COMMONWEALTH OF AUSTRALIA

# Official Committee Hansard

# SENATE

## COMMUNITY AFFAIRS LEGISLATION COMMITTEE

ESTIMATES

**(Budget Estimates)**

THURSDAY, 1 JUNE 2006

C A N B E R R A

BY AUTHORITY OF THE SENATE

**INTERNET**

The Proof and Official Hansard transcripts of Senate committee hearings, some House of Representatives committee hearings and some joint committee hearings are available on the Internet. Some House of Representatives committees and some joint committees make available only Official Hansard transcripts.

The Internet address is: **http://www.aph.gov.au/hansard**

To search the parliamentary database, go to:
**http://parlinfoweb.aph.gov.au**

# SENATE

## COMMUNITY AFFAIRS LEGISLATION COMMITTEE

### Thursday, 1 June 2006

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

**Senators in attendance:** Senators Adams, Allison, Barnett, Brandis, Carol Brown, Crossin, Eggleston, Fielding, Ferris, Forshaw, Humphries, Marshall, McLucas, Moore, Patterson, Payne, Polley, Siewert, Stott Despoja and Webber

**Committee met at 9.04 am**

### HEALTH AND AGEING PORTFOLIO

Consideration resumed from 31 May 2006

**In Attendance**

Senator Santoro, Minister for Ageing, representing the Minister for Health and Ageing

**Department of Health and Ageing**
**Executive**
Ms Jane Halton, Secretary
Mr Philip Davies, Deputy Secretary
Ms Mary Murnane, Deputy Secretary
Professor John Horvath, Chief Medical Officer
Ms Wynne Hannon, General Counsel, Legal Services Branch
**Outcome—Whole of Portfolio**
**Business Group**
Mr Alan Law, Chief Operating Officer, Business Group
Mr Steve Bell, Acting Assistant Secretary, IT Solutions Development Branch
Ms Joanne Bransdon, Acting Assistant Secretary, Communications Branch
Ms Georgie Harman, Assistant Secretary, People Branch
Mr Stephen Sheehan, Chief Financial Officer, Finance Branch
Mr Mike Siers, Assistant Secretary, Corporate Support Branch
Mr John Trabinger, Assistant Secretary, IT Strategy and Service Delivery Branch
Ms Tatiana Utkin, Assistant Secretary, Strategic Management Branch
Ms Laurie Van Veen, Assistant Secretary, Communications Branch
Mr David Watts, Assistant Secretary, Legal Services Branch
**Portfolio Strategies Division**
Mr David Kalish, 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
Ms Jenny Hefford, Assistant Secretary, International Strategies Branch
Ms Susan Rogers, Assistant Secretary, Policy Strategies 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

Ms Carolyn Smith, Assistant Secretary, Targeted Prevention Programs Branch

Ms Allison Rosevear, Acting Assistant Secretary, Drug Strategy Branch

Mr Peter Morris, Assistant Secretary, Strategic Planning Branch

**Therapeutic Goods Administration**

Dr David Graham, National Manager, Therapeutic goods Administration

Dr Rohan Hammett, Principal Medical Officer

Dr Leonie Hunt, Assistant Secretary, Drug Safety and Evaluation Branch

Dr Sue Meek, Gene Technology Regulator

Dr Margaret Hartley, Director, Office of Chemical Safety

Mr Michel Lok, Assistant Secretary, Financial Services Group

Professor Albert Farrugia, Senior Principal Research Scientist

**Australian Radiation Protection and Nuclear Safety Agency**

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

**Outcome 2—Access to Pharmaceutical Services**

**Medical and Pharmaceutical Services Division**

Ms Rosemary Huxtable, First Assistant Secretary, Division Executive

Ms Judy Blazow, Senior Advisor, Division Executive

Dr Ruth Lopert, Principal Adviser, Pharmaceutical Policy Taskforce

Mr Tony Kingdon, National Manager, Office of Hearing Services

Ms Samantha Robertson, Assistant Secretary, Medicare Benefits Branch

Dr Jane Cook, Medical Advisor, Medicare Benefits Branch

Ms Sarah Major, Assistant Secretary, Pharmaceutical Access and Quality Branch

Ms Sue Campion, Acting Assistant Secretary, Pharmaceutical Benefits Branch

Dr John Primrose, Medical Adviser, Pharmaceutical Benefits Branch

**Outcome 3—Access to Medical Services**

**Medical and Pharmaceutical Services Division - See Outcome 2**

**Acute Care Division**

Mr David Learmonth, First Assistant Secretary, Acute Care Division

Mr Charles Maskell-Knight, Principal Adviser, Medical Indemnity Branch

Dr Bernie Towler, Medical Officer, Acute Care Division

Mr Damian Coburn, Director, Acute Care Strategies Branch

Ms Linda Addison, Assistant Secretary, Private Health Insurance Branch

Mr Peter Woodley, Assistant Secretary, Diagnostics and Technology Branch

Ms Yael Cass, Assistant Secretary, Acute Care Development Branch

**Primary Care Division**

Mr Richard Eccles, First Assistant Secretary, Primary Care Division

Mr Lou Andreatta, Assistant Secretary, General Practice Programs, Primary Care Division

Mr Leo Kennedy, Assistant Secretary, National Health Call Centre Network Taskforce
Ms Jennie Roe, Acting 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

**Professional Services Review**

Dr Tony Webber, Director, Professional Services Review
Mr John Jenner, Executive Officer, Professional Services Review

**Outcome 4—Aged Care and Population Ageing**

**Ageing and Aged Care Division**

Mr Stephen Dellar, Acting First Assistant Secretary, Ageing and Aged Care Division
Mr Jacquie Maycock, Acting Assistant Secretary, Residential Program Management Branch
Ms Carolyn Scheetz, Acting Assistant Secretary, Quality Outcomes Branch
Mr Peter Broadhead, Assistant Secretary, Policy and Evaluation Branch
Ms Mary McDonald, Assistant Secretary, Community Care Branch
Ms Fiona Lynch-Magor, Assistant Secretary, Office for an Ageing Australia
Mr Iain Scott, Assistant Secretary, Office of the Prudential Regulator
Dr David Cullen, Executive Director, Financial and Economic Modelling and Analysis Group

**Aged Care Standards and Accreditation Agency**

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

**Office of the Commissioner for Complaints**

The Hon Rob Knowles, Commissioner for Complaints
Ms Jennifer Theisinger, Director, Office of the Commissioner for Complaints

**Outcome 5—Primary Care**

**Primary Care Division – See Outcome 3**

**Outcome 6—Rural Health**

**Health Services Improvement Division**

Ms Margaret Lyons, First Assistant Secretary, Health Services Improvement Division
Ms Alison Larkins, Assistant Secretary, Health Workforce Branch
Mr Nathan Smyth, Assistant Secretary, Mental Health and Suicide Prevention Branch
Ms Linda Powell, Assistant Secretary, Chronic Diseases and Palliative Care Branch
Mr Tam Shepherd, Acting Assistant Secretary, eHealth Branch
Ms Sharon Appleyard, Acting Assistant Secretary, Rural Health Branch
Professor Rick McLean, Principal Medical Advisor, Health Workforce Branch
Professor Harvey Whiteford, Principal Medical Advisor, Mental Health Branch
Ms Colleen Krestensen, Director, Mental Health and Suicide Prevention Branch
Mr David Dennis, Future Focus Taskforce

**Outcome 7—Hearing Services**
**Medical and Pharmaceutical Services Division - See Outcome 2**
**Outcome 8—Indigenous Health**
**Office for Aboriginal and Torres Strait Islander Health**
Ms Lesley Podesta, First Assistant Secretary, Office for Aboriginal and Torres Strait Islander Health
Dr Tim Williams, Senior Medical Officer
Mr Mark Thomann, Assistant Secretary, Program Planning and Development Branch
Ms Joy McLaughlin, Assistant Secretary, Policy and Analysis Branch
Ms Rachel Balmanno, Assistant Secretary, Health Strategies Branch
Ms Haylene Grogan, Senior Adviser, Program Planning and Development Branch
**Outcome 9—Private Health**
**Acute Care Division—See Outcome 3**
**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
Mr Paul Groenewegan, Deputy Chief Executive Officer
Mr Paul Collins, Manager, Statistics
**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
**Outcome 10—Health System Capacity and Quality**
**Health Services Improvement Division – See Outcome 6**
**Outcome 11—Mental Health**
**Health Services Improvement Division – See Outcome 6**
**Outcome 12—Health Workforce Capacity**
**Health Services Improvement Division – See Outcome 6**
**Outcome 13—Acute Care**
**Acute Care Division—See Outcome 13**
**National Blood Authority**
Dr Alison Turner, General Manager, National Blood Authority
Mr Peter De Graaff, Deputy General Manager, National Blood Authority
Ms Sandra Cochrane, Chief Financial Officer, National Blood Authority
Mr Jason Brooks, Management Accountant, National Blood Authority
**Outcome 14—Health and Medical Research**
**Health Services Improvement Division—See Outcome 6**
**National Health and Medical Research Council**
Mr Bill Lawrence, Acting Chief Executive Officer, NHMRC
Dr Clive Morris, Executive Director, Centre for Corporate Operations and appearing for Centre for Compliance and Evaluation

Ms Suzanne Northcott, Executive Director, Centre for Research Management and Policy
Mrs Cathy Clutton, Acting Executive Director, Centre for Health Advice, Policy and Ethics

**Outcome 15—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
Ms Megan Morris, Assistant Secretary, Surveillance Branch

**CHAIR (Senator Humphries)**—I declare open this public hearing of the Senate Community Affairs Legislation Committee considering the budget estimates. The committee will continue examining the Health and Ageing portfolio today. I welcome the Minister for Ageing, Senator Santoro, representing the Minister for Health and Ageing, and Ms Jane Halton, the Secretary of the Department of Health and Ageing. The committee, as members will recall, managed to complete yesterday the whole of portfolio corporate affairs area, plus outcomes 2, 3, 4 and 9. That was not the progress we had hoped to make yesterday, so we have quite a lot to cover today. A draft order has been circulated, beginning with Professional Services Review, and proceeding through outcomes 12, 13, 11, 8, et cetera. It is going to be necessary to allocate times today to each of those outcomes in order to be able to get through them all. Senator McLucas has very kindly drafted one, which is being circulated or has been circulated to other members. If that is acceptable, we will provide that to other members of the committee and provide that to the department so that people have an idea of when they will be required. Is there any suggestion to vary the order of that draft program before we look at the times? If the order is acceptable, we will proceed on that basis and then come back to the timing later. Are there any matters taken on notice yesterday that the department would like to put on the table at this point?

**Ms Halton**—Not as yet that I am aware of, but no doubt someone will come with pieces of paper as we move on.

**CHAIR**—In that case, we will start now on the Professional Services Review. I invite questions. Senator McLucas?

**Professional Services Review**

**Senator McLUCAS**—Dr Webber, I understand in the 2005-06 budget paper there was an indication that there was going to be a review of the Professional Services Review organisation, and that was intended to be completed by December 2005. Did that occur?

**Dr Webber**—It started in March this year. It is being run by the department and it is proposed to report by the end of July or early August this year.

**Senator McLUCAS**—Why did it start in March of this year as opposed to the indication in the 2005-06 budget that it would be completed by 2005? What was the delay?

**Dr Webber**—I am not sure of that.

**Senator McLUCAS**—It was being undertaking by the department?

**Dr Webber**—Yes, it was.

**Senator McLUCAS**—What is the intent of that review?

**Dr Webber**—The review has two major arms: a retrospective look at the effect of the 1999 changes to the scheme and how effective they were, and an assessment of where we are now and where we should go in the future.

**Senator McLUCAS**—Since 2005, how many meetings of the stakeholders that are involved in the review have been held?

**Dr Webber**—Since the review has been started, do you mean?

**Senator McLUCAS**—Since 2005. If the review has just started in March, I suppose, since March.

**Dr Webber**—There have been two formal review committee meetings but quite a number of informal meetings.

**Senator McLUCAS**—You may not know the answer to this, but how much has been spent to date on the review?

**Dr Webber**—I am not aware of that.

**Senator McLUCAS**—We can ask the department. Is that something that the department could respond to?

**Ms Halton**—I will have to find the relevant officer.

**Senator McLUCAS**—We might come back to that. It is proposed that there will be a piece of legislation for the winter sittings of this year. It was proposed that there will be a piece of legislation called the Health Insurance Amendment (Professional Services Review) Bill. What is the purpose of that legislation?

**Dr Webber**—It is minor, if you like, tidying up of issues not affecting the substance of the scheme at all but minor tidying up bits of legislation.

**Senator McLUCAS**—So the purpose of the review is not meant to inform that legislative change?

**Dr Webber**—No, not at all.

**Senator McLUCAS**—I understand the PSR has seen a reduction of about 30 per cent in staffing levels. Is that right?

**Dr Webber**—That is right.

**Senator McLUCAS**—What was the rationale for that?

**Dr Webber**—When I was appointed in February last year, there was a significant downturn in the number of referrals received from the NHIC and, as a consequence, there was not enough work for the staff we had.

**Senator McLUCAS**—Do you have a view as to why there has been that reduction in the number of referrals from the HIC?

**Dr Webber**—That is probably a question for Medicare Australia, but my understanding is that it is because they changed their procedures.

**Senator McLUCAS**—In what way, from your perspective, given you are the people who deal with the referrals? What is the changed nature of the referrals you receive?

**Dr Webber**—The nature of the referrals that we have received have been the same. It is that the HIC, as it then was, undertook a significant review of their processes, and many of the practitioners that were in the process were put back to the start of that process, so there has been a hiatus in work.

**Senator McLUCAS**—I do not quite understand what you mean by 'put back to the start of that process'.

**Dr Webber**—It would probably be better to source that information directly from Medicare Australia, but my understanding is that with respect to doctors who were progressing in the HIC's investigation, once their procedures were changed, those doctors that were part-way through their process were put back to the start of the new process.

**Senator McLUCAS**—We will talk to HIC about that. I do not know if you have seen reports of the AMA that suggest that doctors who are accused of inappropriate use of Medicare items are simply being asked to recompense Medicare rather than going through the process as previously undertaken. What is your view on that?

**Dr Webber**—I have seen those reports. That may well be the case in certain instances. Of course, just repayment of benefits does not in any way assess the quality of the service being offered.

**Senator McLUCAS**—I suppose what Medicare Australia is saying, though, is that this doctor is overservicing. That would usually be the charge, so to speak.

**Dr Webber**—What we have found in the 450-odd cases that we have seen is that almost inevitably where there is overservicing there is extremely poor medical practice and poor patient outcomes. My concern with not seeing enough of these cases is that much more practice and poor health care delivery is not being detected.

**Senator McLUCAS**—Are you concerned that you are not receiving the referrals that you would like to in order not to progress a prosecution but rather to look at what is actually happening in terms of health outcomes for patients?

**Dr Webber**—That is correct.

**Senator McLUCAS**—You would prefer to revert to a system where you were being referred concerns from the HIC or Medicare Australia?

**Dr Webber**—I think PSR has a unique role, whereas Medicare Australia has a right and proper role to be concerned with the expenditure of government money on health care and to look at fraud, inappropriate dealing practice and so forth, attempting to ensure that the quality of services delivered meets acceptable peer standards.

**Senator McLUCAS**—But you use the trigger of a referral to do that?

**Dr Webber**—That is the only trigger we have.

**Senator McLUCAS**—Yes, that is right. I understand you are quoted in *Australian Doctor* as saying that you received only 10 referrals from the HIC in the past year compared with the around 40 or 50 that the PSR usually receives.

**Dr Webber**—In the 2004-05 year we received nine new referrals. In the 2005-06 year to date we have received six.

**Senator McLUCAS**—And the year before?

**Dr Webber**—The year before, about 36.

**Senator McLUCAS**—Do you put that down to the changed practices in Medicare Australia?

**Dr Webber**—That is what they have informed me.

**Senator McLUCAS**—I understand that in 2005 Medicare Australia referred about 70 investigations to the Commonwealth DPP. Do you track those events? I know it is not within your—

**Dr Webber**—No, we do not have involvement in potential fraud.

**Senator McLUCAS**—Do you think that Medicare Australia is almost short-cutting your service and going directly to DPP when they believe a charge of overservicing should be investigated?

**Dr Webber**—I do not think the DPP has a role in assessing overservicing. It certainly has a role in criminal fraud matters. Medicare Australia has different procedures for its assessment of overservicing.

**Senator McLUCAS**—Could overservicing lead to a charge of fraud?

**Dr Webber**—No, but an investigation into overservicing could reveal a case of fraud.

**Senator McLUCAS**—I understand what you mean. All cases of Medicare fraud or potential fraud that are referred to the DPP do not have to go through the PSR first?

**Dr Webber**—No, because it is a criminal offence, not an overservicing offence.

**CHAIR**—Senator McLucas, the time we have allocated for this area has expired and, as you yourself said, I should be rigorous about these things, so we will move on at this point.

**Senator McLUCAS**—We did start at seven minutes past nine.

**CHAIR**—Sorry, but we will not get through this if we do not exercise some discipline. I propose to move on to outcome 12.

**Senator McLUCAS**—Thank you, Dr Webber, I will put some further questions on notice.

[9.18 am]

**Senator MOORE**—Ms Lyons, I have some questions about the funding that is allocated under outcome 12 in the PBS statement—$130,617,000 to administered, and $9,820,000 to departmental. Can you give us a breakdown of where that goes in terms of what is your internal cost—I know that is the administered stuff, but I want to know what that covers—and also more generally what that funding allocation means?

**Ms Lyons**—I might ask my colleague Ms Larkins, who is charge of the Health Workforce Branch, to answer that question.

**Ms Larkins**—If I could just have a minute to find—

**Senator MOORE**—That will be fine. We will go back to that at the end of our time, because it is a straightforward administrative question, to put it on record. I think Senator Brown has some more specific questions that we might be able to move on with.

**Senator CAROL BROWN**—Last year you provided some data on the GP workforce. Are you able to provide that information?

**Ms Larkins**—That is an outcome 5 question. That table of allocated medical servicing comes under outcome 5.

**Ms Halton**—The relevant officer is here, though.

**Mr Eccles**—Senator, was your question about doctor numbers?

**Senator MOORE**—Yes, I wanted an update of the data on GP workforce.

**Mr Eccles**—Anything in particular—the numbers for 2004-05?

**Senator MOORE**—The last one and then—

**Senator CAROL BROWN**—I have here the numbers for 2004-05.

**Mr Eccles**—We do not have numbers for the current financial year, because it has not finished yet. Since the last estimates we have had no new data. I think in the last estimates I gave quite a detailed run-down of the changes over the last decade or so in doctor numbers. I can go into a little bit more detail if you would like.

**Senator CAROL BROWN**—Do you have a ratio of people per full-time equivalent GP nationwide? Can you give me that information?

**Mr Eccles**—Is that a ratio per population?

**Senator CAROL BROWN**—Yes.

**Mr Eccles**—Yes, we do have that information.

**Senator CAROL BROWN**—Can you give it to me now?

**Ms Larkins**—Are you looking at a single national figure? I do not think we have that with us.

**Mr Eccles**—I can make sure that we have that figure for you by the time outcome 5 comes around this afternoon.

**Senator CAROL BROWN**—I have some questions about the Prime Minister's announcement about the 400 medical places per year. How many of the 400 medical places announced in April will be bonded?

**Ms Larkins**—We are still in negotiations with the states and territories. We are still going through the COAG process. We expect the final announcement on the workforce outcome from COAG to be made in July. No decision has been made as to the proportion of those places that should be bonded.

**Senator CAROL BROWN**—Will they be announced some time after July?

**Ms Larkins**—It is still under consideration. No decision has been—

**Senator CAROL BROWN**—There are no indicative figures?

**Ms Larkins**—No, not at this stage.

**Senator CAROL BROWN**—You do not know what regions they will be bonded to?

**Ms Larkins**—In terms of the bonding mechanism, I would not envisage that we would be using the same sort of mechanisms that we currently have in place, which really bond to district of workforce shortage. We would be unlikely to bond with specific geographic location. We would be more likely to say they are bonded to work in districts of workforce shortage. They are defined primarily by the ratio of doctors to population and change over time, clearly, as the workforce moves around.

**Senator CAROL BROWN**—Are you able to tell me what the bonding provisions would be?

**Ms Larkins**—No decision has been made about the mechanism. I would not envisage it will change significantly.

**Senator POLLEY**—Can you outline to us the criteria for the allocation into the areas?

**Ms Larkins**—We currently have a mechanism for distributing primarily overseas trained doctors into districts of workforce shortage. We determine the district of workforce shortage primarily by looking at geographic area and we also look at the ratio of doctor to population. Those areas that are, for instance, not inner city areas and have a lower than the national average ratio of doctors to population are considered to be districts of workforce shortage.

**Senator POLLEY**—Would you be able to give us any indication of the numbers that might be allocated to Tasmania, for instance?

**Ms Larkins**—What I could do is give you a sense of what the current districts of workforce shortage are in Tasmania.

**Senator POLLEY**—Launceston is short of GPs, with most of our GP practices being closed, and yet I have had information that Launceston has been declared a no-go area for overseas doctors as far as your department is concerned.

**Ms Larkins**—Our understanding is that Launceston is not currently a district of workforce shortage as that is defined, meaning it has better than the national average of doctors to population.

**Senator POLLEY**—Probably not as far as my constituents who are sick of trying to get in to see a GP are concerned. What about the north-west coast, in places like Burnie and Devonport?

**Ms Larkins**—There is a recognition that we are dealing with a fairly significant shortage in the medical workforce, and a range of initiatives is currently in place to address that shortage. The district of workforce shortage mechanism is meant to assist us in directing the doctors coming in from overseas into those places of greatest need. We are not suggesting that it meets all need. I do not have figures on Burnie with me, but I can give you, as I said, the areas in Tasmania that are currently considered districts of workforce shortage.

**Senator POLLEY**—I would appreciate that.

**Ms Halton**—We will get that read in a little bit later on, if you like.

**Senator POLLEY**—That would be good. We will move on to the nursing area. The Prime Minister announced that his government would increase the contribution towards nursing training. What is the estimated current full cost of nurses' clinical training?

**Ms Larkins**—I would not have a figure for the total cost of nurses' clinical training. These are really questions that fall within the DEST portfolio. What I could tell you is the current Commonwealth contribution towards nursing clinical education that DEST pays to each university, but I do not have a total estimated cost of nursing clinical education.

**Senator POLLEY**—Would you be able to provide the information you can in terms of the Commonwealth's contribution?

**Ms Larkins**—Prior to the Prime Minister's announcement on 8 April 2006, the Commonwealth contributed $688 per full-time equivalent student per year for the purposes of supporting nurse clinical training. As of next year that will increase to $1,000 per year for all existing and new Commonwealth funded higher education nursing places. That is at a cost of $30.6 million over four years.

**Senator MOORE**—We understand that the actual costings for education is a DEST issue, but we thought that as health and ageing was responsible for the contribution and the publicity around this increased contribution there would be some data in your information that said, if you are now going from $600 to $1,000, there must some idea about how much of that is defrayed. You do not have any data on that?

**Ms Larkins**—I do not have it with me. As I think the Productivity Commission report noted, the issue about costing of various elements of clinical training for undergraduates, postgraduates and specialists is a very complex field.

**Senator MOORE**—It is very complex.

**Ms Larkins**—We may be able to find a research report which gives us a ballpark figure for the clinical costs. I do not have that with me.

**Senator MOORE**—We will send it to DEST.

**Ms Larkins**—It is probably not an exact science; it is an estimation.

**Senator MOORE**—It is acknowledged that there is great variation, though?

**Ms Larkins**—Yes, and I think this is why universities have been saying there has been an issue about clinical training access.

**Senator POLLEY**—Is the department working on a response to the PC report?

**Ms Larkins**—The department is working with other Commonwealth departments on a combined response to the report. We expect that to be a joint Commonwealth, state and territory response. That, again, will come down in the context of the COAG decision in July.

**Senator MOORE**—What is your department's role in working on that response? Once again, I know that it is a cost to departmental and so on. Does health and ageing have dedicated resources being involved in that process?

**Ms Larkins**—Yes, we do have dedicated resources in that process.

**Senator MOORE**—Which division, branch or program is doing that?

**Ms Larkins**—Primarily my branch, the workforce branch.

**Senator MOORE**—How many people are involved in that?

**Ms Larkins**—I will get that for you. I will ask someone to do that calculation.

**Senator MOORE**—When is the next COAG?

**Ms Larkins**—We expect there to be a COAG meeting to announce the COAG workforce response in July.

**Senator MOORE**—Do we have an opportunity to go back to administered and departmental expenses in the program?

**Ms Larkins**—It is coming.

**Ms Halton**—Someone's abacus is working overtime back there.

**Ms Larkins**—What we can tell you in relation to the PBS is the programs that are under each of those programs, 12.1 and 12.2.

**Senator MOORE**—That would be useful.

**Ms Larkins**—Under 12.1 we have the university departments of rural health, the advanced specialist trainee program, rural clinical schools, the RAMA scholarships, allied health scholarships, RHSET grants and the Rural Health Education Foundation.

**Senator MOORE**—They are the programs that will be funded out of that element?

**Ms Larkins**—They are the programs.

**Senator MOORE**—Is it possible to get what funding is going to each of those? Has that definition of allocation been agreed yet?

**Ms Larkins**—I am not sure that it has. I will find out.

**Senator MOORE**—That would be good. What about 12.2?

**Ms Larkins**—That is the specialist re-entry program; the bonded medical program; the outer metro program; the components of the outer metro program that sit within outcome 12, which are GP incentives and specialist trainees; and SSRS and overseas trained doctor programs.

**Senator MOORE**—So there are just those two elements?

**Ms Larkins**—Yes. To go back to your other question, we have six ASL currently working on the COAG processes in my branch.

**Senator MOORE**—I have some questions about Indigenous medical workforce issues. Does that come to you or does it go to the Indigenous area?

**Ms Larkins**—It probably goes to the Indigenous area. We work quite closely with them.

**Senator MOORE**—When you were reading through the programs, the Indigenous area did not come up. So any questions specifically about Indigenous workforce should go to the Indigenous area?

**Senator McLUCAS**—The Puggy Hunter scholarship.

**Senator MOORE**—Is that in Indigenous?

**Ms Larkins**—Yes, it is.

**Senator MOORE**—In the programs you have just read out, where do departmental allocations to cover things like travel, communications and so on appear?

**Ms Larkins**—I do not believe that we have finalised the internal budget that relates to this yet.

**Senator MOORE**—What is the time frame for that? I really want to ask each program these questions. You have been my trial. I will probably put them now on notice to all the programs in exactly that way. I am trying to flush out exactly how the process works. You have been given these sums. What happens now for you then to do the definition as to what goes where?

**Ms Larkins**—We are in a process of business planning in the department. We have done a divisional plan. We are in the process of doing a branch plan. Through doing that branch planning process we will identify things like supplier costs and how we allocate those staff to the programs.

**Senator MOORE**—What is the time frame for that?

**Ms Larkins**—I am not completely sure about the timetable. It has to be ready for the 1 July assessment.

**Senator MOORE**—So each branch will be doing that internal work?

**Ms Larkins**—We are in the middle of a planning process in the department.

**Senator MOORE**—Then that goes back up through another section just to have that reviewed and cleared to see how it fits in the whole departmental process?

**Ms Larkins**—The divisional plans are agreed with the executive. Allocation between divisions is agreed with the executive. The branch plans would be agreed with the division head. I am assuming that that executive has visibility of that as well.

**Senator MOORE**—Then that is signed off for the internal planning process?

**Ms Larkins**—Yes.

**Senator MOORE**—You are responsible for what bit?

**Ms Larkins**—I am responsible for the Health Workforce Branch.

**Senator MOORE**—How many branches are there within that division?

**Ms Lyons**—Senator, are you after the number of sections in the branch?

**Senator MOORE**—I am just getting an idea of how the block operates within the general planning.

**Ms Lyons**—The workforce block?

**Senator MOORE**—Yes, the workforce block.

**Ms Larkins**—So you are asking me internally?

**Senator MOORE**—Yes.

**Ms Larkins**—At the moment we have eight sections in that branch. We are going through a process of working out what is the best allocation and split of those resources to deliver on the PBS outcomes for next year. I am not sure yet what number of sections we will have. We partly have eight at the moment because of our involvement in the Productivity Commission response and the COAG work.

**Senator MOORE**—That is all I have.

**CHAIR**—As there are no further questions in outcome 12, we thank you very much.

[9.37 am]

**Acute Care Division**

**Senator MOORE**—Ms Cass, I have many of the same questions that I asked about the administrative process, and you heard the answers that the people from the other branch gave as to how the internal program is going with working out budgets. I take it it is you to whom I am asking this question about the structure and the programs that are covered, or is it you, Mr Maskell-Knight?

**Mr Learmonth**—It is Mr Maskell-Knight.

**Senator MOORE**—Sorry, Ms Cass, you can relax now. Mr Maskell-Knight, what are the programs that are covered under this program?

**Mr Maskell-Knight**—I am sorry, I was actually on the phone to someone about a question time briefing, so you might need to go back a step.

**Senator MOORE**—Under the outcome, we have the budget figures in front of us from the PBS that show a large number of figures against administered appropriation and a large amount under departmental appropriation under your program. Which particular programs are covered by that? Which particular sources get that money? Which particular areas get that money? What programs get the money under No. 13?

**Mr Maskell-Knight**—There are a number of branches in the division. There is Acute Care Strategies Branch, which looks after hospital funding. There is the Acute Care Development Branch, which does blood, organ donation and casemix development, or what is now called the HIPIP, Hospital Information and Performance Information Program. There is the Diagnostics and Technology Branch, which is part of the division but is not part of this outcome. That is part of outcome 3. There is the Medical Indemnity Branch, which looks after medical indemnity and genetic policy and dental policy insofar as we have one. Then there is also within the division but not within this outcome private health insurance.

**Senator MOORE**—That is in your division?

**Mr Maskell-Knight**—Yes.

**Senator MOORE**—That is actually—

**Mr Maskell-Knight**—It is not part of this outcome.

**Senator MOORE**—How many people are in your division?

**Mr Maskell-Knight**—There are about 280-something. Probably about half of them would actually belong to those other two outcomes.

**Senator MOORE**—In terms of the money that has been allocated to your division under these programs, are you getting extra funding for staffing?

**Mr Maskell-Knight**—I would need to go and check that.

**Senator MOORE**—Can we get that on notice? I understand that your internal budgeting process is similar to that of the other divisions—

**Mr Maskell-Knight**—Yes.

**Senator MOORE**—and that you are at the very preliminary stage of doing that and you have not allocated money across each of those programs.

**Mr Maskell-Knight**—It is a work in progress.

**Senator MOORE**—How rapid is that progress likely to be, from your perspective? What is the time frame for getting the allocation defined across each of those areas?

**Mr Maskell-Knight**—I am partly in others' hands in terms of working out what the total allocation is. The budget for the department is worked out centrally and allocated downwards.

**Senator MOORE**—There was a date was given in the previous answer for when your division has to have a preliminary plan to go to the next level of consideration. Sometime in June, I think, was the answer. Is that right?

**Mr Maskell-Knight**—Yes.

**Senator MOORE**—What is your—

**Mr Maskell-Knight**—My understanding is that we did a preliminary plan without the benefit of the budget information and now we have the budget information we need to update that. I expect to do that in—

**Senator MOORE**—And the date for when you have to do that?

**Mr Maskell-Knight**—In the next few weeks, I would have thought. There is probably an edict somewhere telling me when, but I do not have it to hand.

**Senator MOORE**—I will be putting on notice a question about the definition expectations.

**Senator CAROL BROWN**—In the budget papers additional funding of $48.8 million over four years is indicated. When was this funding provided?

**Ms Cass**—The $48.8 million is the existing base of funds available under outcome 13 for organ donation and transplantation services. In this budget an additional $28.4 million was allocated.

**Senator CAROL BROWN**—$48.4 million is the base each year?

**Ms Cass**—No, it is not the base each year. That is the forward estimate for base funding over the next four years

**Senator CAROL BROWN**—So in 2006-07 it will obviously go up to $48.4 plus this additional $28 million?

**Ms Cass**—Plus the additional $7.6 million, which is the allocation in 2006-07.

**Senator CAROL BROWN**—And in 2007-08?

**Ms Cass**—Of the $28.4 million, the proportion allocated is $8.4 million.

**Senator CAROL BROWN**—Will there be an existing base there?

**Ms Cass**—Yes.

**Senator CAROL BROWN**—Of?

**Ms Cass**—The base continues.

**Senator CAROL BROWN**—Yes, so the $48.4 million continues?

**Ms Cass**—Yes. I will just tell you what the actual base is so that we are working off the right figures. The base in 2006-07 is $10 million, broadly. I can give you the accurate figure. We have added the budget allocation into it. The base in this financial year it is $9.698 million.

**Senator CAROL BROWN**—So over the next four years that $48.8 million—

**Ms Cass**—Yes.

**Senator CAROL BROWN**—Are you able to give me the out years, 2007-08, 2008-09, 2009-10?

**Ms Cass**—The allocation of the budget money?

**Senator CAROL BROWN**—Of the base.

**Ms Cass**—I can give it to you. Can I take that on notice?

**Senator CAROL BROWN**—Yes. Which part of the department administers this funding?

**Ms Cass**—The base money?

**Senator CAROL BROWN**—Yes.

**Ms Cass**—It goes to a range of programs—the Bone Marrow Transplant Program; the International Search for Bone Marrow Program; the national cord blood collection network; Australians Donate, which is the peak body in the organ donation sector; and it goes to a range of allocation and outcome registries, which are registers that collect data on organs for donation and transplantation.

**Senator CAROL BROWN**—How is that funding divided between those areas?

**Ms Cass**—For the Bone Marrow Transplant Program and the international search, it is an identified component that comes in bill No. 1. The others have been based on historical funding since the inception of the program.

**Senator CAROL BROWN**—They continue?

**Ms Cass**—That is right.

**Senator CAROL BROWN**—With respect to the $28.4 million in the budget for organ donation, why is there a decline in 2009-10 from $7.6 million to $4.8 million?

**Ms Cass**—Why is there a drop in the last year?

**Senator CAROL BROWN**—Yes.

**Ms Cass**—That is principally because of some of our early calculations of the construction of the components of that program and how they might be phased out. So there will be some intensity in activity in the first three years.

**Mr Learmonth**—Some of it, I think, has to do with levels of activity and awareness building around specific events, such as the World Transplant Games and so on. There is necessary a tail-off after that when the event is over.

**Ms Cass**—That is right. That has a peak in the two financial years in which it occurs, 2006-07 and 2008-09.

**Senator CAROL BROWN**—Are you able to give me for the past 10 years what other funds the department has provided for organ donation?

**Ms Cass**—Over the last 10 years? Yes. Not now; I would have to take it on notice, but I can certainly provide it.

**Senator CAROL BROWN**—With that information, could you take on notice what education and awareness campaigns the department has funded in that time frame?

**Ms Cass**—Certainly. That is one of the priorities in this budget package. There have been limited funds for education and community awareness.

**Senator CAROL BROWN**—Do you have a table of organ donation rates over the past 10 years as well?

**Ms Cass**—I do.

**Senator CAROL BROWN**—Do you have that here?

**Ms Cass**—Yes, I do. I will just get them for you. I have them for over the last six years.

**Senator CAROL BROWN**—Do you want to read them?

**Ms Cass**—Read them out to you?

**Senator MOORE**—How long is your document?

**Ms Cass**—It is a single figure for each of those years.

**Senator MOORE**—That is fine, yes. If it is just a single figure, that is fine.

**Ms Cass**—Organ donation internationally is measured as the number of deceased donors per million adult population. That is the definition. The rate in 1999 was 8.7 donors per million; in 2000, it was 10.2; in 2001, it was 9.3; in 2002, it was 10.4; in 2003, it was nine; in 2004, it was 10.8; and in 2005, it was 10.1.

**Senator CAROL BROWN**—That has dropped again. Do you have the raw figures, the number of donors?

**Ms Cass**—As in the number of actual deceased donors?

**Senator CAROL BROWN**—Deceased donors.

**Ms Cass**—I do. Would you like those as well?

**Senator CAROL BROWN**—Yes, if you could table that whole document that would be good, but just from 2002?

**Ms Cass**—From 2002, the number of deceased donors was 206; in 2003, 179; in 2004, 218; and in 2005, 204.

**Senator POLLEY**—Is there any reason why these figures are so low and continue to be low?

**Ms Cass**—It is true that the Australian organ donation rate is comparatively low compared with OECD countries. We are acutely aware of that and have put in place steps to boost that rate.

**Senator POLLEY**—Can you outline what it is that the department has done to try and increase the donations?

**Ms Cass**—Last year a significant initiative of all health ministers, Commonwealth, state and territory, was an agreement to change the basis of registration on the Australian Organ Donor Register—that is, to change it from an intent based register to a consent based register. The objective was to make it easier for people to be identified and for consent to be clear so that donation could proceed.

**Senator CAROL BROWN**—I understand the change, but that still requires the family to give final consent.

**Ms Cass**—The objective of changing from intent to consent was to make that a much simpler process so that individuals have actually given legally valid consent to donation. Families are obviously consulted, but they are really asked if they have a serious objection to donation, on the basis that the consent is quite clear.

**Senator CAROL BROWN**—If they do?

**Ms Cass**—Then most of the state based agency organ donation coordination agencies would not proceed.

**Senator CAROL BROWN**—Sorry; I interrupted your flow.

**Ms Cass**—We believe there is a range of reasons why the rate in Australian rate is not the same as it is in other countries. There are different legal frameworks in place and different mechanisms for organ donation support.

**Senator CAROL BROWN**—I imagine that quite a number of people have registered to be organ donors.

**Ms Cass**—We have 5.6 million people on the Australian Organ Donor Register and, of that amount, 730,000 have joined following the consent registration addition.

**Senator CAROL BROWN**—How many potential donors in the hospital system do not proceed to make donations because of family reasons?

**Ms Cass**—What you are really asking about is the conversion rate from potential donors to actual donors. There is some state data on that but not a national figure. States have different methodologies. Some adopt death audits and some have other mechanisms. I can take that on notice and see what data we can provide you.

**Prof. Horvath**—In my former life, I directed a transplant unit for almost 30 years. There are a number of issues. When you do audits of missed donors, the numbers are surprisingly

small. The donation rate has remained almost static for nearly 30 years. There are lots of issues. One reason is that our very effective intensive care systems keep people alive for very long periods, by which stage a lot of the potential donors have complications and therefore cannot be donors. Another reason is our very diverse society. Comparing us with OECD countries can be a little fallacious, because the more homogenous your society is, the higher your donation rate. We have a very diverse and terrific society. We have to cross a lot of cultural barriers, and a lot of members of our society have very deep religious and cultural reasons around donation. It is a very complex area. Lots of people have done a lot of things at a Commonwealth level, a state level and a very regional level. Following certain high-profile events, donation rates peak for a little while and then drop off again. All it needs is a little bit of bad publicity and donation rates drop right off.

**Senator CAROL BROWN**—But we still have, as you have just stated and the figures show, a very low rate of donations. Of course, for each of those missed potential donors, maybe 10 people can be helped. Do you have the waiting list figures?

**Ms Cass**—I do have the waiting list figures. As at 1 January 2006, there were 1,710 people on the waiting list for solid organ transplantation, and 82 per cent of that number is people waiting for kidneys.

**Senator CAROL BROWN**—I do not know how much information you have about the number of people who die while on waiting lists.

**Ms Cass**—I do not have those figures here. I can check that for you.

**Senator MOORE**—Those figures are kept?

**Ms Cass**—They are kept.

**Senator CAROL BROWN**—I would like to have that information for each of the last five years. I attended the Flame of Life launch. Are you able to give me some information about how that is going? That was one of the major initiatives.

**Ms Cass**—The Flame of Life torch, or symbol, was used at the launch of the Australian Organ Donor Awareness Week earlier this year. That event was organised by Australians Donate, with some input from the David Hookes Foundation.

**Senator CAROL BROWN**—The purpose of that was obviously to raise awareness.

**Ms Cass**—It was. We have the figures on the registration rates following that event. There was a peak for the four weeks following the launch of the Flame of Life and the awareness week.

**Senator CAROL BROWN**—So you had a national launch and state and territory launches as well?

**Ms Cass**—That is right. The Flame of Life was shipped around Australia. There were state launches for organ donor families, recipients, clinicians and the donation coordination agencies.

**Senator POLLEY**—Does the department have any figures on people going overseas looking for organs that are not available in Australia because of the shortage?

**Ms Cass**—Not to my knowledge.

**Senator MOORE**—Does the issue of raising awareness of where the future donations are come up at the various meetings of your division? There seems to have been a bit of publicity recently, which Senator Polley was referring to, about people leaving the country because they cannot get the service they need here. Is that a topic that has been discussed or researched by the department? With all his experience, maybe Professor Horvath knows.

**Prof. Horvath**—There is largely state based data and it is also available on the Australian transplant data registries. The figures are reasonably small. A number of countries that did have commercial transplantation have now stopped that on various ethical grounds. There is still a small number of patients who go overseas, usually to India and occasionally to China, for transplantation.

**Senator CAROL BROWN**—Do you keep figures on live donors?

**Ms Cass**—We do have figures on live donors.

**Senator CAROL BROWN**—Are you able to supply those?

**Ms Cass**—I will have to fossick around. I will provide them to you.

**Prof. Horvath**—The number of live renal donors has grown progressively in the last decade and is probably almost on a par, in some units, with cadavers. There is also a small but significant increase in living donors for certain liver transplantations.

**Ms Cass**—I have figures for 2004 and 2005. In 2004, there were 218 deceased donors who provided 863 organs to 789 recipients. On top of that, 243 kidney transplants from living donors were performed.

**Senator CAROL BROWN**—That is 2004?

**Ms Cass**—That is 2004. In 2005 there were 246 living kidney donations, if that is what your key interest is.

**Senator CAROL BROWN**—So it was 243 and 246. I would appreciate it if you could give me the last five years. If you could give me that on notice, that would be fine.

**Ms Cass**—Yes.

**Senator CAROL BROWN**—There was some discussion when awareness week was on about our hospital coordinators. Are there hospital coordinators for coordinating potential donors in all hospitals? Do you have that information?

**Ms Cass**—There are organ donor coordination agencies in each state and territory, which provide support to hospitals when a donor is identified. In addition, some jurisdictions have been employing or setting up hospital based specialist donor coordinators. That is occurring in Western Australia and Queensland. We have asked those jurisdictions to provide us with some information on their plan for outcomes and implementation.

**Senator CAROL BROWN**—I notice that in your list of initiatives one of the things that you are doing is developing a nationally consistent waiting list for organ and tissue transplant. Can you give me an update?

**Ms Cass**—This work will commence shortly and we have funding over the next four years. The objective of looking at nationally consistent waiting lists is that currently there are

different methodologies and mechanisms for collection and use of waiting lists, principally at a specialty level. Funding is available for the Commonwealth to work with state and territory governments and clinicians to look at standardisation of waiting lists.

**Senator CAROL BROWN**—I am an organ donor so I am really interested in this area. I am a bit concerned that the figures are quite static. I can see that there are some initiatives here but they do not appear to be working that well.

**Ms Cass**—The initiatives have not commenced yet. This is one of the drivers for the budget package.

**Senator CAROL BROWN**—Yes, I know, but from 2002 I think there were various initiatives announced by the minister to try to increase the rate of donations. One of the views put across is to have dedicated coordinators in each of the hospitals. I do not know whether it is feasible or not, but it would be a way to up the rate of organ donors particularly where it seems that what has been happening in the past is not working. Do you have a view on that?

**Ms Cass**—We are aware that several states are looking at that issue right now. The minister, in communicating with state and territory governments on implementation of this package, has put to them that we have funding to implement seven new measures to boost organ donation and in return has asked his counterparts whether they would commit to funding medical donor coordinators in the hospital system. That is a priority and we will be pursuing that with state and territory governments.

**Senator CAROL BROWN**—Have you listed the seven measures?

**Ms Cass**—They were in our budget package. Would you like me to run through them?

**Senator CAROL BROWN**—Yes, I would.

**Ms Cass**—Increasing community awareness of organ donation, expanding registration on the organ donor register, improving clinical data on organ donation and transplantation, the work on the waiting lists, quality and safety of organs for transplantation, Transplant Games and World Transplant Games funding, and the last measure is establishing an expert task force of clinicians and specialists who will help in the development and implementation of those measures.

**Senator CAROL BROWN**—Has that task force been put together?

**Ms Cass**—Not yet.

**Senator CAROL BROWN**—Will that be in the next month or so?

**Ms Cass**—That is right.

**Senator CAROL BROWN**—Who is going to make up that task force?

**Ms Cass**—The minister will make an announcement of the membership of the task force, and it would comprise people who have strong expertise in terms of organ donation and transplantation on both sides of the sector.

**Senator CAROL BROWN**—Will they be able to look at other initiatives other than the ones that you have just listed? Will that task force have that brief?

**Ms Cass**—It certainly will be a forum for them to make suggestions about the reform agenda for improving organ donation.

**Senator MOORE**—When you were listing programs that your area covered you mentioned dental health. We have asked questions here before about this. What exactly is the responsibility of your program for dental health?

**Mr Maskell-Knight**—We are the Commonwealth representatives on the AHMAC Working Group that prepared the National Oral Health Plan, and we answer ministerial representations about the Commonwealth Dental Health Program and the performance of the states in providing public dental services.

**Senator MOORE**—So it is a research role?

**Mr Maskell-Knight**—I do not know about a research role; we certainly do not do research. We explain the government's policies and we represent the Commonwealth on the AHMAC working party, which is trying to identify those areas where governments can contribute to improving oral health with a range of different things.

**Senator MOORE**—I am interested in terms of representing the government. We have had discussion about various responsibilities for dental health and expenditures. It is mainly a state issue in terms of the current arrangements. If you are representing the government and being involved in the development of overall policies and you are not researching, what are you doing?

**Mr Maskell-Knight**—Maybe we have a different concept of what research is.

**Senator MOORE**—Perhaps. It could well be that. I often have this discussion with—

**Mr Maskell-Knight**—I understand research to be scanning literature and looking for evidence, perhaps even commissioning evidence, about different things. Our role is more about providing a Commonwealth perspective on different initiatives that were suggested to the AHMAC Working Group, basically providing information to that group about what Commonwealth workforce initiatives there were which impacted upon dental health. To the extent to which we needed to do research to go and find out what those initiatives were, then I guess you could say we were doing research.

**Senator MOORE**—I think there is that overlap there. How many people do you have doing that?

**Mr Maskell-Knight**—About one and a half.

**Senator MOORE**—Would there be an expectation that they work in other parts of the organisation as well?

**Mr Maskell-Knight**—Yes.

**Senator MOORE**—I have difficulty with the percentage of a person—unless you have a part-timer, but I take it that you do not, do you?

**Mr Maskell-Knight**—It is someone who would spend probably half to three-quarters of their time doing that, and then there are others who contribute to it. I would probably spend one-twentieth of my time working in that area.

**Senator MOORE**—I will not hold you to that percentage, Mr Maskell-Knight. How do the divisions work cooperatively? Particularly with Health, there seems to be no health issue that is in one box. There seems to be coordination across all kinds of areas. In terms of acute care, when you listed those programs before some of the issues go right across the health and social-economic processes. What internal coordinating bodies is your area on and also interdepartmental bodies? Is acute care responsible for any interdepartmental operations at the moment?

**Mr Maskell-Knight**—I would have to think about the interdepartmental ones. I do not believe there are any IDCs that we are responsible for at the moment.

**Senator MOORE**—I am sure you have a whole bunch inside.

**Mr Maskell-Knight**—In terms of 'inside', there is a group within the organisation that is beginning to think about the hospital funding arrangements that might replace the current AHCAs. There is a very loose group, for example, which looks at the dental policy issues. As you say, dental extends across a whole range of issues. There are OATSIH dimensions to it, there are Medicare benefit items now that relate to it, there are workforce issues. We have an informal group that gets together every few months and shares information about where things are at on that.

**Senator MOORE**—Specifically on the dental stuff?

**Mr Maskell-Knight**—Yes.

**Senator MOORE**—I have a feeling that we have talked about that before, because we had looked at the importance of dental health across all ranges of health. You have an internal departmental group that focuses on that in an informal way?

**Mr Maskell-Knight**—Yes. We have, again, an informal group that assists us in thinking about medical indemnity issues. Recently, we have been talking to the Population Health Division and the Office of Health Protection about indemnity issues that might arise out of a pandemic and disaster preparedness. You are quite right: in an organisation as big as ours it is important to maintain contact. Possibly I can break the habit of a lifetime and express a personal view here, that it relies very much on informal networks of people knowing who the right people to talk to are and being able to think, 'There is a dimension of this that we do not know about that someone else does.'

**Senator WEBBER**—As someone who has filled in the form, what happens when you join the national register?

**Ms Cass**—Your record is loaded on the register via Medicare Australia. It is then available to authorised officers in hospitals around Australia and they would call it up, if it happened that you turned up in an ICU bed and it looked like you might be a potential organ donor candidate. They would check to see if your name was there, they would check to see if you had authorised release of all organs or just some organs, and then they would talk to your family.

**Senator WEBBER**—If you fill in a form and send it off, do you get anything back? Do I have anything that I carry around that says I am on the national register?

**Ms Cass**—As in do you have a card or something?

**Senator WEBBER**—Yes, or anything—a piece of paper?

**Ms Cass**—Not to my knowledge, no. I can check with Medicare Australia.

**Senator WEBBER**—That would be good, because I have filled it in twice and never heard from anyone about anything, so I am not sure whether I have been registered or not.

**Ms Halton**—You can check online.

**Ms Cass**—You can.

**Ms Halton**—I think the point here—and this goes to what Ms Cass said and what Professor Horvath was saying earlier—is that under the old way you had a sticker on your drivers licence and someone would fish through your wallet. In the worst case scenario, you are run over by a bus and someone would fish through your wallet, find the licence, look for the sticker and then they would go off and find your family. Essentially, this is a much more reliable system. Instead of seeing some visible system connected to you, once they know who you are they just go and interrogate the database.

**Senator WEBBER**—I do not have a problem with that at all. Human nature being what it is, people like to know that, when they have sent something, someone got it. I am sure there are lots of people like me who have filled in the form more than once because we are not sure that it ever got to where it was meant to go; we do not know whether it is on the register or not. I am probably driving them mad in Tasmania or whether they are.

**Prof. Horvath**—There is an important downstream effect of this, which will not be seen in donor rates, hopefully, for a long time, because people who have registered hopefully do not become potential donors. When we started transplantation, we did not have things like coordinators; we did the requests ourselves. Families frequently did not know what their loved ones really wanted. The whole key about this is that you can confidently talk to families and say, ‘This is a very clearly expressed wish of your family member,’ and that takes a lot of anxiety and heat out of the situation.

**Senator WEBBER**—Absolutely.

**Prof. Horvath**—The benefits of this program most probably will not be known for a decade or two or longer, because the people who are now registering hopefully do not come into the donor category for a very long time. It is a long-term investment.

**Senator CAROL BROWN**—The programs that you are initiating will also have an effect on the ones that are currently registered, and hopefully that will encourage them to talk to their family. Senator Webber’s point about not receiving a notification that she had been registered is a good one, because when you receive the letter it is again another focal point of talking to your family.

**Prof. Horvath**—Yes, that is a good point.

**Senator CAROL BROWN**—That is the critical point.

**Ms Halton**—One of my colleagues recently put in his registration and received a receipt. There is a sample up the back. We will have a conversation with Medicare Australia about this. A recent registrant got something, so if you did not there is an issue.

**Senator WEBBER**—That is excellent. As I say, I do not want to drive them mad and fill it in yet again, but I think Senator Brown's point—

**Ms Halton**—This is a prompt for a conversation that we will have.

**Senator BARNETT**—I recently registered and I received a letter, but I did not get the card. I will just pass that back to you.

**Ms Halton**—We will have a conversation with Medicare Australia.

**CHAIR**—When I registered I got my letter and my card.

**Senator WEBBER**—I got nothing, so I am feeling very left out!

**Senator FORSHAW**—Can I ask some questions about blood? The other day I asked whether or not the department had a contract with a public relations company. I understand it is called Royce PR. Can I have an answer to that question?

**Ms Cass**—Yes, we do.

**Senator FORSHAW**—Yes, you do have a contract?

**Ms Halton**—Yes.

**Ms Cass**—As part of the money allocated for the Plasma Fractionation Review, Royce Victoria has been engaged as communications consultants to the department.

**Senator FORSHAW**—The review is otherwise known as the Flood review?

**Mr Learmonth**—The Plasma Fractionation Review.

**Ms Halton**—Which is being chaired by Philip Flood.

**Senator FORSHAW**—Is that contract still in place now?

**Ms Cass**—It is still in place.

**Senator FORSHAW**—Can you give me some details about it—when it started, what the contract was for, what the price was?

**Ms Cass**—It was entered into on 21 December 2005 and it concludes on 31 January 2007. The funds committed were $306,000 in 2005-06 and $79,000 in 2006-07. It was entered through a select tender process using the government communications unit register of communications consultants. There are four key objectives: the first was for them to help us in identifying the 170 stakeholders to be contacted during the review process; the second was to draft a communications strategy for the review process; the third was to provide us with advice on emerging communication issues during the review process; and the fourth was to help in the development of information that we finalise, clear and co-produce with our media unit, but they provided input to material that we load on our website—questions and answers material provided during the national consultation process.

**Senator FORSHAW**—I have not checked the website. Are the details of this consultancy listed on the department's website as required by the Senate order?

**Ms Cass**—Yes, it is.

**Senator FORSHAW**—We will check that. You say it is due to conclude in January 2007?

**Ms Cass**—That is right.

**Senator FORSHAW**—What work has been done to date?

**Ms Cass**—Against those four objectives that I outlined, quite a deal of work has been done. They have helped us in identifying all of the many stakeholders who have an interest in plasma fractionation in Australia and making sure that they receive an invitation to either lodge a submission or give a presentation. They have drafted a communication strategy. They assist us in analysing information in the media, particularly where there is potential for misinformation, and in analysing media commentary. We then work out a handling strategy with our media unit.

**Senator FORSHAW**—Are they providing progress reports to the department?

**Ms Cass**—They do provide progress reports.

**Senator FORSHAW**—They have provided some to date, I take it.

**Ms Cass**—Yes.

**Senator FORSHAW**—What happens after those reports have been provided? Is action going to be taken on them or is this all to be left until the finalisation of the entire inquiry or review?

**Ms Cass**—Royce is just providing one component of the input to the department in the conduct of the review. The substantive work of the review is quite separate and that is done for Mr Flood and the review committee. The review committee will report by 1 January 2007.

**Senator FORSHAW**—A moment ago you referred to 'misinformation'. What is this misinformation that the department is concerned about?

**Ms Cass**—There is scope in a review of fractionation arrangements of plasma for there to be concern amongst donors about what it means. It is a technical area and it is important that the actual focus of the review and the terms of reference are understood.

**Senator FORSHAW**—There is always scope for some confusion or misunderstanding, but you said 'misinformation'. That suggests there is something more than that, that there is in fact false or misleading information being put about that needs to be corrected, whether it is misinformation or disinformation. Can you be more specific about that?

**Ms Cass**—I should correct my words. That was inaccurate language, and I should not have used 'misinformation'. It is about ensuring that there is accurate information about the scope of the review available.

**Senator FORSHAW**—Accurate information on what?

**Ms Cass**—On the scope of the review and what it is and is not covering.

**Senator FORSHAW**—What you are telling me is that you have a review, and one of the issues that this company has been engaged to investigate is that what the review is about is properly understood.

**Ms Cass**—Can I provide an example?

**Senator FORSHAW**—That would be very helpful, because it seems like it is a review into a review, which has not actually been completed yet.

**Ms Cass**—No. There has been talkback commentary, for example, that the Australian government will be closing all blood banks and that there will be no more blood collection in Australia, which is inaccurate. It comes from people not fully understanding the scope of the review.

**Senator FORSHAW**—You are saying that there might be some concerns out there about, say, the impact of the free trade agreement on those issues—is that the sort of thing you are referring to?

**Ms Halton**—No. We need to be quite clear.

**Senator FORSHAW**—I am trying to understand what this is about.

**Ms Halton**—This is not about managing a concern in respect of that issue. The reality is that blood is incredibly technically complicated. People assume a whole series of things about the blood supply. Most people are never required to even think about it, let alone understand the technical complexities. The range of products that can be produced from fractionation, even the notion of what fractionation is, is scientifically and technically incredibly complex. Explaining matters that are highly technical can be difficult. We have exactly the same issues in respect of the TGA processes, which are, as far as most people are concerned, scientific gobbledegook. In respect of blood, it is exactly the same issue. As soon as you lift the lid on this issue, people who are not scientifically trained and even, can I suggest, humble bureaucrats have trouble understanding the technical detail. We have found in the past that an ability to translate science-speak into plain language that people can understand reduces the potential for confusion hugely. This is making sure that the review, which is into Australia's fractionation arrangements, can be properly translated from the scientists and bureaucrats, who do tend to speak in long sentences—exactly as I am doing now—into language that people can understand.

**Senator FORSHAW**—That might be the case, Ms Halton, but what was put a moment ago, for instance, about people being concerned about whether they will continue to be able to give blood or that the current system as it exists will continue, are not concerns that go to technical or scientific issues about the processes of fractionation.

**Ms Halton**—Maybe the officer was attempting to give you an accessible answer. I could get Professor Horvath to boggle you with science in terms of a series of the products that are produced from fractionation and the concerns scientists might have about the technical detail.

**Senator FORSHAW**—You could get Professor Horvath to do that, but I am not asking about that. With all due respect, I am not interested in that aspect at this point, fascinating as it might be.

**Ms Halton**—My point is merely that the officer was attempting to provide an accessible example of what was being done, but the reality is that blood is technically incredibly complex. The people on the review, interestingly, have said to me that, until they started doing this review—and we have technical people on the review, but we also have Philip Flood, who is an eminent former bureaucrat; am I allowed to say eminent former bureaucrat? Perhaps not.

**Senator FORSHAW**—I do not think people would disagree with that. But we are running out of time, and I want to get to some questions.

**Ms Halton**—The point he has made to me in several conversations is that, until he started doing this review, he did not—familiar as he is with the operation of government—know exactly how complex blood is. The point here is translating something complex into simple language that is accessible.

**Senator FORSHAW**—When did the work of the Flood review, if I can call it that, commence?

**Mr Learmonth**—It was announced on 17 February 2006.

**Senator FORSHAW**—When last year did the contract with Royce PR commence?

**Ms Cass**—On 31 December.

**Senator FORSHAW**—Are you aware of any meetings that Royce PR had with any of the relevant groups, organisations or stakeholders in this review?

**Ms Cass**—Yes, I am.

**Senator FORSHAW**—Were they meetings that departmental staff attended?

**Ms Cass**—They certainly were.

**Senator FORSHAW**—Can you tell me when those meetings were held and what the purpose of them was?

**Ms Cass**—I can tell you. I do not have a list on me.

**Senator FORSHAW**—Tell me what you can now and we will see where we get to.

**Ms Cass**—As part of preparing the draft communication strategy, Royce, with my departmental officers, went to talk to a couple of the key stakeholders to say, 'What are the key issues that you will be raising in the review process?' and to pull together a draft communication strategy.

**Senator FORSHAW**—Who were those key stakeholders?

**Ms Cass**—The principal stakeholders they spoke to were CSL and the Red Cross.

**Senator FORSHAW**—Were you involved in those meetings yourself?

**Ms Cass**—I did not go but my staff went.

**Senator FORSHAW**—When were they held? You said you do not have the precise dates or times, but were they held last year?

**Ms Cass**—No.

**Senator FORSHAW**—When were they held? What was the time frame?

**Ms Cass**—March.

**Senator FORSHAW**—So they were held after the formal establishment of the review, which I think was in February?

**Ms Cass**—After the announcement of the review committee.

**Senator FORSHAW**—Were any meetings held prior to November?

**Ms Cass**—On 21 December.

**Senator FORSHAW**—Sorry, December. Were there any meetings held between December and February?

**Ms Cass**—Not to my knowledge, no.

**Senator FORSHAW**—Did you say the purpose of the meetings was to ascertain the issues from the stakeholders?

**Ms Cass**—Yes, to talk to stakeholders about their views in the development of a communication strategy.

**Senator FORSHAW**—Sorry, their views on what?

**Ms Cass**—On the terms of reference and what were their concerns, from their perspective, in the review.

**Senator FORSHAW**—Why would that be necessary at that point?

**Ms Cass**—It was part of a mapping process for us as providing the secretariat for the review committee. We wanted to give them background information from day one or from as early as possible on the different perspectives of players in this review process. They would then obviously follow it up with a submission and consultation process.

**Senator FORSHAW**—That is CSL and the Red Cross Blood Service?

**Ms Cass**—In fact, all 170 stakeholders—and in fact the public—have had the opportunity to lodge a submission.

**Senator FORSHAW**—To what?

**Ms Cass**—To the review committee.

**Senator FORSHAW**—I am here focusing upon the PR company Royce and the meetings they held with the two major stakeholders you mentioned, Commonwealth Serum Laboratories and the Red Cross Blood Service. You say that was directed to helping Royce PR develop the communication strategy, if you like?

**Ms Cass**—Yes.

**Senator FORSHAW**—Let us just keep the focus there.

**Ms Cass**—Yes.

**Senator FORSHAW**—What I am trying to ascertain is: why was that necessary? What was intended to come out of those meetings?

**Ms Cass**—Why is the communication strategy necessary?

**Senator FORSHAW**—No, that is a broader question. It seems to me that having meetings with these companies or these organisations prior to the start of the review is a bit—

**Ms Cass**—It was not prior to the start of the review.

**Senator FORSHAW**—The review is just getting under way. Surely that would come out when CSL, the Red Cross Blood Service and any other organisation-stakeholder makes a submission to the review; what they want to say to the review will go to the review, rather than directly to the PR company that is charged with the communication strategy for the review. There is a bit of putting the cart before the horse here, it seems to me.

**Mr Learmonth**—If you are engaged in, for example, setting out a stakeholder engagement strategy as part of communications for a review—and bearing in mind this review was going to take the best part of a year from February, when it was announced, due to report on 1 January 2007—which was covering substantial terrain over a period of time and where a number of issues would come up, I think certainly the major stakeholders would be looking for more than simply the opportunity to submit a report to the committee. They would want to understand, and we would want to consider, what the nature of our engagement ought to be with the key stakeholders in particular. It seems to me that a very good starting point for that is to actually ascertain their interests in it.

**Senator FORSHAW**—I understand the interests of the stakeholders for the review. I am trying to understand the interests of the stakeholders for the PR company at this point of the process. As was just said by Ms Halton, this is a very complex issue. You are dealing with organisations and people involved in a complex scientific or medical issue. We are not here talking about a media strategy, about promoting a policy position on a public health issue at this point.

**Ms Halton**—There is an officer available who was at those meetings. If you would like that officer to come to the table, I can ask her to come to the table.

**Senator FORSHAW**—That would be helpful.

**Ms Halton**—Dr Towler was at those meetings and would be very happy to answer your questions.

**Senator FORSHAW**—You have been listening to the discussions. Can you enlighten me as to what, in broad terms, was discussed at these meetings?

**Dr Towler**—I am not sure that I can add too much more to what Ms Cass has discussed so far. The broad purpose of those meetings was for the department and our communications consultants to meet with people that we regarded as important to get their views about the plasma fractionation review and their input into what they saw as key issues. We thought it would be important to get those views prior to the development of the communication strategy.

**Senator FORSHAW**—What you are saying is that you thought it was important to have some understanding of the evidence that would be given and the submissions that would be given to the review in advance of it being given to the review by those organisations, and you had the PR company involved in that process with the department? That is what happened?

**Dr Towler**—No, I do not think that is what I am saying. What we are saying is that we felt it was important to be open with people who had a really key interest and had important views for us to take into consideration. It was really an opportunity for them to provide their information and their views on what were the key issues here.

**Mr Learmonth**—This is a long and complex process. This was not so much about the PR aspects. The principal objective here was actually stakeholder engagement.

**Senator FORSHAW**—I am beginning to believe that that is precisely the case, Mr Learmonth, that it was not about PR, at least in that sense. I turn to the Lockhart review into stem cell legislation, cloning et cetera. Was this same process adopted there? Did you have a

PR company and the departmental officials having meetings with stakeholders and people who would prospectively be looking to put in submissions to the Lockhart review, which was on a very complex issue?

**Mr Maskell-Knight**—The secretariat for that was provided by the office of the National Health and Medical Research Council. I am not sure that we are able to answer that question at the moment.

**Senator FORSHAW**—Is it a general practice, if there is a major review conducted by a committee similar to that established here, which is largely external, that there will be pre-review meetings at such an early stage with the PR company and those likely to make submissions and give evidence? Is that a normal practice?

**Ms Halton**—I would not regard it as being an abnormal practice.

**Senator FORSHAW**—I did not ask that. Are you aware whether this has happened on previous occasions when there have been major reviews conducted in regard to important health issues?

**Ms Halton**—I am aware that there are circumstances where there are technical matters and where people will be assisting in communication—and I think there is an issue here about the term 'PR', which sounds, if I can say it, like spin.

**Senator FORSHAW**—That is the name of their company, Royce PR. Sorry, it is not my spin.

**Ms Halton**—The implication here is that they were doing something inappropriate. Ms Cass has gone through with you the terms of reference in terms of what was actually asked for. If you can accuse the officers here of anything, you can accuse them of overdiligence in terms of providing an extra opportunity for the stakeholders to talk through some of the issues. The committee doing the review has stressed on a number of occasions, and to me personally, the need to ensure that a very technical issue was properly communicated. That committee took that view very clearly. When the chair of that committee, Mr Flood, first came to see me, when he was actually considering accepting this appointment, it was one of the key issues he raised.

**Senator FORSHAW**—That was going to be my next question. Was Mr Flood made aware of these meetings that?

**Ms Halton**—I do not know.

**Ms Cass**—Yes, he was aware.

**Senator FORSHAW**—Was he made aware before?

**Ms Cass**—He met with Royce on one occasion.

**Senator FORSHAW**—I cannot hear, I am sorry, Ms Cass.

**Ms Cass**—He was aware that those meetings were occurring.

**Senator FORSHAW**—When did he become aware of them?

**Ms Cass**—Once he commenced working as the chair of the review.

**Senator FORSHAW**—He was informed of them, but was that after the meetings had been held?

**Ms Cass**—No.

**Senator FORSHAW**—Was he informed before they were held?

**Ms Cass**—I believe so, yes.

**Senator FORSHAW**—Could you check that for me?

**Ms Cass**—Yes.

**Senator FORSHAW**—Did he express any view about that procedure?

**Ms Halton**—We can check on that.

**Senator FORSHAW**—I would like you to. I would like to know what advice was given to Mr Flood about the meetings, when that advice was given and what was his view, if any. Will overseas companies and interests be making submissions to the review?

**Ms Cass**—Yes, they will.

**Senator FORSHAW**—I understand Mr Flood is going to travel overseas in July to inspect blood plasma fractionation plants—is that correct?

**Ms Cass**—Philip Flood is going to the United States in July.

**Ms Halton**—Accompanied by other members of the review.

**Senator FORSHAW**—Would you take on notice to give us some details about the intended overseas travel?

**Ms Halton**—Yes.

**Senator FORSHAW**—In view of the time, I will have to put the other questions on notice.

**CHAIR**—The committee will suspend for morning tea.

**Proceedings suspended from 10.49 am to 11.09 am**

**CHAIR**—The estimates committee will now resume its inquiry into Health and Ageing's budget estimates. We have completed outcome 13 and are now to commence outcome 11, Mental health. Are there any issues on notice that you want to provide?

**Ms Halton**—While the mental health team are coming up to the table, could I just come back to one issue. We had a conversation yesterday on what I think was described as the top 10 underspenders and overspenders. I have actually had somebody do the numbers on this. The problem I have is that, because the year is not finished, we do not have actuals. Estimated actuals at this point in the year in a couple of these programs are still not accurate. What I might do, with agreement, is wait till the year is finished and then come back on notice just to give you the top 10. The overspenders are all areas where we have had new policy come in. Again, I have not got a final figure on expenditure on those, either, but the so-called unders are not completely but principally programs that are standing appropriations. Whilst we can estimate, we cannot be completely accurate about what will be spent, so I think it is better to use actuals rather than estimates. With indulgence, we will do that basically at the beginning of July.

[11.10 am]

**CHAIR**—We note that. We have our mental health people at the table. Thank you very much. Questions on outcome 11.

**Senator ALLISON**—Could we have a very brief update on the current review of the National Mental Health Policy and the evaluation of the third National Mental Health Plan? When are they expected to be complete and can we have a bit on the status of them at the present time?

**Mr Smyth**—The policy review was placed on hold pending the outcomes of COAG. That review will be chaired by Professor Harvey Whiteford, who is here, and at this stage we will reassess the timing for that post the July COAG meeting. The review of the current Mental Health Plan is also under way in terms of through the National Mental Health Working Group, which has now become the National Mental Health Standing Committee, and through that process the evaluation is ongoing.

**Senator ALLISON**—When is that due to be completed?

**Mr Smyth**—We hope to have that completed by the end of next financial year.

**Senator ALLISON**—Who is chairing that?

**Mr Smyth**—We do not have a chair for that at this stage. A lot of the work will be conducted through the Mental Health Standing Committee.

**Senator ALLISON**—There are six of those; is that correct?

**Mr Smyth**—There is one standing committee. That was the National Mental Health Working Group. It has now changed its name, because there has been an AHMAC change in its committee structure and it now comes under the HPPPC, which is chaired by Ms Robyn Kruk. I do not believe they have had their first meeting of that new group yet.

**Senator ALLISON**—So the HPPPC takes over from the National Mental Health Standing Committee?

**Mr Smyth**—The Mental Health Standing Committee reports through to the HPPPC.

**Senator ALLISON**—It is very complicated.

**Mr Smyth**—Yes.

**Senator ALLISON**—I understand the department has set up a division for mental health; is that correct?

**Mr Smyth**—That is not yet established. I think Ms Halton talked about what is happening with the departmental structure yesterday, but no decisions have been made.

**Ms Halton**—The proposal is that we will have a division that will have a much clearer focus on mental health. It will probably be combined with the Health Workforce Branch, but at the moment we have a far greater range of issues all concentrated in the one division. The suggestion is that we will have a division with a narrow focus, in other words, to give a big profile to mental health. I talked yesterday about the additional resources coming in, and the great advantage is that we will be able to do that.

**Senator MOORE**—And the general issues of workforce?

**Ms Halton**—We are likely to have a mental health and workforce area.

**Senator MOORE**—Was it outcome 13?

**Ms Halton**—It is 12 and 11.

**Senator MOORE**—It is 12 and 11?

**Ms Halton**—Yes.

**Senator ALLISON**—Have places been advertised for these new positions?

**Ms Halton**—Yes. In anticipation of finalising the structure—we did not want to finalise the structure and then get moving on the advertising; we know we will need people—we have advertised for both SES and clerical level staff, and that process has already commenced.

**Senator ALLISON**—Do you anticipate any problems in attracting staff to those positions? As I understand it, there were some vacancies that have not been filled in the existing workforce. Is that correct?

**Ms Halton**—No, there is a workforce issue in Canberra more broadly. I think work in mental health will be relatively attractive. It is a very high-profile area. There are a lot of people very interested in working in mental health, so I am not anticipating a huge difficulty.

**Senator ALLISON**—How many positions have been advertised?

**Ms Halton**—We have not advertised a specific number. What we have done is advertise generally. The intention is that, when we finalise the structure—and we talked yesterday about the number of resources—we will then draw from a pool of people those who have expressed interest and who are suitable.

**Senator ALLISON**—Going back to your response about the policy review, as I understand it that policy review started back in July 2005; is that correct?

**Prof. Whiteford**—We started reviewing the current policy when the decision was made on the third National Mental Health Plan 2003 to 2008, which was the third five-year implementation of the 1992 mental health policy. The decision was made that we would look at having a new national mental health policy by the completion of the 2003 to 2008 plan, and that we would start 2008 with a new policy and the first plan to implement that policy. Obviously, what has happened since then is that the COAG mental health reforms have come along—and much more than health—and so the drafting of any new policy has been put on hold and, of course, any plan to implement that has been put on hold until COAG deliberations are complete and we know what the total COAG package is.

**Senator ALLISON**—With respect, that sounds a bit like putting the cart before the horse. Why was a decision made to go that way?

**Prof. Whiteford**—The decision that health ministers took was, as I understand it, to start the process of drafting the new policy while the current plan, the 2003 to 2008 plan, was being implemented. That would allow time for consultation and have a new policy and its implementation ready to go by the time the 2003 to 2008 plan was completed.

**Senator ALLISON**—What will the health ministers have to consider? The review started some time ago. Some work presumably must have been done on it. Was there a report of the work done thus far?

**Prof. Whiteford**—No. There had been no meeting of the group that was being assembled to draft the new policy before COAG's announcement was made. The group never met.

**Mr Smyth**—The group was due to meet in early February, and we then received notification that COAG was to meet in relation to mental health on 10 February, so that is when a decision was made to put it on hold. The actual steering committee never met.

**Senator ALLISON**—In the COAG meetings that have been held so far, what discussion has there been about review and policy? I am just trying to work out how the COAG meetings actually fit in to this.

**Mr Smyth**—The discussion in relation to the policy has just been to put it on hold until we see what the full outcomes of COAG and the National Action Plan for Mental Health will be.

**Ms Halton**—Can I comment here? It is fair to say that the resources that we had been going to swing into the review, and all the evidence and information that we had about what had been going on with mental health policy—and I think it is fair to say that this is the case with many of our state colleagues as well—was swung into and behind the people who were contributing to the COAG process. So, in other words, the COAG process and the initiatives, for example, we announced for the Commonwealth as part of our contribution to COAG were very much informed by the experience we had had of the existing policy. The team literally was moved from focusing over here, to focusing over there. The experience we had of the existing policy et cetera, and indeed the people who were party to the process which was run and the committee that was run by the head of the ACT Health Department, who were responsible in this area, were all basically then focused on the COAG work.

**Mr Smyth**—That is true.

**Senator ALLISON**—Yet we have a situation where the Commonwealth's contribution into COAG is the $1.8 billion package released some weeks ago—

**Mr Smyth**—$1.9.

**Senator ALLISON**—$1.9 billion, which seems to have hit something of a brick wall with the state governments. Ministers for health in other jurisdictions—

**Ms Halton**—I do not actually think that is right.

**Senator ALLISON**—This package seems to be very fully worked out when it comes to how many personal helpers there are and how many respite places, and yet the state governments did not seem to know about this package and they seemed to be surprised by the size of the Commonwealth contribution. In fact, we have heard that some states have been annoyed about the way in which it was done. This hardly sounds like a process which is leading into a policy review.

**Ms Halton**—You are asking us to comment on what is essentially a political issue, and we are not going to do that. What I can tell you is that all of the expertise that we had in relation to mental health was contributed to, firstly, the COAG process discussion, which is ongoing,

and, secondly, to the announcement which the Prime Minister decided to make prior to COAG.

**Senator ALLISON**—To what extent is there going to be a review of policy in the COAG process if the Commonwealth has already determined what its contribution is going to be? Is that package now up for grabs in a policy discussion in COAG or not?

**Ms Halton**—That is a question that you would have to ask the Prime Minister, because it is the Prime Minister's announcement.

**Senator ALLISON**—We do not seem to have a minister here through whom we might ask.

**Ms Halton**—No, but he would not be able to answer this either, because essentially this is a matter for the Prime Minister.

**Senator ALLISON**—So the Prime Minister now is setting policy for mental health?

**Ms Halton**—He is the key Commonwealth representative to COAG and this issue is on the COAG agenda.

**Senator WEBBER**—If I may intervene, with all due respect, when the Department of Prime Minister and Cabinet were asked in estimates about the mental health package, they said the health department knew all about it.

**Ms Halton**—Yes, of course we do.

**Senator WEBBER**—You might like to bring us up to date with what the view is then.

**Ms Halton**—No. The question I am being asked is what will happen in COAG.

**Senator WEBBER**—Yes.

**Ms Halton**—In terms of the mental health package, we can give you chapter and verse on the detail of what is in the mental health package. I am actually being asked a policy question about what in fact will occur in COAG, and I cannot answer that because it is not this portfolio's responsibility.

**Senator ALLISON**—The department has no input any longer into this (a) review and (b) policy change if there is to be one following review?

**Ms Halton**—We have input into the COAG process in terms of contributing to the discussion as to what will be the Commonwealth position, but we do not control that and therefore we cannot answer questions about that process. In terms of what health ministers will do, they will discuss mental health and in fact they have ongoing discussions about mental health, but ultimately they will now all have to see what comes out of COAG.

**Senator ALLISON**—We are waiting to see what the states and territories bring forward to COAG by way of packages?

**Ms Halton**—Yes, correct.

**Senator ALLISON**—The Commonwealth is not aware of what the states will likely bring to COAG? Is that correct?

**Ms Halton**—I think a number of state Premiers have made some indication of their likely commitment but, in terms of the detail, no they have not yet had that discussed with us.

**Senator ALLISON**—COAG is going to be a process whereby the Commonwealth has already put on the table its fixed position, if you like, its package. The states will do likewise. Again I ask you, how is this going to inform policy or is the policy going to be written after the event? Is the policy going to just confirm what everybody brought to the table at COAG? Is that how it works?

**Ms Halton**—My expectation of process—but, again, I cannot prejudge and pre-empt what might happen in COAG—is that once COAG has reached an agreement and a position then health ministers will be asked to take away, I would expect, that agreement, that position, that package—whatever it might be—when they have the conversation. I have sat in COAG meetings in the past and ultimately the Prime Minister and the Premiers will, I anticipate, come to some agreement, which will result in a statement. My expectation is they will then say to health ministers, go away and do X or Y, or X and Y, and then health ministers will have a discussion—and there are a number of health ministers meetings scheduled not long after COAG—and they will then have the outcome of COAG on their agenda for discussion and for an agreement about process.

**Senator ALLISON**—Will there then be the completion of the mental health policy review?

**Ms Halton**—I do not know the answer to that question because that will have to be discussed by health ministers.

**Senator ALLISON**—It could be the case that the policy review goes no further. Is that a possibility?

**Ms Halton**—Essentially they could choose to say, ‘We do not need to do that now because there is an outcome that we all agree with and we are happy with it and we were not asked to do this.’ They could decide to do whatever they wish. They are ministers and, ultimately, I cannot prejudge what they might be likely to agree.

**Senator ALLISON**—As I understand it, part of that review was to have an independent international team of evaluators—does this make sense—who were to look at all of the reports and the inquiries that have been conducted since the commencement of the National Mental Health Strategy. Has that taken place? Has there been an outcome of it?

**Prof. Whiteford**—No, it has not. As part of the review of each of the five-year plans that have gone before us we have had international experts come in and provide an international perspective. That happened after the first National Mental Health Plan, it happened after the second one and it was expected that it would happen after the third one.

**Senator ALLISON**—It was expected?

**Prof. Whiteford**—It was expected.

**Senator ALLISON**—What is the status?

**Prof. Whiteford**—The status is that the review of the third plan is proceeding with the collection of data on the current state of mental health. All that we have at the Commonwealth has been fed into the COAG process. The discussions around the COAG process, the collecting of data includes a wide range of data, such as the Senate committee report into mental health, which you chaired, and other reports such as those of the Mental Health

Council. That fairly wide consultation has gone into those sorts of reports. All of that has been fed into the COAG deliberations.

**Senator ALLISON**—Your report as well?

**Prof. Whiteford**—I do not have a report. The committee which was to convene and which was to pull all of that together has been superseded by the COAG process.

**Senator ALLISON**—The committee which was to pull together what?

**Prof. Whiteford**—All the information on the evaluations of the third plan and the drafting of a new national mental health policy. As Ms Halton said, the COAG process is more than health; it is employment and a range of other government portfolios of which health is one part.

**Senator ALLISON**—I understand.

**Ms Halton**—That was essentially my point: there has been a huge amount of work done—you would probably know better than just about anybody else in this area—and what has happened in this COAG process is that, instead of the issue being dealt with within the confines of the health ministers' environment, it has actually been broadened and all of the input that we would have taken into our review has essentially been channelled into this COAG process.

**Senator ALLISON**—That international evaluator's report—they have received all of this documentation, but they are not going to take it any further? What stage are they exactly at?

**Prof. Whiteford**—They have not even been appointed. There is no international group or individual who has been charged with the responsibility of commenting on the third plan or the new policy. We never got to that point.

**Senator ALLISON**—COAG will not be informed by this independent evaluation?

**Prof. Whiteford**—No.

**Senator ALLISON**—COAG is currently being informed by those who are currently working in the system. Is it fair to say that?

**Prof. Whiteford**—Yes.

**Senator ALLISON**—You were reported as saying that accountability was the key contributing factor to the failure of the mental health system over the last 12 years. How is that view to be reflected in this COAG process?

**Prof. Whiteford**—If that was said, I was misquoted. I do not think I have said the current system has failed. One of the problems we have with the mental health system in Australia now has been insufficient resourcing and I think a failure to implement the policies as well as they needed to be implemented. Over time, one of the failures of the system was insufficient information fed through to let us know how we were tracking. That lack of information has been fed into the COAG process and I know it is one of the things that is being considered.

**Senator ALLISON**—What is the process with feeding that in? Is there a document of some sort or what is it?

**Prof. Whiteford**—Certainly the COAG deliberations, or a lot of the information that has gone to COAG and is going to COAG, has pointed out that there has been insufficient information provided in a timely fashion about the mental health system, at a state level especially, and I am expecting that that will be part of the deliberations of COAG in July. So whatever COAG decides in July about reforming the mental health system will include some way of monitoring and reporting on government's implementation of that.

**Senator ALLISON**—Sorry to press this but I am still not clear about the process. COAG will compile in various ways through various bureaucrats all of the reports and evidence that is out there and it is not going to be compressed or summarised or put into another kind of document. Is that what you are saying?

**Mr Smyth**—The document that COAG has been asked to produce is a national action plan on mental health and that is currently still being worked through between the Commonwealth and the jurisdictions.

**Senator ALLISON**—I think, if I can say this, in the briefing that you provided to the committee it was said that this did not relate to the third plan or the National Mental Health Strategy. Is that correct?

**Mr Smyth**—Everything that is currently and has been going on in mental health has been fed into the COAG deliberations. All documents have been assessed, including the Senate's mental health inquiry—your report—and the *Not for service* report from the Mental Health Council of Australia and various evaluations of programs. There has been a whole raft of documents and information that has been taken into account in the deliberations of the senior officials and the health working group, and there has also been consultation with external bodies and agencies to make sure that there is a wide range of community consultation and input into that process. There have also been a number of portfolios across government at the various levels involved in the input into that.

**Senator ALLISON**—Just coming back to you, Professor Whiteford, do you say that accountability is not an issue; were you misquoted in your remarks?

**Prof. Whiteford**—The misquote would have been if I had said that I believe the mental health system has failed in the last 12 years. We have a much better mental health system in Australia now than we had in 1992 when the National Mental Health Strategy started. I think one of the things that changed over time was the amount of information coming to allow us to monitor the system, and in that sense I believe accountability is very important in ensuring that we have a good mental health system and we know how it is tracking over time.

**Senator ALLISON**—With your views on accountability, has that been fed into the COAG process?

**Prof. Whiteford**—Yes, it has.

**Senator ALLISON**—Can we ask in what form?

**Prof. Whiteford**—A large number of people have suggested performance indicators, suggested types of performance indicators, and areas where it is important to monitor changes in the system at a population level, at a service delivery level. I am sure that COAG will give that serious consideration.

**Senator ALLISON**—There is not a document per se that you could provide the committee with?

**Prof. Whiteford**—I have not got a document.

**Mr Smyth**—We are unable to provide any documents out of the COAG process. That is quite a confidential process within government, as you will understand.

**Senator ALLISON**—When you consult widely, as you said you will, what do you give people by way of something to consult on?

**Mr Smyth**—The consultations have been handled by the key agency running the COAG process, which is the Department of Prime Minister and Cabinet, and they have held various consultations with key bodies. They had one a number of months ago in relation to COAG where they pulled together a group of key stakeholders and sought their views, and there is further consultation to take place as well with some key stakeholders prior to the meeting of COAG in July.

**Senator ALLISON**—Chair, I have got some other questions about the package itself, but there may be others who want to ask about this process.

**CHAIR**—I would not mind asking a question. I understand the Commonwealth has put on the table proposals for mental health enhancements for the COAG meeting. Do you know what states have put on the table their proposals for that process—in the public sense, in the sense that the Commonwealth has already put on the table some of its proposals?

**Mr Smyth**—There have been announcements made by New South Wales, Victoria and Western Australia. Obviously we do not know what may be brought to the COAG table as well. That is a decision for those governments to bring forward.

**Ms Halton**—A number of those governments have made what I would describe as budget announcements, as best we can tell. I do not think we are in a position to comment in great detail on those and, as has just been suggested, it would be inappropriate of us to speculate about what states will actually bring to the table for the COAG discussion.

**CHAIR**—I am not asking you to speculate. I just want to know what is already on the table.

**Senator ALLISON**—Hasn't WA announced $25 million?

**Ms Halton**—A number of states have announced moneys in this area. They are rolling out progressively, basically, in terms of their announcements.

**CHAIR**—If it is not too difficult, is it possible to get a copy of the media statements where those announcements have been made?

**Mr Smyth**—No problem at all.

**CHAIR**—Thank you very much. Any questions about the COAG process?

**Senator MOORE**—Just a clarification point. I just want to make my own mind very clear. In terms of the COAG package that is going through that particular process, it is being handled by PM&C. Is that right?

**Mr Smyth**—Yes.

**Senator MOORE**—The technical advice on mental health issues is being handled by your section of the department?

**Ms Halton**—Yes.

**Senator MOORE**—You are briefing PM&C and the minister if required. So if there is information to be regarded on the nuts and bolts of mental health, then that comes through your area?

**Ms Halton**—Yes. When I said earlier all of the resources we had were focused this way, we literally turn around and focus them that way. I do not think Prime Minister and Cabinet would claim any particular expertise in this area and so all of the expertise, the content knowledge, if you like, has come from the portfolio.

**Senator MOORE**—You are really the technical briefers on this area?

**Ms Halton**—Yes.

**Senator MOORE**—In Prime Minister and Cabinet in the estimates, Senator Webber was told that your department was fully aware and involved in the process leading up to the COAG for this particular issue?

**Ms Halton**—Absolutely.

**Senator MOORE**—They also said that the department of health knew about the PM's mental health package on 30 March. Can you confirm that?

**Mr Smyth**—That is when the package went to cabinet, that evening. We clearly had to brief our minister and the parliamentary secretary prior to going into cabinet.

**Senator MOORE**—That was the awareness that you had at that day, that you were briefing Minister Abbott before Minister Abbott went into cabinet, in due process as you would do.

**Ms Halton**—We cannot comment on cabinet processes.

**Senator MOORE**—No, but in terms of when the department was aware of it?

**Ms Halton**—We have been involved in the development of the initiatives all the way along.

**Senator ALLISON**—Professor Whiteford, you are actually contracted to three departments, are you not?

**Prof. Whiteford**—No.

**Senator ALLISON**—You are not contracted to PM&C?

**Prof. Whiteford**—No.

**Senator ALLISON**—Just to the department of health?

**Prof. Whiteford**—I provided some advice to the department of immigration as well.

**Senator MOORE**—We will be asking about that later.

**Ms Halton**—You are very generous, Senator.

**Senator MOORE**—Maybe for the record, just to get that clear, what exactly is your role and how does it work?

**Prof. Whiteford**—I provide advice.

**Senator MOORE**—Do you have a particular title?

**Prof. Whiteford**—Principal Medical Adviser (Mental Health).

**Senator MOORE**—That is through the department of?

**Prof. Whiteford**—Department of Health and Ageing.

**Senator MOORE**—As Principal Medical Adviser (Mental Health) in issues to do with mental health it would be expected that if anyone had need of your advice it would go through the department to see whether that would be appropriate?

**Prof. Whiteford**—That is correct and that is what has happened with the Prime Minister and Cabinet.

**Senator MOORE**—So you have given it to PM&C, Immigration—anyone else?

**Prof. Whiteford**—No. The Immigration one is a separate short-term contract for specific advice—

**Senator MOORE**—It was bracketed around that particular process.

**Prof. Whiteford**—which is now coming to an end. The contract with Health has been to assist the health department in informing and advising the Department of Prime Minister and Cabinet. So when I went to Prime Minister and Cabinet I went with my Health colleagues to provide technical advice.

**Senator MOORE**—Is there a contract with any other department?

**Prof. Whiteford**—No.

**Senator ALLISON**—Are you engaged more or less full time in your department?

**Ms Halton**—I think he would say he feels like it!

**Prof. Whiteford**—It feels like that, but it is not. No.

**Ms Halton**—He has got a day job as well.

**Prof. Whiteford**—I have a half-time chair at the department of psychiatry at the University of Queensland and the other half of my time I spend advising the Commonwealth government.

**Senator ALLISON**—Do you practise as a psychiatrist?

**Prof. Whiteford**—At the university time I do practise as a psychiatrist, yes. It is a requirement of the university that you have a clinical role, which I do.

**Senator FORSHAW**—I have a question about the COAG situation. A moment ago, you were talking about PM&C driving the process. In terms of this relationship between Health and PM&C, after the COAG process is completed do they step back?

**Ms Halton**—Yes, they do. This is not dissimilar, I have to say, to the processes that I chaired when I was in PM&C. Essentially, the process of bringing together across government

a view and a series of proposals in order that COAG can consider it—and this process is mirrored in the states and territories by the premiers' departments, who collectively then advise their chief ministers and premiers—and they and the Prime Minister come to agreements on particular matters. Then, in terms of taking forward those issues of implementation, we would have principle carriage. To the extent that there is ongoing work in COAG on other issues—for example, I am aware that they are working on human capital—we continue to input into those processes to the extent that it is relevant and in terms of running the initiatives. Let us assume that COAG agrees with a swag of initiatives that will be pursued under this broad heading. It is not my expectation, and indeed I do not think that it is theirs, that Prime Minister and Cabinet would have an implementation role. That reverts to line departments.

**Senator FORSHAW**—I understand that. It is probably more a matter for us to pursue with PM&C in the future. As we all know, it is the implementation of this that is the critical issue.

**Ms Halton**—Of course.

**Senator FORSHAW**—Given the direct interest of the Prime Minister, which is replicated in the states with the relevant premiers, I was just thinking about what they are going to do post the COAG process to ensure that it is—

**Ms Halton**—That it happens.

**Senator FORSHAW**—Yes, and that they maintain a direct interest in it.

**Ms Halton**—Of course. My expectation—and, again, one cannot prejudge what will happen—is that there will be a process, and I know this has happened at COAG in the past, but there will be a report back in perhaps 12 months, or whatever they decide is appropriate, in terms of what actually has happened on the ground. You are quite right: you can make an announcement but, unless you deliver on it, you are not going to get the desired outcome.

**Senator FORSHAW**—There is no talk at this stage of a joint implementation unit or anything like that, or some structural arrangement involving both Health and PM&C?

**Ms Halton**—No.

**Senator ALLISON**—My questions relate to workforce issues and the mental health nurses that are to be placed with psychiatrists and GPs under certain circumstances. As I understand it, some issues have been raised about the professional relationship between mental health nurses and GPs. Has that been expressed to the department by nurses, in whatever form?

**Mr Smyth**—We have had consultations since the announcement of the package with the Australian and New Zealand College of Mental Health Nurses and we have also had consultations with the Royal Australian and New Zealand College of Psychiatrists as well. There have not been any major issues raised, as far as we are aware.

**Senator ALLISON**—They did not raise this issue of the professional relationship—is that right?

**Mr Smyth**—A lot of the detail is still to be worked through in relation to these measures.

**Senator ALLISON**—Did they raise this as an issue?

**Mr Smyth**—No. That was not raised with us at all.

**Senator ALLISON**—That is interesting. Concern has also been expressed that these mental health nurses will come out of the public mental health system—out of acute care, areas of mental health services or existing areas. Has that been raised with you?

**Mr Smyth**—Certainly the Australian and New Zealand College of Mental Health Nurses looked at where the workforce was likely to come from. We anticipate that there are quite a number of mental health nurses that have changed professions and are currently out there in the community and would come back into this measure. They would seek to re-enter the workforce. As you know it is a free labour market out there and we cannot decide where people come and go from.

**Senator ALLISON**—Have you done some sort of study to identify how many were trained, how many were doing other kinds of jobs and where they might come from? We are talking about 400—is that right?

**Mr Smyth**—There are 420 mental health nursing places that are going to be established through universities.

**Senator ALLISON**—I am talking about those which will be placed with psychiatrists and GPs.

**Mr Smyth**—I think the figure is $191 million and there is some modelling around the numbers. It may be best for Judy Daniel, who is responsible for this measure in the department, to answer that specific question.

**Ms Daniel**—The number you are quoting is the estimate that we have of the coverage in terms of nurses in the fifth year of this measure. It clearly reflects assumptions about uptake and sector capacity to generate these positions. Workforce is one element of that. Our expectation, as Mr Smyth has indicated, is that there are a number of nurses who are now not working in the sector.

**Senator ALLISON**—Is this estimation a study that you did?

**Ms Daniel**—No. We have taken advice from the sector, but we have not done a formal study to inform that.

**Senator ALLISON**—What do you mean by from the sector? Who did you consult with?

**Ms Daniel**—We consulted through Mr Whiteford with representatives of the industry.

**Senator ALLISON**—What industry?

**Ms Daniel**—With the mental health nursing association and through Mr Harvey Whiteford.

**Senator ALLISON**—The mental health nursing association?

**Ms Daniel**—Yes.

**Mr Smyth**—It is the Australian and New Zealand College of Mental Health Nurses, but I understand it is soon to change its name to the Australian College of Mental Health Nurses. New Zealand has decided to do its own thing.

**Senator ALLISON**—Do you have a ramping up that you could make available to the committee? If it is 400 by the fifth year, what is it in the other years?

**Ms Daniel**—We can certainly have a look through and give you the profile. That would be something that we would have to take on notice. It might be worth commenting, and it is not a measure that I have responsibility for, but there is also provision within the package for additional mental health nurse places.

**Senator ALLISON**—Is there any further detail on which GPs would be entitled to a mental health nurse?

**Ms Daniel**—The implementation date for this measure is 1 July 2007. Our expectation is that part of the development for that will be to determine the eligibility criteria for general practices and psychiatry practices that would take on this role.

**Senator ALLISON**—By what date will you expect to have those criteria established?

**Ms Daniel**—We will be working on development of the implementation. Our process would see us working through those criteria over the next few months in consultation with the sector. The sorts of things that we would see practices having are obviously an appropriate capacity to employ a specialist mental health nurse for a minimum number of sessions and GPs within the practice with appropriate training. The measure is targeted at patients with severe mental illness, so practices would have to have appropriate patient load and patient reminder and recall systems. How those criteria are taken forward. in an implementation sense, is something that we will clearly consult with the industry about.

**Senator ALLISON**—You anticipate that GPs will be treating people with severe mental illness?

**Ms Daniel**—Information that we have sourced—we will have to find the name of the survey—indicates that there are a significant number of patients with severe mental illness across Australia whose treatment is focused within general practice.

**Senator ALLISON**—What sort of criteria will apply for psychiatrists?

**Ms Daniel**—The measure will be open to psychiatry practices. It would be my expectation that it would be available to psychiatry practices that were interested in participating in the measure.

**Senator ALLISON**—If all the psychiatrists apply to have a mental health nurse, how many would there be in that category—a few more than 400, I would imagine?

**Ms Daniel**—The estimates that we have done are based on assumptions about uptake within the sector and about patient load, but clearly it is not assumed that the measure will be universally taken up, and workforce may be one of the limiting factors on that.

**Senator ALLISON**—How many privately practising psychiatrists are there?

**Ms Daniel**—I would have to take that on notice. That is not a number that I have.

**Senator ALLISON**—Is it some thousands?

**Mr Smyth**—Not thousands. We do not know the actual number. This is not a measure where we would see a nurse being attributed to one psychiatrist.

**Senator ALLISON**—So what is it?

**Mr Smyth**—It would be very much dependent on a business case that could be put forward, or the need. A group of psychiatrists put a case to the department that it might be four or it might be five. It would very much depend on their caseload and the employment of that nurse. The same with general practice. We would not be looking to just base a nurse in each general practice.

**Senator ALLISON**—What judgments would you make about caseloads for a psychiatrist? I would have thought that most people who see a psychiatrist would qualify. Psychiatrists deal with mental illness, unlike GPs, who might only have a certain number of patients who have mental illness.

**Mr Smyth**—A lot of the details are still going to be the subject of consultation with the profession; there is no question about that. But when you look at the caseload of psychiatrists, not all of those patients will require or benefit from a mental health nurse. We need to be very flexible in the way that we approach this with the profession, with both general practice and specialists.

**Senator ALLISON**—How soon will you have the criteria developed so that psychiatrists will know what is a winning submission, if you like?

**Mr Smyth**—We will be working very closely with the profession over the coming months. I cannot give you a definitive date.

**Senator ALLISON**—Do you have any idea of the break-up of the 400? Will half be going to GPs and half be going to psychiatrists, or something other than that?

**Ms Daniel**—The assumptions that we have made in costing the measure have assumed a higher rate of take-up of this initiative in psychiatry than in general practice. I do not have that breakdown with me but they are estimates that we have used in constructing the measure.

**Senator ALLISON**—How much higher?

**Ms Daniel**—I do not have in front of me that exact number.

**Senator ALLISON**—We might end up with quite a lot fewer than 200 mental health nurses being available for general practices?

**Ms Daniel**—The basis of the costings generates those numbers. It is based on an assumption of a caseload and clearly an average cost—

**Senator ALLISON**—Your assessment is based on your expectation of take-up and your expectation that fewer than 200 general practices have the sort of caseload that you are talking about?

**Ms Daniel**—Stepping back and remembering that it will not necessarily mean that every practice employs a nurse on a full-time basis. General practice, by its very nature, is a mixed business and to employ the services of a full-time nurse is probably not what most practices will do. Certainly in some large urban practices that might be an appropriate pattern, but it is more likely that that number of nurses will be spread across a number of general practices.

**Senator ALLISON**—This will rule it out for country areas, for instance, where there is only one GP and certainly no psychiatrist. Where is the equity, if you like, for rural people in this proposal?

**Ms Daniel**—Our anticipation in the way that we have constructed the measure to deal with that issue is that certainly in some areas it will not be appropriate for an individual practice to take on the role of engaging the mental health nurse. This is certainly something where we will need to work further to develop the detail of implementation, but we are anticipating that, for example, the Divisions of General Practice may be the auspicing agent for a nurse, so that that nurse's services can be spread across a number of practices where the individual practice size does not—

**Senator ALLISON**—So it will be one nurse spread across a number of practices dealing with people with the most serious illness in mental health. How many do you expect such a nurse to have on her books? It probably will be a her, but it may be a him. What sort of caseload are we talking about here? You did develop caseloads for the personal carers, I understand, of 60 per person. What do you anticipate will be the case for a mental health nurse?

**Ms Daniel**—From memory, the number we have dealt with is 15 patients for a nurse at one time. I would have to take that on notice and check. I think it is 15 hours per patient. I will have to check the patient load. Certainly within that we have allowed for some additional time in the recognition of travelling time in remote areas. In rural and remote areas there is a need for a transport time and distance component.

**Senator ALLISON**—How many patients do you believe this will provide services for?

**Ms Daniel**—Our estimate by the fifth year of the measure is that there will be 36,000 patients covered by this measure.

**Senator ALLISON**—What work was done to look at the need? Will 36,000 meet the needs of all those who would be in this category?

**Ms Daniel**—The measure as constructed will not deliver universal coverage for every patient who is identified as having severe mental illness and being treated in the community but, stepping back from that, it is not necessarily a service that every patient with a severe mental illness will need. Clearly the element of targeting that will also accompany the measure is some decision within a practice about the patients for whom this service will be of benefit and our expectation is that there will be a range of patient eligibility criteria underlying the measure.

**Senator ALLISON**—I have just a quick question about the Mental Health Council. There was an extra $1 million over five years for the Mental Health Council.

**Mr Smyth**—Over five years, that is right.

**Senator ALLISON**—What was the basis of that? Why $1 million and not some other figure?

**Mr Smyth**—It is a decision for government at the end of the day, but it was to increase the capacity and the ability of the Mental Health Council to provide advice to government in relation to mental health issues.

**Senator ALLISON**—They already do that, do they not?

**Mr Smyth**—They already do that.

**Senator ALLISON**—What is it that is additional about what the Mental Health Council will be asked to do?

**Mr Smyth**—The Mental Health Council will be a key stakeholder in the implementation of some of these measures. We have already approached them and told them that we would like to engage them as one of the principal stakeholders in mental health in the country to provide advice to the government on carers, consumers, et cetera, on the implementation of some of these measures.

**Senator MOORE**—Is that a change in their current relationship between you and them?

**Mr Smyth**—Not at all.

**Senator MOORE**—Basically what you are saying is that it is a continuation from your perspective of what is already happening?

**Mr Smyth**—That is correct.

**Senator ALLISON**—What did the Mental Health Council put to you was necessary for a budget?

**Mr Smyth**—We have a proposal from the Mental Health Council that is currently under consideration by the department for a number of program components that they would like to undertake. That is a discussion between us and the council.

**Senator ALLISON**—Did they not put a submission to you about their operating means?

**Mr Smyth**—They did put a submission to us, but I would have to take the question on notice in terms of the actual numbers. That is a submission from them to us.

**Senator ALLISON**—It is my understanding that in previous years they have run at a loss. Can you confirm that?

**Mr Smyth**—I am not sure of the financial situation of the council. That would be a question that you would need to ask them.

**Ms Halton**—Just going back to those questions about the use of nurses in practices, it might be useful for Professor Whiteford just to give you a little bit of a technical background—briefly, I will grant you—and just to make a comment in relation to the number of psychiatrists, because I think it is important to see these positions in context.

**Prof. Whiteford**—The nurses are targeted towards people with severe chronic mental illness. There are a number of those people who are cared for only in general practice. There are close to 100,000 of these people across Australia. The majority are managed in the public sector. Close to 50,000 are managed in private psychiatry and in general practice.

One of the aims of this measure is to allow private psychiatrists to group together to employ a mental health nurse who could do home visits to check on patients' mental states, give medication and monitor their physical health. They could do it where the person is living and then report that information back to the doctor.

What we are trying to encourage—through the MBS-funded system and through primary care and private psychiatrists—is specialist psychiatrist input, general practice input, mental health nurse input and also clinical psychology input, so we have much more of a

multidisciplinary approach in the private sector than we have had in the past. I think there is capacity for nurses to add to that—to ensure patients receive better care, and are prevented from unnecessarily falling through the gaps in service, perhaps ending up in emergency departments in the public sector because they could not get access to treatment. That package is much better now under the proposals that the government has put together and I think the role of the mental health nurse in that is a critical element.

**Senator ALLISON**—Can you comment on my question about how this fits for people in the country?

**Prof. Whiteford**—It does fit in the country because, even though we might not have psychiatrists there and we might have only one GP, the nurses will be mobile. In my discussions with the College of Mental Health Nurses they said that there are mental health nurses who have left public sector psychiatry—

**Senator ALLISON**—Yes, but psychiatrists are not in the country.

**Prof. Whiteford**—No, but the nurses are.

**Senator ALLISON**—So the nurses will work for someone in Collins Street in Melbourne but be off in central Australia? How does it work?

**Prof. Whiteford**—A lot of private psychiatrists see patients from country Australia. They might only see them once or twice a year because the patient has to travel long distances to see the psychiatrist. The psychiatrist may be in a provincial centre and the person be living a long distance from that, but they do go into those centres to see the psychiatrist.

**Senator ALLISON**—The nurse will travel instead of the patient. Is that what you are saying?

**Prof. Whiteford**—The nurse may well travel instead of the patient. The nurse may go to where the patient is, where the GP is, and have a caseload of patients who are spread across a fairly sizeable geographic area.

**Senator ALLISON**—They will spend all their time in the car driving around?

**Prof. Whiteford**—Unfortunately, that—

**Ms Halton**—Someone is going to have to.

**Prof. Whiteford**—That is right.

**Ms Halton**—Essentially the idea here is to have a spread of these nurses geographically across the country. And, yes, there are different issues in the bush about who actually hosts one of these positions. It has been mentioned that we may well look at the divisions of general practice as being a likely location for these nurses, but essentially the trick will be to find a way of connecting the patients with the nurses and with the practitioner who helps to manage that care, which I think is what Professor Whiteford is going to.

If you have a patient in the country, who is normally managed by a single GP and who maybe twice a year sees a psychiatrist in Collins Street or wherever they might be, we should be able, and the plan would be, to use that additional resource to give them more frequent contact, not only with them but also with their medical practitioner. It would enable the medical practitioners—the psychiatrist and the GP—to have someone else, a reliable person

who understands the clinical issues, to liaise and help manage that person's care. You are absolutely right: the question of how we make sure that that cover extends to the bush is something that we are talking to the professions about, but the intention is to make sure that it does extend.

**Senator MOORE**—It is anticipated that this will not kick off until 1 July 2007. So, when we come back in two years' time and we are looking at the necessary questions, whoever is on what side of the table—I just thought I would throw that in—in 2007 and 2008, we should be able to have a model that shows where up to around 400 nurses will be working.

**Mr Smyth**—That is year five.

**Senator MOORE**—There will be a modelling process to ensure that those facilities are spread across the whole country. Is that what you are saying?

**Senator WEBBER**—We are just about to have a WA conspiracy here, Senator Adams and I, I am sure, although she is probably approaching it from a different point of view—

**Senator ADAMS**—Since I live in the bush, yes, I am.

**Senator WEBBER**—but Claire is used to us ganging up on her. In Western Australia we usually get about 10 per cent of whatever an allocation is. So if there were to be 400 by year five, we would get 40 of them by year five. I do not know how you service a state as large as ours. They are not going to be driving anywhere much. If they are down south they will be, but not up north. I think we are actually mounting the case for you to have more, not less. I just want to place on record that 40 by year five—though we will take anything—are not going to get us very far.

**Senator MOORE**—Will the model pick up that geographic spread? Is that one of the things in your model?

**Ms Halton**—That is it.

**Senator MOORE**—And the issue that Senator Allison raised, about the spread between psychiatrist services and GP services: is that also in the model?

**Ms Halton**—Correct.

**Mr Smyth**—Can I also add that, as part of the GP-Psych Support program, GPs are able to access advice from psychiatrists via telephone, fax and the internet on a 24-hour turnaround basis. So there are some in-built consultation processes that we will look to align with some of those programs as well.

**Senator ADAMS**—I come from rural Western Australia, down in the Great Southern. I want to say just how successful our Great Southern mental health team is. They are doing work with the divisions of general practice and working within the GPs clinics. That is working really well and this will just complement it. But we do have a working model, and most of the multi-purpose service areas in Western Australia are really working with the multidisciplinary team. I will be right there behind you with this, because it is just so important, but the models there are working.

**Ms Halton**—Yes, exactly, and we are very conscious of that.

**Senator MOORE**—That is part of the program.

**CHAIR**—Are we done with mental health nurses?

**Senator MOORE**—I have got some questions about the allocation in the program so far for fit-out costs. There is actually a specific allocation, in the public statement, of $4.9 million, described as: capital funding in 2006-07 for building fit-out costs for the Department of Health and Ageing. Can we get some details of that? Why is that so specialised under mental health?

**Mr Clout**—The answer to your question is that, as a whole, the entire collection of mental health measures, on top of the existing group of staff in the department, was such that we approached Finance to agree a costing, not only to allow for the direct costs of the staff on these particular measures but also to recognise the fact that this would take that group of people to a new size—a division, more or less. If that were to be the case, there would have to be some additional overhead agreed for that. So additional staff, as well as things like accommodation, were agreed. When it then came to publishing those estimates, or publishing those measures, we took the additional $4.7 million in capital, that was agreed as that fit-out cost—

**Senator MOORE**—Sorry, I just missed that figure. What was that again?

**Mr Clout**—$4.7 million.

**Senator MOORE**—So that is the same; $4.7 million. Right.

**Mr Clout**—We divided that across all of the mental health measures in that package—

**Senator MOORE**—Okay; so you carved it up.

**Mr Clout**—as a way of at least bringing it to book in the budget measures, because it had to be brought to book some way. But there was not a specific measure agreed by government which said '$4.7 million fit-out cost'.

**Senator MOORE**—On what did you base your estimate?

**Mr Clout**—We attributed it out on the basis of the dollar value of measures in 2006-07, as a share of the total in 2006-07 for measures. I have a table which I could supply to you that shows that—

**Senator MOORE**—That would be good.

**Mr Clout**—but it just takes each of the measures and the value that each measure in dollar terms represents as a proportion of the whole package—

**Ms Halton**—It is an accounting treatment.

**Senator MOORE**—Okay.

**Mr Clout**—The $4.7 million is spread out against each of the measures in proportion.

**Senator MOORE**—That covers all the expected internal costings of buildings. Does new staff come under that, or are we talking only fit-out, as is my understanding of the property and IT fit-out?

**Mr Clout**—There are direct staffing and regular corporate overheads, including corporate staff—

**Senator MOORE**—That would already be in the budget?

**Mr Clout**—for each measure, and that is just agreed as part of the normal course of doing costings with Finance. But in this case, because we had such a large additional group being added to what was already a fairly large group in the department which then took us to a new divisional structure, we agreed with Finance that there would be additional costs on top of that which are already built into the standard ASL rate.

**Senator MOORE**—So you have a diagram that you can give me that will spread out those things? Because I will have further questions, but rather than take up time, line by line, if I can get the document and then possibly come to you on notice.

**Mr Clout**—I can table this. It is just a summary, if you like, so that from all of the measured descriptions and the values published with those measured descriptions you will be able to see what part of that is actually attributed to this. It is part of this side costing that was agreed with Finance and then attributed to each of the measures.

**Senator MOORE**—In terms of the extra staffing that you have identified, we have already had some general discussion about the new branch which will be a combination of possibly mental health and workforce. What new numbers will be coming into your branch to make it up? Do you have any idea? Have you done any estimation of the actual people costs?

**Mr Clout**—What we can do, but I do not have it—

**Senator MOORE**—Do you have a table for that as well?

**Mr Clout**—I can get something generated by later this afternoon which will be just a summary of the new ASL for the mental health measures.

**Ms Halton**—I read something into the record yesterday on a program by program basis—

**Senator MOORE**—You did, yes.

**Ms Halton**—the additional staff. So, if you go back to the record under program 11, the total is there.

**Senator MOORE**—I have got a particular question. Apparently in Budget Paper No. 2, on page 247, there is a figure of $200,000 in fit-out costs for initiatives like ‘mental health in tertiary curricula’. Would that kind of task normally be undertaken by a consultant, or is that an internal process?

**Ms Halton**—That would be this distribution.

**Mr Clout**—Could I just grab the document that you are referring to?

**Ms Halton**—We will just have a look. I think it will be the accounting treatment issue again in terms of making it work.

**Mr Clout**—I cannot see that on my list, but I was warned by my staff who put this together for me that the titles that they have used here do not exactly match the final measure titles. I would like to have a look at that.

**Senator MOORE**—Perhaps if you go away and make it all match up and come back and give me a response to that.

**Mr Clout**—I will come back to you.

**Senator MOORE**—That would be good. And then we may have some follow-up questions about how you have estimated certain things, but we will do that on notice. Chair, I have a couple of questions specifically on the issue of detention and mental health which will take about 10 minutes, so I am happy for Senator Allison to move on to something else, as long as we have the last 10 minutes.

**Ms Halton**—There is just one other thing we wanted to raise in relation to this issue about rural access which, while we are on the subject, I think I might just ask Mr Eccles to cover, if that is all right.

**Mr Eccles**—Some of the senators raised particular issues about rural and remote access to mental health services. I guess I just wanted to make the point that it is important to look at the package in its entirety and to draw attention to the fact that there is an item, 'mental health services in rural and remote areas', which is going to provide $51.7 million over five years to increase access to mental health services for people in rural and remote areas. In some ways it is designed to build on and expand. It is a bit of a MAHS type model—the More Allied Health Services Program managed by Divisions of General Practice—and it is just another brick in the framework, if you like, to improve the access in rural areas to mental health services. I thought it would be useful to draw the senators' attention to that.

**Senator MOORE**—It is actually an extension of the MAHS process, is it not?

**Mr Eccles**—Not strictly speaking. Not technically.

**Ms Halton**—But it is the same kind of thing.

**Mr Eccles**—Yes. We use the same modelling process and divisions will be encouraged to see how best they can utilise the funding to increase access to services in their particular area.

**Ms Halton**—One of the challenges here that we have to manage as a department is looking to see whether we can administer these together, so that if we go to divisions we can say, 'Here is a package of things you could do.'

**Mr Eccles**—That is right.

**CHAIR**—Do we have any further questions before we go on to detention issues?

**Ms Halton**—Detention is not a matter for this portfolio.

**Senator MOORE**—It was in terms of mental health services for people in detention.

**Ms Halton**—We cannot comment on that.

**Senator ALLISON**—You cannot comment on that?

**Ms Halton**—It is not our issue as a portfolio. We do not deal with it.

**CHAIR**—With detention issues?

**Ms Halton**—No.

**CHAIR**—Okay.

**Senator MOORE**—Nothing under mental health?

**Ms Halton**—No. We have no jurisdiction in relation to immigration matters, be it assessment of asylum seekers, mental health issues for detainees, any of that. We have no jurisdiction. None.

**Senator ALLISON**—Professor Whiteford does.

**Ms Halton**—That is him as a private individual and, if you want to talk to him about that, you have to talk to him about that in the context of the estimates for that portfolio. That is not our responsibility and he is not contracted to us in relation to those matters.

**Senator WEBBER**—When Professor Whiteford appeared before the Senate Select Committee on Mental Health and we talked about the treatment of people in detention, in what capacity did he appear then?

**Ms Halton**—I am not sure of that.

**Senator WEBBER**—He did appear before us with a range of government officials.

**Senator MOORE**—Professor Whiteford, are you coming to tell us how you appeared?

**Ms Halton**—He can answer the question for himself.

**Senator MOORE**—How did you appear before the—

**Senator WEBBER**—I just want to know which department I have to go to to put questions on notice.

**Ms Halton**—Which hat did he have on? He might have to come with various hats every time.

**Prof. Whiteford**—I was with Immigration when you spoke to me about those factors.

**Senator WEBBER**—Right. Okay.

**Senator MOORE**—Fine. We can go on to psychologists then, if you want to.

**Prof. Whiteford**—Thank you.

**Senator MOORE**—We accept that. One of the areas in terms of the package was the extension of the access to psychologist services. I know that it is early days in the program, but what can you tell us the number of psychologist services being funded in this program—the modelling and how many?

**Ms Daniel**—The modelling assumes that by the end of year five there will be around 450,000 psychology and mental health related allied health services funded through the new MBS items.

**Senator MOORE**—In terms of the evidence that you just gave us about the roll-out of the mental health nurse initiative, is the modelling based on similar kinds of research?

**Ms Daniel**—Remembering that psychology items come through a GP or a psychiatrist referral, our modelling approach has taken account of GP uptake of those items and then likely referral on from those. We have used a range-of-evidence basis to construct that modelling—information that we have about the level of mental health activity in general practice currently, based on survey data and information about uptake of the existing Better

Outcomes in Mental Health Care activity and usage of those—and I guess our experience with other new MBS arrangements to construct those forward estimates.

**Senator MOORE**—There was considerable discussion within this committee and also at the Senate Select Committee on Mental Health about the comparable roles of psychologists and referral processes. Is there a cap to the number of psychologist visits which can be funded out of this program that has been announced?

**Ms Daniel**—The new items have been constructed in a way which allows access to six psychology services initially and a subsequent six on review.

**Senator MOORE**—This COAG-announced item is going to be linked to a budget item in future processes. Has a review date for an internal review of how these things are operating been built into the model yet? That is a general question across all the initiatives, but I am asking particularly about the psychology one at this stage.

**Mr Smyth**—That is a matter that we are actually going to work on with the professions, because we need to build in data sets, clearly, to establish how we collect all of the information. So, as we implement these models, there will be evaluation components that will be built in and also data collection components.

**Senator MOORE**—That is a given, that that will be built into all the planning?

**Mr Smyth**—That is correct.

**Senator MOORE**—How many psychology services a year does Medicare currently provide for through the existing programs? That was one of the things Ms Daniel said was used to impact on the model about the current usage. Do we have the figures?

**Ms Daniel**—Through the EPC allied health item, we would have to get that number for you.

**Senator MOORE**—So you do not have that data?

**Ms Daniel**—I do not have that data with me right now.

**Senator MOORE**—We will cross-reference that to the other one. But I thought, as the extension of this program which is picking up on further aspects, it would be natural that the current data would be there. But we can get that cross-referenced. One of the issues that has come up, and it was also mentioned in the process, was access for children regarding general mental health—education and early identification of issues. I have a particular question relating to the process of referral to psychologists. It is expected, from the discussion that we just had, that GPs and psychiatrists would be able to make referrals. What about paediatricians? Has that been considered?

**Ms Daniel**—The new item has not considered that. It is based on either a GP or a psychiatrist referral to a psychologist.

**Senator MOORE**—Is there room in the modelling of the new process to consider those kinds of options?

**Ms Daniel**—I think that would be a shift in policy.

**Ms Halton**—We will look at whatever is appropriate in this area. At the end of the day, the item has to be described. We will have a consultation, as we always do, with the relevant players and, if it is agreed that that is an issue, it will be looked at.

**Senator MOORE**—How do you find out whether it is an issue? We have heard that there is consultation with the appropriate bodies—

**Ms Halton**—Yes.

**Senator MOORE**—but how do you actually, through the appropriate bodies, put an issue on the table? There have been a range of public consultations on mental health.

**Ms Halton**—Yes. Essentially, as you know, in any of these item description discussions we have a fairly standard methodology that we work through.

**Senator MOORE**—That is right.

**Ms Halton**—This particular issue, now that you have raised it, it is on our agenda.

**Senator MOORE**—That is what I was hoping the answer would be!

**Ms Halton**—Consider it duly noted!

**Senator MOORE**—Another issue, just for the record, is the role of consumers in the consultation. As you know, that is an ongoing issue in this field—consultation with people who are identified as representing consumers. Is that an in-built level in the consultative process for this area?

**Mr Smyth**—Yes, it is, absolutely.

**Senator MOORE**—I know that Senator Webber has a couple of questions on some things coming up. I will put the rest on notice.

**CHAIR**—Senator Webber? We do have a few more minutes.

**Senator WEBBER**—Can someone update me on the current status of the Youth Mental Health Foundation?

**Ms Lyons**—The contract for the successful tenderer has been signed. I understand that the successful tenderer will be commencing immediately to implement the terms of the foundation.

**Senator WEBBER**—When are we going to announce who the successful tenderer is?

**Ms Lyons**—That has already been announced. The parliamentary secretary announced that in December last year.

**Senator WEBBER**—Okay. So there has not been any shift; it just took a long time to sign it.

**Senator MOORE**—Was there a media release?

**Ms Lyons**—Yes, there was.

**Mr Smyth**—There was. The Prime Minister, in conjunction with the parliamentary secretary, launched it on 12 December in Sydney last year.

**Senator MOORE**—Good. That is one we missed.

**Mr Smyth**—The consortium, if you are interested, is the ORYGEN Research Centre at the University of Melbourne, the Australian Divisions of General Practice, the Australian Psychological Society and the Brain and Mind Research Institute.

**Senator WEBBER**—In New South Wales?

**Mr Smyth**—That is correct. They are the four consortium members.

**Senator WEBBER**—As I understand it, there has been a bit of a delay—I am not reflecting on why—about signing the agreement. How have we been managing the funding for this outfit over the forward estimates?

**Mr Smyth**—There was some money that was rephased last financial year for this, but we anticipate that we will be able to get this year's funding out prior to 30 June. The program will be fully spent.

**Senator WEBBER**—Sorry, Ms Lyons; when did you say the contract was signed?

**Ms Lyons**—The contract was signed on Tuesday.

**Senator WEBBER**—Tuesday?

**Ms Lyons**—Yes.

**Senator MOORE**—Tuesday this week?

**Ms Lyons**—Yes.

**Senator WEBBER**—As in two days ago? Okay.

**Senator MOORE**—Was there a media release about that?

**Ms Lyons**—No.

**Senator WEBBER**—I do not know; the parliamentary secretary likes media releases!

**Ms Halton**—He did not sign the contract, though!

**CHAIR**—Further questions, Senator Moore?

**Senator MOORE**—In terms of the education programs linked to the package, even though that is an education aspect, does that come back through your area as a cross-departmental—

**Mr Smyth**—Can you please specify which educational packages?

**Senator MOORE**—MindMatters.

**Mr Smyth**—MindMatters? That fits within my area. That is not part of the COAG package.

**Senator MOORE**—No, but it is part of the mental health package.

**Mr Smyth**—Absolutely.

**Senator MOORE**—I want to clarify again the role of coordination on these issues. The COAG package has come in on top of a number of pre-existing mental health packages that the department is already working with. We identified the PM&C role earlier in this process as looking after the COAG issues, but can you give us some information on your division's role in the whole-of-government approach to issues surrounding mental health?

**Mr Smyth**—There will be an interdepartmental committee established.

**Senator MOORE**—A new one?

**Mr Smyth**—A new one.

**Senator MOORE**—Called?

**Mr Smyth**—I do not know what it is going to be called yet. It will look at the government's COAG package as a whole to ensure that the implementation occurs in consultation with other key portfolios so that these things link together and so that the government is working cohesively to ensure that these packages hit the ground in the right way.

**Senator MOORE**—I see that with COAG and I think it is valuable, but how does that link in with the general provision of all services regarding mental health which, I would anticipate, would involve pre-existing activities? Looking at the issue of mental health for whole-of-government service delivery, will that be peculiar to the initiatives that have been announced in COAG, or will they pick up general initiatives that will be stimulated to refer to mental health?

**Mr Smyth**—They will pick up existing measures as well so that these are rolled out in alignment and, where necessary, they will be complementary. We are clearly looking to have an integrated package here that builds on existing measures. The Youth Mental Health Foundation is a key one that will build on a number of youth issues and comorbidity issues. It works in conjunction with organisations like beyondblue as well that are funded by the government. So we are looking at a coordinated approach to all of these measures.

**Senator MOORE**—Will Health and Ageing be the primary agency in that interdepartmental committee?

**Mr Smyth**—Yes, it will be.

**Senator MOORE**—In terms of Aboriginal and Torres Strait Islander mental health, which has been mentioned and is a particular issue, how does that work on such issues as cross-departmental responses and also within your own agency? How does it link in?

**Mr Smyth**—We work very cooperatively with OATSIH—

**Senator MOORE**—Well, that is a given.

**Mr Smyth**—on these meetings. I have my colleague from OATSIH here.

**Senator MOORE**—How do you work? I know that you work very cooperatively within the area, but what does that mean? What do you do?

**Ms Balmanno**—OATSIH has been closely involved in the development of the package, as have a number of areas across the department. There is obviously one specific measure in the package which very deliberately targets the Aboriginal and Torres Strait Islander health workforce.

**Senator MOORE**—Which I really hope is in another program.

**Ms Balmanno**—Is in?

**Senator MOORE**—The program on Aboriginal and Torres Strait Islander health.

**Ms Balmanno**—I will be here to answer questions on that measure as well. It is specifically about targeting the existing Aboriginal and Torres Strait Islander health workforce through the primary health care services that OATSIH funds. We do anticipate, however, that the vast majority of the other measures will have components within them that look at the needs of Aboriginal and Torres Strait Islander people, both those who are seeing mainstream general practitioners and mainstream services as well as those who are seeing community-controlled health services across the country. Then, obviously, the measures that are designed to be delivered through non-government organisations or through schools will pick up Aboriginal and Torres Strait Islander people as part of the client group there. We will continue to work with the new division that will lead on the mental health initiatives and provide advice on how best to meet those needs through each element of the package.

**Senator MOORE**—So the interdepartmental committee, which would be looking at the whole issue of mental health across the community, would be picking up the specific mental health responsibilities but also the wider health issues that would have impact on mental 'wellbeing', I suppose is the term.

**Mr Smyth**—The interdepartmental committee will focus specifically on mental health but, clearly, there are other elements that can be woven into that to ensure that there is complementarity. We do not want to do things in isolation. Where there are existing programs that we can build on, we will look to do that as well.

**Senator MOORE**—Specifically in terms of the Aboriginal and Islander area, the recent committee on petrol sniffing has always had links to issues to do with mental wellbeing and the development of issues to do with young people in communities. How would a specific issue to do with substance abuse link in to the overall issues of mental health? What would be the link to make that work?

**Ms Balmanno**—There are actually a number of initiatives in the package specifically about the links that build on existing policies and programs in that area. We have been closely involved in the development of those and will continue to be involved in the implementation, particularly in terms of looking at how it fits with other policy agendas, including those around petrol sniffing.

**Senator McLUCAS**—Ms Halton, you indicated that you would be able to give us the top 10 underspends and overspends at the end of this financial year. Are you saying that that work was not done—you did not have a cut-off point in the lead-up to MYEFO to provide information into the MYEFO process?

**Ms Halton**—We did, but what I am saying is that when we look at the data, what we are having to do to answer the question now is foreshadow in a couple of areas spending to the end of the financial year. It is an expected result; it is not an actual result. It is now the beginning of June. There is one month to when we will have an actual result. In a couple of these programs the results can be volatile, depending on the time of year. I am merely saying that I think it is better to give an actual result rather than an anticipated result because the anticipated could be wrong.

**Senator McLUCAS**—We look forward to that. I wonder whether you could do the same piece of work for 2004-05?

**Ms Halton**—Budget compared to actual?

**Senator McLUCAS**—Yes.

**Ms Halton**—Sure.

**Senator McLUCAS**—For the 10 largest overspends and 10 greatest underspends.

**Ms Halton**—I can do that. Chair, just before we go, that question in relation to the capital—can Mr Clout just clear that up?

**Mr Clout**—Senator Moore, the question you had was about a specific measure. If you look on page 237 of Budget Paper No. 2 there is a list of all of the COAG mental health measures in summary form. In the bottom quarter of that 2½-page table are all of the capital measures, and you will see that they are a simple attribution against all of the measures. You will see that there is full list of all of the health measures. I am not in a position to comment on the employment or the Medicare Australia measures.

**Senator MOORE**—Sure.

**Mr Clout**—But you will see that it totals to $4.7 million and that the $0.2 million that you were referring to in that specific measure is included in the list. It is not specifically to spend capital on fit-out for consultants in the case of that particular measure; it is just the way that the capital for fit-out has been allocated across all of the measures.

**Senator MOORE**—So there may not be $200,000 particularly for that component but, when you carved up the $4.7 million for administrative purposes, you have allocated some funding to each of the elements.

**Mr Clout**—Let us just say that is just so that it is brought to the measure descriptions in the table in some way.

**Senator MOORE**—It is just how it adds up to $4.7 million; is that the technical answer?

**Mr Clout**—Correct. So the table that I was offering to do—

**Senator MOORE**—It is already there.

**Mr Clout**—On page 237 of Budget Paper No. 2.

**Senator MOORE**—But specifically, though, $200,000 allocated against that line does not mean I can find $200,000 worth of chairs and tables somewhere.

**Mr Clout**—Not being specifically used for the delivery of that specific measure, no.

**Senator MOORE**—Does that allow for flexibility so that the $200,000 against that line could well be spent but against another line item to build up your capital cost?

**Mr Clout**—That is indeed the case for all department allocations for all measures.

**Senator MOORE**—Is this part of accrual accounting?

**Mr Clout**—This is not actually a cash versus accrual issue.

**Ms Halton**—This is part of departmental flexibility.

**Senator MOORE**—We will come back, Mr Clout. I want to find those chairs!

**Proceedings suspended from 12.34 am to 1.37 pm**

**Office for Aboriginal and Torres Strait Islander Health**

**CHAIR**—We resume this afternoon with outcome 8—Indigenous Health. Although the minister and the secretary are not here, I presume that you are willing to proceed?

**Ms Murnane**—The secretary and the minister will be here.

**CHAIR**—I see her outside; she is not far away. Outcome 8: questions, Senator Crossin?

**Senator CROSSIN**—I wanted to start with some questions about the COAG trial that is being managed by Health and Ageing in the AP lands. How many trips have you made to the AP lands as secretary and how many trips have department officers made?

**Ms Halton**—I have been there four times. In terms of departmental officers, I do not know if we could count—a good number.

**Senator CROSSIN**—You mean, officers have been there a good number of times?

**Ms Halton**—Yes.

**Senator CROSSIN**—And when was your last trip?

**Ms Halton**—When was I last there? June of last year.

**Senator CROSSIN**—The minister has been there how many times?

**Ms Halton**—Which minister? This current minister has been there once.

**Senator CROSSIN**—Yes.

**Ms Halton**—The former minister had been, as well.

**Senator CROSSIN**—Yes—that is Mr Abbott I am talking about.

**Ms Halton**—Yes, once.

**Senator CROSSIN**—When was that last one?

**Ms Halton**—That was last year, June.

**Senator CROSSIN**—June of last year, with you?

**Ms Halton**—Yes.

**Senator CROSSIN**—Can we have a list of all the department expenditure on the AP trial since it began? Is that in a form able to be tabled?

**Ms Halton**—Yes. We will have to take it on notice, but we can certainly give it to you.

**Senator CROSSIN**—I am actually after, in that question, a breakdown of expenditure by initiative and program.

**Ms Halton**—Yes.

**Senator CROSSIN**—Year-by-year allocations, including projections for out years, if possible.

**Ms Halton**—We do not normally give projections for forward years if it is broken down below the program level, because they are not published data and we are not usually permitted to do that, but we can tell you what is estimated for the forward period.

**Senator CROSSIN**—Also, departmental versus administered allocations.

**Ms Halton**—We cannot, probably, forward project departmental allocations, because they are year on year.

**Senator CROSSIN**—Perhaps the previous, or existing?

**Ms Halton**—We can do current—this current period—and we can provide program figures for forward periods in aggregate.

**Senator CROSSIN**—How many of your staff are actually assigned to work on the trial?

**Ms Podesta**—As of February 2005, we have two staff who are full time on the trial and one staff member who is part time.

**Senator CROSSIN**—So, two and a half staff.

**Ms Podesta**—Roughly.

**Ms Halton**—That does not include the more senior level of attention to the trial. That is the staff.

**Senator CROSSIN**—Are any of those located in the Port Augusta ICC?

**Ms McLaughlin**—No, we do not have any staff in the Port Augusta ICC. They cover the Port Augusta ICC from the Adelaide office.

**Senator CROSSIN**—So your two staff working on the trial are based in Adelaide.

**Ms McLaughlin**—Yes.

**Senator CROSSIN**—Have you commenced an evaluation of your trial site?

**Ms Halton**—There is an aggregate evaluation being done of all the COAG project.

**Senator CROSSIN**—Sorry?

**Ms Halton**—There is an evaluation of the total COAG project, not individuals per se but all of the trials.

**Senator CROSSIN**—In OIPC the other day, they actually mentioned to me that, in relation to the Wadeye trial which FaCSIA are managing, they were going to use Hugh Taylor's work from CAPA—he did a study into Wadeye—as the baseline data for the evaluation at Wadeye. Have you got any baseline data for the evaluation in the AP lands?

**Ms Podesta**—We have a number of projects that are taking place on the APY lands. Certainly, we have milestones identified for the projects.

**Senator CROSSIN**—But that is not actually baseline data. His baseline data goes to cents in the dollar for education spending or average income per household. You are evaluating key performance indicators for each project, but do you have a base that you started from to actually know if there has been any overall improvement in the COAG data?

**Ms Halton**—We do have a range of indicators in relation to the circumstances on the lands. We have information about all the sociodemographic things. There have been numerous reports into the lands. It has not been necessary for us to re-create all of that. There is also a series of pieces of information in relation to, for example, where the money has gone traditionally. So in terms of a baseline needing to be created as a separate exercise—no, it is not our view that that is necessary, because that information is there.

**Senator CROSSIN**—So how is the evaluation being conducted, specifically for your site?

**Ms Halton**—OIPC are undertaking an evaluation of the whole COAG approach. The consultant has interviewed a number of us in terms of the operation of the particular project, recognising that each project is different.

**Senator CROSSIN**—Obviously, officers have been interviewed; Ms Halton, have you?

**Ms Halton**—Yes.

**Senator CROSSIN**—The consultant has travelled to the trial site?

**Ms Podesta**—Certainly.

**Senator CROSSIN**—With you? With officers from your department?

**Ms Halton**—Not with us, no.

**Ms Podesta**—No, the consultant undertook a range of consultations on the trial site. The department did not accompany the consultant.

**Senator CROSSIN**—When are you expecting some sort of first draft of this evaluation?

**Ms Podesta**—The timing of the release of the evaluation is being finalised with the Office of Indigenous Policy Coordination.

**Ms Halton**—It not a matter for us. That is going to the OIPC.

**Senator CROSSIN**—Have you been given an indicative time when you might see a draft for comment or a final draft? What is happening here? Is there a draft for comment or are you just going to get the evaluation? What have you been told is happening?

**Ms Podesta**—We will receive a draft copy of the evaluation to clarify for accuracy. That is the usual practice within government. The timing has not been finalised, as we understand.

**Senator CROSSIN**—You have not been told—you did not expect this by June or November?

**Ms Podesta**—No, we have not.

**Senator CROSSIN**—Do you have any idea when the evaluation will actually be completed?

**Ms Podesta**—As we have indicated—

**Senator CROSSIN**—You are a bit in the dark, are you? What is happening to this whole department?

**Ms Podesta**—It is not our evaluation. We have been consulted as part of the evaluation. We understand that there is a draft and that the Office of Indigenous Policy Coordination are finalising the release of the evaluation.

**Ms Halton**—We do not understand this to be months and months away; we understand it to be imminent but we do not understand as to it being on 25 June. We know that it is imminent.

**Senator CROSSIN**—Sooner rather than later, is that right?

**Ms Halton**—That is my understanding. Until someone disabuses me of that, that is the basis on which we are operating.

**Senator CROSSIN**—Are you also able to provide me with a list of all Commonwealth expenditure on the AP lands? I was able to get out of FaCSIA the other day the list of programs they are funding and they also gave me a separate table of programs that other agencies are funding.

**Ms Podesta**—Yes, we can. We have a list of all of the program expenditure on the APY lands by Australian government agencies.

**Senator CROSSIN**—Is that something you can table or would you need to take that on notice?

**Ms Podesta**—I would like to take it on notice. It is only that I have just put a few handwritten remarks on it myself. But it certainly is compiled.

**Senator MOORE**—Can I have a list of all the state government expenditure in that trial?

**Ms Podesta**—Across every COAG site?

**Senator MOORE**—No, across the APY.

**Ms Podesta**—I do not believe that we have that at this point. We can certainly take that on notice.

**Ms Halton**—We have been given it in the past. Certainly, the state government has done that work and I have certainly been given copies of it.

**Senator MOORE**—Just in terms of an indication of the funding.

**Ms Halton**—I suspect what we had was historical information, but we can certainly see if there is a current one.

**Ms Podesta**—We have all of the expenditure on projects and activities as 'COAG activities' on the APY site, the COAG trial. We have all of the program expenditure by the Australian government on the trial sites. We can certainly take it on notice, if we are able to get it.

**Senator MOORE**—Thank you.

**Senator CROSSIN**—I want to ask you some questions about pages 22 and 23 of the portfolio budget statements. For this particular outcome 8, Indigenous health, do you have a list of the programs that will actually benefit from this appropriation?

**Ms Podesta**—I have a list of all of the components that make up the budget appropriation.

**Senator CROSSIN**—For this outcome?

**Ms Podesta**—For this outcome, yes. Would you like me to take that on notice and provide it to you?

**Senator CROSSIN**—You do not have it with you?

**Mr Thomann**—I can give it to you.

**Ms Podesta**—We can discuss it, we just do not have it to hand out.

**Mr Thomann**—As we have discussed previously, the Aboriginal and Torres Strait Islander Health Program is a one-line appropriation and that is the line you can see in the portfolio budget statement. It is made up of a number of budget reporting entities. Those budget reporting entities are: Aboriginal and Torres Strait Islander Health Services, which is the base of the program—

**Senator CROSSIN**—Yes. Is it easier to table this or is it not in a form to be tabled?

**Mr Thomann**—I have not got it in a form to be tabled, but I am sure we can provide this information to you. But there are only a few.

**Senator CROSSIN**—All right, you read those out and then I will tell you what I am after.

**Mr Thomann**—The Primary Health Care Access Program, the Bringing Them Home program, the Combating Petrol Sniffing initiative, the Healthy for Life program; there is funding for the transition of the coordinated care trials and there is a new budget reporting entity in relation to the announcement of the COAG mental health measure for health workers in Aboriginal medical services.

**Senator CROSSIN**—That is about seven?

**Mr Thomann**—Yes.

**Senator CROSSIN**—What I was actually after, though, was a breakdown of how that $378 million or so is going to be spent under those seven areas.

**Ms Halton**—What do you mean by 'breakdown'? Could you be a bit more precise?

**Senator CROSSIN**—Of the $378 million I would like to know, perhaps, how much is allocated against the Bringing Them Home program.

**Ms Halton**—Mr Thomann can tell you that.

**Mr Thomann**—I can give you that to you now. The Bringing Them Home program in 2006-07 has been allocated $13.943 million.

**Senator CROSSIN**—And for all of the others?

**Mr Thomann**—There is $230.74 million for the Aboriginal and Torres Strait Islander Health Services element. There is $94.667 million for the Primary Health Care Access Program. I have just mentioned Bringing Them Home. The Combating Petrol Sniffing initiative has been allocated $8.703 million for 2006-07. The Healthy for Life program has $21.417 million. The coordinated care trial money in 2006-07 is $6.986 million and the COAG mental health figure is $1.515 million for 2006-07.

**Senator CROSSIN**—What I am actually after now is whether those figures are broken down as administrative funds and departmental funds.

**Mr Thomann**—Those are the administered funds.

**Senator CROSSIN**—So the departmental funds is just the $47.5 million on page 22.

**Ms Halton**—That is right.

**Mr Thomann**—That is correct.

**Senator CROSSIN**—That is the total amount to administer all of those programs.

**Ms Halton**—That is correct.

**Mr Thomann**—That is correct.

**Senator CROSSIN**—You cannot give me a breakdown of departmental funds by program?

**Ms Halton**—No.

**Senator CROSSIN**—It is just that the department administers all of those eight, you do not break them down?

**Ms Halton**—That is correct.

**Senator CROSSIN**—Why do you not break them down to that degree?

**Ms Halton**—Because it is very hard, it would cost us a huge amount and it is not worth it to basically cost everyone's time on an item-by-item basis. So what we do is that we notionally attribute, but we can basically clearly distinguish the moneys that are available to actually administer Indigenous health issues: this particular program—you can see that amount. It is exactly as we had the conversation with Senator Moore before. Basically, we are required in some parts of the PBS to have an accounting treatment in relation to the capital expenditure. But are there $10,000 worth of chairs against this particular item? The answer is no. It is basically a highly expensive and, frankly, not particularly useful exercise to try and attribute right down to the last dollar.

**Senator CROSSIN**—In the departmental allocation of that $47.5 million, do you have a breakdown of, say, travel and staff costs?

**Ms Halton**—No, we do not budget in the beginning of the year based on those components. We make an allocation in respect of individual areas of the department and then there are decisions taken by the manager in relation to each of those components.

**Senator CROSSIN**—Is that allocation available for us to look at?

**Ms Halton**—No, it is not at this stage.

**Senator CROSSIN**—When does it become available for the estimates committee to look at?

**Ms Halton**—It is not traditionally made available. Essentially, this is a matter for internal administration. The decisions in relation to allocations for next year are not yet finalised.

**Senator CROSSIN**—So at what point in the estimates year could I say to you: how much of that $47.5 million are you going to spend or have you spent on travel?

**Ms Halton**—At the end of the year.

**Senator CROSSIN**—So you would be able to give me then a breakdown for the last financial year?

**Ms Halton**—Of what we spend on travel? No. We do not attribute travel against a program.

**Senator CROSSIN**—I am not asking you to do that. In your budget papers you have a departmental line of $47.5 million.

**Ms Halton**—Correct.

**Senator CROSSIN**—I am wondering if you can tell me for last year, then, how much of that is spent on staff and how much of it is spent on travel.

**Mr Thomann**—We have not completed this financial year. We are unable to provide that to you until we have completed this year. We are in a business planning process. I think a number of my colleagues in other outcomes have explained that, at the moment, the department is in the process of planning our priorities against the priorities that have been articulated in the portfolio budget statements. By 1 July we certainly hope to have our business plans in place.

**Senator CROSSIN**—So you must have those figures for 2004-05 then?

**Mr Thomann**—We have not completed 2004-05. I mean 2005-06.

**Senator CROSSIN**—You must have those figures for 2004-05, then.

**Ms Halton**—Yes, we know what we spent in 2004-05.

**Senator CROSSIN**—We might ask you if you would take that on notice then and provide us with the breakdown of the departmental funds in relation to Indigenous health for 2004-05, so I can have a look at—

**Mr Thomann**—At 2004-05, in respect of what items?

**Senator CROSSIN**—That is what I would like you to give me. I want to know what the breakdown of departmental funds was in administering the Indigenous health outcome of the budget for that year.

**Mr Thomann**—Okay.

**Ms Halton**—What I am saying to you is that we do not account for travel by program.

**Senator CROSSIN**—By outcome?

**Ms Halton**—No, we do not.

**Senator CROSSIN**—You do it across the whole of the department?

**Ms Halton**—We do. That is correct.

**Senator CROSSIN**—Perhaps we will ask for that for 2004-05. We will have look at that and see if we can break it down further at the next estimates.

**Ms Halton**—Senator, it might be helpful for you if Mr Clout could actually talk to you about what is in that amount.

**Mr Clout**—The allocations of department expenditure to each outcome are only notional and always have been only notional. Indeed, it includes not only the particular resources consumed by the staff in Ms Podesta's division but also an allocation for corporate overheads, buildings, travel, parts of the executive's and, indeed, my salary or any travel that we undertake or any of those sorts of issues. So for some of the outcomes there may be some alignment between some part of the particular departmental allocation, which is only notional, which would line up indeed with the divisional budget, but in many cases the things that that

division does might also contribute to the work of other divisions. This indeed would be the case with a cross-portfolio division like OATSIH and it includes many other overhead costs.

**Senator CROSSIN**—Is this an excuse why you cannot give me that breakdown?

**Ms Halton**—It is not an excuse. The reality is that we do not account for departmental expenditure by program. We are required to make an attribution—this is how we do it in the PBS—of all costs in the department, the costs of individual programs, but we do not actually manage individual expenditures on a program-by-program basis for the department because, exactly as Mr Clout says, there is a whole series of overheads. It is not practical and it is too expensive to do.

**Senator McLUCAS**—Ms Halton, I wonder if you could explain the $38.4 million.

**Ms Halton**—We use an algorithm, which Mr Clout can explain.

**Mr Clout**—The algorithm is more of an historical division which would have been set up—I might have to get some advice on this—when the department went to the original nine-outcome structure several years ago, and then it has been grown by a certain amount. You have two things going on, though: you have an historical figure, which was initially set when we went to that particular outcome structure, and then on top of that you have got on-and-offs for particular budget measures which are a discrete set of ASL or departmental numbers. So there are two things going on.

**Senator CROSSIN**—But it should be possible for financial years that are completed, for example 2004-05, for you to provide for me the departmental allocation and a breakdown of the different components of that, such as staffing or travel.

[2 pm]

**Mr Clout**— Could I give you an example of the difficulty in doing so. If the secretary were to accompany Ms Podesta for a trip and, while Ms Podesta perhaps returned to Canberra, the secretary went on to Perth to the state office to do some other unoutcome related work, we would not have an accounting system which apportioned some part of the secretary’s travel cost—

**Ms Halton**—You just could not do it.

**Mr Clout**—to outcome 8 as opposed to aged care, which might be the purpose of her business in Perth.

**Senator CROSSIN**—I have not asked for that now. I am just asking you to give us perhaps the total department in 2004-05. If you are saying that it is not possible to give us a breakdown outcome by outcome, you surely must have an idea across the whole department what you have spent on salaries, travel, corporate, buildings, rent, pens and paper.

**Senator MOORE**—You must have that. I am sure you will find a document.

**Mr Clout**—The closest I think we would come is the annual report, which gives an actual by outcome for the department in 2004-05.

**Senator CROSSIN**—So that is the best piece of information you have got; there is nothing more inclusive or precise than what is in the annual report?

**Mr Clout**—Correct.

**Ms Halton**—That is correct.

**Senator MOORE**—How do you map your expenditure month by month? I can remember suddenly being told no more travel was to happen because you had run out of money. How does the department then work out when you are getting close to your budget allocation? Each month do sections of the department fight it out to see who will get the remaining money?

**Ms Halton**—No. Divisions have an allocation, and allocations have to be managed by the manager.

**Senator MOORE**—So there is an allocation?

**Ms Halton**—Of course. It is a division-by-division allocation as against a programmatic allocation. The reality is, as we have discussed here previously, programmatic allocations are almost impossible to do when it comes down to these sorts of microgranular components because, exactly as Mr Clout says, you cannot attribute in an actual sense each component. What you can do is make a notional allocation, and hence the algorithm.

**Senator MOORE**—So could we get a divisional breakdown?

**Ms Halton**—Of what?

**Senator MOORE**—Of internal expenditure.

**Ms Halton**—I suppose.

**Senator MOORE**—We take the point—and I am sure we have heard the argument before—that it is very difficult where you have cross-program operations and some divisions covering three programs, but the divisions would have to have their own administrative allocations for the kinds of things that Senator Crossin is asking for.

**Ms Halton**—Yes, but the trouble is this is actually confounded. My point is you cannot make the point that you are trying to make here. Essentially people have a budget that they work to, that is fine, but what you can derive from that I think is a more difficult issue.

**Mr Clout**—For instance, one of the weaknesses in taking that approach is that it would not allow for the time of any of my branch staff who work exclusively on Indigenous issues and Indigenous budget issues or, indeed, putting together this annual report or the PBS et cetera.

**Ms Halton**—All of which are overheads.

**Mr Clout**—Which go into the attribution. So, while that might give you some of the costs, it would certainly not give you all of the costs and certainly not in a time series comparable way.

**Ms Halton**—Exactly.

**Senator McLUCAS**—It would be useful if you could provide us with the algorithm so that we could get some sort of understanding of—

**Mr Clout**—I can provide you with a description of the methodology used to create and maintain the notional allocations, yes.

**Senator McLUCAS**—As well, could you explain the issues that you raised about its being historical and then things going in and out?

**Ms Halton**—Yes, we can do that easily.

**Senator CROSSIN**—What happens with each of these seven subprograms in Indigenous health? What happens if you come across an item where there are unexpected costs of administering it over and above the budget you have been given?

**Ms Halton**—We make do. Yes, everyone agrees we make do.

**Ms Podesta**—As part of the business planning, we undertake a planning process where we allocate staff to take responsibility for the delivery of the outcomes under each one of the programs, the subprograms. From time to time, if there are delays or changes, at an administrative level we might make a decision to move staff to an area of higher priority or higher demand. But, primarily, it is part of the business-planning process within the division.

**Senator CROSSIN**—So you basically have to try to stick within your budget? If something blows out and you need additional funds, that is bad luck, is it?

**Ms Podesta**—It depends on your definition of ‘blows out’, I think.

**Ms Halton**—We have a fixed amount that we can spend on administration. I think I am relatively well known in the department for saying I do not have a magic pudding under my desk, much as I might like one.

**Ms Podesta**—Alas, that is a very well-known saying.

**Ms Halton**—It is. We basically have the funds that are available to us for administration. Exactly as Ms Podesta says, we go through quite a rigorous business-planning process to ensure that we utilise those funds with maximum efficiency. But, once we have allocated them, that is what we have.

**Senator CROSSIN**—Similarly with the administrative item, that is the program item line, again you stick within budget? If you need to find additional funds for something, how does that occur?

**Ms Podesta**—We report against the administered items. As you are aware—and we have had a number of discussions about this at previous estimates—OATSIH is a single line appropriation. So we have had a substantial amount of flexibility within that program area, and we have been able to make recommendations to the minister with regard to priorities.

**Senator CROSSIN**—But basically you are expected to stick within your budget allocation; is that correct?

**Ms Podesta**—Absolutely.

**Ms Halton**—None of these items is a standing appropriation. As I have said—I suspect you were not here at the time—I think the reality is that the portfolio has different types of appropriations. We have a number of standing appropriations which are effectively demand driven, but in this particular area they are not.

**Senator CROSSIN**—The budget measure for improving access to health services is $39.5 million over four years. There are two initiatives, as I understand it—the establishment of five broker services and you recruit an additional 40 health professionals. Is that right?

**Ms Podesta**—That is correct.

**Senator CROSSIN**—What is the breakdown in that $39.5 million funding between the two components of the measure?

**Mr Thomann**—The brokerage element will be allocated $12.63 million over four years and the remainder of the funds will be applied to providing additional resources for Indigenous specific organisations working in rural and remote areas.

**Senator CROSSIN**—I have your fact sheet relating to the Indigenous affairs 2006 budget. It is not actually from Health and Ageing but from Minister Brough's web site. It says that the 'brokerage services will benefit up to 15000 Indigenous Australians'. How was the figure of 15,000 derived?

**Mr Thomann**—We envisage that each brokerage service will be able to service a population of about 3,000. This is the population that an organisation on the Sunshine Coast currently service. The North Coast Aboriginal Corporation for Community Health is a community controlled organisation who chose to run a brokerage service for the people living in the Sunshine Coast region, and 3,000 is the population that it serves.

**Senator CROSSIN**—How will the brokerage services be established?

**Mr Thomann**—We will be seeking applications from organisations through an open tender process. It will be a national process.

**Senator CROSSIN**—The operation of services will go out to tender?

**Ms Podesta**—Yes.

**Mr Thomann**—That is basically what I am saying, yes.

**Senator CROSSIN**—Do you have an idea of where they will be located or desirability of location?

**Mr Thomann**—The desirability of location would be in urban areas where we have large concentrations of Aboriginal and Torres Strait Islander people living alongside a good supply of general practitioners and allied health professionals.

**Ms Podesta**—Urban and regional areas.

**Mr Thomann**—Urban and regional areas.

**Ms Podesta**—We are going to test the market to see what type of interest we are able to achieve in both of those areas.

**Senator CROSSIN**—Where did the idea of the broker services come from?

**Mr Thomann**—It came from the North Coast Aboriginal Corporation for Community Health up on the Sunshine Coast. It is a model that they have trialled, and the community up there have chosen this as a way to meet the health needs of the people in their region, given that the Sunshine Coast does have a good supply of GPs and allied health professionals, which gives the residents of that region choice and also gives them a much broader spread of

access to health professionals than would have been the case had there been a single facility located in that region.

**Senator CROSSIN**—So it comes out of a sort of best practice/what works model rather than any kind of review or consultancy that was undertaken by the department?

**Ms Podesta**—Precisely.

**Mr Thomann**—That is correct.

**Senator CROSSIN**—How will the recruitment of the 40 additional medical professionals take place?

**Mr Thomann**—We will not be conducting that recruitment process. We will be allocating funds to the states and territories on the basis of our resource allocation model, and we will be negotiating with Indigenous specific health organisations to provide additional funds where they wish to recruit additional health workers.

**Senator CROSSIN**—So you might give the Western Australian government a certain amount of money and they can recruit 12, for example; is that right?

**Mr Thomann**—That would not be the example I have first in mind.

**Senator CROSSIN**—Give me your first example then.

**Mr Thomann**—Through our planning process we are aware of a number of rural and remote areas that are underserviced. We are very aware that regions are well under benchmark in the distribution of our funding. So I would have in mind that we would be approaching organisations in those underfunded and underserviced areas as to whether funds could be utilised effectively to provide more general practitioners, nurses and Aboriginal health workers in those areas.

**Senator CROSSIN**—Are you able to give the committee the list of where you might target these positions?

**Mr Thomann**—I am happy to give you a map showing our expenditure relative to benchmark, and that will certainly identify where there are—

**Senator CROSSIN**—Those areas?

**Mr Thomann**—Those areas.

**Ms Podesta**—That is information that is made available through the partnerships that we have within each state and, as Mr Thomann indicated, it is part of the planning process within Aboriginal health. We do identify areas of need and we seek through that process—the partnership that exists in each state between the state and territory governments and the community controlled sector and us—identification of opportunities to best expand and enhance services to meet those needs.

**Senator CROSSIN**—I will take you up on the offer of the map so we can look at that. The remuneration of these medical professionals would be through different organisations in perhaps those regions—their salaries, for example?

**Mr Thomann**—It is up to the organisations who receive our funds to negotiate those employment arrangements and contracts with the people whom they recruit.

**Senator CROSSIN**—Just remind me again of the allocation against the Primary Health Care Access Program, PHCAP, outcome.

**Mr Thomann**—The allocation for 2006-07 will be $94.667 million.

**Senator CROSSIN**—Is it the same amount that was allocated in 2005-06?

**Ms Podesta**—No, it was $70.54 million in 2005-06.

**Senator CROSSIN**—Sorry, how much was that?

**Mr Thomann**—The amount that was allocated originally—at the beginning of this financial year, so we do not get completely confused with the numbers—was $79.884 million . However, $9.338 million has been rephased into 2006-07, leaving for this year, 2005-06, $70.546 million.

**Senator CROSSIN**—Essentially we have seen in the budget no additional funding for PHCAP?

**Mr Thomann**—The new measures in relation to increased access are accounted for under the PHCAP budget reporting element.

**Senator CROSSIN**—The new measures we have just talked about?

**Mr Thomann**—The new measures we have just been talking about, yes.

**Senator CROSSIN**—The PHCAP money is split, is it? Are you saying you have some of the money under PHCAP and some under the new measures?

**Mr Thomann**—No, what I am saying is that the new measures will be reported under the PHCAP budget-reporting element. It is a continuation of the investment that has been made in the previous budget and the budget previous to that. We are treating it as a continual, gradual expansion of the PHCAP process in relation to budget bidding and funding.

**Senator CROSSIN**—If we just isolate that new measure for a moment—because it is a new measure, it has new money; is that right?

**Mr Thomann**—It has new money, the same as we had a new measure last year which we got new money for, and the year before that we got a little bit of new money as well.

**Senator CROSSIN**—But it is to provide new medical professionals.

**Mr Thomann**—Yes, and the purpose of PHCAP has been to do that all along, to increase access to primary health care.

**Senator CROSSIN**—The initial bucket of funding for PHCAP, though, if you took out that new measure, has not increased from last year to this year?

**Mr Thomann**—It has increased from last year. The contribution of the new measure will be $2.5 million in 2006-07. If you take $2.5 million away from the $94.7 million I have just mentioned, you will be left with $92.2 million, which is still a significant increase on the previous allocation. That is because we have flow-on effects from the previous budget decisions that I just mentioned from previous years.

**Senator CROSSIN**—The $9.8 million flow-on effect?

**Mr Thomann**—The 2005-06 budget decision. In 2005-06 that gave us $5.5 million, and in 2006-07, for instance, it will give us $7.6 million. So it is increasing.

**Senator McLUCAS**—Does that incorporate Queensland as well?

**Mr Thomann**—No. These are new moneys which were identified at the time the budget was brought down. It is in the out years. It is increased real new money as opposed to the rephasing of money in relation to capital works projects.

**Senator CROSSIN**—Can you provide me then with updated figures on the PHCAP allocations for 2005-06, 2006-07 and the out years in this budget?

**Mr Thomann**—I can do that, yes. The revised figure for 2005-06 is $70.5 million. The figure we are now working to in 2006-07 is $94.7 million.

**Senator CROSSIN**—Can I also have an update on the list of projects and sites funded under PHCAP so far this year?

**Mr Thomann**—I would have to take that on notice, I think.

**Ms Podesta**—We certainly can provide that to you.

**Mr Thomann**—In that level of detail.

**Senator CROSSIN**—Were all of the allocated funds for 2004-05 spent?

**Mr Thomann**—Yes, funds were fully expended and committed.

**Senator CROSSIN**—So 2004-05 were fully expended?

**Mr Thomann**—Yes.

**Senator CROSSIN**—There is an expectation that 2005-06 will also be fully expended?

**Mr Thomann**—Yes, we have a full expectation.

**Ms Podesta**—We are on track.

**Ms Halton**—We try not to underexpend anything in this program. It is very hard.

**Senator CROSSIN**—I will try to make sure you keep yourselves to that commitment.

**Ms Halton**—Good. Excellent.

**Mr Thomann**—We appreciate that, Senator.

**Senator CROSSIN**—The minister put out a press release last December relating to $30 million in funding for four new Indigenous health services. That was $30 million from the PHCAP allocation; is that right?

**Mr Thomann**—Yes. That measure was called the improved primary health care initiative. We are treating that as part of the continued budget decisions as part of the momentum that PHCAP has given us since the original decision in 1999 and 2000.

**Senator CROSSIN**—Did that $30 million come out of the existing PHCAP allocation for 2005-06 or was that new money?

**Mr Thomann**—It is new money.

**Ms Podesta**—It is new money.

**Mr Thomann**—All new money.

**Senator CROSSIN**—Can you give me an indication of how the $30 million is broken down between the four regions?

**Mr Thomann**—Absolutely. Yes.

**Ms Podesta**—Against the four sites?

**Senator CROSSIN**—Yes.

**Mr Thomann**—We have four sites. Over the four years we will be spending in total $11.423 million on the Cape York region. We will be spending $11.583 million on Wadeye to substantially increase the clinical facility and services there. In the wheat belt region in Western Australia we will be spending $6.059 million over the four years. In Toomelah, which is a region in northern New South Wales near the Queensland border, we will be spending $1.135 million over the four years.

**Senator CROSSIN**—Have those funds started to flow through?

**Mr Thomann**—Yes, they have.

**Senator CROSSIN**—In the case of Port Keats, are they flowing through the Northern Territory health department?

**Mr Thomann**—The Northern Territory health department run that clinic, and we are making arrangements for these funds to go to them.

**Senator CROSSIN**—What percentage of administered on-costs would, say, the Northern Territory be keeping in administering those funds?

**Mr Thomann**—I do not have that information.

**Senator CROSSIN**—Can you take that on board for me? The reason I ask that is DEST now have an agreement with the state and territory governments that for administrative on-costs they will take no more than 10 per cent of the Commonwealth Indigenous money flowing through them. It used to be 48c in the dollar; it is now 10c in the dollar. Can you tell me how much the state and territory governments are taking out for administrative on-costs for the Indigenous health initiative?

**Mr Thomann**—We would certainly be hoping that the Northern Territory Department of Health and Community Services are able to provide this at marginal additional cost. It is certainly in our interests as well to make sure they are able to do that. So I will take that on notice.

**Senator CROSSIN**—I would like to know what it is and not just for the Territory. In Queensland, is the Cape York initiative running through the Queensland health department?

**Ms Podesta**—No, it is not.

**Mr Thomann**—No, it is not.

**Senator CROSSIN**—It is going to?

**Mr Thomann**—It is going to the Far North Queensland Rural Division of General Practice and the Royal Flying Doctor Service.

**Senator CROSSIN**—In Western Australia and New South Wales, is it flowing through their health departments?

**Mr Thomann**—No. In Toomelah in New South Wales it is going to the Pius X Aboriginal Corporation. So the Toomelah facility will be run as an outpost as part of their whole operation in that region. For the wheat belt, at this stage the auspice would be the Western Australian government.

**Senator CROSSIN**—Could you just perhaps let me know how much the WA and NT governments—

**Mr Thomann**—Okay. Thank you for advising me that 10 per cent is the benchmark.

**Senator CROSSIN**—Yes, it is. When I got into this job I discovered the states and territories were taking out 48c in every dollar in relation to Indigenous education money. I have to say that, to the credit of David Kemp, who was then the minister for education, through the estimates process he moved on that and it is now 10c in the dollar.

**Mr Thomann**—I will take that on board and, through our state offices, we will inquire as to what their cost structures are.

**Senator CROSSIN**—I would like to find out what they are doing. How were those four areas identified as being the targeted ones? I suppose for me Port Keats stands out as a pretty obvious one.

**Mr Thomann—**They were identified according to a need against our planning benchmark. It was also said at the time that we were looking at more remote areas where there is a real shortage in services as a result of the shortage in funding, and certainly these were three areas where our planning against our planning benchmark showed that there was quite a substantial gap in funding.

**Senator CROSSIN**—I have some questions on trachoma and the Bringing Them Home program. Then I have a few questions that probably do not fit in your outcome.

**Ms Podesta—**I hope we can answer them.

**Ms Halton**—What are they about? We might be able to help anyway.

**Senator CROSSIN**—The others relate to AMS and ACCO work force data.

**Ms Podesta—**Yes, we can answer that.

**Senator CROSSIN**—I have questions on eye health and hearing, but I am never sure whether my questions on hearing are for you or for Hearing Services. Come in and brief me one day so I can actually get that divide right.

**Ms Podesta—**We are happy to answer the questions on hearing. But Hearing Services are scheduled after us tonight, so they can take the questions that we are unable to answer.

**Senator CROSSIN**—We know the trachoma surveillance unit was established in December last year and there is to be $920,000 over three years—I am just saying this so I know I have these facts right in my head—$450,000 over the next three years to develop consistent data collection, and $470,000 to train health workers to implement the screening and control measures. That is the breakdown; is that right?

**Ms Podesta**—Yes.

**Senator CROSSIN**—Is the $920,000 new money, or did it come out of the existing eye health program?

**Ms Podesta**—It comes out of the single line appropriation for OATSIH.

**Senator CROSSIN**—So neither?

**Ms Podesta**—It is part of our appropriation, and we made it as a priority in the budget this year.

**Senator CROSSIN**—Where is it in the budget?

**Ms Podesta**—Money was not taken away from the eye health component.

**Senator CROSSIN**—That is predominantly what I wanted to know.

**Ms Podesta**—In relation to the term 'new money' meaning whether we got an additional specific allocation made for this initiative, this was a decision that was made by the minister within the program to allocate to this priority.

**Senator CROSSIN**—I understand. What is happening with the establishment of the surveillance unit?

**Ms Podesta**—We currently have an open tender process in train.

**Senator CROSSIN**—Didn't the tender process close on 3 May?

**Ms Podesta**—Yes, it did, and the process is still continuing. It is 1 June.

**Senator CROSSIN**—It feels like December, really.

**Ms Podesta**—It did close on 3 May. We are in the process of working on that tender. We expect to have the unit operating this calendar year.

**Senator CROSSIN**—Where will the surveillance unit be located?

**Ms Podesta**—That depends on the outcome of the tender.

**Senator CROSSIN**—So I shall ask you some questions about that a bit later.

**Ms Podesta**—I think in the November estimates we will be able to give you an exact date, but presumably it will be made public before then.

**Senator CROSSIN**—I have a few other questions about that. The guidelines for the public health management of trachoma in Australia, produced by the Communicable Diseases Network Australia, were published in March. You would be familiar with those, I guess. Is Australia on track to meet the World Health Organisation's Vision 2020 initiative for eliminating trachoma by 2020?

**Ms Balmanno**—The World Health Organisation commitment is to eliminate blinding trachoma. Some experts in Australia argue that we already have eliminated blinding trachoma, that it is no longer progressing to blindness. Others disagree. Part of the point of establishing the surveillance unit is to get better data on the prevalence and the progression of trachoma so that we have a much better idea across the country about what the situation is and whether or not we are actually on track.

**Senator CROSSIN**—So, if I am still in this job in 10 years time and I ask you how many people in this country have trachoma, you will be able to tell me, won't you?

**Ms Balmanno**—That is the idea.

**Senator CROSSIN**—I will still be asking that question whether I am on this side or that side of the table, I have to tell you.

**Ms Podesta**—Your commitment to this area is absolutely recognised, Senator. We hope you received your copy of the guidelines, which we sent to you as soon as they were published.

**Senator CROSSIN**—I have only been asking the question three times a year, I reckon, for eight years, but we will get there.

**Ms Halton**—And we all know you will ask, Senator.

**Senator CROSSIN**—And you are ready for it every time.

**Ms Halton**—That is right.

**Senator CROSSIN**—Is there national monitoring of antibiotic resistance to treatment?

**Ms Balmanno**—That will be part of the activities that the surveillance unit will be undertaking.

**Senator CROSSIN**—In the meantime, is there any progress in standardising the trachoma data collection systems in states and territories so that the data is comparable?

**Ms Podesta**—The first part of the funding about the management of trachoma will be to assist the relevant state jurisdictions to train their primary health care staff to bring them into line with the CDNA guideline. Part of that will be about better harmonisation of recording of data as well as a number of other clinical aspects of their work, so absolutely. As the surveillance unit is in place and operating, that will take a leadership role in being able to determine where the gaps are in the workforce within the state and territory public health units, where they need to focus specific training et cetera. But certainly in the first instance we will be looking at better skilling up around an understanding and adherence to the national guidelines.

**Senator CROSSIN**—Are there published guidelines for the trachoma screening and control measures; that is the other $470,000? Some of your $920,000 initiative is to assist state and territories to train health workers in the screening and control measures. That is it?

**Ms Balmanno**—In the CDNA guideline, yes. I think copies of that were sent to your office when it was published. That is the CDNA trachoma guideline.

**Senator CROSSIN**—I do not remember seeing that. If there is a spare copy, I would not mind having one.

**Ms Balmanno**—We can send some more copies.

**Senator CROSSIN**—I want just one of them.

**Ms Balmanno**—Yes.

**Senator CROSSIN**—How many shared responsibility agreements with Indigenous communities have included any eye health measures?

**Ms Podesta**—We will have a look. We have a list of all of the shared responsibility agreements.

**Senator CROSSIN**—You can take it on notice.

**Ms Balmanno**—We could probably answer another question while Ms McLaughlin looks it up.

**Senator CROSSIN**—Tell me what is happening at Mulan. Last time I spoke to you the incidence of trachoma had risen.

**Ms Balmanno**—The Kimberley Public Health Unit did their screening at the end of 2005 and published it earlier this year. That showed that the rates in Mulan were higher than they had been in the previous year, but were still lower than some of the years prior to that.

**Senator CROSSIN**—But you have no update on that information?

**Ms Balmanno**—No, there has been no screening done in Mulan since then. There has been the screening and the follow-up treatment, but it will not be until later this year that they do the next screen.

**Senator CROSSIN**—The only new money for eye health in the budget that I can see is for optical health support—$13.8 million over four years. Is that correct?

**Ms Podesta**—It is actually part of the Office for an Ageing Australia. We are finding it a little difficult to give you an answer, Senator, because we are having to go through the entire budget.

**Senator CROSSIN**—Am I in the wrong outcome?

**Ms Balmanno**—The new money for eye health that was announced in this budget was through the Office of an Ageing Australia. It was to do with the implementation of the national eye health framework for action. There was $13.8 million over four years announced, but that is managed by Ageing and Aged Care.

**Senator CROSSIN**—I am in the wrong part of your—

**Ms Balmanno**—Yes, for that particular element. There was no specific new money for eye health in Indigenous health, but there is certainly an Indigenous component to the Ageing eye health money.

**Senator CROSSIN**—I asked a question in February—E05018—about the national budget for Indigenous eye health programs from 2001 to 2004. Do you now have the 2004-05 figures?

**Ms Balmanno**—The spend for 2004-05?

**Senator CROSSIN**—What I asked for and what you gave me was the notional allocation for each year from 2001 to 2004 and the actual expenditure from 2001 to 2004. Do you have the 2004-05 figure now?

**Ms Balmanno**—The 2004-05 allocation was $2.7 million. I think we probably gave that last time. The actual spend in 2004-05 was $2.57 million.

**Senator CROSSIN**—Every year there is a significant underspend: 2002-03, $3.2 million allocated, only $2.92 million spent; 2003-04, $3.2 million allocated, $2.59 million spent; the same now with 2004-05. Why has there been not just an underspend in one year but a continual underspend now, it would seem, for the last five years?

**Ms Podesta**—I am happy to give you significant detail on this, Senator, but I also want to talk a little about the way we are allocating within the program. As we indicated in the answer, it is a notional allocation based on a business plan based on consultation that is provided by the state and territory officers. As the year rolls out, from time to time there are certain things that happen. For example, as you know, and we have given this information previously, a tender process to engage a consultant around the implementation review delayed commencement in one year. A tender process was delayed because there was a need to undertake a second tender for a certain purchase of equipment. This will happen from time to time, and we take that into account.

I want to go into the process of what we are doing at the moment with regard to OATSIH, because we are very conscious of your interest in this area, Senator, and I want to make it very explicit what is happening with regard to the program. Previously, we have been able to nominate a number of inputs into the funding that are provided to services, and services were required to report against the inputs. Because the appropriation for this area has increased by $260 million since 1996, because of a range of increases, it has become exceptionally difficult and in fact counter to better business planning for a service to continually report against a notional allocation by project around inputs or their expenditure. Services have regularly said to us that it amounts to an exorbitant amount of red tape. We have moved towards a single funding agreement that commenced in 2003-04. We are moving away from an input funding approach in this program so that services report, through the service activity reporting data and through the service development reporting framework around outputs, what they did with their global funding and what they were able to achieve.

As part of the action plans, services will still be required to report against priorities. But we recognise that different services will have different targets and different priorities depending on the people they service and the people they work with. So, while we anticipate that we will be able to give you very good data each time on a range of the areas that are priorities—such as sexual health and eye health—no longer will we require individual services to report against that input financially. They will be required to report to us on the outputs of the types and natures of the services that they provided.

I wanted to be really clear about that, Senator, because we know you have a real interest in this. We will be able to report to you in detail, particularly now with significant qualitative information through the planning framework for services, the outputs that services are able to achieve as a result of the funding. From our point of view, it is a better business planning model for the service, and services have certainly reported to us that it significantly reduces their red tape.

**Senator CROSSIN**—I have two questions from that. Each year there has been an underspend, have you flowed the underspend into the following year?

**Ms Podesta**—In terms of our business planning, yes, we have. When we have undertaken the planning for the funding that will be required to meet the objectives, yes, we have. We have taken into account whether there had been a delay in the previous year and we have made a notional provision against that item to be able to do it. But, as we have indicated, sometimes there is a delay in implementation by a service and, therefore, it is not fully expended. That means that, with the business objectives we are trying to achieve, we have moved that into the next financial year if it is still relevant.

**Senator CROSSIN**—Does that mean that your notional allocation and your actual expenditure will be much more precise if you are moving to an output reporting model?

**Ms Podesta**—I hope so. But I will not have any more notional allocations in the same way we currently have. I will have business objectives around those.

**Senator CROSSIN**—Will there be more actual allocations?

**Ms Podesta**—Not at a program level. We will be able to have better reporting on the types and natures of services were provided against those areas of service. Through the service activity reporting data, we are working towards being able to tell you the number of clients seen for particular eye activity through there.

**Ms Balmanno**—So there will be two types of spending on eye health, for example. There will still be projects like the South Australian otitis media project, which is a discrete activity, and that will be able to be identified in terms of the amount allocated and the amount spent. But the eye health program, as it is delivered through Aboriginal community controlled health services, will be part of their global budget. They will, first of all, advise us on what they intend to do in a year and then report on what they actually did do in that year. It is from that data that we will monitor the level of activity in eye health specifically through primary health care.

**Ms Podesta**—Rather than being able to say to you, ‘And we spent $3 million,’ we will be able to say to you, ‘And services delivered X number of services around eye health.’ That will be, to some degree, done gradually. This is the transition phase.

**Senator CROSSIN**—We will pursue that, perhaps, in coming months at the next round. Can I ask you about your response to the review of the implementation of the National Aboriginal and Torres Strait Islander Eye Health program from May 2004. There is an acknowledgment about encouraging optometrists to work in rural and remote areas. Certainly the Optometrists Association of Australia have had a role, I think, with you in this regard. I do not think it is clear, though, how these bodies can oversee the recruitment and monitoring of optometrists as recommended by the review. What reforms of the visiting optometrists scheme have resulted from your departmental review?

**Ms Balmanno**—The visiting optometrists scheme is not administered by OATSIH. It is looked after by the medical and pharmaceutical services program. It is the medical services outcome.

**Senator CROSSIN**—I should put these questions to them?

**Ms Balmanno**—Yes. The visiting optometrists scheme is one of theirs. The medical specialist outreach program, which also covers the outreach assistance program, which also covers ophthalmologists, is managed by outcome 6. So the two programs are separate.

**Senator CROSSIN**—I will put those questions on notice and you guys can sort that out.

**Ms Balmanno**—Yes. We will work out who they belong to.

**Senator CROSSIN**—There is one thing I am keen to follow up here. I raised with you the issue of asthma spacers by Aboriginal medical services. I know your answer to me was, 'Aboriginal medical services do get a bucket of funds, so they should be able to buy them out of that bucket of funds.' But has there been any move to actually enable medical services to buy them at a cheaper rate, such as gold card veterans can, for example?

**Ms Podesta**—I think as we indicated at the last estimates, OATSIH followed through with the questions that you have and we have been working very closely with industry, with asthma peak bodies and with the representative bodies in Aboriginal community health. We have had some very significant outcomes with regard to those negotiations. I really want to give credit to the staff who have pursued those.

**Ms Balmanno**—Can we touch wood. The contract is not signed.

**Ms Podesta**—The contract is not signed yet, but we believe it is—

**Senator CROSSIN**—Could you tell us about it?

**Ms Podesta**—The Asthma Foundation of Australia has negotiated a bulk purchase discounter of between 50 per cent and 65 per cent below retail for three different types of spacers which we believe will meet the needs of all services. We expect all three spacers will sell for less than $8 per unit. The Asthma Foundation of Australia will also run a central ordering and distribution centre for all OATSIH funded services. They will track the stock flows, advise the department of any problems encountered by services and include with every spacer sale a culturally appropriate educational booklet on the use of the asthma puffers and spacers. Most importantly, they have agreed at this stage to run this service on a cost recovery basis and they will absorb the administrative overheads. Given, Senator, your interest in state and territory governments, I know you will be very pleased to know one of the peak bodies has done this with regard to Aboriginal health.

**Senator CROSSIN**—This is the Asthma Foundation, not the Asthma Council?

**Ms Podesta**—The Asthma Foundation, yes. They have agreed to this. We will be sending a sample of each of the three spacers to every OATSIH funded primary health care service to highlight this issue to staff, to assist them to choose the best space so that it meets the needs of their clients and to include the educational leaflet. This strategy was endorsed by NACCHO, our peak body, at the May meeting. We expect the new ordering system to be in place by early July. This, of course, will be supplemented by a range of other initiatives with regard to asthma. We think this is a very important initiative, Senator, and we are very pleased to be able to follow through from your initial questions.

**Senator CROSSIN**—Who specifically in your department has worked on that?

**Ms Podesta**—It is probably inappropriate to name the staff. They know. They have been recognised for their work.

**Senator CROSSIN**—That is a fantastic outcome. I am sorry you cannot name them, but perhaps I can in the *Hansard* publicly recognise these anonymous people.

**Ms Podesta**—They are so good, they will probably be poached by someone else.

**Ms Halton**—That is actually why she will not name them.

**Senator CROSSIN**—That is a good outcome. I am pleased to see that you have worked with the Asthma Foundation. I have mentioned it to Robin Ould, though.

**Ms Podesta**—A big part of what OATSIH does is to try to recognise ways to improve and increase access to services.

**Senator CROSSIN**—Well done.

**Senator WEBBER**—Last time we met we were talking about petrol sniffing—

**Ms Podesta**—We would be disappointed if we did not get a petrol sniffing question.

**Senator WEBBER**—We had a chat about sexually transmitted diseases in young children, particularly chlamydia in children as young as three. We had a discussion about whether it was sexually transmitted or an eye virus. Given all the recent discussions, do we have any more concrete data on that?

**Ms Balmanno**—Since we last met, we have followed up with our colleagues who look after the National Notifiable Diseases Surveillance System. We have the national data for 2004. Seven cases of children under five with chlamydia were reported nationally. That data does not identify Indigenous or non-Indigenous status. There was one case of syphilis. That was the STI data in 2004 for children under five. The next jump up in the data set is children under 13. The numbers go up quite considerably. There was a total of 185 notifications in 2004. That is still the national figure. There is no Indigenous status within that. The majority of those notifications were of chlamydia at 131. There were 52 notifications of gonococcal and two notifications of syphilis.

**Senator WEBBER**—We obviously raised it when we were talking about it, but a number of other people, including the minister for Indigenous affairs, have made some public pronouncements on this. Are there plans to collect any more data on that?

**Ms Balmanno**—The data is collected by the states and territories. They have mandatory notification of sexually transmissible infections. Then it is voluntarily reported by the states and territories to the national system.

**Senator McLUCAS**—I have some questions about the Department of Health and Ageing allocation to the shared responsibility agreements. I understand that $16.3 million is coming out of Health and Ageing.

**Ms Podesta**—Over four years.

**Senator McLUCAS**—Where is that money coming from?

**Ms Podesta**—We have made a commitment of no less than that figure. It will come from a range of programs across the department. At the moment, we are participants in up to 10 SRAs. They have come from a number of programs, including rural, health et cetera.

**Ms Halton**—Essentially, we have not earmarked particular programs. As you would understand the way shared responsibility arrangements develop, there will be a negotiation depending on the particular interests in the particular regions. But, based on our best estimates, we think that would be the minimum that we would commit.

**Senator McLUCAS**—How could the department of families track that you have actually spent that?

**Ms Podesta**—We will be reporting on that through the budget process.

**Senator McLUCAS**—How will that happen?

**Ms Halton**—These will be administered funds.

**Senator McLUCAS**—They are all administered funds?

**Ms Halton**—They will be administered funds. Essentially, there will be projects. With our IT systems, we will be able to identify those individual projects and track expenditure against them.

**Ms Podesta**—OATSIH and the Budget Branch will be working together to report against program areas. We will make a specific reporting in our annual report on contribution to SRAs across the portfolio.

**Senator McLUCAS**—What negotiations occurred between DOHA and FaCSIA to come up with the figure of $16.8 million?

**Ms Podesta**—I believe that was discussed in some detail with FaCSIA. It is based on a share of the Australian government investment in Indigenous programs—expenditure.

**Senator McLUCAS**—It is a notional figure?

**Ms Podesta**—It is a notional figure based on current expenditure across departments.

**Senator McLUCAS**—Give me an understanding of the notional allocation. Is it a percentage of the money that DOHA spends on Indigenous health?

**Ms Podesta**—Yes, that is correct.

**Senator McLUCAS**—What percentage is it?

**Ms Podesta**—I do not know. I would have to take that on notice. It was a budget decision that a total would be allocated across the four years across the Australian government. Each portfolio was given a proportion of that based on our contribution to the Australian government investment in Indigenous expenditure.

**Mr Clout**—I think it was around $80 million. I think we are about a fifth or something like that.

**Ms Podesta**—We can take that on notice, Senator, and give you the precise details.

**Senator McLUCAS**—I am trying to understand this. Is this like an identification of activities that are currently under way that can be streamed into the SRA process?

**Ms Halton**—I would not put it quite like that. You know that one of the challenges has been to actually channel moneys into flexible programs to ensure that they are used for people in Indigenous communities as well as in mainstream metropolitan communities, for example. The essential effort we are going through is ensuring that in the negotiation of a particular SRA—for example, an element of that SRA is relevant to our portfolio; it is something to do with population health—we tap into our mainstream programs to make the contribution to that particular SRA. In other words, it is about ensuring that we harness the mainstream as well as the Indigenous specific. We have reasonable allocations for Indigenous specific services, as you know—we have just been talking about them. But we do not want to provide services to Indigenous people using just Indigenous specific money. We want to be able to harness that mainstream contribution also. This will harness the various programs in a way that is flexible into these SRAs.

**Ms Podesta**—As we have indicated previously, in relation to the solution brokers we have placed in the ICCs, part of their role in their policy contribution to the development of an SRA in an SRA negotiation process is to feed back in through the department. In our department it is through OATSIH, but in consultation with the Budget Branch. We identify the policy parameters around the potential SRA and identify potential funding sources which are in line with the appropriation provided through mainstream or Indigenous health. As the secretary has indicated, we to try to match those appropriately. We do a lot of work to ensure that mainstream parts of departments meet their obligations to provide flexible capacity through shared responsibility agreements because, as you know, Senator Mc Lucas, the shared responsibility agreements go across a wide range of activities that cover our portfolio.

**Senator McLUCAS**—When can I ask where the money has come from—after the event or before?

**Ms Podesta**—It would have to be after the event because that would be when the decision had been made. There is, to some degree, a bit of horse trading between parts of the portfolio to be able to make a decision about where it is most appropriate. So before the event would be only speculation.

**Senator McLUCAS**—But before or after the delivery of the service?

**Ms Halton**—Before; we will know. An SRA will not be signed up which has a health component where we would not have identified before that signing from which program these funds will come. So we will always know. The point at which there is a signature, we will have had to have said, ‘That will come from there.’

**Ms Podesta**—Before the portfolio signs, we have identified the source of funding. We are always careful to ensure that the nature of the SRA and the source of the funding reflect the original decision for the appropriation, and that is the critical part of the work from our end.

**Senator McLUCAS**—Is it reasonable to ask at this point, though, in the planning process—you would have had a notional allocation out of that $16.8 million over four years; let us look at just this year—how much will be allocated to each outcome?

**Ms Murnane**—You need to remember that this comes out of consultation with the community. To a large extent, whether or not there is an aged care component or a population health component will be the result of consultation with the community. So it is pretty hard to

be specific in advance because that would tend to give the impression that we were being determinative prior to consultation.

**Senator McLUCAS**—You do not know at the moment. That is fine. That is all I want to know.

**Ms Podesta**—I will explain the process a little.

**Ms Halton**—No, we do not know. That is the bottom line.

**Senator McLUCAS**—It is a notional amount of money worked out on a formula of how much money is allocated to Indigenous affairs in DOHA. You do not know yet which outcome it will come from, for reasonable reasons. We do not know where it will come from, but we will know before the money is signed.

**Ms Halton**—Correct.

**Senator McLUCAS**—When will we know you have added up to $16.8 million?

**Ms Halton**—Because we will track the cumulative amount. On a year-by-year basis, on an estimates-by-estimates basis, you can say to us, ‘How much have you allocated since last estimates, or what is the running total,’ and we will be able to tell you.

**Senator McLUCAS**—The running total at the moment is none, but I will be able to ask in November—

**Ms Halton**—No, we actually have money allocated against SRAs now.

**Ms Podesta**—At the moment, the running total prior to this current budget decision of the $16 million over four years is $1.027 million from our portfolio for current SRAs. There are currently at least another 19 SRAs, which are at exposure draft stage, which the department is considering investing in. As they are signed, we will report those.

**Senator McLUCAS**—We will ask at every estimates for the cumulative expenditure by outcome on SRAs.

**Ms Halton**—Yes. My expectation is that is what you would be asking. You would say, ‘How much have you signed up in the last whatever, and from which programs are they coming?’ We will be able to answer those questions.

**Senator McLUCAS**—We will ask them.

**Ms Halton**—We will add that to the list of questions we expect from Senator Crossin or whomever.

[3.08 p.m.]

**CHAIR**—We will now move to Outcome 1—Population health. Let us devote an hour or so to general issues, and then we will come back to the various agencies that people want to ask questions of.

**Senator PAYNE**—The minister’s recently established parliamentary liaison group had a meeting in the last sitting period with peak community bodies for HIV and hepatitis C. One of the sets of statistics that were placed on the table at that meeting was about increases of HIV diagnoses, particularly in Victoria and Queensland, for the last calendar year, 2005, including increases in diagnoses in Queensland of about nine per cent, I think, and in Victoria of closer

to 28 per cent. What is the federal department doing to assist or perhaps even to encourage the respective state governments to address these sorts of increases, because in almost any other communicable disease I can think of an increase in the order of 28 per cent would be regarded as most alarming?

**Ms Smith**—Senator, those figures for 2005 which you are quoting are still provisional. We will not get the final, clean figures until around August. But certainly you are correct in saying that there is a pattern emerging in respect of Queensland and Victoria. This issue is attracting quite a bit of discussion within MACASHH, which, as you would be aware, is the Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis. Also, a forum was organised between the Victorian, New South Wales and Queensland departments of health and the Commonwealth department of health to discuss those rises and do a bit of brainstorming about possible responses. The sector is probably at the point of being clearly very concerned about the figures but aware of what a complex issue it is, and is still sifting through what is contributing to those increases and what some of the possible responses might be.

**Senator PAYNE**—Is it possible to tell the committee what came out of the forum discussion you referred to between Victoria, New South Wales, Queensland and the Commonwealth?

**Ms Smith**—I think at this point it was more a sharing of information and trying to drill down into the detail of what might be going on. I would have to take on notice any more specific outcomes than that.

**Senator PAYNE**—Would you mind doing that?

**Ms Smith**—Yes.

**Senator PAYNE**—The reports that we have received through the PLG, which have been commented on publicly, are that the increased infections are overwhelmingly amongst gay men and reportedly around 80 per cent of the diagnoses in both states—80 per cent of the nine per cent and 80 per cent of the 28 per cent, which I acknowledge, as you say, Ms Smith, are provisional figures at this stage. There was discussion at that meeting about the complexity of dealing in HIV prevention these days because of changes in the community or the perception that HIV is a reduced threat because of treatments that are available and those sorts of things. My question relates to the department's response to those changes, particularly in light of the recommendations about prevention in the fifth national strategy document, which set out particularly the development and implementation of what would be described as a culturally appropriate HIV prevention education program with a real priority for actively gay men. I was part of that review team, appointed by a previous health minister, that drafted that recommendation which was then adopted and made part of the strategy. How are you ensuring that the approach taken by the department is culturally appropriate for actively gay men, given those concerns I alluded to earlier about the complexity of the response in the community?

**Ms Smith**—Senator, I think you would be aware that the majority of HIV prevention funding that the department spends is delivered through the community organisations. We provide funding to both the Australian Federation of AIDS Organisations and the National Association of People Living with HIV/AIDS to do a range of highly targeted education

activities that are appropriate for the needs of the gay community and HIV-positive people. We are currently in a process of discussing with AFAO and NAPWA their proposed activities for 2006-07 and very much are tying those activities back to the priority areas in the national HIV strategy. I have a meeting, I think in a couple of weeks, with AFAO where they will be presenting to us their ideas for the things that they will be focusing on next financial year.

**Senator PAYNE**—I assume that approach is about keeping Australia at the forefront of prevention programs, where we have been previously, to make sure that we are responsive to the sorts of complexities that exist in the community.

**Ms Smith**—Yes. That is correct.

**Senator PAYNE**—As you would be aware, the five-year review of the progress on meeting the UNGAS recommendations out of the special session of the General Assembly on HIV/AIDS is occurring now. I know that Australia's representation there is being led by our newly appointed ambassador for HIV/AIDS, Annmaree O'Keeffe. What engagement has your department had in that process specifically? More generally, what engagement are you having with AusAID or DFAT on the development of Australia's very strong regional response?

**Ms Halton**—In fact one of the officers who attended the World Health Assembly with me went on to the UN.

**Senator PAYNE**—And is there now?

**Ms Halton**—And is there now. One of the things we have been very serious about doing is working very vigorously with our colleagues in those other agencies in relation to our engagement in the region. I know Mary talks very regularly with Annmaree O'Keeffe and others, as indeed do I at the senior level. You would be aware that we are actively engaged regionally, and this is something that we regard as being very important. We are very conscious of the issue you raised regarding the albeit draft, not yet confirmed figures which suggest there is a rise. Be assured that that is a matter we will be pursuing.

**Senator PAYNE**—Thank you, Ms Halton. I really appreciate that.

**CHAIR**—Let us move to the National Bowel Cancer Screening Program.

**Senator FORSHAW**—Can you tell me why the proposed start-up or roll-out date of 1 May for the National Bowel Cancer Screening Program was not met?

**Mr Stuart**—The Australian government had a view about how this program was going to roll out, beginning in May. In detailed bilateral discussions with jurisdictions during March and into early April, it became clear that there were some issues from the states and territories that a reconsideration of the roll-out strategy would make life a little easier for them. We have been happy to engage with them further on that in moving from a sort of Australia wide roll-out strategy to a region-by-region strategy. We are now working with them to understand their roll-out patterns, which we hope to start implementing during August.

**Senator FORSHAW**—I understand that concerns have been detailed through the Australian Health Ministers Advisory Council in March. I am wondering what has been done to address those concerns. How is the current eligible population defined and how will this change over time?

**Mr Stuart**—The current eligible population is defined as all those people turning 55 or turning 65 during a two-year period beginning 1 May 2006, which is an approach to starting the program relatively slowly rather than a kind of big bang roll-out to all those aged between 55 and 74. If the program is shown to be effective in 2008, the government has asked for a review of progress in 2008. What would then occur is that we would follow the same people up again two years later and then a new group of people turning 55 and 65, so that over a 10-year period you phase in a program for all those between 55 and 74.

**Ms Smith**—There is also the pilot. The people who participated in the pilot will also be invited to screen again because that will give us a crucial bit of information about whether people are prepared to rescreen when invited.

**Senator FORSHAW**—Who is responsible for the data collection and the management and the evaluation of the data?

**Mr Stuart**—The Australian government is responsible for that, in part in partnership with Medicare Australia.

**Senator FORSHAW**—That follow-up of people who participate in the program over time would be instigated by the department, would it, arising out of this data you have collected?

**Ms Smith**—We are constructing a register within Medicare Australia that will use Medicare enrolment data to invite participants, and then the register will have the responsibility of following people through the screening pathway. We have recently been talking to both the states and Medicare Australia about establishing some data manager positions which would be located within each state. That will be an additional resource to enable people to be tracked as they progress through the pathway.

**Mr Stuart**—There will be a central register. It will follow people through the screening pathways. It will follow then up. It will track people. It will send reminder letters to make sure we do not lose people along the way.

**Senator FORSHAW**—That is what I was trying to get to. That will be the department or the unit or whatever within the department direct to the individual?

**Mr Stuart**—The department through Medicare Australia. Medicare Australia will manage the register and that follow-up system, because it is based on Medicare data.

**Senator FORSHAW**—Will that register also include people who are already undertaking or undergoing regular screening because of GP referrals et cetera?

**Mr Stuart**—I do not think we call that screening.

**Senator FORSHAW**—I mean those who are already in the system and may be having colonoscopies and so on.

**Mr Stuart**—Yes. It is a population based register, so everyone starts out on it. Then we send them a letter with a kit. We have just let a contract to produce those kits. That letter would go out to those people. The letter would make it clear that, if people then go to see their doctor, their doctor will consult with them about whether they have previously or recently had a colonoscopy and then make a decision about whether they need to be referred for another one.

**Senator FORSHAW**—Is the data collection system in place? You are talking about commencing this from August. It is now June.

**Ms Smith**—Medicare Australia is well on the way to having that system in place, and we are confident that it will be in place in time for commencement in early August.

**Senator FORSHAW**—You are confident. Do you know? Can you be more than just confident?

**Mr Stuart**—We have a financial arrangement with Medicare Australia which requires an outcome.

**Ms Halton**—That was an excellent bureaucratic response, Senator, wasn't it?

**Senator FORSHAW**—You said that, Ms Halton; I didn't. What guidelines are provided to GPs and other health professionals who will be seeing these patients?

**Ms Smith**—At the end of 2005 the NHMRC approved revised guidelines on the management of people with colorectal cancer. We will be reinforcing the importance of NHMRC guidelines in all our communication materials to GPs.

**Senator FORSHAW**—Can we get a copy of those guidelines? Is that possible?

**Ms Smith**—Yes, we can provide those.

**Senator FORSHAW**—Have quality control guidelines and standards been developed?

**Ms Smith**—We are in a process of consulting with the profession about quality control guidelines. We have established a working party which contains a number of the key professional groups, such as the Gastroenterological Society, the College of Surgeons and the college of gastroenterologists. That group is very keen to work with us on developing the quality framework.

**Senator FORSHAW**—So they have not been developed?

**Ms Smith**—There are some quality frameworks in place already, but I think it is acknowledged that it would be beneficial if more work were done in this area.

**Prof. Horvath**—In fact the colorectal group, who are the interested party made up of gastroenterologists and surgeons, have been in place for quite a long time. They have quality control standards for performing a colonoscopy—how many colonoscopies you need to do under supervision before you are appropriate. They are looking at those guidelines again to make sure that they are appropriate for more broad population based screening programs. So they are not working off a blank page; it is a modification. The department has already been working with them, and I have had conversations with Professor Stitz, who is the President of the College of Surgeons and a member of that working party.

**Senator FORSHAW**—Are educational materials for GPs and other health professionals being developed as well?

**Mr Stuart**—Yes. That material has been drafted and is awaiting final approval, I believe.

**Ms Smith**—We established an implementation advisory group, which contains a lot of the key clinical groups, to advise us on the way forward. We had a good, hard look at the materials that were provided to GPs and other health professionals during the pilot. We have

received feedback about what was and was not useful. That process is well under way to revise the kit and material that will go out to GPs. We are also in discussions with ADGP and the state based organisations about how they can facilitate GP education in their particular network.

**Senator FORSHAW**—They are awaiting approval from whom? Who has to give the approval?

**Mr Stuart**—We have material, as Ms Smith was saying, from the pilots. We have reworked in consultation with experts. We are asking the Australian Divisions of General Practice to consult with doctors to test whether they are effective with their members. Then it will be ready to go.

**Senator FORSHAW**—Will it be ready to go by August?

**Mr Stuart**—Absolutely.

**Senator FORSHAW**—You are obviously confident. Are any community awareness programs in place to alert people about the screening programs that are to commence in August?

**Mr Stuart**—The key community awareness program is the mail-out process for the kits. If you are not receiving one of those kits, we probably do not need you to be highly aware. If you are receiving one of the kits, you will get a very clear explanatory letter.

**Ms Smith**—We will have to do a deliberately low-key communication strategy in this phase of the program because we are picking only two age groups. If we were to do really broad-ranging communication, we would run the risk that people not eligible for the program would be extremely aware but would not be able to participate. So there will be a low-key communication strategy that will underpin the invitation that goes out to eligible participants.

**Senator FORSHAW**—Certainly I am aware that one of the target groups for colonoscopies is or should be people with a family history of bowel cancer. Generally, as I have found out over the years, that might actually start at a younger age than 55—around 40. I notice Professor Horvath is nodding. It seems the advice I have been given is right. I am pretty sure it is.

There could be people in that situation who should be targeted for screening or be educated about having a colonoscopy but who are not in these target groups. I appreciate this is a particular program with those age groups identified. But, in a community awareness program, I would have thought you might be trying to capture a broader group as well.

**Mr Stuart**—There are two separable issues here. On the one hand, there is the issue of what is a cost-effective target group for a nationwide organised screening program, and we have good evidence from the pilots about that. On the other, there are people with risk factors, family history and/or symptoms. They are dealt with more on an individual basis through the primary care system. I will ask Ms Smith to comment further about that.

**Senator FORSHAW**—I did not raise the colonoscopy issue. That was raised by Professor Horvath. So I thought I would throw that in.

**Prof. Horvath**—Senator, what you refer to would not be regarded as screening. This is not targeting a whole-of-population screening.

**Senator FORSHAW**—I understand precisely that.

**Prof. Horvath**—The high risk is really when a person is identified as a result of another intervention, be it from their symptoms or family. So they are a totally different target group to the ones we are talking about.

**Senator FORSHAW**—I know. I do not want to get bogged down in this. It came to me in the context of community awareness programs.

**Ms Smith**—The NHMRC guidelines indicate the sort of clinical guidance that is appropriate for those with family history and those with symptoms. GPs will be getting information about the NHMRC guidelines and information on how to respond to someone who has a heightened family history if they somehow slip into the net of this program as well.

**Senator FORSHAW**—I would like to keep moving along because I have a few other questions. There are other issues to be covered as well. Are there specific community awareness programs for Indigenous populations or non-English speakers? Do they exist? Are they being developed?

**Ms Smith**—The issue of how this program deals with Indigenous populations is a particularly challenging one. We have been having some very constructive discussions with our colleagues in states that have significant Indigenous populations about how we will be able to do something culturally appropriate as we roll out the program. Those discussions are still at a fairly early stage.

**Senator FORSHAW**—Have funding arrangements between the states and territories and the Commonwealth been reached yet?

**Mr Stuart**—We think so. The shape of the program is that the Australian government is funding all of the moving parts, which includes the FOBT kits, the laboratory analysis, the register and the data collection. Then there is funding for the general practice referral through the MBS. There is funding for private sector colonoscopy through the MBS. We have been speaking to and wishing to partner with states and territories on public sector colonoscopy through usual hospital funding.

**Senator FORSHAW**—Is it proposed to eventually include this program in the public health outcome funding agreements?

**Mr Stuart**—Certainly not for the time being.

**Senator FORSHAW**—What procedures are in place for ensuring that everyone who has a positive FOBT will get a colonoscopy within a reasonable period? You might particularly comment upon persons in rural and remote areas.

**Mr Stuart**—The first part of the answer is that this is in part a role of the register system to track people and follow up and make sure that they have been getting to where they have been referred to. The second part of the answer is that we are working with states and territories now on a region-by-region roll-out. That helps you do a couple of things. It helps you alert the GPs in the particular area and it also helps the states and territories to put in place provision

for colonoscopy in those areas as the program rolls out, in addition to whatever private capacity may already exist.

**Senator FORSHAW**—What do you mean by that, exactly?

**Mr Stuart**—About 70 per cent of all colonoscopy in Australia is performed through Medicare through the private system, through private specialists, which is of course Commonwealth funded activity. So, where there is a private sector, it will deal with a share of referrals under this program as well.

**Senator FORSHAW**—What are the medical indemnity implications if a patient with a positive test cannot get a colonoscopy? Who bears that?

**Mr Stuart**—In the community at the moment people are being referred for colonoscopy by GPs and people are undergoing them in the public sector and in the private sector. This is not really so remarkably different. But we are in discussions with states and territories about clarifying that and doing further work to clarify that at the moment.

**Senator FORSHAW**—That is under discussion too, is it?

**Mr Stuart**—Under discussion.

**Senator ADAMS**—I note in the department's outcomes on population health there is an evaluation of BreastScreen Australia. At the last estimates I asked some questions on screening. Has the evaluation commenced?

**Mr Stuart**—It has not commenced yet. Our next step is to take a plan for that evaluation to the next Australian Health Ministers Advisory Committee meeting in just a few days to discuss with states and territories a shared approach to that evaluation.

**Senator ADAMS**—There will be an expert committee looking at that. Can you tell me who will be on that committee?

**Mr Stuart**—Again, not as yet. It will be a matter for joint decision between the Commonwealth and the states once we get agreement to go ahead with this evaluation at the AHMAC meeting.

**Senator ADAMS**—Would you be able to forward to me, please, the names of the people when you get them?

**Mr Stuart**—Ms Smith has some additional information on that.

**Ms Smith**—I can tell you, Senator, the broad areas of expertise we have in mind. We thought it was important to get some international expertise into this group. In fact, a couple of other countries have done or are about to do major evaluations themselves of their breast screening programs. We will also have a couple of eminent Australian experts. We want some jurisdictional input, and obviously consumer input will be important as well.

**Senator ADAMS**—Will there be any rural consumer input into that?

**Ms Smith**—We have not got down to that level of detail.

**Senator ADAMS**—I would like to suggest there is because it is a very different scene with screening in the rural areas to that in the metropolitan areas, and access is important.

**CHAIR**—If there are no other questions on bowel cancer, we will move to pregnancy counselling.

**Senator STOTT DESPOJA**— I have some specific questions on the telephone helpline and then some general questions on pregnancy counselling, if that assists with who is doing what.

**Ms Murnane**—Mr Stuart will start.

**Senator STOTT DESPOJA**—Mr Stuart, I have some queries about the helpline that has been budgeted for in the last budget. To expedite proceedings, I will try to put most of these questions on notice or at least return to some of the tender questions later. Through what legislative mechanism will the helpline be established? Will it be through a bill to parliament or delegated legislation?

**Mr Stuart**—The helpline will be established through a commercial tender process.

**Senator STOTT DESPOJA**—But there will be no legislative backup for that?

**Mr Stuart**—There is no need for legislation.

**Senator STOTT DESPOJA**—Is it still running on time? Will it be established by December this year?

**Mr Stuart**—Yes.

**Senator STOTT DESPOJA**—Will the helpline be providing a counselling service or a referral service or indeed both services?

**Mr Stuart**—It will be providing a counselling and information service. With regard to the word ‘referral’, doctors refer. They say, ‘I think you need X.’ In the context of a non-directive counselling approach, you do not really say to someone, ‘I think you need X.’ You counsel and assist the person to decide what the person thinks they need, and then you provide information about their options.

**Senator STOTT DESPOJA**—Will the services and information be available to women who are proceeding with their pregnancy, women who are choosing to terminate their pregnancy or women who are completely confused about what they want to do?

**Mr Stuart**—It means being able to provide information about all available services.

**Ms Halton**—To all of those women.

**Senator STOTT DESPOJA**—Where are you up to with the tender process?

**Mr Stuart**—We are working within the department to give expression to the policy as stated, but we are a little way away from letting a tender because we have the issue of obtaining expert advice and making sure we get that right. So we are well away from being in the public arena at this stage with the tender process.

**Senator STOTT DESPOJA**—You have indicated in response to some of the questions on notice that I have lodged—and, thankfully, that the department has answered—that this will involve staff from the department determining a selection criteria against which you will rate and assess the tenders.

**Mr Stuart**—That is right.

**Senator STOTT DESPOJA**—Is that process progressing? Where are you up to? Are we able to have a copy of the selection criteria?

**Mr Stuart**—Not yet. They have not been agreed and finalised. As I said, we have the issue of expert advice yet to be received as well. So that is a little way away. I should point out that this is not really a question I will be able to take on notice either. The first that anyone can see of this material is when it is let as a tender to all those in the marketplace at the one time so that we preserve an equal playing field for all possible tenderers.

**Senator STOTT DESPOJA**—You are not in a position to advise the committee as to whether or not various groups are excluded from tendering? For example, would abortion providers be excluded from tendering for the contract?

**Mr Stuart**—There is some information on the web, a Q&A paper, which I believe goes to that issue.

**Senator STOTT DESPOJA**—My understanding from the Q&A is that they would be excluded. Is that correct? I do not want to jump to that conclusion without—

**Mr Stuart**—Our general principle is that we want to avoid conflicts of interest.

**Ms Smith**—It will be up to organisations to assess the tender criteria and determine whether they believe they can meet it. It is not appropriate for us at this point to rule anyone in or out.

**Senator STOTT DESPOJA**—So no-one is excluded from tendering?

**Ms Smith**—It will be up to each organisation to determine whether they meet the tender criteria.

**Mr Stuart**—Then it will be a matter for the department to assess on the basis of the pitch in the tender whether or not the organisation is meeting the tender criteria.

**Senator STOTT DESPOJA**—I might lodge some questions—predictably so, I suspect—on the issue of conflict of interest in the same way I was curious to elaborate on that last night. Conflict of interest seemed to be determined in a pecuniary fashion as opposed to broader recognition that there may be interests in other spheres. But I will not take up time on that. What role will the health minister have in the selection process?

**Mr Stuart**—The selection process will be staffed by a committee of public servants. The delegate for the decision will be a senior public servant.

**Senator STOTT DESPOJA**—You cannot specify who that senior public servant would be—I do not mean their name, but their title or position?

**Ms Halton**—No, I would prefer not to do that. It will be a senior officer.

**Senator STOTT DESPOJA**—That does not necessarily specify whether or not the minister has a role, as such. Did you want to be more specific on that?

**Ms Halton**—The minister does not have a role in the selection.

**Senator STOTT DESPOJA**—What is the time line for the criteria to be finalised and obviously made available and the successful applicant chosen?

**Mr Stuart**—We want to let a tender late mid-year and to decide within about three months after that. Then there will be a public announcement and then there will be preparation for establishment.

**Senator STOTT DESPOJA**—In December as planned?

**Mr Stuart**—In December.

**Senator MOORE**—What does 'late mid-year' mean?

**Senator STOTT DESPOJA**—Because, if you add three months to late mid-year, it is getting very late.

**Mr Stuart**—July-August.

**Senator MOORE**—July-ish. It will be in the middle of the year, but not drifting into September-October.

**Mr Stuart**—In the middle of the year. You will not see it in June.

**Senator MOORE**—That is narrowing it down, Mr Stuart. So we are hoping for July.

**Mr Stuart**—I am trying to help.

**Ms Halton**—It is no wonder people who learn English struggle with it so much.

**Mr Stuart**—English is my second language, Senator! I apologise.

**Senator STOTT DESPOJA**—I wish we all had that excuse. The department has given advice previously that there will be an advisory committee comprising various representatives from the relevant professions. Has the advisory committee been established?

**Mr Stuart**—Not as yet. The department is in the process of preparing advice on that issue.

**Senator STOTT DESPOJA**—You cannot tell me who would be on that advisory committee?

**Mr Stuart**—No, not as yet.

**Senator STOTT DESPOJA**—Or what the criteria are?

**Mr Stuart**—The criteria are much as you have said, which is professionals from those relevant professional groups. But, no, we do not have names for that yet.

**Senator STOTT DESPOJA**—You do not have names for what professional bodies would be sitting on the advisory committee?

**Mr Stuart**—We could give you an indication of the kinds of professional bodies being contemplated.

**Senator STOTT DESPOJA**—Yes, please.

**Ms Smith**—We will be looking at expertise in non-directive counselling, expertise in reproductive health, expertise in telecounselling, expertise in primary care or general practice. They are the sorts of expertise categories we are looking at.

**Senator STOTT DESPOJA**—How often would you seek to review or monitor the performance of the successful tenderer? Would that be on an annual or monthly basis? On what basis would you check their success or otherwise?

**Mr Stuart**—That takes us into the tender and the tender criteria.

**Senator STOTT DESPOJA**—I have more questions on that, but I might put them aside for some general questions. I want to go to the key issue of non-directive counselling and perhaps some general questions on government funding in relation to pregnancy counselling in Australia. The government is providing around $300,000 on average now to the Australian Federation of Pregnancy Support Services. I realise the name has changed to Pregnancy Help Australia, but I note in the answers to my questions on notice the department tends to use AFPSS as well. They are used interchangeably, as I understand it. For the purposes of my questions, I am happy to refer to either terminology.

Is that umbrella or representative organisation meeting the department's standards and criteria of providing non-directive pregnancy counselling services? In a response to me previously, the department has claimed that this government funded organisation is:

... committed to ensuring that the AFPSS meets the requirements of its funding agreement which is to provide independent non-directive pregnancy counselling.

Is the department satisfied that the terms of that agreement are being met at the moment and that the organisation is providing non-directive pregnancy counselling?

**Ms Smith**—The AFPSS are required to provide non-directive counselling through their funding agreement. An important part of their mission statement is that they provide non-directive counselling. We are confident from the reports that we receive that that is being achieved.

**Senator STOTT DESPOJA**—I refer you to the constitution of the Australian Federation of Pregnancy Support Services. Under 'Objects', point (i) states:

To provide an organisational structure for state, regional and local pro-life pregnancy support service centres with the purpose to offer mutual support, advice and service.

Part (v)(e) states:

Not to advise, provide or refer, directly or indirectly, for abortions or abortifacients ...

Does that comply with non-directive pregnancy counselling?

**Ms Smith**—Counselling is really about the process of supporting decision making and ensuring that the counsellor assists the client to explore their feelings in relation to the issue. The issue of what happens once the client has made the decision and whether there is ongoing referral is a different issue from whether non-directive counselling is being provided.

**Senator STOTT DESPOJA**—Would you suggest that is an organisation complying with the terms under which it receives departmental funding of approximately $250,000 on average and an extra $100,000 as of last November, so roughly $300,000 per annum? Is it meeting the terms of the agreement? With all due respect, I understand your assessment of counselling, be it before or after a decision of any sort, but that is a fairly flagrant reference to a particular position in a constitution.

A web page dedicated to the history of Pregnancy Help Australia, formerly the Australian Federation of Pro-Life Pregnancy Support Services before it was renamed, states:

> In order to explain and clarify our project-life counselling stance that we will not refer directly or indirectly for abortion, [I will quote from a paper] ... I believe that if we send an abortion-seeking client to another professional or government or non-government agency or hospital for abortion counselling, and we do not know whether or not the person at the other end is going to be 100% pro-life, then I would regard that as a soft abortion referral.

The list goes on, but that is actually referring to the federation that does not advise on, provide for or refer directly or indirectly to abortion or abortifacients. Is an organisation that has been referred to as not providing referral non-directive?

**Mr Stuart**—We require them to provide non-directive counselling. We do not require them to provide referral, and we do not require them to provide referral to particular places. We are satisfied that they are meeting the terms of our agreement. We have no information to the contrary. We evaluate that agreement from time to time. There is no evidence or information available to the department for us to call that into question.

**Senator STOTT DESPOJA**—So statements such as constitutional reference or otherwise are consistent with the service agreement with the department?

**Mr Stuart**—I do not think I can give a very quick, simple answer to that at this hearing. But we are satisfied that they are providing non-directive counselling in line with our requirements.

**Senator STOTT DESPOJA**—Perhaps the department should provide to the committee a specific definition of what constitutes non-directive. If that is the criteria with which organisations that are funded by the department are expected to comply and that is consistent or meeting the standards or the department is 'satisfied', perhaps we need to receive a definition of what is non-directive because so much hangs on it.

**Mr Stuart**—We would be happy to provide a definition of non-directive counselling. I think Ms Carolyn Smith did so in her answer before.

**Senator STOTT DESPOJA**—Yes.

**Mr Stuart**—I think we are distinguishing the issue of non-directive counselling from the issue of referral.

**Senator WEBBER**—Could you take on notice how the material that Senator Stott-Despoja has read out complies with the definition? I am curious, particularly given the discussion we had before about the tender process and how we are going to eliminate other people from being allowed to tender. Also, what work do you undertake to ensure that you are satisfied that non-directive services are offered? At the moment you say you have not had any complaints. Do you do anything proactive to ensure that they are complying with your definition?

**Ms Smith**—They have to report six monthly, I think, on how they are delivering on the outputs in their funding agreement. Those progress reports were tabled in the Senate last year, I think, so they are all in the public domain. We have also said that when questions have been raised about these issues we would be happy to investigate any complaints made. So we have been quite up front that we are open to looking at those complaints. To this date, we have not received any.

**Senator STOTT DESPOJA**—I am quite happy to provide to you on notice the detailed quotes. It is not really fair for me to read them out but I will provide those in detail.

**Mr Stuart**—In terms of those quotes from other places, what matters to the Australian government is the performance of the organisation under its contract with us. That is the document that is crucial in our relationship with this organisation. It is our contract and their performance under that contract.

**Senator STOTT DESPOJA**—I understand that, and you are obviously satisfied with their performance.

**Mr Stuart**—Yes, we are.

**Senator STOTT DESPOJA**—You are satisfied that they are complying with non-directive pregnancy counselling services.

**Mr Stuart**—Yes, we are. We have met with them over a long period and we have no information to the contrary.

**Senator STOTT DESPOJA**—Recently Pregnancy Help Australia, previously known as the Australian Federation of Pregnancy Support Services, made a submission, as you would be aware, to the Senate inquiry examining the drug RU486 outlining its opposition to RU486. Given that the department has previously stated that Pregnancy Help Australia is 'funded to provide independent, non-directive counselling for unplanned pregnancy'—that was in response to Senate question 457 on 15 April last year—does the department consider that the selective evidence that was contained in that submission illustrated a case against abortion?

**Ms Murnane**—Again, what is relevant is the funding agreement with us and their meeting the terms of that funding agreement in terms of the money that we give them. Both Andrew Stuart and Carolyn Smith have stressed that we are separating the notion of referral from the notion of non-directive counselling. To our knowledge, they are providing non-directive counselling in terms of talking through these issues with women and assisting them to make a decision.

**Senator STOTT DESPOJA**—They are providing, to your satisfaction, all options available to women with unplanned pregnancies—that is, non-directive counselling in the form of providing all options, of which there are three?

**Ms Murnane**—Options, but not specific—not in the sense of specific referrals.

**Senator STOTT DESPOJA**—No, and there is a distinction, as Ms Smith has made very clearly, between support, counselling and decision making. I acknowledge that. But, when we are talking about the philosophical or otherwise outlook of an organisation that is in receipt of government funding on the basis that it is non-directive and when a constitution specifies very clearly that an organisation has a particular view, not just in relation to, say, its views on abortion and therefore will not refer but also to the fact that it is not providing broad-ranging services or counselling, with those three options in mind, I think that would—

**Ms Murnane**—I want to make it clear that I said they would be providing options. That does not mean specific referrals—the emphasis there is on the 'not'.

**Senator WEBBER**—I understand that. Would it be your view that women who need to avail themselves of these services have as sophisticated an understanding of non-directive counselling as we do so that when an organisation gets publicity for the stance it has those women would know they would get non-directive counselling when they approached that organisation?

**Ms Murnane**—That is a very hard question to answer.

**Senator WEBBER**—Surely it must be part of your assessment process to determine whether the services an organisation provides are non-directive and appropriate, when it takes a very high-profile public stance in telling people its views of the options available to women?

**Mr Stuart**—The Australian government funds a very wide array of civil society agencies to deliver a very wide variety of services to the Australian community, including employment services, social services, social security. The kinds of questions you are asking are able, in a sense, to be asked in relation to all of those agencies—whether you get a little spoon of religion with your employment service. The issue is: what is the contract with the organisation and is the organisation delivering under its contract with the Australian government?

**Senator STOTT DESPOJA**—On that basis, Mr Stuart, can you, for the purposes of keeping it within the context of pregnancy counselling, outline for the committee any other dedicated pregnancy counselling services that are funded by government in Australia?

**Mr Stuart**—We are about to establish one.

**Senator STOTT DESPOJA**—Obviously with reference to the budget papers and the criteria that will dominate that. But clearly this is the one umbrella, peak representative organisation in relation to pregnancy counselling in this country. It is the only one that receives annual federal funding on the basis of meeting select criteria that deal with non-directive, unbiased pregnancy counselling. We are dealing with an organisation that is linked to organisations such as Heartbeat International. Heartbeat International is formerly associated and affiliated with Pregnancy Help Australia, an anti-choice umbrella group for crisis pregnancy services. Their website states that Heartbeat affiliates—so that includes Pregnancy Help Australia—shall not:

> ... advise, provide or refer ... for abortion or abortifacients ...

How can the department believe it is possible for Pregnancy Help Australia to provide non-directive pregnancy counselling when they are clearly a member of an organisation that is specifically designed to counsel women away from abortion? We are not just talking about the distinction between counselling and/or referrals; it is actually established with that view in mind. It is not just about the broader reference to funding of civil society and other organisations. This is a specific criterion that has to be met, and the government and the department are still confident that that organisation provides that non-directive service.

**Mr Stuart**—I need to correct a point, which is that this is certainly not the only organisation the Australian government funds. The Australian government also funds Family Planning Australia—

**Senator STOTT DESPOJA**—I was very specific in talking about dedicated pregnancy counselling organisations.

**Mr Stuart**—and its state and territory subsidiaries through the public health outcome funding agreements to a substantially larger degree overall than this program.

**Senator STOTT DESPOJA**—I understand that. Do family planning associations specifically deal only with pregnancy counselling? Is that their sole function?

**Mr Stuart**—Specifically only?

**Senator STOTT DESPOJA**—No, it is not. AFPSS is the only dedicated pregnancy counselling service in Australia. I acknowledge FPA and its valuable work, but it is not a dedicated solely pregnancy counselling service. There is only one that receives federal funding. Am I wrong in that?

*Member of the committee interjecting—*

**Senator STOTT DESPOJA**—Of course it is. That is not disputed.

**Senator WEBBER**—Because they provide a much wider range of services, so it has to be larger.

**CHAIR**—Before we get into what might be unseemly cross-chat: we are due to have a break. I assume you have further questions in this area, Senator, so we can resume that after we have a break.

**Proceedings suspended from 4.04 pm to 4.24 pm**

**CHAIR**—We are in the midst of examining Outcome 1, Population Health, specifically issues associated with pregnancy counselling.

**Ms Halton**—Before Senator Stott Despoja resumes questioning, can Ms Smith provide some supplementary information in relation to some earlier questions?

**CHAIR**—Certainly.

**Ms Smith**—I wanted to put on record a couple of issues. One is that Pregnancy Help Australia have been funded since 1999. During the break we had a chance to refer to the service charter. The organisation are very clear in their service charter that they provide non-directive counselling. They are also very clear in their service charter that people who ring the help line can expect a range of things in terms of service. They can expect consistent quality of service, confidentiality, accessibility, provision of accurate and consistent information et cetera. They also talk about their commitment to continual improvement of their services. They also stress that they are very keen to hear from people if they have a complaint about the quality of services being provided.

I think Ms Halton and also other departmental officials have been on the record on more than one occasion saying we, too, are very prepared to consider any complaints that are made. Obviously we will take those complaints seriously and deal with them appropriately. But, in terms of the information that the department has at hand at the moment, we are satisfied that the organisation are meeting the terms of their funding agreement.

**Senator STOTT DESPOJA**—Thank you, Ms Smith. I know the service charter. I have it in front of me. Obviously I was referring to a number of other issues, including constitutional matters, websites and affiliates, and reference to 'non-directive', but also to the notion of all-options pregnancy counselling. Would you describe the service charter as encapsulating all options—that is, the provision of counselling on all options available to a pregnant woman?

**Ms Smith**—The service charter talks about non-directive counselling, and the other information that I have seen from this organisation mentions they do provide counselling around all the options that are available to a woman in these circumstances.

**Senator STOTT DESPOJA**—So you would define 'non-directive' as all-options counselling?

**Ms Halton**—The two things may not be the same thing.

**Senator STOTT DESPOJA**—I understand that. It was only because Ms Smith used the terminology 'non-directive' when I asked about all options that I was curious as to whether or not that would be interchangeably used.

**Ms Halton**—No, and I think we should make a distinction here. We do not have the service agreement in front of us, but we should not associate the agreement with this organisation necessarily with the arrangements for the new counselling line, which we will go out to tender for.

**Senator STOTT DESPOJA**—Ms Halton, are you suggesting that there will be different criteria for determining non-directive counselling in the context of the new one?

**Ms Halton**—No. We are clear about what is non-directive counselling, but we will specify in the tender arrangements a variety of additional things in relation to the service that we are expecting to let. The reality is this is an agreement which was first entered into in 1999 following a request, as I understand it, which the minister of the day was prepared to agree to, to fund this organisation. They are funded within the terms of their service charter. This is not a service charter we have established; this is a service charter they have established. But in this case we are talking about the letting of a tender where we will establish the criteria.

**Senator STOTT DESPOJA**—Bearing in mind, Ms Halton, of course, the government's decision to increase the funding provision to Pregnancy Help Australia or AFPSS was in November last year. So there has obviously been a decision to provide additional funding.

**Ms Halton**—As indeed is the government's right. But, in terms of the tender process, the criteria for the tender process will be decided and let publicly and be well known, whereas this has come from the other direction, if that makes sense. There was a request for funding which has been granted, and a request for increase of funding which has been granted.

**Senator STOTT DESPOJA**—You know I am going to want to draw you out on the fact that you are talking about specifying additional things. Can you give us an idea on what you mean by that?

**Ms Halton**—No.

**Senator STOTT DESPOJA**—It almost sounds like there are perhaps certain safeguards or other elements that should be included because of an inference of—

**Ms Halton**—Yes, but, as I think was indicated earlier, because this will be a tender process we cannot go into a great level of detail because it would disadvantage some potential applicants. But the things that are in the public arena already include, for example, the issues in respect of the kinds of organisations that will be able to tender and the issues in relation to information about all available services. There are a series of things which are in the public arena as well which will be part of the tender.

**Senator STOTT DESPOJA**—Will that include a reference to all-options pregnancy counselling?

**Ms Halton**—All available services.

**Senator STOTT DESPOJA**—Will it specify referrals?

**Ms Halton**—We do not want to get into the issue about referrals. We had a conversation earlier about 'referral' being a medical term. The people who will be referring to services will not be medical people.

**Senator STOTT DESPOJA**—To wrap up on the issue of the department's satisfaction with the provision of services by AFPSS or Pregnancy Help Australia, is whether or not they meet their requirements independently verified, or does the department rely on receipt of complaints? That was the impression I got from the comments earlier, but is there an independent verification as to whether or not PHA are meeting their requirements as specified by the department in order to receive their government funding?

**Ms Smith**—The information that the department has available to it is the progress reports that the organisation is required to prepare as part of its funding agreement, and we go through a process of analysing those. Obviously, if you were to receive a complaint, you would also need to consider how that related to whether the organisation was meeting its agreement as well.

**Senator STOTT DESPOJA**—Could you provide us with now or take on notice to provide us with a copy of the most recent six-monthly progress report? I know you referred to it in one of the responses in the February Senate estimates.

**Ms Smith**—Certainly progress reports were tabled in the Senate as part of a return to order. I am just trying to recall when that was. I think it was around November last year.

**Senator STOTT DESPOJA**—End of last year.

**Mr Stuart**—We will see whether there is a more recent one.

**Senator STOTT DESPOJA**—I will leave it with you. In Pregnancy Help Australia's periodic return to the South Australian Office of Consumer and Business Affairs of 2005, the Treasurer's report notes expenditure for a federation meeting in Minister Abbott's office. Is it possible to either take on notice to provide or outline now the purpose of that meeting and when it took place?

**Ms Halton**—We would not be in a position to make any comment in relation to meetings the minister may or may not have had.

**Senator STOTT DESPOJA**—So you cannot indicate perhaps the nature of that?

**Ms Halton**—No. That is not a matter within the department's control, so we are not in the possession of that information.

**Senator STOTT DESPOJA**—I want to follow up some other estimates committee questions. In answer to question on notice E06-006, the department said:

The AFPSS have advised that they anticipate providing the department with the new training manual and curriculum by the end of 2006.

Is that manual available yet?

**Ms Smith**—Not yet, no.

**Senator STOTT DESPOJA**—Do you know when it will be?

**Ms Smith**—No, I do not. I would have to check with the organisation.

**Senator STOTT DESPOJA**—Could you provide us with, either now or on notice, a complete list of the AFPSS's affiliate organisations?

**Ms Smith**—Yes, certainly.

**Ms Halton**—I do not know we can do that.

**Senator STOTT DESPOJA**—It is only because she said yes that I got excited!

**Ms Halton**—I do not know whether we require that of them. I do not think we should be passing on information which is not required by us for some particular purpose. I am not sure that we do require it. We will take on notice whether we can provide it.

**Senator STOTT DESPOJA**—Okay.

**CHAIR**—Are they your questions in this area, Senator?

**Senator STOTT DESPOJA**—I can keep going, but I suspect the mood is against me.

**CHAIR**—I think so. I think we need to move on.

**Mr Stuart**—Just to clarify that last question, at the last hearing I read out and then we provided a list of those organisations to whom this organisation provides funding which is sourced from the Australian government.

**Ms Halton**—Yes, we can do that.

**Ms Smith**—That is what I was indicating we could do.

**Senator STOTT DESPOJA**—I think, Ms Halton, you picked up that, yes, I am interested in affiliates, not just those that receive funding.

**Ms Halton**—That is right, and that is what we cannot do, I suspect. In fact, I am pretty confident that we cannot. So your excitement was a little early.

**Senator STOTT DESPOJA**—I have to take it where I can get it.

**Senator ADAMS**—Could you tell me what the department's normal tender process is, the steps you go through and how the decision is made?

**Mr Stuart**—Certainly. This is really a very well rehearsed process. The department would usually lodge a public tender on the Internet and in newspapers. There would be advertisements. There would be a period for response of six weeks or upwards of six weeks.

There would be a place where willing tenderers go to obtain the documentation. That documentation would make it clear what the criteria are and the time line for response. It would make it clear that late responses are not accepted, unless they are late at the fault of the government itself. Once those responses are all received, there is the formation of a tender selection committee, which in this case will have an expert advisory group advising it. The committee will be responsible for providing advice to the delegate. The advisory group will be responsible for specialist advice to the committee. The committee will provide a report with a recommendation to the delegate, and then the delegate will make a decision as to whom we would enter into negotiation with in the first instance. There would then be a process of negotiation with that party to see whether a satisfactory contract can be negotiated. If so, then there would be an announcement at that point.

**Senator ADAMS**—Is that your normal tender procedure for any tender?

**Mr Stuart**—There are Commonwealth procurement guidelines which we follow.

**Senator ADAMS**—That is what I was wondering.

**Mr Stuart**—They are the kinds of processes that those guidelines set out.

**Senator ADAMS**—So they normally have a committee of experts to put forward—

**Mr Stuart**—Not always. When there are issues that require expertise, we have committees of that sort. We quite often do—in recent times I have been involved in a couple of other purchasing processes where we have—but not always. Sometimes the department simply has an internal committee drawn from a range of areas if we believe we have sufficient expertise to judge value for money in that area.

**Senator ADAMS**—No precedent has been set with this as far as your guidelines go?

**Mr Stuart**—No.

[4.37 pm]

**Therapeutic Goods Administration**

**National Blood Authority**

**CHAIR**—We said we would move on about now to the Therapeutic Goods Administration and the National Blood Authority. It would helpful if the National Blood Authority appeared with the TGA.

**Senator McLUCAS**—If we finish this before the appointed time, could we go back to outcome 1 more generally?

**CHAIR**—Yes. I intended to do that. It was not the intention that, by going to the TGA now, we had finished general discussion.

**Senator BARNETT**—I have questions to the TGA. They relate to answers to questions on notice from 16 February. I want to follow up questions Nos 9 through 18 that I put to the department. They relate primarily to the use of RU486, or mifepristone, and some of the answers relating to abortion and abortion figures. First, the answer to question No. 16, relating to medical practitioners using mifepristone in the second trimester for abortions, provides:

The prescribing of medicines outside of its approved usage is commonly referred to as 'off-label use'. The Commonwealth has no direct power or authority over the way in which individual doctors or the medical profession in general conduct their professional practice—

and it goes on. It seems to conflict with some of the views expressed in our Senate committee of inquiry. At least some of the evidence put to the committee was that it would not be used for second trimester abortions or for a period after the nine-week gestation period. What protocols are used in the use of mifepristone? Are you aware of the protocols used in the US and the UK? What are the likely protocols to be used in Australia, or are there none?

**Dr Hammett**—While the TGA are aware of the use of RU486 internationally, we have not sought or received details of protocols of use internationally. At present, there are no registered applications for use of RU486 in Australia. So we would not anticipate at this stage being able to provide information about the details of a specific protocol for use.

**Senator BARNETT**—So you have not sought or received protocols from overseas, from New Zealand, the US or the UK?

**Dr Hammett**—That is correct.

**Senator BARNETT**—The answer to question 17(d) provides:

The TGA has not received information about fatalities and other adverse events reports following the use of mifepristone to procure an abortion from other medicine regulatory agencies. As mifepristone is not registered in Australia (no application for registration has been received) this information has not been required.

That is sort of consistent with what you have just said. The TGA has given Professor Caroline de Costa approval for the importation and use of mifepristone to procure abortion. What assessment, if any, was made of the safety and efficacy of mifepristone?

**Dr Hammett**—The approval that was provided to Professor de Costa was done under section 19(5) of the Therapeutic Goods Act. She was granted authorised prescriber status for RU486 for use of the agent in specific patients according to a specific protocol. As part of the assessment of that type of application the TGA checks a number of criteria, some of which include the fact that there is evidence that the agent that is to be used has been used in similar regulatory environments to Australia, so in countries such as New Zealand, the US and the UK, where the drug is currently registered; that it has been shown to be efficacious; and that it has not been withdrawn for safety reasons. Those criteria were met in the application that was submitted by Professor de Costa.

In addition, the TGA sought advice about the particular indications that were being applied to use the drug in to ensure that those indications were consistent with both the law related to section 19(5) and authorised prescriber status and the legality of the use of the agent according to state legislation. All of those criteria were met; therefore the application was approved. Dr de Costa has been asked to provide regular updates to the ethics committee which is supervising the use of that agent—

**CHAIR**—I believe we have some technical problems.

**Proceedings suspended from 4.46 pm to 4.49 pm**

**CHAIR**—We will resume. I understand that Hansard is back on line. I am also advised that fortunately the coffee machine at Aussie's did not fail in the power cut! So we are all fine. Senator Barnett, could you start your question again. We will go from the top.

**Senator BARNETT**—I am not sure exactly where we got to, but I will try to recap. On the one hand, we have advice on the record, and you confirmed it today, that the TGA has neither sought nor received information or advice about fatalities or adverse events flowing from the use of RU486 to procure an abortion in other parts of the world—the US, the UK, New Zealand or anywhere else. But, on the other hand, based on certain criteria, you have approved the use of that same drug by Dr Caroline de Costa for that same purpose. Can you please advise the committee how the two correlate?

**Dr Hammett**—I think the key to this is that mifepristone currently is not a registered drug in Australia. If mifepristone were a registered drug, we would routinely receive and seek information regarding adverse events from international sources, from the sponsor of that product and from health care professionals, consumers and any other interested parties within Australia as part of our adverse event monitoring program, which is one of the world's best adverse event monitoring programs. I would be glad to talk with you about that at length, should you wish.

In the situation of Professor de Costa's application for authorised prescriber status, the legislation sets out quite clearly the criteria under which the TGA may approve an application for authorised prescription of a particular product. The application that was received from Professor de Costa met the criteria for approval of that application. That included information on the use of this product internationally—that it was efficacious and had been shown to be efficacious elsewhere, and that it had not been withdrawn anywhere in the world due to safety reasons. All of that information was considered by the TGA.

**Senator BARNETT**—It seems like we have a bit of a conflict: you have not received or sought information about fatalities or adverse events but then you have just said that, with respect to Dr de Costa's application, you have received some of that information which proves to your knowledge that the drug is efficacious, and the decision was also based on your advice and your research. If that is the case, can you please give us details of the criteria required to be met? Could you also please provide the information, the research, the data and any records that you used to confirm that the application by Dr de Costa was appropriate, efficacious and safe.

**Dr Graham**—As Dr Hammett has indicated, what we do is apply the legislation. This is a provision in the legislation for products that are not on the Australian register—in other words, products that have not been through the evaluation process. The intent of the legislation is to give people timely access to unregistered drugs. That is with the understanding of the prescriber and also the patient through informed consent that it is an unregistered drug that has not been independently evaluated by the TGA. It is not the intent of the legislation that we do carry out that pre-market evaluation, and this is a different route. This is a mechanism where individuals can have access to a medicine that a doctor would consider is important for that person, taking into account the fact that it is not on the Australian Register of Therapeutic Goods.

**Senator BARNETT**—So the question is then: how did Dr de Costa gain success with her application? Can you please provide the committee with the advice under section 19(5), which I think you referred to? You referred to the criteria. You referred to the fact that it needed to be safe and efficacious. Could you please advise the committee how that decision was formed?

**Dr Hammett**—I am just looking to see whether we have the criteria here in front of us or whether we will need to take that on notice. Essentially, the application by Professor de Costa was reviewed with the criteria in mind. The issues specifically determined in the criteria include right of access to a product that is thought to be medically required; the fact that there has been informed consent; the responsibilities of the prescribers with regard to compliance with state and territory legislation; whether in fact the application meets the TGA's responsibilities in terms of maintaining evaluation and provision of only temporary supply of products; the supplier's responsibilities, such as the maintenance of quality manufacturing processes; whether there was appropriate ethics committee approval and endorsement of the applicant; and whether there was ongoing monitoring of it. The TGA uses all of that information to analyse a balanced set of criteria, which includes analysis of the fact that these products are available in countries with a similar regulatory framework, that there is evidence of efficacy, that clinical justification has been provided and that the product has not previously been withdrawn due to safety problems. Then it may apply some conditions of approval that stipulate maximum dosage and duration and that the use is done with appropriate monitoring and with acceptance of responsibility for all these facts by the doctor and the patient involved. So that is a brief summary of the requirements of the 19(5) legislation that we used in assessing this application.

**Senator BARNETT**—Thank you for that; I appreciate that. Following that through, firstly, what evidence did you rely upon to confirm that, from the application, the use of it would be safe and efficacious? Secondly, what were the conditions of approval? You referred to that. Thirdly, what protocols did you put in place in terms of appropriate monitoring of the patient, presumably on an ongoing basis?

**Dr Hammett**—With regard to your first question regarding the review of the evidence, as Dr Graham mentioned, as this is an unregistered product we do not undertake a formal evaluation within the TGA of the safety and efficacy of this product. We rely on the applicant, the authorised prescriber, to provide information to us stating that there is evidence of this product being utilised for the purpose for which they are applying.

**Senator BARNETT**—So you are relying on Dr de Costa's views in the application?

**Dr Hammett**—No, not on just her views; on supporting literature that she may provide as part of an application.

**Senator BARNETT**—Do you have that supporting literature? Can you advise the committee of that?

**Dr Hammett**—We have an application that Professor de Costa provided. I would need to check whether that application remains commercial-in-confidence and whether the details of that application can be provided to the committee. I can check that for you, Senator, and get back to you. Regarding the other questions, which I think related to what conditions we

applied to the registration, a number of conditions were applied. I will read some of those to you, if you are happy for me to do that. We have asked that Professor de Costa ensure that the use of this product is monitored by the Cairns Base Hospital human research ethics committee and that specifically every six months that ethics committee provide endorsement of the fact that they have reviewed the outcomes of the use of mifepristone for the patients involved; that they review the maintenance and the security of records related to these patients; that they review compliance with the approved protocol for use of the product; that they review compliance with all the conditions of approval; and that they recommend or adopt any additional appropriate mechanisms for monitoring, including random inspections of sites at which mifepristone may be administered, and review of data and signed consent forms. And they are required to report anything that might warrant review of ethical approval of the protocol, including serious or unexpected adverse effects in patients receiving mifepristone and any unforeseen events that might affect the continued ethical acceptability of its use. So those are some of the conditions that have been applied to ensure that there is appropriate monitoring of this product.

**Senator BARNETT**—That is very much appreciated. You have mentioned 'approved protocol' several times. Can you advise the committee of the approved protocol for the use of the product?

**Dr Hammett**—Again, I would have to check whether that is in fact commercial-in-confidence and whether the details of that can be provided. But I will undertake to do that.

**Senator BARNETT**—But you have set an approved protocol for the use of the product for the purpose for which she has applied?

**Dr Hammett**—In 19(5) applications it is usual for the applicant to define how they propose to use any unregistered product. The details of the use of that product are what we would term the protocol of use. Professor de Costa did in fact delineate how she anticipated utilising the product, and that was part of the application that was reviewed by the TGA.

**Senator BARNETT**—So at this stage we do not have access to the published literature or research that she relied on to support the application? Are you saying we cannot have that, or are you taking that on notice?

**Dr Hammett**—I will certainly take that on notice. Any literature that was provided is publicly available.

**Senator BARNETT**—Can we have that? Can you advise the committee of that literature?

**Dr Graham**—What we will do is go back to Professor de Costa and ask whether she has any objections to our providing the information she provided with her application.

**Senator BARNETT**—Okay; thank you. In relation to question 18, the department advised:

An application to the TGA to register a medicine on the Australian Register of Therapeutic Goods (ARTG) can only be considered if made by a sponsor. Sponsors can only make applications to the TGA in respect of their own products.

If the intention is that use of a drug can only occur in the context of use with another product, then this combination use would have to be the subject of an application for registration.

That is what has been advised. I am asking for clarification now as to whether this answer will still apply once the Australia New Zealand Therapeutic Products Authority comes into operation and in light of the fact that the use of mifepristone with misoprostal to procure an abortion has been approved in New Zealand, although there has been no application for such approval for the producer of misoprostal.

**Dr Graham**—There are two parts to that question. In the first case, if a new application is received by the Therapeutic Goods Administration which requires the concurrent use with another drug, we would require evidence, as a new drug coming onto the market, that there is clinical evidence for the concurrent use of both drugs in terms of safety and efficacy. In terms of the trans-Tasman arrangements, when they occur, there are transitional arrangements for products on both markets. In that case, for a product that is on, say, the Australian market there will be interim approval or a licence given to that product. During a three-year period there would be a requirement for the sponsor—the sponsor is the person responsible for the product in the marketplace—to seek a licence that is issued by the Australia New Zealand Therapeutic Products Authority. Likewise with the New Zealand market, for that interim licence the product can be supplied only in the market that it is already being supplied within. Once they have a licence from the authority, that would permit supply in both markets.

**Senator BARNETT**—In the case of an application by a medical practitioner here in Australia for approval to import and use mifepristone in conjunction with misoprostal to procure an abortion, what effect would the opposition of the producer or manufacturer of misoprostal to its use for this purpose have on such an application?

**Dr Hammett**—At present the approved application under section 19(5) for use of mifepristone is applicable really to only mifepristone. Misoprostal is currently available on the Australian market as a registered product and, unless it were to be removed from the register for any particular reason, it would continue to be available. So it would be anticipated that any further applications would also relate to the mifepristone. The situation Dr Graham was elucidating was, if a sponsor were to apply for registration of mifepristone to be used 100 per cent of the time in conjunction with misoprostal, then it would be normal for that application to be considered together. However, if the mifepristone were to be utilised by itself, then there may not be a requirement for both of them to be used together.

**Senator BARNETT**—My understanding is that the manufacturer of mifepristone, Pfizer, does not support its use with misoprostal. Under that situation, which is the current arrangement, what would happen?

**Dr Graham**—It is a theoretical situation at the moment. But, if an application came in for mifepristone to be used with misoprostal, it would be required that we would have clinical evidence to show the two, if they had to be used together. I am not sure what the situation is in the New Zealand market, whether the approval is for concurrent use. But, as Dr Hammett was saying, at the moment for the prostaglandin that would be an off-label use if that is something that is not supported by the manufacturer.

**Senator ALLISON**—The authorised prescriber approval which we know Professor de Costa has now received was received I think on 12 April?

**Dr Hammett**—That is correct.

**Senator ALLISON**—That took some months to process. Do you anticipate each of the applications under this category to take as long, or would subsequent ones be of a shorter time frame?

**Dr Hammett**—It is hard to make predictions about that. It would depend on the completeness of any particular application. When an application is received, it is assessed according to the criteria which we have already discussed, and where there are deficiencies in applications we communicate with applicants to advise them of those deficiencies and seek further information from them. So a large part of any timing of the approval process is dependent upon timely receipt of information from the applicant.

**Senator ALLISON**—Can you give the committee details of the status of the applications of Drs Bowditch, Pettigrew and Giltrap?

**Dr Hammett**—I have been told that we have not received any applications as yet from those people. If you have information otherwise, we would be grateful to hear it.

**Senator ALLISON**—Yes, I certainly understood—

**Dr Graham**—I am aware that we did receive an application quite a while ago from Professor Pettigrew. My understanding is that it was incomplete and further information has been sought, and I do not think it has been received.

**Senator ALLISON**—So you have not received an application from Dr Bowditch from Mildura or Dr Giltrap from Albury, both GPs?

**Dr Graham**—We are not aware of it.

**Senator ALLISON**—Perhaps it went astray in the post.

**Dr Graham**—If you have information, it might be worth asking them to confirm that we have received the application.

**Senator ALLISON**—I have a question about authorised prescribers. Can mifepristone be used where there is authorisation for non-abortifacient use?

**Dr Hammett**—Relating to the specific applications that have been approved to date, the approval is only for use according to the clinical protocol that has been submitted, and it is quite specific about the types of patients.

**Senator ALLISON**—So the answer would be no?

**Dr Hammett**—So the answer is no.

**Senator ALLISON**—It is quite a lengthy process for non-abortifacient use, according to a constituent who has been through it so far. Given that mifepristone has applications for a range of tumours, meningioma and a gynaecological tumour in particular, and there has been some success overseas, it was suggested that Australia should have a compassionate use program like that in the United States. In Australia, is there anything similar to that program which might facilitate the use of a drug which has not been registered or approved?

**Ms Halton**—We have the Special Access Scheme for that purpose in terms of particular needs in respect of cancer. I am aware that applications have been approved in respect of uses for cancer, and my understanding is they are actually approved quite quickly.

**Senator ALLISON**—It is still a very lengthy process, though.

**Dr Graham**—No, I would tend to disagree.

**Ms Halton**—I do not believe it is.

**Dr Graham**—If a medical practitioner seeks access through the Special Access Scheme, which is a scheme for individual patients—the Authorised Prescriber Scheme is authorising a prescriber to treat a number of patients, whereas this scheme is on a patient-by-patient basis—the approval is—

**Senator ALLISON**—But it is still a very expensive process to go through Customs. There is a three-step process there. This constituent points to the fact that there is a 64-page document which is the guideline to importing medicines of this sort. Have you looked at that process, because there are circumstances where this is life threatening and could be urgent? Is there a way of fast-tracking it through Customs?

**Dr Graham**—An approval is required to pass the Customs barrier, and that approval is issued by the delegate within the TGA as well for products such as RU486. I am not aware that that is a difficult or tedious process.

**Senator ALLISON**—So you would be surprised if you got a ball-by-ball account, if you like, of that process, how long it took, the costs and so on?

**Dr Graham**—We can provide you with some information on perhaps a typical time for a doctor to import a Special Access Scheme drug. It is the responsibility of the doctor to identify the source and to arrange the import.

**Senator ALLISON**—Indeed.

**Dr Graham**—If we have that information, we could give you an example of what might be a normal time.

**Senator ALLISON**—In this case, as I understand it, the person concerned had some difficulty because of medical indemnity insurance, and so that delayed the process somewhat.

**Ms Halton**—That is then an issue between the patient and the medical practitioner.

**Senator ALLISON**—Indeed.

**Ms Halton**—I will ask Professor Horvath to come back to the table because he could probably comment on this as well. Our experience has been that, if a medical practitioner is in search of a product for a patient, particularly in respect of cancer, this actually happens quite quickly.

**Prof. Horvath**—That is correct; and the indemnity issue is clearly an issue that the medical practitioner needs to sort out on their own.

**Senator ALLISON**—Yes, I do understand that.

**Prof. Horvath**—I know from my former life, using transplant drugs that were not registered, that you can usually do them in a very short period, actually, Senator.

**Senator ALLISON**—The history of this case is actually long and complicated, and not a short time at all.

**Senator WEBBER**—There does seem to be some confusion about the length of time, because this issue was certainly raised with me by the late Peter Cook, whose medical practitioner tried to import it, but by the time they got through the process the drug got into the country too late.

**Ms Halton**—In terms of RU486?

**Senator WEBBER**—Yes, mifepristone. So there seems to be some misunderstandings of the processes, perhaps.

**Senator ALLISON**—I have a couple of other small questions.

**CHAIR**—Okay; then we will need to move on.

**Senator ALLISON**—The conditions that were set in that Special Access Scheme in order to ensure that this is not used as an abortifacient seemed to be kind of quite restrictive—I do not know whether you can comment on that—in terms of guarantees that it is not used as an abortifacient. What if that were an accidental occurrence?

**Dr Graham**—My understanding would be that agreement was given for the use that was indicated by the doctor, and therefore, because it is an experimental and unregistered drug, the conditions would specify what that intended use was according to what the doctor had requested.

**Senator ALLISON**—If there were an accidental or a coincidental effect of this working as an abortifacient, would that person be at some risk or not?

**Dr Graham**—I do not know the circumstances. I think that would be a more complex situation that would have to be teased apart to fully understand it.

**Senator ALLISON**—No, it is fairly simple. It just means you get pregnant, although you do not mean to, before you take the drug and the drug has an abortifacient effect as well as a non-abortifacient effect.

**CHAIR**—I think this borders on being a hypothetical question.

**Senator ALLISON**—But it does go to the law. What does it mean in those circumstances?

**CHAIR**—You would need to construct particular circumstances for them to be able to answer the question.

**Senator ALLISON**—I just did.

**CHAIR**—We do not know in what circumstances it is prescribed and so on.

**Ms Halton**—The reality is, Senator, that from our perspective you are allowed to import a particular product for in this case a particular patient with a particular condition. Providing the practitioner has used the particular drug for the particular patient consistent with the approval, there is no issue for us. They have done what they said they were going to do in the way they have said they were going to do it.

**Senator ALLISON**—It is good to have that made clear. Thank you.

**CHAIR**—Are there any other questions about RU486 or related issues?

**Senator FORSHAW**—Mr Chairman, can I raise a point of order. I want to make sure that we get to ask some questions on blood products, which I had indicated. I am conscious of the time and conscious there are other issues.

**CHAIR**—I am also conscious of it, and it would be helpful if people could limit their questions a little so that we are able to get quickly to the point of whatever is going on. We are in this area, so I will ask Senator Fielding for his questions.

**Senator FIELDING**—Hopefully the questions will be to the point as well. Obviously I have a number of questions here. The steps that the TGA applied to grant the request by Professor Caroline de Costa—

**Ms Halton**—We just answered those questions.

**Senator FIELDING**—You went through that before; okay. Is Professor de Costa the only doctor authorised to import RU486 as an authorised prescriber?

**Dr Graham**—There is one other doctor who has an authorised prescriber status.

**Senator FIELDING**—Is that for the same use?

**Dr Hammett**—Yes.

**Senator FIELDING**—As an abortifacient?

**Dr Hammett**—Yes.

**Senator BARNETT**—You cannot say—

**Dr Hammett**—I am unaware that it has been made public, whereas Professor de Costa has been very public in her application. Unless we had permission from that applicant, I would not think we could release that.

**Senator FIELDING**—That was my next question: could you take that on notice? So there are only the two; is that correct?

**Dr Hammett**—Yes.

**Senator FIELDING**—Are these doctors who are authorised prescribers obstetricians or GPs?

**Dr Hammett**—Again, I think that relates to your last question. Without wanting to breach the confidentiality of the application, as you are aware, Professor de Costa is an obstetrician. I think it would be unwise to answer regarding the other applicant at this point.

**Senator FIELDING**—Can the TGA detail whether it has assessed scientific studies on RU486 and, if so, can the TGA provide copies of all the studies—

**Ms Halton**—We have answered this question as well, Senator.

**Senator FIELDING**—So the answer to that is, yes, you will provide them?

**Ms Halton**—No, we have answered this question on notice in terms of the process we went through.

**Senator BARNETT**—They are taking it on notice.

**Senator FIELDING**—Has the TGA received any applications from pharmaceutical companies to import RU486?

**Dr Graham**—No, we have not—or to register.

**Senator FIELDING**—Sorry, to?

**Dr Graham**—We have not received an application for marketing.

**Senator FIELDING**—You received one to market but not to import it; is that right?

**Ms Halton**—No.

**Dr Graham**—No. Importing would be the consequence of marketing. I think you are asking purely about marketing.

**Senator FIELDING**—Can the TGA elaborate on whether it has had any contacts with overseas distributors, such as Danco or Exelgyn, regarding the importation of RU486?

**Dr Hammett**—We have had one inquiry from an international manufacturer regarding the data requirements for TGA registration of a product. We have had no inquiries about actually importing the product. So there has been a preliminary inquiry about what actually is the TGA process.

**Dr Graham**—The inquiry was to us. We have not gone out and sought any information.

**Senator FIELDING**—I have a follow-up question from last time: has the TGA consulted Pfizer, the distributor in Australia of the second drug, misoprostal, that is essential in RU486 abortion? If so, has consent been received from Pfizer to use misoprostal for the purpose of abortion? I know I raised this question last time.

**Dr Hammett**—We have not sought any information from Pfizer about this. As I think we indicated last time, the use of misoprostal is what is termed off-label use. Misoprostal is currently registered in Australia for treatment of gastric ulcers or prevention of gastric ulcers in people using anti-inflammatory drugs. If practitioners choose to utilise that product off label, that is a professional practice issue over which the TGA has no control.

**Senator FIELDING**—So is the approval given to Professor Caroline de Costa an approval specifically to use both drugs together?

**Dr Hammett**—No, the approval is for the authorised use of mifepristone under section 19(5).

**CHAIR**—I think those are all the questions on RU486.

**Senator McLUCAS**—For the record, Professor de Costa is a doctor, but the record should show her correct title. We should refer to her as ‘Professor de Costa’.

**Senator BARNETT**—Very briefly, can I confirm or clarify with the officers that they have taken on notice whether they can provide the committee with the actual criteria as well as the evidence that supports that criteria?

**Dr Hammett**—Certainly, I will find out that information and, if we can provide it, we will provide it on notice.

**CHAIR**—Senator Forshaw has some questions for officers of the National Blood Authority.

**Senator FORSHAW**—I have some questions of the TGA on blood plasma products. I understand some blood plasma products are currently imported into Australia. Who gives approval for the importation of blood plasma fractionation products?

**Dr Graham**—For the importation of plasma products?

**Senator FORSHAW**—Yes.

**Dr Graham**—If they are imported, that would be approval by the TGA to market those products in this country.

**Senator FORSHAW**—What role, if any, does the National Blood Authority have in this process?

**Dr Turner**—The role of the NBA is to implement the supply plan for the supply of blood and blood products into Australia which is approved by health ministers. If that supply plan includes some imported products, then it is up to the NBA to arrange the importation of them, providing of course that they have achieved registration with the Therapeutic Goods Authority.

**Senator FORSHAW**—In the interests of time, you may need to take this question on notice or provide an answer to us in writing. Can you tell me what blood plasma products are currently regularly imported into Australia? I would like particularly the commercial name, the name of the manufacturer and the country of origin.

**Dr Turner**—Yes, I am happy to take that on notice. There is a list of them.

**Senator FORSHAW**—Thank you. Obviously, whoever believes they need to answer this should answer it. In the past four years, what other blood plasma products have been imported for commercial use? This is following on from those that are regularly imported. You may need to take that on notice as well.

**Dr Turner**—Sorry, could I?

**Senator FORSHAW**—I want a list of those that are regularly imported and then a list of the others that have been imported over the last four years.

**Ms Halton**—You just inserted the words 'for commercial use'. What do you mean by that?

**Senator FORSHAW**—Sorry, did I say that?

**Ms Halton**—Yes, you did. It sounded like you were making a distinction.

**Senator FORSHAW**—I withdraw that, for the moment. You have made me think of another question.

**Dr Turner**—We are not aware of a distinction in terms of what is imported. A number of products are imported each year to meet the supply plan. Obviously the quantities that are imported each year will vary depending on the needs of patients. So there is no sort of classification of those that are imported regularly and those that are imported just every now and then. They are all on the supply plan when they are purchased by the National Blood

Authority. For governments it could well be that other products might be imported by individuals. We obviously would not be aware of those.

**Senator FORSHAW**—You are going to supply the full list?

**Dr Turner**—Certainly.

**Senator FORSHAW**—Good. Do the assessments for safety and efficacy include tests for HIV-AIDS, hepatitis, CJD?

**Prof. Farrugia**—All the provisions which are in place for domestic products are also in place for overseas-sourced products, and they include testing for the agents you have mentioned.

**Senator FORSHAW**—If I say HIV-AIDS, hepatitis in each of its various forms, CJD—

**Prof. Farrugia**—There is no test for CJD.

**Senator FORSHAW**—Is there a test for the human variant of BSE?

**Prof. Farrugia**—There is no test for the human variant of BSE, otherwise known as variant CJD.

**Senator FORSHAW**—Why is that?

**Prof. Farrugia**—Because science has not developed one yet.

**Senator FORSHAW**—It is not because it is felt that there is no need for the test?

**Prof. Farrugia**—No, there is a lot of research and there are a lot of companies which are striving to develop the test. We anticipate that the test will be developed over the next five years or so.

**Senator FORSHAW**—Having sat through at least the more recent Senate committee's inquiry into CJD, I must say it is an interesting and rather distressing area. Are the assessments that are done routinely done on a batch-by-batch basis? Are the tests done here? Are they done overseas before the blood products are imported? What is the process here?

**Prof. Farrugia**—In relation to all blood products which are imported and on the Australian market, if a batch is actually supplied to the market it is tested by the TGA on a batch-by-batch basis using the tests which are available.

**Senator FORSHAW**—That testing is done in Australia?

**Prof. Farrugia**—In the TGA Laboratories Branch, yes.

**Senator FORSHAW**—Are the manufacturers required to state where the blood used in the products comes from?

**Prof. Farrugia**—Most definitely.

**Senator FORSHAW**—Are they required to declare whether it is collected from paid donors?

**Prof. Farrugia**—They are required to conform to the requirements of a certain guideline, which includes that information, yes, as well as geographical location and a lot of other provisions.

**Senator FORSHAW**—At the risk of getting something that is rather complex: are those guidelines available in a form that can be provided to us?

**Prof. Farrugia**—Yes. They are public information. The guidelines are actually developed by the European Medicines Agency and also doctors in Australia.

**Senator FORSHAW**—Would you provide them to us?

**Prof. Farrugia**—Yes.

**Senator FORSHAW**—It follows from that, does it, that the TGA itself knows where the blood used in these products comes from?

**Prof. Farrugia**—Yes.

**Senator FORSHAW**—And whether it has been collected from paid donors?

**Prof. Farrugia**—Yes.

**Senator FORSHAW**—You have access to that information?

**Prof. Farrugia**—We have that information.

**Senator FORSHAW**—Can you tell me whether or not the blood used in these imported products has come from countries where there have been established cases of CJD, mad cow disease and its human variant?

**Prof. Farrugia**—In which countries?

**Senator FORSHAW**—No, I am asking you. Can you tell me whether the blood used in those products has come from any countries where there have been established cases of CJD?

**Prof. Farrugia**—CJD is a disease which is prevalent in all parts of the world, including Australia. I think you are referring to variant CJD, are you not?

**Senator FORSHAW**—I was referring to CJD but also mad cow disease and VCJD as well.

**Prof. Farrugia**—Undoubtedly blood has been imported from countries which have had CJD because this is a disease which is also prevalent in this country.

**Senator FORSHAW**—I take your point. My recollection is that it is in very small numbers but it is being—

**Prof. Farrugia**—The prevalence of classical CJD in this country is basically similar to that all over the world. It is a prevalence of about one per million population.

**Senator FORSHAW**—Thank you for that. I am thinking back to some years ago. I thought it was at least higher in the UK, for instance, and some parts of Europe.

**Prof. Farrugia**—Again, I think you might be referring to variant CJD, which is a different disease which has affected about 180 people worldwide, the vast majority of whom have been residents of the United Kingdom.

**Senator FORSHAW**—That is the human variant of mad cow disease?

**Prof. Farrugia**—That is right.

**Senator FORSHAW**—The first inquiry into this was done by Professor Allars some time ago. Then there was another inquiry by a Senate committee. That related to products that had

been obtained from human growth hormones and pituitary glands. I just had a recollection that the incidence of CJD here was lower and that related to how quickly steps were taken to prevent the products which were felt to cause the disease from being released into the market.

**Prof. Farrugia**—We have to understand what you mean by 'incidence'. There is a certain background incidence of disease, and then there is iatrogenically transmitted disease from products or anything like that.

**Senator FORSHAW**—You are a hell of a lot more expert than I am in getting into this technical debate. I suppose I am using the term where people have actually died from the complaint CJD.

**Prof. Farrugia**—From products?

**Senator FORSHAW**—No, persons who contracted CJD from treatment by either human growth hormones or pituitary glands and after some years tragically died from that. I thought there was a higher number of recorded deaths—

**Prof. Farrugia**—Iatrogenic cases is what you are saying; they got it from transmission by therapeutic goods—hormones or whatever?

**Senator FORSHAW**—Yes.

**Prof. Farrugia**—Yes, there are countries which have had a higher incidence of that because of particular circumstances.

**Senator FORSHAW**—What you are saying is that it is certainly possible we are importing blood products from those countries?

**Prof. Farrugia**—Yes. I might add that classical CJD has been, I think, fairly universally acknowledged as not being transmissible by blood.

**Senator FORSHAW**—I understand. How does the TGA certify that good manufacturing practices are used in the production of these products?

**Dr Graham**—There is both the overseas manufacturer and the Australian manufacturer. In Australia we have a team of GMP inspectors who audit plants, whether it is blood or other products, and issue a licence. In the overseas market we may either inspect the overseas manufacturer or, where we have agreements with other countries with similar standards of good manufacturing practice, accept the certification and the information from those overseas regulators.

**Senator FORSHAW**—I am not sure whether I asked you to give me this list, but can you give me a list of the countries from which we do import blood products?

**Dr Turner**—I took that question on notice.

**Senator FORSHAW**—I thought I had asked you that earlier. It certainly includes the UK, doesn't it?

**Dr Turner**—I am not sure that we do import any products from there at the moment. We have got in the past I think some factor XIII, possibly, and factor XI a long time ago. That would be many years ago. As far as I am aware, we do not import any products from the UK now.

**Senator FORSHAW**—I go back to that other point about certification under the good manufacturing practice. What authority and ability does the TGA have to personally inspect these production plants and how often is it done? You may have covered that a moment ago, I am not sure. I am trying to rush through some of this, I am sorry, in the interest of time.

**Dr Graham**—What we do is issue a licence for normally three years, I think with biologicals as well. But we also have the ability to have follow-up audits at any point in time, and we do that. For instance, with the Commonwealth Serum Laboratories we spend quite a bit of time with our auditors inspecting various aspects of manufacture.

**Senator FORSHAW**—We are talking here about overseas production plants?

**Dr Graham**—Yes.

**Senator FORSHAW**—So they go overseas and conduct on-site inspections?

**Dr Turner**—Yes.

**Dr Graham**—Yes. Where we do not have a reciprocal agreement, such as a mutual recognition agreement, we would do the audits ourselves.

**Senator FORSHAW**—That is what I was trying to get at. Are overseas manufacturers required to report to the TGA any adverse reactions from these products that they may become aware of?

**Dr Graham**—The way the mechanism or process works is that there is an Australian sponsor for those goods and that sponsor has a responsibility to report any adverse reactions or adverse events to the regulator, which is the Therapeutic Goods Administration. That would be anything that is reported to the sponsor from overseas or locally.

**Senator FORSHAW**—So the obligation is on the sponsor to advise the TGA?

**Dr Graham**—That is correct.

**Senator FORSHAW**—I assume they do this. Do they?

**Dr Graham**—It is a condition of their products being on the market and, yes, our understanding is they do do that. There is perhaps a liability on the sponsor too if they are aware of information that might be against their product which they do not report to the regulator.

**Senator FORSHAW**—Are you aware of any cases where there have been adverse reactions which have not been reported but have come to light later?

**Dr Graham**—Not that we have found out about.

**Senator FORSHAW**—Have there been any cases of the TGA rejecting or failing to approve a batch of overseas blood plasma products?

**Prof. Farrugia**—I am not aware of any, but we will take it on notice to make sure that is an accurate answer.

**Senator FORSHAW**—If there have been, can you give us the products, the date, the size of the batch and the reason for failure. Finally, have there been any cases of overseas blood plasma products being withdrawn from the Australian market because of problems with quality or adverse side effects?

**Dr Graham**—We do have recalls. For instance, we had a recent one where there was smudging of the label. So, when you talk about quality or adverse events, we may have to take that question on notice.

**Senator FORSHAW**—That sounds like a quality issue.

**Dr Graham**—Yes. It was the ink on the label.

**Senator FORSHAW**—Also, where there has been subsequent identification of adverse or possible adverse side effects.

**Ms Halton**—I think the right question we should come back on on notice is whether there have ever been occasions where a product has been withdrawn because of a problem with the product, as in the substance of the product rather than, say, smudging of the label.

**Senator FORSHAW**—That is what I was sort of asking for.

**Ms Halton**—Yes, I know. You got the full answer.

**Senator FORSHAW**—But this other thing was raised with me. I was starting to imagine just what that would look like.

**Dr Graham**—We can provide that information on quality and adverse events for both imported and local products.

**Senator FORSHAW**—That completes the questions I had on blood importation. I have some other questions of a more general nature for the TGA.

**CHAIR**—We are finished with the National Blood Authority. Let us finish with the TGA.

**Senator WEBBER**—Being from Western Australia, I have the dubious honour of coming from the state with the highest prescription levels of Ritalin for young children, to the point where it has yet again made it into the *Australian*. Some of us who were on the Senate Select Committee on Mental Health had a bit of a look at this issue. Given those prescription levels, could we have a chat about the black box warnings that the FDA are now putting on Ritalin and other ADHD drugs.

**Ms Halton**—They are not.

**Dr Hammett**—We need to correct that misinformation that has been provided publicly. Australian media reported that black box warnings were now being applied to these products in the US. That in fact is not true. We have had direct communication with the FDA and, following a number of their committees reviewing issues related to these particular products, the FDA have informed us that they are considering whether they may need to make changes to their current product information. But at this stage there are no new black box warnings in the US. So we just need to correct that.

**Senator WEBBER**—If they actually make a decision in favour of doing that, is that then something that the TGA would look at as well? The FDA is allowed to declare certain drugs to be safe, and I know we therefore often put certain pressure on you to make the same decision. Do we put pressure on you to put the same warnings on things as well?

**Dr Graham**—We would take that into account. We are in close collaboration with the FDA on this and other matters. In fact, our Australian Drug Evaluation Committee did provide

advice to strengthen the product information a period of time ago, and the product information has been strengthened. So there are different steps you can take to provide that information to medical practitioners. There has been movement in terms of a stronger statement within the product information. A black box is really just highlighting to a larger extent that information if it is necessary.

**Senator WEBBER**—You said that it has been looked at a while ago. Is the TGA planning on having a fresh look at this, given there is a bit of public debate and concern now? Because of concerns about these very powerful drugs being given to children as young as six, even younger, I think the minister in my home state has set up a committee to look at the way we actually deal with ADHD and to try to have a more multidiscipline focus rather than drug-only treatment. Are there any plans to have another look at this?

**Dr Hammett**—The TGA constantly monitors emerging post-market issues with products that are available in the Australian market. With these concerns around ADHD drugs in particular, the TGA is conducting a review and has sought information from the sponsors of these products regarding international occurrence of adverse events. That review has just been completed within the TGA, and it is now being referred to our expert advisory committees so that they can consider the information that the TGA has obtained internationally in relation to these products and what, if any, additional warnings need to be applied to these products.

**Senator WEBBER**—If your expert panel decides that additional warnings should be put on products like this, what then is the process?

**Dr Hammett**—Our expert panels, our expert advisory committees.

**Senator WEBBER**—Sorry; yes.

**Dr Hammett**—They would provide advice to the TGA on what they thought were appropriate steps to take. The delegate within the TGA responsible for making those decisions would consider that advice in the totality of the evidence that existed and then would liaise with sponsors of those products to adjust the labelling requirements that are currently in place for those products.

**Senator WEBBER**—I am wondering about public awareness, education and information—that is all. I know it is a hypothetical case—and we do try to stay away from hypothetical cases here—but, if a decision were taken that we did need to strengthen the warnings, how do we then make sure the parents of these young children know about that?

**Dr Hammett**—The consumer medicines information that is provided with products mirrors the product information which contains those warnings. So, if there were additional warnings, we would expect that they would be picked up and made available to the parents who were looking after those children.

**Senator WEBBER**—So that would go directly to the parents?

**Dr Hammett**—When they purchased that product.

**Senator WEBBER**—One of the joys of being from WA is that some of these issues seem to be automatically dealt with by prescription. If we relied on, say, paediatricians as the only way of getting information out, parents would not necessarily be as fully informed as others.

When will the expert committee panel, whatever they are—I am getting confused now; it has been a long fortnight—come back to you with their decision on what we need to do?

**Dr Hammett**—The expert committee meets in August. We would expect advice from them within a week or so of meeting. We would obviously make decisions and move to implement those decisions as quickly as possible after that expert meeting.

**Senator WEBBER**—So we could have another conversation about this in November?

**Dr Hammett**—We certainly could. I look forward to it.

**Senator FORSHAW**—Can I go to some issues arising from some media coverage and the determination of the Australian Competition and Consumer Commission. I am sure you would be aware of some of the publicity. On 2 May there was an article by Adam Creswell in the *Australian* entitled '"Schmoozing" drug firms go too far'. Is anyone familiar with that article?

**Dr Graham**—I think I saw that one.

**Senator FORSHAW**—I am sure you would have. It refers to the ACCC's determination—I have a copy of the draft—on the application for revocation and substitution of codes of conduct from Medicines Australia. Is there a final determination? If so, have you received a copy of it?

**Dr Graham**—I understand that the interim determination has now been accepted, yes.

**Senator FORSHAW**—You are familiar with it anyway; I am sure you are. I would have liked more time to go through this. There is a series of comments throughout this determination by the ACCC which I could have quoted at length. They express reservations or concerns, for instance, in commenting about—and I quote here from page 48:

> The Medicines Australia code annual reports indicate that some companies have been found to breach the code multiple times. It is concerned that they are regularly breaching the code and that the penalties imposed by the code committee do not appear to reflect this.

They also state:

> The ACCC considers that the new edition of the code contains some improvements but remains concerned that it is not always effective in actually regulating drug companies' conduct.

That is a statement by the chair, Graeme Samuel. They called for tighter monitoring of the rules amid concerns that they are being ignored. That is a comment from the article in the paper. There is a range of concerns about issues to do with transparency and effectiveness of the code. At the end of this article in the *Australian* it states:

> A spokeswoman for the Therapeutic Goods Administration defended the voluntary code, saying it had "worked extremely well".

Firstly, are you aware of whether that is an accurate quote? Secondly, I would like you to comment upon that statement in light of some of the concerns that are raised by the ACCC.

**Dr Graham**—I think the point of view that was put by the TGA and the department was that self-regulation of promotion and conduct within the pharmaceutical industry has worked appropriately in the sense that it has required the industry to monitor its own conduct. Various people have certainly had views about whether that process is transparent enough. But I think,

as indicated by some of the information there, there is a move towards ensuring greater transparency. I think the process and the debate around whether the fines, for instance, are sufficient is one issue. But fundamentally I think the code of conduct as administered by Medicines Australia has made the industry much more accountable and aware. A number of groups, including consumers, keep a very close eye on how the industry manages its code.

**Senator FORSHAW**—Can it be improved?

**Dr Graham**—Yes, and it is. There is continual improvement. This is the next iteration of the code that is being considered by the ACCC. I am aware that in that process Medicines Australia sought input, including from the TGA, about areas of concern within the current code and how they could be improved in the next code.

**Senator FORSHAW**—I got the impression from my quick reading of the ACCC document that they were prepared to endorse it or give it their approval on the basis that there is some improvement but that there is still some way to go. Is that a fair description?

**Dr Graham**—Yes. As I said, I think that it is always going to be an area of continual improvement: the code will be in place; Medicines Australia will apply that code; with the changing marketplace, areas will be identified where there needs to be greater control, for instance on the internet; and the industry can then, with input from other stakeholders, including the TGA, go through the next iteration. I think that process has worked relatively well.

**Senator FORSHAW**—What objective performance indicators does the TGA use to measure the effectiveness of self-regulation?

**Dr Graham**—We certainly monitor promotion of products and the conduct of the industry. If we come across issues, we report those and use the complaint mechanisms, as others should do. So, really, we keep an eye on the responsiveness of the industry and Medicines Australia as to how they respond to complaints that we know about.

**Senator FORSHAW**—There is a view—and I understand this was contained in submissions to the ACCC—that, because you have effectively 100 per cent industry funding, not much is done to oversee the industry's management of its own code or Medicines Australia's management of its own code and that there is a major problem of transparency.

**Dr Graham**—That is nonsense.

**Senator FORSHAW**—If you are going to disagree, I would like you to take this opportunity to respond.

**Ms Halton**—That is completely untrue.

**Senator FORSHAW**—I know you say it, but this was made in submissions.

**Ms Halton**—I understand that. Let's be clear: the department have two roles here. We have the running of the regulatory function role, which is Dr Graham's function, and we have a policy advising function which, as you know, Mr Eccles has been the lead face on, particularly while we have been doing trans-Tasman. I would be the first person, if I thought that the existing regime was inadequate in a policy sense, to be advising government of that—and that is not my view.

**Senator FORSHAW**—You can take this next question on notice. Can you give me some details on the resources, both manpower and finances—

**Ms Halton**—You keep using that term, Senator.

**Senator FORSHAW**—What term?

**Ms Halton**—'Manpower'.

**Senator FORSHAW**—It was written by a bloke. I am looking at the people at the table and I see mostly men.

**Ms Halton**—You have done it several times this estimates and I have restrained myself until now. 'Human resources' will be just fine.

**Senator FORSHAW**—I am looking at all these representatives of the TGA and they are all men; so I am sorry. Can you give me the detail of the resources of personpower and finances—

**Ms Halton**—'Human resources' is excellent.

**Senator McLUCAS**—'Human resource staffing' will do nicely.

**Senator FORSHAW**—My job is to ask the questions. Your job is to answer them. Can you give me some details on the resources, both human resources and finances, used by the TGA in its evaluation, the listing of drugs and the registration processes as against your post-marketing surveillance, your surveillance of the regulatory regime—the voluntary one from the industry—and so on. Can you take that on notice and provide me with some information. The assertion is that a lot of it goes into the front end, the listing and so on, and not as much or not enough goes into the oversight of the code of the marketing.

**Dr Graham**—We have two types of fees and charges. One is the fees which basically fund the pre-market activities, the applications and the evaluation process; the other is the annual charges which apply to products on the register which go towards post-marketing activities, which may be monitoring adverse events, our sample testing, our auditing functions through our GMP inspectors, our surveillance function. They are the primary activities of post-marketing. We can, if you like, show you the split between the fees for pre-marketing and the charges for post-marketing.

**Senator FORSHAW**—Yes. Will that give me a sense of what the split is within the whole of the TGA?

**Dr Graham**—I think so. If you need further information, we can follow it up.

**Senator FORSHAW**—It is your opportunity to refute, if you can, these assertions.

**Dr Graham**—I refute the fact that, because we are under 100 per cent cost recovery, we are too close to the industry. That is absolutely wrong.

**Senator FORSHAW**—You were obviously made aware of that assertion even before I raised it. I have one other issue, and I would like you to provide me the answer on notice. I understand there is a pharmaceutical product called Tebonin, which is marketed for the treatment of tinnitus. There have been some complaints made about the marketing of this

product and the claims that have been made by the manufacturers and the distributors of this pharmaceutical. Are you aware of this issue?

**Dr Graham**—No, we do not have that information with us tonight.

**Senator FORSHAW**—Have you been informed of concerns raised by a consumer group called AusPharm regarding this?

**Dr Graham**—Personally, no. But we can check, if you would like, Senator.

**Senator FORSHAW**—Yes. Given the time, rather than go through these questions, I would like a response from the TGA about that issue—what it knows about it and what its views are.

**Dr Graham**—All right.

**Senator FORSHAW**—There is some disputation, apparently, within the industry about it. Thank you very much, Chair. That completes the TGA, as far as I am concerned. If there are other questions, we will put them on notice.

**Senator McLUCAS**—I want to ask some questions, following up from last estimates, on the Q fever vaccine. At the last estimates I asked whether or not there was going to be a Commonwealth commitment to the upgrading of CSL's vaccination production plant at Parkville. The indication then was that there were negotiations occurring at the time. Can you give me an update on that.

**Ms Smith**—Senator, I think you would be aware that, just before Easter, Minister Abbott and Minister McGauran issued a press release indicating that the department was about to embark on a tender process to find an alternative manufacturer for Q fever vaccine..

**Senator McLUCAS**—Does that mean that the solution that was being touted—that is, the upgrade of CSL's facility to produce Q fever vaccine—is not going to be pursued?

**Ms Smith**—The government is very keen to test the market.

**Senator McLUCAS**—Has that tender, that I think was announced on 13 April, started? Has that occurred? Where are we up to in that process?

**Ms Smith**—The department advertised nationally for interested parties to submit an expression of interest for the manufacture of Q fever vaccine and associated screening tests. That EOI closed on 8 May. The department is currently in the process of assessing submissions.

**Senator McLUCAS**—That would indicate that there are potential suppliers other than CSL; is that correct?

**Ms Smith**—I am not able to go into the details of the submissions. There is a process under way. There will be an outcome in due course.

**Senator McLUCAS**—When will the tender be offered?

**Ms Smith**—Senator, I am not in a position to give you those details at this time.

**Mr Stuart**—We are currently finalising our review of the expression of interest process. Clearly, we are keen to keep moving ahead as quickly as possible on this because we have a

supply gap opening up on Q fever vaccine, as you know. We anticipate having our next step in the process as soon as we can get there.

**Senator McLUCAS**—Is CSL manufacturing Q fever vaccine now?

**Mr Stuart**—CSL has suspended the manufacture of Q fever vaccine and is working towards the release of some new batches.

**Ms Smith**—There are expected to be another two lots of 12,000 doses released in March 2007.

**Senator McLUCAS**—That should cover us for this year and next year?

**Ms Smith**—CSL has also implemented a rationing strategy in terms of current supplies to ensure that those people who are most at risk have access to vaccine.

**Senator McLUCAS**—Does that indicate there are people who would like to be vaccinated but are not able to be?

**Mr Stuart**—There will be a shortage for a period. So the use of the existing supplies is going to be prioritised to areas of highest risk.

**Senator McLUCAS**—How do CSL have the ability to ration? Do they have a legislative right? Under what power do they ration their supply?

**Ms Smith**—CSL are the supplier of this vaccine. They have sought expert advice in determining risk groups. That advice was sought from Professor Barrie Marmion, who is seen as Australia's eminent Q fever expert. But CSL in most states of Australia at the moment are distributing this vaccine through the private market.

**Senator McLUCAS**—To abattoirs and vets and people like that? Have you heard of cases where people who have wanted to be vaccinated have not been able to because CSL have not deemed them a priority person?

**Mr Stuart**—We do not know of individual cases, but we do know that there is a shortage in the marketplace and will be for a while.

**Senator McLUCAS**—What is the level of the shortage that we are facing at the moment?

**Mr Stuart**—That will depend on the speed at which CSL gets these doses into the marketplace and the level of demand, which is a little unpredictable. I do not think we have a figure that we could tell you for that.

**Senator McLUCAS**—I think you told me last time, Mr Stuart, that we use about 25,000 doses a year. Is that correct?

**Mr Stuart**—It has varied, depending on the stage we are at with the Australian government program.

**Ms Smith**—At the height of the program, the usage probably got more to between 40,000 and 50,000 doses a year. In the last year or two it was probably more around the 25,000-a-year rate, but that was with the National Q Fever Management Program operating. At the moment that program has finished in all jurisdictions except Queensland, Victoria and South Australia.

**Senator McLUCAS**—Do you have an understanding of how many vaccinations we will need in this current year?

**Mr Stuart**—Not really. We would be guessing a little, if we mentioned numbers. The program is operated by way of a catch-up and it depends on the turnover of labour in the relevant industries. I think, we would be hazarding a guess and I would hesitate to do that.

**Senator McLUCAS**—Is it two batches of 12,000 each?

**Mr Stuart**—Yes.

**Senator McLUCAS**—Will that serve the need currently?

**Mr Stuart**—We think that they are insufficient to meet the likely need, but it is very difficult to say by how much.

**Senator McLUCAS**—We know that the production of Q fever vaccine is not an economical proposal. No-one will make any money out of it. How is the tender being constructed?

**Mr Stuart**—CSL's decision to cease making it and CSL having been the only maker illustrates, as you say, that there is not a viable private market for this product. It is now being seen as a public interest vaccine. That said, the government is clearly taking responsibility for looking to its future by doing this tender process. The tender process envisages people telling us about capital funding requirements, as well as a price for the goods to make them productive, with the costs subsidised by the government.

**Senator McLUCAS**—Will it be completed in November, so we can talk more then?

**Ms Smith**—We would certainly hope so.

**CHAIR**—That completes outcome 1. Thank you to the officers involved in outcome 1.

[6.09 pm]

**CHAIR**—The committee will now move to outcome 14: health and medical research.

**Senator McLUCAS**—The budget announcements on biomedical research included $215 million that was allocated in 2005-06. Where does that money exist in the budget?

**Dr Morris**—The figures in the budget included $170 million for fellowships, $220 million for medical research institutes and, in 2005-06, about $20 million for health and medical research, which is being escalated up to a total of $500 million over four years.

**Senator McLUCAS**—Is the figure $590.7 million? I do not have the background papers with me. My briefing note says that there is a total of $905 million in research funding in the budget—

**Ms Halton**—Yes.

**Dr Morris**—That is right.

**Senator McLUCAS**—and that is made up of $215 million, which was provided in 2005-06, and that there are a number of allocations in this budget that were identified in this current year but appeared as part of the 2006-07 budget—is that correct?

**Ms Halton**—That sounds too high.

**Dr Morris**—It does. It does not sound right.

**Ms Halton**—$200 million sounds too high for the first year.

**Mr Clout**—The budget announcements included a range of grants to medical research institutions to be paid out in the 2005-06 year. That money is appropriated through bills 5 and 6 of 2005-06, which were also introduced to the House on budget night.

**Senator McLUCAS**—Of the amount of money in bills 5 and 6—that is, the money that was announced on budget night—for 2005-06 is for biomedical research?

**Ms Northcott**—There was not new money announced in 2005-06. It all starts as of 2006-07. In terms of how the new money for 2006-07 is allocated across clinical population health, biomedical research will be an issue that the new research committee, which commences on 1 July, will need to determine and make recommendations to the minister about.

**Ms Halton**—Are you making a distinction, Senator, between the money that has gone to the institutes and the money that has gone into the NHMRC for grants?

**Senator McLUCAS**—I think I am, but I do not have the budget paper with this.

**Ms Halton**—All the money is for research, so maybe we are talking at cross-purposes.

**Ms Northcott**—In relation to the money going to the NHMRC, there is $500 million to enhance research and $170 million for research fellowships. The remainder will be managed by the Department of Health and Ageing and it comprises $203 million for medical research infrastructure and some money for adult stem cell research. That is it.

**Senator McLUCAS**—I understand 17 research institutes received capital funding. How were those 17 institutes selected?

**Ms Halton**—That was a decision of government.

**Senator McLUCAS**—Was there an analysis of the attributes of all the various biomedical facilities in Australia?

**Ms Halton**—It was based on the government's view about facilities that needed funding and a variety of other considerations. As I said, it was a decision of government.

**Senator McLUCAS**—Has the allocation of money to each institute been identified yet?

**Ms Halton**—Yes, it was. There was a specific list announced.

**Senator McLUCAS**—It is in the budget?

**Mr Clout**—It is page 269 of Budget Paper No. 2.

**Ms Halton**—Each institution to receive money from that allocation is listed.

**Senator McLUCAS**—Were the institutes requested to submit bids for this funding or was it a decision of government to say, 'This is what we will do'?

**Ms Halton**—I cannot point you to a process, Senator. It is my experience that health and medical research institutes have been fairly good at telling people what they want and what they need. I think there was a process of aggregating those various issues and requests, which led to the decision of government.

**Senator McLUCAS**—The budget papers say that the commitment follows the government's announcement of its decision to sell Medibank Private and completes the government's response to the grant review. Can you explain the link between the increased commitment to research funding and the sale of Medibank Private?

**Ms Halton**—Yes. Essentially, as I understand the decision, the government decided that, in the context of the decision taken on the sale of Medibank Private, they wanted to reinvest funding—in other words, likely proceeds. It was decided, however, that the notion of being able to make that investment contingent on the sale was not the right approach, that in fact they would anticipate the moneys that they might receive and that they would actually make a formal firm allocation in the budget.

**Senator McLUCAS**—If the sale does not proceed or goes slower or does not realise as much money as the government expects—

**Ms Halton**—That is the calculated risk that has been taken, but essentially it was decided it was sensible to arrive at an amount and make that commitment.

**Senator McLUCAS**—Has the NHMRC been asked to comment on the impacts of the introduction of the research quality framework on grant applications, or just the roll out of grants in the research sector generally?

**Ms Northcott**—The NHMRC has been closely involved in that process. The former CEO, Alan Pettigrew, was a member of the RQF advisory committee. I understand that the incoming CEO has been asked by the new Minister for Education, Science and Training to join that committee. We have made submissions to that process all the way along. My understanding is that, in relation to the RQF process, the time frame for implementation is quite a bit later than originally envisaged, so it is probably 2007-08. There is no obvious link between funding of research grants or the decision-making processes of the NHMRC and the RQF, but I think the RQF and the DEST funding processes may well be informed by the peer review processes of the NHMRC.

**Senator McLUCAS**—You are expecting the implementation of the RQF will have no impact on applicants, on the sort of application that you might get?

**Ms Northcott**—No, we are not expecting that it would, unless there is a radical change from what has been said today.

**Senator ADAMS**—My questions are on the NHMRC funded research into ovarian cancer. The Senate Community Affairs References Committee had a gynaecologist round table four or five weeks ago. We asked a question on notice about whether we could have a summary of expenditure on ovarian cancer. The department has given it to us, but the problem is quite a large amount of the data on the list is for breast cancer and other cancers. Could you please provide us with revised data showing the actual funding attributed to ovarian cancer research? You can take that question on notice. Could the department please advise why breast cancer funding data has been included with the ovarian cancer research data when the associations between breast cancer and ovarian cancer are minimal? It seems to be the data for both conditions is mixed up. Could someone answer that?

**Ms Northcott**—We can take it on notice. I certainly looked at the submission to your committee. There were not a large number of grants. As I recall, there are about nine specifically into gynaecological cancers.

**Senator ADAMS**—What came back had some big funding for breast cancer added into it, so it looked a lot more. But when we looked at it, it was not quite as much as—

**Ms Northcott**—We provided additional information into a range of enabling grant facilities that we fund which are basically underpinning research—cell banks, tissue banks, those types of facilities. A number of those are into cancers generally. It is quite likely that they would be collecting tissue samples that are relevant to gynaecological cancers as well as other cancers, so they would be relevant. I cannot remember seeing breast cancers in that list.

**Senator ADAMS**—I think fellowship and career awards were also included in the report. They were not linked to any ovarian cancer research data.

**Ms Northcott**—I am very happy to take that back and have another look.

**Senator ADAMS**—Another one included was on ATSIC activities when they have no outcome measures. Could DoHA please advise the committee of the number of submissions on ovarian cancer or other gynaecological cancer research initiatives, and what percentage were rejected by NHMRC and other funding groups.

**Ms Northcott**—We can certainly do that.

**Senator ADAMS**—The allocation of $189.4 million to 2008-09 does not adequately represent the needs of the gynaecological cancer sector and it is considered totally unacceptable. Would you be able to look at that? We are having an inquiry into gynaecological cancers and all the issues that go with it; we are getting a terrific number of submissions from consumers, from researchers, from our specialists. This area probably should have been looked at before, but it is certainly attracting a lot of attention now. It appears we will be able to have hearings in Melbourne, Sydney and Perth. The way submissions are coming in, we are still not sure where it is going. It is obviously very important. We would certainly like the NHMRC to be aware of it.

**Ms Northcott**—Getting the applications and looking at the proportion of applications of those who are successful as against those who are not will be quite important. We will do that as quickly as we can for you. But of course the number of grants funded in a particular area depends on the number of applications you receive. Some areas do better than others do because the sole criterion for funding grants through these schemes is excellence, which I am sure you are aware of. We do not look at a particular area and allocate funds to that through our investigator-initiated grants at least.

**Senator ADAMS**—The $31.6 million in 2005-06 for cervical cancer screening incentives for GPs, as cervical cancer is well understood and preventible, is a bonus for health practitioners, but does not necessarily address the needs of other gynaecological cancers and GP awareness and diagnosis of early symptoms. Unfortunately, this disease has very few symptoms and can often be missed. One of our terms of reference is to see how we can educate GPs and other health professionals to be able to pick it up, so we are certainly trying to promote those issues.

**Ms Northcott**—That would not be a matter for the NHMRC; you would need to take that up with the department.

**Senator FERRIS**—What is the amount of government funding that has been given this year to the National Breast Cancer Centre?

**Ms Northcott**—Once again, that is a question for the department. The NHMRC do not fund organisations; we fund research. We could certainly provide you with information about any investigators who are located at the National Breast Cancer Centre who receive funding from the NHMRC. But in terms of support to the organisation, it is not our responsibility.

**Senator FERRIS**—Also, I am interested to know what proportion of that total funding goes to actual research and how much of it goes to administration. Are you able to take that on notice as well?

**Ms Northcott**—It should go to the department. We fund only direct research costs. We do not fund what other countries would provide usually in the form of overheads. The NHMRC do not do that.

**Senator FERRIS**—Maybe somebody from the department can answer that question.

**Ms Lyons**—Could we take that on notice? It is a question that relates to outcome 10, which is on later this evening. If we take it on notice, we might be able to give you the answer then.

**Senator FERRIS**—That would be wonderful. Thank you very much.

**Senator STOTT DESPOJA**—I am happy to put my questions regarding stem cells on notice. But I presume the department would be the most appropriate place to address this question: Minister, when can we expect a government response to the findings of the Lockhart review?

**Senator Santoro**—The report is still very much under consideration. The process is being coordinated by the Department of Prime Minister and Cabinet. Obviously the department is contributing to the development of a response. That is the advice I can give you, Senator.

**Senator STOTT DESPOJA**—Do you know, Minister, whether those recommendations are due to be discussed at the COAG meeting in June?

**Senator Santoro**—There was some discussion about the possibility of that happening. From what I understand about the timing of the process, the consultations required to be had with the states, I am not quite sure that it will make it onto the agenda of that meeting. But I cannot be sure of that. There is a lot of agreement, obviously, to be reached with state governments before it can be placed on the agenda of COAG. There needs to be a lot of discussion and coordination.

**Senator STOTT DESPOJA**—So there is no legislation coming to the federal parliament soon that we should get ready for?

**Senator Santoro**—I think the report is still under consideration. I am not sure that we have yet reached any conclusions about a legislative response.

**Senator STOTT DESPOJA**—Thank you, Minister. I will put all other questions on notice.

**Senator McLUCAS**—I want to go quickly through the funding for the adult stem cell research centre. Can either the NHMRC or the department confirm that the proposal was taken directly to cabinet by the minister for health?

**Ms Halton**—No, I do not believe that was the case. We do not comment on cabinet processes. This was a decision of government, in fact, like those other decisions I just outlined.

**Senator McLUCAS**—It was reported in the *Weekend Australian* of 13 May that Professor Mackay-Sim:

> ... openly acknowledges that he didn't put in a grant application to peer-reviewed funding body like the National Health and Medical Research Council or the Australian Research Council. Instead, he sent a proposal directly to Tony Abbott, who took it to the Prime Minister and Cabinet.

Is that reporting correct?

**Ms Halton**—I have not seen that report, so I cannot comment on it. All I can say to you is that consistent with the other decisions that we just talked about in terms of the allocations to the various health and medical research centres, this was one of those centres about which there was a decision by government to fund.

**Senator McLUCAS**—My recollection is—and I might be wrong—that this funding announcement was announced prior to the budget. Is that right?

**Ms Halton**—Yes, that is my understanding. Some of the decisions that were taken were announced prior to and some were announced in the budget.

**Senator McLUCAS**—When was the department first made aware that this funding would be in the budget?

**Ms Halton**—At the same time the decisions on a number of research facilities were made known.

**Senator McLUCAS**—Was the NHMRC included in discussions about not only this funding but also the other funding to the 17 institutions?

**Ms Halton**—There was a policy conversation. The NHMRC, as in the council, was not consulted. The NHMRC, together with many other people with interest in research, if I can cast the net that widely, had all made their various views—I think I could say that fairly—extremely well known on the need for additional funding into health and medical research, including capital et cetera.

**Senator McLUCAS**—Were the council or the staff of the council asked for their input into drawing up that list of 17 institutions?

**Ms Halton**—No.

**Senator McLUCAS**—Have the Eskitis Institute for Cell and Molecular Therapies, a group of researchers, previously submitted applications for support or funding to the NHMRC?

**Ms Northcott**—We would have to take that on notice.

**Senator McLUCAS**—Could you also advise us what sorts of applications they were, and whether or not they have been successful.

**Ms Northcott**—Yes, we would be happy to.

**Senator McLUCAS**—I dare say that between the department and each of the 17 institutions there is now an agreement about outcomes. Is that correct? Is that the next step in the process?

**Ms Powell**—We are currently negotiating contracts for those fundings with each of those research institutions.

**Senator McLUCAS**—When will they be completed?

**Ms Powell**—Hopefully by the end of next week.

**Senator McLUCAS**—Will those agreements become public information when they are completed?

**Ms Powell**—They will be funding agreements like the department would have with a whole range of institutions. They are not normally made public.

**Senator McLUCAS**—How is the community to understand how that significant amount of money is to be applied?

**Ms Powell**—The funding for the research institutions is broadly capital funding. I think those purposes were spelt out in the budget paper. It is for capital infrastructure.

**Senator McLUCAS**—It is all capital infrastructure?

**Ms Powell**—With the exception of $20 million to the national adult stem cell centre over four years, which will include operational funds.

**Senator McLUCAS**—Let us just do the capital first, and then we will go to that $20 million. We, as in the community, will know that we will get a building or a renovation or something.

**Ms Powell**—Or a bit of one.

**Senator McLUCAS**—That should comfort us and make us feel warm and fuzzy or something. I am sure we will have 17 events where a ribbon is cut; I dare say that is the accountability factor. Let us go to the $20 million that the national adult stem cell centre will have. What sorts of accountability mechanisms and outcomes and what sort of process will be put in place to allow the community to understand what will happen with that money?

**Ms Powell**—We are just beginning our discussions with them about that and forming the contract. One of the things we will be discussing with them is what exactly will the operational funding be used for. We have not finished yet, so I cannot tell you.

**Senator McLUCAS**—Twenty million dollars is not the sort of operational grant that the NHMRC would grant, is it? It is not a research grant.

**Ms Powell**—No, it is not a research grant.

**Senator McLUCAS**—Am I right to think it is not research based?

**Ms Powell**—It is for operational costs.

**Senator McLUCAS**—It is the electricity; it is the staffing; it is the rates.

**Ms Powell**—I expect that is what it will fall out as.

**Senator McLUCAS**—We might come back to that later, maybe on notice, to get a better understanding.

**CHAIR**—Senator, I think we have run out of time, to be frank. Can you put further questions on this area on notice. We have completed outcome 14.

**Proceedings suspended from 6.36 pm to 7.40 pm**

**CHAIR**—We will resume our hearings as the estimates committee into the portfolio of Health and Ageing. We have five outcomes to complete between now and 11 o'clock, so I invite questions on outcome 15, Biosecurity and emergency response.

**Senator MOORE**—I know the department will be prepared for this: comments made by Dr Merridew about our preparedness for critical responses—that we are 'critically underresourced for any major terrorist attack or natural disaster'.

**Ms Halbert**—We consider that Australia has a very well equipped and robust health system that is prepared to respond to major health emergencies. We work through the Australian Health Protection Committee, which has replaced the Australian Health Management Disaster Committee, to coordinate with state and territory health ministries to ensure that we can respond on a whole-of-country basis to any particular health emergency, which we have just recently demonstrated with the East Timor emergency and the earthquake in Indonesia. Ms Murnane convened the AHPC and we coordinated with states and territories to get help to the places that it was needed quickly.

Darwin Hospital in that instance responded that they could take people from East Timor. You might be aware that the government has funded Darwin Hospital to the tune of $65.8 million, I think it is, to improve trauma capacity because of our experiences with the Bali bombings and so on, where we have had to take people in through Darwin. That agreement has only recently been signed but, as you can see from last weekend, we are already well prepared. Just recently the minister has written to his state and territory counterparts, noting that we are well prepared but asking them for reassurance and detail about capacity, particularly in CBD areas, for a major health emergency.

**Senator MOORE**—Your department takes the lead in the AHPC, and I note Ms Murnane's position in the last exercise. Ms Murnane, is that linked to your position in the structure, or is it flexible? Does your position in the structure take on that role?

**Ms Murnane**—Yes.

**Senator MOORE**—In terms of any of these, there will be post-incident reviews, won't there, in terms of evaluating how we went? Is there a schedule for when that is done? Is it immediately after the event, or three months later? Is there any kind of expectation of when that happens?

**Ms Murnane**—It is more than that, and Dr Roberts can talk about this in some detail. We have just completed our second audit of Australia's preparedness and capability. It would be interesting for Dr Roberts to talk about that but I will draw your attention to a response to Dr Merridew that was published in the *Australian* on Monday, 15 May. In that response, Professor Chris Baggoley, who is the chief medical officer in the Department of Health in South Australia, said, 'Australians should be reassured that there is work going on constantly

in this country to prepare our hospitals and our health response in the case of a major crisis.' I will not read it all out, but I will table it. This is an exact extract. We have typed it out from the *Australian*. You will see there that Professor Baggoley, before he was chief health officer, was the medical director of emergency in the Royal Adelaide Hospital, so he is somebody with pretty good credentials to be able to weigh these things up.

**Senator MOORE**—In terms of the evaluation of the particular incidents that cuts in, there is an agreement through the AHPC about how you handle that?

**Ms Murnane**—Yes, we do go back and look. SARS was the first incident we handled and that was before we had a committee. We started to develop structure and a committee around us. The secretary, Jane Halton, took a major role in identifying that and making sure we had links into central agencies after SARS. Since then we have handled the first Bali bombing, the second Bali bombing, the tsunami and we were involved in both the initial emergency meetings, crisis centre meetings, on the London bombing and the evaluation of the response in London. Each time we look at lessons learnt and what we can do better. Another opportunity to take a cool look at what we are doing not so well, as well as what we are doing well, will be Exercise Cumpston, the pandemic influenza exercise later this year.

**Prof. Horvath**—Regrettably, some of my colleagues confuse day-to-day constraints on their resources and surgical waiting lists and emergency department things and somehow extrapolate that if they cannot cope day to day how will they cope with an emergency? Under emergency conditions, things are different because the routine things do not happen. During this recent fielding of two sets of initiatives, one to East Timor and one to Somalia, the moment we were called to have additional nurses and two sets of different types of surgeons, they were in the air within the required time.

**Senator MOORE**—Do you have benchmarks, Professor Horvath? Dr Roberts, I am sure you will probably go into that. There will be benchmarks for how long it takes to get things up?

**Prof. Horvath**—It is not so much a benchmark as it is that when they were asked for they were delivered.

**Ms Murnane**—You just have to do it.

**Senator MOORE**—Yes, emergency conditions. You do not have a goal of within 24 hours?

**Prof. Horvath**—No, you have a goal to do it immediately.

**Senator MOORE**—If not sooner.

**Prof. Horvath**—Our fastest response was during Bali 2, when during the teleconference the Northern Territory requested a neurosurgeon and Queensland not only found a neurosurgeon during the teleconference but found the Premier's plane to fly him there.

**Senator MOORE**—We are pleased about that. I might just read these questions out, because they are all about the response to the kinds of comments that were made negatively. You have already begun to address those. Then we can get a response covering the issues. I think that is a better way of doing it. In the kinds of comments that were in the paper that stimulated the response that Ms Murnane mentioned in the *Australian*, there were concerns

about too few resources, specialists, surgeons and nurses, more training being required for personnel on how to work outside of the hospital area and also ability to work in emergency situations. They were the kinds of comments that were highly publicised at the time.

I would like to have some idea—we have already had some preliminary response from the department—whether there is some acceptance that there is a requirement for more specialised training? Whose responsibility would it be to provide that kind of specialist emergency training? What is being done to involve the resources of private hospitals in emergency preparedness; that old public-private issue. They are the kinds of comments that were highly publicised. Dr Roberts, if you would, please throw in some comments for the record there, from the department.

**Dr Roberts**—We have initiatives along all of those areas that we have been working towards. We have a disaster medicine course that has been funded by the department and has been running in Australia for about 10 years. With the changes in what we have been seeing in recent years with both natural disasters and threats, it was timely to review that course. We have consultants out in the field at the moment talking with people about precisely what we need for disaster medicine training. We should have the report of that in a couple of months and be able to start implementing what we think is most useful for disaster medicine training. At the same time, the university institutions are starting to look at postgraduate qualifications specifically in disaster medicine. You mentioned private hospitals and how the private system is supporting—

**Senator MOORE**—Do they intend bringing private resources into the plan?

**Dr Roberts**—Yes. We have been talking with, particularly, private laboratories in terms of how they can assist with laboratory tests when the public laboratories are overwhelmed. With the private hospital system, they are working within their own jurisdictions about how they can move patients from the acute public hospital system into the private system at times of emergency. For example, Royal Darwin Hospital has an MOU with the adjacent private hospital to do exactly that.

**Senator MOORE**—In relation to the disaster medicine training that you mentioned, where is that done and does it cover all kinds of medical professionals? Is it for the nursing staff, the specialist doctors and the support staff, as well as doctors? Sometimes when you say ‘medicine training’, it focuses almost exclusively on doctors.

**Dr Roberts**—No, this specifically does not focus exclusively on doctors. The disaster medicine training course was conducted at Mount Macedon in Victoria, funded by the department, and jurisdictions were able to nominate people that they thought were appropriate to attend. Those that attended ranged from community nurses, hospital nurses, acute care doctors and public health physicians—lots of people that you would see involved in an emergency.

Another area that we are looking at is disaster first aid. First aid at the moment is about management of an individual and an injury, and we have been working with Professor Fiona Wood on how that might be better placed with some training for a disaster, where you are faced with many individuals with many injuries. We are looking at the possibility of

developing a module, with her guidance, about disaster first aid response for the general public.

**Senator MOORE**—Is the funding for those two training programs through your section?

**Dr Roberts**—Yes.

**Senator MOORE**—Is the expectation that they will be ongoing, so there will be rolling training?

**Dr Roberts**—Yes.

**Senator MOORE**—Is the ongoing evaluation of the whole process through the health minister's grouping? This obviously involves all jurisdictions.

**Dr Roberts**—That is right.

**Senator MOORE**—So is this kind of action the ownership of that group in terms of—

**Dr Roberts**—Yes.

**Senator MOORE**—When they talk about what they need next and when they send congratulations to Queensland for their quick action, is that done through that minister's group?

**Dr Roberts**—It is done through the Australian Health Protection Committee, and the consultant's report will go to that committee, so we all work closely with them to develop what needs to be put in place. We are also working with jurisdictions to develop disaster medical assistance teams. These are civilian based teams of people who have already identified themselves as prepared to respond to a disaster and form part of a team. They can be brought together before an event to have basic training, including what sorts of shoes to pack to go on a mission and the need for a passport to get out of the country, for example. These teams are starting to be formed in the jurisdictions—and are well advanced in Western Australia—and are also being discussed by the Australian Health Protection Committee.

**Ms Murnane**—As we speak, there is a seven-person team, led by Dr David Cooper of Sydney, working through two, and maybe three, hospitals in Yogyakarta.

**Senator MOORE**—How does it link in with the military medical response?

**Dr Roberts**—Some of the team members will be reservists. Where they are reservists, they are registered at the jurisdiction identifying that they have that dual role, because we do not want to be in a position of double counting what is effectively one person going into two separate teams.

**Senator MOORE**—The role of the emergency teams is time limited in terms of what then is taken over by an ongoing relief effort?

**Dr Roberts**—Yes. They will be there for disaster medical assistance in the acute phase.

**Senator MOORE**—The reason I ask that is that we recently had a roundtable through Foreign Affairs, Defence and Trade on the post-tsunami response and your agency was not there. We had the military people talking about their role and the medical aid—

**Ms Halton**—We must have lost our invitation!

**Senator MOORE**—Was it in the mail?

**Ms Halbert**—Defence actually sits on the Australian Health Protection Committee, as well as Emergency Management Australia, to try and coordinate across the different sectors.

**Senator MOORE**—I did not think of it, because it was a huge roundtable with aid agencies et cetera, but Health and Ageing—and particularly in relation to the immediate disaster issue—was not there. It is something that I will take back to that other committee and say, ‘For future exercises of this type, just be aware of that.’

**Dr Roberts**—We are also represented on the Australian Government Disaster Recovery Committee, so they might have been at that roundtable.

**Senator MOORE**—What do you do about that issue? That was something that was organised through another process. You are obviously aware that you were not there. Is that something that you then go back through your public sector interdepartmental—

**Ms Halton**—We will mention it to them.

**Senator MOORE**—You cannot be at everything, I know.

**Ms Halton**—We started the work creating this capacity to respond over four years ago now, and it came about because of some of my experiences when I was in Prime Minister and Cabinet. We are much more reflexively included these days at the very beginning, but every so often there is a little absence. I think sometimes people assume a series of things about Health and we get the phone call a bit late. As I say, this has improved extraordinarily significantly. Mary and I were having a conversation just the other night about the fact that it is not completely reflexive at the moment in some quarters.

**Senator MOORE**—We will take it up as well.

**Senator McLUCAS**—One of the key strategic directions of 2006-07 is to develop communicable disease surveillance systems to detect and respond to communicable disease threats. Does that include multiresistant golden staph, MRSA, both in hospital and in the community?

**Dr Roberts**—Is the question about community acquired multiresistant staph aureus or methicillin resistant staph aureus, hospital acquired infection? They are two quite different entities in how you respond and manage.

**Senator McLUCAS**—If you are going to develop systems to detect and respond to communicable disease threats, does that include multiresistant golden staph both in hospital and in the community? They are both communicable.

**Dr Roberts**—In looking at the communicable disease threats from a national perspective, we are primarily looking for things that have an impact that we can make a difference on, like vaccination and some of the very serious diseases, some that are problems to other countries and therefore are quarantinable diseases. Methicillin resistant staph aureus is a particular local problem for hospitals, and every hospital has its own surveillance system to determine whether they have increasing rates of infection caused by the hospitalisation process. We are aware of pockets of community acquired MRSA, particularly in Western Australia, and there

are groups in the community that are doing surveillance of those, one of which is the Australian government's antimicrobial resistance group that we provide some funding to.

**Senator McLUCAS**—ASPREN was expected to get $100,000 to expand its activities. Did that happen?

**Ms Halbert**—Yes, it did.

**Senator McLUCAS**—How is it going?

**Ms Halbert**—We understand that there are an additional 35 general practitioners who have expressed interest in joining ASPREN.

**Senator McLUCAS**—What is the total number of GPs?

**Ms Halbert**—There are 52 already, so that will be about 87.

**Senator McLUCAS**—It is still low, isn't it?

**Ms Halbert**—One of the issues for GPs, of course, is being able to fit this into their own work, but this is a significantly increased interest from the 52, so we are up to 80-something in the network.

**Senator McLUCAS**—Have you mapped them around Australia?

**Ms Morris**—The existing 52 we have mapped around Australia. One of the reasons that we are interested in increasing the number is to get better representation around the country.

**Senator McLUCAS**—Could we get a map of the total when you have mapped the total number?

**Ms Morris**—Yes, we can, of the total existing number. I am not sure we can map where the expressions of interest have been.

**Senator McLUCAS**—So they are just expressions of interest at this point?

**Ms Morris**—Yes, and to ASPREN, not to us per se. We do not actually have that information.

**Senator McLUCAS**—What is the time frame to get them through the expressions of interest and into the register?

**Ms Morris**—I am not sure that there is a set time frame per se, but ASPREN has been working very closely with the Royal Australian College of General Practitioners to try to increase the number of GPs. You do not need every GP doing it, just sentinel GPs. What we need is a reasonable distribution across the country. It is part of a large surveillance network. It has a role within that network, but it is not the only thing we would rely on.

**Senator McLUCAS**—And these expressions of interest have come from the college kicking off the recruitment process; the process has in fact started?

**Ms Morris**—Yes.

**Senator McLUCAS**—But it will be completed when the GPs have signed up.

**CHAIR**—I hope that is an indication that you have got to the end of your questions because we have got to the end of our time.

[8.02 pm]

**CHAIR**—We now move to outcome 10, Health system capacity and quality. Cancer Australia is part of that. Welcome again to those of you who are coming back.

**Senator CAROL BROWN**—I want to ask some questions about the smartcard initiative. Does your agency have a role, Ms Halton, in terms of the whole-of-government approach, because of the linkages of Health?

**Ms Halton**—It is interesting that you ask that question because I think yesterday morning, in the whole portfolio, we did have a brief discussion on this issue. I said at that point that it was my expectation, based on something that the secretary from Human Services said, that there would be some sort of process, but I did not know yet what it was.

I was sitting here yesterday afternoon, going through my in-tray, and I can report that I did come across a piece of correspondence suggesting that there is a regular process of what is, perhaps not quite correctly, titled purchasing secretaries where there is a discussion that the smartcard would be on the agenda for that particular meeting amongst the secretaries who have a policy responsibility for things that the Department of Human Services delivers. I do not know whether that constitutes 'role', but certainly that was the method of engagement that was being proposed. But in terms of responsibility, even policy responsibility is actually theirs.

**Senator CAROL BROWN**—How about I just ask some questions and we will see how we go?

**Ms Halton**—Not a problem.

**Senator CAROL BROWN**—When was the department made aware of the decision to scrap the smartcard initiative in Tasmania?

**Ms Halton**—We should be clear that the Tasmanian project was different from the smartcard. I think it is important we do not say that they are the same thing because they manifestly are not. I think there was a dialogue with us over a period about were they given the decision to go with a community-wide smartcard with that broader range of functions and whether it was sensible to continue. We were involved in that discussion for a period, so it was not a surprise to us. I could not tell you precisely when it was, but it goes back for some period and I was aware of it.

**Senator POLLEY**—But isn't it a fact that Minister Abbott said at the beginning that it was a national roll-out when the Tasmanian card program was instigated?

**Ms Halton**—Yes, he did. Exactly. The point is that the new decision supersedes that, so there is no point rolling out what would have been a much narrower range of functionality when there has now been a decision to take a broader sweep, if I can put it that way, with the smartcard. It made complete sense to us that you would not continue with that initiative in view of the broader scale that is being anticipated.

**Senator POLLEY**—Especially when it was not working in Tasmania and no-one was taking it up.

**Ms Halton**—That goes to the functionality that was associated with it. Essentially, it was out in front of the electronic health issues with which it was meant to connect. The decision that the government has taken—and, as I said, this is not our area—is about a broader range of entitlement related issues that will connect with this smartcard.

**Senator CAROL BROWN**—Are you aware of who made the decision?

**Ms Halton**—That would be a little difficult for us to speculate about. I know that there was a discussion between ministers. My assumption is that Minister Hockey took the decision. I am being told 'yes'. But I do know there was a conversation between ministers before it occurred.

**Senator MOORE**—Which division of your department looks after this area?

**Ms Lyons**—Health Services Improvement and there is an electronic health branch within that division.

**Senator CAROL BROWN**—To get back to the Tasmania smartcard initiative, were you aware of the take-up rate of the Medicare smartcard being so low?

**Ms Halton**—Yes.

**Senator CAROL BROWN**—Did you have discussions as to why that was?

**Ms Halton**—Yes, absolutely. That informed the broader policy decision in relation to the smartcard writ large.

**Senator CAROL BROWN**—How did you come to the view as to the reason why the take-up was so low?

**Ms Halton**—There was a whole series of things. Mr Shepherd can probably talk about the evaluation issues.

**Mr Shepherd**—There are a couple of reasons and they have already been alluded to. One was essentially around the policy and functionality of the card. The fact was the chip in the card did not offer a lot more functionality than the current Medicare card and therefore the view was that that was impacting on take-up.

**Senator CAROL BROWN**—Yes, I understand that, but how did you make that assessment?

**Mr Shepherd**—The leadership in the program was essentially from the Health Insurance Commission initially, then Medicare Australia and the Human Services portfolio. I understand that the project intelligence was gathered from Medicare officers on the ground and fed back through into Medicare Australia and the Human Services portfolio.

**Senator CAROL BROWN**—Do you know if they conducted surveys, because I think the figure is that it was offered to about 17,000 eligible customers?

**Mr Shepherd**—I understand that feedback was actually captured at the Medicare offices. In fact, last week at this committee Human Services reported that no formal evaluation had been conducted.

**Senator CAROL BROWN**—That is right, but what I am asking about is the assessment of why people were not taking up the smartcard. How was that information captured? Was that captured through a survey at the Medicare offices? Are you aware of that information?

**Mr Shepherd**—I think that is a question for the Department of Human Services.

**Senator CAROL BROWN**—How does the Medicare smartcard fit in with the proposed new access card?

**Ms Halton**—It does not, Senator, because the Medicare smartcard has been discontinued.

**Senator CAROL BROWN**—I will move to HealthConnect. Can you point to where HealthConnect is mentioned in the budget papers in the performance information?

**Mr Shepherd**—I think it is helpful to cross-reference against portfolio budget statements for 2005-2006 and then come forward to 2006-2007. You will see terminology such as 'information management' and 'leadership' in the information management agenda in the 2005-2006 agenda. You will see mention of building of a Health Information Network in 2005-2006. If you come over to 2006-2007, you will see, from pages 133 to 135, consistent language from 2005-2006 at the top of page 133:

- leading a national approach to more effective electronic management of key health information (ehealth) ...

And towards the bottom of page 133:

- facilitate and encourage the health sector to move quickly to electronic clinical communications ...

Then you will see a full paragraph on the role that the department has taken in leadership in e-health on page 135.

The evolution of the text between 2005-2006 and 2006-2007 represents the significant increase in momentum of the program over that calendar year. You will be aware of the establishment of the National E-Health Transition Authority and the acceleration of the standards agenda in this space. You may also be aware of the 10 February decision of COAG to accelerate the development of an electronic health record and to put in place the foundation elements of that program. The subtle change in text represents the upgrading and the focus of that program.

**Senator CAROL BROWN**—So HealthConnect itself, or the program, is not anywhere in the performance information on pages 140 and 141.

**Ms Halton**—It is not actually a program. We should be clear about that: HealthConnect is not a program. There were a series of projects that were funded historically. I think I talked about this yesterday morning. They were, in the early stages particularly, exploring the boundaries and the issues around electronic health. Essentially, we tested privacy issues that were to be managed; patient consent and doctor engagement; issues around transmitting messages; issues around nomenclature. I could go on and on with the list. We have moved now from the trial stage. I think I said yesterday that we have continued with a couple of projects, but we are now moving into an environment where we are looking to a national approach to e-health; not just funding a project in Tasmania or a project in Katherine but saying, 'How is it that you get the whole nation to engage with an electronic environment for health?'

**Senator CAROL BROWN**—Can you give me an update on what is happening with the HealthConnect trials in Tasmania?

**Mr Shepherd**—I gave a comprehensive update on progress in Tasmania at the last hearing, and at that time I flagged that by this hearing the intention was that the first HealthConnect service would be statewide in Tasmania. I am pleased to announce that the first HealthConnect service is now statewide in Tasmania and some 3,442 consumers have so far received a direct benefit from that service. Let me describe for you the nature of that service.

**Senator CAROL BROWN**—That would be good.

**Mr Shepherd**—Before the first HealthConnect service—which is called 'GP notification'—went live in Tasmania, if you were admitted to any one of the Tasmanian hospitals your doctor—

**Senator CAROL BROWN**—Sorry to interrupt. When did that go live?

**Mr Shepherd**—Progressively over the past year. I described it at the last hearing.

**Senator CAROL BROWN**—When was it completely statewide?

**Mr Shepherd**—It completed with the final implementation in the Royal Hobart on 31 March this year.

**Senator MOORE**—Was there a media release?

**Senator CAROL BROWN**—I do not think so.

**Mr Shepherd**—I am not sure. But the media release would have been generated by the Tasmanian—

**Senator MOORE**—The trial has been getting a lot of focus.

**Mr Shepherd**—Yes.

**Senator MOORE**—It is fairly significant that it hit the statewide 'liveness' on 31 March, isn't it?

**Mr Shepherd**—It is definitely on their website, but I am not sure of a media release.

**Senator CAROL BROWN**—GP notification: sorry, I interrupted you.

**Mr Shepherd**—Before HealthConnect, if you were admitted to the emergency departments or then admitted to the wards in any of the three major hospitals in Tasmania, your GP would only find out about that by word of mouth or because an admin clerk in the hospital had to contact the GP because there had been complications. The first HealthConnect service enables an automatic notification to the GP, advising that you have been admitted to hospital and your initial diagnosis. That becomes an impetus for communication between the GP and the hospital, especially if, for example, your medications have changed the day before and you have had an adverse drug event and ended up in hospital. The GP is able to get on the phone and alert Launceston General Hospital: 'There was a change in the drug regime yesterday. Is that why they've been admitted? This is the course of action. Here's their medical history.' It is starting that communication. The view is that this infrastructure will now be used to build a full NEHTA-compliant hospital discharge summary instead of communications bridging the gap between the primary care and the acute care sector.

**Senator CAROL BROWN**—How is the notification from the hospital to the GP communicated?

**Mr Shepherd**—The Commonwealth and state collaborated some time ago on some statewide infrastructure, which was tagged and named GPlinkED. The original notion of this infrastructure was to build a bridge between the acute care and the primary care sector. We have been able to leverage off that initial infrastructure and build the first HealthConnect service on top of it, which is highly advantageous from the state's perspective because the infrastructure has been developed statewide; therefore services are able to be developed and rolled out incrementally across the state.

**Senator CAROL BROWN**—There are three hospitals. How many GPs are involved?

**Mr Shepherd**—This is the great thing about using existing infrastructure and building on it, because every GP in Tasmania is linked to GPlinkED. Therefore HealthConnect is a new service over an existing communications link. We are endeavouring to enhance the communications so the level of clinical data that can go across that link can continue to build in such a way that it will be NEHTA compliant and therefore nationally compliant.

**Senator CAROL BROWN**—What other projects are happening in Tasmania?

**Mr Shepherd**—I do not have the details to hand, but I understand that Tasmania has just completed an expressions of interest process for other projects to be run in the state and that there will be an announcement soon on the nature of those projects.

The Tasmanian approach is a highly sensible one. It is an incremental implementation, delivering on priority electronic health communications as determined by their local professional groups and the state government in a way that is NEHTA compliant. In fact, it is highly likely that the Tasmanian implementation will become a reference site for NEHTA standards implementation because of the way, very aligned with the national standards agenda, that they plan to progress their implementation in the state.

**Senator CAROL BROWN**—How many other projects are we looking at?

**Mr Shepherd**—HealthConnect projects in Tasmania?

**Senator CAROL BROWN**—Yes.

**Mr Shepherd**—There is one HealthConnect project and a number of services being delivered under it. In the GP notifications, the first program I have told you about, there is an expressions of interest process that NEHTA built, and there will be an announcement soon by the Tasmanians. But you can anticipate that, as the NEHTA agenda rolls out, so too will the Tasmanian delivery. So, for example, referrals form an area where there is significant standards development, and you can anticipate that one of the first states to take up the NEHTA standard on referrals will be Tasmania.

**Senator CAROL BROWN**—Can you give me an update about what is happening in South Australia?

**Mr Shepherd**—The approach in South Australia has been quite strategic. We have worked in collaboration with the South Australian government to combine forces on our broadband strategies. You will be familiar with the Commonwealth program called Broadband for

Health. There is also a significant statewide strategy within South Australia which is looking at broadbanding and connecting government agencies. We have decided in South Australia, with the government, to work on that connectivity layer, to build the bridges between the different sectors of the health community and get the community communicating.

So far, of all health providers in South Australia, all public sector agencies are connected to broadband and 52 per cent of health providers outside the public sector are connected to broadband. Across that network, the plans are to run the discharge summary output of the OACIS program in South Australia. One of the great things about South Australia is that the hospital information system is a consistent, coherent system. There has been significant vision in the state over some time to achieve that. One of the big gaps between the acute and primary care sectors and nursing homes is the ability for providers out in the primary care sector to receive accurate, fast information when their patients are discharged. Now that we have a good connectivity layer in South Australia, the groundwork is in place to achieve that.

The other area where South Australia are the leader in the HealthConnect space is that they will pilot, on behalf of the other states and territories, a form of online care planning. The view is that the model—both the clinical model and the IT and the change management around it—that they develop around care planning will be a model that will be equally able to be picked up and adopted by other states and territories; a key issue, given our ageing population and the increased numbers of chronic diseases in all our states and territories.

**Senator CAROL BROWN**—Queensland?

**Mr Shepherd**—The Queensland program is not a statewide implementation program. The statewide implementation programs in the 2004 through to 2008 program of HealthConnect are in South Australia, the Northern Territory and Tasmania. However, Queensland was a lead state in the research and development phase of the HealthConnect program. The service was established in the north Queensland area around this whole issue of hospital discharge, but in particular they went a bit further and added, to the end of that program, organising at-home care for post-acute episodes. That has made major inroads, especially with the elderly that travel some great distances for surgery in the Townsville Hospital. It ensures that they are able to have their at-home care prearranged and communicated back to their community so that, when they get home, things are in order and the appropriate care is in place.

**Senator CAROL BROWN**—Northern Territory?

**Mr Shepherd**—Northern Territory is probably the shining star, Senator.

**Senator MOORE**—Mr Shepherd, the way you have been describing all the other states—

**Ms Halton**—Unremittingly positive, have you noticed? That is good.

**Mr Shepherd**—The Northern Territory project took a long time to start, to be honest. We had underestimated the enormity of the change management exercise that would be required, but the local stakeholders and the Northern Territory government—to their credit—and we took that journey of a long, patient approach to change management, and we really are now reaping benefits. The Northern Territory has a shared electronic health record service in place. As at 31 March, 7,000 people across the Katherine region have enrolled for the shared electronic health service and have a shared electronic health record. They also have what they

call point-to-point service, which is e-health communication between this point and that point. At the moment they are rapidly expanding that across the entire Top End.

The stakeholder acceptance of the program is extremely high. I have just returned from the Northern Territory last week, and I heard some amazing stories from particularly clinicians at the Katherine Hospital. You would be familiar with the fact that only weeks ago Katherine was under water. A number of the clinics, and the filing system at the Katherine Hospital, were cut off. The senior medical registrar told me and demonstrated to me what that meant in terms of their ability to have ready access to health records. The only health record that was available was the HealthConnect record that was held in the shared electronic health record service. It is detail but it is amusing: the reason why it was available was that it is on the second floor of the government building in Katherine. The first floor was flooded.

I think it demonstrates—and we have had a similar example from the New Orleans disaster in the United States—the absolute value of an electronic health record when you have major disaster scenarios such as we saw in New Orleans and to a far lesser extent in Katherine. But the floods there had a large impact in cutting off clinicians' access to important health information.

**Ms Halton**—If I can add to that, the experience in New Orleans is really interesting because the only people there to still have a health record are people who had electronic health records. What the insurers and a series of other people are doing for the other patients in New Orleans is rebuilding health records from electronic data. It is quite interesting. So, for anyone who did not have an electronic health record, they are now patching together the electronic sources of information. I was talking to my American colleagues about this only very recently. I think it is fair to say that in Katherine it was adventitious that the box was on the second floor, but nonetheless it would have been backed up somewhere else had it not been.

**Senator MOORE**—That was going to be my question about the information that is fed in. It is kept, but it is backed up somewhere safely away?

**Mr Shepherd**—That is right.

**Senator MOORE**—So even if your second floor had been flooded, you still would have been okay?

**Mr Shepherd**—That is right.

**Senator MOORE**—You would have lost all your hardware like anybody else.

**Mr Shepherd**—There is a common concept in IT called redundancy. It ensures that you have some backups of the primary source of data. In the Northern Territory the primary data is at Katherine, but it is backed up by a data source in—this scares me—the demilitarised zone within the Northern Territory government's IT system up in Darwin.

**Senator MOORE**—I am not even going to try and ask a question about that.

**Senator CAROL BROWN**—New South Wales: there was a trial there?

**Mr Shepherd**—The New South Wales government are progressing a program called Healthelink. That program went live in about March. I do not have the exact date. So far in

the New South Wales implementation there have been 400 records activated in that project. It is very early days in the project. It is a matter of weeks that it has been running, and we will be happy to keep you updated on the progress of that.

**Senator CAROL BROWN**—Thank you for that. Are you able to provide a full list of the funds committed to HealthConnect since 2001?

**Mr Shepherd**—Since 2001?

**Ms Halton**—This is HealthConnect trials? HealthConnect is an all-encompassing term, so, if we are talking HealthConnect trials, yes.

**Senator CAROL BROWN**—Yes.

**Mr Shepherd**—We can take that on notice.

**Senator CAROL BROWN**—Can you provide a list of funds committed to HealthConnect?

**Ms Halton**—We can tell you what we have been appropriated and what we spent, which goes to the full range of electronic health activities; yes, absolutely.

**Senator CAROL BROWN**—Can you give me that information now?

**Mr Shepherd**—I would need to take that on notice. The earlier program transitioned into an implementation program in 2004, so in a sense you are asking for information across two previous programs which were research and development, so I will need to take that on notice.

**Senator CAROL BROWN**—Are you able to provide me with any information about the funds allocated?

**Mr Shepherd**—I can tell you what the appropriation was for 2004-05 and 2005-06.

**Senator CAROL BROWN**—Okay.

**Mr Shepherd**—Program money for the HealthConnect project 2004-05 was $24,777,000. Sorry, Senator, I need to correct the answer, because you will note that in 2005-06 and then across to 2006-07 the program is not called HealthConnect. In 2005-06 program 9.2 is e-health implementation and in 2006-07 program 10.2 is e-health implementation. That is a correction to the record.

**Senator CAROL BROWN**—So in 2005-06 and 2006-07 the HealthConnect funding is under e-health.

**Mr Shepherd**—Yes, e-health implementation, program 10.2.

**Ms Halton**—To the pilots, plus all our other electronic health initiatives, yes.

**Senator CAROL BROWN**—Are you able to tell me, of the funds allocated from 2004 to July 2007, how much is actually HealthConnect funds?

**Ms Halton**—Pilots?

**Senator CAROL BROWN**—Yes. Can you give me that information?

**Ms Halton**—We can. We will give it to you on notice. We will have to disaggregate the pilots from electronic health more broadly.

**Senator McLUCAS**—Can we get both?

**Ms Halton**—Absolutely.

**Senator McLUCAS**—The disaggregated amount, over time.

**Ms Halton**—Absolutely.

**Senator CAROL BROWN**—I have an article here that talks about the National E-Health Transition Authority, quoting some funding that will be required for their programs, and I would like to get some confirmation of these figures. It is an article that was in the *Australian*. $53 million spent on developing a unique identification number for health care providers?

**Ms Halton**—That is a newspaper article, and I—

**Senator CAROL BROWN**—That is why I am asking you to confirm it.

**Ms Halton**—I have not got that and I do not know whether we have it with us. If you want to know what the government commitment is to any of those particular initiatives I am happy to talk about that, but I cannot comment on a newspaper article.

**Senator CAROL BROWN**—Okay.

**Ms Halton**—You need to identify it and we can talk to you about what the COAG allocation for that was.

**Senator CAROL BROWN**—Yes.

**Mr Shepherd**—On 10 February 2006, when COAG announced funding for individual health identifiers, health provider identifiers and clinical terminologies, the total package was a figure of $129.3 million, but of course that package was shared on a fifty-fifty or on an AHMAC cost share basis with the states and territories. I can give you the breakdown year by year for the total package or I can give you the breakdown year by year of the Australian government contribution to the total package.

**Senator MOORE**—Do you have that in a table form, Mr Shepherd, that has both so that we can see what the total expected expenditure is and what the Commonwealth allocation is?

**Ms Halton**—Yes.

**Mr Shepherd**—I can provide it to you, but the measure starts on 1 July, so the expenditure will be zero.

**Ms Halton**—We can give it to you on notice. We are happy to do that.

**Senator MOORE**—Over how many years?

**Mr Shepherd**—Three years.

**Senator CAROL BROWN**—That is for the unique identification number for health care providers, the unique patient number and the clinical term standardisation code, SNOMED. It is for those three elements you are talking about?

**Mr Shepherd**—That is right.

**Senator CAROL BROWN**—There are a number of other elements to the authority. What is the funding on those?

**Mr Shepherd**—Are you asking a question about what additional funding—

**Senator CAROL BROWN**—You have got funding information about those three elements I have just talked about. There are a number of other elements, I think another four elements: shared electronic health records, secure electronic transmission, national product catalogue, and supply chain. How would these projects be funded?

**Mr Shepherd**—That decision was made some time ago. On the date, the secretary may help me. But that actually is a decision about the total baseline funding for the National E-Health Transition Authority. I do not have the date in front of me. AHMAC's decision was to fund baseline activity to the value of $18.2 million over three years and, once again, the formula is a cost shared formula; the states pay 50 per cent and the Commonwealth pays 50 per cent. All of those other activities you were reading then—in fact, there are more, because there were 12 NEHTA initiatives—are all funded out of baseline funding for the National E-Health Transition Authority as a baseline work program, and the announcement of 10 February was of the new three initiatives out of COAG.

**Senator CAROL BROWN**—The $18.2 million is for the other elements.

**Mr Shepherd**—That is right.

**Ms Halton**—And the COAG stuff is on top.

**Senator CAROL BROWN**—On top; all right. And you will provide that information?

**Ms Halton**—Yes.

**Senator CAROL BROWN**—Given that Medicare Australia and the access card are also working on unique individual identifiers, is this a separate project or is the National E-Health Transition Authority's project linked in somehow?

**Ms Halton**—It is separate. There is an active dialogue going on at the moment about what efficiencies can be had across the two, but the access card is about access to health and welfare benefits and what the individual health identifier does is enable the records for a patient to be connected. We are quite conscious that people have a privacy concern in relation to their health records in particular; it is one of the things consumers have told us quite consistently. We need to be extremely sensitive and very careful about electronic health records. The idea of a health identifier is the key to connecting up the record between your primary care practitioner and perhaps your obstetrician, whomever it might be, together with whatever happens in hospital, and the access card is the process of ensuring that you are entitled to the payment of benefits. We are talking at the moment with Human Services and Medicare Australia about whether there is any common potential infrastructure. It is not clear whether there will be, but certainly the two projects, whilst we need to get value for money and ensure we do not duplicate, are different things.

**Senator CAROL BROWN**—My next question—you raised it there—is about privacy. It was not on the information that I read about the elements that the National E-Health Transition Authority was looking at, so can you update what is happening with that in terms of their work?

**Ms Halton**—Yes, there is a series of things happening on privacy. Firstly, AHMAC, which is the official heads of agencies group, has talked about health privacy on a number of

occasions. In fact, there was a decision taken at the last meeting that there needs to be a piece of work done on a coherent approach to electronic privacy. I talked earlier about the things we have learnt from the pilots and the issues around privacy. That work has not actually taken full form yet. I cannot speak for Human Services about what they are going to do in relation to access cards, but the key message for us in terms of health records is, firstly, that there has to be complete privacy and, secondly, people have to have an ability to be completely confident that their records will not end up in a place they do not want them to be. You want people you have enabled to have access to them—practitioners, whatever—to get access but you do not want them in any sense vulnerable to people who should not see them. In relation to the code that will govern that process, we have a series of requirements at the moment. The debate going on at the moment is about what form going forward the current arrangements should take.

**Senator CAROL BROWN**—Who is doing the work on privacy detection?

**Ms Halton**—Privacy is being auspiced by AHMAC itself. The E-Health Transition Authority have a responsibility to produce the standards, the technology and all that other stuff—the technical side of this—but, particularly, responsibility in respect of privacy is still resting very much with AHMAC and will go to ministers.

**Senator MOORE**—I am interested in the terminology, because for years we have been asking questions about HealthConnect—that has been the jargon, the terminology. I have had a quick squiz at the website, which I had looked at before, and I do not see that word anywhere. It is as though the terminology has moved beyond the issue. Is that deliberate?

**Mr Shepherd**—The website is a nice place to describe the logic, because if you logon to health.gov.au\e-Health you will find there is a complete portfolio of programs on that website, and one of those program tabs is the HealthConnect website, which will give you the up-to-date information around what is happening in the states and territories.

**Senator MOORE**—Which is all those trial things you have been telling us about?

**Mr Shepherd**—That is right. You will find a tab to the HealthInsite website as well—

**Senator MOORE**—Yes, I have that.

**Mr Shepherd**—which is another program that is run in my area. You will also find a tab to e-Health governance.

**Senator MOORE**—Yes, I have that.

**Mr Shepherd**—The rationale and the concept is that HealthConnect is one of a portfolio of programs that are run in the e-Health branch.

**Senator MOORE**—What is the parenting term? Is it 'e-Health'?

**Mr Shepherd**—The parenting term is the name of the program: program 10.2: e-Health implementation.

**Senator MOORE**—And it would be best to maintain that terminology?

**Mr Shepherd**—I think so, because then we can address the raft of programs that sit underneath that broad umbrella.

**Senator McLUCAS**—Can I get a progress update on the establishment of Cancer Australia, please.

**Ms Powell**—I am sure you are aware that the legislation to establish Cancer Australia has passed through parliament and received royal assent, so that body is legally established. The advisory committee has been announced by the minister. Funds for a range of programs to be managed by Cancer Australian were appropriated to Cancer Australia in the last budget, and that funding will begin on 3 July.

**Senator McLUCAS**—Just remind me about the structure of Cancer Australia. What sort of entity is it?

**Ms Powell**—It is a statutory authority, and staff are employed under the Public Service Act.

**Senator McLUCAS**—You said 'advisory committee', so it is not a board.

**Ms Powell**—No, it is an advisory committee.

**Senator McLUCAS**—Have they had their first meeting?

**Ms Powell**—No.

**Senator McLUCAS**—When is that proposed to be?

**Ms Powell**—A meeting has not yet been scheduled.

**Senator McLUCAS**—In relation to their deliberations, will the minutes of the meetings, for example, be public documents?

**Ms Powell**—I would not have thought so.

**Senator McLUCAS**—But there will be some sort of communication?

**Ms Powell**—Cancer Australia will publish an annual report.

**Ms Halton**—This is just my assumption, and we will see what happens, but I would imagine that when that group first meets one of the things they will be thinking about is how they communicate broadly about their activities. I would imagine that will be very high up on their agenda, and by the next estimates I imagine we will be in a position to give you some indication of what it is they have decided.

**Senator McLUCAS**—What sort of staff does the entity Cancer Australia have and what sorts of roles do the staff have?

**Ms Powell**—Staff have not yet been employed by the agency. That will be a decision for that agency once it starts rolling.

**Senator McLUCAS**—In this transitional period, what is happening now?

**Ms Powell**—In the transitional period, staff in the department are working towards establishing Cancer Australia. There is a whole lot of effort that will need to go into setting up bank accounts and various administrative arrangements so that it will be able to operate independently of the department.

**Senator McLUCAS**—We used to have the National Cancer Control Initiative. That was within the department, as I recall.

**Ms Powell**—It was separate from the department.

**Senator McLUCAS**—It was; pardon me. What has happened to that?

**Ms Powell**—Its functions have been subsumed by Cancer Australia and it has ceased to exist.

**Senator McLUCAS**—What funding was allocated to NCCI that has moved across to Cancer Australia, if in fact that is what has happened?

**Ms Powell**—NCCI was funded $800,000 per annum, and there is now a separation appropriation for Cancer Australia that more than covers that.

**Senator McLUCAS**—When did NCCI cease to exist?

**Ms Powell**—At the end of May.

**Senator McLUCAS**—Did they have their own finances and such?

**Mr Kemp**—There was a contractual arrangement with Cancer Council Australia. Cancer Council Australia subcontracted to Cancer Council Victoria, and the relationship was with Cancer Council Victoria. So in terms of the bank accounts, they were with Cancer Council Victoria.

**Senator McLUCAS**—Was there any need at the end of May to transfer funds anywhere?

**Ms Lyons**—No.

**Senator McLUCAS**—What happened to the staff from the National Cancer Control Initiative? Did they stay with Cancer Victoria?

**Mr Kemp**—Some staff did and other staff, as I understand it, sought other employment opportunities.

**Senator McLUCAS**—What was the total staffing component of NCCI?

**Mr Kemp**—That varied, because it had permanent and part-time staff. I think it was around eight staff.

**Senator McLUCAS**—That is eight individual people, but some of them would have been part time. Is that what you are suggesting?

**Mr Kemp**—Yes. I cannot give you a definite answer, but it was around that order.

**Senator McLUCAS**—What has happened to the work program of NCCI?

**Mr Kemp**—As part of the wind-up of the National Cancer Control Initiative, they provided a handover report to Cancer Australia. That report will be considered, as the secretary suggested, as part of its early deliberations and the establishment of a strategic plan.

**Ms Lyons**—The work that the NCCI did is not lost.

**Senator McLUCAS**—No; that is what I am tracking. Is it possible to get a copy of that report?

**Mr Kemp**—We can forward that to you.

**Senator McLUCAS**—Thank you.

**Senator POLLEY**—I have some quick questions on asbestos. I was told in answer to question on notice No. 1299 that the National Asbestos Research Working Group was supposed to meet in April and rank the applications for individual research grants.

**CHAIR**—Senator, do you have any questions on Cancer Australia?

**Senator POLLEY**—No. On asbestos.

**CHAIR**—That is not covered by Cancer Australia. I might let Senator Adams ask her questions about Cancer Australia and when we have finished with that we will move on to that other question.

**Senator ADAMS**—How long is the term of the advisory committee members?

**Ms Powell**—It is three years.

**Senator ADAMS**—Are they all then up for renewal or reappointment, the whole lot together?

**Ms Powell**—Yes.

**Senator ADAMS**—It is not staggered. I have had a number of letters from consumer groups. They are very agitated because there does not appear to be a consumer on the group. I am fully aware that one or two of the members that have been appointed have certainly been cancer sufferers, and probably could deal with that in their own right. But there is a very large group of consumers out there that feel they really would like to see that. It is something I am going to write to the minister about perhaps next time. I know that the committee has already been appointed, but it is something that the general community feels should happen. Also, I know there are a number of the different cancer groups that feel they are represented and others are not. That same issue came up out of our gynaecological roundtable. There are some on there from Breast Cancer Network Australia. I am a member of that too, but there is nobody there representing gynaecological cancer. So there are all these sorts of issues. I know that Cancer Australia is going to be able to deal with these. Whether you are still going to have umbrella groups hanging off it, I do not know, but it is something I thought would be good for you to know about.

**Ms Halton**—I am actually aware of that because a number of people have spoken to me about these issues. I acknowledge that for people who have had a passion for a particular cancer and they have been doing terrific work very often. They have been doing fantastic work. There is an understandable nervousness at the beginning of this process that: 'My particular cancer won't get a fair share.' I am very sensitive to that. I have to tell you that I think Bill Glasson, who is chairing this group, is particularly aware of it. I think it is difficult to give people an assurance that will make them feel completely comfortable until they actually see the group in operation.

What I think we can do, and if you would do this if you are talking to people, is to say to people that we are very aware of their concerns. Certainly I have discussed this with Dr Glasson. I think Professor Horvath has discussed it with Dr Glasson as well. So, yes, we are aware of that. It is completely understandable. I am very sympathetic to their concerns and we are going to do our level best with this group to make sure that their concerns are not realised.

**Prof. Horvath**—Can I just add that one of the things Dr Glasson and I have spoken about—and if you could help us, that would be terrific—is that these are not representatives.

**Senator ADAMS**—No, I realise that.

**Prof. Horvath**—These are people with expertise, there in their own right. We are certainly going to go a long way to ensure that it does not become a representative body or, you are right, we will have lost a lot.

**Ms Halton**—Absolutely right.

**Prof. Horvath**—We will do everything in our power to make sure that does not happen and that we do as much as we can to hear people.

**Senator ADAMS**—The thing is that there are so many people out there and there is so much expertise in the community that I would like to see the different groups of cancers actually be consulted and be in the loop. Just from Breast Cancer Network Australia, it is absolutely incredible the number of people there with advocacy roles that can help.

**Prof. Horvath**—One of the biggest problems—and, in fact, you are alluding to it—is the number of groups. One of the things that I hope we can achieve is to bring some of these groups together. The University of New South Wales has now opened a third prostatic cancer group; a second institute on the same campus. That is just so much waste of energy. So one of the things Bill really wants to do is to bring all of these people together and to be as inclusive as possible.

**Senator ADAMS**—That is very good. Thank you very much.

**Senator MOORE**—Can you clarify where a question about asbestos research goes? In my mind it was linked to the cancer elements, so I thought it would be asked here. But obviously from the response before it actually goes into somewhere else—is that right?

**Ms Powell**—Yes. It was part of the Strengthening Cancer Care initiative managed by the NHMRC, and that would be where you would direct your questions.

**Senator MOORE**—I will put it on notice. I have a general question about the response to our cancer inquiry. Is there work continuing on that one? A few of us in this committee were members of that cancer inquiry so we feel quite close to it, and we are still waiting for a response.

**Ms Powell**—Yes, I think you can anticipate that a response will be tabled shortly.

**Senator MOORE**—I will ask again next time, if it has not turned up.

[8.56 pm]

**CHAIR**—We will move now to outcome 5, Primary care.

**Mr Eccles**—Before we start, Senator Polley asked earlier in the day about what localities in Tasmania are considered to be districts of workforce shortage. I have been given the notes from the relevant area that say, ‘Large sectors of Tasmania are considered to be districts of workforce shortage and we are able to provide you with this information.’

**CHAIR**—Thank you, Mr Eccles. Are there questions on outcome 5?

**Senator POLLEY**—These are to do with a chronic disease management program. Are there figures available for the years 2005 and 2006?

**Mr Eccles**—Yes, there are. We can give you a monthly breakdown up to March 2006 for the uptake of the new chronic disease management items.

**Senator POLLEY**—That would be good. Thank you.

**Mr Eccles**—Would you like me to read those into the record?

**Senator POLLEY**—Are they very lengthy?

**Mr Eccles**—No, there are monthly figures. For the general practice management plans the figures monthly, from July 2005 through to March 2006, are: 23,581 in July, 53,872 in August, 55,118 in September, 55,007 in October, 69,837 in November, 61,281 in December, 44,575 in January 2006, 53,646 in February and 62,747 in March, which is a total of 479,664. Would you like me to do the same thing for the team care item?

**Senator POLLEY**—That would be helpful. Thanks.

**Mr Eccles**—Again, for July through to March: 4,206 in July, 11,610 in August, 14,674 in September, 16,709 in October, 23,768 in November, 22,525 in December, 18,249 in January, 24,685 in February, 30,545 in March 2006; a total of 166,971.

**Senator POLLEY**—Were there more of the CDM items? Was that higher than you predicted?

**Mr Eccles**—It is certainly within our expectations. The uptake to date has been strong and, while in the early days it did exceed some of the forecasts, it is too early to predict the long-term trends; but it is certainly within what we expected to be the case. We are pleased with the uptake.

**Senator POLLEY**—What was the actual cost to Medicare versus the expected cost?

**Mr Andreatta**—To March 2006 a total of $74.255 million was paid out in Medicare benefits for the two items Mr Eccles mentioned—the care plan and the team care arrangements.

**Senator POLLEY**—Was that more than you were expecting?

**Mr Andreatta**—Again, as explained, it is too early to tell at the moment. The take-up did exceed expectations in the earlier months. It is now flattening out. At the end of the year we will know more about how we are tracking against those original estimates.

**Senator POLLEY**—What is the breakdown of the numbers of the allied health and dental services provided at the cost of this by the relevant Medicare number versus the expected?

**Mr Andreatta**—For what period?

**Senator POLLEY**—The same period; for 2005-06.

**Mr Andreatta**—There are three different dental items in the schedule. There is 10975, and I can give you the total number of services for the period 1 July through to 31 March this year.

**Senator POLLEY**—Right.

**Mr Andreatta**—I do not have a breakdown by month, unfortunately.

**Senator POLLEY**—Can you provide that for us?

**Mr Andreatta**—We can. Would you like the totals now?

**Senator POLLEY**—Yes, that would be good.

**Mr Andreatta**—For 10975 the total number of services for that period was 1,625; 10976, the total number of services was 1,910; and 10977, the total number of services was 23.

**Senator POLLEY**—What were the out-of-pocket costs for the AHS?

**Mr Andreatta**—For that AHS?

**Senator POLLEY**—Yes.

**Mr Andreatta**—We do not have an aggregate out-of-pocket expense. We can break them down into each of the items for that period, if you wish.

**Senator POLLEY**—Thank you.

**Mr Andreatta**—Do you want me to go through these or would you like me to just table this?

**Senator POLLEY**—Can you table them?

**Mr Andreatta**—I can.

**Senator POLLEY**—Thanks. Is the AHS part of this program under-budget?

**Mr Andreatta**—The amount paid to 31 March this year was $15½ million in Medicare benefits. The amount estimate was $39.4 million. What we are seeing at the moment is a steady take-up of most of the allied health items, so over time, as the new chronic disease management items have come in, we have seen a corresponding increase in the usage of or the referral to these allied health items.

**Senator POLLEY**—What about with the dental health part of the program? Is that also under-budget?

**Mr Andreatta**—Certainly the dental items are the ones that are not performing as well. The department is in discussions with the Australian Dental Association to try and encourage dentists to participate in this scheme.

**Senator POLLEY**—What are the problems? What has been happening?

**Mr Andreatta**—The feedback we are getting is that dental providers may not see the level of benefits provided under this scheme as being enough to encourage them to participate.

**Mr Eccles**—We are finding out more as we hold the discussions with the Dental Association, as well. We are trying to get to the bottom of it.

**Senator MOORE**—How long has that particular part of the program been in operation?

**Mr Andreatta**—For the dental?

**Senator MOORE**—For the dental.

**Mr Eccles**—Since July 2004.

**Senator MOORE**—And its expected life at this stage is?

**Mr Eccles**—2007-08. It is in the four-year estimates.

**Senator MOORE**—It has already been identified as one where the take-up is not as high as you would hope.

**Mr Eccles**—That is right.

**Senator MOORE**—We are now halfway through the program?

**Mr Eccles**—Halfway, yes.

**Senator MOORE**—And the ongoing review process involves consultation with whom? Is there an ongoing review process in that program? Is there a monitoring group that is watching that program to see how it is going?

**Mr Andreatta**—Certainly we monitor the item uptake on a monthly basis within the branch. Wherever we see that there is a problem—for instance, the dental items—we are taking some action and discussing that with the relevant stakeholder group.

**Senator MOORE**—Is that a formal consultation with the relevant stakeholder group?

**Mr Andreatta**—In most instances it is. You need to factor in the new chronic disease management items that have come in—1 July. They obviously have had a positive impact on the usage of these allied health items and we would expect, over the next year or so, the usage of those items to increase even more.

**Senator POLLEY**—The minister in the 12 May media release regarding Medicare support for people with type 2 diabetes said that this initiative is expected to expand and include:

> ... group intervention services provided by dieticians, diabetes educators and exercise psychologists on referral from GPs.

Why was this new initiative announced only a few days after the budget?

**Mr Eccles**—That was a decision of the minister. It was something that was within his delegation, and I cannot comment on the reasons why. The nature of the item is that it is something that the minister himself has the delegation to make a decision about.

**Senator POLLEY**—How long had the initiative been in the planning?

**Mr Eccles**—This is the group item that the minister announced in May. This is the group intervention item under the allied health and dental care initiative. It is for use by dieticians, diabetes educators and exercise psychologists. I understand which program you are talking about, but what was your question, Senator?

**Senator POLLEY**—What I said was that the initiative was actually announced only a few days after the budget. I wondered how long the department was aware of it before the minister's announcement.

**Mr Eccles**—It is not appropriate for me to go into great detail, but it was something that had been entertained for a short amount of time. The reason it was announced independent of the budget was that the nature of the expenditure was such that it did not require a formal budget process.

**Senator POLLEY**—Why were people with type 1 diabetes not eligible for this item?

**Mr Eccles**—I think the focus of this is very much on the lifestyle aspects of diabetes. The focus, therefore, is on type 2 diabetes, which is the type of diabetes that is most aligned with lifestyle risk factors. This was all about addressing those lifestyle risk factors, where dietitians, diabetes educators and exercise physiologists are most likely to be able to have an impact. It is a physiological factor. Diabetes type 2 is a condition that manifests itself from lifestyle problems like the ones I referred to.

**Senator POLLEY**—How many people with diabetes will be eligible for this item?

**Mr Eccles**—Again, this is just a projection, but we expect to benefit in the order of 20,000 people per year. I think that is consistent with the minister's press release on this matter.

**Senator POLLEY**—What happens if there are more than 20,000? Will they miss out?

**Mr Eccles**—No, they will not.

**Ms Halton**—That is merely our estimate of utilisation, but if more people rock up it is not a problem.

**Mr Eccles**—It is funded through the MBS.

**Senator MOORE**—Do we know how many people identify with diabetes 2 in the population? Is that the kind of data that is kept in your area?

**Mr Eccles**—There is no doubt that people in the department would have a good handle on how many people have diabetes.

**Senator MOORE**—That we know?

**Mr Eccles**—Yes.

**Senator MOORE**—Because the big issue is that people do not know they have it. Have you found the data?

**Ms Halton**—It is in the budget release.

**Mr Eccles**—It is estimated that approximately seven per cent of the adult Australian population has type 2 diabetes.

**Senator MOORE**—How many is that?

**Ms Halton**—What is seven per cent of 20 million, Mr Eccles—minus the children?

**Mr Eccles**—It is about 140,000.

**Senator MOORE**—So a significant number of people in the community are supposed to have this condition.

**Ms Halton**—Yes.

**Senator MOORE**—Twenty thousand, to me, seems to be quite a small number. On what basis does the department propose that this particular program of chronic support, because it is about support—

**Mr Eccles**—The figure is based on the uptake to date of the dietitian items. We use that to extrapolate the number of people who—

**Senator MOORE**—On the expectation that people are already accessing services, they would be likely to continue to access more. Is that the basis?

**Mr Eccles**—That is right.

**Senator POLLEY**—How many people with diabetes currently get GP care and allied health services through the chronic disease management program?

**Mr Eccles**—Through dietitian services or just in general?

**Senator POLLEY**—In general, yes.

**Mr Eccles**—We do not have that figure. We do not classify people by the nature of their disease, because the focus is on risk factors.

**Senator POLLEY**—What is the definition of 'group intervention services' and how many people are in that group?

**Mr Eccles**—It is factored on how many are likely to attend a group session. I think we are contemplating that it would be a minimum of three and I do not think we have set a maximum. It really is as it emerges, as the demand pushes.

**Mr Andreatta**—The development of that item is only in its early stages. We will be consulting with the relevant allied health professionals to work out the actual clinical content of that item, or those items, so it is a little bit early to say that it will be three or it will be four.

**Senator POLLEY**—When will this item be introduced? What is your time frame?

**Mr Andreatta**—It is likely to start in 2007. It was not planned for this year. Development work has commenced, and that will go on for the rest of this year.

**Senator MOORE**—With the diabetes program, has there been any particular attempt to have a look at the take-up of Aboriginal and islander people?

**Mr Eccles**—I am not sure that we differentiate in our data.

**Senator MOORE**—Can you have a look at that for me?

**Mr Eccles**—We certainly will.

**Senator MOORE**—Particularly with the chronic disease stuff, the information that is seemingly there is that, in the Aboriginal population, there are some particular conditions that are—

**Mr Eccles**—The program is certainly available to Indigenous people. We also have some targeted Indigenous items and we are doing more work in that area, but I am not sure whether the general data we collect on these items provides us with the capacity to differentiate.

**Ms Halton**—As you know, we now have the Indigenous identifier throughout Australia. Whether or not there is an overrepresentation of Indigenous people in this group is probably an analysis we can do. But it is not my expectation, knowing the way this data works, that we would be able to say how many of these patients are Indigenous. As you would well understand, there is a proportion of people in the community—Indigenous people—who tend to attend AMSs, which are funded in a different way in any event, so it is a bit difficult.

**Senator MOORE**—What about promotion strategies for some of these particular chronic disease issues in the Aboriginal community? Some of the programs that you have identified in your area of chronic disease affect all Australians, but there is some anecdotal evidence that they are particularly relevant for people from an Aboriginal and Torres Strait Islander background. In relation to the PR strategies that are linked to some of the programs, particularly encouraging people to take up a range of medical services, do you have a strategy for Aboriginal people?

**Mr Eccles**—I will answer that in two parts, in terms of Indigenous issues associated with chronic disease. With all of these items, we discuss with the profession the best ways to optimise uptake and we use the Divisions of General Practice and other means to make sure that as many practitioners as possible are aware of the programs. I do not know whether or not we have anything that is specifically targeting cultural presentations to Indigenous communities, but most of the education and awareness-raising we do is directed to the practitioners rather than the population.

**Ms Halton**—To the extent that we have promoted something, particularly to Indigenous people, it would be the health check. It would be my expectation that that one is easier to understand. I do not mean that to sound terrible, but for any member of the community the notion of a health check is easier to access than a kind of long description of chronic disease. My expectation is that practitioners who actually do the health checks on relevant people will find a group of people for whom there is a necessary intervention, and this actually provides a clear pathway for those people, having identified pre-diabetes or whatever the issues might be.

**Senator POLLEY**—We are ready to move on to the National Health Call Centre Network.

**Mr Eccles**—All premiers and the Prime Minister have signed a heads of agreement committing to work towards the establishment of a national health call centre, and that heads of agreement provides the broad parameters for the governance structure and the nature and types of activities that are going on. There is a commitment by all states and territories, as articulated through their premiers.

**Senator POLLEY**—Is it possible that it is going to be based on the Tasmanian model that they have now?

**Mr Kennedy**—It is more likely to be based on the existing services from West Australia and the Northern Territory. They have models that have been in place for some time and they have worked quite successfully. Also, HealthFirst, I think it is, in the ACT has operated successfully for five years. It will probably be based on those sorts of models.

**Mr Eccles**—It is certainly not a reflection in any way that the Tasmanian arrangement is viewed as being of a second order. It is a different type of service than the ones being—

**Senator POLLEY**—Some would suggest that it delivers better outcomes for patients.

**Mr Eccles**—The Tasmanian model is broader than a call centre; it also links in with service directory and general practice services. The one thing we can say is that in Tasmania, as a result of the national health call centre, there will be no lessening in the standard of services available to any Tasmanian or to any person across Australia. The whole focus of it is to

provide services at the very least equivalent to—if not better than—what people get from local or state based call centre activity at the moment.

**Mr Kennedy**—I might add that we are in discussions with the Tasmanian officials about how the GP Assist line might fit in best with the national health call centre. Those discussions are ongoing and we expect that they will result in that service being successfully assimilated with the National Health Call Centre Network.

**Senator POLLEY**—Is the project ready to roll out?

**Mr Eccles**—It is expected that the first calls will be taken by July 2007, with national coverage within four years. The focus of work at the moment—and there is a lot of work going on, both with the Commonwealth and in all states and territories—is on establishing the company that is going to auspice and let the contracts and the tendering for the national call centre. We are in very detailed daily contact with states and territories on this, with the first calls in July 2007, and we are on target to achieve that.

**Senator POLLEY**—Is that the time frame that you expected?

**Mr Eccles**—It was the time frame that the premiers and Prime Minister indicated was optimal.

**Senator POLLEY**—So tenders at this point in time have not been called for?

**Mr Eccles**—No. The process will be to establish the company first and then let that company oversight the tender process. We expect the tender process to be later this calendar year.

**Senator POLLEY**—How will the tender be assessed and who is going to assess it?

**Mr Eccles**—The states and territories and the Commonwealth are working together to create a company. It will be the company which will be funded and established by the Commonwealth and the states and they will oversight the calling for tenders and the assessment of the tender process.

**Senator MOORE**—Is this a common model? I have not heard of this.

**Mr Eccles**—I do not think it is an uncommon model.

**Senator MOORE**—So you form a company of the states and Commonwealth.

**Ms Halton**—NEHTA.

**Mr Eccles**—There are slight differences to it—

**Ms Halton**—That is the National E-Health Transition Authority. The Aged Care Standards and Accreditation Agency is a company, too.

**Senator MOORE**—I just wanted to have a look at it.

**Senator POLLEY**—Will the tender also include supplying mental health services or will this be done separately?

**Mr Eccles**—No. As part of the announcement, COAG agreed that there would be a specific mental health functionality, for want of a better term, to the call centre. There was an

explicit commitment by COAG to increase the pool of funding that was originally envisaged to facilitate that.

**Senator POLLEY**—Who is going to develop the website that supplies information for the workers?

**Mr Eccles**—I imagine the successful tenderer would be doing that.

**Mr Kennedy**—That is right. The protocols that will be used for the telephone calls and through the website will be based on a series of nationally agreed protocols, to be agreed between the states and territories and with consultation with the profession before they are—

**Senator POLLEY**—Do you have those protocols in place?

**Mr Kennedy**—No. That will probably be the work of the company when it is established. That will be part of the work that it will undertake in terms of bringing the states and territories together.

**Senator POLLEY**—How will the data on this website be varied and updated?

**Mr Eccles**—It is a long way too early on that. Maybe at the next hearing, or even probably the February hearings, we will be able to give you a better steer on that, once the company is up and running.

**Senator POLLEY**—What funding has been allocated for the project?

**Mr Eccles**—A total of $176 million over five years, of which the Australian government is contributing $96 million and the states and territories are contributing the balance, which is $80 million. On top of that, there is a $20 million commitment for the mental health functionality.

**Senator POLLEY**—How many staff will be needed to operate the call centre?

**Mr Eccles**—Again, it is too early. The tenderers will be putting in what they envisage to be an appropriate staffing profile as part of their tender bid.

**Senator POLLEY**—But you would have some sort of indication of the number that you would expect.

**Mr Eccles**—We can get a good sense from how it is working in WA and other places.

**Mr Kennedy**—On the modelling to date, we expect that about 250 nurses would staff the call lines, probably in three locations across Australia.

**Senator POLLEY**—Where are the locations?

**Mr Kennedy**—It will depend. That will be part of the agreements that we will have to work through with the states and territories and through the company.

**Senator POLLEY**—Where will the nurses come from?

**Mr Eccles**—It is one of the perennial issues around the health workforce. The nature of call centre work is such that often it is appealing to nurses who are not otherwise engaged in nursing activity. While it is way too early to even contemplate how it might work, international and domestic experience shows that there are some nurses who are involved in call centre work who work from home through various sophisticated computerisation. That

has been shown to have no lessening at all of standards. It is too early obviously to forecast what the shape will be.

**Senator POLLEY**—When will the hiring and training begin?

**Mr Eccles**—We certainly expect it to be in time to have the first calls by July 2007. That will be potentially optimising staff who are working for existing call centres.

**Mr Kennedy**—It is a staged roll-out so it will be over four years from 2007 to 2011, and the recruitment will be along the same lines. States and territories would come on at different times in that four-year period.

**Senator POLLEY**—I am sure you have thought about this: it is a little way off yet, but what are the measures that will be in place to monitor the quality control of this service?

**Mr Eccles**—I think we can learn an awful lot from the existing activity and the sorts of reports that the call centres provide to existing contractors like the Western Australian government and the Tasmanian government. There are some well-established indicators and reporting protocols that current call centres go through. It is a bit too early to specify, but there is a lot of information around on that. We do not have a sense of exactly how we are going to measure success, but we will obviously be using the international and domestic experience with call centres to date.

**Senator POLLEY**—You have already said that the service will not be based on the Tasmanian after-hours services, which leads me directly—

**Mr Eccles**—We might just clarify that.

**Mr Kennedy**—The Tasmanian service is basically an after-hours service, so it does not operate 24 hours a day. It has nurse triage and then doctor triage. The national health call centre will offer nurse triage, but there is still a capacity for callers to be referred to an after-hours doctor triage service. The Tasmanian model will be interesting in terms of how it might be rolled out around Australia.

**Senator POLLEY**—If you are not going to use the basis of Tasmania, how are you going to link patients directly to GPs and hospital services? How will this integration be done, given that there is a commitment not to undermine these services?

**Mr Eccles**—It is too early to say, but, in the assessment of the tender, the Commonwealth, states and territories will make it very clear to the company that we would expect that there will be absolutely no lessening of the services that are currently available through call centre networks. This is all about improving the current situation.

**Senator MOORE**—This is a COAG project, isn’t it?

**Mr Eccles**—It had its genesis in the COAG process.

**Ms Halton**—It had its genesis a long time before that, but it emerged in the COAG process.

**Senator MOORE**—It got the COAG imprimatur.

**Ms Halton**—That is a nice way to put it.

**Senator MOORE**—How is it going to be evaluated? You are forming a company to give out the tender to the company that is going to do it. Who is going to oversight it in terms of the management model?

**Mr Eccles**—Each state and territory—and these are the things that we are talking about to the state governments at the moment; that is the stuff that is exercising our effort right at this moment—will be considered to be a shareholder and will, for all intents and purposes, own the company. There will be a mechanism in place so that the shareholders have appropriate control of the broad strategic directions and activities of the company.

**Senator MOORE**—Like a board of directors?

**Mr Eccles**—The board of directors is a skills based board; it is not a representative board. That is contained in the heads of agreement that was signed off by the leaders.

**Mr Kennedy**—Each of the states and territories will have a funding agreement with the company so that we will be able to monitor performance through those funding agreements.

**Mr Eccles**—We expect to have the governance arrangements locked down in the next few months.

**Senator MOORE**—Getting that governance agreement would be more or less one of the first steps?

**Mr Eccles**—Absolutely, and that is what we are doing at the moment. We are really focusing on getting the governance structures right. Some of the next level considerations will be around what our service expectations would be. The first thing is to get the company established and the governance things in order.

**Senator ADAMS**—Having been on the steering committee of Health Direct, can you tell me how it is going to change with the national focus?

**Mr Eccles**—It is too early to say—other than, as I mentioned, that there will be no lessening of the quality of service for the people of Western Australia. It could well be quite seamless for the average punter who is using the service.

**Senator ADAMS**—It is certainly a great service. It has improved over time. As far as the quality goes, and any of the evaluation, it is certainly well in hand.

**Mr Eccles**—Yes, and we are working very closely with Western Australia to make the most of their lessons to date.

**Senator POLLEY**—In April, the minister announced that the government was subsidising the employment of practice nurses in all urban areas of workforce shortage. This is to be funded as part of the $80 million Strengthening Medicare practice nurses initiative, which seems to indicate that this program is under budget. How many additional GP practices will be eligible for this incentive?

**Mr Andreatta**—Six hundred and fifty.

**Senator POLLEY**—Can you give me those figures state by state?

**Mr Andreatta**—No—but we could provide them.

**Senator POLLEY**—That would be good, thank you. My understanding is that the ACT was not included. Is that right? If not, why isn't it?

**Mr Andreatta**—The selection of eligible areas is based on workforce shortage. I do not have the information here to determine whether that area was included or not.

**Senator POLLEY**—It was not in the minister's media release. Could you take that on notice for us?

**Mr Eccles**—Yes, we will check that.

**Senator POLLEY**—How much will the expansion cost?

**Mr Andreatta**—That particular incentive is within the current budget of $79.5 million.

**Senator POLLEY**—How much of the $80 million allocated has been spent to date? Has there been an underspend?

**Mr Andreatta**—To date—that is, to 31 March—$15.6 million. That is for 2005-06. The allocation was $20.4 million.

**Senator POLLEY**—So there is an underspend. Why is that?

**Mr Eccles**—It is a bit early to say. There is still a little while to go. The financial year is not over.

**Senator MOORE**—Is it your assessment that you are on track?

**Mr Eccles**—I think we are. I think it is within our ballpark of expectations.

**Senator MOORE**—That is your view—your assessment?

**Mr Eccles**—Yes.

**Senator POLLEY**—So you expect to spend a fair bit of money in the next three or four weeks?

**Mr Eccles**—I do not have the figures here.

**Senator POLLEY**—Sorry, that expenditure was only to March, so you have three months. That is all I have on that.

**Senator MOORE**—Is the RRMA review yours?

**Mr Eccles**—Yes, it is.

**Senator MOORE**—That is a relief. We intend to ask just general questions on RRMA. A discussion paper was released in March and submissions were due by the end of April. Is that for the RRMA process?

**Mr Eccles**—That is right.

**Senator MOORE**—When do you expect that the report will be finalised?

**Mr Eccles**—We do not have a particular idea of when the report is going to be finalised. The process of undertaking the review has taught us a number of things; a number of interesting things have come up. It comes down to the fact that a geographic indicator relies very much on the assumption that rurality is in itself a measure of need.

**Senator MOORE**—Can you run that phrase back? What is a reflection of need?

**Mr Eccles**—Rurality itself is a reflection of health need. We all know there are some exceptions to that rule—that some rural areas are quite comfortable and that some areas that are not considered rural are in quite a difficult stage. At this time, we are not altogether convinced that any alternative geographic indicator is going to be better than RRMA. We are still looking at these issues, and it is important that we do it well.

**Senator MOORE**—We have a copy of the minister's media release of September 2004 which said that bulk-billing incentives were going to continue as an extension of the program. It said the process would be completed by 2006, when these incentives will be reviewed. The recent budget continues these incentives through to July 2008, so we have moved it forward a bit longer with a review of the parameters of the program in the 2008-09 budget. Does that indicate that the RRMA review will not be completed until 2008?

**Mr Eccles**—I do not think it does. I think it just indicates that, by then, there will be a review of the parameters of that program.

**Senator MOORE**—So, from your perspective, they are not linked—they are separate?

**Mr Eccles**—I am not aware. I do not think they are, but I was certainly not around when—

**Senator MOORE**—But the work within your area on the RRMA review is proceeding with the intent to complete this level in 2006?

**Mr Eccles**—I am not sure about the link between the RRMA review and the review of the bulk-billing incentives.

**Senator MOORE**—But the RRMA review is linked?

**Mr Eccles**—There is no link.

**Senator MOORE**—So you expect that the RRMA review will be completed in 2006?

**Mr Eccles**—We do not know. That is a call for the government. We are doing more work on the whole range of options about the best way to make sure that our programs get to the right places—almost a continuous improvement. But to date we have not been able to find another geographic mechanism that potentially does not just replace old anomalies with new ones.

**Senator MOORE**—There has to be something better.

**Mr Eccles**—It comes down to the fact, as I said earlier, that relative rurality itself is not always an indicator of health need. While it often is an indicator of health need, we all know rural towns that are doing well and larger centres that are doing it particularly tough. If we put in a replacement RRMA, we need to make sure that it deals with all those things.

**Senator MOORE**—The RRMA process is the model on which other programs are based, isn't it?

**Mr Eccles**—That is right.

**Senator MOORE**—Everything that is done in terms of assessment—

**Mr Eccles**—Not everything.

**Senator MOORE**—A large percentage of what is done in the health portfolio in terms of distribution and so on is based on the RRMA model.

**Mr Eccles**—It is certainly a percentage. We also have other measures like areas of workforce shortage. There is ARIA, GP ARIA and ARIA+. The challenge is to put in place the locational framework that is best suited to the intention of the program. If it is about workforce, then it means looking at issues from workforce to population. Workforce need is probably the best area. If it is to do with targeting a particular disease or illness, then there is probably another measure that might help us target it. RRMA has been used quite a bit, but over the years we have also used other things.

**Senator MOORE**—But bulk-billing data is based on RRMA?

**Mr Eccles**—Yes, that is right.

**Senator MOORE**—I probably will come out of this focus and ask for a little bit more definition on that, but I will not take up time now. I am trying to get in my mind a bit of a model of the different programs and the bases of them. I am sure you do this work anyway, and put them on top of each other and see how they match, but I will not ask you to do that now.

**Mr Eccles**—Thank you.

**Senator MOORE**—I have a list of requests for figures on an old favourite—doctors in outer metro areas.

**Senator McLUCAS**—We have put a heap of questions on notice. They are just the traditional questions that we usually ask. But could you update the committee on how many full-time equivalent doctors have moved into the outer metropolitan area to date? There is a whole range of different reasons why incentives can be applied.

**Mr Eccles**—You are after the number of doctors who have moved to outer metropolitan areas? I can certainly give you the change in urban and rural FTE.

**Senator McLUCAS**—So the program for all doctors in outer metropolitan areas is in outcome 12 now?

**Mr Eccles**—I think it always has been.

**Senator McLUCAS**—Are workforce shortage grants in this area?

**Mr Eccles**—I am not aware of particular grants, but certainly the workforce area looks after workforce shortage and the programs that are designed to move practitioners into those.

**Senator McLUCAS**—I am actually reading from an email from a doctor who is suggesting that there were grants given to bulk-billing clinics that opened in areas of workforce shortage. Is there any program that—

**Mr Eccles**—Not that I am aware of, no.

**Ms Halton**—No, I am not aware of those. Is it from South Australia?

**Senator McLUCAS**—No.

**Mr Eccles**—I can tell you there are no grants linked to bulk-billing clinics. There are relocation grants available.

**Senator McLUCAS**—But that is to do with outer metro.

**Mr Eccles**—Yes, that is right.

**Ms Halton**—Yes, and there are some grants to people depending on their time there and their training and retention grants. Is it New South Wales?

**Senator McLUCAS**—No, it is Queensland. The assertion is that a grant of $200,000 was given, conditional on operating a surgery for a year. But that does not ring any bells for me.

**Mr Eccles**—Is it an after-hours—

**Mr Learmonth**—There was a proposal some time ago where a number of states were offered, I think, around $200,000 for after-hours GP clinics attached to emergency departments. Queensland was an option.

**Senator McLUCAS**—Clinics attached to hospitals?

**Mr Learmonth**—Yes, bulk-billing clinics for after hours.

**Senator McLUCAS**—Was the money allocated to a private clinic or to the hospital?

**Mr Learmonth**—To a private clinic. They were not strictly bulk-billing, but they were GP clinics attached to emergency departments. From memory, there were proposals around Redcliffe, Caboolture, Toowoomba and Townsville.

**Senator McLUCAS**—I might come back to you on that later.

**Senator MOORE**—I have a clarification question about where primary care fits in the new structure. There have been some questions about program changes and so on. It is going to be in program 5. Are there going to be any changes with program 5 or is it going to be largely as it is?

**Ms Halton**—It will be largely as it is. As I said, we have not finalised all of this yet. I can conceive of some changes at the margin, but bodily change, no.

**Senator MOORE**—Can we ask the same question about this one, about what programs are going to come under the new program. Give us a map when you have finished it.

**Ms Halton**—Indeed, we will. We will give you a detailed articulation of what is where. We will give you the program structure, we will give you the organisational structure and then we will give you—although it will not be completely exhaustive—as long a list as we can of where you can find what.

**Senator MOORE**—That would be wonderful.

**Ms Halton**—Consider it a deal!

**Senator MOORE**—With a date clearly at the top.

**Ms Halton**—Yes, absolutely.

**Senator MOORE**—You are doing that in the next couple of weeks.

**Ms Halton**—Yes. We are going to finalise it in the next couple of weeks.

**Senator MOORE**—With an intent to go into 1 July with your program intact.

**Ms Halton**—That is exactly right.

**Senator McLUCAS**—In relation to the RRMA review, what was the intent of that review, Mr Eccles?

**Mr Eccles**—It was to examine the RRMA classification system and its usages and identify limitations and benefits, in particular to see whether the classification system accurately measures health or other needs as required by programs. It was to examine existing measures and data sources relating to health need, including geographical, workforce health and wellbeing indicators, and determine whether they are appropriate for use in a new classification method, gaps in current health need and measures and requirements for the development of new measures and to provide recommendations on implementation of communication strategies to assist. There are five terms of reference.

**Senator McLUCAS**—It is about the methodology of a system, whatever it might be called.

**Mr Eccles**—It is to explore the limitations of the existing system and see what lessons we can learn in designing something that might be better.

**Senator McLUCAS**—Putting that to one side, is there another process by which the classification of areas is reviewed on an ongoing basis?

**Mr Eccles**—I am not sure. I would need to check with the workforce area to see how they look at areas of workforce shortage, but I suspect that is a dynamic measure.

**Ms Halton**—In respect of RRMA, there have only been a couple of changes made historically. This is principally because every time you change it you create another boundary. Mr Eccles is right that workforce shortage is a dynamic measure. I think it was described earlier as being a relative measure, relative workforce availability, compared to the national average. I think that was the comment that was made by Senator Polley in terms of experienced capacity to see a GP as against the classification. But RRMA itself, to my memory, I think we had only changed once or twice in terms of the classification areas.

**Senator McLUCAS**—For example, moving something from RRMA 3 to RRMA 4 would have only happened once or twice since its inception.

**Ms Halton**—Yes. I think there was only one major structural adjustment. As I say, it has only been a couple of times at most.

**Senator McLUCAS**—Has anything happened in the last 12 months in terms of change of classification?

**Ms Halton**—Not that I am aware of, but I could stand corrected on that.

**Mr Eccles**—No.

**Senator McLUCAS**—Mr Eccles, could you provide me with a map of Queensland with the RRMA areas noted on it.

**Mr Eccles**—Absolutely.

**Senator McLUCAS**—If I say Queensland, I should probably do the rest of Australia.

**Mr Eccles**—We will give you several maps, a national one and one of each state.

**Senator McLUCAS**—Thank you.

[9.57 pm]

**CHAIR**—We will now move to outcome 6—Rural health.

**Senator POLLEY**—I find all this terminology interesting, so I will start off with a pretty basic question: what is a fund-holding provision when it relates to primary hospital care in rural towns? It has been described here as:

It is essentially a fund-holding provision which will apply only to rural and remote communities with populations less than 7,000.

**Ms Halton**—A fund holder is a body who essentially retains a pool of cash with which to arrange and/or purchase other services. Take community care as an example. You might have the community care provider, who is a fund holder, who can organise a meal, a home nurse, whomever. The patient does not have to go to six different services to get six different types of care.

**Senator POLLEY**—In light of that, in these small rural areas are we talking about primary care, hospital care and aged care? Is that what this program is about?

**Ms Appleyard**—We are principally talking about primary and allied health services in rural and remote areas.

**Senator POLLEY**—Who is going to be the fund holder?

**Ms Appleyard**—Can I clarify that you are talking about the COAG budget measure, Better Alignment of Rural Health Services.

**Senator POLLEY**—Yes, allied services in rural and remote areas, Budget Paper No. 2, page 250.

**Ms Appleyard**—There could be a range of possibilities. We could be talking about non-government organisations such as Divisions of General Practice, who are currently fund holders, regional health services providers, state governments in some cases—basically a broad range.

**Senator POLLEY**—What sort of structure is envisaged with these health services?

**Ms Appleyard**—It is more about breaking down the funding silos between the number of the health service delivery programs that we fund at the moment to make it easier to shift funds between one program and another should the need arise. For instance, now if you are funded to provide an allied health service and you cannot spend that funding, generally that lapses at the end of the financial year. What we would envisage with this program is that, if you have a need for specialist services and not enough of a need for, say, allied health, then you would be able to move the funding between one program and the next, to provide services that better target the needs of the community.

**Ms Halton**—This is exactly the same model as we have been using in rural communities where there is not enough demand or capacity to deliver a whole nursing home or a whole physiotherapy service or what have you. By enabling the pooling of funds you create enough critical mass to do a number of bits of these things. It is exactly the same as multipurpose services: it gives you a capacity to provide a service in a place where you would not have the capacity to provide a whole nursing home or a whole hospital, for example. It is exactly the

same principle. It gives you flexibility across community need and it gives you enough critical mass to do something rather than nothing.

**Senator POLLEY**—Is it anticipated that Medicare and the PBS funds would be on top of this funding?

**Ms Halton**—Yes. There will be no change to Medicare or PBS entitlement.

**Senator POLLEY**—What input will there be and what onus will be put on states and territories in relation to consultation facilities, dollars and resources?

**Ms Halton**—You will see in the budget measure that they have agreed to have an approach to their programs, so they might pool some of their programs as well. Clearly we will have to have a conversation with the states about the things we might pool in our funding pool and what they might pool in theirs. You do not want to be crossing over each other or duplicating. Our state offices have a clear responsibility in terms of liaising with their state counterparts. They do that now on the way the MPS operates, for example. There is a well-trodden path.

**Senator POLLEY**—Who has the responsibility for paying for the staff involved?

**Ms Halton**—The auspice, so whomever we auspice this with. Say, for example, we auspiced in a particular area with a division of general practice, the division of general practice would decide, based on the arrangements, whether they contracted staff or whether they hired staff. In some cases, divisions have done that in the past. They would make an arrangement that was appropriate; but whoever is the auspice would be responsible for that.

**Senator POLLEY**—How did you arrive at the figure of 7,000 as a population base?

**Ms Appleyard**—My understanding was that it was a figure that was mutually agreed between the Australian government and the jurisdictions. I think the jurisdictions were particularly happy with the figure of 7,000. It was just something they were comfortable with.

**Senator MOORE**—Do you have any examples of a 7,000 community? I am having difficulty, it sounds so theoretical. It would be easier in terms of just thinking of how it is going to work, because it is in the future. It will be 2006-07. Are there any 'for instances'?

**Ms Appleyard**—Most of the communities that we target under the Rural Health Strategy are populations of under 5,000. I could give you a few examples of those. From the mapping we have done, there are not a lot that conform to exactly 7,000 or under; but once again, as I said, it was a figure that the jurisdictions were comfortable with.

**Senator POLLEY**—I would have thought a place like Tasmania, once again, would rate fairly highly because we have a lot of smaller communities. Would you be able to take that on notice and give us some further information about the likelihood of those communities. It would be very interesting to be able to identify some of those.

**Ms Lyons**—We could do that but we are still negotiating with the states and the territories about how this particular COAG measure is going to roll out. There is still a fair degree of discussion to be had about exactly what locations and what period of time we might be looking at in terms of putting this measure together.

**Senator POLLEY**—Are you going to actually limit the number of communities?

**Ms Lyons**—That will be the subject of some further discussion as well. Certainly initial discussions with jurisdictions have been that perhaps collectively we might come up with a number of individual locations that we could trial some of these consolidated programs and see how they go.

**Ms Halton**—There is a fixed allocation for this program.

**Ms Lyons**—Yes, there is.

**Senator POLLEY**—It looks like we will be revisiting this in the future. Am I right in saying that you see this fitting in with the multipurpose health centres that are already there? It is going to complement those?

**Ms Lyons**—Absolutely.

**Senator MOORE**—This morning we talked about mental health nurses, and communities in rural areas having particular need and having limited access to that kind of specialist service. Is that the kind of service that would work in this kind of pooling? It is coming in from different funding bases and so on.

**Ms Lyons**—It may. It too is a relatively new measure so there is no reason that we could not have them pooled.

**Senator MOORE**—The other thing that we heard a lot at different committees is the allied health services; so if you are lucky enough to have GP access you are then fairly unlikely to have occupational therapy, physiotherapy, social work and all those other things. Is that the kind of pool we are talking about, to try and come up with the allied health services?

**Senator POLLEY**—The states and territories are required to commit to maintaining the health facilities and providing support for primary care. The scope of this measure really is quite narrow. Will it only apply to the agreed rural and remote towns of less than 7,000 people with public hospitals and health facilities? What happens to the smaller communities that do not have those?

**Ms Appleyard**—There is no particular requirement for there to be a public hospital or a health facility, a particular platform. We are mainly talking about the services themselves which could be delivered via a number of arrangements. It does not have to be from a hospital. I am aware of some community health centres and other types of models that may be an appropriate structure.

**Senator MOORE**—Responding to a need that people have been talking about for a long time—and I know that Senator Adams has been raising issues in a number of these areas—in the planning, these two measures seem complementary. In modelling the possible take-up of these things—I know that will be happening over the next period of time—has there been any expectation of what the take-up will be?

**Ms Lyons**—No, not at this stage. We are in very early discussions with the states and territory jurisdictions about how this might be rolled out.

**Senator MOORE**—You have an added complication, I suppose, where you have a high number of Aboriginal and Torres Strait Islander communities in places like north Queensland. I have been trying to trawl through my brain to think of communities about this size. Some of

those have Aboriginal health services as the core service delivery element in a community. Would this be the kind of model that could work with that?

**Ms Lyons**—Yes, absolutely.

**Senator MOORE**—In an ongoing plan a very well-organised Aboriginal health service could, in fact, be the major auspicing body?

**Ms Lyons**—Yes.

**Senator MOORE**—One of the things we found when we were in north-west Western Australia was that at some of the mining communities, the Aboriginal health service was the de facto whole-community service. There was breakdown of getting non-Aboriginal people feeling comfortable and all of those things. That is in the potential model as well?

**Ms Lyons**—Yes.

**Senator POLLEY**—Will all eligible communities be able to participate?

**Ms Lyons**—Any rural or remote community of less than 7,000 people is entitled to participate, bearing in mind that there is a funding cap.

**Senator POLLEY**—Is there a Medicare cap?

**Ms Lyons**—No.

**Senator MOORE**—It is a taste and see program.

**Senator POLLEY**—Moving on to rural medicine infrastructure fund, the provision in the 2005-06 budget provided $15 million over the three years to establish walk in-walk out community medical centres through grants of up to $200,000 to rural communities. How is this money being given out.

**Ms Appleyard**—This measure is actually being implemented by DOTARS, transport and regional services. We have a role in the assessment of applications.

**Ms Halton**—That is what it is. It is a DOTARS thing. Bingo! There you go.

**Senator POLLEY**—How many applications for funding have been received?

**Ms Appleyard**—Nine applications have been received.

**Senator POLLEY**—How many of these applications have been funded?

**Ms Appleyard**—Five.

**Senator POLLEY**—Can you give me a list of where the grants went and how much for each one?

**Ms Appleyard**—This is a program administered by the Department of Transport and Regional Services. It may be more appropriate to direct that question to DOTARS.

**Senator MOORE**—What is your department’s role, seeing as it has ‘medical’ in its title?

**Ms Appleyard**—Our role is to provide a Department of Health and Ageing perspective on the applications, particularly to ensure that they address health outcomes.

**Senator MOORE**—My understanding is that it is to establish community medical centres, so it is linked to local government.

**Ms Appleyard**—Yes, local councils.

**Senator MOORE**—That is the link with DOTARS.

**Ms Appleyard**—Yes, that is correct. Local councils have to be the applicant.

**Senator MOORE**—And they are the ones that get the funding.

**Ms Appleyard**—That is correct.

**Senator MOORE**—The evaluation is done by DOTARS as well?

**Ms Appleyard**—That is correct.

**Senator MOORE**—And your role is to ensure that the medical outcomes to the community medical centres are assessed effectively.

**Ms Appleyard**—The health outcomes, yes.

**Senator MOORE**—Is there joint assessment, or you just provide information to Transport?

**Ms Appleyard**—We just provide input. They do the initial assessment of the application and provide it to us for our perspective.

**Senator POLLEY**—How will these fit into the proposals that we talked about earlier, with COAG?

**Ms Appleyard**—I imagine it is possible that local councils could auspice some of the arrangements for the COAG measure, so to that extent they may fit in.

**Senator MOORE**—You could get another potential model.

**Ms Appleyard**—Yes.

**Senator McLUCAS**—What information does DOTARS seek from you about the need for a grant of this nature?

**Ms Appleyard**—Generally they want to know what we think about the proposal, through our relevant stakeholders, particularly divisions of general practice and rural workforce agencies. Is there a need in that community? Are we having trouble attracting GPs to these areas and would this, therefore, be a useful mechanism for getting a GP in? They just need our assurance, I imagine, that those sorts of aspects are covered.

**Senator McLUCAS**—How many applications have you reviewed?

**Ms Appleyard**—There have been five approved and we have reviewed five, I believe.

**Senator McLUCAS**—You have approved all of them.

**Ms Lyons**—We do not approve them.

**Ms Appleyard**—No, we supported them.

**Ms Lyons**—We just provide advice to DOTARS in order for them to make a decision about whether they approve or do not approve.

**Senator McLUCAS**—I did hear you say that it was not your program so you did not feel you could announce the locations. Why not?

**Ms Lyons**—I guess it is not our program to announce those locations, Senator.

**Senator McLUCAS**—Can you give me, then, the way you assess the information that is received in the application. Do you benchmark it against something?

**Ms Appleyard**—We can take that one on notice if you would like a breakdown of the process.

**Ms Lyons**—I do not know if we have some particular guidelines.

**Ms Halton**—We need to be clear here. We are only advisers to DOTARS. We do not assess the applications. We are not decision-makers. It is really a question for them in terms of the structure of their program. We give them advice on whether we think it is a good or a bad idea but, beyond that, it is really driven by them; it is not driven by us.

**Senator McLUCAS**—I understand that, but they are seeking your advice. I am wondering how you make a decision to recommend a support. Do you measure them against something?

**Ms Halton**—As you know, we have an extensive state office network, so we use them for a view. This is not the kind of program where we can slot it into one of our more well articulated planning models, because it may butt up against what is going on with a relevant division, it may butt up in terms of whether there is an MPS there, and so our state officers would form a view about whether it is a net addition or whether it makes no additional contribution in a particular community.

**Senator McLUCAS**—Then how do you ensure consistency in the review of those applications across the states?

**Ms Lyons**—That would in part be a matter for DOTARS.

**Senator McLUCAS**—I understand that.

**Ms Lyons**—They have particular criteria, I would imagine, for assessing these applications and I have no doubt that they have given us a copy of that, or they might give us an indication of the sorts of criteria.

**Senator McLUCAS**—Can we be provided with that? If DOTARS is setting the benchmark, I am then unsure about why they are even asking Health to make a comment, but if we are asking the premier body, the department of health, to make a judgment about whether this is going to be a beneficial thing or not, then I would think there would be some checklist or benchmark or system by which you would be able to make a recommendation to support or not. And I know that these questions may be better directed to DOTARS. You said that they are applications by local authorities.

**Ms Appleyard**—That is right. Local councils are the applicants.

**Senator McLUCAS**—Are they usually done in concert with private practitioners?

**Ms Appleyard**—Not necessarily. They may be, because it is about the setting up of a general practice; so, yes, I imagine they would have to have some sort of outcome in mind in terms of the service to be funded.

**Senator McLUCAS**—Is one of the provisos that they operate for 12 months?

**Ms Appleyard**—I cannot answer that.

**Senator McLUCAS**—No, that is better given to DOTARS. Thank you.

**Senator MOORE**—On the Royal Flying Doctor Service review, the budget papers say it is ‘undertaking’ and it is due to be completed by late October 2005. Does that mean it has already started?

**Ms Lyons**—Yes, it has certainly started.

**Senator MOORE**—The information in the budget papers says that it is being done. Can I get some information about who is doing it? It says general things about capacity of the organisation to deliver, which is something that has been talked about before, and also operational activities, funding and governance arrangements. Is it a tendered-out review?

**Ms Lyons**—Yes, it is.

**Senator MOORE**—Who is doing it?

**Ms Lyons**—The consultants who won the tender were HMA Consulting.

**Ms Appleyard**—Healthcare Management Advisors.

**Senator MOORE**—And at what stage are you now?

**Ms Lyons**—We have recently been provided with a final report from them and it is currently being considered within the department.

**Senator MOORE**—That seems to be well on track.

**Ms Lyons**—Yes.

**Senator MOORE**—If it is scheduled for October to be completed, to actually have a preliminary report by now would be a favourable time frame.

**Ms Lyons**—We would hope so.

**Senator MOORE**—Who is assessing that? The tender has gone out, the consultancy has been completed and it has come back to the department. What happens now?

**Ms Lyons**—It is a report that we are considering, given that the terms of reference, as you have indicated, touched on some of those matters. We have had a couple of the items peer reviewed just so that we could get some more detail around a couple of the items, and we are currently considering those peer reviews and the final report.

**Senator MOORE**—And it goes to the minister?

**Ms Lyons**—It will be provided to the minister.

**Senator MOORE**—Thank you.

**Senator ADAMS**—What is the update on the Medical Specialist Outreach Support Program?

**Ms Appleyard**—In terms of the number of services, Senator?

**Senator ADAMS**—That is right.

**Ms Appleyard**—There were over 1,000 services provided in the 2004-05 year. I do not have the precise numbers for this year, but I can take that on notice.

**Senator ADAMS**—That is good. Thanks. Has work started on the evaluation of a framework for the Rural Health Strategy?

**Ms Appleyard**—There is internal discussion at this stage and we are in the process of preparing tender documents to have that work undertaken by an external consultant. So there have been internal discussion within the department.

**Senator ADAMS**—So it will be an external person or consultancy that does it?

**Ms Appleyard**—Yes.

**Senator ADAMS**—I have come a little unstuck with outcome 6 because I have been looking at all these other issues. They seem to have changed from last time. As to how the multipurpose service program is going, is it still being taken up? Where are we going there?

**Ms Appleyard**—As you are probably aware, it is more popular in some states than others. We have always had very good uptake and support of the multipurpose service in Western Australia and New South Wales. The multipurpose service program is certainly being looked at in the context of the longer stay nursing home type patients in hospitals.

**Senator ADAMS**—Dare I raise the issue of Patient Assisted Travel Scheme, even though I have already done this once before and been told very strongly that it is not part of the federal arena any longer, which I am fully aware of? But we have been doing our petrol sniffing inquiry and we have travelled all over Australia, this group here. One of the biggest single issues that comes up—given that we are out there talking about petrol sniffing—is that trying to get transport for rural patients to specialist services is a nightmare. I have foreshadowed that I intend to ask this committee to look at having an inquiry into it. I get inundated from all over.

In Darwin the other day, I was speaking to the PATS clerk and the medical superintendent at Royal Darwin Hospital. Their biggest single issue is getting patients out and retrieving them. We had a terrible example of an Aboriginal woman who, because of obstetric services being so difficult in rural areas, was sent to Perth. She had twins and was put on a bus back to Broome. She had to get back to Balgo. She ended up in Broome and they lost her for two weeks with newly born twins and no support whatever. She finally got on the bus to Halls Creek, got dumped off there at three in the morning, and then Balgo was another 300 kilometres to the east.

It is getting very hard. They seem to be able to get there, but getting them back? It is just not fair. It really is a huge bone of contention. So I will just tell you now that that is something that we are considering doing. Looking at the rural health services program, I cannot see why, somehow, it cannot fit in there with an overall national focus to it. Can you help me, please, Ms Halton? I know you told me it was nothing to do with you last time, but I am getting desperate.

**Ms Halton**—I know. I was around when IPTAS was transferred to the states. I hasten to add it was not my idea.

**Senator ADAMS**—I know it was not. The person whose idea it was I sit next to on the plane, quite often, going to Western Australia.

**Ms Halton**—Excellent. Okay, so I do not need to tell you who it was. I am pleased I do not have to tell you.

**Senator ADAMS**—No, you do not!

**Ms Halton**—What can I tell you? I am aware of the issue.

**Senator ADAMS**—I think we should pursue it because, as I said, this committee has travelled all over Australia and, even though petrol sniffing is a different issue, it keeps coming up. So I think we have to do something. I will finish on that. Thank you.

**Ms Halton**—Duly noted.

**ACTING CHAIR**—Any other questions under outcome 6, rural health?

**Senator McLUCAS**—This district workforce shortage information that we got from Mr Eccles on Tasmania: could we have that information for the nation, please?

**Ms Halton**—Yes, absolutely. Consider it done.

[10.27 pm]

**CHAIR**—We are now on our final outcome, which is outcome 7, hearing services. Questions? Senator Polley.

**Senator POLLEY**—As I understand it, clients of the current service providers can access a range of hearing aids for free but have to pay for an additional range of hearing aid top-up devices. In general, my understanding is that these top-up devices require the client to pay the additional sum, although the same service providers will provide some of the cheaper top-up devices at no extra cost. I think that is the understanding that we have. But we have information and a letter that was responded to by the National Manager of the Office of Hearing Services, a Mr Tony Kingdon.

**Ms Halton**—That is him, Senator, here at the table.

**Senator POLLEY**—I cannot read something that far away. It is good to hear!

**Senator SANTORO**—As long as you can both hear each other!

**Senator POLLEY**—My understanding is that there is a cost. What I am trying to ascertain is: what proportion of all hearing devices fitted are top-up devices?

**Mr Kingdon**—The short answer is that the top-up rate currently is running at about 24 per cent, which has actually come down from a figure of nearly 42 to 43 per cent at the end of last year. The reason for that is that we introduced a new set of device standards that were available free to clients from 1 October. Since then we have had a very good response from clients who are very happy with those devices, which offer significant advances on the previous devices. So, for a person who chooses the top-up, that is purely a choice for them to make. We believe that the program offers very adequate devices for people who do not wish to top up, but if people want extra features, or they want particular styles that can be offered in a top-up, then they have that right. But, even with a top-up, the cost is only the difference between the price of the top-up and the price that we would have given for a ‘free to client’. So there is still a subsidy for that top-up.

**Senator POLLEY**—So are the people that are choosing to have the top-up getting a better quality hearing device?

**Mr Kingdon**—That is a difficult question. When you say ‘better’, in some instances audiologically that may not be so because they have chosen to go for a device that has a particular look about it, or goes further in the ear than the one that is offered under the government scheme, or it has a nicer colour. But, to be fair, there are some top-ups that do offer some significant additional features. It really is for the individual to choose. We make it very clear to our clients that they are under no obligation to take a top-up. There is a separate letter from our chief audiologist put into every voucher pack, explaining the system and making it quite clear that, if they wish to go for a top-up, that is very much an individual’s choice.

**Senator POLLEY**—So are you saying then that all clients have equal access to the best quality hearing devices?

**Mr Kingdon**—Again, ‘best quality’ are value words. All clients have access to what we regard as being high-quality hearing devices that will meet their audiological needs. If they do not meet them, there are set special provisions in the program to allow for those necessary features to be offered free to the client.

**Senator MOORE**—I have a couple of questions. They follow on from questions that have been asked here previously. I also bring Senator Crossin’s apologies that she is not here to ask these questions herself. There was special money in last year’s budget to extend access to hearing services to Indigenous Australians over 50 and participants in the CDEP scheme.

**Mr Kingdon**—That is correct.

**Senator MOORE**—Is that funding continuing?

**Mr Kingdon**—Yes.

**Senator MOORE**—So the first round of increase was in last year’s budget, and that is an ongoing extension of services?

**Mr Kingdon**—It was funding for four years, and so there is out year money. This is still only the first year of that money.

**Ms Halton**—The short answer is yes, Senator.

**Senator MOORE**—I think we had a lot of questions about that, in terms of how it was going to work, at the last estimates. What are the plans for reviewing that program, the take-up and the strategies that were being put in to let people know that they are now eligible?

**Mr Kingdon**—It was only introduced from 1 December, so it is a little difficult to review. I can tell you that the take-up rate has been a little disappointing and has not met the target. There has been considerable activity undertaken by Australian Hearing to promote the scheme and to visit communities. The office has also been working with the states and the Northern Territory on means of encouraging people to take up this option, so we are hoping that the take-up will increase. There is a further round of advertising that Australian Hearing has organised, and we are continuing to liaise with other organisations that can help us. We are planning a visit to Queensland in the next month or two to follow up on some issues there.

**Senator MOORE**—So there is a schedule planned for the four years, with benchmarks at different times as to what your expected uptake should be so you can measure your process?

**Mr Kingdon**—We have a target of 10,000 people over the four years, and we have spread that over those four years.

**Senator MOORE**—Where does the figure of 10,000 come from?

**Mr Kingdon**—We had to make an estimate of the number of people in that age group and the number of CDEP participants who had a hearing loss. Then we discounted it on the assumption that not everybody takes up the option to have an aid, and that was the best estimate we could work on.

**Senator MOORE**—The funding was for the assessment and then the provision of an aid, if required.

**Mr Kingdon**—Yes.

**Senator MOORE**—So it would be on the basis that not everybody who had an assessment would need some form of device.

**Mr Kingdon**—That is true. In fact, a very interesting feature is that a significant number of CDEP applicants have not got the hearing loss that we anticipated. It may well start to challenge some of the figures that we have worked on in terms of the level of hearing loss, which will be really quite exciting because it might suggest that the otitis media, which is causing such problems with children, may actually be healing later in life.

**Senator MOORE**—Which is information that you may not have had.

**Mr Kingdon**—No, exactly.

**Senator MOORE**—In relation to the linkage between the establishment of this program and how you are rolling it out with the Aboriginal and Torres Strait Islander unit in the department, what is the kind of interaction?

**Mr Kingdon**—We have been working very closely with them, and we naturally work very closely with all the AMSs, but we have also been working very closely with the states. For example, in the Northern Territory there is a cooperative arrangement between Australian Hearing and the Northern Territory government that their audiologists are able to test people and prescribe, which is a really good collaborative process, particularly as it is so difficult to get to communities on a regular basis.

**Senator MOORE**—You may or may not have heard the questions that were asked in the previous program about the potential for rural and remote servicing and access to different kinds of medical help in areas that may not be able to attract a full-time professional in their own right. Is that something that audiology would come under as well? If we are looking at having these regional or rural hubs that would be able to access a range of medical services, is that something that audiology could be included in, or has it been considered through your branch that audiology could be one of the professional groups involved in such a trial?

**Mr Kingdon**—Audiology is fairly difficult because it is mainly provided in remote areas by Australian Hearing, and they have already worked out hubs in the sense that they will offer visiting services and then will have, say, in Darwin a primary service that can then send out

people to remote communities. In addition, they draw upon their full range of staff across the country and will find that an audiologist from Sydney will be going up to Halls Creek or wherever in order to provide that service. It is very difficult to get a hub without expecting people to travel huge distances again to access those services.

**Senator MOORE**—In relation to the current workforce issues that Australian Hearing has and the process for recruiting people with specialist skills, are all the positions in Australian Hearing now filled? Do you have your full complement of audiologists across each of your networks?

**Mr Kingdon**—I fear we have run into this perennial problem of the distinction between the Office of Hearing and Australian Hearing.

**Senator MOORE**—In the program of hearing, what is the workforce issue?

**Mr Kingdon**—We try to answer questions, but that really is an operational matter for Australian Hearing. It even comes under a different portfolio now, which is Human Services.

**Senator MOORE**—It does, yes. National Acoustic Laboratories?

**Mr Kingdon**—That is really Australian Hearing, but ask the question.

**Senator MOORE**—In relation to the research component and the ongoing funding for research around the range of issues in hearing services, I was going to ask about what programs are now operational, but it is not your area.

**Mr Kingdon**—We provide the funding for the National Acoustic Laboratories for their research program, but they are responsible for the operational part of discharging the research.

**Senator MOORE**—Where do they fit?

**Mr Kingdon**—They fit under Australian Hearing.

**Senator MOORE**—Which fits under—

**Mr Kingdon**—Which fits under Human Services.

**Senator MOORE**—There are a couple of very strong constituents that we have in Queensland who are part of the national group that is looking at raising the profile of hearing issues in the community, and they are very strong advocates. One of the many issues that they raised with me is the services provided when people are seeking help, and we have had questions about the top-up services and the types of devices available. One of the issues that they have raised at length is that it is not just enough to get the device. There is often a great need for ongoing support and guidance to learn how to most effectively use the device. What is the funding component and the service delivery component for the number of times that the client needs to return if they get a device but are having ongoing difficulties in being comfortable with it and making it work effectively? What is the model for the expense and the time that can be spent in going back to get more and more support and help from the audiologist?

**Mr Kingdon**—It is a difficult question because the provider is given a fee for the assessment, the fitting, the provision of the aid and the follow-up, and each of those components is a standard fee. There should be follow-up, and the expectation is that a client should be satisfied with the result. That is what the provider is paid for, but naturally some

people require a lot more follow-up and assistance than others and sometimes it becomes difficult for a provider to offer an infinite number of services. But we do expect a satisfactory outcome, and there is a requirement for the provider to achieve that.

**Senator MOORE**—What kind of expectation do you have of the people that are contracted to do this service, on that particular issue? I imagine there is some model for how much time is involved in servicing individual clients with, as you said, the testing, the choice of the device, the giving out of the device and then there is some component for people getting comfortable in using it. Is there a model for how much time that whole service should take and how much that costs?

**Mr Kingdon**—We have never prescribed an amount of time—

**Senator MOORE**—There is nothing?

**Mr Kingdon**—because it varies from individual to individual. One person will be a very easy and simple fitting, and they will get exactly the same money as a person who is a very difficult fitting. We argue that there are swings and roundabouts that have to apply to the fee setting.

**Senator MOORE**—Have you received any complaints from clients that they are not receiving the kind of follow-up service that they think they require?

**Mr Kingdon**—We do sometimes, and if it has reached the point where there is a very unsatisfactory relationship between the client and the provider, we will seek to relocate that client, if that is their choice.

**Senator MOORE**—Is there a set cost, Mr Kingdon?

**Mr Kingdon**—For what?

**Senator MOORE**—For a service.

**Mr Kingdon**—Yes. There is a whole schedule of fees, just as there is in Medicare.

**Senator MOORE**—The complaint that these particular people bring to me is that there comes a time when they are made to feel most unwelcome and they are made to feel that there is something wrong with them if they need this extra help.

**Mr Kingdon**—We have a formal complaints mechanism, with a 1800 number, where people go through to the complaints service. We want to hear about it, and we will personally follow up each of those complaints to see if we can get a satisfactory resolution. As I said, if it reaches the point where there is a breakdown in the relationship between the client and the provider, then we look at alternatives.

**Senator MOORE**—What is the usage of your complaints service?

**Mr Kingdon**—Complaints run at less than one per cent.

**Senator MOORE**—One per cent?

**Mr Kingdon**—Well under.

**Senator POLLEY**—In relation to the top-up devices, would you be able to provide an average cost of the difference between the basic service and the top-up?

**Mr Kingdon**—Yes, I can. The average cost is $564.59. That is the average for the top-up at the moment, but the top-up can start from zero. Some people offer top-up devices at no cost to their clients, while others will charge $3,000 to $4,000, but the average is running at about $564, as I have just said.

**Senator POLLEY**—Thank you.

**Senator McLUCAS**—My question goes to the intent of Hearing Services. One of your objectives is to reduce the harmful effects of noise. As Senator Moore says, we have a very active deaf and hearing impaired community in Queensland and we are both being educated very quickly. Can you tell us what you do in terms of achieving more community understanding about the harmful effects of noise—things like the increased use of MP3 players, the longstanding issue of nightclubs and people who work in them, not necessarily those who visit them. What sort of work do you do around those issues?

**Mr Kingdon**—It is a difficult question because our program is primarily concerned with the provision of hearing services under the voucher scheme, and we also fund what are called community service obligation services through Australian Hearing. In that community service obligation, there is a prevention component into which the National Acoustic Laboratories has been doing research. In fact, it was a paper that they presented on MP3 players that drew people's attention to the potentially harmful effects of playing them at excessively high levels.

**Senator McLUCAS**—You contract NAL to do that sort of work?

**Mr Kingdon**—Yes. They are given some core funding to do that. In turn, they are charged with disseminating that information.

**Senator McLUCAS**—Do you direct NAL's research work or do they provide you with their research plan? What is the relationship?

**Mr Kingdon**—It is a fairly mutual one. They have a research advisory committee of which we are a member and we try to come to an agreed position on the research projects. To date we have not had any difficulty with their interests and ours matching.

**Senator McLUCAS**—Could you provide us with a list of the research plan from NAL, let us say, over the last five years.

**Mr Kingdon**—I will have to take that on notice.

**Senator McLUCAS**—No, you are meant to know that in your head! Of course.

**Senator POLLEY**—With the acoustics in this room, I think we all leave feeling that we need your services!

**Senator McLUCAS**—Before we close, Chair, I feel that I have to alert you to my concern that over the last two days there have been many hours when we have not had a minister in this room. I would like to ask you to have a look at standing order 26(5), which says:

> The committees may ask for explanations from ministers in the Senate, or officers, relating to the items of proposed expenditure.

On many occasions we ask questions of departmental officials and they provide us with answers because it is a straightforward question, but there have been many times in the last two days where the answer has been that it was a government decision, and that is a correct

answer. When that happens, it is surely appropriate for a senator to be able to ask the minister representing the government the questions that would give us some understanding of why that decision was made, and I think that that is why you need to have a minister in the room at all times.

So I am asking you if you could have a look at standing order 26(5). Can you make a decision about whether or not this committee has been run in accordance with that standing order and maybe report back to us at another time? I am not being petty about this. There was a time yesterday when the minister's own area, outcome 4, was on and he was not here, and that delayed the operations of this committee for over an hour while we waited for him to return. So I ask you to have a look at that standing order—are we in compliance with it?—and what recommendations you might like to make to the committee in the future.

**CHAIR**—Senator, I will look at the standing order you have directed me to and I will provide advice to the committee in due course. Can I say that it has been my impression, as the committee has gone on, that the committee—as is usually the case with estimates committees—has focused on questions of public servants. I am aware on a few occasions that questions have arisen which might be directed at the minister, and when that issue has been raised with me previously by a member of the committee I have indicated that the minister will return in due course and, when that happens, then the question could be directed to that minister. With great respect, I think to raise the issue at this stage rather than, say, two days ago or a day ago might not be the most helpful approach. If I had been aware of that concern, I could certainly have asked the minister to be present at the times when apparently members of the committee wanted to ask him questions, whereas until this point I have not been aware that there were members who were anxious about his absence.

**Senator McLUCAS**—I take your point on that, but it has got to the point of frustration now, and annoyance.

**CHAIR**—Okay. I have taken the point on board. I will take advice. I think the minister is here and he has heard what you have had to say, and that is a matter that perhaps can be addressed in relation—

**Senator Santoro**—Chair, could I crave your indulgence?

**CHAIR**—Yes.

**Senator Santoro**—I have listened to Senator McLucas and I would just like to make two, three, four, maybe even five, points about her statement. I have been in this room in terms of matters relating to the part of the portfolio relating to Ageing for the duration, with the exception of approximately one hour yesterday. You will recall, Chair, that I came to you and said that the Prime Minister required me to be at his office to consult me on two or three matters. I came and saw you. I mentioned to you that, if any concern was expressed about my absence at the time, you were at liberty to explain that. I briefed the department and I briefed the officers that, should a matter of policy come up and there was an insistence that people know where I was, both you and the department were free to inform Senator McLucas or any other aggrieved member. There were some areas of policy that were of interest to Senator McLucas in particular and also, from memory, to Senator Fielding, and immediately after the

dinner break I was able to assist the committee, I would hope—and I was trying to be so helpful that in fact Senator McLucas suggested that I desist from being helpful.

**Senator McLUCAS**—That is a question of opinion.

**Senator Santoro**—The point is that I wanted to be as thorough in my answers relating to government policy as I could. Throughout the rest of the estimates, the committee will have observed that during the times when the committee was considering aspects of the estimates that relate to my portfolio I have made myself available. At other times—the vast majority of the time—the committee was considering areas relating particularly to the Health section of the portfolio. Yes, I could have been here and maybe I could have given some answer relating to policy direction, but, in reality, that answer really is the prerogative of the minister for health. As has usually been the case during other estimates hearings, including on some occasions when I was here for a reasonable period of time, I believe those areas of concern would be taken on notice. Should the minister care to provide some policy oriented answer, he would do so.

I do support your comments, Chair, that had the committee members expressed a desire to have me here physically I would have been here. And I would have been doing here what I have been doing in my office. I have reviewed three cabinet submissions. I have signed over 400 items of correspondence, including correspondence to quite a number of ALP senators and members. I could have been doing that here. The advice from the officers was that they thought, 'If you would like to do so in the comfort and with the support of your office, you might be doing yourself a favour from an operational point of view.'

As for Senator McLucas—no, I will not comment, because I have given my explanation. I have been working just as hard as you have and I stand by my remarks. I will be interested to review the *Hansard*. I will ask my officers to review the *Hansard* and see what areas of policy concern remained unanswered. I will draw those to the attention of the minister for health, because there are certainly no areas of policy unanswered relating to the Ageing part of the portfolio. I will see how many there were. I do not think there will be an overwhelming number, but if there are I will refer them to the minister for health and we will see if we can assist the committee, in particular Senator McLucas, with some answers. I am happy to provide that undertaking.

**Senator McLUCAS**—Chair, I seek your—

**CHAIR**—I do not want to start a debate at the moment if we can avoid it. It is 11 o'clock on a Thursday night.

**Senator McLUCAS**—Can I make two points?

**CHAIR**—Yes.

**Senator McLUCAS**—Senator Santoro, in this place and in the chamber, is the minister representing the minister for health. He has a responsibility in that area to be not only the Minister for Ageing but also the minister representing the minister for health. That is the first point. The second point is that, whilst it might not show in the *Hansard* that there was a request to ask the minister, when you are in the flow of questioning and the answer from the department is, 'That was a government decision,' and you look to the space and the minister is

not there, it is not worth carrying on and asking the department to answer the question. You know that they have given you a clear indication that it is a political decision, but there is no politician there to answer the question you want answered. I have a final question for Ms Halton: did you advise the minister that it was reasonable for him not to be in this place?

**Ms Halton**—The minister had appointments yesterday, as I understood it. In terms of the minister’s commitments, I was not aware of them.

**CHAIR**—Senator McLucas, I think you have made your point clearly. As I have said, I have undertaken to examine that matter in respect of that particular standing order and I will advise the committee in due course if there is any matter that needs to be pursued in that respect. We have all heard what the minister has to say about that matter, so I think there is no point in raking that over any further at this point in time.

I propose to draw these hearings to a close. I want to thank all of those involved. The minister, the officers of the Department of Health and Ageing and Ms Halton for your time here today and yesterday. Can I thank the secretariat of the committee. Can I thank *Hansard* who have had a difficult exercise, particularly with power failures and the like. I think that, notwithstanding the last few minutes, the committee inquiry has been conducted in an environment which reflects well on the work of a Senate committee. I think it has been a committee inquiry which has been conducted with a measure of civilised behaviour which reflects well on the dignity of the Senate. So I thank the members of the committee for having contributed to that environment.

**Senator Santoro**—Can I thank the officers who have been working very hard for the last two days. I am sure you would agree with me that they have provided very good advice and assistance to the committee. Thank you to you and your officers, and also opposition and government members for their assistance.

**CHAIR**—I will draw the proceedings to a close and the committee will report in the required time frame. Thank you.

**Committee adjourned at 11.00 pm**