COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

ESTIMATES

(Supplementary Budget Estimates)

WEDNESDAY, 2 NOVEMBER 2005

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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Wednesday, 2 November 2005

Members: Senator Humphries *(Chair)*, Senator Moore *(Deputy Chair)*, Senators Adams, Barnett, Fielding and Polley

Senators in attendance: Senator Humphries *(Chair)*, Senator Moore *(Deputy Chair)*, Senators Adams, Allison, Barnett, Bob Brown, Carol Brown, Crossin, Evans, Forshaw, Hill, McLucas, Nettle, Polley, Troeth and Webber

Committee met at 9.06 am

HEALTH AND AGEING PORTFOLIO

In Attendance

Senator the Hon. Patterson, Minister for Family and Community Services

Health and Ageing
Whole of Portfolio
Executive
Ms Jane Halton, Secretary
Mr David Learmonth, Acting Deputy Secretary
Ms Mary Murnane, Deputy Secretary
Dr John McEwen, Acting Chief Medical Officer
Ms Wynne Hannon, General Counsel, Legal Services Branch
Business Group
Mr Alan Law, Chief Operating Officer, Business Group
Mr Stephen Sheehan, Chief Financial Officer, Finance Branch
Ms Eija Seittenranta, Chief Information Officer, Technology Group
Mr John Trabinger, Assistant Secretary, Technology Group
Ms Tatiana Utkin, Assistant Secretary, Program Management Improvement Branch
Ms Laurie Van Veen, Director, Communications Branch
Ms Judy Develin, Assistant Secretary, People Branch
Ms Jodie Grieve, Departmental Officer, Communications Branch
Mr Mike Siers, Assistant Secretary, Corporate Support Branch
Portfolio Strategies Division
Mr David Webster, First Assistant Secretary, Portfolio Strategies Division
Ms Shirley Browne, Acting Assistant Secretary, Parliamentary & Portfolio Agencies Branch
Mr Jamie Clout, Assistant Secretary, Budget Branch
Mr Richard Eccles, Assistant Secretary, TGA Transition Branch and Policy & International Branch
Ms Julie Roediger, Assistant Secretary, Economic & Statistical Analysis Branch

Outcome 1: Population Health
Population Health Division
Mr Andrew Stuart, First Assistant Secretary, Population Health Division
Ms Moira McKinnon, Medical Officer, Biosecurity and Disease Control Branch
Dr Leslee Roberts, Medical Epidemiologist, Early Warning and Response Unit
Ms Sandra King, Acting Assistant Secretary, Food and Healthy Living Branch
Ms Jenny Hefford, Assistant Secretary, Drug Strategy Branch
Ms Carolyn Smith, Assistant Secretary, Targeted Prevention Programs Branch
Ms Cath Halbert, Assistant Secretary, Biosecurity and Disease Control Branch
Audit and Fraud Control
Mr Allan Rennie, Assistant Secretary, Audit and Fraud Control Branch
Therapeutic Goods Administration
Dr David Graham, National Manager
Dr Kerri Mackay, Medical Officer, Adverse Drug Reactions Unit
Dr Phillip Chipman, Acting Director, Drug Safety and Evaluation Branch
Ms Rita Maclachlan, Director, Office of Devices, Blood and Tissues
Dr David Briggs, Director, Office of Complementary Medicines
Mr Michel Lok, Assistant Secretary, Financial Services Group
Ms Terry Lee, Assistant Secretary, Legal Services Group
Dr Sue Meek, Gene Technology Regulator
Dr Margaret Hartley, Director, Office of Chemical Safety
Food Standards Australia New Zealand
Graham Peachey, Chief Executive Officer, Food Standards Australia New Zealand
Ms Claire Pontin, General Manager, Office of Safety and Services, Food Standards Australia New Zealand
Ms Melanie Fisher, General Manager, Office of Food Standards, Food Standards Australia New Zealand
Dr Marion Healy, Chief Scientist, Food Standards Australia New Zealand
Mr Dean Stockwell, General Manager, Food Standards (Wellington), 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
Outcome 2: Medicines and Medical Services
Medical and Pharmaceutical Services Division
Ms Rosemary Huxtable, First Assistant Secretary, Medical and Pharmaceutical Services Division
Ms Joan Corbett, Assistant Secretary, Pharmaceutical Benefits Branch,
Dr Ruth Lopert, Pharmaceutical Policy Taskforce
Ms Sarah Major, Assistant Secretary, Pharmaceutical Access and 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
Dr John Primrose, Medical Adviser, Department of Health and Ageing

Primary Care Division

Ms Lisa McGlynn, Assistant Secretary, Budget and Performance Branch, Primary Care Division

Mr Leo Kennedy, Assistant Secretary, General Practice Programs Branch, Primary Care Division

Mr Harold Lomas, Acting Assistant Secretary, Primary Care Policy Branch, Primary Care Division

Ms Megan Morris, Assistant Secretary, Primary Care Programs Branch, Primary Care Division

Mr Swain Jeffery, Director, Budget and Reporting, Primary Care Division

Outcome 3: Aged Care and Population Ageing

Ageing and Aged Care Division

Mr Nick Mersiades, First Assistant Secretary, Ageing and Aged Care Division

Mr Stephen Dellar, Assistant Secretary, Residential Program Management Branch

Ms Gail Finlay, Assistant Secretary, Quality Outcomes Branch

Mr Peter Broadhead, Assistant Secretary, Policy and Evaluation Branch

Ms Mary McDonald, Assistant Secretary, Community Care Branch

Ms Fiona Lynch, Assistant Secretary, Office for an Ageing Australia

Ms Elizabeth Cain, Head, Pricing Review Implementation Unit

Dr David Cullen, Executive Director, Financial and Economic Modelling and Analysis Group

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

Outcome 4: Primary Care

Primary Care Division

Ms Lisa McGlynn, Assistant Secretary, Budget and Performance Branch, Primary Care Division

Mr Leo Kennedy, Assistant Secretary, General Practice Programs Branch, Primary Care Division

Mr Harold Lomas, Acting Assistant Secretary, Primary Care Policy Branch, Primary Care Division

Ms Megan Morris, Assistant Secretary, Primary Care Programs Branch, Primary Care Division

Mr Swain Jeffery, Director, Budget and Reporting, Primary Care Division

Outcome 5: Rural Health

Health Services Improvement Division

Ms Margaret Lyons, First Assistant Secretary, Health Services Improvement Division

Ms Mary McLarty, Acting Assistant Secretary, Safety and Quality Branch

Mr Brett Lennon, Assistant Secretary, Health Workforce Branch

Mr Nathan Smyth, Assistant Secretary, Health Priorities and Suicide Prevention Branch

Ms Sharon Appleyard, Acting Assistant Secretary, Rural Health and Palliative Care Branch

Outcome 6: Hearing Services
Medical and Pharmaceutical Services Division
Ms Rosemary Huxtable, First Assistant Secretary, Medical and Pharmaceutical Services Division
Ms Joan Corbett, Assistant Secretary, Pharmaceutical Benefits Branch,
Dr Ruth Lopert, Pharmaceutical Policy Taskforce
Ms Sarah Major, Assistant Secretary, Pharmaceutical Access and 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
Outcome 7: Indigenous Health
Office of Aboriginal and Torres Strait Islander Health
Ms Lesley Podesta, First Assistant Secretary, Office for Aboriginal and Torres Strait Islander Health
Ms Joy Savage, Assistant Secretary, Health Strategies Branch
Mr Mark Thomann, Assistant Secretary, Program Planning ands Development Branch
Ms Joy McLaughlin, Acting Assistant Secretary, Policy and Analysis Branch
Outcome 8 – Private Health
Acute Care Division
Mr Charles Maskell-Knight, Acting First Assistant Secretary, Acute Care Division
Ms Linda Addison, Assistant Secretary, Private Health Insurance Branch
Mr Chris Sheedy, Assistant Secretary, Diagnostics and Technology Branch
Dr David Barton, Medical Adviser, Diagnostics and Technology Branch
Dr Bernie Towler, Medical Adviser, Acute Care Division
Ms Yael Cass, Assistant Secretary, Acute Care Development Branch
Ms Gail Yapp, Assistant Secretary, Acute Care Strategies Branch
Ms Susan Rogers, Director, Medical Indemnity Branch
Medibank Private
Mr George Savvides, Managing Director, Medibank Private
Ms Sarah Bussey, General Counsel, Medibank Private
Mr Bruce Levy, Group Manager Health Services, Medibank Private
Mr Craig Bosworth, Policy and Industry Affairs Manager, Medibank Private
Outcome 9: Health System Capacity and Quality
Health Services Improvement Division
Ms Margaret Lyons, First Assistant Secretary, Health Services Improvement Division
Ms Mary McLarty, Acting Assistant Secretary, Safety and Quality Branch
Mr Brett Lennon, Assistant Secretary, Health Workforce Branch
Mr Nathan Smyth, Assistant Secretary, Health Priorities and Suicide Prevention Branch
Ms Sharon Appleyard, Acting Assistant Secretary, Rural Health and Palliative Care Branch
Portfolio Strategies Division
Mr David Webster, First Assistant Secretary, Portfolio Strategies Division
Ms Shirley Browne, Acting Assistant Secretary, Parliamentary & Portfolio Agencies Branch
Mr Jamie Clout, Assistant Secretary, Budget Branch

Mr Richard Eccles, Assistant Secretary, TGA Transition Branch and Policy & International Branch
Ms Julie Roediger, Assistant Secretary, Economic & Statistical Analysis Branch

e-Health Implementation Group

Dr Brian Richards, First Assistant Secretary, e-Health Implementation Group
Mr Tam Shepherd, Acting Assistant Secretary, e-Health Implementation Group

Outcome 10: Acute Care

Acute Care Division

Mr Charles Maskell-Knight, Acting First Assistant Secretary, Acute Care Division
Ms Linda Addison, Assistant Secretary, Private Health Insurance Branch
Mr Chris Sheedy, Assistant Secretary, Diagnostics and Technology Branch
Dr David Barton, Medical Adviser, Diagnostics and Technology Branch
Dr Bernie Towler, Medical Adviser, Acute Care Division
Ms Yael Cass, Assistant Secretary, Acute Care Development Branch
Ms Gail Yapp, Assistant Secretary, Acute Care Strategies Branch
Ms Susan Rogers, Director, Medical Indemnity Branch

Outcome 11: Health and Medical Research

Office of the National Health and Medical Research Council

Dr Clive Morris, Assistant Secretary, Centre for Compliance and Evaluation, NHMRC
Mrs Cathy Clutton, Assistant Secretary, Centre for Health Advice, Policy and Ethics, NHMRC
Ms Suzanne Northcott, Assistant Secretary, Centre for Research Management and Policy, NHMRC
Mr Nhan Vo-Van, Executive Director, Centre for Corporate Operations, NHMRC

CHAIR (Senator Humphries)—I declare open this supplementary hearing of the Senate Community Affairs Legislation Committee considering the budget estimates for the portfolio of Health and Ageing. The committee has before it a list of the outcomes relating to matters which senators have indicated that they wish to raise at the hearing. In accordance with the standing orders relating to supplementary hearings, today's proceedings will be confined to matters within the relevant outcomes. I welcome Senator Kay Patterson, representing the Minister for Health and Ageing; the departmental secretary, Ms Jane Halton; and other officers of the Department of Health and Ageing.

I remind officers that the Senate has resolved that there are no areas in connection with the expenditure of public funds where any person has a discretion to withhold details or explanations from the parliament or its committees unless the parliament has expressly provided otherwise. I also remind officers that they will not be asked to express an opinion on matters of policy and that they shall be given reasonable opportunity to refer questions asked of them to superior officers or a minister.

Witnesses are reminded that the giving of evidence to the committee is protected by parliamentary privilege. I also remind them that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. Minister, would you like to make an opening statement?

Senator Patterson—No, but I would love to be finished before 11 o'clock.

CHAIR—We will do our best to oblige that wish, but I would not hold my breath.

Department of Health and Ageing

Ms Halton—Senator Humphries, I understand you may have some questions in relation to MPS, multipurpose services. There is a question about where you want to deal with those, because they are kind of 'Aged care' and they are kind of 'Rural health'. They are administered under 'Rural health', so it depends on the nature of your question. I would not want to have gone past 'Aged care' and then be in 'Rural health' if what you really want to know is relevant to 'Aged care'. We do not have to clarify it now. Perhaps after lunch it would be sensible to work out where things are so that we have the right person to answer your questions, if you see what I mean.

Senator McLUCAS—So they fit better in outcome—

Ms Halton—It is administered in 'Rural health' but the questions we tend to get asked are in more of an aged care context. If we can get some indication of the nature of the questions, we can make sure we deal with them in the right place.

Senator McLUCAS—Can we put them into outcome 3?

Ms Halton—Sure.

Senator McLUCAS—I suppose the only problem with that would be if there were other senators who wanted to ask those questions and they were of the view that they sit in 'Rural health'.

Ms Halton—That is why I raised it. We just need to make sure that we have the relevant people there for the relevant items.

Senator McLUCAS—Can I confirm that the visiting GP aged care program is under outcome 2, not 3—the divisions of general practice.

Ms Halton—It is outcome 4: Primary care.

CHAIR—The order as circulated remains, with the exception that we will reverse the orders of outcomes 5 and 6. So it will be outcomes 7, 6, 5 and 9 this evening. We will attempt to stick within the order and place the breaks as suggested by Senator McLucas, unless there is any different view. I assume there has already been indication from senators about any areas they do not wish to examine. It is a bit hard to indicate that you do not want to examine an area, but if there are any areas that are not required at this point in time it would be useful to know that so that we could send those officers to do something else. We may informally take an audit of that later on during the morning to see whether there are any such areas. Let us proceed with whole-of-portfolio corporate matters.

Senator McLUCAS—I want to first of all thank the department for the answers that were received and for the ones that came in at 9.27 last night, which surprisingly I have not read yet. Can I get an indication of the number that came in last night at 9.27.

Ms Halton—Around 20, I believe.

Senator McLUCAS—Out of how many?

Ms Halton—The total number of questions taken last time was 221, with a total number of parts of 451.

Senator McLUCAS—There were 221 questions and I am advised that 24 came in last night.

Ms Halton—Okay.

Senator McLUCAS—How many are outstanding?

Ms Halton—It is my understanding there are six, and I am attempting to get those to you today.

Senator McLUCAS—What are the issues that those six cover?

Ms Halton—My understanding is that those cover prostheses amendments, the pharmacy agreement, country of origin labelling, the Pharmaceutical Benefits Scheme, e-Health and Broadband for Health. That is my indication of what they cover.

Senator McLUCAS—Why were they so difficult to answer?

Ms Halton—I think it is fair to say that in all these areas, every time they have been answered, something else has changed. As I say, I am attempting to get some answers cleared this morning, I hope. We are attempting to get them cleared and to you today.

Senator McLUCAS—Sorry, I did not catch that.

Ms Halton—Regrettably, in each of these areas, I think every time the question has been answered, then something has been changed in respect of the answer. So there have been multiple iterations. Regrettably, for these ones, some changes were requested, which I am attempting to make at the moment. We are trying to get those to you by lunchtime.

Senator McLUCAS—I am a bit unsure about how an answer can change. Surely there is an answer to a question. Does that mean that you send the answer to the minister's office and then the minister sends it back for an amendment?

Ms Halton—I think we have discussed in the past that there is a process to be gone through with the clearance of answers which does involve some iteration involving a number of parties. Regrettably, these ones have bounced about a bit. I do apologise that those ones were so late last night, but you know that we try to come with no answers outstanding. I am very sorry that this time we have come with six still to go.

Senator McLUCAS—Going to the 24 that came in late last night, when were these provided to the minister's office?

Ms Halton—I think that will vary. To be honest, I do not think I have that information. No, I do not have that information

Senator McLUCAS—For example, there is a series of questions about the Medicare safety net.

Ms Halton—In relation to those ones, one of the officers involved in that work has just been on long service leave. Some of those answers had to be clarified with that officer on their return.

Senator McLUCAS—I wonder if I could put another question on notice, Ms Halton?

Ms Halton—Yes, sure.

Senator McLUCAS—For the 24 that arrived last night, could you provide the committee with the date that they were provided to the minister's office?

Ms Halton—To the extent that we have that information, yes, absolutely.

Senator McLUCAS—We used to get them on time. It is very difficult for the committee to make any sense of this, and the opportunity to come back to it is just lost. It does raise the question of whether or not the minister actually wants us to understand what we have asked by the time the hearing happens. I do note that the annual report came down last week, which, I understand, was on time?

Ms Halton—Absolutely.

Senator McLUCAS—What is the date that the report has to be provided?

Ms Halton—It has to be tabled by the end of October.

Senator McLUCAS—So you made it by a few days?

Ms Halton—Yes. Last year I think you will recall that we had a very disappointed little crew who were not eligible for any awards because of delays in elections and things, so this time they were determined that it would be in on time.

Senator MOORE—It is very green.

Ms Halton—It is very green. But you might notice that it matches the very orange and the very purple ones we had previously.

Senator McLUCAS—I have been provided with a document out of the budget papers which talks about the underspend in Health. I understand that there were delayed payments of $454 million across a range of Health and Veterans Affairs programs, including MPS, NPH and access to public health programs—and contracts for hospital services for veterans. Can I get an understanding of why that underspend exists, please.

Mr Sheehan—The $454 million is related to the Health function, and includes DVA as well.

Ms Halton—Obviously, we cannot make any comment in respect of DVA.

Mr Sheehan—The underspend for the department is $70 million, or thereabouts.

Senator McLUCAS—What is that made up of?

Mr Sheehan—It is made up of a number of underspends and overspends from a number of different programs. Health program variances—cash versus accrual—are $73.113 million.

Senator McLUCAS—Can I find those in the final budget outcomes paper?

Mr Sheehan—I do not think you will find those by program. There were a number of other adjustments as well. One was for an equity adjustment. There are a number of other cash variances. But the program related component was $73 million.

Ms Halton—I will just make the observation that, as a proportion of our total spend, it is pretty low.

Mr Sheehan—The number was calculated by the Department of Finance and Administration, and there are a number of other components to it, but our program component is $73 million of the $454 million. There is also an amount for GST included in that, but that is not specific to the program area.

Senator McLUCAS—I have a note here that says $54 million was underspent on capital investment—is that right?

Mr Sheehan—I do not have that detail with me.

Senator McLUCAS—Will you be here later today?

Mr Sheehan—Yes, I will.

Senator McLUCAS—We might come back to that then. Thank you.

Senator MOORE—I have some general questions on staffing, Ms Halton. I have had a look at the annual report, and it does give some of the general stuff. Basically, Senator Carr asked a number of questions about AWAs, for which we have received answers. They were correct in the last round. Can we put a similar question back on notice, as of now. It is reframing Senator Carr's question about the AWA process—looking at what is happening now. It is mentioned in the annual report but without numbers—and we found the response to Senator Carr's question very useful, because it talked about level, gender and all those kinds of things.

Ms Halton—Yes.

Senator MOORE—I am interested in the capability—

Ms Halton—Framework?

Senator MOORE—Yes—the capability thing. It is lauded in the report, and I am interested in how it is the basis of your whole HR process. Can you give us some more information about that at this Senate estimates, because I think it is going to be an ongoing kind of question—how it is going and how it operates.

Ms Halton—Absolutely.

Ms Develin—The capability map—

Senator MOORE—Map—I do apologise.

Ms Develin—Basically we have come up with a framework that allows us to indicate, from APS1 through to EL2, the expectations of our officers. So the capability map provides the framework, I suppose, of how our officers work—not just what they are working on but the expectations around how they work. We can provide that.

Senator MOORE—That would be appreciated.

Ms Develin—With our performance development scheme, we use that capability map for our recruitment processes.

Senator MOORE—The annual report mentions how it is integrated into all the elements. How is it used in the recruitment process?

Ms Develin—Assessments are made against those capabilities set for each of the classification levels, and the assessment is used in the three phases of our recruitment process. We have a ratings scale in each phase and we use that framework to make an assessment of the behavioural type application, how people have framed around that capability map and the criteria.

Ms Halton—We have been working on this for quite a while; you do not produce this in the blink of an eye. It was partly in response to what staff told us about the need to better understand what they needed to do at a particular level and, importantly, if they wanted to be promoted, what they needed to do to be eligible for promotion. So it is partly in response to what staff told us.

It is also a response, I suppose, from us, saying that we need to be clearer about the skills we need in our workplace. We need to be clearer about what capabilities we need to build and foster in our work force. We also need to be able to have a very unambiguous dialogue with people about performance. I think managing performance, from both sides of the equation, can be quite difficult. The more you can remove ambiguity, the better, so that there is no doubt about what is expected of people at particular levels, both so they can build their capabilities and so you can give feedback in a way which is accessible. Really that is what we have been striving for with this.

I have to say that when we started on this work it was relatively unusual in the public sector. The commission, interestingly, picked up the whole notion, and so there is now something more broadly across the service. We are very pleased that essentially work that we kicked off has now taken on a broader life. I genuinely believe it is a very good document.

Senator MOORE—I did get a copy of your last staff survey. Is there expected to be another one this year?

Ms Halton—Shortly.

Senator MOORE—Is it going to be in a similar format?

Ms Halton—Absolutely.

Senator MOORE—Can we get a copy of that one too, in case there are changes?

Ms Halton—Yes.

Senator MOORE—Can I get you to talk about the staff survey—the questions are quite personal, and I want to ask you about one of those—and how that links with the capability map. I would have thought that in some of those questions, in terms of that stated aim of making people feel more confident and fulfilled in their work, there would be some linkage. Is there a formal linkage between the survey process and the capability map?

Ms Halton—We do not link individuals in the survey process. One of the things we have to be very clear about to people is that they have anonymity and complete privacy. You cannot expect people to answer a series of questions about how they genuinely feel about the workplace, what is good, what is bad, what could be improved, what could help them more, how they find supervision et cetera—all the things that you actually want to know about your workplace—if there is any suspicion that there is going to be any personal identification of answers. So we are very clear about that. In fact I did an all-staff note about the forthcoming

survey, which we are going to run in about 2½ to three weeks, which again reinforces that point.

The clear linkage is that the kinds of questions we ask in the survey—and we have canvassed this before—which go to what people think and feel and how they are managing in the workplace et cetera, are highly germane to what is in that capability map. As I said, we will get you one later this morning and you will be able to see some of that.

Senator MOORE—It was very clear that you were not using individual things. It was more or less the themes that came out. The document is quite themed—although I cannot find my copy. One question is along the lines of: 'Does your mind wander and do you doodle at work?' That jumped off the page for me. Was there any particular reason behind that? I can see the background to most of the questions. That one just floored me: 'Do you doodle at work?'

Ms Halton—I do not know about you, Senator, but I do.

Senator MOORE—I would have to admit I did, but I was wondering what exactly the background to that one was.

Ms Halton—This is where we are in the hands, at one level, of the professional group that actually do this survey. Whether we have ever interrogated the precise meaning of that question I cannot answer. The answer, I am being advised, is no, we have not. But it goes to the whole package of questions. In the past we have discussed the fact that individual questions form parts of individual clusters. All I can say is that, given that they have done extensive work validating the survey, I believe in some way the precise detail would be discriminating. I can find out if you are really interested.

Senator MOORE—I am, but that is not—

Ms Halton—I will ask and at some later point I will tell you.

Senator MOORE—In another series of questions—and I am interested in how it fits into the department planning—there seems to be quite a degree of information being sought about the workplace relationship with the supervisor and the supervisor's supervisor and about comfort levels, perceptions, how you feel, whether you trust and that kind of thing. Is that part of the ongoing safety aspect in the department? It does seem that in that survey there is quite specific questioning about inferences of whether there is bullying in the workplace.

Mr Law—The questions in the survey are actually in two groups. One is a standard group of questions which is used for benchmarking purposes across other organisations, to see how the organisation is going vis-a-vis both public and private sector. Then there are specific departmental questions. It depends where they fit in—whether they are part of that standard questioning set for benchmarking purposes or specific for departmental. I think that goes to the discussion you were having a little bit earlier about the nature of questions, about doodling et cetera. I believe that is one in the standard set of questions.

Senator MOORE—I have the survey in front of me. There are 85 standard questions, and then there is a demographic bunch which links people to where they fit in your department—age, gender, which part of the organisation they work to. You are saying that within those 85 questions there are some that are different.

Mr Law—Yes, there are standard questions across the instrument by the organisation that we use. Then there are specific questions that we put in that are seeking more information from our staff about particular issues.

Senator MOORE—'We have strong, effective and dynamic leadership.' I like that one.

Ms Halton—Those are actually standard. What this particular instrument obviously attempts to do is enable itself to be benchmarked. It enables us to make comparisons of where we sit both in the context of the public sector and right across private sector organisations. As Mr Law says, obviously there are some particular things that we want to draw out a bit more, particularly when you are going through a process of organisational change, to measure how that is going. Also, you want to be able to say, 'How do we compare with other organisations?' As has been indicated, I have a suspicion that the doodling question is a core part of their questions.

In relation to any particular focus on relationships between supervisors, I suspect—but we can confirm this—that that is part of the standard block. Nonetheless, I would want to know that. The reality is that, even though a department of our size is large, your day-to-day working experience is in a small team. That is the nature of most of what we do in the public sector. You work in a section, a branch, a division. Your most common interactions are with the people who sit proximate to you and with your immediate supervisor. If those relationships are good and positive and that is a productive work unit, obviously the place is going to be working better. So it is very important for us to know that we have that right balance in terms of skills et cetera.

Senator MOORE—Which number survey are you up to now? I have got a copy of last year's.

Mr Law—The next survey is the third.

Senator MOORE—So it is early in the process of comparing, benchmarking and so on.

Ms Halton—Yes. When we started on this process there had not been a survey inside the department for quite some time. One of the things I made a commitment to very early was being willing and open—and in fact actually wanting—to being able to see what people thought in the place. So when I started this process we gave a commitment that we would do them annually.

Mr Law—I recently forwarded a copy of the latest survey instrument, which we are running in November. It just might not have filtered through the system yet. It is on its way.

Senator MOORE—Good. Can you just remind me about what the response rate is.

Ms Halton—The last one was 93 per cent, so it has been very high.

Senator MOORE—So we will be able to, next time around, compare some of these processes.

Ms Halton—Yes.

Senator MOORE—Does the survey then go back to the national staff participation forum? Do the results that come out of that survey feed back through that NSPF?

Ms Halton—We provide information on the survey very broadly across the department. It goes to work areas. It is discussed by the SES and the NSPF; basically, anyone who has an interest—and some who do not—gets told about the outcomes.

Mr Law—We do provide specific briefings at the time of the release of the survey results to the NSPF.

Senator MOORE—About the general themes and results and so on?

Mr Law—Yes.

Senator MOORE—In the annual report it says that you have been gathering information, including an overview of the department's work force diversity performance, to support a changed employment agenda. What does that mean?

Ms Halton—In the past we have discussed the importance of ensuring that we have a diverse workplace. In the past we have talked, particularly in relation to our Indigenous staff, about the need to attract and retain good quality Indigenous staff, and that is something that we take very seriously inside the department. I think you would be aware that there has been some concern about some slipping in the statistics across the service in that respect. We have been working with the commission to make sure that our performance remains good, which I believe it has been.

Senator MOORE—I think you have held up, but you have not gone ahead.

Ms Halton—Yes. It is a very active employment market for Indigenous people.

Senator MOORE—Very much.

Ms Halton—Part of me says that I do not want to stand in the way of, particularly, my good staff, whom we have spent a lot of time developing; they get opportunities. In fact, I have just given 12 months leave without pay to one of our SES officers to go off and do some work which expands her career horizons. She is doing that with my blessing but it is going to hurt the statistics. We just need to be continually vigilant in relation to those sorts of equity questions in our workplace.

Senator MOORE—When you say that you are doing a review internally, what does that mean? The term 'doing a review' is thrown around. Is it a formal review of how you are going with your diversity program, looking at processes?

Ms Develin—No. We are just looking at a whole range of different things—recruitment, branding, how we attract people from workplace diversity. We recognise, with the labour market reducing and getting quite competitive, how to better focus on attracting people in those areas. There is no one thing that we are doing; we are doing a range of different things.

Senator MOORE—At the last estimates we had some discussion about the melding of public sector employment with the expectations of the Welfare to Work program, and about the possibilities of part-time work, flexibility and that kind of thing. At that stage, I think you said, Ms Halton, that you were looking at that and that you had some plans. Has that been progressed?

Ms Halton—Again, as Ms Develin said, we have been attempting to look at recruitment. We have a very high level of part-time participation already.

Senator MOORE—Yes, it is one of the highest in the public sector.

Ms Halton—Yes. In fact, it is a very active part of retention for many of our staff—that they are able to balance up family and/or other commitments, which we believe is quite important.

As I say, to say that we are doing a formal kind of review is not right. We are continually looking at our performance to think about what is happening with our numbers and whether we can do better—is there something we can do; is there a barrier we can remove? It is a constant source of attention.

Senator MOORE—I am also interested because of the fact that your department has a lot of almost semi-independent agencies that come under your heading. Does all of that feed through to the umbrella Department of Health and Ageing? The kinds of discussions about employment aspects, conditions, the diversity program—do they feed through to all of the departments that come under your umbrella?

Ms Halton—In terms of the portfolio, clearly we do not set employment policies or anything else for the separate agencies. For the parts of the department, even though sometimes they look slightly autonomous—for example, the TGA—yes, all those things apply. But, for the portfolio, obviously the CEOs in each of those areas have accountability.

Senator MOORE—So there is no automatic link.

Ms Halton—No. That said, we are happy to share.

Senator MOORE—I will put those standard questions about numbers and things on notice.

Ms Halton—Yes.

Senator CAROL BROWN—What are the staffing numbers in the Hobart office of health and ageing?

Mr Law—In the annual report on page 411 we have reported that in Tasmania there were 56 staff members as at 30 June 2005.

Senator CAROL BROWN—Does that break down to what basis they are employed on?

Mr Law—No. I can take that on notice. I have the breakdown across the whole department, but not by state.

Senator CAROL BROWN—I would appreciate that. Has there been any discussion about closing the Hobart office?

Ms Halton—No, there is no discussion about closing the Hobart office. I know there has been a rumour doing the rounds. In fact, I went to visit the Hobart office recently and said categorically that I understood the rumour was doing the rounds and it was categorically not true. There is no plan. We are not intending it. I do not foresee it.

Senator CAROL BROWN—Is there any review of the operations of the Hobart office?

Ms Halton—Other than to the extent that we are continually reviewing how we do our business, the answer is no. Do we need to continually review how we do our business?

Absolutely. Can we find more efficient ways to do things? We always have to strive for efficiency, but we are not singling out in any way, shape or form the Hobart office.

Senator MOORE—Are you singling out any office?

Ms Halton—No, we are not, I promise you.

Senator MOORE—No office is being singled out?

Ms Halton—No.

Senator CAROL BROWN—It is nice to hear that. Is there any discussion around reducing the staff numbers at the Hobart office?

Ms Halton—As I said, it is a year-on-year proposition in relation to how many staff we get allocated to do particular things. The total of departmental resources can vary depending on what budget proposals we get, what goes off in terms of lapsing measures et cetera. We are always striving to find better ways to manage our corporate overhead, because those are things that we are going to get benchmarked against. I know individuals get very worried when they see more change, as more technology comes along. This has been going on in the public sector for as long as I can remember. We have to manage our way through those kinds of changes and we have to deal with the individuals who may feel that they might be personally affected in ways which are sensitive, and we do try to do that. I am very aware that this little rumour has been doing the rounds.

Senator POLLEY—Are you intent on downsizing the Tasmanian staff?

Mr Law—One of the areas that we are currently reviewing is national, from a corporate overhead situation, as the secretary mentioned. That incorporates both Canberra based and state based staff. I am responsible for that review. An undertaking I have given is that, if we change the locally provided corporate services, we are looking for opportunities to in fact transfer and decentralise activities possibly out of Canberra or other places to make best use of the skill resources that we have in those state and territory offices. So it is not directed towards changing staff numbers per se in state and territory offices; it is directed towards possibly changing what they do. Maybe that is where some of this has emerged. It is moving to a more nationally focused corporate support model and looking at how those services are provided.

Senator CAROL BROWN—Are you saying that the employment numbers will not change but what they do may?

Ms Halton—We need to be clear. We cannot give any ongoing guarantees about employment numbers because fundamentally I do not know what I am going to get appropriated in any one budget. But, if there is not a significant change in what we get appropriated, we may still look at how we do the business so as to be more effective and more efficient. Exactly as Mr Law says, that may mean that functions which are currently done in a not very efficient way are done in a different way.

Senator CAROL BROWN—Somewhere else.

Ms Halton—Or, in fact, more functions may be done somewhere like Hobart. It is not our current intention to downsize the Hobart office.

Senator CAROL BROWN—So it is not closing. You are not currently considering that.

Ms Halton—Let us be clear. There are two officers in that office who currently undertake a range of financial tasks. I understand exactly where these questions have come from. They are very concerned that the nature of their work not change. I cannot give that guarantee, because the nature of that function at the moment is not highly efficient. At the end of the day, I am quite confident that we can find work for individuals. Will it be exactly the job that they have been doing for the last however long? I cannot guarantee that.

Senator CAROL BROWN—But they will be in the Hobart office.

Ms Halton—They personally, I would imagine, would not want to be anywhere else.

Senator CAROL BROWN—So that is yes.

Ms Halton—Subject to those caveats, that is exactly right.

Senator ALLISON—I want to follow up from last estimates on the question of IT and the ANAO report that was done in 2002. Can you update the committee on where the IT strategic review is at at the present time? Perhaps give an indication of what procedures have changed in order to avoid the very large loss of IT equipment.

Mr Law—I am a little unsure about what ANAO report you are referring to in that sense.

Senator ALLISON—From 2002, on IT.

Ms Halton—What is the title of the ANAO report? Do you have it with you?

Senator ALLISON—No, I do not, but I am sure you are aware of it. It was one that looked into the stolen, missing or damaged computers.

Mr Law—Not to my knowledge. There was, I think, some broader based discussion across government about lost and stolen PCs in 2002.

Senator ALLISON—So you have not done an IT strategic review? I thought we discussed this at the last estimates.

Ms Seittenranta—At the last estimates, there were no questions about IT at all.

Senator ALLISON—It might have been the one before.

Ms Halton—Certainly not at the last estimates.

Senator ALLISON—So there is no IT strategic review?

Ms Seittenranta—There has not been in the recent past.

Senator ALLISON—How far in the past was there one?

Ms Seittenranta—It would precede my time.

Mr Law—There was the development of an overall IT strategic plan for the department, which commenced in 2002. Maybe that is the issue you are referring to. There was a lot of work done on developing a long-term strategic direction for IT in the Department of Health and Ageing.

Senator ALLISON—What were the changes put in place in order to respond to the ANAO report? I know you cannot remember what it was, but I am sure you will at some stage.

Mr Law—If the question you have is around lost and stolen PCs, I can certainly respond to particular issues there, if you have a concern. But I am still having difficulty relating lost and stolen PCs to an ANAO report.

Senator ALLISON—Let us put it another way: in 2004-05, how many were in this category?

Mr Law—Lost or stolen PCs?

Senator ALLISON—The stocktake deficiency I think it is described as.

Mr Law—In 2004-05, we undertook a major stocktake and review of our equipment, associated with an overall equipment refreshment exercise from our supplier. As a result of that review, we identified 23 laptops which had been reported as lost or stolen.

Senator ALLISON—Twenty-three.

Mr Law—Yes, for 2004-05.

Senator ALLISON—Were stolen.

Mr Law—Lost or stolen. I think two of those were stolen and the theft reported to the police.

Senator ALLISON—They were reported to the police?

Mr Law—Yes.

Senator ALLISON—And investigated? And what was the result of the investigation?

Mr Law—The police have not provided any advice back. We have not heard of any outcome to any investigation.

Senator ALLISON—Do you think they were stolen as a result of break-ins?

Ms Seittenranta—One was taken during a break-in to a staff member's car. I am not aware of what the circumstances were for the second one.

Mr Law—Usually PCs are stolen as a result of a house break-in where the officer has that piece of equipment at home or, as Ms Seittenranta said, as a result of a car break-in.

Senator ALLISON—As I understand it—and I am not sure how long ago this was—there was an issue about the department continuing to pay IBM for equipment which was no longer present.

Mr Law—There was a press report purportedly based on some internal departmental document some months ago. That report was full of misunderstandings, errors and inaccuracies. Fundamentally, that report referred to 100 or so laptop PCs that were missing or being paid for that we did not have. That was inaccurate.

Senator ALLISON—So how many was it? If it was not 100, what was the figure?

Mr Law—As a result of the review that we undertook and the physical stocktake, 23 laptops were identified as being either lost or stolen. That was the figure.

Senator ALLISON—And the payment issue? Was that an issue or not?

Mr Law—No. I think one of the inaccuracies in that report was that it talked about leases on equipment having ended and the department continuing to pay. We do not lease equipment per se; we pay a user charge on equipment. As long as we have the equipment, we continue to pay it. It is not time bound.

Senator ALLISON—But when the equipment goes missing do you continue to pay the user charge?

Mr Law—No. When the equipment goes missing, we do not continue to pay. It is a matter of identifying—

Senator ALLISON—You do not and have not—is that correct?

Mr Law—That is correct.

Ms Seittenranta—Between the declaration of a device being missing and the payment coming off, there is usually a gap in the process cycle of the paperwork going through us and our outsourced service provider. But the payment actually ceases from the date that we declare the device lost.

Senator ALLISON—How often do these stocktakes take place in the department now?

Mr Law—That stocktake was a major stocktake associated with a refreshment exercise. Some of the administrative issues that we identified through that process resulted in us putting in place some improved arrangements between us and our outsource providers about notification and issues of changes. Because the equipment belongs to an outsource provider, they are the asset holder and they have the asset records. But the department has a role in providing information to keep that record as accurate as possible, and that record then becomes the basis of billing arrangements to the department.

As a result of the review—and I must admit I was disappointed with the number of PCs that the review identified as being lost—we put in place a range of controls to tighten up the process between us and our outsource provider. Also, now that we have put in those controls, the department have commenced and are close to finalising an overall internal audit of the broad processes and payment regimes between us and the outsource provider to see whether there are any other improvements that we might need to make to tighten up that control. As a result of that major stocktake, we put in place controls, which are now being reviewed. One of those controls is to have regular stocktakes by our outsource provider, and a physical check.

Senator ALLISON—So what is 'regular'? That is my question.

Mr Law—We are looking at once every 12 months.

Senator ALLISON—And this is now the responsibility of the contractor, not some independent body?

Mr Law—It is the responsibility of the contractor. However, the review that we did involved an independent review, and that review identified the right numbers and made a number of recommendations about how we might improve the controls.

Senator ALLISON—Let me ask that question again: when will the next stocktake be and how frequently can we expect them in the future?

Ms Seittenranta—We are only just finishing the current round of activity, so I would expect in 12 months time.

Senator ALLISON—There will be a stocktake in 12 months time. It is to be an annual event, in other words.

Ms Seittenranta—Yes.

Senator ALLISON—Mr Law, my first question was about what changes you put in place, and you suggested that you did not know what I was talking about. Your subsequent answer goes on to tell me quite a lot about what you are doing, but can I go back to that first question and ask you what the principal changes are that have been put in place as a result of the review?

Mr Law—My response to the first question was that I was unable to identify the ANAO report you were referring to that reported on such matters. I do not believe—

Senator ALLISON—I did ask you about an IT review and you also claimed no knowledge about what that was about.

Mr Law—That was my concern, but you went on to indicate lost and stolen laptops and I was able to provide you with a degree of information about that.

[9.56 am]

CHAIR—As there are no further questions on the overview, we will proceed to outcome 11, Health and medical research.

Senator McLUCAS—I have one issue I want to discuss in outcome 11: the issue of the DVT study that goes back to 2001. In estimates in June 2002 we talked about a study that had been announced the previous year into deep vein thrombosis. I understand that there was some work done; it was joint work between NHMRC and the department of transport. There was a preliminary study published in the *British Medical Journal*, but I understand that further work has been cancelled. Could you tell the committee why that has happened?

Ms Roediger—There was work done in 2001. In 2001, when the work was done, DIMIA had a data linkage unit internal to the department. This did the actual linking process, which meant that no identified data needed to be released. They no longer have that. We started a body of work to do a second round and found that DIMIA no longer had the unit. We therefore cancelled the research until we could satisfy ourselves of the privacy issues associated with the new process.

Senator McLUCAS—There was an article in the *Australian* on 26 September this year which refers to a letter that the department wrote to the *Australian*. Can we get a copy of that letter?

Ms Roediger—Yes, I can see no reason not to provide you with a copy of that letter.

Ms Halton—We will see if we can get it later on this morning.

Senator McLUCAS—There is a different message in this article. The article says the:

… project had been halted because ethics committee approval … had expired.

This is a different reason for cancelling it.

Ms Roediger—Ethics committee approval was never gained for a process which would have involved getting identified data from DIMIA. The previous process in 2001 that you have referred to—that was conducted, concluded and published in the *British Medical Journal*—had ethics committee approval. The ethics committee approval for that process could not be brought forward to the new process because it is fundamentally different. The old process did not require DIMIA to release any identified data. As soon as you are breaching the privacy of individuals by releasing the identified data, it needs to go back for new process and that involves, as part of that process, a new ethics committee approval for the process as it would have to now be.

Senator McLUCAS—So the difference is essentially that DIMIA does not collect deidentified data anymore?

Ms Roediger—No. It was going to be using a different information set, but the main difference is that, the first time, DIMIA had a unit internal to itself. We sent them information about people who had suffered deep vein thrombosis, and they were able to link that to travel data that they held internally, which meant that no identified data had to ever come out. They no longer have that internal unit. A proposal was brought forward to continue the research by pulling identified data out and having the CSIRO, I believe it was, do that linkage, but that is of course a different process. It has a private organisation having access to the data. It would require the process to be written up, cleared through our processes and then cleared through an ethics committee, and that had not been done.

Senator McLUCAS—In the article—and this is a claim that DIMIA was stopped from handing over the flight duration data because of privacy and legislative requirements—it says in the next sentence that this is 'a claim hotly rejected by Immigration'.

Ms Roediger—It is rejected by us too. It is just not true.

Senator McLUCAS—Why did you write to the *Australian*? It is a very strange thing to do.

Ms Roediger—No, the *Australian* wrote to us—

Ms Halton—It was an FOI request for Michael McKinnon.

Ms Roediger—with an FOI request, asking for information about this. We wrote back to them. They asked for a copy of the final report or to be informed if no final report were going to be produced. When we cancelled the research and determined that no final report would be produced, we wrote back to them to tell them so. In that letter, we gave them the reasons why no final report was being produced and the fact that it would require a different process that had not been cleared through an ethics committee. So DIMIA and we have given the journalist exactly the same information.

Senator McLUCAS—Did you consult with DOTARS, because I understand that they part-funded the initial research?

Ms Roediger—No, we did not. We have all the records for what happened with DOTARS, but it is quite a different process now, and DIMIA is now the holder of the information that we would need for the second phase.

Senator McLUCAS—Did DOTARS part-fund the first piece of work?

Ms Roediger—They collaborated with us on the first piece of work, and they were very helpful, particularly with in-kind work. Whether they financially contributed I would have to take on notice.

Senator McLUCAS—No, do not bother; that is fine.

Ms Roediger—They did a lot of the work in drawing together the data. They did the original linkage. They got approval through their minister. They were a very full participant in the first phase.

Senator McLUCAS—Do you intend to revisit this project?

Ms Roediger—Yes.

Senator McLUCAS—How do you intend to progress with it from now on?

Ms Roediger—We intend to progress it in the way that every other research proposal is brought forward. First it will be reassessed against all of the other potential candidates for the funding associated with this, including the extra costs that would be involved now. We have to recost it for the new process. If it is found to be a priority then it will be progressed through a restricted tender. The process that the successful candidate brings forward for doing it will go through an ethics committee approval process. It just goes back into the mix of other research proposals at this point.

Ms Halton—I think the important thing to understand here is that the first piece that was published in the *BMJ* actually made the point about there being an impact so, in terms of cost-benefit, you have to ask yourself the question: 'Given that we've proved the case, do you need to do more?' I am not prejudging the outcome of that consideration at all, but, as Ms Roediger says, there will be additional costs because of this change. I have to say that I have just looked at the letter that was sent to the *Australian*'s FOI editor. I have asked for some copies to be made. I am very happy to table that.

Senator McLUCAS—When do you expect to recommence? You have described how you have to get to that point of restarting the second part of the research. When do you expect that to start again?

Ms Roediger—We expect to probably be looking at it in the round of next financial year's bids for research. We have a data linkage working group, which is under the Statistical Information Management Committee, which draws together research proposals from across the states and territories as well as from the Commonwealth. There are a range of things being brought forward. This would be bidding against the same bucket of money as those.

Senator McLUCAS—You did explain that there would be a process of finding an appropriate person to conduct the research; it would not be an in-house NHMRC piece of work?

Ms Roediger—No, the previous one was to be conducted externally. I am reasonably confident it was by CSIRO. We would be going to a tender against organisations which have the requisite skill sets for doing this. As the secretary has already pointed out, the first phase proved the case for a regular linkage. The second phase was simply to assess whether or not short-haul flights were a risk, which would enable us to say that when you are on a short-haul

flight you do not need to wriggle your toes for the half-hour. Its value would need to be assessed against other proposals.

Senator McLUCAS—You would not necessarily need DIMIA information for that, would you? One would image that you could get short-haul flight information from DOTARS.

Ms Roediger—We do not have good domestic data that we could link, that we could work out how to get access to, and the proposal was to use short-haul international flights as a proxy for a domestic flight. That is how it was originally structured. For medical purposes, it is the duration of the flight rather than which country you end up in that matters.

Senator McLUCAS—I am getting into detail that we probably do not need to get into in supplementary budget estimates, but why can't DOTARS give you that sort of information? Short-haul international information is a hard thing to find from Australia.

Ms Roediger—I have not really assessed whether or not DOTARS can. When I inherited this function we already had a relationship with DIMIA and an agreement with them which would have met the purposes, so I have not needed to look for any other source of information. The question is not the source of information; DIMIA was definitely willing and able to give us the information. The question is the protection of the privacy of Australians.

Senator McLUCAS—Yes, I understand that. I am just trying to identify where a short-haul international flight would come—

Ms Roediger—New Zealand.

Ms Halton—New Zealand, New Caledonia—basically some of the South Pacific countries.

Ms Roediger—There are enough. We assessed that there were enough records to do a reasonable sampling from.

Ms Halton—The reality is that, where that information already has a purpose to be collected for the purpose of border control, DIMIA have a reason to collect information on who has come into the country, which flight they came in on and where they have come from. That data source is already there, whereas DOTARS does not have to know which individual has flown on which flight.

Senator McLUCAS—That is all I have for outcome 11. I know that it was indicated on the documentation you may have received that Senator Fielding was going to ask some questions, but I understand that he is not here. I thought Senator Allison was going to ask some questions.

CHAIR—She does have other questions but she has a meeting and will have to put them on notice. That finishes outcome 11.

[10.08 am]

CHAIR—Are there any questions on outcome 10, Acute care?

Senator CAROL BROWN—I would like to ask a question about medical indemnity.

CHAIR—I think we are ready for that question now.

Senator CAROL BROWN—In December 2003 there was a media release put out by Minister Abbott and Minister Coonan about medical indemnity arrangements following a review, which says:

New measures adopted in response to the Review Panel's recommendations will cost $181 million over four years. This is on top of previous commitments of $438 million over the same period.

In a more recent release by Minister Abbott he indicates the commitment to be '$413 million for medical indemnity insurance'.

Mr Maskell-Knight—I think they are both right in one way or another. I think they refer to different periods of time. Currently the government is spending of the order of $100 million a year. Without having the benefit of having those documents in front of me I cannot speak to the detail of how many years they covered or what period of time.

Senator CAROL BROWN—The first document is a media release from December 2003 following the Medical Indemnity Policy Review Panel. From that the government adopted the recommendation for $181 million to be in addition to the previous commitments of $438 million, which is about $620 million over a four-year period. I would have thought that that would have been from that period. His second release in May 2005 indicates that it is $413 million.

Ms Halton—If you would be happy to let us have a look at those press releases we could probably answer the questions. We do not have them in front of us.

Senator CAROL BROWN—Sure.

Ms Halton—It is easier if we have the documents in front of us then we do not talk at cross purposes.

Senator CAROL BROWN—Yes. I doodled on it and I know you—

Ms Halton—Apropos the earlier question about the—

Senator CAROL BROWN—I know you are doing a review and I did not want you to make assumptions about me. While we are getting a copy of that I have a couple of questions that I am going to place on notice. Perhaps I will take up the time by reading those into *Hansard*. First, can the department provide a line-by-line breakdown of all medical indemnity measures since the crisis in November 2001. For each of these measures please provide the estimated cost and the corresponding actual cost. Second, what has been the total cost to the Commonwealth of the assistance given to the medical indemnity sector and doctors since the crisis in 2001? Third, what is the estimated net effect of all measures following and including the introduction of measures flowing from the Graham Rogers report into the competitive neutrality effects of the government's assistance to UMP? Could you provide that information.

Ms Halton—We will take that on notice.

Mr Maskell-Knight—In relation to the press releases: the one in 2003 was a combination of two years looking backwards and four years looking forwards, and the budget press release from May this year was four years looking forwards. So they are both the right number; it is just that they are a combination of different years.

Senator CAROL BROWN—So, in the 2003 release, the $438 million—

Mr Maskell-Knight—Was approximately what we had already agreed—what we had already spent and what we thought we were going to spend over the next two years at that time. I suspect it then got added into the four-year cost of the additional measures. I think once we provide the table you have asked for you will be able to see it. That is by far the best way of clarifying all these.

Ms Halton—As a rule of thumb, think $100 million a year. That is fair enough, isn't it?

Mr Maskell-Knight—Yes.

Ms Halton—That is probably the best way to think of it. Then it is just a question of whatever the reference period is.

Senator CAROL BROWN—So essentially that $620 million figure—I think it is around about that, or $619 million—is really over a six-year period?

Mr Maskell-Knight—Yes.

Senator CAROL BROWN—Thank you. I am finished.

CHAIR—Are there other questions under outcome 10?

Senator ADAMS—I would like to speak about the patient assisted travel scheme. I know this is no longer a Commonwealth responsibility but, having sat on a number of national committees, this seems to be the biggest single issue for rural patients. I have been speaking to the minister about it, but I really do think we need overarching guidelines, somehow. This function went to the states in 1987, but I think the only way we can get some flexibility with it, with each state, is through the Commonwealth looking at guidelines which perhaps might bring some consistency into it. Could you comment on that for me?

Ms Halton—Obviously we cannot make any comment about policy issues.

Senator ADAMS—No?

Ms Halton—I can confirm that you are right—it was transferred to the states in the late eighties and since that time it has not been a matter that we have had any engagement with.

Senator ADAMS—All right, I will leave it, and I will deal with it in another way.

Senator MOORE—The issue Senator Adams is raising has come up a number of times—this particular area of support for people. Is that on the COAG agenda?

Ms Halton—Not that I am aware of.

Senator Patterson—I would be guided by Ms Halton, and I do not recall it. But it is a real problem whenever you have an issue that the states do not deal with appropriately. We have had a lot of issues about this and it has gone across a number of governments. Since 1987 there have been governments other than Labor ones in power in some states, so I am not making a comment about that. But it is very difficult. We cannot make the states do things. But, Senator Adams, if you want to pursue it through the minister for health, that is the way to do it. But I cannot talk about policy.

[10.18 am]

CHAIR—If there are no further questions under outcome 10, we will proceed to outcome 2, Medicines and medical services.

Senator McLUCAS—I have a series of questions initially on pharmaceuticals and then on Medicare.

Ms Halton—We have lost the division head, but she will be with us any second.

Senator McLUCAS—To start with, I have some questions about funding the PBS generally. Can you confirm the forward estimates for the PBS into the future or at least tell me where to look for them?

Ms Halton—I am sorry; I am finding it a bit hard to hear you.

Senator McLUCAS—We all are.

Ms Halton—We do not have enough volume. I cannot hear.

Senator McLUCAS—Can you tell the committee what the forward estimates for the PBS are into the future?

Senator BARNETT—Chair, it is very hard to hear, I must say.

Senator McLUCAS—I think we need to turn up the volume generally.

Senator Patterson—You can never hear in this room. We have not been able to hear for about 17 years. We say it every estimates, hoping that some audio person will fix it.

CHAIR—I think the volume has been turned up and I think Hansard is aware of the problem. It would help if people sat close to the microphone as well to make it a bit easier.

Senator Patterson—Maybe we could write a joint letter to the President and the Speaker and say that they need to do something about it. We sit here and complain all the time, so I would suggest that the committee write a letter.

CHAIR—We will take that matter up with the Department of Parliamentary Services.

Senator McLUCAS—Ms Huxtable is now going to answer my question.

Ms Huxtable—The forward estimates for the PBS are as published in the 2005-06 Budget Paper No. 1. For the four years from 2005-06 the figure is $6,507.5 million. In 2006-07 it is $6,960.8 million. In 2007-08 it is $7,642.9 million, and in 2008-09 it is $8.470.3 million.

Senator McLUCAS—Have they changed since the budget was released in May?

Ms Corbett—Those are as in the budget report.

Senator McLUCAS—And have they been amended?

Ms Corbett—The only changes would be the addition of some high-cost drugs that have been announced, and those would not be incorporated into those. All adjustments will be made at the next formalised adjustment update, which would be the additional estimates.

Senator McLUCAS—At additional estimates?

Ms Corbett—Yes.

Senator McLUCAS—Do the PBS forward estimates that you have just read out include the impact of the 12.5 per cent policy?

Ms Corbett—Yes, that is included. That was one of the 2005-06 budget measures, so those changes are incorporated.

Senator McLUCAS—I turn to the rate of growth for the PBS. I notice that on notice you provided us with the number of scripts, in a comparative sense. That was question No. 65. I am now interested in knowing what the rate of growth was for the first quarter of 2005-06 compared to the same quarter of 2004-05. What was the rate of growth for each of those quarters?

Ms Corbett—I do not have the rate of growth in scripts with me, but I am sure we can get it for you within the day.

Senator McLUCAS—In a global sense.

Ms Corbett—In a global sense, this is the important thing. Some of the issues that have recently been in the press, for instance, are a little misleading because they just look at Medicare Australia's data, which is online, and which covers the community based PBS scripts that are issued to concession card holders or general patients, but they do not include the impact of those drugs that are subsidised by the PBS but delivered in different ways. So we have highly specialised drugs, for instance, that are delivered through the hospital scheme and other special arrangements that are part of the PBS. So the script volume story does not neatly tally with the overall PBS growth story.

Senator McLUCAS—If we are comparing apples and apples, the same quarter for each period, the same circumstances would have existed then I imagine, where high-cost prescriptions are delivered through a hospital—

Ms Corbett—Yes.

Senator McLUCAS—That would have existed then, I imagine. So in terms of comparing a quarter and a quarter—

Ms Halton—There were a number of other things that happened—for example, the Vioxx withdrawal, which was very significant.

Senator McLUCAS—With the Vioxx withdrawal, surely people moved on to another—

Ms Halton—Not necessarily a prescription treatment.

Ms Huxtable—Over-the-counter treatments are also available. So, as to what happened when Vioxx was withdrawn, it is hard for us to track precisely what it meant for individuals.

Ms Halton—Certainly there were a lot of stories anecdotally about people returning to their physicians and reviewing the whole notion of what therapy they should be taking. Certainly we have been told anecdotally that a lot of people were swapping off prescription therapy.

Senator McLUCAS—They moved straight off Vioxx on to aspirin?

Ms Halton—I cannot comment about what they actually moved on to, but certainly we were told that by significant numbers of people, including pharmacists who were dealing with these patients; so they knew these patients well. John McEwen might have a—

Dr McEwen—Particularly for osteoarthritis, they would move to paracetamol, rather than aspirin. There are no readily available data, but I suspect there has been a considerable uptake of glucosamine, which people purchase over the counter.

Ms Halton—That is certainly what pharmacies and other people are telling us is happening.

Senator McLUCAS—I am getting off the line of my questioning, but I have an interest in this area. Has there been growth in Celebrex, for example?

Ms Corbett—No. There has been a decline in the use of Celebrex—

Senator McLUCAS—Because of the boxed labelling?

Ms Corbett—There has been a lot of publicity around concerns about the whole Cox-2 category and, for whatever reason, it would seem that people are no longer using Celebrex in the same numbers either. So there has been a significant drop-off in all of the Cox-2 inhibitors group. There has not been what we might have anticipated, which is a transfer of increased prescribing into the PBS listed, non-steroidal anti-inflammatory drugs. But a number of those drugs are now available over the counter. So as has been said, you can buy ibuprofen, you can buy naproxen, you can buy various other of these drugs without prescription. That may be happening for particular categories of patients.

Senator McLUCAS—Coming back to the first question I asked Ms Corbett, do you have with you the rate of growth for the PBS for the first quarter compared to the rate of growth in the first quarter of 2004-05?

Ms Corbett—I would rather confirm a figure carefully later, but I think it is a modest figure. There is a reduction. There is a small reduction, but we should have the corrected figure for you within the day.

Ms Halton—We will come back later this morning to give you an absolutely accurate figure.

Senator McLUCAS—What is the dollar level of the savings that reduction in growth represents?

Ms Corbett—That is a little harder to do because that depends on which scripts have shifted. So I do not know that we can easily do that. We could try and take that on notice and see if—

Ms Halton—I think it would almost be impossible to do. Effectively what you are asking us to do is disentangle a whole series of things. The way we run the estimates is as an aggregate and we look at both volume and then anticipated total spend. We do not actually disentangle the construction of those estimates by individual items like this. So, to go back and retrofit an explanation about this, I would be very uncomfortable about that. We can show you what the volume was for the two periods. We can show you what aggregate growth was for the two periods across the whole PBS, which I am quite confident about. I do not have any concerns about methodology. If I start trying to retrofit an explanation about a component part, I think we get into trouble.

Senator McLUCAS—The sorts of things are the Vioxx change—

Ms Halton—You can see the drop in Vioxx. We can tell you—

Senator McLUCAS—You could identify that, couldn't you?

Ms Halton—Absolutely, yes. We can tell you what the volume of Vioxx scripts was in that first period, which clearly now is zero. So you can see that. I have not got a problem with that. It is more balancing up all these other elements. I am very happy to tell you what the volume of Vioxx script was in that first period, then you can make your own judgment.

Senator McLUCAS—The other thing I would be interested in, if there is a way of doing it, is to identify any other changes in prescribing patterns or—

Ms Halton—We will see if there is anything significant.

Ms Corbett—We can break down for you the major drug categories. For instance, the statins are the biggest expenditure group. If we look at the pattern for the statins and one or two of the highest cost or highest volume groups, you would be able to see from that that some of these scripts are varying in different ways. For instance, we do understand that there has been a little bit of a decline in the use of statins over that period, which was not anticipated but shows up in the figures.

Senator McLUCAS—That is unusual.

Ms Corbett—If we take that on notice we can give you some analysis of that.

Senator McLUCAS—What was the contribution of the 12.5 per cent generics provision to the savings that will appear?

Ms Corbett—Over the four years at budget time the 12½ per cent price reduction measure was to deliver $1.035 billion. There has been some need for adjustment to that, as you would be aware, around the decision that Lipitor, a statin, should no longer be priced in the same way as the other statins. That adjustment has not formally been declared at this stage, though there was a press release at the time that that decision was made. So, again, that will come through in the additional estimates.

Senator McLUCAS—Could you disaggregate that $1.035 billion over the forward estimate years?

Ms Corbett—Sorry, Senator, we may not have brought that with us, but I am sure we can get it for you between now and the lunch break. It does grow towards the end. It was slower in the first year, with the first anticipated impacts around halfway through this financial year, and then it does grow. We will get that for you.

Senator McLUCAS—In the same way, how do the increased co-payments affect the forward estimates?

Ms Corbett—I have not brought those four-year breakdowns with me. Again, we can get that for you later on this morning.

Senator McLUCAS—Given the recent experience, does the government now have an estimate of what it thinks the likely effect of the increased co-payment will be on patient demand?

Ms Corbett—As with any increase in co-payments, there is a slight expected reduction in the script volumes, and that carries through the four years. So there is a slight adjustment—

Senator McLUCAS—How is that quantified? Is that quantified in a dollar sense or in a script number sense?

Ms Corbett—We generate the estimated dollars from an estimate of the script impact.

Senator McLUCAS—Could you give us both those figures?

Ms Corbett—Yes.

Senator McLUCAS—I understand that the PBS data was withdrawn from the HIC web site for a period of time earlier this year. Can you tell us why?

Ms Corbett—Part of this is probably best directed to Medicare Australia. But we can certainly confirm—

Senator McLUCAS—We never get time at Finance and Public Administration hearings to talk about Medicare Australia.

Ms Corbett—I gather it was very brief.

Senator McLUCAS—It is my ongoing complaint about the new system.

Ms Corbett—Setting that aside, it is true that there was a problem with the data and it took some time for us to have confidence that the data had been corrected. Some of those changes were around systems changes, including some significant systems improvements with the PBS Online measure. As a result of pharmacies coming onstream with PBS Online, there was an aberration about the collection of data that should have been in those figures. When it was first noticed that they were significantly off where they were expected to be, they were withdrawn for a period. They are now back on and, indeed, the end of the financial year figures are back on and we do have confidence that what is there is correct.

Senator McLUCAS—I will have to come back to you if we need further analysis of what was wrong. Were the changes that were made to the data made from your end or from the HIC end?

Ms Corbett—Medicare Australia made the changes. We were closely liaising with them and we were comparing our expected trends with what was showing up on their data set. But it was something that they did understand and managed to correct.

Senator McLUCAS—In layperson's language, what was the error?

Ms Corbett—The error was that not all of the scripts were being captured in the way that they normally were for those pharmacies that had moved across to the new administrative system of PBS Online. It was a pleasing development that quite a few pharmacies had gone to PBS Online but, because of this unanticipated error, we were not capturing the data as we needed to do.

Senator McLUCAS—That has been rectified retrospectively?

Ms Corbett—It has been rectified and data-corrected. What is online now is accurate.

Senator McLUCAS—Thank you. I would like to talk about calcium now. When will the advice from the PBAC to the minister on calcium tablets be tabled in the parliament?

Ms Corbett—It was tabled this week. It was tabled late on Tuesday, the same evening that the debate was on on the changes to the National Health Act in relation to safety net and thresholds.

Senator McLUCAS—So it was last night?

Ms Corbett—It was actually the night before, I recall—Tuesday night. No, Monday night, I am sorry. It was tabled late on Monday night.

Senator McLUCAS—Given that I did not know that, is it possible to get me a copy of that.

Ms Huxtable—We can get you a copy during the day.

Senator McLUCAS—When was the advice provided to the minister? I understand that the process is that you provide your advice up to the minister and the minister tables it in the parliament. Can you tell me when the advice was provided to the minister?

Ms Corbett—The minister had the advice that PBAC provided at its July meeting. I think it was reasonably soon after that, but I do not have a date.

Ms Huxtable—We will have to come back with the precise date that that advice was provided to the minister, which we can do quite quickly.

Ms Corbett—The minister had requested from PBAC some clarification of their advice, so there was a little bit of a need for getting those issues clear. He had advice not long after the July PBAC meeting.

Senator McLUCAS—Not long after the July PBAC meeting?

Ms Corbett—Yes.

Senator McLUCAS—That is all I need. You do not need to go back for the precise date. Will the advice be included in the December schedule of pharmaceutical benefits?

Ms Corbett—Yes, the minister did announce in a media release last Friday that a decision had been made about the listing for 1 December. The listing on 1 December will retain an authority-required listing for calcium tablets for patients with chronic renal failure. Those patients are very high users of calcium tablets. If their doctor rings Medicare Australia to get an authority, they will be able to continue to have access on the PBS. For other patients, as was decided in the budget, calcium tablets will not be available on the PBS.

Senator McLUCAS—Yes, I am aware of that, and all the people who have written to me do not have chronic renal failure; they have osteoporosis. Has there been an analysis of the cost to a patient with osteoporosis with the removal? I am talking about the cost to the individual rather than the saving to the budget.

Ms Corbett—Yes, there has. The cost of calcium tablets bought over the counter is generally between $13 to $15 for a two-month supply. So a patient buying calcium tablets in a normal sort of dosage, as it is with osteoporosis, would be paying $13 to $15 for a two-month supply.

Senator McLUCAS—I understand there was a saving of $4.7 million in 2005-06 for the deletion of calcium—is that right?

Ms Corbett—That was right, for a half-year in the first year. The total saving over four years was $36 million.

Senator McLUCAS—Now with the changed provision about people with chronic renal problems, how have you changed that?

Ms Corbett—There will be a small adjustment in the savings. It will be less than $3 million. But that figure is yet to be confirmed. We can provide that subsequently.

Senator McLUCAS—It is $3 million over four years.

Ms Corbett—Less than $3 million.

Senator McLUCAS—So now we are saving $33 million.

Ms Corbett—That is right.

Senator McLUCAS—Out of the total budget for the PBS.

Ms Corbett—Out of the total budget for this year of $6.5 billion.

Senator McLUCAS—We are going to save $33 million over four years out of how much?

Ms Corbett—Out of the $6.5 billion PBS cost.

Ms Huxtable—That is the 2005-06 figure, not the four-year figure.

Senator McLUCAS—Yes, so we are actually saving a quarter of $33 million over $6 billion.

Ms Corbett—That is correct.

Senator McLUCAS—It is a very small amount of money that we are saving. That is my comment. You do not have to answer that. On what basis did the department change its mind about people who are renal patients?

Ms Huxtable—This was a government decision. It was initially a government budget decision. It was the minister's decision to review on the basis of the PBAC advice. It was not a departmental position.

Senator McLUCAS—The PBAC made a decision in July.

Ms Huxtable—No, the PBAC provided advice. It was asked by the minister to provide advice, as is required. Should the minister seek to de-list from the schedule, he is required to seek PBAC advice. That advice was sought and provided. On the basis of that advice the government came to a view with regard to that particular measure.

Senator McLUCAS—And then subsequently amended that to not preclude renal patients.

Ms Huxtable—That is correct.

Senator McLUCAS—Did that have to go back to the PBAC again?

Ms Huxtable—No. The PBAC role here is to provide advice to the minister with regard to a proposal to de-list.

Senator BARNETT—Some of these answers have been provided, I think, in response to Senator McLucas, but I wish to confirm the PBS growth over the last three years. I think you

have an estimate for the next four years of the total volume of prescriptions and the cost to the Australian government.

Ms Corbett—As you said, we provided the cost figures a little earlier, so those are in the transcript. We do not make projections of the script volumes per se. Our estimates model takes into account trends rather than specific script volumes.

Senator BARNETT—So your estimates only relate to cost.

Ms Corbett—Our estimates for budget purposes are of costs. We do not have an overall estimate of script volumes, which do vary.

Senator BARNETT—But you do have the volumes of the last three years.

Ms Corbett—Yes, we do have script volumes going back quite a long way.

Senator BARNETT—I am just interested in the last three years. Can we get a breakdown on a state-by-state and territory-by-territory basis? Is that available?

Ms Corbett—Yes, we can. I think we would be better to take that on notice, but we do publish regularly the script volumes and we do do a state-by-state breakdown.

Senator BARNETT—In terms of diabetes type 1 and type II, can an analysis be done of the prescription drugs that are used, and can an analysis be done of the cost over, say, a three-year period—is that possible?

Ms Corbett—I will ask Dr John Primrose, the medical advisor to the Pharmaceutical Benefits Branch, to speak to that. There is a category of diabetic dugs but there are quite a lot of other medications used by diabetics, as you would understand.

Dr Primrose—We can certainly provide data over that period of time for the oral antidiabetic drugs and insulin. Did you want data on any other drug categories that might be used in the treatment of diabetes—say, the statins?

Senator BARNETT—I think statins would certainly be relevant to people with type 2.

Dr Primrose—There are also the ACE inhibitors for renal disease. We could provide data on those groups. The problem with the drugs that are not directly antidiabetic drugs is that there are a large number of other indications.

Senator BARNETT—Yes, I am aware. If you just use your best estimates in terms of the relevance to people with type 1 and type 2, it would be appreciated.

Dr Primrose—Fine.

Senator BARNETT—Can a similar analysis be done of obesity related prescription drugs?

Ms Huxtable—For the past three years?

Senator BARNETT—Yes, that would be good. I gather that you cannot provide any estimates for the next year or two or three.

Ms Huxtable—On a state basis?

Senator BARNETT—No, on diabetes types 1 and 2 and on obesity. Can some sort of estimate of the cost be done?

Dr Primrose—I do not think we do projections for the particular groups, because there can be changes in practice that we might not anticipate.

Senator BARNETT—I would appreciate your best estimate, if that is possible.

Ms Corbett—We could take the question on notice and have a look at what we have. The PBS estimates model has some capability but I am not sure we would be very confident of getting the figures right at that level of breakdown.

Dr Primrose—We do not subsidise on the PBS drugs that are directly indicated for the treatment of obesity. We would have drugs that are used for the complications of obesity, such as antihypertensives—the anti blood pressure drugs—and the lipid-lowering drugs, but we do not subsidise antiobesity drugs per se.

Senator BARNETT—Can you give your best estimate of obesity related illnesses?

Dr Primrose—We will do what we can and provide some explanatory information.

Senator BARNETT—Can you provide the volume and the cost of the top 10 prescription drugs?

Ms Corbett—For the last financial year?

Senator BARNETT—For the last three years.

Ms Corbett—Yes, we can go back and do that for three years.

Ms Huxtable—We have it here. We just need to copy a page for you and then we can table it.

Senator BARNETT—My supplementary question, which is related to that, is about the top 10 drugs in volume and the cost in terms of growth. Do you understand the difference between those two questions?

Ms Corbett—The top 10 drugs by script volume and by dollar growth?

Senator BARNETT—Yes.

Ms Corbett—Including the strongest growth by drug category?

Senator BARNETT—Exactly.

Ms Corbett—We do that regularly. It is online, on our web site, but we can certainly draw that out for you.

Senator BARNETT—Finally, you are aware of the difficulties of getting Glargine through the PBAC and that it does have an impact on people with diabetes. Are you aware of the total number of Australians that would benefit from the listing of Glargine? If so, how many? I am happy for you to take that on notice.

Dr Primrose—We would have that figure.

Ms Corbett—Because that particular drug has been controversial and under consideration, there would be estimates of drug utilisation but, at this stage, they would not have been released into the public domain. We will take it on notice and see what we can tell you from our drug utilisation estimates.

Senator BARNETT—I would not necessarily refer to it as controversial. It may be problematic in terms of the PBAC, but the benefits are significant. That is why there is considerable interest in Glargine in the diabetic community. I can put that on the record, if you need it on the record.

Ms Corbett—Yes, that is understood but there are also some commercial sensitivities.

Senator BARNETT—Yes, I am aware of that as well.

Proceedings suspended from 10.49 am to 11.04 am

CHAIR—We are continuing our discussion of outcome 2. I would like to ask some questions of the PBS compliance branch of Medicare Australia after Senator McLucas's questions.

Senator McLUCAS—It was the advice from the PBAC that identified that calcium should not be removed for renal patients, is that right?

Ms Huxtable—It was not quite framed in that way. The PBAC were concerned about the impact on certain patient groups, and one of those patient groups included chronic renal failure patients.

Senator McLUCAS—Did it identify any other groups?

Ms Huxtable—Yes, there were two other groups identified: (1) the osteoporosis group and (2) the group undergoing treatment of multiple myeloma and bone metastasis associated with certain malignancies.

Senator McLUCAS—The minister took the advice about the renal patients but did not take the advice about the groups with certain malignancies or osteoporosis?

Ms Huxtable—The minister noted the concerns that the PBAC raised. However, in coming to a decision, he also took account of the likely cost impact on certain patient groups. Certainly, in terms of the patients with chronic renal failure, their requirement for calcium is very much higher than that of the other patient groups. The cost to those patients is many times more, and that was an important factor in his consideration also.

Senator McLUCAS—I am also aware that there are some osteoporosis therapies like Fosamax, Actonel and Evista that are meant to be taken with calcium and vitamin D. What happens if the person does not take the calcium, because they cannot afford it? Maybe that is a clinical question.

Dr Primrose—If the patient does not take calcium with the bisphosphonate drugs, the effectiveness of those drugs is reduced. But the trials that have looked at the question of the effectiveness of these drugs have only used one or two calcium tablets a day, coadministered with the bisphosphonate. This would be a small cost impost to the patient. It should be emphasised that most people would have an adequate amount of calcium intake through their diet in any case, so it would only be patients who had a diet that was deficient in calcium-rich dairy products who would need to take the calcium supplementation.

Senator McLUCAS—Is there any data on compliance rates? It is very hard for you to now ascertain whether or not someone is taking this sort of drug, bisphosphonate. You actually cannot work out whether there is compliance or dropouts now.

Ms Huxtable—These calcium drugs are freely available over the counter in supermarkets, so it always would have been not possible for us really to know the levels of so-called compliance in that regard.

Senator McLUCAS—I am concerned that someone taking those sorts of drugs on a pension might decide that they cannot afford their calcium this week. That would be unfortunate, as an understatement. Thank you; I have been indulged.

CHAIR—I want to ask about the multiple payments project. I understand that the project has been ongoing for some time.

Ms Huxtable—I am just finding my brief. It is another branch that manages this component. I should say at the outset that Medicare Australia has the responsibility for compliance interventions in this regard. This is the multiple payments project, is that correct?

CHAIR—Yes. I will ask the question; if you cannot answer it then you can tell me. I want to know how much has been repaid by pharmacists under that project on the basis of inappropriate or incorrect supply of drugs under the PBS.

Ms Huxtable—I will have to take that on notice. It is really a matter for Medicare Australia, and I do not have figures that break down into that level of detail of specific components of PBS risk measures.

CHAIR—I will put these questions on notice. Are there further questions on outcome 2?

Ms Halton—Senator Humphries, I presume you are agreeable that, if we cannot answer those questions, we will pass them direct to Medicare Australia for answering. I cannot see that it is particularly sensible for us to go to them to get an answer to then give to you. It would be better for them to give you an answer direct if it is their question.

Senator HUMPHRIES—Yes, that is fine; I am happy with that.

Senator ALLISON—I have some questions about the 12.5 per cent generic pricing policy. I understand you have canvassed some of those a little earlier, so tell me if the questions I am asking are already on the record. The budget papers suggest that the saving from that measure will be $1.035 billion. At this stage, does that expected saving appear likely or will it be varied?

Ms Huxtable—I think we spoke earlier about the need to adjust that saving due to the Lipitor decision. The level of adjustment in the saving will be made public in the additional estimates process. In regard to how we are tracking against that particular measure, it is really too early in the course of that measure for us to be able to draw any conclusions with which we have confidence. The measure came into effect on 1 August with the publication of the 1 August schedule, and that is not very long ago. As I understand it, there is usually some sort of lag before you see the impact of scripts coming through. So it is really only now that we are beginning to do some of that analysis.

Senator ALLISON—So you are not able to assess the measure proper, but what about Lipitor and that decision? What did that carve out of the expected saving?

Ms Corbett—Senator, at the time that the decision was made, there was a public statement from Minister Abbott in which he explained that the impact on the 12½ per cent savings

measure would be $237 million over the four years. Overall there will still be a saving of around $800 million, but these are the figures that will be confirmed in the additional estimates process.

Senator ALLISON—Can I ask why it was that the government imposed a special patient charge on four medicines where the pharmaceutical company did not reduce their prices by 12½ per cent? What were those for and what was the rationale behind what the government has done?

Ms Corbett—Senator, those four drugs were drugs in reference pricing categories where the 12½ per cent ran through the category group but the company was not prepared to bring the drug price down to the new benchmark level. The drugs concerned were two in the category of anti-epileptics, called Keppra and Topamax. Topiramate is the generic name and the other one is—

Dr Primrose—Levetiracetam; that is Keppra.

Ms Corbett—So those are the two anti-epileptics that were affected. Lexapro is a drug for depression, an antidepressive. That was affected with a small special patient contribution. Alimta or pemetrexed, which is a cancer treatment for non small cell lung cancer, had the most significant of the special patient contributions.

Senator ALLISON—That was my understanding too—that there was one case of a drug for small lung cancer?

Ms Corbett—Yes.

Senator ALLISON—And that the patient charge is in the order of $400. Can you confirm that?

Ms Corbett—That is correct. The special patient contribution is $460.76 on that particular drug.

Senator ALLISON—In that case and perhaps the others, what were the reasons given by the company concerned, and what is the process of appeal, if you like, against this charge being imposed on behalf of the pharmaceutical company? What arguments does the department accept? How open and accountable is that process?

Ms Corbett—The process of negotiation over prices between the department and on behalf of the pricing authority with the companies is usually pretty commercially sensitive. We do not tend to go into a lot of the detail of either the reasons the companies give us for particular pricing proposals or, indeed, the outcomes. So, on this occasion, I think it is not appropriate for me to go into the reasons given to us by particular companies. The reality is that all of those companies said they were—

Senator ALLISON—Perhaps you can make those reasons more generic. I do not need to know about this one in particular. But, in principle, there must be some rules that apply.

Ms Corbett—In principle, there are certainly rules that apply. These circumstances were a little extraordinary because of the nature of this new policy in the early stage of implementation. For companies to face as significant a price reduction as this was a little unusual. The companies did indicate to us that, for their own business reasons, they were not

in a position to bring that price down to the benchmark. So, under the legislation, the situation exists that, in that circumstance, where there is a disagreement technically between government and manufacturer over the price, the minister has the capability to use the special patient contribution.

Senator ALLISON—I realise that, but what kinds of arguments were found to be relevant or acceptable to the department in this process—or to the minister?

Ms Corbett—I do not think it was a matter of finding arguments relevant or acceptable; it was a matter of having reached an impasse. In theory, the industry had agreed to implement the 12½ per cent price reduction policy, and there was an understanding between government and manufacturers that that would happen. Just on these four particular products, it was not possible to reach agreement and that is why we have resolved, by the minister's decision, to make special patient contributions and to allow exemptions for patients whose doctor believes that it is not appropriate for them to transfer to one of the products that have come down to the benchmarked price. So, where a patient is in the situation of not being able to take an alternative to a particular product, that patient's doctor can seek an exemption through an authority with Medicare Australia, and the patient would not have to pay that.

Senator ALLISON—What is the process for getting that exemption? Has this been conveyed to all doctors, for instance?

Ms Corbett—Yes, this has been very carefully conveyed to all doctors and it has been conveyed to other interest groups, and the process is quite a simple one. In fact, three of those drugs already require the doctor to seek an authority from Medicare Australia before prescribing. The additional step that would need to be taken to seek an exemption is to answer additional questions from Medicare Australia about why the patient needs that specific drug and cannot move to another, lower priced product. Provided the doctor answers all those questions at the time they are seeking the authority, the exemption is processed automatically when the script is taken to the pharmacy.

Senator ALLISON—How many complaints have there been about the complexity of this process?

Ms Corbett—No major complaints have come through us.

Senator ALLISON—What about minor complaints?

Ms Corbett—It may well be that Medicare Australia is dealing with some of these when doctors are going through the authority process, and I do not have a report; I guess that is a question better placed with Medicare Australia.

Senator ALLISON—But you would be surprised if some were finding it complex.

Ms Corbett—It is made very straightforward, and we made quite an effort to communicate about it. I think that has worked quite effectively.

Senator ALLISON—Does the department yet have any feel for the proportion of scripts that are likely to be in this category of having a special waiver?

Ms Corbett—We are monitoring that carefully. We have asked Medicare Australia for some data on that. We do have some early data, but it is not yet reliable enough for us to

confidently present it. It covers just the first two months since this came into effect. We have had an initial look at the August and September data, but in August we would still be in the processing transactions for scripts that were managed in July, so there is some blurring of where the thing comes into effect. In another couple of months, the impact will be much clearer, and we are certainly monitoring that.

Senator ALLISON—Is your department monitoring it or is it being done by Medicare Australia?

Ms Corbett—We are monitoring it with input from Medicare Australia.

Senator ALLISON—So you will know at what stage how many patients end up paying the extra special patient charge for those four medicines?

Ms Corbett—Yes, we will. We are capturing that data.

Senator ALLISON—And how many patients have had their special charge waived—you will be able to provide that.

Ms Corbett—Yes, that is correct; we will.

Senator ALLISON—At what point—early next year?

Ms Corbett—Early next year we will have a much better idea of it, and we will certainly monitor it on a monthly basis.

Senator ALLISON—It would be useful also to know what that means in revenue terms and whether there will be any figures to demonstrate that at that time.

Ms Corbett—In revenue terms as to impact on the PBS or on the savings target?

Senator ALLISON—On the savings.

Ms Corbett—Yes. We have estimated that it will be a very minimal impact on the savings overall. We will monitor that too.

Senator ALLISON—Going back to the lung cancer one, is this a pharmaceutical which is likely to be needed on a regular basis? Would whoever is paying this $460 be doing that more than once?

Dr Primrose—Yes, usually this drug is given for four to six cycles of treatment. Basically, it is second-line chemotherapy for advanced lung cancer after platinum based combinations fail. There are alternative drugs. Another group of drugs which is very effective in this situation is the taxanes, which include paclitaxel and docetaxel. The exemption clause that we have here specifies that patients who either are intolerant of these drugs or are likely to be intolerant are exempted from the special copayment for the pemetrexed or Alimta. So they either have the alternative treatment, which is probably as effective, or else they have the exemption and go on the pemetrexed. But you are talking about somewhere between four to six months treatment.

Senator ALLISON—So that could be $2,000 or $3,000 effectively for those patients for that treatment.

Dr Primrose—If they were not exempted, yes.

Senator ALLISON—The National Audit Office review of the PBS: is that now under way?

Ms Corbett—Yes. The ANAO audit commenced formally in I think September, and we had had some initial discussion with them before they started their investigation phase.

Senator ALLISON—So the terms of reference are agreed?

Ms Corbett—Yes. That would be a question formally for the Auditor-General, but yes, they have agreed terms of reference.

Senator ALLISON—Is it possible to provide those?

Ms Corbett—I believe formally they do write to the secretary of our department. The ANAO audited the PBS. The terms of reference for that were probably explained in the letter that the Auditor-General has sent to the department.

Ms Halton—I think so.

Ms Corbett—We will have to look into that and see whether we have—

Senator ALLISON—Perhaps I can just ask you about some of the general issues they might be looking at. If you can confirm them, that would be useful. Are they looking at particular medicines; are they looking at overall expenditure; are they looking at prescribing habits of doctors or marketing practices? Are they all part of these terms of reference?

Ms Corbett—They are looking at whether the patterns of use of PBS listed drugs match up to the intended use for those drugs over a period of time. They are looking at what we do in the lead-up to listing a new drug to ensure that the patient target group is adequately described. Then they are looking at how we follow that up to make sure that in practice the PBS subsidised drugs are going to the correct target group. They are looking at that in relation to some specific listings. So they have examined our files and they have decided on a number of specific drugs and they are going to follow the story of those particular drugs as a way to gather the evidence that they will need to draw some general advice conclusions, in an audit sense.

Senator ALLISON—Are these typically the more expensive drugs that they will be looking at?

Ms Corbett—I think they have chosen quite a broad range, but it is probably better that those questions be handled by them rather than us, because it is very much their business to determine which ones to go into.

Senator ALLISON—Yes, but you must be aware of what they are looking at at this stage.

Ms Corbett—We are. I have not brought with me the drugs that they have indicated. They have written to the companies who sponsor those drugs and they have written also to Medicines Australia about the nature of their inquiries and what they are looking at.

Senator ALLISON—It sounds like a quite different one from the 1997 audit?

Ms Corbett—Correct; it is different. It has certainly drawn some knowledge from that earlier audit, but it has chosen a specific new direction, as the Auditor-General will do from time to time, focusing on what they believe is the most appropriate current issue.

Senator ALLISON—Will it touch on cost recovery?

Ms Corbett—It will not, I believe, touch on cost recovery. From my understanding of the scope, I think that would not be one of its concerns.

Senator ALLISON—And it will not look at marketing practices either.

Ms Corbett—On the question of marketing practices, it may well make inquiries in response to companies about what they have done to ensure that their promotion of products is in line.

Ms Halton—I would expect that they would pay some attention to marketing. If they are looking at consistency of the listing with use—for example, is there a lot of off-label use?—I would imagine, although obviously it is a matter for the auditor, that they would want to see what marketing activity there has been around a particular product and whether it is consistent with the listing, and they would want to make very sure that practitioners understand the basis on which the products should be used.

Senator ALLISON—So possibly it will look at PBAC processes and look for undue influence in various ways from pharmaceutical companies?

Ms Corbett—It could do. That is not inconsistent with its scope, but its processes are for it to determine.

Senator ALLISON—What is the time frame for this? When will it be reported?

Ms Corbett—The audit report is expected in June next year and will be tabled in the normal way.

Senator ALLISON—On the cost recovery question, are there any updates on the cost recovery provisions for the PBAC out of the last budget? Where is that up to?

Ms Corbett—The cost recovery measure goes through quite clearly specified stages. I believe we touched on this at the last estimates. We are almost at the stage of starting a consultation process with the industry, and we hope that within the next few weeks we will have an initial meeting with major industry groups to discuss the cost recovery work that must be done between now and July 2007, when the cost recovery will come into effect. But there are quite clearly specified steps. We have been going through the scoping of cost recovery as an internal exercise and we will then discuss the issues around the implementation of cost recovery through a consultation process, leading up to a cost recovery impact statement and the relevant legislative change in the early part of calendar year 2007. So we are still in quite an early stage of the mapped-out process that government cost recovery requires.

Senator ALLISON—Do you have a time frame for the impact statement?

Ms Corbett—Early 2007, around the same time as the legislative process is under way.

Senator ALLISON—So it requires legislative change.

Ms Corbett—Yes, it does.

Senator ALLISON—Do you anticipate there being any changes to other PBAC processes?

Ms Corbett—Between now and 2007, or indefinitely? At the moment there is a review of PBAC guidelines, which is a good, ongoing process to see whether we can explain the trends, the analysis and the kinds of issues that are coming up. There is not any other major pressure, as I understand it, on PBAC processes at this point, other than the improvements in transparency that are under way, the broader reporting of the recommendations and the reasons for recommendations that are under way. We had our first public summary document go onto the web site very recently. Public summary documents of the recommendations from PBAC go into more detail than we have put into the public domain in the past. That has started as of the most recent set of PBAC recommendations.

Senator ALLISON—What about process changes that might be related to full cost recovery? Is the industry indicating that it wants to see any measures put in place to protect it from unreasonable cost recovery or wastefulness?

Ms Corbett—It is too early to say whether there will be anything coming out of the cost recovery process that impacts in that way. I suppose in a broad consultation process there may well be suggestions that come forward that PBAC or the government might wish to pick up, but it is certainly not an anticipated part per se of the cost recovery process that those PBAC processes will be reviewed. That is not necessary at all. We can look at the PBAC and its existing processes and take that as our base set of costs for this purpose and then go through the consultative steps.

Ms Huxtable—But we have not actually commenced that consultation with industry. We will be doing that in the next few weeks or months.

Senator ALLISON—I have some questions about the Medical Benefits Consultative Committee and decision making around that.

Senator McLUCAS—I have some questions on the current topic, if that is okay. The budget measure proposed increasing the safety net thresholds. Can you give the committee an understanding of what elements led to the savings? I understand that there is $71.4 million over four years. What were the elements that led to that set of savings? How did you model that?

Ms Huxtable—I am sorry; I am confused about which measure.

Senator McLUCAS—It is the increasing of the safety net thresholds. How did we come to $71.4 million?

Ms Corbett—You are asking about a budget measure decision. It is clearly a budget measure that is about shifting the costs—

Ms Huxtable—I am sorry; can I just clarify? The $70.1 million relates to the 20-day supply rule, not to the increase in the copayment thresholds.

Ms Corbett—They are very similar. They are both together $140 million.

Ms Huxtable—I want to clarify precisely which measure we are speaking about before we launch into the explanation.

Senator McLUCAS—In my document it is called increasing the safety net threshold. It might be reinforcing safety net arrangements; is that how it is described?

Ms Corbett—So are we talking about the 20-day rule changes?

Senator McLUCAS—No.

Ms Corbett—We are talking about the core significant adjustments.

Ms Huxtable—The increase in the copayments over the four years.

Ms Corbett—In the thresholds.

Ms Huxtable—Sorry, in the thresholds.

Senator McLUCAS—We are talking about the same thing.

Ms Halton—What page are you on?

Senator McLUCAS—Do not take advice from me on how to read a PBS!

Ms Huxtable—I am being advised that 'reinforcing the safety net' is the 20-day rule; it is not the threshold issue. So the questions are directed to the 20-day rule?

Senator McLUCAS—No; to what is described in my briefing as increasing the safety net thresholds. I have been advised that the savings are $71.4 million over four years. Is that not correct?

Ms Huxtable—The savings are $140.3 million over four years.

Senator McLUCAS—Whatever the figure is, how did we come to it?

Ms Huxtable—We are having a slight dispute about the figure. If I am wrong, we will clarify it.

Ms Corbett—You are asking about the reason for those threshold adjustment changes?

Senator McLUCAS—No. How do you identify the savings?

Ms Corbett—We identify the savings by looking at the existing safety net threshold. We made an estimate of how the indexation will impact on the copayment amount for the concession card holders, a fairly simple assumption that is consistent with the trends for the copayment indexation in the past. We have then looked at the impact of adding twice that copayment amount to the concessional threshold amount in each year, and we have modelled on that basis.

Senator McLUCAS—When you say it was a simple principle—

Ms Corbett—Fundamentally the current concessional copayment is $4.60. For next year we assume $4.70, then $4.80 and $4.90. That has been the sort of pattern of 10c rises over the past. So it is that scale.

Senator McLUCAS—Did that modelling look at the effect on certain groups? Did you make any assumptions or any predictions about different groups' access to the PBS?

Ms Corbett—It was not necessary to do that sort of modelling in order to project for government the impact on the budget of that adjustment. The normal pattern of impacts of changes in policy is, as you would understand, that 80 per cent of PBS costs are with concession card holders and 20 per cent are with the general patients. But that is not necessary for us to model the budget impact for this new measure.

Senator McLUCAS—Or the impact on usage of PBS pharmaceuticals by low-income earners?

Ms Corbett—We have not done that sort of modelling.

Senator McLUCAS—When were the lipid management guidelines last reviewed?

Ms Corbett—The lipid-lowering drugs category has been reviewed from time to time as new drugs come into that group, but there was a specific review of the lipid-lowering drugs. That is probably the thing of interest, if I can just clarify.

Senator McLUCAS—Yes.

Ms Corbett—We commenced the review of the lipid-lowering drugs as a category, with PBAC managing that review process, in 2003. There were some very useful stakeholder discussions and input to that review both from professional expert clinicians and from sponsor companies of the lipid-lowering drugs and others. PBAC drew together the findings of that review and made some recommendations to government about that review in July 2004. That was the biggest single review of that category of drugs for some time.

Senator McLUCAS—So, since July 2004, they have been with the minister. Is that correct?

Ms Corbett—It is a matter for government to consider, with significant budgetary impacts. It has been with government since shortly after the PBAC recommendations were drawn together.

Senator McLUCAS—Just remind me. Are those PBAC recommendations public?

Ms Corbett—Those PBAC recommendations are not publicly released at this point.

Senator McLUCAS—Why?

Ms Corbett—It was a special review conducted by the PBAC at government's request. As I said, it has significant budgetary impact and it is a matter that is being dealt with by government in that way. It is a decision of government not to release publicly at this point.

Ms Halton—It is also commercially sensitive.

Ms Corbett—It is commercially sensitive information.

Senator McLUCAS—I understand the prescribing guidelines but I am interested more in the process that, since July 2004, there has been a recommendation about the guidelines but it has not been acted on.

Ms Huxtable—A report has been provided to government, which it is still considering.

Senator McLUCAS—There is quite a range of data about the value to the health of the community by increasing access to lipid-lowering drugs. I think this review goes to that evidence. Is that the motivation for doing this review?

Ms Corbett—The review arose from some recommendations that had been going to government about particular lipid-lowering drugs. It is in the context of quite a lot of discussion, both internationally and in Australia, about the appropriate use of the statins and other lipid-lowering drugs. So it is a broad context, and there are significant budgetary impacts.

Senator McLUCAS—Can the committee understand how significant those budget impacts are, or is that part of the report to the minister?

Ms Huxtable—That is part of the report, and it is yet to be considered. The potential impact on budget would very much depend on how the report is considered and what comes out of that process.

Senator McLUCAS—I want to go to the authority process, particularly for Alzheimer's drugs. I understand that, when an antidementia drug is given, a written authority is preferred. Is that right?

Ms Corbett—A written authority is preferred. I am hoping Dr Primrose is familiar with that particular authority structure, because I am not.

Dr Primrose—It is just a standard authority prescription that meets the restrictions that the PBAC has put on the drugs to ensure effective and cost-effective use of these agents.

Senator McLUCAS—I understand a regular authority is a simple phone call from the prescribing doctor to Medicare Australia.

Dr Primrose—Yes, that is the usual—

Senator McLUCAS—But it is different for Alzheimer's drugs?

Dr Primrose—I will have to look that up for you.

Ms Corbett—In the case of some drugs, it is necessary for the doctors to provide written evidence of test results, for instance. I am not sure that that is what we are looking for here, but it will be explained in the schedule.

Dr Primrose—It says:

Authority applications for initial treatment and the first application for continuing treatment should be made to the Health Insurance Commission (HIC) in writing. The second and subsequent authority applications for continuing treatment may be made by telephone. Up to a maximum of six months' therapy (one month plus five repeats) will be approved for initial and continuing therapy.

Senator McLUCAS—So the first authority is written.

Ms Halton—My memory is that when this was listed—and I should probably not be talking about memory in this context—there were concerns about the contexts in which these particular therapies were efficacious. There was, however, I think an acknowledgment that for a proportion of people the therapies could potentially be efficacious. I remember that when this issue was considered by the PBAC there was some debate about the circumstances under which it should be available. I think, as has already been indicated, sometimes the standard approach in terms of authorities is a phone call; you are quite right. I think with some of these drugs, however, where there is perhaps more concern about when it is going to be efficacious and when it is isn't, the PBAC is quite within its rights to sometimes modify that process. We can probably go back into the history and check—

Dr Primrose—I think I can answer the question. The reason why a written authority is required is that the treating doctor needs to submit with the application the results of a number of psychological tests. It would be inappropriate to give those over the phone. These results

need to go in and be checked by the Medicare Australia pharmacist to ensure that they do meet the restrictions that are incorporated in the PBS authority.

Senator McLUCAS—So is it the first prescription that requires the written authority?

Dr Primrose—It is the initial prescription and the first prescription for continuing therapy. The reason is that for the first one you are talking about eligibility, and for the second one—that is, the first repeat prescription—you are talking about response.

Senator McLUCAS—I have a question about the time frame from the point of psychological assessment. It is then sent by mail; the doctor sends that assessment to Medicare Australia. Is that right?

Dr Primrose—Yes.

Senator McLUCAS—And then Medicare Australia does what?

Dr Primrose—It would confirm that the application met the criteria within the PBS restriction. In terms of the time line for that, I guess you would need to ask the Medicare Australia people.

Senator McLUCAS—Or Australia Post, maybe!

Dr Primrose—Yes, I really do not think it would take very long. The actual restrictions are not really that onerous. They just spell out exactly what is required.

Senator McLUCAS—And then Medicare Australia sends the authority—is it an actual prescription, or just a letter?— that says, 'You have the authority to receive this drug.'

Dr Primrose—No, they send a form back with the number, so that the dispensing pharmacist will fill that prescription.

Senator McLUCAS—And I understand that is sent to the patient.

Dr Primrose—Good question.

Ms Corbett—My understanding is that it is just incorporated in the coding for that particular script. I do not know that the patient actually sees what is sent to Medicare Australia.

Senator McLUCAS—My understanding of the process is as follows—and it may not be correct. The patient goes to the doctor, and the doctor seeks to prescribe the particular drug. Information is then sent to Medicare Australia. I am advised that Medicare Australia will do one of two things. Either it will send to the patient a piece of paper—I do not know what is on that paper but obviously it is an approval—or the doctor may request that it be sent back to the doctor. The concern from the Alzheimer's community is that, when a person with Alzheimer's receives that authority, they do not know what it is for, they lose it, they are confused about the process and there is failure in the treatment as a result. It has also been put to me that it is only Alzheimer's drugs that have to go through this written authority process.

Ms Corbett—No, there are other drugs with that requirement.

Senator McLUCAS—If you could provide a list of those separately on notice, that would be good. Is that correct—the process that I have just described?

Ms Huxtable—I think should clarify what the process is with Medicare Australia, because, while in the general sense I think Dr Primrose has referred to what the process is, I do not feel confident in responding on their behalf about how precisely that process is administered in this case. So if we can refer that question to them, perhaps they can respond directly.

Ms Halton—We will talk to them about the context of the question, particularly in terms of the concern, and clarify whether in fact that is actually what occurs. I think your point is quite reasonable.

Senator McLUCAS—It is not mine—it is theirs, the Alzheimer's community.

Ms Halton—The point you are relaying is perfectly reasonable. We need to check with them what in fact is the actual practice. If you are happy for us to refer that to them, we will make sure an answer is provided.

Senator McLUCAS—Did the PBAC recommend that the written authority be pursued?

Ms Huxtable—The genesis of the way it is framed in the schedule is through the PBAC advice.

Senator McLUCAS—Because of the psychological assessment and then the increasing by two points, whatever the process is.

Ms Huxtable—Because of the related information that is required.

Senator McLUCAS—I understand that, if the patient does not increase their psychological capacity—I do not know what the term is but let us call it that—by two points over the three-month period of prescribing, they cannot continue with the medication. Is that correct?

Dr Primrose—Sorry, this is a bit out of my area of specialisation. I will have to look through this.

Dr Lopert—I was formerly the medical adviser of the Pharmaceutical Benefits Branch. My recollection is that there is a requirement for patients to demonstrate a response to the therapy in order to be enabled to continue. It is not unreasonable to require some evidence of response to a medication. There are other examples where evidence of response to therapy is required, as there are other examples of where written information is required to support a request for authority. That is correct.

I do not recall precisely what quantum of improvement is required. My recollection is that it is at least two points from the baseline of the mini mental state examination, which is the principal diagnostic method used. It is an assessment of cognitive function. There is also another scale which may be applied, which is the Alzheimer's disease assessment scale, also known as a cognitive subscale, also known as ADAS-cog. A number of instruments are used to assess patients' performance in different forms of dementia. That is the principal method. You assess the patient at baseline, you provide treatment and you assess their response to it. If they continue to decline then the rationale is that there is little point in continuing to treat.

Senator McLUCAS—It is not just decline, though; you have to show improvement. For Alzheimer's you actually have to improve your cognitive function when you have got a degenerative disease. I recognise that the drug is going to improve what is occurring with the

patient, but you are going to have to improve a lot over the natural degeneration that is occurring.

Ms Corbett—I think what you are questioning is the basis on which the expert advice has come to us to manage this particular drug in this way.

Senator McLUCAS—Is that a recommendation of the PBAC? They went through that process?

Dr Lopert—Yes.

Senator McLUCAS—I understand also that the guidelines specify that the confirmation of the diagnosis must be from a specialist—is that correct?

Dr Lopert—Yes, I believe that is the case.

Senator McLUCAS—What happens in rural areas, where access to this level of specialist is limited? Is there any opportunity for a shared care arrangement with a GP, for example?

Dr Lopert—It is only the confirmation of the diagnosis that is required to be confirmed by specialists. It is not the ongoing assessment, as I understand it. Sorry, it is some time since these drugs were listed on the PBS.

Ms Corbett—Shall we take that on notice?

Dr Lopert—We can take it on notice, but my recollection is that it is only in the initial stage that confirmation by a specialist is required. Subsequently it can be managed on a shared carer basis.

Senator McLUCAS—I understand there are three drugs that fit into this category. Can you tell me the number of people that move from one drug to the next one and then to the next one—so that they actually get nine months of treatment, even though their cognitive function is not increasing?

Dr Lopert—We would have to take that question on notice. It would require information from Medicare Australia.

Senator McLUCAS—I would be interested to know that. Can you also tell me, in a clinical sense, whether there is any problem with taking three different types of drugs in sequence like that? I dare say the drugs are quite similar, but would there be any problem with that?

Dr Lopert—I am not aware of any, but I really would not like to state that categorically. I would have to go back and review it.

Senator McLUCAS—Thank you for that. That is all I have for the pharmaceutical branch. I have some questions on Medicare. In terms of registering for the Medicare safety net, we did get some answers to questions on notice. I just cannot find the answer I want, but it is in this pile of documents. What are the registration levels for this year for the Medicare safety net?

Ms Huxtable—The figures for up to 30 September 2005 show that 3.997 million families were registered at that date—3,997,941. That is a cumulative figure. It is all families registered at 30 September 2005.

CHAIR—Are individuals separately covered from that figure, or are they included in that list of families?

Ms Huxtable—Individuals do not need to register. They are automatically part of the safety net. That figure covers the family and the registered family members, as part of the 3.9 million.

Senator McLUCAS—How does that compare with last year?

Ms Huxtable—I was just asking someone for a calculator, because I can net off the number who have registered this year if I can find a calculator.

Senator McLUCAS—Is it feasible for me to ask if you could give me a monthly registration—it is a cumulative figure?

Ms Huxtable—I have the figures for the monthly registrations here but, rather than reading them month by month, it might be easier to provide them to you separately.

Senator McLUCAS—That would be handy.

Ms Huxtable—I can table them at lunchtime.

Senator McLUCAS—That would be good. Can we look at the comparisons? How do they compare?

Ms Halton—To?

Senator McLUCAS—To this time last year.

Ms Huxtable—At the end of September 2004, there were in the order of 3.5 million families registered. There are now close to four million, so in the intervening period we have had half a million families register. If we look at them month by month, there were very large numbers of families registering between March and the end of October last year, but in the months of May, June, July and August the numbers were quite large. From that point, we still see quite a bit of movement but there is more stabilisation in that figure. As you would expect, that will occur over time because a family only has to register once.

Senator McLUCAS—When a family changes its composition, is that counted as a reregistration? What do you do with that?

Ms Robertson—That is a question that we would have to check with Medicare Australia and get back to you on.

Senator McLUCAS—If you can, that would be good. I just do not know whether that would change your figures and by how much.

Ms Robertson—We can try to get an answer for you today.

Senator McLUCAS—How many times has the department revised its estimates for Medicare this year?

Ms Huxtable—Is this for the whole of the MBS?

Senator McLUCAS—Yes.

Ms Huxtable—I think my budget colleagues in the room would confirm that there has not been any revision of the estimates.

Senator McLUCAS—What are we up to in year-to-date spending for the extended Medicare safety net?

Ms Huxtable—The extended Medicare safety net spend to the end of September, which is the last available figure, is $165.9 million.

Senator McLUCAS—And how does that fit with estimates?

Ms Huxtable—That is in line with estimates. It is just slightly under what we estimated would be the spend by the end of September.

Senator McLUCAS—They are the revised estimates in the budget?

Ms Huxtable—They are the estimates as announced in the budget.

Senator McLUCAS—I understand that sort of level of information is not online. Would we usually expect to have that sort of level of information online?

Ms Huxtable—No. I believe the information is normally provided across the financial year. There are regular reporting arrangements that cover all of the MBS, and this is incorporated in those regular arrangements.

Senator McLUCAS—We might give notice that the committee would probably like to receive that data quarterly—that is, the year-to-date spending for each quarter.

Ms Huxtable—That is something that you would normally be asking at estimates?

Senator McLUCAS—I am predicting that we will ask for that quarterly data into the future.

Ms Huxtable—I have that data available.

Senator McLUCAS—Does the department track spending and service levels by broad type of service? Do you monitor each type of service and look at spending levels?

Ms Huxtable—There is a quarterly publication that the Medicare Benefits Branch releases which provides a comprehensive range of statistics, including broad type of service. It is a green-covered book which I believe is made available quite widely. It is also available online.

Ms Robertson—In terms of the estimates, when we are looking at expenditure under the MBS we do track it by broad type of service and update that on the figures that become available.

Senator McLUCAS—There has been some media coverage about pathology. Is the department monitoring service levels in pathology and the impact of cost on Medicare?

Ms Robertson—We are looking at it. This is a question for outcome 10, but I can tell you that I believe it is a processing issue with Medicare Australia.

Ms Halton—We had an agreement with the profession in relation to pathology, and there is a series of processes we go through on a regular basis to monitor the capped agreement expenditure in that respect. That includes disentangling processing issues from real issues. Obviously we adjust the benefit level to meet the target set in that agreement.

Senator McLUCAS—Is that agreement about cost or volume?

Ms Halton—It is about the expenditure.

Senator McLUCAS—But I understand there has been growth in that broad area.

Ms Halton—That is my understanding as well. Whether the cause of that is a processing issue or whether it reflects a real expenditure increase is being looked at. If there is an expenditure increase, consistent with previous practice we would talk with the profession so that the agreement comes in on target in terms of the growth that is agreed between the profession and the government.

Senator McLUCAS—What is 'a processing issue'? Sorry, but I do not understand that.

Ms Halton—It can be everything from when claims are received to when they are processed. For whatever reason, if you have a series of claims that have been backed up and then they appear all at once, it may look like a growth rate when actually it is not a growth rate. So there is a series of things we have to be sure of before we start adjusting people's fees.

Senator McLUCAS—These are claims that are submitted by the pathologist, not by the patient?

Ms Halton—As a lot of pathology is bulk-billed, you would tend to get more claims coming in from pathology. Claiming methodologies—that is, whether people are using IT and all the other things—can therefore impact. This is really a question for Medicare Australia but I think patient claiming is generally more predictable and less prone to those sorts of technological things. Certainly the question for us is the aggregate spend in respect of the agreement on an annual basis. As you are probably aware, we adjust fees one way or the other to make sure we hit the line in terms of the outcome.

Senator McLUCAS—Are you in discussions with the sector to try to ascertain why this growth is occurring?

Ms Halton—Certainly I am very conscious of it because, if they are concerned about it, they come and visit me. I would anticipate that there are lower level discussions going on. Certainly I have not had a visit from the profession or indeed a request for a visit from the profession.

Ms Huxtable—There is a pathology consultative committee which is set up to manage the agreement. It is not under this outcome; it is outcome 10. But they do meet quite regularly.

Ms Halton—Exactly. It works its way through issues as they emerge.

Senator McLUCAS—The growth in obstetrics rebate levels is still very high. Can you give me some explanation?

Ms Huxtable—One of the issues that we are seeing here—and this is the first time, because we are now moving across reporting periods with the safety net—is the quarter-by-quarter figures for patients who are out of pocket. You are looking back to a period where patients who may have hit the safety net have moved into a period where they may not have hit the safety net. So it is quite difficult to compare the first six months with the last six months. That is certainly one of the things we are seeing as we look at this data in the second year of the safety net.

The other issue is the impact of the introduction of the planning and management item, where charges that were previously not within Medicare may have been brought within Medicare and hence you see an increase in the average fee. Interestingly, there has been a significant decline in the fees charged in respect of the regular attendance item—I cannot remember the item number—and you can see an adjustment between the planning and management item and the attendance item.

Senator McLUCAS—With prenatal and postnatal.

Ms Huxtable—You would expect to see that.

Senator McLUCAS—In April this year it was reported that the minister had proposed reviving the relative value study.

Ms Halton—Yes, we all remember the RVS. As far as I am aware, the RVS pops up every so often but I am not aware of an active proposition from the minister to revitalise, revisit or review the RVS.

Senator McLUCAS—What has happened to the Attendance Item Restructure Working Group?

Mr Learmonth—The principal task of the Attendance Item Restructure Working Group was completed some time ago, and that was to look at an alternative structure for attendance items. They indeed presented a report. I guess you could best characterise the status of the group at the moment as being under review on both sides. The profession is having a bit of a think about the kinds of issues it might like to consider from now on, as is the minister, and I expect there will be further discussion.

Senator McLUCAS—When did they last meet?

Mr Learmonth—March 2005 was the last meeting, I am told.

Senator McLUCAS—You said it was in review both ways, so the group itself is considering its future?

Mr Learmonth—It is a matter for the minister ultimately to agree, but the group is considering what it might like to pursue and whether or not AIRWG as a construct is the best way in which to pursue that. Certainly the original task for which it was established is now complete.

Senator McLUCAS—Has the minister given any directions for its activity at the moment? What is the group doing at the moment?

Mr Learmonth—The group really is not doing anything per se. The group is, I guess, contemplating its navel about what it might wish to do.

Senator McLUCAS—Is that an expensive process?

Mr Learmonth—You might say that they are doing that on their own time. There has certainly been a bit of discussion. There was discussion quite recently—a few weeks ago—between the General Practice Reference Group and the minister about the future of AIRWG, as they are known. There were a couple of ideas about things they might like to pursue. There was a little bit of discussion about whether or not they would be priority items in all the circumstances and how they might best be pursued. I think both sides retreated to consider.

Senator McLUCAS—Did AIRWG write to the minister, seeking directions about its future?

Mr Learmonth—From memory, they did certainly write to the minister and propose some future agenda, if you like, which is I guess the genesis of the discussion we are having now.

Senator McLUCAS—When did AIRWG write to the minister?

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

Senator McLUCAS—It would have been post the receipt of the report?

Mr Learmonth—I think there has been a bit of discussion, formal and informal, since that report. I am told that late last year was the last formal correspondence.

Senator McLUCAS—What did they do in March, when they had a meeting?

Mr Learmonth—In March they had a meeting to discuss what they might do in future in response to their initial piece of work, so again it is basically a future-oriented discussion about what their priorities are or could be.

Senator McLUCAS—Is there any proposal to trial the seven-tier MBS attendance item restructure?

Mr Learmonth—No.

Senator McLUCAS—That is all I wanted to ask about AIRWG.

Senator ALLISON—I have a question about the Medical Benefits Consultative Committee. How often does the MBCC meet?

Ms Huxtable—My recollection is that there is no regular meeting cycle, but they do meet from time to time, as required, to review particular elements of the schedule.

Mr Robertson—It really depends on the issue being looked at. Sometimes we receive submissions from particular craft groups where we will convene meetings between the people who use the items. Other times we may be reviewing parts of the schedule and we will contact the AMA to convene an MBCC around a particular issue we are looking at.

Senator ALLISON—How many have been held over the last, say, 12 months? Is that typical? Just roughly; I have no idea whether it is one or 300.

Ms Huxtable—I do not think it is 300.

Mr Robertson—There have been eight in 2005.

Senator ALLISON—Does the committee determine its own workload, essentially, on the basis of the applications that are made and issues that are coming up—is that how it works?

Mr Robertson—It is not really a standing committee. The constants on the committee are the department and representatives from the AMA, but it really depends on which craft groups are involved in the provision of the services.

Senator ALLISON—Craft groups—you often mention that

Mr Robertson—You are not familiar with them? They are groups like colleges and associations that represent medical groups that discuss issues with us around our medical services.

Senator ALLISON—Is the group entirely within the department?

Ms Huxtable—It comprises representatives of the AMA, the department, Medicare Australia and the relevant professional organisation, whether that be the Royal Australian College of Physicians, for example, or the anaesthetists.

Senator ALLISON—So they are called in as and when their expertise is needed.

Ms Huxtable—That is right, depending on what the issues are.

Senator ALLISON—On average, how many submissions are received by the committee every year in relation to changing Medicare items?

Ms Huxtable—We would have to take that on notice; we do not have that detail with us.

Senator ALLISON—Okay. Again, roughly, is it thousands or a handful?

Ms Huxtable—It would not be thousands.

Senator ALLISON—Would it be a handful?

Mr Robertson—I think it varies from year to year.

Senator ALLISON—Do you have a schedule that shows how many there have been over, say, the last few years?

Ms Huxtable—We can certainly take that on notice and provide you with that information.

Senator ALLISON—Could you also indicate how many of those are related specifically to the level of the fee set for that item and how many are for new items and other variations?

Ms Huxtable—I think often those issues are entangled. One of the objectives here is to review elements of the schedule and look at often cost-neutral packages, if you like. Often those submissions will go to various issues around how the schedule is operating. I am not sure that we would say that they definitely will go to this or that issue. It will depend very much on the craft group and the concerns they have.

Senator ALLISON—What I am interested in is how a rebate is increased—or decreased, for that matter, but I am sure the submissions are mostly about increases in rebates—to keep pace with normal inflation. What applies to that—or is it entirely ad hoc and dependent on submissions to be made?

Ms Huxtable—There are two issues here. There is a standard indexation applied to the schedule fee, and that occurs on 1 November each year. The issues tend much more to be around the structure of the range of items relevant to the particular professional group—that is, what those items look like, how they interact and whether they remain appropriate over time. Certainly one of the objectives is to have those discussions within a cost-neutral environment or a minimal cost environment.

Senator ALLISON—Would the standard indexation apply to all rebates equally? Is it an automatic process?

Mr Robertson—Rebates are indexed each year. The only areas of the schedule that are not indexed in accordance with the standard indexation are pathology and imaging, which are managed separately under agreements.

Senator ALLISON—So if there was a difference in the indexation between one procedure, say, and another procedure, we could assume that it is because an argument has been put about one procedure as opposed to the other procedure in terms of something other than indexation?

Ms Huxtable—I am not sure whether from time to time there may have been specific decisions that related to agreements with the profession in regard to specific elements, but as a general rule the indexation applies across all items in the schedule.

Senator ALLISON—How is it calculated?

Ms Huxtable—It is based on the wage cost index No. 5

Senator ALLISON—Do you have records of what that has been in percentage terms over, say, the last four or five years?

Ms Huxtable—I would not have those here, but we can certainly take that on notice.

Senator ALLISON—Okay. Are there reviews, independent of submissions being made about rebate levels, conducted by the department or the minister at any point in time? On a regular basis?

Ms Huxtable—Certainly not on a regular basis, although the government can from time to time consider those issues in a budget context, and it has—whether rebates are indexed or not indexed and how rebates are set.

Ms Halton—Essentially the system ticks along. There is a regular index. The schedule sits as it is. There is a combination of technology sometimes changing and clinical practice sometimes changing, so individual groups might come forward and say, 'We think there is a problem in this area,' or 'We think there is an opportunity.' Similarly if the profession raises with the government an aggregate of concern with respect to a particular area, the minister can and may choose to have a look at those issues. But we do not have a six-monthly or 12-monthly de novo review, if I can describe it that way; it tends to be more responding to the particular issues. Certainly in my experience ensuring that the regular index flows through and then tackling the particular issues as they emerge has been the characteristic of the last however many years.

Senator ALLISON—But it is not something a report is made about is it?

Ms Halton—No.

Senator ALLISON—None of this is open and accountable.

Ms Halton—The committee when it meets has agendas and considers particular items and weighs a variety of issues, so that is a way of providing, if you like, a balance of advice to the minister in respect of particular issues, but the process of indexing is perfectly transparent. The indexes are publicly known et cetera.

Senator ALLISON—Except that there can be some variations to that indexing arrangement. Does the MBCC do reviews, or does it not? I will be more specific: are the decisions that the MBCC makes—and the results of the reviews that, presumably, it does of applications for change—available?

Ms Huxtable—I would not say the MBCC does reviews in that sense. The MBCC is really a forum for a dialogue between the AMA, the department, Medicare Australia and the professional groups. Such dialogue may lead to some consensus or a view about the way in which a group of items may be restructured or changes may be made, and that would be considered by government from time to time. But it is not a process that leads to a formal report and a formal review mechanism. There is the Medical Services Advisory Committee, MSAC, which is a different process. It looks at new technologies. It does those formal reviews and does provide reports.

Senator ALLISON—Is it possible to get a list of the rebates which have been altered, whether increased, decreased or not increased at the rate of the indexation that is common to other rebates? Is it possible to get a list of the variations from the norm, not for new procedures but for existing procedures?

Ms Huxtable—For the last 12 months?

Senator ALLISON—Yes.

Ms Halton—If you like, why don't we do it for this year, so we will start from January through to now? We have already talked about the number of meetings.

Senator ALLISON—That will be effectively 12 months anyway by the time it is done.

Ms Huxtable—There have been two MBSs released in that time. We can certainly provide it in regard to the May schedule and the November schedule, which was released yesterday.

Ms Halton—So then you can see that they are schedules, and you can see the meetings.

Senator ALLISON—Is it also possible to indicate which of these are the result of the committee's procedures and which have been determined by the minister specifically?

Ms Halton—They are all determined by the minister, so—

Senator ALLISON—Varied by the minister.

Ms Halton—The minister takes the decision.

Senator ALLISON—Yes.

Ms Halton—If your question is, 'How many of these are own motion and how many of them have been considered by the MBCC?' we can certainly tell you that.

Senator ALLISON—The MBCC's meeting minutes are presumably not available publicly on the web site?

Ms Huxtable—No.

Senator ALLISON—Nor the decisions or recommendations?

Ms Huxtable—It is an internal process.

Senator ALLISON—The reason I am asking these questions is that I put some questions on notice to do with the rebate for terminations, which seems to be at odds with the indexation that is applied to other rebates. I have not had an answer to those questions, so it would be useful if they were forthcoming.

Ms Halton—You are saying that you believe it to be indexed at a different rate?

Senator ALLISON—It is not clear to me how it is indexed, but other rebates appear to be indexed and, as I say, I am trying to find out what the situation is. They appear to be indexed a different rate. It may be that for some reason they have been elevated. It may be that, for terminations, something else has happened.

Ms Halton—My understanding—but we will correct this if it is not right—is that there has not been any differential treatment in relation to those items, in relation to how they are indexed. But if I am not right we will certainly let you know.

Senator ALLISON—There certainly have been some changes in recent times to do with services that are conducted, whether it is ultrasound or whether it is a range of other anaesthetics and the like. There have been some changes over the last few years, and it would be useful to know if that has been through this committee process and what, if any, reasons or arguments there were.

Ms Halton—It helps to know what the genesis of the questions is, because that means we can do the work properly. So your essential question is: given that there are other items that are proximate to those items that have changed, how has that happened, and is it the case that the termination items are indexed consistently with the other unchanged items? I hope I did not make a complete mess of expressing that!

Senator ALLISON—Correct. It would also be useful to know if there were any submissions made on this issue, either for or against an increase or a decrease, just so that we have a picture.

Ms Halton—Yes, that is fine. We understand what you want.

Ms Huxtable—Did you say that you were going to put those questions on notice or you had put them on notice?

Senator ALLISON—I lodged them some time ago. I may even have them in the folder here; I will have a look and see.

Ms Huxtable—I am struggling to find the relevant questions, so we will have to search for that.

Ms Halton—Did you get answers to the questions? Maybe they are still—

Ms Huxtable—They might still be being processed.

Ms Halton—But we have lodged every—

Ms Huxtable—Was this in the estimates context—

Senator ALLISON—No.

Ms Huxtable—or were these the standard questions on notice?

Ms Halton—Okay; I apologise.

Senator McLUCAS—I have a couple of questions on Medicare. We went through the process of the legislation inquiry into the Health Legislation Amendment Bill. Subsequent to that, the minister announced that he would not require the power that was described as:

... required to allow swift action to be taken to, amongst other things, prevent medical practitioners claiming existing Medicare Benefits Schedule (MBS) items for services which they were never intended to ... cover ...

I think each of us knows what we are talking about. Where did the idea for this power originate? Was this advice from the department?

Ms Huxtable—Yes, that is right.

Senator McLUCAS—What is the need for this power?

Ms Huxtable—We had quite a discussion about this at the earlier hearing. This came to our attention initially through reports from Medicare Australia in regard to what appeared to be inappropriate use of some items. The concern at that time was that it was difficult to respond quickly when it appeared that there was some inappropriate use of the schedule occurring and that the intention of this piece of legislation was to be able to have a more accelerated process to vary an item.

Senator McLUCAS—What is the frequency of that inappropriate use of items?

Ms Huxtable—It is quite low. I think we took some questions on notice at the hearing and we have gone away; we are in the process of responding to those questions. My recollection is that there were around eight instances in 2003 and 2004 where it was fairly clear that this was occurring. There are a range of others, however, where investigations are still occurring.

Senator McLUCAS—Are we talking about eight claiming events or—

Ms Huxtable—No, in regard to the items. I think we talked last time around this concept of a service which probably is better described as a procedure—how you might describe how something happens. Some things are very close to existing descriptors within items but in fact were not the original intention when the item was put in place; in fact, the new device or technology had not been dreamt of at that time.

Senator McLUCAS—We spent a lot of time talking about plastic or concrete—

Ms Huxtable—Cement, I believe. Cement may have been invented some time ago—though not for this purpose.

Senator McLUCAS—If there are eight item numbers, can you give the committee an understanding of what they are?

Ms Huxtable—In regard to that question on notice, we have drawn out some examples of where this may have been the case. Vertebroplasty was the one that we discussed at that time. There are a number of other examples. I am not necessarily the technician around how these things work, but I have been given some examples here. It may be easier if we respond to these on notice, because they can go into a bit more detail about it, if that is okay. I do not know that I can even say some of these words.

Senator McLUCAS—Is that question going to come to the legislation committee shortly?

Ms Huxtable—Yes, we are in the process of finalising the response to that now.

Senator McLUCAS—We are in the process of finalising our report at the moment, so it would be good if we could have that answer quite quickly.

Ms Huxtable—It was quite difficult to get some of this information. Yes, we will do that.

Senator McLUCAS—There was that opportunity, under the legislation as it now stands, for Medicare to write to a practitioner that they thought was inappropriately claiming with a cease and desist type letter. Is that not effective?

Ms Huxtable—In some ways that is a question for Medicare Australia in terms of where they have got to. I think in cases it is effective and in other cases it is not clear that it is as effective as it could be.

Senator McLUCAS—That is where there needs to be a discussion about the definition of the item, I suppose?

Ms Huxtable—Yes, that is right. Sometimes this is quite complex because often these things are matters that are already before MSAC, so there may well be a point of time in the not-too-distant future where this particular procedure comes on to the schedule. But in some ways this is trying to stop the diffusion of technologies inappropriately without going through the cost-effectiveness regime.

Senator McLUCAS—Those are all the questions I have in this area. Ms Halton, I have just had a request that we might ask some whole-of-portfolio questions just after lunch. Is that possible?

Ms Halton—Could you give me an indication of what sort of things—

Senator McLUCAS—No, I cannot, I am sorry.

Ms Halton—I would have to bring the whole division back—I am happy to do it.

Senator McLUCAS—I will get some more information.

Senator Patterson—Mr Chairman, we did agree that we had finished that item, and all the officers have gone back. It would need to be fairly serious to bring them back again.

CHAIR—Yes, I understood that we had finished with the pharmaceutical branch.

Senator McLUCAS—I will not push it; I agree with you. We give you an indication so that your people can get back to doing the other things that they do with their lives.

Ms Halton—I cannot guarantee that somebody has not got on a plane.

CHAIR—And you should not be asked to answer the questions without the right people here. You might put any questions in this area on notice, Senator McLucas.

Senator McLUCAS—I do not know the nature of the questions yet, but hopefully I will be able to get some more information shortly.

Senator Patterson—I have just been reading *Harry Potter*. I think Harry may have been in here. There are voices coming from all around the room. We seem to have got into a different mode now. Once upon a time, in the olden days when I was a girl, people had to ask the Senate staff to pass a question to a senator. We now seem to have questions coming from everywhere via the internet, and I think it is something we have to look at. Somebody can say: 'Aha! We have another question.' If we are going to have some order in it—and I appreciate that Senator McLucas has said that she understands about bringing people back—and if people can use their computers, then we need to understand that, if somebody has an 'Aha'

experience after we have finished, we cannot just bring people back. I have a bit of a concern about people using computers, because the officers are then answering questions from all over and anywhere and we do not know where they are coming from. The questions should be coming from the senators themselves. Obviously messages are being passed up but, if it is going to happen, I will be keeping a very beady eye on it because it makes it very difficult for departments to answer questions in an orderly fashion.

Senator McLUCAS—I would like to respond.

CHAIR—We do not want to have a debate about this.

Senator Patterson—I am making an observation about what has changed.

Senator McLUCAS—What has also changed, Minister, is that our side has brought to this committee a system. We could ask all of the Department of Health and Ageing to stay here from 9 am to 11 pm. I think we as a committee have been quite helpful to the department so that your time is best used. I think that has been quite a welcome suggestion from the committee. But, by the same token, if something does come up, it does come up. And I am sorry about the technology.

Senator Patterson—I am just saying that it now means that the officers are having to answer questions from wherever.

Ms Halton—I think that, rather than speaking speculatively, it would be better if you could get a clearer idea of what is needed. Then I can find out whether the relevant person, whomever they might be, is available; otherwise, I will have to take it on notice. If you can tell me what it is, I am happy to find out.

Senator ALLISON—Can I just make a point. There is nothing in the standing orders that suggests that questions cannot come from any direction. I might say that I do not get mine from the internet per se, but, sometimes, being able to use your email saves our staff being at the back of the room writing you notes and coming up and passing them to us. It is just a bit quicker and easier. I would also say that I think we are all aware that we do not want to keep public servants waiting unnecessarily.

CHAIR—As far as I am concerned, the procedure remains that, when we call an agency or part of an agency to the table to answer questions, they can be asked any questions in the area of their responsibility. But, once we finish with their services and we dispense with those services, we should not be asking further questions unless they are placed on notice.

Senator ALLISON—Chair, it all happens by agreement and by cooperation and most of the time it works.

CHAIR—Indeed. Let us see whether we can adhere to the spirit of that and make sure that we put our questions in the areas concerned while the officers are still at the table rather than at other times. Let us move on. Are there any further questions on outcome 2?

Senator McLUCAS—I have one further question on outcome 2, and that is back to the pathology agreement. I understand that a report, *Review of enforcement and offence provisions of the Health Insurance Act 1973 as they relate to the provision of pathology services under Medicare*, was recently released.

Ms Halton—I think that is a question that should have been dealt with under outcome 10.

Senator McLUCAS—The pathology agreement sits in outcome 10, does it?

Ms Halton—Yes.

Senator McLUCAS—I am sorry; that is my mistake. But you are going to have some questions on notice. I also have some questions on IVF review procedures. The minister announced that there was going to be an independent review of IVF. Can you confirm that?

Ms Huxtable—That is correct.

Senator McLUCAS—What has happened with that review since then?

Ms Halton—It is proceeding. Ms Huxtable is finding her brief. I can tell you that they have been meeting regularly.

Ms Huxtable—On 4 July the minister announced the membership of the review committee and its terms of reference. Unfortunately, I do not seem to have the attachment which gives me that, but that was the 4 July press statement. Since that time, the committee has met on several occasions and it is working through its terms of reference. The last time it met was on 13 October. It is expected that a report will be provided around February next year.

Senator McLUCAS—Is the committee taking submissions? How does the process work?

Ms Huxtable—It is not taking submissions in a formal sense. In part, that relates to the time and the nature of the review which is being undertaken. However, the committee is meeting with key stakeholders. At the meeting I attended on 13 October there were presentations from several of the key stakeholders, so there is quite an open dialogue occurring.

Ms Halton—I have received a number of pieces of correspondence from people who have an interest and wanted to make particular points in relation to that review. We have been scrupulous in ensuring that that information is provided to the committee. So, whilst it is not holding public and formal hearings, certainly a number of parties have identified themselves as having a particular interest, and that material is being fed in.

Senator McLUCAS—Will their submissions be public documents?

Ms Halton—They are not submissions.

Senator McLUCAS—Yes, I understand that. Will the report be a report to the minister?

Ms Huxtable—Yes, that is right.

Senator McLUCAS—Then it is up to the minister whether or not he releases it?

Ms Huxtable—It will be considered by the minister when received.

Senator McLUCAS—Is it possible to provide the committee with a list of people that the review team has contacted as part of their process?

Ms Halton—I do not actually think that that is possible, because they are not having a formal process. Each of them, bringing a level of professional experience in these areas, has a range of contacts. I genuinely cannot say the number of contacts they have had in relation to these matters.

Senator McLUCAS—Okay. I accept that. I understand there is a Medicare item for diagnostic testing for HIV-AIDS. It was announced in October this year that pregnant women would be given routine HIV and STI testing each year through Medicare. Is that correct? What is the genesis of that?

Ms Huxtable—That, unfortunately, is also a diagnostics issue, which is in outcome 10. All the diagnostic and technology issues are in outcome 10.

Ms Halton—I do not actually have the press releases in front of me, but my understanding is that the minister did make an announcement in relation to Medicare subsidised diagnostic testing being available to a range of groups. But I do not have the document in front of me. Do you have a copy of that release?

Senator McLUCAS—Yes. I am actually interested in the motivation for it, because the groups are Indigenous people in Australia. I am particularly interested in what motivated the need for a diagnostic tool to test for HIV-AIDS in the Indigenous community in particular.

Ms Halton—My understanding is that this is a particular issue that has been discussed on several occasions by MACASHH and a number of the other bodies that are relevant in this area. You would be aware that there has been, for as long as I can remember, a concern about potential areas where, if we were to have an increase in the HIV rate, we need to be particularly vigilant. We have been extremely fortunate, as everyone knows, that that has not occurred; but we do watch particular subpopulations quite carefully. I think you will find that that particular item was in response to some people's concerns in relation to possible spread in those populations.

Senator McLUCAS—Do you understand that there has been some growth in the numbers of Indigenous people? My particular concern is about the Torres Strait, to be frank. I did not realise that there was any growth in reported HIV in the Torres Strait—in fact, I did not think there was any.

Ms Halton—My understanding is that there has not been. My understanding is that the very slight increase that we have seen was more evident in the north-west of the country. You would understand the particular concerns we have about some people, in terms of their mobility and there being some public health issues that people were quite conscious of watching fairly closely. But, no, my understanding is that we have not actually seen any increase in the Torres Strait.

Senator McLUCAS—Which is good. It is more by good luck than good management, to be frank.

Ms Halton—I would not underestimate the amount of management that has gone into this. I think your concern to watch what goes on in the Torres Strait is very informed and very appropriate, and obviously it is something that we watch with great care as well. We continue to get—appropriately, I think—positive comments about our response to these issues. But I think we all acknowledge that this is never an area that you do not watch with great care.

Senator McLUCAS—The public education in the Torres Strait, especially the top western islands, is very high. When you see the great big box of condoms that comes in on the ferry every month, you realise that it is working. So that is good. How would the Medicare item

work? I am interested to know why you need a separate item for pregnant women. Can't I just roll up and get an HIV test? Do I have to have some indication that I might need it?

Ms Halton—My understanding is that we have not actually subsidised HIV testing broadly for anyone and everyone.

Senator McLUCAS—There is no item for HIV testing at the moment.

Ms Halton—Let us come back to you on notice in respect of the specific provisions. But most of the HIV testing, I think you would be aware, has been conducted by the states and in respect of things like life insurance et cetera. This was a new thing to have done.

Senator McLUCAS—So if an Indigenous woman presents to her GP and says, 'I'm pregnant,' she will get an HIV test as part of the care process. Is that how it would work?

Ms Halton—Again, that is my understanding. But I am happy, by the time we get onto 'Indigenous health' this afternoon, for us to get someone to confirm the precise arrangements and we will revisit the issue, if you are happy to do that.

CHAIR—If there are no further questions for outcome 2, we will dispense with the services of the officers associated with outcome 2 and make a start on outcome 4 before we rise for lunch.

[12.45 pm]

CHAIR—Are there any questions on outcome 4, Primary care?

Senator McLUCAS—My first set of questions go to the GPs in aged care division of general practice issue. How many divisions have set up aged care panels?

Mr Learmonth—All divisions of general practice have aged care panels operating.

Senator McLUCAS—Including the Cairns division?

Mr Learmonth—I am advised, yes, all divisions.

Senator McLUCAS—Well, that is a change. That is good news. How many GPs are involved in that?

Mr Learmonth—Eight hundred and seventy nationally. There are actually 169 panels. There are more panels than divisions giving us some area coverage and there are 870 GP members all up.

Senator McLUCAS—So those 870 GPs are people who are registered with the panel?

Mr Learmonth—Yes.

Senator McLUCAS—What proportion of the GP population is that—169 and 870 is about three per panel; is that right?

Mr Learmonth—Roughly, yes—a bit more than four actually.

Senator McLUCAS—A bit more than four, I was being a bit ungenerous. Did you expect that the take-up would be—I do not want to sound too negative—so low? You have all the divisions in, but four GPs per panel does not seem like much.

Mr Learmonth—A couple of things to say: one, that is March data, so I would expect there to have been considerable growth since then. This is a program which has been slower

than I think most people anticipated in coming on stream, so I would expect rather a lot more GPs on now. If you looked at the distribution, my guess would be that the panels whilst established are in different stages of establishment. So the ones that are well established would probably have a larger number of GPs, closer to the eight, and the ones that are in the early stages might only have a couple. It is probably a bit skewed, or bimodal, if you like.

Senator McLUCAS—So they are the March figures.

Mr Learmonth—I would not expect most panels to have four. I would expect the well-established ones to have a higher number and the ones in the early phase to be in the process of recruiting.

Senator McLUCAS—The intention of the establishment of this program was to increase the visitation of GPs into residential aged care facilities—

Mr Learmonth—Amongst other things, yes. It was also about improving quality of care within the aged care facilities.

Senator McLUCAS—With the new item number—

Mr Learmonth—Not just use of item numbers but participation by GPs on things like quality improvement panels, committees within aged care facilities, use of drugs and medication, and so on. The new item number has also been a very welcome aspect of it.

Senator McLUCAS—So 870 GPs in March; what was the previous quarter to that?

Mr Learmonth—That was probably the only point-in-time snapshot that we have. We are about to get new data in the very near future as to what the current numbers are.

Senator McLUCAS—So at the end of December last year you did not know the number of GPs that were involved.

Mr Learmonth—I do not think we did a count, no. That has been the first count so far. That is the baseline, if you like.

Senator McLUCAS—Has any analysis been done about whether this has actually changed the practice of the GPs who are now on these panels?

Mr Learmonth—There has been no formal analysis or evaluation. Certainly there have been anecdotes, as I get out and about, that suggest it is having a very positive effect on access. I have heard some extremely positive stories in a variety of places from Perth to central New South Wales about improved access through a variety of strategies. There is no formal study but anecdotally it seems to be a very positive and effective measure.

Senator McLUCAS—The anecdotal evidence that I have is that it has been successful in remunerating those doctors who have not actually changed what they do. You have a lot of GPs who have a commitment to residential aged care and they were going to go anyway, but this at least remunerates them for what they do.

Mr Learmonth—I have heard a lot more than that. I confess that if in part the measure has succeeded in retaining GPs in that aspect of service delivery whereas they would otherwise have left then it is a good thing. But I have actually heard quite a bit of anecdote about genuine improvements in access and service as well.

Senator McLUCAS—Do you intend to evaluate it?

Mr Learmonth—Absolutely.

Senator McLUCAS—When will that happen?

Mr Learmonth—The 12 months review is under way.

Senator McLUCAS—To be completed by when?

Ms McGlynn—It is due for completion at the end of this year and results in the beginning of 2006.

Senator McLUCAS—How are you evaluating it; what are the measures that you are using?

Ms McGlynn—We are looking at performance indicators for aged care panels and looking at those behaviour changes that you were talking about and also looking at good models of care that might be able to be shared around Australia—so where things are working, where GPs are more engaged, and where there are good models of education and training so that models can be spread.

Senator McLUCAS—So in terms of the first performance indicator, are you testing whether the number of GPs who are visiting aged care facilities has changed as a result of establishment of a panel?

Mr Learmonth—We might well—I am not sure we have got that far down the track. But I think the real measure is not so much the number of GPs visiting as it is the number of visits that happen. For example, what may occur in a particular region is that you might end up with fewer GPs actually visiting but those GPs who are visiting show a serious commitment to that particular service stream, and therefore one sees access for all of the residents in that aged care facility improving significantly, because there is an economically sustainable and viable patient population now for that number of GPs. The critical measure is access per se rather than number of GPs.

Senator McLUCAS—I think you do also have to test whether or not there are more GPs in the pool of people going to residential aged care. You know as well as I do that there might be 40 doctors in a region but only five of them are prepared to go to residential aged care. Surely it was an intent of the program to grow that five so that the burden was actually spread amongst other GPs as a pool.

Mr Learmonth—Again, it depends very much on the local circumstances. If you are in a region which is underprovided in terms of GPs prepared to visit I would agree with you entirely, and we would certainly look to measure that. But there are other circumstances where the anecdote that has been related to me—for example, I spent some time around Rockingham in WA with divisions this year—is that it was more the other way around. Quite a large number of GPs were prepared to visit but, because they had only a small number of patients each and those visits came at odd times, it was essentially a very difficult for them economically to sustain that.

Senator McLUCAS—So they consolidated—

Mr Learmonth—So if there is consolidation so that there is higher volume of patients per GP, if the aged care facility is well prepared to actually accommodate the visiting GP by way of things like computers, software, preparation of patients, records et cetera it can make for a far more viable, effective, sustainable and growing kind of service.

Senator McLUCAS—In terms of the remuneration to doctors, it was predicted that the doctors would receive about $8,000 to participate in the panel and to be part of that process. Is that what has happened?

Mr Learmonth—That has been the limit. I guess we will find out in the evaluation what has actually been paid.

Senator McLUCAS—How does that money get paid—just for being on the panel or for attending residential aged care? I just cannot remember how it happens.

Ms McGlynn—That varies again. There are different panel arrangements depending on the area. That is done in local consultation with general practice, the homes and the panels themselves.

Mr Learmonth—Overall what we have tried to do is to recognise there is enormous diversity in the situations in terms of whether they are well or not well provided for and what the general dynamics of the local situation are. We have tried not to put too many speed humps in the road of progress, if you like, to keep it quite flexible in terms of how it is used and how the division has discretion to get the best outcome for the given money.

Senator MOORE—Is the evaluation going to be an internal evaluation through your branch, Ms McGlynn?

Ms McGlynn—It is being run through the branch, yes.

Senator MOORE—So the evaluation is internal; it is not being contracted out.

Ms McGlynn—No, sorry, it has been contracted out. I just thought you meant the management.

Senator MOORE—So the evaluation for this particular program is being coordinated by your branch, the Budget and Performance Branch, but the actual work has been contracted out; is that right?

Ms McGlynn—Yes.

Senator MOORE—Do we know who has that contract?

Ms McGlynn—We do, but I do not have that information. Can we take that on notice?

Senator MOORE—Yes, and also what the time frame of the evaluation is.

Ms McGlynn—Yes.

Senator MOORE—And the price would be good, too.

Ms McGlynn—Yes.

Senator McLUCAS—What was the total budget for the first year of operation for the aged care panels?

Ms McGlynn—The total budget for 2004-05 was $13.3 million.

Senator McLUCAS—And what was the actual spend?

Ms McGlynn—I believe it was $1.4 million underspent.

Mr Learmonth—It would have been about $12 million actually spent.

Senator McLUCAS—So just under $12 million.

Mr Learmonth—Yes.

Senator MOORE—Does that roll over?

Mr Learmonth—Yes.

Senator McLUCAS—So the budget for 2004-05 was $13.3 million, and what is the budget for 2005-06?

Ms McGlynn—It is $9.9 million.

Senator McLUCAS—Why the decrease—set-up costs are not required?

Mr Learmonth—There was a very active discussion with the divisions network when this program was first formulated. They strongly wanted the program front-end loaded, if you like, to cover the establishment and set-up costs.

Senator McLUCAS—How many annual health care assessments have been done for residents of aged care? Am I in the wrong outcome to ask the question?

Mr Learmonth—No, you are spot on. I do not think we would have that level of detail with us, I am sorry.

Senator McLUCAS—If you could take that on notice, that would be handy.

Mr Learmonth—Certainly.

Senator McLUCAS—And the budget—

Mr Learmonth—This is the comprehensive medical assessments, the CMAs?

Senator McLUCAS—Yes, the CMAs. When did that become an item number—was that last year or has it been there and we have just promoted it more?

Mr Learmonth—No, I think it is relative recently. From memory I think it was 1 July last year.

Senator McLUCAS—So we would be able to get data about the number of CMAs that have happened.

Mr Learmonth—Absolutely. We could get you a time series, if you like.

Senator McLUCAS—That would be good. And the budget for the first year of operation of the CMAs?

Mr Learmonth—We will get you the expenditure. It is an MBS item so there is not a budget per se.

Senator McLUCAS—Sorry, yes. That is all I have on that area.

Senator ADAMS—I notice that one division did not meet its target with the funding agreement. Which division was that? That is in your annual report that you did not meet the

target. Out of 120 divisions, 119 divisions did and one did not. I am just wondering which division it is.

Mr Learmonth—My guess would be that it would be the Western Sydney division—I think it is a fair guess.

Senator ADAMS—What process has been put in place to ensure that this division meets its funding agreement requirements?

Ms Halton—It has been wound up.

Mr Learmonth—It does not exist any more.

Senator ADAMS—It has gone?

Ms Halton—That is the process when it does not exists.

Mr Learmonth—It is an ex-division. The replacement is in train.

Senator ADAMS—That is fine. Can you tell me if there is a performance indicator required for consumer participation within divisions and the number of consumers or community members on division boards?

Mr Learmonth—I think the answer is yes to both. There is a direct performance indicator on community and consumer engagement. As to participation on boards, that is due to come. It is part of a governance indicator more broadly which is in development. So there will be one on board composition and skills mix.

Senator ADAMS—So you cannot tell me at the moment how many there are?

Mr Learmonth—No. I mean, ultimately these are private entities.

CHAIR—We will break for lunch at this point and continue with outcome 4 when we resume

Proceedings suspended from 1.00 pm to 2.09 pm

CHAIR—We are on outcome 4, primary care, but I understand that there are some questions of an overview nature. I invite Senator McLucas to ask a question in that area.

Ms Halton—Before we get started, could we deal with a couple of matters that we spoke about before lunch. I have got a couple, as has Ms Huxtable, and Mr Learmonth has one matter. We said we would table a copy of the survey instrument. I have got one: consider it tabled; we will get it copied. We also said that we would provide copies of the capability map, which I am happy to table as well.

Senator McLUCAS—Thank you.

Ms Huxtable—We said that we would table change in PBS script volumes between the first quarter 2004 and the first quarter 2005. The data here is by month and broken into concessional and general. Secondly, we were asked for a breakdown of savings from the 12½ per cent measure for 2005-06 to 2008-09 and I am tabling an excerpt from the portfolio budget statements which provides that. We were asked about assumptions on changes in script volumes resulting from the copayment increase, and there is a question on notice which provides those, which I am tabling.

Senator McLUCAS—Is it a question on notice that we have actually received?

Ms Huxtable—I believe it has been received, yes.

Senator McLUCAS—Did it come in that lot last night?

Ms Huxtable—I am sorry; I could not tell exactly when it came.

Senator McLUCAS—Thank you.

Ms Huxtable—Finally, there is the PBAC advice, which was tabled by Minister Abbott on Monday night regarding calcium. There are those four things.

Mr Learmonth—We were asked whether the aged care panel evaluation was external. We have checked: it is an internal evaluation this time that is being done under the auspices of an external advisory group in the sector. We anticipate an external one in October next year.

Senator McLUCAS—Can we get a list of the membership of the advisory group?

Mr Learmonth—Certainly.

Senator McLUCAS—And in what capacity they are there?

Mr Learmonth—Yes.

Senator McLUCAS—Ms Halton, as I foreshadowed before lunch, there are a couple of questions that we should have asked in the earlier part of today. I have a very good excuse for one of them. It comes out of the annual report and, as you know, we only received the annual report last week. Can the department confirm that the Audit Office, in auditing the department's financial statements, noted that $458 million had been inappropriately appropriated to the department? This is on page 299, and I am paraphrasing.

Ms Halton—This is really more appropriately dealt with by my CFO. I know what I understand this to be. I think I would be better off telling you the technically correct reason. There have been a whole series of things to do with the classification of receipts and expenditures to do with a number of technical matters. My understanding is that this is principally a technical matter, but I would be happy to give you something on notice on this. I will get it wrong if I start going to the technical detail.

Senator McLUCAS—It identifies that money has been provided essentially in contravention of the Constitution and in breach of the Financial Management and Accountability Act.

Ms Halton—My understanding is that this relates to the provision, and it is to do with the signing of a particular instrument. I have to say that this is something which a number of agencies have in common—the question of whether the instruments that were signed were actually technically valid. We had an instrument in place. It is a question of whether that was technically valid. I have to be fair and say that there was a difference of legal opinion between the Audit Office and a number of agencies. Might I also say that my understanding is that the Audit Office itself was caught in breach of this particular provision.

Senator McLUCAS—It is the delegated authority?

Ms Halton—Yes, correct. My understanding is that the instrument we had in place, which had been signed off and was regarded as being appropriate by not only ourselves but multiple

other agencies, was judged by the Audit Office to be technically invalid. Because it was regarded as technically invalid, it means that these funds were technically inappropriately appropriated. My point remains that there is a difference of legal opinion on this issue and the matter has been rectified. In terms of whether this implies that any funds were used inappropriately or misappropriated or any of what I would regard as being very serious matters, subject to being completely confident that this is the matter—I am pretty confident it is—and in any event we do not have any major breaches in that respect, that is my understanding of what this refers to. But I am very happy to give you chapter and verse on the technical provision.

Senator McLUCAS—I will put some very technical questions on notice.

Ms Halton—Fine.

Senator McLUCAS—I would like to know, possibly from your CFO, what the legal consequences of this contravention of the Constitution might be and also what the legal consequences of the breach of the FMA Act might be.

Ms Halton—Certainly the advice I have been given is that, because this is regarded as being an inadvertent and technical breach, there are not, therefore, any consequences for any of the agencies who are caught up in this. It is fair to say that, when this was brought to everyone's attention, people moved very rapidly to ensure that we had in place instruments that were regarded as being appropriate. This long predated my time in the department, and I know the instrument concerned had been checked before it was dealt with by the then relevant officer in the portfolio. We have been back through this in some level of detail, as you would well imagine.

Senator McLUCAS—When was the breach first discovered?

Ms Halton—I cannot answer that off the top of my head. It is not that long ago. It has been running for a few months, but it is not 12 months old.

Senator McLUCAS—What do you mean when you say 'running'? I thought that the noncompliance had happened over seven years.

Ms Halton—The noncompliance goes back for a number of years—that is absolutely true. The noncompliance in fact goes back to when the instrument was originally signed. It actually goes to the validity of the instrument in relation to these legislative provisions. Essentially, what the Audit Office did, as I understand it, was to audit compliance in this respect. In the process they took external legal advice—they did not go to AGS—which suggested that in fact these instruments that nearly everybody had in place were not actually technically sufficient—including their own.

Senator McLUCAS—In your reasonable piece of time in the Public Service, Ms Halton, do you know whether any other breach over such a long time scale has ever occurred in the department?

Ms Halton—Not that I am aware of. Obviously I do not have a memory that spans more than a particular period. This, as I understand it, comes as a consequence of bringing in those new legislative arrangements—FMA et cetera. It is to do with advice that was given, as I have already indicated, to all agencies about what was actually required to legally satisfy the

particular requirements in those acts. Obviously FMA and CAC were all coincident, and this was only found when this audit was done. As I say, there is a difference of legal opinion about this, but nonetheless the auditor is the person who calls the issue. Certainly not only I but a number of other secretaries have had a conversation with the auditor about it.

Senator McLUCAS—We will put the rest of those technical questions on notice.

Ms Halton—I am very happy to answer them.

Senator McLUCAS—The other portfolio issue is around ACIL Tasman, which is a consultant agency. You would have noticed that there has been media coverage about that recently. Do you have any existing contracts with ACIL Tasman?

Ms Halton—Yes, we do. We have a number of existing contracts with them. I do not know that the list I have in front of me is complete. They provide statistical services to the Ageing and Aged Care Division relevant to estimating the true funding base for residential aged care. They are also subcontracted by another consultant as part of the national trial of a new aged care funding instrument. I understand that they are contracted to do modelling work as part of that process. They are a member of the department's panel for health economic services, and I think our annual report lists that they have previously done some work for us on contracts that have been completed. They are listed in the back of the annual report.

Senator McLUCAS—And you are aware that charges were laid recently against various ACIL personnel?

Ms Halton—Yes.

Senator McLUCAS—And that they are under investigation by the AFP?

Ms Halton—Yes.

Senator McLUCAS—Was the health department informed by ACIL Tasman of this development?

Ms Halton—Not that I am necessarily aware of, but obviously it is a matter that we have become aware of. I cannot comment as to whether there had been some lower level contacts. Obviously we are very aware of the matter.

Senator McLUCAS—Do you know whether ACIL Tasman is currently competing for any contracts with the department for which Access Economics is also competing?

Ms Halton—I am not aware of any. That does not mean that there are not any.

Senator McLUCAS—Could you have a look at that and advise the committee?

Ms Halton—Yes. This will be a matter we are looking into, I can assure you.

Senator McLUCAS—Do you have any guidelines which regulate any contract being awarded to companies which are under investigation?

Ms Halton—As you would well understand, there are several issues here, one of which goes to charges that have been laid but not proven in relation to court matters.

Senator McLUCAS—That is right. That is the point of the question. What is the situation? How do you respond in this sort of situation?

Ms Halton—What we have been saying publicly, and you could well imagine that a number of people have asked us, is that we are currently considering how we are going to manage this issue. We are taking a range of legal advice internally. We do have to do the work that you have just indicated in identifying where they may be parties to processes. That work is not complete yet. I think it is probably not appropriate that I in any sense speculate about what our considered position on this matter will be, but I can assure you that it will be a considered position.

Senator McLUCAS—You may have to take this one on notice. Can the department confirm how many times ACIL Tasman and Access Economics competed for tenders in the portfolio in the year 2003-04 and in 2004-05?

Ms Halton—I do not know. What I do not know—but I will certainly endeavour to get a measure of it—is how difficult it will be to find that out. The reality is that we record tenders of a certain size. We understand who the successful tenderers are but, whether or not I can actually go to the number of times that combination has appeared anywhere, I am not sure. If I can provide you with that information I will be happy to.

Senator McLUCAS—You would have the list of the tenderers.

Ms Halton—The question I am asking internally is that we have to identify all the tenders and then we have to go back and find how many people were at what parts of processes. Sometimes people ask for material in relation to a tender and they do not proceed. Sometimes people come in with an expression of interest and they do not proceed. Quite what information we have about each of those elements, I cannot say off the top of my head.

Senator McLUCAS—If you can provide us—

Ms Halton—What I can get you, I am happy to provide.

Senator McLUCAS—The subsequent question, of course, is how many times did ACIL Tasman win those bids when they were competing with each other.

Ms Halton—In terms of what they have won and completed, you have seen that in the annual report because that is required to be disclosed.

Senator McLUCAS—It is when they were competing that I am interested in.

Ms Halton—Fine.

Senator McLUCAS—Also on notice, what was the total worth of the work won by ACIL in 2003-04 and in 2004-05? I am sure you could get it out of the annual report.

Ms Halton—That is fine.

Senator McLUCAS—Given the recent concerns raised in the media, can the department now confirm whether, with any of the bids won by ACIL Tasman, they had access to information from Access Economics?

Ms Halton—Again, we do not have a clear picture and I am not prepared to speculate on what might be the answer. I am happy to take it on notice.

Senator McLUCAS—I would like to also understand the steps the department has taken to assure itself that no improper use of information was used to secure work from the department.

Ms Halton—I should imagine that, at the very least, we will be seeking some information from them. I will take it on notice if you are happy for me to do so.

Senator McLUCAS—Thank you for that.

CHAIR—Are there any further questions on outcome 4?

Senator MOORE—I have a series of questions on the Better Outcomes for Mental Health initiative. They are quite detailed, so I will work through them. Ms Halton, I am not exactly sure which of your officers will be taking the lead. I have a feeling that it could well be Mr Learmonth. The first range of questions looks specifically at the budget, the various changes to money and money coming in and going out. That will be the focus of the questions. I will start running through them and we will see how we go, because I am sure we have done some of this before.

In terms of the money being spent now, in 2005-06, can you tell us what is being allocated to the Promoting Better Mental Health initiative in 2005-06? Supplementary to that question, because this will relate to a graph where all the figures are: how is the money broken down into the various components of that overall initiative? So the questions are: what are the initiatives that are being funded out of this overall program, and how much?

Mr Smyth—Just looking at my figures here, for 2005-06 I have $46.4 million allocated for the Better Outcomes program.

Senator MOORE—To the whole program, Mr Smyth?

Mr Smyth—To the whole program.

Senator MOORE—How is that broken down into the various components?

Mr Smyth—The component parts are the MBS/SIP components, which—and I understand that my colleagues over in the Primary Care Division might want to jump in here as well—are $19.4 million. The program components, which consist of the access to allied psychological services, education and training and the general practitioner psychiatrist support service—

Senator MOORE—Are they all lumped together?

Mr Smyth—They are all lumped together; they are the program dollars. That is $16.5 million. The Department of Veterans' Affairs is $200,000. And then I have departmental dollars as well, which is 1.9.

Senator MOORE—Would that be running costs?

Mr Smyth—That is right.

Senator MOORE—And that includes staffing?

Mr Smyth—That is correct.

Senator MOORE—What about the Youth Mental Health Foundation? Does that come under the same heading?

Mr Smyth—It does not. It is a separate allocation of $69 million.

Senator MOORE—Is that for one year, or is that the whole program?

Mr Smyth—No, that is over the entire four years of the program. That is under tender consideration at the moment.

Senator MOORE—So the $69 million for the youth program that Parliamentary Secretary Pyne announced is a separate allocation?

Mr Smyth—That is a separate allocation, and there is a component of that—around $14 million, I understand—that will be allocated to the Better Outcomes program for linkages with general practitioners for youth-specific issues.

Senator MOORE—But the whole program is $69 million over four years. Was that $14 million that you mentioned?

Mr Smyth—That is correct.

Senator MOORE—Is that over four years?

Mr Smyth—That is over four years. I would have to check, but that is my initial—

Senator MOORE—In fact, we will go through these questions, but then we will probably do as we have done before with this kind of questioning—that is, we have double-checked ourselves by going back and then sending an answer back that links them all. Because, as you know, with this particular program there are a lot of things that come in and out under the heading of 'mental health'.

Mr Smyth—Yes.

Senator MOORE—So is there anything else that comes under the heading 'mental health' or the expectation of expenditure on mental health that is also an outside program like that $69 million?

Mr Smyth—Can I also just add, into that total funding, that there is expansion funding as well of $8.4 million.

Senator MOORE—Yes. That was the one announced in the election campaign?

Mr Smyth—That is correct.

Senator MOORE—So that is actually termed 'expansion funding'?

Mr Smyth—That is correct.

Senator MOORE—Is 'expansion funding' a common term?

Mr Smyth—Yes, it is, I believe.

Senator MOORE—How much is that?

Mr Smyth—That is $8.4 million.

Senator MOORE—Over what period of time?

Mr Smyth—For this financial year—

Senator MOORE—Alone?

Mr Smyth—Yes, for the 2005-06 financial year.

Senator MOORE—Is that expected to go across the whole program, or is it going to go into one particular element of mental health funding? What is the expectation of the expansion funding?

Mr Smyth—The expansion funding is for the program components—those three components that I mentioned earlier.

Senator MOORE—MBS/SIP, access to the—

Mr Smyth—Not the SIP; it is the access to psychological services, education and training and the general practice psychiatrist support service.

Senator MOORE—What about DBA: do they get anything out of the expansion money?

Mr Smyth—No.

Senator MOORE—So in terms of this moment—2005-06—that would be the full listing of expenditure under the various programs of mental health that were in the budget?

Mr Smyth—It depends if you want to include suicide prevention as a subcomponent.

Senator MOORE—I would like to, because I think in terms of the various evidences that people have given us in the mental health committee the suicide prevention strategy is linked. It is a government commitment to mental health. Do you have figures for the funding that is going through to the various suicide prevention programs?

Mr Smyth—It is around $10 million a year ongoing, but I could take that question on notice and get the exact figure for you.

Senator MOORE—That would be good, if you would not mind. What about the expenditure for things like MindMatters: does that come under suicide prevention?

Mr Smyth—That comes under promotion and prevention activities. That is a separate allocation. I will get that figure for you as well.

Senator MOORE—Is that under suicide, or just promotion and prevention, which is another box?

Mr Smyth—It is under promotion and prevention, which is another box. The other box is obviously beyondblue—our funding to beyondblue which is in the order of $39.6 million.

Senator MOORE—Over how long?

Mr Smyth—That is over five years.

Senator MOORE—Beginning with which year?

Mr Smyth—In the 2005-06 budget, there was $39.6 million until June 2009.

Senator MOORE—So that is for four financial years?

Mr Smyth—Yes, four financial years, but I understand that some money was allocated from that in 2004-5. It commenced early because there was a five-year budget cycle, as I understand it.

Senator MOORE—So far we have three boxes. We have the promotion and prevention strategy, we have the expansion funding that came in particularly this year and we have the ongoing budget, which you went through for me—and that was the $46.4 million figure. So we are in agreement now?

Mr Smyth—We are. We also have our Commonwealth Own Purpose Outlays dollars, which are for national mental health reform activities. I understand that component is in the order of $66 million.

Senator MOORE—Can you run that one by me again?

Mr Smyth—That is the Commonwealth Own Purpose Outlays.

Senator MOORE—What is that?

Mr Smyth—That is $66 million.

Senator MOORE—To cover what?

Mr Smyth—That is to cover national mental health reform activities. Included in that would be items like the upcoming second national survey of mental health and wellbeing, the annual mental health report that is soon to be released and a number of activities.

Senator MOORE—That is the government one?

Mr Smyth—That is correct.

Senator MOORE—That is the Australian governmental health report which is like a state of the nation report?

Mr Smyth—It is a national mental health report that details a lot of the outputs of mental health services across each of the states and territories.

Senator MOORE—Does anything else come under that heading?

Mr Smyth—Obviously there is the Youth Mental Health Foundation.

Senator MOORE—Yes, that is where that particular box is.

Mr Smyth—Then we have program dollars. I will have to get the exact figure on that. That does include issues such as promotion and prevention activities et cetera They are lumped into my program dollars for mental health.

Ms Lyons—The Australian government also provides mental health money through the AHCAs. For this current AHCAs term—2003-08—$331 million has been provided to states and territories for mental health.

Senator MOORE—If we take that specialised funding that goes to the states, the Commonwealth Own Purpose Outlays and the other three areas we have already identified, is that the full picture?

Mr Smyth—That is the full picture. So it is the $331 million attached to Australian health care agreements; the National Suicide Prevention Strategy dollars; the National Depression Initiative dollars, which is beyondblue; the Better Outcomes program, my National Mental Health Program dollars, which covers some of the promotion and prevention activities such as MindMatters which I talked about; and the Youth Mental Health Foundation dollars.

Senator MOORE—Which particular box does support for national advisory groups and consumer participation come out of?

Mr Smyth—That comes under my National Mental Health program dollars. Support for groups like the Australian Mental Health Consumers Network, which we have recently funded for three years, comes out of that.

Senator MOORE—What about the Mental Health Council?

Mr Smyth—We fund some specific dollars for projects for the Mental Health Council, but they also receive CSSS finding as well. That comes out of a different area.

Senator MOORE—The Commonwealth was acknowledged as a major sponsor of the *Not for service* report. How much was given from the Commonwealth and which one of your funding streams did that come out of?

Mr Smyth—That would have come out of my National Mental Health program dollars. I will take that question on notice and provide you with that answer.

Senator MOORE—Do we now have a full picture for 2005-06?

Mr Smyth—That is correct.

Senator MOORE—What is the total?

Mr Smyth—I do not have a calculator in front of me, unfortunately, but I will take that on notice and provide you those details.

Senator MOORE—As you would expect, I had a look at the annual report and I also had a look at the various submissions that we have had from different groups. Nowhere did I find a full page with all of this written down.

Ms Lyons—It is quite possible that it is not on one page, but if you would like us to provide it on one page, we are happy to do that.

Senator MOORE—I think that would be very useful, Ms Lyons. In my recent experience I have been questioned quite a lot about the commitments of the government and the department to this area. It would be useful if we could all be talking about the same figures. It would be useful to have that not immediately but as quickly as possible.

Mr Smyth—There are, of course, other components, like the Pharmaceutical Benefits Scheme et cetera.

Senator MOORE—Of course. I know that in the departmental response to the mental health inquiry the expenditure on pharmaceuticals received a degree of consideration because of the amount of money spent there. Would you like to add that into the calculations as well?

Mr Smyth—If we add that into the equation I think we are up to about $1.145 billion.

Senator MOORE—Under Better Outcomes in Mental Health Care, before the various extra things you have added in, how much was spent on that in the years 2001-02 up until 2004-05—so the historical process? My understanding, Mr Smyth, is that would be the expenditure under the original program consideration less the expansion funding that you mentioned and less the 2005-06 that you mentioned. So it would be a historical program up until then.

Mr Smyth—My understanding is that there was some expansion funding provided in 2004-05. That was $2.2 million.

Senator MOORE—Is that in the additional estimates?

Mr Smyth—That is right. On the allocation from 2001-02 to 2004-05, I will refer to my colleagues in Primary Care Division in relation to the SIP and PIP components—the NBS components of this. The actual allocation by the government was $120.5 million. With the expansion funding on top of that it was $122.7 million.

Senator MOORE—It was $122.7 million for that period of time. I am interested in this figure of $63 million that we were told was unspent funds against that program area?

Mr Smyth—I will refer to my colleagues in Primary Care Division.

Senator MOORE—I thought that might go across to the Primary Care Division. The $63 million, Mr Learmonth?

Mr Learmonth—$62.5 million, yes.

Senator MOORE—I will correct my figure then.

Mr Learmonth—That is for PIP, MBS and the program elements around GP support.

Senator MOORE—Can you refresh us as to how that underspend occurred?

Mr Learmonth—That is almost all associated with the Three Step Mental Health Process service incentive payments—SIP.

Senator MOORE—Just the one line item of the figures that Mr Smyth has just gone through?

Mr Learmonth—Yes.

Senator MOORE—The MBS-SIP?

Mr Learmonth—Yes, that is it.

Senator MOORE—So that particular line item that was underspent?

Mr Learmonth—It was $57 million that was underspent in that period, the lion's share of it.

Senator MOORE—What about the other $5.5 million?

Mr Learmonth—The other amount was a very small underspend in the program components, which include GP education and training, access to allied psychological services and GP psychiatric support service.

Senator MOORE—Was that underspend all in one financial year?

Mr Learmonth—No, I think it was in earlier years and a question of slower take-up, but it was very small. The SIP is virtually all of it.

Senator MOORE—So it was an accumulated underspend of $52.5 million?

Mr Learmonth—That is over the four years—that is right.

Senator MOORE—Was it particularly apparent in one year? I am trying to find out when it became apparent that the proposed expenditure, which would have been modelled to show the expected allocation, did not meet it. Did that happen at one time or was it a slow burn?

Mr Kennedy—To look back, it was a new item which had just been worked out in consultation with the profession. Over time, it was quite clear that it was being underutilised. It was not in one big hit; there had been a steady increase since the initiative was implemented.

Senator MOORE—Did the full underspend become public in 2004-05?

Mr Kennedy—I am not sure when it became public. I would need to refer back on that.

Senator MOORE—Can we have that clarified? My understanding is that it was in 2004-05.

Mr Kennedy—It would have been, because an adjustment was made to simplify the SIP improved take-up in May. The underspend already started reducing, so from early on we were anticipating some growth. There was a slow take-up and it ended up being slower than people anticipated.

Senator MOORE—When did the department notice that it was confirmed that it was falling behind to this extent, because $62.5 million is a significant underspend?

Mr Learmonth—It was underspent, to some extent, from the first year.

Senator MOORE—Which was?

Mr Learmonth—It was $11½ million.

Senator MOORE—What year was that?

Mr Learmonth—In 2002-03.

Senator MOORE—So 2003 was the first year the program was announced?

Mr Learmonth—Yes.

Senator MOORE—Was the funding over four years?

Mr Learmonth—Technically, the program was 2001 to 2004-05, but this particular element started in 2003-03.

Senator MOORE—So it was a four-year program and it was underspent from the start but in lower amounts.

Mr Learmonth—In the first full year it was overspent. The overspend reduced towards the end, I think. I expect it was a case of expecting take-up.

Senator MOORE—Watching to see whether in fact there was going to be a flowing to—

Mr Learmonth—When you go back and have a look, a lot of assumptions were made on very poor data information about what the utilisation was. If you like, this was not about spending X amount of money on Y purpose; it was a case of funding a particular incentive item. You had to make assumptions about how many doctors would be interested; how many would choose to do the training; having done the training, how many of those would choose to provide the service to how many people; and what the demand would be. It is behavioural

response to incentive. It is a long way from being a precise science. That is how it was constructed originally. Those estimates were not particularly borne out in terms of the actual utilisation. We expected it to be used more than it did. Certainly the numbers were increasing, and the underspend decreased, particularly in that last year, down to 10 from 17, so progress was being made. But I think that, around that point, it was decided that it was structural and that people were not going to use it. Even giving it a fair bit of time for it to ramp up, it was decided that people were not going to use it to the full extent expected, and it was then that we started to look at why. One of the contributing factors was ease of use. In 2004-05 that changed to reduce three-step to two-step to make it much easier, and other changes are still being contemplated to try to improve that take-up and make it easier still to use while maintaining the integrity of the clinical process.

Senator MOORE—Are you aware of when the department advised Finance and/or the minister about the fact that it was being underspent?

Mr Learmonth—No, I am not, but budgets are done and reported on annually.

Senator MOORE—In terms of this one, because I know there is a departmental review on this whole program—the review of the effectiveness of better outcomes for mental health—

Mr Smyth—There is an ongoing—

Senator MOORE—An ongoing review, yes.

Mr Smyth—There is ongoing evaluation that is conducted by Dr Jane Pirkis from the School of Population Health at the University of Melbourne. The fifth ongoing evaluation report was delivered to us in June of this year.

Senator MOORE—June 2005?

Mr Smyth—June 2005. The prior one was, I think, in April 2005. There is also a minimum data set that complements the ongoing evaluation of the program. Each of those reports that is undertaken by Dr Pirkis and her colleagues focuses on different elements of the Better Outcomes program. As I understand it, the last report looked at the allied health care component, psychologists, and the employment of that group within each of the different divisions—whether there was a brokerage model adopted or whether there was a voucher model adopted. It looked at each of those different elements. There is an ongoing range of evaluations taking place. In addition, a lapsing program review that was conducted last year as well.

Senator MOORE—The program evaluation last year?

Mr Smyth—There was a lapsing program review because of the funding being allocated over a budget cycle.

Senator MOORE—Which is standard practice?

Mr Smyth—That is correct.

Senator MOORE—What about using health care management advisers as a process to formally do an evaluation of the BOMHC program? Is that something you are aware of? Is that a way of referring to Dr Pirkis's work?

Mr Smyth—I am certainly not aware of that.

Senator MOORE—I will follow up on that one. My understanding is that the Better Outcomes Implementation Advisory Group was set up when this program was put in place, as a formal part of the program, and that they are involved with seeing how it is going as well. Is that an accurate statement?

Mr Smyth—That is correct.

Senator MOORE—In terms of the information, do they meet regularly and look at these reports that Dr Pirkis's review group puts through?

Mr Smyth—They do; they meet quarterly. The next meeting is scheduled for later this month.

Senator MOORE—The information you gave about Dr Pirkis's process is that her review is ongoing.

Mr Smyth—It is ongoing.

Senator MOORE—How often does it provide information?

Mr Smyth—As I said, we are up to our fifth review.

Senator MOORE—Was that from the start? Was that particular contract review process from 2001-02?

Mr Smyth—From 2003-04.

Senator MOORE—So it was over a year after the program started that Dr Pirkis's process was put in place?

Mr Smyth—That is my understanding.

Senator MOORE—From 2003-04 the review process for this particular program involves this regular consultancy. An independent, outsourced consultancy is looking at it.

Mr Smyth—That is correct.

Senator MOORE—They provide information to the department and that is fed through to the advisory group as ongoing monitoring.

Mr Smyth—As ongoing monitoring. Obviously, there are issues that are raised by the implementation advisory group both out of session and in meetings that we take into account in an advisory capacity. We look at those issues on an ongoing basis. It is certainly not a program where we are standing still. We are constantly assessing whether the program is hitting the mark and evaluating whether or not we should be changing some of the levers of the program as well. That is ongoing.

Senator MOORE—The way I understood what you said about Dr Pirkis's work is that from quarter to quarter the focus of her evaluation changes. It is not a blanket evaluation of the whole program every quarter. Rather, it would look at particular components.

Mr Smyth—It looks at particular components, but there is a minimum data set—

Senator MOORE—Which is run through all the time.

Mr Smyth—That is run through all the time so that we can look at whether or not there are trends emerging.

Senator MOORE—Do we have that evaluation process itemised anywhere? I have read a number of departmental documents about the program but I honestly do not remember reading about how that evaluation operates.

Mr Smyth—I will take that on notice.

Senator MOORE—Can you take that on notice, because I think that is something we should have and I really cannot remember having that kind of basic information of the evaluation. We knew about the advisory group. We knew about the fact that there was the lapsed program, of course, because that was the decision to continue. We knew about the process that went through to the department last year and cabinet-in-confidence, that we could not see, which we asked about at a previous estimates. We knew about that; we had not seen it. But this particular process we did not know about. So if I could get that it would be good.

The next matter gets back to what Mr Learmonth was talking about, which was the uptake. People consistently ask questions about how it was done. For the record, could you tell me the number of GPs that actually took up the option to have the specific training course and how many have completed it, both level 1 and level 2, and how many GPs have claimed the payment—the three parts of the uptake?

Mr Learmonth—For 2004-05, 1,800 GPs received the SIP.

Senator MOORE—You only count a GP obtaining that once when they obtain it? So once you have obtained it—

Mr Learmonth—That is correct, once they do the first step. They obviously claim the attendance item that is relevant at each step, but the bonus payment is—

Senator MOORE—But it is actually the SIP component they get once?

Mr Learmonth—That is right.

Senator MOORE—And they can only do that once a year?

Mr Learmonth—Yes.

Senator MOORE—So that 1,800 is not 1,800 new GPs that have done that? It is an annual take-up?

Mr Learmonth—It is 1,800 in that particular year, yes.

Senator MOORE—In the mental health committee we are struggling with exactly what level of knowledge and expertise there is amongst the medical community across Australia.

Mr Learmonth—What the take-up is in terms of participating GPs who have done the training who then use the item.

Senator MOORE—Generally. And the take-up of this program is one measure of mental health care—one that is constantly pointed out to us. To clarify my own information—you have not got to give it to me now, it can be on notice—can you tell me how many people got their SIP payment each year?

Mr Learmonth—Numbers trained and numbers then—

Senator MOORE—Yes. I think that would be something that would be easy for you to get in each year.

Mr Learmonth—Yes, time series is easy.

Senator MOORE—I think there has been some confusion in some groups with which I have met about a perception that they are new people all the time. I will not presume to know the figures but, of a certain number in 2002-03, added to a certain number in 2003-04, added to a certain number in 2004-05, a whole bunch of those could be the same doctor who has claimed each year.

Mr Learmonth—You would expect, I think if somebody were trained, they would use it on an ongoing basis.

Senator MOORE—I would expect that but I have had evidence at the committee where they think that 20,000 doctors have been trained whereas in fact it is that kind of thing. So each doctor has to make their claim each year of the SIP payment. They do their training once—

Mr Learmonth—Yes, you would expect them to then claim their share, to use the items each year.

Senator MOORE—You would think so. How many GPs have reached their cap?

Mr Learmonth—Seventeen.

Senator MOORE—This year?

Mr Learmonth—In 2004-05.

Senator MOORE—And for the previous years?

Mr Learmonth—I could not tell you, Senator.

Senator MOORE—Take that on notice too. In 2004-05, it would be—

Mr Learmonth—Seventeen.

Senator MOORE—Is that the whole year? It would be the whole year. In 2004-05, only 17 reached the cap.

Mr Learmonth—Yes.

Senator MOORE—The major thing that we have been hearing in evidence, in asking why this has not been taken up, has been a complaint about red tape. I think even the department gave evidence that they had heard that as well. What kinds of things are being considered to respond to that statement?

Mr Learmonth—There is the change that we spoke about earlier, which was reducing the number of steps from three to two, or rather doing the three steps in two consultations instead of three separate ones. That came into effect in May this year. There are others being contemplated at the moment. As they are in the area of contemplation of policy change—

Senator MOORE—Sure. The program has been a direct response, because it is a very common statement.

Mr Learmonth—As Mr Smyth said, there is a pretty constant strong focus on this. So we are looking at a variety of options and have been for some time to try to simplify it. The

example of the change in name was a very significant one and very welcome, but there are others in contemplation as well.

Senator MOORE—Once someone reaches their SIP cap—a very ugly term—what happens to the doctor and also the patient? Once the doctor has reached the number of consultations they are allowed to refer, they just have to cease using that particular Medicare item?

Mr Learmonth—No, not at all. In fact, most do not. A very small number of GPs, 17 out of 1,800, have actually capped.

Senator MOORE—You can say that with confidence because you have those figures.

Mr Learmonth—Absolutely. Yes. It contributes to about half a per cent of the underspend. It is just not as significant as it has been made out to be. But for them the consequences are essentially invisible to the patient.

Senator MOORE—They never know?

Mr Learmonth—No, it is an incentive payment that goes to the GP. It is invisible to the patient. As to the GP, they continue to be paid the attendance item. There is nothing to stop them continuing to provide the actual services; indeed many do. Of the small number of GPs, there would be some who have done over 100. The cap cuts in at 67. So, while they do not get the additional incentive payment of $150 per, there are substantial attendance items which are actually being claimed on each occasional visit. So nothing actually—

Senator MOORE—So the only impact would be that financial impact of not getting the extra payment per client?

Mr Learmonth—It replicates what happened before SIP was ever introduced—that is, clinical care was provided in response to an attendance item.

Senator MOORE—With the information you have had on the review, have you found any cases where patients have had to go to another doctor because the doctor they were seeing for their services was not going to perform any more?

Mr Learmonth—That is not something I have heard personally.

Senator MOORE—That is not something that has come out in any of the evidence? You have not had any impact statements on patients?

Mr Smyth—Not at all.

Senator MOORE—You have not had any of those complaint letters to the department that we hear about each Senate estimates—from the people who write and complain? There has been no complaint letter on that?

Ms Halton—Not that I have seen. Certainly, as you know, I do get a number of these things. If something is an irritation, usually I get one or two letters, and I have not heard the merest suspicion of this.

Senator MOORE—The issue we raised in questioning at the last Senate estimates hearings was the underspend of $62.5 million and where the money went, and we were

advised that the chronic disease program was where funding was transferred to out of this program. Is that the case? Can I find that somewhere?

Mr Learmonth—Not quite. The figure of $62.5 million was a historical figure for the four years up to 2004-05. There was money transferred from the forward estimates from 2005-06 onwards—from the SIP underspend—as partial funding for the chronic disease management items.

Senator MOORE—How much?

Mr Learmonth—There was $161 million over four years from 2004-05. It depends where you start the year from. But you will find in the 2004-05 additional estimates a figure of $161.6 million over the four years from 2004-05.

Senator MOORE—That went out of the forward program dollars for this particular component to chronic disease?

Mr Learmonth—That is correct. It went to the new chronic disease management items.

Senator MOORE—Then there were the supplementary amounts of money that went into the general program for mental health that Mr Smyth referred to. This is one of those things I have to keep repeating to get myself very clear on it: out of one element of the ongoing program funding, money was reallocated from forward estimates into the wider program of chronic disease. I know Mr Smyth is about to tell me that mental health works within the chronic disease area and in fact it is all together. But it went from that program there and then, specifically on mental health, more money came in, as you described—from the expansion moneys and also general expenditure—and that went across all of them: is that right?

Mr Smyth—I apologise for being confused.

Senator MOORE—I have done this a lot and I am confused.

Mr Smyth—The money allocated in the budget for the expansion funding remains in the Better Outcomes program. The money that was from the forward estimates for the SIP and PIP components was the money that was transferred into the new chronic disease management items. So the expansion funding money remains in the Better Outcomes program.

Senator MOORE—I have difficulty between your program and the primary care—

Mr Learmonth—We have one slice of his program.

Senator MOORE—Yes. At the same time that you are taking a slice out and putting it into one program, more money is coming in, and I have difficulty in understanding that.

Mr Smyth—The money that was coming in is in respect of the program dollars—those are the three components that I talked about. The actual MBS, PIP and SIP components were the money in the forward estimates that was used for the chronic disease management items.

Senator MOORE—Could the forward estimates money that has been reallocated into the wider program come back in, in some way, as mental health but within chronic disease?

Mr Smyth—There is certainly a high incidence of people that would access the chronic disease management items for a mental health condition.

Senator MOORE—So that would be the argument?

Mr Smyth—That is correct.

Senator MOORE—I know you can use other mental health professionals, but it is the use of the psychologist that comes up most. How many visits can a client have to a psychologist through the Better Outcomes in Mental Health Care program?

Mr Smyth—A general practitioner is able to refer a patient to six sessions of psychological intervention by a psychologist and then, after a review, they may allocate another six—up to 12 sessions.

Senator MOORE—Is it an absolute maximum of 12?

Mr Smyth—It is a maximum of 12, as I understand it, in one calendar year.

Senator MOORE—What form does the review take? I have read about the review. Is that the GP review?

Mr Smyth—That is the GP review; correct.

Senator MOORE—There is nothing external? The GP does not have to get any other kind of support for the decision?

Mr Smyth—The GP can ask questions of a psychiatrist through the GP psychiatrist support program if they require advice from a specialist.

Senator MOORE—If you can have 12, what is the reasoning behind the decision to have it as two parts—you can have six and then, with a review, another six? Why can't it just be up to 12 visits?

Mr Smyth—I think that was the advice we received from our clinical advisers and the Better Outcomes group during the establishment of the program.

Senator MOORE—Has that been questioned at any of the reviews you have had about the process?

Mr Smyth—Not at all. I will take this on notice, but the average number of visits to a psychologist through the Better Outcomes program is approximately 3.6. The bulk of people are obviously not even reaching the six, or necessarily the 12.

Senator MOORE—What is the Medicare rebate for each of the visits to a psychologist?

Mr Smyth—That is paid by Divisions of General Practice, and we provide Divisions with that money. Divisions, then, are the fundholders and that money is distributed to each of the divisions. It depends on what mechanism they use to employ the psychologists in each of those divisions—whether it is through a voucher system, a brokerage service or whatever. In most cases, the copayment is no more than $20 for a person that is seeing a psychologist.

Senator MOORE—Do you know what the Medicare item number is for someone to go to a psychologist?

Mr Learmonth—It is not an item number; it is an arrangement where a division of general practice will either employ a psychologist or have them under some sessional contract arrangement. It is more like a private fee-for-service arrangement.

Senator MOORE—As you said, Mr Smyth, I was looking for information about financial years for the number and cost of psychology services that have been funded through the BOMHC program. Can you give me that?

Mr Smyth—I will take that on notice.

Senator MOORE—So you can do that, because you actually provide the money to the divisions for that item.

Mr Smyth—That is correct.

Senator MOORE—Can you tell me whether that is possible on a monthly basis?

Mr Smyth—I have just been informed that it is on an annual basis.

Senator MOORE—If a patient is referred to a psychologist under the new chronic disease management item, they are entitled to five visits; is that correct?

Mr Learmonth—That is correct.

Senator MOORE—Can you explain the difference between the chronic disease model and the BOMHC model? If I were a patient, how would I notice that I was being treated under a different management item?

Mr Learmonth—The psychology service under Better Outcomes is strictly a psychology service. You would be going there for reasons of mental health, you would be referred and you would get a psychology service.

Senator MOORE—And you would have to go to a GP first?

Mr Learmonth—That is correct. The allied health funded on the MBS requires you to have a chronic disease as a precursor and for your GP to—

Senator MOORE—Can that be a mental health condition?

Mr Learmonth—Yes.

Senator MOORE—But it could be diabetes?

Mr Learmonth—It could be both. The GP would do a care management plan for you, under the new chronic disease items, which would include what is called a team care arrangement, and other non-GP health professionals would contribute to that plan. That gives you entitlement to five allied health visits which are Medicare rebateable. You would be able to see a range of allied health people who would be relevant to your condition or conditions—your are most like to have some co-morbidities—and a psychologist could well be one of them. And that is a Medicare thing: you would go to a Medicare Australia office and get a rebate.

Senator MOORE—Do you know what the rebate is for that?

Mr Learmonth—It is $44.95.

Senator MOORE—And the number?

Mr Learmonth—You are stretching me.

Mr Kennedy—For a psychologist it is item No. 10968.

Senator MOORE—What is the difference if I want a sixth visit? If I am going through the process of seeing a psychologist through that chronic disease management program and using my Medicare card to do that, what happens with a sixth visit?

Mr Learmonth—It would be a private matter and it would not be rebateable beyond No. 5 in a calendar year, so you might use your private health insurance or a community health based psychology service.

Senator MOORE—Could I then go to a GP who is practising under the BOHMC program and have up to 12 visits to a psychologist?

Mr Learmonth—I believe you could—under the separate eligibility requirements. They are not linked.

Senator MOORE—And there is nothing to preclude—

Mr Learmonth—It is an MBS structure which is self-contained.

Senator MOORE—Mr Learmonth, can you give me the breakdown and cost of psychology visits provided under the CDM since the program's inception—to match the figures I have asked Mr Smyth to give me for the Better Outcomes.

Mr Learmonth—I will take that on notice.

Senator MOORE—Is that available monthly or is it an annual figure?

Mr Learmonth—I think they would be published annually, as part of normal MBS stats.

Senator MOORE—So there would be no way that there would be monthly figures on that?

Mr Learmonth—We can provide the number of services claimed last year.

Senator MOORE—That would be good.

Mr Learmonth—For the year 2004-05, we had 24,857 services provided in respect of 8,645 patients.

Senator MOORE—When you say 'services' are they psychological services or any services under the program?

Mr Kennedy—Psychological services.

Senator MOORE—Do you have a figure on how much that has cost?

Mr Kennedy—The Medicare benefit paid was $1,204,718.

Senator MOORE—What is the future funding of that program?

Mr Learmonth—It is an MBS item so it is not a programmed budget; it is uncapped. It is demand driven, a special appropriation.

Senator MOORE—I have already asked you about the number of doctors who have done the training. In terms of the Better Outcomes training package and the level 2 training that is funded into the future, can you give me any idea of the estimated number of doctors you are hoping will take up the program in the next two to three years?

Mr Smyth—I will take that on notice.

Senator MOORE—Thank you. There was an input of another $30 million into the program when there was already an underspend in one element of the mental health packages. What rationale was used by the department when you were looking at the whole funding process? What was the justification for extra funding across the board when an identified underspend in one element had already been reallocated?

Mr Smyth—It is my understanding that they are different allocations of funding. The funding for the expansion was because through our Better Outcomes Implementation Advisory Group they were saying there was considerable unmet demand in terms of access to psychologists in the community. The government listened to that and responded appropriately in terms of providing the expansionary funding.

Senator MOORE—And that is the process.

Mr Smyth—That is correct.

Senator MOORE—In terms of what is being said now, is there still the statement about unmet need?

Mr Smyth—The advisory group is saying that there continue to be issues of people wanting greater access to it. There could be more money obviously allocated and it could probably be taken up, but that is an issue we are now monitoring because the expansion funding has only just gone out for this financial year. It is best that we assess that following the uptake of that expansion funding by each of the divisions.

Senator MOORE—Just one more clarification question which links across a little bit with rural health even though it is part of this funding: in terms of the take up from both the doctors, which you are going to give me, and the services that are being used, can we get that by not necessarily putting it down by region but get some idea about whether there has been a difference in the uptake between different parts of the country? There is regular information coming forward that people in regional and rural Australia have less access to services than anyone else.

Mr Smyth—If I could take that on notice—

Senator MOORE—That would be good.

Mr Smyth—But I could give you those figures in a divisional breakdown by—

Senator MOORE—That is general practice divisions?

Mr Smyth—Yes, by general practice divisions.

Senator MOORE—That would be very useful.

Mr Smyth—That is how the funding is allocated, of course.

Senator MOORE—That would be interesting to see. The other major issue, which I know you are aware of, is the provision of services by psychiatrists. We know that is a Medicare funded item but the issue is the access to them across the country. In all of this information that you keep in the department, is there information about how these services are accessed in various parts of the country—whether there is access to a resident psychiatrist in a region or whether it is a fly-in service? Is that the kind of information you keep?

Mr Smyth—I look at the Better Outcomes program. So we look at that component from the general practitioner/psychiatrist support service. My colleagues in other areas of the department would be more informed as to the distribution of psychiatrists around the country.

Senator MOORE—Which program area would that be, Mr Smyth? I would have asked all questions about mental health here.

Mr Learmonth—Senator, I think it is outcome 2.

Senator MOORE—Have we done that yet?

CHAIR—Yes, we did that earlier.

Senator MOORE—I might have to put that on notice. So there is a part of the department that would be able to give us some specific information from the best knowledge of the department about the range of access to psychiatrists?

Mr Smyth—That is correct—

Mr Learmonth—From what they could infer from Medicare billing data.

Senator MOORE—It would be one perfect way of judging it, I would think, the number of people who service them.

Ms Halton—We do know, Senator, that there is a particularly high concentration of psychiatrists on the north Shore of Sydney and east Melbourne.

Senator MOORE—I think we have met them. I think they are the questions I have. However, when we get back the answers taken on notice, we may get back in contact with the department to follow through. But it would be a good start if we could get that kind of information you have given us.

Senator McLUCAS—I have one question that may or may not fit in outcome 4 and it is to do with capital funding allocations to state-run hospitals.

Ms Halton—It is more likely to be acute care, which is outcome 10. Can you tell me a bit more about what the question is, Senator?

Senator McLUCAS—At the last election in Queensland $5 million was promised for the upgrade of the Weipa hospital in Far North Queensland.

Ms Halton—We will have to find the measure. Can we just put that on hold for a bit and come back to it?

Senator McLUCAS—I do not know in which outcome it goes.

Ms Halton—We will find it. While we have this tiny pause, you asked a couple of questions about the PBS performance audit and we talked about what the terms of reference were. The ANAO have said they are very happy for us to table the letter that they sent to us which goes to the terms of the audit. I am happy to table that for you.

Senator McLUCAS—Actually I think it was Senator Allison who was asking that question.

Ms Halton—There you go, but I am sure it will be of interest.

CHAIR—While we have a short interlude, we have had a request from AUSPIC for permission to be given for photographs to be taken today and tomorrow. Is it the wish of the committee that we should allow AUSPIC to take photographs? There being no objection, it is so ordered. Are there any further questions on outcome 4? We are still checking on these questions about the Weipa hospital.

Ms Halton—We will not send those people away.

Senator McLUCAS—I would like to move to outcome 3, if we could.

CHAIR—Did we work out about where the questions about the hospital in Weipa should be asked?

Ms Halton—No, someone has gone to find that out. We were just saying that we will get the people from outcome 3 in. We will not send outcome 4 away.

CHAIR—That is a good idea. There is possibly another question on outcome 4 anyway.

Ms Halton—I think it is more likely to be outcome 10 personally, but we will find out.

CHAIR—If officers for outcome 4 could remain around for a little while because there is another set of questions that might need to be asked as well.

Ms Halton—Are you foreshadowing that you have not finished outcome 4 other than Weipa, that there are more questions to come?

CHAIR—Yes. I understand Senator Adams had a couple of questions about dentists in rural and remote Australia?

Ms Halton—I am just conscious that aged care will go for some time; it always does.

CHAIR—When Senator Adams comes back we will interpose so the people for outcome 4 will not have to hang around for long. With that proviso, we will temporarily leave behind outcome 4.

[3.17 pm]

CHAIR—We will begin on outcome 3, Aged care and population ageing. I invite the officers in that outcome to come to the table.

Senator MOORE—Ms Halton, if I can ask one question while we are waiting: I have been given a copy of a media report that indicates that the Prime Minister has agreed to make mental health issues a priority at the next Council of Australian Governments meeting and that he has flagged setting up a mental health task force. Is that something that the department has been advised about?

Ms Halton—Yes, absolutely. In fact, I was over at the Department of the Prime Minister and Cabinet discussing this very issue yesterday.

Senator MOORE—So it is that recent and that—?

Ms Halton—The announcement was a few days ago but it has been a matter of constant lower level dialogue and, as I said, I went over to PM&C yesterday and had a long talk about this issue. So things are moving.

Senator MOORE—Thank you.

CHAIR—Are there any questions on outcome 3, aged care and population ageing?

Senator McLUCAS—Yes. My first question relates once again to an item in the annual report. On page 120, in the chapter on outcome 3, the very last line says:

Due to an administrative error, the departmental appropriation allocated to outcome 3 was incorrect in the 05-06 portfolio budget statements.

I think that line needs some sort of explanation. Could you explain what that sentence is all about?

Mr Clout—There is not all that much more to explain, beyond what that note already explains. The amount that was allocated notionally for this outcome in departmental expenditure in the 2004-05 portfolio budget statements was erroneously high, and it has been adjusted down to reflect a more appropriate level. You need to look at the 2004-05 PBS.

Senator McLUCAS—That explains it. I was looking in this year's for the error, but it was in last year's—the forward estimates for this year in last year's.

Mr Clout—That is correct—the forward estimates for 2004-05, which the annual report is reporting on.

Senator McLUCAS—How was the mistake made?

Mr Clout—It was simply an arithmetical error. In the spreadsheet that was used to allocate the departmental funding against all the outcomes, there was an arithmetical error and too high a number went in.

Senator McLUCAS—How did you pick it up?

Mr Clout—When we started to generate this table in the annual report that you are looking at, it became quite evident that there was a mistake, and so my staff went back and checked the spreadsheet that was used to construct the 2004-05 PBS and found the error then.

Senator McLUCAS—Does that mean that Finance thinks you have a lot more money than you have?

Mr Clout—I would be surprised if that was the conclusion they would draw from the allocations in the outcomes. Finance are aware that we make those notionally against the outcomes. They do not sum through anywhere to a figure in the appropriation bills.

Senator McLUCAS—I will leave it at that. Thank you. These next questions are not in an absolutely predictable order, but they are all to do with outcome 3. The first issue I would like to talk about is a residential aged care facility called Sir James by the Bay, and the current sanctions that have been imposed on it. Did the department receive any complaints about Sir James by the Bay in Victoria, following its accreditation in February 2004?

Ms Finlay—Yes, we did receive some complaints prior to then.

Senator McLUCAS—Could you give me the dates and the nature of those complaints?

Ms Finlay—Could you remind me of the date again, please?

Senator McLUCAS—They got three-year accreditation in February 2004, so what happened between then and now?

Ms Finlay—We received five complaints in the period between April and May 2005. Those were referred to the aged care standards and accreditation agency, in view of the nature of the complaints. We also received an information call on 16 August 2005 to the complaints resolution scheme.

Senator McLUCAS—So what was the nature of the five complaints made in April and May 2005?

Ms Finlay—We do not normally talk about the nature of the complaints.

Senator McLUCAS—Was it about care, about staffing or about heating being turned off?

Ms Finlay—It was certainly about care issues in the broad.

Senator McLUCAS—Of course you cannot tell me who they are from, and I would not expect you to undermine the confidentiality of having the complaints system, but were they from residents or residents' families or other people?

Ms Finlay—I have not got information with me about exactly who they were from, so I really could not give you that answer. If you like, I can take that on notice.

Senator McLUCAS—No, do not worry. Can you give me some details about what an information call is and, if possible, the nature of the information contained in that call?

Ms Finlay—Yes. We have two categories of complaints, if you like, that come to the complaints resolution scheme. The first category is where an identified care recipient or a person associated with a care recipient has a specific issue that they want the complaints resolution scheme to investigate. The second category that comes to us is what we call information calls, which is the category that you are asking me about. We have an 1800 line which anyone concerned about a home or a care recipient in a home can call and provide the department with information about the matter. It is that second category to which you are referring.

Senator McLUCAS—I do not quite see the difference, but that is probably not integral.

Ms Finlay—The first is about dealing with a specific issue that affects a care recipient.

Senator McLUCAS—About my mum, for example?

Ms Finlay—Yes.

Senator McLUCAS—The next one is a more general comment about a facility?

Ms Finlay—Yes, it could be. Sometimes those general calls can lead to a specific call, asking us specifically to investigate.

Senator McLUCAS—So there were five complaints in April and May this year basically of a care nature?

Ms Finlay—Yes.

Senator McLUCAS—Then an information call presumably also about the quality of care being provided?

Ms Finlay—I have not got information about what the call was about.

Senator McLUCAS—That is fine. What action did you take when you received those five complaints in April and May?

Ms Finlay—Two things happen with complaints of that kind. The first is that, where you receive a complaint and it relates to specific concerns of the care recipient, you initiate action to investigate them under the complaints resolution scheme. You contact the provider. You contact the person who is complaining. You go through a process of assessing the nature of the complaint and see if you can reach a resolution. Our complaints resolution scheme at present is based on an alternative dispute resolution arrangement where we try as much as possible to reach a satisfactory outcome for both the resident and the family concerned and discuss it with the provider.

Senator McLUCAS—And those five complaints were treated in that way?

Ms Finlay—They were.

Senator McLUCAS—Is it unusual to get five complaints around the same time?

Ms Finlay—I cannot comment broadly about what has happened since the scheme was first introduced, but it is often the case that if there is a particular issue of concern in a home, residents may talk to each other and say, 'I have got a concern about that issue,' and we invite people to lodge complaints with the scheme. We think that is a healthy thing to do. We also encourage providers to have their own internal complaints resolution arrangements. Whenever a complaint arises in a home, it is much better if you can deal with it as quickly and as swiftly as possible.

Senator McLUCAS—Certainly, but surely five complaints being received by the same facility would trigger more than linear dealing with each one separately.

Ms Finlay—And it did in this case, as I mentioned to you previously. What we decided to do was refer the information to the Aged Care Standards and Accreditation Agency.

Senator McLUCAS—When did they do their spot check—or their check, because I do not know that it is a spot check yet?

Mr Brandon—We undertook a support contact on 28 July 2004.

Senator McLUCAS—So potentially two months after the first complaints were made?

Mr Brandon—I do not have the dates of the complaints. I have the date of the referral from the department.

Senator McLUCAS—What was the date of the referral from the department?

Mr Brandon—It was 2 July.

Senator McLUCAS—Is a support contact a spot check?

Mr Brandon—A spot check can be a support contact. It is a subset of support contacts.

Senator McLUCAS—And some are advised and some are not advised?

Mr Brandon—That is correct.

Senator McLUCAS—What sort was this one?

Mr Brandon—I have not got that in detail. In fact, I do not know. My records show that it was a support contact on 28 July where we found three noncompliant outcomes and decided to go to review audit. I could find out for you whether it was a spot check or otherwise, but I do not have that recorded here.

Senator McLUCAS—An unadvised spot check. I would like to know that, please. So then the audit was undertaken in August—is that right?

Mr Brandon—No. We did the spot check and then we did the review audit, which finished on 4 October.

Senator McLUCAS—And that is the audit that found that they only passed 23 of the 44 standards?

Mr Brandon—No, the review audit of October 2004 found that they were then compliant on 44 out of 44.

Senator McLUCAS—I have skipped one report. So it was the 28 July audit that found that they were potentially putting lives at risk?

Mr Brandon—No; 28 July was a support contact where we identified three expected outcomes as noncompliant. That then led to a review audit, which finished on 4 October. We decided at that stage that by then they were compliant with 44 expected outcomes.

Senator McLUCAS—Why did it take so long, really, for the audit to be triggered from those five complaints that were raised in April this year?

Mr Brandon—I just need to crosscheck something here.

Senator McLUCAS—Yes, I think you may have the chronology a bit wrong.

Mr Brandon—I am sorry; I was actually a year wrong. I might just go back. The review audit of August 2005—is that what we are talking about?

Senator McLUCAS—Yes.

Mr Brandon—I am sorry. I was in another place. I apologise for that.

Senator McLUCAS—Was it nice there?

Mr Brandon—The review audit of August 2005 is when we found serious risk.

Senator McLUCAS—Right. That is when they only passed 26 out of 44.

Mr Brandon—Yes. There were 18 that were noncompliant. That is correct.

Senator McLUCAS—And their previous review audit was some 18 months earlier?

Mr Brandon—No. The previous review audit was in October 2004, so that is about 15 months.

Senator McLUCAS—My understanding was that they got 44 out of 44 then.

Mr Brandon—That is correct.

Senator McLUCAS—That is a big change from there to 15 months later. Have you done any analysis of the audit process for that earlier audit, the 2004 audit?

Mr Brandon—The work that we have done led us to conclude why there had been a change in accreditation. In October 2004 we had just started new quality assurance procedures, which I have discussed in previous estimates, and the work that we have done gave us a lead into why we thought there had been a change in the compliance.

Senator McLUCAS—You would be aware, Mr Brandon—

Mr Brandon—Given that the review was so far back, it was impossible to form a definitive view about the audit itself. It is a bit like just looking at the score, if you will, and trying to imagine what happened 12 months ago. It is an impossible task. So what we focus on is: did the auditors follow the process? What can we glean out of the audit report and is it internally consistent, based on what we know?

Senator McLUCAS—Internal consistency is the issue that was raised in the Senate committee report and it is the issue that I am trying to get to here. What gets raised with me all the time is: how can a facility change its level of care so dramatically in such a short period of time? It has been put to us previously that it is not necessarily the care being provided but the auditing system that varies. That is concerning if you want to retain confidence in the auditing system.

Mr Brandon—We retain confidence in the auditing system by the selection and training of assessors, the update training and the internal quality assurance, which includes observers on 10 per cent of audits, review of decisions and review of the documentation. As you would be aware, an audit report is a quite large document. One of the ways that we look at that is to read the document and ask, 'Does this bit fit with that bit?' Given that the reviewers are not on site at the time the audit is being done, it is certainly not an easy task. I have to say it is not one in which we could be 110 per cent absolutely confident that it is spot-on, because no-one knows what happened except the auditors who were there at the time. We are very reliant on the selection and training of auditors, the update training and the internal quality assurance.

Senator McLUCAS—The report that the reviewers did in August 2005 is pretty damning of that facility.

Mr Brandon—It is. The other observation I would make about that report—I do not actually the report with me; I am going from memory—is that the difference between non-compliant and compliant is a small amount. If you think it through, a home can be very compliant; others can marginally get over the line. The difference between being over the line and non-compliant can be quite small.

Senator McLUCAS—So this one is really, really, really non-compliant? Is that the point you are making?

Mr Brandon—The point I am making is that, if we could use numbers just for the sake of the argument, if 50 per cent were the pass rate, 51 per cent would make you compliant, as would 99 per cent. If you were a very good home and suddenly became non-compliant, that would constitute a large fall; whereas, if you just made it over the line, it is not far to fall backwards into noncompliance. In looking at the reports, those are the sorts of things that we try to come to grips with—whilst we do not have categories of excellent or otherwise, whether in fact they were an excellent home that has had a huge fall or whether they were, dare I say it, a marginal home.

Senator McLUCAS—I am not quite getting your point. Are you saying that Sir James by the Bay was marginally non-compliant?

Mr Brandon—No, I am saying, in answer to the general question about how we know, that a home which is fully compliant may well be marginally fully compliant, in the sense that everything passes but it is just over the line, while other homes will pass with flying colours.

Senator FORSHAW—If a home is fully compliant but only just over the threshold, is that noted in the reports and assessment anywhere? One of the issues we keep raising at estimates hearings over the years is: how is it that in a short period of time a home can go from compliant with 44 standards to a home where an incident occurs and six months later another team goes in and the home complies with 21 standards or something like that—we have heard of cases like that. That is one of the major concerns we have. I do not think that is explained by your analogy of there being a pass rate of 51 per cent, which is equivalent to 99 per cent. That assumes that there is no recognition that, say, in the first round of assessment, even though a home may have passed all of the 44 standards, it was borderline and there was a danger that it may drop its standard fairly quickly.

Mr Brandon—It is not that the assessors do not report it in that language; they report how they see it for the decision-makers. Some of the clues to that are in how far away the support contact is. The fundamental proposition that I am putting is that, short of being on site oversighting every individual audit, there is no way I can sit here and say to you, 'That one was 110 per cent correct,' because it is post the event. In terms of this particular home and the question of whether in 10 months a home can deteriorate, the answer to that question is: yes, it can. A number of things can cause those changes—for example, changes in key personnel, changes in numbers, changes in staffing numbers and a whole range of things like that.

Senator FORSHAW—Or that they got it wrong in the first place.

Senator McLUCAS—That is the question.

Mr Brandon—Or they got it wrong the second time, if you go down that path. We have discussed that.

Senator McLUCAS—I can read the report, and I do not think they got it wrong the second time. I am happy to read it into the *Hansard*.

Senator FORSHAW—Generally the second report is the one that comes about because there was a problem, and it seems to be a bit more thorough.

Senator McLUCAS—When you compare the reports, the second report is appalling. With some of the things that have happened there—for example, 140 residents, 63 of them high-care residents, and they have two carers overnight; and people being tied into their wheelchairs and their beds on a 24/7 basis—that is clearly a non-compliant type of operation. That is not a criticism of you. If you read the previous report—and this is the issue I am getting to—it is a very bland report. It does not describe any of the care arrangements. It does not describe them as being positive or negative; it just does not describe them. What has the agency done to confirm the quality of that earlier report—to assure the agency that that first report in February 2004 was conducted properly?

Mr Brandon—I do not have the information with me in relation to the work we did to validate that report, but I can tell you about our internal quality assurance processes generally.

Senator McLUCAS—When an event like this happens—where something deteriorates in such a huge way over a short period of time—does that trigger in the agency a validation of the earlier report?

Mr Brandon—We have a process whereby, if a home changes by three non-compliants, we go back and review why that happened. Some of that goes to what happened within the home and we look at the assessment to find out. That is our standing operating procedure when they change by more than three non-compliant expected outcomes.

Senator McLUCAS—I wonder whether I could get on notice the dates that each of the complaints were received by the department and exactly when each of those matters were referred to the agency. Was it one referral to the agency or did the department refer five separately and, with the subsequent information, call the agency? That will then tell us what the delay was between the first complaint and when the audit occurred. Can I also get a list of each spot check or support contact provided to Sir James by the Bay since its inception?

Mr Brandon—Yes.

Senator McLUCAS—In the earlier audit, it notes that it is a new service, that systems are not necessarily in place and that continual support contact visits would have to be provided. When you provide that list, could you tell me which ones were advised visits and which ones were unannounced visits?

Mr Brandon—Yes.

Senator McLUCAS—There is a period of time we can get that information back, but I know that is readily available in the agency. If I could get that back quite quickly I would be appreciative.

Ms Murnane—We will expedite that.

Mr Brandon—We can do that within a week, Senator.

Ms Finlay—You asked about referral of complaints to the agency with this most recent set of issues. On 13 May 2005 there was a agency following one of the complaints that I referred to earlier on. On 23 June 2005 further information was referred to the agency following an anonymous complaint.

Senator McLUCAS—Sorry, I think that is another complaint that I was not aware of—or is that one of the five?

Ms Finlay—This is the anonymous information call I mentioned earlier.

Senator McLUCAS—So 13 May—

Ms Finlay—On 13 May, there was a referral to the agency following one complaint. On 23 June, following the receipt of the information call, there was a referral to the agency. I think because of the earlier discussion, the date that I understand the agency conducted a support contact visit was 15 July 2005.

Senator McLUCAS—So there was a support contact visit on 15 July, and what was on 2 July, Mr Brandon?

Mr Brandon—On 2 August there was the review audit.

Senator McLUCAS—Could I ask for a chronology of interactions between the department and Sir James by the Bay and the agency and Sir James by the Bay?

Ms Finlay—Certainly.

Senator McLUCAS—Has the provider appealed or sought a review of the sanctions that have been imposed?

Ms Finlay—I am not sure. I will have to find out for you.

Senator McLUCAS—Coming back to that chronology, if I read this into the *Hansard* you will get it as well: when was the department first informed of the serious risk to residents?

Ms Finlay—On 5 August 2005.

Senator McLUCAS—When was the minister informed of the serious risk to residents?

Ms Finlay—We do not have a formal process of advising the minister in the sense of a brief to the minister; however, we do advise the minister's office of any situations resulting in a serious risk of this kind and we do it on the day.

Senator McLUCAS—So that would have been on 5 August as well?

Ms Finlay—Yes.

Senator McLUCAS—Then did the department send officers to the facility?

Ms Finlay—Yes, we did.

Senator McLUCAS—When was that?

Ms Finlay—We visited on 9 August to discuss the approved provider's response to the serious risk findings. We liaised with the provider on 12 August in relation to the approved provider's nomination of a nurse adviser. We conducted a site visit on 15 August. We approved the nomination of the nurse adviser on 16 August.

Senator McLUCAS—On 15 August you had a site visit. What was the purpose of that?

Ms Finlay—On 15 August the department conducted a site visit.

Senator McLUCAS—And the purpose of that?

Ms Finlay—It was to make sure that things were progressing well in relation to the serious risk and generally in relation to conditions in the home. On that day the approved provider held a meeting of residents and relatives. What we usually do in those circumstances is make departmental people available to assist in that meeting if they are needed. On 19 August the department met with the nurse adviser to discuss progress in alleviating serious risk. Then on 1 September the department conducted a site visit and did so again on 9 September and did a spot check on 22 September.

Senator McLUCAS—This spot check was conducted by the agency or—

Ms Finlay—I am answering on behalf of the department. The spot check on 22 September was done by the department. I can now tell you the answer to your earlier question, which was: when did the approved provider seek a reconsideration? Their submission on the notice of noncompliance was received on 3 October.

Senator McLUCAS—Was the submission seeking a review?

Ms Finlay—I do not know. I cannot answer that, but I will check that out for you and get you an answer.

Senator McLUCAS—You would not make a submission if you were not seeking a review, would you?

Ms Finlay—No.

Senator McLUCAS—So they are reviewing the sanctions that have been imposed. They are quite significant sanctions, especially the loss of extra service places. That is a quite significant sanction that has been put in place.

Ms Finlay—I believe that we have had those sorts of sanctions applied before.

Senator McLUCAS—Yes, but they are quite significant. The issue that I think is probably the most concerning—although there are many in the report—is the fact that there were only two personal care staff on roster overnight for 140 residents. This goes to compliance with standards. Is that roster in compliance with the aged care standards?

Mr Brandon—In the review audit that was conducted in August, we found noncompliance in continuous improvement; human resource management; information systems; education and staff development; clinical care; specialised nursing needs; medication management; pain management; nutrition and hydration; continence management; behavioural management; mobility, dexterity and rehab; regulatory compliance; leisure interests and activities; choice and decision making; living environment; and infection control. That covers a whole range of things, and the HR stuff would pick up all that.

Senator McLUCAS—That is not the question I asked, Mr Brandon. Are two personal care staff in compliance with the aged care standards for 140 residents?

Mr Brandon—Our view is that the contributing factors to their noncompliance included insufficient staff numbers overnight and insufficient qualified staff.

Senator McLUCAS—So the answer is no?

Mr Brandon—I am not sure I understand the question.

Senator McLUCAS—I find it interesting that you will not answer a question that says: 'Two people overnight is not enough. Do you agree?'

Mr Brandon—The answer is yes. I said that possible contributing factors were insufficient staff numbers overnight and insufficient qualified staff. That is what I was getting to.

Senator McLUCAS—It is the qualification—but it does not matter. Sir James by the Bay was a licensed extra service provider. What was the assessment process that Sir James by the Bay went through to get that status?

Mr Mersiades—Every approved provider who applies for extra service status goes through a process of checking by the department which has regard to the nature of the service they intend to provide, their performance, their experience and their financial situation. There is a general check of their key personnel. My colleague Mr Dellar will be able to give you more details, but there is a check that is undertaken.

Senator McLUCAS—I am interested, Mr Dellar, in whether you have the information on when Sir James by the Bay was assessed and approved as an extra service provider.

Mr Dellar—I am sorry, but I do not have information in relation to extra service. I can take that on notice.

Senator McLUCAS—But you do have it back at the office.

Mr Dellar—We would certainly know when the application was first received and when the extra service status was first granted, yes.

Senator McLUCAS—And when the assessment was undertaken.

Mr Dellar—Indeed, yes.

Senator McLUCAS—You may recall, Mr Dellar, that this is a fairly new facility.

Mr Dellar—I understand that it is about two years old, yes.

Senator McLUCAS—I also understand—and I do not know if this is true; I would like it checked—that they were provided with extra service status prior to opening. If that is the case, I would like to know how you could do that.

Mr Dellar—That is a normal part of the process. Many services are granted extra service status before they open. What would be taken into account would be the performance of that service in the past, the nature of the construction and the nature of the service that the new provider or new service was offering—for example, what things were to be offered in terms of menus and services and standards.

Until quite recently, the extra service application round was an annual round run with the aged care approval round. We still do that, although it is not the only way into extra service. But it is quite normal for people to apply for places and the extra service at the same time and to receive a decision which allows both of those things to run so that the provider can have some certainty when they are constructing their facilities to a standard that might be high—all rooms with ensuites, for example—and before entering into that expense and have some confidence that when it is completed they get the extra service.

Senator McLUCAS—I do not know how you would—but you may be able to—assess the care that is being provided if the care had not started yet.

Mr Dellar—One of the key issues, of course, and I am not talking about Sir James in particular, is the record of the provider. One thing we look at very closely in an extra service application is how they have been getting on in relation to other services they may be providing. There are many providers who are running extra service facilities and who would apply for additional capacity to run a new one.

Senator McLUCAS—I will come back to that point. It is a good point. Did you assess at any time the licence, for want of a better word, for extra services? They were allocated about two years ago. Is there a process of assessing them in that time frame?

Mr Dellar—No, there is not, except to the extent that when a new service comes on stream and it is a service with extra service, the provider has to advise us that they wish to begin to deliver extra service.

Senator McLUCAS—But in this case the extra service status was achieved prior to opening, though.

Mr Dellar—That is correct. Provided the normal things are in place such as accreditation, certification and the like, extra service status would flow.

Senator McLUCAS—So there is no auditing on compliance with the grant of extra service?

Mr Dellar—That is correct.

Mr Mersiades—It is important to draw a distinction between care and extra service of a hotel type service, which is what we are talking about.

Senator McLUCAS—Sure. I am aware of that.

Mr Mersiades—The care is equal whether it is an extra service facility or a mainstream facility. The same accreditation, compliance and quality arrangements apply, whether it is an extra service or a mainstream service.

Senator McLUCAS—But getting approval to operate as an extra service facility or with some extra service beds attracts not only the ability to charge a premium to that resident but also the ability to charge an accommodation bond for a high-care resident.

Mr Mersiades—Yes, that is to cover the extra services that are being provided, not for the care. The care is standard. It is non-negotiable between homes.

Senator McLUCAS—I understand that. I do not know that all those ones are being applied in those ways in residences, but that is a different question. With Sir James by the Bay, is the sanction to remove their extra service status?

Mr Dellar—I believe it is.

Senator McLUCAS—What happens to bonds that have been taken from high-care residents on the basis that it is an extra service place?

Mr Dellar—They remain in place.

Senator McLUCAS—So there is no sanction in a retrospective sense in that way.

Mr Dellar—They do not need to be returned to the resident if the resident continues in that service.

Senator McLUCAS—That is fine. Mr Dellar, you mentioned that you often went back over the history of providers. Are you aware that Sir James by the Bay has a sister organisation in Queensland?

Mr Dellar—I do know that but I do not have information with me on the particular review of St James by the Bay that led to the extra service status. I cannot tell you what we did because I do not have information about that at this moment.

Senator McLUCAS—In March 2004, Sir James Terrace in Queensland failed nine accreditation standards and was also found to be posing serious risk to residents' health, safety or wellbeing. When you have a look back at the extra service place assessment, I would like you to see if there was some analysis undertaken of Sir James Terrace in Queensland that would have informed the allocation of those extra service places at Sir James by the Bay.

Mr Dellar—I would be speculating as to whether the extra service was granted before or after that date in 2004 that you have just mentioned. I simply do not know the answer.

Senator McLUCAS—I think it would be before, but I would like to know whether there was some assessment done of the sister facility in making a decision to allocate those places. Going back to the accreditation agency and maybe Ms Finlay, Sir James Terrace in Queensland was found to be posing serious risk to residents in March 2004. Does that trigger anything in the agency or in the department to have a look at other services that are being operated by the same business?

Ms Finlay—In relation to Sir James Terrace in Queensland, as you pointed out the notice of decision to apply sanctions was made in early 2004. By July 2004 the department had issued a notice of decision to lift the sanctions. I would expect that, from our point of view in looking at various homes, we would have a number of factors that we would take into account in relation to decisions about compliance issues. We have a series of protocols with the agency where, if we find anything—as I mentioned earlier on, for example, that may be through the complaints resolution scheme—or if there is anything untoward happening, we use that as a source of intelligence to inform decisions about what we refer to the agency. We take the view that a lot of what happens in individual homes is a matter for the management and operation of the individual homes. Our emphasis in the department is very much on the care needs of the residents in the individual homes. That is a long way of saying to you that there will be occasions where we do need to have a look across the board at a particular provider. There will be other occasions—and I think this would be the bulk of the occasions—where we will focus on the specific issues in the homes.

Senator McLUCAS—Simply because it is owned by the same organisation, it would not trigger even a cursory glance?

Ms Finlay—It is my understanding that we do not do that as a normal practice. But, that said, there are a number of factors that influence us in making decisions about whether, for example, we would make inquiries. We use a number of sources to assist us with that. We have a network of state and territory officers who keep in very close contact with providers in their state or territory. We also have situations that I believe the committee is familiar with where a provider may decide, for example, to sell a set of homes, and we look across the board at those homes in those circumstances.

Mr Brandon—It does trigger something for us.

Senator McLUCAS—In the agency?

Mr Brandon—In relation to Sir James. We have a process where, if we find noncompliance is an issue in a home and we are aware that the same company owns other homes, we go and look at them. In the particular case of Sir James Terrace, when the serious risk was found in March 2004 we had done a full accreditation audit in Sir James by the Bay less than four weeks before, so we decided no further action was required at that time. However, later on, when we found problems with Sir James by the Bay, we then went back to Sir James Terrace. I can tell you that in Sir James Terrace, since finding the problems with Sir James by the Bay, we have done three support contacts in the space of 16 months and we have another one planned for this month.

Senator McLUCAS—This is back in Queensland?

Mr Brandon—Sir James Terrace is in Queensland. So, when we found the problems with Sir James Terrace the first time, we crosschecked. Just recently, the problems with Sir James by the Bay led us to looking at Sir James Terrace.

Senator McLUCAS—And the reason for the three support contacts at Sir James Terrace?

Mr Brandon—One of which was a short notice visit. We were notified of noncompliance at the Victorian home and that led us to say, 'Let's go and have a look at the related home in Queensland.'

Senator McLUCAS—That was the first check support contact?

Mr Brandon—Yes. There have been three at that home—in November 2004, April 2005 and August 2005. That is the most recent one, and we have one planned for November. So the one in August was the one that was triggered by the noncompliance.

Senator McLUCAS—What was the result of the support contact in August 2005 at Sir James Terrace?

Mr Brandon—The team's advice indicates that no noncompliance was identified. However, we flagged that there were deficiencies in expected outcomes in clinical care, specialised nursing care, medication management and human resource management. That means we put a watch on those expected outcomes. They passed, but I suppose, to go back to my earlier conversation, they just passed. That is why we will be going back at some stage in the future. The date—the reason I am hesitating is that I think it is going to be an unannounced visit.

Senator McLUCAS—I would prefer if you did not give us the date. Probably I would prefer it if you had not told us that it was happening this month, especially if it was intended to be a spot check type visit. But never mind; that is okay. Going back to Sir James by the Bay, the chronology that you provide to the committee will identify the three- to four-month delay from April this year till August from the first complaints being made to the first action being taken on those complaints. Am I right to think that?

Ms Finlay—I would like to do some checking to make sure that we have that absolutely right, so I would like to take that on notice.

Senator McLUCAS—When did the department consider that the residents were no longer at risk?

Ms Finlay—I think that was as a result of the work of the agency, and I will ask Mr Brandon to advise.

Mr Brandon—Following the identification of serious risk, we did almost daily support contacts right through to 24 August. On 5 August we identified serious risk, and then we were there almost daily right through to 24 August when we decided that the serious risk had been resolved.

Senator McLUCAS—I think I might have got these confused when I asked a question earlier. I think I said that Sir James by the Bay has had its extra service approval permanently revoked, but I think it is actually Sir James Terrace, the Queensland operation, that has had its extra service permanently revoked. Why wasn't that measure considered for Sir James by the Bay?

Ms Finlay—I think in the circumstances we were concentrating very much on the matters of serious risk. Because there were a significant number of issues relating directly to care, we wanted to concentrate on those care issues.

Senator McLUCAS—Whereas the issues at the Queensland Sir James Terrace were more of the accommodation type of concern—is that what are you saying?

Ms Finlay—With Sir James Terrace, my understanding is that they covered issues relating, for example, to human resource management and the living environment, and that touched on the question of extra service. I think there were reasons for revoking extra service at that stage. There are a number of factors that are taken into account in making decisions about what form a sanction would take. I think in the case of Sir James by the Bay the department's view was that there would be a benefit in having a nurse adviser assigned to Sir James by the Bay to tackle the care issues that had arisen. Given the matters that were covered in the review audit report, we thought that was a better course of action.

Senator McLUCAS—And it is the department who actually makes the decision about the nature of the sanction and to sanction?

Ms Finlay—Yes.

Senator McLUCAS—There is a lot on notice there and there is a lot of information we need to understand. Thank you for that.

CHAIR—Before you go on, Senator, I am conscious of the fact that we still have outcome 4 people hanging around here, and Senator Adams has some questions for them. We said that we would not oppose that, so can we call outcome 4 people back to the table, please?

Senator ADAMS—I would like to mention dental health in rural and remote Australia and look at undergraduate scholarships. Other allied health professionals have scholarships. Is there any scholarship available for students specifically from rural areas to study dentistry?

Ms Halton—Would you mind repeating that question for the officer, Senator, as he has only just come to the table?

Senator ADAMS—My question regards undergraduate dentistry scholarships. Other rural health professionals have scholarships available to them. Our biggest problem, of course, is

trying to attract people to and retain people in rural areas. I am just wondering if there is any avenue through which scholarships for rural dental students might be made available?

Mr Lennon—Currently scholarships are available at a postgraduate level for allied health professionals—and that would include dentistry professionals who operate in rural areas. You are correct in saying that there are no such scholarships funded by the Commonwealth available for undergraduate students of dentistry at present. It is fair to say that this matter has received some consideration over the last six to 12 months in response to representations that have been made by various stakeholder groups representing rural organisations, and it is under active consideration at this point of time.

CHAIR—I think that is the end of our requirements for outcome 4. We can now dispense with the services of people from outcome 4. Thank you very much for waiting around. We will come back now to outcome 3, aged care. I might indicate though that we understand that the people from Medibank Private are on their way here at the moment but are only available until 6 o'clock. So we will resume on outcome 3, but at some stage, if we do not finish outcome 3 in a reasonable time, we might interpose at least the Medibank Private people and possibly more of private health at that stage. But, for the moment, we will proceed again with outcome 3.

Senator FORSHAW—What is the proposal for dealing with Medibank Private?

CHAIR—The proposal is that we deal with Medibank Private at some stage between now and 6 o'clock, which is when the CEO of Medibank has to climb on a plane to Melbourne. We will not do it just yet, because they are on the way here at the moment. The plan is to return to outcome 3. I invite further questions on outcome 3.

Senator McLUCAS—This picks up from where we were at with another organisation. This takes us a step further. I am now dealing with a matter concerning a facility in South Australia, which I will not name. The issue there was that a complaint was made by a resident's family. The complaint was taken through the Aged Care Complaints Resolution Scheme. The three issues that the resident's son, in this case, was concerned about were basically 'upheld', for want of better language, by the complaints resolution process. There were recommendations that the facility, firstly, review its roster; secondly, change the oral hygiene arrangements in the facility; and, thirdly, provide adequate continence management and personal hygiene.

What happened then concerned this constituent, who has brought this issue to my attention, because there is nothing in the system from his perspective that ensures that those sorts of recommendations are formally adopted or considered by the agency in any assessment process. The agency did a review audit of this particular facility quite soon after the gentleman's father passed away, and there was no reference at all to those issues in the assessment process or the report. That was somewhat concerning to this gentleman. What can you say to a person like that that ensures that the process does support the quite difficult process they have been through in pursuing a complaint through the complaints resolution scheme?

Ms Finlay—Without knowing the details of the case, it is a bit difficult to give you a helpful and direct answer about these particular circumstances. Did the person go to a determination through a committee?

Senator McLUCAS—Yes, there is a determination report, which basically confirms that these things should have occurred.

Ms Finlay—As a result of that determination, did the person concerned feel that no action was then taken—

Senator McLUCAS—That is correct.

Ms Finlay—because of the determination?

Senator McLUCAS—Not because of it; as a result of it.

Ms Finlay—Because of what was in the determination, I should say.

Senator McLUCAS—Yes.

Ms Finlay—We would normally follow up on a determination. I cannot remember off the top of my head the designated period, but there is a specified period. Once a determination has been made by a committee, the department then follows that up with the provider and writes to the provider and notifies the provider that we understand there was a determination in these areas and seeks the provider's feedback that they have taken action. It is difficult for me to take you much more through the steps involved unless I understand the circumstances of the case. I am very happy if it would help to talk with you privately about those circumstances if you feel that would be of help in this case.

From the department's point of view, we are responsible for asking that the determination made is followed up. If we find that it is not followed up, we try to negotiate with the home to try to understand why that might not be the case. If as a result of the contact with the home, and any other information that may be available to us, we find there is a situation where there are continuing problems, we would have a closer look at those continuing problems.

Senator McLUCAS—I am a bit loath to identify the constituent, although he has given me permission. We will leave it at that. That is the concern he has. It may allay his fears but I fear it probably will not. The next issue I want to go to is Chelsea Private Nursing Home. You would be aware there is a coroner's inquest under way to do with an incident that occurred at that home. I want to preface my questions this afternoon by saying that Chelsea Private is now owned by another provider, and this refers to a previous owner of this particular facility. There has also been another assessment since the event occurred that has them 43 out of 44 conditions compliant. By saying that, I am saying that things have moved on, but some issues have been raised in the coroner's inquest that I think warrant some questions. It goes to what options agency inspectors have if they encounter significant non-cooperation by management or staff during an audit. Mr Brandon, you may be able to help us with this one.

Mr Brandon—I should tell you at first that we rarely get non-cooperation or resistance, because people understand the importance of accreditation.

Senator McLUCAS—I thought it might have been unusual.

Mr Brandon—It is extremely unusual. Usually the assessors, and particularly the team leaders, talk their way through the situation with the nursing home management and the assessment goes on. The major impact of that, because it rarely happens, is a bit of a time blow-out but it is not what I would consider a problem for us.

Senator McLUCAS—It may not happen regularly, but what do you do if you find non-cooperation with your reviewers? If your auditors find non-cooperation from proprietors or staff of a residential aged care facility, what avenues are open to you?

Mr Brandon—Do you mean when the home absolutely refuses to participate?

Senator McLUCAS—I think there is a difference between, 'No, you can't come in,' and being non-cooperative. I think that is the word that has been used in the court.

Mr Brandon—Part of the process is to talk with residents and to look at documents and glean what you can out of it. I think the other thing to observe is that the onus is on the provider to demonstrate their compliance. If the owner or the staff were not giving us the information we required and were not able to support it with documentation that they would normally hold, we would find them non-compliant.

Senator McLUCAS—I understand that, but your job is to regulate—to audit. If you are not getting access to information, I suppose the penalty will be that you are non-compliant.

Mr Brandon—If the home cannot demonstrate their compliance, they are de facto non-compliant.

Senator McLUCAS—Is it agency practice for the audit team not to include a report of that non-cooperative type of relationship in their report?

Mr Brandon—It would depend on the magnitude of it, the effect it had on the audit and who it was.

Senator McLUCAS—In the coroner's inquest, the agency staff member said it was agency practice not to report non-cooperation—that it was not a relevant item to put in the report.

Mr Brandon—I have not seen the transcript of that hearing. All I can tell you is that we expect the audit team to put in things that are relevant to the audit, and that would depend on the scope of the non-assistance, if you will. I can tell you, as a statement of fact, we certainly do not have a policy that says you do not ever report non-cooperation.

Senator McLUCAS—I did not think that would be the case. In the headings in the reporting system, which is a fairly consistent generic, there is no area where you talk about the nature of the inquiry generally, except on that front page, really.

Mr Brandon—The assessment team reports on who they spoke to and what information they saw and things like that. As I said, the level of cooperation, if you will, is not something we would try to rank. It would only come into play if the level of cooperation meant we just could not do our jobs.

Senator McLUCAS—That is all I need to refer to in that. My next question is about the agency web site. Why did the agency remove the archived reports on inspections of residential aged care from the web site when the new web site was established?

Mr Brandon—When we redeveloped the web site, we looked at the structure and content of it and formed the view that the archived reports were getting very few hits. So we put in place a mechanism whereby people can request them simply by dropping us an email or a fax or a letter. So the archived reports are still available. It was simply an issue of whether we were going to transfer the five or seven years of records across into a new system or make them available on request. Given that the accessing of them was quite low, we decided we would make them available on request.

Senator McLUCAS—Even though you do not get a high hit rate on a five-year-old audit—and I can understand that—if it were Sir James by the Bay there might be a higher interest in previous audits, not only from people like me, who could not find those, but from residents and their families. It is not evident on the web site that the previous audits are available. You have to know that there is an auditing process and that you can actually ask for previous audits.

Mr Brandon—I do not have the exact wording with me, but I understand there is a message that appears on the web site that suggests that those who want to review an archived report may obtain a copy by requesting in writing the name of the home and the date. You can have it by return email or fax, you can have it printed or you can have it mailed out.

Senator McLUCAS—When I rang up, they said I could get it in the post, and I was a bit concerned about that.

Mr Brandon—I take it from that that they did not offer to send it to you by email.

Senator McLUCAS—No.

Mr Brandon—I can provide you with a copy of the web site where it says that.

Senator McLUCAS—The decision not to have previous audits posted on the web site was a decision totally made by the agency—

Mr Brandon—That is correct.

Senator McLUCAS—Or did you have to consult with the department?

Mr Brandon—No. It was an agency decision.

Senator McLUCAS—Is it more expensive to have all of those old reports there? It does not hurt to have them there, does it?

Mr Brandon—The issue was simply that we introduced a new system, we ran the risk of transferring the data and, as I said, the hit rate was low and we made an alternative arrangement. I can tell you that since we did that we have had 12 requests, most of which have come electronically, and we have responded to them.

Senator McLUCAS—I will know to ask for an email copy of previous ones.

Mr Brandon—I am sorry—it is actually six requests that we have had since August, not 12. Since August, we have had six requests for archived reports.

Senator McLUCAS—What facilities were they for?

Mr Brandon—I do not have that information.

Senator McLUCAS—You do not have to give it to me either. Chair, I notice that Mr Savvides is in the room.

CHAIR—Yes. However, rather than keep chopping and changing, we might do a little more on this. I know Senator Adams has some questions on this outcome. At about 5 o'clock if we have not finished outcome 3 we will go to Medibank Private.

Senator ADAMS—Going back into the rural area, rural aged care facilities have a large number of concessional residents. This is starting to cause quite a problem in small communities, and obviously the number is going to grow. Regarding funding problems, is there any viability funding that these facilities might be able to get?

Mr Mersiades—There is a viability supplement which is available to eligible smaller rural services, depending on the degree of rurality and the degree of remoteness. That amount was increased substantially in response to the Hogan initiatives. So there is a recognition of the additional costs. The increases that flowed from Hogan started at the beginning of this financial year.

Senator ADAMS—Respite for dementia in rural areas is very difficult. Regarding the multipurpose service, when the dementia specific places are allocated they are usually in much larger blocks. If you are in a multipurpose service is there any way you might be able to apply for a dementia specific bed? I will explain a little. I come from Western Australia, where there are an enormous number of multipurpose services—which you would be aware of. Their biggest problem now is that there seem to be a number of people with dementia living on properties. Their carers are starting to fade, and it is becoming a huge problem. If they are wandering, they cannot of course go to the local hospital.

Mr Mersiades—Under the multipurpose concept, centres are not given specific low-care or high-care dementia places. They are given a number of places and they pool the funds associated with those. It is within their remit to adapt the service to meet the local needs. That could involve having dementia specific services as well. A related issue was in the last budget. There was a decision to provide additional funding to multipurpose services for respite.

Senator ADAMS—It is the respite that is the problem.

Mr Mersiades—Yes. That is added to the pool of funds available.

Senator ADAMS—I was very pleased to see in the report that the 92 multipurpose services have all passed their requirements. That is great, because they are certainly very popular in Western Australia and they solve a lot of problems for us.

Mr Mersiades—Just for the record, I said that the additional viability supplement started at the beginning of the financial year. It actually started at the beginning of the calendar year this year—1 January 2005.

Ms Halton—While there is a pause, I note that a series of questions were asked earlier about aged care panels and the implementation advisory group. I have a list of those members, which I am happy to table.

Senator McLUCAS—I go to the question of the capital improvements money—the $3,500 that I think was allocated in the May 2004 budget. Was it 2004?

Mr Mersiades—Yes. It was part of the Hogan response.

Senator McLUCAS—That money was to cover, amongst other things, meeting fire safety standards. Is that correct?

Mr Mersiades—Yes, amongst other things.

Senator McLUCAS—What other things were included in that? People tend to talk about it as the fire safety money.

Mr Mersiades—It was generally to recognise the requirement for aged care providers to achieve the 2008 building certification, with particular emphasis on achieving the fire safety standards, which are a very important component of that certification.

Senator McLUCAS—And they have to meet the fire safety standards by December of this year. Is that correct?

Mr Mersiades—That is correct.

Senator McLUCAS—Am I correct in saying that, out of 2,933 facilities, 1,346—that is about 46 per cent—have not yet passed the fire safety standards?

Mr Mersiades—I cannot vouch for those figures. I am not sure where you have got them from.

Senator McLUCAS—From your web site.

Mr Mersiades—They were probably current on the day. I am not sure that they are current today.

Senator McLUCAS—I got them on 20 October.

Mr Mersiades—Very good.

Senator McLUCAS—It is an interesting system. You have to count them; you cannot add up at the bottom. That involves a lot of staff time. That is another feature you might want to put in—an adding feature so we can add them up. That is about 46 per cent. For two years now they have had access to that money to be able to comply. What will happen in December?

Mr Mersiades—We have sent a number of letters to providers reminding them of that obligation, and they are required to give us details by December on the degree to which they have achieved that compliance. We then will assess where they are up to. We will have to be reasonable in our approach. We would not be looking at immediately taking some sort of compliance action. It could be that they will come back to us and say, 'Look, we're in the process of redeveloping, but it will happen in six months time,' in which case that would be acceptable. We will have a process of vetting and monitoring to see how the homes are going with the achievement of those standards within a reasonable time frame.

Senator McLUCAS—Are you concerned that only about half of them are compliant and we are about a month out from December 2005?

Ms Finlay—At the moment the figure is about 1,300, so there has been some progress since you last looked on the web site. But it is true that there are 1,300 outstanding. We have been working very closely with the peak organisations in particular to make sure that homes

understand what they need to do by 31 December. As Mr Mersiades mentioned, we have also already received indications from a number of homes that, because of the lead times involved in some of the building works that they need to do, they may need a little longer, and we will obviously talk that through with them. We are very shortly to write out to those homes that have not yet advised us about the state of play to encourage them to come back to us to explain how they are currently situated, and then we will talk through with them what needs to be done.

Senator McLUCAS—So you can probably describe the non-compliant ones as those that are in the process of redevelopment or where there is a legitimate reason why you would not put capital moneys into a building that will change. There is probably a group of homes that are having difficulty simply because they cannot get the workers. A lot of it is to do with the ceiling to roof wall—whatever that is called. It is a wall in the ceiling.

Ms Halton—Clearly we are outside our area of technical competence here.

Senator McLUCAS—I reckon they know what I mean.

Ms Halton—I am sure they do. I do not know that they can describe it any better than you have.

Mr Mersiades—Roof cavity will do.

Ms Finlay—That sounds good enough to me.

Senator McLUCAS—For some facilities, people have said to me that they just cannot get the tradespeople to come and do the work. So there is that group.

Ms Finlay—Yes.

Senator McLUCAS—There is a group that worries me. It includes the homes where, whatever you do, it will be really hard to make those buildings compliant with fire safety. Are they the groups of non-compliant ones in your mind?

Ms Finlay—I could not give you a definitive answer, simply because at this stage we have not heard back from the 1,300 about the reasons they are outstanding. It is a bit of a pattern when it comes to asking homes to respond to us that they actually are very practical people—they get on with the job, do the work and then tell us, right towards the end of the process. I think there will be some in that category. But I could not give you a definitive answer on what proportion or what types of issues might be confronting the homes. I have personally dealt with some correspondence of one of the two categories that we have been speaking about where a home have said: 'Yes, we have actually committed the money. We are working on the improvements and we expect to be finished by date X.' I have had others, particularly in regional and rural areas, where they have raised the issue that you have raised about access to tradespeople. We would be sensibly working through with the homes how best to get them to the point where we need them so that we get the best result, both for the homes themselves and the residents.

Senator McLUCAS—What will happen if someone does not have a legitimate reason? If someone cannot say, 'I can't find tradespeople,' or if they are just not answering your letters, what are you going to do in a circumstance like that?

Ms Finlay—This is a discussion we have discussed internally. As I mentioned earlier on, we have a network of state and territory officers. They keep in very close contact with the homes. So we have a pretty good sense of the state of play with homes. If it is necessary, we will obviously talk through with the homes what needs to be done.

Ms Halton—Ultimately this will be a decision for government. The government has set a framework in relation to the improvement of standards. This has been an ongoing process. We have talked a number of times about the ratcheting up of standards, which I think is appropriate. I think some of what you have talked about in terms of constraints is a fair call. Ultimately, when the situation becomes clearer—and I think Ms Finlay is absolutely right—we will see that some people are out there beavering away getting on with it, and they will come and tell us when they have done it. But ultimately the minister will have to take a view about the aggregate position that she finds towards the end of that period. Obviously that needs to be done in an appropriate and timely manner, but I think it would be inappropriate for us to speculate as to what might be her position on these matters.

Senator McLUCAS—I would not want you to do that. I dare say she would need to have an understanding of the numbers we are talking about.

Ms Halton—Absolutely.

Senator McLUCAS—According to my figures, there are 1,346, almost half, which are non-compliant. Let us say half of those were wilfully non-compliant. We cannot just shut them down but, to be frank, to every other facility in Australia, to ones that have been shut down, it is somewhat unfair to not impose some sort of compliance issue.

Ms Halton—My view is that it is a little early even to speculate about the number that will be in that latter category that you just talked about. The reality is that we have a little way to go, we have information that is coming in and I think it is acknowledged that we need to progressively gain a more finely granulated understanding of what the circumstances are. As Ms Finlay says, one of the jobs of our state office network is to be very across the detail of what is happening on a home-by-home basis. That will enable us in a timely fashion to talk with the minister about how we go about it. I think it is too early to start speculating.

Senator McLUCAS—We have one month.

Ms Halton—The reality is that often these things come in a rush. That is our experience of these things in this industry: they come in a real rush.

Senator McLUCAS—Would you declare homes that are not compliant at 31 December uncertified?

Mr Mersiades—No, we could not go to that extent because that would have implications for the capacity to raise bonds. That would be a very significant step. Before we ever got to that stage there would need to be a process of continuing pressure, negotiation and working through the issues. It is important in this whole exercise that, in that period since the budget decision, it is not as if the department has not been centre stage in working, pressuring the sector and reminding them of their obligations in this area. So they are all very aware. It is not as if it has been out of mind for them. We will continue to do that.

We always knew that our capacity to take really hard measures was constrained. It always is in aged care. It is very difficult when you effectively have full occupancy. But this is where it is important to work with the sector. I think the experience is that most of them, if not all of them, will come back with a transition plan and we will get there. I do not take a negative view on the sector's view on this issue. There has been a very significant improvement in the quality of the building standards since we introduced certification a number of years ago, and we just keep that pressure going.

Senator McLUCAS—Ms Finlay, you might be able to answer this. It may be something that I put in advance on notice to you. Come the end of December, could you provide the committee with an analysis of the numbers? We will have the bald numbers of those that are compliant and those that are not. Could you disaggregate the non-compliant ones into the groups that we have talked about? It is a bit of a how long is a piece of string question.

Ms Finlay—Yes. I would have to give that some pretty careful consideration about how realistic—

Senator McLUCAS—Why don't you give it to me in general proportions? Say, of these non-compliant ones, this percentage fit into each of the categories we talked about.

Ms Finlay—I would like to read the *Hansard* entry—because we have been in the midst of a discussion about it—and be sure in my mind about the information that we can reasonably ask in order to be able to answer a question like that. If that is acceptable to you, I will take that approach.

Senator McLUCAS—Certainly. I think you and I both know what we are trying to get to.

Ms Finlay—Yes, I understand what you are trying to get to.

Senator McLUCAS—It is about how realistic it is for me to ask you that, to be frank. If it comes to 31 December and it is absolutely evident that the facility has no intention of complying, what happens to the $3,500?

Mr Mersiades—I doubt that we will get to a situation on 31 December where there will be a home that will say, 'We definitely do not intend doing anything.'

Senator McLUCAS—But if you do.

Mr Mersiades—On top of that, they have been required to tell us how they are spending that $3,500.

Senator McLUCAS—Over time there has been an acquittal process.

Mr Mersiades—Yes, there have been acquittal processes.

Senator McLUCAS—Has everyone been sending in their acquittals?

Mr Mersiades—I believe so.

Senator McLUCAS—All 2,933 facilities?

Mr Mersiades—I will have to take on notice whether we got them all on time. I am not sure of the precise analysis of it.

Senator McLUCAS—We will to have wait until 31 December. What is the nature of the acquittal process at the moment?

Mr Mersiades—An annual statement is required, but I cannot recall—

Mr Dellar—It is part of the fire safety declaration. There are questions in that that the provider is required to answer in terms of the way the money was applied. Although I have just said it is part of the fire safety declaration, the $3,500 is not in any way only able to be spent on that. There were a range of other things as well. But that is covered in the declaration.

Senator McLUCAS—Which is provided annually to the department.

Mr Dellar—That is correct.

Senator McLUCAS—Could I get a copy of that declaration at some stage?

Mr Dellar—We would be happy to provide that for you.

Senator McLUCAS—The 2005 deadline was initially pushed back from December 2003. Is that correct?

Mr Mersiades—I am not exactly sure of the nature of the deadline back in 2003 or how firm that was. I think there was an agreement between the government and the sector that they would aim for that. But, when the additional funding became available post the Hogan $3,500 per resident, the new arrangements were put in place. I am not sure that the earlier arrangements were hard and fast. There was a cooperative agreement between, as I say, the department and the sector to aim for that.

Senator McLUCAS—But, when the cheque went out, what did it say that the home had to do to acquit the money? You just did not write cheques out and say, 'We'll ask you later what you did.'

Mr Mersiades—No. We sent letters out at the time making it quite clear what the expectations were of how those funds were to be used.

Senator McLUCAS—That letter surely would have said, 'And we would like you to tell us by—' and my advice is that it was December 2003.

Mr Mersiades—The cheques had not gone out by December 2003.

Senator McLUCAS—But there was an earlier agreement, was there not?

Mr Mersiades—There was an agreement around certification, but it was not funded in any way. It was an undertaking—

Senator McLUCAS—The money came in 2004.

Mr Mersiades—It came afterwards. That is why it is written in recognition of providers moving towards 2008, bearing in mind some had already done so.

Senator McLUCAS—I know you do not think it will happen but, if you are of the view that a facility—either because they simply do not want to or because it is physically not possible—is not going to be compliant for fire safety, will you require that money to be returned to the Commonwealth?

Mr Mersiades—We can initiate a review of their certification. I think we will cross that bridge when and if it happens. If they have not spent the money in a way which is consistent

with the purposes for which it was put, there may well be a case. It is something that we would have to keep in mind.

Senator CHRIS EVANS—Apologies for not being here at the time; I was watching on the television. Do I take it that almost half the nursing homes in Australia will not meet fire standards as of December this year?

Ms Halton—No. That is exactly what we are saying is not the case. We cannot make that statement.

Senator CHRIS EVANS—That is why I ask for clarification. What are you saying then?

Mr Mersiades—I think we need to draw a distinction between certification and fire safety. Fire safety—and this is why we have a fire safety declaration—is a matter for state governments and local governments. It is their responsibility to certify whether a home meets fire safety standards. That is why we have an annual fire safety declaration. If through that process we identify any shortcomings, we get in touch with the relevant local authority or state government. Building certification is an additional layer on top, which is a higher standard. Under building certification, if a home does not meet fire safety standards, it does not mean it does not meet the state government and local government fire safety standards.

Senator CHRIS EVANS—But one of the conditions of your certification standards is fire safety. Is that right?

Mr Mersiades—Yes, but all the homes are currently certified. They are certified under either the 1997 instrument or the 1999 instrument.

Senator CHRIS EVANS—And that is because they meet the requirements of the certification for fire safety standards.

Mr Mersiades—In those instruments, yes.

Senator CHRIS EVANS—What are you telling me is going to happen in December 2005?

Ms Halton—I think the issue here is that Senator McLucas was asking whether, based on the current statistics about this revised process of certification, which are included on the web site, that was a portent predictive of what would be the situation in December. I think we have been at great pains to point out that what is going on out in the sector is not necessarily indicated by what is currently sitting on the web site. But you need to put fire into one category and this other process into this category. We were actually saying that, with this other category, it is a little early, given what tends to happen in the sector, to make any concrete prediction.

Senator CHRIS EVANS—But what happens in December if people do not meet the certification standards?

Ms Halton—We have already answered that by saying that it will be a matter for the minister to consider, and she will consider that matter in due course.

Senator CHRIS EVANS—But the whole purpose of the certification process was to bring the homes up to—

Ms Halton—Yes.

Senator CHRIS EVANS—I sat here for hours and hours, as you or your predecessors told me that this was the solution to the poor quality of nursing homes around Australia with the dangers and barriers they presented to quality care. The certification was linked very much to the accreditation.

Ms Halton—You might recall that the first person who went on for hours and hours about this was me, when I ran the aged care program. We brought this in at the very beginning of the aged care reform processes. Effectively, we have seen over what now is nearly a 10-year period—it makes me feel old just saying that—a significant increase in the building fabric of homes. In this series of questions we are discussing the current iteration of that process. There is, I think, no argument that what we have seen over this period is a very significant improvement in building fabric. As for this next iteration, I suppose Senator McLucas and we were attempting to crystal-ball what might happen in December. The point being made by the officers but being reinforced by me is that we cannot pre-empt, firstly, precisely what the outcome will be—it is a little early to tell—and, secondly, the minister will have to consider those circumstances as they emerge in the next month or so.

Senator CHRIS EVANS—But isn't it clear under the current system that, if they do not meet certification, they will not get funded, or has something changed?

Mr Mersiades—They are certified now. Most of them are certified under the 1997 instrument. Therefore, once certified, they have the right to charge accommodation bonds, amongst other things. At the same time, we then agreed with the industry that that instrument should be upgraded with what is called the 1999 instrument. That means that all new homes or those that have been redeveloped substantially have to meet the 1999 instrument. We talked about the fire safety standard and the $3,500. That was to help those certified under the 1997 instrument to meet the 1999 instrument, one of the hurdles to which is to do more on fire safety.

Ms Halton—But keep in mind that this is over and above what you are required to do by the regulator, which is the local authority, in respect of fire,.

Senator CHRIS EVANS—Yes, but that is not the point, is it? You certify them not on the basis of what some local government says; you certify them to national standards. Is that right, or has something changed?

Ms Halton—No. The requirement has always been that they meet the local standard.

Senator CHRIS EVANS—And your standards.

Ms Halton—And certification, which these do.

Senator CHRIS EVANS—So why are we now falling back to the local government standard?

Ms Halton—No, we are not falling back. We have always had those as the core element of this work.

Senator CHRIS EVANS—Yes, for the fire safety. But what about for building certification? What do you say will happen in December 2005 to those homes that do not meet the building certification requirements?

Ms Halton—We say that that is a matter for the minister to consider, and she has not yet made a decision in that respect.

Senator CHRIS EVANS—Under the current regulations, what does it say about not making certification?

Mr Mersiades—But they are certified.

Ms Halton—They are certified.

Senator CHRIS EVANS—So, once you are certified, you are certified forever and it does not matter.

Mr Mersiades—That is how the act is written at the moment. There can be a review.

Senator CHRIS EVANS—So the December standards have no force.

Mr Mersiades—There is the capacity to review the certification.

Ms Halton—And it applies to new homes.

Mr Mersiades—It applies to all homes.

Senator CHRIS EVANS—I could pull out one press release after another saying that we are going to force the standard to be adopted. As I understand it, very significant financial decisions have been made by owners of aged care homes on the basis of whether they think they can get them up and how much it will cost to do so.

Ms Halton—Yes.

Senator CHRIS EVANS—I know many aged care providers who have sold homes that they thought they could not get up to the standard. They will be very interested to know if those who bought their homes at a low price are excused.

Ms Halton—And all of that is accepted and acknowledged. The simple point of this whole dialogue was: inter alia, has the minister made any decision about what circumstance will apply in December? The answer, as I best understand it, is no. That is the answer that we can give you. That is a matter for the minister to exercise a decision about, which she will no doubt do.

Senator CHRIS EVANS—What happens in December if there is no ministerial decision?

Ms Halton—You are asking us to speculate.

Senator CHRIS EVANS—No, I am not asking you to speculate. I am asking you what requirements are made of nursing homes come the December deadline, under the regulations—any?

Mr Mersiades—Those that are certified will continue to be certified. There will be a decision to be made as to how to approach those homes that have not achieved the 1999 instrument.

Senator CHRIS EVANS—So there is no automatic impact on them if they have not?

Mr Mersiades—No, not automatic.

Ms Halton—Hence the need for the minister to consider the matter.

Senator CHRIS EVANS—So there is no automatic requirement on those that received specialist funding for fire safety et cetera to meet the certification standards?

Mr Mersiades—To be certified under the 1999 instrument, no, there is no automatic—I do not know what you mean by 'automatic'.

Senator CHRIS EVANS—You gave them money to meet a new standard. Mutual obligation, which the government is very strong on, usually means there is an obligation on both parties. Having handed them the money, what is their obligation to you, or to the taxpayers of Australia?

Mr Mersiades—Their obligation is to achieve the standard by December and we will work with them to ensure that they achieve it or that they have put in place appropriate transition arrangements to get there.

Senator CHRIS EVANS—Aren't these the transition arrangements? When did we set the 2005 December deadline?

Mr Mersiades—It was post-Hogan when the $3,500 allocation was made.

Senator CHRIS EVANS—What does that mean—post-Hogan?

Mr Mersiades—It was the 2004 budget.

Senator CHRIS EVANS—That set the deadline of December 2005?

Mr Mersiades—That allocated the $3,500 per resident, and in that context the deadline was set in terms of achieving the 1999 instrument by December 2005. That is when we said to providers that they had to provide evidence to us that they had achieved that standard.

Senator CHRIS EVANS—But wasn't the standard anticipated prior to the Hogan review? I know that that is when you made the financial contribution.

Mr Mersiades—Yes, but I said earlier that those homes which had been certified at the 1997 standards remain certified and that there was an agreement with the sector which said that they would work cooperatively to implement the 1999 instrument.

Senator CHRIS EVANS—By when?

Mr Mersiades—By 2008.

Senator CHRIS EVANS—So the deadline of 2005 was only arrived at following the financial contribution?

Mr Mersiades—Well, the pressure was put on a little bit given that there was some financial assistance available.

Senator CHRIS EVANS—Was that mutually agreed? I know it was a budget decision.

Mr Mersiades—They did not have to accept the $3,500.

Senator CHRIS EVANS—So you are saying—

Mr Mersiades—They knew the conditions under which that funding would be provided, and that information was provided before the money flowed.

Senator CHRIS EVANS—Did they sign a contract to that effect?

Mr Mersiades—It is paid out under the subsidy arrangements, and contracts of a conventional nature do not apply in those circumstances.

Senator CHRIS EVANS—What does that mean?

Ms Halton—It was paid as a subsidy to the provider, just as we pay subsidies in respect of care.

Senator CHRIS EVANS—But you just told me before, Mr Mersiades, that it was only paid on the understanding that they accepted that they had come up to the standard. Now you are telling me it was made automatically.

Mr Mersiades—No, what I said was: they were notified before they accepted the subsidy what the expected outcomes would be.

Senator CHRIS EVANS—What percentage of nursing homes accepted the subsidy?

Mr Mersiades—All of them.

Senator CHRIS EVANS—So they did not have to contract to anything?

Ms Halton—There was never a contractual arrangement here. That was made quite clear at the time. The government took a decision that it was going to pay an additional subsidy. It made its position very clear when it paid that additional subsidy in respect of what it expected it to be used for. I acknowledge that it is a complicated field. You have rightly said yourself that many of the homes have undertaken a great deal of work, and that is to be welcomed. It is our expectation that, in the next little while, a number will come in and advise us that they have similarly completed work. Senator McLucas has pointed to particular rural areas that may be a bit of a bottleneck in terms of access to skilled trades, and I think that is probably a reasonable reason. But the minister will consider this whole issue in the run-up to December.

Senator CHRIS EVANS—There are also a number of providers who have decided to pocket the money and take the risk.

Ms Halton—You allege that, Senator. I do not have any information to that effect.

Senator CHRIS EVANS—I am sure the department does. It knows the industry very well, as you know, Ms Halton.

Ms Halton—Well, I do not know that we can say any more to you, other than that the minister will consider this issue in the near future.

Senator CHRIS EVANS—You are telling me that you have no legal recourse, no moral recourse or no contractual recourse over providers who do not meet the standards.

Ms Halton—No. You are asking me now to provide you with policy advice about what our options might be in relation to the act in relation to sanctions et cetera.

Senator CHRIS EVANS—No, I am not asking you that.

Ms Halton—The truth of the matter is that there may be a number of options available to us in relation to the payment of subsidy and whether the things have been appropriately delivered in respect of those subsidies. Those are all matters that we will be advising the minister on in relation to options.

Senator CHRIS EVANS—I am not asking you that. I am asking you as a matter of fact what authority, power, contractual right do you have to make providers comply with the certification requirements, given that you sent them the cheque?

Ms Halton—I think Mr Mersiades has already made the point that, for example, we can withdraw their certification. That would be a very significant step. The reason we are not in a position to answer questions about what will happen at the end of December is that it requires a series of considerations by the minister in terms of what will and should happen. Therefore, we are not in a position to tell you what those decisions will be.

Senator CHRIS EVANS—You have the right to remove their certification and therefore their subsidies under a range of conditions, as I understand it. Is there any provision in those requirements relating to people who, having received the money, do not meet the standard by the end of 2005? Is there any specific relationship between the payment and their obligations to you?

Mr Mersiades—I think what we have said to them is that if they do not achieve the standard by the end of 2005 we have reserved the right—I can be corrected if I am wrong on this—to initiate a review, and a consequence of that review could be the withdrawal of certification. But, as I was at pains to try to say earlier, we are not approaching this as the black hat regulator. There has been a lot of good work going on in the sector and we want to keep working with them to move towards achieving higher building standards. There can be very good reasons for some people why the arbitrary date of 31 December is just not feasible or appropriate, and we canvassed some of those. We are working with the sector cooperatively so that we can get a gradual improvement in the quality of the building fabric. We do have reserve powers but we prefer to operate with a velvet glove rather than with a steel hammer.

CHAIR—Senator Evans, I hate to interrupt your stride but we previously made an agreement that at 5 o'clock we would break in and deal with Medibank Private because they have a deadline to meet. We will resume in this area as soon as we have dealt with Medibank Private.

Ms Halton—Can I just make one observation about people's airline schedules: the accreditation agency officials are on an earlier plane than Medibank Private. Whilst I do have an obligation to try to meet the needs of my Medibank Private colleagues, similarly I would not want my accreditation agency colleagues disadvantaged given their relative hierarchy in terms of when their planes are. Is there anything else you want to ask the accreditation agency officials, because they are on a 6 o'clock plane?

CHAIR—We are going to interrupt these questions anyway. Are there further questions of the accreditation agency?

Senator McLUCAS—Not from me.

Ms Halton—So they can have a leisurely drive to the airport?

CHAIR—Yes. We will call Medibank Private to the table next, after which we will resume questions on outcome 3.

[5.12 pm]

CHAIR—We will now move to outcome 8, Private health. I welcome the witnesses from Medibank Private. You will recall, Mr Savvides, that at previous estimates there were a number of questions about access to podiatry services. There was a question about whether people who used a podiatrist for podiatric surgery and people who used an orthopaedic surgeon for that kind of surgery would be able to access the same kinds of benefits for the surgeon and the theatre fees. From recollection, I understand that the evidence given was that work was being done to list those services, particularly the services of an anaesthetist, on the ancillary schedule. Has that been done as far as Medibank Private is concerned?

Mr Savvides—Since the last meeting we have looked at this in greater detail. There are several areas that make this complex. One is that the registration of podiatric surgeons is not a comprehensive scenario in Australia at the moment; it is still in the process of transition. Also, not all hospitals that we are contracted with provide those services. So from a member-experience point of view—and I think that is where this discussion started—it is patchy and not all those services are covered. But that particular provider group or that particular specialist group is still in the process of being transitioned into registered providers. My colleague Sarah Bussey may be able to add to that.

Ms Bussey—It is complex, as Mr Savvides said, because there are a number of factors which influence the level of benefit that Medibank Private pays for this type of procedure, one of which is whether the podiatrist is accredited and another of which is the contractual status of the facility where the procedure is performed. In terms of your specific question about anaesthetists, my understanding is that Medibank does not currently pay any benefit, whether under a hospital table or an ancillary table, for the anaesthetists who are performing part of the service for podiatric surgery. The reason for that is that podiatric surgeons do not have a CMBS number and therefore the principal procedure that is being carried out is not recognised for Medicare purposes. That is my understanding of the current situation, but I know that there have been ongoing discussions with the podiatric surgeons about the status of their not having CMBS numbers.

CHAIR—This is a bit concerning, because we were told in the June sittings of these committees that there was work going on to align podiatric services with orthopaedic services or surgery and that there were directives issued by the government through Medicare Australia to require there to be an alignment of services in both those cases. Are you saying that you understand that there are no podiatrists or podiatric surgeons who have accreditation at the present time or that some have and some have not got accreditation or registration?

Ms Bussey—I understand that some podiatric surgeons do have a accreditation, but I also understand that that does not mean that they have a CMBS number.

CHAIR—We might take this question up with the Private Health Insurance Ombudsman later on. So you understand that the hold-up in aligning these two areas is that there is not yet an MBS listing for these sorts of services at this stage?

Ms Bussey—Yes, that is my understanding.

CHAIR—So do you expect that once that listing occurs there would be a full alignment as far as Medibank Private is concerned between services offered by podiatrists and orthopaedic surgeons?

Ms Bussey—I will have to take that question on notice and let you have an answer about exactly how that would work.

CHAIR—All right. I will pursue that elsewhere.

Senator McLUCAS—Mr Savvides, in relation to the request for proposal process, your movement and relationship with private hospitals, where are the current contract renegotiations up to?

Mr Savvides—That RFP process involved 99 hospitals. It was obviously located in the metropolitan areas of the east coast of Australia, and in Adelaide. We are almost finished. More than three-quarters of the providers are already contracted and, to our delight, we are also able to say they are not just contracted for a year but have multiple-year forward contracts, which is one of the positive outcomes of the process. We think the balance will be pretty well almost done by the end of November, so the balance is very much a work in progress right now.

Senator McLUCAS—Can you tell the committee what proportion failed to meet the criteria?

Mr Savvides—I cannot be specific because part of that outcome is yet to be determined. As you know, through the probity overlay of this process is a tender. We are not able to disclose that until the final process is settled. There has been quite a lot of media about many hospitals, for example, being out of contract. There are some large numbers quoted. We do not expect that that will be the case at all. We know it will not be the case. It will be just a handful—three or four or something of that nature. At this stage, we are not in a position to be specific and to name names.

Senator McLUCAS—You do not have a date, do you, for the actual—

Mr Savvides—Many of the providers have asked for extensions—and the process does permit that—so that there is ample time for negotiation and dialogue. So we have extended many of the negotiations to give people the time that they need and for both parties to work in a constructive way.

Senator McLUCAS—I recognise that you say there are not going to be many, but they might be in significant areas, so what do you propose to do if it is in a regional area, for example, where you cannot organise a relationship with that private hospital?

Mr Savvides—We do not expect that that will be the situation. We will have over 400 hospitals contracted with Medibank and 99 through the RFP process, but there is the overall contracted network, including regional and country. We obviously did not take the tender process into country and regional areas because we thought that that was not appropriate. There has also been the messiness of some major changes in ownership in the industry with the change of Affinity Health and the purchase by Ramsay Health Care. Some of these hospitals in the RFP were part of that change of ownership. That has made it a bit more

awkward and that has added time, because people wanted time to sort out the ownership issue before they settled the negotiation.

That said, we believe that our members will have alternatives if they do not choose to attend the hospital that has the exposure of a gap payment if they fall outside of the members choice networks. We will not be the only health fund in Australia that has non members choice contracted hospitals or the equivalent.

Senator McLUCAS—I notice that your annual report indicates a two per cent reduction in the growth of provider costs. Can you explain how that works?

Mr Savvides—What has happened is that Medibank's outlay—about $2.3 billion worth of outlays paid to our members who have claimed—has, in the year-on-year comparison, had a growth rate of 4.9 per cent. That is the growth rate year on year, and that has been a reduction over the prior year, when it was 6.9 per cent. That is the two per cent. So we have certainly been able to influence. Whilst more and more members every year have enjoyed more claiming from Medibank, the actual unit cost of what they have been receiving in the services that they are getting from their health fund has been improved, in terms of its competitive price, through our purchasing strategies.

We have been able to afford more and more claims, with more and more members utilising the services, but the growth rates of those claims have come down. That is very important because, in being an effective purchaser of health services, that then directly flows on to the premiums that members have to afford to be in private health insurance. As we have reduced the growth rate in premiums this year from last year, we expect as a result of the performance that we have just finalised for 2005 that next year's premium growth will also reduce compared to this year.

Senator McLUCAS—Is that an advertisement, Mr Savvides?

Mr Savvides—It is the purpose for doing what we are doing, because the beneficiaries of the purchasing strategy are our members.

Senator McLUCAS—That is fine. How many shopfronts do you currently have open, how does that compare with previous years and what do you intend to do in the future?

Mr Savvides—We have approximately 104 retail stores. They have actually grown a little in number over the last couple of years. The major work that we have been doing in the 104 centres has been in upgrades, refurbishment and modernisation. Some of that meant relocation to more appropriate places for access for members where higher traffic flows exist. There are no plans to reduce that. We are very much invested in high service levels for our members, not only in our retail environments but also in our call centres. We have added more staff to our call centres overall. All of the metrics that we use for service measurement for call centres and retail have improved over the last couple of years. Service is a very important part of holding members who are already a part of the fund and also attracting new members.

Senator McLUCAS—How is the capital injection from the Commonwealth treated in your books from a financial perspective?

Mr Savvides—How it impacted the financial result for 2005?

Senator McLUCAS—Yes.

Mr Savvides—The $85 million capital injection that occurred just over a year ago impacted the result in that it does not exist in the profit and loss; it sits in the balance sheet. It was there to lift our capitalisation as a health fund to bring it line with other industry players. In the $131 million result for 2005, $68 million of that was investment income and the balance was underwriting profit. Of the investment income, the $68 million, about $9 million came from having that extra $85 million in the balance sheet, so about $9 million is really the impact on the FY05 result from having that additional capital in our balance sheet.

Senator McLUCAS—Do you imagine that it is going to have to be returned to the shareholder, the government?

Mr Savvides—That is up to the shareholder. The shareholders made the investment in their own government business enterprise, and it is up to them as to what decisions they make in the future.

Senator McLUCAS—Has there been any indication to this point?

Mr Savvides—There has not been any indication around the status of that allocation of capital.

Senator McLUCAS—I do not have a very voluminous brief here, Mr Savvides, so tell me about the scoping study.

Mr Savvides—The scoping study announced by Senator Minchin on 16 August was to investigate the performance of Medibank Private, the industry it operates within, the regulations within that sector and whether the government should continue to be an owner of the enterprise or make an alternative decision.

Senator McLUCAS—What is your involvement in that study? Of course it is not being run by you but by Senator Minchin's department.

Mr Savvides—The department of finance have appointed Carnegie Wiley to refresh the scoping study they undertook three years ago. They are participating in the review with our management team at Medibank in Melbourne, but they are also dialoguing with other stakeholders in the sector to come up with a view and present a report to the Department of Finance and Administration and government later in the year.

Senator McLUCAS—How do you interface with that?

Mr Savvides—We make direct representations to the advisor. There is a series of meetings and presentations, and we prepare the content for them and then exchange. It will take us some six or seven weeks to complete that process, and we are halfway through it now. The Carnegie Wiley team will construct their own report. We will not see that; it goes to the minister.

Senator McLUCAS—To Senator Minchin?

Mr Savvides—Yes.

Senator FORSHAW—Can you quantify the cost to Medibank Private of your participation in this scoping study, and has some allowance been made by Finance for that? These are members' funds, aren't they?

Mr Savvides—Yes. The overhead of the business has to run an effective health insurance company and, you are right, that is consuming the contributions that members make to the fund. Coincidentally, at the same time as the scoping study the Medibank management team have been working with the Boston Consulting Group to do an extensive review of our strategy going forward. It is a timely review. Much of the way that we present the dialogue and articulate the various components on the scoping study we are reviewing is very much coming out of the review that we are doing for ourselves with BCG, so there is not a lot of incremental cost. Again, the advisor is paid for by DOFA and it is not a cost that we bear. These additional costs are, I would say, quite incremental.

Senator FORSHAW—Would you put a figure on it.

Mr Savvides—I have not sat down to calculate it. It is a refresh. It is not anywhere near as onerous as the quite extensive work that was done three years ago when the fund was asked to do a scoping study. This is really just a scoping study refresh, and we are not finding it to be an onerous task.

Senator FORSHAW—When was the decision made to undertake the study using the Boston Consulting Group?

Mr Savvides—The corporate planning process with the shareholder is completed in May every year. Following that process we thought that, rather than go through yet another rotation of the three-year rolling study in the year ahead, we would inject a more rigorous degree of strategic intent. Hence we engaged BCG to help us at this phase of the year—

Senator FORSHAW—So it was in May.

Mr Savvides—yes—so that by the time we do the next corporate plan process with our shareholder we would have the benefit of having undertaken this work with BCG.

Senator FORSHAW—I apologise that I was late getting here for the start of your evidence, so I hope I do not go over something that might already have been dealt with. Can I give you a real situation: a member of Medibank Private has a regular procedure every few years, a colonoscopy, for which the in-hospital cost is covered by the fund. They use the same specialist each time, for obvious reasons. What would happen if under these new arrangements that the fund is looking at the hospital where that procedure would generally be carried out by that specialist ends up without a contract with Medibank Private?

Mr Savvides—We do not expect that there will be a provider in the 99 in the RFP. We do not expect any of those providers not to have a contract with Medibank. The purpose of the tendering process is to work out who gets a members choice contract. That is a contract where no gaps exist. That is the best contract a provider can ever have with our fund.

Senator FORSHAW—The situation in the case that I put to you would be that that individual, because of their fund coverage—the level of coverage they have—could have all of their in-hospital costs covered by the fund now.

Mr Savvides—Correct.

Senator FORSHAW—Would it be possible that, if that hospital does not end up in the members choice list—

Mr Savvides—As an in-patient.

Senator FORSHAW—that patient would in future have to pay a gap? It can happen?

Mr Savvides—It can happen, absolutely.

Senator FORSHAW—You were going to go on.

Mr Savvides—They would not have no contract at all. That would be a second-tier default. That would be a huge out-of-pocket expense. What they would be most likely to have would be an alternative—another form of contract where a gap exists. It is up to the hospital to charge up to $80 a day for that gap. We are not imposing that on the hospital. It is up to them to charge up to $80. What we have imposed is the cap. The cap is a $400 limit, depending on the per day cumulation. There is one particular product we have, which is the PremierPlus product, at the top of the table. If the member happens to be on that, they will not receive that gap at all, because that is absorbed.

Senator FORSHAW—Sorry, can you say that again.

Mr Savvides—There is a top table at Medibank. They will not be exposed to that gap even if it is an out-of-contract situation with an alternative contract. It is a narrow gap in terms of those who are likely to be exposed. We do not expect that that member will have an alternative hospital denied them. Many of the surgeons that operate in the hospitals that we contract with operate in more than one. If that provider is not in a members choice contract with Medibank, that surgeon is likely to be operating in other rooms through another nearby facility, and our member would have access that way. That happens quite a lot of the time. That is why we have chosen to do the tendering in metropolitan areas where substitute facilities do exist.

Senator FORSHAW—I am thinking of a specific situation where it is maybe a once every three years procedure which is all about ultimately improving health outcomes if regular procedures are undertaken such as colonoscopies. As I understand it, people would prefer to have the same specialist do it, just for continuity, and invariably they would work out of the same hospital or have it done at the same hospital—usually a private hospital if they are a fund member. We shall wait and see if your optimism is well placed.

CHAIR—Have you finished your questions, Senator Forshaw?

Senator FORSHAW—Yes, I have for this round.

CHAIR—Before I call Senator Barnett, I want to follow up the questions I asked earlier about registration of podiatric surgeons. I have been looking over the transcript of the June estimates committee hearings. The strong impression I get from what was told to the committee then was that the registration of podiatric surgeons for the purposes of MBS registration had actually occurred. In fact, Mr Savvides, you advised us that it had happened in March. You said:

I think the time between March and now—

this was June—

is just part of the process that it takes for us to get these fund rules altered, submitted to the department and approved ...

You went on to say:

This is not something that we will still be talking about at the end of the year ...

Are you saying to me that they still have not actually registered podiatric surgeons or that they have but you are still processing the necessary steps to have benefits paid—to anaesthetists particularly—under your schedules, your tables?

Mr Savvides—I think the confusion—it may have been mine—is in the difference between accreditation and registration. I might ask my colleague if she can shed any more light on it.

Ms Bussey—My understanding is that what we were referring to back in June was the difference, as Mr Savvides says, between accreditation, which I understand is a different process from being registered for an MBS number—

CHAIR—So you are saying that the surgeons were accredited as of March but not registered?

Ms Bussey—That is my understanding.

CHAIR—But Mr Savvides was saying that it would be possible to have anaesthetist services to podiatric surgeons in place by the end of the year. Is that still your understanding or is that again dependent on when registration occurs rather than accreditation?

Ms Bussey—My understanding is that at the time of the last estimates we were looking at whether it was possible for Medibank to pay benefits for anaesthetists, so this is under ancillary tables rather than our hospital tables. It was not possible to pay them under the hospital table. My understanding of the current position—that review having taken place—is that we are currently not paying benefits for anaesthetist services under either hospital or ancillary. I am not aware of any current proposal for that position to change.

CHAIR—I have to say that it was quite clearly suggested to us in June that it was only a matter of time before that was going to happen. Again, I would refer you to the *Hansard*. It is quite clear. At that stage, as you might recall, Senator Knowles was pressing the point. Mr Savvides said:

... we have an administrative process under way. I do not think we have a due date, but I would have thought that we are talking about a period within a few months.

This was the process that would enable members of Medibank Private to get access to anaesthetists if they were using a podiatrist to conduct their surgery. Is it still the intention of Medibank Private, once registration occurs, to have anaesthetist services for podiatric surgery covered? Is it still your intention to do that?

Ms Bussey—I will have to take that question on notice so that I can give you a definite answer. I will need to consult my colleagues. I am happy to take the question on notice, and I can give you some more information about the work that has been done to date and also what the position would be if podiatric surgeons were awarded CMBS numbers.

CHAIR—Thank you.

Senator BARNETT—Thank you for being here, Mr Savvides, and congratulations on a very sound turnaround to sustainability in the last few years. I want to go to an issue that was

raised earlier in terms of the capitalisation—the $85 million that was invested by the taxpayers. Is that complete, is it adequate and are you now adequately capitalised?

Mr Savvides—Against the industry average we are still at a lower level of capitalisation, but we are now substantially in line so as to not be concerned that there would be need for more capital. Obviously the fund is performing well. In terms of the capital that we use to get our job done, we are more efficient than many of our competitors who are more highly capitalised.

Senator BARNETT—Let me go to the last few years in terms of profits or surplus. In 2001 it was negative $175 million. In 2002 it was $11 million positive. In 2004 it was $44 million. Then this year, 2005, it was $131 million. Are there any particular reasons for the turnaround?

Mr Savvides—It is all in the second line of our profit-and-loss statement—the benefit outlays that we pay on behalf of our members. If we are able to purchase effectively and competitively, the growth in those outlays will be contained to a level that is competitive to the market, and that is the case in 2005. That then flows directly on to the premium increases that members receive in the following year. All of our surplus gets directed that way. The reason why it has improved as it has is that 90 per cent of our revenue from members is paid out in claims. If we can buy those services for our members at a more efficient and competitive rate, it does not take too many percentage points—one, two or three—to create quite a large surplus. That $131 million, as healthy as it looks, as just 13 days worth of claims from our members. It is not an excessively large number given the size of our outlays, which, I would like to reinforce, are $2.3 billion.

Senator BARNETT—Nevertheless, it is still a good return on your retained earnings or your net assets.

Mr Savvides—Yes. Obviously, our annual results are a return on shareholder funds of in excess of 20 per cent, which is a healthy metric.

Senator BARNETT—Yes, it is. I was making the point that, unlike other government business enterprises and organisations, taxpayers receive not one bean from Medibank Private—not a return at all. As you say, the funds—the surplus—go back into Medibank Private. It only benefits the members of Medibank Private.

Mr Savvides—Not all the 20-odd million Australians get a benefit, but certainly three million Australians get a benefit from it.

Senator BARNETT—In terms of the scoping study that is now under way, you have answered some questions on that. In terms of the reporting date, do you have that to hand, when do you expect that to be finalised and when is a report due to be made?

Mr Savvides—It is not a process that I am in control of, but I know that it is scheduled for the end of the year. I would have thought that there would be a first report or a draft report appearing on the minister's desk sometime in December.

Senator BARNETT—Minister Minchin made that announcement on 16 August this year. In terms of the status report and your involvement, is there anything further you wish to add to the questions you answered earlier regarding the scoping study?

Mr Savvides—No, there is not.

Senator BARNETT—Can I ask you a question in regard to the coverage of prostheses. I know that the cost of prostheses has been increasing significantly, but I am just making you aware of the concern in the diabetes community in regard to insulin pumps. I understand that Medibank Private does cover insulin pumps for those who require them in accordance with their medical advice.

Mr Savvides—Yes, we do.

Senator BARNETT—There are 140,000-odd Australians with type 1, or juvenile, diabetes but in the last nine months MBF has caused considerable disquiet because of its lack of coverage of insulin pumps. What is the policy of Medibank Private on covering insulin pumps?

Mr Savvides—I do know that we have improved our offering in that area in terms of the pumps themselves. That notice went out to the market several months ago. But I will have to take it on notice to be specific about what improvement we actually offered in specific terms. Medibank Private has been actively involved in that particular part of the sector. We are active participants in JDRF, the Juvenile Diabetes Research Foundation. Many of our staff are involved in their walk, which raises many millions of dollars throughout Australia. We build a good rapport and relationship with that part of the therapeutic community; we look on it as an area of responsibility and try to offer competitive solutions for our members in that area. We know that the technology is moving along. Along with others, we hope for a cure in the next five years.

Senator BARNETT—I am certainly aware of your support for the Kids in the House event a couple of years ago, which is very much appreciated, and your support for the Walk for a Cure, but I am aware of the disquiet and upset by the JDRF and Diabetes Australia because of some others in the industry, specifically MBF. I understand that liaison and discussion is taking place with industry operatives at the moment to try to sort that out. I hope that that can be arranged as soon as possible.

Senator FORSHAW—I want to ask about coverage for non-Medicare procedures or items. Senator Barnett has been asking questions about insulin pumps. What about hearing aids? I might be able to frame the question better for you on notice. I am interested in how you set the refunds for people who have the requisite coverage—generally they have to have an extra level of coverage—for medical appliances and a lot of other non-Medicare-related items; for example, in dentistry. That is a broad question, but I hear complaints. I know of a person who purchased two hearing aids which cost $400 or $500 each and they got a very small refund from the fund, probably less than $50 or $60. There did not seem to be any reason as to why the refund was so low on an item that clearly is not cheap. Would you give me some information on notice about how you determine the level of refund? What scale of prices would you have regard to? What is the way in which you would determine the percentage you would pay back? We understand in hospital and medical procedures that you can use a schedule fee.

Mr Savvides—In the acute and hospital environment, outlays on medical devices and prostheses have gone up from $88 million to $213 million in just four years, so there has been

no hold-back there in trying to offer our members all of the latest technology and innovation that improves the quality of life. Then there is a gradient scale in non-hospital devices as well.

Senator FORSHAW—Yes, the extras coverage.

Mr Savvides—The logic around that I am happy to take on notice.

Senator FORSHAW—I would appreciate that. There are people who, in addition to taking out private health coverage for the usual sorts of things that might come along unexpectedly, also understand that they could be up for a lot of expense with children for dental or orthodontic work, or for a hearing problem or eyesight difficulties.

Senator BARNETT—I ought to mention that I wear an insulin pump and as such I receive a lot of correspondence and feedback from people in the community regarding it. That has motivated the questions I have asked. I wanted to put that on record.

CHAIR—Thank you, Senator Barnett. There any no further questions for Medibank Private; thank you very much.

Ms Bussey—We will look into the podiatric surgery situation and report back in more detail.

CHAIR—Please do.

Senator MOORE—Chair, I have a number of questions on private health insurance. Because of time constraints, I will put them on notice.

[5.49 pm]

CHAIR—I want to come to private health insurance as well, but we did say we would go back to outcome 3. I invite representatives of the department dealing with outcome 3, Aged care and population ageing, to again come forward.

Senator McLUCAS—Mr Mersiades, to finish off the fire safety and certification issue, can you provide the committee with a copy of the letter that was sent out to residential aged care providers with the $3,500 per bed?

Mr Mersiades—The one that notified them of the payment and the conditions associated with it et cetera?

Senator McLUCAS—Yes.

Mr Mersiades—Yes, we can do that.

Senator McLUCAS—The certification standards were agreed to in which year, the 2008 standards?

Mr Mersiades—You are taxing my memory. The 1997 instrument would have been before 1997, but that is way beyond my time. I am not sure of the exact year.

Ms Halton—Development work for the 1997 instrument was done in late 1996, probably even in 1997. Those changes were announced in the 1997 budget and we did not get much sleep in that period. All of those things were done in that very short period after the budget announcement.

Senator McLUCAS—The 1997 standards are the ones being improved on for the 2008 certification standards—am I right?

Mr Mersiades—No, there is the 1997 instrument, which is an assessment instrument, and there is also one called the 1999 instrument, which replaced the 1997 one. Again it was through negotiation with the sector which increased the standard incrementally in a couple of areas. It is the 1999 one—we will confirm this—that set in place the 2008 target date.

Senator McLUCAS—I can get that instrument off the web site, I dare say.

Mr Mersiades—I would be surprised if the instruments are not on the web site. I cannot confirm that. We will get you a copy.

Senator McLUCAS—Thank you. On the government response to the Hogan review, you gave us a breakdown of the expenditure of that on notice. We might come back to that and get further breakdown of where that expenditure has been applied up to now. I understand there is going to be a discussion paper. When is that going to be released?

Mr Mersiades—The budget documentation said that the discussion paper would be released in 2005-06, so it is this financial year. The precise release date is a matter for the government.

Senator McLUCAS—Can you tell me whether it has been printed?

Mr Mersiades—No, it has not been printed.

Senator McLUCAS—It definitely has not been printed?

Mr Mersiades—It definitely has not been printed.

Senator McLUCAS—Is the document agreed by the task force? I might not be using the right language there, but there is a group of people who have been a consultant group.

Mr Mersiades—There has been a reference group and a series of meetings involving that group. They have assisted us with the drafting of the document. We have met on numerous occasions over the last few months.

Senator McLUCAS—I know that the discussion paper is not their document, but has that process with the reference group been completed?

Mr Mersiades—The reference group role does not finish with the release of the discussion paper. We would envisage that they will have a role also once we engaged in the consultation process. One of the suggestions is that they will participate in some of the hearings, for want of a better description.

Senator McLUCAS—In terms of that first phase of developing the discussion paper, is the role of the reference group completed?

Mr Mersiades—There is nothing that says there will not be a need to bring the reference group together again to look at a further iteration of the discussion paper, so in that sense it is not complete.

Senator McLUCAS—I think you are saying that, unless the minister comes back and wants a change to the draft discussion paper, there is no need for the reference group to come together again. Is that reasonable?

Mr Mersiades—I am saying that, as a result of further consultations and clearances that we do within governments and with our colleague departments, we may get to a point where it would make sense to consult with the reference group again to get their suggestions. I am not saying that will happen or it will not happen.

Senator McLUCAS—Certainly, the view around the sector is that it was going to be released last month.

Mr Mersiades—We were working to complete the task as soon as possible. It is a separate issue as to when government processes see the appropriate timing for release.

Ms Halton—I have to say that a number of people—members of the sector at various forums I have been at—have told me with categorical certainty that the discussion paper was to be released on a particular date. When I said, 'I am sorry, that wasn't my understanding at all,' they said I was quite wrong. So clearly there has been a level of—

Senator McLUCAS—Do you have any understanding of why this sector thinks that?

Ms Halton—They are anticipating it and want to see something, which is perfectly understandable.

Mr Mersiades—To be honest, we moved quickly to get something done as quickly as possible to give maximum time for the rest of the process rather than leave it—

Senator McLUCAS—You will promise me it will not be 24 December, or in the week after that, won't you?

Ms Halton—We will try for it not to be then.

Mr Mersiades—I can guarantee you it will not be Melbourne Cup day.

Senator McLUCAS—We had another thing to deal with on that day.

Senator FORSHAW—I was about to ask you that. Is that a core promise?

Senator McLUCAS—In relation to the process after that, what do you envisage the consultation process and the time frames associated with that will be?

Mr Mersiades—Again, they are not settled. All I can say is that the government is committed to release a discussion paper and that there will be a process of consultation. Clearly, ideas have been floated but I am really not in a position to announce them.

Senator McLUCAS—But the intention would be to get it somewhat settled in the lead-up to next year's budget, one would imagine.

Mr Mersiades—As I said earlier, the wording in the budget documentation was that there would be a consultation process and a discussion paper conducted in 2005-06.

Senator McLUCAS—All right, we will leave that. I would like to go to competitive tendering in the community care area. I asked in a question on notice on 5 July this year for some information about the previously funded services under the four programs that were tendered earlier this year and the successful programs that started on 1 July this year, recognising that there is a transition period. I have to say that I was fairly astonished at the response because it did not go anywhere near answering the question that I asked, and I think the question I asked was pretty straightforward and fairly plain.

Can the department provide me with a list of all of the programs that were funded under the National Respite for Carers Program, the Commonwealth Carelink Centres program, the Continence Aids Assistance Scheme—and I recognise that is a slightly different funding system—and the Carer Information and Support program? I want a complete list of them. I also want to know what geographical area and what service style they had. Is it possible to provide that?

Mr Mersiades—I think what we can provide you with—and you use the word 'program'—is an auspiced organisation, its address and the types of services, in broad terms, that it provides. I think that probably covers what you are asking for.

Senator McLUCAS—And the geographical area they cover.

Mr Mersiades—And the area, yes.

Senator McLUCAS—Why didn't the answer to that question come back when I asked it on notice on 5 July this year? If it is physically possible to do it, if that information exists in the department, why didn't it get answered when the minister finally answered it on 4 August this year? No, sorry, that is not right: I finally got the answer on 20 September, after a lot of requests for it to be answered.

Mr Mersiades—What I am saying is that we can go through our information base and gather that information for you.

Senator McLUCAS—Why didn't we get that information when I asked the simple, plain question on 5 July this year?

Mr Mersiades—I would prefer not to comment on what the minister may have given you.

Senator McLUCAS—Your section obviously got the request for the information.

Ms Halton—I wonder whether there has been some misunderstanding about what was actually required. I take your point that the question might have been, to your mind, plain. All I can assume is that there has been some mistranslation, and I apologise for that.

Senator McLUCAS—I have made about five speeches in the Senate about this, Mr Mersiades. I am sure that has been brought to your attention.

Mr Mersiades—The issue is that the questions you have put seem simple but there are complexities in there as well.

Senator McLUCAS—You have just said that it is possible to provide it.

Mr Mersiades—Yes, but I redefined the question to you. I said, 'Is this what you meant?'

Ms Halton—It might have been better, I suspect, to have clarified the actual question before the answer came in. I suspect what has happened here is that the question, as originally posed, caused a problem, and people have attempted to be helpful. What might have been more helpful was to actually do that redefinition of the question before the answer came in. If it is all right with you, now that we have a handle on how we could actually answer that in a way that is helpful to you and is possible, we would be delighted to do that.

Senator McLUCAS—It would be terrific if it could happen in a short time frame so that we can start getting some clarity on what programs have been defunded.

Ms Halton—We will prepare it quickly.

Senator McLUCAS—In answer to the second part of the question, which was essentially the reverse of the first one, those programs finished on 30 June and new programs were funded from 1 July, and I asked for a list of those services funded, auspiced or whatever that were funded from 1 July. In answer to that, you sent me to www.health.gov.au, and that is all. After an enormous amount of work, we did find a list of services and centres funded under the National Respite for Carers Program, but there was no reference at all in the answer to what had happened to the Commonwealth Carelink Centres program, the Continence Aids Assistance Scheme or the Carer Information and Support Program. You did not say anything. It is almost as though you dismissed it. You did not even bother answering that part of the question.

Ms McDonald—That same web site where you got the information about the respite services also shows, within each HACC region, what has happened in relation to the carer respite centres and the Commonwealth Carelink Centres. The list goes through HACC region by region and does show that information.

Senator McLUCAS—Am I looking at the right document if it starts by saying, 'Organisations funded through the National Respite for Carers Program funding agreements commencing March 2005, carer respite services'?

Ms McDonald—It is headed 'NRCP carer funded organisations'.

Senator McLUCAS—I am advised that it took a staff member in Minister Bishop's office a lot of time to find this, too.

Ms McDonald—We could give you a hard copy of what is on the web site.

Senator McLUCAS—That is actually what I asked for. That would be helpful. Thank you. So if I could get in hard copy the two groups of organisations and services that were funded prior to 30 June and after 1 July that would be extremely useful—for the four different programs. I do understand the continence aids assistance program is funded in a different way, but if you could give some explanation of how those services are funded that would also be useful. Was consideration given, in the awarding of contracts which happened just after Easter, to the knowledge and expertise that was available to run the programs that were being tendered for, or was it simply an analysis based on cost?

Ms McDonald—There was a set of criteria which was published for providers who were applying. There certainly was a value-for-money criterion included in the list, but there were also criteria around capability in terms of the capacity of the service provider. All those issues were taken into account as part of the assessment process. Another thing that was taken into account in terms of the region-by-region analysis was also getting the best mix of services for carers within the region. Also, where there was some extra money available, there was an assessment of relative need and service provision levels across areas. So it was targeted to those areas that had greater requirements as well.

Senator McLUCAS—How was the assessment of capability, coordination and all those other non-cost attributes undertaken?

Ms McDonald—As part of the process, potential service providers were asked to provide information to the department in their application. They were given the criteria. It was an assessment based on the information that was provided, including the organisation's experience and what they had been delivering to date, which are the sorts of things that service providers with experience in the area did provide.

Senator McLUCAS—Who did the assessment?

Ms McDonald—The assessments were undertaken by panels of departmental staff, including state office staff who know the regions. The panels were assisted by a procurement company that assisted in guiding the technical processes and probity arrangements for the assessment.

Senator McLUCAS—Who was the procurement company?

Ms McDonald—PSI.

Senator McLUCAS—What is their skill in assessing the capacity, collaboration and service styles?

Ms McDonald—PSI did not do the assessment. They provided technical advice around procurement processes. They are an organisation that are on the department's procurement panel and were chosen through a select tender process.

Senator McLUCAS—I have heard of a new agency that was funded, which simply took over an old agency. The organisation that was newly funded simply took over the operations of the de-funded organisation holus-bolus—it just took over the lot. I cannot ascertain how a tender process would deem one operation to be better than the other when it had exactly the same staff, the same premises, the same equipment and the same data. I cannot identify this agency. Why would a decision like that be made?

Ms McDonald—I am not aware of the situation you are talking about, but the assessment process was on the basis of the information provided by the organisations. It was a fairly in-depth assessment that was made, and certainly there were—I am not so sure if this is a service or a centre that you are talking about—also review processes put in place. Once the first assessments were done, there was another layer of review process that was undertaken in relation to each of these to ensure that the decisions were fair in relation to each of those organisations.

Senator McLUCAS—It seems to me that the tenders were awarded on the basis—I think this is what you are saying—of the quality of the application that was provided. It has been put to me by many in this sector that it came down to what money was used to buy consultants to write a good submission compared to organisations that pulled their own together. The ones who spent $5,000 or $10,000 writing a submission were successful; the ones that were volunteer organisations, by and large, were not.

Ms McDonald—Certainly that was not my experience while looking at the applications that I reviewed. I was not involved in the assessment process itself, but certainly I saw no correlation between people who might have used a consultant and people who pulled together the information themselves. It was the content of the information there that was important, not how beautifully it was written up. If it had been a small volunteer organisation that provided

the substance that was needed to enable the application to be assessed, then that was information we took into account.

Senator McLUCAS—Except that the small community organisation may overlook something that they see as part of the business that another organisation would make a lot of—something like collaboration with other organisations. It is something that is just a matter of course for many small organisations; it is what you do. But other, larger, organisations recognise that is a valuable asset, a valuable attribute, and will make much of it. It concerns me that some of those smaller organisations have been defunded in this process, the extent of which I do not know yet, because I do not have the list of who was defunded.

I want to move on to Burrangiri dementia-specific program, the respite for carers program, in Queanbeyan and Canberra. It has been operating for 12 years, providing respite for carers of people with dementia, especially those in the early phases. There are no other programs operating that service, not a dementia-specific service, in this region now at all. Why was the decision taken to defund that, pretty cheap, service? It was a very cost-effective service.

Ms McDonald—The process involved assessing the applications that came in and looking at them against criteria that included what was value for money and meeting the needs of carers within the region, and what was the best mix of services available. In the ACT, there were a number of services that got expanded or there were new services that specifically met the needs of carers of people with dementia. The Baptist Community Services is a new service that received funding in the ACT region, and Carers ACT Home from Home project also received expanded funding to enable them to better meet the needs of carers within the region.

Senator McLUCAS—I understand this agency particularly provided day respite.

Ms McDonald—This is Burrangiri?

Senator McLUCAS—Yes.

Ms McDonald—Burrangiri were funded to provide respite on a Saturday program. It is Saturday only.

Senator McLUCAS—That is right, it is a Saturday program. I understand that none of the other funded organisations will provide a Saturday program?

Ms McDonald—No, that is not correct. Home from Home and the Baptists provide on Saturday.

Senator McLUCAS—What hours are those programs open on a Saturday?

Ms McDonald—I would need to take that on notice.

Senator McLUCAS—I understand that it is 10 till two, but I would like that confirmed.

Ms McDonald—We will take that on notice.

Senator McLUCAS—Are you aware that there has been considerable upheaval for the people who were using that service? Essentially it was a service, as I understand, for men with dementia. It was a great way for those men to come together and they found great solace in it.

Ms McDonald—Sorry, the Burrangiri program was for people with dementia. I do not think it was particularly men. I will just check that. No, it was not.

Senator McLUCAS—I do not think it was in particular, but I think it developed into that.

Ms McDonald—There is certainly one example of a woman who used the service that I am aware of.

Senator McLUCAS—Thank you. There was a program operating from Blue Care in Kingaroy in Queensland, which has been defunded. It was providing weekend respite and holiday programs for parents of children with disabilities—providing respite for their parents. That was defunded. Can you explain why?

Ms McDonald—Can I just check something? I am sorry, the previous funding arrangements for that organisation only involved holiday programs. The department was not funding any weekend respite through that program. It was just holiday programs.

Senator McLUCAS—Maybe they were finding a bit of money from somewhere else, because they certainly were doing weekend programs as well.

Ms McDonald—Certainly the main funders of a lot of programs for carers of younger people with disabilities, especially children, tends to be state governments through programs such as the CSTDA. It could be that the additional money was coming out of that.

Senator McLUCAS—Anyway the National Respite for Carers Program was funding the holiday care and that was defunded. On what basis was that decision made?

Ms McDonald—An assessment was made about the services across the region and how to best, with the respite program, provide respite for carers in that region. The program in question was not competitive compared to other options within the region. The program that we are talking about is a government respite program. Respite is provided to give people a break and generally should be available across the year, whereas a holiday program is a very specific activity and more appropriately funded through other sources. For carers of younger children with disabilities in this area, there is funding available for respite and that is across whether it be school holidays or other times during the year as well.

Senator McLUCAS—In Kingaroy is that available for children with disabilities?

Ms McDonald—There is some funding available for purchase of those services through the carer respite centre—there is some brokerage funding that they have.

Senator McLUCAS—From Maryborough?

Ms McDonald—We might have to get the specific details as to what is available within the region, but certainly to the carers of those children that previously received services, the arrangement has been that we would continue to provide some respite for those carers, and there is some funding within the region to do that.

Senator McLUCAS—If the funding is the money that has been given to Maryborough, that is 200 kilometres away. I do not know what the trip is going to be like with two children with autism and one with ADHD, but I am glad I am not driving the car.

Ms McDonald—Our understanding—and I will check this for you—is that the local respite centre will broker in the local area and that people were not being asked to travel 200 kilometres away.

Senator McLUCAS—I look forward to receiving that specific information and the number of places that it is going to deliver. That is harder to describe when you are talking about holiday care, but I am looking for how much money it is and how much respite can be purchased with that money.

I turn to Unicare Red Hill in Queensland. It has been providing respite and community activities for unpaid carers for 30 years. It has lost its national respite for carers funding. The services were being provided for children with disabilities and their carers. In its place, from what I can ascertain about what has happened, the department has funded two aged care services. They seem to have received that funding. How do we expect that the aged care providers will be able to provide appropriate respite for parents of children with disabilities?

Ms McDonald—In relation to that one, I will need to get some more information about what mix of services is available in that area. It is not one that I am that familiar with.

Senator McLUCAS—I am also very interested in some information that would explain the loss of funding for the Central Sydney Area Health Service's Inner West Commonwealth Carer Respite Centre.

Ms McDonald—Can I just clarify something. In relation to a lot of the specific examples, we have confidentiality arrangements around information around what applicants actually applied to. These comments do not relate to any particular example, but, because someone was providing a service previously, it was up to them what they put in an application for, what price they were willing to charge and so on. In doing this, we need to be mindful that there are confidentiality arrangements around that—whether the organisation actually did put in an application and what the application was for. From our perspective, we certainly made sure that we had a fair process and that we had probity arrangements in place. We certainly had the assessments and so on reviewed by an independent legal firm—that we had a fair process around selecting the successful organisations. There are limits to what we will be able to give you because of the confidentiality requirements around what organisations actually put in through this process and what we can reveal about that.

Senator McLUCAS—I am not asking for the list of tenderers. All I want is the list of previous providers and successful tenderers. I have to work on the basis that these services did re-tender, because they have told me that. I am not asking you to tell me who tendered and who was unsuccessful. People who have been unsuccessful have been coming to me in droves. That is why I asked the question on 5 July—so that I could provide some clarity for those people.

Mr Mersiades—It is not so much the reason why people were unsuccessful; your greater interest is the range of services involved.

Senator McLUCAS—Yes, the type of service.

Mr Mersiades—That is fine.

Ms McDonald—That is fine. I think that is clear now.

Senator McLUCAS—I turn to the Commonwealth Carelink Program. It operates fairly differently in each of the states. Have you done any analysis—any evaluation—of the success of those programs to this point?

Ms McDonald—That is a national program. We are not aware of the source of the comments you are talking about around them operating differently in different states and territories. We have national program guidelines and arrangements.

Senator McLUCAS—In Queensland, for example, up until 30 June, the contract was let to one entity—BlueCare. In Victoria, it is let to a range of organisations. I recognise that it is the national program, but has there been any evaluation nationally of the success of the Commonwealth Carelink Program?

Ms McDonald—I am not aware of any particular evaluation, but the department does get data to monitor what is happening in each area. We get information, for example, around the number of calls made and routine data around the operation of each of those areas.

Senator McLUCAS—Is that published?

Ms McDonald—No.

Senator McLUCAS—Is it available to this committee—the data you are receiving, the number of contacts, that sort of information?

Ms McDonald—I can go back and have a look to see whether we have it as tables we could provide to the committee. I am not aware of the form it is in.

Senator McLUCAS—I am trying to get an indication of the levels of usage. If there is any sort of evaluative tool, that would be helpful.

Mr Mersiades—I think we can get information on the number of calls that have been received under the program. I recall seeing figures on how they have increased over the years as it has become more widely known.

Senator McLUCAS—It has been going three years now?

Mr Mersiades—Maybe a bit longer.

Senator McLUCAS—Could you give me something that compares the years in terms of number of calls?

Mr Mersiades—We will see what the database is. We will look to see how the level of business has grown as the centres have become better known and information bases have improved.

Senator McLUCAS—I think it was in estimates in February of this year that officers—I cannot recall who it was—suggested that we had to go down the competitive tendering route because of our compliance with the US free trade agreement. Coming back to that issue again, is there any way other than compulsive competitive tendering to comply with the US free trade agreement in terms of the contractual relationship between the department and service providers in community care?

Ms McDonald—Can I first of all clarify that the free trade agreement arrangements only applied to one of the processes—the Continence Aids Assistance Scheme, which was a tender.

There is no relationship with the US free trade agreement in the other processes that were undertaken. They are grant processes and run through a different arrangement.

Senator McLUCAS—So you call the competitive tendering process—the process that was adopted; we are playing around with words through our questions on notice as well—a grant process?

Ms McDonald—It is a grant process. Most of the processes were applications for grants, whereas the administrative management of the Continence Aids Assistance Scheme was a tender for services. Therefore, we needed to have particular formats around a lot of our material. It had to be advertised, including internationally, so that people were able to compete.

Senator McLUCAS—That leads us to the last part of the answer to my question on notice, where you say:

There were no organisations with funding agreements that commenced on 1 July for the Continence Aids Assistance Scheme.

What has happened to that program?

Ms McDonald—It has remained with the existing provider. The previous provider was successful, but the old contract finished on 30 September. The June/July date was not relevant in that case.

Senator McLUCAS—Is it one organisation that provides that service?

Ms McDonald—That is correct.

Senator McLUCAS—Can you tell me the name of that organisation?

Mr Mersiades—It is a Brisbane company.

Senator McLUCAS—This is simply the delivery of continence aids, isn't it? Isn't that what the service funds?

Ms McDonald—It is a ParaQuad organisation, but they have another name.

Senator McLUCAS—The Spinal Injuries Association of Queensland?

Ms McDonald—In Touch is the name of the organisation. They are a division of the ParaQuad lifestyles organisation in Queensland. The contract is for the provision of continence aids to people eligible under the scheme.

Senator McLUCAS—Thanks for that. If there is any lack of clarity in what I am looking for, please do not hesitate to call so that I get it right. I have one quick set of questions. Bed readiness is an issue when bed licences are allocated. In the 2004 approval round, 101 beds were allocated to a company called Kiwi Dale Pty Ltd. How could that decision have been made to allocate those beds, given that Kiwi Dale did not have any land?

Mr Dellar—I will answer that in general terms. Bed readiness is certainly one of the criteria we look at in terms of competitiveness of an application. It is, however, one of only 10 criteria that we look at. In awarding provisional approvals, or beds, we look at a lot of other issues as well: the record of the provider and the fit of the proposal compared with the priorities we have advertised in the aged care approval round. It is not unusual for us to

allocate places to a provider that does not have a block of land, does not have a building or does not have development or planning approval. However, all things being equal, if there were two providers with similar proposals who were judged similarly on other criteria, the bed readiness would be a distinct advantage.

Senator McLUCAS—You cannot tell me the name of other companies that tendered for those beds, can you?

Mr Dellar—That is correct; I cannot give you that information.

Senator McLUCAS—Are you aware, Mr Dellar, that Glen Eira City Council is very keen to attract residential aged care into their local government area.

Mr Dellar—I am aware of that. Glen Eira council made some contact with me in the few days before they auctioned that block of land.

Senator McLUCAS—Is there any way, in the approvals round process, that the department could have recognised that? Given, obviously, that the decision was made to give those beds to that site, could there have been a way to facilitate the beds going to the successful purchaser of the land?

Mr Dellar—I will start by saying that we do not allocate beds to a site; we allocate beds to a provider. In getting those beds, a provider will have put a proposal to us about how they expect to bring those beds online. It is very likely that the provider has said, 'I've found this site and this is the site I would like to use in order to deliver these services.' I will come to the second part of the question in a moment. If, subsequent to the allocation of places, a provider comes back to us and says, 'I couldn't get that block of land but I found this other one,' they can apply to us for a variation, which is basically an alteration of the conditions under which those beds were issued. Provided the department is persuaded that that variation will still deliver the kind of service to the kinds of people originally envisaged, the department would approve that variation.

Senator McLUCAS—And has Kiwi Dale applied for a variation?

Mr Dellar—I do not believe I can give you that information. I think that would be protected information under the act.

I want to go back to your original question, which was: if Glen Eira council had come to us, could we have talked to them? We certainly would have talked to them. Could we have issued beds attached to that block of land? We tried that once; we tried that in the 2004 round in relation to a site in the ACT. That seems to have worked, and the company that was successful in obtaining those beds and that block of land is busily constructing an aged care service there. That is the only time we have done that, so I could not say yes, it would be automatic or no, it would not or that it would be simple, but it would certainly be a discussion we would be prepared to have with someone like the Glen Eira council or some other, similar council.

Senator McLUCAS—In the ACT example, who did you allocate the beds to?

Mr Dellar—It is the Illawarra Retirement Trust.

Senator McLUCAS—In the ACT case, wasn't it an issue of land that the ACT had identified as being appropriate?

Mr Dellar—Would you like me to explain how we did that?

Senator McLUCAS—Yes, please.

Mr Dellar—The first point to make is that the department made its own, and continues to make its own, independent judgment of the merits of an applicant. People who were interested in obtaining those beds, which were advertised in the 2004 round, submitted an application and we assessed them. At the same time those same people—I assume it was the same people—also applied to the ACT government for the right to purchase the block of land. It was not given away. The ACT government did its own process. We did not share views about providers or the merits of particular applicants. However, what we did do was leave the final decision for the department until after the land had been allocated to the successful company, which in this case was Illawarra Retirement Trust.

Senator McLUCAS—Essentially you held back with those beds?

Mr Dellar—We did not need to hold them back, because the normal timing of the round allowed for this to occur. Thus, after the Illawarra Retirement Trust had been given the right to purchase the land, we looked at the applicants. In terms of bed readiness, that gave them a distinct advantage compared to other applicants and therefore they were awarded the beds.

Senator McLUCAS—That is good.

Mr Dellar—It worked, but I would not regard that as a simple process.

Senator McLUCAS—When another level of government is involved it makes it a lot easier, because you have got another level of probity over the land issue. You have got your probity issues over the allocation of beds; it just separates that.

Mr Dellar—And the important point to make is that there can be different objectives. We were not selling a block of land, we were not interested in the price of that block of land and we did not really have a strong view about the development of that land. It is for aged care, but as it is a very large block of land it has got retirement units and independent living units and a number of other things on it as well. There were a lot of issues in relation to the land which were irrelevant to us, so we certainly did not get involved in that and we would not choose to.

Senator McLUCAS—Coming back to the Victorian issue, the Glen Eira council one, the company that has been successful in getting the beds was not successful in purchasing the land. Are you aware that a gentleman by the name of Councillor Peter Goudge was both a councillor on Glen Eira council and a consultant to Kiwi Dale? Did he make representations to the department on behalf of Kiwi Dale?

Mr Dellar—I do not believe I have heard the name Peter Goudge before today.

Senator McLUCAS—Have you heard the name Hurtle Lupton?

Mr Dellar—It is not familiar to me.

Senator McLUCAS—Councillor Goudge is a former councillor of Glen Eira and Mr Lupton is a former member of the Victorian parliament. They both worked as consultants to

Kiwi Dale, which was the successful company in getting the beds allocated. Have you then heard that, once those beds were allocated, Councillor Goudge made strong representations to his own council to gift the land to Kiwi Dale and therefore avoid that second level of scrutiny?

Mr Dellar—I have had no dealings with the selection of the purchaser of the block of land. It was not part of anything that this department has any involvement with. What I can say, however, is that Kiwi Dale are the owners of the provisionally approved bed licences. That time frame is now running, because they were issued early this year—I think it was towards the end of February. They have until two years from then, to 2007, to bring those beds on line.

Senator McLUCAS—Is there anything to stop them selling those bed licences?

Mr Dellar—Yes. Provisionally approved beds cannot be sold or transferred. The only thing they can do, which is something I mentioned earlier, is apply to us to vary. So they could say to us: 'We thought we were going to put them here but we want to put them there. Is that okay?' The other thing they could do is apply for an extension to the two years. We would consider at the time the merits or otherwise of an extension. What helps determine that is what has happened between the time the beds were issued and the time the extension is requested.

Senator McLUCAS—I recognise that they cannot be sold. I did not realise they could not be transferred.

Mr Dellar—Provisionally approved beds cannot be transferred. 'Sold' and 'transferred' are used interchangeably. What a provider does with a bed is sell it. What we do is approve a transfer. But in the case of a provisionally approved bed that cannot be done.

Senator McLUCAS—But it is true to say that just the simple fact of allocating a bed creates that as an asset, doesn't it? It is an asset in a business. It can be used for financial gain.

Mr Dellar—I do not know if I would use the word 'asset', but certainly if you went to a lender and said, 'I have provisionally approved beds. Can I borrow some money?' that would probably enhance your opportunity of getting funds. Is that the nature of the question?

Senator McLUCAS—Yes. This is speculative now.

Mr Dellar—Jane Halton is pointing out to me—and it is quite true to say—that a provisionally approved bed is not a tradable item. You cannot sell it.

Senator McLUCAS—What is to stop, then, an entity who has been given beds but does not have land, especially in inner urban areas where land is the premium, saying to a landholder, 'Let's go into partnership. I'll bring my beds and you bring your land and we'll build something'?

Mr Dellar—I do not believe there is anything to prevent that.

Senator McLUCAS—But then it is an asset, isn't it? It is a very valuable asset in that arrangement if the partnership is based on 101 licences from the Commonwealth government that essentially did not cost much—just the ability to put the application in.

Ms Halton—The key issue is that the beds actually have to be translated to being on the ground. Whilst they have got a provisional application, until they have actually got a facility,

until they have got something—dare I say—concrete, in a sense we do not mind if they develop a partnership with a landholder.

Senator McLUCAS—That is not the issue I am getting to. It is the issue of developing an asset that can be traded. It cannot be sold or transferred, but you can use it to lever a business arrangement.

Mr Mersiades—You can, but the important thing is that in being awarded those places in the first place one of the criteria is to look at the financial viability of the whole proposal. So there would have been an assessment made that that organisation had the resources itself to proceed with that development.

Senator McLUCAS—It is not a question.

Mr Mersiades—If they chose to fund the exercise in a different way, I am not sure that is a significant issue for us.

Ms Halton—It has always been the case that a bed which eventually turns into something on the ground does become a valuable asset. There is no contest about that. That has been the case ever since we have been approving beds. The thing that has changed now is making sure that those beds cannot, in a sense, be guarded speculatively, that there is greater scrutiny over their financial capacity to deliver the service. As Mr Mersiades has been pointing out, this notion of 'bed ready' and being able to deliver on the ground in time is a crucial component of the assessment process. Mr Dellar has explained what happened in the ACT issue, which was fortuitous. That has now translated into a service on the ground. But these have always been invaluable assets.

Senator McLUCAS—I understand that. I expressed some concern about the number of beds that are being bought and sold that are constructed beds in the whole consolidation of the sector. They are a tradable commodity now, and it is just—

Ms Halton—But they have been for many, many years. The reality is that there has been a trade—

Senator McLUCAS—The price is going up.

Ms Murnane—I think I became division head at the beginning of 1990. It was well established then.

Ms Halton—Absolutely.

Ms Murnane—I think it was more than a decade old at that point.

Ms Halton—I would have said it is a minimum of 20 years that this has been happening.

Senator McLUCAS—Does the department track people? It is not your core business, but it affects your operations. You have heard some of the figures about what people are trading beds for.

Ms Halton—Yes, we do.

Ms Murnane—Yes, we do.

Mr Dellar—We hear figures, but we do not track it in the sense that there is a database that we could refer to.

Senator McLUCAS—I understand that.

Mr Dellar—We actually very carefully avoid telling anybody what we think a bed is worth and what it should be bought or sold for.

Ms Halton—But people tell us things informally, yes.

Senator McLUCAS—I could talk for another hour but we are a quarter of an hour into dinner. Thank you. That is all I need to ask questions about on outcome 3.

Ms Halton—Are we done with outcome 3?

CHAIR—Yes, we are done with outcome 3. After dinner, we will commence on outcome 8, Private health.

Proceedings suspended from 6.46 pm to 7.53 p.m.

CHAIR—I call to order the community affairs committee hearing into additional estimates. Before dinner we had just finished outcome 3 and we are now moving the Acute Care Division and will deal with outcome 8—Private health. I invite members to ask questions of the department on outcome 8.

Senator McLUCAS—I have private health insurance questions. They are mainly on notice and about portability.

CHAIR—All right.

Senator McLUCAS—You said you had some questions.

CHAIR—Yes. I did have just a couple of the Private Health Insurance Ombudsman. He is not here, so I am not going to have a chance to ask him any questions. I will put my questions to him on notice as well. That leaves no questions to be asked live on private health.

Senator McLUCAS—Apologies to the officers who thought that was going ahead.

CHAIR—I am sure nobody ever complained about not being asked questions in estimates committees. Outcome 1, Population health.

Senator FORSHAW—I would propose, obviously subject to agreement, that we start off with ARPANSA. Then I have a question or two for FSANZ, but very short. Then we have some matters for the TGA.

CHAIR—Unless anyone has any violent objection, we will proceed in that order. We will deal with ARPANSA, FSANZ and TGA.

Senator FORSHAW—I am sorry, Chair. I had forgotten that my colleague here also has some questions on avian bird flu, which you may want to start off with.

Senator McLUCAS—I could knock those over quickly.

CHAIR—Is avian bird flu under one of these three agencies?

Senator McLUCAS—No. It is more general.

CHAIR—All right. Unless we have any objection, we will deal generally with population health. Then we will proceed to those three agencies as just listed by Senator Forshaw.

Senator McLUCAS—Just before we move on to bird flu, there is the question of capital funding in state hospitals and the issue I raised with you about Weipa Hospital.

Ms Halton—We have so far not been able to find the individual who might be able to answer the question, so I am going to have to take it on notice. We did endeavour to find out who has a bit of an understanding of this. So far we have failed, I am sorry.

Senator McLUCAS—Does that mean that the department doesn't have a unit that looks after capital funding in state hospitals?

Ms Halton—You would be aware, Senator, that from time to time there are commitments and otherwise given in respect of some of these matters, particularly where GP practices can be involved and all the rest of it. We are aware of this particular issue but, in terms of the particular person who has the most information about it, we have not been able to locate them. I am happy to take it on notice.

Senator McLUCAS—All right. Moving to bird flu, Dr McEwen, you might get a role here. Has the decision been made for what strains of hemagglutinin and neuraminidase will be in the 2006 flu vaccine?

Ms Murnane—We are waiting for Dr Moira McKinnon to come in but I can answer that and say no, a final decision has not been made.

Senator McLUCAS—But you are contemplating—

Ms Murnane—A group of experts does consider the composition of the seasonal vaccine.

Dr McEwen—It is my belief that they met and made a recommendation. I think it was on 6 or 7 October. I do not have that here but there might be someone from the TGA who would know, or we certainly could get it for you.

Ms Halton—Senator, you would probably be aware of the process wherein the experts come together and they consider all of the available evidence. Then they make a recommendation. We know that is the process and we know that once the process has been completed that is the basis on which it is compiled. The person who can tell us whether the meeting has occurred or is about to occur—

Dr McEwen—We will find the answer. There are usually two type A and one type B strain. I am just not sure of the changes. They would be on the TGA web site.

Senator McLUCAS—So they have been decided?

Dr McEwen—They have been decided. I will undertake that we get them and provide them to you very promptly.

Senator McLUCAS—You said A and B. I am actually very new to this area and I will be very frank: what does that mean?

Dr McEwen—One subdivides influenza viruses into three main types of type A, type B and type C. The type A then have a whole series of further subdivisions that you would be aware of because they are described by the hemagglutinin and the neuraminidase, so they have HN numbers. In terms of the circulating seasonal influenzas that are of concern and are in the vaccine each year, we are usually concerned about two different type A strains and one type B strain. Type C is unimportant in human health. The vaccines over the last number of

years have had two type A and one type B. Sometimes the same one is used in the following year because there has been very little evidence of change. I just do not have the changes with me but I can get them for you.

Senator McLUCAS—Thank you. As part of that decision-making process was there consideration given to using H5 or N1 in the vaccine to provide some sort of potential—

Dr McEwen—There would not have been consideration of that. What one is concerned about in the seasonal flu is the strains that one can reasonably predict would be circulating. There is a separate process in train at the moment to develop effective H5N1 vaccines. The process that is being done is that manufacturers around the world have been given a strain derived from H5N1 which has been from an earlier attack, I think in Vietnam several years ago, and which has been modified to make it a suitable vaccine strain. Most of that modification involves being sure that it can grow in eggs because that is how many manufacturers make it.

Around the world manufacturers are making that vaccine in trial lots and are putting that into trials in humans to assess whether the same amount of the killed virus will produce what is likely to be a protective immune response. That is all in preparation for when and if an H5N1 strain becomes involved in human to human transition. The hope is that that strain will then be modified quite quickly to make it suitable for vaccine production. It will be put into the process in place of the H5N1 that is being used as the dummy one to make vaccines at the moment.

Senator McLUCAS—But there is no efficacy in using H5N1 in the standard preventative flu vaccine?

Dr McEwen—I believe there is very little evidence of cross-protection at all. There is some benefit in maintaining the seasonal immunisations, quite apart from stopping people getting the seasonal influenza. There is the hope that one will reduce the chance that someone will be co-infected with H5N1 and with the seasonal virus, because that might increase the chance that they will change into a strain that can be transmissible and pathogenic in humans.

Senator McLUCAS—Thank you. In relation to the preparations for the 2006 winter flu season, how many doses of vaccine—the regular preventative winter flu vaccine—have we ordered, or will we order?

Mr Stuart—That goes to our normal management of the vaccination program. In particular, I think you would be asking about the vaccination program for older Australians, and Carolyn Smith, the head of the branch that manages immunisations, is just seeing if she can find those numbers. We might see if we can find those and come back to you a little bit later in the outcome 1 hearing.

Senator McLUCAS—Certainly. In terms of the question of the confidence in our delivery, I understand that there is difficulty in the United States for US suppliers to meet US needs. Is that an issue that you are aware of and could it impact on the timely delivery of our needs for the 2006 winter season?

Ms Smith—At the end of 2004, the Commonwealth entered into contracts with two flu vaccine manufacturers, CSL and Sanofi Pasteur, so we have a guaranteed supply for the Australian programs. Those programs are for older Australians and Indigenous Australians.

Senator McLUCAS—You feel quite confident that they will stand up against American needs?

Mr Stuart—We have those contracts for domestic Australian supply. You might recall that we previously had a discussion here about a shortage that arose in Australia because one of the manufacturers had a lot that did not pass muster with the TGA. We were able to then turn to the other manufacturer, CSL, and have that amount made up, so I think that demonstrates the robustness of the strategy that we have.

Senator McLUCAS—Confidence building! Moving now to vaccine production for a potential flu pandemic, how is the efficacy of the vaccine currently under investigation being tested?

Ms Murnane—There are human trials proceeding at the moment.

Senator McLUCAS—How is the question of safety being assessed?

Dr McEwen—Both those aspects are being looked at, with what I described before as the precursor or a dummy vaccine, because we cannot plug the needed strain in until we know what it is and it has been made into a suitable strain for vaccine production. There are very standard protocols for the testing of the immunogenicity of influenza vaccines in Australia, which follow a European guideline. In this initial phase, relatively small numbers—I think it is of the order of 200 subjects, because that has been discussed publicly—are being given the vaccine, and they are all basically healthy young adult volunteers.

That will give quite good data on the immune response. It does not give evidence on efficacy, because we do not have the challenge, but it gives the standard evidence on the immune response to the vaccine and it also gives the initial insight into the safety of the vaccine. If the vaccine is causing a very rare unwanted event, you will only pick that up when large numbers have been immunised. It is a sequential thing. You get the confidence about basic safety from those, say, 200 or so and then observe larger numbers.

Senator McLUCAS—If the vaccine requires two doses for full effect, how far apart would those doses have to be?

Dr McKinnon—Usually about two weeks.

Senator McLUCAS—If we are going to vaccinate the whole population, as has been mooted, how will we manage to simultaneously vaccinate once and then make sure they all get it two weeks later? That two-week window is fairly important, isn't it?

Ms Murnane—That would have to be phased. Decisions would have to be taken about the phasing of that. We have two suppliers of the vaccine, one in Australia and one overseas. There will be a limitation on how much they can produce per week and per month, and we can start vaccinating as the batches come.

Ms Halton—The reality is that a decision taken to vaccinate an entire population is clearly a very serious one.

Senator McLUCAS—It has been mooted, though.

Ms Halton—Yes, because ultimately that could be one of the possible decisions that could be taken in the event of a pandemic. If you are taking that kind of decision, clearly it is because there is a significant and imminent risk to the entire population. That probably means, because we have not been there yet, that you are going to be managing your response to such an event in ways which are not like the way we would currently manage the role of an immunisation program. We will be in a different state in terms of readiness and alertness and all the rest of it. We would not underestimate the complexity of ensuring that happens effectively, but clearly you would be in some more heightened state of alert than you would be, for example, with respect to the annual flu shots that people get.

Senator McLUCAS—Who is bearing the indemnity costs for the vaccine?

Ms Halton—Do you mean the trial?

Senator McLUCAS—Yes.

Ms Murnane—The contract with the vaccine producer has a clause dealing with indemnity provisions.

Senator McLUCAS—Who carries it? The producer or the purchaser?

Ms Murnane—That depends. If it is a product that is registered in Australia, under normal circumstances we would not think there is a need for an indemnity. If it is a product that is not yet registered in Australia but because of the sorts of circumstances—the unusual, exceptional circumstances—that the secretary alluded to, and the manufacturer required indemnity, with some other products that we have purchased the Commonwealth has provided indemnity. That indemnity has been circumscribed in a variety of ways that are contractual with the supplier.

Senator McLUCAS—In relation to the availability of Tamiflu and Relenza for the 2006 winter season, why do we use those products in that situation?

Ms Murnane—In Australia the influenza antivirals have not been used to any great extent.

Senator McLUCAS—That is what I thought.

Ms Murnane—In some countries—Japan, for example—they have. Dr McKinnon might be able to say more about that.

Dr McKinnon—Australia uses about 10,000 to 20,000 courses of Tamiflu a year for seasonal influenza. The manufacturing companies have two streams of production, one for seasonal influenza and one for pandemic influenza. They are maintaining that supply for seasonal influenza for our winter.

Senator McLUCAS—We have talked before about the stockpile; where it is and whatever. Do we currently have four million doses of antivirals here in Australia?

Ms Murnane—We have more than four million in total because we have 3.95 million doses of Tamiflu.

Senator McLUCAS—How much, Ms Murnane?

Dr McKinnon—3.87 million of Tamiflu and an additional 25,000 courses of Relenza.

Ms Murnane—And some Amantadine. That is another antiviral but it has been found not to be effective in relation to H5N1.

Senator McLUCAS—The government said that they are looking at more Relenza. Is that the case?

Ms Murnane—Yes, it is the case.

Senator McLUCAS—How is that progressing?

Ms Murnane—We are having discussions with the manufacturer at the moment about that.

Senator McLUCAS—It is very hard to predict when you might need it, and hopefully we do not want to.

Ms Murnane—We are of the view that we will reach an agreement for a further supply.

Senator McLUCAS—It has been put to me that a model of purchasing is to use an option price, where you share the cost and the risk of needing the vaccine between the government and the company that produces it. Is that the model that we are using?

Mr Stuart—Are we talking about antivirals or vaccine?

Senator McLUCAS—Antivirals.

Mr Stuart—We are talking about the antivirals. No, the Australian government has purchased the antivirals that it has in order to have the stock delivered and on shore, ready and available for use, rather than having some kind of option which would mean that you would be waiting for it to be produced when you need it.

Senator McLUCAS—That is the risk if you go into that sort of contract which would, I dare say, be cheaper, but you then cannot require that it be produced as you want it.

Ms Halton—Senator, it would not necessarily be. Remember that we actually purchased before there was anybody in the queue. We were first. In terms of a purchase arrangement, I think it is an arguable proposition that at the moment when there is a huge amount of demand, if we had some sort of option which we were trying to negotiate now, I do not think you could reliably say that we would have got it cheaper; in fact, I think the contrary. No-one else was purchasing when we purchased. We were there first.

Senator McLUCAS—What is the expiry time on the stock that we have now?

Mr Stuart—It is five years on the packet. When we get close to that date, we will be seeking to have discussions about the condition it is in and whether its life can be further extended.

Senator McLUCAS—That is sometimes possible?

Mr Stuart—Yes, it is sometimes possible and we are making sure that it is stored very effectively and that the cold chain processes are being observed so that that might be possible.

Senator McLUCAS—That is all I need, thank you.

CHAIR—Any other general questions about population health?

Senator ADAMS—My question relates to the current breast screening target group. The current target group for breast cancer screening is 50 to 69. Is there any evidence available

that shows that the target age could be lowered to 45 and extended to 75? The reason I ask this is that the general public are really pushing very hard for this. I am involved with several of the breast cancer consumer groups. Could someone answer that for me?

Ms Smith—The program actively targets recruitment of women who are aged 50 to 69 as that is where the evidence shows that breast cancer screening is most effective. Women aged 70 years and over are advised to discuss the requirement for ongoing screening with their general practitioner. The evidence for screening younger women is that it is not strong enough to encourage all women in that age group. There is an issue around the capacity of a mammogram to detect breast cancer in younger women whose breasts are more dense. You often get false negatives.

Senator ADAMS—I am fully aware of that but I do know of evidence from 45 on, that is the thing; also with the menopause setting in earlier, which thins the breast out, and with women living a lot longer. These targets have been set for quite some time and there are lots of 70 years and over women now being diagnosed. I suppose it is because our technology has improved. They are all very aware of having to go and have a mammogram. Also, they are not happy about not being invited. There is quite a backlash in Western Australia about this.

Mr Stuart—The balance of evidence from our knowledge still supports the current policy but the government, in conjunction with the states and territories, is preparing to have another look at several aspects of the policy around the BreastScreen program and recently decided to jointly sponsor an evaluation of the program. I guess we will be able to talk with you a little bit more about that over the next year or so.

Senator ADAMS—That would be good. I note in the annual report that 2001-02 there was a participation rate of 57.1 per cent. Has this participation rate improved since these figures were released? Have you any other later figures than 2001?

Ms Smith—They are the latest official figures. We are still working with the states and territories to clean up the data for the later years. The raw results I think indicate there has been a slight improvement since 2001, but I could not give you a formal figure at this point.

Senator ADAMS—I would be very happy to have any further evidence that you could forward if something comes up. The other thing is, what participation rate are we looking at as far as an ultimate goal?

Ms Smith—We are aiming to move towards 70 per cent.

Senator ADAMS—We are down at 57.1. Hopefully, with the Kylie factor—I know in WA we have been inundated with people coming in for mammograms in the target age group, which has been good.

Ms Smith—I think that has been a factor across the country.

Senator ADAMS—That is all, thank you.

CHAIR—We are asking general questions on population health at the moment.

Senator NETTLE—I want to ask about pregnancy counselling services. I have just been looking through the answers to questions on notice recently. There was one to Senator

Boswell which said that the Australian government does not fund abortion advocacy services. I wonder could I get a definition of what you mean by abortion advocacy services.

Mr Stuart—The Australian government policy is that we fund services which provide non-directive counselling which I think is quite a distinct concept from the idea of an abortion advocacy service.

Senator NETTLE—I accept that and I notice that in your answers where you talk about non-directive independent counselling. Just because you specifically use this terminology here, I thought it was worth finding out how you define that bit of terminology.

Mr Stuart—The non-directive counselling is about discussing with—

Senator NETTLE—It is not the non-directive that I want you to define.

Mr Stuart—I am getting there. You need to see those two concepts as related to each other. We support non-directive counselling. We do not support organisations that move away from non-directive counselling towards urging women to have abortions.

Ms Halton—Can I provide a little context? It is alleged—and I think everyone would be aware—by people from various sides of the debate that services that are funded come from a particular perspective. I think the context of that particular answer is to say, 'No, on the contrary, the approach that has been taken in relation to funding, and it is consistent with policy, is that the services that are funded sit in the middle,' which are non-directive.

Senator NETTLE—How do you assess whether or not they are non-directive?

Ms Smith—The services that we fund have to meet a quality framework around the sort of counselling that they provide. They must have counsellors who are trained and who have qualifications that are accredited. It is that sort of quality framework which underpins their counselling.

Senator NETTLE—Can you give us more details about that quality framework—for example, what is the level of accreditation in training of counsellors? What do you require under the framework?

Ms Smith—The main organisation that we fund directly is the Australian Federation of Pregnancy Support Services. All pregnancy counsellors with that organisation and any of their affiliated agencies are required to receive accreditation. They complete a counselling skills development course for pregnancy workers. That is recognised as a professional development short course by the Australian Counselling Association and can be credited towards ongoing professional development requirements for counsellors.

Senator NETTLE—This course is the only requirement in terms of checking that their training and accreditation is up to scratch?

Ms Smith—That is a basic requirement, I suppose, to be a volunteer counsellor with this body. They are then supervised by more senior counsellors.

Senator NETTLE—How do you check whether or not they are supervised by more senior counsellors?

Ms Smith—We are not able to physically go out and check that ourselves. We are relying on the quality framework. They have a process of reporting back to us on the number of

trained counsellors they have, the sort of training that they are undergoing and the courses that they are running.

Senator NETTLE—We are talking at the moment about the Australian Federation of Pregnancy Support Services.

Ms Smith—Yes.

Senator NETTLE—Are you aware of whether any of the services that you fund through them have their telephone counselling phone numbers operate such that they are diverted to a home phone number? I am asking you that on the basis that you said that they are supervised by more senior counsellors.

Ms Smith—I am not aware of that.

Senator NETTLE—If you have a phone number that diverts to a home phone, then it is difficult for you to be supervised by a more senior counsellor at your home unless there is one that lives at your home.

Ms Smith—I think there is a distinction here between actually having someone physically present while they are undergoing the counselling and the notion of professional supervision.

Senator NETTLE—Do you mean that their training is supervised but not their calls?

Ms Smith—There is not someone listening in on every call.

Senator NETTLE—I am going through your quality frameworks, and one that you mentioned was that they are supervised by more senior staff. Am I right?

Ms Smith—Yes. It is a professional oversight, rather than being a physical presence.

Senator NETTLE—I understand the distinction that you are trying to make. You are saying that the professional oversight may include a certain period of time: while they are training, they have someone there, and subsequently they do not. Is that the sort of thing that you are talking about?

Ms Smith—That is the sort of thing that I had in mind, yes.

Mr Stuart—They do monitor a proportion of calls—more so when people are new; less so when people are more experienced. Then there is also, in terms of that professional oversight, the process of discussion about how we deal with particular problems and issues.

Senator NETTLE—Do they report back to you about the monitoring of calls?

Mr Stuart—Not in detail about the monitoring of calls, no. I think that would be getting a bit too invasive for what we ask in terms of reporting.

Senator NETTLE—Is it possible to get a list of your requirements? Are they set or are they different for each organisation?

Ms Smith—Senator, in response to a return to order from Senator Allison, a couple of months ago we tabled all progress reports that we had received from the Australian Federation of Pregnancy Support Services. Those were tabled in the Senate on 7 September.

Senator NETTLE—Thank you. That is great. I want to go back to some answers to questions on notice. You used similar language when you were talking about 'providing a

balanced approach to differing family planning service models'. Before I go any further I will check this with you. Are we talking about the four services? We are talking about the Australian Federation of Pregnancy Support Services, the Catholic Church one which has a long name that I cannot remember.

Ms Smith—The Australian Episcopal Conference of the Roman Catholic Church.

Senator NETTLE—That is the one—also the Sexual Health and Family Planning and Working Women's Centre. Is that all we are talking about?

Ms Smith—They are the four organisations that the Australian government funds directly. We also provide funding through the Public Health Outcome Funding Agreement to the states and territories. That goes towards funding the family planning organisations. Our direct funding goes to the four national organisations.

Senator NETTLE—I am just checking, because it was in answer to Senator Boswell and Senator Stott Despoja:

> The objective of the Family Planning Program is to provide a balanced approach to differing—

under that program that we were talking about before. Am I right?

Ms Smith—The Family Planning Program, I think, has been encompassed for family planning organisations at a state level as well.

Senator NETTLE—My understanding was that they were moved as a part of the arrangements with states—whatever it is called—PHOFA.

Mr Stuart—Public Health Outcome Funding Agreement.

Senator NETTLE—Yes—into that category in 2004-2005. I thought that the Family Planning Program now only referred to those four. Is that not correct?

Ms Smith—The Australian government funds a variety of organisations, both indirectly through the PHOFAs and directly to the four organisations that we have just discussed.

Senator NETTLE—In your answer to Senator Boswell and Senator Stott Despoja, when you say:

> The objective of the Family Planning Program is to provide a balanced approach—

you are talking about the funding to those four and the others?

Ms Smith—That is correct.

Senator NETTLE—How do you evaluate whether or not a balanced approach is being implemented? We were talking before about how you evaluate the kind of training they have and I am trying to go through the information that you have provided, where you talk about a balanced approach. How do you assess whether or not what you are doing is a balanced approach? What do you mean by 'a balanced approach'?

Ms Smith—The notion of a balanced approach is intended to get at the concept of, rather than a program focusing on one particular strategy or type of approach, promoting sexual and reproductive health behaviours that encompass a variety of perspectives. Balance in terms of variety of perspectives is the notion we were getting at.

Senator NETTLE—Are you meaning pro choice, anti choice, or not? I am trying to understand the language that you are using and what you mean.

Mr Stuart—We are talking about a diversity of providers for a diversity of services, such as counselling on contraception; natural family planning is a part of the diversity, and also the family planning services.

Senator NETTLE—When you say 'diversity', do you mean diversity of service or diversity of approach? Your answer then sounded to me more like a diversity of service, whereas I thought that your answer sounded like a diversity of approach. Is there a cohesive answer on that?

Mr Stuart—The cohesive answer is that the government has decided over a period of time to fund a range of different kinds of providers of a range of different kinds of services. They are quite pleased with that diversity and it offers choice to women about a range of services that they might find more comfortable.

Senator NETTLE—All of these, you are saying, fall into that independent non-directive counselling. Is that correct?

Mr Stuart—Yes, that is correct.

Senator NETTLE—Your assessment, when we talked at the start—

Mr Stuart—I am sorry, not all of these services provide counselling about pregnancy. Some are more about fertility.

Senator NETTLE—That is what I am trying to get to. Do you mean of the unplanned pregnancy counselling services you want a balance within that, or is your balance and diversity about some unplanned pregnancy counselling and some other types of sexual health counselling? I am trying to understand what you mean by diversity and balance. Is it within unplanned pregnancy counselling or is that one of the categories of the broader diversity and balance we are talking about?

Mr Stuart—It is diversity across the whole program, both in terms of a range of services and a range of service providers.

Senator NETTLE—You are saying both?

Mr Stuart—Yes.

Senator NETTLE—When you say non-directive independent counselling, would a service that did not refer for pregnancy terminations fall within that definition or not?

Ms Smith—Senator, non-directive counselling is about the process of decision making and supporting a woman to make her own decision. It is not actually influencing the decision that that person is going to make. The question of whether that woman is then referred onwards is quite separate from the fact that the process leading up to that decision is non-directive.

Senator NETTLE—The reason I ask is, for example, the South Australian state Health-funded service, Pregnancy Advisory Centre, in Adelaide take calls from a range of different people, some of whom have previously accessed other services that are available in South Australia. Birthline and Genesis are two of the services that fall under the Australian

Federation of Pregnancy Support Services that operate in South Australia. Sometimes someone will call one of those and then they might call the Pregnancy Advisory Centre.

The Pregnancy Advisory Centre keeps a log of phone calls that they receive from women who, prior to contacting their service, contacted Genesis or Birthline, the ones that are funded through this program that we are talking about. In their log of what the counsellors take down when a woman rings, there are some really horrific stories. I will just read out a couple of those to you. The woman says:

> I rang them to talk about an abortion I had and they told me, 'I think you should name your baby.' She also told me my baby didn't have a place in heaven and asked me if I thought what I did was sinful.

I will read you one other example:

> I have had an abortion before and they told me if I had another one I wouldn't be able to get pregnant again. They said I was a definite high risk to get breast cancer and that they had plenty of couples who would adopt my child if I didn't want it. I said to her, 'You won't give me information about abortion, will you?' and she said to me, 'No. I don't believe in it. No-one here does.'

Those two are from Birthline. The other one is from Genesis:

> The mother of a pregnant 13-year-old young woman rang this number for information regarding options for her daughter. She was told that if her daughter adopted out her child it would be the worst thing she could do and if she terminated, well, that's just killing the baby. She was advised that there would be support for her daughter to keep the baby, like cots and baby clothes. She was also told the government would give money to keep the baby—'a few thousand dollars'.

I am wondering if you would describe that kind of counselling as independent non-directive counselling?

Ms Halton—Senator, before we go on, can I make an observation? It is firstly inappropriate for us to make any comment in relation to a case that you are alleging and we have no independent evidence of, and I will not agree that my officers can make any comment in relation to the two matters that you have just read out. The reality is there is a framework in relation to particular services. If there are specific complaints in relation to the behaviour of the services that are funded, I am delighted to receive those complaints in writing and we will most certainly follow those up. I think it is not appropriate that the officers are asked to comment on allegations in relation to particular cases. If there are matters that people would like to raise with me in writing, I would be more than happy that we consider them. We will investigate those to see whether in fact there has been any breach of any funding agreement.

Senator NETTLE—I appreciate that and thank you. My intention was not to seek comment on the individual case. My intention was to find out whether or not the framework to deliver independent non-directive counselling was working.

Ms Halton—There is a framework. If there is a systemic problem with the way the framework operates, I would like that to be drawn to my attention. If there are individual instances where services behave in ways which are not congruent with the framework, similarly we would like those raised with us and we would be delighted to take them up with the service providers. We do structure our funding arrangements. We are clear about what we expect. Clearly no-one sits on the shoulder of everyone taking every phone call and we do rely on people to tell us of circumstances where they have received suboptimal treatment.

There is a risk that we will end up debating the merits or otherwise of alleged cases, which probably is not helpful, but if people would like to raise them with me in correspondence I would be delighted to pick them up.

Senator NETTLE—Have you had any instances of such complaints being made, either individually or systemically, that you have had to investigate and respond to?

Ms Smith—I have been responsible for the program for some 18 months now. In that period of time we have had no complaints from individuals about the quality of the service they have received.

Ms Halton—I have to say, and I think this has been observed in this committee on a number of occasions, one of the things that individual members of the public do is write to me about things that they see across the portfolio; everything from standards in aged care homes to their views about pharmaceutical products listed on the scheme. I could go on and on. I have similarly not received one piece of correspondence on this matter.

Senator NETTLE—That is interesting.

Ms Smith—The federation also has a service and privacy complaints protocol in place. They too are very prepared to listen to people who are not satisfied with the quality of the service they are getting.

Senator NETTLE—I have some questions to be put on notice but I want to find out if I need to put some of these on notice to you or elsewhere. In your answers to questions on notice you talked about the Australian Federation of Pregnancy Support Services having their training run through a registered training organisation that was accredited under ANTA. If I have questions in relation to that, should I ask them of you? I do not know whether they get funding from the department of health through the Family Planning Program and also through the department of education.

Ms Smith—I think it is appropriate to direct those questions to us.

Senator NETTLE—Okay. I can put those ones on notice.

Senator Patterson—Senator Nettle, you may not be here for that closing date we stipulate for replies to questions on notice. You may need to check the *Hansard*. We put a date on it because otherwise they can dribble in forever.

Senator NETTLE—Thank you. I just want to ask questions on RU486. Is that also—

Ms Smith—No, that is the TGA.

Senator NETTLE—Thank you. There is one more. I noticed in answer to one of the questions on notice that there is not a tendering process for that funding provided under the Family Planning Program. Is that correct?

Mr Stuart—Yes. For policy purposes, for grants to organisations ministers and departments are not required to go to tender. Ministers can make policy decisions to provide grants to particular organisations, and have done so in the past. Some of these grants go back very many years.

Senator NETTLE—I am just checking that I have your answer correct: is there any intention to have a tendering process for these?

Mr Stuart—No. There is no intention to tender for these services.

Senator NETTLE—So each of the four of them receive funding because the minister is able to make those grants without requiring to go to tender. Is that right?

Mr Stuart—These go back quite a way. Some of them go back a long way.

Senator NETTLE—Yes, I am aware of that. In relation to, for example, the Catholic Church one that started getting funding in 1974, the minister that made that decision in 1974 is not reviewed by subsequent ministers, or how does that work? Your answer was that the minister made a decision a long time ago. I would have thought there was—

Ms Halton—Ministers have variously been aware of what is in that current bucket in terms of who is receiving funding. I think it is fair to say that various ministers since then have chosen not to change the way that particular program operates.

Senator NETTLE—They have chosen not to change as part of any review?

Ms Halton—No. These programs have continued. Ministers are aware of how they operate. They are aware of who receives funding. In my experience, no minister to date has actively said, 'Look, I want to think about that and I want to do it a different way.'

Senator NETTLE—Can I put on notice the starting dates for each of those four.

Ms Halton—Yes.

CHAIR—Have you finished in that area?

Senator NETTLE—Yes. The other questions are to the TGA.

CHAIR—We will come to those agencies separately. Are there any other general questions of the department on population health and safety? No? In that case, we will proceed to ARPANSA. Dr Loy is already at the table. I think Senator Forshaw has the call.

Senator FORSHAW—Welcome, Dr Loy. We do not have a huge amount of time, which often seems to be the case with this area. I will start by asking you to give us an update on progress with the consideration of the application for an operating licence for the OPAL reactor, having regard to evidence you gave earlier.

Dr Loy—The assessment is continuing. Amongst the highlights of the last little while are that I have received a report from the Nuclear Safety Committee, which is a statutory committee created under the ARPANS Act, who I asked to examine aspects of the application, including the management of operations and waste management issues. They provided me with a report, which is published on the web site. I referred it to ANSTO for any response they wish to make. As you would know, under the ARPANS Act for a nuclear installation, I am required to seek public submissions and take those into account. Public submissions have closed and the great bulk of them are on our web site. We are producing a summary document of the issues raised in those public submissions, which will be available shortly.

We will have a public forum on 8 and 9 December, at which the major presenters of public submissions will have the opportunity to state their views and to receive questions from a panel comprising myself, Dr Lars Hogberg, a former director of the Swedish Nuclear Power Inspectorate, the nuclear regulator of Sweden, and Professor Jim Falk from the University of Melbourne.

Senator FORSHAW—Where will that be held, Dr Loy?

Dr Loy—That is going to be held in Sydney, in the CBD, on 8 and 9 December.

Senator FORSHAW—You are obviously going to be inviting key groups, organisations and individuals who have made submissions.

Dr Loy—Yes.

Senator FORSHAW—Do you intend to advertise it in an effort to attract more interest?

Dr Loy—Yes, we will do what we can. We will certainly advertise it and draw attention to the existence of the public forum and encourage people who are interested to attend. I am trying to challenge our technology to see if we can webcast it, but I am not sure I will cope with that. We will have a transcript of it that will be published on the web site. The two independent members of the panel will produce their own reports of their views of the forum and the views presented, and they will also be published.

We are following up with another international peer review organised through the International Atomic Energy Agency. That will be a smaller peer review but focused particularly on the procedural documents—that is, the detailed operating procedures proposed for the reactor—and we will get a couple of really experienced people who know their stuff backwards to have a look at it to see if they can raise any questions about the ability or the efficacy of those operating procedures. Otherwise, our own internal technical assessment is proceeding and there are questions and answers going forth between ourselves and ANSTO about the technical matters that my staff are raising. I understand that ANSTO hopes to commence the cold commissioning towards the end of the year or very early in the new year.

Senator FORSHAW—You are talking about the end of next year?

Dr Loy—No, I am talking about the end of this year. This is the cold commissioning.

Senator FORSHAW—Sorry.

Dr Loy—This is something that can be done under the construction licence.

Senator FORSHAW—Yes.

Dr Loy—It obviously is a very important testing time for the whole system, to see that it performs in the way that the design said it should perform and that all the safety systems work, with the kind of performance that the safety case says they need to. That will take a couple of months to be tested through, and will be the final block of evidence that I will need to have before considering my decision on the operating licence.

Senator FORSHAW—What do you now see as the time line in terms of when you would expect to be able to make a decision? How extensive is that consideration going to be? Is it essentially just about the reactor and its operation or is it also going to include the opportunity for people and for your panel to consider issues related to the waste storage issues and so on, as they may impact upon your decision?

Dr Loy—Certainly, issues about radioactive waste management are relevant matters for my decision and I imagine they will be canvassed fairly vigorously in the public forum.

Senator FORSHAW—Essentially, it is all the related issues that you have to take into account.

Dr Loy—Sure. The act says I need to take into account matters raised in public submissions. Obviously, I need to make judgments about the weight of those and then justify those judgments. It is very clear that waste management is a relevant issue and will be one that will be discussed pretty vigorously, I imagine, at the public forum.

Senator FORSHAW—One concern people may have is that, if that is to be dealt with publicly in a forum on 8 and 9 December, some of those things may not be resolved or there may be further things happening after that date, even leading up to the middle of next year, which they may feel they do not have an opportunity to comment on fully, because they are issues that are in train as well. What is the date that you believe you will be able to make a decision by? I think dates have previously been indicated as April or May next year, or something like that. Is that a fair assessment?

Dr Loy—As I said, the final block of evidence—and a very vital block—is the outcome of the cold commissioning program. I certainly could not make a decision before that is completed. It will take me a period of some weeks following its completion to make a decision and, as I said, I think ANSTO's planning—and I emphasis its planning—is that they will hope to start that cold commissioning process about the end of this year and it will take something like three months. Doing the figuring, you are talking about March, April kinds of times. That is an assumption that all those planning details flow through.

Senator CROSSIN—If therefore the cold commissioning starts say in January and it takes a couple of months, is it likely you will be in a position to provide them with a licence by April?

Dr Loy—As I said, I certainly could not make a decision on the operating licence without the completion and a strong report about the outcomes of the cold commissioning program. In a sense, that is in ANSTO and INVAP's hands to complete that program and to provide me with a report on it. All I am saying is that my understanding of their timetable is that that brings us up to about February-March. That means that I could not make a decision prior to that. The time it will take for me to make a decision after that I cannot be certain about, but it will be a number of weeks after that, to bring all the evidence together and to make my decision.

Senator CROSSIN—Even then, that does not guarantee you will be issuing them a licence, does it?

Dr Loy—No. The decision is to issue a licence or not.

Senator FORSHAW—I know Senator Crossin wants to follow up particularly on the waste issues; but just to clarify something about the current licence for operating HIFAR. You issued I think you might call it an amendment or change to the conditions on 26 July this year—I should say these issues were raised with ANSTO this morning—and we obtained a copy of the special conditions schedule 3 which states:

> If the licence holder proposes to operate HIFAR beyond December 2006, the licence holder must, as soon as practicable, make a submission to the CEO of ARPANSA seeking the approval of the CEO to do so.

What I want to clarify, Dr Loy, is: does the current operating licence for HIFAR actually have an expiry date?

Dr Loy—No, it does not, except that I have issued that special licence condition, so it does not expire. But I have said if they wish to operate it beyond that date, they need to come and apply to do so.

Senator FORSHAW—That is consistent with our understandings now. I might also draw your attention to a question which was answered today in the House by Dr Nelson. This was in the debate committee stages, I assume, on the bill that has just been introduced regarding the Northern Territory proposed waste sites. Dr Nelson said, talking about the licence:

> There is no specific end date. There is no doubt, from the government's point of view, that the chief executive of ARPANSA would be seriously stretching his own credibility—

I do not know if you want to comment on that—

> and that of ARPANSA, if he were to allow HIFAR to continue much beyond the end of 2006.

But he has at least, putting aside the other comments, said that there is no specific end date. That is correct?

Dr Loy—That is correct. I think if this were to come to pass and I received such an application, I suppose there is a kind of an early issue and a longer-term issue. The early issue would be that the 2004 major shutdown of HIFAR was a briefer shutdown with fewer tests and maintenance done than we would have otherwise expected because of the shortened time until its shutdown. If they wanted to continue operating beyond the end of 2006, we would certainly want to think about whether some of those examinations should be done in any case. In the longer term, I think I have made clear a number of times that HIFAR does not meet the best of modern safety standards and, if it were to be continued for a significant period, we would want it to be upgraded.

Senator FORSHAW—What we know from the evidence from ANSTO is that they certainly envisage HIFAR continuing to operate until the end of next year and looking at the commencement of full operation of OPAL from sometime around September, assuming they get the okay from yourself, and the stage arrangements which start with hot commissioning and so on. The other issue I wanted to raise is that are you familiar with the evidence that was given in the estimates hearings in June from ANSTO, in the other committee—the education et cetera committee? Have you read it?

Dr Loy—You would have to remind me.

Senator FORSHAW—I will remind you. They were asked questions by Senator Carr about some delays in construction and the pushing out of the start-up dates. They said particularly that some of the fault lay with ANSTO. Dr Smith said, in response to a question from Senator Carr:

> Senator CARR—What is the reason for the delay?
>
> **Dr Smith**—There is a number of reasons that the contractor has put forward. Some of these relate to the regulatory activities of ARPANSA, and some relate to construction difficulties with the reflector tank, which is a very complex piece of apparatus in the core.
>
> Senator CARR—What concerns has ARPANSA expressed to you that would warrant a delay?

Dr Smith—It is not concerns expressed by ARPANSA but the regulations and processes which ARPANSA are enforcing upon the contractor.

Senator CARR—Yes, which is what you expect. There is nothing untoward or unusual about that, is there?

Dr Smith—No. One expects regulators to—

Senator CARR—regulate.

Dr Smith—undertake their work. One hopes that they do it in the most efficient and effective way possible.

Do you have a comment upon the observations there? They seem to point the finger of blame at ARPANSA. They do, I must say, also go on to talk about concerns about the amount of resources that your agency has, which we have discussed at a previous estimates and do not need to go through now.

Dr Loy—It would not be the first time that a regulated body had suggested that its regulator was a bit inefficient and was asking too many questions or that the questions were unnecessary or whatever. There is always that to and fro.

Senator FORSHAW—Have they raised it with you?

Dr Loy—Yes. We have some interesting exchanges from time to time but I regard that as being in a day's work.

Senator FORSHAW—A bit like estimates, isn't it?

Dr Loy—The way we believed we needed to go about this project was the design at the time of the construction licence was a very clear and good design but it had not been fully worked out in detail. So what I did was to say, 'Yes, I accept this design is good enough to proceed to construction but, as you come to the construction of all the individual system structures and components that are important for safety, you have to convince me in detail about those items.' That has meant quite a lot of work by ANSTO, by INVAP and by ARPANSA, and maybe we all underestimated how much work there was. On the other hand, I think it was vitally important that we give that level of scrutiny to those very significant safety systems.

Senator CROSSIN—Can you outline what you know about the National Sites Advisory Committee and whether ARPANSA was a member?

Dr Loy—You are referring to the National Store Advisory Committee.

Senator CROSSIN—The National Store Advisory Committee, is it? It has had a mixture of names, I am afraid.

Dr Loy—Yes. The government has been pursuing two processes. One was the national low-level waste repository and the other was the idea of a national store, and I think there were committees formed for both of those, but most recently for the national store, which was a process that was in train for a while.

Senator FORSHAW—That is to take the intermediate-level waste or the high-level waste, however you want to define it.

Dr Loy—Yes.

Senator CROSSIN—Intermediate-level waste I think it is, isn't it?

Dr Loy—Yes, that is right.

Senator CROSSIN—Were you a member of that committee?

Dr Loy—I was not, but a member of my staff was a member.

Senator CROSSIN—ARPANSA was represented on it?

Dr Loy—Yes.

Senator CROSSIN—Do you know when it would have last met?

Dr Loy—I would have to take it on notice, but it would be some time ago. The reason why I thought it appropriate for a member of my staff to be on it was, of course, that we do have relevant expertise to offer in the discussion of the ways of going about looking for the sites for such a facility, and that was the role that my staff member played. The decision making about how to proceed would lie with the relevant portfolio.

Senator CROSSIN—I understand that committee was looking at a store for intermediate-level waste. We are told today by DEST that that committee has now been superseded because there has been a decision made to co-locate the low- and intermediate-level waste. What, therefore, will you be looking for in order to grant the first licence? I understand the process will be three licences in the building of the dump.

Dr Loy—I am sure you mean 'the facility'.

Senator CROSSIN—We mean 'the dump', because you cobble it together, you just chuck it somewhere. We call it 'the dump'. We might not be as scientific as you, but we are probably a bit more realistic.

Dr Loy—The ARPANS Act talks about the need for the Commonwealth entity to have a licence to prepare a site to construct and to operate a facility in the general sense, so my normal expectation would be that for such a facility I would receive an application at each of those stages.

Senator CROSSIN—What are those three stages?

Dr Loy—To prepare a site, to construct, to operate, and then ultimately to decommission, but we will put that aside for the moment. My belief would be that, in terms of low-level waste, what would be proposed is essentially a form of repository—that is, something that would deal with the waste finally—which means it has to protect it from the environment for a period of at least 100 to 300 years.

Senator CROSSIN—Up to 300 years?

Dr Loy—Yes, to protect it and to demonstrate that, with a high degree of probability, the waste will not enter the environment more broadly for that period of time and, subsequently, to demonstrate that what is left after that period does not present any significant harm to future generations. That is one set of issues. The other set of issues about a store is that it is not the end state of dealing with this material but that it is something that will keep it safe, secure and away from the environment for a period of 50 to 100 years, say.

Senator CROSSIN—What do you do after 100 years? Do you move it somewhere else or turn it upside down or rotate it like a bottle of wine?

Dr Loy—Australia needs to think about what it will do. The options for a repository for that material will develop in the world over the next decades and it is appropriate for Australia to take an interim decision that leaves a further decision to be taken later.

Senator CROSSIN—Do you have any guidelines that will assist you in what you will be looking for to grant the first licence? Is there a framework, or are there any indicators?

Dr Loy—Yes. There is a significant amount of guidance, both Australian and international, about low-level waste repositories. There is a lesser amount about ongoing stores, though that is being developed. What I am proposing to do is to bring that together in a regulatory guidance document that will describe the international guidance and indicate the areas in which I would want to be satisfied at each stage of the licence. I hope to bring that regulatory guidance material together in a draft in the next little while—before the end of the year—and to put it out for a period of public submission early into the new year.

Senator CROSSIN—With a view to finalising that by when, do you think?

Dr Loy—I would hope it would be finalised in the first half of 2006.

Senator CROSSIN—In your mind then, Dr Loy, what is the link between the OPAL operating licence and the waste dump?

Dr Loy—You can read lengthy excerpts from *Hansard* where I have discussed this with Senator Forshaw, including the last time I appeared before the committee. The link is that one of the ways in which the reprocessed spent fuel from OPAL will need to be dealt with in the medium term will be a return to Australia and storage in a store. Having said that, there is the issue that for the first 10 years ANSTO has an arrangement whereby the fuel will be returned to the US and not come back to Australia. As I said, viewed purely through OPAL glasses and from the perspective of the processed spent fuel, one could say that the issue of a store may be not as pressing as it once was, but there still remain the issues of HIFAR processed spent fuel, which will be returning in the relatively near future, and of course other intermediate-level wastes that are generated by the radiopharmaceutical production and by other activities in Australia, that need to be dealt with.

Senator CROSSIN—We heard about those time lines today. I understand the HIFAR spent fuel is now coming back by 2011 rather than by 2015. Is that your understanding?

Dr Loy—That is my understanding, yes.

Senator CROSSIN—Is there some sort of insistence by ARPANSA that there be a long-term waste management strategy in place before the OPAL licence is granted?

Dr Loy—I have said often that I believed I needed to be satisfied that there would be a store to deal with, particularly, processed spent fuel before I could grant the OPAL licence, bearing in mind that in doing so, in essence I am granting a licence to operate OPAL for decades if need be.

Therefore, to do that seems to me to require satisfaction that there is a strategy for dealing with the waste. As I said, the issue of the imminence of the store viewed purely from OPAL

glasses is affected by the immediate arrangements of the 10-year agreement with the United States. Having said that, it still seems to me appropriate that I be able to be satisfied that there will be a store to deal with OPAL spent fuel, or processed spent fuel.

Senator CROSSIN—Do you need to be satisfied that there is progress towards getting that store established and, if so, what would you define as progress?

Dr Loy—The way I have put it is that I need to be satisfied that there will be a store. It is then up to argument from people who make submissions to me that a certain degree of evidence is sufficient satisfaction that there will be a store. Some might argue that that needs to be very solid evidence; some may argue that a plan is enough. That is something that I then have to consider very closely.

Senator CROSSIN—You don't have a view about whether a plan is enough or whether you actually want to see a store?

Dr Loy—What I have said is that I need to be satisfied that there will be a store.

Senator FORSHAW—You have also said, Dr Loy, that features of the design should be settled.

Dr Loy—Yes.

Senator FORSHAW—What we currently have are some proposals for sites and a selection still has to be made.

Dr Loy—I was trying to characterise the kind of progress that might be evidence that there will be a store. Certainly the more evidence there is that the issue has been firmly thought through and that there is a commitment and a plan seems to be pointing towards being a store as opposed to a jolly good idea that there might be.

Senator FORSHAW—I think I know how you are going to answer this, but can we cut to the chase on this. If the current legislation before the parliament is passed, is that sufficient, having regard to your earlier statements on this issue going back in a number of previous estimates hearings about how you might define 'progress'? I appreciate that the issue of the waste going to the US and then not having to come back puts some of the OPAL considerations out, but there is still the HIFAR waste. So come back to the crunch. We are appreciative of the position you are in as the person who ultimately has to make the decision on this application, but that seems to be the crux of where we are at. If this current legislation is passed, would that be seen to be sufficient progress?

Dr Loy—You are putting me on the spot.

Senator FORSHAW—I know.

Dr Loy—In one sense asking me to say what my decision would be.

Senator FORSHAW—That is why I said I think I know how you will answer it. But I have to ask it.

Dr Loy—I will try and avoid that.

Senator CROSSIN—You have already asked that.

Senator FORSHAW—I have not asked that, and it is critical.

Senator CROSSIN—We will come back to it. I want to preface it by saying that the legislation that has been passed in the House of Representatives has a schedule to it that lists three sites. DEST admitted to us today that, once an environmental assessment of those three sites has been conducted, it may well be that none of those sites are suitable. Given what Senator Forshaw said, we would be interested in your comments or thoughts about it.

Dr Loy—I think that is a very appropriate thing for them to say. They should examine the sites and, if none of them are suitable, they will have to start again. If they said anything else I would be worried.

Senator CROSSIN—They did say that they might be able to engineer one of the sites.

Dr Loy—I guess that is the point I am trying to make.

Senator CROSSIN—That is another question that I want to ask you about. How do you engineer a site to be suitable? That is what I would like to know.

Dr Loy—Let us talk about the low-level waste. You are trying to say, 'Here is a description of how we will keep this material from the environment.' The ways of doing that are, first, the nature of the site itself; second, the way in which you store the material—concrete, drums etcetera; third, the engineered barriers. You have those three parts of your armory. The site is one of them and obviously important; the nature of the waste and the structures in which it is enclosed or encased is another; the third is other engineered barriers—concrete, whatever—that would assist you in demonstrating that you can keep this material from the environment for that period of time. It is not just the site, though of course the site is important.

Senator CROSSIN—Is it just the passage of legislation to enable the site?

Dr Loy—No. I guess that is going back to Senator Forshaw's question.

Senator CROSSIN—That is right. Dr Loy, are you putting to us that legislation through the parliament is not significant enough for you to be satisfied that that will deliver a store? You would need to see more?

Dr Loy—Let me put it this way: I would want to see indications that the government and the agencies are fair dinkum in bringing about a store. The degree to which various arguments that they will bring forward to demonstrate that is where my judgment will have to lie.

Senator CROSSIN—When I asked questions today of both ANSTO and DEST about the three sites—I do not know if you are aware, but for your history the stores advisory committee lists the site in Katherine as less suitable and subject to flooding, so I am assuming that out of these 20 or so sites it is one of the least suitable for an intermediate store, but it does not have the two sites in Central Australia on it—and asked what would happen if they were all deemed unsuitable, I was told you could engineer a site. In fact, I think Dr Cameron said last Friday night on *Stateline* that a site can be engineered—that is, I am assuming that they are suggesting that the low- and intermediate-level waste can be stored above ground. Is that your understanding of what engineering a site might mean?

Dr Loy—Not necessarily, no. For low-level waste it may be below ground, but there may be engineered barriers between where the material is stored and beneath it and to the side. I mean, wet countries store radioactive waste. If you go to Sweden, they have a terrific radioactive waste management strategy and it is a very wet place.

Senator CROSSIN—Whereabouts in Sweden? Is that where it is under the Baltic Sea? Is that correct?

Dr Loy—Yes.

Senator CROSSIN—So we could put this dump in Sydney Harbour? It is a possibility, isn't it?

Senator FORSHAW—As long as you do not put it in the Woronora River.

Senator CROSSIN—It is a possibility, isn't it?

Dr Loy—All I am trying to say is—

Senator CROSSIN—Dr Loy, is that not a possibility?

Dr Loy—I do not think that would be a very wise choice for this country to make.

Senator CROSSIN—No. But it could be a possibility.

Dr Loy—Everything could be a possibility.

Senator CROSSIN—Thank you.

Dr Loy—The point is simply that you can address the issues that you need to and you take the best site you have available and deal with its problems and produce the arguments that convince an assessor that you are keeping the material from the environment for the needed period. It is not just a black-and-white issue of the site per se, but the site is very important. If you have better sites inherently, then sure, by all means choose them. But it is the best site that you have available, and availability I guess includes—

Senator CROSSIN—Sydney Harbour.

Dr Loy—political issues.

Senator CROSSIN—Yes. That might well be what is driving all of this, in fact. Some colleagues of mine from the Northern Territory have suggested that a decision on the final site for the waste management dump must be made by April because Australia will no longer be allowed to produce radioisotopes used in hospitals throughout the country beyond that date. Would that be a correct statement?

Dr Loy—Not from my point of view.

Senator CROSSIN—Are there, from your point of view, problems with meeting international requirements about where this dump would be sited if, in fact, such things as native title and Indigenous heritage have been bypassed in the process? Is there not a requirement internationally to have some sort of consultation and community assessment about this?

Dr Loy—Again, you are really inviting me to speculate on a decision that has not come even remotely near me at this point.

Senator CROSSIN—I see.

Dr Loy—Those issues about the acceptability of the site in every sense will no doubt be contested issues in the decision making.

Senator FORSHAW—If the relevant Commonwealth legislation, such as the Native Title Act or the Environment Protection and Biodiversity Conservation Act, is directly set aside during the site selection process or overridden, is that a consideration for you to take into account? If the legislation that leads to the determination of a site or a number of sites from which a site or sites are to be selected involves overriding other Commonwealth legislation that is largely based upon international conventions, is that a consideration?

Dr Loy—My understanding is that the site that is selected will be subject to assessment under the Environment Protection and Biodiversity Conservation Act. It is the selection process itself that I understand is taken out by the current legislation, but the site that is then chosen to be put forward would be subject to environmental assessment, and I would certainly want that to happen, as relating to and in concert with my issue of a licence for the preparation of the site.

Senator CROSSIN—You have three sites. I am assuming at some stage one site will go up to the minister. It might not be any of those three sites; it might be another site somewhere. But this legislation actually bypasses the EPBC Act in choosing that site. On what scientific basis, then, would the site be chosen?

Dr Loy—The choosing of the site is preliminary to the proponents putting it forward for assessment under the EPBC Act and for assessment under my legislation. In relation to the prior process of deciding whether it is site A, B or C, the sort of information that is needed about that is pretty well known, and I will make it much more specific through the regulatory guidance I will be bringing out and no doubt my colleagues in Environment and Heritage will do similar things. Then the site that the proponents have decided is the one they wish to put forward will be assessed under our processes.

Senator CROSSIN—Under the EPBC Act. Is that correct?

Dr Loy—Yes, and under the ARPANS Act.

Senator CROSSIN—In selecting the site, the legislation that has gone through the House today bypasses the EPBC Act. Without this legislation, would the site selection process have had to have been subject to that act, as far as you are concerned?

Dr Loy—I do not know. It would not be subject to my act.

Senator CROSSIN—I see.

Dr Loy—My act is preparing a site for a thing. If you are not doing that, you are not caught by my act.

Senator CROSSIN—Did ARPANSA see this legislation before it was introduced into parliament?

Dr Loy—No.

Senator CROSSIN—You weren't asked to comment on it?

Dr Loy—No.

Senator CROSSIN—Can you tell me if Australia has developed its own classification of nuclear waste into low, intermediate and high—that is, do our three classifications differ from, say, how our waste is classified in the US?

Dr Loy—They probably differ from how it is done in the US, because the US tends to ride a different track from other countries on some of these things. The most recent discussions that have taken place in Australia about the classification of radioactive wastes have accepted that we should follow the approach taken currently by the International Atomic Energy Agency.

Senator CROSSIN—Would that see our classifications change in some way? For example, would it see our intermediate waste reclassified as high-level waste?

Dr Loy—No, I do not believe so.

Senator CROSSIN—Would it change them in any way?

Dr Loy—No. If you like, it formalises a classification rather than brings about a change in the way people have thought about how to deal with it.

Senator CROSSIN—Would our intermediate-level waste be classified as high-level waste under the system in the USA?

Dr Loy—I do not believe so. The distinction between high level and intermediate level turns on the generation of heat by the material, sufficient that you have to take active measures to deal with the heat, and my understanding is that, for example, the reprocessed spent fuel when it is returned does not fall within the definitions of high-level waste because it is not generating that amount of heat.

Senator CROSSIN—Would the waste that is coming back from Scotland and France be classified as high-level waste when transported by ship in international waters?

Dr Loy—No. It will be stored for a period of time, having been through the processing or the reprocessing in France, which will have cooled it, and therefore you are dealing with something that does not require active management of the heat.

Senator NETTLE—I want to ask you about the recent radiation exposure of the badge of the worker at Lucas Heights. Do you know the date you were first advised of that?

Dr Loy—It was sometime during September. The 14th or the 16th rings a bell. It was around that date.

Senator NETTLE—We heard from ANSTO this morning that they were first aware on 9 August of the high radiation exposure on the badge. Do you have any concern about the period of time before you were notified or does that fit with what you would find acceptable?

Dr Loy—I have substantial concern. I think the performance was poor. In fact, internally from ANSTO's point of view it was poor. As I understand it, there were not notifications within its own structure for some time, so there is a significant issue there that I believe is a piece of poor performance. What seems to have happened—and this is a 'seems to have'—is one of those instances in which, when people were confronted with a measurement that contradicted some other measurements and seemed unlikely or unusual, they said, 'This must be wrong,' and acted as if it had not happened or could not have happened. That might turn out to be the case, ultimately, but it is quite the wrong approach for them to have taken, and I think ANSTO will acknowledge that that was inappropriate and it was a piece of poor performance.

Senator FORSHAW—I am not sure that they would acknowledge that at all.

Senator NETTLE—No, I am not sure they would either. Is there any action that you believe should be taken in response to what you describe as poor performance?

Dr Loy—In terms of formal regulatory action I have, first of all, had my officers undertake an inspection. They formally went to the site and interviewed people and looked at documents and so on and provided me with a report, which led me to the conclusion that there may be a number of breaches of the licence conditions. I have put those to ANSTO and they have given an interim response. I, of course, sought a detailed root cause analysis of what had happened and I have received an interim analysis, with the final one promised by, I think, the end of this month and, once I have received that I can make some further decisions in terms of regulatory action on the licence. But, clearly, the most important thing is for ANSTO to learn the lessons of this and to ensure that, even though people might think a measurement is wrong, they have to take notice of it and act on it rather than assume that the reading is incorrect.

Senator NETTLE—Is your concern about the time of notification to you and about what ANSTO did or did not do in that period?

Dr Loy—It is certainly a concern about the time of notification, because if the exposure is real—and you should assume it is initially—then it is a substantial breach of the dose limit and, therefore, a breach of the licence and it is essentially a matter that needed to be reported to us within 24 hours.

Senator FORSHAW—One of the concerns that came out of this morning's evidence from ANSTO was that they also indicated to us, when we asked these questions, that there was a further period of time from the date that they first became aware of the reading to when they were actually able to go into the specific area.

Senator NETTLE—They said this weekend was the first time that they had been able to go into the hot cell.

Dr Loy—Yes. What they want to do, obviously, is to examine that particular hot cell in very great detail and to try and see if they can reconstruct a scenario in which the exposure took place, and I imagine the cell is being used for production purposes.

Senator NETTLE—Yes.

Senator FORSHAW—That is right. That is what they said.

Dr Loy—And this is the kind of break in production that they can use to go in and examine it. That is fair enough. I do not have an issue with that per se, because it does need to be a thorough examination of the conditions of that hot cell, and if there is something going on in there that would expose someone who did further maintenance work, that has not been happening, so it has not been a safety issue for the workers during that period of time.

Senator NETTLE—Whilst people have been in the hot cell, no-one has been doing maintenance?

Dr Loy—They have not been inside it. They have been working with it from the outside, but it is a matter of being able to actually get in there, do a thorough examination and see what might be happening, if anything.

Senator NETTLE—We also heard this morning that there had been medical testing of the worker involved but that there had been no medical testing of any of the other workers. I am trying to get a sense of what your concerns are and whether that would fall into a category of concern or not.

Dr Loy—It appears that this single individual received this dose, or may have received this dose. There is no evidence that others were in a position to have done so and there are certainly no measurements indicating they were in a position to have done so, so I would not have seen any necessity to look at other people.

Senator NETTLE—We also heard this morning that badges do not malfunction. We are talking about two different types of badges.

Dr Loy—Yes.

Senator NETTLE—There is the crystal badge and the digital badge that the relevant worker was wearing on both occasions. Is that a view that you would share: that the badges do not malfunction?

Dr Loy—I have an inherent scepticism that people can find ways to make anything malfunction.

Senator NETTLE—I share that scepticism.

Dr Loy—I suppose that is a safety regulator's point of view. The thermoluminescent dosimeters work on straightforward physical principles and they will measure what they have been exposed to. The question is was it an exposure in the course of his work or was something careless done? We certainly find instances where people put their badges through X-ray machines, so the badge records a dose but the worker has not received that dose. I would not say the electronic dosimeters never malfunction, no.

Senator NETTLE—We also heard this morning about a time line similar to that which you outlined in terms of reporting. We were asking ANSTO, 'When will you know what happened?' which currently they do not, and the date we were given was 30 November. It sounds to me like that is the date when they are getting back to you with their more fulsome response in relation to what you wrote to them. Do you have an understanding of when we might know what happened? Would that be when you receive the full report from ANSTO or when you have been able to have a look at it?

Dr Loy—As I said, ANSTO has indicated to me that they will have the more fulsome report by 30 November. They may choose to make that public, but I will certainly report upon my views of it and any regulatory action that I take subsequently.

Senator NETTLE—Is it possible that on 30 November we still will not know what happened or that we are not likely to know what happened until after you have had a look at what ANSTO tell you? I want to know what happened at Lucas Heights; why a worker had a dose of 66 millisieverts when 55 is the maximum for the year. I want to know the answer to that question in terms of the operations of Lucas Heights. We were asking ANSTO when we will know. I am getting an increasingly different and detailed understanding of what the time line might be, and it strikes me that 30 November is when they will provide you with information, but that might not be when we know what happened.

Dr Loy—I am not sure that I can help you. I will have a more detailed report on 30 November. What it will say, I do not know.

Senator NETTLE—We do not know.

Dr Loy—I will certainly report to the parliament about what I receive and what my reaction to it is.

Senator NETTLE—Hopefully, it will not take too much longer than four months to find out what did happen. Thank you.

Senator CROSSIN—I have two or three quick questions I would like to ask you before you leave, Dr Loy. The proposal at Woomera was to store intermediate-level waste, not low level. Is that correct?

Dr Loy—If you are referring to the radioactive waste repository of last year near Woomera in South Australia—

Senator CROSSIN—Yes, all of that.

Dr Loy—that was low level.

Senator CROSSIN—Low level, not intermediate level?

Dr Loy—Not intermediate level, no.

Senator CROSSIN—You never issued a licence for any of that process to occur. Is that correct?

Dr Loy—No, that is right. At the time the government decided not to proceed with it, I was still in the midst of assessing the licence.

Senator CROSSIN—In relation to the process that is now occurring, where the low and intermediate will be co-located, would it be your view that the low-level waste could be stored above the ground or will you be predominantly looking for a below-ground repository?

Dr Loy—Whether it is above or below is not the prime issue. What I am looking for in a low-level waste facility is the isolation of the waste from the environment for a period of somewhere between 100 and 300 years.

Senator CROSSIN—I see.

Dr Loy—How that is achieved is what the proponents have to bring forward.

Senator CROSSIN—Is it preferable that it is below ground?

Dr Loy—In my view, yes.

Senator CROSSIN—Thank you.

CHAIR—We are now facing a problem with getting the remaining outcomes done in the hour and a quarter available to us. One suggestion that has been made is that we attempt to finish outcome 1 by 10 and that we then deal with outcomes 7, 6 and 5 between 10 and 10.30 and that we deal with outcome 9 between 10.30 and 11. That is the kind of 'no rest before Warsaw' approach we need to take in order to get through it all. Unless there is any violent objection to that approach—

Senator FORSHAW—Mr Chairman, I have a few short questions, I think, for FSANZ and I have quite a number of questions and issues for the TGA. I am happy, given the time, to try and put the ones for the TGA on notice.

CHAIR—That would be helpful.

Senator FORSHAW—I am terribly sorry for keeping those people back here, but we thought we might be able to get to them.

CHAIR—I think that putting the questions on notice is the only way of getting through it all at this point.

Senator FORSHAW—There is no point in starting, which could lead into a lot of discussion and questions and answers and we will just run out of time.

CHAIR—Let us press on with that course of action.

Senator FORSHAW—I do not know about others, but that is where I stand.

CHAIR—We have finished with ARPANSA. Let us now call FSANZ to the table.

Senator FORSHAW—The TGA people can go.

CHAIR—You have no questions live to the TGA? Are there any other questions that people desperately need to ask the TGA that they cannot put on notice? Bear in mind that you will have, at best, five minutes to put them anyway.

Senator NETTLE—I only have three questions.

CHAIR—Can you put them on notice?

Senator NETTLE—If I can have a go at putting them now, that would be appreciated.

CHAIR—Could the TGA stay, please. We will do FSANZ first.

[9.47 pm]

CHAIR—We turn now to Food Standards Australia New Zealand. Because I have a conflict of interest with FSANZ, I am going to hand the chair to Senator Adams.

Senator FORSHAW—I wanted to ask some questions about the recent announcement and endorsement by the ministerial council on a new standard for country of origin labelling, which was literally only a few days ago. The Minister for Agriculture, Fisheries and Forestry put out a media release last Friday, in which he stated:

> Ministers have agreed on a new standard that will ... require distinct statement-of-origin information on packaged products.

Can somebody tell me what is meant by that?

Mr Peachey—I have brought along a summary of what was agreed at that meeting, which might help to facilitate the discussion, because it is quite complex.

Senator FORSHAW—We only have five minutes.

Ms Halton—We will table the document.

Senator FORSHAW—One of the concerns that people have is: does it just mean a statement like ‘made in Australia’ or ‘product of Australia’? For instance, there are

circumstances where a product may be labelled as made in Australia, even if most of the ingredients come from overseas, because of the fact that you take the basic food and then you do a whole lot of things to it. You crumb it, cook it et cetera.

Mr Peachey—Senator, there are two parts to that issue. One is all packaged foods are required to identify the country where the food was produced or came from. Having said that, the arrangements that we have developed are consistent with the Trade Practices Act. Under that act there are two hurdles that are required to be stepped over for classifications like 'product of' or 'made in'. For the 'made in' claims, as you were saying, there is an issue around the value of production in the country. It is over 50 per cent or thereabouts. There is another requirement that there has to have been some substantial transformation of the product. What we have developed is something that is not particularly unique to the trade practices law but it is consistent with it.

Senator FORSHAW—Thank you for tabling this document. We can have a look at that and maybe pursue some further questions at a later date. I also understand that the Parliamentary Secretary to the Minister for Health and Ageing wrote to the members of the ministerial council, indicating that he was intending to direct FSANZ to consider the cost benefit of extending country of origin labelling to products with two or less 'whole food ingredients'. Can you confirm that first?

Mr Peachey—What happened was we received a direction from the parliamentary secretary for Health and Ageing. That direction was for us to do a feasibility study on the types of labelling requirements you have just referred to. Part of that feasibility will go to a regulatory impact statement. It will also require cost-benefit analysis and it will require us to consult with stakeholders, as you would expect.

Senator FORSHAW—I understand that Minister McGauran is saying that this will be considered ultimately by the ministers from the council in March next year. Is this potentially leading to a new standard for country of origin labelling?

Mr Peachey—I can only go to what we have been directed to do. That is to undertake a feasibility study. We have been asked, as you were saying, to bring it back to ministers by the end of March. Where it goes to from there is in the hands of the ministerial council.

Senator FORSHAW—Is this a feasibility study that embraces the potential for a new standard? If that was to be the case then you would presumably have some directions.

Mr Peachey—The feasibility study would be a precursor for the thinking about the standard or the nature of it. It could lead to a variation in the standard.

Senator FORSHAW—But it is not really clear just what the ministers are going to be considering in March?

Mr Peachey—They will be considering the feasibility of revised labelling requirements. In doing so they will have regard to the cost-benefit analysis and the regulatory impact statement that will go with it. If, out of that, there is a good case for change that would be for the ministers to decide.

Ms Halton—Just so we can be clear about this, the ministers at the meeting in Sydney took a clear decision to adopt the standard. You have now got this and it is on the right-hand side of this table.

Senator FORSHAW—That is right.

Ms Halton—The parliamentary secretary is required to consult the relevant state ministers. The meeting did consider a proposal to issue the direction. There was consensus at the meeting in relation to the wording of the direction. That now has extensive coverage. FSANZ will now do the technical work that is consistent with the letter of transmission and the wording of the direction. That work will then come back to the ministerial council. My expectation is that there will not be a brand-new standard but it would be work in respect of varying the standard that has now been agreed. The terms of the work are fairly clear about how you might look at what is the new standard and take that slightly further.

Senator FORSHAW—Good. Thank you for that. I have had my five minutes of fame.

ACTING CHAIR (Senator Adams)—Is that all for FSANZ?

Senator FORSHAW—I do not think I have any other questions. If I do we could put them on notice. I am pretty sure that it is.

[9.55 pm]

Therapeutic Goods Administration

CHAIR—Thank you, Senator Adams. Now Senator Nettle has questions for TGA.

Senator NETTLE—Have any studies been done on the social and health consequences of RU486. I do not know if they have or what they say.

Ms Halton—Senator, that is probably not a question explicitly for the TGA. The TGA is the regulatory agency that deals with application. They do not have a broader research role.

Senator NETTLE—That was why I thought it was outcome 1, Population health, when I went to ask it before.

Ms Halton—Sally forth and we will see whether perhaps between Dr McEwen and myself we can answer some questions.

Senator NETTLE—Do you know if any studies have been done?

Ms Halton—Not that I am aware of and certainly not in Australia because it is not permitted in Australia.

Senator NETTLE—I am aware of overseas studies but I am wondering whether the department of health has done any studies, whether or not they are fulsome studies. They might be literature reviews of overseas studies.

Ms Halton—We are obviously aware of issues in respect of RU486. You would be aware this has been a matter of some considerable debate in the past.

Senator NETTLE—Yes.

Ms Halton—Have we done our own de novo study? Obviously not, because it is not available in Australia, but we are certainly aware of the issues around RU486.

Senator NETTLE—Have you produced any material about what those issues are?

Ms Halton—No. We have acquainted ourselves with the material in relation to the use of RU486 internationally. It is worth putting on the record that we have not received any application in relation to RU486 in Australia. I believe the regulator therefore does not have an opinion in relation to this matter but certainly it is an issue that we are conscious of.

Senator NETTLE—You said you are aware of the issues. Have you formulated a position or a view on what might be the health, medical or social implications of RU486?

Ms Halton—Senator, you would be aware that the department does not have a position.

Senator NETTLE—Yes.

Ms Halton—We are a department and we service government. It is fair to say that we are conscious of some of the medical issues in respect of RU486, so in the event that we are asked for advice in relation to these matters we would give a clinical view about the use of such a product. In a sense that question is a little academic because we have not been asked for that view, nor have we been asked to consider such a view in the context of any request in relation to access to the product in Australia.

Senator NETTLE—You have not been asked for that view by the minister?

Ms Halton—No. We have not had any formal request in relation to that matter.

Senator NETTLE—Do you know whether, in 1996 when the legislation went through, there was any material produced by the department on the medical consequences of RU486?

Ms Halton—I cannot comment about what material might have been produced then. I am aware that Dr McEwen has fairly recent knowledge of some of the medical issues in relation to RU486 which he would be more than happy to talk to you about. In terms of the advice that was given to government at the time, short of digging it all out of archives, I have not got that to hand.

Senator NETTLE—Could I put that on notice, if there is any capacity for you to look at what advice there was at that time.

Ms Halton—It may be a little difficult. It is nearly 10 years ago. It is regrettable but it is a reality that dredging up what happened 10 years ago can prove a little difficult.

Senator NETTLE—It is worth asking the question because it is current now.

Ms Halton—Sure, I understand.

Senator NETTLE—The advice may have been different then to what it might be now.

Ms Halton—The reality is, with any sort of product of this kind—in fact any medical product—a 10-year effluxion of time does mean that you know more, by definition. If you take the example of Vioxx, which is very current, we now know a lot more about the impact of Vioxx so it is no longer on the market. As people know more about a product, the decision that you might or might not have taken earlier may be a different one.

Senator NETTLE—Which is why I think it is helpful to the current debate if we are able to get—

Ms Halton—I will see what I can do, Senator. I cannot make promises because I literally do not know what the state of the record-keeping was.

Senator NETTLE—Can I ask Dr McEwen: the tag about the medical information that you have or—

Dr McEwen—We have really focused on what is in the public domain, and that principally is the information that is available in the compendia that describe the product in the various countries. One can access the very detailed product information from the US. There is a compendium entry from France; one needs to read French. It is available in New Zealand and they have a relatively truncated product description. The US one is probably the most useful because it spells out the details of the clinical trials in the US and France, including the percentages who needed to have some form of intervention after an expiration of 10 to 14 days after they had had the product administered. We can access that sort of information and provide it as an attachment to a question on notice.

Senator NETTLE—Does that include the study by, I think, the American College of Obstetricians and Gynaecologists?

Dr McEwen—It is described as US trials. Just who did it I would need to take on notice.

Senator NETTLE—That would be great. Have you also looked at any studies about satisfaction with the product? You mentioned medical trials. Has that included satisfaction with the product?

Dr McEwen—No, I am not aware of any on patient satisfaction.

CHAIR—We have now made up time for the TGA, so thank you to the TGA representatives.

[10.02 pm]

Office of Aboriginal and Torres Strait Islander Health

CHAIR—We will proceed now to outcome 7, Indigenous health. We have 30 minutes to deal with three outcomes, so I suggest we deal with each in 10 minutes.

Senator CROSSIN—I want to ask you about the *Overcoming Indigenous disadvantage* report produced by the Productivity Commission. Does the department accept the statistical conclusions by the Australian Institute of Health and Welfare in the headline indicators in that report?

Ms Halton—Sorry, the AIHW's conclusions in the Productivity Commission report?

Senator CROSSIN—Two things here. First of all, the headline indicators in the Productivity Commission report.

Ms Halton—I think we have discussed in the past that the Productivity Commission has chosen a group of indicators for a variety of reasons. I am not completely au fait with why. You could have a debate long and hard about whether they are the right group or the wrong group. Do they point to a general issue in respect of disadvantage? No-one has any contest with that. Could we have a lengthy statistical argument about the precise details? Some of them, probably. Is it worth it? Maybe not.

Senator CROSSIN—Are the headline indicators for the baseline data similar?

Ms Halton—I do not have it in front of me, Senator. Can you point to the particular issue?

Senator CROSSIN—I think that the issue it goes to is your tracking of Indigenous health outcomes. Do they in any way line up with the indicators that were used in the Productivity Commission report?

Ms Halton—Sorry, I am a bit confused. The AIHW report?

Senator CROSSIN—There are two. I want to know the comparison between the two, really.

Ms Halton—I do not know that we have done that detailed analysis.

Ms McLaughlin—We have not done a detailed analysis of that, Senator. There are some indicators in the *Overcoming Indigenous disadvantage* report that match some of the indicators that AIHW measures.

Senator CROSSIN—So a person could not look at that report and look at your statistics and draw the same conclusion. Is that right?

Ms McLaughlin—They are not health department statistics. They are AIHW and ABS statistics, largely, that are used. The *Overcoming Indigenous disadvantage* report tends to report on a current point in time. The AIHW and ABS statistics are doing comparisons over time.

Ms Halton—It is also a fair comment that we tend to do a level of analysis which goes, in a sense, below some of those things. The ABS tends to report on more broadly based things. No-one disputes, for example, issues in relation to longevity. We have talked about that here before.

Senator CROSSIN—What is the baseline data that the department is now using in terms of Indigenous health outcomes?

Ms McLaughlin—The most recent data that we have been provided with is from the AIHW ABS report, *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples, 2005*, which you may be aware does show some important improvements in Indigenous health over the period 1991 to 2002: for example, a 25 per cent decrease in mortality in Western Australia for Indigenous people, a decrease in infant mortality over the same period and some significant decreases in mortality from circulatory disease.

Senator CROSSIN—That is predominantly the baseline data that you use. Is that how you track your performance in closing the gap in Indigenous health, using that data when it is produced every so often?

Ms Halton—Yes and no, Senator. You are quite right, we pay very close attention to what the AIHW produce. For that matter, we also pay attention to what the Productivity Commission produce. I think the minister put out quite a long press release when the AIHW data was produced, because to see broadly based data which actually shows some improvement is fantastic and we are delighted. But, as you know, sometimes the kinds of achievements that we are looking at go to the things that are the precursors: for example,

longevity issues are in respect of death rates et cetera; issues around improvement in immunisation, issues in terms of improvement in screening; I could go on.

So, yes, you are right. In terms of how are we going in aggregate, that data is particularly important for us. In terms of how we tell whether the individual components of what we are doing are making a difference, sometimes that does not give us enough granularity.

Senator CROSSIN—Have you set any targets or performance indicators for Indigenous health improvements?

Ms McLaughlin—Not at this stage, Senator. We are developing at the moment—in fact, have almost finished developing—a national Aboriginal and Torres Strait Islander health performance framework which will measure performance in relation to Aboriginal and Torres Strait Islander health at three levels. It will look at health outcomes and health condition, it will look at the social determinants of health and it will measure the performance of the entire health system for Aboriginal and Torres Strait Islander people. At this stage it will not include benchmarks or targets. It may get to that point in the future.

Ms Podesta—As part of that process we are also conducting three service-level data collections, including service activity report, drug and alcohol services report, and Bringing Them Home counsellors data collection, which will be used to inform the reporting under the health performance framework.

Senator CROSSIN—What is the time line for those?

Ms Podesta—It is part of the health performance framework that was agreed in principle by the health ministers in January.

Ms McLaughlin—The first report will be published in late 2006.

Senator CROSSIN—The framework would be at a state where I could ask about that in February?

Ms Halton—You can have the framework now if you would like it.

Senator CROSSIN—I thought you said it was a draft or being developed.

Ms McLaughlin—It is an in principle agreement. We are now waiting for the states and territories to populate what will be included in the health performance framework in terms of the data that we will be collecting so that there will be a national consistency.

Ms Halton—I am happy for you to have what has been agreed so far. It will not give you every line by line detail but it will give you a feeling.

Senator CROSSIN—Okay. Can I go to one particular issue. I understand that Mutijulu, which is the Indigenous community near Uluru or, as it was known, Ayers Rock, had a grant of money from OATSIH of $68,000 for the community to employ a substance abuse worker. The $68,000 is to cover wages, admin and activities. Would you have any idea, or can you take on notice, whether the funds have become available?

Ms Podesta—We will have to take that level of detail on notice.

Senator CROSSIN—Yes, okay. I want to know whether the funds have become available through the office of OATSIH in Alice Springs for the substance abuse worker in Mutijulu, how much funding has been provided and what these funds are expected to cover.

Ms Podesta—Certainly, Senator.

Senator CROSSIN—The funding became available in light of the recent media. We want to know if in fact that funding has been passed on to the community and what it is for.

Ms Savage—The funding has been allocated. It was, indeed, in advance of the media attention, and we will certainly get you the details on whether they have received it and whether that worker is in place.

Senator CROSSIN—And what the $68,000 is for. 'Wages, admin and activities' does not seem to leave a lot for wages, really, at the end of the day, if it is only $68,000.

Ms Savage—Most certainly. Mutijulu is provided with other funding from OATSIH for its primary health care services, so it may just be the wage component and other operational costs drawn from its base funding.

Senator CROSSIN—Can you find me the details of that?

Ms Savage—Certainly.

Senator CROSSIN—How much money is currently committed to the OPAL fuel program?

Ms Savage—In 2005-06 a total of $2.3 million. Over the next four years, including 2005-06, it is a total of $9.426 million.

Senator MOORE—Is that spread evenly across each of those years?

Ms Savage—Essentially. There are slight differences. I can go through that, but it is essentially around $2.3 million, $2.4 million.

Senator CROSSIN—How many Central Australian communities will this roll-out cover?

Ms Savage—There are currently 16 communities in the central desert region that are registered communities in receipt of OPAL. In the roll-out of the regional strategy, we expect there to be at least a further seven communities in the designated area, six roadhouses and a number of pastoral properties. We will really only be able to determine that as we do further work in that area.

Senator CROSSIN—I might get you to take on notice, then, to provide me with a list of those rather than to name them all now. How many communities who will not get OPAL fuel have indicated to the department that they want this fuel?

Ms Savage—No communities have indicated to us directly that they would not want the fuel. It is fair to say that some of the communities in that area have expressed an interest in the OPAL fuel even in advance of the announcement.

Senator CROSSIN—I think you have misunderstood my question. It was, basically, how many communities have expressed an interest in getting the fuel that will not be able to get the fuel?

Ms Savage—You are talking about our capacity this year to roll out?

Senator CROSSIN—Yes.

Ms Savage—We anticipate that in the central desert roll-out of the regional strategy most of the communities will be able to. I cannot give you the exact figure of anybody who would miss out. Our calculations are to cover all the communities in that defined region.

Senator CROSSIN—In the central desert.

Ms Savage—In the central desert, yes.

Senator CROSSIN—That would be a triangle between Coober Pedy, Alice Springs and Warburton, do you think?

Ms Savage—No, not quite. I can define the region if you would just bear with me for a moment.

Senator CROSSIN—Take it on notice. We have an inquiry and I just wanted to ask a few initial questions about it.

Ms Halton—We will give you a map with a shaded area that shows all the communities that are covered.

Senator CROSSIN—Okay.

Ms Savage—It is not quite a triangle and not quite an oblong.

Ms Halton—I think it probably defies a geometrical description!

Senator CROSSIN—I can picture it. I was there last week, and it was 42 degrees, so it was damn hot I have to tell you. On the Greg Cavanagh inquest that was held at Mutijulu, I want to take this opportunity publicly to say that the community were very angry about the photo that appeared on the front page of the *Australian*, not having given that newspaper the authority to take those photos. They are very upset, angry and humiliated about that. Publicly I think a defence of the community should be made. Anyway, the Cavanagh inquest heard that there are an estimated 600 petrol sniffers across the central desert and we know 60 people have died in the Territory over the past seven years. Do you know how many people there are with a known serious petrol sniffing habit in the central region?

Ms Savage—It depends on how exacting you are about 'the region' and whether I, in my mind, have got the same region that you have got in your mind, but the estimates are 600 to 1,000.

Ms Podesta—It varies. The type of activity of that group is significantly varied, from occasional users to substantial users, and we are very conscious of the response needing to recognise that there is experimentation through to chronic use.

Senator CROSSIN—Do you know how many would be seriously disabled as a result of sniffing?

Ms Savage—I would not know that exact figure.

Ms Podesta—We certainly can provide the statistics on the number of people who have sought assistance.

Ms Savage—I might get you to take it on notice, then.

CHAIR—Senator, before you go on, we decided that we would allocate some of this time for hearing services. Are there senators with questions on hearing services?

Senator CROSSIN—Yes, me. I am trying to go as quickly as I can!

CHAIR—If no-one else has any questions, you might as well take the time until 10.30, however you wish to divide it between those two areas.

Senator CROSSIN—Thank you. Probably some of these questions you can take on notice. How much does a disabled person cost the health care system in that region each year if they are diagnosed as being a sniffer? How many people are known to have died from petrol sniffing in that region? I might leave it there, I think.

Ms Halton—Senator, just before you move off the issue, can I provide you with one piece of information. One thing that the department is trying to do is work very closely with OIPC and take some leadership in relation to petrol sniffing. There is a secretaries' retreat every year, and at the last secretaries' retreat I raised the issue of the need to have a whole-of-government approach in relation to petrol sniffing. That met with a considerable level of agreement amongst my colleagues.

OATSIH, together with OIPC, are spearheading a real effort to try and develop a whole-of-government response in respect of petrol sniffing. I would like to underscore that this is something that we regard as being a very serious issue, particularly in relation to Central Australia. It is a problem elsewhere as well, but we are trying to work across government to acknowledge that there is no one single solution to petrol sniffing and a whole-of-government approach is needed if we are going to tackle the issue.

Senator CROSSIN—It is just a precursor. You know the Senate has an inquiry into this.

Ms Halton—Absolutely, and we will be happy to talk to that Senate inquiry.

Senator CROSSIN—I have an extensive range of questions here, but I wanted to go to this, mainly because it is an area I am particularly interested in: it has been brought to my attention that there is a problem in Indigenous communities, particularly in remote Australia, in accessing asthma spacer devices because of the prohibitive cost. In fact, there is a community that has had to make a spacer out of a plastic Coke bottle. It is linked to the cost, as I understand it.

There was an article recently published in the *Australian Family Physician* where around 80 per cent of Aboriginal community-controlled health services in a recent survey reported that Aboriginal people with asthma had difficulty accessing these devices for optimal asthma care. The AIHW report on asthma in 2005 also made mention of this. What is the department doing to address the fact that asthma spacer devices are inaccessible to a substantial proportion of people attending community health services?

Ms Halton—This is the first time I have heard of this. In all seriousness, I have never had it raised with me. I have never had it raised with me by GPs when I go out to communities and I have never had it raised with me in relation to section 100. I am happy to look at the issue, but this is the first time that I have heard about it.

Senator CROSSIN—I have a photo here that was emailed to me of a spacer device that has been made out of a Coke bottle, probably because of this: the spacer devices cannot be

funded under the PBS because it only funds medication, not devices, and the cost of the devices is prohibitive for some Indigenous people. Is there scope for an appropriation of funds from elsewhere for these devices to be provided to Aboriginal community health services?

Ms Halton—Let me take a look at it. As I say, this is the first time I have heard of this as an issue. If you have something in terms of people who have been raising the issue, I am very happy to take all that material away and come back to you.

Senator CROSSIN—An example has been drawn to my attention. The Department of Veterans' Affairs apparently provides funding for these spacers, which appears to be under the PBS schedule.

Ms Halton—You would be aware that the RPBS includes a variety of items, including devices—including, as I understand it, things like incontinence pads—which are not available more broadly.

Senator CROSSIN—Yes, that is true, but I assume for Veterans' Affairs it is because they are probably seniors. Getting an asthma spacer device under the PBS seems to be prohibitive for Indigenous people through an Aboriginal community-controlled health service. Is the department currently scoping any policy options on how these spacer devices might be made available through Aboriginal community-controlled health services?

Ms Halton—The answer is no, because it has never been raised with us. As I say, I am very happy to look at the issue.

Senator CROSSIN—I might give you a copy of this photo and this paper before you go.

Ms Halton—Would you mind? That would be great. I am happy to look at it.

Senator Patterson—Do you know how much spacers cost?

Senator CROSSIN—About $26, $28?

Ms Murnane—Maybe between $10 and $20.

Senator CROSSIN—It depends. If you get them through the Asthma Foundation, they are cheaper. Of course, the Asthma Foundation is not where these people would be.

Ms Murnane—If there is an AMS there, maybe they could buy them in bulk.

Ms Halton—We will have a look at it.

Ms Murnane—Then they could purchase them when they have been bought in bulk.

Ms Halton—If there is a significant health need there, that is something that we would expect AMSs to be able to deal with. We will talk with Mark Wenitong of the Indigenous Doctors Association in terms of the particular things that he is seeing in this respect.

Senator CROSSIN—I will put the rest of the questions on notice. I did want to go to hearing services.

Senator MOORE—I have one question on Indigenous health. It is clarification from the annual report on page 190, which is the financial resources summary. With that financial process, what is the explanation for the significant underspend?

Mr Thomann—This is what we discussed at the last estimates hearings.

Senator MOORE—Yes.

Mr Thomann—We had a budget estimate of $287 million. Is that the figure you are referring to?

Senator MOORE—Yes.

Mr Thomann—The actual expenditure was $265 million and therefore we recognise a variation there of $21.6 million. Those funds have been fully committed to capital projects. Therefore, they are not expensed in 2004-05 but will be expensed this year and in the two following out years. They are recognised in the department's commitments.

Senator MOORE—No money has gone back?

Mr Thomann—No money has gone back.

Senator MOORE—The reason I am asking this question is that somebody has read the annual report, which I think you would be very pleased about, and there is no footnote that explains that.

Ms Halton—We will footnote, Senator.

Senator MOORE—It is a fairly significant issue and there is nothing that explains it.

Ms Halton—In the bright-blue version, or whatever colour we go for next year, it will be footnoted.

Senator MOORE—For their peace of mind, in terms of the process, there was no underspend and no money was returned? That money is committed?

Ms Halton—That is exactly right.

Mr Thomann—Yes. It will be recognised in additional estimates—rephrasing the funds to the years in which they will be expended.

Senator MOORE—Thank you.

Senator CROSSIN—Where are you at with implementing the Workplan for Future Action in Ear and Hearing Health? As you know, that was a plan that was jointly released back in August 2003. I do not think I asked questions about it last year, simply because I assumed you would probably be working on it last year. Could you provide me very quickly with an update on where that plan may well be going?

Ms Savage—There are a number of things that have been progressed. We are currently facilitating further development of Aboriginal health worker training and competencies for both general Aboriginal health workers and specialist roles, including child, maternal and hearing health. We are supporting a regional assessment of uptake and promotion of otitis media recommendations for guidelines through a project that is auspiced by the Far Western Regional Health Services, SA Department of Health. That involves a number of stakeholders, the Royal Australian College of Physicians and six Aboriginal community-controlled health services. It is essentially to test the best way to implement evidence based guidelines that were developed some time ago, which you are very familiar with.

Since the last time we were here, there has been an Indigenous person appointed to the hearing service advisory group and, as you would be aware, there has been a budget measure also with the hearing services for those on CDEP and for those over 50.

Senator CROSSIN—Yes, but that does not kick in until December. Is that correct?

Ms Savage—That is right, although it is not actually me who is across that.

Senator CROSSIN—I am still trying to work my way through Australian Hearing and Hearing Services, and just when I thought I had it sorted out you moved it away.

Ms Savage—That is some of the activity that OATSIH in particular is involved in.

Senator CROSSIN—The Hearing Services Advisory Committee is an advisory group to the department or to the minister?

Ms Savage—To the minister.

Senator CROSSIN—Can you provide me with a list of who is on that committee?

Ms Murnane—We will do that, yes.

Senator CROSSIN—If there is any further or better detail about how you are implementing that plan, could you take that on notice?

Ms Savage—Yes, certainly.

Senator CROSSIN—I wanted to update all of my statistics, which I have not done since 2003, about the number of clients who are accessing a range of services. Is it best I put that on notice? Do they go to you or Australian Hearing?

Ms Savage—It depends on what services you are talking about.

Senator CROSSIN—The community service obligation.

Ms Savage—Australian Hearing.

Senator CROSSIN—I might have worked it out after all. The community service obligation was a question I asked in February this year and you gave me the general principles. I am assuming that that document is still as it stands. The MOU has not been updated at all, has it?

Ms Halton—We need the hearing specialist.

Senator CROSSIN—Is the memorandum of understanding between Hearing Services and the Office of Hearing Services still as it was back in February of this year when I asked that question?

Mr Kingdon—It is substantially the same but we are in the process of negotiating a change because of the new Indigenous additional activities which will have to be included in that. That was the one I talked about at the last hearing, where we have an extra $10.1 million.

Senator CROSSIN—When will they be signing the new MOU?

Mr Kingdon—Very soon.

Senator CROSSIN—So I will ask for an update about it next February. Very quickly, just to warn you, I have a question on notice about the six work force strategies contained in the

report on Commonwealth funded hearing services. They were incorporated into the work plan. Are they the strategies you are talking about that are now being implemented in the work plan? Is that correct?

Ms Savage—Yes, Senator. It also links with the national Aboriginal and Torres Strait Islander health work force strategic framework—I may have too many words in there—to develop national standards and/or competencies for Aboriginal health workers.

CHAIR—I think we have come to the end of Hearing Services. Can I thank Hearing Services and Indigenous Health. You may now go home or back to the office as you see fit. I call now the last outcome, Health system capacity and quality.

[10.33 pm]

CHAIR—We turn now to the Health Services Improvement Division.

Senator POLLEY—In the last 12 months to 30 June this year, how many overseas trained doctors have come to Australia on schemes sponsored by the department? Could we also have a breakdown of the GPs versus specialists and where they have been located?

Mr Lennon—I do not have the numbers for the last 12 months but I have them in the period when the Commonwealth began its recruitment program for overseas trained doctors, which was about the beginning of 2004. From that time until 12 October 2005, as a result of recruitment programs sponsored by the Australian government—that is, through recruitment agencies that were hired through the department of health—225 overseas trained doctors have been placed in rural, remote and other areas of work force shortage by the recruitment agencies. Another 111 doctors have signed employment contracts and will soon commence work in Australia.

You asked me for information about the break-up of those doctors. Of the 225 doctors working in Australia as a result of the initiative, 168 are working as general practitioners and 57 are working as specialists. Approximately 65 per cent or two-thirds of those doctors are working in locations outside of a capital city.

Senator POLLEY—Could we then have on notice the figures for the last 12 months and the actual locations?

Mr Lennon—We are happy to do that, Senator.

Senator POLLEY—Can you also tell me from what countries these doctors have come?

Mr Lennon—They would be from a variety of countries but I am happy to provide that information on notice for you.

Senator POLLEY—Can you also tell me how many of these doctors have come out as permanent residents?

Mr Lennon—I can also provide that information for you on notice.

Senator POLLEY—Is the department aware of a story published in the *Medical Observer* of 30 September 2005 that an Australian company recruiting doctors from overseas was charging up to $5,000 for these recruitment services?

Mr Lennon—Yes, I am aware of that story. Certainly that is not the case in relation to recruitment agencies that have been hired by the Australian government to obtain Australian doctors. The way the system works in that case is that the Australian government pays the recruitment agency a fee for a successful placement, but that is only at the point that the overseas trained doctor is placed, is in work and is Medicare billing.

Senator POLLEY—You believe there are adequate safeguards to ensure that those practices are not taking place?

Mr Lennon—The actual regulatory arrangements for recruitment agencies generally would be a matter for the states and territories. We have sponsored a body to represent nationally recruitment agencies in the medical field and that body has set up a series of standards that ensure that all of its members operate ethically in this field.

Senator POLLEY—Where can doctors lodge complaints about such practices?

Mr Lennon—Doctors can lodge complaints about such practices either with the body which has been established by the Commonwealth or by the relevant regulatory body in each of the relevant states or territories.

Senator POLLEY—Can you tell me the name of the body that has been established?

Mr Lennon—Its precise name I cannot recall at this point but I am happy to provide it to you, along with information about its method of operation, its principles and contact details.

Senator POLLEY—Thank you. The federal government taskforce was set up in June of 2003 to investigate the recruitment and assessment processes of overseas trained doctors. It is not clear what this taskforce has actually achieved. Can you outline their achievements?

Mr Lennon—Yes, I can do that for you. The taskforce has actually achieved a lot. It is responsible, first of all, for the recruitment activity that I have just spoken about, so it has organised the engagement of the recruitment firms and it has done that by way of competitive tenders. It currently has contracts with 16 recruitment agencies that it manages. As I said, as far as recruitment goes, the runs are on the board. We have, through our recruitment agencies, successfully placed 225 overseas trained doctors who are here and working in areas of work force shortage.

Senator POLLEY—I have to suggest that people living in rural and regional Australia, particularly in my home state of Tasmania, would not agree with you.

Mr Lennon—I note what you are saying. As I indicated, approximately two-thirds of the doctors recruited have been recruited to work outside of capital cities.

Senator POLLEY—How often does the task force meet?

Mr Lennon—The task force is a group that operates within Health Workforce Branch. It is a group of approximately a dozen permanent public servants who are working on issues around overseas trained doctors. It does have a reference group which negotiates with, dialogues with and includes all the major stakeholders—medical stakeholders and representatives of overseas trained doctors organisations, for example, that it regularly consults with.

Senator POLLEY—How often do they meet?

Mr Lennon—The task force which operates within the department meets continuously. They work full-time on these activities. The reference group meets approximately once every six months.

Senator POLLEY—When did they last meet?

Mr Lennon—The reference group last met in May this year.

Senator POLLEY—Can you provide a list of the members of that task force?

Mr Lennon—Of the reference group?

Senator POLLEY—Of the actual task force.

Mr Lennon—I could provide you with a list of the public servants who make up the members of the overseas trained doctors group—that group of permanent public servants within my branch.

Senator POLLEY—Thank you.

Mr Lennon—Yes, I could do that.

Senator POLLEY—And the reference group you referred to as well?

Mr Lennon—Yes, happy to do that.

Senator POLLEY—The department apparently backs a self-regulatory model of the industry. How is that addressing the issues that have been highlighted?

Mr Lennon—I think you are referring to the issue of unethical practices in the industry. The self-regulatory model which we financially support is something where the department took a proactive stance and actually funded an organisation to be set up to establish regulatory standards. We believe it has promoted higher quality amongst recruitment agencies and ethical practices. Individual states operate their own regulatory arrangements in relation to recruitment agencies, some of which are not self-regulatory; some of which are. That applies across the board, not only to the medical profession or health workers but to recruitment activities generally. In answer to your question, the department saw advantage in promoting a quality mechanism, which it did through a self-regulatory arrangement.

Senator POLLEY—Has any consideration been given to allowing overseas trained doctors and their families that are here on temporary visas to have access to Medicare?

Mr Lennon—Some overseas trained doctors can have access to Medicare. Permanent residents and citizens obviously can. Most of the overseas trained doctors in Australia are permanent residents or citizens of Australia. Temporary resident doctors, just like temporary resident anything else, do not have access to the same range of Medicare benefits as permanent residents or citizens of Australia, so that is really a much bigger issue than a question specifically about doctors. It is about a general policy position that is taken that temporary residents should not as of right have access to all of the benefits of the Medicare system that permanent residents of Australia have.

Ms Lyons—That is not a framework that we set.

Senator POLLEY—It is a bit ironic, isn't it, that we are bringing these overseas trained doctors out here essentially to help run Medicare, yet they themselves and their families cannot have access to that service.

Mr Lennon—As soon as they become permanent residents of this country or citizens of this country—in other words, make a long-term commitment to stay in this country—they get that right.

Senator McLUCAS—How many doctors do you think we might have lost because of that issue of OTDs who are not permanent residents not being able to access Medicare?

Mr Lennon—That is an impossible question to answer, Senator, with respect. My feeling would be that it is not very many. Australia has a lot of attractions for overseas trained doctors. In addition, temporary resident doctors can take out private health insurance if they so desire. I am sure that the employers of the doctors who need the services of quality doctors will make suitable arrangements to make sure that they are able to make it sufficiently attractive for the doctors to operate in Australia, which has indeed been the case. Australia continues to attract significant numbers of appropriately qualified overseas trained doctors.

Senator McLUCAS—Not quite enough.

Senator POLLEY—Are you aware of any particular cases that have been brought to your attention of doctors that we have lost?

Mr Lennon—No, I am not.

Senator POLLEY—None at all?

Mr Lennon—I am not aware of any individual case where it has been brought to my attention that a doctor has decided not to come to this country because they were not able to fully access the Medicare benefits system.

Senator McLUCAS—That is an impossible question to answer. How many doctors do you know of who have decided to depart Australia, usually after an incident in the family, because they are not supported in their access to medical services?

Mr Lennon—I am not personally aware of any. I am aware that representations have been made from time to time by various groups that temporary resident overseas trained doctors coming here should have access to the benefits of the Medicare arrangements. Those sorts of arguments have been put from time to time.

Senator McLUCAS—Thank you.

Senator ADAMS—There is a quite a lengthy statement here in your annual report on recruitment, which is good. Of these overseas trained doctors, how many have not passed their entrance exam?

Mr Lennon—All of the doctors must achieve medical registration before they can begin to provide any type of medical services, whether they be through the public hospital system or in the community through the Medicare system. Every doctor that operates in Australia must achieve medical registration from a state or territory medical board which declares them to be safe and competent to practise. The answer is all of those doctors have achieved medical registration.

Senator POLLEY—Are we moving on to e-health now?

CHAIR—Yes, that is part of outcome 9. Go ahead.

Senator POLLEY—The Productivity Commission has delivered a scathing report on HealthConnect. In *Impacts and advances in medical technology* the Productivity Commission said:

> After seven years of R&D and 30 independent evaluation reports—some unpublished—many unresolved issues remain, including database design, privacy, security and access control measures, and stakeholder liability.

Then:

> The evaluation studies and trials have been deficient in a number of respects. The consultants examined only a narrow range of benefits and did not adequately demonstrate how HealthConnect would generate the claimed benefits.

How much money has been budgeted to date for HealthConnect?

Ms Halton—Senator, can I just make a comment? Firstly, the PC report is not an evaluation of HealthConnect and I really do not think it should be portrayed in that way. Essentially HealthConnect is a series of interrelated initiatives which go to transitioning the whole Australian health care system to an electronic environment. The particular report, as I understand it, that you are referring to was not an evaluation of HealthConnect, it was a technology report. Is that correct? Can we be clear which report you are quoting from?

Senator POLLEY—*Impacts and advances in medical technology*.

Ms Halton—Yes, exactly. It is about technology more broadly. I have to say that that particular report does not, to my mind, tackle some of the issues in relation to e-health. It has constrained its analysis in a way which is not consistent with where the broad direction of e-health is going. We might have our views about how they have produced their report—that is fine; that is our business—but essentially we need to distinguish between a particular series of pilots called HealthConnect, which were designed to explore and test the whole world of electronic health, and the policy direction that is now in place in respect to this. They really are two different things. Yes, we have existing pilots in place; yes, we continue to learn some things from those; but the broad direction in relation to how we advance electronic health I think is a separate thing and I think it is important not to confuse those. But Dr Richards can give you more detail on that.

Dr Richards—HealthConnect is a change management strategy. It is not actually a set of hardware or software or pieces of technology. The Productivity Commission, in commenting on HealthConnect, commented on a series of pilots or trials of electronic health records in a variety of ways and in a variety of places around Australia, and commented on them in terms of a health technology assessment model as opposed to a change management model, which is what HealthConnect in fact is. The Productivity Commission is entitled to their view in terms of assessing some of the technologies that may or may not have been used in various pilots and trials of electronic health around the country, but that does not move us away from the point that the secretary just made that HealthConnect is in fact not a technology, HealthConnect is a change management strategy.

Senator POLLEY—Could we quickly deal with these questions and the ones you cannot answer can be taken on notice. How much money has been budgeted to date for HealthConnect?

Dr Richards—For the implementation of HealthConnect there was a total appropriation in the 2004-05 budget of $128.3 million over four years.

Senator POLLEY—How much of that has been spent to date?

Dr Richards—To date the 2004-05 appropriation has largely been spent.

Senator Patterson—It was done in conjunction with the South Australian and Tasmanian governments as well—in cooperation with them.

Senator POLLEY—Has any of the money been returned?

Ms Halton—No.

Senator POLLEY—How much of that money was spent on consultants?

Dr Richards—Mr Shepherd may wish to give a detailed answer. My advice is that around $2 million was spent on consultants.

Mr Shepherd—The exact figure is $2.7 million on consultancies.

Senator POLLEY—How much of this money was spent on evaluation studies?

Mr Shepherd—I am happy to take that question on notice.

Senator POLLEY—How much of that was spent on pilot projects and trials?

Mr Shepherd—The majority of the appropriation for 2004-05 was spent on grants to state and territory implementation projects. The remainder of the money was spent on core pieces of national infrastructure, work that has now been progressed via the National E-Health Transition Authority.

Senator POLLEY—Can we get those figures on notice?

Mr Shepherd—Absolutely.

Senator POLLEY—Thank you. What is the budget for HealthConnect for 2004-05 through to 2008-09? Can you give that to me broken down by year?

Dr Richards—Yes, we can take that on notice and provide that information.

Senator POLLEY—What actions is the department taking to address the criticism that I have, obviously, outlined, which you have explained tonight you have some disagreement with?

Ms Halton—We have not, Senator. That is exactly my point. That is a particular perspective which is not informed by what, indeed, is the approach, so we are not taking a particular series of actions to address those criticisms because I do not believe they are valid. Mr Shepherd has just indicated, for example, the significant investment that every government in Australia has made in respect of setting up the National E-Health Transition Authority, which is a company owned by every government in this country. A significant investment has been made in providing the core infrastructure. It is a bit like the infrastructure you need to enable the internet; this is the infrastructure you need to enable e-health. That is

the kind of thing that is going on. These are the sorts of initiatives that we can now very solidly ground in the experience we had of trying in Tasmania and of working in South Australia and of dealing with the particular issues in the Northern Territory. This is why I think the Productivity Commission comments are, frankly, a little odd.

Dr Richards—I have been heading up the e-Health Implementation Group in the department since January this year and I have not had any contact from the Productivity Commission in that time at all.

Senator POLLEY—Has anyone else got any questions?

CHAIR—Have you got a question, Senator McLucas?

Senator McLUCAS—No, not on that.

CHAIR—Senator Polley, we have only got a couple of minutes, but go right ahead.

Senator POLLEY—I want to move on to online billing. How many doctors' offices use HIC Online for non-bulk-billed consultations?

Ms Halton—That is not an issue for us. That is an issue for Medicare Australia.

Senator Patterson—Human Services.

Senator POLLEY—Okay.

Senator McLUCAS—And I could waste three minutes talking about why they should be here, but I won't!

Ms Halton—We couldn't possibly comment!

Senator POLLEY—Can you tell me, then, how many doctors this represents?

Ms Halton—Again, that is a matter that we cannot comment on.

Senator POLLEY—The proportion of doctors' services claimed on bulk-billing is not yours either?

Ms Halton—Issues in respect of bulk-billing statistics is not this program. Issues to do with the approach to billing, be it bulk-billed or patient-billed, are matters relevant to the medical and pharmaceutical services program, and regrettably those officers have gone home.

Senator POLLEY—And the proportion of GP services claimed through HIC Online?

Senator McLUCAS—It is all HIC. But, on that, are there any plans afoot to reintroduce the HIC Online proposal from A Fairer Medicare?

Ms Halton—Policy is as it is announced, Senator.

Senator McLUCAS—Has there been any analysis of that proposal to bulk-bill at point of service?

Ms Halton—You would be aware that Minister Hockey has got some issues in relation to how billing occurs. I think he has been quite public in talking about that; but that is a matter for Minister Hockey.

Senator McLUCAS—I understand that, but it would have, in my view, quite significant ramifications for health expenditure if that were to happen.

Ms Halton—And you would be aware that from a policy perspective we would have some opinions about such matters.

Senator McLUCAS—Exactly, and you have not been asked to liaise with—

Ms Halton—We are having an ongoing dialogue with them on a range of issues. Obviously, the impact of service delivery on policy issues would be a part of the dialogue we are having.

Senator McLUCAS—And that dialogue does include as an agenda item—I do not know if you have agendas in dialogues—a discussion about the reconsideration of reimbursement at point of service?

Ms Halton—I think Minister Hockey is in the public arena talking about an approach to billing. I would not characterise anything he said as being a revisiting of those earlier initiatives, no, but I think he has signalled publicly his interest in streamlining and facilitating consumer access in relation to billing. To the extent that there are policy implications in any of the things he is considering, you are quite right; that is an ongoing matter of discussion between us and them. The technology side of that is theirs. The policy side of it is ours.

CHAIR—I think the point now has been reached. I need to thank the minister, thank Ms Halton and officers of her department.

Ms Halton—Senator Humphries, can I, just for the record—because it is good to have these things on the record—acknowledge that this was Brett Lennon's last estimates. He does not look old enough, but he is retiring.

CHAIR—I see.

Ms Halton—I would like to put on record my thanks to him for his sterling service to the department and, no doubt, to the senators in his time. It is important that we acknowledge people as they go to other occupations.

CHAIR—Indeed it is.

Ms Halton—Thank you for your indulgence.

CHAIR—Thank you, members.

Committee adjourned at 11.01 pm