COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

ESTIMATES

(Additional Estimates)

THURSDAY, 17 FEBRUARY 2005

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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Thursday, 17 February 2005

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

Senators in attendance: Senators Allison, Barnett, Crossin, Denman, Eggleston, Forshaw, Greig, Harradine, Humphries, Knowles, McLucas, Moore, Tierney, Troeth and Webber

Committee met at 9.08 a.m.

HEALTH AND AGEING PORTFOLIO

In Attendance

Senator Kay Patterson, Minister for Family and Community Services

Department of Health and Ageing

Ms Jane Halton, Secretary
Mr Philip Davies, Deputy Secretary
Ms Mary Murnane, Deputy Secretary
Professor John Horvath, Chief Medical Officer
Ms Wynne Hannon, General Counsel, Legal Services Branch
Mr Alan Law, Chief Operating Officer, Business Group
Mr Stephen Sheehan, Chief Financial Officer, Finance Branch
Ms Eija Seittenranta, Chief Information Officer, Technology Group
Ms Michelle Baxter, Assistant Secretary, Legal Services Branch
Mr Gary Williamson, Assistant Secretary, People Branch
Mr David Webster, First Assistant Secretary, Portfolio Strategies Division
Mr Greg Roche, Assistant Secretary, Portfolio Strategies Division
Mr Jamie Clout, Assistant Secretary, Budget Branch
Mr Richard Eccles, Assistant Secretary, TGA Transition Unit
Ms Shirley Browne, Director, Parliamentary and CSSS Section
Mr Phillip Jones, Assistant Secretary, Audit & Fraud Control Branch
Ms Alison Larkins, Acting First Assistant Secretary, Information and Communications Division
Mr Andrew Stuart, First Assistant Secretary, Population Health Division
Dr Moira McKinnon, Medical Officer – Communicable Diseases
Ms Rachel Balmanno, Assistant Secretary, Strategic Planning Branch
Ms Sarah Major, Assistant Secretary, Food and Healthy Living Branch
Ms Lesley Podesta, Assistant Secretary, Biosecurity and Disease Control Branch
Ms Jenny Hefford, Assistant Secretary, Drug Strategy Branch
Ms Carolyn Smith, Assistant Secretary, Targeted Prevention Programs Branch
Mr David Learmonth, First Assistant Secretary, Primary Care Division
Ms Lisa McGlynn, Assistant Secretary, Budget & Performance Branch

Mr Alan Singh, Acting Assistant Secretary, General Practice Programs Branch
Ms Judy Daniel, Assistant Secretary, Primary Care Policy Branch
Ms Megan Morris, Assistant Secretary, Primary Care Programs Branch
Ms Judy Blazow, First Assistant Secretary, Medical and Pharmaceutical Services Division
Ms Joan Corbett, Assistant Secretary, Pharmaceutical Benefits Branch,
Dr Ruth Lopert, Senior Medical Adviser, Pharmaceutical Benefits Branch,
Mr Allan Rennie, Assistant Secretary, Pharmaceutical Access & Quality Branch
Ms Samantha Robertson, Acting Assistant Secretary, Medicare Benefits Branch
Dr Jane Cook, Senior Medical Adviser, Medicare Benefits Branch
Mr Tony Kingdon, National Manager, Office of Hearing Services
Ms Rosemary Huxtable, Acting First Assistant Secretary, Acute Care Division
Dr Bernie Towler, Medical Adviser, 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 Simon Cotterell, Assistant Secretary, Acute Care Development Branch
Mr Chris Sheedy, Assistant Secretary, Diagnostics & Technology Branch
Dr David Barton, Medical Adviser, Diagnostics & Technology Branch
Mr Nick Mersiades, First Assistant Secretary, Ageing and Aged Care Division
Ms Gail Finlay, Assistant Secretary, Quality Outcomes Branch
Mr Warwick Bruen, Assistant Secretary, Community Care Branch
Mr Stephen Dellar, Assistant Secretary, Residential Program Management Branch
Ms Alice Creelman, Acting Assistant Secretary, Policy and Evaluation Branch
Ms Fiona Lynch, Assistant Secretary, Office for an Ageing Australia
Dr David Cullen, Executive Director, Financial and Economic Modelling and Analysis Group
Ms Elizabeth Cain, Head, Pricing Review Implementation Unit
Ms Margaret Lyons, First Assistant Secretary, Health Services Improvement Division
Mr Dermot Casey, Assistant Secretary, Safety and Quality Branch
Mr Brett Lennon, Assistant Secretary, Health Workforce Branch
Ms Jan Bennett, Assistant Secretary, Health Priorities and Suicide Prevention Branch
Ms Jan Bennett, Assistant Secretary, Rural Health and Palliative Care Branch
Ms Julie Roediger, Assistant Secretary, Economic and Statistical Analysis Branch
Mr Tam Shepherd, Acting Assistant Secretary, HealthConnect Implementation 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 Phillip Chipman, Acting Director, Drug Safety and Evaluation Branch
Dr Neil Mitchell, Medical Officer, Clinical Evaluation Section, Drug Safety and Evaluation Branch
Dr Larry Kelly, Director, TGA Laboratories
Mr Pio Cesarin, Director, Non-Prescription Medicines Branch
Ms Rita Maclachlan, Director, Office of Devices, Blood and Tissues

Dr David Briggs, 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 Christianna Cobbold, Director, Joint Agency Establishment Group
Mr Michel Lok, Assistant Secretary, Financial Services Group
Ms Terry Lee, Assistant Secretary, 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, Business Management Group

Food Standards Australia New Zealand

Mr Graham Peachey, Chief Executive Officer, Food Standards Australia New Zealand
Ms Claire Pontin, General Manager, Office of Safety & Services, Food Standards Australia New Zealand
Ms Melanie Fisher, General Manager, Office of Food Standards, Food Standards Australia New Zealand
Mr Paul Brent, Section Manager, Product Safety Standards, Food Standards Australia New Zealand

Australian Radiation Protection and Nuclear Safety Agency

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

Aged Care Standards and Accreditation Agency

Mr Mark Brandon, Chief Executive Officer, Aged Care Standards and Accreditation Agency
Mr Ross Bushrod, General Manager, Aged Care Standards and Accreditation Agency

Office of Aboriginal and Torres Strait Islander Health

Ms Helen Evans, First Assistant Secretary, Office of Aboriginal and Torres Strait Islander Health
Ms Yael Cass, Assistant Secretary, Workforce, Information and Policy Branch
Ms Joy Savage, Assistant Secretary, Health and Community Strategies Branch
Mr Mark Thomann, Assistant Secretary, Program Planning and Development Branch

Office of the National Health and Medical Research Council

Professor Alan Pettigrew, Chief Executive Officer, Office of the National Health and Medical Research Council
Ms Cathy Clutton, 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, Executive Director, Centre for Corporate Operations

Australian Institute of Health and Welfare

Dr Anny Stuer, Acting Director, Australian Institute of Health and Welfare

CHAIR—I declare open this public hearing of the Senate Community Affairs Legislation Committee considering the additional estimates for the Health and Ageing portfolio. I welcome back Senator Patterson, representing the Minister for Health and Ageing, and the departmental secretary, Ms Jane Halton, and officers of the Department of Health and Ageing. Witnesses are reminded of the procedures to be observed by Senate committees for the protection of witnesses and, in particular, the resolution which states in part:

Where a witness objects to answering any question put to the witness on any ground, including the ground that the question is not relevant or that the answer may incriminate the witness, the witness shall be invited to state the ground upon which objection to answering the question is taken.

I also remind officers that they shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of them to a superior officer or a minister. Evidence given to the committee is protected by parliamentary privilege. However, the giving of false or misleading evidence may constitute a contempt of the Senate. Minister, do you wish to make an opening statement.

Senator Patterson—I could be tempted but I will not.

CHAIR—The committee will be working from the portfolio additional estimates statements and I propose to call on the additional estimates in the following order outcome: 2, 4, 5, 9, 7, 6, 3, 1 and 8. Then we will move to whole of portfolio and corporate matters. Before the committee commences with outcome 2 on page 59, I suggest that the committee begin with any questions on the portfolio overview on pages 7 to 39 of the portfolio additional estimates statement.

Senator McLUCAS—Chair, can I make a suggestion that might assist the committee. In a number of committees in this estimates period there have been situations where some outcomes have not been reached because of the interest in certain others. I propose that we put some time frames around some of the outcomes so that, if we can keep to those, at least we will get to the end of the work that we are meant to do today. Can I make that suggestion now and get agreement from the committee that we have indicative times for each of the outcomes that we have in front of us?

CHAIR—In principle, I absolutely agree with you, Senator McLucas. I understand that you have actually put together a proposal.

Senator McLUCAS—I wonder if I could read out the proposed times so that others who are interested participating in these estimates know when the outcome might come up and also so that officers of the department will know when they might be called.

CHAIR—Yes. I think we also need to factor in the time for other senators.

Senator McLUCAS—Absolutely, and that is my intention.

CHAIR—I will go through this. The proposal is that from nine to 9.30 we have the whole-of-government portfolio overview; from 9.30 to 12, outcome 2; and from 12 to 12.30, outcomes 4, 5 and 9. Lunch will be from 12.30 to 1.30. From 1.30 to three, we will have outcomes 4, 5 and 9 in continuation; three to 3.45, outcome 7; 3.45 to 4.15, outcome 6; 4.15. to 6.30, outcome 3; 6.30 to 7.30, dinner; 7.30 to 9, outcome 1; 9 to 10.30, outcome 8; and 10.30 to 11, corporate matters. Any comments?

Senator ALLISON—That is okay by me.

Ms Halton—I would like to make one observation. Originally, we had the whole of portfolio and corporate matters last, so it depends on what you propose to cover under whole-of-government portfolio overview from nine to 9.30. We will have a go, but I just cannot promise I will have everyone here. I am happy to see how we bat on, and we can come back.

Senator McLUCAS—We probably have the right personnel here. That is my assessment.

Ms Halton—Right.

CHAIR—Does anyone have any problem with that planned timetable?

Senator Patterson—No. I think it is a good idea.

Senator HARRADINE—Chair, can I as a participating member make the observation that perhaps if we try and work to this it sets a bit of a precedent—to determine quite definitively: 'We shall do this.' I do not mind trying to keep to this. In fact, I would be happy to place on notice a number of my questions, but I hesitate to do that because on previous occasions sometimes there has been a considerable delay with responses. Perhaps we could have from the minister and from the department a guarantee that the responses to questions on notice will be available within the month.

Senator Patterson—It does not actually set a precedent, because when I was chair of the environment and communications committee we actually set times and agreed to adhere to them. So it is not a precedent; it has happened before. I thought it was a good thing we instigated in that committee, and it worked really well. It gave people a reasonable chance, especially people who sat all day. I cannot speak on behalf of the minister for health. I can draw his attention to the requirement that Senate estimates have a due date for replies to questions, and I presume he will comply with that.

CHAIR—Yes. Senator Harradine, I think that there are a number of committees and a number of instances where a timetable has been set and it has really assisted the committee in trying to share the time among honourable senators. If in principle the committee is agreeable to this proposal then I think that there will also be some latitude given if we run over by a few minutes from time to time. Bearing in mind that we have a finite time, until 11 p.m., we can work within that time frame. Is the committee agreeable to the proposal put forward by Senator McLucas? As there are no voices to the contrary, we will try and keep to that time, bearing in mind that we have now lost 17 minutes of the first half-hour! I will move on to whole-of-government issues.

Senator McLUCAS—Excuse me, Chair, can I just make another observation. When many of us were in the Finance and Public Administration Legislation Committee the other night, it was expressed then—and I want to put it on the record here—that there were questions being asked of the HIC and of Australian Hearing that are more appropriately dealt with here. I dare say today there will be questions asked here that might be more appropriately dealt with by the finance and public administration committee. I urge you as chair, Senator Knowles, to consider discussing with the chair of the finance and public administration committee the potential for doing what we have done with Medibank Private in the past, and that is have the hearing in this committee so that questions that cross over service delivery and policy can be

answered fulsomely at the one time. I know that is a considerable change, with the Department of Human Services being established, but in the interests of dealing with matters effectively I think that might be something that we as a committee and the finance and public administration committee might consider.

CHAIR—Yes, Senator McLucas, I understand your point. The secretaries plus the chairs of the various committees tried to tackle this whole new process in advance of these estimates committee hearings in the full knowledge that there were, potentially, difficulties that were going to arise, and we decided that we would look at it after the event and see how we could accommodate it in the future. So your points will be taken on board.

Senator McLUCAS—Thank you, Chair.

CHAIR—Okay. Any whole-of-government or portfolio overview questions?

Senator McLUCAS—I have a question about the Podger review. Can the committee be provided with the terms of reference for the Podger review of the health care system, please?

Ms Halton—My understanding is that there are a number of documents in the public arena which we are happy to provide you with. In particular I think there was a letter from the Prime Minister to the premiers which indicated what Mr Podger would be doing. Have we got that with us?

Ms Huxtable—No. There was a statement made by the Prime Minister at the time that the Podger review was announced, and that included three points which summed up the terms of reference of the committee. As to reference in letters to premiers, it would be a matter for discussion with a particular premier as to whether or not that letter could be released. But I can certainly read out the three dot points that go to the same issue.

Senator McLUCAS—Ms Huxtable, sorry, I did not quite hear what you said. Did you say a certain premier would have to agree to the terms of reference being released?

Ms Huxtable—No.

Ms Halton—We can tell you, inter alia, what was in that letter.

Ms Huxtable—Ms Halton referred to a letter which included a number of things, including reference to the Podger process, but in terms of what the task force will do the Prime Minister has put that on the public record. I can read that out to you if you wish.

Senator McLUCAS—I think I have that document. Have we moved forward from three points in a statement from the Prime Minister to a formal set of terms of reference?

Ms Halton—Obviously, that is not a matter for our portfolio. We have the material referred to by the Prime Minister, but that is a matter for Prime Minister and Cabinet because that is the portfolio from which this exercise is being conducted.

Senator McLUCAS—So the Department of Health and Ageing is not aware of any terms of reference that have been established to formalise the process of the review?

Ms Halton—Certainly we are aware of a number of things to do with the whole process, but in terms of what the Prime Minister has said publicly, in terms of what Prime Minister and Cabinet have confirmed with us, Ms Huxtable can give you those points.

Ms Huxtable—To statement said that the review would examine the operation of the Australian health system:

—to ensure optimum efficiency and effectiveness of health service delivery for all Australians across the primary, acute, rehabilitative and aged-care sectors, and, in doing so, clarify responsibilities;

—to ensure best use of the funds all jurisdictions put into health improve accountability and transparency in health funding; and

—to identify barriers to seamless service delivery for patients and recommend options to address them.

Senator McLUCAS—Is the Department of Health and Ageing aware of the timetable for the report?

Ms Huxtable—I think the Prime Minister has already announced that the task force will be finalising its deliberations in the first half of the year.

Senator McLUCAS—Who receives the report?

Ms Huxtable—As Ms Halton said, the operating instructions and arrangements for the task force are managed through the Department of the Prime Minister and Cabinet and, as I understand it, there is not as yet any final decision about how their work may be considered.

Senator McLUCAS—I will put the rest of the questions to the Department of the Prime Minister and Cabinet. One question for you, though, is: how will the Department of Health and Ageing participate in the process of the Podger review?

Ms Halton—We have seconded two officers to work with Mr Podger. There is a regular process wherein Dr Peter Shergold, Dr Henry and I discuss work as it is progressing, if I can describe it in that way, so we are aware of what is going on in terms of the work that is actually being undertaken.

Senator McLUCAS—Can you give us a precis of the work that has been undertaken to this point in time?

Ms Halton—You would understand that it is by way of formulation of policy advice, so we are not able to go to the nature of what is—

Senator McLUCAS—That is understood, but how is the process proceeding?

Ms Halton—I think it is fair to say that, in common with many other bodies or groups of this sort, they are thinking a lot. They have talked to a number of people and they are currently, as I understand it, preparing some written material for consideration.

Senator McLUCAS—In terms of what issues are being progressed in that written material, can you give us broadly the areas that the Department of Health and Ageing is thinking about?

Ms Halton—We are not doing the thinking; we are assisting the task force in doing the thinking. We are obviously thinking all the time on other matters—and on many matters. I think it is fair to say, in terms of what we are aware of from the task force's deliberations, that they are completely consistent with those points that Ms Huxtable has just raised—they are consistent with what the Prime Minister said they were going to do. They have not gotten off track.

Senator McLUCAS—They are broad enough not to, I think. Can you tell me the number of staff in the Department of Health and Ageing?

Ms Halton—Can we deal with that under corporate?

Senator McLUCAS—Yes, we can.

Ms Halton—As you would understand, the number fluctuates. While I can give you a number off the top of my head, it would be better if we had our corporate people here to give you the current, to date, figure.

Senator McLUCAS—Can we deal with UMP now?

Ms Halton—Yes, we can.

Senator McLUCAS—We all know the history of UMP, and I do not think we need to traverse that again, but recently UMP announced that 2005 premiums would be cut by as much as 30 per cent. That was not well received by others in the medical profession. I understand that the minister has indicated he would ask APRA to examine the matter. Can you advise the committee whether or not that has occurred.

Mr Maskell-Knight—The Minister for Health and Ageing and the Minister for Revenue and Assistant Treasurer announced shortly before Christmas a review of competitive neutrality in the medical indemnity industry which is intended to review the whole circumstance around the question of whether the government's actions have led to an imbalance and contributed to some insurers being able to price advantageously relative to others. That review is being carried out by Graham Rogers, who was a president of the Institute of Actuaries and sits on the Private Health Insurance Administration Council. He is due to report to the ministers in March.

Senator McLUCAS—So, instead of going through APRA, the ministers have decided to establish this alternative review process?

Mr Maskell-Knight—APRA and ACCC were consulted in deciding what action the government was going to take. I think the issue is that APRA's concerns are not so much with premiums for particular groups of doctors or particular localities but whether the total premium pool is sufficient to keep the organisation solvent.

Senator McLUCAS—Mr Rogers is due to report in March and will report to those two ministers?

Mr Maskell-Knight—Yes.

Senator McLUCAS—Has the minister also asked the ACCC to look at the matter separately or has he simply asked them for advice in establishing the Rogers review?

Mr Maskell-Knight—The ACCC are funded through Treasury to do an annual review of pricing in the medical indemnity market. I believe their latest report is in the process of being finalised, but that covers premiums that were set last June rather than premiums set late last year for United.

Senator McLUCAS—Has that been an established process of the ACCC?

Mr Maskell-Knight—Yes, the government decided on that, I think, in late 2002.

Senator McLUCAS—So they would not have reported? Will this be their first or second report?

Mr Maskell-Knight—I think it is the second report.

Senator McLUCAS—I think it is fair to say that other providers of medical indemnity have expressed concern publicly. What concerns have been formally expressed to the department by other indemnity providers?

Mr Maskell-Knight—Insurers have written to various ministers expressing concern that United were only able to take this action because of the support the government had offered them.

Ms Halton—I think we are aware of the concerns. They have been brought to our attention and there is the action that Mr Maskell-Knight has outlined. I do not think there is a presumption that it is one way or the other, but I think there was an acceptance that we should examine this and have somebody neutral examine the issue and then provide advice.

Senator McLUCAS—Perhaps this is speculative given that we have not yet had the report. I am intrigued as to what action could now occur if it is found that the government's actions have resulted in this incredible decrease in premiums that UMP have been able to provide.

Ms Halton—You would not be surprised to know that there would be a number of policy options that we could and would advise the minister on depending on the outcome of the review. It would probably be inappropriate for us to foreshadow or reflect on that policy advice, but there would be a number of things that we could suggest to the minister if that were appropriate.

Senator McLUCAS—I am sure we will talk about this next time around.

[9.30 a.m.]

CHAIR—We have come to outcome 2.

Senator MOORE—I have some questions. The first few are really asking for statistics and things like that so I can get them on the record. The first area I want to look at is enhanced primary care, and where possible I will try to use the full words rather than the acronyms. We are wanting to get some information data, so that will be the frame for the questions. What percentage of eligible Australians are currently being treated under an EPC plan? Do you have that data?

Mr Learmonth—No, we do not; I am sorry.

Senator MOORE—What kind of data do you have on numbers for EPCs?

Mr Learmonth—We have data on the utilisation take-up rate for the EPC.

Senator MOORE—Do you have data on how many Australians are eligible?

Mr Learmonth—No, we would not have. There is not very precise data about the number of people that would be eligible. Eligibility is based on the doctor's own professional judgment about a person's condition and whether it meets the criteria for being complex and chronic.

Senator MOORE—Would you be able to tell us how many plans are currently used or implemented?

Mr Learmonth—I will see.

Mr Singh—Senator, we do not have that information with us but we can get that for you.

Senator MOORE—Sometimes I think I should just ask what data you have and then we can go down into the second round. We will go through this and see what we can get. Can you tell us how many plans are now registered? Is 'registered' the right term?

Mr Singh—It is completed or claimed or registered.

Senator MOORE—Do you know the proportion of GPs who are using EPC claims?

Mr Learmonth—We do. Certainly we have some information that indicates, for example, a significant increase in the use of EPC plans. For example, in October 2003 around 13 per cent of GPs were doing EPC plans. That number has now reached 23 per cent as of October 2004.

Senator MOORE—Does that mean you keep the statistics annually or is it just to do with how you had a look at it?

Mr Learmonth—It is generally monthly but the way we would regularly monitor it is by monthly year-on-year comparisons, so the proportion of doctors using EPC planning has close to doubled. Similarly we can tell you about the number of services per month, so if we look at similar time periods, from October—

Senator MOORE—You have read my mind: that is going to be my next question, although it is not to do with the month. It is about the number of actually allied health services. I am after a breakdown of the allied health services and the number of services and the cost of those services provided under plans. Can your data provide that?

Mr Learmonth—Most of that we would have to take on notice. I could give you an idea of uptake, for example.

Senator MOORE—I am happy to get it on notice, given the knowledge that you can do that. So the database can provide that degree of detail?

Ms Halton—Let's be clear about what level of detail we are looking for.

Senator MOORE—I am after the breakdown by allied health service of the number of services, and the cost of these services, provided under plans.

Mr Learmonth—I believe that can all be provided. I would caution, though, that for the cost of services provided under plans we would be able to provide data on the services that were rebated, but there would be services under care plans that would not be rebated.

Senator MOORE—Okay. When we get the data, if we have supplementary questions, we will come back to you. Is that okay?

Mr Learmonth—Yes.

Senator MOORE—Following from on that, I am also after the average number of services and the cost of these services per patient. Is that something you can do?

Mr Learmonth—I believe so.

Ms Halton—Is that per patient on an EPC?

Senator MOORE—Yes, on an EPC that is rebated.

Ms Halton—That should be possible. We think some of this actually may be on the HIC web site but we will come back to you on notice with it.

Senator MOORE—I think some of it is.

Ms Halton—Yes, that is fine.

Senator MOORE—Do you know what the out-of-pocket costs for patients who receive allied health services under EPCs are?

Mr Learmonth—No.

Senator MOORE—You cannot get that?

Mr Learmonth—I will take that on notice.

Senator MOORE—One of the things that has received a lot of media coverage, particularly in some areas, is the promise to cut red tape. I see that these plans would be one way of limiting the amount of red tape. Can you give us any information about how that is going: what has been implemented, what is on the drawing board and how you are working out what will and what may not work?

Mr Learmonth—Absolutely. There is one issue in particular there, and that is the profession's views about the complexity of using EPC items. One of the responses has been to develop two new EPC care-planning items which are much simplified. One is GP-only managed care, planned care, for people with chronic diseases and the other is a second team care arrangement item, where the GP consults with two or more allied health practitioners in coming up with a care plan. Both of those items are close to being finalised. They have been through a significant consultative process with the Medicare benefits consultative committee and we are due to make a recommendation to the minister in the first half of this year.

Senator MOORE—This financial year?

Mr Learmonth—Yes. We believe there will be a significant reduction in red tape right there. The professions agree with it.

Senator MOORE—In terms of the way these have been developed, when they are public will it be quantifying to some extent what the advantages will be, what red tape will be cut, how this will work better? Will all those things be spelt out?

Mr Learmonth—I think it would be readily apparent in the guidelines, in terms of what is required.

Senator MOORE—I do not think anything in this portfolio is readily apparent! It is one of those things: for everything that changes, there seem to be a whole lot of other things that are consequential. In whatever comes out, will the concept of where the savings in red tape are be clear?

Mr Learmonth—I do not think we had proposed to do any kind of quantitative analysis of that. I think that is quite difficult because, whilst the item will provide general guidelines, and

those guidelines will be—it is our intent and the intent of the professions we are working with—much clearer and simpler than the existing ones, there is always a degree of professional discretion in how they are actually applied from patient to patient. So things like time and movement studies, cost relativities and so on are very difficult. We certainly had not planned on trying to quantify it, but I think qualitatively those who have been involved in the process would agree that they represent a significant reduction.

Senator MOORE—And we are hoping for that this financial year?

Mr Learmonth—It is near finalisation.

Senator MOORE—Because of the amount of interest there has been around this whole issue of cutting red tape, is it proposed that this work will continue—that we will bring out these two programs now but this particular focus on the simplification and ease of process will be an ongoing part of the research?

Mr Learmonth—Absolutely. There is a consultative process that has been set up that has a longer term agenda to look for simplification of EPC. That work will be carried out this year, and a range of other things.

Ms Halton—Senator, I think it is important to understand that there is a commitment to trying to reduce red tape—'red tape' is a very latent term—to reduce unnecessary bureaucracy. But you would appreciate that, exactly as you say, things sometimes have consequences and we have to work through those. Relationships with the profession as we try to sort our way through these are pretty good, and we are very definitely working our way seriatim through the issues.

Senator MOORE—And whatever comes up will be guidelines, allowing for the flexibility for people to operate in their own way?

Ms Halton—It will depend on the nature of the issue. I think, as Mr Learmonth has indicated, there are a number of areas as to how the profession relates to the requirements where we acknowledge, and we are in complete concert with them, that we could probably streamline it. We have to do that, though, in an orderly manner. The reality is that we have to be accountable to you and the parliament more broadly for the funds that we spend, so trying to find ways to manage our expenditure in a way that it is accountable and meets the profession's requirements obviously dictates quite a long process of talking to them, as well as—to borrow from an earlier conversation with Senator McLucas—us thinking about it.

Senator MOORE—Also there are privacy aspects, because every time these issues come up that weighs over the top.

Ms Halton—Absolutely.

Senator MOORE—I think that is enough for enhanced primary care. You may be the right people for practice incentive programs as well. These are the same kinds of questions. How many practices are signed up for the various practice incentive program activities? Can we get a breakdown of numbers and percentages by activity?

Mr Learmonth—The breakdown, I will take on notice, Senator. Overall, about 80 per cent of practices are signed up for PIP.

Senator MOORE—Of all registered practices, about 80 per cent?

Mr Learmonth—Yes.

Senator MOORE—When you are getting that on notice can we get a breakdown of payments by activity?

Mr Learmonth—Yes.

Senator MOORE—From that basis—and this is where I am not sure—is it possible to get an average payment by activity by participating practice?

Mr Learmonth—I believe it would be, yes.

Senator MOORE—That was quick—that is all on the practice incentive programs. It is simply that data. Are service incentive payments your area?

Mr Learmonth—Yes.

Senator MOORE—Can we have a breakdown of service incentive payments by activity? We are also interested in the kind of averaging as well, so the particular wording is: an average service incentive payment by activity per participating practice.

Mr Learmonth—Yes.

Senator MOORE—There was some media comment about the PIP payments—there is interest in the industry about how they are going. One particular comment we want to know about is on the reasons, if you can get them, why service incentive payments under the GP immunisation incentive schemes went down. I know you will have all this back in the department but it says, 'Service incentive payments under the general practice immunisations incentive scheme dropped by almost 14 per cent to $2.7 million.' Is there any kind of awareness of why that happened?

Mr Singh—I think that might have been based on some incorrect information. I will need to clarify that.

Senator MOORE—That would be good. That is why we are asking. We just want to find out.

Ms Halton—It does not sound right, Senator. We might get that clipping from you too and have a look at it. We would be happy to clarify.

Senator MOORE—You are more than welcome—and, of course, this is the one clipping that I have not carefully written which paper and when, but it is genuine and I will get that to you. I have some questions on the PET report. PET goes back into history a bit, as you would know, and I am interested in terms of the process in 1999 in discussions between the MSAC and the minister.

Mr Sheedy—I can deal with that. There are also other people dealing with the Medical Services Advisory Committee.

Senator MOORE—If that is needed, they can come forward. I am interested on any advice that was given particularly to the then minister by the MSAC at that time about PET technology and PET as a process.

Mr Sheedy—Advice was given to the minister in about 2000, in fact.

Senator MOORE—My information says 1999, but it was still in the formative stage.

Mr Sheedy—Yes, there were processes running for some time, and as a result of the analysis by MSAC the feeling was that, while PET was a very promising technology that certainly gave good diagnostic advice, it was unclear the extent to which the use of that diagnostic advice changed clinical practice and therefore led to a cost-effective use of technology. Since that time, again on the advice of MSAC, there has been a series of PET providers collecting data which will feed into analysis that will go to MSAC. At this stage it is expected that that analysis and research will go to MSAC next year to help MSAC review the effectiveness, cost effectiveness and safety of positron emission tomography.

Senator MOORE—I am just trying to get the process clear in terms of the series of advices in relation to what was called 'promising technology' in the 1999-2000 process. This may well be a question more for the MSAC people, but is it standard for that kind of advice to be given to MSAC about different procedures and types of service?

Mr Sheedy—MSAC does analyses or assessments of new technology. I am a little bit wary of stepping on others' toes but, in general, MSAC does that by conducting reviews of the appropriate literature in association with or with the advice of relevant clinicians. MSAC can come up with all sorts of recommendations. It can recommend to the minister that a particular procedure is safe, cost effective and effective and that it ought to be considered for public funding. It can say that the procedure has not been proven or that it is unclear at this stage and there is not sufficient evidence one way or the other. The nature of the PET analysis was that there was not sufficient evidence at the time to unequivocally say that it was a cost-effective, safe and effective imaging technology.

Senator McLUCAS—I wonder if I could just step back a little further. I understand that something somewhat unusual happened in 1999 when MSAC actually wrote to the minister referring to the cost of the technology and seeking advice from the minister about that. That seems a fairly unusual step for MSAC to take. Can you confirm that that occurred and explain the circumstances surrounding that?

Mr Sheedy—I am afraid I do not have that detail with me.

Senator McLUCAS—Do you recall that?

Mr Sheedy—There was correspondence, I have just been advised, between the MSAC chair and the minister setting up the review for PET, but we do not have the detail here.

Senator McLUCAS—That goes back to 1999?

Mr Sheedy—Yes, it does.

Senator McLUCAS—With Minister Wooldridge?

Mr Sheedy—Yes.

Senator McLUCAS—Do you recall—or does the other officer recall—that the chair of MSAC essentially advised the minister of the cost of the technology and sought his comments on the issue of cost?

Mr Sheedy—I have no recollection of that.

Senator McLUCAS—It might be useful to the committee if you were to go back and check that correspondence.

Mr Sheedy—Yes, we will check the documentation to see if there was such a reference.

Senator McLUCAS—That might be able to happen in the course of today.

Mr Sheedy—Yes. In general, can I point out, however, that there are two processes in dealing with the introduction of new technology through MSAC. One is an evaluation, which is conducted by MSAC, and then there is the consideration of MSAC's recommendation by government to determine if and how it is able to fund any recommendations coming from MSAC.

Senator McLUCAS—The recommendation that came from MSAC after that initial process, I understand, concluded that PET was clinically effective. Is that your recollection?

Ms Halton—It is regrettable that we do not have an officer here who was there at the time. You would probably be aware that this is a fairly contested space. If it is acceptable to you, I would prefer that we go back and examine the files and give you quite particular answers in relation to this issue. Senator Denman, I know we have this dialogue with you every Senate estimates and we are very conscious of your interest in the issue, but there are others around who have taken a particularly intense interest in this issue. I am conscious that in trying to be helpful officers may say something which is technically inaccurate and, as this is a very difficult space, I would rather we be absolutely accurate—on indulgence, if you would not mind. There is no doubt that the arrangement, as broadly described by Mr Sheedy, is absolutely accurate.

I think the role of MSAC is well understood. We have an arrangement where, effectively, an opportunity to collect extra evidence was provided. As to how that came about and what the process of correspondence was, I would like to go back and check the files. I do have a memory, having looked at the issue myself because of the interest some people have in it, but I think it would be ill-advised even for me to tell you what I remember of that evidence because I may be inaccurate.

Senator McLUCAS—Is it possible for us to reconvene on this issue at a later point today?

Ms Halton—That would be fine. We will get someone to go to Woden and have a look. In fact, if you have a series of things you would like to know, I will make sure we can provide you with answers.

Senator McLUCAS—Essentially, I am looking for the chronology of the decisions, the reporting process and the recommendations of MSAC at various points in the assessment of PET. When do you think officers may be available?

Ms Halton—Can we come back after lunch?

Senator McLUCAS—Let us do it as the first item after lunch.

Senator MOORE—Can I get some information about the recommendation for the PET scanner for Westmead Hospital, as announced in September 2004. Also can you give me some general information about how decisions are made for new PET scanners and the Medicare rebates for scanners.

Mr Sheedy—The announcement on PET at Westmead was made as an election commitment.

Senator MOORE—What is the process for decisions on the installation of such expensive and valuable equipment and how does it link to Medicare rebates?

Mr Sheedy—In relation to that one, in particular, I cannot say anything because it took place during the election caretaker period.

Senator MOORE—I have carefully noted that.

Ms Halton—In other words, there was no advice from the department on the matter.

Senator MOORE—Generally, when you give advice, what kinds of things are taken into account and how are those decisions made—except for that one?

Mr Sheedy—All the other PET machines funded by the Commonwealth have been through the MSAC process and associated decisions by them.

Senator MOORE—What kinds of things are taken into account?

Mr Sheedy—The advice from MSAC on what was necessary to allow a better understanding of the effectiveness of the technology. As a result of that, a decision was made to fund a certain small number of PET machines throughout the country to enable data collection to occur.

Senator MOORE—Is that to see how it goes?

Mr Sheedy—To allow data collection to occur to add to the research base for MSAC's future assessment.

Senator MOORE—Is there a checklist about what sorts of things are taken into account?

Mr Sheedy—This all arose from the process that Senator McLucas has been inquiring about.

Senator MOORE—The original one; okay.

Senator TROETH—I have a question about Medicare schedule item 35643. Is there any consideration or any plans to place certain requirements or prerequisites that must be met before a medical practitioner can provide a service under that schedule number?

Ms Halton—Not that we are aware of.

Senator TROETH—Can you tell me the present level of funding provided to the Australian Federation of Pregnancy Support Services in the last budget year?

Mr Stuart—The amount provided to that organisation in 2004-05 was $245,580.

Senator TROETH—Is there a comparable level of funding provided to other agencies providing those services?

Mr Stuart—The Commonwealth funds a range of services. Whether you see them as comparable or not would be a matter for you to consider. But we provide, in addition, about $100,000 per annum to Sexual Health and Family Planning Australia—the umbrella organisation for family planning; and, in 2004-05, $114,000 for Working Women's Health and

$918,800 to the Australian Episcopal Conference of the Roman Catholic Church. That is all in addition to the $14 million or so which is provided for family planning organisations.

Senator TROETH—Why is the amount provided to the episcopal conference much larger than that to the other services? Is it a bigger service or does it provide a wider range of services?

Mr Stuart—It provides a different kind of service. It provides a service of advice on natural family planning.

Senator TROETH—So you would describe it as a different sort of service?

Mr Stuart—In that it provides advice on natural family planning.

Senator TROETH—What do you mean by natural family planning?

Mr Stuart—Alternatives such as the Billings ovulation method, amongst others.

Senator TROETH—What are the others?

Mr Stuart—The symptothermal method. I think that covers the field.

Senator TROETH—I have questions about the provision or nonprovision of ECP Postinor 2, also known as the morning-after pill, and RU486. Are these in this section or under TGA?

Ms Halton—It depends on the question.

Senator TROETH—Is there a policy reason why the morning-after pill has not been placed on the PBS?

Ms Halton—It is an over-the-counter product, and there has not been an application to put it on the Pharmaceutical Benefits Scheme.

Senator TROETH—It can be bought over the counter?

Ms Halton—Yes; correct.

Senator TROETH—What about RU486? I know there has been debate about this in the past, but apparently there is currently a legal restriction in place that requires direct ministerial and parliamentary approval of an application for it into this country.

Ms Halton—I will ask one of our medical advisors to explain the difference between the products.

Ms Blazow—There are two products: RU486 and Postinor-2.

Senator TROETH—I realise they are not the same.

Ms Blazow— They are different. They are not the same product.

Senator TROETH—I realise that.

Dr Lopert—Could you please repeat the question.

Senator TROETH—You gave me the explanation that the morning after pill, Postinor-2, is available over the counter and no application has been made to put it on the PBS.

Dr Lopert—That is my understanding; that is my advice.

Senator TROETH—My other question was about RU486. I understand there is a legislative restriction in place at present that requires direct ministerial and parliamentary approval of an application for the importation of it into this country. Is that so?

Dr Lopert—I am sorry, I am not able to answer that question. That question would have to be addressed by the TGA.

Senator TROETH—That is fine. Thank you very much.

Senator BARNETT—I will just follow up on pregnancy support services funding. Some $14 million is provided for Sexual Health and Family Planning Australia. What amount of services do they provide for pregnancy support, if any at all?

Mr Stuart—We fund family planning entirely for it to provide a range of non-directive counselling information and referrals. Pregnancy support would be a part of the discussion in all or most cases.

Senator BARNETT—I think you said the funding to the Australian Federation of Pregnancy Support Services was $245,580. Do you have a figure of the total amount of funding for pregnancy support services?

Mr Stuart—We are not able to disaggregate out of the family planning funding what amount would go to discussion about pregnancy support in particular, because it is part of wider conversations about a range of options.

Senator BARNETT—Are you able to identify how much funding goes to pregnancy support services or services of the like?

Mr Stuart—No.

Senator BARNETT—Thank you. Can I go to MBS item No. 35643 and item No. 16525. Is the department able to advise the committee of the number of procedures under those items in the past 12 months and, if possible, in the past 10 years? Can you break that down on a state by state basis?

Ms Blazow—I am not able to break it down on a state by state basis from the data that I have here, but I can take that on notice. I am able to give you the numbers. I have it by age range in a table. I can add that up to give you the total numbers against those two items.

Senator BARNETT—When you say the age range, you mean the age of the mother in each case?

Ms Blazow— Yes. For item 35643, there were 72,214 procedures.

Senator BARNETT—Is that for the last 12 months?

Ms Blazow—For the period January to December 2004. For item 16525, there were 683 services for the same period.

Senator BARNETT—Are you able to table that and provide those figures for the last 10 years?

Ms Blazow—We would have to take that on notice.

Senator BARNETT—Can we get that today? Is that difficult to do?

Ms Blazow—I am sure we could do that today.

Ms Halton—We will come back later today.

Senator BARNETT—That would be great, thank you. Are you able to break that down on a state by state basis?

Ms Blazow—Yes.

Senator BARNETT—Is that possible today?

Ms Blazow—Apparently not today. We will have to go back to a number of different records, but we will do it as quickly as possible.

Senator BARNETT—Thank you. Are you able to identify the duration of the pregnancy in each case?

Ms Blazow—No. That would be clinical information that is not held in our records.

Senator BARNETT—Item No. 16525 relates to second trimester procedures.

Ms Blazow—That is correct.

Senator BARNETT—What is your definition of the second trimester?

Ms Blazow—As this is a medical issue, I will call on my medical adviser, Dr Jane Cook. She can give you a definition of second trimester.

Dr Cook—Second trimester is the period from the third calendar month to the sixth calendar month, which is around 13 to 26 weeks pregnancy.

Senator BARNETT—To confirm: there were 683 procedures in 2004 in the second trimester.

Dr Cook—Sorry, could you repeat the question.

Senator BARNETT—I want to confirm that the figure you just provided me under item No. 16525 is 683 for the last 12 months.

Ms Halton—That is correct.

Dr Cook—Yes.

Senator BARNETT—Are you able to identify during that period when those procedures took place?

Dr Cook—No.

Ms Halton—No.

Ms Blazow—I assume you mean the number of weeks of pregnancy?

Senator BARNETT—Yes.

Ms Halton—No.

Ms Blazow—No.

Ms Halton—That is clinical information that is not part of the information collected by the Health Insurance Commission.

Senator BARNETT—So all we know is that it is somewhere in that second trimester?

Ms Halton—That is correct.

Senator BARNETT—Studies have been done of the number of procedures in total. We are talking about Medicare funded procedures.

Ms Halton—That is correct.

Senator BARNETT—Some studies have been undertaken showing that between 13 and 33.8 per cent of abortion procedures are not Medicare funded. Do you have—

Ms Halton—I do not know to which study you refer.

Senator BARNETT—The Victorian study that found that between 13.1 per cent and 33.8 per cent of women who had abortions in Victoria may not claim the Medicare rebate.

Ms Halton—I cannot comment. I have not seen that. I will take your word for it.

Senator BARNETT—Do you have an estimate of the total number of abortions that take place in Australia outside of the figure for Medicare funded abortions that you have just provided the committee with?

Ms Halton—We believe it is very hard to come up with a precise estimate of the number. It is possible to come to an approximate range, but it is very difficult to come to a precise figure. By derivation it is therefore very difficult to say the number that are not funded by Medicare.

Senator BARNETT—Can you provide the range to us? We know that in the last 12 months to 2004 there were around 73,000, based on the figures you have just given us. Based on those outside of Medicare funded abortions, can you provide an estimate to the committee?

Ms Halton—We would think an upper limit would be about 90,000. We believe that is the upper limit.

Ms Blazow—Can I make one other qualification. There are some procedures performed under the two items that we were talking about before, which may not involve a live foetus. It is very difficult for us to know how many of those there are.

Senator BARNETT—Thank you for that. I appreciate that. That confirms my advice as well. I understand Medicare data does not include pregnancy terminations performed on public patients. Is that your advice?

Ms Halton—That is correct.

Senator BARNETT—Do you have any idea of how many that might include?

Ms Halton—Obviously that is information that is held by the states. My earlier comment was about it being very difficult to come up with an estimate, but we would believe the upper limit to be about 90,000. That is because that data is not held by us and therefore we cannot tell precisely and that, for the reasons that Ms Blazow just indicated, a number of these items that you have just referred to would involve a death in utero.

Senator BARNETT—So that information is held by the state governments in their public hospital systems somewhere and that is information that you do not have with you?

Ms Halton—I cannot comment on where they hold it, but it is not Commonwealth held information.

Senator BARNETT—I understand. When you come up with the number of up to 90,000, do your figures include an estimate of those procedures in public hospitals?

Ms Halton—That is correct.

Senator BARNETT—I understand that the Medicare data excludes women who have terminations in private settings and do not claim the Medicare rebate. I am assuming that is confirmed by you.

Ms Halton—Obviously the only information we hold is information which is produced as an administrative by-product of the claim to Medicare.

Senator MOORE—Could you get for us statistics as to how many comprehensive medical assessments have been undertaken?

Mr Learmonth—Yes.

Senator MOORE—Does the department have any statistics about how many GPs have actually used the rebate?

Mr Learmonth—I can tell you that. For the year to date to December, 13,659 comprehensive medical assessments have been undertaken.

Senator MOORE—Are those figures collected monthly as well?

Mr Learmonth—I believe so.

Senator MOORE—You said earlier that to do a comparison with some of the statistics you pick an annual process. Is there any particular month that you will putting in when doing an annual evaluation as to CMAs?

Mr Learmonth—I have not even thought about that. They only came in on 1 July last year.

Senator MOORE—That is what I was thinking. This is a question about the type of statistical planning because there is so much data that you keep and so many requests that you have for it. Do you spread out the kind of comparative tasks across the years? You said earlier, in response to one of the previous questions, that you used an October date for the annual comparison of percentages. When you are doing your work plan, do you spread the number of things that you are comparing across the year?

Mr Learmonth—I do not think there is any planning in spreading the workload. It depends on the individual item. When an item is introduced, it takes some time for the utilisation to essentially stabilise; you expect a ramp-up period. In a sense when an item is introduced the dynamics as to how quickly it is taken up will essentially determine when the first valid comparison point might be for an ongoing time series when it first becomes stable after a take-up period. That is what really would determine when you might first choose a period.

Senator MOORE—As it is relatively early, has there been any analysis done to see whether this is a good result so far? When the program was introduced, were some goals put in place that by a certain amount you would have so many practices using it and so many tests done?

Mr Learmonth—There are certainly projections done of the expected uptake of that item and I would say that utilisation is well in line with those projections.

Senator MOORE—Is the projection information public? Do you have the information about how many you wanted to have done in the first year? Is that a public document?

Mr Learmonth—I am not certain.

Senator MOORE—Would you take that on notice as we would really like to know in analysing the success. You are saying that 13,659 in December is in line with what the program was hoping to achieve. It would be good to know what kind of flags you have got for what you expect over a period of time. We would like that if possible.

Mr Learmonth—Certainly.

Senator MOORE—Because this was a high-profile introduction and involved lots of consultation beforehand, what kinds of things is the department doing to encourage GPs to use this process?

Mr Learmonth—I think, as with all items that have been introduced, there is always a fairly comprehensive awareness campaign conducted about them in the publications of the Health Insurance Commission that go out to practices, in the specialist media and other forms of communication. Generally they are all well publicised.

Senator MOORE—One of the things we have found out in a couple of other inquiries is concern from doctors about the facilities for their use in aged care homes. These are the facilities of specialised rooms for them to do assessments and to talk with clients. Do you have any idea through your data, particularly linked to this program, how many residential aged care facilities have private consultation rooms?

Mr Learmonth—It is not something that we would collect, I am sorry.

Senator MOORE—Is it an issue that you have heard about?

Mr Learmonth—I certainly have heard of it over time. What I do not have is any particular sense of how significant an issue it might be.

Senator MOORE—In a previous hearing in another committee it was on evidence that one person made the statement from the profession that more aged care homes had hairdressers than GP consulting rooms. It was just a statement. I think it is of interest with this particular program that they are encouraging some private consultation process. I know that there have been surveys that the department has done—this may or may not be this area but it is linked to the program, so tell me if it should be in another program—

Ms Halton—I would like to make a comment about that as this is on the record. I would make the observation that aged care homes often have multipurpose rooms.

Senator MOORE—We said that as well. It was actually a statement made on the point that, for people taking up this type of service, particularly GPs operating in the aged care area, one of the problems was the appropriateness of the service.

Ms Halton—Exactly. I think what GPs are often looking for is a dedicated space in a facility.

Senator MOORE—Absolutely.

Ms Halton—Whilst it may be true that services offer hairdressing and a bunch of other things, as we all know when we go round, often that is in a multipurpose room. I think the issue here is about being able to set space aside permanently. We would not want the public of Australia to think that people were worried more about their hair than their health. They might be.

Senator MOORE—I think they are deeply linked! Nonetheless, it was of interest to members of the committee that this was a public statement made about the uptake of this program. How many surveys has the department received about aged care residents' access to GPs?

Mr Learmonth—There was a survey which was done in relation to the Aged Care Panels Initiative which was designed to capture a range of information around GPs, primary care and residential care facilities. I believe that included questions about access.

Senator MOORE—It did, yes.

Mr Learmonth—That has only just recently been completed and the results are still being analysed.

Senator MOORE—I heard a term last night from another department that 'the results are being cleansed'. This was not in terms of changing the data but cleaning it up. Is that the stage which this particular survey is at in your department?

Mr Learmonth—I could not tell you with any specificity. The results are still being collated and analysed.

Senator MOORE—Is there any expectation when that data will be made public?

Mr Learmonth—I am hoping the report will be completed by the end of the month.

Senator MOORE—For the record that will be February 2005—is that right?

Mr Learmonth—That is my intention.

Senator MOORE—You cannot give us any idea of how many surveys were returned?

Mr Learmonth—I can.

Senator MOORE—That would be good.

Mr Learmonth—I will have to take that on notice.

Senator MOORE—That is fine.

Mr Davies—Just going back to your earlier line of questioning which, writ large, was about the relationships between GPs and aged care facilities, part of the package of measures last year was the funding to actually set up the GP panels. That was funding that was going to the divisions of general practice. Part of what that is aiming to achieve is to strengthen that relationship between local GPs and the aged care facilities. I am not pretending that will necessarily lead to dedicated rooms, but getting a more collaborative and close working relationship is certainly part of what is intended there.

Senator MOORE—And it is all part of that whole goal in terms of access and confidence and those things—

Mr Davies—Precisely.

Senator MOORE—and I think there are going to be some questions specifically on that in the appropriate outcome, which I had kind of slid into there. One of the issues, because we are looking at other health providers through this process, is the issue of dental care. That has been coming up a lot in discussion with a range of people. Is there any background to why dental care was not included as part of this particular program, the comprehensive medical assessment?

Mr Singh—There is a link between the care planning items and the dental items.

Mr Learmonth—Senator, were you asking about the aged care panels?

Senator MOORE—No, I am asking about the comprehensive medical assessments—I drifted away to aged panels for a while but I have come back.

Mr Singh—Dental care is certainly something that can be looked at under the comprehensive medical assessment service and that would then possibly be taken forward in the care plan process, which would then allow people to access the dental items.

Senator MOORE—Under the current comprehensive medical assessment, dental care and dental services can be linked in with that?

Mr Singh—The comprehensive medical assessment allows the doctor to make that assessment. Dental issues may be one of the things that they want to look at. What I am saying is that they might then chose to take that forward into a care plan which would involve a dental element, and that would allow access to the dental items now on the MBS.

Senator MOORE—I might come back to that.

Senator McLUCAS—How would a doctor, a GP, be able to do an assessment of need for dental services?

Mr Singh—What I am saying is that the doctor might decide that there is something there that needs to be looked at by a dentist, in terms of whole patient care and the care plan that they might subsequently do after a comprehensive medical assessment. I am not suggesting that a doctor would necessarily be able to make the same diagnosis as a dentist at that initial health assessment.

Senator McLUCAS—It would be very general: 'The patient requires dental work'?

Mr Singh—That is right.

Mr Learmonth—I think the key is that the issue of dental has to relate to its contribution relevance to the chronic disease that the doctor is looking at or to the patient's condition—it has to be a contributing factor—rather than a general dental check-up per se.

Mr Davies—We are jumping between the comprehensive medical assessment and the EPC item. If you look at the wording of the item which allows dental services to be delivered as part of an EPC, you can see—I cannot remember the exact wording—that the concept is a dental condition which is having an adverse impact on the patient's health. I think the

analogous situation in the comprehensive medical assessment would be if the medical professional, the GP, was doing a medical assessment of a resident of an aged case facility and determined that there was a dental condition that was having a adverse impact on that patient's health, then that would be the sort of assessment of dental condition that would be encompassed in that comprehensive medical assessment. As Mr Learmonth said, it is not looking for teeth that need filling; it is, as can often be the case, assessing that a certain dental condition is exacerbating or contributing to a medical problem.

Senator DENMAN—This may have already been asked and I have not been paying attention: when a person goes into a residential care place is their own GP able to attend them?

Ms Halton—Yes.

Senator DENMAN—But if they move into an aged care facility in an area where their GP does not live then the nursing home will choose a GP for them?

Ms Halton—You always have a choice of doctor. As you say, if you move somewhere locally or your general practitioner is prepared to travel—and I know that is the case for many people—then you are at liberty to continue seeing that general practitioner, or not, if that is your wish. If you go to an area, what you will very frequently find is that the nursing home may provide you with advice. In fact, I know of a number of circumstances where, for example, a person has moved to be closer to a daughter and they have asked the nursing home about who they would advise them to see. But if you have moved to be closer to your daughter and your daughter already has a general practitioner whom you would like to see, you are absolutely at liberty to make that choice.

Senator McLUCAS—But that GP also has a choice about whether or not they take you as a patient.

Ms Halton—Of course.

Senator McLUCAS—I think that is the issue.

Ms Halton—Yes.

Senator McLUCAS—Especially when people move into areas where there is a high number of residential aged care facilities.

Ms Halton—As you would understand, one of the things we have been trying to do is facilitate access by residents of aged care facilities to appropriate medical advice. I have talked to providers right around the country myself about exactly that issue. One of the reasons we have come up with this initiative is to try to facilitate appropriate and timely access to general practice by people who need it.

Senator MOORE—What is the relationship between CMA and residential medication management reviews and is there any link between those two related initiatives from the department's or the government's point of view?

Mr Learmonth—No, there is no link between the two.

Senator MOORE—There is no relationship?

Mr Learmonth—No, they can be done independently.

Senator MOORE—They are complimentary, are they not?

Ms Halton—Yes.

Senator MOORE—But they do not have to be linked, is that correct?

Mr Learmonth—They do not have to be.

Senator MOORE—Do you have any statistics on residential medication management reviews?

Mr Learmonth—We do.

Senator MOORE—I would like those as well.

Mr Learmonth—This is quite a new item. Whilst we have some initial statistics, I would be very loathe to suggest they are at all representative. The item only came into effect on 1 November. As at 31 December, there have been 542 services claimed.

Senator MOORE—Those are very quick statistics.

Mr Learmonth—That is right. I would not all see them as representative.

Senator MOORE—Probably by the next round of estimates we could ask.

Ms Halton—We would have a better feel by then.

Senator McLUCAS—Is your data collection on the GP panels that have been established able to ascertain how many doctors have taken up visiting residential aged care as a result of the establishment of the panels?

Mr Learmonth—I do not believe so; not as yet. Certainly something we would be looking at as the panel process evolves and matures is data around performance in the area of access.

Ms Halton—Whether you could ever directly link the panel to changed behaviour might be more difficult. As Mr Learmonth indicates, we will probably be able to see the number who attended in one period and the number who attended later, albeit in different proportions. But in terms of saying, 'That doctor commenced attending aged care facilities because of panels,' would require a more detailed study.

Senator McLUCAS—But the intent of the panels was to encourage more doctors to become—

Mr Learmonth—It was to encourage better access—whether that is more doctors—but certainly better access.

Senator McLUCAS—It has to be more doctors, doesn't it?

Mr Learmonth—It could be the same doctor doing more.

Senator McLUCAS—The doctors I have spoken to do not want to do more. They are stretched enough as it is. We will in the future want to know whether or not there have been greater numbers of doctors who are attending residential aged care facilities as a result of this measure.

Ms Halton—I think we need to look at both the numbers of individuals and the number of attendances because—and I accept what you are saying anecdotally—as Mr Learmonth says,

individuals are choosing for themselves to spend more time on that kind of a practice. So I think the two need to be looked at to get a fair reflection.

Senator McLUCAS—On the latter description of doctors—of those who wish to specialise, shall we say, in residential aged care—how would the establishment of the panels have affected the intention of those doctors? If a doctor is going to do that, they are going to do that; they do not need the panel process to do it.

Mr Learmonth—I think as the panel arrangement evolves we might see a variety of things. There is money available for remuneration for GPs to be put on retainers to encourage access to GP services in nursing homes. There is finding tied up within the initiative that might well encourage those things.

Mr Davies—You may know where that arrangement is working when you have the GP or GPs who are interested in or dedicated to or committed to that sort of work. The impact of the panel may be more to make that arrangement more robust in terms of providing backup and locum cover when those GPs take holidays. Those arrangements, while very effective, can sometimes be fragile at the margin. The impact of the panels, rather than filling a gap, would be more in terms of ensuring that what is working continues to work.

Senator McLUCAS—When it was packaged it was very much about encouraging doctors into residential aged care.

Mr Davies—That is the primary goal undoubtedly.

Ms Halton—That is true.

Senator McLUCAS—I think we have to measure that.

Ms Halton—We will. My point is merely that we need to look at the total of medical care that is going into nursing homes, not just the straight number of bodies, to get a fair reflection of how it is going.

Senator McLUCAS—We will watch with interest.

Ms Halton—So will we. In 12 months?

Senator McLUCAS—Yes, I think we could get some indication of what is happening in 12 months, I imagine.

Ms Halton—I would think so.

Senator McLUCAS—I would like to talk about the PBS. Can you tell us what percentage of PBS prescription medicines are dispensed to concession card holders and non-concession card holders.

Ms Blazow—About 80 per cent.

Senator McLUCAS—To concession card holders?

Ms Blazow—Yes.

Senator McLUCAS—What percentage of PBS prescription medicines are currently being dispensed below the non-concessional copayment price?

Ms Blazow—We do not have data on the below copayment, so I am not able to answer that question. There is a survey that is done of pharmacies to give us an estimate. I cannot even recall the figure that comes out of that but it is an estimate based on the survey of pharmacies. We do not hold the HIC data on under-copayment prescriptions.

Ms Halton—No information is provided by pharmacies to the Health Insurance Commission on scripts that are provided at a price lower than the copayment.

Senator MOORE—How often is that survey done?

Ms Blazow—Annually.

Senator MOORE—In which month?

Ms Blazow—It is a continual survey to gather data using a rolling sample.

Senator McLUCAS—What is the size of the sample?

Ms Corbett—The sample size is between 100 and 150 pharmacies. The guild collects that data and passes it to us.

Senator McLUCAS—What data is collected?

Ms Corbett—The data covers the item number, because these are PBS listed items, and it tells of the number of scripts for that item. But we do not get comprehensive information on the prices charged for those items. It is primarily the number of scripts under each item code.

Senator McLUCAS—So we do not know; we have no way of knowing?

Ms Corbett—At this point in time, we do not gather comprehensive data.

Ms Halton—We have no way of knowing.

Senator McLUCAS—We have no way of knowing which medications are being dispensed under the copayment price, whether that be copayment for concessional or non-concessional?

Ms Halton—Correct, and that has always been the case.

Senator McLUCAS—So how is it that the minister could say that generics will lead to costs coming, for the first time, below the copayment?

Ms Halton—Because that would be in relation to products that are currently above the copayment and knowing that if the price drops a certain amount it will take them below copayment.

Senator McLUCAS—So we know the costs of drugs that are over copayment but we do not know what is being charged for drugs that are below copayment?

Ms Halton—Yes. We can therefore say—if they are above the copayment area and if we know what their prices are—we know that they will come down by that amount and if they will go below copayment.

Ms Corbett—Every PBS item that is listed has a price registered in the PBS schedule book, which is available online or in book form. It is not actually a difficult matter to look in the book for things that are currently over the general copayment level of $28.60 and work out from the price registered in the book which ones would, if they had a 12½ per cent price reduction, come below $28.60. We can be quite accurate about which drugs are likely to be

affected by this measure in that sense. That is where the information that the minister provided comes from.

Mr Davies—Of those most likely to come off the general copayment, in contrast with the ones we were discussing earlier, we do have details on the number that are dispensed.

Senator McLUCAS—So how many are in that range?

Ms Corbett—Out of our 2,600 items in the PBS book, currently about 1,500 are priced below the general patient copayment level of $28.60. That number will move from time to time as each reviewed set of prices is put out, but it is around the 1,500 mark currently.

Senator McLUCAS—The difference is that we do not know the actual price charged.

Ms Corbett—That is correct.

Senator McLUCAS—But we know what the scheduled fee is?

Ms Corbett—Exactly right.

Senator McLUCAS—So there may already be drugs which certain pharmacies charge less for?

Ms Corbett—It is possible that pharmacists are charging less for some drugs than is in the book. It is possible that some charge more.

Ms Halton—You cannot discount the copayment. If it is an above copayment item—so it is in the area where we collect the data—the pharmacist may not discount the copayment.

Ms Blazow—That is correct. If the price in the book is above $28.60 the pharmacist must charge the $28.60—or nil, depending on safety net arrangements and so forth—and then the government bridges the gap between that $28.60 and the price of the drug with our subsidy. We collect the data on that because there is a subsidy involved.

Ms Halton—Exactly.

Senator McLUCAS—I will understand the PBS one day.

Ms Halton—It has taken me 20 years.

Senator McLUCAS—I have a long way to go. The 12.5 per cent policy on the PBS is intended to encourage sustainability in the PBS. How will the department do that?

Ms Blazow—By improving the role of generic medicines in the PBS by encouraging price reductions, therefore reducing the amount of subsidies that have to be put into the PBS and ensuring greater affordability for patients.

Senator McLUCAS—How does it encourage price reductions?

Ms Blazow—It is actually requiring price reductions.

Ms Halton—It is a gentle term, Senator.

Ms Blazow—When a new brand comes forward after the implementation date we will require them to offer the 12.5 per cent reduction in order to get listed on the PBS, which mean that the price in the book will come down and the subsidy comes down. Those medicines that then fall below the copayment will also be cheaper for patients.

Senator McLUCAS—Part of the package of policy that the government announced included the reduction of about $800 million from the PBS. How will the PBS accommodate that? How is that a sustainability measure?

Ms Blazow—We would be providing fewer subsidies but the manufacturers would be still listing at those prices. We would be subsidising it less because we would be getting a price reduction. It means that we are expending less for the same outcome.

Senator McLUCAS—How was that $800 million figure arrived at?**Ms Blazow**—Using modelling, of course. We had to look at where we thought drugs would be coming off patent over the next few years, which would of course stimulate a generic to come in and compete with the originator brand product. So we looked at where patents were expiring and where we thought there was still scope in the existing listings on the program for perhaps greater competition, where a generic manufacturer may wish to bring a new brand forward and take the 12½ per cent price reduction.

Ms Corbett—To clarify, that certainly applies to the first official estimate of the savings from the government, which was reported in the Charter of Budget Honesty. The figure that was announced in the election context was a little higher—the figure of $830 million that you referred to. When we used government processes, our estimate was actually $740 million, which the department of finance published with the Charter of Budget Honesty.

Senator FORSHAW—Is anything in this proposal directed at doing more to encourage the profession to prescribe generics—obviously ones appropriate to treat the condition—in effect to ensure that this measure actually works?

Ms Halton—This measure is obviously a pricing measure. The whole question of appropriate encouragement to the profession to prescribe generically is in a sense a slightly different area, so is not wrapped up in this particular measure.

Senator FORSHAW—At the end of the day, pricing mechanisms can only work if the profession is part of the—

Ms Halton—That is not quite true. The way the Pharmaceutical Benefits Scheme works is that pricing measures work because of reference pricing.

Senator FORSHAW—I understand that.

Ms Halton—We will get the savings because of reference pricing. The way the whole Pharmaceutical Benefits Scheme works is that, once a product comes on and there is a reference pricing, other products either will price at that level or will have to have a premium.

Ms Blazow—Our subsidy falls as a result of the price falling.

Ms Halton—So we will get the saving. There is a separate question which is about how you encourage generic prescribing.

Senator FORSHAW—That is a general issue, I understand that.

Ms Halton—That is exactly my point. So we will get those savings.

Senator FORSHAW—I understand the logic of what you are saying. Behaviour can change.

Senator McLUCAS—There has been some commentary in the media from various pharmaceutical companies that this may be a disincentive for them to list or apply to have their drug listed on the PBS. What is the department's view about the veracity of those claims?

Ms Blazow—I think you need to look at the PBS in two categories. The first one is new listings where there is a brand-new drug—the chemical compound is new. That is not affected by this measure at all, so companies will still go through the normal process with regard to those drugs. They will put their submissions to the PBAC, be assessed for cost-effectiveness and be listed in the normal way. This measure affects products which are already off patent, or coming off patent in the next two years, where there will be new competition.

The one exception is where we have products price referenced in groups. The common case is the therapeutic group situation, where the PBAC has assessed various drugs that all deliver the same health outcome. Therefore, they are reference priced to each other for pricing arrangements, and we set the subsidy level at the same rate because all of those drugs deliver the same health outcome.

It is possible that some of the products in those groups will be on patent and some of them will already be off patent, so the medicines industry has claimed that there may be a disincentive to bringing forward new medicines that would be on patent into those groups. The counter to that is that, if the products are in fact doing the same thing, it begs the question whether we actually need a heap more of those products anyway. But the companies can still make their commercial decision as to whether they list or do not list at whatever the benchmark price is.

Ms Halton—Whether they have a brand premium, if that is what they wish. There is absolutely no doubt that if this is a brand-new therapy to treat something we have not been able to treat before—

Senator McLUCAS—It cannot be listed with other drugs unless it is a new therapy anyway.

Ms Blazow—Because it is on patent.

Senator McLUCAS—Can you explain to the committee what the department does to monitor drugs coming off patent? How do we track that?

Ms Blazow—This is quite complex. In fact the companies have whole teams of people who do this sort of work. For some drugs it is not simply one patent; some drugs have many different patents operating on them. It is not possible for us as a department to replicate the research work that the companies do but we do some work to that effect. That is how we have done some of our modelling. Since the measure was announced we have worked with the industry and they have given us a lot more information about which drugs they think are going off patent. It has been very useful for us to work closely with them and look at their modelling in that regard.

Senator McLUCAS—Is it possible to provide the committee with an understanding of the bases of the modelling, or is it possible to provide us with the modelling so that we can have a look at the question of sustainability?

Ms Blazow—The Department of Finance and Administration are the custodian of the estimates and it is not their normal practice to reveal the model. However, during the consultation period we explained to the industry some of the basic assumptions that we used because we needed to have a dialogue with them about that. We would be very happy to table the material that we have given to the industry in that regard.

Senator McLUCAS—That would be useful, thank you, Ms Blazow. What information was provided to foreign governments about the 12.5 per cent policy?

Ms Blazow—We provided them with the same information that we gave to our domestic industry people during the consultation. We have certainly had representations from foreign governments about the measure and we have given them access to the information that we have been using in the public arena.

Senator McLUCAS—Are you referring to the public information that is available in Australia?

Ms Blazow—That is correct. We have had discussions with them but we have used the same information that we have made available to the industry and the people who have been interested in the measure here in Australia.

Senator McLUCAS—What is the interest of other governments in what we are doing?

Ms Blazow—Many of the companies that trade in Australia have head offices in other countries—either in Europe or in the United States.

Senator McLUCAS—So they were basically representing their constituent companies?

Ms Blazow—Yes.

Senator McLUCAS—I imagine that would include the US?

Ms Blazow—Yes.

Senator McLUCAS—What other countries are interested in what we are doing?

Ms Blazow—I would need to check but I know there have been European countries that have made representations.

Senator McLUCAS—So what is the nature of the representations to Australia?

Ms Blazow—The representations have been from their embassies.

Ms Halton—I would characterise it as a desire to understand the measure.

Senator McLUCAS—What is the view of the department on how this policy affects the US free trade agreement?

Ms Blazow—There is nothing within the free trade agreement that is a pricing obligation—how we do our pricing in Australia—so we have a very strong view that this is not affected by the US free trade agreement. This is a domestic policy matter available to the Australian government regardless of the obligations. I have just received a note about the other countries: France and the United Kingdom have approached us, as well as the United States.

Senator McLUCAS—Did you take advice on whether or not this policy offends the USFTA?

Ms Blazow—Yes, we have consulted with DFAT.

Senator McLUCAS—Does DFAT agree with the view of the department?

Ms Blazow—Yes.

Senator ALLISON—Can the minister advise whether it is correct that the original proposal would have taken more than $2 billion out of the PBS? The pharmaceutical industry did a calculation which showed that. Is that the case?

Ms Blazow—During the consultation the two industry sectors—Generic Medicines Industry Australia and Medicines Australia, representing the innovative companies—commissioned modelling of the issue and came up with estimates of larger savings than the government savings. However, as I said, we had a dialogue with the industry about those models—and the Department of Finance and Administration was involved also. We do not agree with the extent of the savings that they have estimated. There were a couple of factors that we had disagreements about. We have agreed to disagree with them about that. One of the key things that were not in their models was what we call 'counterfactuals', the savings that we would have had from generics or new brands coming in regardless of this measure. We have taken that into account in our modelling.

Senator ALLISON—Do the industry agree with the new figure, the $740 million? Have they looked at the changes and agreed that is what the savings would be?

Ms Blazow—I do not believe that they have agreed with us. I think we have agreed to disagree about this matter.

Senator ALLISON—So what do they say is the likely saving from the currently proposed measure?

Ms Blazow—I am not aware that they have re-estimated since we had the dialogue with them. They have not re-estimated either since the recent decision was made.

Ms Halton—Not that we are aware of.

Senator ALLISON—We will ask them that. Can I ask about when or if we are going to see legislative change on this measure. I understand you intend to change the legislation. I ask when we will see it and why it was necessary to do that, given that the current PBS arrangements for pricing are not spelt out in legislation.

Ms Blazow—It can be done in either of two ways. It can be done through legislation or it can be done on the model that we currently use, which is an administrative policy approach. The government is still considering the best way in which to implement the measure.

Ms Halton—It is considering both options.

Senator ALLISON—And the start-up date is still 1 April?

Ms Blazow—The government is still considering the start-up date. Certainly during the consultation period we advised people that 1 April would possibly be the select date. It was

originally 1 January. During the consultation we advised 1 April, but it is the prerogative of the government to still consider that date.

Ms Halton—That is currently being discussed.

Senator ALLISON—A start-up on 1 April would be a very tight time frame in which to get the bills through parliament. We have two sitting weeks remaining.

Ms Halton—As bureaucrats, we are attempting to make everything possible if the government decides one way or the other. You are right: it would be a tight timetable.

Senator ALLISON—Impossibly tight, one might say. How many acts would need to be changed?

Ms Blazow—Only one act, the National Health Act. The PBS is captured in the National Health Act.

Senator ALLISON—Have you already gone through the questions about consultation with consumers?

Ms Halton—There was an extensive consultation process around the measures. We did touch on a number of aspects of consultation.

Senator ALLISON—Can you provide a list of those organisations consulted on this and when?

Ms Blazow—Yes, we can certainly provide that. I cannot give you the days off the top of my head but I know that the Generic Medicines Industry Association, Medicines Australia, the Pharmacy Guild of Australia and some consumer representatives are participating in our committees, together with the Consumer Health Forum. We will take the dates on notice as I do not know those off the top of my head.

Senator ALLISON—The Consumer Health Forum claims that there has been no effective consultation. What do you say to that?

Ms Blazow—I suppose 'effective' is the word. We certainly discussed it with them. I think Ms Corbett did it personally.

Senator ALLISON—If it were possible to have the dates when all of that happened, that would be useful to some extent for us knowing whether it was effective. There has been a fair bit of talk about whether in fact patients will not pay the savings of 12.5 per cent by a practice which I understand is known as patient premiums, whereby the patient pays a premium over and above the PBS payment. Can you guarantee that this 12 per cent will not just end up as a patient premium and be a virtual increase in the copayment?

Ms Blazow—Premiums are allowed. They must be authorised. It is an approval process for a drug to be listed on the PBS with a premium. The act actually calls it a special patient contribution. The policy in that regard is that, wherever there is a drug that is interchangeable or substitutable—in other words, the patient can choose another drug at the price for the copayment only—then we do allow the competitor products to have a premium. However, if there is no drug that the patient can choose, then we do not allow a premium and it is not authorised in those circumstances. That is our policy.

Senator ALLISON—So pharmaceutical companies cannot just lump 12½ per cent on top and charge patients?

Ms Halton—No. And the patient has to be able to access a treatment without a copayment.

Senator ALLISON—Given the fact that so many drugs will be off patent in the next short while, can you anticipate whether there will be many drugs in this situation, whereby there is another drug which is available at a lower price?

Ms Halton—We cannot anticipate what the behaviour of companies will be. So if a new product comes in with the 12½ per cent, through reference pricing there would be an expectation that that would flow. In terms of which companies would decide to seek an extra contribution, our experience is that there are very few of those sorts of premiums and they are fairly low, but it is a matter commercially for the companies.

Senator ALLISON—Have you done a kind of impact statement on this measure to try and predict what is going to happen? Do you, for instance, expect this $740 million just to come out of the profits of pharmaceutical companies? How do you expect it to be delivered? Where does it actually come from?

Ms Blazow—The PBS works in such a way that we do not force companies to list a product, we do not force companies to list a brand. We have our rules around how we list, and then the companies make their own commercial decisions whether they come forward and list a brand or a new drug under these circumstances. We do not attempt to go and assess what their profit levels are or what is happening out there in that sense. We simply make very transparent what our arrangements are and what our policies are and then they choose to participate in the PBS on that basis. The PBS, of course, guarantees volumes and guarantees that Australians can afford those drugs. Those are basically the ground rules for the PBS.

Senator ALLISON—So you basically do not know where the money is likely to come from. It is up to the market how they respond to this—some drugs might be made available, some might not. Have you got no idea? This is nearly a billion dollars.

Ms Blazow—The money will come from price reductions for new brands coming forward onto the PBS. In fact, one of the major differences between us and the industry in the modelling has been that they estimated far more new brands coming forward than we did. Their estimations were actually in excess of ours in terms of the number of new brands.

Senator ALLISON—That is generic brands or brand name brands?

Ms Blazow—Brands are brands. Even the innovator companies, as they are called, or the originator companies often have a number of brands of the product on the market already. They make their own commercial choices about whether they list a new brand and if they wish, for our reference pricing purposes, to undercut the price of their own existing brands, for example.

Senator ALLISON—What assurances can you give, firstly, to consumers that the brands which would otherwise be made available are there and, secondly, to taxpayers that there will be no reduction in the number of generic brands we are likely to see as a result of this measure? Because that is what the industry are saying, that there will be fewer drugs they will

bother selling here and there will be less generics coming on board because of this measure. I think it is reasonable for the government to explain why this is not the case.

Ms Halton—I think you only need look at their own modelling. Their own modelling actually suggests that there would be significantly more brands coming to market. In fact, as Ms Blazow has just indicated, one of the points of difference in the modelling is that we actually assumed fewer brands would come to market. If you go to the industry models, they were actually assuming a significant number of additional brands coming into the market.

Senator ALLISON—As result of this measure?

Ms Halton—In the next little while, yes,

Senator ALLISON—As a result of this measure?

Ms Halton—With the measure in place.

Ms Blazow—With the measure in place.

Senator ALLISON—Is it possible to get some more information from you on how this measure works? We have only had press releases and what is in the budget is not clear to me.

Ms Halton—We can give you a written description.

Ms Blazow—During the consultations we did a presentation for industry groups and other people at those sessions and there are some slides which we are very happy to make available.

Ms Corbett—There is also some information on our web site. There are some questions, which have been asked over the last few weeks, and some answers.

Senator ALLISON—Could we also have some predictions on the availability of generic brands—so we are able to measure the success or otherwise—and whether there has been an impact on generics. Presumably, it is one of the objectives of the government to encourage generics because they are cheaper. How will we know whether the predictions that this is going to have a major impact on the uptake of generics are correct?

Ms Halton—I think we should be clear that one of objectives here is to actually have a reduction in the price that the government pays as a consequence of products coming off patent and therefore being available generically. We need to understand that companies—with a brand of product that was previously a patented product—can bring down the price. It is our expectation that they will do that. Where you have a generic competitor—the proportion of the market that they each have will be a matter of competition in the market. But we will pay less, as a country, for those products.

Ms Blazow—As part of the presentation we did actually list where we thought drugs were going off patent that we were making assumptions about. That is in the slides.

Ms Halton—We will get that for you and table it after lunch.

Senator DENMAN—I have a question but I am not sure whether it is appropriate here.

Ms Halton—Why don't you ask us and we will see whether it is appropriate. I have several medical officers here, Senator.

Senator DENMAN—I know paracetamol is not illegal but is being used illegally. Do you have stats on the illegal use of it?

Ms Blazow—In what respect is it illegal?

Senator DENMAN—It is used by young people particularly in the northern part of Tasmania. There was a report done in 2004 called the drug action report. In northern Tasmania, it found that young people were overdosing on paracetamol. Have you not seen that report?

Ms Halton—I cannot say that I have. I do not know whether anyone else has. Have you got an article that refers to this?

Senator DENMAN—Not here with me but I do have an article.

Ms Halton—Would you mind getting it to us? Then we will have a look at it.

Senator DENMAN—The rest of my questions revolve around that particular issue in northern Tasmania. I will put them on notice.

Ms Halton—If you could get the report at lunchtime then we would be happy to have a look at it. If we can deal with the questions, I would delighted to.

Senator BARNETT—I have a question in regard to the prescription drugs per person per year. I was wondering if you had those figures, if they had been averaged out and if they could be provided on a state by state basis.

Ms Blazow—I think Joan has something in her folder about the actual number of prescription drugs per annum. In terms of a state by state basis, we may need to take that on notice and come back later in the day.

Senator BARNETT—When I say 'prescription drugs' I mean PBS prescriptions. Do you have any feedback on the fact that we now have full disclosure on the drug itself—that is, on the packet or the bottle— where we have the total amount and then the government or the taxpayer contribution? That is something that I think is an excellent policy. It was introduced, I think, from 1 August the year before last. Has there been any feedback on that in terms of its implementation?

Ms Blazow—It has gone very smoothly. It is happening. It is on the prescription labels now. I think consumers are finding it useful. Initially there was some concern about extra work for pharmacists and that sort of thing but that has all died down and it is happening and going well.

Ms Halton—I have to say anecdotally—I am sure you find this as well—that when people discover what you do, they will give you all sorts of anecdotal feedback about your work. That is one measure that a number of people have mentioned to me. I think it is actually very visible to people. They say, 'I never knew that X product that I take costs this.'

Senator BARNETT—That is absolutely correct; that is the feedback I get. Up until recently, people were in the dark about the real cost of these drugs to the taxpayer and the community. Is there any way you can average out the cost on a per person and per state basis?

Ms Blazow—I believe we have that data. The average cost to the government per prescription?

Senator BARNETT—Yes. Have you got that figure there?

Ms Corbett—I have prescriptions per capita for both the PBS and the repatriation PBS. For the 2003-04 financial year it is 8.2 scripts per capita.

Senator BARNETT—That is 8.2 scripts for the average Australian?

Ms Corbett—Yes, that is right. The percentage change from 2002-03 to 2003-04 was 2.5 per cent.

Senator BARNETT—A 2.5 per cent increase?

Ms Corbett—A 2.5 per cent increase in prescriptions per capita.

Senator BARNETT—Can we get those figures for the last 10 years?

Ms Corbett—I think we have those.

Senator BARNETT—Just in terms of the increase. That would be helpful.

Ms Corbett—I can give you a breakdown by state for the last financial year.

Ms Halton—My bet is that will be a time series that will not be comparable, because we have had a number of policy changes over that period. Because of the changes at the various points at which copayments have moved, that will probably confound the data on the things that are subsidised and not subsidised.

Senator FORSHAW—That could also be influenced by changes in the nature of prescriptions. For instance, the number of repeats that could be prescribed may have been brought back to a smaller number.

Ms Halton—And you can have a whole new product coming onto the PBS. I can think of Vioxx and a series of other things.

Senator BARNETT—I am sure there are a lot of reasons why you are not able to exactly compare apples with apples, but it would be good if you could provide some data going back at least a few years so that we can get a feel for the level of usage.

Ms Halton—So long as you understand that, whilst the comparison may be generically apples, we are going to have the macintosh, the granny smith et cetera. This will not be a time series that is strictly comparable.

Senator BARNETT—What is the average cost per script of the 8.2 scripts per person?

Ms Blazow—The average cost to government per script in 2003-04 was $30.17.

Senator BARNETT—What is the cost to the consumer?

Ms Halton—Ms Corbett, the average dispensed price would probably give us that.

Ms Corbett—I have the average patient contribution per script. In 2003-04 it was $5.67.

Senator BARNETT—Per script?

Ms Corbett—That is right. I have the average dispensed price per script, but I do not know whether that is what you are asking for.

Ms Blazow—It would be; it adds up.

Ms Corbett—The patient contribution of $5.67 is consistent with the figure Ms Blazow gave earlier, which is that 80 per cent of the PBS is going to concession card holders, who in that year would have been paying $3.80 for their scripts.

Ms Halton—That means the average dispensed price per script is $35.84, of which the government pays $30.17.

Senator BARNETT—I can work that out on a percentage basis. It is obviously a very high percentage. Did you say 80 per cent of scripts were for concession card holders?

Ms Corbett—Yes.

Senator BARNETT—Has that been consistent for the last couple of years?

Ms Halton—Yes, that has been a longstanding and stable figure.

Senator BARNETT—That is very helpful. I look forward to getting the other information on that.

Senator FORSHAW—I have some questions, firstly, about MRI Medicare licences, which the government made some announcements about last year, particularly during the election campaign. How many licences did the government commit to?

Mr Sheedy—I assume you are referring to the recent invitation to apply for Medicare eligibility for MRI units.

Senator FORSHAW—I understand that the government actually made an announcement during the course of the election campaign and gave a commitment to some additional Medicare MRI licences. If my understanding is not correct, can you explain what the announcement was and what the intention is?

Ms Huxtable—That is correct. During the election campaign there were commitments made in respect of the Sydney Children's Hospital, the Royal Darwin Hospital and Dubbo, as well as trialling a mobile MRI unit to service the Gippsland region. They add onto announcements which preceded those to put three machines into children's hospital units, which occurred in July last year. Previously to that, the government announced that around 20 additional units would become available, and the process is in place through an invitation to apply.

Senator FORSHAW—So we had 20 in July of last year.

Ms Huxtable—All up it is 27. There were 20, then three for children's hospitals and then an additional four. Once all those are operational there will be 101 eligible units across Australia.

Senator FORSHAW—What was the basis upon which the decision was made to announce these additional licences?

Ms Huxtable—Which ones?

Senator FORSHAW—For a start, the ones during the election campaign.

Ms Huxtable—That was a decision of government during the caretaker period.

Senator FORSHAW—Was it based on advice from the department? It wasn't. It was a straight-out election commitment?

Ms Huxtable—Yes.

Mr Sheedy—Yes, Senator.

Senator FORSHAW—You ran through a list of locations. It might be easier if you provide this in a table or written form. Where were those four again?

Ms Huxtable—I am happy to run through those again: Sydney Children's Hospital, Royal Darwin Hospital, Dubbo and the Gippsland region.

Senator FORSHAW—Are they in public or private hospitals?

Ms Huxtable—No. In Gippsland the intention is to trial a mobile unit to service the Gippsland region and southern New South Wales. In Dubbo there is no decision as yet on the siting of that facility. The other two are in hospitals.

Senator FORSHAW—Are there any conditions attached to the eventual granting of a licence, such as a requirement to bulk-bill some or all patients?

Ms Huxtable—No decisions have really been taken as yet. It is fairly early days since these commitments were made. With regard to the Royal Darwin Hospital, that was part of an announcement about an MRI machine to support a critical care and trauma centre, so there will be additional undertakings around that particular unit. As yet, there have not been further decisions by government about the criteria around the others.

Senator FORSHAW—There have not been further decisions by government?

Ms Huxtable—At this stage we have not really had a dialogue about how those will be implemented. It is fairly early days.

Senator FORSHAW—Is the department doing any work at the moment on bringing these commitments to fruition?

Ms Huxtable—Yes. We are at a stage of actively working up how those would be rolled out. At the same time, we have been finalising a broader MRI process for the 20 units that I referred to initially. That has been the focus of our attention in recent months.

Senator FORSHAW—Do you have a time frame in mind as to when these licences will be granted?

Ms Huxtable—We anticipate that they should be operational in the second half of this year.

Senator FORSHAW—None of them have been granted up to this point? I am asking about the whole 27. Certainly none of the four announced in the election campaign have been granted?

Ms Huxtable—Of the three children's hospital units which I referred to two are operational, the other will be operational shortly.

Senator FORSHAW—Which one?

Mr Sheedy—The Royal Children's Hospital in Brisbane will come on stream later this year. The two that are now operational are Princess Margaret Hospital for Children in Perth and the Women's and Children's Hospital in Adelaide.

Senator MOORE—How many mobile units are there? You said there one has just been approved which is a trial. Is that the only mobile unit?

Mr Sheedy—Yes. It is likely to be the first in Australia.

Senator MOORE—It is a trial of the whole thing: mobility and regional servicing?

Mr Sheedy—Yes.

Senator FORSHAW—What is the total cost of the commitments for the whole 27 and the costs, broken down, of the four that were announced during the election campaign, the 20 and the three?

Mr Sheedy—On average, the cost to Medicare of an MRI unit is in the order of $1.3 million or $1.4 million per annum. Just multiply that by the number of machines. Individual machines will probably have different throughputs and therefore be slightly different, but on average it is about that cost.

Senator FORSHAW—With regard to the ones announced in the election, where is the funding to come from?

Mr Sheedy—Additional funding will be provided for those units.

Senator FORSHAW—I assume we will see that budget. They have already made the announcement.

Mr Sheedy—The Gippsland and Dubbo MRIs are included in these additional estimates.

Senator FORSHAW—They are the two where the licence has already been granted and they are operational?

Mr Sheedy—Yes.

Senator FORSHAW—I have some similar questions regarding after-hours clinics. How many after-hours clinics did the government commit to providing? I am again talking about commitments during the election campaign.

Mr Learmonth—During the election campaign under the Round the Clock Medicare initiative the government announced a range of things. It announced start-up grants for new after-hours practices in five locations in 2004-05. It announced subsidies for a new or recently established after-hours services for 30 new services—10 per year over the three years from 2005-06. It announced start-up seeding grants for, again, up to 30 services over three years from 2005-06. It announced up to 100 competitive recurrent grants each year by way of supplementary grants for established after-hours services.

Senator FORSHAW—I did not get all that written down but it is on the *Hansard*. When you say services are you talking about individual clinics?

Mr Learmonth—Individual arrangements—they might be cooperatives.

Senator FORSHAW—You may want to take this on notice. Let's just go back to the election campaign. All of those announcements that you have just referred to—those commitments were announced during the campaign. Is that correct?

Mr Learmonth—That is correct.

Senator FORSHAW—Can you provide us with a list of where those facilities are to be located.

Mr Learmonth—I can tell you where the five locations announced will be. The rest of the competitive grant process is over the three years from 2005-06. There were five locations that were due to start this year. They are Kallangur in Queensland, Tweed Heads in New South Wales, Ryde in New South Wales, Glenside in South Australia and Williamtown in Victoria.

Senator FORSHAW—Can you give us the particular cost for each of those.

Mr Learmonth—It will be $200,000 over two years for each. Obviously that is an up to figure depending on the proposal from those particular areas.

Senator FORSHAW—Are they all similar in nature in terms of what is to be provided or are there some differences?

Mr Learmonth—They are not existing services. These are service development grants for new services, so in each of those areas the nature of the service is still under consideration by interested parties. We advertised for expressions of interest for people to receive those grants and to start new services. They were advertised on 22 January, so we do not yet know what particular shape the individual proposals might take.

Senator FORSHAW—Could you give us information about the processes to bring these commitments to fruition?

Mr Learmonth—The expressions of interest were advertised on 22 January, they close on 22 February and there will be an assessment process then and identification of successful applicants to follow.

Senator FORSHAW—When would you expect that to be completed?

Mr Learmonth—As soon as possible afterwards. They are due to start this financial year.

Senator FORSHAW—So it will be before the end of June. If I do the maths, the total cost of the commitment for the five is $1 million over two years.

Mr Learmonth—That is right.

Senator FORSHAW—Is there anything in the additional estimates for the funding for the remainder of this financial year, if they start before the end of June?

Ms Morris—I cannot point you to the right page in estimates but the money has been appropriated for this financial year.

Senator FORSHAW—How much has been appropriated for this year?

Ms Morris—It is on page 59.

Senator FORSHAW—That is $2 million.

Ms Morris—That is right.

Senator FORSHAW—Is that just for the five or does that pick up some of the other commitments that relate to existing services?

Ms Morris—In the actual commitment—Round the Clock Medicare—that amount was set aside for the five, but there has also been a continuation of the whole program. Existing

service development grant recipients and trials funded under the After Hours Primary Medical Care Program have been extended. So there have been other calls on the program this financial year.

Senator FORSHAW—And it is all to be funded by additional budgetary funding both in these additional budget figures and, presumably, in the next budget.

Ms Morris—Yes.

Senator FORSHAW—It is listed in the forward commitments here as well.

Ms Morris—Yes.

Senator BARNETT—Can I ask a follow-on question in relation to the after-hours service?

Senator FORSHAW—Yes, certainly.

Senator BARNETT—Can you advise the funding for the Tasmanian after-hours service?

Ms Morris—GP Assist?

Senator BARNETT—Do you have information in relation to how many services they provide and the quantities of those services?

Ms Morris—I would take that on notice. It is a level of detail I do not have with me.

Senator BARNETT—Do you have details to confirm the funding that has been provided?

Ms Morris—The funding that we expect to have been provided to 30 June 2005, from the beginning of funding for GP Assist—

Senator BARNETT—Which was when?

Ms Morris—It was two or three years ago.

Senator BARNETT—We can check that.

Ms Morris—The total funding to the end of this financial year is estimated to be $5,820,000, exclusive of GST.

Senator BARNETT—Do you have the figure for last financial year?

Ms Morris—I am sorry, I do not. I will get it to you.

Senator BARNETT—Is there any way that you can advise on the number of services provided by GP assist? Do you have that sort of information?

Ms Morris—I think we should be able to you that information.

Senator BARNETT—In terms of consultations and so forth?

Ms Morris—It is currently being evaluated, so we should be able to get that information.

Senator BARNETT—Can you advise us on the evaluation?

Ms Morris—We are expecting the final report on the evaluation in about June of this year. The entire program is being evaluated, not just GP Assist. That is just one element thereof.

Senator BARNETT—Do you have funding for 2005-06 or has that not been decided?

Ms Morris—The funding has been confirmed and I am fairly confident that the contract extending the funding has been signed.

Senator BARNETT—Can you advise us on the details?

Ms Morris—Of the extension of funding?

Senator BARNETT—The details of 2005-06 funding and the future year funding.

Ms Halton—Just so we are clear, for GP Assist you would like to know last financial year's—

Senator BARNETT—This financial year and, if there is an agreement, next financial year.

Ms Halton—We will see if we can get those figures.

Mr Learmonth—We will get funding for each year.

Ms Halton—We will read them into the record a bit later.

Ms Morris—I can tell you now that the additional funding for the 2005-06 financial year is $2,600,000, GST exclusive. I am fairly sure, but we will confirm with follow-up information.

Senator BARNETT—Thank you.

Senator FORSHAW—I have a couple of questions about the commitments with regard to new Medicare offices. Is that a subject for other officers?

Ms Halton—It depends on the question. I think this is the point at which Senator McLucas—

Senator FORSHAW—First question: how many new Medicare offices did the government commit to during the election campaign?

Ms Halton—The decision in relation to the opening of new Medicare offices is relevant to the Health Insurance Commission.

Senator FORSHAW—I should have done this on Tuesday night in the 10 minutes or whatever it was we had available. So no-one can tell me. Minister, can you tell me how many new Medicare offices the government promised during the election campaign?

Senator Patterson—I am not the minister for health.

Senator FORSHAW—I know you are not but you are representing the minister for health, aren't you?

Senator Patterson—I do have a good memory but not for that sort of detail. I can take it on notice.

Senator FORSHAW—I will put these questions on notice then.

Ms Halton—For the Department of Human Services?

Senator FORSHAW—I know it is not your fault, Ms Halton. It is the problem of trying to deal with these issues when it is now partly in Department of Finance and Administration.

Senator Patterson—I will pass the questions on. I have to say that when I was in opposition I had to chase up one issue through three estimates committees because people refused to answer questions. But, because of the changes to the machinery of government, on this occasion I will pass the questions on to Mr Hockey and the relevant committee.

Senator FORSHAW—Only three, in opposition.

Senator Patterson—On one issue. You do not want me to reiterate what the issue was; you would not want to hear it.

Senator FORSHAW—These are the questions: how many new Medicare offices did the government commit to during the election campaign? Where are those offices to be located? What is the proposed start-up date for the offices? What is the cost of the offices? Where will the funds come from for this commitment? I assume the answer to that will be through the budgetary allocation. If you could take those questions on notice, I would appreciate that. I have a few questions about the operation of the Medicare safety net. At the risk of asking a general question, what is the objective of the safety net policy? I think I have an idea, but for the record what is the objective of the policy?

Ms Blazow—The objective is to assist with patients' out-of-pocket costs to help them pay for their medical services, and it is consistent with the objective of Medicare of making health care affordable for all Australians.

Senator FORSHAW—What data does the department collect about the safety net and how often is it collected? I appreciate that the new safety net arrangements have been in operation for a short time, but there have been safety net arrangements in place for some time, and presumably data has been collected.

Ms Blazow—We collect data against every single item in Medicare in respect of the out-of-pocket cost of the service, what doctors are charging for that service and how much benefit is paid. Therefore, we are able to deduce what were the out-of-pocket costs for the patient. We are also able to monitor when the patients meet their thresholds, which of course trigger their eligibility for the safety net, and then we are able to monitor the payments that go out against every single item in the schedule under a safety net arrangement, either the original safety net or the new safety.

Senator FORSHAW—How is that information collated? I understand that it is collated, for instance, across electorates.

Ms Blazow—It is collected at the patient level at the moment. The department does not have patient names. As you would appreciate, there is a confidentiality issue, so it is all de-identified. But it is at a unit record basis. We do know the location of those patients and we are able, using certain methodologies, to aggregate that data into various small area analyses, including electorates.

Senator FORSHAW—I recall that during the election campaign the minister released data showing safety net moneys claimed across electorates by income, I understand it.

Ms Blazow—Not that I am aware of.

Senator FORSHAW—I have not got it here with me, but didn't the minister release some data during the election campaign which was electorate based?

Ms Blazow—Yes, he did.

Ms Halton—By income, of course, we do not hold the detail of income. What we do know is who is eligible for the lower threshold and the higher threshold.

Senator FORSHAW—Yes, I had that in mind. Remind me of the nature of the data that the minister released in the election campaign. Do you recall that?

Ms Halton—I do not know—

Senator FORSHAW—It was the amount paid per electorate.

Ms Halton—My memory is that it was the number of people and families who qualified and total expenditure.

Senator FORSHAW—That is right. That is my recollection., but per electorate.

Ms Halton—That is my recollection.

Senator FORSHAW—The latest figures of the Medicare bulk-billing data were released last week. They included those on an electorate basis but there was not any data similar to that released in the election campaign on the Medicare safety net. Was there any reason as to why not?

Ms Blazow—At the moment the minister is still considering his position on the series of data that would be released on an electorate basis. so that matter as to how we release electorate data is still pending.

Ms Halton—I think it is important to understand—and you understand this well, Senator—that we release bulk-billing data on a very regular basis. There is a long time series.

Senator FORSHAW—Yes, I know that.

Ms Halton—That process continues. We have discussed on a number of occasions how information will be released regularly on an electorate basis.

Senator FORSHAW—I am not complaining about that at all. I am not complaining at this point in time in respect of this question, which is that those figures were released but the data which was put out during the election campaign on safety net payments, which are seen as a measure to help people with the costs of medical treatment, have not been updated since. That is a fact. Do you have any indication as to when the minister might decide?

Ms Halton—No, we do not. I have learnt never to predict about ministers.

Senator FORSHAW—So at this stage the department does not have any intention of releasing periodic updates on the safety net. Is that a decision for the minister?

Ms Halton—The minister will make a decision about the regular time series that will be released.

Senator FORSHAW—Can you give us any information about the cost of services by specialists since the introduction of the safety net policy?

Ms Blazow—Yes. As I said earlier, we do monitor every item. As you would imagine, that is quite a big job as there are a lot of items. To assist us in the task of monitoring the safety net in particular, we have selected baskets of items across the schedule—that is, samples of things. We particularly look at those quite regularly for any changes in the pattern of charges, particularly the out-of-pocket costs. We are monitoring those, and we have regular discussions with the medical profession about what is happening.

Senator FORSHAW—As a general point, isn't it accepted that out-of-pocket costs are obviously greater for specialist services than GP services?

Ms Halton—Depending on which specialty you are talking about; in fact some professions actually have a very high level of bulk-billing.

Senator FORSHAW—I know I am making a general observation, but that is the case. Is there any evidence of any notable movements in the cost of specialist services in recent times since the safety net came in?

Ms Halton—No.

Ms Blazow—The general trend is that there has been no great impact.

Senator FORSHAW—In any of the areas of professions are there any other notable changes that you have picked up in collecting this data since the safety net?

Ms Blazow—The obstetrician issue was certainly an issue early in the introduction of the safety net where it became apparent that obstetricians had been charging patients a fee outside of their medical service fee, which they moved into their medical service fee on the introduction of the safety net. We saw that trend very quickly. We received anecdotes about it and then we looked at the data and we saw the trend. We talked to them about what was happening. As I said, we consulted with the profession regularly about these things. We got legal advice and our legal advice was that it was a false and misleading statement for them to put into the consultation item a service which was not actually the consultation; it was about managing a pregnancy basically, as they explained it to us in our discussions. They made a case to the government that they would like, therefore, a special item to deal with this because it was something that had been charged before; it had not been recognised in Medicare and patients were bearing it as an out-of-pocket cost. As a result of the case that was put forward by the profession, the government introduced a new item in September which is for the management of a pregnancy, for the out-of-hospital component of managing a pregnancy over the full term of the pregnancy. It is chargeable after 20 weeks of pregnancy.

Senator FORSHAW—How is an account fee treated in terms of both the rebate from Medicare and the safety net? Some doctors do actually say, 'If you pay on the day you pay X dollars but if you take it away and pay it later there is a higher fee,' and it may be described as an account processing fee.

Ms Blazow—It is the actual fee that the patient ends up paying, in my understanding—

Senator FORSHAW—So it is the total amount.

Ms Halton—If it is a fee in respect of the medical service—and that is an important distinction. If something is a fee for a medical service it is eligible. If something is a fee for something else it is not.

Mr FORREST—I think that we are all aware of GPs who do this. If you pay on the day you might get charged $44 but if you take the account away it might cost you—

Mr Davies—There is a discount for prompt payment.

Senator FORSHAW—That is right, but it is not described that way.

Ms Halton—I think that we have all had those circumstances, and certainly the bills I have received of that kind will say, 'You receive a discount in terms of the medical service fee if you pay now.' It is a business practice.

Senator FORSHAW—Figures last week indicated that the average patient contribution for obstetrics went up by 98.5 per cent.

Ms Blazow—Yes. That is a direct result of things that were happening prior to the safety net outside of the Medicare data that were not being shown. But the introduction of the new item enabled some of those charges to be brought in. Not all of them were. In fact the profession has decided about out of hospital and in hospital, and so not all of the charges are brought into the safety net. Those charges are now shown against the Medicare receipts. Part of it is rebatable and the safety can also be triggered.

Senator McLUCAS—I have a question that follows up on bulk-billing figures. In our discussions in the special hearing that we had recently, I recall—and I think my recollection is correct—that the department requested the Australian Bureau of Statistics for a report. That was to go to the questions of the cost of production and also the veracity of the statistics. Is that correct? Maybe it did not go to the cost of production.

Ms Halton—This is the concordance issue, is it?

Senator McLUCAS—Yes. Is it possible for the committee to be provided with both the request to the ABS for the report, so that we get an understanding of what we were actually asking for, and a copy of the report from the ABS that goes to the statistical robustness.

Ms Halton—Unless you want to canvass the issues now, I am happy to take that away and have a look at it. I do not know if there is any issue about proprietorial ownership of the material from the ABS—not that I can think of—so I cannot see any reason why we could not provide that. It was in the report.

Senator McLUCAS—It was in the report provided to the special hearing?

Ms Halton—Yes. In that material.

Senator McLUCAS—I will go back to that.

Ms Halton—If it is not clear, let us know.

Senator McLUCAS—In that report, does it also have the request from the Department of Health and Ageing to the ABS?

Ms Halton—Yes.

Senator McLUCAS—So it outlines the nature of the analysis.

Ms Roediger—Yes, it does.

Ms Halton—Yes, the actual written request does.

Ms Roediger—The report goes from the *Hansard* statements through to the questions that were derived from the *Hansard* statements, which were passed to the ABS, and it includes the ABS's responses to those questions.

Senator McLUCAS—Thank you. I will go back there.

Senator MOORE—I have a question on MRI and one on CT scanners, but I have more questions on safety nets—should I finish those off first?

Ms Halton—Yes, sure.

Senator MOORE—Following on from Senator Forshaw's questions, I have an information collection question. I always have to start with those. Can the department outline any information it collects regarding the pricing of services by specialists since the introduction of the safety net policy?

Ms Blazow—As I explained, yes, we do collect data on every item. That is quite a big data set, and it takes us time to analyse. We are working through that at the moment. But, to help, we also have a basket of items as a sort of indicator set against various specialties.

Senator MOORE—Can the department provide any insight into the additional funding revealed in the PEFO? I am just trying to remember what PEFO stands for.

Ms Halton—Just use the acronym; everyone else does.

Senator MOORE—PEFO is the pre-election economic and fiscal outlook. The additional funding was explained at the time as a parameter variation, which is another wonderful term. Did the variation arise from figures that were done through your department or through Treasury, seeing that it is a finance document?

Ms Blazow—No, it is a joint exercise with the Department of Finance and Administration, in that we provided them with the data. They take responsibility for the PEFO, but they need to source data from us to be able to do that work.

Senator MOORE—So it is your data collection because that is your area—

Ms Blazow—Yes.

Senator MOORE—and then Finance or Treasury do that.

Ms Halton—Yes. We tell the department of finance what we think in respect of a particular issue. They either agree with us or do not, and then we have a dialogue.

Senator MOORE—It was described in the PEFO document as the increase due to increase of registrations.

Ms Halton—Correct.

Senator MOORE—It was just one little line, and it was $140-odd million, I think.

Ms Blazow—Yes.

Ms Halton—Many more people registered than had originally been anticipated.

Senator MOORE—We talked earlier, on another question, about the anticipation process that you have for any of these ideas. Is the department expecting further growth in the registrations process? Was that redone after that initial flush?

Ms Blazow—At the moment we are on track. Certainly it was redone in that PEFO context, having regard to our early experience, and we also had some new data about the actual out-of-pocket costs for a year that was not available when we first costed it. So we took all of that into account. The estimate was updated at the PEFO time, but now we are running

on track, so we are pretty confident that that revised estimate that went in PEFO is in fact pretty accurate. We are running on track at the moment for the year, as it is currently standing, against our current financial year estimate.

Senator MOORE—Is there a particular modelling process used for the figures in this framework? With your registration growth figures, are you using a particular model for how many you are expecting to come on?

Ms Blazow—Yes. The modelling is always quite complex. There is always a model underneath the estimates. It would take account of the number of people qualifying, the number of people—families—registering, because you cannot access it if you are a family and you do not register, the number of families and individuals reaching the safety net and the estimates of their out-of-pocket costs.

Senator MOORE—Can we get the details of the model?

Ms Blazow—It is not Finance's normal arrangement to release all of the details.

Senator MOORE—So it is actually a Finance model that you are using?

Ms Halton—There is a model agreed with Finance, and the standard protocol is that we do not release the details of the model.

Senator MOORE—We went through modelling and projections with FaCS last night. But in terms of the kinds of information, it is the number of people registering, the number of families—and there was one other thing you mentioned.

Ms Blazow—The number of people qualifying at the thresholds, and then their actual out-of-pocket costs once they have qualified.

Senator MOORE—So that all goes into the mix?

Ms Blazow—That is right.

Senator MOORE—How often do you update that?

Ms Blazow—Constantly. There is a regular cycle of doing the estimates process—additional estimates, budget estimates and so forth. It is being constantly monitored. New data that comes forward as a result of the roll-out of the safety net would be fed in over time. At the moment we are pretty confident, with the PEFO update, we are on track.

Senator FORSHAW—I have a final question which you might take on notice. I am interested to know what work the department has done or is doing to see how the operation of the safety net is reflected in assistance to people on different income levels. In other words, is it skewed such that those on higher incomes actually end up getting a greater proportion of the safety net funds back because they spend more on health services, for instance?

Ms Blazow—We are not doing any specific work on that.

Senator MOORE—Ms Halton, because of the time constraints, I will just get some of these questions on record and put the rest on notice. This question is to do with the data kept on bulk-billing. In particular, we are trying to see exactly how the incentive program, the $7.65 incentive process, is working and how it is being monitored. We would like to know the

list of areas that were originally announced and the areas that have come on since and when they came on. For the sake of time, it probably is just better for me to get these on record.

Ms Halton—Yes, I am happy to take them on notice.

Senator MOORE—We would like to know about the commitments that are being made to other areas and when these will come on line. We want to know about the process: if you are actually in the process of making commitments to a variation to another area, how that is happening and when they could come on. We want to know how those decisions are made—that is, what is actually taken into account. I know that, since it has come in, people have been very concerned to get their group into the scheme, because they think they would do it. I am particularly interested in the one in Western Australia that hit the media—there are probably others that have not. A particular group of GPs in Western Australia came up with their own modelling idea for what would work and submitted it to the government as a proposal. I want to know whether that was successful and whether that is helping with operating other places.

Ms Halton—Not that I am aware of.

Senator MOORE—The media coverage was that they had submitted it, they were getting support from their local MP and they were waiting for some feedback to see whether that had been successful. We would like to know the process of that.

Ms Halton—It has not come to my attention.

Senator McLUCAS—I understand it was an issue in Western Australia.

Ms Halton—I am happy to take it on notice and have a look at it.

Senator McLUCAS—No-one is aware of this particular matter?

Ms Halton—I am not. I do not think those of us at this table are aware of it.

Senator MOORE—The data man knows.

Mr Learmonth—I am aware of it, but I will have to take on notice as to where it feeds into the process.

Senator McLUCAS—That is one step forward.

Senator MOORE—We have established there is an awareness of that one.

Mr Learmonth—Yes, there is an awareness.

Senator MOORE—It is just an interesting model that a group of GPs have looked at and come forward with.

Mr Learmonth—I think it came down to the size of locality over which the incentives were applied. I dare say that the ideas will, at the very least, be caught up and considered within the broader RAMA review process that is going on.

Senator McLUCAS—So the application has been received and referred to the RAMA review?

Mr Learmonth—I could not confirm that. I understand that issues have been raised in relation to the size of the geographical area over which the bulk-billing incentives have been applied. I think that is the key point they have been making—about the granularity, if you

like, of the view that is being taken in applying incentives. That is an absolutely key issue that the RAMA review will be considering in its technical progress over the next two months.

Senator McLUCAS—Is it usual that an MP would become involved in direct advocacy with the department about the inclusion of an area in this incentives program? There have been a number of members of parliament involved in this process, as we know, including on the floor of the Senate.

Ms Halton—We could get bits of correspondence from members of parliament of every persuasion advocating on behalf of people in their areas. It happens all the time. We always write back very politely.

Senator McLUCAS—This one seems very active.

Senator MOORE—There has been a lot of media around trying to encourage specialists to bulk-bill or get close to it. I want to find out what incentives and encouragement the department or the government is giving specialists to get them to take up this process. One particular group is the paediatricians, because they have been talking within their own group about that kind of thing. I have a particular question about OPSM. It is our belief that OPSM has decided for its people in the ACT and Tasmania that they will no longer bulk-bill and that that is likely to be extended to other states. Is the department aware of that? We thought there was an agreement that they would be bulk-billing.

Ms Halton—You are right. I have to say that issue was only in the press yesterday or the day before, and my understanding is that after the initial report in the press OPSM came out and made a qualifying statement. But, as it is so new, it has only just come to our attention, so we are going to have to look at it.

Senator MOORE—What process happens when you come to an agreement and then, for whatever reason, a party to the agreement has another idea?

Ms Blazow—The OPSM optometry agreement is not around bulk-billing; it is schedule fee compliance.

Ms Blazow—So they choose to bulk-bill on top of the agreement.

Mr Davies—I think the OPSM decision is to charge the scheduled fee—

Ms Halton—I do not know; we need to be clear about what the decision is.

Mr Davies—so, if that is the case, that is not in breach of the agreement, because that is the agreement. Most of them go beyond the agreement and bulk-bill, and have done traditionally.

Ms Halton—But I think there is a lack of clarity about—if, indeed, they have taken the decision—what it is. We need to find out.

Senator MOORE—And how it operates.

Ms Halton—Yes.

Senator McLUCAS—Mr Davies, the OPSM decision, as you understand, is not to bulk-bill but to charge the scheduled fee?

Mr Davies—That was my understanding, but that was only from the media coverage, so I would not want to attribute that definitely to OPSM.

Senator McLUCAS—I cannot believe they would charge it but not bulk-bill it.

Ms Halton—They made a clarifying statement. We should not be making any observation about this because it is confused. There have been various reports. We will get to the bottom of it.

Ms Blazow—There is another issue there, and that is the separation between doing the eye test, which is the professional optometrist, versus the supply of the spectacles, which is the spectacle maker, which I understand is OPSM. You often see collocation, for patient convenience, but there are two separate things happening: the eye test, which is rebatable, and the supply of the spectacles, which is quite separate.

Senator MOORE—The question about what OPSM are planning to do has been around for a few weeks. Now we need to clarify what it is and how it will work with whatever agreements. We are interested to know, in view of the recently signed pathology MOU about which there is much interest, what level of bulk-billing is expected for pathology services over the five years. Have you got any ideas about what you are expecting?

Mr Sheedy—The level of bulk-billing in pathology is very high; it is over 84 per cent. We have a small component in a pathology agreement recently signed with the profession giving them an incentive to continue a high level of bulk-billing. We expect it to remain at around the same rate over the five years of the agreement.

Senator MOORE—So it is more maintenance expectation than growth or decline—would that be fair?

Mr Sheedy—Yes.

Senator MOORE—You are the gentleman who deals with the MRI process too, aren't you?

Mr Sheedy—Yes.

Senator MOORE—The ability for people, once they have a licence, to transfer it has been brought to my attention. In Rockhampton in my state there was an MRI with a licence in that community, and we believe the decision has been taken by the person who owns that licence to transfer it to Melbourne. I am interested to know how that works—getting a licence and being able to move it around—in the contract. For a community like that which is going to be quite significantly disadvantaged is there any warning process or consideration given to how you get a licence back there once somebody has had one and moved it?

Mr Sheedy—In short, it was within the regulations for the owner of that machine to shift it to Melbourne. It was not something that we would have preferred, of course. The owner in fact shifted the licence, left a machine there and undertook to provide services at low or no fees for patients.

Senator MOORE—But if you are a client you cannot get your Medicare rebate if it is not licensed—is that right?

Mr Sheedy—That is correct. This is not how we would like things to proceed in future. Our recent moves have pinned down the location of the machine, so any future allocation of Medicare eligibility will have to stay exactly where it is unless there are special circumstances.

Senator MOORE—So those numbers that we heard before about the new licences—except for the mobile one, which we expect to be mobile—will be located where the licence was given?

Mr Sheedy—Yes, that is right.

Senator MOORE—I will put the rest of my questions for this outcome on notice.

[12:03 p.m.]

CHAIR—We will now move on to outcome 4, Quality health care.

Senator MOORE—I have a series of fairly straightforward questions about work force enhancement schemes for doctors. The first questions are about the back to work scheme. How many doctors were to be attracted back to work under this program? What was the estimate of how many doctors you were hoping to bring back under the $2.8 million program?

Mr Singh—Unfortunately I do not have that number here.

Senator MOORE—Please take it on notice. When you are getting that figure, can you see whether there was a breakdown between specialists and GPs? My understanding is that it was covering all doctors. I would like to have that broken down.

Mr Singh—Yes.

Senator MOORE—Do you know how many doctors have actually returned to work through the scheme?

Mr Singh—Yes; the answer is none.

Senator MOORE—Do you know how many doctors made inquiries about the scheme and were thinking about taking it up?

Mr Singh—I should clarify that answer of none. It relates to general practitioners; for specialists, the situation is different.

Senator MOORE—So no GPs, but we might have some specialists.

Mr Lennon—There are separate re-entry schemes covering general practitioners and specialists, and they were both part of the Strengthening Medicare package. In relation to the specialist re-entry area, which I look after, the target is to get 53 specialists back into the work force over a period of three or four years. We are on track in terms of the number of specialists that we are seeking to get re-entered in the first year. At the moment we have got six, and that was the target for the first 12 months.

Senator MOORE—So your target was six. These are doctors of various specialties?

Mr Lennon—Yes, they are. We consult with all of the relevant medical specialist colleges and work with them to identify positions in practices and mentors. Through that there are three or four specialist colleges that are now working with us. We have already got six

specialists on the program and we believe we are on target to get our 53 specialists over three or four years.

Senator MOORE—Was yours a separate allocation from the $2.8 million? Was it $2.8 million for GPs and another allocation for specialists?

Mr Lennon—Yes, the Specialist Re-entry Program has a separate allocation.

Senator MOORE—Can you tell me what that is?

Mr Lennon—I do not have a figure at my fingertips at the moment, but I can certainly get that for you.

Senator MOORE—That would be lovely. Now I have got two boxes, GPs and specialists. I have the same question for both of you: how many doctors and specialists have actually applied for the scheme? Is that the kind of data you keep? I know you have got six in train—

Mr Lennon—Yes, we would keep that data.

Senator MOORE—but I would like to know how many actually applied.

Mr Lennon—I am happy to provide that. In broad terms as long as they met the broad eligibility conditions for the specialist scheme, we would be very happy to take them on to the scheme.

Senator MOORE—Is that the same for GPs, Mr Singh?

Mr Singh—That is right. I should clarify that I do not have $2.8 million for the GP side of things. Mine is $396,000 over four years for the GP re-entry. There were certainly a number of expressions of interest when the scheme was first introduced in relation to the general practice side of things. Unfortunately, none of those translated into people taking up the program—

Senator MOORE—Yet.

Mr Singh—yet—but one of the Sydney based regional training providers has now received a number of expressions of interest for this coming year. We now expect there will be a number of people taking it up in 2005.

Mr Lennon—I have now found the right spot in relation to the funding of the Specialist Re-entry Program. The funding is $1.4 million over four years.

Senator McLUCAS—Mr Singh, you only get $396,000 over four years for GPs?

Mr Singh—That is correct.

Senator McLUCAS—You did well, Mr Lennon.

Senator DENMAN—Are the specialists that you are bringing in overseas trained specialists as well as Australian trained specialists?

Mr Lennon—They could be overseas trained specialists who have obtained fellowship from an Australian college, but in the main they are Australian trained.

Senator DENMAN—If they are overseas trained specialists then do you pay their airfares and so on to relocate them? Or do they bear the costs themselves?

Mr Lennon—As part of our overseas trained doctor initiatives program, and as part of the strengthening Medicare package, there is a range of initiatives to get extra appropriately qualified, overseas trained doctors into Australia. We work with 11 international recruitment agencies. We pay the recruitment agencies a fee when they get a specialist or general practitioner suitably placed in an area of workforce shortage and beginning to bill Medicare. That is the arrangement under which we operate. We pay a flat fee to the recruitment agency and it is then up to the recruitment agency to organise the placement and the assistance for the OTD to get there.

Senator DENMAN—Are they obligated to remain in Australia for a certain period?

Mr Lennon—They have to have a minimum Medicare billing component. They have to be in place, working and have taken up the employment opportunity. There is no requirement beyond that for them to be in Australia for a minimum time, but what we generally find is that a number of them are interested in and committed to staying in Australia for either a lengthy period or permanently.

Senator DENMAN—Thank you.

Senator MOORE—Do these provisions apply to the GPs back to work program that we have just heard about?

Mr Singh—Only GPs qualified to practice in Australia who are currently out of the GP work force are eligible to participate in the program.

Senator MOORE—It has similar kinds of criteria. I know that the specialists are on track, but, Mr Singh, your area is a bit slower on the uptake. Have the doctors that have expressed interest and not gone forward—or people who have just talked with you—expressed any reason as to why they have not leapt into the scheme?

Mr Singh—I am not aware of the details. They mostly deal straight with General Practice Education and Training, which is administering this on our behalf.

Senator MOORE—Can we find out from them?

Mr Singh—The sorts of reasons?

Senator MOORE—Yes, investigate any kinds of reasons that people have given that they have not taken the next step. It has been going for a while now. Have you got any idea how much of the budget has been spent so far in both your programs?

Mr Singh—At December, we had spent $6,242.

Mr Lennon—The funding level for the Specialist Re-entry Program for 2004-05 is roughly $400,000.

Senator MOORE—There has been a question about doctors who currently work limited hours. Does the program consider the needs of doctors who want to or currently work limited hours either making the transition of going into your program full time or wanting to come into the program and work in a limited hours capacity? Is that one of the criteria?

Mr Lennon—There is capacity, under the Specialist Re-entry Program, for those doctors who have been working a minimum number of hours and who want to substantially increase those hours. There is also flexibility within the program regarding the total number of hours

that a specialist might work. Some might be interested in going from very limited or no hours to a significantly increased number of hours but still working part time, for example. There is quite a deal of flexibility in the program. We look at the Specialist Re-entry Program on a case by case basis.

Mr Singh—I believe, in the instance of general practice, that the program has been targeted at people completely out of the workforce and that there has been some discussion with the doctor groups about extending the programs to those who are looking to increase their hours, but we have not had any formal discussions with them yet.

Senator DENMAN—Do you have a breakdown state by state of the shortage of specialists?

Mr Lennon—We have data about shortages of specialists state by state in particular specialist professions. That data comes out of individual medical work force studies that are carried out by the Australian Medical Workforce Advisory Committee, which is an independent Commonwealth-state body that does that kind of work. We can have a look at what we can provide you with. We are happy to do that.

Senator DENMAN—Thank you.

Senator FORSHAW—I have some questions that continue with work force issues. The Australian Institute of Health and Welfare released some data recently that shows that GP numbers nationally have risen or are rising but the number of full time equivalent GPs has dropped. They compared the figures from 1997 with 2002. Do you have any more up-to-date data than that, and what is your observation or comment about the institute's work?

Mr Learmonth—I am not familiar specifically with their work. What I can say is that we have more up-to-date data in the sense that, if I heard you correctly, theirs was 2002-03; we have information up to 2003-04 on the GP work force. From that, the view is that the pure head count, which we do not regard as a good measure, is virtually unchanged over the period from 1996 to 2004, but that full-time workload equivalent and full-time equivalent have both increased by a little over five per cent nationally.

Senator FORSHAW—Increased?

Mr Learmonth—Increased 5.2 per cent in the case of FTEs and 5.1 per cent for FWEs over the period 1995-06 to 2003-04 and increased by some 20 per cent in rural areas over that period.

Senator FORSHAW—That suggests that the figures in the AIHW analysis are different—they paint a different picture—or do I take it that it is a different timeframe?

Mr Learmonth—It is a different time period. In particular, last year would pick up some of the more recent initiatives about encouraging GPs and so on. That last year was quite possibly a significant year.

Senator FORSHAW—The More Doctors for Outer Metropolitan Areas program is being continued for a further 18 months, isn't it?

Mr Lennon—There are a number of components to that program. The relocation incentive grant, which provides one-off assistance for doctors who move from relatively well supplied

inner metropolitan areas to less well supplied outer metropolitan areas, has been very successful. As a result of that, the minister recently took a decision to extend the time frame to apply for the relocation incentive grant to 30 June 2006.

Senator FORSHAW—Let us say approximately 18 months. And the additional cost is $2.224 million?

Mr Lennon—Off the top of my head, the additional cost that we are expecting would be of the order of $2 to $3 million.

Senator FORSHAW—Where is that additional funding coming from?

Mr Lennon—The additional funding is coming from the broad funding buckets we have available, including the funding that was made available for the More Doctors for Outer Metropolitan Areas program when the government introduced the measure in 2002-03. That was a four-year program, with funding provided over four years, and we supplemented it with a bit of extra money from within the portfolio's capacity. So, from both of those sources, we are able to keep the relocation incentive grant running within existing resources.

Senator FORSHAW—There are 183 doctors currently in this scheme—am I correct?

Mr Lennon—As at 31 December 2004, 184 doctors have taken up the relocation incentive grant component of the More Doctors for Outer Metropolitan Areas measure and agreed to relocate to, or substantially increase their hours of work in, outer metropolitan communities.

Senator FORSHAW—Could you take it on notice and provide information, if you have the detail, on where those doctors are going to and where they have relocated from. Is that possible?

Mr Learmonth—Yes, we can provide that information to you.

Senator FORSHAW—I have some questions with regard to overseas trained doctors. There have been reports and statements in recent times that the government is stepping up its efforts to hire doctors from overseas. Can you fill out some information about just how many doctors have been recruited in the current campaign and how many are out there on the ground and working?

Mr Lennon—Yes, I can. As I mentioned, the Strengthening Medicare initiative contained a number of measures to increase the supply of appropriately qualified overseas trained doctors. One of those was a recruitment program. The Australian government, through the department, has recruited 11 international recruitment agencies and as of January 2005 around 72 overseas trained doctors had actually been placed in districts of work force shortage as a result of that recruitment activity. In addition, another 165 doctors have signed employment contracts and will commence work soon. In addition there were also changes made, under the government's overseas trained doctor initiatives, to the immigration arrangements, to make it easier for overseas trained doctors who come here on a temporary basis to stay. The maximum visa validity period was extended from two to four years. Since then, as I believe, close to 1,000 temporary resident overseas trained doctors have taken the opportunity to operate under the temporary resident visa in excess of two years, since it has been extended, so they have taken out temporary resident visas that are now somewhere between two and four years.

Senator FORSHAW—How many did you say?

Mr Lennon—It is of the order of 1,000. I will have to check that number but I believe that to be the case.

Senator BARNETT—Is there any breakdown on a state-by-state basis?

Mr Lennon—We will seek to provide that.

Senator FORSHAW—I was going to ask you, but I appreciate you could take this on notice, for a breakdown in terms of the countries that the 72 and the other 165 doctors have come from or are coming from, where they did their training, those who are GPs and those who are specialists, and also where they have gone to work. Senator Barnett has mentioned a breakdown by state, but it would be more helpful if you could be a bit more specific in terms of districts or RAMA areas. Can you do that for us?

Mr Lennon—We can do some of that. We will certainly do as much of it as we can.

Senator FORSHAW—How much has been spent on this initiative to date?

Mr Lennon—The overseas trained doctor initiatives have a number of components. There has been significant expenditure on some of those components, which include international recruitment and training initiatives. I do not have a complete comprehensive number in front of me but I am happy to provide that. There has been significant expenditure.

Senator FORSHAW—I was looking for the total figure and then I was going to ask you to give me a breakdown in terms of amounts spent on recruitment agencies, training, accreditation and any other aspects, but if you are able to take that away and provide us with the details that would be good. So you will do that?

Mr Lennon—Yes.

Senator FORSHAW—The other thing that I wanted you to get a response on is this: the Australian Rural and Remote Workforce Agencies Group released a policy paper that claims, in summary, that outer metropolitan overseas trained doctor schemes in the MedicarePlus package threaten the rural work force and the ability to attract overseas trained doctors to rural areas. Are you of aware of that paper put out by them?

Mr Lennon—I am not aware of that particular piece of paper. In broad terms, overseas-trained doctors are limited to working in districts of work force shortage for some minimum period of years. Those districts of work force shortage have been predominantly in rural and remote areas. More recently, some outer metropolitan areas have also experienced work force shortages and have thereby qualified to receive overseas trained doctors. All overseas trained doctors coming in under the government's Strengthening Medicare initiative must go to areas of work force shortage, either in rural areas, outer metropolitan areas or provincial areas. They have to go to areas of work force shortage. A significant number of them would continue to go to rural areas.

Senator EGGLESTON—Has there been any leakage of doctors who would have gone to rural areas now going to outer metropolitan areas under the outer metropolitan strategy? It has always been one of my concerns that, if they had the choice, they might prefer to go to outer metropolitan areas rather than to rural areas. Has there been a decrease in the number going to rural areas?

Mr Lennon—Under the government's Strengthening Medicare programs for overseas-trained doctors we are going to increase significantly the number of overseas trained doctors coming to Australia, over and above what would have otherwise been the case. We are talking about a net increase in doctor numbers. Some of that net increase will go to rural areas and some to outer metropolitan areas. It should not be a significant issue, because we are increasing the pool of overseas trained doctors considerably over time. We are looking to increase the number of overseas trained doctors by 750 over four years, over and above what would have otherwise been the case. Quite a large number of those will go to rural and remote areas, others will go to regional towns and some will go to outer metropolitan areas.

Senator EGGLESTON—I have one follow-up question. Do you have a defined number of places in these designated areas of unmet need? If you bring in, say, 700, will you fill up X number of slots or is it a general program without a specified number of places available in each area?

Mr Lennon—No, the system is quite rigorous. A district of work force shortage is defined on the basis of the doctor to population ratio. Where the doctor to population ratio in an area is worse than the national average then that area can qualify as a district of work force shortage and get overseas trained doctors. But as soon as that area gets sufficient overseas trained doctors to bring it back to the Australian average it no longer qualifies.

Senator EGGLESTON—Thank you very much for that information.

Senator McLUCAS—I understood, Senator Eggleston, that you were asking whether or not there was any leakage of doctors from rural areas into the outer metropolitan program.

Senator EGGLESTON—That was my first question, yes.

Senator McLUCAS—Mr Lennon, I was under the impression that the provisions specifically excluded any movement from non-metro into the outer metro program.

Mr Lennon—Yes, that is correct.

Senator McLUCAS—Has that been maintained?

Mr Lennon—Yes, it has. I was taking the senator's question to mean had there been a leakage of overseas trained doctors who would otherwise go to rural areas who are now going to outer metropolitan areas. In fact, though, you are quite correct. The More Doctors for Outer Metropolitan Areas Measure only allows movement of doctors from better supplied inner metropolitan areas to more poorly supplied outer metropolitan areas. It does not allow movement of doctors from poorly supplied rural areas to poorly supplied outer metropolitan areas.

Senator McLUCAS—And that principle has been adhered to?

Mr Lennon—It has.

Senator FORSHAW—There was a paper I referred to earlier which stated that the measures or the incentives under the MedicarePlus package for outer metropolitan OTDs could promote that sort of shift, if you like, from the existing five-year scheme. But you are saying that cannot or should not happen?

Mr Lennon—I am saying that it should not happen. I am not saying that there is not some potential issue there but, against the background we are looking at—increasing the number of overseas trained doctors considerably above what would otherwise have been the case—we would expect and we are seeing evidence that a significant proportion of those are going to rural and remote areas. We believe that issue can be managed. The government believes that outer metropolitan areas that have shortages of doctors are entitled, as rural areas are, to supplement their doctor supply with suitably qualified overseas trained doctors.

CHAIR—It being after 12.30—

Ms Halton—Senator, it is after 12.30 but I thought before we went to lunch just to prove the enormous efficiency of the department, I would table a series of documents in relation to questions that we have been asked in this morning's session. Firstly, I have the time series of the two Medicare items that were asked for by state for the last ten years. I also have the PBS prescriptions per capita by state. Senator Allison asked a series of questions about the 12.5 per cent. We have a list of consultations of who and when. We have the presentation that was made to people in January 2005, noting of course that the policy did vary slightly from the original proposal. We have therefore also sought to table the press release which went to what the actual policy was and, importantly, the questions and answers that explain that policy. We will table that bundle if we may.

CHAIR—Thank you very much.

Proceedings suspended from 12.32 p.m. to 1.36 p.m.

CHAIR—Ms Halton, I understand you have come back with some information on PET.

Ms Halton—Senator McLucas asked me a question in relation to whether there was correspondence. I can confirm that there was a letter from the Chair of the Medical Services Advisory Committee, MSAC, to the then minister. I can also indicate that there was a fairly brief response from the minister. What I am proposing to do is table the letters, table the summary of the MSAC report and—because this matter has been the subject of what I might describe as extensive correspondence there was an article and a response published in the *MJA* in relation to this matter which I think is a fairly good summary—table the response in the *MJA* as materials for the senators to consider. I would be happy to table all of that material.

Senator McLUCAS—I recognise now that it is an issue that has had a lot of attention from the department. I would like to ask you some questions, Ms Halton, which you may be able to tell me are contained in the documents you are tabling. Does it go to the question of the recommendation that went from MSAC to the PET reviewing steering committee where the recommendation was clinically effective?

Ms Halton—As soon as we get into that question, there is a lengthy answer. If you are happy, I am happy to table this. If you could give me all those other issues on notice, we will give you a considered response. Even a question about clinical effectiveness becomes extraordinarily complicated because it depends on which indications it is.

Senator McLUCAS—Fair enough. I have a more general question. What is the current status of recommendations from MSAC or the PET steering committee? Where are we up to?

Ms Halton—We are happy to cover that.

Mr Sheedy—Pursuant to the review that took place in the year 2000, PET is now funded by the Commonwealth in eight sites across Australia. Part of the conditions of funding are that those facilities take part in a data collection exercise designed to demonstrate the effectiveness and the cost-effectiveness of PET. That data collection is proceeding. As I indicated earlier, we expect it to be complete by about the middle of next year—by which time it will be presented to MSAC for their further consideration.

Senator McLUCAS—Am I right to use the word 'trial' to describe what is currently occurring? Is it a trial or a data collection process?

Mr Sheedy—It is an evaluation and a data collection exercise designed to answer the questions that MSAC was not able to answer at the time it did its review.

Senator McLUCAS—You said at a number of sites. How many sites?

Mr Sheedy—There were eight sites. Would you like me to list them for you?

Senator McLUCAS—Yes, please.

Mr Sheedy—The sites are: in New South Wales, Liverpool Hospital and the Royal Prince Alfred Hospital; in Victoria, the Peter MacCallum Cancer Centre, Moorabbin private hospital, and the Austin and Repatriation Medical Centre; in Western Australia, Sir Charles Gardiner Hospital and St John of God Health Services; in Queensland, the Wesley Hospital; and in South Australia, the Royal Adelaide Hospital.

Senator McLUCAS—The word 'trial' is probably incorrect, but the plan was to roll it out in eight hospitals in order that data be collected?

Ms Halton—There was a decision from the minister.

Senator McLUCAS—When was that decision taken?

Mr Sheedy—I gave an incorrect listing of a funded machine. The machine at St John of God is not funded; it is an unfunded machine. The others I listed are the ones that are funded by the Commonwealth.

Ms Halton—Former minister Wooldridge announced the result of the tender and letters were sent to unsuccessful tenderers on 1 November 2001.

Senator McLUCAS—There was a tender process to identify eight sites around Australia and eight sites were selected. How did St John of God get one without being funded?

Mr Sheedy—Sorry, I was reading from the wrong list. There are some PET machines in Australia that are not funded as part of this process and I mistakenly read from the wrong list.

Senator McLUCAS—So the record will show eight funded centres?

Mr Sheedy—There are eight funded. Seven of those were funded as a result of the tender process and the Austin and Repatriation Medical Centre is funded through a slightly different process. But all of those eight are taking part in the data collection exercise.

CHAIR—Senator McLucas, can I make the point that you are consuming time that is allocated to three outcomes.

Senator McLUCAS—I will be quick. When was that data collection to be concluded?

Mr Sheedy—We had expected it to conclude this year. The process is quite complicated because it involved developing data collection protocols for a number of different clinical indications that took longer than we thought. There have also been some difficulties in recruiting patients to those protocols in the various hospitals. Now we expect it will be mid-next year, as I said earlier.

Senator McLUCAS—Mid-2006?

Mr Sheedy—Yes.

Senator McLUCAS—On what recommendation then could the minister announce a PET scanner for Westmead?

Mr Sheedy—I am unable to comment.

Ms Halton—It is an election commitment.

Senator McLUCAS—It was completely outside the normal processes that we have been undertaking since 1999 to identify the usefulness and location of PET scanners. Is that correct?

Mr Sheedy—It was a different process. It was not part of that exercise.

Senator DENMAN—Is there any likelihood in the future of there being a PET scanner in Tasmania?

Mr Sheedy—That will have to wait until the resolution of the processes that we have just been describing.

Senator DENMAN—Until the report. I will put the rest of my questions on notice.

Senator HARRADINE—Did the then minister indicate that a PET scanner would be provided for Tasmania?

Ms Halton—Not that I am aware of—we could check that.

CHAIR—We will now go back to outcomes 4, 5 and 9 that were under consideration. It is proposed that we move to outcome 9 even though we have not done outcome 5.

Senator MOORE—I have a couple of questions on outcome 4.

CHAIR—Okay, we will complete 4.

Senator MOORE—The questions are basically to do with research—GP research. I want to ask a couple of questions around the BEACH—Bettering the Evaluation and Care of Health—program. My understanding is that its contract with the department ended at the end of last year. Is that right?

Mr Learmonth—The contract with the department ended in July last year—30 June, end of the financial year.

Senator MOORE—My understanding is that the BEACH scheme provided independent national research on general practice issues, and that was the kind of information that fed through to the department as research. Is that right?

Mr Learmonth—It provided data, rather than research. That is, at least, what we are paid for.

Senator MOORE—Now that that contract has ended, what kind of process does the department have to get the kind of data that the BEACH contract serviced?

Mr Learmonth—We have changed the nature of the relationship we had with BEACH. We have gone from a process where we had, in essence, a shareholding in the BEACH project. Through that we contributed something under 50 per cent. Other organisations, including pharmaceutical companies and Commonwealth departments, were also contributors and remain contributors. What we have essentially done is changed our arrangements from a block funding process, whereby we buy in advance a certain number of reports and chunks of data, if you like, to go to a more ad hoc arrangement where, instead of buying a large quantity up front which we may or may not use, the individual areas within the department will purchase, like any other customer of the BEACH survey, whatever data they might need from time to time.

Senator MOORE—When you were a shareholder—I use the term you use, 'shareholder'—that is, when you were in the previous relationship with BEACH, did that give you any special kind of directional ability, if you were in that kind of semi-board process? Did it give you any advantage over the single block purchase that you now describe?

Mr Learmonth—It certainly enabled us to choose the nature of the reports that we wanted. I do not know whether it gave us any particular advantage over any other funder, any other customer.

Senator MOORE—Can I get any information about how much money was spent on the previous contract?

Mr Learmonth—Certainly. It started off in 1998-99. For that year and the following year we contributed $200,000. For the years 2000-01 and 2001-02 we contributed $400,000 per year as there was a resignation, if you like, from some of the other funders at the start.

Senator MOORE—So you increased your share.

Mr Learmonth—Yes. Essentially what we went to was a series of underwritten shares, whereby we provided additional funding, which would be refunded if they attracted other funders to take our place. In 2002-03 and 2003-04 the amounts were $440,000.

Senator MOORE—Now you are actually just buying information as required—that is how you describe it.

Mr Learmonth—That is correct. We are in the process of negotiating a final payment for the first six months of this year, and then we will move to simple customer arrangements.

Senator MOORE—So we cannot have those figures because they have not been finalised yet?

Mr Learmonth—That is correct.

Senator MOORE—You are aware that people from the AMA and also the RACGP, which I am not going to spell out, have been concerned about the potential loss of valuable resources. Has that kind of comment been fed back to the department?

Mr Learmonth—I think they are concerned that policy is based on appropriate data. That data source remains open to us, as do other data sources. We provide less than half of the funding that goes to BEACH, and BEACH will continue to be funded by pharmaceutical companies and others, I would imagine.

Senator MOORE—The funding that ended with the contract—has that been redistributed to research processes within the department? Has that been a change within the same program allocation?

Mr Learmonth—I do not think it was a specific allocation that has been redistributed, no. It would be hard to speculate. There will continue to be funding to BEACH from the department but it will be done on the basis of individual programs choosing to buy particular reports and blocks of data rather than an up-front pre-purchase arrangement, if you like, to buy a predetermined number. So funding has not ceased; it has simply changed its basis to something which is more responsive to demands so that we can get better value for the dollar.

Senator MOORE—And probably less.

Mr Learmonth—It will be demand driven. I would not speculate on what future demand will do.

Senator MOORE—Is there an allocation in the budget for 2004-05 for research purposes?

Mr Learmonth—Again, we do not fund BEACH for research.

Senator MOORE—For data collection?

Mr Learmonth—There is no specific allocation, no. It came from general departmental administration money, departmental expenses.

Senator MOORE—Following on from that, there is the General Practice Partnership Advisory Council—

Mr Learmonth—GPPAC.

Senator MOORE—When the government disbanded that particular group last year—it is my understanding that it was disbanded last year—it was indicated there would be a review of all the GPPAC research. Is that your understanding, that there would be a review of the research?

Mr Learmonth—That is not my understanding. My understanding was that there were a number of pieces of work that GPPAC had been looking at in its time and that there was a general sentiment expressed that the value of that work, such as it was, should not be lost and it should be made available in terms of feeding into policy. To the extent that it is indeed so relevant, it has undoubtedly fed into the policy process.

Senator MOORE—Right. There was not a general review of everything that was done; it was just going to have a look at what was there and see what was useful?

Mr Learmonth—Certainly in the process of winding up we catalogued what had been done and what was in process. A decision was obviously then made by the relevant program areas as to what if anything would be done with the product.

Senator MOORE—Is it possible that some of the work that was done will now be published?

Mr Learmonth—It is possible, but I cannot give you specific examples.

Senator MOORE—Can you remind me—and this could be for you, Ms Halton—about the process of deciding what is published from that form of research that goes to the department: whose decision is it about what is then published in the kinds of journals that your department contributes to and that people rely on? Who decides, with that form of research, what is then published and what is not?

Ms Halton—It really depends on what was the origin of it. It is very hard to give you a cast-iron rule on this. Essentially, with work that we commission for a review of something, we tend to put that out in the public arena. But everything is managed on case-by-case basis. It is not like we are, for example, the NHMRC, where there is just a rolling program of research and there is a standard process that attaches.

Senator MOORE—And it is published even before it is done that there is going to be a research project on this issue.

Ms Halton—Yes. It really is a little hard to say there is a rule. Sometimes, as you know, we commission particular bits of work that are particularly germane to what might sometimes be described as a very boutique issue in terms of how we run things. You would not necessarily expect that that would be published. Often we will release it if people are interested, but to say that we would actually publish it is probably a slight overstatement.

Senator MOORE—It is the double thing: some things are formally published and given accreditation, and other things are just made public in committees like ours.

Ms Halton—Exactly.

Mr Learmonth—I would not characterise GPPAC as concerned with research. It was on an advisory committee; it was a consultant forum.

Senator MOORE—My understanding is that they did actually produce reports. They would be looking at issues around GP activity.

Mr Learmonth—They may have commissioned things, yes. But principally they were set up with a time limit for a very specific purpose, and that was achieved.

Senator MOORE—One of the things that we are interested in is the work that had been commenced on the measurement and reward of quality GP care. We were of the belief that that was something GPPAC were doing. Is it your understanding that there was a project looking at the measurement of quality care?

Mr Learmonth—I am not familiar with it. I cannot say definitively.

Senator MOORE—Can you take that on notice.

Mr Learmonth—Yes. Could you repeat the name, please.

Senator MOORE—I do not know what the formal title is, but the idea was around the measurement and reward of quality GP care. My next question is about the Australian Primary

Care Collaboratives Program—APCCP. How much funding has been committed to the Primary Care Collaboratives Program? What is the funding process?

Mr Learmonth—The budget for the program is $15,648,860 GST exclusive over four years.

Senator MOORE—Are you sure?

Mr Learmonth—Yes.

Senator MOORE—In which budget did that start?

Mr Learmonth—In 2004-05.

Senator MOORE—What was the process for how the funding was to be used? What was the expectation of the PCCP?

Mr Learmonth—It was anticipated that the funding would be split into certain areas. For example, if we are talking about the GST exclusive amounts, there are several roles in the National Primary Care Collaboratives costs, which is the central unit that we have contracted with to deliver the program—$3,192,000 was taken by that. There was local level support involved to the participating divisions and others of $4.255 million. There were costs of training workshops of $3.2 million, participating practice payments of $4.5 million and some advice and training of $500,000.

Senator MOORE—How many divisions were initially expected to take part? I have seen the advertisement that went in the paper calling for people to be part of it. What was the expectation of the department of people who would take up that opportunity?

Mr Learmonth—The expectation was around 25 divisions and 600 individual practices. We received 24 applications, but some of them are collaborative and 45 divisions are covered, so it is well oversubscribed.

Senator MOORE—There was some media coverage—and I always advise that it was media coverage—that divisions stated that they would face losses of $750,000 if they took part in this project. Did you hear of people making those kinds of statements?

Mr Learmonth—I confess I have not heard those particular ones. Certainly, I have seen comments in the press about discussions between the collaborative centre, who we contracted with, and the divisions' movement about the level of support that might be provided to divisions to participate.

Senator MOORE—Did the department respond to those concerns?

Mr Learmonth—Only insofar as we encouraged our contracted party, whose responsibility it was to clearly reach an appropriate arrangement with the divisions, for support to enable the program to go ahead. The numbers would seem to suggest that they have done that.

Senator MOORE—Do you have any idea of what the added costs were? The program was planned and advertised and, once divisions got into it, they were making statements that there would be extra costs. Are you aware of what they claimed those additional costs would be?

Mr Learmonth—I have not seen any specific information. It would have been, in some ways, unremarkable for them to make those claims when they were in the process of negotiating support funds.

Senator MOORE—So there was no responsible department, except through the advice to the contracted party, to negotiate?

Mr Learmonth—They had the responsibility to agree to payments of the divisions as part of their contract. I would imagine they had quite extensive consultation with the divisions' network and its leadership in coming to a satisfactory arrangement.

Senator MOORE—Has the funding allocation been changed as a result of those negotiations?

Mr Learmonth—No.

Senator MOORE—Are you aware through your contracted—

Mr Learmonth—There has been no change to our contracted price.

Senator MOORE—No change at all. And you are still, according to the figures you gave me earlier, oversubscribed?

Mr Learmonth—Yes.

Senator MOORE—So the department would not agree with the allegation that the program has been scaled back?

Mr Learmonth—Absolutely.

Senator MOORE—How many of the participating divisions would you consider come under the departmental definition of 'rural'?

Mr Learmonth—We would have to take that on notice. We think it is about 51 per cent, but we will have to take it on notice.

Ms Halton—If we are wrong, we will come back and correct that, but we assume it is about that.

Senator MOORE—Can we get a list of the people who are participating divisions? Is that information publicly available?

Mr Learmonth—It is on the Collaboratives web site.

Senator MOORE—So, if you can get back to me with the ones that you say are rural and I will check your web site as well and see whether we agree that they are rural, how is that?

Mr Learmonth—Done. We believe 51 per cent is correct, though we will come back if we check and find it is incorrect.

Senator MOORE—I have just mentioned the areas of data collection and research, and at least two of them have ended. Can you give me an overview of how the department sees GP research operating at the moment? What forms of research are active now?

Mr Learmonth—I would again stress that they have not ended. BEACH has not ended. We have changed the funding arrangement, but it has certainly not ended.

Senator MOORE—One form of that would be, as required, seeking the support of BEACH; is that right? Is that one form of research?

Mr Learmonth—I guess I am just making the point that it has certainly not ended. We have changed the payment arrangements; that is all.

Ms Halton—I think it is important to understand we do not do research—independently, quality control, refereeing et cetera. That is not our job.

Senator MOORE—You contract that in, don't you?

Ms Halton—If we need advice on a particular issue that pertains to policy or indeed program administration, then we might commission some work that will assist us in providing the minister with policy advice. But I do think it is a misnomer that we conduct research into—insert whatever is the issue—general practice, dot, dot, dot. It used to be the case I think a reasonable amount of time ago that there were areas that did research. That is not really a function the department has undertaken in quite some time.

Ms Morris—I would just like to correct something. We earlier said funding for Collaboratives started this financial year. It actually started in 2003-04.

Senator MOORE—Did it start at the beginning of that year or during the year?

Ms Morris—The contract was signed on 29 June 2004; so at the very end of that financial year.

Senator MOORE—Fairly close to 2004-05.

Ms Morris—Yes, but technically it started 2003-04.

Mr Learmonth—And there would have been a payment made.

Senator MOORE—I think that is all I have on outcome 4.

[2.04 p.m.]

Senator HUMPHRIES—I have some questions on outcome 9. I want to ask about the HealthConnect trial in southern Tasmania and get some information about how it had been assessed and whether it was seen as a success and, if it is a success, what the next stage of its roll-out might be.

Ms Larkins—I might ask you to repeat the question for my colleague.

Senator HUMPHRIES—Yes, certainly. I just wanted a report on the department's feeling about the progress or success of the HealthConnect trial in the southern part of Tasmania. Can you tell me about how it has been seen, whether it has been viewed as being successful? I realise that a formal process of evaluation has probably yet to occur, but at this stage what is your impression of its success and how will the evaluation proceed in a formal sense?

Mr Shepherd—You are correct, the southern Tasmanian HealthConnect trial ceased in November last year. You are also correct that we are still in the stages of wrapping up the final evaluation of that trial. The evaluation approach in the trial has been a formative approach; therefore, reports have been released along the way over the two-year period. Views have been expressed publicly by the general practitioners and pharmacists participating. Generally, the view of stakeholders on the ground is that the trial has been a great success in proving that

the concept of an electronic health record can work. It has identified a number of important issues which will be reported upon in the evaluation report. Those issues will be used to influence the implementation approach.

Senator HUMPHRIES—How long will the formal assessment or evaluation take?

MrShepherd—The evaluation process has been ongoing over the past two years; so we have been learning as we go. The wrap-up report for the evaluation is due to be published in March this year.

Senator HUMPHRIES—So its cessation in November was planned; it was not the case of its having run out of money or anything like that?

Mr Shepherd—Correct. The very strong view held on the ground by stakeholders was that we needed to cease the trial, take on board the lessons from the trial and apply those in the implementation approach. We are following that strategy.

Ms Halton—The very clear message, as I understand it, we had from the profession is that they wanted to draw a close to the trial. So everything that has occurred has been absolutely in concert with the profession.

Senator HUMPHRIES—Their wanting to draw a close to the trial was not an indication they wanted to move away from the trial or end it?

Ms Halton—No, it was an acknowledgment that the trial was a trial and that we now needed to learn the lessons from it. So this was expected. It was consistent with the agreement with the profession. Business as usual.

Senator HUMPHRIES—Do you have any general impression of the utilisation rate by GPs? Was it intended that all GPs in southern Tasmania would have the opportunity to sign up to the trial and, if so, do we know at this stage how many did?

Mr Shepherd—The intention of the trial was to sign up every GP that had software that was able to interact with HealthConnect. The result was that 80 per cent of those GPs who had that software signed up to the trial. The specifics around the question you have just asked will be the subject of the evaluation report published in March.

Senator HUMPHRIES—Is it intended that, if the trial is evaluated as having been successful, it would be then extended to other parts of Australia, or would it be a matter that is in the hands of government?

Ms Larkins—Trials are already under way in other parts of Australia, and we have had completed trials in other parts of Australia. We can give you those details.

Ms Halton—Can I make a sort of overarching comment, though, about this, Senator. I think we should understand the context here. The context is that electronic health, a bit like electronic banking, is where we are going. This is not a 'Will we decide to do this—yes or no?' The world is moving on into the electronic age and medical practice—what happens in a doctor's surgery, what happens in a hospital—is going to ultimately end up in a more electronic environment than it perhaps currently is in some places. So there is not a notion here of 'Will we do this or won't we?' Rather, it is how do we take the appropriate steps so

that can in fact be enabled effectively, efficiently, and rapidly? That is certainly the minister's agenda.

Senator BARNETT—I want to follow up Senator Humphries's questions re the Hobart HealthConnect trial. How many practices were involved in the 80 per cent utilisation rate by GPs?

Mr Shepherd—We do not have the exact figure to hand, but we will be happy to provide that to you on notice.

Senator BARNETT—I think you mentioned there was positive feedback from the stakeholders. Do you have a list of the key stakeholder groups and advisers? I know the diabetes community, for example, have a special interest and have been very pleased with the results. Can you help us in that regard or add anything further?

Ms Larkins—I mentioned that the stakeholders are included in the evaluation report—the people who were consulted.

Mr Shepherd—We would be happy to supply you with a full list of those stakeholders involved in the trial nationally and locally. I think you will find that it covers the broad width of the stakeholder groups in the health sector.

Senator BARNETT—I think you said the evaluation report will be published in March, which is next month. Will that be released or made available to us or can it be in due course?

Mr Shepherd—The interim evaluation report was published by HealthConnect just over 18 months ago. We are anticipating that, consistent with that approach, the trial's evaluation wrap-up report will go through a review and sign-off process and likewise be published.

Ms Halton—I cannot see any reason why it will not be.

Senator BARNETT—Thank you. Just linking in, Ms Halton, with your comments about the other trials around the country and there being a work in progress in terms of electronic health, as it were, what findings have we had? To date have there been any clear key outcomes from the other HealthConnect trials around Australia?

Ms Halton—I guess it is a little hard to give you a very simplistic overview of the key lessons. What I can tell you is that we know a lot more about both barriers to it and things that will make it more accessible, from working with individual doctors, working with software providers, working with people who understand the technology issues. If I can give you a particular example, we have had in the recent past an agreement from all the states and territories to establish the National E-Health Transition Authority, and one of the key lessons we have learnt and the reason we now have a national e-health transition authority is that, unless you have a common set of standards, it is very hard to get one plug to go into another.

So, in terms of the enablers, the things that will make a difference to realising the electronic health environment that I have just talked about, cooperation from all of those parties is imperative. A core standards base is imperative. Appropriate privacy protections are a complete prerequisite. We know that we have in this country probably a better opportunity to make this work than a lot of other countries because we do have Medicare as a system and because we do have a willing and able profession to work with. We could go to a particular trial and say, 'We learnt this about telephony and we learnt this about that,' but—

Senator BARNETT—I am not really wanting all these answers now, but could you lead me or the committee to relevant reports? I presume there are other evaluation reports from the different trials. Can you perhaps list them?

Ms Halton—We could give you a reading list.

Mr Shepherd—We will give you a reading list. The other point to make is that the wrap-up report is actually a wrap-up of all of those reports. It actually is a report on all of those trials.

Senator BARNETT—It is the March report. Excellent.

Mr Shepherd—That is what you are looking for.

Senator BARNETT—I am interested in this area. I think it is very exciting. I think this is an opportunity to improve the health of the nation. So I am trying to get an overview.

Mr Shepherd—That report will address your questions.

Senator BARNETT—I just want to ask about MediConnect out of Launceston and—is it Ballarat?

Mr Shepherd—Yes.

Senator BARNETT—How far through are we in the evaluation of that study and how is it progressing?

Mr Shepherd—The time frame is exactly the same. The MediConnect field test went into a wind-down phase in December last year. The evaluation time frames are actually inclusive in that wrap-up report. So you can expect that in March the lessons from the MediConnect field test will be part of that overall report.

Senator BARNETT—I am looking forward to the month of March. Thank you.

[2.14 p.m.]

CHAIR—Senator Moore had just a few more questions on outcome 4.

Ms Halton—I was going to ask about that, because my outcome 4 colleagues are itching to get away.

Senator MOORE—I do apologise. My questions are for the Acute and Coordinated Care Branch and also the Australian Institute of Health and Welfare. Dr Stuer, I want to ask some particular questions on data collection. It seems to be my thing. To make sure that I am clear, can you give me an overview of the kinds of things your agency does. I know I have got it, but just an opening statement.

Dr Stuer—The institute basically collects, analyses and reports on data across a range of health topics as well as community services and housing assistance. In relation to health, it covers health status and health services. In doing so, we work very closely with the states. Although we have an act which has very strong provisions for data security and confidentiality, that act does not actually compel the states to provide us with information. But we have established well-developed mechanisms to ensure collaboration from the states. They all work on the Statistical Information Management Committee, which reports through the National Health Information Group to AHMAC. This is where the decisions are made about

the type of collection undertaken in the states. We develop what is called national minimum data sets, which are agreed definitions between the jurisdictions on the kind of data that we collect. Behind these definitions are standards, which we call metadata, which ensure consistency in the data we collect as well as comprehensiveness and quality of data.

Senator MOORE—So consistency and comprehensiveness?

Dr Stuer—Yes.

Senator MOORE—Do you collect data from the private and public hospital sectors?

Dr Stuer—We collect data from all public hospitals and most private hospitals. We do not collect statistics from private clinics.

Senator MOORE—Is there any reason for that, Dr Stuer?

Dr Stuer—I think this depends on what the states provide us with. For example, it is only in the last couple of years that we have had higher returns from the private hospitals in states like Victoria and Queensland. So as the legislation of the states compel them to return particular data we are getting more data.

Senator MOORE—So the state legislation compels, but you cannot compel the states?

Dr Stuer—No.

Senator MOORE—But the state legislation actually compels them to give data?

Dr Stuer—That is my understanding—at least I understand the legislation in Queensland has required them to provide us with data on private hospitals; similarly in Victoria.

Senator MOORE—The return rate is good? You said it was improving.

Dr Stuer—We are getting most private hospitals now, which is the reason that some of our figures are increasing in various categories—because our coverage is larger. But I do not have the percentage of coverage handy.

Senator MOORE—Do you have it, though?

Dr Stuer—I could get it.

Senator MOORE—I put that on notice. You perform analysis on that data?

Dr Stuer—In relation to hospital statistics?

Senator MOORE—Yes.

Dr Stuer—The analysis that we undertake is still relatively limited. To give you an example, we have something like 5,000 diagnoses and 10,000 codes for procedures. So, whilst we collate the figures against each of those codes, the extent of analysis we do is still very limited and would be subject to a lot more resources than we have. Our resources are basically going towards the collation of the data, the cleaning of the data and ensuring consistency between states.

Senator MOORE—What is the relationship between your data collection work and the department's data collection?

Dr Stuer—In relation to a particular collection?

Senator MOORE—No, just generally.

Dr Stuer—The department is one of our clients. The department sometimes ask us to do work for them under a memorandum of understanding. We provide these reports on a strictly cost-recovery basis. We describe our relationship as a partnership to develop better information. But some of our data is funded by our own appropriation, which is a fairly small and static appropriation of $8 million. So most of the new areas of work have to be funded by others.

Senator MOORE—Do you seek funding from other places? Do you operate on contract?

Dr Stuer—We sometimes do. It all gets, I guess, discussed within the work program. We have a work program which is guided by our board. The department sits on our board. We also respond to requests for work. In the engagements that we have with our clients as well as with the Statistical Information Management Committee, we of course put areas where improvements to data are required. But of course the number of areas to be covered is huge compared to what we can actually provide.

Senator MOORE—You collect data on private and public hospitals. What other places collect data specifically on hospitals?

Dr Stuer—I think I had better take this question on notice. I am not really familiar with that collection, but we do collect all the diagnoses and procedures. We also collect data on the hospital establishments, so the buildings themselves and the activities within those hospitals. But I am not sure what other data you are after. Can I take this on notice?

Senator FORSHAW—Are you or Ms Halton aware of similar work being done within the department itself?

Ms Halton—Sorry, I missed the end of the question.

Senator FORSHAW—You have explained what the institute is doing. I am wondering whether or not similar work in terms of the collection of that sort of data is being done within the department or by some other agency that is contracted to the department. Does that happen?

Ms Halton—I think it depends on the nature of the data.

Senator FORSHAW—We are talking here about hospital admissions data, separations data—that sort of thing.

Ms Halton—No, not that I am aware of. Consistent with the conversation we just had with Senator Moore about research or information and evidence we gather in respect of particular questions, if we are seeking to answer a question and data is available to us through hospital collections that are held by AIHW, obviously we would always go there first. I think everyone is loath to ever duplicate anything, and there is a great consciousness about cost.

Senator FORSHAW—I do not think we are necessarily suggesting duplication here—maybe more complementary but the same type of data collection.

Ms Halton—In those circumstances, what we would look at is cost effectiveness. If we enter into a purchasing relationship, if we have a particular piece of work that needs doing, we would look to ensure that we purchase whatever it is we need in the most cost-effective

manner. In many instances that will actually be AIHW because they will either have access to or be able to quickly get access to material that we might need. But that would not be universally the case, because in some cases others may be more cost-effective sources.

Senator MOORE—Dr Stuer, I know your organisation collects separations data. Can you outline how and how often it is collected, and whether regular updates are available?

Dr Stuer—We collect the data every year.

Senator MOORE—It is an annual collection?

Dr Stuer—Yes, it is. It has been for about the last 10 years and it comes out every year at the end of June.

Senator MOORE—This is data collected by the public hospitals, and most of the private hospitals give you that information?

Dr Stuer—No, we get the data from the state departments of health.

Senator MOORE—So it is collected from the state departments?

Dr Stuer—Yes.

Senator MOORE—So you have no automatic relationship with the hospitals—the data goes from the hospitals to the state departments and then they feed the data through to you. Is that right?

Dr Stuer—That is my understanding.

Senator MOORE—This data is all publicly available on your web site?

Dr Stuer—Yes.

Senator MOORE—Do you do printed publications as well?

Dr Stuer—Yes.

Senator MOORE—So the way you would find that out would be to go to your web site, which I have looked at, and also through getting the standard print copy. Is that the methodology?

Dr Stuer—Yes.

Senator MOORE—Do you have current data on separations with you, or do you need to take that on notice?

Dr Stuer—No, I do not.

Senator MOORE—On notice, can you outline key data with regard to separations, current average cost per separation and current average cost per separation by age group. From what you said earlier, you actually publish these in June. Is that right?

Dr Stuer—Yes.

Senator MOORE—So the last available one would be June 2004?

Dr Stuer—It would be 2003, which would have been published in June 2004. Actually, I think this year it will be published earlier for the first time—in May.

Senator MOORE—That is what I would like to have.

Senator FORSHAW—Senator Moore referred a moment ago to—was it the Acute and Coordinated Care Branch?

Ms Halton—That is going back some years. That is obviously an officer who has long since left the department.

Senator MOORE—What is the new name for that kind of area?

Ms Huxtable—It would depend on which part.

Senator MOORE—The structure has changed so much that those groups are no longer one group—is that what you are saying?

Ms Huxtable—That is right. Good luck!

Senator FORSHAW—What is the costing in the ambulatory classification section? Does that exist? What do they do? That is what I really want to know.

Ms Huxtable—There is an area in the acute care division which looks at casemix classification systems.

Senator FORSHAW—That is it, is it—that is what it is called?

Ms Huxtable—I am not sure what it is called. What is it called? I am sure the words 'classification' and 'casemix' are there. I am not sure if 'ambulance' is.

Senator FORSHAW—And 'section', probably!

Mr Cotterell—The branch is called the Acute Care Development Branch. We have just changed the section structure and there are three sections. Basically they all start with casemix and do different elements of it.

Senator FORSHAW—Do any of these sections collect data from public and private hospitals?

Mr Cotterell—Yes, they do.

Senator FORSHAW—How is that work done? Is that similar to what we have just been hearing about from the institute, or is it totally different? Can you fill this out a bit?

Mr Cotterell—It is similar, but it is done for a different purpose. This data is collected under the Australian health care agreements and is provided for that purpose—for the Commonwealth to analyse what is going on in hospitals and hospital costs, and also to share that information with the states and territories.

Senator FORSHAW—So in that role is there any sort of a relationship, either direct or indirect, with the Institute of Health and Welfare?

Mr Cotterell—That is right. My branch administers the MOU with the Institute of Health and Welfare, and we collaborate on the development of these data sets.

Senator FORSHAW—The data you collect, you say, is used in respect of negotiations with the states for the health care agreements and so on. Is it also shared with hospitals directly?

Mr Cotterell—That is right. If hospitals ask for the information, we provide it.

Senator FORSHAW—You said it had been restructured recently—I am just trying to understand this. You said earlier there are these three sections, if you like; that is the recent restructuring, is it?

Mr Cotterell—That is right.

Ms Huxtable—That is at a fairly granular level of the department's activity.

Senator FORSHAW—Granular level?

Ms Huxtable—Correct.

Senator FORSHAW—Granular level?

Ms Huxtable—I am not sure whether it is you or me, Senator!

Senator FORSHAW—That is a sort of less than minute level, is it?

Ms Halton—Very small, Senator.

Senator FORSHAW—Very small?

Ms Huxtable—That is right.

Senator FORSHAW—Sort of a nanogranular, minute level?

Ms Halton—If we get to molecular level I think we will have some problems!

Senator FORSHAW—Let's not go that far; we will be diagnosed! Senator Moore asked about the institute's costs for collection of separations data and so on. Is that done by this section as well?

Mr Cotterell—That is right.

Senator FORSHAW—I am trying to understand whether there is any duplication or little duplication of what you as a departmental section are doing and what the institute is doing.

Ms Huxtable—The data that we collect is under the auspices of the Australian health care agreements, which Mr Cotterell has referred to, and it would be largely the same data as that which the AIHW also receives.

Mr Cotterell—They get it at the same time.

Ms Huxtable—But the purpose of this is somewhat different.

Mr Cotterell—Part of the difference with what we do is we develop the methodology for some of this costing activity. We do not receive patient-level data on costs. We receive aggregate data on costs, and we develop a methodology for allocating that to each patient.

Senator MOORE—How much is aggregated?

Mr Cotterell—In the case of private hospitals, for example, we will basically get the general ledger of the hospital.

Senator MOORE—Each location, though, so you get aggregate data from a hospital?

Mr Cotterell—That is right.

Senator MOORE—I was thinking aggregate data of every patient in Queensland or something like that—but no?

Mr Cotterell—We will get the number of separations from each hospital.

Senator MOORE—Per site?

Mr Cotterell—I think we do get it per site, but it is de-identified so that we cannot say a particular hospital is more or less efficient. We look at it across a state, for example.

Senator FORSHAW—Is your data made publicly available or is it kept in-house?

Ms Halton—What do you mean by 'data'? Do you mean the product of the work or the data that went into it?

Senator FORSHAW—Both, actually. We have heard from the institute that they make the data available.

Mr Cotterell—We make the product of the work available. The raw data is not available publicly.

Senator FORSHAW—Do you do that publicly on the web site?

Mr Cotterell—It is on the web site.

Senator FORSHAW—Forgive me for not having looked at it. It is very granular!

Mr Cotterell—I would need to check whether that is on a publicly available part of the web site or whether it is limited to hospitals and state and territory governments.

Senator FORSHAW—That is what I was trying to get at. We know the institute make it publicly available generally; I wanted to know whether that was the same for your section or whether it was basically back to the states and to those hospitals that may request it. Thank you.

CHAIR—Thank you to all from outcome 4. Senator Harradine makes an apology that he will not be asking questions. He will be putting them on notice.

[2.34 p.m.]

Office of the National Health and Medical Research Council

Senator FORSHAW—I assume the council is aware of the outcomes and recommendations of the Uhrig review?

Prof. Pettigrew—Yes, we are very well aware of the Uhrig review.

Senator FORSHAW—What do you believe might be the implications of the recommendations arising from that review, particularly with regard to the council's advisory role?

Prof. Pettigrew—I might just backtrack slightly, one level, insofar as the Australian National Audit Office tabled a report on the government's administration of the NHMRC and drew attention to governance issues that need to be addressed. We have been working with the department on that particular issue. Subsequent to that report coming out, the Uhrig review, as you know, was tabled, and it sets out the forward direction for statutory authorities, agencies and so on. In addition, there was a release of the review called the investment review, which was chaired by Mr John Grant. That review makes some recommendations on the future

governance arrangements of the NHMRC. Those issues are currently being considered by the department.

Senator FORSHAW—They are being considered by the department?

Prof. Pettigrew—Yes, that is right.

Senator FORSHAW—Have they been considered by the members of the NHMRC? I call them board members, but I mean the appointed members of the council.

Prof. Pettigrew—Certainly I have brought to the attention of the council the conclusions of the Uhrig review and the investment review, which was only recently released and which has implications for the forward progress of this issue. I have been collaborating and working with the department to take the forward directions arising from all of those reviews. So it is work in progress at present.

Senator FORSHAW—Has the council formed a view about its response?

Prof. Pettigrew—Not at present.

Senator FORSHAW—Is it happening by way of interaction between the department and the council? Are they considering the recommendations of the review and the Audit Office, and working to some conclusion that way rather than the council having a response and putting that back to government—is that a fair description?

Prof. Pettigrew—These processes are still being worked through. We have not finalised a course of action at this point. Bear in mind that the council meets only four times a year. There is a meeting coming up in March, and the issues of the investment review, which was released in December, will be discussed by the council at its March meeting. So we would have to wait for council's deliberations on that issue before I could comment any further on that.

Ms Halton—At the risk of confusing the matter, Senator, I think the matter of the NHMRC is more complex than seeing it through just the frame of the Uhrig report, because, exactly as Professor Pettigrew has indicated, governance in respect of the NHMRC has been on the agenda for a while and there are a number of things that need to be taken into account in terms of what I think we agree is the need to resolve some of those issues. I think it is a poor reflection of the process to say: go to the committee, and the council consult and then take that away. I think it is a more iterative process. Exactly as Professor Pettigrew says, whilst they meet only after a fixed period, a number of the key people on the council actually have been involved in dialogues with me, with other senior people in the department and with each other in terms of their thinking about this process. So I think there is a fairly free-flowing approach to debating, discussing and exchanging ideas.

Senator FORSHAW—That is actually what I was trying to get at. I was assuming that was what you were describing. I was not trying to reflect on it in any way. It is more a comment than a question about the status, if you like, of the NHMRC in terms of its independence, its expertise. Its advisory role has to be kept in mind, as distinct from maybe other areas that might be told, 'This is what has to happen,' and—

Ms Halton—Yes. I think there is a great deal of awareness of exactly that issue and a healthy level of sensitivity in respect of that issue.

Senator FORSHAW—That is why I asked about the approach the council had taken to the recommendations. But I understand that it is a work in progress.

Ms Halton—It is. But I can assure you there is a healthy dialogue on the matter. We have not got to the point of finalising what we all think, but I can assure you that we are in dialogue. If your concern is that there will be an application of a standard process and therefore a standard outcome to this, that is not what we are anticipating.

Senator FORSHAW—I was just asking the questions. Thank you. I will leave my concerns until the next estimates, when we get an update.

[2.40 p.m.]

Senator HARRADINE—I refer to the report of the licensing committee to parliament—that licensing committee being established under the Research Involving Human Embryos Act—for the period 1 April 2004 to 30 September 2004. I see that almost 60 per cent of the licences issued did not, when audited, comply with one of the standard licensing conditions. Could you tell the committee what you have done about that? Isn't this a fairly big failure rate?

Dr Morris—The issue you refer to related to one licence-holder where there had been a simple administrative error when a minor change in personnel had not been reported. There is a condition of licence which says that changes in personnel should be reported to the licensing committee within seven days. When the inspection occurred, which was within two weeks of the licence being issued and well before any work had been undertaken, this administrative error was discovered, reported and corrected at the same time. So we have reported it as a minor noncompliance and it has been resolved.

Senator HARRADINE—What action has been taken against the licensee? Is there only one licensee?

Dr Morris—There is one licensee, four licences. The issue was corrected. It was a minor administrative error.

Senator HARRADINE—So it was not a breach, as reported by the audit?

Dr Morris—It was an unintentional breach.

Senator HARRADINE—I thought that ignorance was no defence.

Dr Morris—In terms of a criminal offence against the act, a breach would have to be significant and proven to be intentional. This is a compliance issue, not necessarily a significant issue which requires any action on the part of the licensing committee.

Senator HARRADINE—I notice that the NHMRC Licensing Committee has recently completed an investigation into allegations that Reproductive Medicine Albury was involved in commercial trading of human sperm, because it was advertising in a Canadian publication, offering return airfares to Australia, accommodation and daily allowance in return for sperm. What have you done about that?

Dr Morris—As you can read in the biannual report, the investigation was conducted. We sought legal advice on the matter. It was determined that there had been no breach of the legislation. The organisation in question had advertised once in a paper overseas and they

have not pursued the matter. They were urged to seek their own legal advice on it, and the matter has not been pursued.

Senator HARRADINE—Are you saying that it is not a valuable consideration for somebody in Canada to be flown out first class to Australia and to receive certain other remuneration? Is that not a valuable consideration?

Dr Morris—The advice we received was that if it had occurred, which it did not, then it would have depended on the nature of the consideration. For example, if the donors had received a standard economy-class airfare, been billeted and done nothing but the donation, then perhaps it would not be. But it would have to go to a court of law. It would really depend on the circumstances involved.

Senator HARRADINE—I refer to the hearing of the Community Affairs Committee. It was anticipated in evidence to that committee that this problem could arise. I refer to 4.51 of that committee's report, which states:

> Clause 22 prohibits the commercial trading in human eggs, sperm or embryos. A person commits an offence if they give or receive valuable consideration (not including reasonable expenses) for the supply of human eggs, sperm or embryos. Valuable consideration is not limited to monetary rewards and includes any inducement, discount or priority in the provision of a service. Reasonable expenses may relate to the costs of collection, storage or transport. However, as noted earlier, the Bill does not prohibit commercial trading in embryonic stem cells.

That is the finding of this committee. It goes on at 4.52 to state:

> The Committee heard evidence from Professor Michael Good and Professor Peter Row, that excessive handling fees had been offered within the United States to escape provisions equivalent to Clause 22. In response to this suggestion, the NHMRC advised the Committee that—

this is your advice to this committee, or the committee under another hat—

> The legislation prohibits the giving or receipt of valuable consideration for the supply of a human egg, human sperm or human ovum. Valuable consideration is further defined to include any inducement, discount or priority in provision of a service, and it is intended that this would include such things as a handling fee.

So at the time the NHMRC said that the legislation prohibited inducements for the supply of human gametes. Why was your advice to the committee incorrect?

Dr Morris—As I said, this was a single ad placed by a clinic in a newspaper overseas and they did not proceed with that.

Senator HARRADINE—This evidence was referring also to the United States.

Dr Morris—If the IVF clinic had proceeded, then that issue would have been investigated on its merits and the outcome may have been different. But, as it stands, there was no breach of the legislation.

Senator HARRADINE—You have advice which says that the provision of an all-expenses paid trip to Australia from Canada is not a valuable consideration.

Dr Morris—What the advice said was it would need to have been looked at on its own merits. It would depend on the nature of the offer.

Senator HARRADINE—So it is not saying that it is not a valuable consideration?

Dr Morris—It is not saying directly that it is not. The advice was that it would depend on the nature of the offer. For example, if it were a business-class, open-ended airfare, it may be different to if it were an economy-class airfare. That is the advice we have got. Given that it did not occur, we cannot investigate the matter further.

Senator HARRADINE—Perhaps I can just follow this through. Wouldn't any reasonable person consider that an all expenses paid fare from Canada to Australia with accommodation here and all the rest of it would be a valuable consideration? Wouldn't the ordinary Joe Blow agree with that?

Dr Morris—We can only go on the advice of the Director of Public Prosecutions.

Senator HARRADINE—But the advice does not say that. The advice does not say that it is not a valuable consideration. It says that it will be considered case by case. Of course it will. What are you doing about it so that it does not occur again?

Dr Morris—I think by publishing it in the biannual report it makes people aware of the issue, and that helps make sure that clinics do not undergo that course of action if they need sperm donors.

Senator HARRADINE—Do you give any consideration to the rights of the child in respect of knowing who its father was or is?

Senator Patterson—That is not a question for Dr Morris.

Senator HARRADINE—I thought it might not have been! I could ask you, Minister.

Senator Patterson—I should not have popped my head up.

Senator HARRADINE—Has the government given any consideration to that aspect?

Senator Patterson—I did not actually hear what you asked, Senator. I was a little bit preoccupied with writing a letter, since it is not my direct portfolio anymore—although I love all these people dearly. What was the question?

Senator HARRADINE—We are talking about sperm donation and whether a return airfare to Australia with all expenses and accommodation paid is a valuable consideration. I asked then, incorrectly of Dr Morris, whether consideration has been given to the rights of a child to know who their father is.

Senator Patterson—I am not an expert in this area. I think responsibility for legislation regarding reproduction is the states' jurisdiction, but I will check.

Senator HARRADINE—Take it on notice.

CHAIR—I draw your attention to the time, Senator. We have seven minutes to go.

Senator HARRADINE—I have put 70 per cent of my questions on notice. I recognise that. I am sorry.

CHAIR—We still have rural health to go.

Senator HARRADINE—I am sure the NHMRC would have been disappointed if I did not ask a question of them!

CHAIR—No doubt they would have.

Senator HARRADINE—It is my second last chance.

Senator Patterson—We will still expect them on notice when you are gone, Senator! Senator Newman was watching question time on TransACT yesterday and sent me a note. So, you see, old senators never die.

Ms Halton—Did she send you a question?

Senator Patterson—She did not send me a question, no. She might be watching now. We can send her a cheerio.

CHAIR—Are there any further questions on outcome 5?

Ms Halton—While people are considering the outcomes, may I say we did provide some information about the Primary Care Collaboratives Program and what proportion were rural. I have a list of those collaboratives and which ones are rural. I am happy to table it.

CHAIR—Thank you. I thank the officers from the NHMRC.

[2.55 p.m.]

CHAIR—We will return to outcome 9.

Senator FORSHAW—With regard to HealthConnect and patents, I understand it was recently reported that the department was not aware that the Pharmacy Guild had requested a formal examination of a patent application. I understand the patent application was lodged by a CR consultancy, or IP Australia.

Ms Halton—This is actually a program 2 issue, I regret to tell you. It is about the relationship with the guild.

Senator FORSHAW—I think we will deal with that on notice, then.

Ms Halton—That would be excellent. Thank you, Senator.

Senator FORSHAW—What is the split now of policy work between the Health Insurance Commission and the department on the HealthConnect trial? Can we deal with that now?

Ms Halton—Of course we can. Would you like me to say you can ask Human Services?

Senator FORSHAW—No.

Ms Halton—I did not think so. Senator, in fact you would know that we have been working very closely with the Health Insurance Commission on a number of aspects of electronic health, if I can describe it in that broad way. As it happens, I think in response to a question I was asked earlier I was describing the establishment of the new National E-Health Transition Authority. In conjunction with that change in the landscape we have been reviewing who basically is undertaking what work in this space—who is doing policy work, who is doing roll-out implementation work, what the role of the transition authority should be. We are literally—and in fact we had this conversation in my office yesterday—looking at the various roles of various players. You may or may not know that Brian Richards, formerly an officer from the Health Insurance Commission, has joined the department for a period as the implementation—I will get the label wrong—director?

Ms Larkins—At the moment.

Ms Halton—We decided 'director' is a variable word, but the function is pretty clear. We are literally working through—now that we have this different structure in place—who should be actually undertaking what to streamline, if I can put it that way, our implementation of HealthConnect. The policy role is ours. We do have a role exactly as we have already outlined in relation to the trials for implementation. But it is very appropriate that with the transition authority we make sure that the standards work is done there. Some of the architecture work we think should be done there. Obviously we will be looking to employ people in the field, including the Health Insurance Commission, in roll-out, because all the different players will have different roles.

Senator FORSHAW—Within the department, is it the information and communications division that is doing this policy work?

Ms Halton—The policy role at the moment sits there. But, as I said, we are literally about to restructure.

Senator FORSHAW—You are about to restructure?

Ms Halton—Yes, we are in the process of it.

Senator FORSHAW—What has taken place to date in terms of that restructuring, particularly with regard to how it affects staffing levels—recruitment, redundancies et cetera?

Ms Halton—I can get Ms Larkins to give you a brief on that.

Senator FORSHAW—That would be good.

Ms Larkins—We are still working through the details of the restructure. We should be in a position next week to have a better sense of how it might impact on our internal staffing levels. At the moment we have not got to a final decision on the new structure that we will be going to or the level of staffing we will need for those functions. We are still in a process of consultation with staff and others.

Senator FORSHAW—In the interests of time, it may be more useful if I put these questions to you on notice, because they relate to what I have just asked. Who is doing the work of liaising between the federal and state governments concerning HealthConnect? Is that done through the departmental people?

Ms Halton—It depends on in what respect. The National E-Health Transition Authority has a board which is comprised of state and Commonwealth CEOs. So, to the extent that there is liaising going on at that level, it is me. To the extent that we are into the particular technical detail around some standards, again it occurs at the appropriate level. It is fair to say that a dialogue on this issue is going on at a variety of levels and in a variety of contexts.

Senator FORSHAW—I will put the rest of those questions on notice. What is the average cost for a GP to provide the security upgrade that will be needed for HealthConnect? Does anyone know that?

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

Ms Halton—If you are talking about certificates and things like that, HeSA has a structure put in place by the Health Insurance Commission. If you are happy to give us the questions

and there is one in there that is appropriately directed over the road, we will make sure that that is where it goes.

Senator FORSHAW—There is a series of questions that follow on from that one, so I think we will put them on notice.

Ms Halton—We will be very happy to look at them.

Senator FORSHAW—It has been reported that there is a decision to scrap MediConnect as a stand-alone system. Is that correct?

Ms Larkins—That is not correct. I think the decision has been made to build on the functionality from the MediConnect trials and to incorporate that into the broader picture of what we are doing under HealthConnect.

Mr Shepherd—It was always envisaged that A Better Medications Management System, as the program was formerly known, was to eventually become the medicines component of the HealthConnect program. What you are seeing right now is that transition phase where the better medications management system, MediConnect, becomes a component of that overarching HealthConnect program.

Senator FORSHAW—Has there been any write-off of the value of the software that was developed for MediConnect.

Ms Larkins—That is a matter for the HIC; it is an internal financial management matter for the HIC.

Ms Halton—I think you will find it is in their accounts. You can go to their accounts and see it.

Senator FORSHAW—So these questions should go to the HIC?

Ms Larkins—Regarding the write-down?

Senator FORSHAW—Yes.

Ms Halton—Yes, that is correct. I am aware of it. As you know, I am a commissioner of the Health Insurance Commission; it is in their accounts.

Senator FORSHAW—If we give these questions to you, they can be passed on to the HIC?

Ms Halton—We will triage them for you.

CHAIR—That concludes outcomes 4, 5 and 9. Thank you to all have been concerned with them. Would the people from Hearing Services please join us. We will move to outcome 6.

[3.05 p.m.]

Ms Halton—If I could just make the observation that sometimes we do find that Senator Crossin's questions should have been asked under program 6. I just make that observation.

CHAIR—I do think that Senator Crossin actually had some questions in program 6, but I think her colleagues might be going to cover for her on this occasion.

Ms Halton—We have had this problem before.

Senator McLUCAS—We are just massaging at the moment. We are trying to organise traffic.

Senator MOORE—There are some very specific questions here on hearing services so I will run through them and we will go from there. When did the current Commonwealth Hearing Services Program commence?

Mr Kingdon—In 1997.

Senator MOORE—How is an individual able to access the government's subsidised Commonwealth Hearing Services Program? How do you get seen by the Hearing Services Program?

Mr Kingdon—You have to meet eligibility criteria, which in most cases means having a pension entitlement card. Those people can access the service either through a hearing service provider or through a doctor. They have to have a doctor to sign off that it is appropriate for a voucher to be issued. The application comes to the Office of Hearing Services where a voucher is issued to the client. They can then choose which hearing service provider accredited with us they will select as their service provider.

Senator MOORE—So one of the key points is the medical referral?

Mr Kingdon—It is a key point. You have to have a medical referral. The exception is the case of some Indigenous communities where it is too difficult and it has been waived.

Ms Blazow—That is for the voucher component. There is another component in the program which is for special needs people. That is done through Australian Hearing. That is for children, people with severe hearing loss and Indigenous people.

Senator MOORE—It is a more streamlined approach then for those particular groups, isn't it?

Ms Blazow—Yes, that is a direct service provision. So people in those categories go directly to Australian Hearing and receive the service there.

Senator MOORE—So if people front up to the office, they would be given that information to be assessed whether they would be able to meet the special needs arrangements and get an appointment straight away or be told about the medical referral?

Ms Blazow—Yes, Australian Hearing also takes voucher clients. So at Australian Hearing, which is the government owned provider, people could get advice about accessing the program through either of those mechanisms.

Senator MOORE—These are standard costings and data questions. In financial year 2003-04, how many individuals requiring treatment or assistance from that government subsidised Hearing Services Program were referred to accredited hearing service providers?

Mr Kingdon—In 2003-04 there were 78,677 new clients and 81,584 returned clients—these are people who have returned after having had their first fitting.

Senator MOORE—So they are not so much ongoing clients, because there may not be—it might just the one return visit?

Mr Kingdon—No, they would be people who, say, after three or five years have returned to see if their aid is still meeting their requirements.

Senator MOORE—Is there an expectation of a regular return service?

Mr Kingdon—Yes, after three years.

Senator MOORE—Would that depend on the appliance they have or is it always after three or four years?

Mr Kingdon—No, there is always a follow-up process after three years.

Senator MOORE—So three years is the standard one?

Mr Kingdon—Yes.

Senator MOORE—Can you give me the average cost per person for those who access your programs and hearing services? Is that data kept?

Mr Kingdon—Yes. The average cost for new clients in 2003-04 was $948 and for return clients it was $616. Overall in the program—I am very close but it will have to be a guess—it is about $780. In there are costs relating to maintenance and replacement. The average costs for all clients is notional but the two key ones are the new and returning clients. The costs for returning clients are less because they do not necessarily need a replacement of their hearing aid.

Senator MOORE—That makes sense. You told me before about the standard way of accessing the service. I want to make it clear for myself. Can an accredited hearing service provider of a hearing services program make a direct referral for the program?

Mr Kingdon—No, the client has to make an application. It is generated by the client and endorsed by the medical practitioner.

Senator MOORE—Can you advise of the process undertaken in selecting an accredited hearing service provider?

Mr Kingdon—We go through a quite lengthy examination of the provider's capacity to deliver a professional service . We look at their viability. We look at their premises—we do not necessarily go in physically—to ensure that they are accessible to people with physical handicaps and that there are adequate facilities in that location. Then we determine whether it is going to be a permanent site or a visiting site. If it is a permanent site, they have to meet certain hours which are virtually full time. For a visiting site they have to meet minimum standards of visiting hours.

Senator MOORE—That is the accessibility of the service?

Mr Kingdon—That is the accessibility so that clients know that the place will be open and that there will be a service available to them.

Senator MOORE—What is the length of the accreditation?

Mr Kingdon—I do not know. I will take it on notice. I think it is until the person relinquishes their accreditation or they do something that causes us to remove it. I will confirm that.

Senator MOORE—If you get something from the service it is a three-year turnaround but the people giving the service do not have that same kind of process.

Mr Kingdon—No, once you are accredited and you are constantly monitored and under standards there would be no reason why you would want to renew that accreditation providing you maintain the standard. I am almost certain that there is no duration but I will confirm that for you.

Senator MOORE—Are there formal assessment criteria that a provider has to meet before they are accredited?

Mr Kingdon—Yes.

Senator MOORE—Can we get a copy of them?

Mr Kingdon—Yes, I will get that document for you.

Senator MOORE—Once you are accredited are you accredited just in one area or can you go state to state depending on need. If you get your accreditation when you have set up in Queensland, are you then accredited to work in New South Wales or Victoria or wherever for your service.

Mr Kingdon—Yes, it is national, but you have to have each site approved.

Senator MOORE—So you are accredited but you have to be accredited when you set up.

Mr Kingdon—Yes, you can be an accredited provider but then if you want to have multiple sites, you have to advise us where those sites are and confirm to us that they meet the criteria that we have set.

Senator MOORE—Can you give us a state by state break-up of the current accredited providers? I am sure you can.

Mr Kingdon—I actually cannot.

Senator MOORE—You cannot? Why not?

Mr Kingdon—I can give it to you on notice. I do not have it with me. There are sole providers and there are multiple providers. Is that how you would like it broken up.

Senator MOORE—I would like both and also where they are located on a state by state basis. For the year 2003-04 can you provide the amount each of these providers receive from the Commonwealth for services as an accredited service provider? I am asking how much each accredited provider got from the department during the year.

Mr Kingdon—I would like to take that on notice—

Senator MOORE—Yes, you can take that on notice.

Mr Kingdon—but I also have a reservation here: that is, I think you are asking for a fairly commercially sensitive piece of information. If every provider knew what everybody was getting, they would understand what their market share was. I would like to take advice on that, but I think it would probably be quite unfair to service providers if we were to give you that information.

Senator MOORE—Can we get it as commercial-in-confidence?

Ms Halton—I think we will take that on notice.

Senator MOORE—I am fine with just putting on the record that we would like to have it.

Ms Halton—Leave it with us.

Senator MOORE—Is there any agreement between the Office of Hearing Services and the accredited provider about how they advertise and, in particular, how they advertise that they are accredited?

Mr Kingdon—There are some very strict conditions in the contract that we have with the provider about how they must not represent themselves as a government body and that they can only indicate that they are contracted to the government to provide services. They must not advertise themselves as a government body.

Senator MOORE—Can we get that part of the contract, that element?

Mr Kingdon—Yes.

Senator MOORE—And would the understanding of those guidelines cover how the providers advertise free hearing tests?

Mr Kingdon—Only to the extent of how they represent themselves.

Senator MOORE—So it is a general thing; it is not that specific.

Mr Kingdon—No, it is not that specific. There is no prohibition on a contractor advertising; it is not like it used to be for a lawyer. You can advertise your service, and you can encourage people to come in to your service, but you have to meet certain conditions from us about how you represent yourself.

Senator MOORE—And that is all part of their ongoing performance.

Mr Kingdon—Yes.

Senator MOORE—Is the department aware of any allegations of any accredited hearing service provider using telemarketing to generate a Hearing Service Program funded consultation?

Mr Kingdon—Sorry?

Senator MOORE—Have you had any allegations or are you aware of any allegations that an accredited provider has used telemarketing to generate hearing services?

Mr Kingdon—We know they do. That is not an allegation. We certainly know that telemarketing is used as one of the tools by at least one provider and maybe more.

Senator MOORE—And it is fine for them to use telemarketing?

Mr Kingdon—Providing they meet the conditions of not misleading people and not putting duress on our clients we would regard that as acceptable commercial behaviour.

Senator MOORE—So, as long as it meets those elements, it is just another form of advertising?

Mr Kingdon—Yes.

Senator MOORE—How long has National Hearing Centres been an accredited hearing service provider for the Hearing Services Program?

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

Senator MOORE—Sure. Could you also take this on notice—and it will probably be in the same file: in what states does National Hearing Centres practise as an accredited provider?

Mr Kingdon—I would have to take that on notice, but I believe it practises in Victoria, New South Wales, Western Australia and possibly Queensland.

Ms Halton—We will correct that if it is wrong.

Senator MOORE—Are you aware of any complaints regarding National Hearing Centres and their process for advertising?

Mr Kingdon—Yes, we are aware of complaints.

Senator MOORE—We are aware of a particular complaint made in September 2004 by a general practitioner in Perth. Are you able to provide the details of that complaint?

Mr Kingdon—I do have that complaint.

Senator MOORE—We know about the complaint; you know about the complaint. The question is: what has happened with it?

Mr Kingdon—That is fine. We have investigated the complaint, which goes to the nature of telemarketing and practices that follow through from the telemarketing. We have made initial investigations and written to the organisation outlining the nature of the complaint. The general practitioner gave us the permission of the particular patients whose cases he raised, so that we could send that information on to the organisation. We have had an initial response, and I am in the process of some follow-up investigation. So it is being reviewed very actively. We take every complaint seriously, and I can say with all honesty that every complaint is followed up in this organisation.

Senator MOORE—Have you been in regular contact with the complainant through that, letting them know what is going on?

Mr Kingdon—The complainant has had two responses from me. He has come back and has been very helpful in what he has provided. We have had some difficulty in terms of how much we can advise that complainant about the commercial activities of another organisation. It is very difficult for us, because sometimes doctors can have a relationship with a service provider and we have had instances where we have had complaints that have turned out to be more about commercial practice. I am not in anyway suggesting that that is the case here, but it does put a bit of a limitation on how much we can feed back to a complainant. But he has been assured—and you have my assurance, too—that this issue is being taken very seriously and being followed through.

CHAIR—But there was no illegality, was there?

Mr Kingdon—There was no illegality, but there were some things that went to pressure on clients, and that does concern us. The program is not to be abused in that way.

Senator DENMAN—If the doctor has, say, a financial interest in one of the hearing service provider's practices, do they have to declare that?

Mr Kingdon—One would hope they would.

Senator DENMAN—Do they have to?

Mr Kingdon—No, they do not have to.

Senator MOORE—What is the investigation process happening with this particular complainant? We understand that it has gone to the Minister for Ageing as well, because the complainant has been active in that process. Is it being investigated by you, by the department or by both?

Mr Kingdon—I would like to think I am the department.

Senator MOORE—Your ministerial section.

Ms Halton—I will honour him—he is the department!

Senator MOORE—There are two levels of investigation: there is the investigation by the appropriate area and also the investigation stimulated by a ministerial. Are there two separate investigations?

Mr Kingdon—The minister has asked me as well. It has been formal correspondence between a particular member and the minister.

CHAIR—The minister, I might add, has responded to the member.

Mr Kingdon—Yes, she has responded to the member.

Senator MOORE—To the member?

Mr Kingdon—Yes. Clearly the minister has indicated that the matter is being followed through. I am assuring you now that it is in the process of being undertaken.

Senator McLUCAS—I think Senator Moore's question goes to the essence of the complaint, which is that, because of the actions of the hearing company, there is potentially greater impact on Medicare because of the referral process. I think that is what Senator Moore is getting too.

Senator MOORE—That is part of it, yes—its credibility.

Mr Kingdon—There is a certain irony in this. The irony is that the very reason we have medical referrals in all cases is to ensure that people are appropriately referred into the program for a voucher. At one level the doctor who has been concerned about what he saw was actually doing the very thing we wanted him to do—that is, identify where we are getting inappropriate referrals. He was not prepared to sign off on these cases, which was absolutely what we expect the doctor to do. So whilst there may have been a referral cost, we have also seen a saving to the program. We have talked about the average cost per client. As most of these would have been new clients we are talking about close to $900, against a Medicare cost of a doctor referral. It is a pretty good investment to ensure that we do not get inappropriate referrals. Nevertheless, the fact that the doctor is saying that this appears to be a pattern is a matter of concern. That is what I want to investigate. If there is a pattern of inappropriate referrals, we will need to get to the bottom of it and make sure that it does not continue.

Senator MOORE—My understanding is that in one response to the complainant they were referred to the Western Australian office of fair trading as a commercial complaint. Where do Fair Trading come into this?

Mr Kingdon—Telemarketing—

Senator MOORE—It was from that element?

Mr Kingdon—It was only in relation to telemarketing; it was not to do with the program. Telemarketing is something that does not come within my purview unless, as I say, the client is being unduly influenced. Unfortunately, telemarketing starts at a point where they are not necessarily our clients. In fact, as we understand it, it is aimed towards people aged 50 and upwards where you are expecting to have higher hearing loss. This means that if there is a complaint about the telemarketing per se then Fair Trading is the place where you raise those concerns. Some years ago when telemarketing first started and we had complaints, we took these matters up with Fair Trading in a number of states and we were advised that they would prefer the individual to make the complaint directly. They were not interested in a secondary complaint. So since then we have always advised our clients on that issue to go directly to Fair Trading.

Senator MOORE—I refer to hearing tests for children. Is that your area as well, Mr Kingdon?

Mr Kingdon—It could be us.

Senator MOORE—I am just wondering, with the sound quality here, whether we are going to get any questioning that we are not going to have to repeat all the way though.

Ms Halton—Is it not possible to turn the volume up a bit?

Senator MOORE—I do not know. No, I have been told, it is not possible—I have to lean towards the microphone! Is it correct that the Australian Hearing Services facilities at 175 Castlereagh Street in Sydney have lost their lease and there is now no ability to offer services in the Sydney CBD?

Mr Kingdon—Unfortunately, that is an Australian Hearing Services issue and they would have to answer that, but I have been assured that there has not been a loss of service in the city centre.

Ms Halton—But he is not answering their question.

Senator MOORE—I know, and I think it shows great interdepartmental support that you are able to say that. We had Australian Hearing Services here for only a very short time the other night.

Mr Kingdon—I can now answer one question which I was vague on. It was on the accreditation of services. That is not time limited. There were a number of other questions that I have taken on notice but I can answer that one.

Senator MOORE—Are there regular reviews of the people who are accredited? Do they have to go through a review process?

Mr Kingdon—Yes.

Senator MOORE—That is a methodology of making sure they are still—

Mr Kingdon—Yes, they are constantly monitored. We have an audit and accreditation team who work on this on a regular basis and we do a high level of auditing of service providers. Where complaints and issues arise that appear to be irregular, and we can pick up patterns in claims, then we will target our attention on those as well.

Senator MOORE—Have any service providers been removed from your accreditation list?

Mr Kingdon—Yes.

Senator MOORE—Is that made public?

Mr Kingdon—No, not the names.

Senator MOORE—So from that time on that person is unable to in any way display that they are part of the service?

Mr Kingdon—They cannot offer a service, because the person expecting a free service will not be able to have that service redeemed.

Proceedings suspended from 3.29 p.m. to 3.41 p.m.

CHAIR—We will move on to outcome 7, Aboriginal and Torres Strait Islander health.

Senator CROSSIN—Can you begin by telling me the total allocation for hearing services for this financial year?

Mr Kingdon—Are you referring to the community service obligation component of the program or the total program?

Senator CROSSIN—You can give me the total program to start with, if you like.

Mr Kingdon—The total program expenditure for 2003-04 was $206 million and it is estimated for 2004-05 at $231.9 million. Community service expenditure was $29.8 million in 2003-04 and the estimated community service obligation expenditure in 2004-05 is $32.7 million.

Senator CROSSIN—Do you have an estimation of how much of that you will spend this year?

Mr Kingdon—We have two estimates. One relates to the voucher, which to some extent is demand driven, and the other to community service obligation, which is a capped amount. That has been determined in the budget at $32.7 million so we would expect to spend that money this year.

Senator CROSSIN—I understand that in the voucher system the voucher amount is variable, depending of course on how many vouchers are utilised. It is very hard to determine that amount. That is correct, isn't it?

Mr Kingdon—That is right.

Senator CROSSIN—How much of the community service obligations budget is allocated to the Australian Hearing Specialist Program for Indigenous Australians?

Mr Kingdon—$2 million.

Senator CROSSIN—So $2 million out of $29.8 million?

Mr Kingdon—No. Last year, it was $1.568 million out of $29.8 million.

Senator CROSSIN—And $2 million out of the $32.7 million?

Mr Kingdon—Out of the $32.7 million it is estimated to be $2 million.

Senator CROSSIN—Can you explain to me how that program works?

Mr Kingdon—The program is designed to cover groups outside the voucher eligibility group. You have children, which would be the most dominant group: that is, children under 21. You have complex adults—and these are people who are entitled to a voucher but have complex needs that are then serviced by Australian Hearing. We have cochlea replacements. We have AHSPIA, which we have just referred to with regard to the $2 million, and there is also $3 million for research.

Senator CROSSIN—Growth in the budget for that program has been from $1.56 million to $2 million. Is that correct?

Mr Kingdon—For AHSPIA, yes, there has been a growth from $1.56 million to $2 million, which represents something like a 20 per cent increase.

Senator CROSSIN—Are you able to provide me with a breakdown into states and territories of the clients of that service?

Mr Kingdon—I will try.

Senator CROSSIN—I am after the Indigenous Australians.

Mr Kingdon—I do not think I have that information at state level. I can give you a breakdown of individual services but not at a state level. I can take that on notice for you.

Senator CROSSIN—That is fine. What are the defining features of the service contract between the department and Australian Hearing for 2004-05?

Mr Kingdon—The defining features that have made it different relate to the fact that we have identified expected numbers in the contract that will be serviced and that we have identified specific amounts of money that we wish to see allocated to the individual activities. Previously, a more open figure has been granted to Australian Hearing, and they have had more flexibility to choose where they spend that money. This time, we have been much clearer about the expectations—what we would like from the money that they are being allocated. We have signed an MOU with them on the basis of that.

Senator CROSSIN—So this time you have specifically identified numbers and activities?

Mr Kingdon—Yes.

Senator CROSSIN—Is it possible for us to get a copy of that?

Mr Kingdon—I am sure we could do that for you.

Senator CROSSIN—Can you take that on notice?

Mr Kingdon—Yes.

Senator McLUCAS—Can you provide figures on the uptake of Aboriginal and Torres Strait Islander preventative health assessments—I understand it is item No. 710—from May until the present time?

Ms Evans—Is that the Indigenous adult health check you are referring to?

Senator McLUCAS—Yes.

Ms Evans—I do not think I have those figures with me; I will check. If not, I will take it on notice.

Ms Savage—In response to your question, information from the Health Insurance Commission indicates that the uptake of the new item has increased from 249 services in May 2004 at its commencement, to 688 services in November 2004, representing a 176 per cent increase. A total of 3,936 services have been provided to November 2004.

Senator McLUCAS—Ms Savage, do you have any idea what proportion of the potential population eligible for that item number that covers?

Ms Savage—Those who are eligible for the item, as you may well know, are 15 or more—for the adult health check. I am not sure of the exact number and how that translates to a proportion of the total Indigenous population, but we can certainly give you that figure.

Senator McLUCAS—Thank you; that would be good. Is it the view of the department that that is a strong uptake? Are you pleased with that result to this point in time? There must have been a prediction of what the preventative health check take-up would have been.

Ms Savage—Yes, certainly there were some predictions as to uptake. It is fair to say that it has not been as fast as we predicted or would have liked, but, in terms of its application, it is a fairly comprehensive item. We are pleased with the uptake so far, but, sure, there is room for improvement.

Senator McLUCAS—You say it is a comprehensive health item. What does that mean?

Ms Savage—I mean it covers a number of health checks, or interventions, if you like, for adults which really go to the heart of early detection of a range of conditions that are seen in the population. It is not five minutes of medicine; it is comprehensive, with referrals and so forth to other providers. It provides a good basis for a comprehensive health check in that it is whole body, not just eyes, ears or other body parts, and tailored to the age group of 15 and above.

Senator McLUCAS—Are you saying, Ms Savage, that there are a range of health professionals who would be involved in undertaking one assessment?

Ms Savage—My understanding is that the GP, if you like, in terms of the item, is almost like the lead in that consultation and certainly makes referrals to others who are part of an overall plan for that individual.

Senator McLUCAS—Are they counted as undertaking a preventative health assessment at the initial meeting with the GP or at the completion of the event?

Ms Evans—Can I suggest that we get you a description of what is covered under the item, because there are a range of tests, referrals et cetera and it is quite comprehensively described. We can get you a description of that.

Senator McLUCAS—What other blockages does the department identify as hindering take-up? The comprehensiveness—yes. Are there are any other things militating against people taking up these assessments?

Ms Evans—I think that, with any new item, it takes a while for it to get known. There has been a communications distribution to doctors about information, but I think that just getting to know that the item is available and becoming familiar with using it is always an issue for take-up. My colleagues in the MBS branch are probably better able than we are to talk about that.

Senator McLUCAS—I understand there is a guide that has been developed for preventative health assessments, a substantial guide developed through the Royal Australian College of General Practice. Has that been published? Is that being promulgated?

Ms Savage—To my knowledge, no, it has not to this date, although the department are in discussions with the RACGP around the preventive health assessment guidelines.

Senator McLUCAS—Was it provided to the department by the RACGP in February 2003?

Ms Evans—This is a question for another division in the department. Sorry to do this to you, but we do not manage that one in OATSIH.

Senator McLUCAS—Does it link to the program that you are funding, or are these questions misdirected?

Ms Evans—The adult health check is an MBS item, so we do not manage it as a cash thing. It flows from the MBS system.

Ms Halton—It is actually program 2. Essentially, as you know, we have been trying to embed and entrench appropriate treatment for Indigenous people right throughout the department. This is one of the examples of what we have done through the mainstream programs to try and improve screening and improve health conditions.

Senator McLUCAS—We might put these questions on notice to outcome 2 people. What is the status of the funding to NACCHO?

Ms Evans—We have a contract with NACCHO for this year.

Ms Cass—In this financial year, 2004-05, NACCHO received $2.1 million.

Senator McLUCAS—I understand that was simply a continuation of the previous arrangement of the 2003-04 funding agreement—is that correct?

Ms Evans—We have an annual contract with them. It is negotiated on a year by year basis.

Senator McLUCAS—I understand NACCHO was seeking increased funds to cover increased costs, that it was not CPI adjusted or adjusted to accommodate any of their requests—is that correct?

Ms Evans—The grants are adjusted under the safety net adjustment, so NACCHO would have received that. I am not aware of them asking for a substantial increase in funding that was knocked back.

Senator McLUCAS—Ms Cass, was it exactly the same as the allocation for the previous financial year?

Ms Cass—I will have to check for you how it stacks up against the allocation in 2003-04. I think it is very comparable. There was not a request for additional funding.

Senator McLUCAS—Sorry, I think I may have misread this letter. I work a lot in rural areas as well. Maintaining contracts with staff is always very difficult. I understand NACCHO were interested in looking at extending their funding arrangement, rather than having an annual funding arrangement, to a longer term funding arrangement so that they could actually give a contract to a staff member for more than 12 months and do some real planning over a longer period of time. Was that request communicated to the department?

Ms Evans—First of all, I will give a clarification: NACCHO is actually based in Canberra. Its staff are all employed in Canberra, so it is not a rural organisation. We have had discussions with NACCHO over several years about a three-year funding agreement. There are issues to date about financial accountability and performance accountability. We have decided at this point in time not to consider a three-year funding agreement until we can sort out some of those issues.

Senator PATTERSON—It has a long history of serving a purpose, from personal experience.

Senator McLUCAS—What do you do to assist? Was it a late acquittal? Was that the issue?

Ms Evans—There were issues with acquittals this year, yes.

Senator McLUCAS—Did the department recently advertise the position of a medical officer for OATSIH?

Ms Evans—We did advertise for a senior medical officer to replace Dr Fagan.

Senator McLUCAS—Was the position filled?

Ms Evans—We have not filled it yet. That recruitment round did not produce a suitable person for appointment.

Senator McLUCAS—Will you readvertise?

Ms Evans—We are looking at how we can cover that. At the moment we have a continuing contract with Dr Fagan, who provides part-time advice to us, and a number of medical practitioners who have particular expertise. We have within the office a medical officer at a senior level, but we would like to fill the position with a senior medical officer—and we will be pursuing that.

Senator McLUCAS—I understand that with the changed arrangements for ATSIC there is some impact on OATSIH. Could you give us a brief on what has occurred and what is occurring.

Ms Evans—By the changed arrangements do you mean programs that came across to us from the former ATSIS?

Senator McLUCAS—Yes.

Ms Evans—We inherited the LinkUp program, which is a family tracing program.

Ms Halton—'Inherited' was possibly a poor word to use. It was transferred to us.

Senator MOORE—Has that gone to your area?

Ms Evans—Yes, It has gone to OATSIH.

Senator MOORE—I got the list of who went where, but I did not know exactly where. So it went to your unit?

Ms Evans—Yes, and it actually sits quite well because we were managing Bringing Them Home.

Senator MOORE—Sure.

Ms Halton—That was one of the initiatives that came out of the same package, you might recall.

Senator McLUCAS—How is the department managing the transfer of resources? I refer you to page 109 of the PBS. I think it might show up there.

Ms Halton—Transfer of resources comprises two elements, one of which is in relation to programs that have moved around. In terms of the administrative arrangements, Ms Evans has indicated we have had that particular program transferred to us. Also a number of departmental staff and resources have transferred. We are part way through finalising that issue. Because our program component is actually quite small, all that has been fairly easy to resolve. The staffing issue is slightly different, because one of the things we are doing is looking at what resources we can use in ICCs. There has been a transfer to us from that. There have been two elements to this.

Senator McLUCAS—How many staff are being transferred across to OATSIH?

Ms Halton—Again, this is part of the issue, because it is not all staff. So there are some individuals who have come, some individuals who will go to our state offices and some who will perhaps be located in ICCs. That has not been completely resolved yet.

Senator McLUCAS—What is the total number of people that we are talking about?

Ms Savage—In the first wave of transfer, based on the principle that people follow function, I think it was 22 positions, of which 19 were filled.

Ms Halton—But that is not finalised yet, so there is more to go.

Ms Savage—No, that is right. There are continuing transfers.

Senator McLUCAS—What sorts of positions did those individuals hold? Were they coordinators?

Ms Savage—I will just explain. When the program transferred, it was based on the principle of staff following function, so essentially they were aligned with the LinkUp program which was transferred. A mapping exercise was done so staff who transferred to central office continued to manage the LinkUp program. So for us it was actually quite good because we had continuity in relation to the ongoing administration of the program.

Ms Halton—But we did not get 22 staff for LinkUp.

Ms Savage—No, that is right.

Ms Halton—We got a small number of staff for LinkUp. In the discussion about the new arrangements in respect to Indigenous affairs—and particularly the creation of ICCs—I made the point that Health does not have a regional network and I do not have a resource in the current department that allowed me to just deploy staff for this purpose. It was agreed that, if there were people available at the end of the process of looking at programs going to various places, it would be sensible to provide us with an additional allocation. So a number of staff have come to us as part of that broad wrap up of the former arrangements.

What we have then tried to do is to accommodate people where they were. So, to the extent that there were people here, we have tried to accommodate them. You will understand that, ultimately, we are going to look at our capacity to service the ICC network using some of those resources, and we will try to do that in a way that is sensitive, given the people that have come across to us. We are only part-way through that process, so 22 positions, 19 people, have been transferred, but there is another tranche coming. In time all of this will wash through the system, but we are trying to manage that as carefully as we can.

Senator McLUCAS—I suppose I am having difficulty with LinkUp from the community end. Are you saying that there used to be 22 people?

Ms Halton—No, that is exactly my point. I think there was a possibility of misinterpreting the answer.

Senator McLUCAS—Yes, I did.

Ms Halton—I cannot remember exactly, but there were only a couple of people who came with LinkUp itself.

Ms Savage—There were four.

Ms Halton—And the balance are about this broader function that we will now undertake.

Senator McLUCAS—Just for the benefit of the committee, could you give us a one-page briefing paper that sets out what used to exist, what it is hoped will exist and where the process is up to now?

Ms Halton—Yes. We will wait until we have finished this final wash-up—because, rather than give you an incomplete picture, I would like to be able say, 'This was the bottom line drawn; these are the number of people and the number of positions, the resources, that were transferred; and this is our intention in terms of how we're going to go forward.' It might just take us a little while, that is all.

Senator McLUCAS—When are you expecting to wrap this up?

Ms Halton—Soon, we hope.

Ms Evans—We are hoping to have it wrapped up in the next month.

Senator McLUCAS—I hope I am hearing you wish it was done yesterday.

Ms Evans—Can I just clarify: as we said, four staff in central office came across to manage LinkUp, but a larger number of staff came to state offices, and some to central office,

at various levels when the division of ATSIS staff was happening. So there is LinkUp, which is then different to a broader number of staff that came across to help—

Ms Halton—to help us with these other functions. But we will give you a piece of paper where I promise it will be as clear as we can make it.

Senator McLUCAS—Fantastic; I look forward to it. If we look over the page, C7.2, there is $12.5 million in rephased amounts for capital grants for Aboriginal and Torres Strait Islander Health Services. Can I get an explanation of that?

Ms Evans—Certainly. This is our moveable feast for how fast capital works develop. So this is rephasing capital works. You would be very familiar with the fact that you can set a time frame that depends on contractors being available, weather conditions. So we constantly reassess within our capital works program and then rephase when there are slippages and delays in construction. That is all around the capital works. It is not actually service as in staff. It is actually capital works construction.

Senator McLUCAS—The sum of $12.5 million is not an enormous amount, given the costs of construction in remote areas. How many locations does that cover?

Ms Evans—I could take that on notice, but in terms of giving you relativities, we have about $117 million worth of capital works going on at the moment, so it is quite a small amount.

Senator McLUCAS—Don't take that on notice—that is all right. So it is one or two—maybe three.

Ms Evans—Yes.

Senator McLUCAS—The $2.8 million transfer from DIMIA to Health for family tracing, how is that project being managed?

Ms Savage—That is the LinkUp program. We will provide you with that information.

Ms Evans—That is a half-year effect—proportional.

Senator CROSSIN—We wanted to ask about performance measures of PHCAP—table C, 7.3 in the additional estimates, page 111. Of the 152 organisations providing or purchasing primary health care, how many are currently providing these services?

Ms Evans—These are the performance measures you are looking at?

Senator CROSSIN—Yes.

Ms Evans—The performance measure is at least 152 organisations, and my understanding would be that we have at least 152.

Senator CROSSIN—At the moment you would have that many?

Ms Evans—Yes, we would have that many.

Senator CROSSIN—How many of those would be operated by Indigenous organisations?

Ms Evans—The overwhelming majority of them.

Senator CROSSIN—Is there any way you would be able to determine that?

Ms Evans—We could, yes. As I said, the overwhelming majority—perhaps most of them. But I can certainly give you accurate figures on that.

Senator CROSSIN—The 66 services for substance abuse—how many are there now?

Ms Evans—These are mid-year. At the end of the year we will be reporting on them. Once again, I would have thought we would have 66 providing them—not 66 stand-alone substance abuse services, but 66 substance abuse services and some primary health care services that have a substantial substance abuse program within them.

Senator CROSSIN—So when you said an indicator or performance measure of the 152 or the 66, are there many more than those or is that how many you intend this funding will reach?

Ms Evans—We tried to benchmark it on what we have or think is reasonable within the funding available.

Senator CROSSIN—So there well could be one hundred substance abuse services out there but your funding might perhaps only be able to reach 66 of those? Does it work like that?

Ms Evans—What we are looking at is what we manage to do in the programs and what is possible under this program, and we try to ensure that we maintain it and if possible increase it. That is what these figures are a measure of.

Senator CROSSIN—What is the budget allocation for the substance abuse for this year?

Ms Savage—The allocation for this year is $20.9 million.

Senator CROSSIN—And that is spread across 66 services—is that correct?

Ms Savage—Yes, 66 services. That is a combination, as Ms Evans has said, of both stand-alone substance abuse services and other services providing substance use support and services.

Ms Evans—And that money is spread across it, yes.

Senator CROSSIN—How does that money get to those services? Is it by grant application?

Ms Evans—We have tried in this program, once services are funded and on contract, to let them run. While on annual contracts, we do not have an annual submission round for bidding. Those that are existing and performing will continue to be funded as long as they continue to perform. Then when there is growth money based on regional planning that we do with states and territories in the community sector we assess where the highest priority is and where the gaps are and, if there is money for new services, we allocate it then.

Senator CROSSIN—The 57 communities for new expanded services—which communities have been targeted?

Ms Evans—I could get you a list of those, Senator. I will take it on notice. Those are ones, as I said, that have come out of our joint planning and prioritising.

Senator CROSSIN—At least two remote communities have been identified for improved living conditions. Which two are those? Do we know?

Ms Evans—Once again, I can let you know that, Senator.

Senator CROSSIN—What does identification for improved living conditions involve? How does that process work?

Ms Evans—That relates to the AACAP, the Army Community project, as I understand it, which is managed now by FaCS and is about infrastructure, housing and health. ATSIS used to run it. Health contributes to it, but it was managed out of ATSIS, and Army has had a number of sites where it has developed. But it has always been managed by ATSIS and now it is managed by FaCS, and Health contributes funding to it and we sit on the planning group.

Senator CROSSIN—I am assuming it comes under this table though.

Ms Evans—Which table are you referring to?

Senator CROSSIN—Is it still an indicator under table C7.3? I cannot see it.

Ms Evans—It is the 'in collaboration with other agencies, projects to improve living conditions in at least 2 remote communities.' That is the performance measure.

Senator CROSSIN—It is a FaCS managed program.

Ms Evans—It is run by FaCS and we contribute funding to it which gets transferred to FaCS.

Senator CROSSIN—The 17 new clinics—the redevelops and the relocations—could you take on notice for me where they are?

Ms Evans—Yes, we can.

Senator CROSSIN—And the budget allocation for the new clinics.

Ms Evans—Yes.

Senator CROSSIN—With the abolition of ATSIC how is the department meeting its objective of providing opportunities for stakeholders for community participation, advocacy, policy planning and program development—now that you do not have ATSIC to consult or liaise with? Or, if not now, pretty soon you will not have them.

Ms Evans—As you know we work very closely with the community controlled health sector. Being community consultation organisations, they have pretty good access to the communities. In most of our state planning forums the existing ATSIC commissioners and, in some cases, the ATSIC regional councillors are still involved in that planning but that will obviously come to an end at the end of this financial year.

Senator CROSSIN—So that will pretty much stay the same post ATSIC—your liaison with the Aboriginal community—

Ms Evans—Our relationship with the Aboriginal community controlled sector, yes.

Senator CROSSIN—Do you participate in the Indigenous Communities Coordination Taskforce? I am assuming that might be the new ministerial secretaries group.

Ms Halton—I participate in that because I am the secretary.

Senator CROSSIN—Yes, but is there any other level at which, say, someone like you would participate?

Ms Halton—There are multiple meetings.

Senator CROSSIN—I mean given the new management of Indigenous affairs post ATSIC basically?

Ms Halton—There is a lot of activity.

Ms Evans—There is a ministerial taskforce which you are probably aware of, there is the secretaries group that Ms Halton is on and there is a senior managers taskforce that Ms Savage and I sit on. At each state level our state managers are involved in taskforces and we have multiple subcommittees that we sit on. There is early childhood, community safety, single budgets—there is a lot of collaboration going on.

Senator CROSSIN—Can you remind me which COAG trial you are the host for.

Ms Halton—Pitlands.

Senator CROSSIN—How is that going? We only have five minutes, remember.

Ms Halton—In that case let me just say that you would know that the Pitlands is regarded as a challenge and we are working very closely with our South Australian colleagues to advance work in that area. Indeed there is a workshop next week that Ms Evans and I will be attending, with a full range of representatives of government and the community to, if you like, move forward after the recent elections in the Pitlands. I should say that we have been continuing—whilst there has been this electoral process, which you are probably very aware of—to work on the particular projects identified as being of priority to the community. This was whilst all that other process was going on. In fact I think there has been some quite good progress made, not only on work on the stores policy, which obviously goes to nutrition and a whole series of other issues, but also on work on rural transaction centres and the capacity to connect up and provide better services in those communities.

Senator CROSSIN—Is it at a stage where initial evaluations need to be made about how progress is being made in that trial site?

Ms Halton—There is an overarching evaluation framework across all of the COAG trial sites. They are all extremely different and they are governed by local circumstance. In a sense none of them are comparable, for precisely those reasons. There is an ongoing review that we and our South Australian colleagues are doing in terms of how things are progressing. In a sense, the political issues—which, as I said, I am sure you are very aware of—have caused a bit of a pause in terms of overarching discussions about SRAs and things of that sort. But the tangible work on things to improve at the community level is actually going reasonably well.

Senator CROSSIN—Is it too early to undertake a large-scale evaluation of what is happening there?

Ms Halton—I would say so. If you think about the governance arrangements, whilst we are working on bits and pieces or individual projects, really the governance arrangements in the Pitlands need to be sorted and on a good footing before we can genuinely realise the benefit of the trials—and you are aware of how hard that has been.

Ms Evans—I understand that the evaluation branch within OIPC has made the evaluation of the COAG trials a priority, but, as Ms Halton says, to date it probably would have been premature.

Ms Halton—It would have been. As I have indicated, there is a framework for how the evaluation is going to occur. That has been looked at by departmental secretaries—in fact, that was a while ago. So we are very aware of the need to actually learn the lessons from all of the trial sites, even though the lessons are going to be different, because their circumstances are different.

Senator CROSSIN—I will leave it there, and I will see you in June.

Ms Halton—We will keep Hearing Services here for that one, too.

Senator CROSSIN—I have heaps more questions. I will have to put them on notice for you.

Ms Halton—Okay.

[4.26 p.m.]

CHAIR—That is the conclusion of outcome 7. Thank you to the officers associated with outcome 7. We can now move on to outcome 3.

Senator McLUCAS—First of all, I thank the office of ageing for providing me with the answers to those questions in an extremely short time.

Ms Halton—Thank you.

Senator McLUCAS—I think that will make our discussion a lot more efficient. It is very much appreciated.

Ms Halton—We were very conscious that the orders are to get questions answered before estimates if it is humanly possible.

Senator McLUCAS—You have done well. Question No. 2 goes to the ratio of operational places. I am interested in the point at the end where you say that nearly 60 per cent of all operational residential places are used for high care. Mr Mersiades, we actually had this discussion last week when we were talking about the number of places that are allocated as low-care places and the number of those places that are then utilised as high-care places.

Mr Mersiades—That is right.

Senator McLUCAS—I think you or one of the officers—I think it was you, Mr Dellar—gave me to understand that low-care places are taken up, by and large, as low-care places. But I was interested in the time it takes for a place to move from being a low-care place to being a high-care place, using the principles of ageing in place, which was the explanation you gave me. I am still interested in how long it takes for that place to move.

Mr Dellar—What I think we said on Friday was that people enter as low care but may be subsequently reclassified. It they are reclassified, they are subsidised at the high-care level. I think we undertook to get some data for you if possible on the average time between a person entering as low care and becoming high care. I do not think we have that data available yet.

Senator McLUCAS—I am just flagging it as a continuing area of interest. I would like to go to answer No. 5. I said 'places more than two years old', and I appreciate you decoding that and putting it into departmental speak for me. Yes, it is the number of places that have been allocated but not yet brought into operation. You say as at June 2004, there are 16,353 provisional allocations—they are allocations that have not been taken up—and that 6,238 of those are more than two years old. Are there any that are more than three years old?

Mr Dellar—We have information for places that were issued in various financial years. Broadly speaking, the two-year old figure would be places issued before 2002. In the 2000-01 financial year, there are currently 2,367 places of that 6,000 that are not yet operational. For the previous year 1999-2000, there are 341 places.

Senator McLUCAS—So 341 places are four years old?

Mr Dellar—Yes. For places older than that the total is 11.

Senator McLUCAS—So 11 places have been allocated for more than five years?

Mr Dellar—More than four years ago. It is often hard to say exactly how many years, because the places allocation process is a bit variable from year to year. As we speak they are more than four years old but probably less than five.

Senator McLUCAS—So that I get this absolutely correct, is that document something you could table at some point in time?

Mr Mersiades—We could get you a proper age profile of the places, rather than working off available information. We will have a good look at it and give you a good age profile.

Senator McLUCAS—When do you trigger a review of those allocations? I understand that there are 11 that are over four years old, but there are still 2,367 that are nearly three years old.

Mr Dellar—The act has a provision, which is essentially that places must be brought online within two years. If they are not then the organisation concerned has to come to us with a story, essentially, and if we are persuaded we will grant an extension. Once places click over for two years, each three months the provider is required to give us a written report on the places and what progress they are making in bringing the places online. There can be many reasons a particular service does not achieve the two years. Most—and it is around 70 per cent—of the reasons the providers give us relate to finding and obtaining suitable land and getting through the planning and development application processes. Quite often, when people decide that they would like to build an aged care service on a particular site, people who live nearby have views about that and it can lead to community issues, appeals and all sorts of things.

Ms Halton—I would like to make an observation about this. When I ran the program—and when Ms Murnane ran the program prior to me—we had many more places that just when on and on. When we changed the arrangements we did it for precisely the reason that we wanted to bring beds on and not have them sitting in an ethereal non-existent way out in the community. In those days, the reasons people gave—if and when we asked them—were not grounded in the practical problems of bringing beds on. I think that is a fair reflection of the incentive that is now in the system to bring beds on line as soon as you can. The reality is that

there are sometimes practical impediments. We are not completely unreasonable in that respect but we push people to bring the beds on stream.

Senator McLUCAS—How do you do that?

Ms Halton—We do that by holding them accountable—very meticulously, on a three-monthly basis—for what is happening with those beds.

Senator McLUCAS—I understand the planning reasons and I would hope that before beds are allocated there is at least some indication that some approvals may have been reached, and certainly that financial arrangements have been established?

Mr Dellar—We put a lot of effort into that precise thing.

Ms Halton—Absolutely.

Senator McLUCAS—But if it is a new residential aged care facility—

Mr Dellar—It can be at times.

Senator McLUCAS—do you require them to have planning approval? Do you require them to have land identified?

Ms Halton—You cannot do that, in many cases.

Mr Mersiades—One of the criteria we have in assessing applications looks at what we call 'bed readiness'. Amongst the suite of criteria that we have to take into account, the extent to which they have made preparations which would reduce that elapsed time acts in their favour.

Ms Halton—They have to be financially viable.

Senator McLUCAS—Mr Mersiades, I did not understand what you said last.

Mr Mersiades—The extent to which they can demonstrate that they have purchased the land or done things to make themselves more bed ready—and therefore reduced the elapsed time between approval and becoming operational—counts in their favour in the assessment process. But that has to be balanced against the other criteria as well. That is not the pre-eminent criteria; they are all important.

Senator McLUCAS—What other reasons, other than town planning issues, do you accept as reasons to delay operationality?

Mr Dellar—When we get to the two years we examine the whole picture and, if it is our view that the provider has taken no particular action to move towards turning these beds into reality, we take those places back. But if the provider has been making good efforts and has had some difficulties, we try to be reasonable, because the consequence of abandoning a particular provider and starting again is that you ensure that there will be a significant delay before the places come on line. After the issues of land availability, development approval and planning approval, the reasons taper off pretty quickly. There can be a number of reasons: availability of finance is probably the next largest. I would need to have a look at the other reasons but there are all sorts of things that can happen. In some parts of Australia bad weather may interfere with construction.

Senator McLUCAS—But that would only delay it for six months.

Mr Dellar—That is correct. That is exactly the sort of thing we look at: is the delay caused by something that can be overcome; how can it be overcome; when can it be overcome? So after the two years, if we are going to allow the process to continue, we grant an extension and in granting that extension we take into account what we think is a realistic period within which the places can be finished and brought on line.

Senator McLUCAS—I think there was an answer to a question—I cannot put my hand on it at the moment—about places that had been revoked, and you said there had been none.

Mr Dellar—That is correct. Revoked places are those that we take back. There is another category of places—people give them back. At times people do that. They come to us and say that, for whatever reason—the business plan has changed or the needs of the community have varied in some way—they want to return these places.

Senator McLUCAS—Have we had any given back in that period?

Mr Dellar—Yes. If you would like the numbers I would need to take that question on notice.

Senator McLUCAS—Yes, I would, thank you. I am a little perturbed that finance is an issue that delays construction, because I would have thought that, in making a decision to allocate places, you would be allocating to an entity that had sound financial bases and also an opportunity to access finance to do any construction required.

Mr Dellar—That is precisely correct. One of the criteria that we look at is the business proposal being put to us by the person who wants places. One of the things we do look at quite carefully is the financial situation. We do, from time to time, seek professional accounting advice on a particular application and we have various indicators that might lead us to do that. In spite of all that, it may be that something that looks fine on paper, in two years time, when many things might have changed, is not quite as fine as it was at the beginning of that process.

Senator McLUCAS—What discussions do you have with providers who have been allocated places? Do you have any discussion with them up until that two-year point? Is there some sort of opportunity at, say, the 12-month point to send a 'how-are-you-going' letter?

Mr Dellar—There is no formal point but there is certainly a lot of dialogue. Our state and territory offices tend to manage this and generally have a very acute and quite detailed knowledge of where the places are and how they are going.

Senator McLUCAS—Thank you. I will go back and look very closely at the aged care planning district differences, because I think there is a lot to learn out of that. I appreciate your answers about the time it takes for CAC and EACH packages to be taken up. I presume it would be almost immediate but—

Mr Dellar—It is almost immediate. The probable exception to that is where there is a new service. That can mean finding premises, hiring staff, getting a car and a few things like that. That can create a few weeks delay between the time we allocate and the time they are operational but broadly speaking—

Senator McLUCAS—But is it about two weeks before?

Mr Mersiades—I would not want to generalise quite so quickly. I think my colleague was suggesting that with a new provider with a new business it would take more than two weeks to get established. I would not want to hazard a guess how long but it would be longer than an existing provider just expanding with a number places. That is the point.

Senator McLUCAS—Just to give me an understanding of providers of community care packages, how many new providers come on every round, in your view?

Mr Dellar—I do not have that number but—

Senator McLUCAS—I suppose I am looking for a feel for it rather than an actual number, Mr Dellar.

Mr Dellar—In relation to the last round or two the answer is: not very many. The reason for that is that community aged care packages have been established for a while. There are quite a few providers and most often it is a provider looking to have an increase. That is not to say there are no new providers—of course there are from time to time.

Senator McLUCAS—In answer to question 8 you said that December 2004 stocktake results are not yet available. When do they usually become available?

Mr Dellar—Our current timetable is to have them completed by the end of this calendar month. We are running about two weeks later than usual. It is a question of setting priorities. The aged care approval round this year, which involves the same people, has been the largest round we have done for quite some time. So we are completing that and when that is complete the stocktake will follow shortly after.

Senator McLUCAS—That deals with my questions on that, thank you. How do you collect data on the number of older patients who are in hospital awaiting residential care? Is it collected?

Mr Mersiades—To my knowledge, it is not collected systematically. But under the auspices of a Commonwealth-state working party looking at older Australia, a survey was undertaken a few years ago which identified the number of people in various categories in hospitals for a specified period. I think a lot of the data that has been used or quoted since has been based on that survey.

Senator McLUCAS—Who conducted that survey?

Ms Creelman—It was conducted under the auspices of the Care of Older Australians Working Group established by the Australian Health Ministers Advisory Council. Healthcare Management Advisers undertook the consultancy, and it was managed by the New South Wales Department of Health.

Senator McLUCAS—Was it a snapshot of what was occurring at a certain time with regard to the number of older people who were awaiting residential aged care?

Ms Creelman—It was a more comprehensive survey than that. It was a survey of all older hospital patients in public hospitals on a particular night, except those who were in intensive care—and there may have been one other category. Essentially, it was a survey to establish the characteristics of all those older hospital patients on that particular night. Among the questions that were asked—and I do not have the survey form here, but in essence—there was

a question as to whether, in the opinion of the clinician completing the survey form, the person was receiving the appropriate type of care. If not, that led to other questions about what in their opinion was the appropriate type of care and further questions about whether they had been assessed. If they were not receiving that type of care, there was an attempt to gauge reasons why they were not receiving it. It could include types of care within the hospital system—rehabilitation, for example—or it could include types of care outside the hospital system. A follow-up survey was done—from memory, three weeks later—of the same population to establish what had happened and where those people now were—were they still in hospital or were they receiving other forms of care.

Ms Halton—Senator, this work was undertaken under the auspices of AHMAC and you will know that the background to this is of longstanding debate. The only data we ever had was anyone who was classified as an NHTP, a nursing home type patient, which was erroneously used as being the same as a person eligible for nursing home admission. My memory is that this particular survey attempted also to look at people who had actually had an ACAT assessment and who would have been appropriately placed. Of course, that ended up with a different outcome to just saying that all NHTPs are theoretically eligible for admission to a long-term care facility. I think the advantage of that particular piece of work is that it was genuinely conducted under the joint auspices of all of the jurisdictions. It was an attempt to demystify, if you like, what had been quite a contested space.

Senator McLUCAS—Is that a public document?

Ms Halton—Yes, it was released. In fact I think it is on a web site somewhere.

Ms Creelman—Yes, it is on our web site.

Senator McLUCAS—I will look for it, thank you. What was the analysis that informed the recent policy shift so that the ratio changed from 40 to 50 to 10, to 40 to 48 to 20?

Mr Mersiades—The work that was done by Professor Hogan as part of the pricing review. His team looked at current provision levels and compared them with estimates of ABS statistics on disability rates. There would have to have been a bit of qualitative input as well. There is a growing understanding that within the community there is a growing preference for people to receive care in their own homes. It was a balance of those sorts of considerations. I do not think you can point to a formula which led specifically to that configuration.

Senator McLUCAS—I do not think anyone would disagree with the doubling of the CACPS places. Did Professor Hogan recommend that there be a reduction in the number of residential aged care beds?

Mr Mersiades—No, I do not believe he did recommend a reduction in residential places. He did recommend an increase to 108 and greater emphasis on community care. How you achieve that greater emphasis is another matter.

Senator McLUCAS—That is what I am trying to get to: how the department came to the view that reducing the actual total number of residential aged care beds by two was appropriate.

Mr Mersiades—As I said, it was not a completely scientific process. One of the considerations is that how places are allocated is not a good reflection on how they ultimately

are used. The fact that the ratio is what it is is not as significant as it would appear, because of the ageing in place capacity.

Ms Halton—I think in common with the way the ratio was originally established—and it was many years ago; I regret to say Mary and I were both around—there was a certain amount of science and a certain amount of judgment. This is in exactly the same category.

Senator McLUCAS—I think Dr Cullen gave us evidence last week, in fact, about the old ratio being just basically a look at what was there. The ratio developed out of what was happening on the ground, and it has grown from there.

Ms Halton—As I said, both Mary and I were around. My memory of it is that there was more science to it than that. There was an assessment, yes, of what was there, there was an assessment of need and then there was a judgment applied. Ultimately this is not a completely mathematical science. There were judgments—both policy, practical and others—brought to bear on the matter.

Ms Murnane—In the 1985 or 1986 review it was determined that there was a need for more low-care places, and the ratio was very deliberately structured so that low-care places would increase over the next decade. The ratio dealt with the two forms of residential care—nursing homes and hostels, as they were then called. It did not deal with care packages. It made a judgment that 100 per 1,000 people over 70 was sufficient. The people that did that review and then the people that judged it were looking at it from a standpoint of responsibility. While obviously you do have to take a good look at what is there, it reflected more than just saying, 'Whatever there is is right and let's put some words around that.' We can probably provide you with a photocopy of that 1985 review, if you would like. I know we have very few copies left, and I personally have not got one, but Warwick Bruen, who was a member of the review team, probably has something we could photocopy for you.

Senator McLUCAS—Thank you, Ms Murnane. I will be honest: I probably will not read it. I am actually looking forward rather than back—unless it is going to be worth something for historical purposes into the future, but I do not think so. I am concerned, Mr Mersiades, about your comment that we go through this process of coming up with a ratio and allocating places according to that and then you seem to be saying that it is not really that meaningful. I think that goes back to the fact that a lot of people who are in residential aged care are in an allocated low-care place but are in fact receiving higher levels of care. Is that the point you are making?

Mr Mersiades—All I was indicating is that in formulating what the balance should be there is a bit of a random factor in there, which is to do with how allocated places are actually used, and we need to take that into account as well. That is not always easy to do.

Ms Halton—If we go back in history—and this goes back to Ms Murnane's comment—one of the concerns that people had was to ensure that there was a little bit of balance, particularly in terms of places you could be admitted to. When we did the reforms in 1996-97 for ageing in place, people were very concerned about the capacity to age in place, which was perfectly reasonable. But you do not want a whole system where everything ends up being a high-care place because there are genuinely people with a need for residential care who are low care. So there has to be at least some balance, particularly around places you can be

admitted to, and then a capacity to age in place. That really goes to Mr Mersiades' comment that what happens to those people once they are in care will vary.

Senator McLUCAS—Which is why I am interested to know what the time lag is between entry to residential aged care as a low-care patient and the change to high care.

Ms Halton—We have indicated that we are going to do some work on that.

Mr Mersiades—That is right. The other thing I would point out is that those places revert to their original allocation status when the person leaves.

Senator McLUCAS—Yes. I want to go back to a question from the last round of estimates. In question EO4222 we asked where the cost saving was in the Department of Veterans' Affairs. You answered that by saying that the decrease in the appropriation reflected the small decrease in the residential care provision ratio. Extrapolating that from the Department of Veterans' Affairs to the Department of Health and Ageing, how many less beds were advertised across Australia because of the change in the ratio?

Mr Dellar—The other bit of context, though, is that in terms of operational beds we did not have 90. We have actually got less than that. In terms our release strategy, we are not only matching population change but also approaching the 88. So it is fair to say that the change from 90 to 88 has not had any effect on the places that we release.

Senator McLUCAS—There were no less advertised with the changed ratio?

Mr Dellar—The aged care approval round 2004-05 has the largest number of residential places ever released.

Senator McLUCAS—Because of the growth, but—

Mr Dellar—In part because of the growth.

Senator McLUCAS—it is the proportionality that I am looking to.

Mr Dellar—No, there are two factors running. The first is the number of additional people who reach this age cohort in each year. In round figures it is 40,000 extra people in this year or two. But, in addition to that, there is the difference between the operational ratio and the target of the operational ratio. In the figures that you have got for June 2004, I think the operational ratio—I would need to look this up—is about 83.9 or 84. That means that there is a gap between that and the 88, which is the target. So in releasing the places we aim to both move the actual operational ratio from 84 to 88 and, in addition to that, keep pace with changing population.

Senator McLUCAS—I do understand that, but the point of the question was the reduction in total number of beds because of the changed ratio and what that has meant for the last round.

Mr Dellar—I do not understand what you are saying, I am sorry.

Ms Halton—If your question goes to what would have been the hypothetical number of beds advertised, what Mr Dellar is attempting to say is that you cannot come to that, because several things were going on at once, and you would have to presuppose all the other moving parts stopped moving to come to the figure you are looking at and, as they all were moving, you cannot come up with a figure in isolation.

Senator McLUCAS—It would be an interesting figure to know, though.

Ms Halton—If you could stop all the other bits moving.

Senator McLUCAS—Sure. We are dealing with people; we are not dealing with machinery. While there has been an increase in Community Aged Care Packages—and I think that is very welcome—there has been a decrease by two in the actual number of beds that are going to be offered out of the whole pool. While we recognise that growth in Community Aged Care Packages is always where we are looking to go, there is still an unmet demand in residential aged care that reducing the number of beds, even by two, may exacerbate.

Ms Halton—That is a hypothesis. You are quite right. But the counter proposal is that it is to catch up. We have already heard about what is on the ground in terms of the ratio, and I think the intention is that with this extra release we will increase the actual number of beds on the ground—that is the new ratio in terms of residential care places. I think it is a fair question to ask, once those beds are there and we are closer to delivering the actual target on the ground, what adequacy people judge there to be.

Senator McLUCAS—Let us make it really simple: we used to have 90 residential aged care beds per 1,000 people; we now have two fewer per 1,000 people. We might have more Community Aged Care Packages, but we have two fewer beds.

Ms Halton—In terms of the planning ratio. The point that is being made here is that in terms of delivery we are hoping to deliver more of those beds so we are on target on the ground, instead of always having beds that are offline waiting to come online. I think the judgment that needs to be made once we hit the target is: is that adequate? The judgment that is being formed at the moment is around a ratio where we do not actually have all of the beds. The whole point about this very, very large release is to assist us in actually achieving that target.

Senator McLUCAS—There is planning and then there is operation.

Ms Halton—Exactly.

Senator McLUCAS—That is fine but, if your planning is less than what you used to plan for, you will end up with less, surely?

Ms Halton—Correct. My point is that we can have two debates, one of which is about planning which then does not translate to what happens on the ground. The point you are making is that some people believe there the number of beds is not adequate, and that is actually about delivery. My point to you is we will deliver more beds on the ground under these new arrangements. We have a strong view that we will get those beds on the ground and that will probably deal with a good deal of that concern, but we will have to make an assessment when the beds get on the ground.

Senator McLUCAS—We will watch that closely. How many EACH packages were available for 2004-05? Did you provide that information to us?

Mr Dellar—We advertised the availability of 900 EACH packages in the ACA 2004 round.

Senator McLUCAS—You probably have caps there as well?

Mr Dellar—Yes, the number of community aged care places we advertised was 2,020.

Senator McLUCAS—I want to look at some particular residential aged care facilities and their status with accreditation, please. The first one is Mission Homes, which is in New South Wales. I understand Mission Homes was given three years accreditation, but I do not have the date on which it was given three years accreditation. Recently it was under sanction—it has two sanctions—and the agency identified serious risk at that facility. Can you give the committee some understanding of the problems that were occurring at that facility?

Mr Brandon—Mission Homes was accredited for three years some 18 months ago. Subsequent to that, we did a review audit in January this year, having previously done some support contacts, and we found significant non-compliance in a number of areas, including continuous improvement, regulatory compliance, education, staff development, human resource management, inventory and equipment, information systems, clinical care, specialised nursing care, medication management, nutrition and hydration skin care, incontinence management—and the list goes on; I can probably just give you the list.

Senator McLUCAS—Thank you.

Mr Brandon—Subsequent to that, we determined to revoke their accreditation, because we were of the view that they were not in a position to recover that situation. In accordance with our normal practice, we identified a number of contributing factors to their change in status over that 18-month period, and they have not disagreed with us on that issue.

Senator McLUCAS—Have you gone back and looked at the original three-year accreditation process and made some judgment?

Mr Brandon—Yes, we have looked at the audit that was done 18 months ago, and we are of the view that it was accurate. That is reinforced by the fact that we have identified the reasons—the recent changes in activity at the home. Those changes include a change in senior management structure. You would understand there were actually two nursing homes on this site—a nursing home and a hostel—and they had an executive director of nursing position, which was abolished, which oversaw all their aged care services. There is no formal system in place now for the organisation to monitor and manage performance at the home, and there have been frequent changes in senior management at the home. In fact, there have been four directors of nursing in the last 12 months.

Senator McLUCAS—Is it possible to get a copy of the review audit that showed the serious risk? Is that a document we could have?

Mr Brandon—I would have to take that on notice; I am not quite sure.

Senator McLUCAS—So there have been significant management issues. You have required them to have a nurse adviser employed, and they have done that.

Mr Brandon—On the issue of sanctions, the nurse adviser is one for the department, not for the agency.

Ms Finlay—Yes, it is a requirement, and we have asked the home to appoint a nurse adviser for six months.

Senator McLUCAS—That will finish in July.

Ms Finlay—Yes.

Senator McLUCAS—What happens then?

Ms Finlay—In this case, if you are talking specifically about the Mission Homes nursing home, the home has made a decision to close the nursing home itself and plans to consider the question of reallocation of residents. But what we require in these circumstances is that the sanction calls for a nursing adviser to be in place for that period, and that will continue. What will happen after that period is that, together with the agency, we will have another look at the situation. We are keeping a very close eye on things during this entire period while the nursing adviser is there and on site.

Senator McLUCAS—Does the department have any role in selecting the nursing adviser?

Ms Finlay—The normal arrangements for nursing advisers are that we have a panel available in each state and territory from which we choose a nursing adviser, so we chose a nursing adviser from one of those panels.

Senator McLUCAS—When you say 'we', do you mean the Department of Health and Ageing?

Ms Finlay—'We' as in the department, I beg your pardon.

Senator McLUCAS—Mr Brandon, you said that there was a nursing home on site. I did not realise there were two facilities on the same site. The web site actually says 'Mission Homes hostel'. Are the sanctions applied to both the hostel and the nursing home?

Ms Finlay—Senator, I can answer that. The answer to that is yes. It is true of both the Mission Homes hostel and the Mission Homes nursing home.

Mr Brandon—I will add for clarity that they are two separate services on the same site. There have been two review audits—one on each of them—and they are both revoked. The decision was to revoke both of them.

Senator McLUCAS—I understand, from what you are saying, Ms Finlay, that the nursing home will close. How many residents are in the nursing home?

Ms Finlay—The information I have at the moment is that it is a 39-bed care facility.

Senator McLUCAS—What is the process of finding appropriate residential care for those people?

Ms Finlay—It will be a matter for the approved provider, with assistance from the department. We will be asking the approved provider to look at other facilities that they may have available in the location around this nursing home where we can find the right place for people.

Senator McLUCAS—Did you say that the provider will find it?

Ms Finlay—The provider is responsible for deciding and working through how best to re-allocate the people who are currently in the home.

Senator McLUCAS—Does the provider have other institutions in the same area?

Ms Finlay—I understand that it does.

Senator McLUCAS—Is there any requirement on the resident to go to a facility that is owned by the current provider?

Ms Finlay—No, there is not. The issue is really finding the best place for the people concerned.

Senator McLUCAS—We will watch that one. The next one I want to talk about is Ridgehaven retirement facilities in Queensland. They had sanctions imposed on them in December 2004. What was the problem that ended up with that solution?

Mr Brandon—We undertook a review audit in July 2004 and identified 15 non-compliant expected outcomes largely in the areas of continuous improvement, education, staff development, information systems, clinical care, behavioural management, medication management, leisure industries and activities, and occupational health and safety. Subsequent to that audit, in July 2004 we varied their accreditation to expire in June 2005.

Senator McLUCAS—When was it previously to expire?

Mr Brandon—It was previously to expire in October 2006.

Senator McLUCAS—So you have taken away 13 months?

Mr Brandon—Yes, that is correct.

Senator McLUCAS—Was it originally a three-year accreditation?

Mr Brandon—Yes, it was.

Senator McLUCAS—Have you had a look at the original accreditation process to see if there were any errors made then?

Mr Brandon—With that one, because of a change in staff, we are unable to conclusively conclude whether the audit was right or wrong, but on the face of it the audit was accurate.

Senator McLUCAS—Would you explain that a little further? You said that because of a change in staff you cannot ascertain whether the audit was correct.

Mr Brandon—As part of our process, we talk to the people who did the audit. My understanding from our Queensland office is that we were not able to contact one of the people who did that audit. I can clarify that. So as far as we are concerned, the audit that was done, and I am trying to look for the exact date—there was a review audit in February 2003 and the decision to accredit for three years was in October 2003; I am sorry as I think I gave you a wrong date before—

Senator McLUCAS—October 2003 was the three-year accreditation?

Ms Finlay—Correct.

Senator McLUCAS—When was the first review audit done?

Mr Brandon—In July 2004.

Senator McLUCAS—Then the length of accreditation was reduced. The sanctions that are in place—essentially, a nurse adviser—expires in June 2005. What will happen at that point with this particular hostel?

Ms Finlay—The expectation is that, given the process that we have been going through, the complex should be able to remedy the issues. We would expect we would be able to ensure that the residents are taken care of in the process.

Senator McLUCAS—It is a hostel. Are they all low-level care residents?

Ms Finlay—I think it is called a 'retirement complex'. There are 15 low-care places in the hostel part and 15 high-care places in the nursing home.

Senator McLUCAS—Is it all in the one institution?

Ms Finlay—As I understand it, it is one connected complex.

Senator McLUCAS—I turn now to the Eyre Peninsula Old Folks Home. The background to that looks a little more serious, to be frank. Were they originally accredited and for what period of time?

Mr Brandon—They were originally accredited in July 2003 for a period of three years to expire in October 2006.

Senator McLUCAS—This sanction was because they refused access to the agency to come onto the premises, I understand?

Ms Finlay—Yes, that is correct.

Senator McLUCAS—Can you give me the background to what happened there?

Ms Finlay—I understand that the context was that initially they had refused access. Usually what happens in those circumstances is that we negotiate with the home concerned. In this case, those negotiations were not successful and the department decided to impose a sanction under the accountability principles.

Senator McLUCAS—What was the basis for the refusal of access?

Mr Brandon—The provider felt that they were not happy with the manner in which the auditors had conducted the audit. They did not actually dispute the outcome. They were in discussion with us over how it was conducted—the attitude and the approach of the assessors.

Senator McLUCAS—When was that? In mid 2004?

Mr Brandon—Yes.

Senator McLUCAS—Why were the assessors there?

Mr Brandon—We undertook a review audit in August 2004.

Senator McLUCAS—So you had access to the facility?

Mr Brandon—Yes, we had access. It was subsequently that access became the problem.

Senator McLUCAS—What was the result of the review audit?

Mr Brandon—The review audit was conducted from 2 August to 6 August 2004. We determined that they had noncompliance in eight areas and varied their period of accreditation to expire on 25 May. There was then correspondence—a request for reconsideration. When we went back for a support contact on 22 September, they refused access.

Senator McLUCAS—So are there any sanctions coming out of the review audit?

Ms Finlay—I think the short answer is no, but at the moment the issue is about the access question.

Mr Brandon—Our position at the moment from the non-compliance perspective is that the home has remedied their noncompliance.

Senator McLUCAS—How do you know, Mr Brandon? They would not let you in.

Mr Brandon—We have been back since—I am sorry, Senator. There was the issue of failure to give us access, but we have subsequently had access and completed an audit, and we have now formed the view that the home is fully compliant.

Senator McLUCAS—But the sanction remains for the refusal of access, essentially as a penalty?

Ms Finlay—Yes, it does.

Mr Mersiades—Unless they seek to have the sanction lifted.

Senator MOORE—You said in your previous answer that in these circumstances you attempt to negotiate. Is there much evidence of people going to review being refused access?

Mr Brandon—No. I have not been with the agency that long, but I understand that in the space of the last five years we have had two or three instances where we have been denied access.

Senator MOORE—So it is not a common occurrence.

Mr Brandon—No, not at all. Normally the homes understand why we are there. It is in their interests and those of the community. We do not have a problem.

Senator MOORE—And the prospect of having a sanction for nonaccess would seem to be well known. I had not heard that before. In evidence to other committees, we had not actually looked at being kept out of the facility. I will have to ask more questions now.

Senator McLUCAS—I understand they have applied twice to have the sanction lifted. That has been considered on two occasions, and the department on both occasions has not lifted the sanction. What are the reasons for that?

Ms Finlay—I would have to take that on notice. I am not clear in my own mind about why that is so. I may be able to provide an answer during the course of this afternoon.

Senator McLUCAS—Has the department found any basis for the refusal of access? Was it a personality clash? They would not have been happy with the audit, I am sure, but what was the basis of the refusal of access?

Mr Brandon—In our discussions with them—and the state manager did talk with the CEO—there were fundamental issues, in that they did not particularly like the behaviour of the assessors. We did a complaint investigation of that, and I have subsequently written to the CEO of the home outlining our position and the outcome of our findings. That was in early December, and I have had no contact with her since then. In fact, we did a complete site audit on 8 December, found the home 44-out-of-44 compliant and gave them a two-year accreditation period.

Senator McLUCAS—Forty-four out of 44?

Mr Brandon—From 6 to 8 December we conducted a site audit for their accreditation, because there was a crossover with the review audit. The time periods crossed over.

Senator McLUCAS—But you only gave them two years rather than three?

Mr Brandon—That is correct.

Senator McLUCAS—Why didn't you give them three years?

Mr Brandon—Because, in the lead-up to that site audit on 6 December and prior to our going in there for the review audit, there had been a history of noncompliance. It was not severe, but it was certainly enough to cause us to think that two years accreditation would be more appropriate than three.

Senator MOORE—Did the same assessors go back to do the follow-up assessments?

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

Senator MOORE—I would like to have that on notice.

Ms Finlay—I have the answer to an earlier question that you raised about why the department has not lifted the sanction. I am advised that the approved provider has not provided assurances to the department that access will not be denied in the future except in limited circumstances specified in 1.13 of the accountability principles that apply under the Aged Care Act.

Senator McLUCAS—Mr Brandon, you have gone back and looked at the behaviour of the assessors and made some analysis of that?

Mr Brandon—Yes.

Senator McLUCAS—That is an internal agency process?

Mr Brandon—Yes.

Senator McLUCAS—What input does the provider have into that process?

Mr Brandon—Because of the significance of this—and as we would with most large complaints—I appointed the general manager of accreditation to investigate the complaint. As part of that investigation he flew to Port Lincoln and met with the board, the CEO and the staff of the home. Then there was ongoing discussion and correspondence which led to my final letter back. I am of the view—on the basis that if they had not been they would have told me, because that is their history—that they are satisfied with that outcome.

Senator McLUCAS—There is no independent process, external of the department and the agency?

Mr Brandon—If a home is not satisfied with the outcome of the accreditation they can apply for reconsideration, or they can apply to the AAT—and processes flow from that.

Senator McLUCAS—I have some other questions about particular homes which have been reviewed and have sanctions in place, but I will put those questions on notice. I am seeking straight forward information along the lines that we have been discussing.

Mr Brandon—I would like to correct something. I believe I said the Mr Bushrod met with the board. He has just advised me that he only met with some members of the board, not the complete board.

Senator McLUCAS—Is that an issue?

Mr Brandon—No, it is not an issue, at all. I was just making sure I told you the truth.

Senator McLUCAS—I want to go to the issue of prudential arrangements. Thank you, Mr Brandon and Ms Finlay. Can you give me some background on the whole issue of prudential arrangements? I understand there has been a process of trying to improve the arrangements for accommodation bonds. What is the current state of play with that issue, Mr Mersiades?

Mr Mersiades—In the government's response to the pricing review there was a decision to establish a guarantee fund to strengthen the prudential arrangements. We are currently in consultation with industry and sector representatives about the arrangements for such a fund.

Senator McLUCAS—How long have those discussions been occurring?

Mr Mersiades—The discussions were engaged in earnest in about November last year. The timetable is to try to have the fund in place by mid-this year.

Senator McLUCAS—Who are part of those negotiations?

Mr Mersiades—The minister has established a conditional adjustment payment and prudential reference group which is chaired by an independent person, Ian Struthers. I do not have the names of the other representatives but I can get them to you quite quickly. I suspect my colleagues may have them and that we can pass them on to you. As well as that, the minister's implementation task force will have a role in looking at the arrangements which are proposed.

Senator McLUCAS—I understand, though, that this whole issue has been around for much longer than the last three or four months. It precedes Professor Hogan.

Mr Mersiades—Previous ministers have encouraged the peak organisations to have a good look at the prudential arrangements and suggest options for strengthening those arrangements. That process was effectively truncated by the decision, arising out of the Hogan report, to set up a guarantee fund.

Senator McLUCAS—Is there general agreement from providers that that is an appropriate course of action?

Mr Mersiades—I could not comment on that, Senator. Certainly the reference group that we are dealing with are working with us very constructively and cooperatively in the framing of the appropriate arrangements, but I really could not comment on the view of the sector at large.

Senator McLUCAS—And you are hoping that those discussions will conclude by June?

Mr Mersiades—That is correct. We are aiming to have the fund in place by about mid-year, or certainly have the arrangements established so that those decisions can be taken, and action taken.

Senator McLUCAS—The resident classification scale reform process—once again, there is quite a history to this. I understand that the government announced a reform of the RCS and then there was the RCS review. What was the purpose of that review?

Mr Mersiades—I am not quite sure about the reform. Minister Andrews, a couple of years ago—the precise time escapes me—announced a review of the RCS and there was that process under way. As part of that process, a report was prepared. The then minister announced the acceptance of some of the recommendations of that review, and referred a number also to the pricing review, which was operating in parallel.

Senator McLUCAS—So the review process did not actually complete. Is that what you are saying?

Mr Mersiades—The review process reported, and the minister provided a response to the recommendations. As a result of those recommendations, there were a number of activities initiated around, for example, developing a reduced RCS question form. The existing one has about 20 questions and, as a result of that review and subsequent work, a reduced RCS question schedule was developed. As well as that, there was a pilot undertaken to test the use of external assessors for conducting the RCS.

Senator McLUCAS—Did that complete that pilot?

Mr Mersiades—Yes.

Senator McLUCAS—Has the result of that pilot been promulgated?

Mr Mersiades—The result of that pilot has certainly been discussed with the relevant industry groups.

Senator McLUCAS—There was not an evaluation of the pilot project?

Mr Mersiades—Yes; there was an evaluation. There is a report available about it.

Senator McLUCAS—That included the e-commerce system of aged care payments. Can you explain that to me?

Mr Mersiades—They are not directly related. They are related to the extent that they both seek to address paperwork issues. The RCS review did not address the e-commerce approach. That is being taken forward separately.

Senator McLUCAS—What is the status? There is a pilot happening with the e-commerce; is that correct?

Mr Mersiades—That is right. The new payment system in the new funding model will have an electronic platform, but in the meantime we have developed a front end for the existing payment system. The initial take-up of that started in January—at very small scale. It is being tested. By all accounts, it is being favourably received. We expect it now to gather momentum and to be extended to more providers, and to also be extended to a wider range of forms and data to be exchanged.

Senator McLUCAS—Is that linked to the HIC?

Mr Mersiades—The HIC was contracted by the department to develop that front end.

Mr Dellar—Because it is important when people wish to transact with the department that there is an understanding of who it is who is transacting and that the information is transmitted, we are using the HIC technology to achieve that.

Senator McLUCAS—You are contracting to the HIC?

Mr Dellar—We have contracted that work to the HIC. When one of these few providers now logs onto the system to send us electronic information, it is actually through the HIC gateway.

Senator McLUCAS—This is a trial. Are there a number of participants in the trial?

Mr Dellar—We are not calling it a trial; we are calling it stage 1. By that we mean that we are perfecting the electronic transaction path. We have received and processed a very small number of successful electronic transactions, but it is a very small number at this stage. As we improve the systems that support that and, more particularly, as aged care providers get the software that they will need to transmit their electronic information to our electronic information, we expect that to grow. There is no sense in which we would stop and ask: 'Will we continue?' There is a strong commitment to continue, but we are starting slowly and it will be a one step at a time process.

Senator McLUCAS—Do you have a feel for the time line that it will take?

Mr Dellar—We have divided the electronic communication process into three major steps—or three releases, as we call them. This first release is about the resident entry record and departure events so that we know when people are coming in or leaving the service. The next addition to that will be for providers to submit claims for payment, which is a significantly more complex thing. Yes, we have a proposal, and essentially the end point is that towards the end of 2006 it will be fully functional. Between that point and now, we have a series of stages for implementation. As I said, it is a slow implementation because we are taking it one step at a time and making sure that each step is working well before we move to the next one.

Senator McLUCAS—IT capacity is a real issue in a lot of residential aged care facilities, not only in their business but also in other issues. Is the software available for them to participate in this process?

Mr Dellar—There are already a fair number of software providers who give or sell software to the industry. We are working with those providers to adapt their products to enable them to talk effectively with the department's. There are quite a few companies that are doing exactly that with us. We have design working groups comprising us, the industry, the HIC and the software providers. Yes, the technology is very much nascent, but it is growing and will be there as providers are ready to take it up.

Senator McLUCAS—Has the issue of linking more than just the business side of IT been discussed in this whole discussion about e-commerce? I know this is very much a commercial discussion, but there has been a lot of discussion around the place about improving IT from a patient record point of view and managing care plans electronically.

Mr Dellar—Perhaps I will make two comments. Firstly, we are funding five projects which are called clinical IT projects. They are designed to demonstrate various applications of

IT to the clinical practice in aged care. Those projects are just getting under way at this moment. They have been approved and announced. In addition to that, or complementary to that, there is a committee called the transactions and technology committee, comprising members of industry, the department and the HIC, and we talk broadly about the application or the applicability of IT to the delivery of aged care.

Senator McLUCAS—Are the projects that have been approved on the web site?

Mr Dellar—The projects that have been approved are on our web site. The list of them and what they are about is certainly available.

Senator McLUCAS—Is there a time line established for the introduction of the new RCS?

Mr Mersiades—We are working to introduce the new payment model and the new payment system in 2006. It will inevitably be towards the end of 2006 rather than the beginning.

Senator McLUCAS—The reclassification process that will have to happen at that point: have you put your mind to how that will occur?

Mr Mersiades—As part of the development of the new model there will be a very extensive trial undertaken, starting around April this year and going for several months, that will be testing a new funding assessment tool. As a result, that will give us a lot of information whereby we can compare how people are assessed with the new tool compared to the existing tool. We will be able to use a lot of that information to see who the winners and losers are and to configure an appropriate model around that.

Senator McLUCAS—Is all the development of the new funding model happening within the department or is some of that work being contracted?

Mr Mersiades—Quite a deal of it is being contracted. The whole exercise is being done in very close consultation with the sector through a specific reference group.

Senator McLUCAS—Thank you. Have the first payments been made on the conditional adjustment payment?

Mr Mersiades—The conditional adjustment payments commenced at the beginning of this financial year.

Senator McLUCAS—How are they paid?

Mr Mersiades—They are paid through our payment system as a supplement. There is an amount per resident which is paid.

Senator McLUCAS—So, as of January this year, the 1.75 per cent was simply added to the payments?

Mr Mersiades—As of July last year.

Senator McLUCAS—Pardon me—as of July last year. Has there been agreement about what providers have to do to receive that 1.5 per cent—and it will be growing—payment?

Mr Mersiades—The minister announced today the arrangements for the application of the conditions.

Senator McLUCAS—Yes, I noticed that, actually. It was one of those questions you know the answer to. How long has agreement been attempted to be reached? It is a bit hard for you to have started paying it and then say that they have got to do some things. You have let your big stick out of the bag, haven't you?

Mr Mersiades—Providers can always opt out if they do not accept the conditions.

Senator McLUCAS—What are the conditions?

Mr Mersiades—Most providers had a pretty good idea of the nature of those conditions—they were pretty clear. It was the detail that had to be worked through carefully with the sector.

Senator McLUCAS—To be frank, the minister's press statement was expressed in basically the same language as when the program was announced. Is there more detail than that? Is there a memorandum of understanding? Is there an agreement that operators will have to sign to continue to get the conditional payments?

Mr Mersiades—The principles provide for a number of actions that providers have to undertake, which vary depending on the condition. The principles make it quite clear what is required of the providers.

Senator McLUCAS—It just says they are required to offer better training opportunities. You would need a little more detail than that, wouldn't you? I am reading from the minister's press release of today.

Mr Mersiades—I was suggesting that the greater detail is provided in the principles formed under the act. That is where the detail will be.

Senator McLUCAS—But will there be, essentially, a contract between each provider and the department surrounding that agreement?

Mr Mersiades—No, not a contract per se except to the extent that the legislation puts certain requirements on those providers. In that sense the legislation performs the role of a contract.

Senator McLUCAS—How do you monitor compliance?

Mr Mersiades—To answer that question we need to talk about each of the conditions, because there are different arrangements that apply to each of the conditions.

Senator McLUCAS—How will it happen?

Dr Cullen—To take the staff training condition, to begin with, in order to be eligible for CAP providers must do two things: they must encourage staff training and they must provide a declaration to the secretary that they have encouraged staff training and provide information about staff training. That declaration is due by 1 March each year. If a provider failed to make a declaration by 1 March in a given year then CAP would cease to be paid to that provider until the beginning of the payment period immediately after they did provide the statement.

Senator McLUCAS—So they have to encourage their staff to be trained and they have to give them some information about that training.

Dr Cullen—Correct.

Senator McLUCAS—They do not have to provide the training. So basically if you put a few brochures in the staff room, wrote an email to every staff member to say, 'You should go and look at the brochures in the staff room,' and then filled in the declaration before March, that is all you have to do.

Mr Mersiades—They are also required to indicate the nature of the encouragement that they provided, and they need to sign their name to that declaration.

Senator McLUCAS—Essentially, the compliance is the declaration. If you receive a piece of paper from any aged care provider that they have done that, you are not required to look into how that occurred. Their compliance is the provision of the declaration. Is that correct?

Mr Mersiades—That is correct.

Senator MOORE—Could there be an unsatisfactory declaration, one that did not meet the requirements?

Dr Cullen—The requirement, as specified in the principles, is that the approved provider must make a statement to the effect that they encourage staff training and they must provide information about the training opportunities that they offered to the approved provider. As long as they provide that information on the form then they would be compliant.

Senator MOORE—So the answer to my question was no.

Dr Cullen—The answer to your question is the answer I gave.

Senator McLUCAS—What is the second condition?

Dr Cullen—The second condition is around financial reports. To make it clear, a provider must be compliant with all three conditions, and I am giving you each of them separately on the assumption that they are always compliant with the other two, otherwise it becomes very complex. With regard to financial reports, the approved provider must do the following things. They must prepare, in essence, a general purpose financial report that would have been produced by a reporting entity required to report under the Corporations Act—in other words, in accordance with the accounting standards. Moreover, they must prepare that report as though they were a for-profit entity, not a not-for-profit entity. This relates to certain technical matters in the accounting standards. Not only must they prepare that general purpose financial report but they must have it audited by a registered company auditor or a person approved by the secretary if they cannot access a registered company auditor. They must obtain from the auditor an opinion which states that the audit was conducted in accordance with the standards and an opinion from the auditor as to whether or not the general purpose financial report presents a true and fair view of the financial position and performance of the entity.

The last condition is that they must provide a copy of their financial report to any of the following people: a resident of the service; someone who is approved for residential care and considering becoming a resident of the service; a representative of either of those two sorts of people; or a person or agency authorised by the secretary.

Those are the things that they must do. Finally they must make a statement to the secretary that they have complied with those matters. That statement is due by November each year. Again, if a provider fails to make such a statement, then CAP ceases to be payable from

1 November until the payment period which commences immediately after they do provide the statement.

Senator McLUCAS—There are a few questions that come out of that, Dr Cullen. You said that the standards require entities to construct their statements on a for-profit basis. Does that mean that not-for-profits will have to have a dual accounting system?

Dr Cullen—Not at all. There is one place in the accounting standards where a requirement is placed upon for-profit entities which is not placed on not-for-profit entities, and that is the requirement that accounts be segmented according to business segments. The requirement in the principles is that providers must show residential care as a separate segment. In other words, if an approved provider conducts any other activities, they must segment their accounts to show not only the total position but also the position within residential care. The accounting standards do not impose that requirement on not-for-profits, but the principles require all providers to produce statements in that way. I should say, however, that the principles allow a provider to prepare their statements either at the provider level or at the residential care service level.

Senator McLUCAS—So that is an option?

Dr Cullen—That is an option. That is what that is designed to cover. If a not-for-profit provider does not wish to provide information on their non-residential care activities, they can do that by preparing statements at the residential care service level.

Senator McLUCAS—For an entity that has a number of residential care facilities, this does not require them to report facility by facility?

Dr Cullen—No, it requires them to report at the level at which the risk lives, essentially. In essence, bonds are held by an approved provider and not by a residential care service. Therefore, the relevant balance sheet, if you were a resident concerned about solvency, is the approved provider balance sheet and not the individual service balance sheet.

Senator McLUCAS—But residents and potential residents are also looking at that operational cost. Sure, the accommodation bonds are a significant issue, but residents and potential residents are also extremely interested in the basic books of any residential aged care facility. This condition does not mean that all reporting will be done facility by facility?

Dr Cullen—No. It was a matter of balancing the administrative burden which would be imposed on providers against residents' needs. It was considered that this was the appropriate balance.

Senator McLUCAS—Okay. Thank you. This is my last question on this particular condition. You explained who had access to the financial statements. How does the department intend to inform the community that they can have access to these financial statements? It is all very well telling the residential aged care facility that they have to produce them, but the purpose is to enable residents and potential residents to have some surety about what is happening there. How do we intend to tell them that this is a right that they may have?

Mr Mersiades—It will be reflected in the various communication brochures and the documents that we have with individuals.

Senator McLUCAS—There is no plan at this point about how to promulgate that information?

Mr Mersiades—Fact sheets have been produced and circulated. There will be an ongoing program of alerting people to their rights in this regard.

Senator McLUCAS—And the third condition, Dr Cullen?

Dr Cullen—May I give you a little bit more information on the second condition?

Senator McLUCAS—Certainly.

Dr Cullen—The principles contain a power for the secretary to exempt approved providers from certain requirements if they demonstrate that it would be impractical in the short term for them to meet those requirements. We spoke about one of those, which was the registered company auditor. Providers can also apply for an exemption from the segmentation requirement or from any other accounting standard, if they can demonstrate that it would be impractical in the short term for them to meet that while they are developing new financial reporting arrangements. The third requirement is that the provider must take part in the work force census. Compliance against this will be judged by whether or not the provider takes part in the work force census.

Senator McLUCAS—But most people do now, anyway.

Dr Cullen—That is correct.

Senator McLUCAS—What is the level of participation in the census?

Mr Mersiades—There was one undertaken. I think the participation rate was in the high 80s, but I would have to check that. It was not complete; it was not 100 per cent. It was 85 per cent.

Senator McLUCAS—We will get that recalcitrant 15 per cent?

Mr Mersiades—We will get a 100 per cent sample.

Dr Cullen—The way in which this condition will operate is that the department will contract a third party to undertake the census. That party will receive the data and then pass the names of those entities that provided data—but not attached to the data—to the department, so as to provide the de-identification necessary to get good data and the information that the department needs.

Senator McLUCAS—Is the work force census currently done in-house?

Dr Cullen—No, it is done externally on a de-identified basis. This maintains that de-identification but passes the information that is necessary for the CAP.

Senator McLUCAS—You would be aware that there were strong calls for wage benchmarking to be included in the CAP arrangements. Were discussions about wage benchmarking included in the discussions that have led to today's decision and today's agreement with the sector?

Mr Mersiades—What do you mean by 'wage benchmarking'?

Senator McLUCAS—The suggestion, especially from workers in residential aged care, both the nursing staff and the care providers, is that this injection of funds should have been

strongly linked to increases in wages. It is generally regarded that there are a whole range of negatives that flow out of the poor relative pay of aged care workers. But I know there were strong calls to the government from workers' representatives to link CAP, the conditional adjustment payment, to growth in wages. Was that part of the deliberations in the meetings that were held?

Mr Mersiades—In recommending the conditional adjustment payment, Professor Hogan made it quite clear that one of the key reasons for the conditional adjustment payment was so that providers could pay more attractive and appropriate salaries for staff attraction and retention purposes.

Senator McLUCAS—Yes, I am aware of that. The call has been that that should be a condition of the payment, that the allocation of these funds should be linked to increased remuneration for aged care workers. That does not exist in the conditions as they have been described. My question is: was it part of the negotiations with the sector? Were there discussions about whether that would be a desirable condition to apply to the payment?

Mr Mersiades—Certainly since the report was handed down the department has not been engaged in any discussions of that nature with the sector. I am not sure about how Professor Hogan conducted his inquiry.

Senator McLUCAS—So there has not been a process of communication between the sector and the department in the lead-up to today's announcement? I thought this was an agreement between the sector and the department.

Mr Mersiades—What I am saying is that we had not discussed with the sector the idea of wage benchmarking, as you described it. That just was not government policy; it was not on the agenda.

Senator McLUCAS—I understand now. That is all I need, thank you.

Mr Mersiades—If I may, Senator, I have a correction. The participation in the work force survey was 62 per cent, as I have just been told.

Senator McLUCAS—I thought it was much higher than that.

Mr Mersiades—From my earlier answer, I thought it was too. But I have just been told that I was astray.

Senator McLUCAS—That is 62 per cent of all residential aged care facilities?

Mr Mersiades—It is probably the providers.

Senator McLUCAS—So that might mean more facilities, then. I think that is why my thought was that it was much higher than that.

Mr Mersiades—That could be the case, yes.

Senator McLUCAS—I understand that the aged care work force committee has been around for a fair while. Can someone give me some background to that committee?

Mr Mersiades—It predates my arrival in the position. It certainly has been around for several years. It operates as a vehicle for consultations with the sector, including with staff associations, on work force issues affecting residential aged care. It has a representative group

of members who are appointed by the minister and it is chaired by the department. We can provide you with the information on the membership.

Senator McLUCAS—That would be useful, thank you.

Mr Mersiades—We will do that out of session.

Senator McLUCAS—When did they last meet?

Ms Finlay—The committee last met in March 2004. A meeting was scheduled for later in the year; however, the election intervened.

Senator McLUCAS—Is it normal that the committee would meet twice a year; is that the normal pattern?

Ms Finlay—Usually, twice a year is the normal pattern. However, if there are significant issues that need to be canvassed at the committee there is an opportunity to do so in teleconferences, between formal face-to-face meetings.

Mr Mersiades—The committee also operates working groups and subcommittees on various issues.

Senator McLUCAS—Who sets the agenda for the committee?

Mr Mersiades—It is a combination of the department and issues raised by the members.

Senator McLUCAS—What are the current activities?

Ms Finlay—I think they are probably in three very broad categories. Firstly, they have been considering and developing a wider work force strategy for the aged care work force. I think the department referred to that in its annual report in 2003-04. Secondly, they have been assisting the department in examining the results of the census, and will be working with the department on the development on the next census, so that is an important area of work. Thirdly, they are providing the department with a means of discussing the implementation of a number of the work force initiatives which the government announced in the 2004-05 budget.

Senator McLUCAS—When are they next going to meet?

Ms Finlay—The next scheduled meeting is in early March.

Senator McLUCAS—This probably goes back to the census question. There has been a call from doctors to be included in the work force census for residential aged care. Is there a reason why they are not included in that census? The census directly goes to those employed by the residential aged care facility but I understand that doctors have expressed the desire to be recognised as part of the service delivery even though they are not necessarily employed by the facility. Has the department thought about this request?

Mr Mersiades—I am not aware that it has been discussed at any of the work force committees but it is certainly something that we could give some consideration to.

Senator McLUCAS—You have not received formal representations—

Mr Mersiades—Not that I am aware of; that does not mean we have not received them.

Senator McLUCAS—A document was produced in February 2004 by the National Institute of Labour Studies called *The care of older Australians: a picture of the residential aged care workforce*. Did that come out of the census?

Mr Mersiades—I believe so. That was a distillation of the findings of the census and the survey.

Senator McLUCAS—Does that go to the work force committee for agreement? I am trying to ascertain the status of this report.

Mr Mersiades—I am sure it would have been discussed and considered at one of the work force committee meetings but I would have to take on notice its status in relation to the work force committee. I would have to check that.

Senator McLUCAS—Could you do that for me?

Mr Mersiades—Yes.

Senator McLUCAS—Thank you. On RCS reviews and the issue of downgrades, last June you provided us on notice the number of downgrades and upgrades that had occurred after review. That is question EO4227. The data you provided was for the year ended 30 June 2004. Could we possibly get that information to the end of December 2004 or do you only collect it on an annual basis?

Ms Finlay—I am not sure whether the figures to the end of 2004 are available but the figures for July to September 2004 are available on the department's internet site. I have them with me now if you would like me to give you the totals.

Senator McLUCAS—No, I am worried about the time, Ms Finlay. When the figures to December come out, can they be provided to the committee?

Ms Finlay—Certainly.

Senator McLUCAS—Thank you. Have you looked further into that information to work out what the value of the downgrades and the cost of the upgrades have been to the department? Have you quantified the changes in the review process?

Mr Mersiades—Do you mean the effect on appropriation?

Senator McLUCAS—Yes, that is right.

Mr Mersiades—Yes. We have annual figures on that but we just have to find them.

Ms Finlay—Based on the reporting in our departmental annual report, the savings represented were annualised at $33.2 million.

Senator McLUCAS—So that is accommodating the upgrades and that was $32 million?

Ms Finlay—It was $33.2 million.

Mr Mersiades—It was a reduction in the appropriation.

Senator McLUCAS—I understand that it is the department's position that when a reclassification occurs, the view is that the error has occurred on the part of the provider of that care. When and by whom is the original classification done?

Mr Mersiades—It is done by the provider or his or her representative.

Senator McLUCAS—You are telling us about the number of upgrades and downgrades. Could you also tell us what that is as a proportion of the residents of aged care facilities? The raw number does not give me a feeling for whether that is good or bad or whatever in a relative sense.

Mr Mersiades—We can get those figures for you. We will take it on notice.

Senator McLUCAS—Thank you. There is a very high number—4,927—of downgrades and a much smaller number of upgrades. Is it the view of the department that the original error was made by the provider?

Mr Mersiades—The finding of the review officer is that they do not agree with the original provider's assessment, so it follows from what you are saying that that is the case.

Senator McLUCAS—Does the department have a view about how that can be avoided?

Mr Mersiades—Over the years the department has undertaken numerous training exercises to try to improve the capacity of people who complete the review orders to avoid errors. There has been significant work done over the years around that.

Senator McLUCAS—And what is intended to occur? You gave us some answers in question No. 228 that did not comfort me as to the direction of the department in terms of review of the resident classification scale.

Ms Finlay—Can you clarify why that would be? I think at the time those questions were being asked it was quite early.

Mr Mersiades—That question related to a strengthening of the review process as a result of the last budget. It was very early days at that stage as to how that strengthening would be undertaken. The additional resources were provided because, under the Hogan arrangements, ACATs were no longer required to do the assessment in going from low care to high care. In response to accountability requirements around that the government increased the level of review audit that would be undertaken. The question was directed to how that additional work would be done; it was very early days and that had not been developed. This answer was prepared quite a while ago.

Senator McLUCAS—It is almost six months ago—at least. How does this budget measure link with the review of classifications? I understand that occurs from time to time.

Mr Mersiades—It provides additional resources to increase the sample which is undertaken—a risk rated sample.

Senator McLUCAS—Right—as a normal review. Will there be more reviews as a result of that?

Mr Mersiades—Yes.

Senator McLUCAS—Can we go through those questions? What will it involve?

Mr Mersiades—There will be additional reviews.

Senator McLUCAS—I wonder if I could place on notice that question and you can update it. That might solve that problem.

Mr Mersiades—Certainly.

Senator McLUCAS—Thank you. I understand there was additional funding of $47.9 million for ACAT assessments. At last the estimates we asked some questions around that allocation to try and ascertain what would happen to waiting times. You said that it will assist in some reduction in waiting times; I think it was a fairly tentative statement. Have you done any measurement about what waiting times there are for ACAT? Have you got anything a bit stronger that might make us think that it has worked?

Mr Bruen—Yes, we do have some figures on waiting times. They are fairly detailed; can I provide them to you on notice rather than read through them now?

Senator McLUCAS—The other thing is that we could table them and that allows the committee to have them, if they are in the appropriate form.

Ms Halton—Could I have a look at them over the dinner break and if we can table something after dinner, we will.

Senator McLUCAS—That would be great, thank you. Mr Bruen, has there been a general decrease in waiting times?

Mr Bruen—It depends from where to where.

Senator McLUCAS—Prior to the application of those funds up to the most current that you have.

Mr Bruen—For the 2004-05 year, we only have figures on one quarter so far so the funds would not have been applied yet to have effect.

Senator McLUCAS—What was the implementation of that strategy?

Mr Bruen—The funds were allocated to aged care assessment teams in proportion to the funds that they already got. As you know, the assessment teams are managed by the states on our behalf. The extra funds were just added to the base funding for each assessment team.

Senator McLUCAS—Which basically allowed them to employ more personnel.

Mr Bruen—Yes.

Senator McLUCAS—Have those personnel been employed? Essentially, is it happening?

Mr Bruen—We understand it is. We would not have data yet on the number of staff. The states report to us at the end of each year. We do not normally require numbers of staff; the kinds of figures we are interested in are the ones that you are asking about—that is, where the waiting times are reduced. It is up to the states how they employ staff. We collect the number of assessments carried out as well. It is just a bit early to tell whether that money has had an impact. It was distributed to the states around about September or October last year, so it would not show up in our figures yet.

Senator McLUCAS—So it has not worked through the system yet?

Mr Bruen—No. We get figures collected quarterly, but the last quarter I have is the first quarter of 2004-05.

Senator McLUCAS—And they did not even have the cheque by that stage.

Mr Bruen—No, that is right.

Senator McLUCAS—Mr Bruen, we might continually look at those figures on a quarterly basis just to get a feel for what movement there is.

Mr Bruen—Certainly.

Senator McLUCAS—The states report to you quarterly on waiting times.

Mr Bruen—Yes, and they report the time from referral to the time of the first face-to-face contact by the ACAT.

Senator McLUCAS—Do they also report numbers as well?

Mr Bruen—The numbers of people, yes they do.

Senator McLUCAS—What else do they report?

Mr Bruen—Where the assessment took place—that is, whether it was in hospital or in the home—because there is quite a difference there.

Senator McLUCAS—It would be useful to have that on a quarterly basis, thank you.

Mr Bruen—Certainly.

Senator McLUCAS—In June estimates last year we were advised that the advertising budget for '04-05 was going to be $7.4 million; '05-06, $1.2 million; '06-07, $1.3 million; '07-08, $1.3 million. There is a lot of money being spent on advertising in '04-05. How much of that money has been spent and what was it spent on?

Mr Mersiades—The division who manages the communications budget is not us. We will have to take that one on notice.

Senator McLUCAS—So I could ask that question in corporate?

Ms Halton—No, they are not corporate. It will take me a while to work out which program they are.

Senator MOORE—We had one last night called relationship building. It could be that one.

Ms Halton—I will find out if they are coming back later on. Would you mind repeating the question?

Senator McLUCAS—There was $7.4 million allocated for advertising in 2004-05. Then we have got the out figures: $1.2 million in 2005-06 and then much less. I want to know how much of that $7.4 million has been spent to this point in time. I would actually like to know what the monthly spend is and how much was spent monthly in the year to date.

Ms Halton—The advice I have—and if this is wrong we will come back and correct it—is that, of the $7.4 million, we estimate we will only spend $1.6 million and that we are going to rephase the balance. That is what I believe to be the case, but I will check that. If that is not right, we will dig up the correct answer for you and I will tell you after dinner.

Senator McLUCAS—We have just found $6 million.

Ms Halton—Rephased.

Senator McLUCAS—The 2004 aged care approvals round was announced earlier this year. Are details of approved places sent to all the local members?

Mr Dellar—The minister made those announcements and the information was distributed by the minister's office, so I cannot tell you exactly what she wrote to whom.

Senator McLUCAS—I understand that it is actually only provided to coalition members, but that is not necessarily a matter for the department.

Mr Dellar—I cannot comment on that.

Senator McLUCAS—I understand that. Minister Bishop, in a letter—and the minister might have to help us with this—she provided to coalition MPs, says that there will be a certificate to present to successful approved providers. I understand that certificate is only available for coalition held seats. I would like to know if that is in fact the case. Probably on notice, we will have to know what the cost of the production of those certificates is and from which budget line item they come. It is not a question to the department. Mr Dellar has explained that after the 2004 aged care approvals round the minister wrote to coalition held seats, to members of the coalition, advising them of which residential aged care facilities had been successful, but also offered a certificate to present to successful approved providers in the electorate. My question is: is it true that the certificate is only offered to coalition members? Also, what is the cost of the provision of that certificate and who pays for it?

Ms Halton—I do not know that we are aware of this.

Senator McLUCAS—I am sure you are not; I am sure it comes from the minister's office. That is why I am placing this question on notice.

Ms Halton—Which means we may not be able to answer it.

Senator McLUCAS—The minister will be able to.

Senator Patterson—I am not in a position to answer it either.

Senator McLUCAS—I realise that, Senator Patterson.

Senator Patterson—And I would not, because I am not in a position to.

Ms Halton—But you will understand that, if it is not something that we are responsible for, we may ultimately say that the department is unable to answer the question.

Senator McLUCAS—But the question is in fact not only to the department; I can also question the minister.

Ms Halton—I understand that.

Senator Patterson—You might put the question on notice to the minister, because it is may not be an estimates question. It may be something that she is doing herself. I do not know about it.

Senator McLUCAS—I recognise that you do not know, but we will find out.

Senator Patterson—I do not know whether she has done it. You are alleging that she has done it. I think you should write to her and ask her.

Senator McLUCAS—Maybe the minister could also explain why the member for Hindmarsh was sent a copy of the letter that was provided for coalition MPs and others. Once again, it is not a question for the department, but that is where the offer of the certificates came from.

Senator Patterson—I will bring this section of the *Hansard* to the minister's attention, and I think you could write to her and ask her, or put a question on notice.

Senator McLUCAS—Thank you, we have done that. Mr Mersiades, I have a question about the concessional ratio. I understand that 40 per cent of residents in residential aged care are concessional residents. There is not a penalty. Am I right that, once you get under that 40 per cent, there is a penalty per day?

Mr Mersiades—That is essentially correct.

Senator McLUCAS—Can you explain to me where the figure of 40 per cent came from? What is the modelling that said that 40 per cent is the right number to give the balance of concessional to non-concessional residents?

Mr Mersiades—I am not aware of the basis of that decision. It was taken quite some time ago. I think it was probably in the mid-1990s or thereabouts, perhaps 1997. It has been part of the system for quite a while. I am not aware of the basis for that decision.

Ms Halton—My memory is that, when the legislation was being considered in the Senate in 1997, there was a debate about what was the appropriate level—in fact I think this preceded the introduction of the legislation—that we should require to ensure that there was reasonable access for people on lower incomes to residential care. I could be corrected on this, but my memory is that there was an examination of a variety of pieces of information, income data—I could go on—in order to strike a balance to ensure reasonable levels of access for people on lower incomes. I can recall this issue being discussed at the funding and other implementation working group committee that we had running at that particular time.

Senator McLUCAS—Has any other work been done to ascertain whether that is the right level to ensure that access for concessional patients is readily available? Is that the right number?

Mr Mersiades—The only work I know that has been done around that issue is that which would have been done as part of the pricing review. I am not sure what that would have been. I only say that to the extent that one of the medium-term recommendations goes to this issue.

Senator McLUCAS—I understand that there are in the vicinity of 30,000 CAC packages.

Mr Mersiades—Yes.

Senator McLUCAS—Can the department provide me with the number of people who actually receive support through CAC packages?

Mr Dellar—There is a one-to-one correlation there: the CAC package is for one person. If there are in the order of 30,000 packages, as you said, then there are in the order of 30,000 people at any one time receiving the service. There would be a different issue of throughput, which I would have to take on notice.

Senator McLUCAS—I was given to understand that was not the case. What is the question of throughput, Mr Dellar?

Mr Dellar—It is just that in a given year some people start to receive a service and other people stop receiving a service. Therefore in a given year it will not be one person that has received a service, it will be a series of people, perhaps, in relation to some packages.

Senator McLUCAS—We have based in North Queensland a 'training and resource officer, Indigenous aged care'. Are there more than one of those around the nation?

Mr Mersiades—That nomenclature for one of our staff members escapes me. I will have to take that on notice. That might be a local Queensland office arrangement. I will have to check that, unless Mr Dellar has got information on that.

Mr Dellar—No. We would need to take that question on notice.

Senator McLUCAS—All right. I understand there has been an FOI request for access to a copy of the Westwood Spice report on the performance of the aged care accreditation agency. Why can that not be complied with?

Mr Mersiades—That is a report which was commissioned and prepared for the agency. My advice is that we do not have a full copy of that report in the department.

Senator McLUCAS—And because the agency is a company wholly owned by the Australian government it is not subject to the FOI provisions?

Mr Mersiades—That is the advice I have received.

Senator McLUCAS—Is the department happy with that situation?

Mr Mersiades—We are not unhappy with the situation. As a member of the board, we would have had access to a discussion of what was in that report. I think we would have received summary reports and a briefing on it, but we just do not happen to have a copy of the full report.

Senator McLUCAS—My question goes to the level of scrutiny that can be applied to the agency if it is not subject to FOI provisions.

Mr Mersiades—We do not set the policy as to where the FOI policy provisions apply.

Senator McLUCAS—Has there been any consideration of a review of the situation? I understand the policy position. My constituent is concerned that there is no ability to scrutinise the agency or the operations of the agency using FOI methodology. Has there been no consideration of the situation?

Mr Mersiades—Not by the department. Sorry, I misled you earlier: the department is not a member of the board; it is an observer on the board.

Senator McLUCAS—Is it possible for this committee to request a copy of the incomplete document that is held by the department or is it possible for this committee to request a copy of the complete document held by the agency?

Mr Mersiades—I will have to take that on notice as well because I am not quite sure what the status of board papers is. I would have to get legal advice on that.

Ms Halton —Senator, I suspect that, whilst you can request it, there will be a discretion on the agency's behalf as to whether it is provided.

Senator McLUCAS—If you would look into the legalities of providing that report to the committee that would be good.

Ms Halton —We are happy to give you advice.

Senator McLUCAS—That concludes my questioning over outcome 3. Thank you very much.

Mr Mersiades—Before I go, I will correct one other matter on behalf of my colleague Ms Creelman. She referred to the consultants who did the work for the Care of Older Australians Working Group as health care management advisers. Their correct name is aged care evaluation and management advisers.

Senator McLUCAS—Thank you.

Proceedings suspended from 6.35 p.m. to 7.35 p.m.

Ms Halton—Before dinner, we were asked a question about the response rate to the Aged Care Workforce Census and Survey. I have been asked to give you a little bit more detail, if I might. A written survey form was sent to all aged care facilities registered with the Department of Health and Ageing. In total, survey forms were sent to 2,881 facilities. Useable responses were received from 1,746 respondents referring to 1,801 facilities. You understand about collocation and all those other sorts of issues.

Senator McLUCAS—Yes.

Ms Halton—The effective response rate was 62.5. Then you asked a question about the Aged Care Workforce Committee census and survey. Again, I am advised a subcommittee of the Aged Care Workforce Committee was formed to facilitate the census and survey. Following completion of the survey, the Aged Care Workforce Committee endorsed the survey findings. We have a little bit further to go in terms of getting complete completion.

Senator McLUCAS—Can I ask a question on that, Ms Halton? Was that 62.5 per cent of all residential aged care facilities that provided a useful response?

Ms Halton—That is my understanding. My understanding is that, of 2,881, we got responses relevant to 1,801. There was also—I think this was not your question, Senator; I think it came from this side of the room—a question asked in relation to funding to GP Assist. It might have been Senator Barnett. He asked some questions in relation to the funding for GP Assist in relation to particular periods. I have that information and I am happy to table it as well.

Senator McLUCAS—I have some questions for the Therapeutic Goods Administration.

Ms Halton—We have at least some of the TGA here, Senator. Why don't you start and we will see how we go?

Senator McLUCAS—Okay. I will start with the audit that was undertaken by the Auditor-General. I would like to go to some of the recommendations that were made and get an indication from the TGA of what progress has been made to date in responding to those recommendations. The first one is recommendation 3, which goes to strengthening management of and accountability for the process of assigning GMP audit frequency. Can I get an indication from the TGA or the department of what is happening there?

Ms Halton—Senator, I would like to make an overarching comment about how we are handling the ANAO report. I have Phil Jones, who is head of our audit area, with me as well. You will see that most of these recommendations we have agreed. I think the audit has been

an extremely useful exercise. You would understand that the TGA, in the processes we conduct, is regarded as being one of the world leaders in relation to this entire area. The approach the ANAO took we found to be very useful and very constructive, so we have been pleased that we are getting an opportunity, if you like, to further strengthen the work that we do in this area. Essentially we are looking, in an overarching sense, at all of these recommendations together with governance issues.

Mr Jones—In relation to that particular recommendation, the department is planning to engage a consultant to look at strengthening the accountability processes for managing the GMP audit process. There is a whole range of risk management and other issues involved in this recommendation and others throughout here. There are quite a lot of recommendations and they overlap a bit. So the department is looking at engaging a consultant to review what is there at the moment and make recommendations about how the TGA can strengthen in those particular areas.

Senator McLUCAS—Is the consultant being employed to look just at that recommendation?

Mr Jones—No.

Senator McLUCAS—So the role of the consultant is to develop a work plan that would respond to this document?

Ms Halton—Yes. I think as is acknowledged in the document and I think you will see in our response, a number of actions have already been taken—and we are in progress in any event—in relation to the work that the TGA undertakes. We are going to get the consultant to take an overarching view of governance plus that work against the background of the recommendations provided by the ANAO to ensure that the changes that were in progress are sufficient to meet the recommendations of the ANAO, and if they are not, and in areas where we do not currently have work in progress—I particularly have in mind personally some of the issues in respect of governance—that we actually take appropriate steps.

Senator McLUCAS—When was the consultant employed?

Mr Jones—We have not gone through the process of engaging the consultant yet, but it is planned over the next few weeks.

Ms Halton—Essentially we have already agreed what the governance arrangements inside the department will be in relation to this process. Having done that, we will go to the market in a competitive process to find someone to do the work.

Senator McLUCAS—Their task is just to develop the work plan or is it more than that?

Mr Jones—We would see it being quite a lot more than that. As I said before, there are a number of specific recommendations. As the secretary said, work has been progressing on those anyway. We probably need the TGA to go through and talk specifically about those, but there are some broader recommendations around risk management, performance management and performance indicators. We would see the consultant particularly focusing on those and looking to implement new procedures within the TGA itself as well as looking at change management issues.

Senator McLUCAS—I have a particular interest in recommendations 3, 6, 7, 9 and 19. Do they fit in the scope of what you are hoping that the consultant will—

Ms Halton—Absolutely.

Mr Jones—That is absolutely right. They are the key ones. Recommendation 13 might be another one. That is reviewing recent key enforcement actions of the TGA to see what lessons can be learnt and to do further improvement on those. So the ones you have mentioned and those broader kinds of recommendations are precisely the ones we anticipate the consultant would look at.

Senator McLUCAS—I recognise that you have not let the contract yet. Have you in mind a time frame in which the consultant would complete that piece of work?

Mr Jones—I am not sure. We would hope that we could get a bit of an assessment of the work first. We have not really got that yet.

Ms Halton—I will use the word 'timely', Senator. My expectation is that the work will be done in a timely fashion. I would be hoping we would have the work completed by midyear. At the end of the day, the market might tell us that my expectation is unreasonable, but that would be my hope. As we have indicated, we already have work in progress in a number of these areas, but you would be hoping we would get a timely report from the consultant looking to implement and/or continue to implement what we are already working on so that by mid the second part of this year we are in a very good position in this respect.

Senator McLUCAS—Mr Slater, we are talking about the ANAO report and Mr Jones has explained that a consultant will look at some of the broader questions. Can you advise the committee on what actions the TGA itself has taken to implement some of the recommendations which do not fit into that broader category?

Mr Slater—There are 26 recommendations and the department has accepted them all. The TGA has already completed work on 17 of those recommendations. Those recommendations relate to changes to processes and procedures and to improving various systems and standard operating procedures that we have in place. There is a group of ongoing issues that are dependent on the information system improvements that we implemented in October. That database is coming online. That will go to another four of the recommendations. Then there are four or five recommendations that are caught up in two major consultancy studies that we would undertake to address the longer-term issues that the ANAO has recommended.

Senator McLUCAS—So the first consultancy is the one we have just discussed, I think.

Mr Slater—The second consultancy is to look at the risk management framework and to look at performance management and the issues around improving our performance reporting.

Senator McLUCAS—Performance reporting as an organisation or in terms of the material you deal with?

Mr Slater—The ANAO were quite specific about areas that we needed to improve—our management information, our information to external stakeholders and internal management reporting—that would help us ensure that the TGA's performance was as good as it could be. We are not just looking at the ANAO view, which was for non-prescription medicines. We will take those lessons and apply them right across the board.

Senator McLUCAS—So you will take the learning from that report to all processes that the TGA undertakes?

Mr Slater—Yes.

Senator McLUCAS—Why did you take that decision, Mr Slater?

Mr Slater—This has been a very valuable review for the TGA. It has pointed to areas where we can do better and where we can improve our systems, our administration and our processes. We are taking those recommendations seriously. We will look across the board at whether those recommendations do apply to other areas of regulation that we are responsible for and make certain that we take full advantage of the work that has been done.

Senator McLUCAS—Your dealing with prescription medicine, though, in my understanding is a completely different process to what you do with non-prescription.

Mr Slater—I agree that there is a different risk framework, but the ANAO said altogether we should look at our risk management framework to make certain that it is structured. Some of the learnings, for example, out of the laboratory testing program that recommended better priority and performance management of the testing program I think would apply. At least it is well worth looking at whether it would apply to prescription medicines.

Ms Halton—The reality is, Senator—as we have indicated, we have found this is very useful exercise—that we would be remiss if we did not say, 'What can we take from this particular audit, which focused on a particular area, and what are the lessons we can learn from this more broadly?' That is our intention. As I have indicated, the TGA rightly prides itself on being a world leader. We would like to stay in that position. We regard the work done by the ANAO as a useful contribution to exactly that, so we would be completely foolish if we did not say, 'How do we apply this in the prescription area? How do we apply this in terms of devices?' That is our intention.

Senator McLUCAS—Mr Slater, is there a document that describes the actions that the TGA is taking in response to the audit? There is the response of the department to the audit and the next steps that describe the two consultancies et cetera. Is there a document that the committee could have a look at that would give us an understanding of the variety of responses that the TGA is undertaking?

Mr Slater—As you would expect, we have done a lot of work on shaping our response to the recommendations and we have a number of pieces of paper that describe how we are approaching it. I would like to take on notice whether we can consolidate that and make it available to the committee.

Ms Halton—I am happy, Senator, to give you an overarching view of exactly what we are doing in this area. As we have indicated, a number of pieces of work are not yet completed, but in terms of the approach we are very happy to give you a statement on that.

Senator McLUCAS—And if you could add to that the time frame in which you expect these pieces of work to be completed.

Ms Halton—Yes.

Senator McLUCAS—And also if there are any costs associated with changed practices. Mr Slater, you talked about a new information system. Is that a new computer? What is it?

Mr Slater—This was a piece of work we were working on well before the ANAO audit. We commenced this in October 2002. That piece of work has been implemented as of October 2004. We are now loading up the data and making certain that the system is robust. If you like, the capital expenditure on that has already been—

Senator McLUCAS—That was in train?

Ms Halton—Yes. It was an investment in place.

Senator McLUCAS—And recognised by the ANAO as being appropriate?

Mr Slater—Yes. They have recognised that that is a very important piece of work that will address a large number of their concerns about the information reliability that we use for our audit scheduling and for our performance management.

Senator McLUCAS—I might leave the audit at that. We look forward to seeing that documentation. Also, I would like talk to you, Mr Slater, about adverse reaction reporting. Mr Slater, can you advise the committee, when was reporting adverse reactions by the TGA web site and the 1800 telephone number introduced?

Dr McEwen—I cannot give you the dates off the top of my head. They are approximately two years ago, but we can get you the exact dates and give you them on notice.

Senator McLUCAS—That is great. What was the background to the introduction of these alternative or different methods of reporting?

Dr McEwen—For both of those, internationally everyone is looking for ways in which to augment the reporting of adverse reactions, particularly from health care professionals. Traditionally, that has been done by supplying doctors and dentists and pharmacists with reply-paid report cards that come through the mail. So, moving with new technology, we have put a report card on the web site. We have also created the 1800 number. The other step that is in progress is to get a reporting facility built into the common software programs that are used, particularly by general practitioners in their medical records so that if they enter that a patient has had an adverse reaction to a medicine it will create the opportunity for them to send in a report about that. It is hoped that that will be operational with two of the major software manufacturers within this year.

Senator McLUCAS—So you just have to write the words ‘adverse reaction’ or something like that and it will pop up?

Dr McEwen—Yes. There is a series of terms, and I do not have the technology in my head, but it would be common for a doctor writing a medical record to enter ‘drug reaction’ or ‘allergic reaction’ and less common to formally say ‘adverse reaction’, but it is designed to be triggered by those things.

Senator McLUCAS—Can you tell me, Dr McEwen, since the instigation of the web site and the 1800 number has there been any change in the level of reporting?

Dr McEwen—They have not made big contributions to date, and I would need to get the exact numbers for you, but it is fair to say that they have been slow to take off and they have not been big contributions.

Senator McLUCAS—I understand in 2002-03 there were approximately 12,000 adverse reaction reports. Is the number static? What has happened over the last couple of years?

Dr McEwen—The number is more or less static. A small number of years ago we revised what we required to be sent in by pharmaceutical manufacturers. We were getting lots of reports of minor and already documented or expected adverse reactions, and we told the pharmaceutical industry in Australia that we did not need them to report them, so there was a bit of a dip. Since then it has been relatively constant at about those numbers over the last few years. We can get those figures for you and give you them on notice very easily.

Senator McLUCAS—That would be useful, thank you. The other thing I would be interested in, Dr McEwen, is the separation: how many are received by the traditional reply-paid document, how many are through the phone number and how many are from the web site?

Dr McEwen—We can give you those breakdowns.

Senator McLUCAS—Great.

Mr Slater—Senator, I think it is worth saying about our adverse drug reaction system that Australia and probably New Zealand are regarded as having the best level of reporting in the world. That is not to say we are standing still, as Dr McEwen said, in terms of the initiatives we are taking to promote even greater reporting, but without doubt we are the envy of the world when it comes to getting practitioners involved in adverse reporting.

Ms Halton—It is not just the reporting; it is the actual telling people about what has been reported, Senator, which I think is important.

Senator McLUCAS—I am getting to that.

Ms Halton—Have you got the bulletin?

Senator McLUCAS—No, I will get to that point.

Ms Halton—I get the bulletin and then I have to ring someone and say, 'What does this one mean?'

Senator McLUCAS—No, I do not get the bulletin. And New Zealand has a fairly similar regime to ours?

Mr Slater—New Zealand's is a different model but the level of reporting is comparable and we are, together, seen as leading the world in terms of reporting levels.

Senator McLUCAS—So the web site and the 1800 number have essentially replaced the more traditional types of reporting; they have not provided greater opportunity for the community to report adverse events?

Dr McEwen—They have not had a big impact to date. We hope that in time we will see a greater proportion and that it will add to the total number per annum.

Senator McLUCAS—Thank you. What do we do then when an adverse reaction report is made, and I dare say most of them are by medical personnel—what does the TGA do?

Dr McEwen—They come to the adverse reactions unit within the TGA. The staff includes some medical practitioners and some science-qualified people, including a pharmacist. They are reviewed—each report is reviewed individually within three working days. That includes the serious reports. The reports of serious reactions and a number of other pre-specified ones are reviewed by one of our medical practitioners who work there, and they make an initial assessment and give an initial coding. They help categorise where that report fits in and they make decisions about whether we should follow it up and get further information, and then it is entered into a database. So we have a group of people who are doing coding of those entries into a database. There are two performance criteria. One is the that the report must be reviewed within three working days, and then the second is that it must be in the computer within two weeks so that if we look in the computer it is an up-to-date record.

A subset of those reports—it is roughly a quarter to a third of them that revolve around serious reactions—are reproduced and divided up so that they are sent in advance to members of the Adverse Drug Reactions Advisory Committee, which is a committee of experts, non-government people, and they review their subset of those before the meeting, so they do some homework. That committee meet eight times a year and, as part of their meeting, they comment on what they have seen in those individual reports that might be unusual or of importance. They also oversee the preparation or the publication of the bulletin that has been referred to. As well, they devote some of their time to looking at things like published literature, because there will be some things published that arise from formal studies that do not get picked up in our own reports.

Senator McLUCAS—Do you go back to the person who provided the adverse reaction information? Do you go back to the doctor or the GP who said, 'This is what has happened to one of my patients'?

Dr McEwen—With a relatively small proportion of them, particularly serious reports and serious unusual reports, we would try and get as good documentation as possible. So we might go back to the doctor or to the pharmacist who sent the report and say, for example, 'May we have the serial liver function tests?' so that we know when this person was known to be normal and became sick, and then we can follow the recovery after the drug was stopped. We have done that sort of routine for many years, and that gives us a well-documented case series in those areas in which we are interested.

Senator McLUCAS—It has been put to me that if there were a more routine feedback loop—a response back to the person who has provided the information—it would reinforce the role of the TGA in accepting that information and therefore implicitly encourage further adverse reaction reporting.

Dr McEwen—I agree absolutely. We have gone through a redevelopment of the computer system which is not finished, and as part of that we have in mind to generate more informative feedback to the individual doctors and pharmacists so that they get a report which includes an up-to-date printout from the computer as to what has been reported. It is one of several mechanisms. The bulletin is obviously another one. Another is online access to the

summary of what has been reported in Australia for a particular drug, and we are working to get all of those into place.

Senator McLUCAS—What is the split between the types of people who do report adverse reactions; are they mainly GPs?

Dr McEwen—Yes, I can get those figures for you. I am working from the top of my head: there are roughly a quarter from the industry, about a third from general practitioners, then the others come from hospitals—principally hospital pharmacists but some specialists—then smaller numbers from pharmacists and a very small number, say, from dentists, and a small number from consumers, a relatively small proportion. We have those figures and we can provide them to you year by year for recent years.

Senator McLUCAS—That would be great. The number of consumers who would know to ring up the TGA would, I imagine, be fairly small. Can you give the committee an understanding of the nature of the adverse reaction reports that consumers would directly make to the TGA?

Dr McEwen—They can cover almost everything in medicine. Consumers might ring up and say that they have had a very severe hepatitis to a conventional antibiotic, one that we happen to know causes hepatitis. In other instances they might ring and have rather diffuse symptoms with a complementary medicine. So it really does cover the whole array. There is a history not of not wanting to take reports of consumers, but, particularly if one has reports on the telephone, it is very demanding of resources. The same issue is being tackled in other countries as well to give someone a feeling that their report has been taken seriously and has been adequately investigated. It is time consuming. So we have not ever refused, I think—certainly not in the last 15 years—to take reports from consumers but we have not gone out and sought them.

It is important to add that with some funding from the Council on Safety and Quality in Health Care in the last couple of years an Adverse Medicine Events Line with a 1800 number has been established in Brisbane. That operates out of the Mater Hospital. It is staffed by some pharmacists, and we have an arrangement with them. Clearly, what gets reported to them is not all just adverse reactions. They have other issues raised. But of the adverse reactions they send reports on to us and they are incorporated into our database. So we have a strong working relationship with them and we are represented on their advisory group at the moment.

Senator McLUCAS—In terms of consumers who report adverse reactions, do you try to complete that feedback loop with them a bit more?

Dr McEwen—At the moment I think the answer is no. We give them the same acknowledgments as others would get. Clearly, that is an area that ideally we could do better in. We perhaps need to do more work on that in order to establish what would be the best way of feedback.

Mr Slater—It does cross the line, though, of course, with the doctor-patient relationship, Senator, so we would need to be very mindful of making certain that in the end we do point consumer adverse reactions appropriately to their medical practitioner.

Senator McLUCAS—Are you suggesting, Mr Slater, that a consumer might ring and essentially seek medical advice from the TGA?

Mr Slater—I could not confirm that they are seeking a second opinion but, equally, they might ring without having medical advice about what could be a serious adverse event. We would want them to make certain that they got appropriate professional advice. It is important in any feedback loops that we do not replace that doctor-patient relationship. So it is one of the considerations to take into account in closing the loop, as you were proposing.

Senator McLUCAS—I suppose it goes to the level of information you provide back to the consumers.

Mr Slater—Yes.

Senator McLUCAS—All right. We look forward to receiving that information in the future. Thank you. I have a left-field question for you, Mr Slater. I have very little information about this potential, but I thought it might be worth while asking you the question so hopefully we can clarify the matter. I have been advised that there is a food code called Codex Alimentarius. Can you tell me about this?

Ms Halton—This is not a TGA issue. This is a FSANZ issue. It is also a food policy issue. So it depends on what area your question is centred.

Senator McLUCAS—The reason I went to the TGA is that the suggestion in the information has been provided to me that the adoption of Codex Alimentarius will affect greatly the cost of over-the-counter medicine—herbs, vitamins and the like.

Mr Slater—I cannot imagine how that would be the case.

Ms Halton—We need to be clear here, Senator, that Codex Alimentarius actually goes to issues which are regarded as foods. The TGA deals with matters from prescription medicines right through to complementary medicines, but unless I am badly mistaken, the line is exactly where we hit Codex Alimentarius. So FSANZ and my food people from the population health area deal with all of those issues, but this is not a TGA issue. That is where we draw the line.

Senator McLUCAS—Can I put an allegation to you that is made here in this?

Ms Halton—Please.

Senator McLUCAS—It says that Codex now applies to Norway and Germany, amongst others, where zinc tablets rose from $4 a bottle to $52 a bottle; echinacea rose from $14 to $153. They are now described as drugs, and the person who sent this to me is alleging that this is as a result of Codex Alimentarius.

Ms Halton—No, that would not be the case. The reality is, Senator, anything which makes a therapeutic claim in relation to the product we would treat under the TGA in relation to complementary medicines. Anything which is a food we would deal with, and a lot of our arrangements—I cannot go over them chapter and verse. My colleague Graham Peachey from FSANZ could probably talk in more detail about this, but we are very consistent with Codex Alimentarius and in fact we are regular and quite vigorous participants in that forum. Our colleagues from AFFA are also party to this arrangement.

I cannot comment about specifics in relation to those particular countries. But we already have a varying—we just talked about the ARO in relation to complementary medicines and anything that makes a claim in relation to a therapeutic area we would deal with in that way. As you would well understand, we have a different approach in terms of how we regulate complementary medicines as against pharmaceutical products and that is for a very good reason in terms of relative risk, but anything that makes a therapeutic claim, we would treat under the TGA. But Codex is not part of that process.

Senator McLUCAS—Have you heard this sort of allegation before?

Ms Halton—No, I have to tell you I have never heard it. If you have got something, I would be delighted to have a look at it only to give you informal advice or formal, but this is not something that we are aware of.

Senator McLUCAS—What would be very useful I believe—

Mr Slater—No, there would be differences—

Ms Halton—Sorry, we understand what the difference is in terms of treatment, but what has happened in those particular countries, no-one has brought this to my attention.

Mr Slater—To an extent, Australia's regulation of complementary medicines along with Canada and some European countries is leading the world because we treat these as low-risk products so long as the ingredients are selected from a known list that we have tested for safety and the quality standards are met. In some European countries, anything that wants to make a claim is treated as the same as a pharmaceutical—

Ms Halton—A medicine.

Mr Slater—and needs to go through a very strict regime of providing evidence. That could be one of the reasons why in particular countries they face considerably more expense than Australia.

Ms Halton—We are not in a position to comment about those two particular cases. We just do not have the detail, but the reality is in this country we already have an approach to the regulation of complementary medicines which is world leading. I am very confident when I go to international fora when I talk about our approach being quite balanced in terms of our regulation right across that spectrum, which can go right from pharmaceuticals through to foods and the claims we allow people to make and how we regulate in respect of the product and the claim they want to make and how we regulate GMP—good manufacturing practice—in respect of those products.

Senator McLUCAS—It might be useful if you could direct me to an easy to read, understandable facts sheet on Codex.

Ms Halton—We would be happy to give you something.

Senator McLUCAS—Mr Peachey, did you have words of wisdom for us? I do not want to waste the time of the committee on this.

Mr Peachey—No. It probably would be better to get you the facts sheet that the secretary was talking. There is quite a history to it, as I understand, but the facts sheet will explain it.

Ms Halton—Yes, we would be happy to give you something.

Senator McLUCAS—That would be great. Thank you. That is all that I had for TGA. I now want to ask some questions around FSANZ. Can you give me an update on the development of the trans-Tasman food standard, if you would—proposal P293. Does that mean something to you?

Mr Peachey—That is the standard on health claims. We have gone out for a round of public consultation on that. We have received a number of comments on our initial assessment report, which basically sets out questions around a health claim standard. We are looking at those questions now and coming to a view that we will go to our board on shortly.

Senator McLUCAS—And what was your consultation process?

Mr Peachey—We are bound to consult very widely. The legislation sets down two rounds of public consultation. In doing so, we notify all of those with an interest in the matter. We have that very extensive mailing list. We publish things regularly in our FSANZ newsletter. In this case, given the interest around health claims, we actually convene working groups around the country both here and in New Zealand and there is quite a good roll-up. I think that we had about half a dozen—but I can be corrected on that. The roll-up generally is about 80 or so people at each. Each case is more or less a bit of an information exchange, a bit of a discussion around health claims and an opportunity to raise awareness about health claims generally.

Senator McLUCAS—The sectors with an interest, obviously, to consumers is that essentially represented through the Australian Consumers' Association.

Mr Peachey—Not only. We have worked hard to try to reach the grassroots in consumer interest generally. ACA is quite active, as you would expect, but what we are trying to do is just to broaden our reach beyond the ACA itself.

Senator McLUCAS—How to you do that?

Mr Peachey—Partly through what I mentioned earlier—to try to publicise what we are doing. We do go through national newspapers and publications, through our own newsletters and through seminars and opportunities like that that I mentioned before. It is a difficult issue to get to the grassroots, but certainly that is our aim. We have people on our board with particular consumer interest and they become advocates for us and assist us with getting to those far corners, if you like.

Senator McLUCAS—What other stakeholder groups are actively involved in the development of this standard?

Mr Peachey—I guess with food matters generally, it touches all of us. So there is a bit of an interest across the board.

Senator McLUCAS—The producers?

Mr Peachey—Producers have an interest.

Ms Halton—The Australian Food and Grocery Council, for example.

Mr Peachey—Yes, there is obviously an incentive there for industry to be aware and up to date on what is going on. There are people at the food and drug interface. We have to make

sure that there is a clear divide between treat, manage, cure, which falls under medicines and health claims.

Ms Halton—Yes, that conversation that we just had.

Mr Peachey—And I could go on the list. I think that there is a general interest across the community about health claims. I guess that is the short story.

Senator McLUCAS—A2 Milk might fall in there.

Ms Halton—Yes.

Mr Peachey—It does. Putting A2 Milk aside for a moment, by any manufacturer that makes a claim, the standard will come to a point where there are some very clear requirements in terms of evidence and evidentiary requirements per claim. In the future, it would divest things like the A2 Milk issue that you are referring to. There would be a clear understanding what was necessary before a claim could be made.

Ms Halton—And as we have just discussed, if people want to make claims that go further, there is a point at which they actually fall over that line into therapeutic—

Senator McLUCAS—Therapeutic.

Ms Halton—Yes, absolutely.

Senator McLUCAS—So the second round of consultation is completed. What happens next, Mr Peachey?

Mr Peachey—We have done one round.

Senator McLUCAS—Sorry, I misunderstood you.

Mr Peachey—We will go to the board with our conclusions and comments on the first round. In each case, we, as we generally do, comment on each submitter. We will then go back for a second round and in that second round of consultation we will be looking at firming up a position in terms of what the draft standard might look like. Again, it is an opportunity for public discussion and we would certainly be encouraging that through that second round.

Senator McLUCAS—And the second round model is quite similar to the model that you have adopted for the first round of consultation?

Mr Peachey—In terms of consultation, it would be, yes.

Senator McLUCAS—And how many submissions have you received to date on the standard?

Mr Peachey—We have received 147 submissions, as I understand it.

Senator McLUCAS—And a break-up of the nature of those submissions? How many would be from consumers, how many from industry?

Mr Peachey—I would be taking a punt at the moment. I could provide that detail for you—

Senator McLUCAS—A punt would be sufficient.

Ms Fisher—Most of the submissions came from industry and public health groups and consumer representatives. We did get some, but not many, from individual consumers. We can provide you with the actual numbers.

Senator McLUCAS—That would be good. Thank you. And the time frame, Mr Peachey? Your report to your board is pending and quite close. How long from there to the adoption of the standard, if in fact we do?

Mr Peachey—I hope it will get to the board meeting around midyear. Our timetable, all going well, would be to get the health claim standard up in early 2006.

Senator McLUCAS—Thank you. Those are all my questions on FSANZ. Dr Loy, we are looking at the requirements for the approval of the new reactor at Lucas Heights, which I understand is now called the OPAL reactor. Is that correct? It has been a little while since I have been associated with this issue.

Dr Loy—Dr Nelson launched the name for what we have gotten used to calling the replacement research reactor—calling it the OPAL—about a month ago, I think.

Senator McLUCAS—So I am not that far out of the loop. One of those requirements, as I understand, Dr Loy, was that you had to be satisfied that the issues of waste were managed, were planned for and were achievable. I am sure you can say that in much better language than I can. What was that requirement?

Dr Loy—Certainly as part of the assessment of any application I need to take into account the radioactive waste management plan for the particular activity and to be satisfied that that is an effective plan. The particular issues, I guess, surrounding the reactor are the disposition of the spent fuel. That particular form of waste, I guess, is the flagship issue in terms of radioactive waste management and the OPAL reactor.

The arrangements that were put forward at the time ANSTO applied for a construction licence included that the spent fuel would be reprocessed or otherwise processed and conditioned in either France or Argentina and waste product returned to Australia. Clearly, the issue of what would happen to that waste product when it returned to Australia was important and relevant. The subsequent developments since ANSTO has applied for an operating licence have been that the United States Department of Energy has extended a program that goes by the title of Foreign Research Reactor Spent Nuclear Fuel Acceptance Program. That basically says, 'If the fuel you are using in your research reactor uses uranium that was enriched in the United States we the United States will take that fuel back and we will look after its disposal.' That program was set up some time ago particularly with an antinuclear weapons proliferation objective to make sure that high enriched uranium was taken out of circulation, if you will.

The Americans have decided to extend the time that that program will apply and have also decided that it will apply to the replacement research reactor, or OPAL, and the time of extension is 10 years. So ANSTO now have put forward in their submission that their prime method of disposal of spent fuel, at least for that initial 10 years, will be the return to the United States.

Senator McLUCAS—Do you think that satisfies your requirements as the regulator?

Dr Loy—I do not know the answer to that question. I have not decided that. That will be a matter about which many public submissions will be put to me no doubt. It is a matter that my Nuclear Safety Committee will give me advice on. Obviously ANSTO will make its arguments. Nonetheless, it seems to me clear that it is a significant development and one that obviously needs to be taken seriously in consideration.

Senator McLUCAS—You would have to put your mind to what might happen after that 10-year period, though?

Dr Loy—Indeed. That is correct. Certainly ANSTO is then relying upon the contracts it has and the arrangements it has with the French company COGEMA to reprocess fuel in France and return a waste product to Australia. The fallback option from that is then processing in Argentina.

Senator McLUCAS—Do you see the contract, Dr Loy?

Dr Loy—Contract for what, Senator?

Senator McLUCAS—I imagine there must be a contract between ANSTO and the US Department of Energy.

Dr Loy—I am not sure that there is. Perhaps I can respond to that on notice. I think there is a declaration by the Department of Energy that they will do this. This is their program. Obviously detailed arrangements need to be made, but whether that is in the form of a contract or some memorandum of understanding I am not sure. Quite what the specific arrangement is I am not sure, but I will respond to you on notice on that.

Senator McLUCAS—Thank you. I do not know how many years the new reactor is projected to be in commission. Do you know that?

Dr Loy—I do not think it has a defined life.

Senator McLUCAS—I remember that the first reactor was meant to have stopped working some time ago.

Dr Loy—It has been in operation for over 40 years.

Senator McLUCAS—For longer than it was intended to.

Dr Loy—As far as ARPANSA is concerned, clearly we would want to have, over time, confidence in maintenance arrangements and periodic major shutdowns in which the reactor was inspected. And probably from time to time my successors would undertake a major safety review of it, say at a period of every 10 years or so, and provided it passed those checks, if you will, as far as we were concerned it could operate.

Senator McLUCAS—I might leave it there on the issue of waste disposal at Lucas Heights. Senator Crossin has other matters she wants to deal with.

Senator CROSSIN—I want to ask you some questions about site 40a in Woomera in South Australia and the issue about the preferred site for the repository. Can you tell me the cost of assessing the DEST licensing application for that site?

Dr Loy—Not precisely. I would have to take that on notice. My recollection is that the application fee was $400,000. I am sure we have spent that.

Senator CROSSIN—So you are saying it could be in excess of that?

Dr Loy—It would be of the order of that, plus or minus a small amount.

Senator CROSSIN—Can you take it on notice to provide us with the exact amount?

Dr Loy—Yes, of course.

Senator CROSSIN—When an application is made for a licence, such as the one that was made by DEST in August, I think, of 2003, how is the application fee received subsequently allocated to resources by ARPANSA? What is the process?

Dr Loy—Overall, the structure of our application fees is that they are set by regulation. So a fee is set for an application for a facility such as a low-level waste repository of that size and shape, and we have set that fee on an estimation of the costs of the assessment that we would have to undertake. That is based upon our experience of a major assessment of, say, the construction licence for the replacement reactor. It is not a particularly precise process, but we have to set a fee and we have to do some estimation about what our assessment will cost. We did that and arrived at the application fee.

Senator CROSSIN—So, if we were looking at perhaps an application fee for a repository for an intermediate level waste, the fee could well be higher?

Dr Loy—Not necessarily insofar as some of the issues for an intermediate level waste store, which is what is talked about, are in some ways more straightforward than a repository—since in a repository you are looking at disposal of the waste; it will not ever come back to it. In a store you are looking after the waste for a period of time. So some of the issues are simpler; some of them are more complicated. The public obviously would be very much involved, so there would need to be significant public processes. I think that would add up to roughly the same sort of requirement.

Senator CROSSIN—Can you tell me what cost ARPANSA incurred for the forum held in Adelaide on 25 and 26 February last year?

Dr Loy—The costs included the organisation of the forum, the hiring of the venue and the travel of people to the venue—all those sorts of normal costs.

Senator CROSSIN—Do you have amounts there?

Dr Loy—Not with me, but again we could respond to that on notice.

Senator CROSSIN—If you could take that on notice. I particularly wanted to know the expenses for the provision of the services by the members of the panel, Professor Lowe and Mr Jack.

Dr Loy—Yes. I engaged those two gentlemen to assist by being members of the panel, and we negotiated with them and arrived at arrangements that they found satisfactory. If you want precise details of what they were paid—

Senator CROSSIN—Can you take that on notice, because we would like that.

Dr Loy—Yes.

Senator CROSSIN—Can you tell me how many external reports were commissioned by ARPANSA during the course of the process to consider the DEST application?

Dr Loy—In terms of external reports, the major one that springs to mind is the report by the International Peer Review Team organised through the International Atomic Energy Agency. That involved a number of people travelling to Australia, undertaking an assessment of the application and providing a report.

Senator CROSSIN—Was that report made publicly available?

Dr Loy—Yes.

Senator CROSSIN—Could it be provided to this committee?

Dr Loy—I am sure it has been. It is a public document. In fact, it is on our web site.

Senator CROSSIN—That will be fine. I can get it there. What other external reports were commissioned?

Dr Loy—None other spring to mind at the moment. I would need to check my memory with the file to be sure of that, but at that point we had not, I do not believe, commissioned other external advice.

Senator CROSSIN—Can you take that on notice, please?

Dr Loy—Yes. In perhaps a slightly different context, I sought advice from the Nuclear Safety Committee and the Radiation Health Committee—both are committees established under the ARPANS Act—on particular aspects of the application. Again that was provided and again it is publicly available.

Senator CROSSIN—They are both on the web site, are they?

Dr Loy—Yes.

Senator CROSSIN—Who is responsible for bearing the costs of reports produced during the DEST application? Is that part of the $400,000 fee?

Dr Loy—They are part of ARPANSA's assessment process and we bear the costs.

Senator CROSSIN—That would have been part of the $400,000 you had billed to DEST; is that correct?

Dr Loy—That is correct.

Senator CROSSIN—That would include the international peer review report you just mentioned?

Dr Loy—Yes.

Senator CROSSIN—When was ARPANSA informed of the decision to rule out site 40a as the location for the repository?

Dr Loy—On 14 July 2004.

Senator CROSSIN—The same day it was announced; is that correct?

Dr Loy—Yes.

Senator CROSSIN—Can you tell me how many staff were permanently allocated to the application assessment process?

Dr Loy—Staff were not permanently allocated to the assessment process. We have a cadre of staff who perform regulatory functions and assessment processes and other staff who were diverted from other activities into that assessment. So those staff went back to doing other things.

Senator CROSSIN—Did you need to increase staffing levels during that time?

Dr Loy—No, we did not increase staffing levels.

Senator CROSSIN—You just took people off certain tasks?

Dr Loy—Yes. We were aware this application was coming in, so in planning our workload we accounted for it.

Senator CROSSIN—How many staff would have been involved in the application process?

Dr Loy—Some staff would have been working on a part-time basis and would have done tasks from time to time. In terms of full-time staff, it might be only two or three people. I can probably give you a better answer if I take that on notice.

Senator CROSSIN—Okay. How many staff does ARPANSA have?

Dr Loy—In total, around 120.

Senator CROSSIN—So having two or three people working on this full time would have been a small proportion of your staff; is that correct?

Dr Loy—Yes, that is correct.

Senator CROSSIN—Would the need to spend some time dealing with this licensing application have had an effect on your normal operations, or was it considered just part of another task ARPANSA was asked to do?

Dr Loy—Like any organisation we plan to deal with the workload. Clearly, if we are not dealing with an application for a national waste repository, we would be doing something else. So the priorities would have to be changed, reshuffled and reordered, and that was done. But that is what people would expect us to do.

Senator CROSSIN—Were external consultants engaged during this time to assist with this process?

Dr Loy—The external consultants, I suppose, would have constituted the people from the international peer review, and Mr Jack and Professor Lowe were engaged formally as consultants for their role in the public forum, but we had not engaged any other consultants—

Senator CROSSIN—To assist with the day-to-day handling of the application; is that right?

Dr Loy—No. People receive applications for other conduct, so it is not something in and of itself that is unusual for us. Obviously this was a focus of activity and a very high priority, but it was done within an overall workload that included continuing work on the replacement reactor and on all the other things we regulate.

Senator HUMPHRIES—Dr Loy, I want to ask about the public education program ARPANSA runs from the money it receives from the government from the levy on

radiocommunications licences each year. How much is that contribution each year towards the public education program?

Dr Loy—I will have to check my memory. I think it is of the order of $400,000. I will need to confirm that on notice.

Senator HUMPHRIES—I understand it is more in the order of $300,000. Let us assume it is $300,000 for the moment. Can you tell me anything about the public education program ARPANSA actually conducts with that money?

Dr Loy—There is a range of activities, partly responsive and partly pre-emptive, if you like. We have certainly developed a substantial amount of explanatory and descriptive material about radio frequency radiation. That is available in pamphlet form and on our web site. From time to time we also take part, when we are invited to by participants in usually a controversial siting of a base station, in public meetings and explain our understanding of the issue about health effects of RF radiation. We have joined with the Australian Communications Authority in putting out some information, including a DVD. At the very basic level, our staff spend quite a substantial amount of time talking to people on the telephone. It is actually quite a demanding task when people do have concerns and are upset about possible effects of mobile phone radiation. We have provided the tool whereby the carriers calculate the emission levels of base stations and make those available as part of the community consultations. There are probably other things, but that is what springs to mind at the moment.

Senator HUMPHRIES—That amount has been made available for a number of years from the same levy—in fact since 1996-97, I understand. Is it possible to get a breakdown of what ARPANSA is doing with that money by way of public education and other activities of the kind you have described?

Dr Loy—Yes, I would be glad to do that.

Senator HUMPHRIES—Thank you. You mentioned pamphlets and the web site. Do you know how many pamphlets have been produced by ARPANSA?

Dr Loy—The major distribution is via the web site. In fact, it is one of the more used parts of our web site. From memory, there are something like 10 or 11 fact sheets dealing with different aspects of the mobile phone and base station issues.

Senator HUMPHRIES—They are on your web site?

Dr Loy—Yes.

Senator HUMPHRIES—And the pamphlets are produced in-house. How are they distributed? To whom do you distribute them?

Dr Loy—It is really a matter of someone asking for information. If they would prefer to have it in a written form, then we would send it out. I think probably the Australian Communications Authority takes a lead, but we work with them in preparing more, if you like, glossy public material. They have produced posters and other print material of that kind. Again, we work with them in doing that.

Senator HUMPHRIES—Would you have any idea of how many such pamphlets you mail out each year?

Dr Loy—Not off the top of my head, no. I will have to take that on notice.

Senator HUMPHRIES—You say that you are sometimes invited to forums where issues of mobile phones or mobile phone towers are raised. Do you only interact with those sorts of issues when you are invited to do so?

Dr Loy—Yes. I think that is the case, largely because we have a finite resource and the number of potential meetings we could attend is infinite. We try and limit it, so it is when there is an invitation and when it is clearly the case that we are able to present an objective view rather than being seen as being on one side or the other of the issue.

Senator HUMPHRIES—Forgive me for saying this, but I would have thought that with $300,000 a year over eight years—that is about $2.4 million in the last eight years—maintaining a web site and producing 10 or 11 pamphlets to make available when someone asks for them, not to send out proactively, is not really pushing ARPANSA to the limit of that expenditure. I take it that you can account for how that money is being spent at the moment and demonstrate that it is actually making a difference in the public perception of what is happening with mobile phone towers?

Dr Loy—Yes. This information does not write itself. It does require staff time to actually produce this information, to attend the meetings and to prepare the material that is used by the carriers. I guess the other part of our activity that I did fail to mention and that occurs to me is the undertaking of programs of measurements of base station emissions. We have done one program of that of base stations throughout Australia—in 1999 or 2000—and we have just completed another one of actual base station measurements.

Senator HUMPHRIES—Is that really within the purview of funding made available for public education, though?

Dr Loy—I think it is central because, in my view, one of the most important things for people to know is the extraordinarily low levels of emissions around base stations. The way they can know that in real life is by somebody actually going and measuring them, not just making up a number or doing a piece of theory.

Senator HUMPHRIES—You mentioned the ACA working with you on a campaign, which I think happened last year. Do you know how much money ARPANSA put into that campaign?

Dr Loy—No. I will have to take that on notice.

Senator HUMPHRIES—If you would not mind, please. Have you done an evaluation of the effectiveness of your public education campaigns to date?

Dr Loy—No.

Senator HUMPHRIES—Any plans to do that?

Dr Loy—I think that would have to be a matter that is wider than ARPANSA because the issue is wider than us. It is certainly something that is worth us thinking about.

Senator HUMPHRIES—Do you think there is a general awareness in the community about ARPANSA's role? If someone suddenly had a mobile phone tower going up in their neighbourhood, do you think many people would know that ARPANSA was the organisation to turn to for advice or information?

Dr Loy—A fair number of people seem to know, yes. Most of the interest groups that take a view on these issues are aware of our role. There is a reference group of interested organisations that talk to us. I would not necessarily think we are on the top of everyone's head in these issues, but I think we are relatively well known.

Senator HUMPHRIES—Do you do any mail-outs or outreaching programs to local councils, who are most usually caught up in these mobile phone controversies?

Dr Loy—We do not go out and actively do that unless we are asked to do so. One of the issues for us is to be objective and clear that we are providing advice about the knowledge of the science of any health effects of RF radiation. We are not there to advocate the use or otherwise of mobile phones or the location of this or that base station.

Ms Halton—If I can make a generic point about the regulators and the portfolio, because I think this is an issue that does not just apply in ARPANSA's case but to the TGA, to FSANZ—and I could go on: it is not necessarily the role of each of these organisations to go out and create a major profile. I think they need to be accessible, and I think for those who are interested they have to be able to be identified quite readily, but in terms of a major promotion exercise around their work I think there is a line there.

Senator HUMPHRIES—I just would have thought for $2.5 million we would actually see the organisation going out to educate people rather than waiting for people to come to them and ask them, 'What can you tell me about mobile phone towers or mobile phones?'

Ms Halton—To be fair, that is over quite a long period. The reality is—and it is a regrettable fact—$300,000 or $400,000, depending on which is the correct figure, and obviously that is going to be clarified, is a modest amount of money for public education. It is, I think, adequate for the work that needs to be done, but the creation of a profile is not the makings of a major media campaign. I will grant you that ARPANSA as an acronym is not the most catchy label, so it does not lend itself to immediate accessibility, but it is not the foundation of a household name. It is the foundation for the provision of information to people who are interested. I think that, as Dr Loy has been outlining, is a responsible approach that is taken in ensuring that people who are interested are provided with information and indeed, as he has indicated, that an officer goes where there is a particular interest in hearing their advice.

Senator HUMPHRIES—All I can say is that I look forward to the evaluation—if you consider doing it and you eventually do it—and seeing what that produces.

Senator BARNETT—I just want to get an update from the department in regard to the tobacco company's use of 'light' and 'mild' descriptors on their cigarette packets.

Ms Halton—You would know, of course, that this is an issue that the ACCC has taken a particular interest in. We cannot comment in detail about their action, but obviously we are familiar with it.

Senator BARNETT—Can you provide us with any further feedback on that? I am aware of the view of the ACCC that it is misleading and deceptive, but I am not aware of any agreement or consent by the tobacco companies to respond to and to fix the problem.

Ms Halton—I think this is best described as a work in progress. That is our understanding. We would be optimistic that something would occur in the near future, but this is a matter for the ACCC.

Senator BARNETT—It is a matter for the ACCC to act and to prosecute as appropriate if it is in contravention of the act. But have you had any discussions with tobacco companies or are you aware of any discussions where they have voluntarily said, 'Yes, we will remove these illegal descriptors from these cigarette packets'?

Ms Hefford—It is not an issue that we have actually been discussing with the tobacco industry, because almost three years ago there was a Senate reference which referred this matter to the ACCC. The ACCC have had carriage of the matter since then. I am not aware of the tobacco industry at any time agreeing that the descriptors 'light' and 'mild' were, as you describe them, illegal. I know they are in negotiations with the ACCC about the ACCC investigation of the matter. I am not aware of any outcome as a result of that investigation.

Senator BARNETT—Mr Samuel made it clear in the public arena—I think it was yesterday—and put it on the public record that it was in contravention of the Trade Practices Act 1974. So, in light of that, has any further information come forward to your knowledge that the tobacco companies are going to consent and remove the descriptors?

Ms Hefford—I would be surprised if the decision was that clear-cut. My understanding is that the ACCC conduct an investigation if they believe an industry or a manufacturer has a case to answer. They have two choices before them: one is to take the matter to court and have it proven in a court of law; the other is to try to reach a settlement out of court. I do not know that the outcome in this case is resolved. I think that it could go either way. Those negotiations are under way. I certainly would not want to say anything that might prejudice the matter.

Senator BARNETT—I appreciate your response, and it is difficult to respond in light of the announcement yesterday, or the views of Mr Samuel yesterday, and in light of a lack of response from the tobacco companies. So it is not a reflection on you, but obviously it will have to be taken up in other areas.

Ms Halton—Obviously, from a health perspective, we would hope that those labels come off those packages.

Senator BARNETT—That sounds like a very fair response—an entirely appropriate one.

Senator McLUCAS—I would like to get an update on the PHOFA funding arrangement. You gave us a very good table at the last estimates that showed the offers to the states and territories for the renewed PHOFA. Are those figures still current?

Mr Stuart—No, they are not current. It is the table that we have here. That would be the table of the offer before the government increased the offer across the states by a total of $21 million over five years.

Ms Halton—We will get copies and we will table it tonight.

Senator McLUCAS—Thank you. That arrangement is under the broadbanded arrangements as well?

Mr Stuart—Yes, it is.

Senator McLUCAS—It is not tagged funding in any way.

Mr Stuart—No, it is not. It is broadbanded.

Senator McLUCAS—I understand that agreements have been reached with all of the states on PHOFA.

Mr Stuart—With seven of the eight. New South Wales is yet to sign and we hope that it will do so soon.

Senator McLUCAS—Is it appropriate for us to know why? I suppose that is part of the negotiations.

Mr Stuart—A significant additional offer has been made. New South Wales has been considering it. The set of indicators, which were the last remaining piece of work that needed to be settled, is now agreed and out of the way and a number of states have now signed those. So the decks are really clear as far as the PHOFAs are concerned and there is nothing in the way of New South Wales agreeing, should it wish to do so.

Senator McLUCAS—But was New South Wales given an increased allocation?

Mr Stuart—Yes, indeed. New South Wales, because they are a large state, received the largest share of the increase of $21 million. The amount was $13.3 million. The increase to the states that received an increase was sufficient to restore those states in real terms to the amount they would have got if the previous PHOFAs had been continued. So New South Wales was made a fair offer in line with that principle.

Senator McLUCAS—I do not know if you recall our conversation at the last estimates, but you gave us a table which explained quite clearly what was coming in and what was going out of PHOFA.

Mr Stuart—Yes.

Senator McLUCAS—So the $21 million brings the allocation, without immunisation and with Family Planning South Australia—those bits you had to tidy up—

Mr Stuart—Yes. Senator, it has not changed the architecture of the PHOFAs at all. In respect of what is included, or the broadbanding, the offer to include family planning, the removal of immunisation to a separate bilateral agreement; that all remains. It is simply an additional offer of broadbanded funding.

Senator McLUCAS—And then that brings the figure up to a CPI—it is not the right term, I am sure, but an indexed figure that duplicates what used to be paid under PHOFA.

Mr Stuart—Within those elements that remain in the PHOFA, yes.

Senator McLUCAS—In terms of the agreements, you seem to be saying that there was a funding agreement and then subsequently a performance indicator agreement, so it was in two parts, was it?

Mr Stuart—There was an initial indicator set included with the initial offer and subsequently a further set of performance indicators remained to be agreed, and they were finalised in the last couple of days before Christmas.

Senator McLUCAS—And are they publicised, Mr Stuart?

Mr Stuart—I believe they are on our web site.

Ms Balmanno—The agreements will be made public when they have all been signed. As these are currently an offer, which is a variation to the agreement and not all states and territories have accepted, they are not on the web site yet.

Senator McLUCAS—I understood Queensland and the Northern Territory were on the web site, or were public, anyway.

Mr Stuart—The agreements, yes.

Senator McLUCAS—Just the agreements?

Mr Stuart—Yes.

Senator McLUCAS—We are now six or seven months into the year that this—this is the first PHOFA year. Has that impacted on service delivery anywhere to your understanding?

Mr Stuart—States and territories were given an extended period of time under the previous PHOFA until the end of February this year to consider the offer and agree. So there has been no financial disadvantage on behalf of the Commonwealth in terms of any services being delivered.

Senator McLUCAS—Sorry, the states have carried the funding of services that are delivered through this program.

Mr Stuart—We have continued to fund the states in line with the previous PHOFA.

Senator McLUCAS—I understand.

Mr Stuart—And we did a limited period extension to the previous PHOFA.

Senator McLUCAS—And that will finish at the end of February.

Mr Stuart—That offer will finish at the end of February. Only New South Wales remains.

Senator McLUCAS—So did the PHOFA year begin last July or—when will it start?

Mr Stuart—The new PHOFA begins from the date on which the relevant state agreed.

Senator McLUCAS—Is signed?

Mr Stuart—Yes.

Senator McLUCAS—And then there is a pro rata separation of under the old agreement and under the new agreement

Mr Stuart—Yes, that is right.

Senator McLUCAS—We will see that come out in the wash come the budget, I am sure. Concerning the nature of the agreements, Mr Stuart, is the Commonwealth requiring that all elements of activities that were provided under the old eight programs are continued with, or

is that now totally the prerogative of the states to ascertain where they are going to put their effort?

Mr Stuart—Just before we go to that, in relation to your comment just now, at the top of page 49 of the PAEs, the additional funding offer of 21 million is the top line in that table on page 49. It adds up to 15.2 because it is a five-year arrangement and there is only four years in the forward estimates.

Senator McLUCAS—Okay.

Mr Stuart—But that is the first four years, is the 21.

Senator McLUCAS—Yes, I understand what you are saying.

Mr Stuart—All of the previous activity which was undertaken under the PHOFAs, with the exception of immunisation—which is now the subject of agreements which have all been concluded—obtain some kind of expression in the PHOFAs. Some are ongoing areas which are required and which have indicator sets around them, and others are things which are mentioned as part of broader programs for which the funds may continue to be used.

Senator McLUCAS—Are there any extra elements that have been required by the Commonwealth to be included?

Mr Stuart—For a number of states and territories, family planning. A couple of states and territories previously had family planning under the PHOFAs.

Senator McLUCAS—Yes.

Mr Stuart—For others, they have been offered family planning as part of the PHOFAs for this time.

Senator McLUCAS—South Australia and the ACT.

Mr Stuart—You are right, they were the ones that had family planning as part of the PHOFAs previously.

Senator McLUCAS—Yes.

Mr Stuart—So there was an anomaly there, and all states have now been offered family planning as part of the PHOFAs.

Senator McLUCAS—The money outside the PHOFA for family planning for other states was $13 million—that is on an annual basis. Has there been a commensurate increase to include those costs now in the PHOFA agreements?

Mr Stuart—Yes, there has, Senator, and, in fact, that is in the PAEs, too.

Senator McLUCAS—Right.

Mr Stuart—In the middle of page 48 you will see there is a half-year effect of $7.7 million, and then full-year effects of 13, rising to 14.5 over the subsequent three years.

Senator McLUCAS—Thank you. All right, good luck with New South Wales.

Mr Stuart—Thank you.

CHAIR—Does that just about do it for outcome 1?

Senator McLUCAS—No, one more. I understand that, Professor Horvath, you gave some advice to the minister, and as a result the minister asked ATAGI to review the most recent evidence about chicken pox and injectable polio. I cannot ask you about advice that you have given the minister, but can you give us an indication of the issues surrounding chicken pox vaccine and injectable polio?

Prof. Horvath—In March of 2004, whilst at the WHO, I had meetings with doctors Chris Maher and Bruce Aylward, who at that stage were—and I presume still are—the directors of the polio eradication program for WHO. When getting a briefing from them they expressed some concern at the imminent move to injectable IPV polio at that time because of the ongoing outbreaks of wild polio in Nigeria, Afghanistan, Pakistan and parts of India. They had concern re the United Kingdom where there was a fair amount of travel from that part of the world. The discussion was held around Australia because of our frequent travel between those parts of India, Afghanistan and Pakistan, and there was some concern that OPV gave better coverage for a whole lot of technical reasons if wild polio was, in fact, going to be imported.

Their suggestion and advice at that time to me was that we reconsider the situation later on in the year as there was a lot of work at that time trying to get immunisation programs back on line. In fact, Kofi Annan visited Nigeria at that time. You may be aware that there was a lot in the media at that time that certain religious groups were advising against polio immunisation because it caused sterility in men, so that was their suggestion.

At that stage in March last year there was some serious concern that polio might break out further rather than be eradicated. I then liaised with David Salisbury in the UK who is the director of polio eradication. He indicated that they were considering changing later in the year but, because a change around the entire immunisation program would take some time, they would reconsider it later in the year. I shared this knowledge with Professor Margaret Burgess, who is a member of ATAGI and most probably Australia's leading vaccination expert, and she undertook to have discussions with WHO later in the year when she visited. She in fact did so in June of last year. So that was the basis of my concerns around polio immunisation.

With regard to chicken pox, my concern was that at the time there was little data, which of course late in December was published in the *New England Medical Journal*. Around the issue of herd immunity, herd immunity when it comes to immunisation is very important, and that is mostly one of the great benefits. The data at that stage still did not allow us to make any judgments about herd immunity and chicken pox. There was some concern that adults may well be exposed to a much more serious infection in the unimmunised state. This was the basis of my concern.

Senator McLUCAS—Subsequently you said that Professor Burgess spoke with the WHO about injectable polio.

Prof. Horvath—She in fact had discussions with them, and in middle to late June she indicated that she had received further information. Her intention was to take it back to ATAGI for further consideration.

Senator McLUCAS—So that was in June?

Prof. Horvath—Yes.

Senator McLUCAS—Thank you very much, Professor. I might talk to you more about the herd immunity question around chicken pox, but let us traverse polio first. The minister then asked ATAGI to review the situation with both polio and chicken pox. What has happened since then?

Mr Stuart—ATAGI has considered all of the new evidence and very recently completed its advice. The advice was signed off by the chair of ATAGI on 28 January and received by the minister on 28 January—on the same day—and is under consideration.

Senator McLUCAS—How long does it usually take for the minister to consider a report like that? We do not have a lot of these.

Mr Stuart—That would depend a lot on the nature of the report and the extent to which there are budgetary issues involved which require working through government. I do not think I can give you a one-line answer to that.

Senator McLUCAS—Is ATAGI tasked with cost-benefit analysis or simply clinical analysis of the suitability of a certain vaccine?

Ms Smith—ATAGI has a dual role. It provides advice both on the clinical effectiveness of vaccines and also provides advice to the minister in terms of funding priorities for the national immunisation program. The second of those matters does depend on a consideration of the cost-effectiveness of the vaccine.

Senator McLUCAS—The issue especially with injectable polio interfaces with the question of the number of vaccines that are required given the new vaccines that have come on to the schedule. I understand that children are needing to be immunised on six separate occasions and that the potential of introducing injectable polio will reduce that number of injections that children are required to have.

Ms Smith—Babies receive their injections at two, four and six months old. Currently, since the addition of the pneumococcal vaccine to the schedule at those age points, babies are receiving three injections.

Senator McLUCAS—What can be combined? There are three injections at each point.

Ms Smith—On each occasion they are getting three injections.

Senator McLUCAS—Right. If you introduce injectable polio, is there an opportunity for certain drugs to be combined so that you are not getting those three injections?

Ms Halton—So can you combine the vaccines?

Senator McLUCAS—Can you combine the vaccines that we currently have? Is it contingent on injectable polio being part of those combinations?

Ms Smith—There is a vaccine which is a hexavalent vaccine which would enable the three injections to become two. That hexavalent vaccine has the injectable polio as part of it.

Senator McLUCAS—So three would become two?

Ms Smith—Yes.

Senator McLUCAS—What three become two?

Ms Smith—You would have Prevenar as one of the injections and then all the other antigens that are required would be combined in the other injection.

Mr Stuart—DTPa—

Ms Smith—Polio, hep B and Hib.

CHAIR—What is the cost of it?

Ms Smith—The hexavalent vaccine has a wholesale price of around $100. That is on the private market, though.

Senator McLUCAS—There is some commentary—I do not know whether it has been verified—that families, when faced with the reality of having three separate injections at one doctor's visit, are taking the alternative to not do all three at the one time. It is all just a bit too much. Is there any evidence to support that commentary?

Mr Stuart—We are also hearing the reverse. There is this sort of talk around, but there are GPs also saying that when they explain to parents the importance of immunisation and the importance of the pneumococcal vaccine parents are very likely to agree to take the three injections at the one time. We do not have data on this and it is very early still in the days of the pneumococcal vaccination program, which commenced on 1 January.

Senator McLUCAS—The commentary I have heard is that they will eventually have all of the injections, but they have them over a different time phase. This week they will have pneumococcal and have the triple antigen next week just simply because of the trauma of having three separate injections at one sitting.

Ms Smith—There are also three separate injections required at 12 months of age, and the evidence there is that parents are finding that quite acceptable and they are not splitting the visits.

Senator McLUCAS—Is that because the child is a little older?

Ms Halton—There is probably an argument that says it is more difficult the older the child gets, I have to tell you. My 15-year-old was recently stabbed three times for a variety of reasons and he was quite compliant, so it gets better. He claimed it did not hurt.

CHAIR—You sure it was not at a night club?

Ms Halton—We will not go to the reasons why he was actually at the doctors surgery, but it involved tetanus as well.

CHAIR—That is all right.

Senator McLUCAS—Is there any way to collect data about what is really happening? We have heard stories about people spreading it out over time. Mr Stuart, you have heard stories about how people are keen to do it all together. Can you collect Medicare data that links the immunisation event with the GP consult?

Mr Stuart—It is not currently collected, I do not think, because the—

Ms Smith—We need to recognise it is early days with the pneumococcal program. It only commenced on 1 January. We have not yet seen the data come in from the Australian Childhood Immunisation Register. While that will not give a conclusive picture, I think it will

give us a feel for how that program is being introduced and if it is having any impact in terms of the level of coverage of the two-, four- and six-month points.

Ms Halton—I think the concern you raise is a reasonable concern, Senator. Certainly it would be our normal practice, but I think we will make a particular effort in this respect to make sure that we are both talking to general practitioners and others who have an interest in this to get some feedback. The technical data, other than the population wide data Ms Smith talks about, is hard to get. Getting into the Medicare data is almost impossible in this respect, but I am happy to undertake that we will keep an eye on exactly this issue and be alert to the sort of feedback that you are talking about.

Senator McLUCAS—There has been a lot of media commentary about it. Immunisation and children crying is all very emotive and no-one ever wants to do it but you have to. But it makes good copy, especially over Christmas when it is a bit slack.

Ms Halton—Yes.

Senator McLUCAS—I think if the debate were informed by some real information—

Ms Halton—We will see what we can get.

Senator McLUCAS—We can get to the bottom of whether it truly is a deterrent and then we can go on to the next step. There may be a cost to Medicare that we are not factoring into the cost-benefit analysis of the immunisation program.

Ms Halton—Yes.

Senator McLUCAS—I understand the cost of the oral polio vaccine has gone up considerably recently.

Ms Smith—Senator, yes, there have been some increases in the past. It has been relatively stable in recent months.

Senator McLUCAS—What does it cost now?

Mr Stuart—In 2003 I am advised it went from 70c to $3.05 per dose.

Senator McLUCAS—Do you know what we can attribute that cost rise to?

Mr Stuart—No, Senator, I am not aware exactly of what we can attribute that to. It was a pricing decision made by the manufacturer.

Senator McLUCAS—Is there only one manufacturer for polio?

Mr Stuart—There is only one supplier in Australia, Senator.

Senator McLUCAS—And that would change the question about shifting to injectable polio, one would imagine.

Mr Stuart—It would move the considerations a little bit.

Senator McLUCAS—What does an injectable polio cost per dose?

Mr Stuart—Is this separately or as part of the hexavalent? There are a number of options. It is a bit difficult to answer that question precisely, but Ms Smith did point out that in the private market the hexavalent is around $100 currently.

Senator McLUCAS—That is combined?

Mr Stuart—That is right.

Senator McLUCAS—Do not try to work out what it is disaggregated.

Mr Stuart—This, in part, explains some of the time taken through ATAGI to conclude their advice.

Senator McLUCAS—Would ATAGI include an analysis of the cost to Medicare if we were to come to a view that there were increased visitations to Medicare because immunisations could not be combined? Would that be information that ATAGI would use to come to a cost-benefit analysis?

Ms Smith—Those kinds of assumptions about the impact on Medicare are built into the cost- effectiveness evaluation.

Senator McLUCAS—Just very quickly, Professor Horvath, could you explain the chicken pox herd immunity?

Prof. Horvath—Yes, Senator. First of all, chicken pox is a pretty unusual virus that does not go away and is not seen again, as we can see with the elderly who broke out with herpes zoster, which is really latent chicken pox virus coming out in another form. Chicken pox in childhood is a reasonably mild disease, though not always, but certainly as you get older and certainly in adults it is a very serious form of disease. The concerns that the literature had and the reason some of the other developed countries such as Canada had not gone to the program was that there was no evidence in the literature what would happen to the herd immunity—that is, the amount of chicken pox virus in the whole community. There were concerns that with the immunisation of children there would be an extended period— unknown—that there would be a reduction in wild type virus around and that there would be latent immunity problems in the elderly and the middle aged and that we would get late infections, more severe infections and possibly reinfections because there is not a latent virus volume around to keep your immunity up.

In December of last year those answers were in fact made available to the world with a very comprehensive study in the *New England Medical Journal* that really did answer those questions very convincingly, and I am sure that ATAGI used that data in their assessment.

Senator McLUCAS—What were the findings?

Professor Horvath—I do not have it chapter and verse from my memory, I am sorry, but basically that there was a total reduction in chicken pox mortality at all ages over a large group and that herd immunity was going down. So all the things you would like of an immunisation program this very large study in fact showed did happen, and this is the first study in the literature.

Senator McLUCAS—Over what period was that, professor?

Professor Horvath—I honestly cannot remember. We can provide you with a precis of it.

Senator McLUCAS—It is almost like my education. I should not be indulging. Thank you very much. That was my 10 minutes extra.

CHAIR—That was a little longer than 10 minutes, but that is all right.

Senator Crossin—But we all learnt a lot.

CHAIR—That is right. Thank you very much to the officers associated with population health and safety immunisation. We will let them go home. We will now proceed to outcome 8.

[9.33 p.m.]

Senator MOORE—The topics are medical profusionists, secretariat support for a committee and private health insurance figures. It might make it easier if you know they are the questions. You might be able to let other people go home. My understanding is that recently a health insurer, BUPA, has acted to exclude claims by medical profusionists, and I am wanting to know whether that is an issue with the department and whether it breaches any of the undertakings it would have had.

Mr Maskell-Knight—I do not think any of us are the right people to answer the question, Senator, but from my knowledge it is an issue about access to Medicare benefits rather than health insurance. Health insurance funds will pay benefits under the Health Insurance Act if a benefit is payable under Medicare for professional services. My understanding is that this particular brand of people are not medically qualified in the sense that the Health Insurance Act requires. Hence Medicare benefit is not payable to them; hence health insurance funds are not allowed to pay a top-up 25 per cent difference between the 75 per cent that Medicare would pay and what the schedule fee is.

Senator MOORE—My understanding is that one particular insurer has made a recent decision to exclude payments from this particular group of practitioners who believe that they used to be able to get that provision. Now this group has decided not to pay it, which means, using your argument, their position would have changed. Is that not right?

Mr Maskell-Knight—I think they may choose to pay it under ancillary benefits rather than under hospital benefits, but they are certainly not required—

Ms Halton—So in other words it is a choice. It is a commercial decision for the insurer.

Senator MOORE—Right. I will check that, because I have just got the letter saying that they have chosen, under their Ezyclaim service, to exclude medical profusionists. I now know what they are, which is good. From your point of view, it does not relate to your area; it is actually the Medicare site. That is your answer?

Mr Maskell-Knight—Were the Health Insurance Act to require payment of a Medicare benefit, then the health insurance funds would have to pay the 25 per cent gap.

Senator MOORE—I will check the Health Insurance Act and then look at that further.

Ms Halton—We have had some contact from the professionals recently. I understand that they are concerned about that. I have had an approach and Mr Davies has had an approach about this issue. Ultimately, it is a commercial decision that the insurers—I am not aware of this particular case, but I am aware that it is topical—

Senator MOORE—Within the industry it is.

Ms Halton—Within the industry it is topical.

Senator MOORE— We have been advised that the department has decided to cease providing secretariat support to the Private Health Industry Quality and Safety Committee; is that right?

Ms Huxtable—We went through a process last year in a tight budgetary situation to look at the services that we provide that are not required under legislation, or by direction of government. This was one instance that fitted us within that remit. But also there was already the safety and quality in health care review of future government arrangements occurring and the Australian Council for Safety and Quality in Health Care, which has on it the chair of the PHIQSC committee. The chair of that committee continues to represent the private health industry on the Australian council. I understand that there have been discussions with the council about the potential for them to fund specific private health sector safety and quality projects on a case-by-case basis.

Senator MOORE—As an alternative source of this kind of work?

Ms Huxtable—That is correct.

Senator MOORE—How long had the department been providing that secretariat support?

Ms Huxtable—It was established as a departmental initiative in January 2001.

Senator MOORE—So it has been a couple of years, through into 2004. Do you have any idea what the cost of that secretariat support had been?

Ms Huxtable—The only figure that I have here is what we anticipated it may cost in 2004-05, but I do not have a figure in regard to what it may have cost in the years previous to that.

Senator MOORE—So the anticipated cost in 2004-05 would be the known saving from that period?

Ms Huxtable—Correct.

Senator MOORE—The basic rationale for the decision was budgetary.

Ms Huxtable—That is correct.

Senator MOORE—And that was told to the committee and the alternative now—I am aware that the head of PHIQSC is now still on the national council representing private health insurance—

Ms Huxtable—That is correct.

Senator MOORE—The concern that has been expressed is that this is the key area that looks after quality and safety issues for the private sector. Has that been the argument that has been raised with you? I am sure that they would have written to you that this secretariat is an invaluable service to them, it is the only support they have and so on.

Ms Huxtable—We have certainly had representations that would have been along the same lines, no doubt, as the representations you have received.

Senator MOORE—Is there any other organisation looking after health and safety issues for private hospitals?

Ms Huxtable—As I said, the Australian Council for Safety and Quality in Health Care—

Senator MOORE—Which is the national body.

Ms Huxtable—That is right.

Senator MOORE—That is not peculiar to the industry, is it? It is for the whole—

Ms Halton—But it does have a remit that crosses the entire sector, Senator.

Senator MOORE—Were other secretariat type functions cut at the same time? You said that there had been a budgetary review at that period. Was this the only one that got cut?

Ms Huxtable—I can only comment on what occurred within my division.

Senator MOORE—Within your agency, there was a general review across these things.

Ms Huxtable—Yes.

Senator MOORE—So were there other bits of the department—

Ms Halton—Yes, there were.

Senator MOORE—And there were other cuts?

Ms Halton—There were, Senator.

Senator MOORE—Can we find out what they are?

Ms Halton—It is a little hard to give you a kind of great long catalogue.

Senator MOORE—Was there a great long catalogue?

Ms Halton—There were a number of changes made to functions within the department to accommodate our budgetary position. This one is visible, because it is a particular function, but as is the case in every year we have a budget that we have to live within and, exactly as Miss Huxtable has indicated, we have been through a process to determine what we have legislative responsibility to do.

Senator MOORE—Core business—that kind of thing?

Ms Halton—Core business, plus, as you would appreciate, some things we have to do by legislation, some things are budget initiatives. Some things we have mandates in other respects. This did not fit into any of those categories and there was an overarching alternative.

Senator MOORE—Right. You said earlier, Ms Halton, in answer to a previous discussion that the role of the department had changed. I was talking about research and so on—that perhaps the department in its focus has moved over a period of time. Could that be linked to that same kind of process?

Ms Halton—I think the reality—and certainly in my experience in 25 years in the public sector—is that we have become much more focused on core business. I think it is also the case that we have responsibilities now and we are more conscious of some things now that we were not before. I will give you a particular example. When I joined the Public Service we did not even use the term 'risk management', whereas now we have a whole series of people. FOI was not even thought of. The nature of work has changed. That means continually, and certainly within the department the people behind me will tell you that I bore people to death by saying that we actually have to focus on what we have funding for.

Senator MOORE—They are not saying that, Ms Halton. I am looking at them.

Ms Halton—They will tell you privately, I have no doubt. We have to focus on what we are funded for.

Senator MOORE—But the commitment of the department to the need for the importance of quality and safety issues in the private sector continues?

Ms Halton—Absolutely. The notion that quality is absolutely fundamental to our health system is a core objective of the department.

Senator MOORE—I think the last bunch of questions that I have relate specifically to private health insurance and recent membership stats. I draw the department's attention to the recent membership statistics released by PHIAC. So they have published the latest membership. Do the movements in membership which have been published correspond with the department's forecasts in PHI membership? I know the department did forecast private health insurance membership. Do the department's stats equate to what your forecasts were?

Ms Addison—Can I just ask you to clarify what you are referring to when you talk about forecasts.

Senator MOORE—It is my understanding that the department actually forecasts for budgetary purposes the expectation of the rise in the take-up of private health insurance.

Ms Addison—Senator, we do estimates around the cost of the rebate, and there are a number of factors which we work into the cost of the rebate.

Senator MOORE—Including possible growth?

Ms Addison—To the extent that potentially growth in membership would be there. That would be an element of how we look at those figures.

Senator MOORE—We have the annual report from the Department of Health and Ageing for 2003-04, on page 230 of which are the estimates at that stage for private health insurance.

Ms Addison—This is for the cost of the rebate?

Senator MOORE—Yes, specifically the cost of the rebate. They are the current figures that you are working on from that particular phase?

Ms Addison—Yes, Senator.

Senator MOORE—Can the department provide the estimates and actual cost of PHI since its introduction?

Ms Addison—You are after the cost of the rebate?

Senator MOORE—The 30 per cent rebate, yes.

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

Senator MOORE—But that is the kind of data you do keep?

Ms Halton—They are all published.

Senator MOORE—I know I have seen it. I just wanted to have it up to date. How has the cost of the rebate varied and what factors have been driving these variations?

Ms Addison—The cost of the rebate varies partly related to the growth in premiums and the cost of premiums. As well, as you have noted yourself, there will be variations in the

participation rate, which will have an impact on how many people are actually receiving the rebate. The passage of the higher rebate for older Australians will also have an impact on the total cost of the rebate.

Senator MOORE—Is there any way of quantifying the particular impact of each of those factors, or is it just the amalgam and the end result?

Ms Addison—It is basically the amalgam and the end result. We do not publish or make available publicly the growth factor in terms of the rebate. Those figures are included in the budget papers as part of the contingency reserve and they are not revealed.

Senator MOORE—That is an in-confidence document, isn't it?

Ms Halton—Yes. You would be aware—we have canvassed this in previous estimates—that we do not tend to give a great big signal to the industry of what we think they are going to cost, on the grounds that it will become a self-fulfilling prophecy.

Senator MOORE—Every time the figures come out people celebrate successes and ignore things that have gone down, but in particular there has been a lot of media around the increase in membership for people over 55. That has been tracked, and you have said that that is going to occur. In the current figures there have been some declines as well, particularly in that group just below the over-55s. There have been declines in membership for those under 45. It is almost as though you get one bit up and the other one goes down.

Ms Addison—If I recall correctly, the 20 to 24 age group had the greatest growth in the latest figures. When you take the cumulative over-55s—that includes 55 to 59, 60 to 64 et cetera—the growth in that, up to 95-plus, is greater in total.

Senator MOORE—I am fascinated to meet the people who have got private health insurance who are 96. It is a very small number, those 95 and over.

Ms Halton—They are optimists, Senator.

Senator MOORE—I could not believe the graph had a little cohort of 95-plus. So that is the over-55s? It is not just 55 to 60; it is everybody over 55?

Ms Addison—Yes.

Senator MOORE—So you are adding each of those increases together, which makes it up. Has the department looked at the impact of the fact that it is the ones just underneath that who have got the decrease?

Ms Addison—In this particular quarterly result?

Senator MOORE—Yes, which is the latest one.

Ms Addison—There has been a small reduction, as you say, in the 40 to 45s and the 45 to 49s. That is correct. We are trying to look at what variations there are over time rather than just on a quarter-to-quarter basis. We do have a look at what is happening from quarter to quarter in terms of what might be driving those changes. We have not looked at that in detail for this particular quarter.

Senator MOORE—But if the trend continues that might actually stimulate some more work on it?

Ms Addison—Yes. When you look at what is happening to the participation rate, you are looking to see where the changes are occurring and what might be driving those changes, because in the broader context that might influence the policy adjustments you might need to make or want to make in order to effect that change.

Senator MOORE—Is the department aware of any recent research into private health insurance and effects on waiting lists? Is that a particular area of consideration?

Ms Huxtable—I believe there was some recent media coverage of an article by Professor Duckett which may have been in *MJA*.

Senator MOORE—Naturally you are aware of that process.

Senator Patterson—We are aware of his views, too.

Senator MOORE—Well, it is research. Is the evidence basis of that research something the department has considered? Obviously the minister is aware of other things and has a view. But is the evidential basis of that research something the department has considered?

Ms Addison—We have had a look at the paper, certainly.

Senator MOORE—The other issue there is the behaviour of doctors since the introduction of the PHI rebate to see whether it has anything to do with the incentive processes that go through. Is that something the department has looked at?

Ms Addison—Not that I am aware of in detail in relation to PHI. We track what is happening with the gap cover arrangements and movements that might be occurring there.

Senator MOORE—Which is linked in to membership of the funds, of course.

Ms Addison—Yes. But specifically in terms of doctors, not that I am aware of.

Senator MOORE—It is just that there has been some discussion in the media about the role of the medical profession and whether waiting lists are growing because of gaps and things. But in terms of particular work from the department, that has not been done?

Ms Addison—No.

Ms Halton—If I can make a comment on that, people have not been particularly bringing that to our attention as a matter of great concern. Whilst I am aware there has been the odd piece in the press, certainly I have not had people beating my door down on that issue.

Senator MOORE—Do they beat your door down on any particular issues, Ms Halton?

Ms Halton—All the time. Actually, I should say that my door is always open, so it is not necessary to beat it down.

Senator MOORE—You said that before, Ms Halton.

Ms Halton—I am serious. It is.

Senator MOORE—In terms of private health insurance, what are the issues that people raise? They do write to the department and I know they call the department. What concerns do they raise? I do not want every single one. What are the top three?

Ms Halton—Certainly the thing people raise with me is a desire to understand the product a little better. I think we would agree that it is complicated. I think even some of the

conversations we have here would suggest that it is hard sometimes to understand the product and how it works. I think sometimes, as we have discussed here, funds changing arrangements for some of the people they have arrangements with can cause people issues. Again, we have canvassed those issues here. I actually think largely the issues we have canvassed here are a fair reflection of the kinds of things people would raise with us.

Ms Addison—I would just add to Ms Halton's commentary that the Private Health Insurance Ombudsman's reports give you a sense of the key issues that are raised with the department. The things you would see the ombudsman report on would be the kinds of concerns and issues that people would raise with the department as well.

Senator McLUCAS—Premium increases would certainly top the list, wouldn't they?

Ms Halton—I have to say no. I do not think they take that to us in the same frequency as some of the other issues. They do bring it to us, but I would not say that was the top of the list of things that people bring to us, certainly in my experience.

Senator MOORE—Premiums are rising. People are less able to afford premiums and then questioning the whole lifetime cover process.

Ms Addison—What you can actually see from the PHIO's report is that concerns about premium increases have been reducing. I think the Private Health Insurance Ombudsman's most recent report notes again that those kinds of concerns are declining.

Senator MOORE—Maybe after today they might not.

Ms Addison—As the secretary referred to, the complexity of the product is certainly an issue that people grapple with. There are 6,000 products out there for people to choose from and 40 health funds. I think that is an area where people struggle a little.

Senator MOORE—Do people question the effectiveness of lifetime health cover?

Ms Addison—Not that I am aware of in particular.

Senator MOORE—It is not a concern of the department?

Ms Halton—I have to say that it has not been raised, not to my knowledge.

Senator BARNETT—On private health insurance: I may have missed it but, in terms of the latest figures, can you provide a state-by-state breakdown for us of those figures? Are they available?

Ms Huxtable—Which particular figures?

Senator BARNETT—The take-up of private health insurance.

Ms Huxtable—The participation rate by state?

Senator BARNETT—Participation rate, on a state-by-state basis.

Ms Huxtable—The latest release?

Senator BARNETT—The latest 12-month figures. I think you have a quarterly figure, haven't you?

Ms Huxtable—We may have to take that on notice. We just have to see if we have got it handy.

Ms Addison—The information is available on the PHIAC web site, but I am happy to have it compiled and tabled for you.

Senator BARNETT—That would be fantastic. Do you have the hospital cover and ancillary cover figures?

Ms Halton—We will table them before we finish, if we can.

Senator BARNETT—Do you have the latest updated financials on Medibank Private for 2003-04?

Ms Halton—What do you mean by 'financials'?

Senator BARNETT—Figures about their turnover and their market share, for example.

Ms Halton—We have officers here but, while they are coming to the table, Senator McLucas, you asked us about PHOFAs— public health outcome funding agreements. We can table the figures for the original offer and the supplementary offer.

Senator BARNETT—With respect to Medibank Private, I have read the 2003-04 financial figures—$2.4 billion turnover, over $400-odd million in net assets, and nearly $45 million in profit. Is there a six-monthly report or can you provide any further financial figures on the status of Medibank Private from 2003-04?

Ms Bussey—Medibank Private has not released six-monthly figures to date. To my knowledge, no decision has yet been made as to whether six-monthly figures will be released. Historically, for the first time, Medibank released half-yearly results for the six months following the year in which a $175 million loss was posted. That indicated a small profit of $2.8 million for the first six months of the 2003 financial year, but no decision, to my knowledge, has been made to date about whether they will release half-yearly results for the current year. There is no requirement for Medibank to do so.

Senator BARNETT—When was the $44.8 million profit for 2003-04 released?

Ms Bussey—That was tabled in parliament in September 2004 and the annual report was released after it had been tabled.

Senator BARNETT—In the previous year a six-monthly report was tabled?

Ms Bussey—Half-yearly results were released; that is correct.

Senator BARNETT—What time of year was that tabled?

Ms Bussey—I believe that would have been released in February or March 2004.

Senator BARNETT—Has the financial position improved since 2003? You said that it made a loss one year, a small profit in that six-monthly report and then obviously an improvement again in 2003-04. So there seems to be a trend of improvement. Is it continuing to improve?

Ms Bussey—I am not able to advise on the current financial performance. Unfortunately, that information is obviously commercially sensitive to Medibank. We are in a competitive market. Our competitors generally do not release half-yearly results. So, until a decision is made by our board when and if those results will be released, I am not able to disclose that at this time.

Senator BARNETT—That is fine.

Senator MOORE—Does Medibank Private cover medical perfusionists' fees?

Ms Bussey—We believe that Medibank Private does not pay for medical perfusionists' costs.

Senator MOORE—We have the standard industry figures about where memberships have grown in certain age groups and where they have gone down in others. Without actually releasing too many private details about your particular business, is it the experience of Medibank Private that there has been a growth in the over-55s membership and some tapering off in that 40 to 45 bracket?

Ms Bussey—I do not have detailed figures on the age profiles. I can certainly take that on notice.

Senator MOORE—You do keep them, though? There is information in your annual report about membership by age group?

Ms Bussey—That is correct. We do have information about our membership base and in which parts of the age cohort we are seeing growing or declining numbers. But I can take that question on notice.

Senator MOORE—We had a discussion with the department about the kinds of issues that people raise. Does the issue of rising premiums and gap payments take up a degree of the complaint calls that you get?

Ms Bussey—Certainly, the issue of rising premiums is of concern to us as well as to our members but, given the recent history of rising premiums over the last few years, I would agree that that seems to have caused a declining amount of noise for our members. The issue that the secretary raised about the complexity of the products is certainly a concern, both for us and for our members. We spend a lot of time and effort in ensuring that our communications to our members are as clear and as understandable as possible. We accept that the product is complex. There are a number of issues such as waiting periods and benefit limitation periods which we work hard to explain to our members to ensure that, particularly at the time that they acquire the product, they understand the restrictions which attach to their cover.

Senator MOORE—They understand the concept of lifetime cover?

Ms Bussey—Lifetime health cover, we believe, is fairly well understood by our members. We believe that it has been well communicated to the market. It is more the conditions attaching to particular products which we endeavour to ensure are well understood.

Senator McLUCAS—Were you a sponsor of the Sydney international tennis tournament?

Ms Bussey—Yes, we were.

Senator McLUCAS—How do you make decisions about whether to sponsor a tennis tournament? You get some name recognition and it is an advertising opportunity, but how do you do the cost-benefit analysis of an opportunity like that?

Ms Bussey—This particular sponsorship arrangement was part of our overall marketing strategy for the year. We obviously look at a number of different opportunities. We are in a

very competitive market and it is important that we do advertise as our competitors do. A decision was made that this was an opportunity that afforded good value in brand exposure for Medibank. It also appealed to our preferred demographic of younger people, whom we obviously want to attract to the fund. We were satisfied with the amount of coverage. It was widely broadcast on television. In assessing the value to the fund of all our marketing projects, obviously after a certain period of time has elapsed our marketing team would conduct an independent review of the success or otherwise of the particular initiative. In this case that review has not yet been completed, but I can say that overall Medibank has been satisfied with the level of interest that it appears to have generated.

Senator McLUCAS—It was in your original marketing plan?

Ms Bussey—My understanding is that it was an opportunity that had arisen during the course of the year, but certainly when the marketing plan is drawn up a certain amount of funding is allocated to sponsorships as well as other discrete marketing activities.

Senator McLUCAS—Is it wrong to say that you were a last-minute sponsor?

Ms Bussey—I do not have the details on timing, but I believe it is correct to say that it was an opportunity which arose perhaps not at the last minute but certainly during the course of the year.

Senator McLUCAS—I have a few more questions that I will put on notice, given the time.

CHAIR—We will now move on to corporate matters.

Senator McLUCAS—I have a question about the timing of the annual report. When is the annual report required to be tabled?

Mr Clout—The annual report is required to be tabled at the end of October each year. This year, because the parliament was not sitting at the time, the Department of the Prime Minister and Cabinet gave another five-day extension. Technically, we had until 5 November.

Senator McLUCAS—When was it tabled?

Mr Clout—I believe it was tabled on 4 February.

Senator McLUCAS—So you had a five-day extension from 31 October.

Mr Clout—That is correct.

Senator McLUCAS—But you did not comply with that?

Mr Clout—We were unable to comply with it this year; that is correct.

Senator McLUCAS—Is that a breach of the requirements and a breach of whose requirements is it?

Mr Clout—Unfortunately, technically, yes, it is a breach of the requirement to table the annual report by 31 October.

Senator McLUCAS—What penalty do you get?

Mr Clout—Thankfully we do not suffer a penalty under the law. Unfortunately, though, for the team that produces the annual report, they are disqualified from winning any awards or running for awards.

Ms Halton—This is a serious issue in the department.

Mr Clout—Last year we did in fact win a bronze award for the printed version and a gold award for the online version. So it is with a great deal of disappointment that we were not able to meet the deadline. We take a great deal of pride in the annual report. We think it is a very high quality document. We are very happy with the product this year. We hope that it has been useful.

Senator McLUCAS—It is a very useful document. It was very late, though. Can you tell us why it was so late?

Mr Clout—We ran into logistical difficulty when we went to the printers. Once you miss your spot with a report of this size—and this is one of the bigger reports around town—you go to the back of the queue. When you go to the back of the queue with a report this size, you then have to go back to the indexer again. It takes over three weeks to prepare the document and get it ready again to go to the printer. By the time we got towards that point, we were running into the Christmas shutdown and the printers that we had contracted were unable to start printing the report until late January.

Senator McLUCAS—So you actually had it ready for production, but then it was simply a technical problem getting it through the printer. Why could you not photocopy one and table that?

Mr Clout—I am not entirely sure about the requirements for tabling, but it is a 500-page document at this point.

Ms Halton—I genuinely do not think anyone thought about a photocopy, Senator.

Mr Clout—No, it had not come up as a requirement for us. No-one had asked us for that, so we were still hoping to be able to get to print and get it ready. But it was one of those issues that every time we did get that far the printer or the indexer was unavailable to us.

Senator McLUCAS—Who do you advise of these delays so that people know?

Mr Clout—I believe we advised the Senate Table Office. I would have to take that on notice, though. I cannot guarantee who was advised and when. I would only be speculating.

Senator McLUCAS—All right. It is a valuable document and let us hope you get that gold medal next year.

Mr Clout—Thank you, Senator.

Ms Halton—Next year, Senator.

Senator McLUCAS—Next financial year.

Senator MOORE—So you are not excluded from going for it next year or anything like that?

Ms Halton—No, we will be there with bells on.

Senator MOORE—I am just thinking about the previous discussion about the agency looking at the aged care homes being locked up for a while in that agency.

Senator McLUCAS—The last set of questions relates to the issue I raised earlier in the day about staffing. Can we have the number of staff of the department?

Mr Law—With the staff numbers at the end of the 2003-04 financial year, I have prepared a table in anticipation.

Senator McLUCAS—Am I that predictable?

Mr Law—I have continued the format that we have had in questions on notice. I might table that if that is okay.

Senator McLUCAS—That would be terrific. The increase in staff numbers from 2002-03 to 2003-04 is how many people, Mr Law?

Mr Law—In the department and the TGA it increased by 72. New policy proposals in the budget for that year accounted for 54.5. With regard to additional estimates, I do not have the exact number but it would have accounted for the rest in that growth. So the growth in staff numbers is probably reflected by the new policy proposals in terms of staff numbers.

Senator McLUCAS—Which policies in particular, Mr Law?

Mr Law—Medicare Plus and national illicit drugs were some of the major ones in that budget for 2003-04.

Senator McLUCAS—So 54.5 can be attributed to new policies.

Mr Law—In the budget and of the 72—

Senator McLUCAS—And the others?

Mr Law—Sorry, but we do not have the numbers for the additional estimates.

Ms Halton—It will be bits and pieces across various programs.

Mr Law—I apologise, but I will take that on notice and give you the additional estimates as well for the total increases in staff in that financial year as a result of new policy.

Senator McLUCAS—Thank you. Do you have staffing numbers currently?

Mr Law—Yes, I can provide current staff numbers. The full-time equivalents or the ASL, which is the average staffing level—and we have had this discussion before about average staffing levels and FTEs, as you know—at the end of January 2005 is 3,801.8. As you are aware, that is an average of the monthly full-time equivalents for that period for the year to date.

Senator McLUCAS—Sorry, but what was that figure again?

Mr Law—It was 3,801. This is for the core department and TGA.

Senator McLUCAS—You will have to help me again, Mr Law; I am sorry. How does that relate to the 2003-04 figure on your bit of paper?

Mr Law—It is an increase on the 2003-04 figure. On the paper I tabled the second last dot point shows the ASL figure of 3,646. So there has been an increase from 3,646 to 3,801.

Senator McLUCAS—So 3,801.

Mr Law—Yes, in the seven months year to date.

Senator McLUCAS—Thank you for that. Can you give me an indication of what the cost of consultancies has been over the last three or four years?

Mr Law—Yes, I can do that. For the 2003-04 financial year the total consultancy expenditure was $38.986 million. For 2002-03 that expenditure was $29.265 million, and for 2001-02 it was $22.987 million.

Senator McLUCAS—That is showing strong growth, along with staffing levels.

Mr Law—Yes, it shows strong growth and, looking at that growth, to some extent it does reflect the growth in the department's overall expenditure because those consultancy expenditures would include both administered and departmental expenditure. One of the things that might well impact on that number is that in July 2004, I believe, or June 2004 the Department of Finance and Administration released new guidelines on the interpretation of consultants versus contractors and what are the consultants to be reported.

I would suggest that in those revised guidelines the department has certainly taken a very conservative approach: if in doubt, to report a figure. I think there is some indication that we have reported in 2003-04 in the preparation of the annual report possibly consultants that fall into a category that we may not have reported in past years, because of that revision of the guidelines. So I think there are a number of factors, but I think the overall factor is a growth in overall expenditure; possibly we might be comparing a little bit of apples and oranges. In overall terms, looking at the expenditure in 2003-04, the percentage of total budget, although it has gone up from 2002-03, reflects some of the percentage of budget in past years, or close to.

Senator McLUCAS—What was the percentage of budget for 2003-04?

Mr Law—The percentage of overall budget for 2003-04 was 0.115 per cent—of expenditure on consultancies.

Senator McLUCAS—In 2002-03?

Mr Law—In 2002-03 it was 0.094.

Senator McLUCAS—The year before that?

Mr Law—It was 0.08. I have some figures that go back further. For instance, in 1997-98 that figure was 0.11, which is very much akin to the percentage in today's terms. So it has fluctuated up and down between, I would suggest, about 0.070 and 0.115, which is the latest.

Ms Halton—Senator, if I can make an observation, firstly, in relation to Mr Law's comments about erring on the side of conservativism in terms of what we classify, we were one of the few agencies who participated with the department of finance in refining those guidelines, so we were active in assisting in those definitions. But, as you would well understand, there are now extra requirements on us in relation to how governments work and budgeting. For example, with lapsing programs, we are required to evaluate, to review those programs and bring those evaluations into the budget process before those lapsings are reconsidered. In fact, as I go through this list, there are many of these programs that were lapsing programs and you can see the reviews, the formal evaluations of these programs, reflected in these consultancies. There has been a lot of change in, for example, aged care. Again, I can find these here. We have canvassed this evening the TGA and the work that we are doing there to improve our business processes. In a sense, as Mr Law has indicated, there

is a kind of ebbing and flowing of this. What you are seeing is, in a sense, a function of timing and also these extra requirements on us.

Senator McLUCAS—I think, though, the point needs to be made that at the same time as there is a growth in actual employees there is also a growth in consultancies, and the argument usually is that consultancies are used in an increasing way when staff cannot do that sort of work. The converse is that if you increase your full-time staff there will be less requirement for consultancies. These figures certainly show a growth in both staffing and consultancies.

Ms Halton—Yes. Mind you, Senator, I think anybody who thinks that it takes no staff to manage consultancies is incorrect. We all know that if you are going to get a good outcome from a consultancy you actually have to actively manage it. So you could argue the converse in one sense. Also, the technical requirements of many of these pieces of work are not the kinds of staff we will keep in an ongoing sense in the department. They are highly technical skills that we hire for. Yes, it is true that we do have the staff in many instances who understand this work and who are able to oversight the work, but we do not keep a core of qualified evaluators, for example, who are doing nothing but evaluating programs. And, as much as anything else, it is often very useful to us to have an external, impartial body come in and give us feedback.

Senator McLUCAS—There are times for consultancies, but I just need to make the point that that has been noticed.

Ms Halton—I understand.

Senator McLUCAS—The annual report lists the consultancies. That is correct, isn't it?

Ms Halton—Yes, they are here.

Senator McLUCAS—I just mislaid mine.

Ms Halton—They start on page 463.

Senator McLUCAS—Does it actually identify which area of the department?

Mr Sheehan—By outcome, Senator.

Ms Halton—Yes, it does, and I think with most of these it is relatively clear where they have come from. For example, legal advice relating to the application of the Aged Care Act—it is perfectly clear where that has come from. Work in relation to the residential classification scale, which is a matter we have canvassed this evening—again, that is relatively clear. I cannot say in every single case, but I think the majority of them are pretty clear.

Senator McLUCAS—Okay. That covers off my questions.

Senator MOORE—Could you actually do some work on the rate of Indigenous employment in the department over the last five years at levels? I would really like to see the number of Indigenous staff at each level in the department for the last five years. It is going to be an ongoing issue for the next couple of years, in line with the Public Service Commission's report and also with the integration now of ATSIC.

Ms Halton—Yes, fine. We are happy to do that.

Senator MOORE—It would be really good.

Mr Law—I can give you some information now, if you wish.

Senator MOORE—The annual report has it for last year, doesn't it?

Mr Law—Yes, and it did show an increase last year over the previous year.

Senator MOORE—I could say 20—but five years will be enough, just to have a look at it, and at each level as well because I would like to see the transition, particularly into the senior executive service, and so on.

Mr Law—I think our percentage in the annual report for last year was 1.2 per cent.

Senator MOORE—Yes, it was, which was very high across the Public Service.

Ms Halton—Yes. We work very hard, Senator—we do not always get it right, but we do have a very active Indigenous staff network. We bring them together regularly. I actually attended the conference last year—I resisted the temptation to sing karaoke: they are much better than me. But it is something we do our best in.

Senator Barnett asked a series of questions about private health insurance participation by state, on the rates et cetera. I am happy to table those documents before we close.

CHAIR—Thank you.

Senator McLUCAS—On that participation question, Ms Halton: you can do it by state—can you do it by region as well? Can you separate metropolitan and non-metropolitan by state?

Ms Halton—Mr Maskell-Knight can tell you that this is difficult.

Mr Maskell-Knight—My understanding is that there are problems with it. It would rely on data that the Health Insurance Commission have. They collected the postcode of people with health insurance when people enrolled for the 30 per cent rebate the first time. If people have moved they may well have updated their address. On the other hand, they may not have. If they are getting their rebate paid through their health insurance fund, there is no particular reason for them to. So the data does exist, but it is by postcode, and my understanding is that it is not particularly accurate.

Senator McLUCAS—I will not ask for it then. Thank you.

CHAIR—Thank you very much. I would like to thank the minister, Senator Patterson, and also Ms Halton and all the officers of the Department of Health and Ageing. Thank you for your patience, tolerance and your answers.

Senator Patterson—I have had a lovely day. Thank you very much.

CHAIR—I declare the meeting closed.

Committee adjourned at 10.26 p.m.