increased as a proportion. I do not have last year's PBS, but I would put serious money on it. So the issue is about those other outcomes and their relative share because of the significant—and it has been a very significant—injection in outcome 2.

Senator CROSSIN—I understand that on 25 February this year the minister announced that a number of areas would receive a one-off injection of new funds. I am assuming that is correct. The announcement is labelled 'More money for Indigenous health' and mentions '$4 million in extra funding to employ new health care workers and buy equipment for

Indigenous health clinics'. Do you have a comprehensive list of those areas and how much each received?

Mr Broadhead—Yes. We could give that to you but we would have to take it on notice to do it.

Senator CROSSIN—You didn't bring it with you?

Mr Broadhead—No.

Senator CROSSIN—How much is it altogether? Is $4 million right?

Mr Broadhead—I am not certain of the document to which you are referring, so I cannot comment.

Senator CROSSIN—I am talking about a press release of 25 February.

Mr Broadhead—I do not have that document in front of me, so I would be cautious about confirming that.

Senator CROSSIN—Was that new money—money that I will find in this PBS?

Mr Broadhead—That would have been from our existing appropriation for this year. It would have been money that was in our appropriation and then had been allocated out to specific initiatives. So the announcement would have been about the allocation of money from our appropriation to particular initiatives.

Senator CROSSIN—Has that money been distributed?

Mr Broadhead—Again, without knowing the precise document and the particular initiatives, I would be cautious, but I would imagine so.

Senator CROSSIN—If the attachment I have got to it is correct, it allocates specific amounts to different Aboriginal medical services.

Mr Broadhead—Yes.

Senator CROSSIN—So they would have been appropriated?

Mr Broadhead—Again, as part of providing the detail that you have requested, we could also confirm that the money had arrived with the services.

Senator CROSSIN—Can you tell me on what basis each of these areas was provided with this one-off funding? Did they apply for these funds? Did someone make an assessment that Amoonguna, for example, needed $6,094? How was that amount arrived at and the AMSs identified?

Mr Broadhead—Again, I would be happy to explain that as part of the answer we provide. I would be certain that there was an assessment underpinning the figures and the allocation of the funds, but I cannot—

Senator CROSSIN—Perhaps you might want to get your hands on a press release over dinner time and have a look at it. I am interested to know how these AMSs were identified and how the amounts were identified.

CHAIR—What press release are you referring to?

Senator CROSSIN—25 February. Would it be easier if I just gave you a copy of it?

CHAIR—I think it would be easier. Give them a copy and then we can see whether an answer is available.

Senator CROSSIN—I do not mind doing your estimates work for you!

Ms Halton—We may actually have to consult the files. We may not be able to go to Woden in the dinner break, I am sorry. Can I just make one comment in relation to the PBS. I am pleased to report that I am wrong in terms of the very small components of this. In fact, outcome 7 has not moved. As you would appreciate, there would be rounding here, but as a proportion of the portfolio, it actually does not change. There are shifts at the margin and there are other bits and pieces in terms of where the budget measures fell.

Senator CROSSIN—So it is still point 0.8 per cent?

Ms Halton—Yes.

Senator CROSSIN—It was 0.8 per cent in last year's PBS.

Ms Halton—But some of the other components have moved around a bit, as you would anticipate.

Mr Broadhead—We have identified the source of this. We will get you an answer. As you suggest, if we are still here after dinner, we will provide it then.

Senator CROSSIN—After dinner perhaps. I do not think I am going to get through all this before dinner. I have quite a few questions on Indigenous health, but I think I will do those later as a block lot maybe. Turning to the COAG trials in the APY lands, I understand that this department is the lead agency in the APY lands. Is that right?

Ms Halton—That is correct.

Senator CROSSIN—That is identified on pages 210 and 211 of the PBS?

Ms Halton—Yes.

Senator CROSSIN—How long has the department been the lead agency for this trial?

Ms Halton—For as long as the trials have been in place.

Senator CROSSIN—How long has that been?

Ms Halton—About a year and a half. I would have to go back and get the precise date on which we actually reached in broad terms an agreement with the South Australian government, but it is of that order. It might be slightly closer to two years than a year and a half.

Senator CROSSIN—What date was the shared responsibility agreement signed?

Ms Halton—There is a draft of the shared responsibility agreement at the moment. It has been discussed and negotiated. We have signed it. The South Australian government has signed it. My understanding is that has not been signed by AP—when I last heard.

Senator CROSSIN—Are we able to get a copy of the draft?

Ms Halton—Yes. It is pretty widely available. I would be happy to provide you with a copy.

Senator CROSSIN—I understand you do not put drafts on the web site?

Ms Halton—No.

Senator CROSSIN—You just put signed ones up there when they are done?

Ms Halton—Yes.

Senator CROSSIN—Who were the partners to this agreement—the South Australia government, that Commonwealth and—

Ms Halton—ATSIC. The relevant commissioner was party to the agreement. This was obviously drafted previously.

Senator CROSSIN—If it is not signed after 1 July who will then sign it?

Ms Halton—That is a question that I do not have an answer to yet. It depends on what happens with the legislation but, as you would understand, there is a proposal that the elected regional structures would remain for a period. If that is the case then the partnership with that elected structure could continue for a period.

Senator CROSSIN—So would you just get the chair of the regional council to sign the document?

Ms Halton—Depending on what the timing of the signing and the timing of the legislation might be. We have not had that conversation with AP. You would probably be well aware that ongoing negotiation with AP is being conducted by former senator Mr Bob Collins in relation to a series of issues, and that process has to get a little further down the track prior to us revisiting the shared responsibility agreement.

Senator CROSSIN—ATSIC is the third partner. Is there any other organisation or partner to sign the agreement?

Ms Halton—There is a fourth. There are four parties.

Senator CROSSIN—Who is the other one?

Ms Halton—They are AP, the Commonwealth, the state and ATSIC.

Senator CROSSIN—The APY congress?

Ms Halton—Yes, the executive.

Senator CROSSIN—If this department is the lead agency, what role does that mean for you, as the secretary? For example, do you take particular matters concerning the APY lands to meetings of the secretaries group?

Ms Halton—Correct. It is probably important to understand that there has been a group of secretaries who have a responsibility for one of the trial sites. They have met every month for about the last 18 months; I can get you the details. Each of those secretaries has been nominated as the lead secretary and therefore takes a particular interest in a particular trial site. But that secretaries group has been discussing, more broadly, issues around how you improve the contribution all government programs make in improving outcomes for Indigenous peoples.

Senator CROSSIN—When was the secretaries group formed?

Ms Halton—I would have to take that on notice, but it was about 18 months ago.

Senator CROSSIN—Did you say that they meet monthly?

Ms Halton—They meet monthly. The meetings are chaired by the secretary of DIMIA, Bill Farmer. That group has had both a micro-agenda, which is looking at those particular trial sites, and a macro-agenda, which has been discussing some of the impediments to improving outcomes.

Senator CROSSIN—Even if it is education or Centrelink delivery?

Ms Halton—Absolutely. You are precisely right.

Senator CROSSIN—Can you tell me what dates the secretaries group has met?

Ms Halton—We would have to go back and check our records but, with the possible exception of Christmas, it has met monthly.

Senator CROSSIN—What happened at Christmas? Why didn't you meet then?

Ms Halton—I think we might have been eating turkey and plum pudding.

Ms Evans—It meets on the first Tuesday of the month.

Senator CROSSIN—Have you attended all the meetings of the secretaries group?

Ms Halton—I would not want to swear to you that I have been to every single one.

Senator CROSSIN—If you do not go, does someone go in your place?

Ms Halton—Sometimes; not necessarily. If I have missed any it would be maybe one or two. I have chaired it in the past when Bill Farmer has been unavailable.

Senator CROSSIN—Have you made a visit to the site?

Ms Halton—Several times.

Senator CROSSIN—I think you have covered what the lead agency does. How is the trial going, and what outcomes do you think can be attributed to the trial?

Ms Halton—I think it is acknowledged that the APY site is possibly the most difficult site in the country and, as a student of these issues, I am sure that you are aware there have been some significant governance issues in relation to the APY. You are also no doubt aware that the South Australian government has asked Bob Collins to undertake a particular role in relation to governance and a whole series of other issues in the lands. We have been working quite closely with Bob Collins in that regard. It is probably useful to talk about the project at two levels, one of which is the work we have done talking to people on the ground in individual communities about their priorities and aspirations and the other is a kind of higher governance level. If I talk at the lower level for a second I think it is probably easier to disentangle some of the broader politics. At the lower level there are a number of things that the community identified as priorities, one of which is getting the stores project up and running. Another one is in relation to—

Senator CROSSIN—Stores project?

Ms Halton—You understand the issues around nutrition in communities, which obviously go not just to health but to obesity and a series of other things.

Senator CROSSIN—Have you had a look at what Woolworths have done at Beswick?

Ms Halton—Yes, we are very aware of that. In fact I visited Beswick not long before that started and we are in contact with people from the Fred Hollows Foundation, so we are very familiar with it. This is an approach in terms of looking at the relationship between local employment, purchasing, nutrition—the whole package—and it is an initiative that has been developed and driven by people in the communities with the assistance, in this particular case, of a couple of key workers in Nganampa Health. They identified that is being a real priority. Funding has been provided for the project and in the long run you would be hopeful that we might be able to do something similar to what is happening with Woolworths. I think the reality is that this is probably more remote than Beswick and probably a little bit more difficult. But I think there is some progress we can look to there.

Similarly, we have helped the community come up with a series of funding propositions in relation to the rural transaction centre. You are very familiar, I know, with issues around people not paying their fines and the car registrations and all consequences that come from that and their being arrested et cetera. Again, this was a priority for the community. We have worked with them on getting proposals to put in place a RTC which would encompass a series of functions and include Centrelink, and those propositions are currently awaiting consideration. We are hopeful that they will receive good consideration. There are a number of other things in the offing and I think, mindful of the conversation we had earlier about not making ministerial announcements, it would possibly be impolitic of me to explain to you what some of those are because I think certain ministers think they might be making announcements, if you understand my constraint.

Senator CROSSIN—You can tell us the date, if you like. It is a good try, isn't it? I thought that after eight days, we might—

Ms Halton—It is a good try. We have been working at that kind of micro level. Then there are the issues which have been extensively covered in the press around governance, elections, functionality or otherwise of some of the institutions in the lands, and that is something which we have been discussing with our colleagues in Premier and Cabinet in South Australia. I have to say we were pleased when the South Australian government chose to appoint somebody to deal with those issues and I was particularly pleased when they appointed Bob Collins, whom we are working with very closely. He is doing an excellent job. I have to say that I go to meetings with secretaries, and their trial sites—

Senator CROSSIN—Are easier?

Ms Halton—Yes.

Senator CROSSIN—But Port Keats comes a close second to yours, I would say.

Ms Halton—I reckon that is easier, I have got to tell you. If Bob Collins does as I think and hope he will then we will be in there competing with Port Keats not to be bottom.

Senator CROSSIN—Your first dot point on page 210 talks about five regional reform priorities. Can you very quickly tell me what they are?

Ms Cass—The five priorities relate to, first, improving health and wellbeing; second, improving education attainment, training and employment opportunities; third, improving access to social and community services; fourth, improving physical infrastructure, such as

essential services, roads and housing on the lands; and, fifth, strengthening regional governance structures.

Senator CROSSIN—Is the regional stores policy you have mentioned actually a health and ageing policy?

Ms Halton—It is not our policy; it is actually a program.

Senator CROSSIN—Is it something you are developing with them?

Ms Halton—No, they developed it. It is called Mai Wiru. It is a policy developed by people on the lands.

Senator CROSSIN—Can the committee be provided with a copy of that?

Ms Halton—Absolutely. It is actually a terrific piece of work.

Senator CROSSIN—Is there a time line for the implementation of that?

Ms Cass—Yes. It is being implemented over the next three years.

Ms Halton—We can give you all of that.

Senator CROSSIN—Are the eight communities involved the eight communities in the Pit lands?

Ms Halton—Yes.

Senator CROSSIN—What role do you play in each of the other trial sites?

Ms Halton—Guidance, counselling and moral support of colleagues would be to trivialise it. For example, in Port Keats—and Mark Sullivan is the sponsor in that case—my officers in the Northern Territory, in the Darwin office, are working very closely with the FaCS people at that site. Understand that this is about recognising that the traditional stovepipes around government and government programs do not necessarily get the best outcomes, particularly in small communities.

Senator CROSSIN—If they have got particular problems in health, can they come straight to you?

Ms Halton—Yes.

Senator CROSSIN—So they get sorted out at a peak level quickly?

Ms Halton—The whole point about this is trying to sort things out quickly. Firstly, there is a very clear instruction to officers right down through our departments that we have to find different ways of doing things. That means being creative, being flexible and not putting up bureaucratic barriers. They are tasked to basically sort it. If they cannot sort it then it comes up the line. The point about this is not having things drag. Again, you know well that very often what happens is that a good idea which somebody in a regional office has come up with basically gets blocked and stuck for years. The whole point about this is ventilating and exposing those notions, those ideas, quickly and, if necessary, bringing them in front of the secretaries group for us to basically knock heads or sort out whatever that might be. It is a constructive forum. It is about finding solutions to problems, particularly in a partnership way—trying to find things that will generate better outcomes.

Senator CROSSIN—Is the Aboriginal child health study something that is yours?

Ms Cass—The Western Australian one is, yes.

Senator CROSSIN—The first volume of findings was launched today. If I am correct there was an article in the *Australian* newspaper this morning which read a summary of its findings. Is that correct?

Ms Evans—Yes.

Senator CROSSIN—They are not particularly good outcomes—would you agree with that? The findings are not particularly glowing, are they?

Ms Evans—No, they are not very positive.

Senator CROSSIN—Can you tell me how you supported the project?

Ms Cass—Yes, I can. Our department coordinated the Commonwealth level contribution to stage 1 of the Western Australian Aboriginal child health survey. Overall Australian government agencies contributed $1.685 million to actually conducting the survey, and we are playing the same role in relation to stage 2, which is the production of the reports and dissemination of results. We have contributed, as a department, over $1 million over three years to this second phase.

Senator CROSSIN—Have you had a chance to look at the summary of the findings today?

Ms Cass—We had it embargoed—

Senator CROSSIN—I see. You have had more than today to look at it.

Ms Cass—for a short amount of time one day.

Senator CROSSIN—What are some of your reactions to this summary? Do you believe the report will inform your work and the department's work in coming months?

Ms Savage—This has been a most comprehensive survey and it certainly will contribute significantly to the work of the office in the next little while with regard to child and maternal health. We obviously have a number of areas to look at and there is obviously room for improvement. This will help to inform that work.

Ms Evans—We have been in no doubt that this will give us more detail and a better handle on both the fact that investment in antenatal care and care for mothers and babies in the first couple of years is essential for making a difference in the long-term health of people, because the impact on unborn children carries through into life, and the gains that can be made in targeted programs for mothers and babies. This study certainly gives us some good information on that.

Senator CROSSIN—I do not have any more detailed questions about it because I have not quite had the time to read it like you have. I promise you that if I am on this side of the table in November we will spend a couple of hours looking at it. I want to go to the implications of the abolition of ATSIC and ATSIS. On page 211, the PBS says:

The Department will also work with other agencies to ensure the successful implementation of the changed arrangements following the abolition of ATSIC and ATSIS.

My understanding is that the budget papers provide for the abolition of ATSIS and the complete defunding of ATSIC. Would that be correct?

Ms Halton—We cannot comment about other people's PBSs and budget papers.

Senator CROSSIN—No, but do your budget papers provide for the abolition of ATSIS?

Ms Halton—Our budget papers do not anticipate the machinery of government issues that may or may not flow.

Senator CROSSIN—So any allocation that might be coming to you from 1 July—

Ms Halton—It is not reflected here.

Senator CROSSIN—It is not reflected in the PBS as yet?

Ms Halton—No. As I understand it—this might have changed in the last 24 hours, which I doubt, because the Prime Minister is out of the county, but it is conceivable that the Acting Prime Minister could have done some of this—the machinery of government changes which program goes where. This has been the subject of extensive conversation and has not been finalised yet.

Senator CROSSIN—What do the proposed arrangements mean for the operation of your department?

Ms Halton—I guess we are a little different—everyone probably agrees with that—to other portfolios because we have had a responsibility for a significant program of services delivered to Aboriginal and Torres Strait Islander people for a good number of years. We already have the bit of government, if I can describe it that way, that is relevant. I am anticipating that there may be a few programs which ATSIS administered that may be a good fit with our portfolio but we are not like some of the other portfolios where a good chunk of ATSIS business is aligned with their core business. It is not something that they currently do. We have been participating in all of the discussions about machinery of government.

A letter will go to staff in ATSIS. All the secretaries are concerned that staff understand that secretaries are very supportive of them and the work that they do, that we are going to try to make their transition as seamless as is possible and that they will get a great deal of support in that kind of transition. For example, we have our own Indigenous network in the department, and staff have come across to us. It is my intention to ask the Indigenous network to provide support to those staff as well. But in terms of things that we might receive, we will be at the very small end of a much larger equation, simply because we already have the responsibilities that we do.

Senator CROSSIN—The department has had full responsibility for Indigenous health for a number of decades, hasn't it? It is 19 years, I think.

Ms Halton—No, since 1995.

Senator CROSSIN—I thought it might have been 1985.

Ms Halton—No.

Senator CROSSIN—I want to take you to the latest *Social justice report*, by Dr William Jonas. It talks about the fact that life expectancy for Indigenous women has declined since

1996. The life expectancy gap between Indigenous and non-Indigenous men and women has grown in the same period. Has your department ever looked at why that is the case?

Ms Halton—There is a short and a long answer to that question. The reality is that life expectancy is something we worry about, because it is a reflection of a series of things. One of those things goes directly to health services but I think many other things come from other parts of life, and government therefore. Do we spend significant resources doing demographic analyses of these questions? The answer is no, because the facts stand on their own and we do no need to analyse them a lot. Are we doing things in the way we operate that we believe will have a material impact on longevity for Indigenous peoples? Yes. Do we expect that what we do on its own will impact on longevity? No. I am on the record in a number of places as saying that health and health services are a necessary but not sufficient condition in this respect.

One of the great things about the report that we reflected on earlier, the Dwyer report, is that it does show us the benefit of some of these investments that we are making and how they flow into improvements in a disability-free life et cetera. But in terms of the things that contribute to earlier death, many of those antecedents are laid in childhood. The report, which has come out today, puts into the public arena the work that Professor Fiona Stanley and her colleagues have been doing and it shows quite clearly that there are multiple factors at play here. So, yes, it is something we are aware of and, yes, we worry about it, but we are trying to deal with the health side of how we tackle those issues.

Senator CROSSIN—I want to ask you about some of the funding issues in the PBS. I refer to pages 221 to 222. Table C7.2 provides for Aboriginal and Torres Strait Islander health, as you can see, a figure of $281.183 million. Is that correct?

Ms Evans—For next financial year, yes.

Senator CROSSIN—And this amount includes the funds for PHCAP. Is that right?

Ms Evans—It does, yes.

Senator CROSSIN—In a document that was produced by DIMIA that outlined expenditure on health services in Indigenous communities in PHCAP, the amount given was $293.956 million. Can you explain the difference for me?

Mr Broadhead—I am unaware of where that figure comes from, so I do not know what it is based on.

Senator CROSSIN—It comes from a document entitled *Budget 2004*, produced by the Minister for Immigration and Multicultural and Indigenous Affairs. This page is headed 'Identifiable Commonwealth Indigenous Expenditure'.

Ms Halton—Does it include departmental appropriation?

Senator CROSSIN—It just says, 'Health services in Aboriginal and Torres Strait Islander Communities' and 'Aboriginal and Torres Strait Islander Primary Health Care Access Programme' The two figures together add up to $293.956 million.

Ms Evans—Can we take that on notice and have a look at it? I suggest it probably is our total administered appropriation plus departmental appropriation, but we would need to look at it.

Senator CROSSIN—Okay. What is the total departmental appropriation then? That should be pretty easy to work out. It should be around $12 million if that is the case.

Mr Broadhead—If you turn to page 219 of the PBS, you will see where it talks about departmental appropriations. The figure given there is $24.160 million, which gives you a tally that is higher than the one that has been mentioned.

Ms Evans—Can we take that on notice?

Senator CROSSIN—Yes, but is that the total department?

Mr Broadhead—No. That is the departmental money that is allocated to output 7. Administered appropriation is $281-odd million and the departmental appropriation is $24.160 million for a total of $305,343,000, as you will see at the bottom.

Senator CROSSIN—Where would this $293.956 million have come from?

Mr Broadhead—Without the opportunity to study the document and try and determine on what it is based, I could not venture an opinion.

Ms Halton—They have to ask DIMIA. It is not our document, so it is a little hard. We will have a look over dinner.

Senator CROSSIN—Don't you provide them with these figures?

Ms Halton—We provide them with our figures.

Senator CROSSIN—Why wouldn't they have used you figures?

Mr Broadhead—We would need to have a look at the document and try and determine on what it was based in order to make an informed comment.

Senator CROSSIN—Can you take on notice for me why there is an apparent discrepancy?

Ms Halton—We shall.

Senator CROSSIN—It may well be according to you, Mr Broadhead, that they might have underestimated what you are spending in Indigenous health.

Mr Broadhead—I do not think I said that.

Proceedings suspended from 6.28 p.m. to 7.33 p.m.

Senator CROSSIN—I will take you again to pages 221 and 222 of the PBS. There are 18 performance measures identified on table C7.2, and I have questions about some of those. Do each of the measures have a particular budget allocation?

Ms Evans—No. As you know, we have a single-line appropriation, so each measure does not have a budget allocation identified to it.

Senator CROSSIN—In the first one, where you have at least 152 organisations providing or purchasing primary health care, I am assuming there is no allocation against each of those 152 organisations. Is that correct?

Ms Evans—We have a contract with each of those organisations, but there is not a specific allocation. We have a contract with them and they have a budget, yes.

Senator CROSSIN—You could not say to me, 'Organisation X is going to be getting this amount in the following year'?

Ms Evans—They each have budgets in their contract.

Senator CROSSIN—At what stage in the cycle do you determine the amount of money they are going to get for the next year?

Ms Evans—For the services that are recurrent it is usually the amount that they received in the previous year, with the safety net indexation, unless there is some particular additional amount or if they have, for instance, an underspend, and that is taken into account in their next year's allocation.

Senator CROSSIN—Are the primary health care services that are particularly covered under this outcome Aboriginal medical services?

Ms Evans—Yes.

Senator CROSSIN—As well as substance abuse organisations?

Ms Evans—Yes.

Senator CROSSIN—As well as emotional and social wellbeing organisations?

Ms Evans—Yes.

Senator CROSSIN—In other words, there are three types?

Ms Evans—Yes.

Mr Broadhead—There is a separate measure under primary health care services that refers to substance use organisations. You will note that in 66 it comments that 23 of them appear in both categories—that is, there are 23 organisations in the primary health care category that also provide substance use services.

Senator CROSSIN—Do you have a specific budget allocation for the first two outcomes?

Mr Broadhead—There is no line as such which equates exactly to those organisations.

Senator CROSSIN—Could you tell me what amount you budgeted against those two performance measures?

Ms Evans—We could provide you with figures for those services, because they all have budgets.

Senator CROSSIN—I might get you to take that on notice.

Mr Broadhead—We could provide figures, for example, for what we are funding this year. If you are talking about next year, we have not generated the budgets for organisations yet. We could give you an indication, but we could not give you a precise figure per organisation.

Senator CROSSIN—How easy is it for you to give me a list of the 152 organisations and the budget allocation? Is that a spreadsheet?

Mr Broadhead—The budget allocation for this year?

Senator CROSSIN—Yes.

Mr Broadhead—Yes, we could do that.

Ms Evans—Bearing in mind that that would be the amount in their contract. The actual wash-up at the end of the year may be slightly different.

Mr Broadhead—The figure would be as at a date.

Senator CROSSIN—What was the expenditure for the equivalent three classifications we identified—that is, the AMS, substance abuse and emotional and social wellbeing—for the 2003-04 period?

Ms Evans—It will not be a total figure until the end of the financial year.

Senator CROSSIN—I understand that. Would you have to take that on notice?

Ms Evans—Yes. Would you prefer to wait until the end of the financial year, since we are nearly there, or would you like the figures now?

Senator CROSSIN—You may as well. I do not think anyone is going to be looking at your figures in the last two weeks of the June sitting period.

Mr Broadhead—In essence, it would therefore be the 2003-04 expenditure by service.

Senator CROSSIN—Yes, which you would probably give us towards the middle or end of July, would you?

Ms Evans—Probably a little later than that.

Mr Broadhead—We go into a sort of processing frenzy in terms of the transition between years, so give us a little bit of breathing space, but certainly towards the end of July we could give you those figures.

Ms Halton—Senator Crossin, I do not want to get into trouble with Senator McLucas for being late with questions.

Senator CROSSIN—No. Slip them to me, and you will be all right! Are you saying the 2004-05 allocations for the organisations will be predominantly what they are getting now, plus the CPI indexation?

Ms Evans—With any adjustments that are needed, yes.

Mr Broadhead—There will be some ups and downs where we have funded an organisation, for example, to do a particular project that is time limited, and so it has come to an end, and that would not be in their base funding in the next year. There will be movements according to particular initiatives, which are not constant. There might be particular funding given in a year for a particular thing that does not necessarily go on.

Senator CROSSIN—Do organisations have to provide you with service activity reports or business plans and identify their needs? Is that what the funding is also based on?

Ms Evans—As part of their contractual obligation, they provide us with service activity reporting each year, which tells us about the range of services they provide, the number of staff, the episodes of care et cetera. That gives us an indication of their activity and their work force.

Senator CROSSIN—Do you have the figure that will be allocated for the administration of the patient information recall system for 2004-05?

Ms Evans—We are still working out internal allocations at the moment. As you know, we have a single-line appropriation.

Senator CROSSIN—When would you know that? Can you take it on notice?

Ms Evans—Yes.

Senator CROSSIN—In relation to the work force development and the implementation of the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework, you will be working out a budget amount against those?

Ms Evans—Yes.

Senator CROSSIN—What were the previous amounts? What was the previous amount for the recall system?

Ms Cass—The allocation for the patient information recall system was $2 million in this financial year. For Workforce in this financial year, it was $11.847 million.

Senator CROSSIN—Similarly, in relation to the National Strategic Framework for Aboriginal and Torres Strait Islander Social and Emotional Wellbeing, what was the amount allocated to that this year?

Ms Savage—The 2003-04 allocation was $6.2 million. Under the Bringing Them Home program, funds allocated were $14.6 million.

Senator CROSSIN—You must have my brief! Under the Bringing Them Home program, is the $14.6 million for counsellor positions?

Ms Savage—Yes, that includes Bringing Them Home counsellor positions and innovative grants.

Senator CROSSIN—Can you give me a breakdown of the state and territory counsellor positions and the amount allocated to them?

Ms Savage—I do not have that figure with me.

Senator CROSSIN—Can you take that on notice?

Ms Savage—Yes.

Senator CROSSIN—Are all those counsellor positions professionals?

Ms Savage—The services that are recipients of this funding decide the appropriate level of qualifications. It also depends on work force supply and availability. Some certainly are professionals. They cover a range of professionals, from certificate level counsellors through to psychologists, and that would vary from site to site.

Senator CROSSIN—Will any counsellors' positions that are funded in this year cease to exist next year?

Ms Savage—No, they will not.

Senator CROSSIN—What is the relationship between this funding and the National Strategic Framework for Aboriginal and Torres Strait Islander Social and Emotional Wellbeing? Is the Bringing Them Home portfolio part of that?

Ms Savage—The social health program includes the Bringing Them Home in our social emotional wellbeing funding.

Senator CROSSIN—What funds will be allocated to the Indigenous substance abuse programs, with reference to what I understand are 67 substance abuse community controlled health services and 28 residential rehabilitation services?

Ms Savage—The funding allocation for 2003-04 is $21.7 million.

Senator CROSSIN—In those programs, would that cover funding that, say, night patrol programs would get in Indigenous communities?

Ms Savage—My understanding is that night patrols have been largely funded by ATSIS or ATSIC.

Ms Evans—When health was transferred as a responsibility from ATSIC to the Health portfolio in the division of responsibilities, there was a decision made by cabinet that night patrols would remain an ATSIC responsibility, so they did not come across as part of the program.

Senator CROSSIN—Are they intended to come across to you from 1 July?

Ms Evans—It is not my understanding, but, as Ms Halton said, those arrangements are still being finalised.

Senator CROSSIN—Where would that go—to FaCS?

Mr Broadhead—It is not yet decided.

Ms Halton—Essentially, none of that is finalised yet. I think it improbable we would get night patrol, but we do not know.

Senator CROSSIN—You might, you are saying?

Ms Halton—We do not know.

Senator CROSSIN—Can you also then take on notice what funds will be allocated to the Indigenous substance abuse programs? I think I have asked that, but I am not sure if I was clear what I was asking for.

Ms Evans—For 2004-05?

Senator CROSSIN—Yes.

Ms Evans—Yes, we will take that on notice.

Senator CROSSIN—And what funds will be allocated to the 17 new clinic redevelopments or improvements and the 15 new health staff houses and duplexes in remote areas?

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

Senator CROSSIN—Do you know where the new staff houses and duplexes will be located?

Mr Broadhead—We could give you a list of our capital works, if you like, and the locations and the amounts.

Senator CROSSIN—That would be good. Do you have a discretionary bucket of money that is put towards Indigenous community participation and advocacy in policy planning and implementation, or is this just channelled through the AMSs?

Ms Evans—As you know, NACHO is a peak advocacy body. We provide core funding to NACHO.

Mr Broadhead—In general, we would not have an identified amount of money that we provide to a particular AMS for advocacy, for example, though many of them would engage in that. On the other hand, from time to time we will be funding things that are to do with community development or planning and so on.

Senator CROSSIN—What is the relationship between the regional Aboriginal health planning and some of these identified measures?

Ms Evans—The regional health planning is part of the process described earlier: to identify existing services on the ground in both Commonwealth funded and state population and to identify where the gaps are and where the highest priority needs are.

Senator CROSSIN—Is that part of the PHCAP?

Ms Evans—It is part of the overall program management and it has been certainly a core part of allocating where PHCAP money goes, yes.

Senator CROSSIN—Is that planning done on a year-by-year basis?

Ms Evans—Not on a year by year basis. It was done initially, and the intention is that it should be upgraded and updated, but it is not done on a year-by-year basis, no.

Senator CROSSIN—When would have been the last update of that?

Ms Evans—It varies across the regional plan.

Mr Broadhead—I do not have a list of the dates. We have plans that literally have arrived in the last month that have been updated.

Senator CROSSIN—Is that at the discretion of your state and territory managers or regional areas?

Ms Evans—It is a joint collaboration between the state forums and central office.

Senator CROSSIN—Page 210 of the PBS refers to improved service development and reporting arrangements for OATSIH funded services. It is at the top of the page. That says the arrangements will be implemented with respect to selected services in 2004-05. Can you tell me what services, or how they are selected?

Ms Cass—We are running a pilot of this project at SDRF with 34 services in the next financial year. The process of selection has really been run through our state and territory offices, in consultation with the state affiliates of NACHO.

Senator CROSSIN—What is the pilot meant to do?

Ms Cass—The pilot intends to establish a more complete non-financial reporting framework with funded services. It supports them to develop action plans or business plans for the year ahead and to identify the key performance measures that they will use to demonstrate what they are achieving and doing against the plan.

Senator CROSSIN—How did you pick the 34, or did they self-nominate?

Ms Cass—It was really a bit of an iterative process. It was some suggestions from our state and territory offices, partially based on where they knew that there was an interest or engagement in business planning already, from funded services, and then in discussion with affiliates about whether they had suggestions about services that would be interested in participating.

Ms Evans—But it was then voluntary.

Ms Cass—It was then voluntary. We then went to each service and said, 'Would you like to participate?'

Senator CROSSIN—The new reporting arrangements will be developed as part of this pilot project. Is that correct?

Ms Cass—That is right. That is what this project is. It is a pilot with those 34 services and involves an evaluation component.

Senator CROSSIN—And it is over what period of time?

Ms Cass—This next financial year.

Senator CROSSIN—Is there an allocated amount for the cost of developing and implementing the pilot?

Ms Cass—There is an allocated amount which I do not have at my fingertips but I will provide to you. It involves providing funding for the participant services to develop their action plans and it offers access to quality improvement incentive funds to implement organisational reform in their service.

Senator CROSSIN—You work with service providers to understand and develop the framework. Is that correct?

Ms Cass—Yes.

Senator CROSSIN—According to the PBS, a key component of the new framework is the assessment of risks to an organisation's management performance and providing a basis for early identification and support to organisations that require it.

Ms Cass—Yes.

Senator CROSSIN—Is that to assist also with financial accountability?

Mr Broadhead—The payments introduced a standard approach to assessing risks to the organisation's management performance so that we can better identify early signs, and assist organisations where they may be struggling. We have had some approaches of this kind across the country, but we have not done it in a standard way across the country, and so we are now looking to do it, particularly because we think it is important that the approach we take is transparent—in other words, if we assess an organisation as medium rather than low risk, they understand the basis of the assessment and what we think are the signs of troubles. The aim, therefore, is to intervene earlier and to support organisations where they are identified as other than low risk. Of course, where an organisation is already, say, a service in difficulty, then they would be in a high-risk category.

Senator CROSSIN—The new reporting framework is yet to be developed. Is that right?

Mr Broadhead—No. The service development and reporting framework is—

Senator CROSSIN—It is there, is it?

Ms Cass—Sorry. There are 35 services participating in the pilot in the next financial year. Those 35 have been involved with us over the last several months in getting their business plans developed. We have provided a template which has been developed in consultation with services, so they are all ready to go from 1 July.

Senator CROSSIN—The new reporting framework has been developed in consultation with them, or the department has developed it?

Ms Cass—The template has been developed in consultation with NACHO and state affiliates principally. They are the peak bodies for the services.

Senator CROSSIN—Okay, so this is a pilot. Is the department currently offering single funding agreements to AMSs in 2005?

Mr Broadhead—We are proposing to have, wherever possible, a single funding agreement with each funded organisation in the coming financial year.

Senator CROSSIN—Is the scope of these restricted to programs or initiatives only from the office of OATSIA?

Mr Broadhead—Yes. The scope of the agreement at the moment is the funds that we provide to organisations. At this stage, we do have some agreements which involve other parties on the funding side; they are not our usual agreements. But, in general, the scope of this is the office's agreements with funded organisations. At the moment, we would have multiple agreements with some organisations. That can get complicated. We are looking to consolidate, wherever possible, all of our relationships with a particular funded organisation into a single agreement.

Senator CROSSIN—Do you have agreements with AMSs that are not incorporated?

Mr Broadhead—No.

Ms Evans—No non-incorporated organisations.

Senator CROSSIN—All of your funding relationships are with AMSs that are incorporated?

Ms Evans—Yes.

Mr Broadhead—Where they are with AMSs. We have funding relationships obviously with other bodies.

Senator CROSSIN—Can you tell me what prevents you from having, or even trialling, triennial funding for AMSs?

Mr Broadhead—It is amongst our intentions to do it at some stage but we would need to consolidate the arrangements we already have into single funding agreements before we start exploring the possibility of multiyear agreements. It is also the case that there are, when we work from annual appropriations, some impediments to moving to a three-year funding agreement since clearly we are committing beyond the current year's appropriation. It is certainly on our list of things to consider, but at this stage we think there are other more pressing priorities in terms of consolidating and simplifying our funding arrangements with organisations.

Senator CROSSIN—But it is in the pipeline?

Mr Broadhead—We are considering it, but it is not in the pipeline in the sense that we have work on it that will deliver it within a given time frame.

Ms Evans—The processes we have put in train at the moment—single funding agreement, risk assessment, the performance framework—are all part of, hopefully, leading towards three-year funding agreements. As Mr Broadhead has said, to get permission to have multiple-year funding, we have to be able to show clearly to other financial guidelines that we have the capacity to assess outcomes and risk et cetera, so we need to be firming up on those arrangements.

Senator CROSSIN—The Tough on Drugs expenditure—

Ms Evans—Senator, Tough on Drugs is an outcome 1 program, I am sorry.

Senator CROSSIN—Is it? The sexually transmitted infections and blood-borne viruses. Is that in your area?

Ms Savage—The sexual health strategy? Yes, it is.

Senator CROSSIN—What funds were allocated to the sexual health strategy in 2003-04?

Ms Savage—In 2003-04, a total of $12.5 million was available for sexual health activities.

Senator CROSSIN—What amount of funds was directed towards the Indigenous people through the fourth National HIV-AIDS Strategy?

Ms Savage—I would not be able to give you that exact figure. That strategy is managed by Population Health Division and I am not sure of the extent to which that is dissected down as a quantum of funding for Aboriginal and Torres Strait Islander people specifically, but certainly the strategy would also provide services and activities for Aboriginal and Torres Strait Islander people.

Senator CROSSIN—What amount of funds will be allocated in 2004-05 to the sexual health strategy? Do you know that as yet?

Ms Savage—No, we do not know that as yet. As with the previous questions relating to 2004-05 funding, we will have to take that on notice.

Senator CROSSIN—With respect to the states and territories, what controls and reporting procedures are in place to ensure that the necessary funds are spent on the Aboriginal sexually transmitted infections and the blood-borne viruses? Do you tie funding, or is it on a grants basis?

Ms Savage—We do fund state and territory health departments. Our process for the allocation of sexual health funding, as with many of the programs, is in partnership with the forum partners at the state and territory levels, based on identified needs and gaps and so forth. State and territory health departments can certainly be recipients of sexual health funding alongside Aboriginal medical services.

Ms Evans—We do not have any tied or matched funding arrangements that then require the states to contribute a particular amount to this program.

Senator CROSSIN—How do you ensure the states are spending the money on what you have asked them to in these two areas?

Ms Evans—The specific funding given for sexual health goes under a contract with outcomes.

Senator CROSSIN—Now I have a couple of question about a health service here in Canberra, whose name I am not even going to try and attempt to pronounce, unless you can do it for me.

Ms Savage—Would that be Winnunga Nimmityjah?

Senator CROSSIN—Yes, that is it. I understand a key recommendation of that health service's current and former strategic plan is the appointment of a practice manager. Is that correct?

Ms Evans—The specifics of a particular service are managed by our local offices, so we would probably have to take questions like that on notice.

Senator CROSSIN—You probably will because it goes to whether or not there is a dietitian in place and funding.

Ms Evans—Can we take those on notice? We fund 152 services and the responsible state project officer would have that detail. I cannot give that to you off the top of my head.

Senator CROSSIN—I will let you off the hook this time.

Ms Evans—Thank you.

Senator CROSSIN—I have some questions on eye health and then we might be almost finished with outcome 7. I have one other question for you on the 50 per cent fringe benefit tax subsidy. You would appreciate that for the last three years there has been a 50 per cent FBT subsidy paid to community health organisations to cover 50 per cent of the salary packaging for doctors. I understand that for Indigenous organisations this has been channelled through ATSIC. Essentially, it is used to help retain doctors in remote communities. Can you tell me if this subsidy has been renewed as part of the rural health package? We were not sure

whether this was outcome 5 or 7. It is money that is predominantly given to Indigenous AMSs, I think.

Mr Broadhead—We pay supplementation to AMSs for the changes in the FBT arrangements that were introduced in 2001. We do make supplementary payments to funded organisations that are public benevolent institutions that are subject to different arrangements as a result of the changes to FBT in 2001.

Senator CROSSIN—Is this the 50 per cent FBT subsidy?

Mr Broadhead—I thought it was 100 per cent, but I am struggling. As I understand it, there was the introduction of a cap.

Senator CROSSIN—Yes. Everyone else is capped at $14,000, I understand, but for AMSs or Indigenous organisations it was much higher than that.

Ms Evans—It was a transition arrangement, as you say, because there were concerns that a large number of services had packaged agreements, and the packages were outside the new parameters of the FBT, and this might then have caused them to lay off staff. It was not only doctors; it was health care staff. It was an arrangement to make up the difference in the shortfall in the transition year. It is ongoing, in the sense that it was for the packaging where they ended up with a debt because of the change in the FBT arrangements at the transition time, if that makes sense. I may not have explained myself clearly.

Mr Broadhead—I do not recognise the notion of a 50 per cent subsidy. I am a bit confused by that.

Senator CROSSIN—I think we are talking about two different things.

Mr Broadhead—That is quite possible.

Senator CROSSIN—Let me take you back in time. This may refresh your memory. A study was commissioned by the Department of Health and Aged Care in conjunction with the Aboriginal and Torres Strait Islander Commission—ATSIC—to examine the impact of the FBT capping legislation. That was when it was capped at $14,000. My recollection was that at the end of the day that cap was lifted for AMSs. Is that correct?

Ms Evans—No.

Mr Broadhead—No.

Ms Evans—There was no change in the cap—absolutely not.

Mr Broadhead—You may be referring to the study that we had done by Walter and Turnbull and associates to estimate the impact of the changes to FBT. That was then used as the basis for paying supplementation to funded organisations to offset the assessed impact.

Senator CROSSIN—Then an allocation of $43.7 million in additional funding over the four years was made to assist nonprofit Indigenous organisations to adjust to the introduction of the new FBT arrangements. Is that correct?

Ms Evans—That is correct, yes.

Senator CROSSIN—The four years are coming to an end at the end of June. Is that right?

Ms Evans—No.

Mr Broadhead—No. I think they come to an end in 2004-05. The coming financial year would be the last year of the four years.

Senator CROSSIN—Technically, you are telling me that there should still be moneys out there to supplement the capping, basically?

Mr Broadhead—We are still making payments this year, yes.

Senator CROSSIN—In other words, there should still be no change. Is that correct?

Mr Broadhead—What do you mean by 'no change'?

Senator CROSSIN—Let me put it this way: doctors who are leaving remote Australia or who are leaving AMSs on the basis that the assistance with fringe benefits tax is no longer there is an incorrect statement, is it?

Mr Broadhead—There were a number of possible things that happened when the changes were introduced. We assessed the amounts that we would provide as supplementation to offset the changes; then the services themselves could choose to continue with the same packaging arrangements but paying a higher level of FBT, supplemented by us. In some instances they would repackage: they would change the make-up of the package. That did not of itself affect the supplementation we provided, because we provided it based on the assessment made in 2001. It is possible that there have been changes in packaging arrangements following the introduction of the changes in FBT—many organisations, I believe, then restructured their packages—

Senator CROSSIN—You are telling me that it is nothing to do with the subsidy you are providing?

Ms Evans—Our subsidy was a transition arrangement. It assisted services to meet that difference and the FBT that they had to pay for the packages that were already in place at the time of the transition. There was no change in the capping arrangements on an ongoing basis for Aboriginal services, so that any packaging that happened after the change, the organisations had to comply with the same FBT rules as everyone else.

Senator CROSSIN—In other words, organisations still have until the end of next year's financial year to adjust to having FBT arrangements like everyone else. Is that correct?

Mr Broadhead—Yes.

Senator CROSSIN—The subsidy is still in place for another financial year. Is that correct?

Mr Broadhead—Yes. It has been paid this year and it will be paid next year.

Senator CROSSIN—On what basis would doctors in remote communities be claiming that they will have to move and look for work elsewhere?

Mr Broadhead—It may be that there is some individual circumstance occurring there which is not necessarily related to the change in 2001 and the subsidy but due to some change in the packaging arrangements in that particular organisation.

Senator CROSSIN—As the organisations adjust, do you mean?

Mr Broadhead—It may be that they have adjusted; it may be for other reasons that they have determined to change.

Senator CROSSIN—I need you to say yes. I am asking you these questions for a specific purpose. I cannot write my letter and say, 'And at this point in time they all nodded, yes.'

Mr Broadhead—I would like to be obliging. What I am saying is that, without knowing the particular circumstances where those claims are being made, it is hard to tell what is, in fact, going on.

Ms Evans—Mr Broadhead can clarify if I make a wrong statement. For any new packaging arrangements, any new employees that are taken on after the change in legislation, the organisation has to comply with the current FBT arrangements. The packaging may well be different to packaging they were providing prior to the change in the FBT legislation.

Mr Broadhead—Yes. The subsidy relates to the cost at the time of introduction. It does not adjust for future positions.

Ms Evans—We did not want services to be in a situation where they had to terminate contracts with existing health staff because they simply could not afford to pick up the difference in that transition.

Senator CROSSIN—Is the department going to have a look at or do any study about the impact that this will have on attracting doctors to remote communities if they suddenly can only salary package $14,000 of their costs?

Ms Evans—It will not be sudden, because they have known for three years and can take this into account.

Senator CROSSIN—If it is a new doctor under your great plan, and they have graduated from Melbourne University and suddenly see the light and come to remote Australia, they might say to themselves, 'Well, why would I do that if I can only salary package $14,000 of my salary?'

Mr Broadhead—If they are working for any organisation in that situation, whether it was remote or otherwise, it would be true,. We have not done a study to attempt to establish the differentials that may now apply in packaging arrangements between before the changes to FBT and now. Were we to attempt to do so, we would be delving into the particularities of individual salary packages for particular individuals. I am not sure how much cooperation we would get.

Senator CROSSIN—Come 1 July 2005, all AMSs or organisations can only salary package up to $14,000. Is that correct?

Ms Evans—They can. I just want to make sure I get it absolutely correct. Since the change in the FBT regulation, for any new contracts they have entered into they have had to comply with that or pick up the difference themselves. This is a lapsing program. At the end of next financial year, if it does not continue and they still have people on old packages that create a difference for them and a debt, and if this program lapses, yes, there will be an amount they have to pick up.

Senator CROSSIN—Do you know at this point in time how many people out there this may affect; how many people who will still be employed who were there pre 1999? Do you have any figures?

Mr Broadhead—I can say that we pay supplementation to 54 organisations and I believe the number of positions affected is 437.

Senator CROSSIN—So technically there will be at least 430 people affected, if they all stay there, come 30 June next year. Is that right?

Mr Broadhead—It depends on whether the packages have been restructured. For example, when there is staff turnover the outgoing person may have been on one arrangement and the incoming person may be on a different arrangement. We based it on an assessment of what was the case at the time that the changes to FBT were made, so that would be the number of positions that were affected at the time the changes were made. The number of people occupying those positions who are still on arrangements which are the same as they were when the changes to FBT were made is unknown.

Senator CROSSIN—If there are any particular examples, you would need to look at the specifics of those. Is that right?

Mr Broadhead—Yes. If there are people making those claims, provided they are prepared to share information with us we would be happy to try and establish what was going on, but that is all we could do.

Senator CROSSIN—Thank you. We now move to eye health. The government's response to the Aboriginal eye health program released on 28 May supports the recommendations in the review but makes no specific suggestions about how to address them. What approaches will be taken to integrate eye health into primary health care?

Ms Savage—As you know, the government's response to the review report and those 24 recommendations span state, territory and Australian government responsibilities and relevant areas of the health system. The implementation is to embed eye health in primary health care practice. It is also about embedding it in existing regional and jurisdictional planning so that it does not stand isolated or disconnected from the delivery of primary health care. A consultation process will occur over the next 12 months and will provide an opportunity for all key stakeholders to discuss the reorientation of the program. A set of principles will guide those consultations.

Senator CROSSIN—Where is the set of principles, or are you developing those?

Ms Savage—The set of principles is in the review. That is my understanding. I will have to have another look. I have only brought the response with me.

Senator CROSSIN—Okay.

Ms Savage—Very briefly, eye health is a component of comprehensive primary health care, and mainstream programs and services, including specialist services, have the same responsibility to address the health needs of Aboriginal and Torres Strait Islander peoples at all levels of the health system. Importantly, the regional approaches to eye health will, over time, place more emphasis on strengthening the capacity of local primary health care services to ensure an organised approach to chronic disease detection and management. Trachoma control in endemic regions will require a public health response, with the involvement of public health units, primary health care services, housing and other essential services. As an absolute priority principle the existing capacity of eye health will be preserved and program

development and implementation should be based on the best available evidence. That is, essentially, what will guide and be underpinning principles of those consultations in the implementation of the review.

Senator CROSSIN—That, of course, leads me into my favourite subject, really. What action will the Commonwealth be taking to ensure that trachoma control is undertaken by state and territory public health units? That is one of the recommendations, I understand.

Ms Savage—Yes. In particular the Communicable Diseases Network of Australia, for which the Population Health Division provides secretariat support, has already established a steering committee to develop national guidance for the surveillance and public health control measures for trachoma. That is a step that is already in train.

Senator CROSSIN—When did that commence?

Ms Savage—I could not tell you off the top of my head.

Dr Fagan—September 2003.

Senator CROSSIN—Late last year?

Ms Savage—Yes.

Senator CROSSIN—Will this approach be integrated with the PHCAP programs, as part of the primary health care?

Ms Savage—Certainly. My colleagues have spoken earlier about PHCAP and how it is a whole program line appropriation, and certainly eye health is embedded as part of that approach, so it aligns with the broader processes of the program.

Senator CROSSIN—The Communicable Diseases Network of Australia has a key role in this area?

Ms Savage—Absolutely. I think we have gone down the track before about national data and surveillance and this will be certainly a positive move to ensure we get improved public health approaches to trachoma.

Senator CROSSIN—Do you think we might start to see some collection of data in this area?

Ms Savage—It certainly will improve our surveillance and collection of data, yes.

Senator CROSSIN—Can I ask then how much funding has been allocated to Indigenous eye health in this year's budget?

Ms Savage—In this year's budget an allocation of $3.2 million.

Mr Broadhead—To clarify, that is in the budget within OATSIH.

Ms Savage—That is right.

Mr Broadhead—That is the allocation within the office's appropriation. There is some confusion around terminology when you say 'allocation in the budget'.

Senator CROSSIN—Yes, sorry. In the last estimates, Ms Halton, you indicated that in relation to the Indigenous eye health an assessment was being made to the current status of the various programs, and this is the quote, from February:

The work that is going on at the moment is to look to see what is going on and then to make an assessment about whether that work is consistent and whether we need to do more.

Has OATSIH had input into this assessment? Ms Evans, you might be able to answer it?

Ms Evans—Sorry, Senator, could you repeat the question?

Senator CROSSIN—At the last estimates we had a quote in relation to Indigenous eye health. An assessment, I understand, was being made to the current status of the various programs in relation to eye health, to see whether the work was inconsistent or whether there was a need to do more.

Ms Evans—Yes.

Senator CROSSIN—Can you tell me if that assessment of the program has occurred? What has been the outcome?

Ms Savage—Are you are talking about the review?

Ms Evans—Yes.

Senator CROSSIN—I think at the time we thought there were other programs being assessed, or some other evaluation was occurring. Perhaps we were a bit confused about that. In February, you were talking about the review, were you?

Ms Evans—We were talking about the review.

Ms Savage—We were talking about the eye health review.

Senator CROSSIN—How much in total has the eye health review cost to date?

Ms Savage—I will have to take that on notice. I do not have that figure in front of me.

Senator CROSSIN—Can you also perhaps provide me with a cost on not only the review, but a breakdown of the consultant's fee?

Ms Savage—Yes, I can.

Senator CROSSIN—You mentioned a minute ago that a steering group has been devised. This is what you said last November in estimates:

A steering group has been established which is made up of state and territory members of the Communicable Diseases Network Australia to look at issues around developing not only a better sense of the data but also a more consistent approach to definitions and survey methodology as well as screening methodology and treatment protocols.

Is that the same group you mentioned a moment ago?

Ms Savage—Yes, it is.

Senator CROSSIN—Who is in that again?

Ms Savage—The CDNA, as I understand it, is made up of state and territory representatives as well as the Commonwealth, and it monitors communicable diseases.

Senator CROSSIN—Is this a national steering group?

Dr Fagan—It is led by the Commonwealth, but it has representatives of each jurisdiction's state and territory public health units. It is the Communicable Diseases Network of Australia.

It is a way to develop some national leadership around consistency in the approach to the public health control and data collection in relation to the health issue of trachoma.

Senator CROSSIN—Has a particular steering group been established to drive this?

Dr Fagan—Yes. It is a steering committee, which is a smaller group of the larger group. Indeed, we are in the process of negotiating a consultant with the appropriate expertise to conduct the project and to provide recommendations to go back to the CDNA.

Senator CROSSIN—Is there Indigenous representation on the steering group?

Dr Fagan—We would have to check.

Senator CROSSIN—What is the steering group up to, at this point in time? What recommendations have they made?

Dr Fagan—They are in the process of getting the—

Senator CROSSIN—They have not met yet. Is that right?

Dr Fagan—The steering committee has met but the consultant has not yet been appointed. That is in the process of negotiation. The terms of reference of the committee have been developed.

Senator CROSSIN—Can we have a copy of those, please? Is it possible to get those?

Ms Savage—I cannot see any reason why not.

Senator CROSSIN—If you can get them, that would be good. Can you tell me what you might be doing, or where the Commonwealth is at, in collaborating data already available in Indigenous communities in relation to trachoma, to ensure a consistent approach? Have we had any change from previous months?

Dr Fagan—We did make a very large effort to aggregate and collate the data from across the country, which, as we have discussed before, is largely regional or specific community data, in order to provide a report to the WHO. Through that process we demonstrated the varying approaches to the sample selection, the age group screened and the methods and timing and frequency of screening, and approach to control. That was a useful process for us to go through, and it supports the development of this.

Senator CROSSIN—What is the date of that work? When was that done?

Dr Fagan—When was it completed?

Ms Evans—Probably a couple of months ago.

Dr Fagan—Early in 2004.

Senator CROSSIN—Can I get a copy of that?

Ms Savage—Yes, certainly.

Ms Evans—We were discussing whether we had sent you a copy. We were not sure whether we had or not. We can certainly do that, if we have not.

Senator CROSSIN—I do not remember seeing it, no.

Ms Evans—We will certainly give you a copy.

Senator CROSSIN—That would be good. Can you tell me what progress has been made in relation to the implementation of the specialist health guidelines for use in Aboriginal and Torres Strait Islander populations, developed in 2001; specifically what progress has been made in regard to the guidelines developed for cataracts in Indigenous communities, diabetic retinopathy and trachoma.

Ms Savage—These were the guidelines developed—

Senator CROSSIN—It is *Specialist eye health guidelines for use in Aboriginal and Torres Strait Islander populations*. The guidelines were developed in 2001. I want to know what progress has been made in implementing those guidelines.

Dr Fagan—The implementation is really through the eye health program to date, which has just been reviewed.

Senator CROSSIN—The guidelines have just sat there?

Dr Fagan—They have been distributed to health service providers.

Ms Savage—And to practitioners for use in their everyday practice.

Dr Fagan—To guide their practice.

Senator CROSSIN—You would expect them to be using them. Is that right?

Dr Fagan—We would indeed, yes.

Senator CROSSIN—What happens there? Is there a specific plan of implementation, or do you develop the guidelines and send them out and hope they are picked up?

Dr Fagan—They are guidelines for practitioners.

Senator CROSSIN—You do not have a training plan or an information plan?

Ms Savage—It was a little bit before my time, but I imagine that there would have been distribution and some sort of communication strategy, perhaps, with the distribution of the guidelines. They are obviously targeted at practitioners, but they are also available for use in other settings, for educational and other purposes. Certainly the eye health coordinators would hold onto them—I would say almost like a bible—in terms of ensuring effective practice at the local and regional level.

Senator CROSSIN—For example, your trachoma guidelines specifically recommend that children aged from two to seven should be screened. Do you know if that is happening? Do you require it to happen?

Dr Fagan—They are national guidelines, and our experience has shown that regions take varying approaches; they adapt such guidelines to their local circumstances. Indeed, the data that we collected in that process I referred to earlier demonstrated that there are varying approaches to the age groups that are screened in different settings across Australia. That report will show that to you. These are the sorts of issues that this steering committee will be addressing.

Senator CROSSIN—Were the retinal cameras provided as a result of the $4.8 million announced by the Prime Minister in 1998?

Dr Fagan—That was part of our package, yes.

Senator CROSSIN—It was part of that package.

Dr Fagan—The equipment, yes.

Senator CROSSIN—What ongoing funding has been provided since 1998 for those cameras, or for the training in the use of those cameras?

Ms Evans—It forms part of the overall eye health program.

Ms Savage—The difficulty is, as Ms Evans has just said, that it forms part of the overall funding and eye health program, so making those discrete dissections is somewhat difficult.

Senator CROSSIN—Which is another outcome, is it?

Mr Broadhead—It is this outcome. What I think Ms Savage is suggesting is that this is covered by the general funds that are provided under the eye health program. We do not have a specific amount identified within that which is particularly about the cameras. The cameras were provided and then there is funding provided for the program as a whole.

Senator CROSSIN—You cannot tell me that each year since 1998 you have allocated this amount for the maintenance of the cameras and this amount for the training and use of them?

Ms Savage—We certainly would not have that level of detail with us here, but the funding is to fund the package—the components, the elements, of the eye health program—of which cameras are a part; the upkeep and maintenance.

Ms Evans—You will have to excuse me, because I do not have details of the review at my fingertips, but one of the things the review did conclude was that we should review the purchase and maintenance of equipment and the availability of it in different settings. That is something the implementation will be looking at.

Dr Fagan—That is correct.

Senator CROSSIN—Where you have a funding arrangement, say, with an AMS, if nothing has been done to maintain these cameras since the year 2000 or no money has been expended towards training in the use of these cameras, you would say, 'That is the AMS's problem. We give them the money and, if they choose not to do that, that is bad luck.'

Ms Evans—It is one of the roles of the regional eye health coordinators to manage the equipment.

Senator CROSSIN—To go around and ask, 'Who is using the cameras? Who needs funding?'

Ms Savage—The management of the equipment is the responsibility of the regional eye health coordinators.

Senator CROSSIN—Do you audit the work that they do?

Ms Savage—No, but we are certainly planning to do that as part of the progress on the implementation of the government's response to the review, so we should have a far better handle on that in due course.

Senator CROSSIN—In relation to trachoma, what research or studies have been conducted recently or are currently under way in an effort to eradicate the disease in

Australia? Is there any updated research or studies? Are we any further progressed since this time last year?

Dr Fagan—I think that the most significant initiative has been the one we spoke about earlier in relation to improving the consistency of the approach to screening and control. I am trying at the moment to think of any other research that I am aware of in relation to trachoma, and I cannot think of any off the top of my head.

Senator CROSSIN—Is any consideration being given to specific models similar to those that were used in the eradication of TB, for example? Is that being investigated by your area in relation to trachoma?

Dr Fagan—Not that I am aware of.

Senator CROSSIN—Have you looked at the suggestion by Professor Hugh Taylor to have a team, using a similar model to TB eradication, to get out there and eradicate trachoma?

Ms Evans—We had quite lengthy negotiations with the Hollows Foundation about four years ago, where they were quite interested in looking at the possibility of having teams targeting areas where there were still high rates of trachoma. In those discussions, we encouraged them to put forward a proposal that made use of specialist teams, but working closely and integrating with the primary health care services, and at the end of the day that did not result in any proposal from them. We have not proceeded with that.

Senator CROSSIN—That is all I have for outcome 7.

Senator McLUCAS—Could I get an update on the COAG trials in Cape York? I know that Senator Crossin traversed COAG trials, but I am not sure that you got to Cape York.

Senator CROSSIN—No, I did not.

Senator McLUCAS—What do the changed arrangements for ATSIC mean for those COAG trials? I can read the *Hansard* to find out what Senator Crossin has learned in the broad. In the specific, I am looking at what is happening for Cape York.

Ms Halton—At one level, we cannot answer the question. More practically, we can predict that the trials should continue. To say that there will be no impact, I think, is to deny that there will be at least some change. What it will be I cannot tell you. We talked a little bit with Senator Crossin about the fourth partner in the Pitlands trial, but my expectation is that the trials will continue. In fact, secretaries have discussed recently the need to keep up the effort and the priority on those trial sites. Particularly while some of the other arrangements are bedding down, it is important that we do not have a hiatus. The issue will be, on a site by site basis, who are the players and how we manage the issues of players. As to whether there will there be a diminished commitment to Cape York, I think I can predict no quite confidently.

Senator McLUCAS—I know things are moving quite quickly, but if anything were to change in the next few weeks I would appreciate an update.

Ms Halton—To the extent that we know, I am happy for us to do that. If we hear something which we think is germane that you will not hear from another source, we will make sure that you are informed.

Ms Evans—DEWR, the lead agency for the cape, would be able to give you a more detailed accounting of what is happening in that trial.

Senator McLUCAS—We have finished with this outcome, thank you very much.

[8.37 p.m.]

ACTING CHAIR—We move to outcome 6, Hearing services.

Senator CROSSIN—Can you tell me what is the total amount provided for the Commonwealth hearing services program for 2004-05?

Mr Kingdon—$214.9 million.

Senator CROSSIN—And for 2005-06?

Ms Blazow—On page 204 there is a bar chart with the out-year forward estimates, showing a slight increase. There is not fine enough detail in the bar chart. We have the actual for 2003-04 on page 203, we have the budget estimate for 2004-05 on page 203—

Senator CROSSIN—Take me to page 203, then, and tell me where specifically is the item for the hearing services program.

Ms Blazow—Total administered appropriations for outcome 6. Outcome 6 is exclusively the hearing services program.

Senator CROSSIN—I see. Are these increases just CPI and inflation increases?

Ms Blazow—No, growth in demand is built into that as well.

Senator CROSSIN—What would that be for the coming year and the year after?

Ms Blazow—We are trying to disaggregate between growth in demand and the CPI factor. They would both be in that increase. It is $26 million.

Senator CROSSIN—That is the growth funding. Is that correct? Do you want to take that on notice?

Ms Blazow—Yes. We can disaggregate it for you. It is difficult to do. But both would be in there—growth in service and also an allowance for cost increases.

Senator CROSSIN—If you could take that and disaggregate that out for me for the 2004-05 and 2005-06 periods, that would be useful.

Ms Blazow—Yes.

Senator CROSSIN—What is the total amount spent on ear health for 2003-04?

Ms Blazow—It is for hearing services and it is $196.105 million—again on page 203. That is for the administered appropriations, not including the cost of the departmental expenses.

Senator CROSSIN—You can't tell me what component of that was spent on Indigenous people?

Ms Blazow—No, we cannot. We have been through the complexity of this before. It is a two-stage program—it has the voucher component and the community service obligations—and in the voucher component not all people who are Indigenous identify as Indigenous. It is very difficult for us to say with any certainty exactly how many Indigenous people are using

vouchers, although we have better data on the community service obligations component. We have talked about that data before.

Senator CROSSIN—What would that be? Do you have an amount for community service obligations?

Mr Kingdon—Yes.

Senator CROSSIN—Under the community service obligations, you are going to allocate $32 million to Australian Hearing.

Mr Kingdon—Yes.

Senator CROSSIN—Of that, approximately $11.4 million will be used for services to Indigenous people, clients with complex rehabilitation needs, and eligible clients in remote areas. There are three areas covered by that $11 million. Is that correct?

Mr Davies—As you point out, that $11 million goes beyond just Aboriginal and Torres Strait Islander people. In the paragraph immediately above, some of that in the voucher system will go. There is some Aboriginal hearing under the voucher system—$182 million—and not all of that $11.4 million is Aboriginal. We cannot combine those two subtotals to get the full total.

Senator CROSSIN—No, but can you tell me what amount of that $11.4 million you are expecting to spend in each of those three categories?

Ms Green—The $11 million is projected for 2004-05 to be $10.6 million to adults and $800,000 to AHSPIA—Australian Hearing Specialist Program for Indigenous Australians—but we are currently renewing that expenditure. AHSPIA, as you know, Senator, is our outreach program.

Senator CROSSIN—Yes. That is $10.6 million to adults. They might be adults that are Indigenous, or they might be non-Indigenous adults with complex rehabilitation needs.

Ms Green—Correct, yes.

Senator CROSSIN—They might be non-Indigenous adults in remote areas. Is that right?

Ms Green—That is correct.

Senator CROSSIN—Out of those three areas, how many Indigenous people will benefit from the $10.6 million?

Ms Green—I can give you some of those figures year to date this year, if that would be helpful.

Senator CROSSIN—Yes.

Ms Green—Year to date, services to Indigenous clients—this is to the end of March—for children we have 1,484 and for adults 267.

Senator CROSSIN—That is people, is it?

Ms Green—Yes. These are Indigenous clients, either through our hearing centre services or through our outreach program.

Senator MOORE—These are clients who have identified as Indigenous when they have claimed services?

Ms Green—Yes, they are.

Senator MOORE—It is self-identification?

Ms Green—Yes. There would be additional clients possibly coming through the normal voucher system. That is not in this group. This is specially identified through our CSO work.

Senator CROSSIN—What amount of money does that translate into?

Ms Green—I do not have the money broken down under children and adults.

Senator CROSSIN—If you could just give me a total Indigenous perhaps.

Ms Green—Yes. The current anticipated expenditure for this year is in the order of $800,000 for the outreach program. The expenditure for all children is $15.1 million. The expenditure for all adults is $10.4 million. We have some other expenditures on cochlear upgrades and, of course, we have our expenditure on research.

Senator CROSSIN—What is the cost to your service of the 1,484 children and the 267 Indigenous adults—those 1,740 clients?

Ms Green—I do not have the actual cost for that group of clients. I have the totals.

Senator CROSSIN—How will it be possible for you to tell me, out of the $10.6 million, how much of that you will spend on Indigenous people, how much will be spent on clients with complex rehabilitation needs and how much on people in remote areas? Is it possible to break down that $10 million?

Ms Blazow—As you are aware, we enter into a service contract each year with Australian Hearing, which is the government provider that takes care of this particular area under their community service obligations. We are still negotiating the service contract for 2004-05, so those discussions have not finished yet. But we are making very good progress in terms of giving higher priority for next year to Indigenous people and looking to allocate more money next year.

Senator CROSSIN—Tell me about this year then. You have figures to March?

Ms Green—Yes.

Senator CROSSIN—You can tell me how many Indigenous clients you have in terms of children and adults. What is the money next to that?

Ms Green—I think I have just given you the estimate. We cannot break it down specifically for Indigenous children or for Indigenous adults. I have the total amount for all adults and all children.

Senator CROSSIN—Australian Hearing Services cannot tell me how much money they spend each year on Indigenous people?

Ms Green—I can tell you the amount we spend on the outreach program, which is a large proportion of the children and a large proportion of the Indigenous services.

Senator CROSSIN—That is $800,000?

Ms Green—That is $800,000.

Senator CROSSIN—But you do not have your total expenditure on Indigenous people?

Ms Green—I do not have the adult broken out, no.

Senator CROSSIN—Have you ever tried to do that?

Ms Green—Yes. We are looking at that very closely at the moment.

Senator CROSSIN—You have never done it in the past, though?

Ms Green—Not on a case-by-case basis.

Senator CROSSIN—Or even on a collective basis.

Ms Green—We have not analysed the adult expenditure outside of the outreach program.

Senator CROSSIN—I will come back to that, because I want to get on top of this allocation of money and expenditure by Australian Hearing Services. I want to spend a fair bit of time on that. This question is for the Office of Hearing Services. Can you tell me the final number of vouchers issued last financial year?

Ms Blazow—Yes, we can tell you that.

Mr Kingdon—The number of vouchers issued last year was 161,000. This year obviously we cannot give you an accurate figure, because it has not finished, but we think it is going to fall within the range of 170,000 to 180,000.

Senator CROSSIN—You were projecting in June last year a growth of 10,000 in vouchers but there was a projected growth of 15,000 in vouchers issued. Is that on line between your 170,000 and 180,000? Is that about right?

Mr Kingdon—That is right.

Senator CROSSIN—It is around the 10,000 to 15,000 increase. Is that correct?

Mr Kingdon—About 10,000 to 15,000, yes.

Senator CROSSIN—Were you successful in your bid for an additional $14.2 million to cope with the anticipated growth in the number of vouchers? We were talking about this at the last estimates.

Ms Blazow—The vouchers are a demand driven component and, yes, we have sufficient funds available to cover the value of the vouchers that are redeemed.

Senator CROSSIN—What is the number of vouchers that have been factored into the budget increase?

Mr Kingdon—Approximately 10,000 to 15,000 again.

Senator CROSSIN—An answer to a question on notice was that there would also be an increase in the demand for more expensive services as well as the number of vouchers redeemed. On what basis does your office make an estimated increase or decrease there? You said there would be an estimated increase in the demand for more expensive services. On what basis do you make that?

Ms Blazow—We would look at the trend in terms of the way the vouchers are being used, the types of devices that people are choosing and the complexity of the cases. We would make an estimate, therefore, on the increase required in the program to cover that increased complexity.

Senator CROSSIN—Were additional funds included in the budget to accommodate the demand on the more expensive services?

Ms Blazow—Yes, that would be built into our model for forward estimating purposes.

Senator CROSSIN—You do not know how much that was?

Ms Blazow—There is a high level of complexity in this segregation.

Mr Kingdon—About $17 million.

Senator CROSSIN—What does 'more expensive services' mean?

Ms Blazow—The devices. There is a schedule of devices, and the device they need depends on the complexity of the person's hearing loss. There is a range of prices on those devices. The actual assessment may take longer for a person with a complex need, for example.

Senator CROSSIN—Can you tell me what programs are in place or are planned which specifically target newborn babies?

Ms Blazow—We do not do anything specific for newborn babies. Can you be clearer?

Senator CROSSIN—We know that the New South Wales government, for example, has a program in place that screens babies within the first 24 hours. Are you part of that?

Ms Blazow—No. Those are state government programs. Some states—not all states—have what they call newborn screening whereby they include a test which indicates the hearing capability of the child at a very early stage.

Senator CROSSIN—The Commonwealth has nothing to do with that at all?

Ms Blazow—We do not do the screening. That is the state government. It is done in the hospitals. Not all states do it.

Senator CROSSIN—You do not provide funding for it or monitor it?

Ms Blazow—No.

Senator CROSSIN—Or discuss the success or otherwise of that program with states?

Senator Ian Campbell—I have been given a very detailed briefing by the person who invented the program in Western Australia. I have an understanding because of that briefing. I was informed by him that the WA state Labor government had cancelled the program after many years of success and it is an issue I was intending to take up with the WA state administration.

Senator CROSSIN—I understand New South Wales have implemented it in the last year because they believe it is very successful.

Senator Ian Campbell—Apparently it is very useful for early intervention.

Senator CROSSIN—I am just wondering if the Commonwealth has any role in this program.

Ms Blazow—No, the Commonwealth does not have a role in the program. However, how it impacts on our program is that there can be a very early referral of a child that is detected and the referral goes to Australian Hearing, the Commonwealth owned provider that Anthea is representing tonight. It is early intervention.

Senator CROSSIN—I understand that is a flow-on. I am wondering if you have any role in the newborn screening, an interest in it in any way, or collaborative discussions.

Ms Blazow—Australian Hearing have collaborative discussions, because they pick up the referrals from the hospitals.

Senator CROSSIN—Is there a preventive strategy for hearing health, for example, in remote Indigenous communities? Are you part of that or is that Australian Hearing Services?

Ms Blazow—Australian Hearing would provide that as part of their services. I will ask Anthea to explain.

Ms Green—The outreach program is designed to go into communities, ideally with an Aboriginal medical service there, with a trained Aboriginal health worker. Part of the program that we provide there is involved in hearing awareness, health of hearing and training people how to make sure the children's ears are clean. Those are the sorts of educative and preventive things that we encourage in those communities when we visit and help the Aboriginal health worker deliver those sorts of programs on as regular a basis as they possibly can.

Senator CROSSIN—How many people accessed the Commonwealth Hearing Services in the last 12 months, adults and children? What would have been the total?

Ms Blazow—The Hearing Services Program, both components, or just Australian Hearing?

Senator CROSSIN—Both components.

Ms Green—I can give you my figures. Do you want last year's figures, Senator?

Senator CROSSIN—Yes. That is probably the most recent you have.

Ms Green—The client numbers are: total children, 28,015; adults, 10,873; and total clients, 38,888. The AHSPIA program, which is the outreach program, saw 1,269. We have recorded across the AHSPIA or outreach program and our other programs a total of 1,814 Indigenous clients.

Senator CROSSIN—How many of your 28,015 children were Indigenous?

Ms Green—Some 1,632 were Indigenous children.

Senator CROSSIN—How many of your 10,873 adults were Indigenous?

Ms Green—I do not think I have that figure for last year.

Senator CROSSIN—You might want to take that on notice.

Ms Green—Yes, we will take that on notice.

Ms Blazow—There is always a problem about 'Indigenous' in terms of whether people identify or not.

Senator CROSSIN—Yes, I understand that. Commonwealth Hearing Services—what are your figures?

Mr Kingdon—Our figures in total are about 200,000 people who have come actively into the program. We have approximately another 100,000 in maintenance. Therefore, we have a total of 300,000 actively participating in the program.

Senator CROSSIN—Do you know how many of those are children?

Mr Kingdon—They would be the same figures.

Ms Green—There would only be these figures.

Ms Blazow—All children go to Australian Hearing. The voucher program is not for children.

Senator CROSSIN—In relation to Australian Hearing Services and in relation to the contract you have with them, has there been any evaluation conducted by either Australian Hearing or the department in the delivery of services, or unmet needs and demands?

Ms Green—In the children's services we give our emphasis to the children that need hearing aids or aiding and we feel that that is a fairly static figure which we are meeting with a fairly high quality service worldwide. We have really streamlined that process to try and give preference to children who are aided, because that is our purpose. Our purpose is to help the children who need some form of aiding. In relation to Indigenous services, we know that we are not meeting all the needs of all the communities but we are working hard to build profiles to make those services as effective as possible over a period of time.

Senator CROSSIN—What accountability mechanism is in place for your contracted service there?

Ms Green—We meet quarterly.

Senator CROSSIN—You provide an annual report?

Ms Green—Correct. We have a service level agreement with the Office of Hearing Services—and our memorandum of understanding. We have clinical standards that we have written and have attached to that, and that is part of the discussion on the current memorandum of understanding, and we would seek to provide as much service as we possibly can within our budget.

Senator CROSSIN—Is there any survey of clients or health workers, for example, which measures in any way the delivery of service?

Ms Green—In the CSO area we have not done that for quite some time. I think we did do it some years ago. We have not done it in the last two years.

Mr Kingdon—For the Office of Hearing Services, we have an annual survey of clients.

Senator CROSSIN—Okay. And there is no mechanism by which health workers are surveyed or assessed in some way to look at the delivery of service?

Ms Green—The Aboriginal health workers or the health workers who work for us?

Senator CROSSIN—Both, I think.

Mr Kingdon—For the Office of Hearing Services we have a clinical services team that monitors clinical delivery, and they do spot audits. They do regular checking of all service providers.

Senator CROSSIN—Where does that information go, or how is it collected?

Mr Kingdon—That information is collected for the department and there is follow-up where there seem to be breaches or inconsistencies in the quality of service. Those are followed up with appropriate measures.

Senator CROSSIN—Is the contract between Hearing Services and Australian Hearing Services publicly available?

Mr Kingdon—I do not believe it is. We have two contracts. We have the contract for voucher services—because, at the voucher level, Australian Hearing acts as a contestable player, just like any other hearing service provider we enter into contracts with. Then we have the separate deed of understanding which will become an MOU. The first one is a commercial contract, which we do not make available for any of our providers.

Ms Blazow—In regard to the vouchers, Australian Hearing competes in the marketplace with private providers for people to use their vouchers, so I believe that that level of contract is of the same nature as the contracts we have with private providers. They are all under the same arrangements. But for the community service obligations that is more or less like grant funding. As I said, we are negotiating one for next year at the moment, and when we have finished that discussion with Australian Hearing I think we could very readily provide that and say exactly what the targets are for next year for the funding.

Senator CROSSIN—Can I ask Australian Hearing: why is it that you only allocate $800,000 to your AHSPIA or your outreach services? Why is that so low?

Ms Green—The funding has been historical. We have built that up over the last two years. We would like to build it up further, and we are in discussion on that with the department. When we work in the communities, we need to have infrastructure in the communities that makes the funding going to them sustainable and brings about a good result. I think over time we are trying to build a greater amount of money and resource going to that service.

Senator CROSSIN—How is the $800,000 decided upon?

Ms Green—It has been an historical line of funding within the CSO line.

Senator CROSSIN—What do you mean by that? That the contract from CSO says, 'You will provide an outreach service and here is $300,000 to do it,' and then over time it has become $800,000?

Ms Green—Yes. When the first contract was set some years ago, amounts of money were allocated for the work that Australian Hearing was doing at the time. There were children, adults, complex adults and the outreach AHSPIA program. Those amounts of money have been—

Senator CROSSIN—They have historically stayed that way, have they?

Ms Green—And also research. I have been forgetting that there is also a research component in there for NAL research. Those amounts of money have stayed fairly static for a number of years. In the last year, 2003, there was an increase on the year before.

Senator CROSSIN—Of how much?

Ms Blazow—I think it went from $800,000 to $820,000. Someone can tell me if I am wrong.

Senator CROSSIN—A $20,000 increase.

Ms Blazow—It has been growing. We are optimistic that we will be able to allocate a greater amount for next year, but I do not want to pre-empt the outcome of those discussions.

Senator CROSSIN—How do you make an assessment about how much the outreach service ought to be? I am assuming this is the money that Australian Hearing Services use to go to remote communities. Is that correct?

Ms Green—That is correct.

Senator CROSSIN—To get right out there where the majority of the hearing problems are.

Ms Green—Yes. The outreach program is specifically designed to be delivered in a culturally sensitive way. There are some outreach programs in urban areas, because they are housed in Indigenous medical services where the program delivery is particularly focused. But the bulk of it is remote.

Senator CROSSIN—What capacity is there for the Office of Hearing Services to provide some sort of realistic funding there—$800,000, if that is a research component, is a drop in the ocean.

Ms Blazow—There is a capped allocation to Australian Hearing. It is capped, and therefore they try to do the best they can, in discussion with the department about what the priorities will be.

Senator CROSSIN—Who caps it then? Do you cap it?

Ms Blazow—No, the government caps it. That is a policy decision.

Senator CROSSIN—All right. So out of that does Australian Hearing Services then decide to spend $800,000 on their outreach service, or is that the amount of money in the allocation of their contract with you that you say is for the outreach service?

Ms Blazow—There is a total amount of money and then we have discussions with Australian Hearing about the targets for expenditure of that money, and there has been, as Anthea said, a historical situation where about $800,000 or $820,000 has been spent on the outreach program for Indigenous people. We are currently in discussions for next year to see what we can do to give greater priority to that program.

Senator CROSSIN—What needs to happen to make that $2 million or $3 million?

Ms Blazow—We are in discussions in respect to next year at the moment and I cannot pre-empt the outcome of those discussions.

Senator CROSSIN—Are you giving me some hope you might double or treble it then?

Ms Blazow—I would not like to say we would be doubling or trebling it, but I am giving some hope that we may be able to allocate a greater amount next year.

Senator CROSSIN—I hope you are going to increase it by more than $20,000. I hope it does not go from $820,000 to $840,000, with you telling me this time next year, 'Yes, but there has been an increase.'

Ms Blazow—When we have finished the discussions and briefed the minister, we will provide the information.

Senator CROSSIN—You understand where I am coming from, don't you?

Ms Blazow—I certainly do.

Senator CROSSIN—I read your annual report, I come to estimates, and I look. I think, '$32 million for Australian Hearing,' and when I peel back the layers, probably less than $1 million of that goes to an outreach service. I am horrified at that. Most people who look at the figures ought to be horrified at that.

Ms Blazow—There is money being spent through the mainstream—through the voucher system and through the other money that Australian Hearing is spending on complex adults—that Indigenous people are benefiting from. It is just much harder to identify that. It is the same issue we have right across the portfolio with Indigenous health. There is targeted money, specific money, and then there is mainstream money, and unless Indigenous people actually identify in our mainstream programs, which is a voluntary arrangement, it is very difficult for us to track every dollar.

Senator CROSSIN—Which they probably will not do.

Ms Blazow—It is the same in the Hearing Services Program, so the $800,000 is not the only amount of money we spend on Indigenous people.

Senator CROSSIN—I will look forward to an increase in the amount. I am wondering if you can tell me if there is a quality assurance component in the contract with Australian Hearing Services?

Ms Green—The current discussions have also been involving clinical standards and outcomes that the office requires of us in relation to a range of those programs.

Senator CROSSIN—On 26 February the minister for health put out a press release announcing new funding of $50,000 for the Central Australian Aboriginal Congress for the treatment of hearing problems in Indigenous communities. Can you tell me where this funding is allocated in the budget?

Ms Blazow—We think it is probably OATSIH money. But the OATSIH people have left, have they not?

Ms Halton—Yes.

Senator CROSSIN—It did not come out of Hearing Services then?

Ms Blazow—It not a Hearing Services program.

Senator CROSSIN—I put a question on notice at the last estimates about the cost of extending access to the Commonwealth Hearing Service programs due to CDEP participants.

Were those costings on the basis of the average incidence of hearing loss in the Indigenous community?

Mr Kingdon—Yes. It was at a higher rate, yes.

Senator CROSSIN—That is right. You told me it would be—

Mr Kingdon—From about 30,000 people.

Senator CROSSIN—If you have 39,000 people on CDEP and 40 per cent of the Indigenous population have a hearing loss, did you take 40 per cent of the $39,000 to 39,000 to work out your costs?

Mr Kingdon—No, because about 25 per cent would have fallen in as children, as they would have been under 21; therefore, we were talking about 75 per cent of 39,000. Then we applied the 40 per cent.

Senator CROSSIN—Sorry, just go through that again for me.

Mr Kingdon—We took off the group that were between 15 and 21, who would have been eligible as children under the Hearing Services Program already. They would be receiving services, so we took them away from that estimate.

Senator CROSSIN—So 75 per cent of the 39,000 was the base figure you used?

Mr Kingdon—Yes, that is right, and then we used roughly a 40 per cent inflator for the incidence of hearing loss amongst that group.

Senator CROSSIN—So the $3.5 million per year would be a maximum amount, do you believe?

Mr Kingdon—Absolutely maximum, because we seem to have a very poor take-up rate. Even when Australian Hearing goes to those communities, we are surprised how low the take-up rate is.

Senator CROSSIN—I understand someone was conducting a review about who was eligible or not eligible for hearing services. CDEP people are currently excluded.

Mr Kingdon—Yes.

Senator CROSSIN—Has there been any work done at looking at including them on the list now?

Ms Blazow—There has been no change in policy in regard to eligibility.

Senator CROSSIN—So a CDEP recipient still has no access to hearing services?

Ms Blazow—That is correct.

Mr Kingdon—Unless they are under 21.

Senator CROSSIN—But a non-Indigenous person on Work for the Dole?

Ms Blazow—No, it is pensioners.

Senator CROSSIN—Pensioners, or people in receipt of health care cards. Is that right?

Mr Kingdon—Yes, that is right.

Ms Blazow—People on the pensioner concession card, which is not all health care cards, and not people on Work for the Dole.

Ms Halton—Unless they are there voluntarily.

Ms Blazow—In simple terms, it is mainly people on age pension or continuing disability pension.

Senator CROSSIN—It is pensioners, people who are on pension benefits, rather than some sort of Job Search or whatever else?

Ms Blazow—Or sickness allowance, as Tony is just pointing out. It is only a subset. Of all the people who have health care cards, it is only a subset. The simplest way to say it is that it is age pensioners, people on disability pension, not on the Job Search allowances, or a continuing sickness benefit.

Senator CROSSIN—What is the total amount of funding allocated to training by Hearing Services?

Ms Blazow—Australian Hearing?

Senator CROSSIN—Either, I suppose.

Ms Blazow—In the program we do not allocate specific money for training.

Senator CROSSIN—But Australian Hearing Services would?

Ms Green—We get contracted to do training by OATSIH and the training is for the Aboriginal health workers.

Senator CROSSIN—How much is that?

Ms Green—We could take that on notice, Senator.

Senator CROSSIN—All right.

Ms Green—We train all our audiologists on the job and we train a lot of them in paediatric services, which is the only place they can learn paediatric services in Australia. If that sort of training is also what you are looking for, we can give you an estimate of that.

Senator CROSSIN—I am after the breakdown of the total funding for the training and the total funding for your equipment program and what that includes. I will just run through these quickly. When you get the transcript, you can have a look at them.

Ms Green—Okay.

Senator CROSSIN—What is the amount paid to Australian Hearing Services and what is the training component of that total?

Mr Kingdon—There is no such breakdown. There are two means of payment for Australian Hearing Services.

Ms Blazow—I think the confusion is the Office of Hearing Services and the Hearing Services Program as opposed to Australian Hearing, which is the provider.

Senator CROSSIN—Right.

Ms Blazow—Is your question: how much does Australian Hearing, the provider, spend on these components?

Senator CROSSIN—I am just going back to the February 2003 transcript, where the training component was about $286,000.

Ms Blazow—I think it is Australian Hearing.

Senator CROSSIN—And the training and equipment was $380,000. It would be Australian Hearing, I think. In relation to otitis media specifically and the recommendations of the 2002 report on Commonwealth funded hearing services to Aboriginal and Torres Strait Islander people, have the six Workforce recommendations been progressed?

Ms Blazow—Can you remind us of those six? I do not have that in front of me.

Senator CROSSIN—I might ask you to take them on notice, if that is okay.

Ms Blazow—We can give you a response on notice to each recommendation.

Senator CROSSIN—We might be another hour if we go through each six perhaps. I am also wondering what progress has been made to date on implementing those—in particular recommendations 6 and 7 of that report, if you could have a look at that.

Ms Blazow—We will give you a response on that.

Senator CROSSIN—So we have the total amount that has been allocated to Australian Hearing Services in the last financial year—this financial year. The contract is due for renegotiation at the moment.

Ms Blazow—That is right. The new contract starts on 1 July.

Senator CROSSIN—Australian Hearing Services: can you tell me what amount of your budget is spent on travel to remote communities?

Ms Green—I can give you the amount spent on travelling to the outreach program. For 2003-04 at the moment—and this is at 30 April—it is $126,347. That covers visiting 94 sites. Last year we visited 129 sites. We still have the rest of this year to complete. As you know, this is a period when they do a lot of their visits because it is more accessible.

Senator CROSSIN—It is supposed to be dry.

Ms Green—Yes.

Senator CROSSIN—But that has not happened.

Ms Green—No, it has not.

Senator CROSSIN—It has not yet in Darwin. How many audiologists are employed by AHS?

Ms Green—The number of clinical staff we have is 379. That is clinical staff. We have a larger total than that. For clinical staff—the majority are audiologists and there are, I think, 11 audiometrists—the total number for Australian Hearing is 379.

Senator CROSSIN—In your last annual report of 2003 you referred to an operating profit of approximately $4 million. Can you explain to me how this is achieved?

Ms Green—The operating profit is derived from the work we do totally in the voucher market, as one of the 150 providers there are.

Senator CROSSIN—How do you make a profit out of that? Do you put a fee for service on top of your work or your delivery?

Ms Green—All of the providers in the voucher market offer services to their clients and those services are reimbursed by the Office of Hearing Services. Some providers offer additional services for which the clients pay an additional amount.

Senator CROSSIN—Which is a fee for service from you. Is that correct? What would they pay you for, over and above what you are funded for by the Office of Hearing Services?

Ms Green—In our case, they would pay for a more technologically sophisticated hearing aid device that was above the level that was being offered on the schedules that the Office of Hearing Services have for the fully subsidised device.

Senator CROSSIN—How do you make a profit out of that? Do you sell it to them?

Ms Green—All the providers are obliged to offer clients choice between the devices that are on the schedule for OHS, which are very high quality. Some clients choose to take a higher quality device, and they are sold. That offers some form of profit. Other providers offer other assisted listening devices as well.

Senator CROSSIN—What happens with your profits?

Ms Blazow—The government owns Australian Hearing, so it is a matter for the government to decide how much dividend is returned to the government and how much is channelled back into service provision. It is a policy matter.

Senator CROSSIN—You could take the $4 million profit from your 2003 report and put it in your outreach program. You would not have to find any additional money.

Ms Blazow—That is a policy matter.

Senator CROSSIN—It is something you might want to consider in your allocation.

CHAIR—It does not concern the department at all. The money comes into revenue; it does not come into one department.

Senator CROSSIN—Does the $4 million profit come into revenue or does it come back into the Office of Hearing Services?

Ms Blazow—The department of finance takes responsibility for the GBEs.

Ms Halton—There is one large piggy bank and, regrettably, we do not have it in Woden. It is in Parkes.

Ms Blazow—The government will have to make a policy decision about the use of that money.

Senator CROSSIN—Theoretically, if they decided to increase the outreach money from $820,000 to $4 million, they would not have to look too hard to find the $4 million. It is there in their profits.

CHAIR—Senator, that is not a question the department can answer.

Senator CROSSIN—It is there on the record.

CHAIR—It is a very simplistic way of looking at it, but it is not the way government works.

Senator CROSSIN—How many children currently have cochlear implants? Is that something your office would know?

Ms Green—There are approximately 1,200 children with cochlear implants at the moment.

Senator CROSSIN—How many are currently needing upgrades?

Ms Green—Approximately 280 children have requested an upgrade.

Senator CROSSIN—How many will need upgrades in subsequent years?

Ms Green—We have an approximation of those figures. The number of cochlear implants is growing at 10 per cent a year.

Ms Blazow—I am doing this off the top of my head, but I think the estimate was about 200 children per annum to benefit from the cochlear implant speech processor upgrade new policy initiative in the recent budget.

Senator CROSSIN—How often are the upgrades needed?

Ms Green—That varies. Sometimes it is a technology upgrade and sometimes they are lost or damaged.

Senator CROSSIN—How many upgrades did you say are currently needed?

Mr Kingdon—It is in the PBS.

Senator CROSSIN—You are anticipating 330. Is that right?

Mr Kingdon—Yes.

Senator CROSSIN—But how many are currently needed?

Mr Kingdon—That is the figure that we anticipate will be currently needed that will be met next year. Right at this point of time, it will be down nearer to the 280 mark. Obviously, we have people coming on all the time.

Ms Blazow—That was based on an actual figure, about which we got information from Australian Hearing at the time. That was based on the actual waiting list.

Senator CROSSIN—Are you saying to me that in the budget there are more than adequate funds to cope with the number of upgrades?

Ms Blazow—There are adequate funds.

Ms Halton—It was based on being able to do those for people who need them.

Senator CROSSIN—Are clients required to pay an annual fee directly to the service provider for the maintenance of hearing aids or batteries?

Ms Blazow—Yes. Under the voucher program, people can choose to go into the maintenance program. They pay a copayment and the government also makes a payment. I think the figure is something like $32.30 for the client copayment and the government contributes $150 per annum.

Senator CROSSIN—Are you aware that providers are currently sending out invoices for the annual maintenance and battery fees—$32.30—whether or not such services have been provided?

Ms Blazow—If people nominate to go onto the maintenance program, and all of the aids need batteries and they sometimes need maintenance—they need cleaning, for example—then being on the maintenance program entitles them to take their aid back to their provider of choice and have batteries fitted and have the cleaning done and so forth.

Senator CROSSIN—What if people have not elected to be on that maintenance program?

Mr Kingdon—Then they pay for the cost of the repairs and for the batteries out of their own pocket.

Senator CROSSIN—But if they are on a replacement program, they will be invoiced for the annual service and batteries. Is that correct?

Mr Kingdon—Repair program, yes.

Ms Blazow—If they have elected to be on the program, their provider would know that and would keep in touch with them to make sure that that is happening.

Senator CROSSIN—What auditing is done by your department to ensure that annual maintenance services are provided if people are on the program?

Mr Kingdon—The provider is only reimbursed for the cost of whatever repairs and batteries they have provided.

Senator CROSSIN—You automatically reimburse providers for maintenance, without any supporting information or evidence that such services have been provided?

Mr Kingdon—They provide the evidence of the repairs they have undertaken.

Senator CROSSIN—They have to provide that evidence before they get reimbursed?

Mr Kingdon—Yes, and they bill us. They will tell us what they have done. Obviously they do not send every receipt, and that is why we do spot audits. We go through the files on a spot check basis to make sure that these claims are valid.

Senator CROSSIN—It is conceivable that there could be some providers who are sending people an account for $32.30 who have not requested to be on the maintenance program and then they go and seek that reimbursement from you? That may be happening?

Ms Blazow—If you suspect that that is happening—that people have not nominated to go on the program and they are receiving accounts from providers—can you ask those people to contact the office directly and we will follow that up, because that could be inappropriate behaviour by the providers.

Senator CROSSIN—Okay. How much money is spent on reimbursements for maintenance services?

Mr Kingdon—For 2002-03 it was $41.146 million. We do not have a break-up for this year, because we have not completed this year. For the last completed year it is $41.146 million.

Senator CROSSIN—The hearing services review in 2001 found that very few Aboriginal and Torres Strait Islander people access the Commonwealth Hearing Services Program. What steps have you taken since then to increase the number of Aboriginal and Torres Strait Islander people accessing the program?

Ms Blazow—We have done quite a lot of work with Australian Hearing on the outreach program, for example. We work with OATSIH on the programs that are delivered through the AMSs, the primary health care network, to encourage people to have their ears checked and tested and be aided as appropriate.

Senator CROSSIN—There has been no particular dedicated program or advertising campaign?

Ms Blazow—No, we have not had any specific advertising campaigns about the vouchers, for example.

Senator CROSSIN—No promotion?

Ms Blazow—No, no promotion.

Ms Green—When we visit the communities, we do give out information. We are currently designing new pamphlets to give out to people to promote the services across the CSO band of work. When we are out in communities we do try to make sure people understand that the services are available.

Ms Blazow—The key thing there is that Australian Hearing is often the sole provider in remote communities, so the work that Australian Hearing does on the ground is a promotion in itself.

Ms Green—National Acoustic Laboratories are currently conducting a study to see why there are differences between children in Aboriginal communities not taking up hearing aids as opposed to their peers in non-Aboriginal communities. We are trying to look to see what are the drivers that will encourage hearing aid use.

Senator CROSSIN—Finally, does the current contract you have with Australian Hearing contain specific performance indicators to improve the accountability and transparency of delivery of services to Indigenous people? Does it currently have those specific indicators or objectives in the contract?

Mr Kingdon—No.

Senator CROSSIN—Is it likely that it will be in the one you are negotiating now?

Mr Kingdon—It is likely that in the new one we will be requiring more reporting.

Senator CROSSIN—It is likely to be in the new one?

Ms Blazow—Yes.

Senator CROSSIN—I will look forward to it. Thank you. That is all I have.

[9.33 p.m.]

CHAIR—We will move on to Outcome 8.

Senator McLUCAS—Funding for policy advice in the PBS on page 234 provides $4.9 million for this output, which is considerably less than the actual cost from last financial year of $7.7 million. Can you give the committee an explanation of why that has occurred.

Ms Halton—Keep going, Senator McLucas, and we will come back to you when we have an answer.

Senator McLUCAS—On page 234 again, it shows a special appropriation of $150 million to PHIAC, that seems to be linked to the Private Health Insurance (Reinsurance Trust Fund Levy). Can I get an explanation of what that allocation of funds is, please?

Mrs Ginnane—That is actually the reinsurance trust fund that has been in place for many years, but the arrangements with PHIAC have changed and PHIAC comes under the consolidated revenue from 1 July next year. For that reason, for the first time, the reinsurance trust fund is being reflected in the budget papers. It is an arrangement which supports community rating and on a quarterly basis PHIAC calculates an average benefit and some health funds pay into that reinsurance trust fund, from which the money then goes out to other health funds to support community rating for high-claiming members.

Senator McLUCAS—Was it just that there was not enough money in that fund?

Mrs Ginnane—No, it is a zero sum pool every quarter. This is the first time it has been recorded in the budget. Prior to that it went through PHIAC trust fund.

Senator McLUCAS—On page 235 it shows an increase in output costs for PHIAC from $2.8 million in 2003-04 to $4.3 million 2004-05. Is that linked to the annual *State of the health funds* publication?

Mrs Ginnane—No, it is not. Those are PHIAC's operation costs. The board of PHIAC took a decision to increase staff in PHIAC. That is reflected in our budget for the next year.

Senator McLUCAS—That is quite a big increase, if it is just for your operation.

Mrs Ginnane—It is.

Senator McLUCAS—What extra work are you having to do?

Mrs Ginnane—PHIAC has been increasing its reviews of health funds. We have put in place a review program. We are also looking fairly closely at some issues in terms of corporate governance and developing a number of processes to ensure that health funds act in the best interests of their contributors.

Senator McLUCAS—What is the increase in actual staffing?

Mrs Ginnane—At the moment the number of PHIAC staff is 12. We are anticipating that there may be some increases over the next year, probably to 14 or 15 people.

Senator McLUCAS—They are either going to be very well paid or there is a lot of other work to do. Other than staff, where will that money be used?

Mrs Ginnane—PHIAC does not have in-house lawyers or actuaries, for example. We outsource all of that advice because it is not possible to have that expertise within a small organisation. Some of the increase is going to pay for that expertise.

Senator McLUCAS—On page 230 of the PBS there is an allocation of $48.2 million to develop electronic claim lodgment and information processing system environment. There is an explanation that tells us that it is going to streamline billing between the health funds, the hospitals and doctors. Why is the Commonwealth involved in essentially a relationship between private health insurance funds and the hospitals and doctors? I am interested in the policy question.

Dr Morauta—My colleague from the Health Insurance Commission could explain that.

Mr Kelaher—The Health Insurance Commission is already involved in working with the private health funds. As you would understand, we process the 30 per cent private health insurance rebate with the health funds. We also handle what are called simplified billing claims where, for in-hospital services involving both a Medicare component and a private health fund component, there are transactions between the HIC and the health funds. That system does not work very well. There are problems with data quality. There are many problems with patients waiting long periods of time for settlement of accounts, and we and the health funds have come up with a new design for a system to handle those claims much more efficiently, which will be better for the patients and better for administration costs for both the HIC and the health funds.

Senator McLUCAS—That system will remain the property of the Commonwealth?

Mr Kelaher—Yes. It has been built with Commonwealth funds and the health funds will benefit from the infrastructure being put in place by the HIC. The health funds for their part are also making back office changes to be able to participate in the scheme, so they are not getting a free ride, but that infrastructure is being provided by the Commonwealth.

Senator McLUCAS—There is no cash contribution from the health funds?

Mr Kelaher—No.

Senator McLUCAS—When you describe 'back office changes', what does that mean?

Mr Kelaher—In order to route these claims over the Internet, the Commonwealth is building some infrastructure to handle claims coming in from the health funds. The health funds all need to standardise on business rules and transaction structures in order to be able to participate in the scheme. All of the health funds need to make changes to their systems in order to be able to do that.

Senator McLUCAS—What benefits to the public sector are achieved?

Mr Kelaher—There are quite a few. A major benefit is that better data will be submitted by health funds and be processed by the Commonwealth, resulting in more accurate payment of claims. Public hospitals will also be able to participate in this transaction environment. Public hospitals presently struggle to have in-hospital services involved with health funds settled quickly. This will enable public hospitals to participate in the scheme. Of course, members of the public who presently participate in schemes with private health funds often experience a great deal of uncertainty about what their gap will be and what the final out-of-pocket amounts will be when bills are received from anaesthetists and specialist hospital claims over an extended period. This new system will provide a much faster and more certain

settlement of claims, perhaps with a gap being known up-front by the patient and being able to be settled in one payment.

Senator McLUCAS—In the PBS it says that there will be savings for the health funds as a result of this measure. Have you done any modelling to work out what sorts of savings they are?

Mr Kelaher—We have done some estimates, and the health funds have been somewhat helpful there. We have made estimates of how many times we need to interact with health funds for claims that are difficult to process or with poor data quality. Those estimates indicate that the health funds will incur much less in back office processing costs as a result of adopting this new scheme of processing. It will take some time for all of them to change their systems and deploy them, but our view is that, over the first four years of the operation of this new environment, the Commonwealth will meet the full cost of building this infrastructure as a result of reduced payments on the 30 per cent rebate.

Senator McLUCAS—The $48.2 million will be saved in increases?

Mr Kelaher—That is our estimate.

Senator McLUCAS—That is providing that the funds do pass on those savings in premiums—well, they will not be decreases but they will be, hopefully, smaller increases.

Mr Kelaher—That is right.

Senator McLUCAS—How can you monitor that?

Dr Morauta—That is something that is monitored through the management expenses ratio, which is one of the key ratios that are reported very regularly by PHIAC and which we look at closely, for example, in the premium rounds. The effect would be seen in the management expenses reporting for the funds and in the ratio of management expenses to their benefits paid. I think we get that data quarterly from PHIAC.

Senator McLUCAS—We do not have formal discussions with each of the funds now about increases in premiums. They can increase their premiums to the CPI without that formal discussion occurring. I am a bit at a loss, Dr Morauta, to work out how you identify the ratio. How then would the Commonwealth be able to say, 'We think you've made greater savings because of our investment into this e-commerce system'? I am trying to work out at what point in that discussion you can say, 'What about those savings we made for you?'

Dr Morauta—It is true that you cannot disentangle these things to the last accurate figure. However, management expenses ratios have been dropping in the industry and, if they continue to drop and progress is made there, we would expect that to be reflecting this kind of development. We would expect them to take the savings, if they were available to them, because that improves their competitive position and where they are. We would not expect them to be coy about taking those savings and passing them on, because that is a separate element of their management expenses, which is monitored, and labour costs are a very big part of those management expenses.

Senator McLUCAS—I suppose we can all hope that that might occur. Thank you for that. The outreach to patients in aged care facilities, which is on page 226 of the PBS, talks about

the delivery of private sector outreach services to residents of aged care homes. Can I get an explanation of what the intent of that program is?

Dr Morauta—Could I have the reference again?

Senator McLUCAS—Page 226. It is about halfway down the page, entitled 'Access to private health services'.

Dr Morauta—There is a broad movement to see if we can find ways of trialling out the private health insurance product in different settings. In this case the trials we are looking to establish are for residents of aged care homes. Private health insurance is largely for hospital services, but when people are chronically ill their position in a nursing home is somewhat analogous to being in hospital, and so we are looking at whether there are models we can develop for care in aged care homes that are insurable, for the times when people are severely ill. At this stage, that is on the trial side of things. It is possible under the current legal arrangements, but we are still trying it out, because of the need to try and get the boundaries right between nursing and medical care and other care.

Senator McLUCAS—So will it be nursing care and medical care?

Dr Morauta—When people are having the kind of care that they might otherwise receive in hospital—

Ms Halton—A hospital in a nursing home might be the—

Dr Morauta—Yes, that might be the way to look at it. We are looking at whether that is something for which they could then get benefit from their health insurance. We are looking at that and how those boundaries and definitions would work.

Senator McLUCAS—How will the trial operate? Have the trials been constructed yet?

Dr Morauta—I had better take this on notice. This is not something that I am very familiar with and I do not think we have briefing with us. Let me take that on notice and get back to you, Senator.

Senator McLUCAS—What I am looking for is: what the trials will involve—what are we looking at; what the costs will be; and where the funding is. I cannot track the funding for them in the PBS.

Dr Morauta—They would not be funded separately. They would simply be part of broader arrangements.

Senator McLUCAS—So it is an internal operation at the moment?

Dr Morauta—Yes, that is right.

Senator McLUCAS—It said that six trials were to be established by June 2005. I was going to ask where those trials were going to occur.

Dr Morauta—Let me find out if that is known, and we will report on the current state of play.

Senator McLUCAS—Thank you.

Ms Halton—Speaking of reporting, the question you asked about the policy advice component is too complicated for us to unpick here this evening. Would you be happy for us to come back to you on notice on that?

Senator McLUCAS—Yes.

Dr Morauta—That is the apparent reduction in staffing expenses on—

Ms Halton—It is the figure at the bottom of that table that you referred to.

Dr Morauta—Policy has gone down; program management has gone down; everything has gone down. We will have a look at that.

Senator McLUCAS—Sorry. Remind me again about that.

Mr Davies—I think it was your first question.

Ms Halton—It was your very first question.

Senator McLUCAS—Thank you. I need to write a note to myself about that.

Ms Halton—It is on page 238. We will give you something on notice.

Senator McLUCAS—On page 226—it is actually the next heading under the one we have just spoken about—there is discussion about development of an industry code of conduct for staff of health funds and agents and brokers. What is the intent of that piece of work?

Ms Addison—I understand the purpose of the code of conduct is to more closely align practices of the private health insurance industry with those of other financial service providers, such as life and general insurers. The Australian Health Insurance Association is currently developing the code in consultation with industry.

Senator McLUCAS—The AHIA is developing the code?

Ms Addison—Yes.

Senator McLUCAS—What input does the department have into the development of that code?

Ms Addison—I understand we have been discussing the development with them, but primarily the association is working on it.

Senator McLUCAS—There is no cost to the department? It is just a matter of negotiation and discussions? There are no staff costs?

Ms Addison—There is no allocated funding for it, no.

Senator McLUCAS—When the code of conduct is developed, it will be administered by the AHIA, I imagine.

Ms Addison—I would have to check on that. I would imagine so, but I would like to confirm that.

Dr Morauta—My understanding is that it is to be one of these voluntary industry codes and the government reserve the right—should it not do the job satisfactorily—to revisit the question of whether it was a voluntary industry code or not, but at this stage that is where it is headed.

Senator McLUCAS—Is there a time frame on the evaluation? It has to be developed, it has to be implemented and then, obviously, there will be some review of its effectiveness. Is there a time frame for that?

Ms Addison—At this point the government has reserved its right to revisit the issue in September. It will be looking at how far the association has progressed and revisiting the position in September. The industry and the association understand that they are working towards that timetable, and we will be seeing what they have come up with then.

Senator McLUCAS—When do you think the code will be finalised?

Ms Addison—I would not be able to say at this stage. As I said, the association is aware that the government has said that it would revisit it in September, so I would expect that they would try to get it in place before then. Sorry, it was confirmed that it was voluntary and to be administered effectively by the association through the industry.

Senator McLUCAS—Thank you. On page 227 there is a reference to performance indicators that will be introduced by August 2004 to ensure that health funds comply with the policy of community rating. Who developed those performance indicators?

Ms Addison—They were developed through an interdepartmental process and then there was a consultation process with government. They were finalised through that process. We are in the final stages at the moment of circulating those to various parties for sign-off before finalisation.

Senator McLUCAS—The department was the lead agent, shall we say?

Ms Addison—Yes.

Senator McLUCAS—Who will oversee those performance indicators and their effectiveness?

Dr Morauta—They will form part of the government's regulatory framework, and they are one of the ways that the government will check that the broad objectives of community rating and the other policy objectives are being met—that they are targeted on those particular policy objectives.

Senator McLUCAS—The 2003-04 budget foreshadowed the development of new prostheses arrangements, and we have discussed that on many occasions here. Have those arrangements been concluded?

Dr Morauta—No, they are still under consideration.

Senator McLUCAS—Is there a time line for when that might happen?

Dr Morauta—We think it will be very shortly now. Development work has continued in a number of areas in the interim.

Senator McLUCAS—What have been the barriers to the development of these arrangements? It seems that we have been talking about this for quite some time now.

Dr Morauta—Yes. I think it is like a lot of very new things—and this is really very new. It takes a long time for everybody to get their ideas aligned and to really develop the thing together. I would not say that it has been unusual, but it has been a very collaborative effort

between parties who do not always sit around the table and collaborate, and I think that has taken a long time to be worked through. There is a very good common understanding across the parties now, but it has taken probably longer than one would initially have expected to reach that point.

Senator McLUCAS—There will be publication of the arrangements when they have been finalised?

Dr Morauta—I think there will probably an announcement, yes.

Senator McLUCAS—We will look out for it. In 2000, data was compiled by electorate for the number of people covered by private health insurance for the months of June, July and September. It was provided to this committee in response to a question asked in November 2000. Has any further private health insurance membership data by electorate been collated since that time?

Dr Morauta—Why don't we take that one on notice? I am sure there has been something since that time, but I am not sure of the timing of it.

Senator McLUCAS—Yes.

Dr Morauta—We will take on notice the question of what the most recent set we have is.

Senator McLUCAS—When you find out what the most recent set is, if it after September 2000, could we have that data, in the series that it has been collected in?

Dr Morauta—Yes, we will provide that as appropriate.

Senator McLUCAS—You will have to take this on notice as well: we would like to know what the cost to the department was of doing that work in 2000. I do not know how you are going to ascertain that.

Dr Morauta—No, I think that is a bit in the hard area. Why don't we see what we can do on that? But I am not particularly optimistic about—

Senator McLUCAS—We have had these sorts of discussions earlier, but if a computer program had to be designed in order to work out where people lived—in what electorate and those sorts of things—

Ms Halton—I just think it will be difficult to do.

Senator McLUCAS—I understand it will be difficult, but if the answer is, 'It was staff time and that is all, and we think it was probably two people for eight days,' or whatever—

Mr Davies—If the answer to your previous question is that we have done this analysis more recently, then would it be okay to give you the cost for that more recent exercise? It is a hypothetical question, but we are more likely to have the costs for a more recent exercise.

Senator McLUCAS—Yes. It is indicative.

Ms Halton—I think the further we go back, the more it will be—

Senator McLUCAS—I understand. I suppose the question I am trying to ask is: did we have to buy a piece of software?

Ms Halton—Yes. If there is an identifiable cost, where we bought something or had a contractor, I think that will be fine. It is more when it is a question of, for instance, two-thirds of this person and a third of that.

Senator McLUCAS—Yes.

Ms Halton—We will see what we can do.

Senator McLUCAS—If you are currently compiling data by electorate of private health insurance membership, that would be useful as well—if that information is being compiled.

Ms Halton—I do not think we are doing anything. We have not done anything for a while. We will check, but we do not think so.

Senator McLUCAS—Could you check, please.

Ms Halton—Yes.

Senator McLUCAS—I understand that the department recently approved a rule change to permit Australian Unity to limit for 12 months the full benefits for members who had transferred from another fund and who wished to claim for psychiatric and rehabilitation services. Is Australian Unity the only insurer that has been given that exemption?

Ms Addison—It is correct that Australian Unity applied for that rule change and they were granted it. They were the only health fund that applied for that particular change at that particular time in January. A number of the health funds have benefit limitations on various aspects of their products but, in terms of those that have limitations on psychiatric, there are 11 funds in total.

Senator McLUCAS—And they are all to do with portability? All the exemptions are to do with portability aspects of the cover?

Ms Addison—No, the benefit limitations provide for a range of things.

Senator McLUCAS—Could I have a list of the funds and the limitations?

Ms Addison—We would have to take that on notice.

Senator McLUCAS—From what you know, are they all to do with psychiatric and rehabilitation services?

Ms Addison—No.

Senator McLUCAS—What is the nature of the other exemptions?

Ms Addison—They cover things like obstetrics and lithotripsy—and I have to confess I do not know what lithotripsy is.

Senator McLUCAS—*Hansard* will have trouble typing it out, too.

Dr Morauta—It is the breaking up of gallstones.

Senator McLUCAS—Obstetrics—that is a cause for concern. Are these exemptions to do with portability, or can an exemption be applied for for any reason?

Ms Addison—I think the latter is correct. If we talk about the particular circumstances with Australian Unity, Australian Unity applied for that in the particular circumstances they found themselves in in January. But these are things that various health funds have applied for

at various times as they have created their products. They cover different things and there are different circumstances under which they have sought them.

Dr Morauta—It is a way of producing a cheaper product, obviously, and that might be something that a fund is looking for in a competitive market.

Senator McLUCAS—Can you give me an understanding of what the process is for an insurance company to apply for an exemption?

Ms Addison—I will talk about the Australian Unity process, which I have become familiar with. Australian Unity approached the department and said they were seeking this particular rule change for particular reasons. The department discussed that with them and then suggested that they might reconsider. The health fund then took some time and had a look at the circumstances that were developing in their particular market, which was the reason why they were seeking the change. Then they came back to the department and presented their circumstances at a later date and the department considered it at that time. In terms of the process more generally, I think the funds look at their products. As we talked about, some of them are about creating cheaper products for particular purposes. They would come to the department, discuss it and then put forward the request for the change.

Senator McLUCAS—Is the decision made in the department to grant the exemption?

Ms Addison—The department decides not to disallow the request that the health fund makes for the rule change.

Senator McLUCAS—That is done completely internally within the department? It is not a matter that is then referred to the minister for his signature?

Ms Addison—It is a delegated authority from the minister.

Dr Morauta—There are very large numbers of rule changes running through all the time. Some of them may be of more interest than others, but there really is a very large number going through.

Senator McLUCAS—Can it be described as—I do not think it can, but I will ask the question anyway—a loophole in the legislation that allows that sort of negotiation about changing coverage?

Ms Addison—No, Senator.

Ms Halton—It is quite clear what the product provides. I do not think we would agree that 'loophole' is the appropriate way to describe it. It is quite a legitimate thing to do. As Dr Morauta says, we get a lot of these sorts of rule changes.

Senator McLUCAS—Do you publish those rule changes on a periodical basis?

Ms Addison—The health fund would publish the rule changes.

Senator McLUCAS—There has been some disquiet expressed about this particular one with Australian Unity.

Ms Addison—That is correct.

Senator McLUCAS—And I understand that there has been a referral to the ACCC.

Ms Addison—I am not aware of that, but I am aware that there have been concerns expressed about that particular rule change.

Ms Halton—Of course, the funds are required to ensure that a consumer—someone who is currently a member or a potential member—is apprised of either the existing rules or any change in the rules. If you have a product where they are thinking of changing something, they must tell you that. But if you are looking to buy a product, it must be quite clear what is covered by that product. If, say, a product excludes hip replacement or some other such thing, you must be told that.

Senator McLUCAS—I am starting to understand the scope of this now. Are they commonly due to portability requirements? Are they commonly associated with portability?

Ms Addison—No.

Senator McLUCAS—So of the 11 that you spoke of earlier, they are the ones that are related to portability?

Ms Addison—No.

Ms Halton—It is fundamentally a way of differentiating the product you have on the market. Otherwise, basically what you would get on the market is a series of homogenous products: you can buy the blue one, the green one or the red one, but fundamentally the shape, size and the performance characteristics of this blobby thing are identical. What this enables the companies to do is to basically market a differential. There are other reasons why you have these rule changes, but fundamentally it enables you to craft a product that you then put on the market.

Dr Morauta—Quite a lot of products completely exclude certain kinds of services. These are not excluding these services; they are just reducing the benefit for, say, 12 months and then they go back to the normal benefit.

Ms Addison—This might help: I have some examples of some rule changes. One of them, for example, is removal of a postcode restriction on pharmacy benefits. They can be quite banal, if I can put it that way.

Mr Davies—They can also be benign. They are not always reducing cover. The example we just heard is one where, in fact, it is making the product offer more for the member.

Ms Addison—Another one is increased dental benefits, for example.

Senator McLUCAS—I am getting the picture. What was the argument that Australian Unity offered for reducing benefits for 12 months for that set of potential patients?

Ms Addison—There are a range of commercial issues that were relevant to that decision for Australian Unity at that time, and that is what they put forward.

Senator McLUCAS—And in the literature that a company like Australian Unity would develop as a result of the exemption, do we monitor closely that it is very clear to potential purchasers of those policies?

Dr Morauta—It is a requirement under the act that changes are clear and what is being offered is clear to members, and if members feel they were not fully informed there is recourse to the Ombudsman under the act.

Senator McLUCAS—We did not call the Ombudsman. Are you aware whether the Ombudsman has had complaints to do with changed policy?

Dr Morauta—Yes, from time to time he has complaints on rule changes.

Senator McLUCAS—We might get some questions to him about that. It has been argued that this particular one is very discriminatory because it is identifying a particular illness or potential illness that an individual may have. Do you consider those issues when you are making a decision on an exemption?

Ms Addison—I think it is probably fair to say in the broad, Senator, we would not describe it as discriminatory. However, what we would look at is whether the rule change was in contravention of the act, and the rule change in these particular circumstances did not contravene the act; therefore, the delegate chose not to disallow it.

Senator McLUCAS—We have correspondence from a range of organisations suggesting that it is in fact discriminatory. Did you take advice on whether or not it was discriminatory?

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

Senator McLUCAS—All right.

CHAIR—Are we finished?

Senator McLUCAS—Can I just put on the record my thanks to the departmental officers for their cooperation over the last two days. Thanks to the secretariat and thanks to our respective staffs for all the work they do in preparing us to come along to these estimates hearings.

CHAIR—I, too, thank you all for being here and for your tolerance with us jiggling around with the agenda from time to time, and also with the times. Thank you, one and all. No doubt we will see you in November.

Committee adjourned at 10.11 p.m.