COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

ESTIMATES

(Additional Estimates)

THURSDAY, 16 FEBRUARY 2006

C A N B E R R A

BY AUTHORITY OF THE SENATE

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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Thursday, 16 February 2006

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

Senators in attendance: Senators Adams, Allison, Crossin, Eggleston, Fielding, Forshaw, Humphries, McLucas, Moore, Polley, Watson and Webber

Committee met at 9.05 am

HEALTH AND AGEING PORTFOLIO

In Attendance

Senator Santoro, Minister for Ageing

Department of Health and Ageing
Whole of Portfolio
Executive

Ms Jane Halton, Secretary
Mr Philip Davies, Acting Deputy Secretary
Ms Mary Murnane, Deputy Secretary
Professor John Horvath, 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 Laurie Van Veen, Assistant Secretary, Communications Branch
Mr Mike Siers, Assistant Secretary, Corporate Support Branch
Ms Tatiana Utkin, Assistant Secretary, Strategic Management Branch
Mr David Watts, Assistant Secretary, Legal Services
Mr Gary Williamson, Acting Assistant Secretary, People Branch
Mr John Trabinger, Assistant Secretary, Technology Group
Mr Steve Bell, Acting Assistant Secretary, Technology Group

Portfolio Strategies Division

Mr David Kalisch, First Assistant Secretary, Portfolio Strategies Division
Ms Shirley Browne, Assistant Secretary, Parliamentary and Portfolio Agencies Branch
Mr Jamie Clout, Assistant Secretary, Budget Branch
Ms Julie Roediger, Assistant Secretary, Economic and Statistical Analysis Branch

Audit and Fraud Control

Mr Allan Rennie, Assistant Secretary, Audit and Fraud Control Branch

Outcome 1—Population Health
Population Health Division
Mr Andrew Stuart, First Assistant Secretary, Population Health Division
Ms Jennifer McDonald, Assistant Secretary, Food and Healthy Living Branch
Mr Bruce Wight, Acting Assistant Secretary, Drug Strategy Branch
Ms Carolyn Smith, Assistant Secretary, Targeted Prevention Programs Branch
Mr Peter Morris, Assistant Secretary, Strategic Planning Branch
Therapeutic Goods Administration
Dr David Graham, National Manager
Dr Rohan Hammett, Principal Medical Officer
Dr Leonie Hunt, Director, Drug Safety and Evaluation Branch
Ms Rita Maclachlan, Director, Office of Devices, Blood and Tissues
Mr Mark Doverty, Director, Manufacturer Assessment Branch
Dr David Briggs, Director, Office of Complementary Medicines
Ms Alice Creelman, Director, Joint Agency Establishment Group
Dr Sue Meek, Gene Technology Regulator
Dr Wafa El-Adhami, Acting Director, Office of Chemical Safety
Outcome 2—Medicines and Medical Services
Medical and Pharmaceutical Services Division
Ms Rosemary Huxtable, First Assistant Secretary, Medical and Pharmaceutical Services Division
Ms Sarah Major, Assistant Secretary, Pharmaceutical Access and Quality Branch
Dr Ruth Lopert, Principle Adviser, Pharmaceutical Benefits Taskforce
Ms Joan Corbett, Assistant Secretary, Pharmaceutical Benefits Branch
Dr John Primrose, Medical Adviser, Pharmaceutical Benefits Branch
Ms Samantha Robertson, Assistant Secretary, Medicare Benefits Branch
Mr Tony Kingdon, National Manager, Officer of Hearing Services
Dr Jane Cook, Senior Medical Adviser, Medicare Benefits Branch
Ms Judy Blazow, Senior Adviser, Medical and Pharmaceutical Services Division
Primary Care Division
Mr Richard Eccles, First Assistant Secretary, Primary Care Division
Mr Leo Kennedy, Assistant Secretary, General Practice Programs, Primary Care Division
Ms Megan Morris, Assistant Secretary, Primary Care Programs Branch, Primary Care Division
Ms Judy Daniel, Assistant Secretary, Primary Care Policy Branch, Primary Care Division
Ms Lisa McGlynn, Assistant Secretary, GP Divisions and Information Branch, 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
Ms Carolyn Scheetz, Acting Assistant Secretary, Quality Outcomes Branch
Ms Mary McDonald, Assistant Secretary, Community Care Branch
Mr Stephen Dellar, Assistant Secretary, Residential Program Management Branch
Mr Peter Broadhead, Assistant Secretary, Policy and Evaluation Branch

Ms Fiona Lynch, Assistant Secretary, Office for an Ageing Australia
Ms Elizabeth Cain, Head, Pricing Review Implementation Unit

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

See Outcome 2.

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
Ms Alison Larkins, Assistant Secretary, Health Workforce Branch
Mr Nathan Smyth, Assistant Secretary, Mental Health and Suicide Prevention Branch
Ms Jan Bennett, Assistant Secretary, Health Services Improvement Division Taskforce
Ms Linda Powell, Assistant Secretary, EHealth Policy Branch
Mr Tam Shepherd, Acting Assistant Secretary, EHealth Implementation Group
Ms Sharon Appleyard, Acting Assistant Secretary, Rural Health Branch

Outcome 6—Hearing Services

Medical and Pharmaceutical Services Division

See Outcome 2.

Outcome 7—Indigenous Health

Office for Aboriginal and Torres Strait Islander Health

Ms Lesley Podesta, First Assistant Secretary, Office for Aboriginal and Torres Strait Islander Health
Mr Mark Thomann, Assistant Secretary, Program Planning ands Development Branch
Ms Joy McLaughlin, Assistant Secretary, Policy and Analysis Branch
Ms Rachel Balmanno, Assistant Secretary, Health Strategies Branch

Outcome 8—Private Health

Acute Care Division

Mr David Learmonth, First Assistant Secretary, Acute Care Division
Mr Charles Maskell-Knight, Principal Adviser, Medical Indemnity Branch
Ms Linda Addison, Assistant Secretary, Private Health Insurance Branch
Ms Gail Yapp, Assistant Secretary, Acute Care Strategies Branch
Ms Lana Racic, Director, Acute Care Strategies Branch
Ms Yael Cass, Assistant Secretary, Acute Care Development Branch
Ms Elizabeth Flynn, Gene Technology Review Act
Mr Peter Woodley, Acting Assistant Secretary, Diagnostics and Technology Branch
Dr David Barton, Medical Officer, Diagnostics and Technology Branch
Dr Bernie Towler, Medical Officer, Acute Care Division

Medibank Private

Mr George Savvides, Managing Director, Medibank Private
Mr Bruce Levy, Group Manager Health Services, Medibank Private

Mr Craig Bosworth, Policy and Industry Affairs Manager, Medibank Private
Mr Chris Wheatley, Health Policy and Economics Manager, Medibank Private

Private Health Insurance Ombudsman

Mr John Powlay, Private Health Insurance Ombudsman

Private Health Insurance Administration Council

Mrs Gayle Ginnane, Chief Executive Officer, Private Health Insurance Administration Council

Outcome 9—Health System Capacity and Quality

Health Services Improvement Division

See Outcome 5.

Portfolio Strategies Division

See Whole of Portfolio.

Outcome 10—Acute Care

Acute Care Division

See Outcome 8.

Outcome 11—Health and Medical Research

Office of the National Health and Medical Research Council

Mr Bill Lawrence, Acting Chief Executive Officer, National Health and Medical Research Council
Dr Clive Morris, Executive Director of Centre for Corporate Operations and Centre for Compliance and Evaluation
Mrs Cathy Clutton, Acting Executive Director, Centre for Health Advice, Policy and Ethics
Ms Suzanne Northcott, Executive Director, Centre for Research Management and Policy

Outcome 12—Biosecurity and Emergency Response

Office of Health Protection

Ms Cath Halbert, Acting First Assistant Secretary, Office of Health Protection
Dr Moria McKinnon, Medical Officer, Health Protection and Policy Branch
Mr Simon Cotterell, Assistant Secretary, Health Protection and Policy Branch
Dr Leslee Roberts, Health Emergency Planning and Response Branch

CHAIR (Senator Humphries)—I declare open this hearing of the Senate Community Affairs Legislation Committee considering the additional estimates for the portfolio of Health and Ageing. I welcome Senator Santo Santoro, Minister for Ageing and Minister representing the Minister for Health and Ageing; the departmental secretary, Ms Jane Halton; and 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 should be given reasonable opportunity to refer questions asked of them to superior officers or to a minister.

In addition, I draw the attention of the committee to privilege resolutions agreed to by the Senate on 23 February 1988 concerning the conduct of Senate committees and, in particular, resolutions 1(9), part of 1(10) and 1(16). Privilege resolution 1(9), which deals with the question of relevance, reads:

A chairman of a committee shall take care to ensure that all questions put to witnesses are relevant to the committee's inquiry and that the information sought by those questions is necessary for the purpose of that inquiry. Where a member of a committee requests discussion of a ruling of the chairman on this matter, the committee shall deliberate in private session and determine whether any question which is the subject of the ruling is to be permitted.

The Senate endorsed in 1999 the following test of relevance of questions at estimates hearings:

Any questions going to the operations or financial positions of the departments and agencies which are seeking funds in the Estimates are relevant questions for the purposes of Estimates hearings.

I ask senators to bear this in mind when framing their questions. The emphasis is on financial positions and operations.

Privilege resolution 1(10) goes to the question of the procedure that must be followed by a committee if a witness objects to answering a question. This resolution is partially overridden by standing order 26(2), which requires legislation committees considering estimates to take evidence in public. The section of privilege resolution 1(10) which applies to estimates reads:

Where a witness objects to answering any question put to the witness on any ground, including the ground that the question is not relevant or that the answer may incriminate the witness, the witness shall be invited to state the ground upon which objection to answering the question is taken. Unless the committee determines immediately that the question should not be pressed, the committee shall then consider in private session whether it will insist upon an answer to the question ...

Where a witness, including a minister, declines to answer a question to which a committee has required an answer, the committee may report the matter to the Senate. Alternatively, the committee can also consider reconvening outside the estimates process to pursue a matter under one of the committee's other powers, as provided for in standing order 25(2)(b).

Today the committee will be working through the portfolio additional estimates statements in Health and Ageing. I propose to call on the additional estimates in the order of the circulated program. Senators have advised that they do not have any questions on outcome 6. Any questions for this outcome will be provided as written questions on notice. Outcome 12, Biosecurity and emergency response, is an additional outcome to the portfolio structure from our last session and will be considered in outcome 1. Minister, do you wish to make an opening statement today?

Senator Santoro—No, Mr Chairman.

[9.10 am]

Department of Health and Ageing

CHAIR—I suggest the committee commences with questions on the portfolio overview on pages 5 to 23 of the portfolio additional estimates statements.

Senator ADAMS—I want to ask some questions on the funding of pregnancy counselling services. I would also like a list of the organisations that are being currently funded. Could you tell me which outcome that would come under?

Ms Halton—That would be under outcome 1, Population health, which is scheduled for 9 o'clock.

Senator ADAMS—I have been a member of the Therapeutic Goods Administration private member's bill. Representatives of an organisation in Sydney who do statewide phone counselling were saying that they had applied to the department for funding and had not had any help. They made several comments that, because their organisation were looking at advising on terminations and not on a pro-life choice, they felt they were not being looked after properly in that respect; that they had applied for funding and had not really got anywhere. So I would like a list of the organisations that are currently funded to advise on pregnancy counselling.

Ms Halton—I believe we provided that on notice in the past. Whilst the officers are not here, I will endeavour to find copies of the answers that we provided in relation to those matters. You might find that helpful. I would also make the general observation that, in that area, the program has not grown. If you have details of new organisations that are emerging, that might help me to make some more inquiries.

Senator ADAMS—This was the Bessie Smyth Foundation. It presented to our committee in Sydney last week.

Ms Halton—I will get a couple of phone calls made. Let us go back through particular questions on notice that we have dealt with, because I am sure that in the past we have given a list of the organisations that are funded. I will see if I can retrieve that and at least provide that to you early, if that would be of use.

Senator ADAMS—That would be great.

Senator McLUCAS—Ms Halton, can I thank the department for that schema of where rural health fits. That was helpful. I want to ask some questions about the underspend in the HECS reimbursement program for rural doctors. Does that fit in outcome 4?

Ms Halton—Yes. I had to ask the same question, Senator; these things are a little complicated.

Senator McLUCAS—The other issue I want to talk about is questions on notice. I have not done a tally of how many questions were received by the appropriate time, which I understand was 16 December. Can you indicate to the committee what number was received by that date and what number was not?

Ms Halton—Thirteen questions were provided on that date, 97 were provided within a month of that date and 236 were provided inside two months of that date.

Senator McLUCAS—I understand all questions are now answered?

Ms Halton—Yes, that is my understanding.

Senator McLUCAS—Can you indicate to the committee the reason why such a large number were late, particularly by two months?

Ms Halton—I think you and I have discussed in the past the iterative process around these answers, with them going backwards and forward. All I can say is that we sit on this as much as we can and try to move them forward. To be fair, in this particular case there were some questions that were quite complex. Certainly, once we hit the Christmas period, when, as you

would be aware, a lot of people were away, regrettably the process of clearance was difficult to achieve.

Senator McLUCAS—I am particularly interested to know why question EO5_354 came back only yesterday.

Ms Halton—I will have to look at it. I do not know. I will dig it out and have a look.

Senator McLUCAS—We can talk about it more in outcome 2. Could we have the answer by then?

Ms Halton—I will have a look at it.

Senator McLUCAS—I want to go now to the question of advertising. Could I get an indication, please, of what spending the department has undertaken in advertising and market research in this financial year to date?

Ms Halton—The officer is next door. We will just go and get her. In relation to your question about EO5 354, we do not hold the original data for registrations. This is a function performed by Medicare Australia. I am advised that we were waiting for a data point from Medicare Australia. So we did not actually have the information and we were waiting for the information in order to answer the question.

Senator McLUCAS—What is a data point?

Ms Halton—The number. It is a table, as you would be aware, and we were waiting for a number.

Senator McLUCAS—You were waiting for the December number?

Ms Halton—I presume it was December. I understand, on advice, that there was something we were trying to clarify with Medicare about the data. We had to wait for them to confirm information with us. I can get more precise information, but we were actually waiting for confirmation from Medicare Australia in relation to the numbers.

Senator McLUCAS—This is becoming a bit of a pattern. In November estimates this question was answered at 9.27 the night before. We got the answer to this question yesterday morning, so I suppose we are 12 hours better off. I will be interested to know what the dispute between Medicare Australia and the department was and whether that is a recurring dispute that you have about the numbers. Given that this committee knows that that data is transmitted weekly, I am surprised that it has taken till 15 February to get the December figures.

Ms Halton—I cannot speak to the specifics, but I will find out. We do often find in the data we receive that it is often uncleaned, if you understand what I mean.

Senator McLUCAS—No.

Ms Halton—There can be errors and anomalies in data. Our people spend a lot of time ensuring that the data are accurate. There is a high level of traffic between ourselves and Medicare Australia in relation to data, because we have an obvious concern that we do not put into the public arena data that is potentially inaccurate. Let me find out. I was not aware of the fact that it was the same question last time. I will find out.

Senator McLUCAS—We will talk more about it in outcome 2. Let us go back to advertising.

Ms Van Veen—Would you mind repeating your question, please?

Senator McLUCAS—What spending has the department undertaken in the two separate areas of advertising and market research to date?

Ms Van Veen—Because our advertising campaigns run across financial years, I will go through them campaign by campaign. With respect to the National Drugs Campaign, which has run across two years, the expenditure has been $13.4 million.

Senator McLUCAS—Is that over two years or is that the current financial year?

Ms Van Veen—No, over two years. The developmental period has been over more than two years, but predominantly the last two financial years, including the current year. With respect to the market research that has informed the campaign, it has been a total of $1,083,000. That covers the formative research that informs the campaign, which was done with parents and young people, right through to the benchmark research and the tracking research to evaluate the campaign.

With respect to the nutrition campaign, known as the Go for 2&5 campaign, launched last year, the total expenditure across the two financial years has been $4,058,000—I am rounding the figures here. The total research component has been $257,665. I should also mention that part of the market research is not only the formative research to understand consumers' mindsets and issues of the target audience but also the research to concept-test the materials to ensure that whatever we develop is appropriate to convey the messages to the audiences. As you might imagine, given that the physical activity campaign was launched last week, all the bills will follow, but $800,000 has been spent on it to date and $337,000 has been spent on the market research.

Senator McLUCAS—Just on that one: is that $800,000 on production costs?

Ms Van Veen—That is the sum we have spent to date, which would include the market research as well as the production costs with the advertising.

Senator McLUCAS—So the $800,000 includes the $373,000?

Ms Van Veen—That is right, and there is some money in there for campaign support materials and some minor costs with media. But the big media bills will not be in until after its completion in the next few months. Leaving the national tobacco campaign, I have with me this morning for the senators show bags on both the physical activity campaign and the health warnings campaign, which started running last night, so I will provide those to you. They contain all the materials that have been developed for consumers—the copies of the ads on CD-ROM and all the factual information on that.

Ms Halton—We will table those in a minute.

Ms Van Veen—The first phase of that activity has centred around health warnings. The total figure on that to date has been $511,000. Again, it is in the early stages in terms of getting the bills in. With respect to research, there have been two components here: one is

predominantly around the concept testing, which has been $86,000, and the other is associated with annual surveys and is $131,000.

Senator McLUCAS—What is the purpose of the annual surveys?

Ms Van Veen—We conduct them each year to monitor prevalence and consumption issues related to tobacco. It is associated with things like chop chop, illegal tobacco, and awareness of our campaign messages. It covers a range of measures associated with policy issues, as well as with campaign issues.

Senator McLUCAS—What are you surveying in that survey?

Ms Van Veen—With respect to that, we are surveying smokers to understand what their level of cigarette consumption is, their level of awareness of campaign messages and their level of awareness of things like health warnings. This would be done in a benchmark capacity so that, by the time we run this campaign, we can measure whether or not smokers are aware of our messages and whether they have had an impact and been effective. That covers off the advertising campaign.

Senator McLUCAS—Are there any plans to promote a revamp of the Medicare system?

Ms Halton—That would be a question in reference to that newspaper article.

Senator McLUCAS—That is correct.

Ms Halton—I was delighted to hear that the newspaper had taken the decision that we were going to be spending a large amount of money. We are not aware of any such plan. It came as a complete surprise to all of us and, can I say, the minister.

Senator McLUCAS—The article says: '... tens of millions of dollars are likely to be spent promoting a revamp of the Medicare system'.

Ms Halton—Not that we are aware of.

Senator McLUCAS—How much was spent on Strengthening Medicare?

Ms Van Veen—I can get that information. I know we have answered it on notice. It goes back a couple of years. I do not have it with me today.

Senator McLUCAS—From my recollection, that was about $14 million.

Ms Van Veen—I would need to check that.

Senator McLUCAS—Have all of these campaigns been approved through the ministerial committee?

Ms Halton—Absolutely.

Senator McLUCAS—You have given me the expenditure to date. Maybe you could provide us on notice the total budgeted expenditure for each of those campaigns.

Ms Van Veen—That would be fine. I can give you the budgets that we are working to on campaigns.

Ms Halton—It might be easier if we tell you now. It saves questions that might be late.

Senator McLUCAS—All right.

Ms Van Veen—The government announcement associated with ‘Go for 2&5’, a nutrition campaign, was $5 million.

Senator McLUCAS—Over what period of time?

Ms Van Veen—Over two financial years.

Senator McLUCAS—What are the two financial years?

Ms Van Veen—They are 2004-05 and 2005-06. There was some rephasing associated with the funding, because campaign activity often spans two financial years and bills do fall in the following year. The total budget for the physical activity campaign is $6 million. Funds were rephased from the 2004-05 year into 2005-06 year. Again, that campaign had some expenditure last year as well as this year. The total funding package for the national tobacco campaign is $25 million over four years. We are in the first year of that expenditure. I can give you the budget allocations for each of the four years, if you like.

Senator McLUCAS—No, that is fine. And the drugs campaign?

Ms Halton—Have you seen the physical activity ad?

Senator McLUCAS—I do not get enough time to watch television.

Ms Halton—I know. I would suggest that you have a look at the one we give you; it is very good. It is mainly running in children’s viewing hours, and I suspect most of us do not watch television in children’s viewing hours.

Ms Van Veen—The national drugs campaign is approximately $13.5 million. Again, that runs across several years, right through to this current financial year.

Senator McLUCAS—So the ad says, ‘Now you’re watching TV, turn it off’?

Ms Halton—It has a chair that tips you. It is a very good ad. Senator Forshaw, there is a copy for you as well.

CHAIR—Politicians are very sensitive to that kind of imagery, you understand.

Ms Halton—It is a red chair, Senator.

CHAIR—Sounds nasty!

Senator McLUCAS—I think that covers my questions on advertising. You can be unequivocal, but there is no intention to be spending money on a revamp of the Medicare system?

Ms Halton—Obviously I cannot fetter any decision the government might make in the future, but there is no plan that I am aware of and there is no decision. I have discussed this with the minister in the last couple of days.

Senator McLUCAS—Did you do any checking to find where that suggestion might have come from?

Ms Halton—I think it is fair to say there was a suggestion that there might have been a letter to the paper concerning that particular report.

Senator McLUCAS—Pardon?

Ms Halton—I think there was a suggestion that someone might be writing to the newspaper about that particular report.

Senator McLUCAS—Moving, then, to media monitoring, how much does the department spend on media monitoring?

Ms Van Veen—In the last financial year, 2004-05, the department spent $767,740 on media monitoring.

Senator McLUCAS—That was last financial year.

Ms Van Veen—I can give you figures to date for this financial year as well.

Senator McLUCAS—So last financial year it was—

Ms Van Veen—$767,740.

Senator McLUCAS—And the figures to date for this year?

Ms Van Veen—$387,648.

Senator McLUCAS—So about the same?

Ms Van Veen—About the same. Obviously with issues such as bird flu, avian influenza, it is a bit difficult to predict how much monitoring will go on in that area. But we are on track with what is happening and we have done real work to pare down our costs in this area.

Senator McLUCAS—Who provides your service?

Ms Van Veen—Rehame.

Senator McLUCAS—What does it include?

Ms Van Veen—Basically, we have a password protected news monitoring website which is available to all the departmental officers, and we have monitoring across metropolitan newspapers, regional newspapers and radio and television organisations. We also receive from Rehame a live alert service for breaking news and ordered transcripts, video tapes and audio tapes.

Senator McLUCAS—And you get that almost immediately; it is not like the daily news clippings like we used to get in the olden days?

Ms Van Veen—That is right. We have moved totally away from paper based news clips; we are totally electronic in how we receive this service.

Senator McLUCAS—What areas or people do you monitor?

Ms Van Veen—The portfolio has a very vast area of issues, everything from communicable diseases and the reporting associated with that to a range of other population health issues—hospitals, Medicare. It is quite comprehensive. I do not have the full list with me.

Senator FORSHAW—Are you talking about Australian based media? Is there monitoring of overseas media as well?

Ms Van Veen—Not by Rehame.

Ms Halton—I should say that we do keep an eye on some of the international press in relation to our biosecurity intelligence, but that is a different thing and it is certainly not done in that way.

Senator McLUCAS—What people do you monitor—I dare say you have given a list of names to Rehame to monitor?

Ms Van Veen—We do not have a list with Rehame.

Ms Halton—No.

Senator McLUCAS—It is issue based?

Ms Van Veen—Yes.

Ms Halton—It is issue based. We do not monitor people.

Senator McLUCAS—Does the minister's office have access to that monitoring website as well?

Ms Van Veen—Yes.

Senator McLUCAS—That is all I have on advertising. If you find out you have a lot of money to spend on revamping Medicare, you will tell the committee, won't you?

Ms Halton—Indeed.

CHAIR—There being no other questions on whole-of-portfolio or corporate matters, we will move to Medibank Private.

[9.42 am]

Medibank Private

Senator McLUCAS—Good morning, Mr Savvides. Can you provide an update to the committee on the contract negotiation process around what I think is called the request for proposal process?

Mr Savvides—The hospital purchasing strategy, which is what we call these negotiations, are pretty well all complete now. The only thing that we are finalising is the paperwork part of the negotiations. All of the agreements are in place in terms of agreed positions. Some 99 hospitals submitted to the tender. That is all of the hospitals we invited to participate. All of the hospitals have commercial contracts with Medibank. Ninety-six of them have Members' Choice contracts and three have non Members' Choice arrangements, but they are contractual arrangements with Medibank Private.

Senator McLUCAS—How does that compare with the number before the process began?

Mr Savvides—All 99 had contracts with Medibank Private. These were hospitals which were targeted in metropolitan districts and high population zones. We did not apply the tender process to regional and country jurisdictions.

Senator McLUCAS—Could you provide the committee with a summary of these hospitals and where they are located by state?

Mr Savvides—I can certainly provide that information, but I will have to take that on notice.

Senator McLUCAS—How many hospitals that had a relationship with you previously do not now have one with you?

Mr Savvides—All of the 99 tenderers have a commercial relationship with Medibank Private with agreed fees for services, accommodation and theatre. Ninety-six of the 99 have the highest form of contractual relationship, which is the Members' Choice terms. The three who do not are the St Vincent's Private Hospital in Sydney, John Flynn in Queensland and also the Epworth Hospital in Melbourne. They are the three that have the alternative contracts to the Members' Choice contracts.

Senator FORSHAW—When you commenced this initiative, did Medibank Private invite hospitals to tender? So did Medibank Private in effect draw up a list of hospitals that they invited tenders from? Or was it some sort of open, at-large tender so that all hospitals that you had previously had a relationship with, or all hospitals in total, had an opportunity to try and get into this arrangement, and then you culled that list? How was the choice made?

Mr Savvides—All hospitals in the markets that we defined as markets that had multiple choices of supply of services were invited to tender, and all of those hospitals had pre-existing contracts with Medibank. But this was the first time we had ever applied a process where there was a simultaneous submission for pricing for services in a tender form. The reason we did that was to deal with the extraordinary range of prices for identical services that existed in suburban locations within five or 10 kilometres of each other where you would have a plus or minus 25 per cent range for, say, a hip or knee replacement. What became apparent to us was a lack of competitive tension in the market for winning contracts with Medibank, so we applied a conventional tendering process.

Senator FORSHAW—But were you only looking at hospital costs when you were doing that, or were you also considering the costs that could ultimately be covered by private health insurance which go to gaps and to the specialist fees that are not fully covered? That is where there could be a substantial variation in the charge, as distinct from the hospital bed cost per day.

Mr Savvides—Actually, the medical specialty fees were not included in the tender. This was a hospital tender.

Senator FORSHAW—That is what I wanted to establish.

Mr Savvides—But the variation in charges—plus or minus 25 per cent—exists in the hospital accommodation and theatre charge market.

Senator McLUCAS—What does that mean, then, for those three hospitals, for the patients that go to those hospitals?

Mr Savvides—Because they have a contract with Medibank Private, our members can continue to go to those hospitals, but, because they were not able to make the highest form of contractual relationship with the company, we put in place an arrangement where they could not charge any more than a daily copayment that would be incurred by the hospital on the member. Our desire was to make sure that that was capitated. There is a series of different copayments for the three hospitals, but we had made sure that the daily charge has a cap on it—in some cases, that is $80; in other cases, it is $100—and that the overall journey of

servicing does not go beyond, in one particular provider, $400 for example. That is the Epworth Hospital in Melbourne.

Senator McLUCAS—And I understand that you wrote to members—

Mr Savvides—We did.

Senator McLUCAS—Which members did you write to?

Mr Savvides—We took a postcode based and also a file based view of all the members that were serviced by those hospitals in the past. So we made sure that we took two approaches to the mailing to make sure that we maximised the catchment for communication purposes. The hospital also engaged in its own communication to members as well.

Senator McLUCAS—Let us take John Flynn Hospital in Brisbane. Did you write to people in Brisbane only?

Mr Savvides—We wrote to people who had used that hospital before and we wrote to members in a catchment zone. I do not know specifically the size of the catchment, but we certainly know where our members live. We wrote to those people who we expected to be potential users of that hospital or other hospitals in that area.

Senator McLUCAS—Do you understand that a lot of people from regional Queensland would go to John Flynn Hospital and would go for one event only, potentially? You probably did not write to people in Cairns?

Mr Savvides—I can take that on notice to determine how big that catchment was. There may have been an inclusion of all the country members because of the nature of the services that that hospital provided. I am thinking more about the suburban hospital in Melbourne, where I know it was much more of a geographic approach given the nature of the services that they provide there. Also, there is a requirement of the medical specialists and the hospital to inform members in advance of any unforeseen charges. I need to stress again that these costs are not costs that Medibank Private impose on their members; it is a cost that the hospitals choose to impose because, for whatever reason, they feel they did not get the fee reimbursement that they desired from the health fund.

Senator McLUCAS—Let us take a circumstance where a specialist will work out of one of these three hospitals and the patient is covered by Medibank Private but the specialist deems that they would like them to go to one of those three hospitals. Have you had much complaint from people who are caught in that circumstance—where they think they have full health cover and they go off and have their hip or knee replacement and then get a very big bill?

Mr Savvides—It is our understanding that in most cases surgeons operate out of more than one facility, that they have rooms in multiple hospitals. Therefore, it would be a rare event that a surgeon would be exclusively aligned to one particular facility. It does happen in some cases, but that would be the exception. We have also put in place in many cases quite a substantial notification period, depending on the kind of treatment. If it is a chronic treatment, a regular treatment, people have a six-month notification before any arrangements change. The third area in terms of member protection is that our top table, which is called Premier Plus, avoids the exposure to these charges. If members choose to be on that top table or if they

are already are on that top table, they have no exposure at all to this particular gap payment which the hospital imposes as a result of not having a member's choice relationship with Medibank Private.

Senator McLUCAS—Can you explain the six-month measure?

Mr Savvides—All members with repeat treatments have a six-month period before they get any exposure to the daily copayment for that kind of treatment.

Senator McLUCAS—So they have had an event and have to go back for another event?

Mr Savvides—Say, for example, that they have some kind of therapy treatment, a regular monthly treatment, they would have six months of that treatment without any changes in terms of new fees charged by the hospital before those charges would arrive. We made sure that we gave people plenty of time. Obviously, individuals with obstetric bookings have nine months of protection before any charges are imposed on them. We have tried to avoid the immediate impact of these new arrangements.

Senator McLUCAS—What is your level of complaint following the finalisation of the contract?

Mr Savvides—I thought that question might come up today, so I got those numbers. The three hospitals take on around 25,000 Medibank member episodes a year—so there is a 25,000 throughput out of the three hospitals—and we have received 75 complaints to date. That is about a third of one per cent of the member traffic through those three facilities.

Senator McLUCAS—That is a high number of complaints, I would imagine, for Medibank Private?

Mr Savvides—It is much lower than we had anticipated. I think the timing that we have given people to make alternative arrangements, the reality that surgeons actually operate in multiple facilities so alternative arrangements can be made and also the option of being able to take up the top table protection—all of those factors—have mitigated unnecessary exposure to members in this arrangement.

Senator McLUCAS—Do you think people have actually moved up to the top table because they are patients of those three hospitals?

Mr Savvides—I know that we have received quite a few member upgrades to the higher table, and we have also removed the pre-existing timing requirement, the deferred timing requirement, so that people are not unnecessarily prevented from getting protection. There are multiple options. Some members, we know, have moved to other funds through the portability arrangements that exist. The alternative fund might have their version of a members' choice contract with that hospital, and hence their treatment has become uninterrupted in their favoured facility.

Senator McLUCAS—What were the nature of the complaints?

Mr Savvides—I do not have the break-up or the reason code around those complaints here with me, but I can take that on notice and provide a summary.

Senator McLUCAS—Thank you. I have a question for the Private Health Insurance Ombudsman. Mr Powlay, have you received complaints about this particular issue with Medibank Private and these three hospitals?

Mr Powlay—Only a handful. The last time I checked there were about five complaints. We have had fewer complaints since Medibank brought in the arrangements than the number of complaints we had about what Medibank was planning to do, when people read about it in the media. I think we had about a dozen complaints relating to the media reports and people objecting to what they thought Medibank was doing, but we have had very few complaints since.

Senator McLUCAS—More broadly, what is the nature of the complaints in the current year? How are complaint levels tracking compared with previous years?

Mr Powlay—Over the last financial year, and since then, complaint numbers have been down over what they have been historically. The main driver of that has been a reduction in complaints about premium rises, but complaints of that—

Senator McLUCAS—People are just used to it now, are they?

Mr Powlay—That is possible, but complaints about benefit levels are increasing slightly.

Senator McLUCAS—What do you put that down to?

Mr Powlay—It is difficult to put it down to anything in particular. There are now more people on products that do not pay full benefits for certain treatments. That may be a factor. In some instances, it looks as though the incidence of doctors' gaps is increasing in some places. They seem to be important factors in keeping up that level of complaint.

Senator McLUCAS—Mr Savvides, how many branch closures have occurred in Medibank Private?

Mr Savvides—I am aware of one recently. I will have to take it on notice for the last 12 months. There are very few, and the nature of all our closures is about the refit and refurbishment program we are just about to complete; we have been doing it for the last three years. We have about 105 retail stores—that has grown in the last three or four years by a few, by about seven or eight per cent. We recently moved the Tweed Heads facility to a nearby expanded retail environment. The reason was that the lowering of claiming activity and servicing levels in that facility were well under our normal benchmark servicing requirements for volume. We are pleased we have done that now, because the new facility is reporting significantly more usage by members. We have actually moved to a more effective catchment, and that is the motivation for any of the moves we make. Before we do the balance of our refit program, we do not want to refit stores that are likely to be moved because they are in poor catchments. That is the nature of the move we have made recently.

Senator McLUCAS—I understand that there was already an office in Pacific Fair. It was quite close to where the new Tweed Heads one has been relocated. What was the rationale for putting them seemingly so close together?

Mr Savvides—Our retail specialists tell us that the catchments there are utilising the facilities at the required level. To spread them in a way where you get underutilisation of those facilities actually creates quite a cost burden on the fund, which members then have to

pay for through premiums. So getting the right balance between servicing and costs obviously is the challenge. The metrics we are always looking for are that relocations result in improved levels of servicing, more traffic flow, because we are reaching people and improving the access. That has been our experience in the refurbishment program over the last two years.

Senator McLUCAS—Have you had complaints from elderly members, in particular, about the relocation?

Mr Savvides—We did have a few complaints. Obviously around a change we communicate prior to the change and make it clear as to where we are relocating. Often our members do not realise that there are alternative facilities. Australia Post provide facilities for our members for claiming and payments of premiums. You can also make those arrangements by telephone through our call centre. Most recently—and I know it may not apply to all of our older members—we have an online service through the web, so through that portal you can make payments and claims and request that lost card be replaced et cetera.

Senator McLUCAS—Can you explain to the committee what is happening with the sale of Medibank Private?

Mr Savvides—The actual decision making around the sale is a shareholder driven exercise, and asset sales in the Department of Finance and Administration are administering the entire activity. Our contribution to the process has been the interaction we had with the Carnegie Wiley team, and that has been completed. That was done just prior to Christmas. That is our only contribution to that exercise.

Senator McLUCAS—The Carnegie Wiley team did the scoping study?

Mr Savvides—Yes, that is right.

Senator McLUCAS—And that is completed?

Mr Savvides—That is complete, yes.

Senator McLUCAS—Have you received any indication about the time frame for a response to that?

Mr Savvides—No. We do not receive a copy of the study. It is not designed for Medibank; it is designed for the owner. It is entirely up to the owner as to the timing of the review and the decision that they make.

Senator McLUCAS—Have you had meetings with the Department of Finance and Administration on this issue?

Mr Savvides—We have, yes.

Senator McLUCAS—The discussions that you are having are around what areas?

Mr Savvides—The meetings were prior to the commencement of the scoping study, around August last year. They were about the scope of activities so that we would be properly prepared and so that there would be an efficient interaction. They were really to refresh or to update us on a prior study that took place three years ago. That was the nature of the dialogue with the department—so that we would be properly informed and they would understand the boundaries around which we would interact with the scoping study team. Since then we have not had any interaction beyond the normal, which is our monthly review with shareholders.

Senator McLUCAS—Finally, with regard to the *Operations of the registered health benefits organisations annual report 2004-05*, the PHIAC commissioner commented:

The industry has further improved its financial position ... but I must again note the largest contribution to the surplus was from investment income.

What are your comments on that statement?

Mr Savvides—It certainly reflects the very nature of our improvement as well. There are two profit lines in the Medibank Private profit and loss statement. One comes from the business itself of selling health insurance. The second profit line, which is called the underwriting profit, comes from the interest and capital gain that we receive from our surpluses which we invest. They are surpluses to protect the risk of the insured population. While we hold those surpluses, we invest them and we receive an investment income—as does every other health insurance company in the sector. Last year, for example, in our 2005 financial results around 50 per cent of our total profit came from investment income and 50 per cent came from underwriting profit. That is a very healthy investment income contribution, and it reflects the buoyancy of both the interest rate markets that we participated in last year and the equity markets. You may be interested in the profile. We are very conservative with our investments. Around three-quarters—actually 80 per cent—of our prudential reserves is invested in just cash interest. Only 20 per cent, through appropriate professional managers, is invested in equities. That is a very conservative mix, but that is the nature of our outlook as a board.

Senator McLUCAS—He went on to say:

There is no guarantee that this will continue and investment income cannot be relied upon to fund future growth in benefit outlays.

Does Medibank Private concur with that?

Mr Savvides—It does. So we are very cautious to not rely on buoyant investment income markets to prop up our performance. We need to make sure that our underwriting profit—our core business in selling health insurance—has sufficient surplus to protect the fund from volatilities that occur in benefit outlays from time to time. Ninety per cent of our revenue from members is spent in paying claims. If that 90 per cent were to jump around by plus or minus two or three, it would have a significant impact on the bottom line surplus; it would move to deficit very quickly.

Senator McLUCAS—Thank you, Mr Savvides, and happy travelling to Melbourne.

CHAIR—Thank you very much. There are no further questions for Medibank Private. I had been planning to ask you some questions about access to podiatric surgery benefits, but I am told that good progress has been made on that subject since last estimates, so congratulations on that.

[10.06 am]

CHAIR—We will now proceed to outcome 9, Health system capacity and quality. We understand that there are no further questions required for the Private Health Insurance Ombudsman, so if Mr Powlay is still here he need not stay.

Ms Halton—Thank you, Senator.

Senator MOORE—I had a couple of questions about the Better Outcomes program, following on from previous estimates. We have talked before at estimates about the evaluation process for the Better Outcomes program, because it has been around for a while now. We want to know whether there has been an evaluation done on this program by the consultant group Healthcare Management Advisors.

Mr Smyth—That was the lapsing program evaluation. It was conducted by Health Outcomes International.

Senator MOORE—And that has been concluded?

Mr Smyth—That is correct.

Senator MOORE—Is that a public document?

Mr Smyth—No, it is not.

Senator MOORE—Without releasing the whole process, are there core recommendations or advice out of that that could be made public?

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

Senator MOORE—This is a straightforward question about expenditure, as you would be expecting. How much was allocated and how much was spent on the Better Outcomes program for each financial year, including this one, since its inception?

Mr Smyth—Part of this sits within outcome 4, which is the Primary Care Division. They are responsible for one element of it and we are responsible for the other.

Senator MOORE—In your unit, which is the mental—

Mr Smyth—The Mental Health and Suicide Prevention Branch; we have changed the name.

Senator MOORE—I was trying to find a way of congratulating you for putting ‘mental health’ into the title; I am very happy about that. In terms of the following of the expenditure, because Better Outcomes was so focused in this area, do you keep figures across the whole expenditure, even though, as you have said, some elements are in another program?

Mr Smyth—Yes, we do.

Senator MOORE—Is it easier for you to provide that in writing? Is that a table you have?

Mr Smyth—I do have a table here. I think we provided that information on notice at the last Senate estimates hearings.

Senator MOORE—We just keep getting the documentation and comparing it, so could we have the one you have now. Does that clearly define what is in your branch and what is in the other program as well?

Mr Smyth—Yes, it does.

Senator MOORE—So we can look at that and ask questions if we are confused. Does that include up-to-date expenditure in this financial year?

Mr Smyth—Not at this stage.

Senator MOORE—Can we get that separately? Would you have a running expenditure as of the last month or something like that?

Mr Smyth—Not up until the last month. I will check with my colleagues in the other division, and we will get the most available information to you.

Senator MOORE—Would that be likely to be quarterly? Each area seems to have its own kind of cycle.

Mr Smyth—I would have to check; it is not my area. In terms of our area—

Senator MOORE—What is you area?

Mr Smyth—My area is more concerned about the general practice support components, which is access to allied health care components. That deals with psychologists and the fund holding activities of the Australian Divisions of General Practice.

Senator MOORE—What is the last available figure for expenditure on that program?

Mr Smyth—We have fully expended our allocation for this year, which is $24.9 million.

Ms Halton—I make the comment that, whilst Mr Smyth said that he would take it on notice, the reality is that the reviews that are done as part of the budget process cannot be made public. So in terms of the outcomes of that, they are really cabinet documents.

Senator MOORE—Even the outcomes?

Ms Halton—Yes; they are cabinet documents.

Senator MOORE—Was there any public statement about that? I am trying to remember, because of the focus on mental health over the last few months. There was nothing out of that which indicated—

Ms Halton—No. It will not surprise you to know that, if we pick up something that is material in terms of the context of the program, be assured that we will be giving that due consideration in our administration of the program.

Senator MOORE—Mr Smyth, do you keep a list of divisions of general practice that have received funding under your program? Until I say differently, this is all to do with Better Outcomes.

Mr Smyth—We do have a list of the divisions, yes.

Senator MOORE—Can we get that—and how much they have got?

Ms Halton—We can get you a copy; we will table that.

Senator MOORE—I am sure that this is the kind of thing we have asked be forwarded.

Ms Halton—We will table that.

Senator MOORE—Can you tell us how many and what proportion of GPs are registered to participate in the program by state, territory and RRMA since it started? There is a bit of a challenge there. We consistently ask questions in this area about RRMA take-up and RRMA focus, because that is the grouping. I want to see whether you keep data on that area.

Ms Halton—No.

Senator MOORE—You do not?

Ms Lyons—We certainly do not keep it by RRMA in our division. We could break it up state by state, but not by RRMA.

Senator MOORE—So other forms of health funding are done by RRMA but this particular one is not?

Ms Lyons—I cannot answer for my colleagues in Primary Care Division, but certainly in our division we do not keep any data by RRMA.

Ms Halton—I think it is probably important to distinguish between programs that have a particular target that is RRMA relevant and RRMA as a unit of analysis. That is an important distinction. We run a number of programs that have a particularly rural focus, and therefore you are eligible for a program based on whether or not you are in RRMA. That is a key feature of the program as against saying, 'Have we analysed the data by RRMA?' Does that make sense?

Senator MOORE—Yes, so in terms of the department, there is not a RRMA focus across the whole department?

Ms Halton—If we are doing a particular piece of work on something, we might well set someone the task of going out and interrogating an array of data. Because we do not have the systems capability to do this yet—we are working on it—we would not automatically cut every piece of data in that way as a matter of course.

Senator MOORE—The distribution of doctors is done by RRMA, isn't it?

Ms Halton—We can say how many doctor are where, yes.

Senator MOORE—I understand your point that whether the program is RRMA focused or not determines how you analyse that. That is obvious when you think about it. Senator Forshaw has asked many questions in this area about doctor allocation in various RRMAs. I am not sure whether he has any questions today, but I know that it is an issue he has raised.

Senator FORSHAW—I am happy for you to keep doing it today, Senator.

Senator MOORE—On that basis—because you are looking at doctor distribution on the division of GPs within a RRMA area—I thought you would have the data already in the system somewhere, because of the focus.

Ms Halton—The problem with asking a question about an individual practitioner is that, if the database that has the information about the whereabouts of the Better Outcomes money is not the same as the database with the information on the doctors who are identified, together with RRMA, you cannot do the analysis. If you were to start combining a whole series of databases which have a unique identifier across 'doctor', you could match the data. There would be a series of people in the department who would love that as a challenge. Do you understand the point I am making?

Senator MOORE—The IT section here?

Ms Halton—Exactly. You have got it.

Senator MOORE—For the purpose of this series of questions, these two groups of data are not talking to each other?

Ms Halton—Correct.

Senator MOORE—So we will be able to get a list of the general practice groups that have received funding and their location, and we will be able to manually have a look at that and see about RRMA, but you cannot press a button and have them merging?

Ms Halton—That is exactly the point.

Mr Davies—I will add one more complicating factor to that—

Senator MOORE—I am so glad!

Mr Davies—Always a pleasure, Senator. Mr Smyth mentioned that some of the programs that he looks after provide funds to the Divisions of General Practice. In fact, a single division of general practice may encompass areas that are in different RRMAs. For example, I think I am right in saying that the whole of the Northern Territory comprises two divisions of general practice.

Senator MOORE—That is correct.

Mr Davies—A division is not homogeneous in terms of RRMA.

Senator MOORE—So in terms of trying to merge it, it is a bit like trying to compare things with stats units?

Ms Halton—Absolutely. It sounds so simple until you try and do it.

Senator MOORE—Have any divisions requested or applied for additional funding under the program since January 2005 and, if so, how many divisions and how much of their funding have they been able to get?

Ms Lyons—Yes, they have. Mr Smyth will provide the detail for you.

Mr Smyth—We have received requests from seven divisions in this financial year.

Senator MOORE—Since July?

Mr Smyth—Since July this year.

Senator MOORE—Have they been successful requests?

Mr Smyth—They are under consideration. At this stage all of our money for the program is fully expended.

Senator MOORE—You already said that. That is what I am coming to. Is there any chance for additional funding?

Mr Smyth—That would be a decision of government.

Senator MOORE—You have spent all the money on the original allocations and now you have seven requests for more money?

Mr Smyth—That is correct.

Ms Lyons—Can I clarify something. At the outset of a financial year, we provide to the Divisions of General Practice a certain amount of money. They then distribute that according

to the particular divisions. It seems that part of the reason for the request may be that some divisions are managing their budgeting less well than others.

Senator MOORE—Part of their arrangement in this program is that all of that administration is done by the Divisions of General Practice.

Ms Lyons—Yes.

Senator MOORE—They are contracted, aren't they?

Ms Halton—Correct.

Senator MOORE—The process is done by the Divisions of General Practice requesting amounts; they have to put a request in for a certain amount of the staff?

Mr Smyth—The amount is based on the outcomes based formula, which is basically a population analysis, and the money is distributed according to that.

Senator MOORE—They do not have to request it; that is churned out by the model that you keep?

Mr Smyth—The money is then offered to those divisions and they can decide to accept it or reject it. We do not get many rejections.

Senator MOORE—I have already asked you how many were using the system. How many have not taken up the offer at all? Senator Forshaw and I are both interested in this.

Mr Smyth—We allocated about $8 million in expansion funding in September last year. Seventy-three per cent of divisions accepted that additional funding.

Senator MOORE—They were people who were already funded but were getting additional funding at that stage?

Mr Smyth—That is correct.

Senator MOORE—I know it is something that we could easily do, but if you can do it, that would be good: which divisions have not received any funding?

Mr Smyth—There are 116 divisions out of 119 that are funded.

Senator MOORE—That is three that at this stage have not received any funding under this program?

Mr Smyth—That is correct. The Kimberley division is currently considering a funding agreement that we have with them, the Pilbara division is yet to apply for the funding and the Manly Warringah division is not interested in participating.

Senator MOORE—What are the similarities between Manly Warringah and Kimberley? That is a silly question, but there are three in Australia and you have named two in extremely remote Western Australia and northern Australia and one in the centre of Sydney.

Mr Smyth—That is correct.

Senator MOORE—That is interesting.

Senator FORSHAW—Has a particular reason been advanced as to why the division that covers Mr Abbott's own electorate is not interested in participating?

Mr Smyth—I am not aware of the reason.

Senator FORSHAW—I probably should not have asked it that way, but has no reason been given? Did they just write back and say that they were not interested?

Mr Smyth—We have no reason from them, actually.

Senator FORSHAW—Did you seek a reason? Did you seek some explanation, given that they might be the only one left?

Ms Lyons—We would not normally seek a reason.

Senator MOORE—In terms of the relationship between the divisions and your unit on this program, which has received a fair bit of comment and scrutiny because it was a landmark program when it was introduced, there is a contract for distributing the money, but is there an arrangement between the divisions and the department for regular discussion about how it is going? From the time you have effectively allocated the money, which is part of your responsibility, what is the expected relationship thereafter between your unit and those divisions?

Mr Smyth—We have a liaison officer within the Australian Division of General Practice that we fund. That liaison officer—

Senator MOORE—In their national office, Mr Smyth?

Mr Smyth—Yes, in their national office. We also fund divisional liaison officers in each of the state based organisations. We are in the process of renewing funding agreements with each of those. We actually go down to the state based level to receive information back through the coordinator at the divisional level, who is in regular contact with the department in relation to the program.

Senator MOORE—Is there any kind of formal link between the department and that liaison person or do they establish how those people will best work—their work patterns?

Mr Smyth—It is an ongoing relationship. We would be in weekly contact with that person.

Senator MOORE—The issue your area is responsible for on the use of psychologists has been widely discussed and will continue to be so. Are you aware through that liaison of any concern at the divisional level about the use of psychologists through the program?

Mr Smyth—No, I am not.

Senator MOORE—That has not been raised as an issue through the liaison officer. We have established that there is a limit on the number of psychologists' visits or the usage of psychologists in the program; is that agreed?

Mr Smyth—The limit is dependent upon the funding that divisions actually receive and how they manage that funding allocation—whether they decided to directly employ psychologists within the program or whether they decide to use a voucher system to engage private psychologists.

Senator MOORE—For your point of view, is there any particular limit to what they can do?

Mr Smyth—There is a limit on the number of psychologists' sessions that are able to be referred to. I think we provide the information on notice, which is six plus six, following review from a general practitioner.

Senator MOORE—Yes.

Mr Smyth—Across the division I suppose the limiting factor is the funding and the way that the division manages the demand for that program.

Senator MOORE—And that has not come up in discussions as a major concern?

Mr Smyth—There are discussions and, as you would have seen, press articles in relation to the demand for the servicing.

Senator MOORE—Does the department have any data or information on the number of patients who have identified with mental health issues who have not been able to access psychologists because of the six plus six limit?

Mr Smyth—I am not aware of any data.

Senator MOORE—Is that the kind of data collection you keep on the usage of the program?

Mr Smyth—As we mentioned, the evaluation of the program by Dr Jane Pirkis from the University of Melbourne looks at a minimum data set in each of the divisions. I would have to take that question on notice in terms of exactly—

Senator MOORE—I know we have discussed that previously, and I recall there were certain key areas that you looked at. Can we take that on notice, because we have talked at length here and in other places about the cap on the number of referrals to psychologists, the possible impact of that and how that works across the whole scheme of mental health? If we could see any data on that, that would be good.

Mr Smyth—Yes.

Senator MOORE—The government had a particular allocation of $15 million to focus on mentally ill teenagers and young adults and their access to allied health professionals. Is that particular program being funded through Better Outcomes in Mental Health Care?

Mr Smyth—That is a suballocation of the Youth Mental Health Foundation initiative.

Senator MOORE—Does that come through your area, Mr Smyth?

Mr Smyth—Yes, it does.

Senator MOORE—Is it linked to the Better Outcomes in Mental Health Care funding or is it a separate allocation within your branch?

Mr Smyth—It is a separate allocation, but we will be in discussions with the successful consortium; with the divisions of general practice, who were one of the consortium members; and also within the department as to how that money can be best allocated to achieve the impact that is desired by the government.

Senator MOORE—Has that kicked off?

Mr Smyth—No, it has not.

Senator MOORE—When do you expect that to actually happen?

Mr Smyth—We are in the middle of funding negotiations with the consortium as we speak. It is our anticipation that the signing of that agreement will occur in late March or early April.

Senator MOORE—Of this year?

Mr Smyth—That is correct.

Senator FORSHAW—Do you anticipate that the funding will be spread across all of the participating divisions, or across most of them, or are there some criteria that might focus upon particular regions or areas that statistically might show a higher proportion of younger people or a higher proportion of younger people who are suffering some mental illness?

Mr Smyth—We are in discussions with the consortium that was successful in the application for the Youth Mental Health Foundation. We will discuss with that consortium the roll-out of some of their national programs in terms of the allocation of that $15 million—as to whether it should be put out on a population basis through the divisions, as we currently do, or whether we should better focus the targeting of that money in conjunction with the activities of the Youth Mental Health Foundation. That is yet to be determined.

Senator FORSHAW—Any initiative in this area is welcomed. How effective it is, of course, is another issue. I am not being critical, but if it is spread across all of the participating divisions there will not be such a large amount of money for each one.

Senator MOORE—You mentioned the consortium. It is a terrible term, isn't it—'the consortium'. Have any decisions been made about the National Youth Mental Health Foundation as a group—the board and how it is going to operate and all those things—or is that still under discussion?

Mr Smyth—The chair of the board has been announced. He is Mr Ryan Stokes. The make-up of the remainder of the advisory board is yet to be finalised.

Senator MOORE—Is that by ministerial appointment?

Mr Smyth—Yes.

Senator MOORE—I would have presumed so—if we have not found out who is on it. We spoke about the $15 million that was for that particular part of the focus. Are you responsible for the $54 million budget as well?

Mr Smyth—That is correct.

Senator MOORE—Has any of that been spent yet?

Mr Smyth—Not yet. There was some rephasing last year to ensure that that money was put into this financial year and the out years of the program. As I understand it, there has been a small amount but it is not really that relevant in terms of it.

Senator MOORE—So, as of now, the answer you gave to the previous question about the $15 million, which was that funding negotiations are occurring, would be the same for the whole budget and the whole program.

Mr Smyth—That is correct.

Senator MOORE—Would the date you gave, which is March-April, be when you would expect to have more information generally?

Mr Smyth—That is when we hope to have the funding agreement in place.

Senator MOORE—In time for the next round of estimates. I want to ask one other question about the better health program, because it has received so much discussion. I think there was an announcement by the minister that they were going to focus more on rural and regional areas in mental health because of information that had come out and, I think, some very good work from community groups raising that area. Can you give us information from your point of view as to whether there has been any particular focus on the rural areas? I think those announcements were towards the end of last year.

Mr Smyth—The expansion funding that went out to divisions in September, the $8 million plus, was to be focused on four specific areas—rural and remote, Indigenous, youth and comorbidity—as I recall.

Senator MOORE—Has the funding you mention gone out across those four areas?

Mr Smyth—It has.

Senator MOORE—Are special projects involved in those?

Mr Smyth—I am not aware of any special projects as such. There may be within each division in terms of the priority they give that money. We have asked them to focus the expansion funding in terms of those priority areas.

Senator MOORE—Where you gave that money, was there any kind of process where the divisions requesting the funding had to make a further commitment that they were going to focus the extra money they got into comorbity, youth, Indigenous or rural and regionals?

Mr Smyth—In part of the letter allocating funding we are now asking them to specifically look at those areas.

Senator MOORE—Asking them to do it and saying, ‘This is a necessary part of the expenditure,’ seems to me to be a bit of a gap. From your perspective, is it a direction that they spend the extra money in those areas or a suggestion?

Mr Smyth—It is very hard in some respects in terms of, as you can imagine, the demand on this program. But we are working with the divisional liaison officers through the state based organisations, as well, and the national primary care coordinator to ensure, as best we can, that the money uptake in those areas is being spent on the priority areas.

Senator MOORE—In reporting back, I know that the review that was done by the doctor, whose name has escaped me—

Mr Smyth—Dr Pirkis.

Senator MOORE—was looking at quantity data in terms of quality assessment. How is that done? If I were in a group of general practitioners bidding for the money and I said that I was going to do things for youth, what kind of information would I have to give you, to stimulate the funding, about what I was going to do with youth? How would that be assessed?

Mr Smyth—That would be assessed through the relationship we have through the primary care coordinator and the divisional liaison officers. We receive progress reports in terms of some of the qualitative and quantitative data, and that is assessed by the department.

Senator MOORE—One of the issues is best practice. So, if a program is developed in one area that seems to have particular value, how is that then shared to see whether it would be operational elsewhere and to get that focus?

Mr Smyth—Some funding is provided to Flinders University, to a program called PARC, which is really part of a dissemination of mental health in the primary care setting of initiatives, best practice and key learnings that is distributed to all the divisions of general practice.

Senator MOORE—Is that like a clearing house?

Mr Smyth—It is, in some respects.

Senator MOORE—That would be the initiative. Is the responsibility for providing that information to Flinders your area?

Mr Smyth—We are in liaison with Flinders in relation to that, yes.

Senator MOORE—So that is the linkage. You fund the work in the expectation of an outcome. The general practice divisions feed that back as to what they have done and then it is somewhere in your unit that actually spreads that further.

Mr Smyth—It is done in two ways: through the divisional liaison officer function with the primary care network and the coordinator in divisions of general practice at the national office, and through PARC.

Senator MOORE—So the funding under Better Outcomes includes specific funding for those liaison positions as well as program funding for each practice?

Mr Smyth—Yes, it does.

Senator MOORE—I know that your area has submitted many pieces of information, but is it clear how much of the funding allocation goes into the administration position and how much goes out to program operations? Is that differentiated?

Mr Smyth—It is differentiated in terms of our departmental dollars. There are other components there—the Department of Veterans' Affairs has a component, there is the GP Psych Support service, which we have talked about before, there are education and training elements and then there is access to psychological services, which is the direct funding to the divisions.

Senator MOORE—Will the magic document that you are going to supply us have that differentiation?

Mr Smyth—It will have that breakdown, yes.

Senator MOORE—And then we will be able to ask questions on that.

Mr Smyth—Yes.

Senator FORSHAW—Regarding the information you provided us about the divisions participating in the Better Outcomes in Mental Health Care program, the three that are not involved at the moment are the Kimberley Division of General Practice—

Ms Lyons—The Pilbara.

Senator FORSHAW—The Pilbara is the second and Manly Warringah is the third. You said the Kimberley is negotiating a contract at the moment.

Mr Smyth—That is correct. They are considering their funding agreement with the department.

Senator FORSHAW—What about the Pilbara?

Mr Smyth—The Pilbara division is yet to apply for funding. Some of these issues relate to accreditation, which is probably best handled by my colleagues in the Primary Care Division.

Senator FORSHAW—But they have not ruled it out?

Mr Smyth—No, not at all.

Senator FORSHAW—You are confident?

Mr Smyth—In fact, we are very keen to ensure that those areas, particularly the Indigenous populations in those areas, receive some access to this kind of program.

Senator FORSHAW—Yes, and I would have thought you would be.

Mr Smyth—Yes.

Senator FORSHAW—We are left with Manly Warringah, who have apparently said point-blank that they are not interested. Could you provide us with copies of any correspondence between the department and the Manly Warringah Division of General Practice? I am interested to know why they reached their decision. You said you are not aware of any reason, but—

Ms Halton—You would be aware that we do not supply correspondence between ourselves and other parties as a matter of course without the agreement of the other party. If you are interested in whether they have expressed any view to us about this, I think it might be easier if we just examine our records and advise you on whether a reason has been enunciated to us. Would that be acceptable?

Senator FORSHAW—I am not suggesting that they have not given you a reason. Mr Smyth spoke about that and I am not in any way doubting it. I am trying to get to the interaction between the department and the division. I assume you wrote to inform them that the program is available. What did they do? Did they write back and say, 'We're not interested'? That is what I am trying to establish, which is why I asked for the correspondence. Perhaps you could take it on notice and advise me how this came about.

Ms Halton—I suspect if I ask a third party whether they are happy for us to give you all of our correspondence with them the answer is going to be no.

CHAIR—Fat chance.

Senator FORSHAW—You are not declining to answer the question.

Ms Halton—No indeed. I am trying to find a way to give you an answer to your question. We understand what you are interested in. If you are happy we will examine our files and provide you with an answer.

Senator FORSHAW—I will be happy to receive that, and whether I am happy after that is another question.

Ms Halton—I think you have already said, 'We'll see you next estimates,' so—

Senator FORSHAW—If you could provide me with a summation of the interaction that occurred between the department and the division on this, I would appreciate it.

Ms Halton—That is fine.

Senator FORSHAW—I would still like a copy of the letter—I still make that request and you can follow it up—and information on when they notified the department that they were not interested.

Ms Halton—That is fine.

Senator FORSHAW—They appear to be the only division not to take up the program, subject to your reaching agreement with the Kimberley and the Pilbara. Thank you.

Ms Halton—While there is a pause, can I just say that Senator Adams asked me that question about pregnancy counselling and, as I thought, we had answered that question on notice. I would like to table that answer again, so that Senator Adams and other senators can have a copy of it. Senator Adams, can I also say that I have checked and, after this question was answered, the minister announced $50,000 a year for 2005-06 and 2006-07 to go to the Australian Federation of Pregnancy Support Services. So this answer together with that extra piece of information is a complete answer, and I am happy to provide that again.

Senator ALLISON—I wanted to follow up on a question I asked last year about the TGA warning on the use of selective serotonin reuptake inhibitors as antidepressants for pregnant women. A warning was provided by the TGA about their use but, as I understand it, there is still evidence that pregnant women are using them, with the consequences of increasing congenital heart defects in the developing foetus. The purpose of my question was to ask whether consideration had been given to alternatives to antidepressants for pregnant women. The answer was no, but I would like to ask again whether, since that time, there has been further consideration of this, whether the department regards this as a significant issue and whether, with developments in Better Outcomes, there is a need for us to focus on this particular issue?

Prof. Horvath—I would have to take that on notice. I am not sure what the adverse reactions have been since that time on the SSRIs in pregnancy and what other steps we have taken to look at those issues.

Ms Halton—We might make a phone call, Senator, and if there is any additional information we can give you we will come back to that, if that is acceptable.

Proceedings suspended from 10.43 am to 11.01 am

CHAIR—We will resume our hearings of the Department of Health and Ageing portfolio. We are in the midst of outcome 9.

Senator POLLEY—My questions relate to the Medicare smartcard. I am trying to understand the project and how it is progressing and whether there are any problems. How many Tasmanians now have a Medicare smartcard?

Mr Shepherd—You will be aware that the smartcard pilot in Tasmania is a pilot being run by Medicare Australia. However, I am informed that to date just over 3,000 smartcards have been issued in that Tasmanian pilot.

Senator POLLEY—What percentage is that, as a proportion of the eligible population?

Mr Shepherd—That question is a question for Medicare Australia.

Senator POLLEY—I think I can work it out. How many people who are potentially eligible have not been able to get a card because they have been unable to supply the necessary personal identification criteria?

Mr Shepherd—Once again, that is a question for the administrators of the program, Medicare Australia.

Senator POLLEY—My understanding is that there are some people who are having huge problems with the cost involved in accessing their birth certificate. Your department does not have any responsibility for that?

Mr Davies—The arrangements for ascertaining eligibility for a Medicare card, proving eligibility and subsequently issuing Medicare cards rests with Medicare Australia, which comes under the Human Services portfolio.

Senator McLUCAS—Were there any discussions between the Department of Health and Ageing and Medicare Australia in ascertaining the method by which a person would become eligible for a smartcard?

Mr Davies—I am not aware of any discussions on that specific topic. But, as I understand it, the eligibility criteria for a Medicare smartcard, in the Tasmanian context, are the same as for a Medicare card—a non-smartcard, if you see what I mean.

Senator McLUCAS—That is not my understanding.

Mr Davies—We can check that with Medicare Australia and get back to you on any differences in the eligibility criteria.

Senator McLUCAS—I understand that you have to show a birth certificate for every name that will appear on the smartcard.

Mr Davies—As I said, it is a Medicare Australia issue, but I think we could certainly ask that question of them and get back to you, hopefully, before the end of the day. I am not sure we can go into detail with respect to the previous question, but we could certainly get for you the facts relating to differences in the requirements.

Senator MOORE—I have a couple of questions along the same lines. As for your explanation, I think it is the responsibility of Medicare and not of health. Perhaps we could turn to the review of national health priorities

Senator McLUCAS—I think you should ask your question. Perhaps they could get the answer back to you from Medicare Australia.

Senator MOORE—This issue relates to an Australian citizen who regularly leaves the country to travel overseas and work on overseas aid programs. On their return to Australia, if their Medicare card has expired, they have great difficult in getting it renewed, as they do not know when and for how long in the future they will be here. This is a real case example. Is that an issue for health or for Medicare?

Ms Halton—The rules for who is eligible are for us but not for this program; the administration of those rules is for Medicare. It depends on whether your question relates to the rules.

Senator MOORE—With the way the client has been caught out, this seems to be a rules issue. They have been working overseas in aid programs, whereby they travel back and forth to Australia. Their Medicare card expired. When they went to a Medicare office to try to renew it so that, when in Australia, they could access Medicare, they were advised that they had to inform Medicare exactly how long each year they would spend in Australia. As they could not do so, they were advised that they could not get a Medicare card.

Ms Halton—That does not sound right. Perhaps you would like to give me the details that case.

Senator MOORE—Yes, I will write to you.

Ms Halton—I have come across a circumstance quite recently where probably some not very good advice was given. This was in relation to a former staff member of ours who came to me in the end and said, ‘Can you sort this out?’ The truth is, if you are back in the country, you are entitled to a Medicare card. My understanding is that Medicare Australia will not issue a card if you are not physically here. But, if are you a resident or normally a resident, the fact that you may spend periods out of the country is neither here nor there. It is not as though you have taken up residence somewhere else, so you retain your entitlement. My understanding is that Medicare will not issue a card unless you are physically here. In addition, there has to be an Australian address to which the Medicare card can be sent. If you would like to give me the details, I will have that looked into.

Senator MOORE—Thank you. So the rules relate to a person’s physical presence at the moment as opposed to applying in writing if in Andalusia or somewhere. I will send that particular case to you.

Ms Halton—If you would. I will be happy to look at it.

Senator MOORE—I have some straightforward questions about national health priorities. Is a general review of national health priorities under way?

Ms Lyons—I am advised that there is a review of NHPAC, which is the National Health Priority Action Council, being undertaken by AHMAC, which is the Australian Health Ministers Advisory Council. I understand that the review will be considered on 2 March. Once that review has been considered, there will be consideration of a review of the national health priorities.

Senator MOORE—So it is a stepped process.

Ms Lyons—Yes.

Senator MOORE—So you will not know when it will be completed until after 2 March.

Ms Lyons—That is true. Until 2 March, a decision will not be made about if and when a review of the national health priorities will occur.

Senator MOORE—Are the reviews to which you refer normally made public? Are the documents public or internal?

Ms Lyons—Is a review of NAHPAC, which is an AHMAC review, normally public?

Ms Halton—No, not formerly so.

Senator MOORE—It would be the same kind of response given to the previous one: if there were an issue that the minister wished to make public, that would be the methodology.

Ms Halton—Absolutely.

Senator MOORE—Are you aware whether obesity is being considered as a national health priority area?

Ms Halton—No.

Senator MOORE—I want to find out when the last reports on each of the following national health priority areas were completed. I have a list here in front of me. If I read them out, can you let me know whether I have missed any and then tell me whether there have been any reports or assessments done of these programs? I will go through the entire list and then you can tell me whether I have missed any: safety and quality in health care, asthma, cancer, cardiovascular health, diabetes, injury prevention, mental health, arthritis and musculoskeletal conditions. Is that a full and accurate list of the national health priorities?

Ms Lyons—I do not think ‘safety and quality’ is a national health priority per se as determined by health ministers but, as you have mentioned, ‘injury prevention’ is a priority.

Senator MOORE—Are all of the various conditions that I have read out priorities? I am sorry; it is a very silly way to ask the question.

Ms Lyons—Perhaps I could read you the list that I have.

Senator MOORE—You read the list and I will tick mine off.

Ms Lyons—Cancer, diabetes, asthma, cardiovascular, arthritis and musculoskeletal, mental health and injury prevention.

Senator MOORE—I have all those conditions. We have the list matching up with the question around whether the term ‘safety and quality in health care’, which appears to override the other terms, could or could not be defined as a priority. We have the right list. Are there reports on how these national priorities are going? Is there a formal reporting mechanism for them?

Ms Lyons—I would have to take on notice to provide you with when each of those has been reviewed. Certainly, from within the department, many of them are subject to some lapsing program reviews. As for reviews by AHMAC, the chief medical officer might be able to assist you.

Prof. Horvath—All of them have had their strategies and national service improvement framework submitted to and approved by AHMAC and ministers, as a part of a large package

that went to ministers progressively. We can give you the dates up to the national chronic disease strategy, which was submitted to ministers in November last year and adopted. That was the overencompassing body of work for all those groups. That is the output of those groups.

Senator MOORE—Can we get a synopsis of that process from the department?

Prof. Horvath—Yes, I am sure that the dates are available.

Senator MOORE—We would appreciate receiving those dates because we have a particular interest in the progress of the national chronic disease strategy. As you have mentioned, something has gone to ministers. Is there any understanding of what will happen next?

Prof. Horvath—Ministers endorsed a number of implementation strategies in November last year.

Ms Lyons—We could provide those to you because they are on the public record. That is the national chronic disease strategy. Beneath that is a number of what are called 'national service improvement frameworks', which are disease specific.

Ms Halton—We will try to get you some copies of those after lunch.

Senator MOORE—That will be very useful. Is that where the treatment guidelines are developed? Is that where you have the information that goes out to the GPs?

Ms Lyons—I think it would be fair to say that the service improvement frameworks are not 'clinical specific'.

Senator MOORE—Clinical guidelines; that is what I am after, yes.

Ms Lyons—No. Clinical guidelines would fall underneath that.

Senator MOORE—Do those that have been identified have clinical guidelines developed?

Ms Lyons—I am aware there are some clinical guidelines in some of the health priorities. Again, we could identify those and provide them to you.

Senator MOORE—That would be lovely. Professor Horvath, you might be able to help me on this: are the clinical guidelines part of the strategy with the issues of each disease?

Prof. Horvath—The material that has been developed so far is more high level than that, although Ms Lyons is correct: in some places there are some guidelines. The definitive guidelines for treatment of individual diseases have been developed usually by the specific groups coming through NHMRC. The national service improvement frameworks are very high-quality large documents that take diseases from prevention all the way through to palliation—the whole course of the disease, from prevention to diagnosis, screening, acute management et cetera at quite a high level. They are not prescriptive in the same way that guidelines are, but they inform the guidelines process. They sit very comfortably with the chronic disease strategy for that particular one. For example, the cancer strategy is an overall strategy that sits over the framework and very well within the whole chronic disease strategy. From there, for example, the cancer guidelines have been developed very specifically and endorsed by NHMRC. I think you are referring to the more prescriptive ones.

Senator MOORE—And that degree of detail has been developed for not all of these but only some.

Prof. Horvath—Correct.

Senator MOORE—We will be able to get some indication of which are and which are not more prescriptive and follow up with questions from there.

Ms Halton—Yes, certainly.

Senator MOORE—To summarise, you are going to give me some information on national chronic disease.

Senator McLUCAS—To start with, I go to the press release of Minister Abbott, dated 12 January, about workforce issues, and particularly to overseas trained doctors. The attachment to that media release identifies that 2,409 overseas trained doctors are working or about to start working in Australia. Can you give me a breakdown of how many of them are permanent Australian residents?

Ms Larkins—I am sorry, I will have to take that on notice; I do not have it with me.

Senator McLUCAS—I want to know how many are permanent residents, how many are temporary residents, how many of those are GPs, how many are specialists, how many are working in private practice and how many are in hospitals—and I recognise that some will be working in both.

Ms Larkins—There will be an overlap, yes.

Senator McLUCAS—In addition, I want to know how many have a Medicare provider number. You might be able to answer that last one.

Ms Larkins—I am trying to clarify what we can actually give you.

Ms Halton—I am not sure that we hold information about the number of people who come in to practise solely in hospitals. We will have to check that.

Senator MOORE—So that figure of 2,409 may not include people who have been recruited to work in state government hospitals.

Ms Larkins—Yes, that is right. It does not include people who work in public hospitals.

Senator McLUCAS—Do you have any method of collecting that information?

Ms Larkins—No. There is no central Australian government collection of information on overseas trained doctors in state public hospitals. The information that we have is through Medicare fill-in data.

Senator MOORE—What about the number who are working in private practice but who do have VMO—

Ms Halton—That is a different issue. Basically, if a doctor comes in to practise private medicine as a GP or whatever, be that on a bonded scheme or whatever other arrangement, we will know about them. But, as you are probably aware, some doctors—recently some relatively well-known doctors—have come in to practise solely in hospitals and we do not necessarily know about them.

Senator MOORE—You possibly will not know how many of these 2,409 have VMO rights.

Ms Halton—No.

Senator MOORE—If you do not have data on any of the questions that I have asked, just indicate and, if you think it is relevant, perhaps comment on why not. The minister's media release says that, since July 2004, $4.7 million has been allocated to GPs for training under the Training for Rural and Remote Procedural General Practitioners Program. Can you give me an understanding of that funding?

Ms Larkins—That question should be directed to the Primary Care division in outcome 4, which manages that program.

Senator McLUCAS—You might be able to help me with this one. The release says that since 1996 the number of rural doctors has increased by more than 20 per cent. Can you give me an indication of what the numbers were in 1996 and what they are now?

Ms Larkins—Again, that is a question that comes from Medicare billing data and is a question that primary care can answer under outcome 4.

Senator McLUCAS—Okay. Can you explain the situation where we have a number of doctors who do not have a Medicare number because they are not vocationally registered or they are not non-vocationally registered? I was unaware of the situation until recently. Can you explain that circumstance?

Ms Larkins—Yes. Australian doctors and permanent resident doctors under changes to the Health Insurance Act in 1997 have to be vocationally registered to be able to bill Medicare, unless they are on a number of restricted programs—in areas of workforce shortage primarily.

Senator McLUCAS—But I understand that there are Australian trained doctors who are neither VRed nor non-VRed.

Ms Larkins—They would have been doctors who were not vocationally registered at the point that that legislation came into effect and they are still not—they have not undertaken the training program.

Senator McLUCAS—You are not describing the non-VRed, grandfathered cohort of doctors, are you?

Ms Halton—Are you asking about non-registered practitioners—I am aware that there are some Australians who are not Australian trained who are not registered as medical practitioners—or are you talking about OMPs, other medical practitioners?

Senator McLUCAS—I understand that they are Australian trained, but in 1996 they were not vocationally registered. They then did not apply to be—

Ms Halton—OMPs.

Senator McLUCAS—Sorry, what is an OMP?

Ms Halton—Other medical practitioners.

Senator McLUCAS—Is that a non VR?

Ms Halton—Yes.

Senator McLUCAS—But there is this other group of people who are not non-VR or OMPs and they are not vocationally registered. They do not have a Medicare number. Basically they must practice in public hospitals.

Ms Halton—If they do not have a Medicare number, the only category I am aware of who are Australian trained—and I understand there is a small number; Professor Horvath may know more about this than I do—are a small number of doctors who work in hospitals. They are staff doctors in hospitals and they have never registered for the purpose of Medicare. I do not know how many of them there are, but I am aware that they exist.

Prof. Horvath—There are a number. It is difficult to get the total on them because they are known by different titles in different states. Most of them are known as career medical officers, with the title of CMO, so there are other CMOs—

Ms Halton—None as important, though!

Prof. Horvath—Thank you. There is also a group in New South Wales titled hospitalers who similarly do not have Medicare provider numbers and are largely doing various hospital—almost permanent residency—roles.

Ms Larkins—We understand that the number of doctors in that category is around 500.

Senator McLUCAS—I have had another bit of education in the language of health. Thank you, Doctor.

Ms Halton—We learn something new every day, if it makes you feel any better.

Senator McLUCAS—I want to go to a series of questions around the whole e-health question—first of all about Health*Connect*.

Ms Halton—While people are organising themselves, can we come back very briefly to that question you asked in relation to question on notice 354, which was the table? Remember you asked why this question was late twice?

Senator McLUCAS—Yes.

Ms Halton—I had a look at this. As I said to you, I was not aware that it had been late twice. In the first instance, you might recall that a couple of estimates back we had a long exchange about some of that data. The first time this question was late we were waiting for the relevant officer to come back from leave. Do you remember that we said we had to clarify some things in relation to the time frames and that there was an officer away on leave who was not contactable and we had to wait for her to come back from leave? After the estimates in November, we went to Medicare Australia and asked them to confirm whether the data had been cleansed for adjustments to family composition during the reporting period and whether the data was actual calendar month as reported. So we were looking for some clarity about the quality of the data.

They advised us that the data was adjusted for family composition changes but that it was provided as at the date that the report had been run and this was often some time after the calendar month. In other words, it did not actually reflect calendar month. Understand that we were trying to report calendar month—I think that was the essence of what you had asked for—so we asked Medicare Australia to do the data again. They told us that they could not,

that they did not have the systems available to provide that precise calendar month data and to provide it cleansed. So we did a draft response—basically, by the reporting date, you will be amazed to know—using that uncleansed data.

On 15 December Medicare Australia advised us that they could provide us with cleansed data that would be comparable to the period required. But they then told us much more recently that, no, in fact it was going to take some time for them to do the data again for the whole of the 2005 year so that the whole thing would be consistent. You will see that the answer has a series of caveats on the bottom of it. At that point we took the decision that we would give you what we had.

As I suggested to you, there is a lot of interchange between Medicare Australia and us about the quality of the data—in fact, whether what you get in a table is actually what you think it is. In this particular, we discovered, no, it was not. That is the reason why this one has been to-ing and fro-ing between us and them. It should be possible for them to give us the actual calendar month, because that is what we want too and that is what we will be pursuing with them. So they were two very different cases. In the first instance we were waiting for an officer who was uncontactable to come back from leave—

Senator McLUCAS—That was for the November question.

Ms Halton—Yes, and this time we have had this to-ing and fro-ing about what is actually in the data.

Senator McLUCAS—The numbers are somewhere around 20,000, but I thought it was quite extraordinary that they do jump around quite a lot.

Ms Halton—It may well explain it; that is exactly right. I think that is why our people have said, 'I think we'll go back and unpick some of this and ask some questions.'

Senator McLUCAS—Are you confident that that table is correct?

Ms Halton—I am confident that it is at the point at which they ran the run. That is exactly my point. We will take it on notice again this time, but we are going to try to get you cleansed data, actual month.

Senator McLUCAS—And if that needs revision?

Ms Halton—We will tell you.

Senator McLUCAS—Why are the family registrations an issue?

Ms Halton—People come in and go out of families, so you would always have to make sure that your data reflected actual family composition. You would have technical work to do to make sure that people were classified in the right place.

Senator McLUCAS—I cannot imagine that that would be a large number.

Ms Halton—It probably is. I think the movement in and out of families can make a material difference—children going in and out of families.

Senator McLUCAS—While we are on questions, at last estimates I indicated that we would like to get quarterly spending data for the Medicare safety net. Did that question come in?

Ms Halton—If it was on a question on notice, it would have come in.

Senator McLUCAS—I do not know that we actually put it on a question on notice; it was a discussion that we had.

Ms Halton—We might have missed it. I was not conscious that we had missed something.

Senator McLUCAS—One of your staff might be able to deal with this today. It was at page CA49, where I said:

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 Halton—I think we gave something to you at the time, and you said you were going to put it on notice. You said that you would ask us for it in future estimates. When we come to this program—

Senator McLUCAS—Which is 2?

Ms Halton—We will do it in detail, if you like.

Senator McLUCAS—Can you give me an understanding of what NEHTA is, please?

Ms Halton—The National E-Health Transition Authority is a company limited by guarantee, which is basically the vehicle for activities undertaken jointly on behalf of all the states and territories and the Commonwealth to, if you like, set standards in the electronic health space. It is the vehicle by which ministers have agreed to advance a whole raft of electronic health activity.

Senator McLUCAS—What is the current level of Commonwealth funding to NEHTA?

Mr Shepherd—Commonwealth baseline funding for NEHTA over the period 2005-06 is $3.9 million. The total Commonwealth contribution in 2005-06 through to 2007-08 is $9.1 million. That is a 50 per cent share with the states and territories. So over the same period the states and territories are contributing $9.1 million.

Senator McLUCAS—Before it was established as a not-for-profit company, what was the allocation of funds prior to then?

Ms Lyons—The allocation of funds is based on the AHMAC formula, which is 50 per cent Commonwealth and 50 per cent contribution from the states and territories. NEHTA was set up before the company entity was set up, and the funding was on the same arrangement.

Senator McLUCAS—How does NEHTA interact with Health*Connect?* I am trying to understand how they work together.

Ms Lyons—NEHTA's role primarily is looking at standards and infrastructure for electronic health records.

Ms Halton—And electronic health.

Mr Shepherd—There are five dimensions to the agenda: a strong research base, standards agenda, state and territory cooperation and alignment, driving behavioural change within the clinical community and consumer uptake. NEHTA forms a role in the second dimension around driving the national standards agenda. How it fits in is that, as you are aware, the NEHTA board members are the secretaries of the state and territory governments and the

Australian government health departments. Therefore, there is a very clear mandate that, once e-health standards are agreed by the board, those standards can be incorporated into the procurement processes within the states and territories in the Australian government. In fact, this was a specific outcome of the COAG meeting last week.

Senator McLUCAS—I understand that Health*Connect*'s focus has changed recently as well. I am still unsure how the two entities enmesh.

Ms Halton—It is probably important to understand that Health*Connect* is not an entity.

Senator McLUCAS—One is an entity; one is a program.

Ms Halton—Health*Connect*, if you like, has attempted over quite a long period to, firstly, see a change in the sector in terms of electronic uptake but also to understand how best to go about facilitating and encouraging the move from a paper based system in health to an electronic based system in health. That includes everything from how to manage clinical systems; how to manage messaging between practitioners; how to protect patient privacy; what it is that patients want to see in a system that goes electronic, what utility they are looking for; and what the issues are for practices in managing both their business and their clinical load if you move to an electronic world. What the Health*Connect* label has done is to basically do research around those questions.

It has also run trials—put something into the field to see what works and what does not work, to see what the issues are for clinicians and what the issues are around connecting, for example, general practice right through to acute care. All that work has led us to a far more mature understanding of what the basics are that we need if we are going to have an electronic health world. The NEHTA work has very much grown out of our experience with Health*Connect*. So NEHTA work around, for example, the fact that we need an appropriate clinical terminology. If you are going to start recording things electronically, you need the same lingua franca for practitioners. So if you are going to describe a particular condition, an operation or part of the body, you have to be able to do that in a way that is consistent. You have to start saying to yourself, 'What does electronic health look like?' This is a vast enterprise; you do not even know the body of work you have to do. Work on Health*Connect* has enabled to us to refine very clearly what work is necessary to enable this e-health revolution if we are not to have a rail gauge problem.

If we work on the basis that a patient wants seamless care of their health but they want their privacy completely protected, then you know from the work we have done on Health*Connect* that we need secure messaging; ways of describing conditions, procedures and practices; and the technology that enables messages—say, for example, referrals—to appear easily from one place to another. So there is a series of lessons we have learnt and NEHTA is now giving effect to a significant part of those lessons and messages, which is that we need common standards nationally.

Senator McLUCAS—Does it also grow out of the fact that some of the states were looking at their own e-health systems?

Ms Halton—Inevitably, IT has formed a major part of every part of the hospital system for a long time. If you look at the big hospitals, they have all had systems around ordering, around patients—around all sorts of things. Over time, those things grow as capability and

technology grow—the big providers have sought to sell technology to the sector. There was a concern amongst, firstly, the people working on places like Health*Connect* but also amongst the CEOs that if we were to not double invest—in other words, if we were not all to duplicate each other—we would be far better to harness the investment collectively and not have a rail gauge problem. That is where the NEHTA initiative came from.

Senator McLUCAS—It operates as a not-for-profit company but reporting to all the states and territories and the Commonwealth, really, simply because they are there.

Ms Halton—The CEOs are the board.

Senator McLUCAS—Does it have an annual report?

Ms Halton—It will have.

Senator McLUCAS—How many people are employed in NEHTA?

Ms Lyons—We would probably have to take that on notice.

Ms Halton—It is not huge.

Senator McLUCAS—Are they directly employed or is it on a contractual basis?

Ms Halton—There is a variety. Essentially, they are not looking to set up a large bureaucracy. The general philosophy is that they will purchase the particular products and the pieces of work they need. They obviously do need some staff in order to deliver that, but a number of people have come on for limited periods to undertake particular tasks.

Senator McLUCAS—Could you provide that to us.

Ms Halton—Yes, we will.

Senator McLUCAS—The number of staff, those who are permanent staff members—I do not want the names.

Ms Halton—I think you will find that there is no such thing as a permanent staff member. Everyone from the CEO down will be on a time limited contract.

Senator McLUCAS—It is all on contract?

Ms Halton—Yes.

Senator McLUCAS—Also, could you give me an indication of those people who are administrative and those people who have some technical expertise?

Ms Halton—Yes. In fact, I can say from experience that we will give you the numbers. Apart from the company secretary, who I do not think professes a vast knowledge of IT, all the other staff I have dealt with are highly experienced. In fact, they have been remarkably successful in recruiting a very high calibre of expert, which, if I can say, was part of the strategy.

Senator McLUCAS—Back to Health*Connect*. How many health care providers are participating in the trial of Health*Connect* at the moment?

Mr Shepherd—The first point to note is that all trials of Health*Connect* ceased in 2004. The program is in an implementation phase now. The providers participating in the Tasmanian implementation of Health*Connect*, for example, at the moment are the Launceston General

Hospital, and every general practitioner within the catchment area of the Launceston General Hospital is able to receive messages from that hospital. The functionality that they have put in place here is scalable across the entire state and it is only a matter of time before all GPs will find out the moment their patients are admitted to hospital the initial diagnosis and the important information that is transferred back to the general practice community. In South Australia, where the focus has been on driving the connectivity before you start with the applications that run over the connectivity, we have the numbers up to 31 December 2005. The uptake in South Australia has been 52 per cent of those who are eligible to participate and the total number of practices is 327. Would you like me to keep going?

Senator McLUCAS—I want to come back to the Tasmanian situation first. I understood that the initial intention of the Tasmanian program was that it was going to be right across Tasmania.

Mr Shepherd—Yes, that is right. You will be aware that in any major IT program the approach to implementation is usually a very sensible, incremental approach. You start off in a beta site and iron out all the bugs. Once you know you have a robust system, you can migrate the implementation around the state. What has been implemented in Tasmania has been implemented on top of state based infrastructure so it is entirely compatible throughout the north-west and the south. The implementation is in its first phase, so once the initial bugs have been ironed out—and I can report that that process is nearly complete—the implementation will rapidly spread to the north-west and the south.

Senator McLUCAS—I will come back to the issue of privacy in a moment. In South Australia, what was the intent of the roll-out there?

Mr Shepherd—The department has an MOU in place with the South Australia government. The scope of the South Australian roll-out has sensibly started with deriving connectivity. You would be aware that the South Australian government have made a huge investment in hospital information systems; the program is called OASIS. Therefore, their hospital sector was ready to communicate with the community. But the difficulty was that there was no infrastructure in place to actually support that. So, sensibly, the state government and the Commonwealth government have aligned the Commonwealth's Broadband for Health Program and the South Australian state government's broadband program and we are working together on the ground to build that infrastructure up so that the hospital sector can communicate with the primary care sector in a safe, secure and fast manner.

The second stage of the South Australian roll-out, which is already under rapid development, is looking at the development of electronic care plans. Care plans, as you know, Senator, are critical in supporting multidisciplinary models of care. We have rapidly increasing figures of chronic diseases that require patients to go to multiple different providers and carry their information with them. This is a key priority for the program and the South Australian government have held up the flag in terms of piloting that aspect of the program.

Senator McLUCAS—I made you go back to Tasmania and South Australia. You were going to continue.

Mr Shepherd—In the case of the Northern Territory, once again, the approach has been incremental. The implementation in the Northern Territory starts across the Katherine area

which, as you would be aware, has a population of between 10,000 and 17,000 depending on whether it is the dry or the wet season. So far, the number of consumers who have been registered for the program is at 5,350 and that is as at the end of January. That is really critical because these are actually Indigenous patients out in the communities. We have managed to register, in most of those communities, 100 per cent support for the program.

That means that, when populations start to migrate across the region—and some of the populations have risk factor statistics that, as you know, are way above national averages—and a renal patient comes to the west from the east and they have had some planned care in the east, the nurses that see them on their way now actually have some background and history about this patient. When a patient walks in, the nurses no longer have to start from zero. They understand your situation—whether or not you are a well managed diabetes patient or whether or not you are actually someone that needs some urgent care. The percentage of providers that have taken the program across the Katherine area is 100. The support for the program from the Northern Territory government, the Commonwealth and state government primary care funded areas is very strong. Rapid implementation is actually under way across the whole of the Northern Territory of the next phase of the program.

Senator McLUCAS—How do people get registered?

Mr Shepherd—In?

Senator McLUCAS—In a remote Aboriginal community, for example, how do you get registered?

Mr Shepherd—You would be aware that in Indigenous communities the approach to registration needs to be quite tailored. We have worked very closely with agencies such as Medicare Australia to come up with a completely culturally appropriate process. What we have found is that the use of community education tools, such as specific communication tools, as well as having members of the communities actually promoting the program as champions have worked very well. This does not come in a vacuum. This comes on the back of three years of working with these communities in Health*Connect* programs, so there is a level of trust and that has already been built up. Also, the Katherine area in particular has been hugely successful in terms of programs around linking critical data about particular patients in order to help those patients better manage their health. Sometimes in the territory we have had to sit under a tree and talk for a few hours about the program. I have actually had experience of that and have also seen that in the territory.

Senator McLUCAS—Where is this program going to end up? We have three little events happening. The original intention, from my understanding of Health*Connect*, was that we were going to have an electronic record system for all Australians. That is where we started from three or four years ago. While I do recognise that there are difficulties, is it still the intention of the program to achieve that goal?

Mr Shepherd—That is still very strongly the intention of that program. I will take you back to the five areas that I talked about before. The first area was a strong research base. What we found from the evaluation was that if you start with an electronic health record as your starting point there are all sorts of major bits and pieces missing around you: standards and infrastructure. Take clinical training, for example. It is wrong to start in that place. If we

learnt one lesson from the research and development phase, it was that we need to start from the first step and then walk forward. The second element is standards. You need standards—and we have had a long discussion around the National E-Health Transition Authority and its achievements so far.

The third element is you actually need state and territory governments to come with you. This program has over the past 12 months successfully signed up every state and territory to a memorandum of understanding and to an agreed set of priorities and objectives around how to take this program forward. If you take a step back and look at it, you see it has a strong research base, with standards in train—in fact, they have been accelerated and they are ahead of expectations—and state and territory alignment has happened over the past 12 months.

The next two places that you need to go to are to drive that clinical change out in the community and to drive consumer uptake. In the area of driving the behavioural changes required in the community, the department has in fact worked for a long time to look at all the key programs that we run across the department to see how we help drive that readiness. For example, you would be aware, Senator, of the practices in centres program and the discussions around bringing that program forward. In terms of consumer capability, one of the things that is really hard to do in these agendas is to establish consumer networks. We have worked hard with consumer health forums to establish those networks. We feel confident that we have got fairly strong consultation mechanisms in place—the web and tentacles are out all over Australia. The USA are actually so jealous of the framework that they have asked to steal it.

Senator McLUCAS—Make them pay! Sorry, it is a free trade agreement, so we have lost that opportunity; we cannot charge them anymore.

Mr Shepherd—The next stage is to utilise that framework and get some momentum. I think the deputy secretary might like to add to that.

Mr Davies—I was just going to reinforce Tam’s message by trying to bring to your attention the scale of this task in the Australian context. I think I saw a figure the other day of 400,000 different health care provider bodies in Australia. To link all those up and give them all the capability is not something that is going to happen in a very short time frame. But I think where we are now with NEHTA, and what we have learned from Health*Connect*, means we are much better placed to do that now than we were a few years ago with the standards agenda that NEHTA is pursuing very vigorously. We saw some additional investment from COAG last week. We are also in a better space to make sure that that investment is not wasted through what I think the secretary described as a rail gauge problem. We are well prepared but it is a very large task in such a diverse health system.

Ms Halton—It is important to understand where we sit in the world in this context. We sit very comfortably when we compare ourselves with elsewhere in the world. The UK system has gone in the direction of a very heavily, centrally driven and mandated system at huge expense. We are talking hundreds and hundreds of millions of pounds that they are spending. We have come from the standards and capability side and in fact a lot of people around the world are looking to our lead, particularly with the establishment of NEHTA. I have been asked about that I cannot tell you how many times from colleagues in the international

context. In a way, the hard thing has been to sort out the factors that Mr Shepherd talked about and to be able to understand how you migrate a whole sector without trying to build this vast infrastructure, because it is not possible to do that. If you like, it is a bit like the web. If you sat down and worked out an implementation plan for the web, you would have probably torn your hair out. What we are doing is effectively migrating the whole world to this electronic environment.

Senator McLUCAS—We have been talking about MediConnect and then Health*Connect* for a long time. Four or five years ago the goal was to get Australia e-connected—

Ms Halton—Yes.

Senator McLUCAS—I understand what you are saying: it is going to take a while; we have to get systems in place. We will get to the question of privacy in a minute. I just feel as if I would like to take bigger steps.

Ms Halton—I do not disagree with that but the rate limiter here is the individual practitioner, the individual patient and the technological capacity to do what we are talking about. In a sense, I like to see this as being individual milestones. We know—and Mr Shepherd will have the data—that the number of prescriptions that are now written electronically is a huge proportion; it is 90 per cent or something of that order. It is an enormous proportion. If you think about a doctor's business practice with their billing et cetera, and then you think about their clinical practice, it is effectively changing their clinical practice so that they routinely use an electronic information storage mechanism and all the things that that requires. That is a very big task. But what we can look at now are some ticks in some boxes in terms of progress made on the way. There is a tick against national standards, which has seen a major change. There is a tick against electronic prescribing. There will be increasing changes in referral patterns, as we are already seeing now. Referrals are starting to be delivered electronically. We are now seeing pathology tests being delivered electronically. You can see the change coming, but will you one day wake up and all of a sudden some standard system will be implemented? No. That is not what it will look like.

Senator McLUCAS—It might not be a standard system but, hopefully, everyone can talk to each other.

Ms Halton—Absolutely. That is precisely where we are going. If in fact we do not have those standards and that interoperability and communications, we will have that rail gauge problem which would be terrible.

Senator McLUCAS—Let us go to the question of privacy which has been a problem, certainly with MediConnect to my recollection. What measures are you putting in place to protect patient privacy with the electronic health record? What are the issues that have been identified and, hopefully, solved?

Mr Shepherd—As you know, privacy was a key area of research during the first four years of the program. You will also recall that one of the fundamental issues was that, when you have information stored in a form that pulls together data from multiple sources, there are the issues with consent and sharing that information across both the public and private sector and then outside state and territory borders. The privacy debate in this context, the policy work, is still being completed. But that does not present an issue for us at this time, because

the implementations that I have just described within Tasmania, South Australia and the Northern Territory can all happily exist and operate within the states' existing privacy arrangements and existing federal arrangements.

The other point to make is that, in both the research and development phase and moving forward to implementation, we have kept the Federal Privacy Commissioner very much abreast of developments. My understanding is that their office is very happy with the arrangements that we have in place.

So the issue going forward will be, when we are ready to have a totally interoperable nationwide sharing of data for electronic health records, will the privacy framework be robust enough to sustain that. Early indications are that there may need to be some minor adjustments; however, on the whole those arrangements are sufficient. However, I did note at the beginning that that advice and that piece of work are still ongoing in both the context of the work that the National E-Health Transition Authority is doing on the development of a consent framework and within the department in terms of the Australian government's position on privacy. I do not know that I can give you any more of an update on that.

Senator McLUCAS—The other issue is doctors feeling comfortable with the fact that their practice notes will potentially be shared with other professionals and other people. How is that being dealt with?

Ms Halton—I think we should make a distinction here. I do not think that there is necessarily an accepted notion that practice notes which go to a level of detail will be broadly available. What we have always talked about is a medical record. Again, this is where we have to get a common language around what is meant. Essentially, if a medical record provides the detail of a significant and relevant medical history, that well may not include practice notes. It may well say, 'This is the practitioner you need to talk to in relation to this particular diagnosis,' or whatever else—in other words, give you the pointers. But I think the notion that every single sheet of record in relation to you will be available to any practitioner—that is not where I think we are going.

Senator McLUCAS—That was the intention, though.

Ms Halton—I don't know that it was.

Mr Shepherd—The intention was always that that record would be a summary record. In fact, the international experience—the NHS is a classic example, where they try to collect everything—was that national sets of infrastructure cannot actually cope with trying to collect that sort of data.

Ms Halton—No, it is too big.

Mr Shepherd—Outside of the policy issues.

Ms Halton—Yes. Again, this is where being informed by what has been going on elsewhere is incredibly important. If you take a commonsense approach—Professor Horvath, being the medical practitioner, may want to make a comment about this—then the notion that you would have your entire medical history available electronically to anybody who is a medical practitioner or relevant to your care is, firstly, not necessary, I would suggest.

Secondly, there is the notion that you would have the system capacity to do that. Professor Horvath, you would agree, wouldn't you? What we are really looking at is the summary.

Prof. Horvath—I am happy to come in here. The earliest attempts—and I was involved in this back in the seventies—failed for the very reason that every little note saying, 'Mrs Smith came in and felt unwell' made too much noise. You cannot get through it and you lose the value of the information.

The current iteration that has just been described by Mr Shepherd is the valuable way to go. It is a comprehensive put-together that any practitioner—be it a doctor, an allied health worker or a nurse—can see the critical issues for the management of the patient, which is separate from the practice where you often put a fair bit of other personal detail that may not be relevant.

Mr Davies—Just for the record, we also need to stress, to avoid any confusion, that it would only be available to other practitioners with the patient's explicit consent. That overrides everything.

Senator McLUCAS—The other question that fits in there, though, is the question of legal liability and doctors feeling reticent. Even if you do not put total practice notes into the electronic record, the record probably will show something like, 'March 2005. Diagnosed diabetes. Dr Smith.' And what if Dr Smith got it wrong and it was actually a cold?

Mr Shepherd—This policy was explored in detail during the research and development phase of the program. The advice from the medical defence organisations—of course, the organisations that have most concern about this issue—was that from evidentiary perspective we were actually lowering risk. Because if you get the standards right, if their clinical terminologies around those are standardised, you are actually making it easier for the doctor to record the detail in the consultation. You do not have the issue of transcription errors or forgetting to write things down on a piece of paper so, from an evidentiary perspective, the advice from the medical defence organisations in the research and development phase was that this is actually a risk-lowering activity.

Ms Halton—And, if you think about it, in our view the whole safety and quality agenda will actually be significantly augmented because, exactly as Mr Shepherd says and as we all know, doctors' handwriting is legendary—only surpassed by health ministers', I can tell you, and the team would agree with me. The reality is that the ability to misread a handwritten referral, note, prescription, dosage or anything else is very significant. In terms of advancing the safety and quality agenda, actually having data more clearly recorded and transmitted would be a very significant step forward.

Senator McLUCAS—I think the first course you have to do at medical school is 'bad handwriting'.

Ms Halton—I could not agree with you more.

Senator McLUCAS—I think we have gone a little bit over time on that, but I appreciate it.

Ms Halton—Professor Horvath is maintaining a proud tradition, I have to tell you. His writing is ordinary.

Prof. Horvath—Correct.

Senator McLUCAS—Did you fail that course, Professor?

Ms Halton—Yes, he did. He clearly was not a high achiever in the bad handwriting course!

Prof. Horvath—Absolutely not!

Senator McLUCAS—Continuing the electronic theme, how many GP practices are now using HIC Online?

Ms Halton—This is actually a Medicare Australia issue.

Senator McLUCAS—I could have my normal bleat about the structure of this committee, but I think I would get put back in my box. But, with HIC Online, you collect no information; it is completely Medicare Australia collected.

Ms Halton—Yes.

[12.04 pm]

CHAIR—We will now move to outcome 2, Medicines and medical services.

Senator FORSHAW—I will commence with some questions on the safety net changes—the 20-day rule. We received an answer to a question on notice, which is No. E05-176, which indicated that the forecast growth for the period 2004-05 to 2008-09 would be nine per cent and that that had been reassessed downwards from a forecast four-year growth rate of 9.3 per cent. Do you have the answer to that question? That rate of nine per cent is across the five-year period 2004-05 to 2008-09—is that right?

Ms Corbett—Yes, that is correct. That figure is the figure that was correct at the time of budget for the average growth over the four years. However, as you are aware, there have been significant variations to the PBS estimates since budget time in May.

Senator FORSHAW—We received an answer to a question of Senator Nettle's in the budget estimates, E05-046, which listed growth rates for total PBS expenditure in each of the four years. In 2005-06 it was eight per cent; 2006-07, 7.5 per cent; 2007-08, 9.7 per cent; and 2008-09, 10.9 per cent. How does that revised figure of nine per cent align with the growth rates that were provided in that answer to question E05-046 in June last year?

Ms Corbett—The breakdown that we provided in response to Senator Nettle's question looked at the data that was underlying the report in Budget Paper No. 1, where we had a forecast for the PBS, and it provided a year-by-year direct calculation of the growth between those estimates. However, it is a much more meaningful thing to provide you with what the average annual growth is over the whole four-year period, because there is, as you know, a lot of variation in the estimates and at almost every estimates update there will be a change on a program this big. So we usually quote, in the budget context and other contexts, this four-year average annual growth figure. It was as stated in that answer at the time of budget, but has now shifted down so that it is now 7.8 per cent over the forward estimate years—that is the four-year average of the growth, given the current estimates position.

Senator FORSHAW—A lot of numbers are now being thrown around. The figure that is in the answer to question E05-176 says, 'It has been revised from a previously forecast four-

year growth of 9.3 per cent to a current forecast growth of nine per cent.' You have just given another figure of 7.5 per cent—

Ms Halton—The MYEFO figure.

Senator FORSHAW—as an annual average—

Ms Halton—Average annual—

Senator FORSHAW—average annual over the four years. I am trying to make sense of—

Ms Huxtable—Can I just clarify that?

Senator FORSHAW—Yes.

Ms Huxtable—The response that related to the nine per cent was based on the budget estimates. The 7.8 per cent average annual figure relates to estimates at MYEFO. At the time that we responded to the question on the safety net 20-day rule and used the nine per cent, the MYEFO figures had not been published.

Senator FORSHAW—Okay. When were those growth rates revised then?

Ms Huxtable—At MYEFO.

Ms Halton—At MYEFO. As to when MYEFO was released, we think it was 15 December.

Senator FORSHAW—What is the basis for the revision? Could you explain that a bit to me? I am a bit mystified by how this works.

Ms Halton—We have a very complicated model which goes to volume and price. The model predicts growth and we obviously calibrate what comes out of the model with our actual experience. You find, exactly as Ms Corbett said, that we amend the estimates relatively regularly in this program because of volatility.

Senator FORSHAW—So you are now saying the annual average is going to be 7.8 per cent, but can you break the four years down for these revised rates in the same way as you did when it was provided in the earlier answer?

Ms Halton—We could, but, as Ms Huxtable has just outlined, the problem with Senator Nettle's question, with respect, is that the year on year is not as meaningful as the weighted average—the average over the four years—because there is time-on-time fluctuation. We find that it is better to talk about the average four-year context as a more reliable figure.

Senator FORSHAW—Is that yes, you can do it but you would rather not?

Ms Halton—We can do it. It can be done, but we think if people start using it in a public context it is actually quite misleading.

Senator FORSHAW—Could you do it anyway, because we have those other figures for those years.

Ms Halton—Yes, it can be done.

Senator FORSHAW—What are the expected savings for the PBS over the four-year period?

Ms Halton—From the 20-day rule?

Senator FORSHAW—Yes, over that four-year period we are talking about.

Ms Huxtable—The PBS is a growing program, so when we talk about making an estimates variation, which we do regularly, it is projecting growth at a lesser rate in this instance, and it may be predicting growth at a greater rate. Nevertheless, the program is growing.

Senator FORSHAW—So are you saying they are not saving—

Ms Huxtable—The question is not about the 20-day rule, is it?

Senator FORSHAW—Yes, I am still talking about the 20-day rule. You have had a revision of the projected growth. I am trying to understand what savings that results in. Are you saying it is not savings because it is growing anyway?

Ms Huxtable—Yes, that is right.

Senator FORSHAW—It is just growing at a lower rate.

Ms Huxtable—It is growing at a lesser rate.

Ms Halton—We have not changed the savings estimate from the 20-day rule.

Ms Huxtable—That is right.

Ms Corbett—The savings from the safety net 20-day rule measure were $70.1 million over four years. That has not changed. We have not needed to change that particular estimate at this point in time.

Senator FORSHAW—Where was that figure? Was that in the budget?

Ms Huxtable—That was a budget measure.

Ms Corbett—Yes, it was.

Senator FORSHAW—But if you revise the growth rate, doesn't that mean that you would have to revise the savings figure?

Ms Halton—Not necessarily.

Ms Corbett—Not necessarily, not for each of the budget measures specified. That would become very complex, I must say. But, no, we do not normally do that.

Senator FORSHAW—I can understand that, but I can also contemplate that it may lead to a difficult—

Ms Halton—If you are talking about a savings measure that represented a really significant proportion of the PBS, then you are quite correct. In the event that you were amending the forward estimates, either up or down, you would probably look to amend the savings in respect of a particular measure. As for the 20-day rule in terms of materiality to the total and therefore the question of whether those savings figures should be amended, the answer is no.

Senator FORSHAW—Your answer is that the figure is as it was estimated in the budget?

Ms Halton—Absolutely.

Senator FORSHAW—Does the breakdown for growth over the forward estimates include highly specialised drugs—section 100 drugs?

Ms Corbett—It certainly does.

Senator FORSHAW—What effect does that have on the overall number?

Ms Corbett—The Highly Specialised Drugs Program was mentioned by my colleague Sarah Major. The growth in the component of overall PBS expenditure is quite high and the program now costs over $400 million per year, so it is quite significant. But if you have detail on that, you could defer to my colleague.

Senator FORSHAW—It would be good if we could get detail of that group and the rest. Are you going to give us that, Ms Major?

Ms Major—For the Highly Specialised Drugs Program for the financial year 2005-06 the allocation is $521.4 million. For 2006-07, it is $571.7 million. For 2007-08, it is $627.7 million and for 2008-09, it is $683.9.

Senator FORSHAW—What is the growth rate then that the government is predicting for PBS spending for the financial year 2005-06?

Ms Huxtable—The growth rate for 2005-06—and 2004-05—taking into account the actuals in the early part of the year was 5.5 per cent at MYEFO.

Ms Corbett—There have been some minor adjustments since, but 5.5 per cent is the most recent public figure for our growth estimate at MYEFO. Since then, there have been some announcements of new high-cost drugs et cetera. This figure moves all the time, but it was 5.5 per cent at MYEFO.

Senator FORSHAW—Is there a different figure—there should be—if you exclude highly specialised drugs?

Ms Corbett—No. Highly specialised drugs are a component of the total PBS forward estimates. There has not been any need to vary our estimated figures for highly specialised drugs. To clarify what I meant a moment ago, there is a difference between high cost drugs and highly specialised drugs. What I meant by ‘high cost drugs’ is, as you would be aware, from time to time, the minister will announce the listing of a new high cost drug. If a high cost drug is going to add any more than $10 million to our program in any one year, cabinet will consider that before an announcement is made by our minister. That relates to high cost drugs. Some of them are highly specialised drugs; some of them are not.

Senator FORSHAW—I understand that highly specialised drugs account for around 10 per cent of the PBS. Is that correct?

Ms Corbett—I think it is a little less than that for highly specialised drugs. If you look at the whole category of the section 100 programs—‘PBS Other’, as it is recorded—you will see that it is about 10 per cent of the PBS cost. Highly specialised drugs within it are the largest of a number of components, but there are more than just highly specialised drugs in what is flagged in the reports as ‘PBS Other’.

Senator FORSHAW—You are saying it accounts for less than 10 per cent but not much less?

Ms Corbett—It is around 10 per cent. That tallies with our figures.

Senator FORSHAW—The question was, ‘around 10 per cent’. That is what I have here.

Ms Corbett—But it does not just concern highly specialised drugs.

Senator FORSHAW—I am trying to clarify this. Does all that tell me that the growth in the PBS this financial year will be below the average of growth in recent years?

Ms Corbett—Correct.

Ms Huxtable—Yes.

Senator FORSHAW—What is the reason for that?

Ms Huxtable—We have looked at some of the growth patterns across the major drug groupings. There are some drugs for which the growth in the volume of the scripts has progressed at a little lesser rate than we anticipated. I would probably need to ask my colleague the Chief Medical Officer to give his views about what some of the reasons for that might be, but they do go to what appears to be some variation in prescribing patterns. That means the prescribing patters that we have seen historically and which historically have been built into the forward estimates have grown at a lesser but still significant rate than in previous years. In fact, when you look at those across the drug groupings and the variations, you see that there are some that have gone down and there are others that have gone up. As Ms Halton was saying earlier, this is a very dynamic program and there are variations occurring all the time in prescribing patterns.

Prof. Horvath—I can expand on that a bit. When looking at it, it is actually very clear that the system works extraordinarily well. The major falls have been in musculoskeletal following the drop-off of the Cox and Vioxx issue, and that is a very clear message that not only did Vioxx drop off but the profession has taken a degree of caution in using that whole class of compounds. The second area was following the SSRI issue and the publicity in the papers about SSRI and safety concerns. They have dropped significantly also. The cardiovascular areas of statins and hypertensives are interesting. They have grown but they have not grown as far. This was against a projected curve suggesting that at some stage they had to flatten as unmet need was taken up. I suspect where we are at now is that it has flattened off with the unmet need through a lot of work on good education of both the public and the profession.

Lastly, there are the antiparasitic products, which are mainly quinine, which was taken off the PBS for an indication that it was shown not to work for cramps and in fact should not be used for those but should be kept for malaria. They are the large reductions you can see in the numbers. Clinically and not surprisingly, areas around the cancer drugs and the new rheumatology drugs have gone up significantly so there have been some increases. Similarly, the ones around some of the genito-urinary system and hormones have gone up also. So the ones that have gone down are clinically predictable and appropriate decreases in prescriptions.

Senator FORSHAW—So you are talking about prescriptions that are written or the volume of prescriptions that are actually filled?

Ms Huxtable—These are effectively prescriptions that are reimbursed.

Senator FORSHAW—So it is measuring what is actually being consumed?

Ms Huxtable—Yes.

Senator FORSHAW—Are you able to give us that information and any additional information in a written form? I refer to the details that you have just read out about the movements in script volumes for particular drugs that have gone up and others that have gone down. It would be handy to have an analysis on paper of the overall picture with that break-up.

Ms Halton—We can do that in terms of the actual movement in those big groups.

Senator FORSHAW—Yes, I do not think we need every one of the thousands. It would be so we could track that through.

Ms Huxtable—We are happy to take that on notice, but we did do a question very much along those lines at the last estimates, which we responded to on notice. It showed also some of those script variations.

Senator FORSHAW—What was that one?

Ms Huxtable—I cannot recall now. I think Senator Barnett may have asked the question.

Senator FORSHAW—I apologise if I am asking you for the same information.

Ms Huxtable—We can update it.

Senator McLUCAS—Regarding the movement of Vioxx, taking the professor's point, we do not have Vioxx there, but there has been a reduction in Celebrex and other Cox inhibitors. If a figure could be put on those changes, that would be useful.

Ms Halton—We will see what we can do.

Senator FORSHAW—Can you give us the growth in overall PBS script volumes for the 2005 calendar year?

Ms Halton—Not for the calendar year. Would you like it based on the MYEFO for 2005-06?

Senator FORSHAW—I will take it in whatever form you can give it to me. I am trying to get an idea of what has ultimately happened in script volumes, and obviously this relates back to certain government budget initiatives such as increases in the co-payment and things like that.

Ms Halton—Remember that this goes to subsidised scripts; we do not have figures for below co-payment scripts. You used the word 'consumed' before; we cannot tell you about consumed scripts.

Senator McLUCAS—Don't you follow people home and make sure they take their scripts!

Ms Halton—In some cases I think we should!

Senator FORSHAW—Consumed was the wrong word; I mean scripts that are actually taken to a pharmacist and dispensed.

Mr Davies—It is not even dispensed, because, as the secretary just pointed out, if the cost of the drug is below the co-payment, which is currently $29, that is invisible to Medicare Australia.

Senator McLUCAS—So you cannot count prescriptions that are filled?

Ms Halton—Below the co-payment? No. This is an issue we are discussing with the guild as we speak.

Senator McLUCAS—You have the total expenditure on the PBS.

Ms Halton—If they are below the co-payment they do not appear.

Mr Davies—It is the total cost to the government.

Senator McLUCAS—They do not appear?

Ms Halton—No.

Senator McLUCAS—So we do not know how many below co-payment drugs are being prescribed or consumed or anything?

Ms Halton—No, exactly.

Mr Davies—We do get some data on that on a survey basis from the pharmacists.

Ms Halton—But we do not have the actuals. In fact, we talked to the president of the guild about exactly this issue only last week.

Senator FORSHAW—Ms Huxtable, I think you were going to add some further information.

Ms Huxtable—You asked about script volumes.

Senator FORSHAW—Yes.

Ms Huxtable—I have data for the financial year only for 2003-04 and 2004-05. The script volumes in 2003-04 were $165.8 million and in 2004-05 they were $170.3 million. Obviously, I do not have a figure for 2005-06 because we are still in that financial year.

Senator McLUCAS—With those two figures, how do you know that they are the prescribed—

Ms Huxtable—They are the scripts which were subsidised through the PBS—

Ms Halton—And which were dispensed.

Ms Huxtable—That is for all scripts where the charge is above the patient co-payment level and the government is providing a subsidy.

Ms Halton—So, clearly, for concessional patients, because the co-payment is significantly lower, you will catch a greater proportion of the scripts.

Senator McLUCAS—For those under the $29.

Ms Halton—That is right, but for general patients, because the co-payment is higher, we know less about the totality of scripts actually dispensed for that group.

Ms Huxtable—I should add by way of clarification that that is in respect of PBS scripts. There is another, smaller number in respect of scripts in the RPBS—the Repatriation

Pharmaceutical Benefits Scheme—which we would often add to those when we are reporting. Those figures are $15.6 million for 2003-04 and $15.7 million for 2004-05.

Senator FORSHAW—What about the situation—and I think this has been raised in previous estimates—about scripts that are written out but then not dispensed where the patient does not follow through? Do you have data on that?

Ms Corbett—We are not able to collect data on that directly. There are some surveys about doctors prescribing that we can draw on for general information. We are not able to collect it; we collect at the point that the data goes to Medicare Australia.

Senator FORSHAW—When you say 'we', who are you talking about—the department and including Medicare?

Ms Corbett—The department for the management of the PBS and the analysis of PBS costs. We are not able to draw on accurate data about the number of scripts that are written by doctors. We can draw just on the data that goes through to Medicare, which is collected at the point of dispensing from the pharmacy. Then, of course, in a section 100 case, we collect some data about what happens through those hospital provision services.

Senator FORSHAW—Going back to that discussion you were having with Senator McLucas about those scripts for which the data is invisible because they are below the copayment, are you saying that that has had an impact on the movement in script volumes? It has always been the case, hasn't it, that these have not been able to be identified?

Ms Halton—Yes, that is right, and the effect is lumpy. A particular group of drugs going off patent, for example, and therefore being subject to generic competition will see the price decrease substantially at a particular point in time. You may find a whole class of drugs all of a sudden going from being in the subsidised category to being below that category. There are a number of things that can impact on where a drug actually sits relative to those payment scales.

Senator McLUCAS—But that does not change volume?

Ms Halton—Yes, it does.

Ms Corbett—It changes the volume that we record.

Ms Halton—It may not change the aggregate volume in terms of what the consumers are having prescribed and/or dispensed, but what we see—the snapshot that we get—is absolutely affected by that.

Senator McLUCAS—What drugs would have gone off patent in the last 12 months that would have affected those? The statins are not off until—

Ms Halton—No, it is the general principle. At any one time this can happen. I am not saying that in the last 12 months we have seen necessarily that effect. My point is simply that the data we have is referenced to the program that we run, and that is not necessarily a reflection of where things may sit, because they are impacted by whole bunch of other factors, which are about their price.

Senator McLUCAS—On the flattening or even per capita decrease in script volumes, you cannot say why that is happening. Is that the message we have?

Ms Huxtable—There is not a decrease in script volumes. We are talking here about a growth less than we had anticipated—a variation.

Senator McLUCAS—But you are saying that you cannot explain that?

Ms Halton—No, we know some things. We know about the Vioxx withdrawal. There are things that we do know but, can our explanation be complete, by definition, no, because we do not have the complete data set. There are things that we know clinically. Professor Horvath and others with clinical expertise know things about what is going on clinically. We can look at particular classes and say, 'That has happened here'. Exactly as Professor Horvath says, 'That is not unexpected clinically. I understand that.' But as we do not have a complete data set, we cannot have a complete picture of total dispensing—understanding of course that there is no way that can have a complete picture of the total prescribing.

Senator FORSHAW—When there is a change or an increase in the co-payment, and that is going to work its way through the system, you presumably can measure the impact of that after it has been in operation for a year or so. Is that right?

Ms Halton—It is hard to disentangle all of the various reasons for movement.

Senator FORSHAW—Yes, I know.

Ms Halton—If and when a co-payment changes we could come up with an estimate.

Senator FORSHAW—So you will be able to work that out to give us some indication of what impact the co-payment has had on—

Ms Halton—We always have an estimate—and you would see this published in the budget figures—of the anticipated impact. Can we retrospectively disentangle all of the components of movement and say, 'In fact, this 40 per cent was as a function of the co-payment'? That is more difficult.

Senator FORSHAW—Let us leave it there for now but we will come back to it.

Proceedings suspended from 12.35 pm to 1.40 pm

CHAIR—The committee will resume with outcome 2. Are there any answers to questions taken on notice that are ready to be provided at this point?

Mr Davies—If there are, they may well be with the secretary.

Prof. Horvath—I have one for Senator Allison when she returns regarding the SSRIs and pregnancy. I could wait until Senator Allison returns.

CHAIR—Yes, we will. In that case we will proceed with questions relating to outcome 2.

Senator FORSHAW—There are a couple of areas that I want to ask questions about in regard to the PBS, and then we will move onto some questions relating to Medicare from Senator McLucas. I understand that there is an interdepartmental committee looking at further cuts to the PBS for this year's budget. Is that correct?

Ms Huxtable—I think it has been widely reported that there is an interdepartmental committee that has been looking at some issues around the PBS.

Senator FORSHAW—That is a very good answer, Ms Huxtable.

Ms Huxtable—Thank you.

Senator FORSHAW—Which departments are represented on the IDC?

Ms Blazow—IDCs normally comprise departments that have an interest in the issue, so it would be the usual suspects that are on IDCs—the coordinating agencies and so forth; Health, of course, is on it.

Senator FORSHAW—Health and Ageing. Which other departments?

Ms Blazow—The coordinating agencies always have an interest in these things—Finance, Treasury and so forth; Prime Minister and Cabinet.

Senator FORSHAW—Can you give me a list? Surely, if the committee has been set up, there is a specific list of who is on it.

Ms Huxtable—It would not be normal practice for us to provide details about interdepartmental considerations that may be informing government in regard to issues that have not as yet even been considered by government.

Senator FORSHAW—I am not necessarily asking what they are coming out with. I just wanted to know which departments were involved. I assumed Health and Ageing, Finance and Treasury. Are there any others that I cannot think of that would be directly involved here?

Ms Blazow—Can we take advice?

Senator FORSHAW—Veterans' Affairs, for instance, if you are talking about repatriation issues? I am just trying to get an idea of the scope, that is all.

Mr Davies—If it is okay with you, Senator, we will take advice on what the precedent is in terms of identifying memberships of IDCs.

Senator FORSHAW—You can take that on notice, thank you. There was an article in the *Financial Review* on 11 January by Annabel Stafford entitled 'PBS cost-cutting options go to cabinet'. Obviously, Ms Stafford has access to some information about possible changes to the PBS. According to her article, one option that was being recommended by the department of health was to take $830 million out of the PBS each year. Another option favoured by the industry department—so she apparently has some idea of who is involved in this IDC—would take $370 million out of the PBS each year. Are you aware of the article?

Ms Blazow—Certainly I am aware of the article. There is no option that is the Department of Health and Ageing's option. We would not be prepared to discuss an option in this context.

Senator FORSHAW—Even if there was one, you would not discuss it—

Ms Blazow—We would not discuss it because—

Senator FORSHAW—but you are telling me there is not one.

Ms Blazow—it is a confidential process and we have no idea of the source of Ms Stafford's information. In fact, we had an investigation in the department and we are not aware of how she got access to that information. I mean, journalists speculate about things. In addition, there has been an industry group working that has put various options to the government, and it is possible that there has been speculation around those—

Senator FORSHAW—That is Medicines Australia that you are talking about, isn't it?

Ms Blazow—They are an industry body that has been putting options forward.

Senator FORSHAW—That is normal practice, isn't it?

Ms Blazow—Yes, exactly. The government considers ideas from all sorts of sources.

Senator FORSHAW—This is an article that is written seeming to reflect detailed information. It is not just of a general nature. She seems well informed.

Mr Davies—I would not assume any correlation between the level of detail and the level of accuracy.

Senator FORSHAW—I am trying to find out whether it is accurate. These articles get written and it would be nice to know if there is any truth in them. So you cannot confirm whether Ms Stafford's article is correct or not.

Ms Blazow—We could not.

Senator FORSHAW—I will ask you these questions anyway. Has the government done any analysis or modelling on the proposals and various options that were canvassed in that article?

Ms Blazow—The article has no credence as far as the department is concerned. As I said, we had an investigation. She has quoted the department totally inaccurately. We have found no evidence that any material was provided to her by anybody in the department. We are not prepared to discuss what she is speculating about.

Senator FORSHAW—One option apparently reported is that the prices of drugs within a therapeutic group would be reduced to match the price of the winning tenderer's drug. Is that an option that has been modelled?

Ms Blazow—There have been industry bodies and industry participants who have actually proposed tendering, and I think that is probably part of the sorts of things that they have been talking about, for example, but I cannot confirm or deny what has been happening in the department about those issues.

Senator FORSHAW—So you cannot confirm or deny whether or not this is the preferred model of the health department.

Mr Davies—No, we cannot.

Ms Halton—Let us be clear, Senator—

Senator FORSHAW—That is what Ms Stafford says.

Ms Halton—Yes, and without going to any particular issues, I can promise you that the department has not expressed an opinion that could lead Ms Stafford to make that statement with any accuracy. Can I also make the point that I actually had that issue taken up with the relevant journalist and inquired on what basis she could make such a statement—and to say that the answer was flimsy I think would be generous.

Senator FORSHAW—She might have said she cannot either confirm or deny, just like you!

Ms Halton—No, she said more than that, in my understanding.

Senator FORSHAW—She might take notice of the department's position.

Ms Halton—She did concede that she had no actual basis or evidence upon which that claim was made.

Senator FORSHAW—Okay. I appreciate the position you are in and what you are saying in regard to the coming budget, but if a particular proposal were being considered by the department—or by whoever has a responsibility for preparing the budget and looking at savings in the PBS—would the consideration of such a proposal include endeavouring to analyse the health outcomes on individuals who may have financial pressures in being able to purchase prescription medicines?

Ms Halton—Senator, you are asking us to answer a hypothetical question.

Senator FORSHAW—It is not hypothetical. One of the constant concerns raised is that, if the copayment goes up and if changes are made to the listing of drugs and the subsidisation of drugs, those people who may find themselves unable to afford to access that particular prescription medicine may not do so. What I am trying to ask is: in the overall consideration of these sorts of proposals, is that impact considered, or do you just look at the financial impact upon the cost of the PBS?

Ms Halton—I think it is fair to say that in terms of the aggregate impact on measures in respect of copayments there is a view taken about whether that impact is reasonable or otherwise in the aggregate. In terms of a particular product, it is rare—in fact, I cannot think of a case—to take a budget decision which would have that kind of impact in a copay sense. I cannot recall an occasion where we have modelled individual effects. However, you are asking a hypothetical question so I cannot say to you whether we would or we would not.

Senator FORSHAW—I can recall some years ago there was a debate about certain classes of drugs that were going to become more expensive—I think there were something like six classes of drugs. There was a large public reaction, and the government changed its mind in regard to certain classes of drugs, some of which related to depression and to controlling blood pressure. You can look at cost factors and at the financial impact upon the PBS, but is some modelling work also done to analyse whether, if ultimately these classes of drugs become more expensive, some people who might otherwise have been prescribed them will no longer be able to afford them? Is that consideration ever entered into?

Ms Halton—Yes, remembering that in nearly all cases a drug in a particular category needs to be available to a patient at the copayment level. It might be that you exercise the choice to go with a different brand, for example, but in essence the principle which we observe is that the copayment is, by definition, affordable.

Senator FORSHAW—Yes, I understand that.

Ms Halton—You are either concessional or you are general, and in either event it is an affordable amount and in all circumstances you are protected by the safety net in terms of your aggregate spend.

Senator FORSHAW—I do not want to labour this, but I remember that at one stage some years ago there were proposals about the number of repeat prescriptions that people could have in some classes of drugs. There was concern expressed about the length of time in which

the number of repeat prescriptions would be available. I do not think I am going to get any advance information on the budget out of you, Ms Halton.

Ms Halton—You would be right there.

Senator FORSHAW—I would be surprised if I did.

Ms Halton—We would be having an aberrant day if that were the case.

Senator FORSHAW—I would welcome it. Maybe I should call Ms Stafford! There were some questions put in writing at the last estimates about the new PBAC responsibility for approving vaccines. What has been the industry's response to date on those proposed guidelines for implementing the new vaccine assessments?

Ms Corbett—There has been good discussion between the department, the Pharmaceutical Benefits Advisory Committee, the section of the department with the responsibility for vaccines, and members of ATAGI about all of this. There is a good working relationship with a subgroup within Medicines Australia, which is operating as the focus within that organisation around vaccines and vaccines issues from the industry point of view. They are calling that group MAVIG, Medicines Australia Vaccine Industry Group, and we have regular opportunities for discussion with them. We now have draft guidelines. They will be finalised once we have had final comment on them from industry groups and other interest groups. That should proceed very soon.

Senator FORSHAW—Are those guidelines going to be released publicly?

Ms Corbett—They will be made public, as are the other guidelines for PBAC, once they are finally signed off and agreed on.

Senator FORSHAW—Sorry; the proposed guidelines will not be made public?

Ms Corbett—The proposed guidelines have been released to the industry for comment.

Senator FORSHAW—Yes, but they have not been released broadly.

Ms Corbett—They have not been released more widely for comment at this point.

Senator FORSHAW—That is what I meant. Will the proposed guidelines be released widely for more comment?

Ms Corbett—No, I do not believe that is the intention. I believe that the arrangements that we have reached with the agreement of the industry are for a process for development between the major stakeholders—the industry stakeholders, the department and PBAC—with input from ATAGI.

Senator FORSHAW—I understand that the PBAC meets three times a year. Is that correct?

Ms Corbett—That is correct.

Senator FORSHAW—I understand that there is some concern that, because these arrangements for the new vaccine assessment process have not been finalised, companies have been unable to lodge applications for consideration at the coming meeting in March. Is that the case?

Ms Corbett—That is not the case, from my understanding of it. On the contrary, we have no barrier in the way of consideration by the PBAC from its March meeting onwards. It is not our usual practice to divulge what is or is not with the PBAC for consideration. I can assure you, though, that there is no barrier for considerations coming in from the March meeting.

Senator FORSHAW—So you are saying there is no impact upon the ability of companies to make applications to be considered at the March meeting?

Ms Corbett—That is correct.

Senator FORSHAW—Do indirect costs associated with communicable diseases form part of the assessment process done by the PBAC?

Ms Corbett—The costs and benefits of the so-called herd immunity factor of an immunisation program are ones that the PBAC will be grappling with. They have not done it on that basis before. That is one of the reasons why we have built up a whole new area of expertise around the PBAC. I think that is heading towards what you are asking about—yes?

Senator FORSHAW—I think the answer you are giving is yes. Do you have any additional information?

Ms Corbett—I have just been reminded that, of course, this analysis has been done before in advising government about its National Immunisation Program. It has not been done by the PBAC before. The new dimension is that the PBAC will be grappling with that economic analysis.

Senator FORSHAW—Has a review of the Visudyne therapy program been completed?

Ms Huxtable—It is in the Medicare area.

Senator FORSHAW—It is stated in the PBS that it was going to be conducted last year and it was expected to be completed by September of last year.

Ms Corbett—A proposal about Visudyne was considered at the PBAC in November 2005 and the outcome of that will be on the website with the other recommendations from the PBAC. There are some other issues outstanding around the Medicare Benefits Scheme. This is one of a few cases where there are very closely linked issues between Medicare Benefits Scheme management and Pharmaceutical Benefits Scheme management.

Senator FORSHAW—What has been the amount of spending on the program compared to the budget estimates?

Ms Corbett—That is the Medicare Benefits part.

Ms Robertson—For 2004-05 our expenditure was $21.6 million.

Senator FORSHAW—And what was the budget estimate for the year 2004-05?

Ms Robertson—The budget estimate was $26.6 million.

Senator FORSHAW—So there is a $5 million underspend against the estimate?

Ms Robertson—That is right.

Senator FORSHAW—Why?

Ms Robertson—As I understand it, patients are having fewer treatments than we initially budgeted for.

Senator FORSHAW—With all due respect, I think I could work that out. But, why, do you know? Is the eligibility criteria too strict?

Ms Huxtable—In regard to a program like Visudyne, at the outset there is some estimate made on the basis of medical input about what the expectation is both for the number of patients and for the number of treatments. My recollection of this program is that there was quite a slow start up, and as the program has developed it has been found that patients are not having as many treatments as we had initially estimated. That estimation, however, was based on advice, as I recall, both on the part of the company that provides the Visudyne product and also on the part of the medical profession in regard to what the expectation was. This is one example where the reality has not quite matched what we expected.

Senator FORSHAW—Do you have any figures for the spending for the current year to date?

Ms Robertson—I do not have that with me.

Ms Huxtable—We can take that on notice.

Senator FORSHAW—In this review, has consideration been given to expanding the eligibility criteria? Is that one of the things that has been looked at?

Ms Robertson—We are coming to the end of the period for which the money was initially appropriated, so we have to go back and do a review of the effectiveness of the program

Senator FORSHAW—Does that include looking at the eligibility criteria?

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

Senator FORSHAW—Finally, the US-Australia free trade agreement is subject to a review in March. Has the US put issues regarding the PBS on the table for review in March?

Ms Halton—It is not within our jurisdiction to comment on the free trade agreement or indeed the review, because that is not actually organised by this portfolio.

Senator FORSHAW—Have you been involved yourself, Ms Halton, in discussions with the US on this issue?

Ms Halton—Yes, Senator, courtesy of the *Australian*, my trip to Washington—

Senator FORSHAW—Courtesy of who?

Ms Halton—The *Australian*—the front page of the *Australian*; while I was attempting to have a beach holiday—

Senator FORSHAW—I thought you had meant that they had paid for the trip.

Ms Halton—No. The fact of the meeting of the first Medicines Working Group was canvassed quite extensively on the front page of the *Australian*; I think it must have been a slow news day. We met with our interlocutors in the United States, convening the first meeting of the Medicines Working Group in early January. That was a meeting that lasted a full day. That Medicines Working Group, you would recall, is required to be convened under

the terms of the agreement and we were required to convene it once a year. So we have had the first meeting of that group.

Senator FORSHAW—Can you tell us who you met with and give us some more details about the meetings that you attended—this was in Washington, wasn't it?

Ms Halton—That is correct.

Senator FORSHAW—And can you tell us what the topics for discussion were?

Ms Halton—I can tell you, Senator, that we canvassed a range of issues. One of my colleagues, who has got the bits of paper in front of her, can probably give you more detail. But in terms of the broad areas, obviously we canvassed the operation of the PBS. I have to say that this was largely us providing information to our American colleagues about how the PBS actually works. I think it is fair to say—and I think even in this place we find—that the complexity of the PBS is often not well understood. So we did spend quite a large proportion of the meeting talking about what our objectives are with the PBS, how it actually operates, and dispelling what I might describe as some misunderstandings about the operations of the PBS.

Senator FORSHAW—Did those meetings include representatives of the pharmaceutical manufacturers group?

Ms Halton—No. The Medicines Working Group comprises, obviously, nominees from both sides. From our side, it comprised me, as the leader of the delegation, and I took a couple of officers from the department with me. We also had representatives from the Department Of Foreign Affairs And Trade, both Australian based and Washington based, with us. From the other side, the representation was principally from Health and Human Services. There was a representative from Trade in the United States, but they were government officials.

Senator FORSHAW—So PhRMA, the pharmaceutical manufacturers' group, were not involved in those meetings?

Ms Halton—No.

Senator FORSHAW—Were there any separate meetings held with them?

Ms Halton—No.

Senator FORSHAW—Did the issues that were discussed include the provisions regarding protection against evergreening and concerns within the US about that?

Ms Halton—As I have said, we did actually provide a range of information about the way our system operates, particularly the robustness of our patent regime and a series of other things.

Senator FORSHAW—So, from that, do I take it that that includes things such as protection against evergreening—the provisions that were inserted into the final legislation here?

Ms Halton—I think it is fair to say that, in a broad discussion that canvasses the legislative framework that governs the operation of all of our arrangements, inter alia, part of that includes the protections against things like evergreening, for example. In fact, the large

proportion of the meeting constituted us providing information about how our systems actually work.

Senator FORSHAW—That is very good. I would have thought that the Americans would have been keen to have known all of that before the negotiations. I assumed they did, in fact. That is one of the reasons why they were complaining.

Ms Halton—And I think it is fair to say—

Senator FORSHAW—I am not being critical of you. I am just saying that I find it a bit interesting that they are getting a detailed explanation of our system after the trade agreement has been finalised.

Ms Halton—You would be aware that, in a number of cases—

Senator FORSHAW—I am not sure I am aware, but go on—

Ms Halton—people from the other side of the table, when we were in the United States, would have received a range of information from a range of parties, some of it—you are quite right—from industry, some of it from a range of other people. In a number of instances, the perceptions formed based on that information are not accurate.

Therefore, in discussing the way our system works and particularly their perceptions about the way our system works, it is important that we were in a position to go into quite some detail about why in some cases those perceptions were not accurate. Ms Blazow was there at the time, as was Dr Lopert. My view is that it was a very constructive meeting, because we were able—and I am sure my colleagues would agree with me—by the end of the meeting to have quite a strong sense that there was a better understanding amongst the people we met with about how our system actually works.

Senator FORSHAW—It is good to know that our American friends are once again finding out the facts after the event.

Ms Halton—The thing to remember—

Senator FORSHAW—You do not need to respond to that.

Ms Halton—But I should make an observation. The people we are now dealing with in the Medicines Working Group are largely Health and Human Services officers, so they are largely the line people. At the end of the day, it is not their stock in trade to understand all the finer detail of how our system works. So in a sense it is not surprising that a good proportion of that dialogue was going to those facts.

Senator FORSHAW—Has the department had any meetings with Medicines Australia recently and particularly following meetings in the US—say, since the last round of estimates—about the generic pricing policy and/or the evergreening provisions in the free trade agreement?

Ms Halton—We meet with Medicines Australia all the time. They are very common interlocutors with us. In terms of whether we have met specifically on this subject, I am not aware of such a meeting. It is possible that this has come up as a side issue in one of those discussions, but I do not know.

Senator FORSHAW—Could you take it on notice to give us some details?

Ms Halton—The people who can answer the question are here.

Senator FORSHAW—Okay.

Ms Blazow—Medicines Australia has certainly written to the department with their ideas about the speculation about generic pricing and so forth. In terms of specific meetings, Medicines Australia is a participant in a group called the Pharmaceutical Industry Working Group that is jointly chaired by our minister and Minister Macfarlane, the industry minister. The industry has put ideas to the ministers in that sort of context. As the secretary said, there is continuing engagement on these sorts of issues with industry.

Senator FORSHAW—When was that most recently done?

Ms Blazow—There was a meeting about these sorts of issues with the ministers in late November, where the industry did engage with the ministers.

Senator FORSHAW—Thank you for that. You might take it on notice to advise us if there have been any other meetings. When was the last round of estimates?

Ms Halton—November. Can we work on the basis that the answer is no, there has not been a specific meeting, unless we come back and notify you otherwise?

Senator FORSHAW—That is what I was getting to.

Ms Halton—That is fine. I certainly have not had one. If Ms Blazow has not had one or if Ms Huxtable has not had one, the very strong likelihood is that there has not been one.

Senator FORSHAW—But you can confirm that these issues were clearly discussed at that meeting, because Medicines Australia were putting their views to you?

Ms Blazow—Not evergreening.

Ms Huxtable—You raised two issues: generic pricing and evergreening. The answers are in respect of the former rather than the latter.

Senator FORSHAW—Finally, I will raise this and see if I get an answer. Is it still government policy that the evergreening provisions in the free trade agreement remain as is?

Ms Halton—There has been no change in policy that I am aware of.

Senator FORSHAW—So there is a commitment to retaining those evergreening provisions that were put into to the agreement?

Ms Halton—We are not aware of change in government policy in this area.

Senator FORSHAW—Good. Thank you for that. That is all I had on the PBS issues.

Senator McLUCAS—I am going to try and cover the Medicare safety net questions between now and 2.30, because we have lost a bit of time in this area. We spoke a little earlier today about the figures that were provided to the committee. Could you briefly explain some of the fluctuations in the data of families registering for the Medicare safety net? For example, in August, 50,000 families registered and in September, 13,000. It seems to fluctuate a bit.

Ms Huxtable—This goes to the issue that Ms Halton was addressing earlier. In the process of gathering this data from Medicare Australia, we were also surprised at some of the fluctuations that appeared to be in the month-by-month registrations. Around the time this

question was being finalised, we went back to them to check that the data was correct. It became clear at that time—I have to say that there was a bit of noise and some discussion between the agencies in trying to understand what was going on here—that the date the monthly report for August, for example, was run may have been several weeks into September. The data it was capturing was covering August plus those two weeks in September. You will see that August and September are good examples. What I understand is that the August data covers more like a six-week period and the September data covers more like a two-week period. It has proven quite difficult, as Ms Halton said, to get what we would deem to be accurate month-by-month data, which is why, in the interests of answering this question before today, we have put in a caveat that the periods may not be an exact calendar month. We are continuing to discuss with Medicare Australia getting that data. They have to look back over the last 12 months, and that is proving a little more time consuming than we would have hoped.

Senator McLUCAS—The second question is about the cleanliness of this data. I accept that these may not in fact be months—let us put that aside. The 'cleanliness' goes to whether or not families are registering as families and people are being put into their correct family unit. How significant an issue is that in terms of actual numbers?

Ms Huxtable—I might just start with what I understand is in this table. I think we had a discussion about this at last estimates and we were unsure as to whether it was new or amended, or new and amended. We have now clarified that this data is clean in terms of the number of families that it is counting. The cumulative totals are clean data. They comprise cumulative counts of new families and reformed families. If a family splits in two, two will be added and one subtracted, so you get a net addition of one. Therefore, we believe the cumulative totals to be accurate. In terms of the overall numbers, we probably would have to take on notice the number of amended families that form new families, if you like. I am advised that it is relatively significant—in the order of some tens of thousands each year.

Senator McLUCAS—At the last estimates you provided us with a figure for the year-to-date spending on the Medicare safety net—which I apologise for not having with me. Where are we up to with that?

Ms Huxtable—The most recent figure that I can provide is in respect of the 2005 calendar year. At the end of the 2005 calendar year, expenditure on the safety net was $272.2 million.

Senator McLUCAS—For the financial year?

Ms Huxtable—No. It is a calendar year program.

Senator McLUCAS—What was the spending for the calendar year 2005 for the whole of Medicare?

Ms Huxtable—I am advised that it was $10.06 billion.

Senator McLUCAS—Is that calendar or financial?

Ms Huxtable—We do not have that by calendar year; we only have it by financial year. That is how it is reported.

Senator McLUCAS—Yes, I realise that. Is it possible for you to give us, on notice, the total spend on Medicare for calendar year 2005?

Ms Huxtable—We will look into that.

Senator McLUCAS—It is probably much the same, really.

Ms Huxtable—The expenditure in 2004-05 was $10 billion and the estimated expenditure for 2005-06 is $10.6 billion, so it would certainly be of that order or around there.

Ms Halton—We will take a punt: $10.3 billion.

Senator McLUCAS—Have you had to revise the estimates for Medicare this year?

Ms Huxtable—There was a revision of the estimates in the MYEFO context. At the 2005-06 MYEFO, the 2005-06 estimate was increased by $181 million.

Senator McLUCAS—Can you turn that into a percentage for us?

Ms Huxtable—If I had a calculator, I could.

Senator McLUCAS—It is $181 million divided by $10.06 billion, I think.

Ms Huxtable—It is $181 million divided by $10 billion—divided by 10,000 actually—which equals 1.7 per cent.

Senator McLUCAS—You might want to take this on notice: was there a revision on the figures on just the Medicare safety net in that period?

Ms Huxtable—No, there was no adjustment in respect of the Medicare safety net.

Senator McLUCAS—Have you been monitoring different service types over the last period?

Ms Huxtable—I think we have talked before about this. We have a reasonably regular discussion with the AMA about some of the data regarding a basket of services that we have looked at now for some years. The last meeting we had with them was last week. It was a fairly short meeting because nothing significant popped up out of the data that we normally discuss. Really, the only thing that was discussed related to some of the claiming around the obstetrics planning and management item. In December, in the last quarter of 2005, there seemed to be a bump or a blip in the data.

Senator McLUCAS—So to speak.

Ms Huxtable—You are obviously on the same page as me. We will probably want to keep an eye on that. Something similar also happened last December. You will recall that that planning and management item relates to a pregnancy after 20 weeks. Normal charging is at 28 weeks and, to fit into the safety net calendar year, it is being brought forward to 24 weeks. We are not really sure about that, so we will continue to look at it and talk to Medicare Australia about it.

Senator McLUCAS—What about pathology?

Ms Huxtable—No, there would be nothing in particular on that.

Senator McLUCAS—I am advised that there was an increase of 24 per cent in pathology from August 2005, compared with August 2004.

Ms Huxtable—You might want to direct those questions to those responsible for outcome 10, as they manage the agreements that cover pathology. I am probably not completely across some of what might have been happening in that area.

Senator McLUCAS—Would diagnostic imaging be the same?

Ms Huxtable—Yes.

Senator McLUCAS—I understand that Minister Abbott has said he is prepared to act against specialists who charge exorbitant fees. What action could be envisaged to achieve that; what could occur?

Ms Huxtable—Certainly, as part of monitoring the Medicare safety net, it has not really been an issue. But it is important that items are being claimed for the purpose for which they are intended and that other charges are not loaded into the item. That was certainly one of the things we talked about with the profession early on in the piece. We have not seen any evidence that coming through; otherwise, we would have expected much more movement around fees charged than we have seen. There have been fairly flat trend lines in that regard. I am not sure I have anything more to add about what we monitor and Medicare Australia monitors to ensure that items are being charged for the purpose for which they were intended and as stated in the MBS book.

Senator McLUCAS—It was reported in November last year that a corporate organisation suggested that doctors can earn in excess of $620,000 and then went on to explain how that can happen. The minister made some comments about that as well. What tracking do you undertake of corporate general practice?

Ms Huxtable—Medicare Australia probably have more of the technical detail around how monitoring occurs. As I understand it, the monitoring that occurs is much more on a provider basis rather than the organisations in which providers may aggregate. I am not sure that we can access data concerning that, because it is driven by provider number and not practice aggregation.

Mr Davies—We have no knowledge of what corporate structures individual medical practitioners operate under.

Senator McLUCAS—You just have the Medicare provider number.

Mr Davies—Correct.

Ms Huxtable—In reality, doctors may well practise in a variety of places and provide a variety of services.

Senator McLUCAS—The ability to crack down on corporate 'overservicing'—which is the allegation—is quite limited.

Ms Huxtable—Probably the issue there that tends to be discussed more is around referral patterns. While, again, this is a matter for outcome 10, I am aware that recently there was a review of practices around pathology. It probably goes more to doctors referring to pathology services and the like—capturing the downstream benefit, if you like. Certainly, within Acute Care Division, work is occurring in conjunction with Medicare Australia and the profession around some of those practices.

Senator McLUCAS—Is that in outcome 10?

Ms Huxtable—Yes.

CHAIR—While Senator McLucas and Senator Forshaw confer, we might give rough indications of what we expect to be the markings that we give to the next few stages of proceedings. I assume that we will start outcome 3 very shortly. We will not move on to outcome 4 before 4.30 pm, outcome 7 before 5.30 pm, outcome 8 before 7.30 pm, outcome 10 before 8.30 pm, outcomes 1 and 12 before 9.30 pm and outcome 5 before 10.30 pm. As the night goes on, we might need to make those times at which we start those particular programs rather than the earliest possible start times.

Ms Halton—Chair, what about outcome 11?

CHAIR—Outcome 11 we will have to squeeze in at whatever time is left over after outcome 5.

Ms Halton—So they should probably be here at 10.55 pm?

CHAIR—Something like that.

Ms Halton—I was just checking.

Senator FORSHAW—We will take that on notice.

Ms Halton—Will we get an answer before close of business?

CHAIR—We ask the questions around here!

Senator FORSHAW—I refer to the operation of the Medicare safety net and changes as they apply to cataract surgery. Firstly, can I confirm that as of November last year changes to the Medicare benefits schedule meant that cataract surgery done out of hospital was no longer eligible for the Medicare safety net. Am I right? Is that correct?

Ms Huxtable—Yes, that item and many other items. There was a process undertaken with the AMA in the course of last year which looked at those items which were very predominantly delivered in hospital—more than 95 per cent of services being delivered in hospital. There was a review of all of those items, undertaken in conjunction with the AMA and relevant colleges and societies, to get advice about whether these services should be only delivered in hospital or whether they should and could be delivered both in hospital and out of hospital. In respect of that item—and I think there were 50-odd other items—the advice was that this was a service that should only be provided to admitted in-patients and therefore a 75 per cent MBS rebate should apply to this item.

Senator FORSHAW—Was that item 42702?

Ms Huxtable—That is correct.

Senator FORSHAW—So the answer is yes, and I appreciate the explanation.

Ms Halton—We need to be clear. You used the general term ‘in hospital’. It may well be that you actually have a procedure performed in hospital but not as an admitted patient. There is an important distinction there. The schedule as it applies in this particular case is in respect of admitted patients. If in fact you had a procedure of that kind performed as a non-admitted patient, that would be the distinction. So it could still be in hospital.

Senator FORSHAW—A non-admitted patient could be somebody who has their cataract removed. It takes a few hours and it is done in a hospital setting but they go home the same day.

Ms Huxtable—They may well still be admitted on a same-day basis.

Senator FORSHAW—That is right. I understand that situation. You said there was consultation with the AMA and the colleges about this item and a number of others. Did you say there were 50 all told?

Ms Huxtable—Fifty-nine were affected by the change on 1 November but more than 59 were consulted upon. What was driving our further analysis was that threshold of 95 per cent of services being provided to admitted in-patients, so it was anything that was over the 95 per cent mark. I think that is correct. I am being advised there were almost 1,500 items reviewed.

Senator FORSHAW—Sorry, I missed that last bit.

Ms Huxtable—Almost 1,500 were actually reviewed as part of this exercise with the AMA.

Senator FORSHAW—When was the decision made? It was implemented from 1 November. When was the decision actually made and who made it?

Ms Huxtable—There would have been advice provided to the minister. This predates my coming back into this division. I would have to take that on notice to tell you exactly when that decision was made.

Senator FORSHAW—Would you take that on notice?

Ms Huxtable—Yes.

Senator FORSHAW—How was it communicated? Was it a media release? Was it widely publicised?

Ms Huxtable—I might have to take that on notice. I am not sure of the exact detail of how it was communicated. I understand that there was certainly a role for the AMA and the colleges in that communication, but I will take on notice the precise mechanism.

Senator FORSHAW—If you could provide us with the details of when the decision was made and how it was communicated not only to the profession and the hospitals, but also to the general public. Would it be fair to say these cataract removal procedures are overwhelmingly provided to elderly people? Is that a fair statement?

Ms Halton—We will ask the elderly person at the end.

Prof. Horvath—The majority of cataracts are—

Senator FORSHAW—I think they have already answered. They just want you to be the one to do it.

Prof. Horvath—however, cataract surgery is needed for groups of other people. Diabetics commonly get cataracts earlier in a younger group, there are some congenital cataracts and there are some cataracts associated with light exposure, but the vast majority of people are older, yes.

Senator FORSHAW—My follow-up question, which you can take on notice, is part of the earlier question about communication to the broader public. Were there any special efforts made to communicate this decision to organisations—for instance, senior citizens, nursing homes, retirement centres, groups like that—comprising those that may be specifically affected more than most by the decision? You can take that on notice.

Ms Huxtable—I will take that on notice. I just want to go back. The effect of this decision was to confirm that this is a procedure which, in the view of the profession, is appropriately provided and appropriately only provided to admitted in-patients.

Ms Halton—We are aware that there is a view in one particular section of the country, because we have had correspondence on the matter, that this may not be appropriate.

Senator FORSHAW—What do you mean by one part of the country?

Ms Halton—I mean WA. I have received correspondence on the matter from the Director-General of the WA Department of Health. I have not had any correspondence on this issue from any other part of the country, and we have asked the Director-General of the Western Australian department to discuss it with the profession. It is exactly as Ms Huxtable says: this is the profession's view about what is appropriate, and to come back to us.

Senator FORSHAW—I was not going to ask you anything about WA, but thank you. I am particularly concerned about the knowledge of patients and how they find out about these changes as well. I am not exclusively concerned about that, but that was the point of my question. How many cataract procedures in Australia are done on non-admitted patients?

Ms Huxtable—I would have to get the exact figures for you but, as I said at the outset, we were only reviewing items with the AMA where more than 95 per cent of the services were provided to admitted in-patients. While I can certainly get back to you with that information, that figure will be less than five per cent of the total number provided.

Senator FORSHAW—Okay, you have answered the second question anyway, but I would like the actual number of procedures. What percentage of patients in the last year who had their surgery done as an outpatient received reimbursement under the Medicare safety net? Do you want to take that on notice?

Ms Huxtable—I am not sure that we will be able to answer that. We will take it away and have a look at it. Claiming of benefits under the Medicare safety net will relate to where people are at with thresholds and the like. Whether we can actually drill down into an individual's claiming behaviour and get to that particular information, I would need to talk to our colleagues in Medicare Australia.

Senator FORSHAW—What you are saying is, because reaching the threshold could involve a number of different medical costs associated with different procedures, visits and so forth—

Ms Halton—Sorry, we have just learned that one of our officers had a car accident.

Senator FORSHAW—I am sorry. I am just trying to understand your last answer, Ms Huxtable. You are saying that there is a whole range of things that go towards reaching the safety net threshold. Was that the point? It may be hard to extrapolate.

Ms Huxtable—I am just trying to think it through. Up till November, for that small percentage of patients who may have had cataract procedures as outpatients, non-admitted patients, whether or not those services qualify for the safety net would relate to what out-of-pocket costs were charged and whether that person, as part of a family or not, had progressed to the threshold. There is a variety of factors that would input. I just need to talk to Medicare Australia about how we might get that data.

Senator FORSHAW—Staff in Medicare offices would have been provided with advice if queries were made regarding the change from 1 November.

Ms Halton—Again, that is really a question more for Medicare Australia. But I would anticipate that, as schedules are released and re-released, information is provided in Medicare offices about any changes that would be relevant for claiming of items.

Senator FORSHAW—So questions about the advice and the impact should be directed to Medicare Australia.

Ms Huxtable—The questions you are asking really go to the internal management process of Medicare Australia in terms of training and supporting staff.

Senator FORSHAW—You see, it has been alleged, or we have been informed, that there have been different reasons given to people depending on which office they may have attended and also there have been different reimbursements for the same procedure. Now, I should direct that to—

Ms Halton—The latter point should not be the case.

Senator FORSHAW—No, that is right.

Ms Halton—But, as to information that is provided by accountable telephone staff, the reasons for this are perfectly clear in our minds and certainly were communicated clearly to other agencies. As has been outlined in an extensive process of discussion with the profession, what has actually happened with the service delivery—at the risk of Senator McLucas pulling one of those faces—this is a question for Medicare Australia.

Senator McLUCAS—I think you should direct those to the chair.

Ms Halton—Yes, through the chair and with respect.

Senator FORSHAW—That is all I had.

[2.44 pm]

CHAIR—We will now proceed to outcome 3, Aged care and population ageing.

Ms Halton—I cannot table 14 copies of the information you asked me for right now. I have managed to produce two copies in the time; so we will provide them to whichever senator would most like them.

CHAIR—Thank you very much for that.

Senator McLUCAS—I want to raise the issue of fire safety declarations. Can you tell my how many facilities passed the 1999 fire safety standard certification on 31 December, 2005?

Mr Mersiades—We did an analysis of the returns over the early part of this year, and as of 14 February all but 567 homes have given us independent evidence that they meet the fire safety standard.

Senator McLUCAS—So 567 have not yet passed?

Mr Mersiades—That is correct.

Senator McLUCAS—Out of 3,000-odd. How many have passed?

Mr Mersiades—The precise number is 2,935.

Senator McLUCAS—So as a percentage that is—

Mr Mersiades—It is about 80 per cent.

Senator McLUCAS—Can you confirm that compliance is required with the 1999 fire safety standard?

Mr Mersiades—Just a bit of background in answering that. All homes are required to meet state and local government fire safety standards.

Senator McLUCAS—Yes, that is a separate issue.

Mr Mersiades—They also all meet the 1997 certification standard. What we are talking about is the higher standard agreed with industry representatives in 1999 that they meet the 1999 certification instrument. As part of the Hogan package, $3,500 was provided per resident to homes in recognition of that agreement with the sector to move to improved fire safety standards and building standards. As part of that allocation of funding there was a requirement for homes to demonstrate to us by the end of December 2005 that they had achieved the fire safety standards.

Senator McLUCAS—So they had to do it?

Mr Mersiades—Yes. Well, they had to provide us with an assessment indicating where they had got to.

Senator McLUCAS—And 80 per cent have?

Mr Mersiades—That is correct.

Senator McLUCAS—Basically it is not voluntary?

Mr Mersiades—In the sense that there is nothing in the legislation or the principles which underpins that target date. It was a condition that we attached when we wrote to the providers and told them about the $3,500. As I said earlier, it was part of a partnership arrangement that we had negotiated with the sector back in 1999 that the sector would gradually move towards those targets.

Senator McLUCAS—In the letter you wrote to them you said:

If such evidence is not provided by December 2005 this may result in a review of the home certification under the Aged Care Act 1997.

Mr Mersiades—Correct.

Senator McLUCAS—I do not think that is voluntary.

Mr Mersiades—It said it ‘may result in a review’. Obviously we were moving to put as much pressure on people to move as quickly as humanly possible, recognising that buildings have different life cycles and that there is an appropriate time in which to make those sorts of capital investments. We did not want to push them to do it at a time which was inopportune and would have meant good money going after bad.

Senator McLUCAS—So what sanctions are going to be imposed on that 567?

Mr Mersiades—We have a number of avenues available to us, but our first preference is to work cooperatively with the sector. They have demonstrated that they have been doing that since 1999—there has been a huge amount of investment being made in upgrading and rebuilding the homes. Our first preference is to work cooperatively with them, but we do have fallback positions. As part of that review you referred to, one of the fallback positions, if they are not cooperating, is to constrain them in their abilities to charge accommodation bonds and accommodation charges and to receive concessional resident supplements. As well as that there is scope to have them assessed against the accreditation principles by the agency. So we have a number of avenues available to us. But I reiterate: our first preference is to work with them very closely and carefully in good faith, because the overwhelming majority of providers, if not all, are interested in the welfare of their residents and will do the right thing when it is financially a sensible time to do it.

Senator McLUCAS—But the safety of residents must be pre-eminent?

Mr Mersiades—I emphasise that all homes have to meet state and local government fire standards. They have to have a certificate of occupancy to be operating.

Senator McLUCAS—We will get to that later, Mr Mersiades. Tell me about the 567. What sort of information do you have about why they have not been able to comply to this point in time?

Mr Mersiades—The overwhelming majority have given us information on when they think they will be in a position to comply to achieve that level. I can give you that information. I do not have the information as to why. There would be a variety of reasons, and it is probably different for every home. But I can give you information as to where they are at with their upgrading and redevelopment work.

Senator McLUCAS—But are there themes such as people not being able to get upgrading work done—some people have talked to me about the difficulty of getting tradespeople.

Mr Mersiades—Yes, that is correct.

Senator McLUCAS—What are the reasons people have not been able to do it?

Mr Mersiades—For some of them it is the availability of assessors. There are not that many of them out there. We put a heavy workload on them by setting that timetable.

Senator McLUCAS—It has been extended for two years, though?

Mr Mersiades—Yes, but we have a number of them who are still waiting on the results of those assessments. As I said, I do not know the precise details of the other reasons. I was more interested in when they intended to achieve the target. My colleague might have information on this.

Ms Halton—I think it is important to understand that in respect of every single one of these homes, the staff in the department—mostly in our state and territory offices—have been in contact with them. As Mr Mersiades is pointing out, as part of a consensual agreement with the industry we acknowledged that we should collectively lift the bar for the standard of accommodation we offer our older citizens. We agreed with them on this approach and, in terms of this number, which in most cases have building work under way but have not yet completed that work, our staff are talking quite regularly with each one of these homes about the progress.

Senator McLUCAS—That is basically what I am asking so that I can get a feel for why we have a fifth of Australia's aged care facilities that do not meet the standards that were agreed on in 1999.

Ms Halton—Essentially, my interpretation of the data I have in front of me is that, for example, 42 of the 567 are awaiting sign off on building work done. In other words, 42 of that 567 have done the work, they just want someone to give them a tick. There are another 246 that will finish their building work by 31 March. There are another 139 which will be done by June. These are not pie-in-the-sky targets. These are things that our staff are checking the details of to make that the claim that is made is real and deliverable.

Senator McLUCAS—So 42 are waiting to be signed off?

Ms Halton—Yes.

Senator McLUCAS—There will be 246 by the end of March—

Ms Halton—Correct.

Senator McLUCAS—and 139 by the end of June. That is still about 100-odd outstanding; probably a bit more.

Ms Halton—There will be 44 by September and 28 by December.

Senator McLUCAS—Twenty-eight by December?

Ms Halton—Yes.

Senator McLUCAS—Does that add up to 567?

Ms Halton—Not quite. I think there are a number with completion dates in 2007. I do not have those.

Senator McLUCAS—How many of those?

Ms Halton—Thirty-four.

Senator McLUCAS—Does that add up to 567?

Mr Mersiades—No, it does not. There are still a number that we are seeking additional information on to establish their status.

Senator McLUCAS—What is the plan from the department's point of view now, given that the letter to the homes clearly stated that if they did not comply by the end of December there would be the potential for a review? What do you intend to do?

Ms Halton—That potential exists.

Senator McLUCAS—But what do you intend to do about a fifth of the homes who have received money from the Commonwealth to upgrade their fire safety standards? Are we just going to let it all happen?

Ms Halton—No. We will consider each of these homes on a case-by-case basis. We are considering the advice they give us and what we know about the circumstances they claim in relation to whether those plans are achievable and what we believe. For example, we know there are 42 waiting for their building work to be assessed. I think that is fine. We will, however, on a case-by-case basis make an assessment of each of these homes as to whether or not their plan and delivery timetable is achievable and whether it is acceptable.

We all know that there are different circumstances. If you are completely rebuilding your entire facility, I think it is fair to acknowledge that that might take a little while. It is a different judgment to one you might form if someone just has to do a relatively minor building job. If the reason is that you are in a very remote area and you have not got a tradesman, that still might be reasonable mitigation. This is why our staff have to work with each one of these homes—to be sure that in each of these cases it is not now necessary and timely for us to go and do a full inspection.

Senator McLUCAS—I accept that the 42 that are looking for a sign-off now are intending on doing it; they have joined in with the spirit of the government's proposal. It is the question of equity, when you know that some of those 2,935 that are compliant—sorry, some of those, however many, who have complied—have actually spent a lot more than $3,500 per bed, and there is an equity question between those that have put in a lot more money than the government has supported them with, and those that have been a bit recalcitrant, should we say.

Ms Halton—I do not know that I agree with that contention, Senator. When you say 'equity', it may well be that a number of the homes which were there early are brand new buildings. It may also be that some of the ones who are in here had very elderly buildings which they are completely replacing. It may also be the case that, in some of these cases, they have chosen to do not just the minimum that is required; they have chosen to do some fairly substantial work that is taking them slightly longer. So I think it is very hard to say, as a blanket statement, 'It is inequitable that this group is later.'

Senator McLUCAS—I am not saying that, Ms Halton; I am not saying that at all. What I am saying is that, of that group of 567, there is potentially a group who have not joined the spirit of the government's intention and, in my view, we need to be able to identify that group—

Ms Halton—Yes, and we agree with that.

Senator McLUCAS—and then I want to know what the department intends to do in terms of applying the review and potentially applying a sanction.

Ms Halton—Yes, and—

Senator McLUCAS—There are two groups. There are people who are trying to do the right thing—42 are clear; some of this next cohort you have described as 'possibly'. But what

are we going to do with that group of people who are going to take $3,500 a bed from the government and then just keep it?

Ms Halton—Essentially, as I have indicated, we will manage the group which you describe, which I do not think will be a large group—

Senator McLUCAS—No, neither do I.

Ms Halton—That group will be managed on a case-by-case basis. The reason I do not want to give you a blanket answer is because there is a whole series of things—the circumstances of the home, the management, the residents, where the home is—that will actually be relevant to what the appropriate action is. With your general point, which is that we should not let this slide, there is no disagreement at all; absolutely none. And, as Mr Mersiades was starting to point out, there are a number of actions that can and will be taken, depending on the circumstance. What I cannot tell you yet, because we have been going through this process of looking at the details case-by-case, is what will be the balance of response in respect of this minor group. It is too early to answer that question.

Senator McLUCAS—But sanctions will be applied to the group, that we do not know the number of.

Ms Halton—If that is appropriate.

Senator McLUCAS—Well, why isn't it appropriate?

Ms Halton—You are asking me to answer a hypothetical question about a range of circumstances we have not yet got all of the detail about. And, essentially, if a sanction is the appropriate response to rectify the problem, or if it is necessary to move over time to manage a home—either a new place or into a new building or whatever might be the appropriate response—we would take the action that is appropriate to the circumstance.

Senator McLUCAS—Which will mean a review?

Ms Halton—Yes.

Senator McLUCAS—Yes, because Minister Bishop said, in November last year, that any home that fails to meet that deadline will have their certification reviewed. It is very clear.

Ms Halton—And when we work out which homes are in this category, there would not just be review as one of the options—there would be a whole series of other things that we could decide to do. And that is why I am loath to give you a precise answer on this because I do not want the industry coming back and saying, 'You only said you were going to do X, Y and Z in respect of homes in this category.' We want to keep the full array of options available to us in terms of a response.

Our objective is to have this standard met. That is the objective. The question is: how do we get there in as timely a fashion as we can? I have to tell you that the achievement of the industry in moving the whole sector forward, in terms of building standards, I actually think has been nothing short of fantastic. Look at what has been spent. It has been $2 billion since the changes. We have another $2 billion worth of building work in progress at the moment. This has been a major change in the sector. If I think of what aged care used to be like, when I first worked in it, the buildings were not good in a lot of cases—

Senator McLUCAS—I agree there has been a huge change—a huge shift, for most.

Ms Halton—What we need is to keep that momentum.

Senator McLUCAS—I am concerned about that cohort of 20 per cent that are not currently certified to 1999 standards and to ensure that we can say everybody meets that level

Ms Halton—Yes, and we have no disagreement with that objective.

Senator McLUCAS—Surely, you can say, Ms Halton, that the first step in dealing with that group of people who are dragging their heels—whatever set of words we use to describe them—would be a review of their certification.

Ms Halton—I guess that is my point to you. I do not know that it would be the first step. It might be that we basically go in and slap sanctions on somebody immediately.

Senator McLUCAS—On what basis? How would you put on a sanction?

Mr Mersiades—If they were to say categorically tomorrow, 'We have no intention of doing it.' I do not know of anyone who has said that.

Ms Halton—But if somebody were to—this is why I think it is very difficult to speculate other than for us to say that the full range of actions that we can take will be part of what we will consider in response to a case-by-case analysis.

Senator McLUCAS—So what other options have you got?

Mr Mersiades—I indicated that through the review process, we can restrict their capacity to levy accommodation bonds, accommodation charges and receive concessional residents supplement. That is quite an influential sanction. Through the accreditation process, because these homes are also going to be referred to the agency, when they are assessed against those standards it may open the opportunity for a wider range of sanctions to do with their capacity to bring in new residents. These are the normal range of sanctions that we have available.

Senator McLUCAS—And if a facility is clearly not going to attempt to comply, if they are not rebuilding or not moving the beds to another facility, would you ask for the $3,500 per bed money to be refunded?

Mr Mersiades—I think my objective would be to get the standard improved. I think, with the threat of a major source of revenue being turned off, that will really concentrate the mind.

Senator McLUCAS—I think so.

Mr Mersiades—The realistic options which are borne out through the accreditation and certification we have done to date is that people decide to leave the industry and sell up.

Senator McLUCAS—How many people have done that?

Mr Mersiades—I would have to take it on notice. A lot have.

Senator McLUCAS—So the situation is that $3,500 per bed has been given to aged care operators on the basis that they will improve the fire safety of that particular facility. Some people have decided to sell up, move and sell off their beds. In those cases have you asked for that money back?

Mr Mersiades—No.

Senator McLUCAS—Why not?

Ms Halton—It would not be appropriate. Essentially any new provider who takes on a bed, takes on the obligation. We are not party to any details of any sale between providers and in terms of what is material to a sale—that is, the factors they take into account in determining price—presumably, that would have been relevant.

Senator McLUCAS—It becomes part of the asset of the facility?

Ms Halton—Yes, absolutely.

Senator McLUCAS—Okay, back to the sanctions then. Do you consider that there might be—you have talked about major sanctions, Ms Halton.

Ms Halton—Potentially.

Senator McLUCAS—Closures?

Ms Halton—Potentially. Let us reinforce here. Our overwhelming interest is that residents have an excellent quality of life and they live in homes—because they are their homes—which provide them with a level of amenity that we agreed consensually with the industry that we would aim for. That is our interest. It is not our interest to disrupt an older person's life.

Senator McLUCAS—Absolutely.

Ms Halton—You know that we work very hard to manage those kinds of issues in circumstances—and we have had a number—where homes have had to close. We are very careful to manage those situations, and the residents' interests in that process are paramount. But in all of these things we are balancing a whole range of very complex issues. It is very difficult.

Senator McLUCAS—So if we are looking at potential closures for those facilities that are not intending to comply?

Ms Halton—We should not speculate.

Senator Santoro—That is hypothetical.

Ms Halton—Exactly. The minister is rightly saying that is hypothetical. Essentially, what we are saying to you is that the whole array of options remains and is open to us and may well be used, but until we work on a case by case basis with each one of these homes we will not have a clear view as to what will be the action that we will take. We have referred all the homes that have not met the 1999 instrument to the Aged Care Standards and Accreditation Agency, so we have taken that preliminary step and we are talking to and working with each of them. We need to say now that we keep that full array of options open to us but that we will always balance issues around residents' interests et cetera. Clearly, we try to do these things in a cooperative spirit; that is our principle interest. It is easier for everybody if we can reach an agreement and actually move forward positively than end up at the other end of a table arguing.

Senator McLUCAS—But you have to have a sanction.

Ms Halton—Yes, a stick.

Senator McLUCAS—Yes, you have to have a stick.

Ms Halton—Exactly; that is right. It has always been in this sector a question of balancing the sanction and the potential to take very serious action against the need to work with the providers.

Senator McLUCAS—I agree. By far the great majority of providers have worked very hard and are continuing to work hard and do a fantastic job—all of that.

Ms Halton—Exactly.

Senator McLUCAS—But it is essential that the department stick by what was intended in 2004.

Ms Halton—The thing I can categorically promise you is that we are absolutely determined to do that. The officers in the division are very conscientious in quite methodically working through this to continue towards our objective. Our objective—and it is a 10-year approach—is to basically substantially improve the quality of aged care in this country, and I think we have made huge gains. It would be remiss of us in this latter part of this process—and arguably it is the harder bit, because you are right at the end of it—to slack off.

Senator McLUCAS—I agree. So sanctions may have to be applied, although let us hope not.

Ms Halton—Indeed.

Senator McLUCAS—I certainly hope we do not have to see any closures as a result of this.

Ms Halton—Indeed.

Senator McLUCAS—But the upside is that those people who have actually complied can be assured of providing greater safety to the residents of those facilities. Given that we are going to potentially apply sanctions and given that we potentially have to look at closure, I think it drawing a long bow to call it a voluntary program.

Ms Halton—The truth of the matter is that in terms of the program we did strike a consensus agreement with the industry, and that is the basis on which we have operated.

Senator McLUCAS—As I said, I think it is drawing a long bow to call it voluntary.

Ms Halton—It is a matter of opinion.

Senator McLUCAS—In question time last week the minister said that there were 10 nursing homes that did not fall within the accreditation and certification processes. Can you tell us about those 10 residential aged care facilities?

Mr Mersiades—I have not got precisely what was said, but to us the figure 10 relates to homes that we have identified as not meeting the state and local government fire standards.

Senator McLUCAS—I understand that. I was actually asking about the issue that we have just canvassed—that is, the number of facilities that do not meet the 1999 fire standards—but the minister misinterpreted it by saying that there were 10 that do not fall within the accreditation and certification process. So I understand there are 10 that do not meet state, territory and local government fire safety standards.

Mr Mersiades—That is correct.

Senator McLUCAS—So I would like some information about those 10, please.

Mr Mersiades—That number is now down to eight.

Senator McLUCAS—How did that happen? What happened between last Wednesday and today?

Mr Mersiades—We have been on their case and they have managed to get the documentation from their government, because that is where the responsibility lies for administering their standards. We have been putting pressure on them. We have got two of them back and we are working very closely with the balance of them to ensure that is done as quickly as possible as well.

Senator McLUCAS—Can we have the names of those 10 facilities?

Ms Halton—I probably will take that on notice. I am not entirely sure about the legal status of this information so, if you are happy, I will just take it on notice and we will come back to you.

Senator McLUCAS—Can you give me a state breakdown of where they are?

Mr Mersiades—I think we can do that. We do have information on what they have advised us as to when they anticipate they will be compliant with state and local government standards.

Senator McLUCAS—Let us call them A to J and let us go through them.

Ms Halton—In terms of date?

Mr Mersiades—The dates of each one?

Senator McLUCAS—What I want to know is the date that they will be compliant, but also the date you were advised that they were not compliant. How far back does this go?

Mr Mersiades—You need to understand that the responsibility for compliance with state and local government regulations and fire standards is with local government. On top of that we have instituted, for the first time, a process where annually every home has to put in a declaration indicating whether they have met the fire standards during the preceding 12 months. They send an annual statement in.

Senator McLUCAS—What date does that statement have to come in?

Mr Mersiades—It normally is around February.

Ms Scheetz—The providers are required to put a statement in on 1 March every year for the preceding 12 months up to 31 December. The information we have on these homes relates to the 2004 year.

Senator McLUCAS—So in 2004 we know there were 10 facilities that—so for all of 2004 they were noncompliant with their state and territory fire regs and all of 2005?

Mr Mersiades—The question was whether at any time during that year they were noncompliant. It could have been they were noncompliant for a week because a bulb was not working at an exit sign, for example.

Senator McLUCAS—And is that the case in terms of these 10?

Mr Mersiades—No. Obviously with those it is a more substantial issue.

Senator McLUCAS—I thought it would be. These 10 did not send in their certification at 1 March 2005 for the 2004 year, and there are 10 substantial noncompliants?

Mr Mersiades—When they sent in their declaration they indicated they were not compliant. As soon as we got that information we referred it to the relevant state and local government authority for them to follow up. As well as that, even though it is not part of—

Senator McLUCAS—Just so that we get this in the right chronological order, can you tell me what happened on 1 March 2005—that is, 10 people did not get a form in. Is that right?

Ms Scheetz—All homes provided us with returns. At that point 246 homes had indicated that there was some noncompliance with state and local government laws. Over the last 12 months, all but eight of those homes have rectified that situation and have given us information that they—yes, that was the first time we had a fire safety declaration. We have been working with these homes; all of the homes are working closely with their local councils and their fire authorities. At this point those authorities, which are the responsible authorities for this issue, are allowing them to continue to operate given the issues that they have. Three of the homes have indicated that by March they will meet those laws, three of the homes have indicated that by June this year they will meet them, and the other two, which are two very small homes in small rural towns, have plans to build new buildings, which will be in 2007.

Senator McLUCAS—The fire standards we are talking about are fairly basic fire standards. They are not like the 1999 fire standards, which are at a much higher level. These are the sorts of fire standards that any public building would have to have.

Ms Scheetz—Some of the issues relate to things like insufficient water pressure. They are issues that are difficult for these services to resolve, which is why they are working very closely with their local authorities to find either solutions for those problems or alternative arrangements so that residents are safe. What they have been doing with their local councils and their fire authorities is working through exactly all those issues to ensure that there are arrangements in place to deal with whatever the issues are that they do not meet.

Senator McLUCAS—Are these facilities continuing to receive funding?

Ms Scheetz—Yes.

Senator McLUCAS—Is that allowed? They are noncompliant; they should not be certified.

Ms Scheetz—They are certified.

Senator McLUCAS—How are they certified?

Ms Halton—They are certified against the original instrument, and that certification remains in place until such time as it is redone. So they are eligible to continue to receive funding.

Senator McLUCAS—But you have known for nearly a year that they are not—

Mr Mersiades—They have also been referred to the agency and the agency has assessed them against the standards.

Senator McLUCAS—The agency has assessed each one?

Mr Mersiades—Yes. It has visited them as well. So there is a lot of pressure coming on them from many sources.

Senator McLUCAS—Have the residents of these facilities been advised of the status of their facility?

Mr Mersiades—It is a matter for the approved provider to notify this information to the residents. We would expect them to have done that.

Senator McLUCAS—Do you know whether they have?

Mr Mersiades—I cannot be certain. I would have to take that on notice.

Senator McLUCAS—It would be good to find that out. Are you quite happy, Mr Mersiades, for these two that are going to be rebuilt to continue business for this year without meeting public building fire safety standards?

Mr Mersiades—I am loath to talk about the circumstances of the particular homes. If we gave you a private briefing, you would understand the circumstances and see it from the perspective of the residents, the provider and the local council in these very small communities. These issues have to be balanced off.

Ms Scheetz—I think the point is that the state and local authorities, which are working closely with these homes, have accepted the situation and have allowed them to continue. They are the ones in a position to judge.

Senator McLUCAS—I am interested that local government has got experience in the monitoring of aged care services now.

Ms Halton—No, they have a responsibility in respect of monitoring fire safety.

Senator McLUCAS—Sure.

Ms Halton—That is their responsibility and their competence. As has just been pointed out, because this is their area of responsibility, they have actively taken the decision that these places can continue to operate subject to moving forward in terms of agreed plans for upgrading.

Senator McLUCAS—I recognise that, but I am concerned that we have public buildings with elderly Australians in them and we are going to let them remain open and continue to fund them and hope like hell they do not burn down.

Ms Halton—The judgment about whether it is safe to so do has been taken by the competent authority. The competent authority, which in this case is local government, in each of these cases has made that judgment.

Senator McLUCAS—I think it is the state government in some jurisdictions.

Ms Halton—State and local, yes.

Senator McLUCAS—In the portfolio additional estimates statements, there is a reduced estimate of $129.5 million. Could you explain that to me?

Mr Broadhead—The question, I take it, was a reference to the reduction of $129 million in the estimate for this year in relation to residential care.

Senator McLUCAS—Yes.

Mr Broadhead—We have a fairly complicated model by which we attempt to project what will be spent in both the current year and the out years on residential care. This model has a whole bunch of parameters in it, including the mix of people by RCS level, the kinds of supplements paid, the levels of occupancy and parameter adjustments for indexation et cetera. Three times a year we adjust the model based on new information on what is actually happening. This particular reduction relates to a bunch of variations in those parameters—some up, some down—but the net effect is a reduction in the projection of what we will spend this year, and that is what has been put forward in this process.

Senator McLUCAS—You do it three times a year?

Mr Broadhead—Yes. It does not always result in a change, but we look at how it is travelling compared to the new data we have, three times each year.

Senator McLUCAS—Over the last few years, would it be usual for you to revise down the budget figure by that amount?

Mr Broadhead—I honestly do not have the history there, I am afraid, but we would have been adjusting it each year for the last X years. I think since 1998-99 this particular approach has been used, but I cannot absolutely confirm that because I have not been here that long. It would not always be a reduction; sometimes it would be an adjustment upwards, I would expect. It is simply an attempt to make our elaborate model reconcile to how things are travelling as new data becomes available. For example, about two-thirds of the reduction that you have identified relates to shifts in the numbers of people and by RCS categories—that is the level at which we make basic subsidy payments under the resident classification scale.

Senator McLUCAS—So you insert real data—

Mr Broadhead—New data—

Senator McLUCAS—three times a year.

Mr Broadhead—Yes. As time goes by, we have updated figures and we put in those. As I say, it has many different parameters in it and some of them have gone up, but the net effect of all of that within this model is a reduction as shown in the portfolio additional estimates statements.

CHAIR—Minister, my question relates to matters that you touched on last week in question time. I was concerned about the media release I had seen put out by the member for Canberra in which she says:

> Elderly people in Canberra will face longer waiting times to get into aged care facilities in future, because the Howard government has reduced the number of beds for every 1,000 people aged over 70 years ...

I was concerned about that, and I was not sure that it accurately painted a picture of what was going on in the ACT. In light of what you said last week in the chamber, can you indicate whether the concerns raised by the member for Canberra have any foundation?

Senator Santoro—Senator Humphries, you indicated to me before these estimates that you had that concern and that you may raise the matter with me, which I appreciate you doing, and I have taken the liberty of getting some statistics and some opinions from the department. I suppose what we are really talking about here is operational places. I can inform you that in 1996 there were 141,282 operational places. This compares, as of June 2005, with 193,753 operational places, which represents an increase of approximately 52,000 actual operational places.

I think it is fair to say that, as a result of that, tonight over 161,000 older Australians can sleep in residential aged care beds, compared with less than 137,000 in 1996 and that there are over 32,500 older Australians receiving care through community places. Again, that is a good statistic because it compares with approximately 4,400 places in 1996 which, if you like to look at these things in percentage terms, means there are about 700 per cent more now than was the case then. What the federal member for Canberra failed to point out in the media release—and I say this with respect—was the commitment of the coalition government to increase the aged care ratio from 100 places per 1,000 people aged over 70 years to 108 places. That is a statistic that cannot be argued with. I think it is a statistic that in fact shows that there is much commitment on behalf of the coalition government in this area of policy development and implementation.

There has also been a big increase in community places, which I would suggest is precisely what older Australians want. I am sure that even our Labor colleagues would prefer to receive care in their own homes than in a nursing home if in fact they had that option. That option has become increasingly available, as I have indicated, as a result of implemented policies of the coalition government. In fact, even the former Labor government acknowledged this when they decreased residential aged care in order to provide community care places. I do not mind going on the record saying that that is a credit for that very significant shift in policy in recognition of the desire of older people to have a choice as to whether they go into residential or community care situations. I want to stress that the community care places have improved since the Labor days. The ones that are available today provide equivalent care—and I think that needs to be stressed—to that provided in residential care. It provides care in peoples own homes, acknowledging that this is the wish, I would think, of the majority of Australians.

Turning to the figures in relation to the ACT, I think it would be a good idea at this stage to provide some of the precise figures. I have been advised that the ACT has 2,080 aged care places—residential and community—that are open for business. If all the places that the Australia government has made available were open, there would be 2,777 compared to the 2,080. I suppose at this juncture the question arises: what has happened to the others?

Senator McLUCAS—Better be careful. The chair is the former Chief Minister. We might have to sheet it back home to him.

Senator Santoro—I am going to talk about chief ministers because, to be honest with you, in all of my dealings with former chief ministers of the ACT, including Senator Humphries, I found them to be quite reasonable. As I was about to say, I actually find the current Chief Minister quite reasonable in his attitude towards this issue.

CHAIR—It goes with the job.

Senator McLUCAS—You have to leave it there, though. Isn't that terrible?

Senator Santoro—It is the ambience of the good country location. I know only one or possibly two spots, including the ACT House of Assembly, where things are not terribly tranquil from time to time. Apart from that, Canberra is quite a tranquil place. I want to acknowledge what the ACT Chief Minister, Jon Stanhope, had to say recently subject to the release of the Productivity Commission report on government services. What he basically said, and I thought it was a fair reflection, was that the major reason why these other nursing home places or facilities are not there is because of town planning reasons. He went on the record as saying that. I have been meaning to ring him and say, 'Thank you for not scoring political points.' I think that his attitude is more constructive than that which was expressed by our federal colleague, the federal member for Canberra.

The federal member for Canberra, and her colleagues on either side of the political spectrum, may be interested to know that the ACT in fact has the second-highest ratio, after the Northern Territory, of operational community care packages in the country. The ratio is 21.6 compared to a national average ratio of 17.2 packages for every 1,000 Australians aged over 70, as at 30 June 2005. Again, Senator Humphries, you and most reasonable and fair people would acknowledge that this represents activity by the coalition government to compensate for the slow development of residential places.

I should also add that it is not just Canberra that exhibits some bottlenecks in appropriate town planning considerations and approvals. If there is one complaint that is coming through loud and strong to me, as a minister in this area of government policy of just under three weeks, it is that right across Australia there are complaints about the slowness of town planning approval. We are not trying to pass the buck. Those days where you just passed the buck in an insensitive and unrealistic way are over. But that is a point that I think local governments themselves would acknowledge, and the delays are there for all sorts of reasons. I can also advise you, Senator Humphries, that from 1996 to 2004 the government has increased operational aged care places in the ACT by 52 per cent—that is, growth has been 14.9 per cent higher than the national growth rate of operational places. If you consider all of those facts and all of those explanations, including that one that I thought was a fair and reasonable response to the recent Productivity Commission report by the current ACT Chief Minister, there is a pretty good record there that we can talk about. I thank you for the opportunity to put those facts on the record.

CHAIR—Thank you, Minister. I assume that, with a 52 per cent increase in the number of aged care places in the ACT in the last 10 years or so, it is quite unlikely that waiting times are actually going to grow longer, as has been suggested by the member for Canberra.

Senator Santoro—I think that, if everybody puts their shoulder to the wheel, that should be the case. The coalition government here in Canberra at a federal level have done that, and we are very happy to keep on working very cooperatively with the ACT government. But if that government also goes about its business of reducing bottlenecks in some of the approval processes I think your expectation that waiting lists will not increase—that is, the time that people are on waiting lists to get into a facility—is a reasonable one.

Senator McLUCAS—Mr Mersiades, the way that aged care beds are allocated is based on a formula, isn't it? It is based on a ratio.

Mr Mersiades—As a starting point, the objective is to achieve the 108 per 1,000 over 70 in each region. But you have to recognise that we are still carrying the legacy from the pre-planning days, where we had a larger number of homes in some regions. Short of closing them down, you can only deal with that through growth. In inner western Sydney, in some parts of north-east Adelaide—

Senator McLUCAS—Charters Towers.

Mr Mersiades—It could be.

Senator McLUCAS—Charters Towers is a very good example.

Ms Halton—It is.

Senator McLUCAS—The point I am making is that, when you are talking about raw numbers of beds—and Senators Humphries and Santoro have been talking about raw numbers of beds and growth in actual numbers—it takes no understanding of the ageing population. It is actually mischievous, I should say, to talk just about raw numbers of beds in getting community understanding about what growth is. Could you remind me of this, Mr Mersiades. Do you remember the number of operational residential aged care beds per 100 people over 70 in 1995?

Mr Mersiades—Yes, probably.

Ms Halton—I would say about 131,000.

Senator McLUCAS—No, it is the ratio that is important, Ms Halton.

Ms Halton—You want to know the ratio.

Senator McLUCAS—You can talk about 135,000 beds or 222,000 beds. It does not give you any indication of what the need is. If you look at the ratio, you are actually looking at the real need, given the discussion we have had in the past about what the ratio means. We have all agreed that we are going to look for a certain number of beds per 1,000 people over 70 years old. What was the ratio in 1995?

Mr Mersiades—My understanding is that it was about 93, but my colleague would have the direct figure.

Mr Dellar—Mr Mersiades' number is right. It is 93-point-something, but I do not have the point-something with me. I would make two points about it. Firstly, that includes the 3,000 or so community aged care beds or packages that Senator Santoro just mentioned.

Senator McLUCAS—If you remove that and we just talk about residential aged care beds, my figure is 92. Would that be about right?

Mr Dellar—That would be about right, yes.

Senator McLUCAS—What was the ratio of residential aged care beds that were operational in 2005 per 1,000 people aged over 70?

Mr Dellar—The current operational ratio as at 30 June 2005 was 85.1.

Senator McLUCAS—In 1995 we had 92 residential aged care beds per 1,000 people aged over 70 and now we have a government that is trumpeting its success by talking about 85.2.

Mr Dellar—If I could just make—

Senator McLUCAS—I know the point that you are going to make, but there are differences in need between residential aged care beds and community aged care packages. There has been growth in community aged care packages and there is not a soul in this country that does not welcome it. But the need for residential aged care beds remains, always will remain and, in my view, will grow, especially for high-care people. There are two points, I suppose, that I am making. Just to talk about raw numbers of beds is not indicative to the community of what is happening and I think we have to start talking about the ratio of beds to numbers of people who might need those beds. I am prepared to use the ratio system of the government and the department, which is number of beds per 1,000 people aged over 70. The purpose of my contribution is in response to the discussion between Senator Santoro and Senator Humphries and I do not need to engage the department at this point. I suppose it was more of a political discussion.

Senator Santoro—Let me engage you, Senator McLucas. Part of my answer clearly indicated to you—and I do not think that you are disputing it; if you are, I would invite you to dispute it—the advice that I have been given by the department, which is that we are talking about equivalent care in terms of residential or community care. The value of that equivalent care is that there is choice.

Senator McLUCAS—No-one disputes that.

Senator Santoro—I gave credit—if you would let me finish, with respect—to the previous government in terms of moving towards a greater emphasis in relation to availability of community care places and I think that was good. We have continued that trend in providing equivalent care within the community because everybody tells us, as they were telling the previous Labor government, that they like the idea of choice. You may think the dorothy dixer was just about political points scoring. I like to think that it was about putting on the record information that is accurate and not alarmist. But I also understand what you are trying to do with your 93-point whatever the figure is.

Senator McLUCAS—It is 92.

Senator Santoro—With that 93.2 you also trying to score a political point, which I do not think is intellectually sustainable.

Senator McLUCAS—I do not know that we are here to talk about political points scoring.

Senator Santoro—We are not.

Senator McLUCAS—Given that you started the round, I could not leave misleading information on the public record without the clarification—

Senator Santoro—It is not misleading.

Senator McLUCAS—It is.

Senator Santoro—Unless you can tell this committee or the department for which I have responsibility that community care places are not equivalent to residential care places in

respect of the amount of care and service provided, I do not think, with respect, that you can legitimately go about quoting the figures that you quoted before.

Senator McLUCAS—It is not a matter of equivalence; it is a matter of desirability.

CHAIR—Senator, you should ask questions rather than make points.

Senator Santoro—I do not mind having this exchange.

Senator McLUCAS—I hope you take that advice yourself, Chair, because the minister has actually acknowledged that that was a dorothy dixer, and I do not know whether that is a good use of the time of this committee.

CHAIR—A dorothy dixer is still a question, whether you like it or not. I just want to confirm the facts that the number of aged care places in the ACT has increased dramatically in the last 10 years and there has been a huge increase, particularly in those figures, in community based places, which addresses an increased demand in the community for people to age in their own homes rather than in residential care facilities. Is that the case?

Mr Dellar—I can confirm that is the case. There are 697 residential aged care places in the ACT that have been issued but are not yet operational. The reasons for that have been discussed. But, if they were operational, we would not be having this discussion.

Senator McLUCAS—I wonder whether the department could confirm that there are 72 beds per 1,000 people aged over 70 in the ACT as opposed to the national average of 85.2.

CHAIR—Do you mean beds per head of population or operational beds?

Senator McLUCAS—Operational beds per head of population aged over 70.

CHAIR—Could you confirm that one of the reasons many of them are not operational is because of the ACT government's—

Senator FORSHAW—I raise a point of order, Mr Chairman. Senator McLucas asked a question, which I think the officer was about to answer. You sought clarification from Senator McLucas of what the question was. She gave that clarification and you proceeded to start a new question. I think the officer should confirm whether Senator McLucas's figures are correct.

CHAIR—Thank you for your observation, Senator Forshaw.

Senator FORSHAW—It is not an observation; it is a point of order.

CHAIR—I was asking the officer to answer another question at the same time.

Senator FORSHAW—No, you were not. You were going to make a statement.

CHAIR—No, I was not.

Senator FORSHAW—Yes, you were and that is what the *Hansard* will show.

CHAIR—I was going to ask the officer to confirm also that those beds in the ACT include beds based in the community.

Senator McLUCAS—No, they do not.

CHAIR—Operational beds—and that the delay in the provision of operational beds is due to the fact that the ACT government has not had the rate of delivery of those beds that one

would expect in other parts of Australia. Do you want to answer both of those questions, Mr Della?

Senator FORSHAW—Do you remember the question from Senator McLucas? I think her question was whether the figure in the ACT was 72 compared to the national average of 85.

Mr Dellar—I think I have been asked two questions. I will say firstly what the operational ratio is for the ACT as at 30 June. I can confirm that residential is 72.1 and that community care is 21.6, making a total of 93.7. I think the second question was what we have done about it, essentially. Is that correct?

CHAIR—Yes, and I assume that there are still many beds yet to come on line because of delays in planning approval processes.

Mr Dellar—That is correct. I would say that two factors have led to the ratio in the ACT. The first is the general slowness that we have experienced in the past in relation to bringing beds on line. It is an issue that I think has been addressed and will be corrected over time, but it does take quite a long time to build a bed or to build a service that has a bed in it.

Ms Halton—There is also a statistical point here. Because it is a very small jurisdiction, one facility or two facilities will shift the ratio very significantly. Waiting for one facility, which we are—

Senator FORSHAW—Exactly, which makes claims about a 52 per cent increase a bit of a nonsensical proposition.

Ms Halton—No.

Senator FORSHAW—It does, if you are talking about a low base.

CHAIR—She did not say a low base; she said that there were statistical anomalies with a small number—not necessarily a low base.

Senator FORSHAW—But the minister talked about a 52 per cent increase.

CHAIR—That is accurate.

Senator FORSHAW—It is accurate, but one plus one is a 100 per cent increase. We are getting into a debate here and I think we should get back to questions.

Senator SANTORO—I did not talk about one plus one; I talked about figures slightly larger than that.

CHAIR—I think you did. Are there any further questions?

Senator FORSHAW—You did not give any figures, Minister; you gave a percentage.

Senator McLUCAS—What is the current status of the response to the long-term strategies that we enunciated in the Hogan report?

Ms Halton—Those strategies are under consideration by government.

Senator McLUCAS—A committee was established last year; has it finished meeting?

Ms Halton—I think the committee has finished meeting, but the matters that were discussed—and, of course, there are broader issues to be canvassed—are under consideration by government.

Senator McLUCAS—Has the report of the committee—which operated during most of last year, I understand—been finished?

Mr Mersiades—No. The committee's role was as a reference group; it was not its role to produce the report.

Senator McLUCAS—So that consultation was completed. Did that finish in November?

Mr Mersiades—It is substantially completed. That does not mean it cannot come together again if needs be.

Senator McLUCAS—What is the hold-up?

Mr Mersiades—The next step is consideration by ministers.

Ms Halton—And we have had a change of minister.

Senator McLUCAS—Has that advice gone to the minister, either previous or current?

Ms Halton—You know that we do not comment on advice.

Senator Santoro—Maybe I can answer that, Ms Halton. When I took over the ministry three weeks ago, Senator McLucas, I received, without any shadow of understatement, an enormous amount of advice, an enormous amount of briefings and an enormous amount of information. Obviously, I am trying to come to grips with the knowledge that is contained within that advice, including details of the deliberations of the previous committee. I am in the process of assimilating all that advice and formulating my own views as to how we move forward, and I look forward to doing so in the near future. There is an enormous amount of advice, including that provided by providers, as to how we should be moving forward and how fast. I can assure you that it is all under very active consideration.

Senator McLUCAS—Do you imagine that there will be a response to the long-term strategies as recommended in the Hogan review?

Senator Santoro—The track record of this government since 1996 is exemplary in terms of its long-term responses to the issues that the ageing communities of this country have been facing. I can assure you that we will continue to look at this issue from a long-term perspective. The strategic approach of this government has in fact been recognised. I can remember—I think it was in the 2004 budget, in the *Intergenerational report* that was brought down by the Treasurer—

Senator McLUCAS—Minister, it is a very straightforward question. The industry is waiting for it and the sector is looking for it, so it is actually when or if the government will be responding formally to that second tranche of recommendations that were in the Hogan report.

Senator Santoro—I think I have indicated that. I was not going back historically just for the sake of it. I just wanted to emphasise that we have adopted a strategic long-term approach to addressing the issues of ageing in Australia and that that process, I can indicate to you again emphatically, will continue. I think that is a fairly definitive answer to your question.

Senator McLUCAS—We can disagree on whether it is definitive or not.

Senator Santoro—Just watch this space.

Senator McLUCAS—We have been for a very long time.

Senator FORSHAW—How much did this review cost?

Senator McLUCAS—Some $1.3 million was allocated in the 2005 budget—so that is only the current expenditure—and we still do not have a document, but I am going to watch this space a bit longer. It is interesting to note that the time that Professor Hogan was given to compile the report—and everybody recognises it is a significant report—was shorter than the time that it has taken for the government to respond to it.

Senator Santoro—We have implemented the bulk of the Hogan committee report.

Senator McLUCAS—There are two parts to it.

Senator Santoro—As a government we have allocated far more resources than what any other government in the history of this country has. So for you to suggest, as I think you are implying, that the government have not responded very seriously to the Hogan report is a suggestion—

Senator McLUCAS—So you are suggesting that the government will respond to the long-term recommendations in the Hogan report?

Senator Santoro—What I have said is that the government will continue to respond in a strategic and with a long-term perspective to the ageing issues in Australia and that includes continuing consideration of the totality of the Hogan report.

Senator McLUCAS—But you cannot commit to a formal response?

Senator Santoro—We will continue to respond in a strategic and long-term way to the conclusions of the Hogan report. We have demonstrated repeatedly in the last 10 years of the Howard coalition government that we are very serious—far more serious than any other government, including the one that preceded ours for 13 years.

Senator McLUCAS—I refer to Commonwealth own purpose outlays. I thank you, Minister, for the answer to the question which I received yesterday which shows that indexation on COPO on aged care subsidies averages around $93 million per year. How is the department intending to index residential aged care subsidies this year?

Mr Mersiades—The indexation that applies to the residential aged care subsidies is part of a suite of indices that apply to a wide range of government programs, and the precise nature of those, as I think the minister indicated in his reply, is under consideration.

Senator McLUCAS—Yes, that was in the response to the question. Is that under consideration by the department or by the government?

Mr Broadhead—The department does not unilaterally decide what index will be applied to what program.

Senator McLUCAS—I would like to pursue that because I have had different points of view from different departments about who makes it up. It seems to be a perennial fight between Finance and the other departments.

Ms Halton—There is a robust dialogue and there is a government decision.

Senator McLUCAS—Could you explain—not for terribly long—who makes the decision about the indexation. Is it your department or is it the department of finance?

Ms Halton—No, it will be a government decision.

Senator McLUCAS—I understood COPO was linked to the national wage case.

Ms Halton—Historically, when the indexation arrangements were changed there was a decision taken by government in relation to those changes, and then those new indexes were applied to the relevant programs. As Mr Broadhead has indicated, there has not yet been a decision about what the case will be in respect of all government programs—it is not just ours. It would be my expectation that there would be a government decision on this question because it is a whole-of-government issue.

Senator McLUCAS—I understand that previously—let us look at last year for an example—the wage case gave you the wage indexation. Then, for example, COPO has a 60-40 mix of wage and CPI—doesn't it?

Mr Broadhead—I believe there are nine wage cost indices. I may be incorrect in that, but there are many of them. They are variously made up, usually of a composite of CPI—consumer price index—changes and what were known as safety net adjustments arising from wage case decisions. I believe there are various ratios of those, and also some of them pertain to different periods of time. For example, it may be during the 12 months to December under one index, it may be during the 12 months to March in another index and so on.

Senator McLUCAS—So it is complex.

Mr Broadhead—Yes, there are a bunch of different ones, and in some instances I think straight CPI is also used for some kinds of adjustments, so it depends entirely on—

Senator McLUCAS—Where there is no wage component.

Mr Broadhead—Yes.

Ms Halton—And we use any number of those indices inside the portfolio. There is WCI 1,WCI 5, and the most appropriate index depends on what sector that index is to be applied to.

Senator McLUCAS—I understand residential aged care subsidies are 75-25. That is the split.

Mr Broadhead—I believe that is correct.

Ms Halton—I think that is right.

Mr Broadhead—That has been the composition of the index applied to date.

Senator McLUCAS—And 75 per cent of the total indexation is the wage component?

Mr Broadhead—It is the safety net adjustment, as it was termed.

Senator McLUCAS—It was the safety net adjustment. So what I am trying to understand is how the government is going to do it without a national wage case.

Ms Halton—That is a matter for government to determine, and it is not appropriate for us to comment on that. That whole matter is under consideration. Clearly it is my expectation

that there will be some consultation with line agencies in relation to those issues, but fundamentally it is a whole-of-government matter which needs to be managed on that basis.

Senator McLUCAS—Have you had any indication about when that decision will be made?

Ms Halton—No, I am not aware of a timetable. You would certainly appreciate that this is a matter that a number of secretaries are interested in.

Senator McLUCAS—I am sure.

Ms Halton—And as yet I have not had any definitive advice about when that will be the case.

Senator McLUCAS—When is the indexation applied to residential aged care subsidies?

Mr Broadhead—Midyear, I believe.

Senator McLUCAS—With the first payment in July?

Mr Broadhead—Yes, 1 July.

Senator McLUCAS—So we have three months to sort it out. I appreciate the background information on the value of the application of the wage cost index. It is $93 million a year. It is a significant amount of money.

Proceedings suspended from 4.00 pm to 4.13 pm

CHAIR—Before the break we were asking questions on outcome 3, Aged care and population ageing.

Senator McLUCAS—Does the department monitor the financial relationships between a provider and a landlord and any other entity when it comes to maintaining a facility to certification standards?

Mr Mersiades—No. That is a commercial arrangement between the parties. We are concerned about the end product—the quality of care. To the extent that it becomes public knowledge that there are financial problems, then obviously we become involved then, but not in the financial affairs of the parties.

Senator McLUCAS—If the entity that holds the beds is a tenant who rents a premise from another entity, do you have no involvement in that?

Mr Mersiades—That is a commercial arrangement.

Senator McLUCAS—The responsibility for the management of the building in that commercial arrangement is of no concern to the department?

Mr Mersiades—It certainly is a concern to us, but the responsibility rests with the approved provider to ensure that the standards are met. What inputs a provider seeks to achieve those standards is a matter for them in running their business.

Senator McLUCAS—And are you aware of circumstances where the owner of a building has made it a condition of the lease that, should the approved provider move, the bed allocation will go to the owner of the building?

Mr Mersiades—I can imagine that there may be instances where such an arrangement exists.

Senator McLUCAS—How then does the department respond if that happens?

Mr Mersiades—It is a matter for the parties to apply the law and the terms of their commercial arrangement.

Ms Halton—Two parties cannot between them put in place a contractual arrangement that obligates us to transfer beds from one party to another.

Senator McLUCAS—Are you aware of cases where that might be the case?

Ms Halton—Where they have put in place contractual arrangements? That is a matter between parties. We certainly are aware that that may be the case. But we are very clear: our relationship is with the approved provider and, in the event that someone seeks to transfer beds from one person to another, we cannot be obliged to transfer beds from one person to another.

Senator McLUCAS—Are you aware of a facility called Blackburn Aged Care where this event is happening?

Ms Halton—Senator, this might be one of those circumstances where a conversation in the abstract would actually been more useful. To talk about the specific circumstances of a home will, I think, take us into a space which is quite difficult quite quickly.

Senator McLUCAS—Sorry, it will take us to a difficult—

Ms Halton—We will find it difficult to answer about specifics of a particular home but, in terms of the broad issue—of whether we can be obligated in any sense by a contract which has been executed between two parties—the answer is no. We cannot be obligated, even if there is such a contract. I am aware that this has been a practice, particularly in some places in Victoria over number of years—even when I ran the program, this was the case—and we used to make the point ad nauseam to providers that they could not bind us because they had in place a contract that had that provision in it.

Senator McLUCAS—I have received a copy of a letter that was from Mr Andrew Stuart when he was with the Ageing branch. He says, ‘Where a landlord has done little to improve premises over a period of time, it is unlikely that they would be approved as a provider on the basis of this record.’ Is that still the case?

Ms Halton—The issues would go to who can be and their fitness to be an approved provider. There is a range of criteria. Mr Stuart has rightly made the point about demonstrated commitment. We look at each case as to their fitness to be an approved provider if we receive an application from someone who is not currently an approved provider.

Senator McLUCAS—The situation is that this particular facility actually has the oldest Australian in it, a woman of 111 years. It is evident that this facility is going to close down but there is this contractual arrangement by which, if that contractual arrangement continues, the beds will be allocated to the landlord.

Ms Halton—No, Senator. Let us be very clear: our bed allocation cannot be subject to an externally executed contract.

Senator McLUCAS—Has it happened very much?

Ms Halton—A provider cannot oblige us to transfer the beds he or she holds to any particular person.

Senator McLUCAS—We will watch that one then with interest. I turn now to a nursing home in South Australia, Barton Vale, and I probably need the agency here.

Ms Halton—They are here, Senator.

[4.20 pm]

Aged Care Standards and Accreditation Agency

Senator McLUCAS—Mr Brandon, can you tell the committee what prompted the agency to visit Barton Vale Nursing Home only seven months after it had passed 44 out of 44 expected outcomes?

Mr Brandon—Could you give me a clue as to the date—they have been accredited a couple of times?

Senator McLUCAS—The report was finalised in November 2005, but I understand that the visit was around June or July.

Ms Scheetz—We referred information to the agency that we had received through our complaints line and as a result of that the agency then visited the home.

Senator McLUCAS—Was it an announced check or an unannounced spot check?

Mr Brandon—I am trying to make sure to get the date correct. Was it the visit in October 2005?

Senator McLUCAS—Was there a visit between April 2005 and October 2005?

Mr Brandon—Yes, there was an accreditation audit in April 2005.

Senator McLUCAS—That was when they got 44 out of 44?

Mr Brandon—That is correct.

Senator McLUCAS—The next one?

Mr Brandon—Following advice that there was new ownership, we undertook a support contact on 17 August and then an unannounced visit on 5 October 2005.

Senator McLUCAS—Then there was an audit done following that 5 October visit?

Mr Brandon—Yes, following the 5 October unannounced support contact we then did an unannounced review audit—or spot check, if you will—on 17 October 2005.

Senator McLUCAS—Just while we are playing with the language here, can you give me the proper terminology for visits that the agency has to residential aged care facilities?

Mr Brandon—There are three sorts of activities. There is a site audit, which is in response to an application for a period of accreditation. There is a review audit, which is conducted when we want to review the whole 44 expected outcomes. The third is a support contact, which is defined in the legislation as a visit or an activity for the purpose of monitoring compliance with the accreditation standards and other requirements under the act. The latter

two, the review audit and the support contact, can be conducted with notice or unannounced, which is colloquially known as a spot check.

Senator McLUCAS—So let us use the term ‘unannounced spot check’ or ‘spot check’.

Mr Brandon—I am happy with ‘spot check’.

Senator McLUCAS—‘Spot check’ means that I will ring you up and tell you I am coming and an ‘unannounced spot check’ means I will just turn up on the doorstep.

Mr Brandon—No. A support contact is an overarching term in the legislation for a visit which is not a review audit or an accreditation audit. A support contact has two types—announced or unannounced. An unannounced visit is known as a spot check. That is a visit where we provide 30 minutes or less notice that we are going to be there.

Senator McLUCAS—Let us call it an ‘unannounced support contact’ so we get our language very clear.

Mr Brandon—Yes.

Senator McLUCAS—What happened on 17 October?

Mr Brandon—We did an unannounced review audit.

Senator McLUCAS—How long did that take?

Mr Brandon—I do not have the exact details but a normal review audit would take two to three days. My recollection—I stress that this is only my recollection—is that it was two and a bit days.

Senator McLUCAS—So 5 October was an unannounced support contact?

Mr Brandon—That is correct.

Senator McLUCAS—Your agency recommended that the accreditation of Barton Vale be revoked. Is that an unusual action for the agency to take?

Mr Brandon—No.

Senator McLUCAS—How regularly do you recommend revoking accreditation when you find a facility is noncompliant in the number of expected outcomes that Barton Vale has experienced?

Mr Brandon—I thought you said we recommended sanctions. Did I mishear that?

Senator McLUCAS—My recollection is that you recommended revocation.

Mr Brandon—Not of Barton Vale. Our decision in relation to the unannounced review audit on 17 October was that there was noncompliance in 27 outcomes and we reduced their accreditation period to expire on 29 May 2006.

Senator McLUCAS—I will go back and check that; I thought it was a revocation. Are you aware that there was a private investigator employed by the provider to investigate the allegations of bullying at Barton Vale?

Mr Brandon—We have heard that.

Senator McLUCAS—Have you heard of that sort of action happening before?

Mr Brandon—I have not, but I cannot state that it has not happened before.

Senator McLUCAS—Do you have concerns that a provider would undertake that sort of action?

Mr Brandon—I think the actions that a provider takes in relation to the management of a home is a matter for the provider. Our interest is in the quality of care for residents in how the home conforms or complies with accreditation standards.

Senator McLUCAS—But the issue that was identified in your assessment was that it is not a very happy place for a number of the staff there and there are considerable allegations of bullying. I would be concerned that the agency was not worried that the ability of staff and residents to be open with a private investigator hanging around might be a bit difficult.

Mr Brandon—How the provider manages his home or how he makes inquiries into such allegations is a matter for him. In doing the accreditation audit or the review audit we interview residents and relatives ourselves and we do that in private. There is an opportunity for residents, relatives and employees to talk to us about any concerns they might have.

Senator McLUCAS—How do you select nurse advisers? When you go through this process and find that there is a problem, the regular recommendation is that a nurse adviser be appointed. How does that happen?

Mr Brandon—We do not appoint nurse advisers.

Ms Scheetz—It is a program that the department manages but the approved provider appoints the nurse adviser from a list that we have. When there is a sanction where we impose a nurse adviser requirement at the home, they receive a list of nurse advisers from our database and the home selects the nurse adviser from that list.

Senator McLUCAS—How do you pull that list together?

Ms Scheetz—We have recently advertised for those positions. Each state has made an assessment of the people who applied. It was through application and then assessment against criteria. The list was determined from that selection process.

Senator McLUCAS—What qualifications did they have to have?

Ms Scheetz—I do not have that information with me. The requirements for a nurse adviser are provided in the act. I could take it on notice to give you that information.

Senator McLUCAS—Maybe you could just indicate where it is in the act.

Ms Scheetz—It is division 66A on page 260.

Senator McLUCAS—I will follow that up.

Ms Scheetz—There is a list of criteria.

Senator McLUCAS—Does the agency approve the appointment of the nurse adviser, Mr Brandon? Once you have recommended it, is that the end of your involvement?

Mr Brandon—We do not recommend the appointment of a nurse adviser. That is a function of the sanction system arrangements and the department managers.

Ms Scheetz—The department has to agree to the choice of the provider, but the provider engages the person.

Senator McLUCAS—And they pay them?

Ms Scheetz—They pay them. They have a contract with them.

Senator McLUCAS—Another facility, St Davids Nursing Home in the suburb of St Peters in Adelaide, has a sanction report on the website, but there is no evidence of the nursing home's existence now. Can you tell me whether that facility still exists? Is it still operational?

Ms Scheetz—It is certainly not a home that I am aware of. We would need to check our databases to see whether that home is operational.

Senator McLUCAS—It does not appear on the fire safety website either as approved or unapproved.

Ms Scheetz—Then it is not there.

Senator McLUCAS—I need to go back to the website before we finish off. This issue came up last estimates when we were talking about Sir James by the Bay and Sir James Terrace. I think you indicated then that the ownership of a facility does not particularly indicate to you that you need to spend more time monitoring the quality of care being delivered. Is that your recollection?

Mr Mersiades—I could be proven wrong, but I would be surprised if we answered that way.

Senator McLUCAS—I am just trying to recollect which way you said it. Are you aware that St Davids, which we think has closed down, was owned by the same owner as Barton Vale?

Mr Brandon—Maybe I can help here. According to my records, St Davids closed in April 2003.

Senator McLUCAS—Why did it close? Do you know, Mr Brandon?

Mr Brandon—No. It is not something that I would be aware of.

Senator McLUCAS—Was it sanctioned?

Mr Brandon—I have no information about St Davids other than it closed in April 2003.

Senator McLUCAS—There is a sanction report from 2001 on the website. What happened as a result of that report? I know it is going back a bit in time.

Ms Scheetz—We would need to go back and look at the history of that home. It is certainly not one on which we currently have information available to us.

Senator McLUCAS—The owner of Barton Vale purchased it in June 2005 and very soon after that this whole series of events occurred. Given the discussions that we have had previously about approved providers and their appropriateness, what checks do you do before someone becomes an approved provider?

Mr Mersiades—They are required to put in an application. There are a number of criteria against which we assess them. They pertain to their record and whether they have a history of

relevant experience. We do an assessment of their financial strength—those sorts of issues. The matters that we address are set out in the act.

Senator McLUCAS—Can you advise me, maybe on notice, if the department was aware that the prospective owner of Barton Vale—that is, the bed owner—was the previous owner of St David's?

Mr Mersiades—Certainly. We would have to check that through; I do not recall that information.

Senator McLUCAS—My next question goes to the appointment of a nurse adviser. Is the department aware that the nurse adviser currently at Barton Vale was a member of the assessment team that assessed another facility owned by the same operator and do you see a potential conflict there?

Ms Scheetz—We were not aware of that. People who operate in this consultancy area of aged care often do work in different parts of the sector. We would have to look at the specifics of that circumstance to see whether that would be an issue. These people are private operators who are nurse advisers; they often do work in a range of other areas, which we would not necessarily be aware of.

Senator McLUCAS—It is a small industry with a small number of people with very high levels of expertise, and they will appear in different parts of the industry from time to time. Do you have any way of monitoring the potential conflict that might be there between someone who is an assessor in one circumstance and a nurse adviser in another circumstance with the same owner—a different facility, but the same owner?

Ms Scheetz—Are you suggesting they are an agency assessor, an accreditation assessor?

Mr Mersiades—I do not think we have the systems to be able to track that.

Senator McLUCAS—Do you agree there might be a conflict there?

Mr Mersiades—I would have to look at the circumstances.

Senator McLUCAS—Are you also aware that the nurse adviser made a comment in the newspaper when this was being canvassed some time ago along the lines of 'If you think Barton Vale is bad, you should see some others'. Did you see that comment?

Mr Mersiades—I personally did not see it.

Ms Scheetz—No.

Senator McLUCAS—Mr Brandon?

Mr Brandon—I am sorry, I was actually getting information about your question. I need to take that on notice because we did have communication with the nurse adviser following those comments.

Senator McLUCAS—Could I also ask the department what action you took—and I recognise, Mr Mersiades, you do not read the Adelaide *Advertiser*; it does not arrive in Cairns on Saturday mornings either—

Ms Halton—That may be a good thing, Senator.

Mr Mersiades—But maybe our state office does.

Senator McLUCAS—as I dare say your department was aware that the comment was made. I would like you to advise the committee, if you would, what action the department took as a result of that comment.

Ms Halton—We will take that up.

Senator McLUCAS—Thank you. Could I have on notice the number of residential aged care facilities which have closed in the last two years?

Ms Halton—And you do not mean moved? You mean shut down? This is where you get into all sorts of definitional issues.

Senator McLUCAS—I cannot think of a facility that has closed and they have given the bed licences back to the department. I do not think that would ever happen. I suppose what I am getting at is that it is often said that there have been no closures as a result of the accreditation system. I am not sure that is correct. I am asking the department if you could provide me with a list of—

Ms Halton—If you are happy, we will have a look at the data and try to give you something which is meaningful. For us to sit here with a definitional rule over the issue now is very difficult. Let us look at the data and we will give an answer, and if it is not adequate you can tell us.

Senator McLUCAS—Thank you. The fire safety website had a bit of trouble last Friday. I think we solved the aged care crisis on Friday; we had 400,000 beds in New South Wales, which was a lot of fun.

Senator Santoro—You gave us no credit for it, though.

Senator McLUCAS—I was about to, and then it shut down. Is it back online?

Mr Mersiades—Yes. There was a 'corrupted download of data', which I think is the technical term.

Senator McLUCAS—And there was a facility with 3,680 beds in it.

Mr Mersiades—A terrible place to be delivered, I expect.

Ms Halton—It is in the category of 'machine error'.

Senator McLUCAS—But it is now fixed?

Mr Mersiades—Yes.

Senator McLUCAS—Up to what date in terms of compliance with fire safety?

Ms Scheetz—It was updated on 9 February.

Senator McLUCAS—The update of 19 January occurred. Can you explain why, then, on the day following or the day after that the website was updated to say that these figures were true as at 23 December?

Ms Scheetz—There was a mind to update the information in January—I cannot remember the date; you may know the date. The upload of the information was started, and we then realised there were errors in the information. So we took it off until such time as we could be

sure of the information going up. I think it was up for only a number of hours before it was taken off. I can guarantee that it is right now.

Senator McLUCAS—Thank you. I do have other issues, but I shall put them on notice.

Senator FORSHAW—I have a further question on aged care. Does the department have a contract with Jackson Wells Morris to undertake issues management on aged care?

Ms Halton—It is Jackson Wells these days, I think.

Mr Mersiades—Not that I am aware of, but I do not know all the contracts we have. I am seeing a shaking of heads so it is probably best that we take it on notice.

Ms Halton—If we do have we will come back to you on notice. If we do not have—

Senator FORSHAW—You will come back to me and tell me that you do not have it? I would like to know one way or the other.

Ms Halton—We do not think so. The answer we think is no, so if we do we will correct that.

Senator FORSHAW—If you do, would you also advise when that contract was first entered into and its cost.

Ms Halton—Would you like to give us a hint of what you think they are doing?

Senator FORSHAW—No. I am just asking you a straightforward question: do you have a contract? If you do, when was it entered into, what was it for and how much? If the answer to the first question is no then the subsequent questions are not relevant.

Ms Halton—You do not even know what they are meant to be doing? We genuinely cannot imagine what they would be doing.

Mr Mersiades—Are they engineers, architects or—

Senator FORSHAW—Jackson Wells Morris is a PR firm. They have been engaged on occasions to help with the management of certain issues. But you have taken it on notice. The question is straightforward.

Ms Halton—Yes. In all honesty I am pretty confident that the answer will still be no.

Senator FORSHAW—If the answer is no, then fine. I just would like to know. I will leave it at that. Chair, are we ready to move to outcome 4?

[4.45 pm]

CHAIR—We will now move to outcome 4, primary care. We have set times for each of these next few sessions. I am not sure whether it is people's expectation that they should be vaguely indicative or that they should be enforced so that we do not run out of time towards the end of the day. I will take that as it comes.

Senator FORSHAW—I do not think we are going to be that long on outcome 4. I have a feeling that some things will be taken on notice. We are conscious of trying to get back to that indicative timetable.

Ms Halton—You have to be nice to the newly promoted Mr Eccles, who says he knows nothing about primary care, which of course is a lie.

Mr Eccles—Two weeks.

Senator FORSHAW—You have been in the job two weeks. That is better than one day, Mr Eccles!

Mr Eccles—Very true.

Senator FORSHAW—Do you know anything about the AWB contracts to Iraq that you would like to share with us? Okay. I thought I would give it a go! I will move on to chronic disease management. I predict that you will take these on notice; you will understand why and I will too. I wanted to ask you about some particular details with regard to the enhanced primary care items, which were then superseded by the chronic disease management items, for which payments are made to GPs. I will read these into the *Hansard*. For the six months since July 2005, could you provide details of the number of services by month for each of the EPC items 720, 722, 724, 726, 728 and 730? I am sure, Mr Eccles, in the short two weeks you have been in the job, you are already on top of that. Can you provide those to me now?

Mr Eccles—I do not think we can by month.

Senator FORSHAW—At all?

Mr Eccles—I am not sure. I think we might have annual amounts handy.

Senator FORSHAW—I am happy to take information—

Mr Eccles—We have 721 and 723 but we do not have those, so it is probably safest to take them on notice.

Senator FORSHAW—All right. That is the first set of figures. What proportion of patients with an EPC plan were referred on to an allied health service professional or a dentist? For each of the six months since July 2005, could you provide services by month again for each of the CDM, or chronic disease management, items? Those numbers are 721, 723, 725, 727, 729 and 731. I notice they are all odd numbers and the others are all even. I take it you are taking those on notice too?

Mr Eccles—I think it is probably better. We can do a couple of them, but you would probably prefer it all in a job lot, so to speak.

Senator FORSHAW—I think so, yes. I can probably give you this in writing later on, after the session, rather than you having to wait for the *Hansard*. The follow-up question is this: what proportion of patients with a CDM plan were referred on to an allied health services professional or a dentist? Finally, is there any data about how many patients received five allied health services and/or three dental services? Does that make sense to you? It probably makes more to you than it does to me. You can provide that?

Mr Eccles—Yes, we can provide that.

Senator FORSHAW—Could you take that on notice and, if you are able to get it to us earlier than the set date—

Mr Eccles—It is all pretty straightforward. We will get that to you as soon as we can.

Senator FORSHAW—That would be good. The next issue is the 2003 review of general practice. In the PBS at page 91, it states:

The Government response to the 2003 review of the Divisions of General Practice will be implemented from 1 July 2005, after extensive consultation throughout 2004-05.

It went on to indicate, ‘A key component of the new arrangements is the implementation of a national quality and performance system, which includes such things as national performance indicators, a quality system leading to accreditation and comprehensive planning and reporting arrangements.’ Those are not all of them, but they are some of the key ones. I would like to get some information on the review. How is the national quality and performance system being implemented?

Ms McGlynn—We are well advanced on the national quality and performance system. That has been finalised and agreed to by the divisions. They have also signed up to collecting some performance information data, which we will not have for some time. But the packages of information and all of the education materials et cetera are out there.

Senator FORSHAW—What are the national performance indicators?

Ms McGlynn—They are linked to the government’s national health priorities. They have also been included into the new planning and reporting pro formas. They are around mental health, some governance indicators, diabetes and a number of other health priorities. They have been researched by a body of national and international experts and have also been heavily consulted with the divisions of general practice.

Senator FORSHAW—How are reports made against those indicators?

Ms McGlynn—That is only just commencing now. The first reports have not been made. Divisions are just being provided with information on how to collect that information and what the source data will be. We also acknowledge—and have been very up-front with divisions—that the information we know at the beginning will not be as good as we would like it to be, but this is the first step. Also, collecting the information will also inform the standards and qualities for the future. So it starts divisions thinking about their performance in those areas, which is also an important part of them progressing to improve both clinical quality and their own performance as organisations.

Senator FORSHAW—Moving to the accreditation system, what changes have been made there?

Ms McGlynn—Accreditation for divisions of general practice is a new thing. We have given some incentives to all divisions of general practice and most, if not all, of them have signed up for those incentives. Previously, we had not required divisions of general practice to be accredited, although some had done that of their own initiative. It has been very well accepted. Many of them have become accredited already and others are well on the way.

Senator FORSHAW—When you say ‘incentives’, what do you specifically mean?

Ms McGlynn—The divisions of general practice could apply for a $5,000 incentive payment which would assist them in doing some of the administrative work that goes with accreditation.

Senator FORSHAW—How many of the divisions have already become accredited?

Ms McGlynn—I would have to take that on notice. We can give you the numbers that have become accredited and those that are under way.

Mr Eccles—I understand that all 118 divisions have signed up.

Senator FORSHAW—It is 119, isn't it?

Mr Eccles—One hundred and eighteen divisions have signed up to undertake the accreditation process.

Senator FORSHAW—We were given the figure of 119 earlier today.

Ms McGlynn—We do have 119 Divisions of General Practice, however. We are just signing a contract with the new provider for the Western Sydney division. That is yet to sign up but I imagine it will.

Mr Eccles—You would be aware from previous hearings that there was discussion about the Western Sydney Division of General Practice, which closed its doors a little while ago. We are waiting for a replacement for that.

Senator FORSHAW—I thought you were going to mention another one for a minute. We heard about it a couple of hours ago. So Manly-Warringah are in this one, are they?

Ms McGlynn—They are.

Senator FORSHAW—What is the cost to practices of going through the process of becoming accredited? You said that $5,000 is available, but does that cover the cost? What sort of cost would an individual practice and also a division have?

Ms McGlynn—I can speak only for the divisions. The accreditation relates to the Divisions of General Practice, not to individual practices. The costs would vary dependent on the provider of the standards. Each cost in different ways, sometimes depending on the size of the organisation et cetera, and then there would be staff costs and those sorts of things. We have assisted divisions also by getting them through the state based organisations and through the Australian Divisions of General Practice. Getting support shared nationally about divisions that have already undertaken accreditation and getting them to link up with one another modifies some of the materials, policy and procedure manuals and things that would also assist in reducing the resources required to do it.

Senator FORSHAW—Are there incentives to the state based bodies and to the ADGP as well?

Ms McGlynn—They could apply as well, yes.

Senator FORSHAW—For $5,000?

Ms McGlynn—Yes. But we would also see it as the role, particularly, of the state based organisations and the Australian Divisions of General Practice to take some leadership on some of those things as well, given also that this is about an organisation reaching high quality standards of performance which we think are important for the divisions.

Senator FORSHAW—The planning and reporting arrangements is another one of the components. Can you enlighten us as to what is happening there? What are the changes?

Ms McGlynn—The Divisions of General Practice have submitted their plans for the 2005-06 financial year using the new nationally consistent plans and reporting arrangements. They were put together using a working group of people from the Divisions of General Practice and

from the network, so they had a hand in working with the department to build those. We have always acknowledged that we would roll out the new plan in the reporting framework and then pause and review it so that if any unanticipated things were not working we would commit to the divisions that we would make those changes, because we want it to be able to work for them. They are only just putting out their first six-monthly report using that reporting framework. We will meet with them after those first reports to see how that is going with a view to decreasing the resource requirements of completing the documents and making sure again that the information is easy to find for them and for our state and territory officers who review those.

Senator FORSHAW—How does the new system link in with looking for improved health outcomes?

Ms McGlynn—I thought it was important, when we considered the government response to the review of the Divisions of General Practice, that we were clear about what our expectations were: that we were looking for consistency and high quality in terms of what divisions were able to do so that they could genuinely support general practice to deliver better health outcomes to the communities that they serve. Improving planning and reporting, and giving divisions population health based information to better plan within the boundaries of their division—for example, understanding what the numbers of diabetics et cetera are in their areas—allows them to focus things like professional development, support and training, better access to clinical guidelines and identified priorities for general practice to improve those health outcomes.

Mr Eccles—They are also working on providing direct services through the More Allied Health Services Program, for example, where the divisions directly employ health workers to work with GPs.

Senator FORSHAW—If some problems are identified through that, what remedial action is able to be taken and is there a—

Ms McGlynn—I think it has allowed the department also to reflect on the way we do business and for us to ensure that we have a clear and transparent way of providing regular feedback to divisions. We have just revised the guidelines for the program. They are much clearer about what the divisions can expect from the department and what the department can expect from divisions. That includes things like an ability to raise issues, making it very clear about how long it will take us to respond, and what kind of a response they can expect. Again, with more clarity around planning and reporting, it is easier in the very beginning to sign off on a plan that is clear about what the division is going to do. I think it means that where issues arise we deal with them more promptly and more transparently.

Senator FORSHAW—Is there a particular section of the department that is responsible for this?

Ms McGlynn—Yes, that is the branch that I manage.

Senator FORSHAW—Sorry, that branch again is the—

Ms McGlynn—The General Practice Divisions and Information Branch.

Senator FORSHAW—Is there a particular budget for this activity? Or is it just part of the allocation of funds to your branch?

Mr Eccles—There are particular budget items for Divisions of General Practice, their core funding, as well as particular budget items for some of the add-on programs that we provide through divisions.

Senator FORSHAW—Then is there a particular budget item for this?

Mr Eccles—For the quality improvement aspect?

Senator FORSHAW—For what we have just been talking about. Yes, the quality; I suppose that is it.

Mr Eccles—Or just the general Divisions of General Practice Program?

Senator FORSHAW—No, I am thinking particularly about the quality improvement program.

Ms McGlynn—The quality improvement part of it goes across a number of functions in the branch, so at times we would draw in the expertise of the people who are managing. It is not defined after that.

Mr Eccles—It is sort of a core expectation that we would expect under their main core grant.

Senator FORSHAW—I will now move to one other area: HECS reimbursement for rural doctors. Since 2000-01, how many doctors have received funds under the HECS Reimbursement Scheme for rural doctors?

Mr Kennedy—I have a total, since 2002-03—which is when the HECS reimbursements were first paid—of 345 doctors who have been receiving payments. That is a cumulative total.

Senator FORSHAW—Since 2002-03, when it started to be paid.

Mr Kennedy—That is right.

Senator FORSHAW—Have you got year-by-year figures?

Mr Kennedy—They are cumulative figures—

Senator FORSHAW—Yes, I appreciate that.

Mr Kennedy—In 2002-03, 91; in 2003-04, 179; in 2004-05, 299. And then, as I said, coming up to 2005-06—as at 16 February—345.

Senator FORSHAW—They are cumulative because, as each year passes, a new group comes into the scheme.

Mr Kennedy—Yes.

Senator FORSHAW—The scheme pays the reimbursement back over five years.

Mr Kennedy—Over a five-year period, yes.

Senator FORSHAW—So 345 have been paid. Those who were first paid in 2002-3 still have a couple of years to go.

Mr Kennedy—If they are still out there, yes.

Senator FORSHAW—If they are still in practice, yes.

Mr Kennedy—They might have moved.

Senator FORSHAW—How much money in total has been paid?

Mr Kennedy—I can go through the years again. In 2002-03, it was $459,000; in 2003-04, $1.65 million; in 2004-05, $1.73 million; and to date, as at 16 February, $1.054 million.

Senator FORSHAW—Have you done the maths, or can you get that little calculator out again? This will be a little easier than the other question.

Ms Halton—The man with the little calculator is not here.

Senator FORSHAW—Are we talking about somewhere around $4½ million, almost $5 million?

Ms Halton—Would you like us to add it up? There is a man with a much bigger calculator sitting here this time.

Mr Kennedy—I would say it is about $4.7 million or somewhere just under $5 million.

Senator FORSHAW—Somewhere between $4½ million and $5 million.

Mr Eccles—To date, it is $4.893 million.

Senator FORSHAW—How much was allocated to this program?

Mr Kennedy—I can go through it by year again.

Senator FORSHAW—Yes.

Mr Kennedy—The allocation for 2002-03 was $1.17 million; for 2003-04, $3.44 million; for 2004-05, $3.13 million; and for this year we are predicting $5.24 million.

Senator FORSHAW—Has anyone calculated the total?

Mr Kennedy—I can do the variation too, if you want me to.

Mr Eccles—It is $12.98 million, but that includes a full-year amount for this year.

Senator FORSHAW—Yes, $12.98 million.

Mr Eccles—But that includes a full-year amount.

Senator FORSHAW—For how long is this program intended to run? Does it have a defined life, or will it just be revisited at some point in time?

Mr Kennedy—It is funded until 2007-08.

Senator FORSHAW—I have in my notes that it was envisaged that about $37 million would be provided for this scheme over its duration.

Mr Kennedy—That does not gel with my figures.

Mr Eccles—We undertook a lapsing program review and last year it was extended for another four years.

Senator FORSHAW—The extension of four years takes us to 2007-08.

Mr Kennedy—Yes, 2007-08.

Senator FORSHAW—What is the estimated spending on the program for the period from when it first came into operation through to 2008?

Mr Eccles—I do not have that.

Ms Halton—We would have to go back and check this, but my memory is that when we announced this program, it was part of the More Doctors, Better Services package. A number of items were probably rolled into the one figure, which were about increasing the number of doctors. It included the scholarship money. If we have the history, you might find that the 37 actually includes that. Do you know where you got the 37 from?

Senator FORSHAW—No, other than that is the advice I got. I am aware that it was subject to review as a lapsing program.

Ms Halton—We think we know what your 37 is. We think it is the new general practitioner registrars.

Senator FORSHAW—Okay. Let us put that figure to one side, then. But in any event, the total figure for the years that you gave me were: expected expenditure totalling around about $12.98 million up to the end of this financial year, but spending is running at pretty close to $5 million if we round it off from here to the end of this financial year. That would seem to me to be somewhat of a significant underspend, at least for the years it has been running so far. Is there an explanation as to why that has occurred?

Mr Kennedy—It is a demand driven program, so you need to build into the estimates an expected number of doctors who would take it up. We are concerned to make sure that the doctors who are out there who can qualify for the scheme are aware that they can qualify and also, that anyone who anticipates going into rural practice or training for rural practice or general practice in a RRMA 3 to 7 location are aware that this is an incentive. So in October last year we undertook an information campaign which involved the divisions of general practice, the medical schools, GP training providers, universities, and training hospitals to raise awareness of the scheme.

Senator FORSHAW—Have any changes been made to the scheme?

Mr Kennedy—No changes to date.

Senator FORSHAW—So it is still operating under the same rules.

Mr Kennedy—Yes.

Senator FORSHAW—The figure you gave me for 2004-05 was $1.73 million. For this year to date it is $1.054 million. Even allowing that this is February—I cannot project it—it may well come in under the last year's figure, or about the same. Would you not expect this amount to grow somewhat exponentially this year as new doctors come in? You still are, hopefully, reimbursing the ones who have already applied and qualified.

Mr Kennedy—I guess the issue is that, once they come in, they have to do their service first and then they get the reimbursement, so the reimbursement would start after the year of service.

Senator FORSHAW—But the figure should still grow each year. It is achieving what it is intended to do.

Mr Kennedy—The figure is growing, and the number of doctors has increased significantly since 2002-03.

Senator FORSHAW—As I said, I cannot say what the figure will be at the end of June this year, but it was $1.73 million last year, and it is now $1.05 million. I just noticed that there was a substantial jump in 2002-03 to 2003-04 and then not much difference between 2003-04 and 2004-05. I am trying to understand why it is not increasing at a higher rate than it is.

Mr Eccles—There are 345 people receiving the funding this year so far; and 299 last year, up from 179 the year before. That is a fairly steady growth.

Senator FORSHAW—I do not know if it is steady. If we go to the Channel 9 cricket commentary, the strike rate was going pretty well for the first couple of years and then it started to level a bit. There might be a perfectly logical explanation in relation to how the scheme runs.

Mr Eccles—There could be backlog in the first year, there could be a lot of people who are going out right now because of the end of the university year, there could be other aspects and it could be due to the awareness campaign. It kind of went up by 90-odd and then 120. Given how we are tracking this year given seasonal variations, it could well be more than 120. There has been a slight increase year to year, with an initial bulb of 91 straightaway.

Senator FORSHAW—I am trying to be scrupulously fair here. I appreciate that we are looking at it here in February, with four months to go, and that there are a multiple set of factors involved. But you would be concerned—and it appears that you have been concerned—that there was a substantial difference between the budgeted expenditure of $13 million as against $5 million in actual expenditure.

Ms Halton—I remember the estimates for this program when they were done. I was actually involved in this, in the microdetail. On this one we had no idea of what level of demand we would get. It really was a case of, 'About there, we guess.' In a sense it does not surprise me. We have now found the natural level, and I think we rightly had pointed out by Mr Kennedy that we have done a number of things to actively promote the program. But the truth is that when we first introduced this initiative we genuinely did not know what the level of demand was going to be, remembering that at the time we introduced this we were also doing things like increasing the number of scholarships for rural students. It was part of a much broader package. In a number of these areas we were taking multiple steps to increase the number of doctors in the bush and some of them said, 'Well, let's have this initiative and we'll see what take-up we get.'

Senator FORSHAW—You at least knew what the cohort was, what the number of doctors within the target group was?

Ms Halton—Yes, absolutely.

Senator FORSHAW—You had an idea there.

Ms Halton—Yes.

Senator FORSHAW—You obviously overestimated. I will leave it at that for the moment. No doubt we can have another look at the figures at the end of the financial year. We have nothing else for outcome 4.

CHAIR—We will now move to Indigenous health.

Senator McLUCAS—Did we ask the question about overseas trained doctors? Overseas trained doctors was in outcome 4, wasn't it? That was one that we put in the wrong spot.

Mr Eccles—We can give you some information.

Ms Halton—It depends on what you want to know.

Senator McLUCAS—Earlier today I asked some questions and someone indicated, I thought—

Mr Eccles—We can give you GP workforce statistics.

Senator McLUCAS—Thank you, Mr Eccles. Those questions were about rural doctors, weren't they?

Mr Davies—You did ask this morning for the number of doctors in rural areas, as I recall.

Senator McLUCAS—I am referring to the minister's press release earlier this year about doctors and nurses.

Ms Halton—You talked about the increase.

Senator McLUCAS—It says:

Since 1996, rural doctor numbers have increased by more than 20 per cent ...

We were looking for the actual number of doctors that would inform that statement.

Mr Eccles—We can give you the figures for rural and remote doctors. Others have talked about it at earlier estimates hearings. Probably the most accurate way to describe the statistics is to use the full-time workload equivalent measure as opposed to headcount and other methods. I can give you the figures for rural and remote GPs by FWE for several years. Is that what you are after?

Senator McLUCAS—When you say 'several', how many are we talking about?

Mr Eccles—I think from 1995-96 to 2004-05.

Senator McLUCAS—Rather than read them out laboriously, is it possible to provide a photocopy of them to the committee?

Ms Halton—Yes.

Senator McLUCAS—What are the full-time equivalent figures for 1996 and 2005?

Mr Eccles—In 1995-96, the FWE is 3,551 and in 2004-05, 4,416.

Senator McLUCAS—Is your definition of a rural doctor on RRMA?

Mr Eccles—It is RRMA 3, which is a large rural centre of 25,000 down to remote.

Senator McLUCAS—It is three through to seven.

Mr Eccles—Yes.

Senator McLUCAS—You do not do anything about GP training, do you? You just deal with workforce issues?

Mr Eccles—Which aspects of GP training?

Senator McLUCAS—There was $4.7 million allocated to GPs for training under the Training for Rural and Remote Procedural GPs Program. Is that this section?

Mr Eccles—That is us.

Senator McLUCAS—The $4.7 million is over what period? Can you explain to me that figure?

Ms Morris—The $4.7 million figure was the actual expenditure in 2004-05. The program has funding through until 2006-07.

Senator McLUCAS—What is the total expenditure over the three years?

Ms Morris—It started in 2003-04. There was no expenditure that year. It was slow to be started up. The only expenditure figure I can give you is for last year, which is $4.6 million. I can tell you that, to 31 December 2005, 829 procedural GPs have registered for the training.

Senator McLUCAS—What is the total budget over the four years?

Ms Morris—It is $75 million over four years.

Senator McLUCAS—How many GPs are registered now?

Ms Morris—As at 31 December 2005, 829.

Senator McLUCAS—Who is eligible to be trained under this program?

Ms Morris—GPs who do procedural work.

Senator McLUCAS—I am trying to get an understanding of what proportion of potential candidates is 829.

Ms Morris—We do not actually have an accurate figure on the number of GPs who do procedural work because most of the procedural work that they do is in public hospitals—state hospitals—so it is not a Medicare item. The most reliable figure we have is from 13 November 2004, from the Rural Workforce Agencies Minimum Data Set Report. That set the known number of proceduralists nationally in RRMAs 3 to 7 at 933.

Senator McLUCAS—That is a good take-up rate.

Ms Morris—That is a large proportion of them, yes. That is a very large proportion. It was slow to start but it is going well.

Senator McLUCAS—Thanks for that.

[5.25 pm]

CHAIR—As there are no further questions on outcome 4, we will proceed to outcome 7, Indigenous health.

Senator CROSSIN—I want to start by updating my knowledge of a few areas. OATSIH's people's complementary action ran from 2003 to 2006. I am happy for you to take this on notice.

Ms Halton—Okay, because that is actually in program 1.

Senator CROSSIN—So that is in program 1, is it?

Ms Halton—Yes, but that is fine. We will take it on notice, so pop it on notice now and then we will deal with it.

Senator CROSSIN—Because it runs from 2003 to 2006, I wanted to know if there were plans to review this; if so, what were those plans; if it is not going to be continued, why is that the case; and can I have a breakdown of the funds that have actually been committed over that three- to four-year period.

Ms Halton—What we will do, even in the event that you are not here, is read the answer to that question in when the officer concerned in outcome 1 is here, which means you will have an answer in the *Hansard*, which will be quicker.

Senator CROSSIN—All right. I am not planning to be around. I do not think I can do four nights until 11 o'clock.

Ms Halton—That is fine.

CHAIR—We cannot blame you for that.

Senator CROSSIN—It is in my folder and I can ask it again in May, but I was keen to have—

Ms Halton—No, we will have the answer this evening.

Senator CROSSIN—It is the same with Workforce funding. I was wondering if you could provide me with the allocated amount for 2005-06.

Ms Podesta—We can.

Senator CROSSIN—Do you need to take that on notice?

Ms Podesta—No, we have the information here. As for the total figure available at the moment for the Workforce program, OATSIH has a figure of $10,678,000 allocated for Workforce initiatives.

Senator CROSSIN—My records tell me that I did not get the figure for 2004-05. Can you take that on notice?

Ms Podesta—We will take that one on notice.

Senator CROSSIN—Is that amount on track to be spent?

Ms Podesta—We have made a great deal of progress in respect of the Workforce initiatives and we do not anticipate any underspending across the OATSIH program this year.

Senator CROSSIN—If there is an underspending, what happens to that money? Does it roll over into this output in the next financial year?

Ms Podesta—It does. The OATSIH program has a degree of flexibility, because we set expenditure targets against initiatives. We do a review of spending against those initiatives. If we are unable to fully expend the anticipated amount, it is allocated to other priorities that are identified through the framework agreements.

Senator CROSSIN—What sorts of things is the money spent on?

Ms Podesta—A range of activities. We do not anticipate that there will be any underspend in Workforce. But, if there is, within the single line appropriation of OATSIH the money is primarily allocated to activities in primary health care. With the Workforce money, we would look to see whether there are any other initiatives within Workforce that were required to be expended that year. But we do not anticipate there being any underspend in Workforce, so it is not an issue that we have needed to examine this year.

Senator CROSSIN—I just wanted you to tell me what you do; sometimes it is good to put it on the record. So the money goes towards training health workers?

Ms Podesta—The money is spent on a range of initiatives, including curriculum development; the scholarships program, which is a big part of Workforce; the associations that support Indigenous doctors and nurses; strategic development; and Indigenous health sector training.

Senator CROSSIN—Do you keep a database of the number of Indigenous doctors we have in this country?

Ms McLaughlin—We do not keep a database in OATSIH of the number of Indigenous doctors in Australia. We generally rely on census data. The numbers are still quite low.

Ms Podesta—However, we fund the Australian Indigenous Doctors Association. They have membership lists, which include people who are currently practising and people in training. Whilst it is certainly true that they do not have 100 per cent coverage, they are fairly confident through their networks that they have a good understanding of who is working, where they are working and their current status. So from that point of view, we have a strong network within the sector to understand the numbers of professionals in that area.

Senator CROSSIN—Expenditure on Aboriginal eye health might be easier for you. You provided me an answer on this back in 2003. The question was E03025. You gave me a breakdown of what the money was going to be spent on in Indigenous specific initiatives in the department. I was really just looking for an update of that table. I know some of those initiatives or programs will no longer be there.

Ms Podesta—I can give you a breakdown of what the spending is for this year under eye health. For 2005-06 we expect to spend $2.9 million. That includes $2.42 million for the 34 eye health coordinators. I know that you are very familiar with their role, so I will not go through the detail of their role.

Senator CROSSIN—It may be the next tab we come to.

Ms Podesta—There is also just over $50,000 for articles in *Vibe* magazine, which is part of the ongoing community and sector education around the importance of eye health; approximately $100,000 for the stocktake of eye health equipment; $10,000 for the eye health specialist project in South Australia and $320,000 this year to monitor and respond more effectively to trachoma.

Senator CROSSIN—Yes, we will get to that in a second. What is the total spend on eye health then?

Ms Podesta—The targeted expenditure this year is $2.9 million.

Senator CROSSIN—The question I was referring to was the general expenditure on Aboriginal health across the board. It was a breakdown of at that stage your $288 million—at that stage—on Indigenous specific initiatives. If you want to take that on notice, you can.

Ms Podesta—We can give you the information tonight.

Mr Thomann—You are after the total appropriation in administered funds this year?

Senator CROSSIN—Yes, for Indigenous specific initiatives.

Mr Thomann—The total appropriation for outcome 7 is $354.55 million following the additional estimates.

Ms Podesta—Would you like a breakdown by program?

Senator CROSSIN—Yes, if you want to do that, that would be good.

Ms Podesta—With regard to Aboriginal and Torres Strait Islander health services, we anticipate $232.9 million; for the Bringing Them Home program it is $9.6 million; for the Link Up program it is $4.1 million; for combating petrol sniffing it is $4.6 million; Healthy for Life, $9.2 million; Primary Health Care Access Program, otherwise known as PHCAP, it is $79.8 million; and for the Indigenous coordinated care trials it is $14 million.

Senator CROSSIN—There is no longer money put into the Croc Festival from the department?

Ms Podesta—The Croc Festival is funded by outcome 1, and I am certain that they will be able to give you the information on that.

Senator CROSSIN—All right. Has the fringe benefits tax supplementation finished?

Mr Thomann—No, it has been rolled into the base of the program, and you will find it in the first element, the $232.9 million element of the program.

Senator CROSSIN—What amount of that is for this year? Can you give me a breakdown of that?

Mr Thomann—I cannot give you the value of the FBT.

Ms Podesta—We will get the information while we are here and come back to you.

Senator CROSSIN—Just take it on notice. That is fine.

Ms Halton—Would you like the Croc Festival funding now? We do have the officer concerned.

Senator CROSSIN—No, I just wondered if you still funded the Croc Festival. That is all.

Ms Halton—Yes, we do.

Ms Podesta—It might take a few minutes to get the FBT supplementation figure, but we will get it tonight.

Senator CROSSIN—I will just keep going. Let us turn to hearing services training. What is the exact figure of the contract that you have with Australian Hearing for 2005-06? I am not sure if you gave me that last time. You might have.

Ms Podesta—I think we gave you a big update on the question on notice.

Ms Balmanno—The hearing training program is in three elements. The contract for training within Australian Hearing, and it includes the maintenance and calibration of equipment element, is $397,272. There are also separate contracts for Central Australia and for the Top End of the Northern Territory.

Senator CROSSIN—What are they?

Ms Balmanno—They are not with Australian Hearing. The Central Australian contract is with Congress, which is a health service in Alice Springs. That contract is for $79,868. For the Top End the contract is with the relevant Northern Territory department, and that contract is for $50,853.

Senator CROSSIN—The contract with Australian Hearing still includes training and equipment?

Ms Balmanno—Yes, and that covers the rest of Australia other than the Northern Territory. The Northern Territory is covered under those two specific arrangements.

Senator CROSSIN—Thank you for that. Also in the hearing health budget, what is the total budget for hearing health in 2005-06?

Ms Podesta—In OATSIH?

Senator CROSSIN—Yes.

Ms Podesta—In 2005-06 it is $2.6 million.

Senator CROSSIN—For hearing health?

Ms Podesta—For ear and hearing health, yes.

Senator CROSSIN—What is the breakdown of that? The last time you answered this question for me there were five areas. It is an old question—E03099. You are on the ball; I have been doing this too long. It is like the Indigenous education people I had last night; they get to read your mind after a while.

Ms Podesta—However, it means that we can get the information ready and available for you, and that is good.

Ms Balmanno—The largest component is the funding for the specialist sites. That is $1.7 million.

Senator CROSSIN—Is that the child health sites?

Ms Podesta—Yes, and there are 30 sites around Australia.

Senator CROSSIN—And that is $1.7 million now?

Ms Balmanno—Yes. The three training and equipment contracts that I mentioned are the next three elements.

Senator CROSSIN—And the total costs were $397,000, $79,000 and $50,000?

Ms Balmanno—Yes. The next element is additional costs around the purchase and replacement of hearing equipment. That is $192,243. The final element is a project that we are currently doing in South Australia looking at improving the uptake of the otitis media guidelines. That has been allocated $175,455.

Senator CROSSIN—What does that project involve?

Ms Podesta—We have a regional level funding agreement with the Northern and Far Western Regional Health Service to manage and implement this project. It is being undertaken in conjunction with the Royal Australasian College of Physicians who developed the proposal. They are assisting us by working with the South Australian Department of Human Services, the Aboriginal community controlled health service and other stakeholders in South Australia to develop a collaborative regional program focusing on the management of Aboriginal and Torres Strait Islander children under five with otitis media. The project proposes that health workers, nurses and doctors are trained in the guidelines, and an advertising campaign directed at parents and families will be developed, highlighting to parents their contributions in recognising ear infections and accessing early health care. It is a genuinely collaborative approach between the profession, the sector and families to see if we can improve management of otitis media within families and within the services.

Senator CROSSIN—Has the Menzies School of Health Research got anything to do with that trial or project?

Ms Balmanno—Yes, we understand that they do. It is a project rather than a trial. We can get more details about that if you want us to.

Senator CROSSIN—I just know that Dr Amanda Leach at Menzies has done some—

Ms Podesta—Terrific work.

Senator CROSSIN—amazing research in this field and I just wondered if she or they were linked to this.

Ms Podesta—We will find out about this specific project, but certainly there are a number of researchers and practitioners now doing some terrific work. I think Dr Sandra Eades is also doing some really interesting and useful research in New South Wales around ear issues and on training and better management. We certainly encourage that collaboration and, through the investment we make in the research centre, that that information is collected and facilitated through the sector, because everyone recognises that this is an area where there is a need to improve practice. I agree with you; we have been really impressed by some of the research. The Menzies research is very good.

Senator CROSSIN—How long is this project for? Just a rough time frame will do, like whether it is one year or five years. I do not want an exact date.

Ms Podesta—We will find out. Ms Balmanno and I are both relatively new in this area and the contract preceded us. But the officer who negotiated it is here, so we will be able to give you the exact information.

Ms Balmanno—At this stage, the project is only funded for this year and we will make a determination about future funding when we consider priorities for next year.

Senator CROSSIN—Is there information about it on your website?

Ms Balmanno—No, there is not.

Ms Podesta—But when we get the findings from this project as a part of OATSIH's commitment to improving knowledge within this area, we will make sure that it is more publicly available—depending on the results, obviously.

Senator CROSSIN—And the end result is to actually reduce the incidence?

Ms Balmanno—Absolutely.

Ms Podesta—And to improve management and better use of the guidelines.

Senator CROSSIN—Now it is in the *Hansard*, I might follow it up in November. I have had direct experience with that and it is a good thing that it has received some attention.

Ms Podesta—I think it is very firmly on the action research agenda. It is an important element within Aboriginal and Torres Strait Islander health to encourage practitioners to see their work as contributing to the research, and the research as contributing to practice. This is very much an example of good collaboration, and they are the sorts of linkages that we really encourage and we see the benefits of them clinically.

Senator CROSSIN—The eye health review was undertaken some time in 2004, was it?

Ms Balmanno—It was 2003.

Senator CROSSIN—I am assuming that has been completed?

Ms Balmanno—Yes, it has.

Senator CROSSIN—Forgive me for this, but have I seen the outcomes of that review?

Ms Balmanno—This is Professor Taylor's review?

Senator CROSSIN—Yes.

Ms Podesta—We are more than happy to provide that to you if you have not.

Senator CROSSIN—Is it on your web site, to save you time?

Ms Podesta—The government's response is a public document, which we can make available to you today or tonight.

Senator CROSSIN—That would be useful. Was that actually finished in 2003? My question about expenditure was after the event, is that correct?

Ms Podesta—A review of the implementation was undertaken in 2003, and the government response was in May 2004.

Senator CROSSIN—So what recommendations out of that have been implemented?

Ms Podesta—The review identified the need for the program to be more strongly integrated into primary health care and for eye health to be addressed across the whole of the health system, including mainstream programs and services. I will go into a bit of detail, because I know you have got a particular interest in this area. It states specifically that eye health must be addressed as a component of comprehensive primary health care; that mainstream programs and services, including specialist services, have the same responsibility to address the health needs of Indigenous Australians as they do other Australians and at all levels of the health system—so it is a recognition that this is everyone's problem—that regional approaches to eye health will over time place more emphasis on strengthening the

capacity of the local primary health care services in an organised approach to chronic disease detection and management; the trachoma control in endemic regions requires a public health response with the involvement of public health units, primary health care services, housing and essential services; that existing capacity in eye health in the Aboriginal and Torres Strait Islander primary care setting must be preserved; and that program development and implementation should be based on best available evidence. They were the strands that came out of that and they were endorsed by government.

Senator CROSSIN—And that would be reflected in your PHCAP funding?

Ms Podesta—Within each service, they are required to undertake a range of activities. Through the funding arrangement with each one of these services, they identify the outcomes that they anticipate and they allocate resources accordingly. Eye health is accorded significant priority from OATSIH. As you are aware, and I know we have had discussions about this a number of times here, we do not require services to allocate specific levels of resources from OATSIH in a prescriptive way because we recognise that individual services and regions will have particular needs. But eye health is certainly accorded a very high priority, and the guidelines are disseminated and training is provided. The role of the regional eye health coordinators is really critical there in ensuring that primary health care services funded by OATSIH are responsive to them and are putting the emphasis on it that they require. It is really about being able to respond appropriately to the population to which you serve. In areas where eye health is a particular concern, the health service is required to develop the appropriate responses.

Senator CROSSIN—So it is part of the primary care program?

Ms Podesta—Yes, it is.

Senator CROSSIN—You talked about the regional eye health coordinators. Last time I asked, I think there were 29 of them.

Ms Podesta—There are 34 coordinators.

Senator CROSSIN—And they would be in some of the major centres, I suppose?

Ms Podesta—Would you like a list of their locations?

Senator CROSSIN—Sure.

Ms Podesta—Would you like us to read it out or would you like us to table the list?

Senator CROSSIN—You can table it if that is easier. Thank you for all of that. I now want to follow up on—

Mr Thomann—Senator, I have the FBT figure that you were after.

Senator CROSSIN—Yes.

Mr Thomann—The FBT figure incorporated into the base of our program this year is $7.8 million. That amount will obviously increase with the various price parameters that apply to the whole program.

Senator McLUCAS—Ms Halton, when Mr Mersiades and I spoke about those homes that do not meet the fire safety standards of the states and territories, he indicated that he would

give me the locations—that is, the state or territory that they were in. We then got sidetracked, talked about other things and did not come back to that. I know that Mr Mersiades has left, but would it be possible before the close of hearings this evening to provide that information?

Ms Halton—I think he did not have it with him, to be fair. By all means, if I can find somebody who has that information I am happy to let you know. He was going through the file and he did not have the state or territory location. But we will make a phone call.

Senator McLUCAS—Thank you.

Senator CROSSIN—I want to follow up the question that I asked about the asthma spacer devices. I have to say that I was a bit disappointed with the answer, to be honest with you.

Ms Podesta—We have continued to address that issue in the department.

Senator CROSSIN—If I recall correctly, I threw it in during the last two minutes of the night, so perhaps I can give it a bit more attention today. Basically, your answer suggested to me that Aboriginal community controlled health services are funded and, therefore, they should provide the spacers out of their funding. As you would know, my questions arose from some research done by NACCHO, where I think in conjunction with a number of stakeholders they undertook a survey. There were 27 Aboriginal focus group participants, and I assume it must have been members of NACCHO who participated in that. Quite clearly that shows there are very few Aboriginal health services that are able to access the asthma 3 plus plan, because of the way in which it is structured. Has any thought been given to having a targeted ATSI asthma strategy?

Ms Podesta—Asthma is the responsibility of another outcome, outcome 9. I can certainly talk about discussions that have been held across the department to address this issue and about some of the decisions we have made to improve access and awareness. Would you like me to do that?

Senator CROSSIN—Yes. If you do that, it might eliminate some of my other questions.

Ms Podesta—You certainly did raise the issue of access to asthma spacers. As we indicated to you in our answer to a question on notice, which I think we completed just after estimates hearings, the reality is that Aboriginal community controlled health organisations do receive a global allocation. They can make decisions. I think the research that Dr Couzos and Mr David undertook indicated that a number of the services do purchase spacers.

We noted that that research indicates that they believe up to 80 per cent of services may have an issue with regard to access. So we decided to see whether there were options that we might be able to expand. We are not in a position to supply free spacers. They are a medical device, and there are number of issues that preclude our capacity to provide medical devices for free. However, we have looked at a joint approach, a number of initiatives, and we are going to undertake in collaboration with colleagues across the department a strategy to improve the supply of devices to Aboriginal controlled health services, monitor the use of the spacer devices through those services and raise the profile of the issue among the medical and administrative staff at Aboriginal controlled health services. We intend to work with the peak asthma bodies to provide a more streamlined ordering and distribution service, which will

enable the services to obtain the spacers at a discounted rate, and OATSIH will invest that component of the initiative.

We will also review the take-up of the use of those spacers, so we will put in place the discounted purchasing arrangements through to 2008. We will include in the service activity report particular questions regarding asthma spacer usage in 2006-07 and 2007-08. In that way we can gather information by services and do some analysis of that information. We understand there will be an asthma awareness campaign under the department's asthma management program. We understand that there will be an Indigenous specific component of that awareness campaign regarding information and training. We will have input into that campaign through OATSIH.

We are aware of the concerns. From our point of view, we are interested to see if a trial of this type can improve the provision of spacers but we are also interested to see that it is not done in a way whereby spacers are given out without information. Our experience is that what happens is you get stockpiles of unused equipment, and that is not an efficient and effective way to do it. So we are going to look at a strategy which will be enhancing supply at a lower price but using the data and including that as part of a broader information and awareness campaign around asthma management generally.

Senator CROSSIN—So it is in a sense a form of an asthma strategy for OATSIH people?

Ms Podesta—It is an initiative to look at the issues to do with access.

Ms Balmanno—One last element that I think will assist is that the introduction of the newer Medicare items more generally around chronic disease management provides an alternative pathway to the Asthma 3+ Medicare items so that GPs can work with their patients, including those in Aboriginal community controlled health services where there are GPs employed, to develop an asthma plan and to manage it through that process rather than being tied into the process prescribed in the Asthma 3+ arrangements.

Senator CROSSIN—Would you have any idea of how many actually access the financial incentives through PIP?

Ms Podesta—The asthma program is not part of OATSIH.

Ms Halton—It is in outcome 9.

Ms Balmanno—But if it is specifically about access to the Medicare items, that would actually be in outcome 2.

Senator CROSSIN—Okay. I will leave the questions to Leonie and she will sort them out. What I really want to know is how practical an Asthma 3+ plan is for an Indigenous person. That is the issue. I am under an asthma management plan and I can get to a doctor three times in three weeks, but I am really talking about the whole inflexibility or about the cultural inadequacies of that plan and whether there has been any discussion about actually reviewing how appropriate that plan is for Indigenous people to access.

Ms Podesta—I think it is more appropriate that it be handled by that part of the department that looks after asthma. We will take that on notice.

Ms Halton—The reality is that we have implemented successfully the Asthma 3+ management program in populations right across the country. The truth of the matter is that it does require the proactive engagement of the general practitioner. We have had very good take-up rates and it has actually worked incredibly well. I think what we have indicated is that we will have a look at this—and we are having a look at this, particularly with the AMSs. That has been successful because of course the funding mechanisms are different and the funding mechanism that has been used more broadly is actually targeted very much on a fee for service based style of practice. That is not what we are looking at here.

Senator CROSSIN—In terms of access to the spacer devices, you are right: out of that focus group 13 of the 27 actually said they had a problem. But have you actually investigated perhaps having a subsidy scheme with the Asthma Foundation, like the one they currently provide, or have you even thought about having the same arrangement that the Department of Veterans' Affairs has for providing devices such as this on the PBS?

Ms Halton—At the end of the day, the way Veterans' Affairs works in terms of recruitment services and devices for veterans is not the same as for the general population. In terms of the PBS, there is not a proposal. I think it is highly unlikely that we would end up with things like spacers, because as soon as you have spacers you have potential for a whole raft of other devices, and that is not the function of the PBS. The RPBS has a slightly different and broader function in terms of its provision of aids, appliances and other materials including, for example, things like continence aids. So it would not be our intention to look at expanding the scope of the PBS.

Senator CROSSIN—What about a subsidy scheme through the Asthma Foundation?

Ms Halton—Similarly, as I think Ms Podesta has indicated, it is not our intention to start funding individual devices, and that would be the same if there were a subsidy through that particular body. How would we distinguish between Indigenous peoples and non-Indigenous peoples? The issue is how to ensure that people in remote areas who perhaps attend an AMS or what have you, or people who do not attend a general practitioner who is participating in the more mainstream program, get a good standard of care. That discussion across the department that Ms Podesta has talked about is designed to do that.

Senator CROSSIN—Is there a general intention, though, to facilitate an MOU with Aboriginal medical services and the asthma foundations?

Ms Podesta—The centralised streamlined ordering and distribution system that we are intending to trial will certainly encourage a closer collaboration and relationship between the peak bodies because we will be involving the peak bodies in the distribution and ordering of those devices. The intention is to create, by access to a discounted supply mechanism, a professional relationship between the bodies. We will also then encourage the peak bodies to provide awareness and training for the Aboriginal controlled community health services involved in the scheme. As I said, because we will be drawing out data through our service activity report, we will be able to monitor the effectiveness of this intervention over the next two years to see whether in fact it is a worthwhile investment.

I think you will appreciate, Senator, we have had one piece of research. Certainly it has raised awareness of the issue and, from that point of view, the department has made available

an opportunity to see whether, by doing this and gathering data at the same time, it has an impact. Otherwise we would need to do a lot more research to look at any other broader initiatives in this area. I think this is a very pragmatic and sensible step in addressing what is obviously an issue from some areas but also in drawing the data together and being able to see whether in fact it has an impact.

Ms Halton—If I can add to that, we have a finite number of resources, and we need to make sure that our effort is targeted in the areas which are going to make a significant difference. We need to take a measured approach to this and work out whether we are going to get a lot of gain out of what may be a significant effort in terms of departmental resources. I am a bit conscious that we need to step through this cautiously.

Senator CROSSIN—I will follow that up in a few months time. I want to ask some questions about hearing services. I made a comment in the November estimates about the access for people on CDEP to hearing services, about CDEP workers being eligible for hearing services.

Ms Halton—Are you in program 6 at this point?

Senator CROSSIN—I do not think so, because I am pretty certain that you answered this last time. I think I might have praised you for actually ensuring this initiative was in last year’s budget.

Ms Halton—I do recall that we had a compliment from you, Senator, and everyone noticed it and we are all very grateful!

Senator CROSSIN—I know, but I am wondering whether I was a bit early in making my complimentary comments. I am looking at a press release that was issued on 1 December by then Minister Bishop, the Minister for Ageing, and Minister Hockey, the Minister for Human Services. I had understood that the extension of the hearing services for CDEP workers was simply that across the board. The initiative was due to cut in on 1 December, so this is a press release to say, ‘Here’s the day; this is when this great initiative is going to start.’ It says:

Free hearing services are also available to Aboriginal and Torres Strait Islander peoples up to 21 years of age on the Community Development Employment Project ...

Ms Podesta—This is program 6. My understanding with regard to the community service obligations under Australian Hearing is that there are three groups: children under 21 years of age, adults aged 50 years and over and participants in the CDEP program.

Ms Halton—That is right; that is our understanding.

Senator CROSSIN—That is your understanding in the—

Ms Podesta—In the Indigenous Hearing Services budget initiative.

Ms Halton—Yes, in terms of program 6. I do not have that press release, but the advice I have in front of me confirms my understanding of the budget, that in fact that program has extended to—

Senator CROSSIN—I am happy to give you a copy of the press release.

Ms Halton—We are happy to look at it.

Senator CROSSIN—What I would really like you to do is to clarify what is happening here. Is it in fact all participants on CDEP or is it in fact only CDEP participants up to 21 years of age?

Ms Podesta—We will clarify that. In fact, we might be able to clarify that before we finish. It is outcome 6, though, but we can certainly seek information on it.

Ms Halton—The advice I have in terms of the Indigenous clients is that 6,000 Indigenous Australians over the age of 50, which is one of the target groups, and 4,000 people participating in CDEP will gain access.

Senator CROSSIN—That cannot be all CDEP workers, because there are 39,000 CDEP workers.

Ms Halton—These are the people who have a need for hearing services.

Ms Podesta—In CDEP.

Senator CROSSIN—Can you clarify it?

Ms Halton—Yes, we will.

Senator CROSSIN—The press release says:

Indigenous Australians aged 50 years and over will receive greater access to hearing services through a $10.1 million program ...

That is the program that was announced in the budget. It goes on to say that participants on CDEP will be people up to 21 years of age. When I looked at it I thought that maybe I had congratulated you a bit too early.

Ms Halton—It is certainly our understanding—

Senator CROSSIN—Do you think the press release might be wrong?

Ms Halton—It is my understanding that it is all CDEP participants, and it is Ms Podesta's understanding that it is all CDEP participants.

Senator CROSSIN—That is what I thought too.

Ms Halton—We will make a phone call.

Senator CROSSIN—I was ready on 1 December to back up the press release until we double looked at the fine print and thought, 'Has there been a change of policy here or did we get it wrong all through 2005?' I will leave you with it.

Ms Halton—I do not believe this is correct, but I will find out.

Senator CROSSIN—That would be good news if it is not. If you could clarify that it would be useful.

Ms Halton—Someone has gone to make a phone call right now.

Senator CROSSIN—Okay. You have provided me with—and thank you for this—the work plan for future action in ear and hearing health. I am not going to go through that, but I will ask two questions. Who is the Indigenous representative that has been appointed to the Hearing Services Advisory Committee?

Ms Balmanno—We will have to take that on notice.

Senator CROSSIN—Perhaps you could give me all the names of the people on the Hearing Services Advisory Committee, or is it in the Hearing Services annual report?

Ms Podesta—Again, that is outcome 6 but we will check. We will ask the same person that question as well.

Senator CROSSIN—I am sorry about that.

Ms Podesta—There is a lot of interaction between the programs but Hearing Services are actually in a different outcome.

Senator CROSSIN—That is why we used to have them here at the same time. We will do that next time.

Ms Halton—That's right. The good news is that not all Indigenous matters are dealt with by OATSIH; they are dealt with in a number of mainstream programs, which is important.

Senator CROSSIN—Yes, I know. I was kind of hoping that this whole-of-government initiative might break down these silos, but we live in hope.

Ms Podesta—We have addressed the CDEP issue as part of whole-of-government.

Senator CROSSIN—Under the pilot for the hearing aid bank in remote communities it simply says: 'A further supply of hearing aids to congress was provided by OHS in January 2005'. Can you give me a little bit more information about that?

Ms Podesta—Once again, it is the Office of Hearing Services—outcome 6. We apologise, but we just do not have that level of detail. We coordinated the response to the question on notice, because a significant part of it came from OATSIH, but a number of the answers also came from the Office of Hearing Services.

Senator CROSSIN—All-right, I will leave it then. Under 'monitor development of best practice in health promotion and facilitate dissemination of relevant information' it says that 'the department is exploring the use of health promotion officers within communities'. Is there an update on that? Have you decided to put them there?

Ms Podesta—I think once again that that might be for the Office of Hearing Services. We will take that one on notice. I apologise.

Senator CROSSIN—I am a bit confused. Even though I asked this in outcome 7, and you have given me the answer—have you given me the answer across the board?

Ms Podesta—As I said, we coordinated that response because a number of the sources of information came from outcome 7 and some of them came from outcome 6. We consolidated it because it was the department's response to the work plan. I think this has shown us that we need to make sure outcome 6 sits next to outcome 7 at estimates.

Senator CROSSIN—Yes, we will do that next time. To clarify that I just wanted to know where progress is on the use of health promotion officers within communities.

Ms Podesta—We will come back to you—if not tonight then as a question on notice. We have just had a phone call from the Office of Hearing Services; there is confirmation that all CDEP participants are eligible.

Senator CROSSIN—So the press release—

Ms Podesta—Appears to have an error.

Senator CROSSIN—I know where they have got the confusion from. In one of the DEWR programs participants have to be up to 21 years of age to get certain payments from DEWR. I suggest that they have probably got a bit confused. I am pleased to hear the minister's joint press release is incorrect.

Ms Podesta—The minister has underplayed the achievement, yes.

Ms Balmanno—Apparently the list of names of the members of the Hearing Services Advisory Committee has been provided in a previous question on notice. We are getting the details of that and a list of the names for you now.

Senator CROSSIN—It could be in their annual report. I just wanted to know who specifically the Indigenous person was.

Ms Podesta—Yes, we are just finding that out now.

Senator CROSSIN—On eye health, I want to ask you what is happening with trachoma. I know that you have allocated $920,000 over three years. There are three initiatives there; I can see that in your answer. I will go to the first one: 'Establish a national trachoma surveillance'. Can you tell me how much has been allocated towards that over the three years?

Ms Podesta—Over the three years we are nominally allocating $450,000. However, we are about to advertise a request for tender—so, as you will appreciate, there may be some movement with that figure, depending on the results of the tender.

Senator CROSSIN—And this is simply really to count the number of people and get a database of the number of people who have this disease?

Ms Balmanno—It is essentially to draw together the data that is being collected, largely by public health units employed as part of state government services. It is also to improve the quality of that data. The basis on which it is collected, the screening methods and the sampling are inconsistent around the country and inconsistent from year to year. By applying a similar method across the country or across the regions that are affected we hope to improve the quality of the data in terms of how many people are affected and hence to be able to monitor the impact of treatment strategies.

Ms Podesta—It is significantly more than just collecting a lot of numbers. One of the things that we know around communicable disease and good practice in epidemiology is the need to ensure that those who collect the data are collecting consistent data within a consistent time frame and in a consistent way. The data must be cleansed, accurate and able to be broken down and mined for information. One of the things that the surveillance unit will do is to ensure that we have, for the first time in Australia, really high quality trachoma surveillance data. At the moment, as Ms Balmanno indicated, it is largely the responsibility of the state and territory public health units. We are very pleased to say we have now negotiated and agreed national guidelines. We now have to support the national guidelines, a service which will make sure we have consistency in the reporting as well. We know that you cannot embark upon a campaign backed up by information without that type of surveillance.

Senator CROSSIN—So the $450,000 is basically about $150,000 a year.

Ms Podesta—Approximately.

Senator CROSSIN—It is not just across WA, NT and South Australia?

Ms Podesta—No. It will clearly—

Senator CROSSIN—It might tell us in three years time—

Ms Podesta—No, it will tell us much earlier than that. We anticipate that we will get a very competitive series of bids to take on that role because there are a number of academic and epidemiology areas which have expertise in this area. We do not think it will take in any way three years. There has been a lot of lead-up work into this to be able to get going quickly.

Ms Balmanno—Just to note, although the guidelines are national and the surveillance unit would notionally be national, there are only three jurisdictions at the moment that have active trachoma. Those are the Northern Territory, South Australia and Western Australia. They are the three jurisdictions that we are working with most closely around the roll-out of these initiatives and roll-out of the guidelines.

Ms Podesta—But because the guidelines are national, they are part of the Communicable Disease Network of Australia. All state public health units will receive access to the guidelines. They will receive information from the surveillance unit and, most importantly, when the training is undertaken for the public health units and for the Aboriginal community controlled health services there will be increased awareness in case there are isolated cases of trachoma in other parts of Australia that have not been recognised. We think it is unlikely but this will ensure that the awareness and the training are there to make sure that we know.

Senator CROSSIN—How much is set aside for the targeted workshops?

Ms Podesta—In this year, it is $170,000. That will be to ensure that—

Senator CROSSIN—What about in other years? Or is it only for the first year?

Ms Podesta—It is only in the first year. That will assist in the roll-out of the guidelines. In the second and third years we will provide direct financial support to states and territories to help them enhance their existing screening and control activities.

Senator CROSSIN—So two and three are actually—

Ms Podesta—They are staged.

Senator CROSSIN—In your answer to me, the targeted workshop is actually year one and the augmentation of existing states and territory services is years two and three. Is that right?

Ms Podesta—That is exactly right.

Senator CROSSIN—How much is set aside for the third area?

Ms Podesta—Approximately $300,000 over the two years.

Senator CROSSIN—There is no money in this to actually buy the treatment—is that right?

Ms Balmanno—It is already provided free.

Ms Podesta—It is provided free on the PBS. What this will do is to ensure that people have ordered their supplies when they do screening and have them available in line with the

CDNA guidelines to treat cases immediately. One of the things that we are aware of anecdotally has been that in some areas they have not ordered sufficient supplies to be able to treat when they are doing the screening. The screening is conducted by services of public health units on a seasonal basis.

Senator CROSSIN—It will not come as any surprise to you, of course, that I have the Kimberley Population Health Unit bulletin of January 2006. Why have we seen an increase in trachoma—not everywhere, I have to say, but in Mulan. It has gone from 75 per cent in 2003 down to 16 per cent in 2004 and back up to 58 per cent in 2005. I do not want to sound cynical about petrol bowsers, but that SRA, as far as I know, required face washing. What else was deficient in that SRA that did not encompass the SAFE strategy? I know surgery would not have been an issue because they are young kids, but why is it that we have a trachoma strategy that includes three or four phases but an SRA that picks up only one of those phases? I am not surprised that I see a 58 per cent incidence of trachoma in that community. What is the department doing about the provision of the antibiotics and the environmental health aspect?

Ms Podesta—It was an ambitious target in the SRA.

Senator CROSSIN—Thank you for your honesty.

Ms Podesta—There have been a number of discussions with you at estimates around that. As you correctly identified, environmental health is the critical issue in that community. In the SRA the community agreed to improve waste management, and that is important. But there are also a number of other issues with regard to the amount of dust within that community—

Senator CROSSIN—That is true.

Ms Podesta—that will be addressed through whole-of-government negotiations regarding environmental health.

Senator CROSSIN—When the AMA puts out a call saying we need to spend $400 million more in Aboriginal health, part of me suggests that maybe we ought to spend $400 million sealing the roads and getting rid of the dust, because half of the problem in Indigenous health is the state of the roads where they live. Sorry to interrupt you there, but you are right—you cannot have a strategy to reduce trachoma that includes just one or two of the phases. So what challenges does your department now have in trying to press ahead with what we know as the SAFE strategy?

Ms Podesta—I think I have just mentioned that one of the issues that we identified in that community, particularly in the last screening period, was that there appeared to be an interruption to supply of the antibiotics during that period.

Senator CROSSIN—Why was that?

Ms Podesta—It appeared to be a local issue with regard to their ordering. That is what we understand. As I have indicated, the training and the new guidelines will certainly address through public health units the need to have adequate supplies. Sorry—Professor Horvath, I cannot say the name of the antibiotic and I know that you can.

Prof. Horvath—Azithromycin.

Ms Podesta—Thank you, Professor Horvath.

Senator CROSSIN—I just like the fact that in the SAFE strategy the A is for antibiotic and the antibiotic also starts with A. I just keep calling it 'the antibiotic'.

Ms Podesta—I do that too.

Senator CROSSIN—We will be on the same wavelength if we do that.

Ms Podesta—But for purposes of accuracy I thought we would let the Chief Medical Officer make sure that he is providing that clinical guidance to us, as he does. But that is a critical part of the response. The new guidelines certainly indicate need for treatment for affected family members, so part of this will be to ensure that in this community but in all of them—Mulan gets a lot of attention for other reasons—it is part of the broader issue to do with trachoma eradication that the guidelines are understood and adhered to and that the supplies are in place so that, if there is a spike in cases, we know particularly for the under fives that all family contacts are treated simultaneously. We need a recognition in public health units that family contacts, particularly in Indigenous communities, are often not just mum and dad; there are extended family contacts. We know that, for example, in Mulan, and we are talking about 10 to 25 children in Mulan. It is a small community with a small number of kids. But they might have slept in three to four houses.

Senator CROSSIN—It is highly doable here. The figures in the Kimberley bulletin you would have read. They are not flash. At Lombardine the rate is 65 per cent. They are pretty chronic.

Ms Halton—The challenge—and this is a public health challenge—is: how do you put in place in a sustainable way all of the elements of that strategy because, at the end of the day, if you miss any one of those elements your numbers are going to go backwards in a major way. What we are really striving for here is a sustainable implementation of each of the elements of that strategy. If we can get that, we will get the numbers down and, what is more, we will keep them down. The simple reality is we are going to have episodic cases. We know that. But if we can get everyone tackling, from each of the perspectives of that strategy, those cases when we see them, then you will not have the escalation of the kind that you have outlined.

Ms Podesta—There is one other thing that I do want to put on the record, and that is that the public health unit does make a qualification over the prevalence rates there, and that is because of the availability of subjects for screening. Because it is a relatively small community, we understand that, of the 70 potential children in that community who could have been screened, only 31 were screened in 2005. Because the data is based on percentages, it is a bit hard to draw direct comparisons each year because the number of children actually screened is critical. That is part of the new guidelines and work that will take place to get accuracy. We gave you a very long answer about why the surveillance unit is so important, but that is part of it—to ensure that there is consistency so that if incident rates are being reported publicly they also reflect what percentage of the potential population was actually screened so that the incident rates can be consistently recorded. That is not to downplay the seriousness—not in the slightest. We are very committed to it. We are very conscious that, with a very small sample, incident rates seem to go up probably a bit more sharply than they actually do just because the screening size drops some years.

Senator CROSSIN—I understand that. It has been tackled in Third World countries. So there has to be an answer there.

Ms Podesta—We agree.

Senator CROSSIN—I don't know how many years I have been asking questions about it. I am pleased to see that there is some money being allocated towards it. Colleagues I talk to suggest that it is not enough.

Ms Podesta—I think the money is very important too, but the biggest breakthrough is getting the communicable disease network of Australia guidelines agreed to.

Senator CROSSIN—That has happened, hasn't it?

Ms Podesta—Yes, it has in the states and territories. I know Professor Horvath wants to comment on this too. We always talk about the Australian government's responsibility for this area—it is an area where we have a strong objective in public health terms; no question—but the actual day-to-day responsibility is the states and territories. The critical thing has been a support to the network to get agreement around concerted action.

Senator CROSSIN—So when were they actually agreed then? What timeline were we talking about last year?

Ms Podesta—They agreed at about the end of last year.

Prof. Horvath—I think that really is important. For the first time we have this peak body of people who are actually going to do the work to agree to a whole list of things like diagnosis, surveillance and these issues. It took a lot of negotiation between all sorts of parties to get this across the line, and now it is across the line. I think it was agreed in October or November.

Senator CROSSIN—How big are the guidelines? Are they pages long?

Ms Podesta—We will get you a copy. I think it is absolutely appropriate, Senator—you have played a very big role in making sure they exist. They are not quite at the point of publication.

Senator CROSSIN—I will actually read them if you send them to me.

Ms Podesta—We will just send you a copy.

Senator CROSSIN—Thank you. At the last round of estimates, I established that over $1 million was spent in eye health over the last three years. Are you expecting another underspend this financial year, and can you tell me what happened to that $1 million?

Ms Podesta—As I think we explained at the last hearing—Mr Thomann will give more details about this—we make a nominal allocation within the program for anticipated expenditure. I think there was a very extensive question taken on notice precisely about this issue since the last estimates to explain where there was a difference between anticipated expenditure and actual expenditure. What happens in OATSIH is that we do a mid-year review within the program to look at expenditure. I think there were a range of reasons. There was a delay in a tender for one aspect of it. There were a range of activities. If we believe that there will be a potential underspend against that nominal expenditure level, the funds are reallocated to other priorities within the program. We never not spend the money. The money

is always spent. I think you will see in our annual report that in most cases we are meeting or exceeding our performance indicators for what we anticipate will be spent through the outcome. Primarily, the money goes to other priorities identified through the framework agreement and the negotiator.

As you know, within each state and territory we have a forum for providers, the Aboriginal community controlled sector, the state government and ourselves. We identify the priorities for the expansion of the program, which has happened every year for a number of years. A purchasing plan is developed and signed off and contracts entered into are negotiated. There are sometimes delays because it is a sector where there is often a lot of negotiation. We then go to other priorities that were identified but not able to be met at that time and we commence negotiations et cetera. So the money is then spent on the next round of priorities at all times.

Senator CROSSIN—So basically you have a half-yearly review. If there is going to be an underspend in areas, you reallocate it. So by the end of the financial year you can account for or have spent all of your money?

Ms Podesta—Absolutely. We can account for, have spent or committed it. I say ‘committed’ because one of the things that happens within this outcome is that we have made a significant investment in capital works. As you know, we have opened a number of new clinics and we have enhanced and expanded a number. Those commitments go over one year, because of their nature. There has been a significant rephasing. I know we have had a lot of discussion previously about the rephasing, which is about meeting the capital works commitments through OATSIH.

Senator CROSSIN—Thank you for that. I have questions about Vision 2020. Which outcome are they in?

Ms Halton—They are in outcome 3.

Senator ADAMS—I have a quick question after listening to that debate. Has there been any evidence of eye disease or glaucoma in communities that have swimming pools and those that do not? Is there anything positive there?

Ms Podesta—Yes, there is. There are two things that I would comment on. There has been some research undertaken by the Western Australian health department about the health benefits of swimming pools in Indigenous communities. We have certainly taken note of that. But we are also independently seeking a tender at this point to do precisely that. There are a number of swimming pools being funded through SRAs. We are looking at a tender to identify some baseline data regarding a number of health conditions, which we will be monitoring, for eyes, skin and ears. We will also be monitoring social and emotional wellbeing.

Senator ADAMS—I was just going to say that it is amazing what a swimming pool can do—

Ms Podesta—There is a very significant issue around depression. There is also a feeling of optimism because of exercise.

Senator ADAMS—I am from Western Australia and I spend a lot of time in the Kimberley, so I certainly know the difference, especially in the Pilbara, swimming pools can make in everything.

Ms Podesta—The Indigenous representative on the Hearing Services Advisory Committee is Mr Daniel McCawley.

Senator CROSSIN—Do you know where he is from?

Ms Podesta—No.

Senator CROSSIN—You would think after seven years you would learn how to ask the right question, wouldn't you? They are not a person I know.

Ms Podesta—We are trained to answer what you ask us!

Senator CROSSIN—Ms Podesta, in closing, a colleague whom I went through university with some years ago has done an enormous amount of research on the benefit of swimming pools. Maybe I should put him in touch with your request for tender, because I think you will find that he has done the work already.

Ms Podesta—Absolutely.

Ms Halton—On a strictly no promises basis.

Senator CROSSIN—I understand that. He sent me quite a large document that he had compiled in relation to that work.

Ms McLaughlin—It is in my area, so he should contact me.

Ms Podesta—It is to be publicly advertised as a request for tender.

Senator CROSSIN—I will send him this transcript and leave it to him.

Ms Halton—Senator Humphries, on the assumption that somebody in Senator McLucas's general sphere is watching, she asked for the numbers and the location of homes that did not meet the fire requirement—four in New South Wales, three in western Australia and one in Victoria.

CHAIR—Thank you. I hope that is the extent of the information that Senator McLucas requires.

Ms Halton—I understand that to be the case.

CHAIR—We might talk to her about that later. I thank representatives of the department in outcome 7 for their time this evening.

Proceedings suspended from 6.36 pm to 7.42 pm

[7.42 pm]

CHAIR—We have finished outcome 7 and are ready to start on outcome 8, Private health. Before we do that, are there any answers to questions taken on notice earlier today which anyone wishes to provide at this point?

Ms Halton—Other than material that has been circulated, I think we are up to date.

CHAIR—Thank you for that. We start now on outcome 8.

Senator McLUCAS—I have a question for Ms Halton. The Parliamentary Library regularly gets requests for information, and the normal practice, I understand, has been for library staff to contact relevant officers in the department. I understand that has changed.

Ms Halton—Yes.

Senator McLUCAS—Could you explain why.

Ms Halton—A couple of particular officers in the Parliamentary Library have taken it upon themselves to ask questions, in some cases, of officers not qualified to answer those questions. In order that we can ensure that they get accurate information we have asked them to provide it centrally, and then we can make sure they get the right answer.

Senator McLUCAS—So all inquiries from the Parliamentary Library now have to go through your office?

Ms Halton—Yes.

Senator McLUCAS—You say that it is Parliamentary Library staff who have taken it upon themselves to ask certain staff in your department.

Ms Halton—Yes.

Senator McLUCAS—Isn't it the responsibility of that staff member, if they do not know the answer, to say, 'Please speak to my superior'?

Ms Halton—The reality is that there is a particular officer in the Parliamentary Library who has gone to very junior members of staff who do not necessarily understand that there may be a broader context in which the question should be answered. Indeed, the Parliamentary Library—as you are aware, I have no doubt—has issued papers that in fact were wrong on a couple of occasions. I think that has been the subject of questions here in the past. We believe it would be more helpful if they always get accurate information. That is done very quickly, very effectively, and the information is derived from the correct officer who can actually answer the question.

Senator McLUCAS—What delay do you think is occurring in terms of response from the department to the library?

Ms Halton—None. No delay.

Senator McLUCAS—You may not know this, or you may have discussed it with your colleagues at secretary level, but is yours the only department that has adopted this strategy?

Ms Halton—I have not discussed it with my colleagues. As far as I am concerned, it is an issue in relation to matters inside my portfolio. In order to ensure that anyone requesting information from the Parliamentary Library is not misled and to ensure that correct information is provided, that is what we have asked to happen.

Senator McLUCAS—Is there one central point in the Department of Health and Ageing for anyone from the Parliamentary Library to speak to?

Ms Halton—They can either talk to my office, or they can talk to the head of the Portfolio Strategies Division, whose job, in any event, is to coordinate everything from questions on

notice to what have you. I will give you two examples. We have regulatory functions and a policy function. For example, in relation to food and therapeutics, the regulatory function—FSANZ and the TGA—is in one place; the policy function is somewhere else. The policy answer on a question is often what is appropriate. It may be a technical delivery answer, in which case we make sure that the information provided is accurate.

Senator McLUCAS—Will you monitor relations with the Parliamentary Library to ensure that information flow is timely?

Ms Halton—Absolutely.

Senator McLUCAS—How do you intend to do that?

Ms Halton—I am aware of the requests that come in, and we are very conscious of providing information in a timely fashion. In fact, I personally ask the question about whether we provide the information and in what time frame.

Senator McLUCAS—To the library?

Ms Halton—No, of my staff.

Senator McLUCAS—In a general sense?

Ms Halton—No, on a specific, case-by-case basis.

Senator McLUCAS—How did you communicate that policy change to the library?

Ms Halton—I had a conversation with the head of the parliamentary department.

Senator McLUCAS—All right. Let us hope you continue the flow of information. Thank you.

Senator MOORE—My questions are about the monitoring of the higher rebate for older Australians, and the Private Health Insurance Administration Council. Are these the right people?

Ms Halton—Yes, they certainly are.

Senator MOORE—Has the department been monitoring the impact of the higher rebate for older Australians?

Ms Addison—Yes, we have.

Senator MOORE—What does the data show about the number of older Australians with private health insurance and the number of younger Australians with private health insurance? What is the key focus of the monitoring?

Ms Addison—The policy intent was retention. The higher rebates for older Australians were about retention of private health insurance by the people that were affected by, or benefited from, the higher rebate. We have been checking whether or not that has been effective in terms of the retention rates. What we have found over the quarter since it was introduced is that it seems to be effective in terms of those people retaining their membership.

Senator MOORE—How long has the monitoring been going on?

Ms Addison—The higher rebates for older Australians were introduced from 1 April last year.

Senator MOORE—So it is coming up to 12 months. What is the form of monitoring?

Ms Addison—We generally have estimates of what we think would have been the participation rate of the particular age groups affected by the rebate. We look at the number of people who hold health insurance in those particular age groups.

Senator MOORE—Is that kind of data then published?

Ms Addison—Yes, PHIAC publishes it. That is the information PHIAC makes available in its quarterly reports, yes.

Senator MOORE—So the data that you are analysing, or monitoring to see what is happening, is the same data that PHIAC publishes?

Ms Addison—Yes.

Senator MOORE—Exactly the same thing?

Ms Addison—Yes.

Senator MOORE—Has the department done a review, as was stated, or commissioned a review to be done of the PHIAC process?

Ms Addison—When the legislation was being debated in the House of Representatives, the minister indicated that a review would be undertaken within six to 12 months. In early December, I think it was, the minister approved the terms of reference for the review. We have subsequently sought submissions and those submissions close on 17 February.

Senator MOORE—Is that on your website?

Ms Addison—Yes, we also wrote to stakeholders.

Senator MOORE—Who is doing the review?

Ms Addison—It is an internal review; the department is conducting it.

Senator MOORE—That is within your own resources, in your area?

Ms Addison—That is correct.

Senator MOORE—Is the expectation that this is going to be a public review?

Ms Addison—We have certainly sought submissions from industry and various parties. Once we have received those—as I said, they are due on the 17th—and analysed them, we will provide advice to the minister. Then it will be a matter for the minister to decide.

Senator MOORE—Has there been any information about what the additional costs of the higher rebate for older Australians have been since it was introduced in April?

Ms Addison—No.

Senator MOORE—Will that be part of the review—whether there has been extra cost?

Ms Addison—The costs associated with the higher rebate would be reported through the budget processes.

Senator MOORE—If it came in last April, its first budget cycle probably would not have hit the one last time, so its budget cycle would be this one.

Ms Addison—That is correct.

Senator MOORE—So it will be an element in there. There is no information currently about the dollar cost of the 35 per cent rebate and the 40 per cent rebate?

Ms Addison—Not beyond the estimates that were published in the last budget.

Senator MOORE—You would be using those estimates as a benchmark?

Ms Addison—That is correct.

Senator MOORE—To see how it comes in?

Ms Addison—Yes, that is right.

Senator MOORE—Is there any concern about the sustainability of the current trends? You said earlier that we still have not got too much going, but has any trend emerged?

Ms Addison—We thought the higher rebates would assist retention, and the statistics in terms of the particular age groups bear out the fact that the higher rebates appear to be effective in assisting those people to retain their private health insurance.

Senator MOORE—So people are staying in the system?

Ms Addison—Yes.

Senator MOORE—That is being borne out?

Ms Addison—That would appear to be the case, yes. That is what the figures look like at the moment.

Senator MOORE—Is there still bleeding from the system? People are still leaving?

Ms Addison—The PHIAC numbers for December came out yesterday.

Senator MOORE—That is good. I have not read them.

Ms Addison—They show that the participation rate overall is stable. It was 43.1 per cent for December, as it was for the previous September and the previous June, so what we see is stability. After adjustment for population, we certainly see that the participation rate is stable.

Senator MOORE—It stays around that 40 per cent rate?

Ms Addison—It is 43.1 per cent, yes.

Senator MOORE—Basically, the review has started, you have submissions closing on the 17th, and then we will be able to go into more discussion about that in the next round of estimates. Would that be right?

Ms Addison—Yes.

Senator MOORE—Mrs Ginnane, you will be pleased to know that the brief actually talks about 'his' views!

Mrs Ginnane—The commissioner is a 'he'; I am chief executive officer.

Senator MOORE—Are you speaking on behalf of the commissioner, Mrs Ginnane?

Mrs Ginnane—Yes.

Senator MOORE—I want to ask about the views expressed in the annual report and about the remark that was made that funds are still too reliant on investment income. That is in the report; it is quoted. Why is that still the case?

Mrs Ginnane—The commissioner made that comment because last year, while health funds did report an operating surplus, two-thirds of the profits that they reported were from investment income, in what is a very good investment environment. The concern expressed was that, if that investment environment changed, there is not much of a difference in their underwriting margins to absorb.

Senator MOORE—So the line is very thin?

Mrs Ginnane—In terms of the costs, which we are still seeing going up, the commissioner also reported that there were ongoing cost increases as a result of price increases in some cases but also increases in utilisation. All of those feed into the underlying costs for health funds.

Senator MOORE—In the view of the commission, what level of membership growth is required to offset that, or is it more a question of utilising rates?

Mrs Ginnane—I am not sure I can answer that question. We have done no work on what rate would be sustainable.

Senator MOORE—There has been no analysis of that?

Mrs Ginnane—No.

Senator MOORE—In that same report, it mentioned that the increased utilisation seemed to be coming from hospitals rather than ancillaries.

Mrs Ginnane—Yes, that is correct.

Senator MOORE—Does the commission believe that the past issues concerning ancillaries and their contribution to the level of benefits paid have now subsided—because there was a bit expressed in previous years?

Mrs Ginnane—There is a difference in that the ancillary area is quite tightly controlled by health funds because it has dollar limits or percentage limits that members can claim in relation to particular services such as dental, optical et cetera; whereas hospital services are utilised on the basis of need, if you like. That is much harder for health funds to control—and rightly so. They do not control access. For example, often they will only find out that their member has made a claim when the hospital claim is submitted; whereas ancillary claims are very tightly controlled with those often dollar limits. So I think that is really why we are seeing more of the growth in the hospital area. The utilisation factor is coming out of the ageing of the population.

Senator MOORE—Is there increased utilisation both from the hospital visits and from the ancillary claims? Both those areas have grown?

Mrs Ginnane—We are seeing both of them growing, but the rate of growth within hospital appears to be higher.

Senator MOORE—That is relatively recently, isn't it? Until then, the ancillaries were growing?

Mrs Ginnane—I think I would have to take that question on notice and check that.

Senator MOORE—In terms of a trend, I think that in that last report there was a bit of a rebalancing. I know this is an issue that Senator Humphries is interested in as well—that is, the issue of prostheses, or prosthetic devices, as I prefer to call them. Does the commissioner believe that the changes to this area will have an impact? Is that built in, in terms of possible changes? We have had a lot of discussion through an inquiry on prosthetic devices.

Mrs Ginnane—I think the reforms are the responsibility of the department. We are tracking what will happen. The anecdotal evidence I have been given by a couple of health funds only is that they do believe that there has been some slowing in the rate of growth. We will not know that until our numbers indicate it, probably by the end of this financial year.

Senator MOORE—When did that reform come in?

Ms Addison—The legislation took effect around midnight, 31 October, so it really came into effect from 1 November with the new schedule, with the new prostheses list.

Senator MOORE—On past experience—this is an opinion, I know—how long does it take before things begin to show either way? That started in November. When will you expect data that will begin to show impact, if in fact there is any impact? Does it take 12 months before figures are solid?

Mrs Ginnane—I would anticipate that, if that pricing is coming through, it is coming through now and we would see it fairly quickly, perhaps even in the March quarter if there are significant variations. That March quarter data is not due to PHIAC until 28 April and would be published in our analysis about mid-May.

Senator MOORE—That would be the first bunch of figures that look at that change?

Mrs Ginnane—There might have been some change in the December quarter, but it was too hard to pick, I think.

CHAIR—The minister has to list particular prosthetic devices that the new policy applies to, doesn't he?

Ms Addison—The way the process works is that, yes, the minister has established a ministerial committee called the Prostheses and Devices Committee. It provides advice both on the listing of prostheses and on the benefits payable for those prostheses. We grandfathered from the old arrangements virtually all the items already existing on the list, unless the supplier removed them and did not apply for them to be relisted. They were grandfathered across onto the new list. The Prostheses and Devices Committee has already had a process of assessing certain groups of those items through clinical assessment processes, and the first round of benefit negotiations occurred with respect to those items plus the new items that came onto the list in November. Yes, the committee makes a recommendation to the minister and then that determines what goes onto the list.

CHAIR—How many new items were put on the list in November, approximately?

Ms Addison—Around 600. We get around 500 to 600 applications. We do two lists a year. We plan to continue that process, which was the arrangement under the old list, and we would generally get between 500 and 600 applications for new items each round.

Senator MOORE—Has any work been done in PHIAC about the possible impact of the sale of players such as Medibank Private?

Mrs Ginnane—No, it is not an issue for PHIAC.

Senator MOORE—I think this morning we asked a question to Medibank Private about whether there had been any consideration of sale, and they said 'No' as well, so there is consistency. Has the use of actuarial advice affected the nature and quality of information coming from funds requesting premium increases?

Mrs Ginnane—PHIAC required the original involvement of actuaries with the department about three years ago.

Senator MOORE—It is that long now?

Mrs Ginnane—Yes, for that long. Certainly, from PHIAC's perspective, we believe that the quality of the data coming to us has improved, which makes the provision of advice to the department easier.

Senator MOORE—Apart from the actual data that comes through, which of course you analyse, is there any kind of process of discussion with the players? Anecdotally, do the players themselves tell you that that introduction of the actuarial requirement has meant any change for them?

Mrs Ginnane—I would broaden the answer slightly, in that PHIAC also requires, from last year, a financial condition report. The feedback that we have been receiving from the industry is that they have found that process very useful in making sure that they fully understand what their cost drivers are.

Senator MOORE—Their feedback has been particularly about the second change as opposed to the—

Mrs Ginnane—I think it is probably a combination of both, because the actuarial advice has been increasing within health funds over the last few years.

Senator MOORE—And that works together?

Mrs Ginnane—Yes.

Senator MOORE—On the issue of the funds' own actuaries, is there some sort of oversight process of their appointment and/or the quality control by PHIAC?

Mrs Ginnane—Not by PHIAC, but there are significant controls within the Institute of Actuaries around their own professional standards.

Senator MOORE—So that is as a professional body?

Mrs Ginnane—Yes.

Senator MOORE—That would all be public, wouldn't it, in terms of their status?

Mrs Ginnane—Certainly, it is a public organisation. I am not sure exactly how they go about publicising their peer review process, but they have a very public disciplinary process—in fact, it was invoked in relation to HIH.

Senator MOORE—They also have qualification requirements and so on, don't they?

Mrs Ginnane—Yes, they do.

Senator MOORE—It is like there is self-regulation.

Mrs Ginnane—Yes.

Senator MOORE—But there is no role for PHIAC in that.

Mrs Ginnane—PHIAC has not taken a role because we have been satisfied with the quality of the advice we have received. I think if we found that we were not satisfied, it would be appropriate for us to take more of a role.

Senator MOORE—You could do that?

Mrs Ginnane—We certainly could.

Senator MOORE—Within the operations you have, that could be something within your ambit?

Mrs Ginnane—Yes.

Senator MOORE—What is the status of the review of the reinsurance scheme?

Ms Addison—We commissioned some work to be undertaken following government deferral of the reinsurance reforms last year. That report came in before Christmas and it is currently under consideration.

Senator MOORE—Who is considering that?

Ms Addison—It is with the department at the moment. We will eventually put together advice to the minister.

Senator MOORE—So it is at the departmental consideration stage prior to going to the minister?

Ms Addison—That is correct.

Senator MOORE—When was that commissioned?

Ms Addison—On 24 September.

Senator MOORE—That is from the department. Does PHIAC have a role in that?

Mrs Ginnane—We have provided information to the department on the outcomes of some of the models that have been considered.

Senator MOORE—So you are more a contributor to the review?

Mrs Ginnane—Yes, we are heavily involved. As we administer it when it is finished, the department needs to be certain that we can adequately do that.

Ms Addison—A member of PHIAC was on the tender assessment panel as well.

Senator MOORE—There was no expectation that PHIAC would do the review?

Mrs Ginnane—No.

Senator MOORE—So it is a departmental review?

Mrs Ginnane—It is a policy decision, not a practical implementation matter, which is what we do.

Senator MOORE—I am trying to find out whether PHIAC is commissioning work or undertaking its own work in the area of review.

Mrs Ginnane—We will be reviewing the prudential standards this year. We gave a commitment when the new prudential standards were put in place in 2001 that they would be reviewed, and we will be doing that over the next 12 months. It will probably take 12 months and will involve industry consultation as well as some quite definite modelling work, to be sure that the prudential standards we come up with are appropriate.

Senator MOORE—There was a commitment that PHIAC was going to do that?

Mrs Ginnane—That was a commitment that PHIAC gave when the standards come in.

Senator MOORE—As they were introduced, the expectation was that you would be the reviewing body?

Mrs Ginnane—Yes, but we will probably subcontract some of that work.

Senator MOORE—Have you done reviews in the past? Has that been part of your organisation's job?

Mrs Ginnane—In some areas, yes. In other areas, we work closely with the department. Where it is a mechanical issue—the way in which we collect the statistics, for example—that is an internal PHIAC matter, but where it involves policy on health insurance it is a departmental decision and we work very closely with the department in dealing with those issues.

Senator MOORE—The two arms would cross over regularly, wouldn't they?

Mrs Ginnane—They do, and we have a constant working relationship.

Senator MOORE—In the industry it would be hard to see where much would fall exclusively in one box or another.

Mrs Ginnane—Yes.

Senator MOORE—Is that the department's view as well?

Ms Addison—As we have highlighted, the department clearly has the policy responsibility in providing the advice to the minister as to the framework in which reinsurance takes place. That clearly is our role, and we take responsibility for that. PHIAC, as Ms Ginnane has said, has responsibility for implementation and monitoring, and that is where the line is drawn. To the extent that policy might need to be evolved, yes, those two roles work in tandem. Because of the actuarial impact, we need to be very conscious of that. The clear distinction is around the policy versus the implementation of the policy.

Senator MOORE—To whom does PHIAC report?

Mrs Ginnane—To the Minister for Health and Ageing.

Senator MOORE—So your agency's line is directly to the minister?

Mrs Ginnane—Yes.

Senator MOORE—Your manner of review at the moment is the standards you mentioned. Are there any other ongoing reviews that your organisation owns?

Mrs Ginnane—No, not specifically.

Senator MOORE—Are there many reviews operating at the moment in your area of the department?

Ms Addison—We have a number, yes.

Senator MOORE—Which ones are they?

Ms Addison—We commissioned some work last year from Access Economics and we also commissioned some work from the Allen Consulting Group. The Access Economics work was in relation to developing a policy model—an economic model—and the Allen Consulting Group was commissioned to undertake a review of second-tier and default benefits and the gap cover arrangements.

Senator MOORE—The one that we talked about before, which is closing on 17 February, is internal.

Ms Addison—That is correct.

Senator MOORE—You have not needed consultants at any level for that one.

Ms Addison—No.

Senator MOORE—The only external ones are the three you have mentioned.

Ms Addison—Yes—Allen Consulting, Access Economics and Ernst and Young for the reinsurance review.

Senator MOORE—Internally, would review be part of your normal workload?

Ms Addison—Where the minister has requirements for report-backs to government, to the cabinet et cetera, yes.

Senator MOORE—But in terms of specific responsibility for reviews, apart from the one that you are doing at the moment, are there any other formal reviews that the department is conducting in this area?

Ms Addison—Other than the ones I have mentioned?

Senator MOORE—Yes.

Ms Addison—No.

Senator MOORE—I think that is it, Chair.

CHAIR—Senator McLucas?

Senator McLUCAS—I do not have anything more on outcome 8.

CHAIR—Any further questions, Senator Moore?

Senator MOORE—No.

CHAIR—We might have dispensed with outcome 8 in that case. Thank you very much indeed.

CHAIR—That leads to outcome 10—acute care.

Senator McLUCAS—I understand that there was a campaign to increase organ donations.

Ms Cass—That is right.

Senator McLUCAS—Can you give us some details of that, Ms Cass.

Ms Cass—A national mail-out to all Australian households was conducted last year, from April to June 2005, encouraging Australians to register on the Australian Organ Donor Register.

Senator McLUCAS—How effective was that?

Ms Cass—As at the end of January 2006, 724,000 people have been added to the register.

Senator McLUCAS—Up from?

Ms Cass—From 4.8 million.

Senator McLUCAS—Sorry, I do not think you understood my question. I said up from what prior to the campaign?

Ms Cass—From 4.8 million.

Senator McLUCAS—So 4.8 million people—

Ms Cass—Is the base figure, with 724,000 new registrants.

Senator McLUCAS—What are the figures on actual organ donation?

Ms Cass—The 2005 figures show that 204 deceased organ donors provided organs to 735 recipients.

Senator McLUCAS—And in 2004?

Ms Cass—There were 218 deceased donors providing organs to 789 solid organ recipients.

Senator McLUCAS—It is a slight drop—it is not huge, but has any analysis been done of that?

Ms Cass—There are analyses done. We have analyses of organ donation tracking back to 1999 and before. There are fluctuations around the 200 level. They seem to be related to community awareness campaigns. The Transplant Games in Australia, which are biennial, seem to bring a peak in organ donations.

Senator McLUCAS—Maybe we should make them annual—a funding opportunity for the Department of Health and Ageing. Why was it considered that a mail-out was the appropriate form of publicity for the organ donation program?

Ms Cass—The national mail-out coincided with a change in policy by all Australian governments to change registration on the register from an intent based registration to a consent based registration. The effect is that it is a more explicit legally valid form of consent which is intended to reduce the amount of family objections to donation.

Senator McLUCAS—Do the people who were previously on the register have to be reregistered as consent based?

Ms Cass—No, they do not; they remain on the register.

Senator McLUCAS—What is the circumstance, then, if you registered prior to the change in position?

Ms Cass—They have the status of indicating their intent to be a donor. The practice, which is implemented by the organ donor coordination agencies—which are state run agencies—is that there is probably more intensive seeking of explicit consent from families for those people who are intent registrants rather than consent registrants. I think they ensure that families are comfortable with the decision, regardless.

Senator McLUCAS—Was the decision to do a mail-out, as opposed to a range of other activities, tested prior to making the decision?

Ms Cass—The mail-out was one of several strategies that are in train. It was a way of reaching all Australian households in a concentrated period of time. In addition to that, work is being done through Australians Donate, the peak body of the organ and tissue donation sector, which also runs community awareness campaigns as well as other projects. For example, we are about to enter Australian Organ Donor Awareness Week. There are regular campaigns which are run, in addition to the one-off mail-out last year.

Senator McLUCAS—Ms Cass, you said you have figures going back to 1999. What are the numbers of people who have donated from 1999 through to now?

Ms Cass—In 1999, 164 deceased donors; 2000, 196; 2001, 185; 2002, 206; 2003, 179; 2004, 218; 2005, 204.

Senator McLUCAS—Thank you very much for that. In the PBS it says:

> ... the Government is undertaking a number of measures to ensure that the radiotherapy workforce increases in line with the increase in facilities.

I want to get an understanding of the sorts of measures that are going to be undertaken to achieve that goal.

Mr Coburn—There are a few elements to these activities. The primary activities are increasing the number of radiation therapy trainees in universities. Some of these increases in places were funded under the 2002 Better Treatment for Cancer Patients measure. There were about 150 students funded under that measure. The first of those graduated last year and are entering the workforce this year, I believe. Additional places were being funded under the Strengthening Cancer Care measure. That funding is in the DEST portfolio, but I mention it because both sets of arrangements are also being supported by other work to assist the sector to take on new graduates from universities, such as providing funding assistance for the sector to employ new graduates in their professional development years, which is a kind of internship.

The final thing to mention in this regard is that some places are being funded for training of radiation oncology medical physicists. They have another role in radiotherapy in that they are responsible for radiation safety and the safe operation of equipment. Their training is part academic. The formal training is a masters of medical physics and part of the training is on the job. We are providing funding as support for salary costs of employing those trainees.

Senator McLUCAS—Let us work backwards. How many of those medical physicists is the department supporting in the way you have described?

Mr Coburn—We are aiming to have a first cohort of up to 10 medical physicists commencing this year. We are in the process of entering into agreements with various

radiotherapy services and government authorities to provide that funding. We expect to fill all those 10 places. We have similar funding for starting next year and the year after.

Senator McLUCAS—Are the interns more technical people? Am I right to think that?

Mr Coburn—There are two components of the radiotherapy workforce. The internships are for radiation therapists, which are to a radiation oncologist rather like a radiographer is to a radiologist. They undertake, under the supervision of the radiation oncologist, planning of how an individual's cancer treatment will proceed and then they take the patient through most of the treatment on the radiotherapy equipment.

Senator McLUCAS—How many interns are part of the program?

Mr Coburn—There are 49 this year.

Senator McLUCAS—You said there are 150 university places.

Mr Coburn—That was over three successive years, adding up to about that number. This is just for the first set of graduates.

Senator McLUCAS—You did say—perhaps you were a bit silly!—that you have them by state. Do you have those places for the three elements of the program by state?

Mr Coburn—Not by state as such, no. We can take that on notice.

Senator McLUCAS—If you could provide it, that would be terrific.

Mr Coburn—I will just confirm that my mental arithmetic is correct.

Senator McLUCAS—I am sure it was. Thanks for that. The next issue is access by people who have a health care card to MRIs. The PBS says, referring to MRIs:

All providers of the additional Medicare-funded services announced in early 2005 have committed to ensure that there are no out-of-pocket costs for pensioners and healthcare cardholders;

Is the department aware that in Queensland the company Queensland Diagnostic Imaging advised that from 1 January this year it will no longer bulk-bill people who are on the Commonwealth seniors health care card?

Mr Woodley—I was not aware of that. If that company was providing services through MRI machines that were licensed under the 2004 arrangement, my understanding is that would be in breach of those arrangements. However, there are MRI machines with licences under about four different arrangements, so in this particular case we may be speaking of an arrangement other than the 2004 ITA process.

Senator McLUCAS—In the PBS it says that people have the right to bill Medicare for those MRIs. It says they have 'committed to', but was there a formal agreement?

Mr Woodley—Yes, it was a condition of funding.

Senator McLUCAS—And it includes all health card holders?

Mr Woodley—That is the case.

Senator McLUCAS—Including the Commonwealth seniors health care card?

Mr Woodley—Yes, it does.

Senator McLUCAS—I have been advised as well, but if there were the case, what action could the department take against a company that breached that agreement?

Mr Woodley—This may be a hypothetical situation.

Senator McLUCAS—Yes.

Mr Woodley—We do not know the circumstances of this company and the arrangements by which they provide MRI services. However, if it were under one of the 2004 ITA process arrangements, we would seek legal advice within the department in the first instance and take appropriate action.

Senator McLUCAS—Mr Woodley, you said there are four different types of arrangements for MRI. Could you quickly sketch those for me?

Mr Woodley—A number of units became eligible in 1998. Those providers who had an operational unit at a particular date became eligible. There was a 2004 ITA process. The government has committed funding to a number of other units as part of election commitments. The other ITA process was 2001-02.

Senator McLUCAS—So really only those announced in 2004 have the requirement that they bulk-bill health care card holders?

Mr Davies—Those announced in 2005. The process struggled at the year end, so it was in January or February 2005.

Mr Maskell-Knight—I might add to an earlier answer: in the 2001-02 process I think there were seven or eight machines granted licences as a result of that, and my recollection is that for the majority of those machines commitments were made that either they were going to bulk-bill cardholders or they were not going to charge cardholders more than a certain amount.

Senator McLUCAS—How does the consumer know which MRI to line up with?

Mr Woodley—It would be the responsibility of the provider to inform patients, as they were referred, of what their charging arrangements were.

Senator McLUCAS—But you have to know that there is an issue there before you can ask the question. I am just unsure how a consumer would know. If a specialist directs you to have an MRI and someone says, 'That will be $500,' you just pay it.

Ms Halton—In a sense, this is a common issue. Informed financial consent is an important part of medical treatment. We have talked to the profession and we encourage the profession to make sure that people are aware of charges. Indeed, we actually ask consumers to ask those questions as well. Whether or not people are very good at asking those questions—for example, before they get a referral—I am not sure about, but the reality is that this is a feature of the system in total. You may well be referred to a specialist for a particular treatment. Some people ask the doctor who is referring them what they are aware of in terms of their charging, but I suspect most do not.

Senator McLUCAS—I think you are right, but it is interesting that if you are a cardholder it is the luck of the draw if you happen to turn up at one that has signed the agreement with

the government. You would not know that you have been lucky, and if you went to one that had not signed an agreement you would not know that you had been unlucky, really.

Ms Halton—It is a bit like the reforms we have had of private hospitals. We have talked a lot in recent years about people actually making the inquiry. As I say, I cannot be confident that the number of patients who do that is very high, but we do remind people and, indeed, we do tell doctors that they should be disclosing their charging.

Mr Woodley—I have just been informed, too, that the charging policies of those units approved in the 2004 process are available on our website.

Senator McLUCAS—For those ones who have the commitment to bulk-bill?

Mr Woodley—Yes, to bulk-bill seniors card holders.

Senator McLUCAS—I think if you need an MRI you are not going to go looking on your website, I am sorry. Going back to this hypothetical situation where a company that has a 2004-05 MRI decides not to bulk-bill one group of health care card holders, you said you would be seeking some legal advice.

Mr Woodley—Yes. If there were evidence of a breach of a contract of any nature with the department, it would be so investigated.

Senator McLUCAS—And what could happen after that? Are the penalties clear in the agreement?

Mr Woodley—I am not sure that the contract actually specifies penalties.

Senator McLUCAS—It just says 'you will'?

Mr Woodley—Yes. It is a clear undertaking that that was a condition of funding.

Ms Halton—Essentially, obviously, we are looking to enforce the conditions of any contract.

In the event that, on discussion of the matter with the provider, they were recalcitrant or reluctant to change their practice, we would be looking to a legal remedy and we would take advice about the appropriate legal remedy. But these are licences issued on a clear understanding of the behaviour and, if they are not now offering the service consistent with that contract, we would be looking to enforce the requirements of that contract.

Senator McLUCAS—We will watch that to see what happens. That is all I have on outcome 10.

CHAIR—I thank the witnesses.

Ms Halton—What would you like to do first in outcome 1?

Senator McLUCAS—I have questions about obesity. The Building a Healthy, Active Australia package is the issue I want to talk about first. Can you tell me how much money has been allocated from the grant program to help schools, families and children develop healthy eating practices? I might rephrase that question. The whole program, I understand, is $15 million.

Mr Stuart—Yes.

Senator McLUCAS—Can you break that down for me into the component parts?

Mr Stuart—Can I inform you about the first question first and Jennifer can find the answer to the second one. When we did the annual report in 30 June 2005, we had a total of 2,492 applications that had been received. That has now gone up to 6,382 applications, so it has more than doubled in that time with an increase of 3,890 applications. Turning to the money, there has been a total of $6 million in grants paid. There are, of course, other grants that we have received applications for still in process—that is, of the $14.2 million available for the schools grants program.

Senator McLUCAS—Of the 6,382 applications, were they all successful applications?

Mr Stuart—Yes, they are.

Senator McLUCAS—And the $6 million is $1,500 times 6,382.

Mr Stuart—There are two factors there: one is that not all of the funds have yet been paid in respect of the grants approved, so the sum does not exactly add up. Also there were some requests for funding which were not for the full $1,500, so for that reason it does not entirely add up.

Senator McLUCAS—Who can apply?

Mr Stuart—All government and non-government schools at primary and secondary school level were sent an application pack.

Ms Halton—It did not have to be the school. For example, if the P&C wanted to apply in a particular case, that was fine.

Senator McLUCAS—You could not get double-dipping, though.

Ms Halton—No.

Mr Stuart—And an organisation affiliated with the school.

Senator McLUCAS—But basically it is one pot of money per school in Australia.

Mr Stuart—That is right.

Senator McLUCAS—How many schools do we have in Australia?

Mr Stuart—We originally sent out 9,000 kits for application.

Senator McLUCAS—Do you expect the other 3,000-odd to trickle in over time?

Mr Stuart—Some of them may. We have undertaken a range of activities to send reminders and they have obviously resulted in a doubling of the take-up since we last spoke, but I do not think it is realistic to think that every school that is given an opportunity will, in the end, apply for the money.

Senator McLUCAS—What does the school have to tell you they are going to do with the money?

Mr Stuart—We have a very simplified application form which just flows one way. They send us a plan about what they are going to do and we provide them with the funding. There are some very simple guidelines in the information pack about what we are looking for. I do not have that with me now, but perhaps Jennifer does.

Ms McDonald—The examples provided in the information pack include healthy school canteen menus, cooking classes, lunch box guidelines, breakfast programs, curriculum resources and vegetable gardens.

Senator McLUCAS—Have you done any analysis of what sorts of options schools have taken?

Mr Stuart—Yes, we have. About half of the grants so far have been related to school canteen activities. These percentages do not sum to 100, because obviously you can do something in the canteen and in the curriculum as well. About half are school canteen activities; about 58 per cent have done something classroom based; 22 per cent are breakfast programs; 19 per cent are vegetable gardens; and there are some other bits and pieces—special events and other things as well.

Senator McLUCAS—What sorts of things are schools doing in their canteens? One of the best things would be to sell the pie machine, wouldn't it, to make money out of it?

Mr Stuart—They are displaying menus—things to encourage healthy eating by the kids in the canteen. There is some synergy here with other programs and jurisdictions which have particular canteen programs and the schools are making programs work effectively together by so doing.

Senator McLUCAS—Have you seen the Queensland government's proposal?

Mr Stuart—Yes.

Senator McLUCAS—That has some merit. How will you evaluate this $6 million, Mr Stuart?

Mr Stuart—There will be an evaluation of the success of the program towards the end of the program.

Senator McLUCAS—How do you intend to do that?

Mr Stuart—We will let a consultancy do that.

Senator McLUCAS—What will you be asking the consultancy to evaluate?

Mr Stuart—I imagine, given that we have not done this yet, that we would generally look at issues of administration and what we have learnt about administration, and what we can glean about effectiveness.

Senator McLUCAS—The objective is to promote healthy eating.

Mr Stuart—That is right.

Senator McLUCAS—Are you going to test whether there has been any behavioural change?

Mr Stuart—That is very difficult, but we can certainly test what has been done with the money and whether that has had an impact. Actually testing behavioural changes is a difficult thing, but we can look at what is happening in canteens, what has happened in curricula, whether there are now sustainable breakfast programs in place and things of that kind.

Senator McLUCAS—You would have to have baseline data to compare that with, wouldn't you?

Mr Stuart—Not necessarily; not for an implementation review.

Senator McLUCAS—So it is a review of the implementation rather than of the impact of this program on obesity?

Mr Stuart—That is right. Looking at impact is more something that you do in a much broader-brush surveillance system—for instance, the kind of nutrition and physical activity survey that we are now embarking on where you look at the whole population to see whether there are any differences over time in diet, activity and obesity levels. It is very difficult to isolate a group of children losing weight with a particular intervention in a particular place. You want to ask that question more broadly across a range of interventions.

Ms Halton—You have raised, quite rightly, the work that the Queensland state government has done and you would be aware that New South Wales has done quite a bit of work—

Senator McLUCAS—No.

Ms Halton—They have. We have just had a meeting with the Obesity Taskforce where we have canvassed a number of these issues. The way I think of this particular program is that it is part of a number of efforts that are being made to raise awareness, to change some things in respect of school cultures, to look at what actually goes on in schools and, over time and incrementally, to make a change. Can you actually take this particular microprogram and say, 'We had this enormous effect'? The answer is going to be no.

But as to the broad environment in which children find themselves, my younger son's primary school was a recipient of one of these grants. He did come home—and not that he knows what I do at work every day—and very proudly told me about all the things that they were doing. Raising awareness is part of the broad range of things that we are trying to do, including our ad—you know, the red chair—to encourage a change in behaviour.

Senator McLUCAS—If you make a decision to spend $6 million, which is a lot of money, though perhaps not in the entire budgetary scheme of things, to say, 'Right, we're going to paint some tuckshops'—I am not being negative, but all these things happen in little ways all over Australia—how do you know that it would not have been better to, say, put that $6 million into one community and really make it work in that community? How do you make that sort of decision? How do you know that the incremental change has occurred?

Ms Halton—That is a completely fair question. In this area, as Mr Stuart says, there are attitudes and behaviours. In order to promote the change that we are trying to evoke, particularly in relation to obesity, which is a very difficult problem to tackle, we have adopted a range of strategies. Some are community based, focusing intensively on work in particular communities as particular sites to investigate a series of things, and some are across the Australian community more broadly. It is absolutely fair to say that parents and the community broadly are worried about childhood obesity. I think if we had just chosen a very heavy focus on a couple of particular communities, we would have been rightly criticised as not attempting to address that question more broadly. So we have struck a balance, and the government chose to strike a balance between intensive work in a couple of places and a broad approach across the community. That is what you are seeing. If you think about it, when we started looking at this issue, we took extensive advice from the experts in the field. The

Obesity Taskforce and all states and territories have been very engaged in tapping into the best expertise. That was consistent with the advice that we received.

Senator McLUCAS—So a school gets their $1,500. Is it just sent to them in the mail?

Ms Halton—They have to tell us what they are going to do with it—we have to agree that that is what they will do.

Senator McLUCAS—They put in their application, describe what they are going to do—

Ms Halton—We send them the money and they have to come back to us and say they have spent it.

Senator McLUCAS—There is an acquittal process?

Ms Halton—Yes, there has to be an acquittal process. Government money has to be acquitted.

Senator McLUCAS—There will be a financial acquittal, but is there also a process by which they describe what they feel has been achieved rather than, 'Yes, we spent it on painting the tuckshop and making some nice signs'?

Ms Halton—I do not think we would be necessarily painting tuckshops.

Senator McLUCAS—They have to look healthy.

Ms Halton—I suppose.

Senator McLUCAS—Some of them are pretty daggy.

Mr Stuart—They do provide us with an acquittal and they do have to tell us what they have done with the money. As you would understand, with up to 9,000 schools it is not a process that we wanted to over-engineer.

Senator McLUCAS—I understand. That is $6 million worth out of the total of $15 million.

Mr Stuart—That is spent so far. There is more already in the pipeline from the recent applications that we have had. We are also looking at options now to spend the balance of the funds.

Senator McLUCAS—You have not identified the program from here on?

Mr Stuart—No. There will be further advice about the specifics of that, but the government has agreed to take the remaining available funding into next financial year so that the $15 million can be fully spent.

Senator McLUCAS—That was only for one year originally?

Mr Stuart—I believe it was over two financial years. There is a remaining tail of funding and that will be available now into the third financial year.

Senator McLUCAS—I noticed an advertisement in the paper regarding the national children's nutrition and physical activity survey. Has the tender been let?

Mr Stuart—No, not strictly. The advertisement that you saw probably would have related to an expression of interest process. We have chosen to go with a two-step process—firstly, an expression of interest to see what kind of capacity and interest there is in the marketplace and,

secondly, a tender. We have now received a number of responses to the expression of interest and we have evaluated those. We have met with the technical reference group of experts that has been appointed to help us with that task and we are close to now going back to the people who have put in good expressions of interest to ask them to tender. A tender is going to take a lot more work and thought from those who put in the expressions of interest. It is a way of surveying the market and then going back to those with the capacity to provide.

Senator McLUCAS—What is the intent of the survey? What are you hoping to achieve?

Mr Stuart—It is a long-term monitoring tool—a surveillance activity rather than a piece of one-off research. In Australia we have had two previous nutrition surveys, the last of those in 1996. Since then quite a lot has changed in terms of body weight and shape, nutrition and diet and the patterns of physical activity. We see this element as the first part of a new ongoing nutrition and physical activity monitoring system, covering children and adults in Australia. The first wave is focusing on children.

Senator McLUCAS—Isn’t there a longitudinal study on children as well?

Ms Halton—Not in this portfolio.

Senator McLUCAS—It is in FaCS?

Ms Halton—I think so, but it does not include this kind of data. We have been very keen to get another survey and then to get ongoing data, because for us to be able to monitor what is going on in the population is incredibly important, so we are very pleased with this initiative.

Senator McLUCAS—What is the budget for this work?

Mr Stuart—The budget for this phase is $3 million. The government has, however, made $1 million available ongoing from the health portfolio to form the basis for the ongoing work.

Senator McLUCAS—That will be?

Mr Stuart—Every year.

Senator McLUCAS—So it turns into a longitudinal study anyway.

Ms Halton—Yes, that is right. Essentially, we will be able to get a solid baseline and then keep going and monitor what is going on in the population.

Senator McLUCAS—I understand that the Australian Food and Grocery Council has contributed $1 million to the project as well.

Ms Halton—Yes.

Senator McLUCAS—What do they get for their $1 million? Do they sit on a board with you? What is their involvement in the project?

Mr Stuart—Their contribution of $1 million is, I think, illustrative of their interest and the industry’s interest in this area. There is a whole industry responsibility agenda being run through the Food and Grocery Council, and I think this is really a contribution to a public good from them. They have contributed $1 million and the Department of Agriculture, Fisheries and Forestry has contributed $1 million, both one-off, to help us kick-start the children’s wave of the survey.

Senator McLUCAS—But then Health will continue their—

Mr Stuart—Health will continue. We are discussing with states and territories the prospect of state and territory governments partnering us on this in the long term.

Senator McLUCAS—But the question was: do they sit on a board? Do they have an ongoing involvement with the project at all?

Mr Stuart—There is not a board. There is a sort of managing committee that I chair and a representative of the AFGC and a representative of DAFF join me on that committee. There is, in addition, a technical reference group that also advises the department about science and stats. Essentially, the decision making is through the Department of Health and Ageing, and I am the delegate for that.

Senator McLUCAS—When do you expect the tender to be let so that the process can start?

Mr Stuart—We are days or weeks away from that; we are checking the draft now. It will not be a public letting of a tender; it will go back to those who put in expressions of interest.

Senator McLUCAS—Are you looking for a particular group of people?

Mr Stuart—We are looking for the very best group of people who have expertise in nutrition and physical activity and have the wherewithal and the logistics to manage a large survey.

Ms Halton—And provide value for money.

Mr Stuart—Yes.

Senator McLUCAS—Thank you for that. That is interesting work. On the DOHA website there are some pages associated with nutrition and healthy eating. Is there a reason why they have not been updated since December 2003?

Mr Stuart—I am sorry, it is a bit hard to answer your question. I am aware of quite a lot of new material that has gone onto the website over the last year.

Ms Halton—If it is the particular bit I am thinking of, I am not sure that there is a need to update that material. But, without seeing what it is you are looking at—

Senator McLUCAS—You may like to comment after you have gone back and looked at them. The pages are Nutrition and healthy eating, Promoting healthy weight and Promoting healthy weight about our work.

Ms Halton—Yes, we will look at it.

Senator McLUCAS—I want to move to Cancer Australia now.

Ms Halton—This is not this program; cancer Australia is program 9. Those representatives were here this morning. What do you want to know? If it is in the generality—in fact, even if it is in the specific—I might be able to respond, or would you rather put it on notice?

Senator McLUCAS—I will put it on notice. It is administrative. Would national bowel cancer screening also be in program 9?

Mr Stuart—No, that is in this program.

Senator McLUCAS—I understand that funding was included in the 2005-06 budget for the National Bowel Cancer Screening Program, but the commencement of the program has been delayed. Is that correct?

Mr Stuart—The budget announcement was in 2005-06. At that time, the commencement was set for 1 May this year, and that is what we are working to.

Senator McLUCAS—What will happen when the new money provided in the budget kicks in? What happens on the ground?

Mr Stuart—Invitations are sent to people in the selected age group. They receive an envelope containing a letter of invitation and a kit.

Senator McLUCAS—That is too much information.

Ms Halton—I think we have had this conversation before. You don't want to go there!

Senator McLUCAS—I think we have. It is an FOBT—let's move on!

Mr Stuart—It is an FOBT in the mail, Senator!

Senator McLUCAS—When the FOBT is positive—God help us!—what happens?

Mr Stuart—If the FOBT proves positive, the client and the client's nominated GP are sent the results. The next step is that the client is urged to go and see their GP.

Senator McLUCAS—Is that the extent of the Commonwealth's national screening program?

Mr Stuart—No. The program really depends on a central register, which will continue to collect information about the client on an ongoing basis and follow them up through time to make sure that there is no dropping of the ball on the transition of the client, should cancer be detected, between different stages in the process.

Senator McLUCAS—If an individual has a positive FOBT, they go to their doctor. The doctor would usually prescribe a colonoscopy.

Mr Stuart—They would make a referral.

Senator McLUCAS—Yes, you are right. If the person does not have private health insurance, what happens?

Mr Stuart—There are two options for the GP: one is referral to a private practice and the other is referral to a public hospital.

Senator McLUCAS—And potentially some delay if the person is referred to a public hospital?

Mr Stuart—That depends on the particular circumstances in the area.

Senator McLUCAS—Because the FOBT will just detect blood. It will not go further than that; that is all it tells you.

Mr Stuart—Yes.

Senator McLUCAS—But it will indicate that something needs to happen quite quickly.

Ms Halton—It needs to be followed up.

Mr Stuart—It is an indicator.

Senator McLUCAS—There has been some criticism of the program because it stops at the FOBT rather than funding the next stage. I do not know if you have seen an issue of the *Medical Observer* from late last year, where Professor Young expressed some concern that people who were not privately insured would potentially not be able to get a colonoscopy. He raised the question of whether or not it, in fact, can be called a 'national screening program'.

Mr Stuart—We have a number of screening programs in which we partner with states and territories. In this program, we are seeking to partner with states and territories on the provision and quality of colonoscopy services and we are involved in discussions with them about that. The current pattern is that about 70 per cent of all colonoscopies conducted in Australia are done in the private sector and 30 per cent in the public sector. Under the program, colonoscopies which occur in the private sector would be funded through the MBS in the usual way. We are inviting states and territories to partner with us on the proportion which occurs in the public sector. They have quite a strong vested interest in reductions in bowel cancer in the states and territories because all of the downstream health costs are really in the public hospital system.

Senator McLUCAS—Going back to the FOBT, if a person does not nominate a GP, what happens then?

Ms Smith—We strongly encourage participants to nominate a GP, but they are not required to. The reason we have done it that way is that, in the pilot, when we insisted that they put those details on the form, some people who did not have a regular GP were nominating someone who was not their regular health care provider and that person was getting results about someone that they had no idea about. The clinicians who are advising us on the roll-out of the program felt that, in this phase of the program, it was more appropriate to encourage people to do it. When they get the letter with their results, they are encouraged and advised to see a GP and they are followed up a couple of times to make sure that happens.

Senator McLUCAS—If they have not nominated a GP when they send the envelope back, what can you do?

Ms Smith—The results go back to the patient. I suppose it is a reflection of the fact that it is quite difficult for a GP who does not know that patient to be effective in following up. The most effective follow-up mechanism is to have letters going from the register to the patient—in those cases where they do not have a regular GP.

Senator McLUCAS—Is there an option for a community health centre or a hospital to be entered as the GP type individual? I am thinking of people who live in communities that do not have GPs, which I would think, given the health indicators of those communities, are people you would want to pick up.

Ms Halton—I think that would be quite difficult. You would have to go and negotiate with all of those facilities around their role and the information that they would be supplied in respect of a patient for whom they do not necessarily have a day-to-day responsibility. As Ms Smith has indicated, we have been taking quite extensive clinical advice on this matter. There are a reasonable number of people who do not have a regular GP, particularly people in certain age groups. They may see the doctor less regularly or perhaps they are mobile, and the

notion that you would send anything to a provider—be that a medical service, a hospital or, indeed, a GP—with whom you do not have an established relationship would prove quite difficult, I think. If they have nominated someone, fine; clearly there can be information flow. If they have not nominated someone and we follow up that patient on several occasions to remind them that they should seek care, they could then go to a health service or whatever—obviously, they can choose wherever they wish to go. In terms of efficiency and effectiveness, I think that is more likely to be reliable.

Senator McLUCAS—Is there any indication, Mr Stuart, that people are not proceeding with the screening because they cannot fill in the box that says 'Please put your GP's name here'?

Mr Stuart—I will have to investigate if we have any evidence on that from the trial. Of course, we have not started the roll-out of the program yet.

Ms Smith—The short answer is, no, we do not know.

Mr Stuart—It appears we do not have very good information on that from the pilots. I think it is worth saying that the government has, as part of the budget announcement, asked us to undertake this roll-out and then undertake an evaluation process in time for the 2008-09 budget, at which time it will consider the further finetuning and roll-out of this program.

Senator McLUCAS—Thank you. An issue that we have spoken about before is hep C and hep C drugs. Mr Stuart, how many Australians are estimated to be infected with hep C at the moment?

Ms Smith—It is between 240,000 and 250,000.

Senator McLUCAS—And hepatitis B?

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

Senator McLUCAS—And HIV-AIDS?

Mr Stuart—A number of 16,000 comes to mind, but I am not sure whether that is ever infected or currently infected. We will check that.

Senator McLUCAS—Let us take it as 16,000 and if it is different Mr Stuart can let me know. In 2004-05, what was the mortality rate for hep C, hep B and HIV-AIDS?

Ms Smith—We will take it on notice.

Senator McLUCAS—You do collect that data, though, don't you?

Ms Smith—We do certainly for hep C and HIV. I will have to check in relation to hep B, but I think we do.

Senator McLUCAS—When we did the hep C inquiry, hep B was not on the radar. How many people with hepatitis C are in treatment programs with PBS section 100 drugs?

Ms Smith—Around one per cent of those diagnosed with hepatitis C are being treated annually. I think last year it was just under 2,000 people.

Mr Stuart—It is a major part of the new strategy to increase the referral for and uptake of treatment. I think it is a really important issue.

Senator McLUCAS—That is to do with the liver biopsy that is required prior to moving onto the drug. I cannot remember the name of the drug now.

Ms Smith—Certainly, a number of people feel that the requirement to have a liver biopsy before you can access treatment on the PBS is deterring some people with hepatitis C from being treated, but I think there are other barriers as well. One of the issues is that many people are put off because the treatment is long; it is about 12 months and has very unpleasant side effects. People need to be in a position in their lives where they have appropriate support to enable them to keep having treatment. It is a multifactorial issue.

Senator McLUCAS—I do not remember what they test, but I understand the disease has to progress a certain way before you can start being treated. How many people have a biopsy to see if they can be treated but are not sick enough?

Mr Stuart—I do not know that. We would have to take that on notice.

Senator McLUCAS—Would you have that data?

Mr Stuart—Perhaps it is somewhere in the department. I do not think my division has that data.

Ms Halton—I cannot be confident we have that, but we will have a look.

Senator McLUCAS—That would be useful. Is it correct that the PBAC has recommended dropping the requirement for a liver biopsy?

Ms Smith—Yes, that is correct.

Senator McLUCAS—On what basis did they make that recommendation?

Ms Smith—That was on the basis of cost effectiveness.

Mr Stuart—I think the strategy reflects that. The new feature in this area is that we now understand that, under this treatment, a substantial proportion of patients can actually clear the virus as a result of the treatment. So to have more people in treatment means that you have an opportunity to reduce the overall pool of infection in Australia and therefore reduce the spread of the disease.

Senator McLUCAS—When did the recommendation from the PBAC go to government?

Mr Stuart—That was very recent.

Ms Smith—That recommendation went to government sometime between mid-November and Christmas, I think. It is under consideration.

Senator McLUCAS—It is under consideration now. What is the process from now on, to change that requirement for a liver biopsy? Is there some decision at a government level, at cabinet level perhaps?

Mr Stuart—Yes, there would be a government decision. To go beyond that I think Carolyn and I would be stepping outside our area of responsibility; it would be Pharmaceutical Benefits.

Senator McLUCAS—Mr Stuart, you are probably right; this is a question I should be asking the pharmaceutical branch. But do you know whether there has been any analysis of

the cost to the PBS of not requiring the biopsy—that is, putting a much larger number of people through the treatment—and the benefit in terms of the savings that might bring?

Mr Stuart—Yes, that would have been part of the PBAC analysis.

Senator McLUCAS—Are you privy to that analysis or is that still part of the advice to government from PBAC?

Mr Stuart—I personally have not seen it because it is dealt with in another division. Yes, it would be part of the advice to the government.

Senator McLUCAS—Thank you. Of those 240,000 people who are currently infected: from a population health point of view, by how much do you bring that down before the infection rate actually starts to diminish, in an epidemiological sense?

Mr Stuart—That is quite a complex epidemiological modelling task and I do not have the answer to that with me. I am not certain whether the department has that modelling, but we could take that on notice and see.

Senator McLUCAS—If you could point me in the direction of a study that looks at that sort of data it would be interesting. What is the success rate of clearing the virus in people who undergo the treatment?

Ms Smith—It does depend on which genotype you have. I have to confess I cannot remember precisely which one. With one of the genotypes I think 50 per cent of people will clear the virus; and with another genotype, around 80 per cent.

Prof. Horvath—That is absolutely correct. There are a number of genotypes and that is the reason for the change in the attitude of the profession to liver biopsies. As Mr Stuart and Ms Smith commented, the therapy is not without very significant side effects. The reason for requiring liver biopsies was that you could see replicating viruses and certain biopsy changes that indicated that that group of patients would benefit from therapy. Since then the data from the different genotypes—there are some genotypes that you can measure just with a blood test and they have up to an 80 per cent clearance and potential cure—has changed the approach to the treatment of this disease. But I cannot remember the numbers. They have different names and algorithms which we might have to supply to you separately.

Senator McLUCAS—If every one of those 240,000 people were able to access the treatment, and did, what clearance of the virus would you get, given the fact that there are different types of the virus and effectiveness—

Prof. Horvath—I would have to take that on notice. I do not remember the precise number of patients that fall into each of the three genotypes.

Senator McLUCAS—That is what I am asking, yes.

Senator McLUCAS—If someone could give me an indication of what could happen, that would be great. Thank you. I have some questions about vaccines, but I am aware there are other people in the room.

CHAIR—I might give you a break, Senator, and throw it to Senator Fielding.

Senator FIELDING—When I spoke yesterday to the officials from the Families, Community Services and Indigenous Affairs portfolio they assured me that a question I asked

had nothing to do with them and that I should speak to the Health portfolio. You had a bit of notice on this question; I am sure you followed what happened yesterday. I still happen to think the question is about a social and community problem rather than a health problem, but I hope you will be able to answer my questions. You may have seen the recent Senate Community Affairs Legislation Committee report on the RU486 recommending a range of things, including greater social support for women who choose to continue with their pregnancy. What is the department doing to assist women who are pregnant under difficult circumstances to continue with their pregnancy?

Ms Halton—If I can make a comment with respect to the 'difficult circumstances.' To the extent that you are talking there about social programs, you are right—that is not a health responsibility. Issues in respect of people who have problems with social supports are not our responsibility; our responsibility is health services. We do, however, fund some counselling services. In fact, we have already tabled today the information we have provided previously on notice. I can see Senator Adams has a copy there if you would like to look at it, in terms of the funding that we provide to services. So that information is available.

Senator FIELDING—I may have a question on notice for the department from yesterday, because it sounds like there is a little bit of toing-and-froing between departments there. In the RU486 debate that has happened in the Senate and is now in the House of Representatives, one of the common statements on both sides of the debate was the acknowledgment that people would like fewer abortions. Has the department done any work on how women facing a difficult pregnancy, who feel they have no other choice but abortion, might be assisted to continue to birth and beyond?

Ms Halton—In terms of the work that has been done inside the portfolio, I think the minister in his speech yesterday did indicate an interest in counselling, but in terms of studies of the matter, the answer is no. But, as I said, the minister did give some indication of his particular interest in this respect in his speech yesterday.

Senator FIELDING—That is all I have. I have some stuff for the TGA, which I assume will be up next.

Ms Halton—Shortly.

Senator ADAMS—I have a question on the counselling issue the minister referred to in his speech yesterday. I do not know whether you can answer it, but I just want to run through a few things. Do you have any idea how it is planned for the counselling he was discussing to be delivered and who would deliver it?

Ms Halton—He has gone in public as far as he obviously felt able. Because he is discussing matters that are in front of government, obviously we cannot comment.

Senator ADAMS—I will leave that till later. At November estimates I asked about the target age for breast screening and whether there was going to be any lowering of the target age or extension of it.

Ms Smith—I think we indicated in the November hearing that we were planning an evaluation of BreastScreen Australia. That is something that the Australian Health Ministers Advisory Council has agreed would be a timely thing to do. One of the issues that will be

examined as part of the evaluation is the issue of the appropriate target group. As you indicated at the last hearing, it is something that there are a range of views on and we need to review the latest evidence.

Senator ADAMS—So it is moving somewhere.

Ms Smith—It is moving, but no decisions yet.

Senator FIELDING—Following up that question about what has the department done in that area of difficult pregnancies: is there any reason why the department has not done any research on the issues, knowing that there is a fairly large community issue there? I do not think it has only recently been around.

Ms Halton—It is not our role to initiate research. Our role is to administer programs and provide policy advice. I have to say that that is not a matter that we have been asked to do any research on.

Senator FIELDING—Thank you.

CHAIR—We might move to the TGA now.

Ms Halton—Can I ask whether anyone else is required in respect of program 1? If they are not, I might let them go. Did Senator McLucas have something more she wanted to come back to?

CHAIR—Yes, she is coming back. But the Food Standards Australia New Zealand people can leave.

[9.25 pm]

Therapeutic Goods Administration

Senator FIELDING—We have seen today the RU486 bill go through the House of Representatives, and it has already gone through the Senate, which means the TGA will be responsible for signing off approval for any application to register RU486 in Australia. One of the concerns raised in the Senate committee hearings on the bill was that there is no obligation on doctors and pharmacists to report adverse reactions to a drug. Would the TGA consider making the reporting of adverse reactions mandatory for RU486 were it to be approved?

Dr Graham—At the moment you are correct, it is not a mandatory requirement; but they are strongly encouraged to report. We have a group within the TGA called the Adverse Drug Reaction Unit, who in part support another group called the Adverse Drug Reactions Advisory Committee. Both their roles are to monitor adverse reactions on the Australian market. We get adverse reactions reported through a number of means. There is also a requirement on companies such that, if they come across adverse reactions, it is a mandatory requirement that they are reported to the department.

Senator FIELDING—Can you repeat that last bit.

Dr Graham—If companies that have registered products become aware of information that is relevant to the safety of their product they are required to report that to the Therapeutic Goods Administration. In the case of prescribers and pharmacists there is always a very strong encouragement for them to report anything that they come across. Perhaps their legal exposure is also an encouragement for them to report to the TGA adverse reactions that they

came across—or, if they are reported back through the company, for the company to report that on.

Ms Halton—If I can add to that, I think it is widely acknowledged across the world that our adverse reaction reporting arrangements actually work very well.

Senator FIELDING—Could I come back to the question. Do you have the power to make the obligation on doctors and pharmacists to report adverse reactions to a drug mandatory?

Dr Graham—My understanding would be no, because they come under state registration. Again, we can encourage, but the TGA would not have the power to make it mandatory.

Senator FIELDING—So the answer is no, as far as having the power to make it mandatory is concerned.

Dr Graham—Yes.

Senator FIELDING—If you approve the RU486 for use in Australia, what discretion do you have to apply conditions for its use and can you legally enforce those conditions?

Dr Graham—Our charter under the Therapeutic Goods Act is to look at the quality, safety and efficacy of a drug. In terms of that evaluation, we can apply conditions related to the quality, safety and efficacy in the marketing approval, but that is the limit of what we do under the Therapeutic Goods Act.

Senator FIELDING—Are you able to legally enforce those conditions?

Dr Graham—If they are related to the marketing approval of that drug, yes. And if there are breaches of the legislation by the sponsor—this is the sponsor who is responsible for marketing that drug on the Australian market—yes, we can.

Senator FIELDING—What about its use? Marketing is different. What about the actual use of it?

Dr Graham—There are many aspects to use. In terms of the supply by the sponsor, many of our powers come under that end of the market. In other words, there are requirements on the sponsor of the product to advertise that product correctly, to supply that product correctly and to comply with the conditions of supply that apply to that product, because it is on the Australian Register of Therapeutic Goods. We do not intervene between the prescriber and the patient. We do not have the power to do that. We do not interfere, in that sense, in medical practice between the individual prescriber and the individual patient.

Senator FIELDING—Can you give me some details of the range of powers you have in this area? I am still trying to grapple with that. It is the use I am talking about. I am not so much talking about the marketing of it, how it is positioned in the market. I am talking about how it is actually applied and putting conditions on its use. During the Senate committee we heard that 'if it was not used in a certain way' et cetera. Can you give me some current examples of a drug that has a very strict use and how you legally enforce that, which is the issue here.

Ms Halton—Dr Graham has been quite clear. The TGA has the power to indicate, in terms of registration purpose, for example. If you look in respect of a number of drugs you will see the context in which it is registered. As he has indicated, in terms of medical practitioners and

their prescribing, and ultimately the use of a product, that is managed via a different arrangement with medical boards and in relation to state based arrangements.

Senator FIELDING—But am I correct in saying that the TGA cannot legally enforce the way it is used?

Ms Halton—The TGA has responsibilities in respect of the registering and the marketing of the product. Use of product is governed under a separate arrangement.

Senator FIELDING—So it not the TGA that would legally enforce that use.

Ms Halton—That is correct.

Senator FIELDING—I understand that the TGA is soon to become part of a new statutory authority to be established on 1 July 2006 to regulate therapeutic products in both Australia and New Zealand. Given that RU486 is already registered and used in New Zealand, how will that affect your treatment of an application here?

Mr Eccles—Your question goes to the establishment of the trans-Tasman agency and what effect that might have on the regulation of restricted goods.

Senator FIELDING—Really it goes to how that amalgamation would affect your treatment of an application here in Australia.

Mr Eccles—The intention is that, under the harmonised scheme, a single process would apply for the registration of products in both Australia and New Zealand. Essentially, what is proposed is to have a single agency and a single regulatory scheme.

Senator FIELDING—Would you follow the same approaches followed in New Zealand?

Mr Eccles—No.

Senator FIELDING—What approach would you follow?

Ms Halton—The approach that will be followed will be consistent in the broad with the arrangements we currently have in place. The Australian government has said very clearly that it will not agree to a diminution of the regulatory approach and the rigour of our regulatory scheme in moving to a trans-Tasman agency. Senator, I should correct you in one respect. You used the date 1 July 2006, I think.

Senator FIELDING—That is correct.

Ms Halton—At the moment there is not a date in terms of the commencement of that scheme, but I can guarantee you it will not be 1 July.

Senator FIELDING—When will it be?

Ms Halton—That is a matter of discussion between the Australian and New Zealand governments at the moment.

Senator FIELDING—Is it expected this year?

Ms Halton—That is a matter of discussion between the Australian and New Zealand governments. I could not possibly speculate.

Senator FIELDING—The answer is, no, you will not follow the same approach as used in New Zealand. I heard the word ‘broad’ used.

Ms Halton—The same rigour that we currently apply to the registration of products will be applied in the new arrangement.

Senator FIELDING—You are no doubt aware that the standard regime for RU486 includes the use of the drug Misoprostol, which is used off-label and against the manufacturer's advice. Would that be of concern to the TGA if an application were received?

Dr Graham—To do what, Senator?

Senator FIELDING—To be used in an off-label way. The manufacturer continues to say that it does not approve its use as an abortifacient.

Dr Graham—If the manufacturer wanted to extend the range of uses that that product is registered for, it would go through the normal process of having to supply the evidence that it is sufficiently safe and efficacious in the marketplace. If a doctor wanted to use a product that is not consistent with its registration, that is a matter for the doctor.

Senator FIELDING—So the TGA would not be concerned about a drug being used in a way that the manufacturer does not approve of?

Ms Halton—As we have indicated, that is not a matter for the Therapeutic Goods Administration. Essentially, the regulation of the use of approved registered products is a matter both for medical boards and state based instrumentalities. The TGA assesses an application for registration in respect of efficacy and safety; the matters that Dr Graham has gone to. If a product is placed on the register, its use is governed by a range of factors, including medical registration, and I could go on.

Senator FIELDING—Let me get this right. The drug Misoprostol is currently being used in other countries off-label.

Ms Halton—That particular product is a registered product in this country, correct.

Senator FIELDING—But it is being used for a purpose that the manufacturer does not even support. That does not concern the TGA? If the TGA were approached for it to be registered for that purpose—in other words someone else was registering it—but the manufacturer did not approve it for that purpose, wouldn't that concern you?

Dr Graham—If the doctor decided that that was an appropriate use for their patient, and they had informed consent for that process, that is a matter for the doctor and the patient. In the hypothetical situation that there were adverse events against that use and we became aware of that, we certainly would investigate that safety aspect of the product.

Ms Halton—The TGA is not a regulatory body in respect of use. That is not its role.

Senator FIELDING—Has the TGA approved drugs before that require use of an associated drug off-label and against the manufacturer's advice?

Dr Graham—We would not know. There are many products that possibly have some off-label use by doctors. We control how a product is promoted in the marketplace and the information to support that product in terms of the evidence that has been supplied to us. Again, it comes back to a matter for the individual doctor and the patient.

Ms Halton—It would not be appropriate for the TGA to speculate about a presently non-existent application and the content of any application. There is no application in front of the

TGA for registration in respect of this product, and it would not be appropriate for them to speculate about how that would be handled, other than to point you to the legislative responsibilities they would carry in respect of assessing any such application.

Senator FIELDING—Are you aware that on 31 January this year the *Australian* newspaper reported:

But a spokesman for Pfizer Australia, said the company did not think it should be used after RU486. ‘We would not recommend use outside TGA-endorsed indication and at this stage that just involves stomach ulcers,’ the spokesman said.

Ms Halton—That is not a matter that the TGA should be commenting upon, Senator. You are asking them to comment on a media issue which is not relevant to their responsibilities.

Senator FIELDING—I must admit I am concerned, and I will be following this up a little bit further. You have answered the questions, but I am not convinced about legally enforcing it and then approving a drug for use when the manufacturer of it does not want it to be used for that purpose. It just seems strange to me.

CHAIR—Is that all the questions you have, Senator?

Senator FIELDING—Yes.

CHAIR—Thank you for your attendance tonight.

Senator McLUCAS—I have questions on ‘Biosecurity and emergency response’ under outcome 12. Diphtheria-tetanus vaccine, I understand, is no longer available in Australia. Is that correct?

Ms Smith—CSL did announce in November that it was intending to cease production of a number of vaccines and that included Tet-Tox, which is a tetanus vaccine and adult diphtheria-tetanus. They have ceased production but there are remaining supplies still available.

Senator McLUCAS—When you say ‘adult diphtheria-tetanus’, is that a different vaccine to what you would give a child?

Ms Smith—Yes, that is correct.

Senator McLUCAS—It has been put to me that there are children who have an adverse reaction to pertussis and currently the vaccine that is in circulation and used is a diphtheria-tetanus-pertussis vaccine.

Ms Smith—Yes, DTPa.

Senator McLUCAS—What does the ‘a’ stand for?

Ms Smith—Acellular.

Senator McLUCAS—Right. If a child will have an adverse reaction to pertussis I understand that a child diphtheria-tetanus vaccine should be used. Does that mean that those vaccines are not available anymore, given that you said it was adult and not child?

Ms Smith—I am advised that it is quite rare for children to have an allergic reaction to the pertussis component, but there is a child diphtheria-tetanus vaccine that is available from overseas manufacturers and that can be ordered in through the Special Access Scheme. In

terms of the adult diphtheria-tetanus vaccine that CSL is discontinuing, there are other overseas manufacturers and CSL is negotiating with those to continue to supply them in Australia.

Senator McLUCAS—You say it is very rare: how rare is it? Are we talking tens or hundreds or thousands of children?

Ms Smith—I could not give you a precise figure at this time, but we can seek advice on that point and take it on notice.

Mr Stuart—Adverse reactions to vaccines that are rare are not counted in the hundreds or thousands, but we do not have the numbers at our fingertips.

Senator McLUCAS—One day I will tell you my story about measles and what happened to me.

Ms Halton—Measles-mumps-rubella?

Senator McLUCAS—My daughter was allergic to egg, so that was fairly unattractive; but never mind—we got there. What is the Special Access Scheme? You said it would be available through the Special Access Scheme.

Ms Smith—The Special Access Scheme is available through the TGA for people to get access to drugs that are not registered in Australia, but that access is for their personal use only.

Senator McLUCAS—Do doctors know about that system? Is it well known and well understood?

Ms Halton—It is a very well-known provision. You might be aware of a certain high-profile application in respect of a particular drug at the moment and I have to say that we in the TGA do process applications under the Special Access Scheme relatively regularly. It works very well. Doctors are highly aware of it.

Prof. Horvath—And it is very non-bureaucratic and easy to access. Just to come back, the ‘a’ for acellular in DTPa is the reason why it is now very rare. Most of the previous allergies to pertussis were before they made the acellular vaccine.

Senator McLUCAS—I could ask why, but I will not.

Prof. Horvath—You would have to ask on notice.

Senator McLUCAS—No, I would get a volume this thick. I understand CSL have said they were also ceasing to manufacture Q-fever vaccine, but that has been reversed. Do you understand why that happened? What was the reason behind the reversal of that decision?

Ms Halton—We had a series of discussions with the company—I think ‘high level and intensive’ would probably be the appropriate way to describe it—and we were very pleased when the company reversed its decision.

Senator McLUCAS—Was their ceasing of production of it in part due to the regulatory requirements that the TGA had brought in?

Mr Stuart—CSL advised us that their plant was outdated, that they would have to invest quite a lot to update it and that they had a greater priority for the making of viral vaccines, in

particular flu. I am reporting what we have from CSL and what I think CSL has put into the public record.

Senator McLUCAS—I understand that CSL is going to develop ‘improved facilities at its Parkville site for the production of Q-fever vaccine’. Is there any Commonwealth money in that proposal?

Mr Stuart—We are still exploring, with CSL and otherwise, what the options are in the long term for Q-fever. CSL has committed to maintain production and to keep the vaccine available for the medium term.

Senator McLUCAS—I do not think you answered my question, Mr Stuart. Is the Commonwealth putting any funds towards the Parkville plant?

Mr Stuart—There has been no decision about that, Senator.

Ms Halton—No particular commitment was made before they made their announcement about continuing.

Senator McLUCAS—But it is being discussed?

Mr Stuart—We are engaged in discussions with the CSL about long-term options and we are also preparing to provide advice to government about other possible alternatives.

Senator McLUCAS—So they would like some money, please. Okay, we will move on. What are the current supply needs for Q-fever vaccine?

Mr Stuart—Last year I think there were about 14,000 or 15,000 doses used in Australia.

Senator McLUCAS—Most of them in Queensland?

Mr Stuart—I beg your pardon. Last year it was 25,000. I think the projection this year is 14,000 or 15,000.

Senator McLUCAS—Why the drop?

Mr Stuart—Last year there was the completion of a catch-up program for workers involved in handling meat.

Senator McLUCAS—I am now going to the question of cost. Is there any indication that there will be increased cost to government for the supply?

Mr Stuart—The CSL has committed to maintaining the supply at the current cost for the time being.

Senator McLUCAS—Until these negotiations and discussions—

Mr Stuart—Until the longer term supply is sorted out.

Senator McLUCAS—Will cost recovery principles apply?

Mr Stuart—No. I think it is probably fair to say that this is a rare vaccine, not used very much elsewhere in the world. We have a particular need for it in Australia. It appears to be not profitable to make on a commercial basis, and so the government needs to look at options.

Senator McLUCAS—When they move to the new facilities, will they comply with the TGA’s new regulatory regime?

Mr Stuart—I think new facilities are still just an option. There has been no decision about that.

Ms Halton—Essentially, in the manufacture of any vaccine, the manufacturer has to satisfy the TGA that it meets good manufacturing practice. That is the role of the TGA, and obviously the TGA will be working with CSL to ensure that Q fever vaccine production meets those standards.

Senator McLUCAS—Now to human papilloma virus—which we all know how to say!

Mr Stuart—You are doing very well.

Senator McLUCAS—I was calling it HPV last year because I never knew what it meant, but now I know.

Mr Stuart—I am still calling it HPV!

Senator McLUCAS—This is a TGA question, I think. Has there been an application filed for TGA approval of the new HPV vaccine?

Ms Smith—I think the issue of whether a company has made an application is commercial-in-confidence.

Ms Halton—In some cases, Senator, you would be aware that companies are quite public about whether they have made their application, but it is not a standard practice for us to comment about whether we have received an application.

Senator McLUCAS—I understand that. I am sorry; I should not have asked the question. Let us speak hypothetically then. If an application for something as significant as this vaccination may be were filed, what would be the time frame that one would expect it to take to go through the process?

Ms Halton—That is a little hard to answer because, as you would understand, things vary significantly. It would not surprise me if this took about 120 days, but it could vary quite significantly.

Senator McLUCAS—120 days for the TGA to deal—

Ms Halton—To consider registration. You would know that we have brought the registration period down quite significantly. In some cases, in respect of important lifesaving drugs et cetera and if there were an evaluator available, the time could come down to 12, 14 or 15 weeks. There really is a degree of variability.

Senator McLUCAS—The process from there is that the applicant then applies to the PBAC under the new regime?

Ms Halton—In some cases, they can be lodging with the PBAC concurrently. You would have to be very confident that your registration application is going to be successful—the amount of work there is in producing a PBAC submission is not to be underestimated—but it is not unheard of.

Senator McLUCAS—I think the next question is speculative, but would the PBAC assess the application as a universal vaccine?

Ms Halton—That is a speculative question. I cannot answer that. It depends on what the application is for.

[9.53 pm]

Senator McLUCAS—Now we are onto the new outcome 12.

Ms Halton—Excellent. Can the people for the old outcome 1 go home?

CHAIR—Or back to work.

Ms Halton—Yes, indeed, Senator Humphries, they could go back to work.

Senator McLUCAS—Before they do, can I confirm that the antiviral stockpile is in outcome 12.

Ms Halton—Yes.

Senator McLUCAS—And the issue of preparedness is in outcome 12?

Ms Halton—Yes. We have had a bit of moving about, so there are a lot of people who have been in their jobs for a very short period of time, including Ms Halbert.

Senator McLUCAS—Congratulations, Ms Halbert.

Ms Halbert—Thank you.

Senator McLUCAS—When did outcome 12 happen? When did the restructure occur?

Ms Halton—Yes, the spontaneous combustion inside the department!

Ms Halbert—It commenced as soon as the announcement was made. We made a semiofficial announcement within the department about a week and a half ago that we had set up the infrastructure within systems and so on to create the office, but it basically came into being after the announcement, and we have been building up the staff ever since.

Senator McLUCAS—So 10 February was when the office was established?

Ms Halbert—The announcement was in December 2005.

Senator McLUCAS—I missed that. I might have been on leave. That was the announcement to establish the Office of Health Protection?

Ms Halton—That is right.

Senator McLUCAS—Is that when the new outcome 12 was established internally?

Ms Halton—Shortly thereafter.

Senator McLUCAS—Are they one and same thing?

Ms Halton—We have created this particular outcome to bring together the work that we have been doing in relation to emergency preparedness et cetera. In essence, the things occurred coincidentally.

Senator McLUCAS—How has it affected your budgeting? Have you collected moneys out of other activities and put them together?

Ms Halton—Largely program 1.

Senator McLUCAS—Rather than read me your budget, could you provide a document that indicates where those funds have come from and the total budget for the office.

Ms Halton—Yes, we are happy to do that.

Senator McLUCAS—Can you project that out over the budget in the out years as well?

Ms Halton—Yes, we can.

Senator McLUCAS—How many staff do you expect to have when you are at full complement?

Ms Halbert—When we have our full complement, I believe the number will be 154.

Senator McLUCAS—Ms Halbert, are any of those positions new or are they all relocated positions?

Ms Halbert—We transferred staff over from the previous Biosecurity and Disease Control Branch, which was around 79 or so people, and the rest will be built up from new positions.

Senator McLUCAS—So 79 existing and the rest new?

Ms Halbert—I would have to check whether that was 79 full-time staff. There might have been more actual bodies.

Ms Halton—In terms of the budgeting issue, if you look at our additional estimates document and you turn to pages 104 and 105, I think that will pretty much give you what you need in terms of things that have come into outcome 12.

Senator McLUCAS—$18.6 million. Is that where I should be looking? The whole page?

Ms Halton—Yes, the whole two pages.

Senator McLUCAS—That explains it.

Ms Halton—Yes, it does. I think this is basically what you want.

Senator McLUCAS—That will also explain where the money has come from.

Ms Halton—Yes.

Senator McLUCAS—On 11 December, Minister Abbott made an announcement, essentially saying that there would be ‘a further $184.8 million over five years to significantly boost Australia’s capacity to prepare and respond to major health emergencies’ such as a flu pandemic. Where does that money come from?

Ms Halbert—I can list the measures, if you would like.

Senator McLUCAS—I have the measures. They run down the page and add up to $184 million. What I am trying to ascertain is whether that is new money.

Ms Halbert—Yes, it is.

Senator McLUCAS—It is all new money?

Ms Halton—Yes.

Senator McLUCAS—The appropriations bill that is in the House this week has $131 million for the National Medicines Stockpile. How is that money to be spent?

Dr Roberts—The National Medicines Stockpile moneys that were allocated within the December announcement included $60 million for the purchase of antivirals, $19.9 million for the purchase of antibiotics that can be used intravenously to treat secondary infections following a pandemic influenza infection, bacterial pneumonia predominantly, $16.6 million for the specific H5N1 vaccine that is being developed at the moment and $35.7 million for personal protective equipment for front-line workers for use in an influenza pandemic.

Senator McLUCAS—How is that $131 million different from the $79.9 million? I think I have worked that out: $60 million for antivirals and $19.9 million for antibiotics.

Dr Roberts—That is correct.

Senator McLUCAS—That money appears in the appropriations bill as antivirals in the National Medicines Stockpile.

Dr Roberts—It is antivirals and antibiotics, yes.

Senator McLUCAS—The minister announced $6.5 million for the expansion and strengthening of Australia's influenza surveillance networks. How does that fit with the GP network—I think it is ASPREN—that we talked about before?

Ms Halbert—Part of that money will go to support the ASPREN network. We have already had $10 million in the previous budget for the biosecurity surveillance system. Part of the surveillance money that was announced in December will go to building up the number of GPs that report through the ASPREN surveillance system. Eventually they will report through the Biosecurity Surveillance System.

Senator McLUCAS—Does that mean all of that $6.5 million basically goes to the ASPREN project?

Ms Halbert—No, that is not the case.

Senator McLUCAS—How much does?

Ms Halbert—About $100,000 is for the ASPREN program, but we do not have an exact amount yet—we need to scope that—and the rest is to support surveillance through hospital emergency departments.

Senator McLUCAS—How does that work?

Ms Halbert—For example, in the event of pandemic influenza, it is quite likely that cases would turn up in hospital emergency departments and/or to GPs. So they would be reporting through the national notifiable diseases system, which is our key surveillance system, because they are probably the first port of call for people with symptoms.

Dr Roberts—This is particularly important in the early phases of the pandemic, where we are trying to work out quickly how many cases we have in Australia and how we might be on the phase of the pandemic erupting. If there are only a few cases in Australia and we are able to contain them quickly by interventions, then we can delay the onset and protect Australians for longer. Later in the pandemic we would not be particularly interested in surveillance, because we know that everyone has it, but very early in the pandemic we need to have everybody in the health system alert for influenza and reporting it quickly and efficiently.

Senator McLUCAS—Of the $6.5 million, it was $100,000 to ASPREN. I am trying to understand how that money will be applied.

Dr Roberts—As well as the ASPREN system, there are state based general practitioner systems that do surveillance for influenza as well. Some of the money will go to expanding those state based systems, to get more GPs enrolled and have more representativeness. In addition, there is a need for infrastructure to accept this reporting and act upon it. Influenza surveillance coordinators are needed to receive this information and report it through. In addition to the emergency departments, there is also the move towards electronic notification, again getting back to the need for it to be speedy—early detection—and the infrastructure around that.

Ms Halbert—Which eventually will go through the national biosecurity surveillance system.

Senator McLUCAS—You said there were state based systems of GPs. I thought ASPREN was a national GP network.

Dr Roberts—ASPRN is a national system that was set up originally by the college. The state based systems have worked within the states and have sometimes been assisted in the collection of specimens, the performance of interventions and the monitoring of what has been going on in each area.

Senator McLUCAS—Why is that not duplication?

Dr Roberts—ASPREN is not widely representative across the country. In some areas it could be duplication but in other areas there have been specific programs where both the state has seen it is as important and the companies that produce vaccine have seen it as important to assess the types of vaccine that are circulating in the area in that time, and the GPs have been willing to participate in such schemes.

Senator McLUCAS—Hopefully, there is a desire to get all those state based organisations talking to each other.

Dr Roberts—Yes. We pool the information at the Commonwealth level.

Senator McLUCAS—In November we asked how many GPs were members of ASPREN, and the answer was 50. What is the number now?

Dr Roberts—I would be surprised if it had changed since November.

Ms Halbert—The minister announced a small amount of funding to boost ASPREN—$218,000—but that would not have had an impact as yet.

Senator McLUCAS—What do you put the slow indication of interest by GPs in this project down to?

Dr Roberts—General practice is a very busy occupation, and another piece of paper to fill in and another report to make is a burden for general practitioners. Electronic notification is going to assist, we believe, and that is part of the initiative to try and lessen the burden for GPs.

Senator McLUCAS—Is that a task that you are about to undertake?

Dr Roberts—Yes.

Senator McLUCAS—I do not think I have a breakdown of that $6.5 million. On notice, could you provide a breakdown of that.

Dr Roberts—Yes.

Senator McLUCAS—Last November we had Exercise Eleusis. I understand that the report from that exercise was due for completion in January. Has that occurred?

Ms Halbert—That report is being prepared by the Department of Agriculture, Fisheries and Forestry and it is near completion.

Senator McLUCAS—Did DAFF undertake Exercise Eleusis?

Ms Halbert—Yes. It was basically a zoonosis exercise but it was based around diseased chickens, with only a small element around human disease.

Senator McLUCAS—Will you get a copy of that report eventually?

Ms Halton—That is a matter for DAFF, Senator.

Senator McLUCAS—When all orders are filled for the antiviral stockpile, we will have 8.75 million doses. Is that correct?

Dr Roberts—Courses: one treatment course consists of 10 tablets.

Ms Halton—Multiply your number by 10 and you have the number of tablets, Senator.

Senator McLUCAS—You can use Relenza and Tamiflu prophylactically and as a treatment, I understand?

Dr Roberts—That is right.

Senator McLUCAS—But there are different doses for each event?

Dr Roberts—One course is a treatment course for an infection. But that one course of 10 tablets or Rotadisks can provide prevention, prophylaxis, for 10 days. That can be after someone has been exposed to the virus, so post-exposure prophylaxis, or it can be a continuous dose for someone who has been in a very high-risk situation to prevent them from getting illness.

Senator McLUCAS—Regarding the regime for prevention, if you dose someone for 10 days, do they develop an immunity that will carry on, or not?

Dr Roberts—You cannot be certain of that without testing them with laboratory tests to see if they have shown immunity. The only way that you know that someone is protected without such testing is for them to continue to take the medication daily.

Senator McLUCAS—If someone was a high risk because of their age or their health, or because of their potential for coming in contact—

Dr Roberts—That is right, mostly because of exposure. If they are nurses who are working to care for a person in a respiratory unit in a hospital, then they will be in contact with people with influenza every day, so they will need to take a tablet every day to prevent onset of illness.

Senator McLUCAS—For all of the time?

Dr Roberts—So far the evidence only shows us that we have safety for six weeks. There have not been any studies beyond six weeks yet to show the safety beyond that period. If it were a 12-week pandemic, you might consider some staff for six weeks and then have them go off work and other staff for the subsequent six weeks. This is all still being investigated and developed. As you realise, it is all changing very quickly, so the policies are changing to keep pace with it.

Senator McLUCAS—When you say current evidence is that it is safe for six weeks, it is safe for the person to take it for six weeks?

Dr Roberts—That is right—continuously for six weeks.

Senator McLUCAS—Has there been any analysis of how the national stockpile would be used?

Dr Roberts—Yes, there have been considerations of how the stockpile would be used. Partly the considerations need to include where we are with respect to the phase of the pandemic at the time. If we were in a position where we had a vaccine that was effective, we had many doses and we were able to vaccinate the entire population, then the role of the antivirals in prevention is not quite as important. You would vaccinate first the people at highest risk from their exposure, such as the nurses working in the respiratory unit.

If we are not close to a vaccine at the time the pandemic hits in Australia, then the role of the antivirals changes somewhat and fits within the Australian management plan of initially trying to contain the disease and, subsequently, if we are unable to contain it and we have widespread influenza, to maintain essential services. The containment phase of the disease will not use a large proportion of the stockpile, even with very generous containment measures.

Senator McLUCAS—The number of people at the front line is not that high?

Dr Roberts—The number of people at the front line when you are in containment, when there are few cases, is not that high and it is not using a lot of the stockpile to treat one person and to give one post-exposure prophylaxis course of 10 tablets to 20 or 50 people around them. The estimates that we have done to look at stockpile use in the containment phase suggest that we can use them very generously at that time to contain disease.

Senator McLUCAS—In October last year, the NHMRC called for applications for urgent research in a series of areas. I probably should address this question to NHMRC. Have these research grants been made?

Ms Halton—I can answer that: not yet.

Senator McLUCAS—If they are not yet granted, I cannot ask the next question. Was the request from NHMRC to look at the question of resistance to Tamiflu? Is that part of that series of investigations?

Ms Halton—Not that I am aware of, Senator.

Prof. Horvath—That is one of the questions that is being asked—the efficacy, modelling and resistance to Tamiflu.

Senator McLUCAS—What are the other areas that the grants will look at?

Dr McKinnon—The areas that were prioritised following a process with key influenza researchers around Australia were detection and diagnostics; the value of public health interventions, including infection control; modelling; the development of new drugs to treat pandemic influenza; the dose and effectiveness, and how to assess the effectiveness, of antivirals and including the resistance of antivirals; new vaccine technologies; and public behaviour; so public response, community perceptions, community priorities, how health care workers at a front line might deal with management and detection of pandemic flu. There was also a section for other areas, which allowed for people looking at different novel clinical applications for management of pandemic cases in a clinical setting, so it was a fairly broad range of priorities.

Senator McLUCAS—For people who have been asked to apply for grants, has that first phase finished? When are decisions to be made and the grants announced? What is the time frame?

Dr McKinnon—I think that information is with the minister at the moment.

Ms Halton—I understand it is in process. I would not want to use the word 'imminent' on the grounds I might be misconstrued, but my understanding is that it will be soon.

Senator McLUCAS—That is all I have, thank you.

[10.17 pm]

CHAIR—We will now open the batting on outcome 5, Rural health.

Senator McLUCAS—The rural health strategy funding on preventative health I understand is a program that is under way. In the PBS it says:

In addition to continuing funding for existing programs, the new Rural Health Strategy is going to provide additional flexible funding.

Can you give the committee an indication of, first of all, how much funding is identified there?

Ms Appleyard—That program refers to a program called the rural preventative health program and it consists of a couple of subprograms, one of which is the Building Healthy Communities program. That program is aimed at preventative activities in very small rural and remote communities. The budget for that activity is in the vicinity of $8 million this financial year.

Senator McLUCAS—It is $8 million, and it is called Building Healthy Communities?

Ms Appleyard—Yes.

Senator McLUCAS—You say it is for small, rural—

Ms Appleyard—Yes, it is generally for very remote communities with a low capacity, and it is to assist them with those factors that contribute to the prevention of illnesses and injury prevention. It is targeting obesity, smoking, alcohol abuse, fitness—that sort of activity. It is generally also targeted at communities with a low capacity.

Senator McLUCAS—How will the program be delivered?

Ms Appleyard—The program is generally delivered on a local basis. Our state officers work with local communities to identify where projects would be relevantly placed and then implement those projects. We have a firm of consultants working with us on that program, and they are assisting with capacity building at the community level.

Senator McLUCAS—The state identifies a number of communities where a program would be useful?

Ms Appleyard—Yes.

Senator McLUCAS—Is there a tendering process there?

Ms Appleyard—No, there is not. Because of the specific nature, the targeted nature, of these programs, they apply to a fairly small number of communities, so we are able to enable them to self-select.

Senator McLUCAS—How do communities indicate to the department of health that they might be an ideal target?

Ms Appleyard—Generally our state officers are in touch on the ground. They know what communities are out there through things like our Regional Health Services Program and through some of our other targeted rural programs. They are generally in contact with communities. Information is available on the website about this, and there is some promotion of the program, so communities are aware that way.

Senator McLUCAS—That $8 million is in this current financial year?

Ms Appleyard—Yes.

Senator McLUCAS—Have any projects begun?

Ms Appleyard—Yes, indeed they have. There are about 18 projects at the moment where we have funding agreements in place, but there are approximately 31 potentially under development.

Senator McLUCAS—In a general sense, the funding agreement is between the department of health and whom?

Ms Appleyard—It will be under the auspices of the local community, and there are many different types of auspices: the Royal Flying Doctor Service auspice some of the projects; it could be a division of general practice; it could even be a primary school in some cases. It is just wherever the capacity is located within the community.

Senator McLUCAS—I wonder if you could give the committee a list of those 18 projects that are under way—

Ms Appleyard—Yes, indeed.

Senator McLUCAS—and a bit of an indication of what is intended to be achieved, the funding allocation to each, and perhaps the auspicing body as well.

Ms Appleyard—Yes.

Senator McLUCAS—How will the evaluation of those projects happen?

Ms Appleyard—The evaluation of those projects has already commenced. We felt it was very important, because we are dealing with low-capacity communities, to get in there from the beginning. Morgan Disney is the consulting firm we have engaged to assist us to implement and evaluate this project. It is done on an ongoing basis. We have undertaken an education program with the various projects to explain to them what evaluation means. We have encouraged the use of the word 'story' in Indigenous communities, to say we want them to tell the story of how this is working for them. Basically we will be conducting that evaluation for each of the four years of this program.

Senator McLUCAS—Just coming back a step, how do your state officers make a decision about where those projects will be located?

Ms Appleyard—As I said before, we are targeting small communities and remote communities, so we are looking at communities of under 5,000 in population. That is the criterion.

Senator McLUCAS—There are a lot of those in Queensland.

Ms Appleyard—Yes.

Senator McLUCAS—How do you make a decision between the town of Ravenshoe and the town of Hughenden?

Ms Appleyard—We have not had the problem of being inundated with numbers yet. Generally, we have not had to make that sort of decision, but it will be based on the merits of their idea and whether or not it meets the program objectives.

Senator McLUCAS—I am trying to work out how it would happen in a rural community. Does a person from Brisbane turn up and say, 'We think you are not very well; would you like some money?' I am just trying to work out how it happens practically.

Ms Halton—I think we might give you the precise mechanism on notice.

Senator McLUCAS—The precise mechanism?

Ms Halton—Rather than having a lengthy, wordy description, I think we will just give you a nice, pithy answer on notice which will be more accessible.

Senator McLUCAS—Pithy?

Ms Halton—Yes, we can do pithy.

Senator McLUCAS—Explanatory, maybe.

Ms Halton—You can have explanatory and pithy and hopefully timely as well.

Senator McLUCAS—And that will explain to me how decisions between various communities are made?

Ms Halton—Yes.

Ms Appleyard—Yes.

Senator McLUCAS—All right. Back to the evaluation then: are they going to have health indicator benchmarks to evaluate, or is it going to be about the process of spending the money?

Ms Appleyard—It would be about both. Mainly we are interested in making sure that the program has delivered in accordance with the objects identified for the community. If it were to address a particular chronic disease factor then we would want to make sure that that was, in fact, what occurred.

Senator McLUCAS—Thank you for that. The Royal Flying Doctor Service has been in the newspapers. Has the review of the RFDS been completed?

Ms Lyons—The review has not yet been completed. We have a report from a consultant that arrived in the department at the end of January. There are some aspects of the report that are being peer reviewed as we speak. As soon as those reviews come back to us and we look at the consultant's report, we will then be in a position to provide some advice to the minister.

Senator McLUCAS—What is the time frame for that?

Ms Lyons—We are expecting the peer reviews to come back to the department by the end of this month. We will then assess those, as I said, together with the consultant's report.

Senator McLUCAS—Who did the report? Who were the consultants?

Ms Lyons—Healthcare Management Advisors.

Senator McLUCAS—Do they have specific expertise in rural health?

Ms Lyons—They certainly have expertise in health and my recollection is—and I could take this on notice—that indeed they have done work on rural health matters including, at one point some time ago, for the Royal Flying Doctor Service, so they have some familiarity with it.

Senator McLUCAS—They understand the operation.

Ms Lyons—Yes.

Senator McLUCAS—Could you provide the committee with the amount of funding provided to the RFDS by the Commonwealth over the last five years.

Ms Lyons—For five years we would have to take that on notice.

Senator McLUCAS—I would be happy to receive that on notice. The other issue is about what the other contributors, mainly the states, are putting into the operations of the RFDS. Does the Commonwealth know that figure?

Ms Lyons—You are right when you say that it is generally the states and territories that provide the other funding, as well as the fundraising activities that the Royal Flying Doctor Service undertakes. The states are not obliged to tell us what they put in. Again, I will take the question on notice, but it may very well be that we cannot provide you with those figures.

Senator McLUCAS—That is fine. The line in the budget for the funding of the RFDS—when is the end of that period? When does that program lapse?

Ms Appleyard—June 2007.

Senator McLUCAS—Thank you. But you can assure the people of rural Australia that the RFDS will keep flying, even through this process?

Ms Lyons—As far as we are concerned, yes.

Senator McLUCAS—Multipurpose services are outcome 3, aren't they? All right, No. 11. Thank you. That is all I wanted from rural health.

CHAIR—Have you finished with outcome 5?

Senator McLUCAS—Yes, I have finished rural health.

[10.30 pm]

Office of the National Health and Medical Research Council

CHAIR—What about outcome 11—Health and Medical Research?

Senator McLUCAS—Yes, I have two issues for the NHMRC. Can you give me an indication of where the organisation is at, in terms of its structure?

Dr Morris—The process of establishing the NHMRC as a portfolio agency is in train. The intention of government is that the NHMRC will be established as of 1 July 2006. We are working closely with the department to make sure that everything happens in time.

Senator McLUCAS—In your view, that will happen on that day?

Dr Morris—Yes.

Ms Halton—We believe so.

Senator McLUCAS—With the move to an agency of the department, you will be moving to outcome number—

Dr Morris—It will not be an outcome.

Ms Halton—They will be a separate agency.

Senator McLUCAS—Sorry, it is the reverse.

Ms Halton—We have a number of agencies, as you know. The NHMRC will basically go from being inside the tent to just slightly outside the tent but still in the portfolio.

Senator McLUCAS—Is there an organisation in the department of health that you think your organisation might mirror?

Ms Halton—No, they are unique and special in their own way.

Senator McLUCAS—What will it look like?

Dr Morris—When the government announced that the NHMRC would go through this change, it said that there would still be a council of the NHMRC, which does make the NHMRC unique. When other agencies have been Uhrig'd, if you like, there has been a process of setting them up fairly closely, but in the case of the NHMRC they determined that the council would stay as an integral part. So there will be a CEO and there will be a council.

Senator McLUCAS—So the structure is not that dissimilar to what it is now.

Dr Morris—Yes.

Senator McLUCAS—Is the line reporting different?

Dr Morris—Clarifying the lines of reporting and clarifying the governance.

Ms Halton—In the past we have discussed the lack of comfort in relation to the way that the current arrangements work. I think I have described them on several occasions as being a bit half-pregnant—you are neither pregnant or not. We have made this work for the last few years, but it was our strong preference to basically clarify it and make really clear what the reporting arrangements were. rather than have the staff be nominally my staff but be basically working for the CEO, who was independent. All of that would be a little awkward. I think this will be a good thing in terms of clarity.

Senator McLUCAS—So the CEO will be appointed after 1 July. Is that correct?

Ms Halton—Essentially, there will be a new CEO appointed. You would be aware that the former CEO has gone off to be vice-chancellor of a university. Dr Lawrence has kindly stepped in to assist us in this period, and we are very grateful for that. As we move into this new environment, there will be a new CEO appointed.

Senator McLUCAS—You expect that will happen after 1 July, or in the lead-up to it?

Ms Halton—I do not know, is the short answer. These things can go one of two ways and it would be silly to speculate, but I am hopeful that it will be around the same time.

Senator McLUCAS—Has any work been done to get out there and look for an appropriate person?

Ms Halton—Yes.

Senator McLUCAS—There might be one inside, but I am not going there. Regarding the Lockhart report, it was very tragic that Justice Lockhart passed away.

Ms Halton—Yes. We have expressed our condolences to his widow, particularly so shortly after he handed down his report.

Senator McLUCAS—Yes. I think it is a fairly significant piece of work, but that is an opinion. Can you explain to me what happens now. We have that report. What will be the process that will ensue after receipt of the report?

Dr Morris—The report has been provided to all Australian governments, and during 2006 Australian governments will consider the report. I understand that it will probably be considered at a COAG meeting later in 2006. As to the process, that is yet for government to determine.

Ms Halton—That is not clear.

Senator McLUCAS—Is NHMRC managing that process?

Dr Morris—Not at this stage, no. I think it is really for governments to determine how it will be handled.

Senator McLUCAS—So it is a report to governments.

Ms Halton—That is right.

Senator McLUCAS—That came out of COAG initially.

Ms Halton—Yes. What we now have to do, from a policy perspective as against a technical perspective, is work with central agencies on that COAG process and that will proceed. Obviously, the discussion across governments about that report—it will have to be a

bureaucratic discussion—will have to occur prior to something going to premiers, chief ministers and the Prime Minister.

Senator McLUCAS—Unfortunately, that is all I have.

CHAIR—Senator Adams has a question.

Senator ADAMS—How is the council for the NHMRC appointed?

Ms Halton—That is a matter that the minister currently has under consideration.

Senator ADAMS—Can you give me some idea of the types of people that may be appointed?

Ms Halton—He has some statutory obligations under the legislation, as you would be aware, as to the kinds of people that he needs to be looking for. I know he is very aware of those statutory categories and he is actively considering appointments, I can assure you.

Senator ADAMS—Thank you.

CHAIR—Thank you. Our reward is that we are now finishing 20 minutes earlier than the scheduled time.

Ms Halton—Can we just make a note that it is at approximately 10.40 that we are completing?

CHAIR—Indeed—unprecedented in my experience of estimates. Before anyone changes their mind, may I thank the minister; Ms Halton and officers of your department for your patience throughout the day; members of the committee and the secretariat of the committee and the staff of Hansard for their cooperation today.

Senator Santoro—Mr Chairman, before you conclude, can I put on the record the enjoyment that I have experienced from my first estimates. I have been on both sides of the table in state parliaments and they were far more adversarial and perhaps not as satisfying as these. Thank you to the secretary and her officers, all of whom have presented, I think, expert advice and evidence to the people that have been asking the questions. Also, thank you to opposition senators for the courtesy that you have displayed to the officers.

It is great to be able to conduct hearings such as this with goodwill and I have been very impressed with some of the exchanges that occurred between the officers and the senators opposite. It really is nice to see that good things can come out of events and undertakings where goodwill exists. Thank you to all of you for making my first estimates a pleasant experience.

CHAIR—If you enjoyed that experience, Minister, you need to get out more!

Senator Santoro—And to you, of course, Mr Chairman, despite your last remark!

Senator McLUCAS—For the record, Minister, we have been doing it this way for some five or six years. It has certainly been the position of senators on this side of the table that our fight is not with the staff of the Department of Health and Ageing. If we have a fight, it is with your kind self.

Senator Santoro—I do not want a fight.

Senator McLUCAS—That is the attitude we bring to Senate estimates.

CHAIR—Thank you very much. I declare the proceedings closed.

Committee adjourned at 10.41 pm