COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

STANDING COMMITTEE ON COMMUNITY AFFAIRS

ESTIMATES

(Supplementary Budget Estimates)

WEDNESDAY, 1 NOVEMBER 2006

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SENATE

STANIDNG COMMITTEE ON COMMUNITY AFFAIRS

Wednesday, 1 November 2006

Members: Senator Humphries *(Chair)*, Senator Moore *(Deputy Chair)*, Senators Adams, Allison, Carol Brown, Fierravanti-Wells, Patterson and Polley

Senators in attendance: Senators Adams, Barnett, Crossin, Eggleston, Chris Evans, Ferris, Fierravanti-Wells, Humphries, Marshall, McLucas, Milne, Moore, Nash, Nettle, Patterson, Siewert, Watson and Webber

Committee met at 9.05 am

HEALTH AND AGEING

Senator Santoro, Minister for Ageing

Department of Health and Ageing
Executive
Ms Jane Halton, Secretary
Mr Philip Davies, Deputy Secretary
Ms Mary Murnane, Deputy Secretary
Mr David Kalisch, Deputy Secretary
Mr David Learmonth, Deputy Secretary
Prof. John Horvath, Chief Medical Officer
Ms Wynne Hannon, General Counsel, Legal Services Branch
Outcome: Whole of portfolio
Portfolio Strategies Division
Mr Jamie Clout, First Assistant Secretary , Portfolio Strategies Division
Ms Julie Roediger, Assistant Secretary, Budget Branch
Ms Shirley Browne, Assistant Secretary, Ministerial and Parliamentary Support Branch
Ms Jenny Hefford, Assistant Secretary, International Strategies Branch
Ms Jacqueline Ball, Acting Assistant Secretary, Economic and Statistical Analysis Branch
Mr Damian Coburn, Acting Assistant Secretary, Policy Strategies Branch
Audit and fraud control
Mr Allan Rennie, Assistant Secretary, Audit and Fraud Control Branch
Business Group
Mr Alan Law, Chief Operating Officer, Business Group
Ms Karen Gavrilovich, Acting Assistant Secretary, Corporate Support Branch
Ms Georgie Harman, Assistant Secretary, People Branch
Mr Stephen Sheehan, Chief Financial Officer, Finance 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

Regulatory Policy and Governance Division

Ms Linda Addison, Acting First Assistant Secretary, Regulatory Policy and Governance Division

Ms Teressa Ward, Acting Assistant Secretary, Governance and Agency Relationships Branch

Outcome 1: Population health

Therapeutic Goods Administration

Dr David Graham, National Manager

Dr Rohan Hammett, Principal Medical Officer

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

Ms Rita Maclachlan, Assistant Secretary, Office of Devices, Blood and Tissues

Prof Albert Farrugia, Principal Scientific Adviser, Office of Devices, Blood and Tissues

Dr Sue Meek, Gene Technology Regulator

Dr Margaret Hartley, Director, Office of Chemical Safety

Dr Roshini Jayewardene, Acting Director, NICNAS

Population Health Division

Ms Margaret Lyons, First Assistant Secretary, Population Health Division

Ms Carolyn Smith, Acting First Assistant Secretary, Ageing and Aged Care Division

Ms Andriana Koukari, Assistant Secretary, Targeted Prevention Programs Branch

Ms Linda Powell, Assistant Secretary, Chronic Disease and Palliative Care Branch

Ms Virginia Hart, Assistant Secretary, Drug Strategy Branch

Mr Peter Morris, Assistant Secretary, Strategic Planning Branch

Dr David Dumbrell, Director, Infrastructure, Workforce and PHOFA Section, Strategic Planning Branch

Ms Sharyn McGregor, Director, Hepatitis C Section, Targeted Prevention Programs Branch

Ms Avril Kent, Director, Immunisation Section, Targeted Prevention Programs Branch

Ms Marissa Otuszewski, Director, Bowel Cancer Screening Section, Targeted Prevention Program Branch

Ms Julianne Quaine, Director, Screening Section, Chronic Disease and Palliative Care Branch

Ms Cath Phillips, Director, Illicit Drugs - Emerging Trends and Comorbidity Section, Drug Strategy Branch

Mr Bruce Wight, Director, Partnerships and Treatment Section, Drug Strategy Branch

Mr Chris Milton, Director, Lifestyle Prescriptions and Injury Prevention Section, Food and Healthy Living Branch

Ms Lesley Paton, Director, Nutrition Section, Food and Healthy Living Branch

Ms Kerri Kellett, Director, Food Policy Section, Food and Healthy Living Branch

Ms Jennie Shortt, Acting Director, Alcohol and Indigenous Programs Section, Drug Strategy Branch

Ms Catherine Gay, Senior Adviser, Food Policy Section, Food and Healthy Living Branch

Dr Bronwen Harvey, Medical Advisor, Targeted Prevention Program Branch

Mr Ian Krebs, Acting Director, Immunisation Funding and Strategy Section, Targeted Prevention Programs Branch

Ms Sue McHutchison, Acting Director, Overweight Obesity and Physical Activity Section, Food and Healthy Living Branch

Outcome 2: Access to pharmaceutical services

Pharmaceutical Benefits Division

Ms Rosemary Huxtable, First Assistant Secretary
Ms Sarah Major, Assistant Secretary, Community Pharmacy Branch
Ms Joan Corbett, Assistant Secretary, Pharmaceutical Evaluation Branch
Dr John Primrose, Medical Officer
Mr Declan O'Connor-Cox, Assistant Secretary, Access and Systems Branch

Outcome 3: Access to medical services

Medical Benefits Division

Ms Megan Morris, First Assistant Secretary, Medical Benefits Division
Mr Peter Woodley, Assistant Secretary, Diagnostics and Technology Branch
Mr Tony Kingdon, Assistant Secretary (General Manager), Office of Hearing Services
Ms Samantha Robertson, Assistant Secretary, MBS Policy Implementation Branch

Primary and Ambulatory Care Division

Mr Richard Eccles, First Assistant Secretary, Primary and Ambulatory Care Division
Mr Leo Kennedy, Assistant Secretary, Service Access Branch, Primary and Ambulatory Care Division
Ms Sharon Appleyard, Rural Health Branch, Primary and Care Ambulatory Division
Mr Lou Andreatta, Primary Care Financing Branch, Primary and Ambulatory Care Division
Ms Judy Daniel, Assistant Secretary, Primary and Ambulatory Care Policy Branch, Primary and Ambulatory Care Division
Mrs Jennie Roe, General Practice Divisions and Information Branch, Primary and Care Ambulatory Division
Ms Lisa McGlynn, Assistant Secretary, E-Health and Technology Branch, Primary and Ambulatory Care Division.

Outcome 4: Aged care and population ageing

Ageing and Aged Care Division

Mr Andrew Stuart, First Assistant Secretary, Ageing and Aged Care Division
Ms Carolyn Smith, Acting First Assistant Secretary, Office of Aged Care Quality and Compliance
Ms Fiona Nicholls, Assistant Secretary, Quality Policy and Programs Branch
Mr Iain Scott, Assistant Secretary, Office of the Prudential Regulator
Mr Stephen Dellar, Assistant Secretary, Residential Program Management Branch
Ms Carolyn Scheetz, Assistant Secretary, Quality Outcomes Branch
Mr Peter Broadhead, Assistant Secretary, Policy and Evaluation Branch
Ms Sue Gordon, Acting Assistant Secretary, Office for an Ageing Australia
Ms Mary McDonald, Assistant Secretary, Community Care Branch

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

Outcome 5: Primary care

Primary and Ambulatory Care Division – See Outcome 3

Outcome 6: Rural health

Primary and Ambulatory Care Division – See Outcome 3

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 Adviser

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, Assistant Secretary, Services of Concern Taskforce

Outcome 9: Private health

Acute Care Division

Ms Kerry Flanagan, First Assistant Secretary, Acute Care Division

Dr Bernie Towler, Medical Officer, Acute Care Division

Mr Charles Maskell-Knight, Medical Indemnity Branch, Acute Care Division

Ms Gail Yapp, Acute Care Strategies Branch, Acute Care Division

Ms Yael Cass, Acute Care Development Branch, Acute Care Division

Ms Veronica Hancock, Private health Insurance Branch, Acute Care Division

Mr Steve Nerlich, Healthcare Services and Financing Branch, Acute Care Division

Medibank Private

Mr George Savvides, Managing Director, Medibank Private

Private Health Insurance Administration Council

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

Outcome 10: Health system capacity and quality

Mental Health and Workforce Division

Prof. Rosemary Calder, First Assistant Secretary, Mental Health and Workforce Division

Mr David Dennis, Assistant Secretary, Workforce Distribution Branch

Ms Natasha Cole, Acting Assistant Secretary, COAG Workforce Implementation Branch

Ms Maria Jolly, Acting Assistant Secretary, Education and Training Branch

Mr Nathan Smyth, Assistant Secretary, Mental Health Reform Branch

Ms Colleen Krestensen, Acting Assistant Secretary, Mental Health and Suicide Prevention Programs Branch

Ms Jan Bennett, Principal Adviser, Mental Health and Workforce Division

Prof. Rick McLean, Principal Medical Adviser, Mental Health and Workforce Division

Prof. Harvey Whiteford, Principal Medical Adviser, Mental Health and Workforce Division

Primary and Ambulatory Care Division—See Outcome 3
Outcome 11: Mental health
Mental Health and Workforce Division—See Outcome 10
Outcome 12: Health workforce capacity
Mental Health and Workforce Division—See Outcome 10
Outcome 13: Acute care
Acute Care Division—See Outcome 13
Outcome 14: Health and medical research
National Health and Medical Research Council

Prof Warwick Anderson, Chief Executive Officer, National Health and Medical Research Council

Dr Clive Morris, Acting Executive Director of Centre for Corporate Operations and Centre for Compliance and Evaluation

Regulatory Policy and Governance Division—See Outcome: Whole of portfolio

CHAIR (Senator Humphries)—I declare open this supplementary hearing of the Senate Community Affairs Committee considering the budget estimates for the portfolio of health and ageing. The committee has before it a list of the outcomes relating to matters which senators have indicated they wish to raise at this hearing. I assume by a process of elimination that, if it has not been raised, if the agency concerned has not been notified it is wished that it appear, it is not required to appear today. That is the usual custom.

In accordance with the standing orders relating to supplementary hearings, today's proceedings will be confined to matters within the relevant outcomes. Under standing order 26 the committee must take all evidence in public session. This includes answers to questions on notice. I remind the witnesses that in giving evidence to the committee they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee and such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to a committee.

The Senate by resolution in 1999 endorsed the following test of relevance for questions at estimates hearings. Any questions going to the operations or financial positions of the departments and agencies which are seeking funds in the estimates are relevant questions for the purpose of estimates hearings. I remind officers that the Senate has resolved that there are no areas in connection with the expenditure of public funds where any person has a discretion to withhold details or explanations from the parliament or its committees unless the parliament has expressly provided otherwise.

The Senate has resolved also that an officer of a department of the Commonwealth or of a state shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude questions asking for explanations of policies or factual questions about when and how policies were adopted. If a witness objects to answering a question, the witness should state the ground upon which the objection is taken and the committee shall determine whether it will insist on an answer, having regard to the ground on which is claimed. Any claim that it

would be contrary to the public interest to answer a question must be made by the minister and should be accompanied by a statement setting out the basis for the claim.

That is the paperwork this morning. We do have an indication of an approximate program—that is, an order in which we will be taking witnesses or departments and agencies and the sort of timeframe we would be looking at to engineer an orderly throughput of witnesses today. Senator McLucas, I understand, has a suggested program for the committee.

Senator McLUCAS—Thank you. I suggest that we work on this basis: 9 to 9.30, whole of portfolio; 9.30 to 10.30, outcome 9; 10.30 to 11.30, outcome 2; 11.30 to 12.15, outcome 5; 12.15 through to 3.15, acknowledging that there is lunch in there—and I cannot remember what time lunch is—

CHAIR—12.30 to 1.30.

Senator McLUCAS—Can we make it one o'clock today?

CHAIR—One until two?

Senator McLUCAS—Is that all right?

CHAIR—Yes. That being agreed by the committee, it is so resolved.

Senator McLUCAS—From 12.15 through to 3.15, outcome 4; 3.15, outcomes 3 and 11 together; at 4.30, outcome 8; at 5.30, outcome 12; 6.30 to 7.30 is dinner—is that right, Chair?

CHAIR—Yes, that sounds reasonable.

Senator McLUCAS—Then at 7.30, outcome 6; at 8.15, outcome 10; at nine o'clock, outcome 1; at 10 o'clock, outcome 13; and at 10.30, outcome 14.

CHAIR—I take it the committee is happy to be fairly rigid about those times. If we run out of time at the end of that particular allocated time, we will move on to the next area. I think we can also take it as read that, if your agency, area or outcome is designated for, say, late in the afternoon, there is no need for the agency concerned to appear before mid-afternoon—that is, we are not going to bring these forward dramatically.

Senator McLUCAS—I would be surprised if we did.

CHAIR—I think that, if we happened to do so and there was not an agency present, there would not be a problem. It being agreed by the committee that that timetable be adopted, it is so resolved.

I am happy to welcome this morning Senator Santo Santoro, representing the Minister for Health and Ageing, his departmental secretary, Ms Jane Halton, and officers of the Department of Health and Ageing. Thank you very much for your presence here today, Minister, and Ms Halton and officers. Minister, do you wish to make an opening statement?

Senator Santoro—No, Mr Chairman. We are happy to assist the committee as requested.

CHAIR—Thank you very much. The first area is the whole of portfolio or corporate matters, and we will proceed to questions in that area.

Senator CHRIS EVANS—I want to ask some questions about the Matthews Pegg consultancy. I do so now because I have got a deal with the chair that if I ask them now and bugger off and not interfere for the rest of the day, it will suit the rest of the committee, so my

apologies if it is not quite where it should be asked. Looking at the annual report, I can find three contracts let for Matthews Pegg Consulting Pty Ltd in the last financial year. I just want to confirm that those are the only three. There is one for $72, 000 under outcome 1, I think, one for $101,000 under outcome 3 and one for $34,000 under outcome 9. Is that the totality?

Ms Murnane—For the year ended 30 June 2006?

Senator CHRIS EVANS—Yes.

Ms Murnane—To my knowledge, yes, that is the totality.

Senator CHRIS EVANS—This consulting firm has obviously been given quite a bit of work from you over the last four or five years. What is the nature of their speciality?

Ms Murnane—The nature of the speciality of Andrea Matthews is assistance with the framing of legislation.

Senator CHRIS EVANS—What does that mean? The Parliamentary Counsel generally provides—

Ms Murnane—She is a lawyer who specialises in legislation, and she is particularly skilled in assisting with the converting of specifications and instructions into law. As you are aware, when we go through a process of stating what we want, there can be all sorts of consequences, whether they are amendments to the act or a new act, and she has particular skills in that area that we do not have in-house. Of course, the formal drafting is done by the Office of Legislative Drafting, but there is a lot of toing and froing on that, and Ms Matthews is expert in that.

Senator CHRIS EVANS—I am not trying to cast any aspersions on Ms Matthews; I am just trying to understand this. Is her expertise legal, not scientific?

Ms Murnane—Yes, she is a lawyer.

Senator CHRIS EVANS—A lot of people are lawyers who then claim to have other skills. Are you hiring her for her legal skills?

Ms Murnane—Absolutely.

Senator CHRIS EVANS—This is in addition to what you get the Parliamentary Counsel to do?

Ms Halton—Yes, and you would be aware that, increasingly, departments do not maintain a very large stable of in-house lawyers, not all of whom you use on a day-to-day basis. We tend to build up that capability as the need arises.

Senator CHRIS EVANS—I remember the days when it was claimed it was going to be a savings measures, Ms Halton; that is how far I go back.

Ms Halton—I remember that day too, Senator.

Senator CHRIS EVANS—No-one has claimed for a long time that that was a saving to the Commonwealth, as the bills for Clayton Utz and others keep rolling in. I do not mean to pick on Clayton Utz; there are a lot of them on the public payroll now. The consulting firm seemed to be averaging, in the early years—2002-03, 2003-04—in the order of $300,000 per

year, and less last year. I have not worked out that total yet. Does she do all the work herself or is it actually done by the firm?

Ms Murnane—In the processes I have been involved with her in, yes, she does all the work herself.

Senator CHRIS EVANS—She must be pretty well working for you full time.

Ms Murnane—At times; she is pretty well full time when we are preparing something.

Senator CHRIS EVANS—Is it a per hour contract?

Ms Murnane—To get her charges historically, we would have to go back and provide that on notice. I am a bit reluctant to say what her most recent charges are because that is probably commercial-in-confidence, but it is a per hourly charge.

Senator CHRIS EVANS—It is a per hourly charge. I was just trying to understand the basis of the contract. I was not going to ask how much per hour. It would make us all too jealous! Which contracts have been let to Mathews Pegg Consulting since the end of the last financial year?

Ms Murnane—I think I am right in saying that there have only been two. One is for assistance with the preparation of the amendments to the Aged Care Act on the quality and compliance measures that Minister Santoro announced—some prior to the budget—concerning police checks, reporting to the police and mandatory reporting, and some measures that were announced in the budget concerning changes to the complaints system. There was also another contract that the department handled. This contract was for technical assistance to Senator Patterson in preparation for the private member's bill.

Senator CHRIS EVANS—Have you got the cost of the first one?

Ms Murnane—I have not, Senator. That one is ongoing. We will be able to give you the complete cost of that probably at budget estimates next year because that will continue until the introduction of this legislation.

Senator CHRIS EVANS—So it is fair to say that that is a fairly large, ongoing contract.

Ms Murnane—Yes, it would be substantial.

Senator CHRIS EVANS—And the second one, the technical assistance regarding Senator Patterson's—

Ms Murnane—Yes. The total cost of that—we finished on 19 October—is in the order of $22,000.

Senator CHRIS EVANS—That was from when until 19 October?

Ms Murnane—I cannot remember exactly the starting date—

Ms Halton—14 September, I am advised.

Ms Murnane—14 September to 19 October.

Senator CHRIS EVANS—What outcome is that under?

Ms Murnane—We always have a certain amount of choice here; I would say it would be outcome 14 because that is the research outcome, and this was in respect of the things that arose from the Lockhart report. That is dealt with under research and the NHMRC.

Senator CHRIS EVANS—So you are doing that under outcome 14. Can you tell me how this was authorised?

Ms Murnane—Minister Santoro's office asked us to organise some technical legal assistance for Senator Patterson in the framing of the private member's bill. This was approved by the Prime Minister's office and was the basis on which we undertook to contract Matthews Pegg to provide this assistance.

Senator CHRIS EVANS—Why was it Senator Santoro's office and not the office of the Minister for Health and Ageing?

Ms Murnane—Minister Santoro is responsible for the human cloning and embryo research legislation.

Senator CHRIS EVANS—Outcome 14 is under the Minister for Health and Ageing generally, is it not?

Ms Halton—No, there are split responsibilities in the portfolio. This has been the case in the entire time I have been secretary, so it is under a number of different ministerial configurations.

Senator CHRIS EVANS—I am not questioning that; I am just trying to understand it.

Ms Halton—It is not a complete—

Senator CHRIS EVANS—So you split the management of outcome 14 research among the two ministers?

Ms Halton—Yes, and it has been that way for a good number of years.

Ms Murnane—Absolutely. And some of the outcomes are split between deputies and divisions. I do not think there is any other way to do it. It is not possible to get a complete symmetrical line-up.

Senator CHRIS EVANS—I can understand research on aged care matters being under Senator Santoro; that makes obvious sense. I am not using Senator Santoro in a personal sense here. I just do not understand how the Minister for Aged Care is responsible for stem cell research.

Ms Halton—Because someone decided that way back in the past.

Ms Murnane—It was part of a letter of commission.

Ms Halton—Minister Bishop—

Ms Murnane—Minister Andrews had that responsibility and was given that responsibility in his letter of commission.

Senator CHRIS EVANS—So when Mr Andrews started in the portfolio that was when stem cell research was allocated to the aged care minister? Was it just stem cell research? What other areas were allocated?

Ms Halton—I would like to go back and actually check that. I think that was—

Ms Murnane—It is.

Ms Murnane—That was it.

Ms Halton—If it is not, we will come back and let you know.

Ms Murnane—And hearing.

Senator CHRIS EVANS—Sorry?

Ms Murnane—Hearing.

Ms Halton—Hearing is also—pardon?

Senator CHRIS EVANS—If that was not deliberate.—it seemed like a really cheap joke.

Ms Halton—It is a bit early for those sorts of jokes.

Senator CHRIS EVANS—I am genuinely struggling to hear you. So there is stem cell research and hearing related research?

Ms Murnane—The Hearing Services program.

Senator CHRIS EVANS—I understood the minister had those, but in terms of outcome 14 and research—

Ms Halton—As the minister for continence and continence senator points out.

Senator CHRIS EVANS—I remember debating continence with then Minister Bishop and I do not want to go back there. In terms of outcome 14, which is Health and medical research, what responsibilities under that outcome lie with the Minister for Ageing?

Ms Murnane—Only stem cells and human cloning and those terms as embodied in the legislation.

Senator CHRIS EVANS—And that dates back to administrative arrangements put in place when Mr Andrews came into the portfolio?

Ms Murnane—That is right.

Ms Halton—Actually, it goes back to when Senator Patterson was portfolio minister. That was the time. When the ministerial team comprising Senator Patterson came in, that was when those arrangements occurred.

Ms Murnane—That is right.

Senator CHRIS EVANS—So was Mr Andrews the first?

Ms Halton—He was the junior minister in the portfolio, so the split of responsibilities took place at that time.

Senator CHRIS EVANS—But that is the same time, is it not?

Ms Halton—Yes.

Senator CHRIS EVANS—You are not making a different point. At that time, Senator Patterson became minister for health and Mr Andrews became Minister for Ageing?

Ms Halton—It would have been the end of 2001.

Senator CHRIS EVANS—So stem cell research was hived off to his responsibilities then and it remained with the relevant minister and, as you described the process, 'The Prime Minister's office requested Senator Santoro to authorise this'?

Ms Halton—I do not think we can comment on exactly what the internal process was, because we were not privy to it. But, essentially, in respect of a request for technical assistance that we became aware of, we then asked the minister, and he—

Senator CHRIS EVANS—I thought the evidence was that the minister's office asked you?

Ms Halton—There was a letter from Senator Patterson. I think there was a conversation as well as correspondence. To work out which is the chicken and which is the egg is a little difficult.

Ms Murnane—They were parallel. I received a phone call from Senator Santoro's office—

Ms Halton—And I received a letter at the same time.

Ms Murnane—More or less, simultaneously.

Senator CHRIS EVANS—So, formally, Senator Santoro's office requested the department to commission someone to provide support in drafting the bill?

Ms Halton—No. We were asked to provide the senator with technical assistance. Having been authorised to do that, that is what we did.

Senator CHRIS EVANS—If technical assistance does not mean drafting of the bill, what does it mean? Is there a difference?

Ms Halton—We were not asked to provide assistance in the drafting of the bill; we were asked to provide technical assistance—and technical assistance comprised the drafting of the bill.

Senator CHRIS EVANS—Can you tell me when that request was made of you?

Ms Halton—Senator Patterson announced her intention to provide a private member's bill on 14 August, but the letter requesting assistance was on 7 September.

Senator CHRIS EVANS—Ms Murnane, was that around the time you received the approach as well?

Ms Halton—I think it was all on the same day—

Ms Murnane—Yes, it was the same day.

Ms Halton—because we were getting bits of paper off faxes and having conversations in the corridor outside my office. It was on the same day.

Senator CHRIS EVANS—Was that the only request that you received to provide assistance in relation to stem cell legislation?

Ms Halton—Yes.

Senator CHRIS EVANS—You have not provided any other assistance to Senator Patterson or others in relation to these issues?

Ms Murnane—Other technical assistance was provided.

Ms Halton—The question was about what requests we received.

Senator CHRIS EVANS—No. The question was about other involvement or assistance.

Ms Halton—We have just provided the technical advice to Senator Patterson. Sorry, I am not quite sure what the question is.

Senator CHRIS EVANS—Have you been involved in any other way in recent times in stem cell research, advice or technical assistance?

Ms Halton—To anyone else?

Senator CHRIS EVANS—Yes.

Ms Halton—No.

Senator CHRIS EVANS—On any other aspects?

Ms Halton—We have provided technical assistance to Senator Patterson.

Senator CHRIS EVANS—That is the totality of your involvement in recent times on stem cell issues?

Ms Halton—That is correct.

Senator CHRIS EVANS—There was no advice provided to Senator Stott Despoja?

Ms Halton—No, there was not.

Senator CHRIS EVANS—You commissioned the work by direct sourcing?

Ms Halton—Yes. We had a conversation internally about whether we had anyone available in-house who had the time, at that moment, and the technical capability. The decision was that we did not and, therefore, we had to find someone who could actually do that work.

Senator CHRIS EVANS—You used Matthews Pegg Consulting for the original stem cell legislation, didn't you?

Ms Murnane—Yes. PM&C were involved in that too.

Senator CHRIS EVANS—But they were the people who provided the technical advice on that legislation?

Ms Murnane—Indeed.

Senator CHRIS EVANS—That contract has now expired; it is about $22,000.

Ms Halton—That is correct.

Senator CHRIS EVANS—Minister, how did you come to make that request?

Senator Santoro—It is basically very much along the lines that have been provided by the secretary and by Ms Murnane. I had a discussion with Senator Patterson. There obviously have been other discussions. I sought some advice from PMO, given the across the overall government interest that that office has in the issue. After listening to that advice and listening to points of view that were put to me by Senator Patterson I decided to write a letter to the department, to the secretary, requesting that they provide technical assistance to Senator Patterson.

Senator CHRIS EVANS—I know she can be very persuasive and dogged. Did you speak to the Prime Minister about this, Senator?

Senator Santoro—No, I did not speak to the Prime Minister about that.

Senator CHRIS EVANS—You got advice from his office that they were comfortable with the—

Senator Santoro—The Prime Minister's office, yes.

Senator CHRIS EVANS—You initiated that or they initiated it?

Senator Santoro—After I had a discussion with Senator Patterson, I thought that I should seek some guidance in terms of jurisdictional capacities. I was advised that in the interest of having good legislation, or as good legislation as possible, come before the Senate and the House of Representatives in the form of the private member's bill that was being then proposed by Senator Patterson, it was decided that it would be a reasonable thing to do in the interest of good legislation being considered and debated.

Senator CHRIS EVANS—I agree, Minister; it is a very good precedent. I will be knocking on your door shortly myself.

Senator Santoro—If you wish to do that, as you know, my door is open to all senators and members and I would be happy to talk to you also.

Senator CHRIS EVANS—Good on you! Did you discuss it with or seek Mr Abbott's approval?

Senator Santoro—I honestly cannot recall, but I do not think so.

CHAIR—Senator Evans, we did decide we were going to be fairly rigid about time frames and it is now—

Senator CHRIS EVANS—If I get one more question out, I will be finished—I'll be out of your hair.

CHAIR—Right.

Senator CHRIS EVANS—Was the minister, Mr Abbott, formally consulted at all?

Senator Santoro—I honestly cannot answer that question because I do not have any knowledge of that. I do not know if the department wishes to add to my answer.

Senator CHRIS EVANS—Maybe the secretary could say if they corresponded with the department of health or if the department of health was consulted?

Ms Halton—No, there was no correspondence with Minister Abbott on this issue. The correspondence was between me and the minister, in terms of seeking authority. That authority was given and then the assistance was provided.

Senator CHRIS EVANS—So Mr Abbott's office was not involved either?

Ms Halton—Not that I am aware of.

Senator CHRIS EVANS—Thank you.

[9.34 am]

CHAIR—We will now have questions on outcome 9, Private health.

Senator McLUCAS—I first want to go to the question of the sale of Medibank Private. What role did the department have in the lead-up to the announcement of the sale and what role does it have currently?

Mr Maskell-Knight—The decision to sell Medibank Private was announced on 26 April. The department provided comments on documents prepared for government consideration leading up to that. Since then we have been involved in providing advice to the department of finance on elements of the legislation that has been introduced to give effect to the sale.

Senator McLUCAS—When you say you gave advice on elements of the legislation, do you mean in a policy sense or in a drafting sense?

Mr Maskell-Knight—In a drafting sense in that there are a number of amendments proposed to the National Health Act, which is our minister's responsibility.

Senator McLUCAS—In a policy sense, though, have you had any analysis done of the broader impacts on health?

Mr Maskell-Knight—The policy responsibility rests with the minister for finance.

Senator McLUCAS—When did the department hear about the deferral of the sale of Medibank Private?

Mr Maskell-Knight—I do not know that you can ask an individual in the department a question about the department's state of mind. I read about it in the newspapers, I think, along with everyone else.

Senator McLUCAS—Is the department making a submission to the Senate inquiry into the sale of Medibank?

Mr Maskell-Knight—No.

Senator McLUCAS—Why not?

Mr Maskell-Knight—It seems to us that our role in providing advice to the minister as regulator does not go to who owns a particular insurer.

Senator McLUCAS—There may be implications—there may be—for health costs in particular. Is that not an area in which the Department of Health and Ageing might want to make a contribution?

Mr Maskell-Knight—I think what the effect on health costs may be of Medibank Private changing ownership is a matter for speculation.

Senator McLUCAS—I recognise that; that is why I phrased it in that way. Has Health done any analysis of that speculation?

Mr Maskell-Knight—I do not think it is our role to speculate. If one were—

Senator McLUCAS—I am not asking you to speculate; I am asking you whether or not you have analysed the speculation.

Mr Maskell-Knight—I do not think there is any basis on which to analyse. What the future owners of a privatised Medibank might do in terms of the policies they adopt, the premiums they have and the products they sell is pure conjecture.

Senator McLUCAS—We will get to the broader health cover questions a bit later. On 20 October—

Mr Maskell-Knight—Could I add that, were we to look at the historical pattern about what has happened, as you would be aware, BUPA is the largest for-profit health fund at the moment and its premium increases over the last five years have been about 1½ per cent less than the industry average. So were one, to use a weather forecaster analogy, to look at the weather yesterday to forecast the weather tomorrow, one would say that a large for-profit fund has been able to achieve significantly lower increases than everyone else.

Senator McLUCAS—I suppose it is more in terms of the broader potential coverage that Medibank Private, and other funds for that matter, will have with the broader health cover proposal. It is not necessarily related, I understand, to the sale of the entity.

Mr Maskell-Knight—We discussed the effects of broader health cover at the estimates hearing in May, and the modelling that we have done suggests that that will be broadly cost neutral.

Senator McLUCAS—Okay; we will get to that in a moment anyway. I understand that Minister Abbott put out a press release on 20 October, the date of the deferral—the date we found out about it by reading the *Australian Financial Review*. In it he said:

> The Department of Health and Ageing has consulted extensively with the private health industry.

Who ran those consultations? Your department, Mr Maskell-Knight?

Mr Maskell-Knight—The private health insurance branch in the division and a number of my staff—I work in the division but not in the private health insurance branch.

Senator McLUCAS—Who did they consult with?

Mr Maskell-Knight—Ah, I'm glad you asked me that question! Let me look.

Senator McLUCAS—This is not a Dorothy Dixer, Mr Maskell-Knight! I need to make that very clear.

Ms Halton—Absolutely, but it is just testament to the preparation and the nerves that go in, in the department, to Senate estimates. This is where large amounts of paper get flicked.

Mr Maskell-Knight—We held six industry consultation forums in June and July, in Canberra, Sydney, Brisbane, Melbourne, Adelaide and Perth. They were advertised to the people we deal with through the private health industry circulars. We got a total of 410 people who turned up from health insurers, hospitals, medical groups, various ancillary health service organisations. We then held two further workshops specifically for the health insurance industry on 18 and 19 July and a total of 134 people attended them. We subsequently, in late August and late September, held two further meetings with key industry stakeholders.

We have also released a discussion paper, at the start of the process in June. We have released a paper particularly about broader health cover and other elements of the legislation, on 21 August, and we have released an exposure draft of the legislation, on 20 October.

Senator McLUCAS—Thank you. Why is it that we only consulted with industry?

Mr Maskell-Knight—I am sorry, I should also have said that we have consulted with state and territory governments and we have spoken directly to the Consumers Health Forum. When we say 'industry', the private health insurance circular list goes to a very wide range of groups, including consumer groups; legal advisers; accountancy advisers—a whole range of groups. There are over a thousand people on that list who have an interest in health insurance.

Ms Hancock—I would also add to what Mr Maskell-Knight just said that we have provided funding to the Consumers Health Forum specifically for engagement in the process of the development of the reforms.

Senator McLUCAS—The Consumers Health Forum is the only consumer group that you formally consult with?

Ms Hancock—We also consulted with the Australian Consumers Association.

Senator McLUCAS—Are there any other consumer groups that you consult with?

Ms Hancock—There are no other groups that we specifically sought out.

Senator McLUCAS—I recognise it is actually difficult to find health consumer groups. Consulting with private health insurance members is a nebulous concept but was there any attempt to try and do that?

Mr Maskell-Knight—There was not explicitly; as you say, it is very hard to consult with members. I think the reality is that probably 70 per cent of the people we consulted with were in fact members.

Senator McLUCAS—Sure; but maybe were not wearing that hat at the time.

Mr Maskell-Knight—As were 70 per cent of the people undertaking the consultations.

Senator McLUCAS—The exposure draft consultation period ends at the end of this week. How many submissions or comments have you received to this point?

Mr Maskell-Knight—One.

Senator McLUCAS—Who made that submission?

Mr Maskell-Knight—It was a director of a health insurer.

Senator McLUCAS—Are you expecting more?

Mr Maskell-Knight—I would be very surprised if we did not get more.

Senator McLUCAS—We still have a couple of days to run.

Mr Maskell-Knight—Yes.

Senator McLUCAS—Will those submissions or any other submissions be made public?

Mr Maskell-Knight—We have not indicated to people that we would be making them public and I do not believe it would be appropriate to do so.

Senator McLUCAS—The exposure draft says:

Applications must be approved under subsection 66-10(3) unless the Minister is satisfied that the proposed change would be contrary to the public interest.

Then there is a sentence that I need some explanation of. It goes to the approval process for premium increases:

The Government will issue guidance on the factors to be taken into account by the Minister in exercising this power.

Can you explain the purpose of that sentence and how that would work?

Mr Maskell-Knight—There is a view in the industry that the current legislation confers a very broad discretion on the minister and that it would be helpful if there were greater certainty around the factors that the minister might take into account in exercising that discretion. So what we have in contemplation is that we will keep the power as it exists under the current act, which has the public interest test at section 78(4)(a), but that we will issue a circular each year outlining the sorts of factors the minister will have regard to in deciding whether something is or is not in the public interest.

Senator McLUCAS—So it will just be by way of circular to the industry?

Mr Maskell-Knight—Yes.

Senator McLUCAS—What sort of factors might be included in that guidance from government to the minister?

Mr Maskell-Knight—I think you are inviting me to speculate again. I suppose we would look implicitly at the factors that are taken into account at the moment and just write them down—so the level of solvency and capital adequacy a fund has would be one of the key criteria.

Senator McLUCAS—Any other issues?

Mr Maskell-Knight—I think that encapsulates most things about a fund's performance. That is certainly the obvious one.

Senator McLUCAS—Not the economic state of the nation?

Mr Maskell-Knight—I think the point of regulating health insurance is to make sure that people buying products get their claims met. If that means that premiums have to go up more than some benchmark to make sure that those prudential standards are met, then the general economic state of the nation is not particularly relevant. You would not want to keep a constraint on prices and then see people not have their claims met.

Senator McLUCAS—So essentially the internal operations of any particular fund would be the guidance that the minister would indicate?

Mr Maskell-Knight—Their prudential standing. In reality, I think the practice over the last decade or so in which I have been involved on and off in this has been to look at things like management expenses as well. Clearly, if a fund has much higher than average management expenses and wants a larger than average premium increase, you go back to them and ask a few pointed questions. I imagine that another criterion might be the level of management expenses that the fund has relative to others.

Senator McLUCAS—When will that circular be issued?

Mr Maskell-Knight—There is still some discussion within government about how the mechanics of the process will work each year, so I am not in a position to make a statement about that yet.

Mr Kalisch—Those guidelines would be issued in plenty of time for the industry to be able to make informed decisions about the proposed premium increases.

Senator McLUCAS—And when is that? I just cannot recall.

Mr Kalisch—That pricing cycle generally operates from 1 April.

Senator McLUCAS—So from 1 April, they apply—

Mr Kalisch—Yes, so you work back from there.

Senator McLUCAS—So you work back from 1 April. That is an unfortunate date. Mr Maskell-Knight, will this circular be made public? I dare say if it is a circular it goes to that group of 1,000 people.

Mr Maskell-Knight—And it is put on the department's website.

Senator McLUCAS—Moving now to broader health cover, I know we did talk about it last estimates. On pages 7 and 8 of the guide to the exposure draft, in item 2 of that section, it says that where a Medicare benefit for hospital treatment is covered by the private health insurer, the PHI can cover the amount not covered by the 75 per cent of the schedule fee up to 100 per cent. But then it states, 'This does not prevent a payment of a benefit above the schedule fee.' Can you explain in what circumstances a fund would seek to provide the additional coverage?

Mr Maskell-Knight—Under the legislation at the moment, funds may seek the minister's approval for gap cover schemes which allow them to pay over 100 per cent of the schedule fee. We are essentially seeking to simplify the legislation. Rather than have insurers seek approval for the arrangements under which they pay more than 100 per cent, we just say that they may pay more than 100 per cent.

Senator McLUCAS—And then the insurance provider will package up whatever they want?

Mr Maskell-Knight—Yes.

Senator McLUCAS—Has the department done any modelling on the effect of this measure on health costs generally?

Mr Maskell-Knight—Which measure, Senator?

Senator McLUCAS—The broader health cover measure.

Mr Maskell-Knight—We discussed this at the last estimates. Yes, we have; our view is that it will be largely cost neutral.

Senator McLUCAS—Just remind me—did we ask you for a copy of that modelling?

Mr Maskell-Knight—I do not remember whether you did, but if you had I know what we would have said.

Senator McLUCAS—Well, let me ask now.

Mr Maskell-Knight—We would have said that the modelling is still being used in policy development and we would not wish to make it available to the committee.

Senator McLUCAS—Can you give me an indication of the assumptions behind the modelling? I recognise that you cannot give me the modelling, but on what basis are you trying to model the impact of broader health cover?

Mr Maskell-Knight—The fundamental conception of it is that it will allow funds to pay for things that could be done in a hospital outside of the hospital environment. That will certainly lead to more convenience for patients and it may lead to lower costs for those things. Dialysis is possibly a good example. Dialysis, as you know, is treatment for a chronic condition; patients need to receive dialysis numerous times each year. At the moment, funds pay benefits for dialysis provided in the hospital as an admitted patient. There is actually no technical reason why that service cannot be provided elsewhere. It can be provided in people's homes or in community centres.

At the moment funds could pay benefits for that out of their ancillary benefits. The problem is that they are not able to count that for reinsurance purposes, and because people receiving large numbers of dialysis services would obviously go into the reinsurance arrangements the funds are reluctant to pay for it other than under the hospital cover. Broader health cover will allow them to pay benefits for that outside the hospital and still have it covered for reinsurance purposes.

Senator McLUCAS—So broader health cover will cover what range of services?

Mr Maskell-Knight—At the moment with the way the legislation is structured we say that it covers hospital substitute services. So if you get something which could have been done in a hospital and is not then it will cover that. The legislation provides for rules to be made to cover what other things can go in there, and we have in contemplation rules that will go to letting funds put disease management services into the broader health cover and hence into the reinsurance arrangements as well.

Senator McLUCAS—So that would essentially move it to a general consultation from a specialist?

Mr Maskell-Knight—I don't think so, no. We do not envisage it going to GP consults and specialist consults. What we have in mind are programs where someone may enter the market to provide a diabetes management service which will coordinate podiatric services and dietician services, remind someone to go and see their endocrinologist every six months, encourage them to get better nutrition and encourage them to have exercise—that sort of thing.

Senator McLUCAS—You could describe those visits between a patient and a provider as a consultation, I think.

Mr Maskell-Knight—You could. We have said in the legislation, or in the guide, that we do not see it paying for what are essentially consultation items and that we will make rules to stop that.

Senator McLUCAS—How will we see those rules?

Mr Maskell-Knight—They will be subordinate legislation.

Senator McLUCAS—A regulation?

Mr Maskell-Knight—No, not a regulation. The legislation provides for the idea of rules which are similar to the principles made under the Aged Care Act. So they are made by the minister. They are legislative instruments: disallowable, 'frillyable'—all that stuff.

Senator McLUCAS—Given the time, I might move on to the Private Health Insurance Administration Council. Can PHIAC describe for the committee the process through which a fund becomes a registered health benefit organisation.

Mrs Ginnane—Under the current legislation, a health fund has to provide a series of information to PHIAC which includes its financial plan for a period of a minimum of two years and detailed information about the products that it would offer to make sure that they conform with the act, and we would consider that. At the moment the registration committee involves a member from the department, an officer from the office of the Australian Government Actuary and an officer of PHIAC. They make a recommendation which PHIAC's board considers and we would then register it, provided that it met all the requirements of the National Health Act.

Senator McLUCAS—In recent years how many funds have changed their status from not-for-profit to for-profit?

Mrs Ginnane—In the last three or four years, none. The most recent was a change, I think, of a couple of friendly societies where the parent remained a mutual but the health fund that they ran changed to for-profit. Most of those were in cases where they needed additional capital from the parent which allowed them to pay a dividend back to the parent. I am not aware that a dividend has been paid.

Senator McLUCAS—I understand that there have been six occasions in history. Would the way you describe those friendly society parent arrangements cover most of those six?

Mrs Ginnane—That would cover all of them with the exception of what is now Bupa. That change actually occurred as the result of a Federal Court case when what was then National Mutual Health Insurance actually took over HBA in Victoria and Mutual Community in South Australia, which were—it was before my time but I understand this is so—in significant financial difficulty.

Senator McLUCAS—What sort of scrutiny do you undertake? I recognise not a lot of events have occurred, but what sort of scrutiny does PHIAC undertake when there is a move from not for profit to for profit?

Mrs Ginnane—That is not really an issue that PHIAC can deal with. That is a matter that is dealt with by a change of rules within the Department of Health and Ageing.

Senator McLUCAS—You have a role though.

Mrs Ginnane—In the ones that did occur we were of the view that change should be supported because it did allow the organisations to receive financial support from their parents; otherwise we would have had to take other regulatory action probably including perhaps the wind-up and certainly the merger of those organisations with other companies.

Senator McLUCAS—So you consider the interests of the contributors and the financial position of the fund?

Mrs Ginnane—Yes, we do.

Senator McLUCAS—There are proposals for Medibank Private to move from a not-for-profit to for-profit entity. Have you been involved in any of the discussions to this point in time?

Mrs Ginnane—Not specifically around that change.

Senator McLUCAS—Do you expect to be?

Mrs Ginnane—No.

Senator McLUCAS—I thought you had a role in almost—this is not the language—'protecting' consumer interests.

Mrs Ginnane—It is not clear that the difference between not-for-profit and for-profit funds affects the consumer significantly in any way. The ones that have changed in the past were ones where there were very specific financial troubles, and that would seem to me to be a different circumstance from a possible change of Medibank Private.

Senator McLUCAS—So PHIAC has done no analysis of Medibank Private's move from a not-for-profit to a for-profit entity?

Mrs Ginnane—There is nothing specific that we could analyse that would make such an analysis worthwhile.

Senator McLUCAS—Does the department have a role, Ms Halton, in analysing what the effect of a health insurer like Medibank Private moving from a not-for-profit to a for-profit entity would be?

Ms Halton—I think that goes to the issue that you were canvassing before. I think Mr Maskell-Knight dealt with that issue.

Mr Maskell-Knight—I think that is right. It is very much a matter of speculation about what that change might entail and it depends upon taking a view about what kinds of policy decisions the new owners or the new directors of the entity might make.

Ms Halton—My view is that our analysis of any change utilises effectively the same criteria—is there going to be good stewardship; will the rules be followed; will members receive their entitlements et cetera—and I do not think we do that making any real distinction.

Senator McLUCAS—I understand the bill allows for compensation to be paid in the event of members taking legal action—is that correct?

Mr Maskell-Knight—That is my understanding.

Senator McLUCAS—Given that the bill does allow for compensation to be paid, the bill clearly is predicting that there might be a potential impact on members.

Mr Maskell-Knight—Without being privy to the discussions with the drafters of the legislation and without working with the department of finance, which is responsible for it, as a general observation it is not uncommon to see that sort of clause in Commonwealth

legislation. I believe it is known in the trade as the 'historic shipwrecks clause', due to the fact that it was first put into the Historic Shipwrecks Act. It is essentially a safeguard.

Ms Halton—It is not a portent.

Senator McLUCAS—I was just thinking that this is going to be a really good headline.

Ms Halton—No. The minister is not foreshadowing anything in bringing forward a bill with this clause in it. It is a historical reference.

Mr Maskell-Knight—The Medibank Private sale has this clause in it.

Ms Halton—Yes. I am saying that the clause is a historical clause. It is not a portent; the minister is not forecasting the future.

Mr Maskell-Knight—A shipwreck.

Ms Halton—Indeed.

Senator McLUCAS—It is not a portent; it is a shipwreck.

Ms Halton—It is a clause that comes from the shipwrecks act.

Senator McLUCAS—Please continue, Mr Maskell-Knight.

Mr Maskell-Knight—I was saying that it is not uncommon to have such a clause. My understanding of the reason is that, if such a clause were not there, the High Court may strike down the whole act on the basis of constitutional invalidity.

Senator McLUCAS—What does section 78 of the National Health Act indicate?

Mr Maskell-Knight—My memory is that it is about organisations changing their rules.

Senator McLUCAS—What does section 78 actually say?

Mr Maskell-Knight—I do not have it before me, but essentially it says that if an organisation wishes to change its rules it must notify the department. I think it also says that it must notify the secretary and that the minister may disallow the rules if he thinks they are not in the interest of the contributors or not in the public interest. The public interest provision explicitly relates to premiums.

Senator McLUCAS—Has the ACCC been contacted by the department about the possibility of the Trade Practices Act being breached by a change of status?

Mr Maskell-Knight—Not to my knowledge.

Senator McLUCAS—You have not been in touch with the ACCC?

Mr Maskell-Knight—No.

Senator McLUCAS—Perhaps it is the Department of Finance and Administration that has sought that advice.

Ms Halton—Possibly, but we cannot comment.

Mr Kalisch—Given that it is their legislation.

Senator McLUCAS—Yes. I understand the difficulty. Is PHIAC or the department intending to appear at the inquiry on Friday?

Mrs Ginnane—PHIAC has been required to appear, but we are not making a submission.

Mr Maskell-Knight—The same is true of us.

Senator McLUCAS—So PHIAC is not making a submission either?

Mrs Ginnane—No. The issue of the ownership of a health fund is not a matter for the regulator.

Senator MOORE—The department is not putting in a submission?

Ms Flanagan—No.

Senator MOORE—But you are required to appear?

Senator McLUCAS—Mrs Ginnane, I would like to turn back to the question of guidance for premium rises. Does PHIAC have a role in the development of what the guidance might be?

Mrs Ginnane—We have not specifically been asked, but I imagine we would have. As Mr Maskell-Knight mentioned earlier, the types of issues that PHIAC take into account now in providing advice to the government is the financial position of the health funds—solvency, capital adequacy position. We also look at management expenses, and we have been giving a bit of a hard time to a few organisations with higher than average management expenses.

Senator McLUCAS—We have had that discussion with Mr Maskell-Knight. What other factors would PHIAC see as relevant in providing guidance to the funds?

Mrs Ginnane—The level of increase sought, given their financial position, is really the critical question. We have a preference, I suppose, to see that funds do break even or better. That is a natural conservative instinct of a regulator. We actually like to see a profit, even if it is quite small—which most health fund profits actually are—because it ensures that there are sufficient funds to pay the benefits, which after all is what people insure for.

Senator McLUCAS—Will your role in developing that guidance be a formalised process, do you imagine?

Mrs Ginnane—I am not sure, but I certainly believe that it will largely take into account the types of considerations that are done now. I can see no reason why they would change.

Senator McLUCAS—You are currently consulted in the process of the minister making a decision on whether or not to approve a premium application?

Mrs Ginnane—Yes, we are. Section 78(4) in particular, which you asked about before, allows PHIAC's advice to be sought, and we are part of the premium process in advising on what the financial positions of organisations are.

Senator McLUCAS—Considering the time, I might thank those witnesses and ask for Medibank Private please.

[10.11 am]

Medibank Private

Senator McLUCAS—Mr Savvides, can you tell us when Medibank was advised of the decision to defer the sale?

Mr Savvides—About an hour before the releases. Whether it was the decision to privatise or the decision to sell via an IPO in 2008—there were several decisions through the journey—the norm has been that we get a notification about an hour prior.

Senator McLUCAS—An hour prior to the *AFR* being printed?

Mr Savvides—About an hour prior to the release by Senator Nick Minchin of the announcement.

Senator McLUCAS—I understand that it was in the *AFR* that morning of 20 October. There was a press release that was put out on 20 October. So was it an hour prior to that?

Mr Savvides—The notifications that I am referring to are when the shareholder makes an announcement about its position on the organisation. We are given the courtesy of being notified an hour prior to that. With regard to press releases, I am not sure how I can respond to that. I am not in control of when—

Senator McLUCAS—I understand that. Could you go through the advices that you have had from the shareholder ministers about the future ownership of Medibank Private.

Mr Savvides—Through the process initially—in April I think it was—there was the announcement about their intention to sell.

Senator McLUCAS—Yes.

Mr Savvides—Then they participated in a process by which to determine the means of sale, and that involved the adviser Carnegie, Wylie servicing the Department of Finance and Administration. Out of that came a decision, I think it was in September, to announce that they had decided both to defer the sale and to make that sale through an IPO, indicating 2008 as their timetable.

Senator McLUCAS—On both of those occasions you were informed about an hour before?

Mr Savvides—Informed about the public release of those decisions, yes.

Senator McLUCAS—Of those decisions.

Mr Savvides—That is right.

Senator McLUCAS—Were you involved in the decision or the announcement as an entity?

Mr Savvides—No. The actual deliberation over how the organisation should be sold, whether it should be sold and all of that, we are not a party to obviously. We have a bias view, so we are not participating in that. The organisation Carnegie, Wylie, who are advising the government, certainly interacted with Medibank Private to understand the health fund's perspective on the industry and the way we operate. They took that information onboard but they also gained that through the scoping study.

Senator McLUCAS—Who has been involved in dealing with the Department of Finance and Administration now that the timing and its intention has been confirmed?

Mr Savvides—In my corporate strategy department there is a small unit, a couple of individuals, who are interacting with the department. They are the same people who interact

with the shareholder anyway in our regular reports to the shareholder on the performance of the health fund.

Senator McLUCAS—What communications have gone out to members?

Mr Savvides—At the rate change announcement just prior to April this year, all members were notified of their contribution changes as a result of their policies and in that letter we also noted the intention of the shareholder to pursue the sale of the organisation.

Senator McLUCAS—Could you table one of these letters?

Mr Savvides—Yes.

Senator McLUCAS—And that is all we have had to this point?

Mr Savvides—Yes, other than the enormous amount of public discussion.

Senator McLUCAS—You would want to be asleep if you had missed it.

Mr Savvides—That is right.

Senator MOORE—Mr Savvides, there is a standard letter you get each year—and a lot of people in the room are members of Medibank, I am sure—advising that the premiums have gone up. That is something you get as a matter of course. Certainly there is a bit of a view that you get a letter from Medibank Private like that and you know your premiums are going up and you chuck it. You just get rid of it. You just expect that it is going to be, 'Thank you for your membership. As of the X of Y your premiums have increased by X'. Did you have any feedback from people as to whether having the two messages in a standard letter was a good idea?

Mr Savvides—There are a couple of issues around that. First, at the time that notice went out we did not really know whether there would be a sale on a certain date, we had no timetable, we did not have a means of sale. The only thing we did know is that the shareholder had made a decision, looking forward, to sell the asset. So we could not be very specific about the message. Secondly, we did refer it to a special part of our website which will be updated, as we go through this period of time, on the latest that we understand and communicate to members about this issue. Also, our call centre staff and our front line retail staff had been given a serious of Q&As to assist them to be better briefed so that they can assist members who do ask questions about the sale—what does it mean for them, etcetera—so that we are consistent in our responses and able to help when we can.

Senator MOORE—I could talk for days on the effectiveness of the communication in that kind of process but, just as a shareholder, I know that when you get the standard letters from Medibank Private containing information about your premiums going up, there is nothing to flag that that is more than the ongoing relationship with the organisation, particularly with the large number of people who have their premiums taken out through their payroll. So you have no role personally in that case.

Mr Savvides—I take your point.

Senator McLUCAS—What sort of feedback have you had from members following both the indication that you have given them about the impending sale and more broadly?

Mr Savvides—We have only had a very small amount, if you like, of feedback that has been of a concerning nature—people who were fearful of their entitlements being lost or changed or whatever, much less than we had anticipated. We have had all kinds of feedback. We have had people call us saying, 'I thought the company was already sold.' We have had people who were interested in what shares they were going to get in the sale of the business. We have had lots of breadth in the correspondence. The percentage overall, I think, is in the several hundreds. We are talking about three million lives covered in the health fund. So there has been a low level of inquiries so far.

Senator McLUCAS—So 300?

Mr Savvides—I think it is about 300. I can table the exact number. It is a changing number, obviously. To 24 October we had 208 and, of those, 39 were a complaint.

Senator McLUCAS—What were the others?

Mr Savvides—Just inquiries, wanting more information—119. For a classification called 'feedback'—I am not sure what that means—it is 47. For 'process' it is one. For 'outbound' it is two—that is when we are calling out and in the outbound communication they raised the question then. So that totals the 208. I can table that for you, Senator.

Senator MOORE—So you have talked to them about something else, and you have recorded that in the midst of that conversation someone said 'And by the way, about the sale'.

Mr Savvides—Yes, they raised it. In our call centre technology, in our CRM system, we have the ability to capture that and have a tally because we are obviously monitoring members' sentiment. We are concerned obviously, to run a very good business, as we deal with the change of ownership.

Senator McLUCAS—And the feedback might be that this is a terrible idea.

Mr Savvides—I assume that in those complaints that would be part of the 39.

Senator McLUCAS—So there were 39 complaints about the 47 of the feedback. But we do not really know what the feedback was.

Mr Savvides—I can have that analysed.

Senator McLUCAS—You would be aware that opinion polling nationally does not show that the sale of Medibank Private is a good idea. Have you done any polling or any analysis of that?

Mr Savvides—No, we do not specifically poll that particular agenda item. I do not think that is the place we want to be. We do a regular polling of member sentiment about a lot of issues—for example, what products they want to buy from the health fund and what they think about service. We try to capture some feedback and ideas about things we could be doing that we are not doing currently. We have this sort of service and customer satisfaction survey as a regular process. We are very pleased that the whole profile of feedback that we are getting through the intentional survey is very positive, and it is an improving landscape.

Senator McLUCAS—But you are not asking the question about what members think of the sale of Medibank?

Mr Savvides—I am not aware that we are doing that specifically. I think we are capturing member sentiment about the sale. Obviously it is out there.

Senator McLUCAS—How do you do that then?

Mr Savvides—In that questionnaire process we ask them their view of the fund. And we pick up those people who have an attitude or a sentiment about the sale because they had been reading about it in the newspaper.

Senator McLUCAS—So do you have data on that member sentiment about the sale?

Mr Savvides—We probably do. I could look into that. I do not have that with me at the moment.

Senator McLUCAS—How would you provide that to me? I am trying to understand how to ask you the question.

Mr Savvides—Well, if that data exists and it has been analysed—and it is not information that would commercially damage the organisation—then I could come back and provide it.

Senator McLUCAS—Thank you. If you could take whatever that question is that I just asked you on notice, that would be really good.

Ms Halton—He will look at the data and give you whatever answer he can, on notice.

Senator McLUCAS—Are you taking any action to comfort members about the future of Medibank?

Mr Savvides—We do that as a business, anyway. We try to attract people to the organisation. We have been very successful in doing that in the last couple of years. I think our focus is not to be involved in the discussion around the sale, because it is really an issue for the owner. Our No. 1 priority is to sell the best private health insurance we can sell in this country, and to service our members in the best possible way we can. We put a lot of effort into improving our customer service; improving our products and making them more appealing, especially to younger members; establishing our brand more effectively; and modernising our retail network. That is what our business is about on a daily basis. And, also, most importantly, it is our business to be much more commercial and focused around the costs of the services that we provide our members through the contracting that we do with hospitals and ancillary providers. That is a very important part of our business.

Senator McLUCAS—Could you provide us, for this current calendar year, with a month-by-month snapshot of the number of new members you have received, the number that have withdrawn and a split on age? The question of young members is important.

Mr Savvides—I can certainly give you some information about our growth because it has been a very healthy period of growth. We have had a substantial growth in the number of people joining Medibank Private in the last year.

Senator McLUCAS—Can you do it month by month?

Mr Savvides—To be specific about net gain and net lapse on a monthly basis is to give my competitors a lot of advantage.

Ms Halton—It is commercially sensitive information.

Mr Savvides—I have 37 competitors out there who want to know the answer to the very question you have just raised.

Senator McLUCAS—The reason I am asking the question is that I want to know whether or not there has been any change in the number of people joining or withdrawing from Medibank as a result of the announcement in April, and then the subsequent one in September.

Ms Halton—Mr Savvides can answer that question. He can look at the data but I think his concern would be—and I think it is a fair concern—that providing that level of granular data is very sensitive commercially. He understands the nature of your question, and I think he can take that question on notice without disclosing the commercial information he would be worried about.

Mr Savvides—But overall I can say that the growth that we have experienced in the last 12 months, and it is recorded in the annual report for 2006 that was distributed a couple of weeks ago, has been our strongest period of growth since Lifetime Health Cover was introduced in 2000.

Senator McLUCAS—I am looking at the specific months. Those events often trigger consumer reaction. I am trying to ascertain whether there has been any.

Mr Savvides—Through that, I have not seen any material change as a result of the announcement of sale. Maybe one area to look at would be the lapse rate of membership, people leaving. Again, that has been reducing materially in the last two years, and that reduction has not slowed down as a result of the announcement of the intention to sell.

Senator McLUCAS—Can I ask you have a look at your figures and provide me with what you can provide to me?

Mr Savvides—I certainly will.

Senator McLUCAS—Does Medibank have access to the government's legal advisers to the sale, Blake Dawson Waldron?

Mr Savvides—No, they service the shareholder.

Senator McLUCAS—Has Medibank sought legal advice about the potential for compensation to be sought from members if legal action is taken?

Mr Savvides—I do not want to remove the privilege that exists from the legal advice our board gains on many issues, but specifically on the sale I can say that the legal advice that we have received is not inconsistent with the advice that the shareholder government has received on the sale of Medibank Private. It is from a different source, obviously, but it is not inconsistent with the advice that the shareholders receive.

Senator McLUCAS—In terms of the shipwreck compensation issue that I spoke with Mr Maskell-Knight about, have you taken advice about where the compensation will be paid from if any is required?

Mr Savvides—No. That really is an issue for the drafter of the legislation, the department of finance. I think the assumption you are making is that we had input into the structure of

that. It is not our legislation. It is the owner's legislation, and what they choose to put into it is their prerogative.

Senator McLUCAS—No, the question I am asking is: has Medibank done any analysis of who may be responsible for compensation payments?

Mr Savvides—Medibank Private's view is that Medibank Private is owned by the Australian government and the business that it operates is owned by Medibank Private so there is no issue about compensation.

Senator McLUCAS—So compensation would rest with the federal government, if any compensation is going to be paid?

Mr Savvides—Again, I cannot speak for the intent of the legislation and its design. It is not an area that we participated in.

Senator McLUCAS—So your advice is that Medibank Private, as a privatised entity, would not have a potential compensation bill.

Mr Savvides—It is hypothetical. It is assuming that there would be one. Again, the view that we have is based on the legal advice that we have, which is not inconsistent with the advice that the federal government has on that issue.

Senator McLUCAS—But you have asked for legal advice on that issue? That is what I am getting to.

Mr Savvides—The legal advice that we have is comprehensive and covers all issues—the response to members et cetera—and that is, again, a component of the overall advice.

Senator McLUCAS—The issue of the broader scope of coverage is also a part of the legislation. Has Medibank done any actuarial work or any modelling on the impact of that measure on premiums?

Mr Savvides—Yes. We applaud the broader health cover initiatives. I guess the industry in general, and it has been public for some time, has been pushing for the ability to overcome the discontinuities in cover that private health funds find in the marketplace because of the original health act legislation that focuses itself around the hospital gate and the services provided within hospital. From a general point of view, we see the legislation as bringing health cover and health capability into the 21st century because it overcomes these restrictions that private health providers have in terms of hospital based services.

More specifically, a large part of our health burden in our health fund is due to chronic diseases now. It is not optimal to treat chronic disease in a hospital setting. Certain parts of the intervention require a hospital, but a lot of the maintenance and the routine part of the treatment can be done in step-down or alternative care facilities. Therefore, we are excited about the legislation being able to give us genuine substitution and, we hope, more cost-effectiveness benefit and member benefit in terms of serviceability and access.

Senator McLUCAS—That is nice, Mr Savvides, but I asked you what sort of impact it is going to have on premiums.

Mr Savvides—Overall, it would mean that we are hoping that substitution is genuine and therefore that we do not end up with increased cost burdens by creating duplication. The way

it is drafted, the health fund does have a say in selecting alternate services rather than having them imposed on it. If the imposition was there, rather than the selective process, then you could be incurring extra cost. We see the freedom to choose the services that we wish to have as substitute being a key to keeping those costs under control.

Senator McLUCAS—Do you think there is going to be a question of definition about which services are in broader health cover and which are not? I had a discussion with Mr Maskell-Knight about when a consultation is in or out.

Mr Savvides—My hope is that we do not try to apply a rigid rule in that all funds have to do the same thing, that Medibank would choose what it believes to be the right substitution services for its cohort in specific locations. Other funds may choose other pathways. Overall, that is probably good for the marketplace in diversity and competitiveness. All of that is better than being contained in the current structure which significantly restricts the ability of funds to directly contract with substitute service providers today.

Senator McLUCAS—Do you envisage then, Mr Savvides, the same sort of relationship developing with, say, medical specialists that you have with the private hospital sector?

Mr Savvides—We do have relationships with medical specialists today.

Senator McLUCAS—Usually through the hospital, I imagine.

Mr Savvides—Yes, and day surgeries. There is a significant amount of—

Senator McLUCAS—I am thinking of a direct relationship with, say, a group of specialists.

Mr Savvides—If you are implying that some health funds may buy into some health specialist business ventures—

Senator McLUCAS—Yes.

Mr Savvides—That is not really on our planning horizon at Medibank Private, but other health funds may be thinking of that. Other health funds have owned hospitals before as well.

Senator McLUCAS—Thank you, Mr Savvides.

Senator MOORE—Mr Savvides, we have had questions about notification from the different shareholding ministers and also from the share place about the delays in sale. I am interested in the internal mechanisms that you use as management to let your staff know what is going on. We have the web based situation and the letters to shareholders. You may want to take on notice what methodologies you have put in place within the organisation to let them know what is going on because, as we talked about before, they are seeing all the media as well. It might be easier to take that on notice, if you can give us a brief on what the staff communication methods are.

Mr Savvides—I will do it briefly and give you detail on Friday. We spend a lot of time in staff forums, management to staff. I personally make sure I go around the country twice a year, and do 30 or 40 staff forums at every cycle, to speak to all staff about all of the issues we are dealing with—the business as well as issues around ownership. We also have communications through our human resource department, we have internal newsletters and we have a lot of FYI communication through intranet across all of the screens in the company

because most of our staff are screen connected. We have invested a significant amount. My staff will give you an inventory of that on Friday.

Senator MOORE—That communication strategy would be useful. That gives you a bit of notice before Friday.

CHAIR—Thank you very much to the representatives of Medibank Private.

Proceedings suspended from 10.34 am to 10.50 am

CHAIR—We have concluded outcome 9. We now move to outcome 2, Access to pharmaceutical services.

Senator McLUCAS—Just before we start, Chair: when we were talking earlier about appearances at the Finance and Public Administration hearing on Friday about the sale of Medibank, Mrs Ginnane said a word that I cannot recall, but I thought it was something along the lines that they had been directed to appear. I do not think she said 'ordered'.

Ms Halton—Required.

Senator McLUCAS—Required.

Ms Halton—Yes.

Senator McLUCAS—I understand that there was an invitation from the committee to the department and to PHIAC. In the normal course of an invitation—

Ms Halton—That is correct. That correspondence did come in. You are quite correct. I do not know that the word 'required' is in the correspondence; I think it was an invitation—

Senator McLUCAS—It was an invitation.

Ms Halton—which I think people had accepted.

Senator McLUCAS—As an invitation?

Ms Halton—As an invitation.

Senator McLUCAS—Lovely. I am glad that that is clear.

Ms Halton—Yes.

Senator McLUCAS—Going now to PBS outcome 2, can I get an understanding of the departmental assumption for growth rates over the forward estimates for the PBS.

Ms Huxtable—The forward estimates as at budget 2006, which we talked about somewhat at the last estimates, are based on a model which the department updates annually. Within that model is detailed information around prescription volumes utilisation in previous years, historic utilisation which is updated annually. It is also updated each year to take account of population change and concessional coverage, and on that basis estimates are made. Of course, the other factor is to incorporate any new listings that have occurred in the period, and on that basis projections are made in respect of future growth.

Senator McLUCAS—What are the projections for the out years currently?

Ms Huxtable—As yet, there have not been any estimates variation finalised, so the projections are as at budget 2006. From memory, I think it was an average annual 7.8 per cent growth over the four years.

Senator McLUCAS—When do you remake the model?

Ms Huxtable—The model update is usually done around this time of year, in a period after we get final prescription volumes in for the previous financial year. That takes a bit of time because there is a bit of a lag. The work is done in this period. Normally the estimates variation, if there is one, is around the end of this year or early in the new year, normally in the MYEFO process—from time to time, there is an estimates variation around that time, which is normally in December, from memory.

Senator McLUCAS—Can you provide the committee with information about the department's estimates for PBS growth in terms of how it has changed since 2003?

Ms Huxtable—The actual growth rates?

Senator McLUCAS—Yes, please.

Ms Huxtable—The actual growth rate from 2003-04, which is the year I go back to on this bit of paper, is 10.9 per cent. It is seven per cent in 2004-05 and in 2005-06 it was 2.7 per cent.

Senator McLUCAS—So the estimate—

Ms Huxtable—That was the actual growth in each year.

Senator McLUCAS—Could I just finish getting down the number. Can you take me back to what the estimates were?

Ms Huxtable—I am going from memory here but the estimate in respect of 2005-06 was varied on several occasions in the course of that year. I probably need to refer to my notes. In terms of the information that I have at budget 2005 we expected a 7.8 per cent growth rate. I am sure that was varied at MYEFO but I do not have that figure and I would be going from memory for that. It is probably best not to speculate, but we can get back to you with that figure. Around December or January there was a variation to the estimate which dropped it down a bit, I think, to around five per cent. Then at budget 2006 there was a further estimates variation that took it to 2.8 per cent. The actual figure was obviously close to that 2.8 per cent.

Senator McLUCAS—Could you provide us with almost a chronology from 2003 until now of when the modelling predicted a growth rate and when those were changed? Also could you give us an indication of what were the factors that meant there was a change, such as a new listing, new information about demographics or something like that?

Ms Huxtable—The model update itself is done annually.

Senator McLUCAS—But you said earlier there were a couple of times when that changed in 2005-06.

Ms Huxtable—Yes, that would be in respect of the year which we are in. So from time to time there is a review of where we have got to in that year and that will take account of script tracking in that year and also new listings in that year and then a variation in respect of actuals for that year. What it does not do is a whole model update. The model update process itself is a very comprehensive and complex thing and takes some considerable time. It is not the sort of thing that we do more than once a year; we simply would not be able to do it more than once a year.

Senator McLUCAS—If we do this big thing once a year and then we change the prediction a couple of times during the year, I am trying to understand what factors lead to that sort of change?

Ms Halton—What Ms Huxtable was going through before are the things which would be taken account of in any change in the published figure, which would occur at AEs, MYEFO, around that time would be actual experience. So you have an estimate of what might happen but actual experience in terms of script volumes and listings plus delistings if there were any and you know that we have had a couple of high-profile, large items that have been taken off the market. Those experiences would then be used not to update the entire model but to calibrate what is expected to happen in the year that we are in.

Senator McLUCAS—Yes, I understand that. What I am asking for is a chronology of change so that when Vioxx comes off, for example, that means something. I am trying to understand how when events occur there will be a change in the projected growth and how that will work.

Ms Halton—We can go back and give you the published figures from the various times when they were published and then we can give you the actuals and, in broad terms, the kinds of things that may have fed in. But, as you would appreciate—and in fact we have great trouble doing this ourselves—we cannot disaggregate $35 according to this and $200 million according to that; we just can indicate what the broad range of factors were that contributed. So I will take that on notice.

Senator McLUCAS—I suppose I am asking you to be as specific as possible.

Ms Halton—Our finance colleagues find this quite difficult as well, but because the model is so big and everything is so interrelated—because often things have impacts on each other—disentangling specifics is difficult. But we will take it on notice and we will give you those published figures and then the factors that were relevant.

Senator McLUCAS—I understand it is a very complex model, but there must be a set of inputs that go into that at a point. You know—someone realises: 'Oh, my goodness! There are so many more people with diabetes; we have got to factor that into the model.'

Ms Halton—Yes, we will give you something on that.

Ms Huxtable—I think that previously, on notice, we have answered questions that go to how the model works, in general terms, and we can certainly refresh that and provide it again.

Senator McLUCAS—Thank you. Could you also in that document give us an indication of what the projected growth will be, on current forecasts, for the out years in the PBS?

Ms Huxtable—Yes. That figure is 7.8 per cent.

Senator McLUCAS—For all out years?

Ms Huxtable—It is an average annual growth of 7.8 per cent. We do not disaggregate it greater than that amount.

Senator McLUCAS—And that is using this very complex model?

Ms Huxtable—That is what the model projects. The model drives that figure.

Senator McLUCAS—Even though the actual growth is 2.8 per cent now—

Ms Huxtable—2.7 per cent.

Senator McLUCAS—The model is predicting—

Ms Huxtable—Yes, but that was, as I said, at budget 2006. We are going through the process of doing a model update, but as yet that process has not been finalised.

Senator McLUCAS—Okay, thank you. In answer to a question about underspending, the department indicated that there was a PBS underspend of $7.7 million, and that was explained as being due to lower than expected demand in some drug groups—cholesterol-lowering, arthritis and antidepressant medications—and partly offset by new listings. Can we have a breakdown of that drop in PBS due to lower demand and also costs of new listings? Can you disaggregate that answer—that $7.7 million?

Ms Huxtable—I think that answer that you are referring to was in respect of the 2004-05 financial year; is that right? In any event, we can certainly provide information on new listings in respect of a financial year.

Senator McLUCAS—I think it is 2005-06.

Ms Huxtable—Is it? I beg your pardon.

Ms Halton—What number is that?

Senator McLUCAS—E06_260.

Ms Huxtable—Certainly we can provide information on what the new listings were in that period. In respect of the lower than expected expenditure on certain elements—and we have spoken about this before—we certainly do not go into disaggregating all the various components of what would build up into the model, at that level, but there is no doubt that there has been some lower than expected use in these drug categories.

I would note, however, in that regard, that some of these have been very rapidly growing. For example, the lipid-reducing agents, the statins, were growing at a very significant rate, and they continue to grow, but at a lesser rate than that at which they have grown in the past. So it is not a reduction in their uptake.

I know we have talked about what the various components are here at length at other times. Also embedded in these figures is the impact of something like the Vioxx withdrawal and a significant drop-off in that category, and possibly some consumer reactions to media coverage of adverse events in regard to some drug groups. We see, I think, some of the research around the hormone replacement therapies, and there were other things around antidepressants, and you see at that time some reduction of what was expected in those groups. I think Professor Horvath has spoken of some of these things previously here.

Senator McLUCAS—Is it possible to disaggregate according to those three categories of drugs?

Ms Huxtable—What we certainly can do is show what the actuals have been year on year in respect of those drugs and you can see from that some of the patterns and the changed patterns in utilisation.

Senator McLUCAS—As for that explanation, some of it will be self-evident: Vioxx is taken off so there is a reduction in arthritis medication usage. If there are other indicators as to why the lower demand or the lower growth have occurred, could you provide the committee with that information too?

Ms Halton—Yes. The other thing to remember—and my memory is that we talked about it last time—is there have been other things in terms of changes in medical practice which are also relevant here. I think we had the conversation about longer consultation times and this actually resulting in fewer scripts.

Prof. Horvath—In fact the changes are predictable, Senator. When Vioxx went off, not only did the Vioxx script disappear but the whole range of COX-2 inhibitors went off. There was a professional anxiety as well over the non-steroidals, which make up a large group. The naproxens and those dropped also as the profession got anxious, similarly with the antidepressants and similarly with the HRT, which was a fair amount of issue. What specifically the secretary refers to is this: about the same time a lot of activity was put into general practice, especially around antibiotic usage, to encourage longer consultations, which has been reflected in fact in the long consultation items, better history and the lowering of the use of antibiotics. That is reflected also.

Similarly, there was the removal of a whole class—that is, the quinine group, which were used for cramps. In fact, they were taken off because they were shown to be ineffective. Lastly, the statins and some of the antihypertensives had been on a very, very steep growth curve because of unmet need in people now moving toward guidelines, and a lot of that unmet need was being filled. As Ms Huxtable said, the growth is there but it flattened out more in keeping with ageing and population than with unmet need. If you look at other parts of the growth—the ones where we expected it, where new products came on such as anticancer drugs—they appropriately increased above demographics.

Senator McLUCAS—Thank you.

Ms Huxtable—The other factor that I think we have spoken of before is that phenomenon where PBS subsidised scripts fall below the general co-payment and basically become lost to view. We did respond to a question on notice in regard to the number of drugs that fell below the co-payment in January 2005 and provided a list, and there were quite a significant number. That is a factor that is in the mix as well.

Senator McLUCAS—I think that is enough for that issue.

Senator MOORE—Ms Huxtable, I refer to the answer to the question which covered two successive financial years—and the same answer was given in 2004-05 and 2005-06—and the underspend. I think that is one of the reasons we are following up on the question. That underspend was significant in 2004-05. Whilst not as great in 2005-06, it was the same. It was a downward pattern, as explained by Professor Horvath, and exactly the same reason was given in the response. It says:

Demand was lower than expected in some drug groups (eg: cholesterol lowering, arthritis and anti-depressant medications).

That was in both years. That is why we wanted to follow up and see what the rationale was, given the same thing was happening significantly over two successive years.

Ms Huxtable—I think it might be a phenomenon across a calendar year that has been picked up in one year and then the next. I would need to look at just what we are reporting here in terms of the point in time at which the final estimate was done and what the 'actual' then reflected back against. Looking at this quickly, in the end we were very close to spending what we expected to in 2005-06. We expected 2.8 per cent; the 'actual' was 2.7 per cent. In respect of 2004-05, if the estimate variation was done at the MYEFO then maybe there was something happening in that period. There is probably quite a logical answer to that, but I will take it away and have a look at it.

Senator MOORE—We must watch this year as well because, if it continues, we will not know until after we see the actual expenditure finalised whether it is the same trend for the same reasons. What stimulated our particular interest in the why and how, apart from the fact that there was an underspend and we always like those, was that the answer from the department was for exactly the same areas. If that was ongoing, we need to see whether there had been particular work done as to why those three conditions seemed to be given as a department for the major underspend. We will follow it through and, at that end of this year, if the same underspend continues in the same areas then that will stimulate some more discussion.

I have some questions about special patient contributions, therapeutic premiums and the way the whole system works and ticks over. We will be putting questions on notice as to how many there are, but I am trying to get a handle on this area. As you have said, this area is dynamic and the way the model operates is dynamic. I tend to get confused. We have the standard contribution and then we have these other terms about which I often have to stop and think, 'Which is which and how?' That is the background.

Ms Huxtable—You are not the only one, I can tell you.

Ms Halton—Some people have been working on the PBS for 20 years and they have to pause occasionally, so you are in good company.

Senator MOORE—They are probably very frequent users of the PBS too. Is 'SPCs', special patient contributions, the terminology?

Ms Halton—Yes, well done.

Senator WEBBER—So far so good.

Senator MOORE—How many PBS listed medicines now attract the SPC? Can you give us a list of each medicine, the amount of the SPC and when it was added? Is that table easily at hand?

Ms Corbett—Yes, I can give you that data. There are brand premiums, then we have a category called therapeutic group premiums and then we have some special patient contributions that do not fit into either of those groups. I will talk first about the brand premiums.

Senator MOORE—I am particularly interested in the brand premiums, particularly since the 12.5 per cent generic policy came in, which had an impact on the brand premiums. Since the policy changed, which was highly publicised with lots of discussion about the 12.5 per

cent reduction, has there been a change? How many PBS listed medicines have added a brand premium since that 12.5 per cent policy change?

Ms Corbett—There has been very little movement in the number of brand premiums from year to year. As at June 2006 we have 345 products on the PBS out of 2,800 products altogether, so it is clearly a minority of products that have a brand premium. The average brand premium was $2.76 for this year, and the premiums range from about 6c up to a maximum that is just under $80.

Senator MOORE—That is a big range.

Ms Corbett—That is a big range, as is the range of prices for our PBS products.

Senator MOORE—Can we get a list of them and can we get the specific—

Ms Corbett—They are listed on the PBS schedule. With each update of the PBS schedule there is a green lift-out, but we can certainly table the lift-out from the latest update.

Senator MOORE—And that has a list of which is 6c and which is just under $80?

Ms Corbett—Yes, that is in the schedule.

Senator MOORE—June 2006 was after the 12.5 per cent policy change, wasn't it?

Ms Corbett—The 12.5 per cent policy came in in 2005, so right through 2006 in our major updates you are seeing—

Senator MOORE—Does that data show the numbers that have come on to the brand premium process since the introduction of the change—newly listed ones?

Ms Corbett—What is in the schedule does not specifically list that. We can specifically list that.

Senator MOORE—That would be good.

Ms Corbett—There are less than a handful, I think, of new brand premiums that have resulted directly from the 12½ per cent. It has not been common practice for companies to use the brand premium option, but there are now, for instance, brand premiums on a couple of the better-known simvastatins. So there have been a few that have come in, and the average of them is still relatively small.

Senator MOORE—And you can highlight those for me?

Ms Corbett—That policy was introduced in 1990. We have given an update on the premiums generally—all kinds of them—in the most recent annual report of the pricing authority, which was tabled yesterday.

Senator MOORE—We have a copy—though we do not have the orange one; we only have the purple one.

Ms Corbett—The orange one is very recent.

Senator MOORE—So some of the information I have asked for is in that?

Ms Corbett—There is a description of what the premiums are and there is a table given of numbers of the premiums. I think you will find that that is helpful. The one thing that we may need to do for you on notice is to specifically look at brand premiums that came on in relation

to 12½ per cent price reductions, but there are not very many of those, so that one is simple to do on notice.

Senator MOORE—I do apologise, because I will still wade through the questions. Some of these may be in that document, but I have to admit I have not read it yet.

Ms Corbett—I am not surprised!

Senator MOORE—I will wade through it, and then we might be able to refine that down the track. The other issue is the dose form. Of interest to me is the dosage and how it is taken. That is listed in the overall thing as well, isn't it?

Ms Corbett—Every different dosage of a product is listed in the PBS, and the prices are all itemised for every dose and strength.

Senator MOORE—Are there any medications that vary in price according to the form of the dose?

Ms Corbett—Yes, there certainly are.

Senator MOORE—So that is actually a factor in the cost?

Ms Corbett—Yes, it is—absolutely.

Senator MOORE—Do you want to go with special patient contributions or therapeutic premiums next? It is your call.

Ms Corbett—It is probably simpler if I explain therapeutic group premiums first and then move to the other ones. The therapeutic group premiums are applying only to four particular groups of drugs that are large in both price and volume on the PBS: the ACE inhibitors, the calcium channel blockers, the HMG-CoA reductase inhibitors—we know those as the statins—and there are also the H2 receptor antagonist drugs for peptic ulcers. Those four groups have been determined with the advice of PBAC to be drugs that are therapeutically equivalent and substitutable at the patient level. So you can use any one of the statins, in a sense. With very few exceptions, patients can move between them.

So those are the therapeutic groups. In those categories, everyone in the category can use a therapeutic group premium if they choose to do so. Again, many players in these groups do not choose to have a premium, but there are a number of premiums there. With those particular premiums, there is the mechanism available of an exemption, so that, if your doctor says that you really need to stay on the particular statin that you are on, for instance, for whatever reasons, and that has a therapeutic group premium on it, your doctor can seek an exemption for you from the payment of that. Medicare Australia will then handle that particular script in a different way and you will just pay your co-payment.

Senator MOORE—Is that automatically approved?

Ms Corbett—It is automatically approved on the recommendation of the doctor. The doctor must seek an identifiable authority, so then there is an authority number that goes with the script. That script is processed by the pharmacist as just a co-payment owing from the patient.

Senator MOORE—So it is not seeking approval as much as making a statement, because no-one is actually saying yea or nay. The doctor makes a statement, that is automatically accepted and then it happens?

Ms Corbett—Yes. As with any other authority, Medicare Australia will ask the doctor the reason for that—the doctor will have to give a reason—but, clearly, if the doctor has gone to the point of seeking that exemption, they have in mind that there is a reason.

Senator MOORE—So there is an interaction?

Ms Corbett—There is an interaction between the doctor and Medicare Australia for every authority approval. This is handled in that same way.

Senator McLUCAS—Could we get an indication of the number of authority approvals for scripts where doctors have requested that the premium payment not be applied? Is that possible?

Ms Corbett—It is possible for us to identify the exemptions in the categories where they are available, yes. That data is collected by Medicare Australia. I do not have details of it with me, but we could do that.

Senator MOORE—That would have to be a line in the costing. That data would have to be available.

Ms Corbett—Yes, it is identifiable. We can give you an estimate of the numbers. The number of therapeutic group premiums currently is only 75. It is only for 75 items that we have a therapeutic group premium.

Senator MOORE—Seventy-five groups of items?

Ms Corbett—No, 75 items altogether out of 2,800. There are only 75 items that have a TGP. The range of the TGPs is from $1.35 to $7.01, so it is a narrower range than with the brand premiums.

Senator MOORE—Since the time that the new policy, the 12.5 per cent generic policy, came in, can we find out how many drugs—they are all called drugs, are they?

Ms Corbett—Yes.

Senator MOORE—have got a new therapeutic premium listing?

Ms Corbett—I do not have that with me. We can do that. There are a small number of the therapeutic group premiums that have changed in relation to the 12½ per cent reductions.

Senator MOORE—And the same information—what they are, what the premium is.

Ms Corbett—What they are, how much it has changed.

Senator MOORE—And the dose form. You talked about the way it was done. Is it usual that you get the therapeutic group premium at the time it is introduced? Does it happen when it comes on, rather than some time down the track?

Ms Corbett—No. On the contrary, it can be at the initiative of the sponsor, when some other change has occurred in pricing, or at the point in each year when an annual review of the pricing of that group of drugs comes up. In addition, companies have an entitlement to bring

an ad hoc request for premiums to us for consideration by the pricing authority. So there are various stages when it can happen.

Senator MOORE—Who makes the determination?

Ms Corbett—The determination is made within a certain set of rules that are approved by the pricing authority. Some of them are very straightforward and are handled under the delegations that rest in the department. If there is anything controversial or unusual, that would be a matter that would be considered by the pricing authority.

Senator MOORE—So each case is handled on its own merits and determined on the complexity; would that be right?

Ms Corbett—That is true.

Senator MOORE—And then the delegation is determined.

Ms Corbett—Most of them are very straightforward.

Senator MOORE—I have questions about Zantac effervescent tablets and Tritace.

Ms Corbett—Ramipril, yes.

Senator MOORE—I would like to have some understanding of the rationale behind increasing the therapeutic premium for a medicine like Zantac effervescent tablets from $2.14 to $4.18. Considering the range you gave me, that is a bit of a chunk.

Ms Corbett—Yes. It is interesting. That drug, Ranitidine, is in a reference pricing group with a number of other very similar drugs. There are four other drugs in that grouping. The company has chosen to increase their therapeutic group premium from October to $4.18, but they did have a therapeutic group premium of $2.14, as you said. Their original introduction of a therapeutic group premium goes back to 1998. They have been there at about $2.10 for a very long time. That has been the choice of the sponsor of Ranitidine, and there are other products in that group that patients can move to if they are not prepared to pay that particular premium.

Senator MOORE—Was that considered to be a straightforward decision? Was it an internal decision or was it more controversial?

Ms Corbett—It was straightforward. It was in association with a 12½ per cent price reduction in that group. So in a 12½ per cent price reduction process, every sponsor affected is notified and they are given an opportunity to give us an indication of what they want to do as a pricing response. So it is a very straightforward process. Adjustments of premiums are very rarely controversial at all; they are pretty simply managed.

Senator MOORE—The other one is Tritace.

Ms Corbett—Ramipril.

Senator MOORE—It has been around for a long time, I understand. Its therapeutic premium has increased to $3.25, depending on the dose.

Ms Corbett—Yes, that is true. They have also had a premium for some time, since December 2004, so it is an increase in a premium that already existed. I have it dose by dose here, but that is the fact.

Senator MOORE—Is there a big variation in those—

Ms Corbett—Again, it was in relation to a 12½ per cent price reduction round. There are many drugs in this group with Ramipril—Captopril, Enalapril, Fosinopril, Lisinopril, Perindopril, Quinapril and Trandolapril. So people can go many ways from this particular product.

Senator MOORE—They were all 'prils,' except for this one.

Ms Corbett—Its chemical name—it is a 'pril'—is Ramipril.

Senator MOORE—Is it the same rationale then: this one had been around for a long time and, after the 12.5 per cent policy change, the sponsor then made a decision to come back and say, 'We want to increase.' Is that fair enough?

Ms Corbett—That is right.

Senator MOORE—It was considered to be straightforward?

Ms Corbett—Straightforward—lots of alternatives for patients.

Ms Huxtable—Lots of alternatives at the benchmark.

Senator MOORE—That is actually a factor—the fact that there is a whole bunch of other drugs that people can use. Is that a contributing factor to the decision?

Ms Halton—It has to be something at the benchmark price.

Ms Corbett—It has to be something at the benchmark price for the patients.

Senator MOORE—With Tritace, is it true that it has both a therapeutic premium and a brand premium?

Ms Corbett—That is true.

Senator MOORE—Are there many of those that fit into that category that has both levels?

Ms Corbett—No.

Senator MOORE—Why would this one have both?

Ms Corbett—Because it is in a therapeutic group—there are only those four groups of drugs that have the therapeutic group premium status—they have both options, and it is a matter for them to determine what they call a brand premium and what they call a therapeutic group premium.

Senator MOORE—They can have both?

Ms Corbett—They can have both in that group. The brand premium only applies once there is generic competition for the drug, so there must be multiple brands of the same actual chemical entity. So there are now multiple brands of Ramipril. Some of the other drugs in this group, Perindopril, for instance, is still on patent at the moment, so it does not have multiple brands, but they could have a therapeutic group premium. For reasons that I cannot share with you, but the sponsor would be understanding, they have made a decision to use both.

Senator MOORE—That just increases the cost?

Ms Corbett—As far as the patient is concerned, they are not likely to be told separate premiums. They are likely to be told that they need to pay a total amount for Ramipril, if they are going to stick with Ramipril. If a concession card holder is using the 1.25 milligram tablet, $7.70 is what they would pay, rather than $4.70. That is what they will be told.

Senator MOORE—Can you just tell me what that $7.70 is made up of, because that is going to be three bits, isn't it?

Ms Corbett—That is true. The $4.70 is the concession card holder's copayment, there is a $2 brand premium and there is a therapeutic group premium of $1.

Senator MOORE—So there are three bits that add to the total cost, but the person at the pharmacy would just know they have to pay the final amount? They would have an idea of what the basic cost would be, and they would have an idea what the gap would be but not how it is made up. Is that right?

Ms Huxtable—We need to be careful here. We are talking here about groups of drugs where there are many brands of exactly the same drug, so there will be an originator brand and there may be many generic brands. I have got an example here of Amoxicillin, and there are 10 different brands of this drug.

Senator MOORE—Amoxicillin is an example?

Ms Huxtable—There is a particular dose of Amoxicillin. There are 10 brands of that dose. It is exactly the same chemical entity, just different suppliers. There are multiple suppliers for this one. There is generic competition. In respect of one of these brands of Amoxicillin, the originator, there is a $1 brand premium, but there are nine other brands that are exactly the same, for which there is no brand premium. The pharmacist will probably ask the patient, 'Would you prefer a cheaper brand?' and there are nine alternatives there for the patient to choose. It is exactly the same medicine. With respect to brand premiums, it is important to remember that sponsors are making a decision, in a sense, about what premium they wish to have on their brand, in full knowledge that that will have an impact on their market share, and there are many alternatives for patients.

Senator MOORE—But when the changes came in, one of the key issues was users having full knowledge. Everyone agreed that should happen—that the person going to the pharmacist and to the doctor, because the doctor also has a role, who was actually going to use the medication would have full knowledge of all that kind of stuff. And we all know that some people will not go into that at all; they just want to do what they have always done. I am just trying to get an idea of what kind of cost impost there is for different reasons, so if you are going to choose—

Ms Huxtable—The distinction I am trying to make is that in respect of brand premiums, definitely. To have a brand premium there must be an alternative that is exactly the same medicine at the benchmark price.

Senator MOORE—That is the prerequisite.

Ms Huxtable—That is a really important concept, and the vast majority of the premiums that we are talking about here are brand premiums. For therapeutic group premiums there must be a medicine which is interchangeable at the patient level available at the benchmark

price. I think Ms Corbett referred to 300-and-something medicines with premiums. The absolute vast majority of those medicines fall into one of those two categories.

Senator MOORE—Is it true that companies—and I suppose sponsors, because the company is the sponsor—are allowed to add a therapeutic premium instead of a special patient contribution? They can make that choice or request that?

Ms Corbett—In a sense all of these premiums are special patient contributions under the legislation, so the distinction that you are making is not quite clear. There are brand premiums, and that is what most people use in the situation where there are multiple brands because they are post-patent. There are therapeutic group premiums, which are generally used for brands that have not yet come off patent but they are in a group. And then there is a very small number—still only seven—of the special patient contributions that do not fit either of those categories.

Senator MOORE—And they are going down in number.

Ms Corbett—Yes, they are. That's right.

Senator MOORE—We started out asking about special patient contributions and I will ask on notice for each medicine the amount of the special patient contribution and when it was added. Can I get that? That may well be in the orange book, but I would like that.

Ms Corbett—Yes, we can do that.

Senator MOORE—I know that Senator Allison has asked and we have asked questions before about how much was paid in special patient contributions, but I want to clarify that for financial year 2005-06. Is that in someone's report?

Ms Huxtable—I think we did a question on notice on this last time, actually.

Senator MOORE—Senator Allison asked for the information up to a certain time. But for the financial year 2004-05—

Ms Huxtable—I have 1 August 2005 to 31 May 2006. Will I keep going?

Senator MOORE—Yes, a whole month after that. I just want the financial year.

Ms Huxtable—Okay. I will take that on notice.

Senator MOORE—It could just be the difference, and I would imagine that somewhere in the annual reports that kind of thing is there, but for the financial year it would not be too much. And how many scripts were dispensed in that year.

Ms Huxtable—So it is really an update of that question.

Senator MOORE—Very much. I am trying to remember the question. It asked about exemptions?

Ms Huxtable—Yes.

Senator MOORE—Good.

Ms Huxtable—How many sought and received exemptions.

Senator MOORE—The one that is not covered in that question is Alimta, for lung cancer. We have been following up on that. How many dispensed scripts attracted an SPC particularly in that area?

Ms Huxtable—I will take that on notice if that is okay.

Senator MOORE—Good. I want to ask some particular questions about selective serotonin reuptake inhibitors, which I hope to call SSRIs—is that right?

Ms Halton—We would prefer you did.

Senator MOORE—There has been discussion about them and how they work before because there has been public interest in them. I want to know what the savings to the PBS are over the forward estimates as a consequence of the 12.5 per cent reduction in August 2005. Have you done calculations of what the impact of that will be?

Ms Huxtable—You are asking specifically about SSRIs?

Senator MOORE—Yes.

Ms Halton—I don't think we do.

Senator MOORE—You do not go into that degree of definition.

Ms Halton—No, we do not disaggregate to that level.

Senator MOORE—The price changes as a consequence of the weighted average monthly treatment cost—I did get an explanation of that at a previous time—review, meaning savings. Have you quantified that particular review in savings? It was my understanding that this could be done. Is that right?

Ms Corbett—Yes, that is correct.

Ms Huxtable—Ms Corbett is the WAMTC expert.

Ms Corbett—I am just looking at my WAMTC brief. I think I have it here. If not, we can certainly do it on notice.

Senator MOORE—Ms Corbett, I will run through these questions in case it is all in the brief and we will go from there, because they are all along the same lines. On the savings aspect of the WAMTC review of SSRIs, how many of the medicines currently have an SPC of the SSRIs?

Ms Corbett—There is one of those that does have a special patient contribution.

Senator MOORE—There is one. What about brand premiums? Do any of them have a brand premium?

Ms Corbett—Brand premiums on SSRIs—I don't think so. No. We might need to crosscheck, but I don't think so.

Senator MOORE—What is expected to happen to the SPCs when these 1 December price cuts take effect? Would you expect to move to increase the price?

Ms Corbett—Because we are still not at the point of the 1 December changes being in the public domain, I cannot really address that now. We could look at that after that point in time.

Senator MOORE—I think the return for these questions, if everything goes to plan, is 7 December. What is expected to happen to the brand premiums when these 1 December price changes happen? It is a significant date for price changes and what happens, because there has been a lot of discussion about the SSRIs, their cost and the way they have been prescribed. Has any work been done on out-of-pocket costs to patients for these medicines?

Ms Corbett—Out-of-pocket costs for SSRIs, again, are going to be linked to which premiums, if any. I do not think there are many, but we would have to look at that in the same context, going through them one at that time.

Senator MOORE—How many PBS prescriptions were dispensed for SSRIs in 2004-05 and 2005-06?

Ms Corbett—Yes, we can do that.

Senator MOORE—I want to get in a couple of questions about Fosamax. We have had discussion about this particular medication before, and we know that the PBAC has recommended that Fosamax be listed. That is accurate, isn't it?

Ms Corbett—Fosamax is already listed, Senator, but PBAC has recommended an extension of indications, so its recommendation would pick up a substantial number of new patients eligible for Fosamax on the PBS.

Senator MOORE—It used to be available only if you had an actual break. The approval of who can get it has now been widened. Simplistically put, is that right?

Ms Corbett—Subject to certain tests being established, it would be available to a wider group.

Senator MOORE—Now that the recommendation has been made, what happens next?

Ms Corbett—The cost of that initiative is over $10 million and, therefore, it needs the cabinet's consideration. So that is a step that needs to be taken.

Senator MOORE—So the department puts the paperwork together to go to the minister—

Ms Corbett—The department prepares cabinet submissions in usual processes, in consultation with other agencies.

Senator MOORE—So, Minister, can you give us any information about the process of this medication going to cabinet for approval?

Senator Santoro—I need to take advice on that one. As you would appreciate, I do not immediately have the information available, but I will ask the department to help me to convey that message to the minister.

Senator MOORE—Has it gone through MSAC yet?

Ms Huxtable—We have been having discussions with our colleagues in the Medicare benefits division about managing the government's consideration of Alendronate because, as you know, there is an issue about bone mineral density testing. We will be providing advice to government on both of those things—hopefully in the near future.

Ms Corbett—It actually has been to MSAC twice. They are very familiar with it.

Senator MOORE—We know it has been there. As you would know better than most people, there is huge interest in this one. We have one level of approval to go to cabinet for one process. How do cabinet approval and the MSAC process work together?

Ms Huxtable—In this instance, it would be a matter for government to consider that, but certainly we are very mindful of the interaction between the two and, in taking this forward, we are looking to make it as expeditious a consideration as we can.

Senator MOORE—And who is taking it forward? Is it from the department to the cabinet and then—

Ms Corbett—Minister Abbott takes the cabinet submission forward.

Senator MOORE—Do you have an expectation in terms of time frames?

Ms Corbett—It is the cabinet's business to determine. We are really not able to let you know cabinet timing.

Senator McLUCAS—You have finished your part of the process—

Senator MOORE—and it has gone up to both areas.

Ms Halton—No, not quite.

Ms Corbett—We have it under active consideration. That is the best way to put it.

Senator MOORE—Minister, can we hear back in terms of your understanding through Minister Abbott? We have talked at length about the cost with osteoporosis. It was bone week quite recently, wasn't it, and there was a public awareness campaign—

Senator McLUCAS—It was International Arthritis Day.

Senator MOORE—It was one of the issues being raised at that time, and this particular medication was on people's minds at that time.

Senator Santoro—I will seek some advice on that and get back to you.

Senator MOORE—That would be good. As well as the questions we have asked, we will put some on notice because of the time frame. I have a couple of questions I think we have asked before about the position of the head of the PBPA, the Pharmaceutical Benefits Pricing Authority. Is the position still vacant?

Ms Corbett—If I may be so bold, it is not vacant at all. I am the acting chair.

Senator MOORE—But in terms of the substantive filling—

Ms Corbett—It has been the longstanding practice when the chair is not available that the—

Senator MOORE—I deeply apologise if there is any—

Ms Corbett—I assure you I will not take offence.

Senator MOORE—I am talking in terms of substantive filling. I would always expect that the position would have an acting person in it. If there is an acting person in it, my understanding is that the substantive vacancy exists.

Ms Corbett—That is correct.

Senator MOORE—I do apologise also for putting you in the position of asking these questions when you are sitting in the job. It is something I would prefer not to do.

Ms Corbett—That is fine.

Senator MOORE—Can we get an update of the process for substantive filling of the position?

Ms Corbett—It is a ministerial appointment, so it is under the minister's consideration.

Senator MOORE—Minister, turning to you again, would you be able to get an update for us on the expectation of permanently filling that position?

Senator Santoro—I was going to suggest that after today's performance by Ms Corbett I would be quite happy to provide a reference. I would be happy to follow that up with the minister.

Senator MOORE—This is a standard question. Are all medicines approved by the PBAC for PBS listing referred to the PBPA for pricing consideration?

Ms Corbett—Traditionally that is the case. However, we are in a process of streamlining, and this will that mean from December of this year, when we move to a monthly publishing cycle, nearly 25 per cent of the new drug proposals that go to PBAC will be able to proceed to the listing point without direct consideration by the pricing authority. That will speed up the listing time.

Senator MOORE—And that is a result of a review of the process?

Ms Corbett—That is right. We are going to categorise our submissions to PBAC into three tiers. The definitions of these are available on the website and as part of our monthly publishing cycle. Tier 1 drugs, which are the simple ones where there is not controversy over the price, will go immediately through to the listing process. In 2007 we are hoping to have those listed within eight weeks of the recommendation and we will move, we hope, to even faster listing when we fully automate processes in 2008.

Senator MOORE—And that system becomes operational in December.

Ms Corbett—The first of our monthly publishing updates will be on 1 December. It is a great new website; I hope you will like it.

Senator MOORE—I will rush to have a look.

Ms Corbett—There is a lot more information there.

Senator MOORE—I would not be doing my job if I did not have my question about Herceptin, even though the decision has now been made. Can you let us know the role of the PBPA in price negotiations with Roche over the introduction of Herceptin for breast cancer.

Ms Corbett—The pricing authority had a full report from the PBAC about the cost effectiveness analysis and, on the recommendation of the PBAC about the price, accepted that Herceptin should proceed through the rest of the steps to be listed. That is quite a normal process. In the meanwhile, and indeed from a point before PBAC's consideration had been completed, we had commenced discussion with the sponsor, Roche, about risk sharing and related arrangements. The process of negotiation is managed by the department according to

the guidelines set by both PBAC and the pricing authority, and sometimes the sponsors initiate that discussion even before PBAC stage.

Senator MOORE—I know the PBAC process because of the listing role, but what is the department's role in that? Do they have a designated role as well?

Ms Corbett—The department manages the negotiations on behalf of the pricing authority. So we initiate those in as timely a way as we can and we invite the sponsors to work with us as early as they see is appropriate around those arrangements. We report to the pricing authority. We certainly do not do things that will compromise the pricing authority's role around negotiations. They quite often set a limit for us about what is a sensible negotiation, drug by drug. But with new listings it is often quite a straightforward matter. If the PBAC have determined that the drug is cost-effective at the price that they have looked at in the submission then the pricing authority are most likely to just say: 'Okay, up to that price; fine. If you can negotiate risk-sharing arrangements around that, well and good.' The negotiation process is often straightforward, and it was with Herceptin.

Senator MOORE—Ms Halton, does the secretary have a particular role in these negotiations? Is there any particular designated role for the secretary of the department in price negotiations?

Ms Halton—No, other than a broad governance role.

Senator MOORE—There is no particular role that is set out for the secretary of the department to take.

Ms Halton—Obviously one takes an interest in some of these issues. But in terms of forming performing a particular role, no, there is not.

Senator MOORE—I have some questions about pathology tests around PBS drugs, and I know that that is an issue around cancer drugs. Professor Horvath talked about the interest in the cancer-specific drugs that have come on in the last years. I would like to check with the chair whether I should keep asking these questions or just let you know that they are going to go on notice.

CHAIR—We are intruding into the time we have allocated for outcome 5. I do not know if Senator McLucas is comfortable with that.

Senator MOORE—I will just let you know what my questions on notice will be. They are to do with pathology costs associated with certain cancer drugs and how that operates. You have the questions that we have asked about the various forms of premiums and categories. I think that covers that area. If there is anything further, we will let you know by the end of the week.

Senator McLUCAS—There are some questions about the PR campaign on improving community understanding of generic drugs which we will put on notice. I have a question on that as well. It always astonishes me when you are in a pharmacy and the pharmacist says, 'Would you like to have the cheaper drug?' and the consumer says, 'No, I don't want a cheap one; I want a good one.' Hence the need for the campaign. When a premium, whether it be a brand premium or a therapeutic premium, an extra charge, is added to a specific drug brand do you track consumer reaction to that?

Ms Corbett—No, we do not do that currently. It would be rather difficult, but certainly of interest. We do not do it. We would need, I think, some sort of a survey of the pharmacists to do that. It is really only the pharmacist's interaction with the patient that is going to get at that, and nothing that they subsequently process through the Medicare Australia system is gathering that at all. So it is knowledge that we do not have.

Senator McLUCAS—So we do not know how many doses of this particular brand made by this particular pharmacy are used? We must know that.

Ms Corbett—Yes, we do. But what we do not know is what was prescribed.

Ms Halton—If it is subsidised, we do.

Ms Corbett—We may not see all of those because of—

Senator McLUCAS—You do not know what is prescribed, of course.

Ms Corbett—No, that is right.

Ms Halton—So we know what is subsidised.

Ms Corbett—The doctor may, for instance, have prescribed Zocor, which is a simvastatin, but not ticked the box that says 'no brand substitution'. The patient has gone to the pharmacist with that. The pharmacist has offered a cheaper brand with no premium. The patient has taken that. Terrific. But we cannot match that processed Medicare Australia claim with what was prescribed. And neither, indeed, will the doctor usually know unless the patient goes back and shows the doctor which pills they have got—for example, which version of simvastatin they have got. You would have to do it with some sort of survey.

Senator MOORE—The only person who would actually know, and they may not keep the data, would be the pharmacist at the point-of-sale.

Ms Corbett—Pharmacists would have some idea, but it would be hard to generalise.

Ms Halton—I would be surprised if they kept records of that.

Ms Corbett—I do not know that they do now. You would have to ask them to see that.

[11.50 am]

CHAIR—That concludes outcome 2; I thank the officers. I call officers concerned with outcome 5, primary care.

Senator McLUCAS—The first set of questions goes to the PIP and SIP programs. Mr Eccles, can you give a list of all the practice incentive and service incentive programs? I want to confirm that we know all of the different elements of PIP and SIP. Is it a document that you could table? That might make things a bit faster.

Mr Andreatta—Yes, we can table it.

Senator McLUCAS—Thank you. Is it possible for us to ask you for the percentage uptake by GP practices and by GPs for each of the different elements? Is that something that you collect data on, firstly, and can it be provided to the committee?

Mr Andreatta—I do not have that information with me.

Senator McLUCAS—The question goes more to whether it is a reasonable question to ask.

Mr Andreatta—Would you repeat the question, please?

Senator McLUCAS—Can we have the percentage uptake by GP practices and by GPs?

Mr Eccles—You want to know the number of GPs that are receiving a benefit from PIP for the particular subcomponents?

Senator McLUCAS—Yes.

Mr Eccles—Yes, that is possible.

Senator McLUCAS—Can we have the number, and could we then have it as a percentage of GPs? I know that means that you have to know how many GPs there are.

Mr Eccles—We could do it because it is a payment that goes to practices.

Ms Halton—But I think doing it by GPs would be very difficult.

Mr Andreatta—It is. We can certainly do it by practice, but not accurately by GPs.

Ms Halton—As you would understand, Senator, individual practitioners wander around. It would be a huge data-matching exercise, but we can do it quite happily for the practices.

Senator McLUCAS—That is only for certain of the programs. Can we get an understanding of the number of patients that are receiving benefit from this program?

Mr Eccles—The PIP is really not a program that goes to patients.

Senator McLUCAS—Yes, I understand that, but there is a diabetes program and there are mental health programs.

Mr Eccles—Could we take that away and have a think about how we can present that information to you in the most useful manner?

Ms Halton—I suspect that that is going to be very difficult, Senator, without employing a team of PhDs.

Senator McLUCAS—But there are six or seven of them.

Ms Halton—Yes, I know. They have day jobs. Let us see what we can do. There might be a rough and ready way to give you an estimate.

Mr Eccles—We can for SIP.

Mr Andreatta—The service incentive payments certainly can be provided.

Ms Halton—Yes, but that is different. For PIP—no, that would be difficult.

Senator McLUCAS—All right, let us work on the SIP program in the first instance. Could we also get the budgeted and actual expenditure on both SIP and PIP over the last five years? And that recognises that there have been changes in the programs over that period. Mr Eccles, is that doable?

Mr Eccles—I am not sure. I am just trying to think. I am probably jumping ahead of myself in how we would present that. I am visualising a table and it has very many columns,

because sometimes there are adjustments throughout. I think we can give you the high-level information. I do not think that will be a problem.

Senator McLUCAS—That would be at the total program level—like all of PIP?

Mr Eccles—We can certainly do a total program level. That is very easy. It is taking it down to the next level—asthma, mental health and cervical screening. I am certain we can tell you what the expenditure has been for those but—

Ms Halton—We will have to have a look at it. We will see what we can produce that is coherent.

Senator McLUCAS—We are looking for what was budgeted for each of the elements and what the actual expenditure was—what the take-up was, essentially.

Mr Eccles—By year.

Senator McLUCAS—By financial year, yes.

Mr Eccles—We will have a look at that for you. We certainly do it. I guess I am trying to work out how we can get a handle on a particular allocation that might be three years old. We can certainly get that information, but in light of expenditure sometimes there are shifts within the broader program.

Senator MOORE—It is just in terms of monitoring the success.

Mr Eccles—Absolutely. We do that.

Senator MOORE—I just seems to me that that should be accessible. We will see what we can get.

Ms Halton—I think one of issues here is that this has been a responsive and involving program.

Senator MOORE—Sure. I think it has changed every budget.

Ms Halton—Yes, exactly. So trying to get a static view of what was an incredibly dynamic program is a problem. This is not one of those programs like the PBS that has been trundling along for years and, yes, there are changes here and there and what have you; this has been much more dynamic. Again, we will see what we can do that is clear.

Senator McLUCAS—Mr Eccles, could you give me an understanding of the alternative funding for general practice program?

Mr Andreatta—Can you elaborate on that.

Mr Eccles—The 'alternative funding for general practice program'?

Senator McLUCAS—I understand there was a program called the alternative funding for general practice program which has a link to the General Practice Immunisation Incentives Scheme.

Mr Eccles—That is the broader appropriation from which PIP is drawn. What was the question?

Senator McLUCAS—Sorry, could you explain that again, Mr Eccles. I believe that could help me.

Mr Eccles—I believe that the title 'Alternative Funding for General Practitioners' is the broad overarching program and that there are several subcomponents. PIP and SIP are under that broader umbrella.

Ms Halton—If we go way back in history, which regrettably I can, this was, if you like, one of several funding streams that were going into general practice, some of which as you know are benefit related. There was a broad heading, which was 'Alternative funding streams' to recognise that they were not in the benefits category.

Senator McLUCAS—That helps me greatly. Mr Eccles, it would also be helpful if you could tell me what the elements of the alternative funding for general practice program are, just by bulk—PIP, SIP and then whatever else.

Ms Halton—Yes.

Senator McLUCAS—Thank you. How does the General Practice Immunisation Incentives Scheme fit into that?

Mr Eccles—That is also one of those.

Ms Halton—That is what we just whispered to each other.

Mr Eccles—So PIP, SIP and GPIIS are three of the programs that are under that alternative funding.

Senator McLUCAS—So that is the third?

Mr Eccles—That is right. I will just need to turn around and check to see if there are any more, but I think there are only three. Yes, that is it.

Senator McLUCAS—So that was originally not funded in 2004-05, and then there was an allocation for the immunisation incentives scheme. When that money was allocated, how did that happen? Was that a new allocation? I am just trying to track where that money came from.

Mr Eccles—I will have to take that on notice. That precedes my familiarity with the program.

Senator McLUCAS—There is someone behind you who knows. I think we need eyes in the back of the heads of departmental officials. If they were all mothers they would be fine.

Mr Eccles—I am told it has always been under that appropriation. It has just been explained that it has always been under that appropriation, but a couple of years ago it was transposed into this current arrangement.

Senator McLUCAS—It has always been under what?

Ms Halton—The alternative funding sources for general practice.

Mr Eccles—That is right.

Senator McLUCAS—And then it was transposed into what?

Mr Eccles—Let me get this right. Two years ago it underwent a name change. It used to be called primary care practice alternative funding and now it is primary care practice incentive funding. I think I have confused myself as much as you.

Senator McLUCAS—For immunisation?

Ms Halton—The bottom line here is that back in history we had this alternative funding arrangement for general practice which was that it was not a benefit, so we will just say that it was alternative. It has not much changed in the content—other than that dynamic process we just talked about—but it has become this primary care incentive. Am I right? Yes. You see, my memory is not that bad! It now has a new level which reflects that it is about incentives that are being given to practices to adopt good practices and do particular things that we try to encourage. So it is the same thing but the label has changed.

Senator Moore interjecting—

Ms Halton—In the broad, yes, subject to those earlier caveats.

Senator McLUCAS—How was that $300 million for the immunisation incentive schemes inserted into the structure?

Ms Halton—As with all these things, when we are looking to place something in our appropriation structure and in our program outcome structure we find the logical place to put it. Remember that in the old world the only thing we ever did was pay a benefit. When we started to decide that there were other mechanisms that we wanted to use for financing to encourage particular approaches to practice—this being one of them—that is where it went.

Senator McLUCAS—I am trying to track whether the money came from another allocation and was put into the immunisation incentive program.

Ms Halton—No, I do not think so. If I am wrong will come back and confirm it.

Senator McLUCAS—Will meningococcal and pneumococcal vaccines be part of that program?

Mr Eccles—There are no plans for that.

Senator McLUCAS—No plans at all?

Mr Eccles—Not that I am aware of. It is certainly not on our work program.

Senator McLUCAS—I think I learnt something then; good. How many full-time practice nurses and allied health workers have been employed under the Practice Nurse and Allied Health Worker initiative to date? When did it start? Was it in 2005-06?

Mr Andreatta—There are two components to practice nursing. There is the rural component and the urban component. I have the number of practices that are currently participating in both of those. Is that what you are after or are you after more than that?

Senator McLUCAS—That would answer the question, I think.

Mr Andreatta—Under the urban practice nurse incentive, originally 1,100 practices were invited to participate. In April this year, 650 new practices were also added to that initiative.

Senator McLUCAS—To the total pool of potential users?

Mr Andreatta—Correct—so around 1,750 in urban areas of workforce shortage. Of the 650 that were newly added to that list, as at August this year 246 are participating in the initiative.

Senator McLUCAS—Out of that extra 650?

Mr Andreatta—Correct.

Senator McLUCAS—So, out of the 1,100, how many have taken up the option?

Mr Andreatta—There are 918 in total who now participate in the urban area.

Senator McLUCAS—Is that the total number for both groups?

Mr Andreatta—No—for the urban area workforce shortage.

Senator McLUCAS—Is 246 a subset of 918?

Mr Andreatta—Correct. That was the new initiative that commenced in April this year, where it was extended.

Senator McLUCAS—The rural area?

Mr Andreatta—In the rural area there were 1,129 practices participating as at August this year.

Senator McLUCAS—Out of a total of?

Mr Andreatta—Eligible—1,427.

Senator McLUCAS—That is the number of practices. Does that mean that for each practice there will be one full-time equivalent practice nurse? What do you know about what is happening there?

Mr Eccles—I do not think we have a breakdown on whether there is an FTE or whether it is a part-time nurse who is servicing the particular practice. I think there may even be instances where a nurse may support two practices.

Mr Andreatta—The allocation is $40,000 per practice, and it is up to the practice to use that money to engage practice nurses in whichever way is beneficial to them.

Senator McLUCAS—How do they acquit that money? How do they tell you that they have used that money wisely?

Mr Andreatta—Medicare Australia do annual audits. They are obliged to inform Medicare Australia of any changes to their circumstances so that the payments are made correctly and their eligibility is checked.

Mr Eccles—There are criteria for accessing it, much like with the other payments that are administered by us, and the practices are expected to comply with those.

Senator McLUCAS—It changes the way in which the practices operate in terms of their billing activity. But the $40,000 is a straight incentive—that is the way it works, isn't it?

Mr Eccles—That is right.

Senator McLUCAS—Would you therefore assume that they have employed a practice nurse?

Mr Eccles—Yes—much like we assume that practices are doing the appropriate things for the practice incentive payments. It is the same sort of concept. It is subject to the same sort of

scrutiny that Medicare Australia provides over all general practices on all payments they receive from the government.

Senator McLUCAS—So for $40,000 you could employ a practice nurse for half an hour a week? I am not trying to suggest that this happens, but I am just trying to understand the level of scrutiny you have of the expenditure.

Mr Eccles—I think there are minimum sessions that are prescribed. In return for the $40,000, the criteria contain expectations in terms of the sessions that would be required of the nurse.

Senator McLUCAS—Is that something you could provide to the committee?

Mr Andreatta—Yes, we can.

Senator McLUCAS—So out of that program we cannot then come to a view about the number of practice nurses who have been employed in Australia?

Mr Eccles—The hours that they work—I guess you are looking at full-time equivalent. No, we cannot. But we know the breadth—the number of practices that are receiving the services of a practice nurse.

Senator McLUCAS—That is fine. Mr Andreatta, do you have the same data for the allied health workers?

Mr Eccles—We do. I think it is the same sort of—

Mr Andreatta—We do.

Senator McLUCAS—You could either read it out, or you could be provide it to us—whatever.

Mr Andreatta—What were you after?

Senator McLUCAS—The number of practices that have taken on that incentive payment program.

Mr Andreatta—Could I just ask you to repeat that question so that it is clear what you are after.

Senator McLUCAS—How does the allied health worker incentive payment work? Let us start from the top.

Mr Andreatta—It is the same as the practice nurse incentive payment. It is up to the practice to either employ a practice nurse and/or an allied health provider. It really depends on each practice—

Senator McLUCAS—The nature of the practice.

Mr Andreatta—and their circumstances.

Senator McLUCAS—Okay. This is actually getting to it. I am trying to ascertain the number of allied health workers and the types of allied health workers that have been utilised under that program.

Mr Eccles—The split between psychologists, physios or whatever—the range of services?

Senator McLUCAS—Exactly.

Mr Eccles—I think we would need to take that one away.

Senator McLUCAS—Do you collect that sort of data?

Mr Andreatta—We do not, no. We simply provide the incentive. Again, it is up to the practice to determine how to use that incentive, and there are rules and criteria set out for the minimum sessional times for each of those types of providers.

Senator McLUCAS—But you cannot give us a split between the types of AHWs?

Mr Andreatta—Correct. We do not have that information.

Ms Halton—I think it is important to understand here that when this initiative was developed it was about enabling the practices to specify and to decide themselves, based on their patient load, what was going to be useful. Essentially, providing that those funds are acquitted, there is a balance to be struck here in terms of how much reporting et cetera there is. Your point from the discussion of the practice nurse item is absolutely valid, which is that we need to have proper accountability so that we are getting the minimum of what we said we were going to get. I am absolutely confident, based on what I have been told by a number of practices, that we are getting well above that. But I am pretty confident that it would be very hard to break down 'nursing/allied health' into a more refined category, because it was always conceived of as nursing and allied health.

Senator McLUCAS—Yes. And if you have a practice that is generally with children, you do not want a podiatrist, probably.

Ms Halton—No, exactly.

Senator McLUCAS—But I am trying to get a handle on what the take-up of the various categories is. Is there some way that you could—I know you are not asking the practice to tell us what the AHW was.

Ms Halton—I think we will have to ask. We will have a little rummage around and see what we know in this area, so we will come back to you on notice. I cannot promise that we can say anything other than things that might be a little anecdotal, but we will certainly see what we can find out.

Senator McLUCAS—Thank you. I would like to ask about the national health call centre, please.

Mr Eccles—Yes, Senator.

Senator McLUCAS—I understand that there has to be agreement between various states and territories to establish the National Health Call Centre Network as a jointly owned, limited liability company. Is that correct?

Mr Eccles—Agreement has already been gained between the Commonwealth and the states and territories in the form of a heads of agreement that was signed by the Prime Minister, the premiers and the chief ministers in February. That outlined the broad construct and the governance arrangements, the aims and objectives and some of the processes that needed to be undertaken between now and when the call centres would start up.

Senator McLUCAS—How is getting past the HOA to a final agreement progressing?

Mr Eccles—The premiers and the Prime Minister signed the heads of agreement in February this year. So far, the Commonwealth, Western Australia, the Northern Territory, South Australia and the ACT have signed a document that is known as a shareholders' agreement. That group of shareholders is meeting and actively progressing the establishment of the call centre. Discussions are continuing with the other states, and we are hopeful that they will join up in the near future.

Senator McLUCAS—Which states have not joined up?

Mr Eccles—Queensland, New South Wales, Victoria and Tasmania have yet to sign the shareholders' agreement, but they all signed the COAG heads of agreement, which is the overarching blueprint.

Senator McLUCAS—The in-principle document?

Mr Eccles—Yes. It is actually quite a detailed document that goes into the nature and operation of the call centre.

Senator McLUCAS—What is the delay—and I am careful about using that word. Why is it that we do not have the eastern part of Australia in yet?

Mr Eccles—That question would be best posed to them. We are in dialogue trying to understand their concerns. There has been a significant amount of correspondence urging them to sign up. I think it comes down to them reconciling within their own jurisdictions exactly the impact of the call centre on the area and how it is going to work.

Ms Halton—We should also recognise that we have had an election in Queensland and there is about to be an election in Victoria. It is fair to say that that sometimes causes a slight delay.

Senator McLUCAS—Some of those states run their own call centres as well. Is that an issue?

Mr Eccles—Again, it is one of those things. Bear in mind that Western Australia, the ACT and the Northern Territory also run call centres. I am not entirely sure about the extent to which that is an issue. But Queensland, Victoria and Tasmania have a call centre. Three of the four states have their own local area call centre.

Senator McLUCAS—What is going to happen if a state or states do not join in? What does the heads of agreement say? What happens next?

Mr Eccles—Our expectation is that the heads of agreement was signed on the basis that all jurisdictions will participate. It would be a call for existing shareholders as to how to proceed. It is important to note that no state has formally opted out; no-one has said they are not part of it. That would be a call for the shareholders, once the final shape and breadth of the network is known.

Senator McLUCAS—We are meant to start in July '07. Are we are on track to deliver that outcome?

Mr Eccles—It is technically possible, but we are certainly hoping that the jurisdictions that have yet to declare their hand will do so as soon as possible so that that time frame is not jeopardised. But we are progressing on the basis of 1 July.

Senator McLUCAS—In a financial sense, I think there is $100 million from the Commonwealth and $80 million from the states collectively.

Mr Eccles—Generally speaking, that is the ballpark figure. The Commonwealth is funding the establishment costs and 40 per cent of the ongoing operational costs.

Senator McLUCAS—If a state does not join in, could that have an impact on the viability of the service?

Mr Eccles—Obviously, as we can see from Western Australia, Tasmania and Queensland—the states with a call centre—they are viable in a smaller area, not just nationally. It comes down to what the impact on cost is going to be. The concept that is used is the cost per call—that is the best metric that people use. All jurisdictions, not just the Commonwealth, are trying to work out what the impact on the cost per call may be if a jurisdiction chooses to opt out, because that may have an impact on a jurisdiction's contribution.

It comes down to what the impact will be on cost. The way these things are configured, the concept that is used is the cost per call; that is the best metric and the one people use. All jurisdictions, not just the Commonwealth, are trying to work out what the impact on the cost per call may be if a jurisdiction chooses to opt out. That then may have an impact on that jurisdiction's contribution.

Senator McLUCAS—There will be a tendering process for both the national call centre and for the mental health hotline. Will that process happen together or separately?

Mr Eccles—The tender process will be for the National Health Call Centre, which incorporates a mental health module.

Mr Kennedy—The mental health component will be part of the overall National Health Call Centre. Whatever is decided to be done on the mental health component will form part of that process.

Senator McLUCAS—And $20 million has been allocated.

Mr Kennedy—That is $20 million between—

Mr Eccles—Yes, that is right.

Senator McLUCAS—Where does that $20 million sit? Where did it come from?

Mr Eccles—It was a COAG commitment.

Senator McLUCAS—Is it out of the mental health money out of COAG?

Mr Eccles—No.

Mr Kennedy—No, it is new money.

Mr Eccles—It is new money; it was added.

Mr Kennedy—Fifty per cent is from the Commonwealth and the rest broken up on the AHMAC formula between all states and territories.

Senator McLUCAS—Given this is going to be a company limited by a guarantee, will those tender documents be published?

Mr Eccles—Yes, I think there will be a call for tender.

Senator McLUCAS—It will be an open tender process?

Mr Eccles—Absolutely, yes—run by the company that is being established.

CHAIR—I thank officers associated with outcome 5 for their appearance here today and for their contribution.

[12.21 pm]

CHAIR—I now call officers associated with outcome 4, Aged care and population ageing, and the Aged Care Standards and Accreditation Agency. I welcome officers from outcome 4 and I invite questions.

Senator McLUCAS—First of all I would like to go to the impact of the Fair Pay Commission's decision on Commonwealth own-purpose outlays, or COPO, indexation level. The Fair Pay Commission's finding of an increase of $27.36 per week is, I am advised, below real wage movement in aged care. Is the department looking at how indexation will be applied, given that reality?

Mr Broadhead—I am not aware that it is different from real movements; I could not actually answer that specifically. In terms of the way it would be incorporated in indexation, as you know there are a number of wage-cost indexes. My understanding is that—and this applies not only to this portfolio but across the board—the Fair Pay Commission determinations will replace the safety-net adjustment in the calculation of those wage-cost indexes and so, come June next year when we are looking at indexing aged-care rates for the coming financial year, we would be using an index that incorporates the Fair Pay Commissions determinations in part, along with CPI. My understanding of the actual increase that has been awarded is that it is about 5.6 per cent of the federal minimum wage, and that, because it applies to a period that was longer than a year, it is about a 3.8 per cent increase in the federal minimum wage on an annual basis and a 2.6 per cent increase for a wage of $700 a week, because it applies to pay scales up to $700 a week. During the period that is covered by the commission's decision, the Australian government subsidies for residential aged care have increased by an average of 3.7 per cent, so the increases that have been provided are in line with the increases that the Fair Pay Commission has awarded.

Senator McLUCAS—The current COPO is 3.7 per cent.

Mr Broadhead—That is the effect of increases that the Australian government has provided over that period in average terms.

Senator McLUCAS—For the annual year 2005-06, or the 18-month period—

Mr Broadhead—The increases that have been provided by the Australian government to subsidies over the period covered by the Fair Pay Commission's determination equate, on average, to 3.7 per cent per annum.

Senator McLUCAS—For that year?

Mr Broadhead—Yes, for that period.

Senator McLUCAS—Are we talking about that same thing—year 2005-06?

Mr Broadhead—Yes, I think so.

Senator McLUCAS—You said earlier that you were unsure whether or not the—

Mr Broadhead—I could not comment on the relationship between the Fair Pay Commission's determination and real wage rates across that various rates that are paid across the country.

Senator McLUCAS—Do you do any collection of information about movement in wages?

Mr Broadhead—We do monitor movements in wages.

Senator McLUCAS—How do you do that?

Mr Broadhead—In particular, we use a bulletin that is produced by the Australian Nursing Federation, for example, which routinely tracks the awards and outcomes of decisions and enterprise agreements and so on for people working in the sector.

Senator McLUCAS—And what about personal care workers?

Mr Broadhead—I am not aware, off the top of my head, of our source for that.

Senator McLUCAS—Could you provide that to us when you track it down?

Mr Broadhead—Yes.

Senator McLUCAS—What about other more generalised wage growth? It is different across states.

Mr Broadhead—For example, one of the new sources of information we have on costs to the sector or on the sector's financial performance is the general purpose financial returns that are now required as part of the conditional adjustment payment. That source plus other surveys that are conducted by private companies allow us to monitor the degree to which input costs and margins are changing across the sector. We use a range of those, plus the analysis of the GPFRs—that is, the general purpose financial returns—to monitor the extent to which costs and margins are changing in the sector.

Senator McLUCAS—Is this is the first round of the GPFRs?

Mr Broadhead—Yes.

Senator McLUCAS—Have you got those data in? They have only just come in, I imagine.

Mr Broadhead—I believe we have done some analysis of the initial GPFRs.

Senator McLUCAS—Is that for 2005-06?

Mr Broadhead—Yes.

Senator McLUCAS—Really—and they are all in?

Mr Broadhead—I could not tell you whether they are all in. I have just been told that the analysis has been done on 2004-05 but the 2005-06 GPFRs are due on 30 November.

Senator McLUCAS—What did the analysis of the 2004-05 year show in terms of wages growth across the whole sector?

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

Senator McLUCAS—That would be excellent to know because the 2004-05 COPO was—

Mr Broadhead—I think it was 1.9 across the sector and two per cent this year in average terms nationally. The different rates in different states and territories are under the equalisation program.

Senator McLUCAS—Okay. Has the department done any assessment about whether or not the current COPO is adequate to accommodate growth in wages in the sector?

Mr Broadhead—We do not determine the COPO.

Senator McLUCAS—We have had that discussion before.

Mr Broadhead—We do financial and economic modelling of the sector. The results that we have from that modelling suggest that changes in subsidy rates have kept pace in broad terms with changes in costs across the sector and are in line with CPI. That is my understanding.

Senator McLUCAS—How do you do that modelling?

Mr Broadhead—Again we use a range of sources, including surveys conducted by private companies, to look at costs across the sector. We know what our own rates are, movements in our own rates and the profile of people in the sector.

Senator McLUCAS—My next issue is allocation of bed numbers. What was the operational ratio of residential aged care beds in December 2005?

Mr Dellar—When you say beds, Senator, do you refer only to residential places?

Senator McLUCAS—That is correct.

Mr Dellar—As at 31 December 2005 it was 163,432 beds.

Senator McLUCAS—I was looking for the ratio.

Mr Dellar—That was 86.3

Senator McLUCAS—So that is 86.3 beds for every 1,000 people over the age of 70?

Mr Dellar—That is correct.

Senator McLUCAS—And in June 2006?

Mr Dellar—The two numbers are 165,782 and the effective ratio is 85.6.

Senator McLUCAS—So that has gone down?

Mr Dellar—Yes, I can explain the reason for that.

Senator McLUCAS—More people got old!

Mr Dellar—That is correct, but there is a feature of our system that also tends to increase the difference between those two ratios. It is essentially this. We use as our denominator the estimate of resident population projected by the Australian Bureau of Statistics and that projection is only as at 1 July each year. In December 2005 the denominator is actually the June 2005 denominator but in June 2006 we are using the June 2006 denominator, so we have a tiny sawtooth effect. That is, every December, because we have not changed the population base, it tends to raise the ratio a bit and then the June figure tends to decrease it a bit. So it is generally safer, when looking at what is happening to the ratio and the numbers, to compare June with June or December with December rather than December with June.

Mr Stuart—Then we get an apples and apples comparison.

Senator McLUCAS—I understand that. What is the growth in the population of people over 70 from June to June?

Mr Dellar—I do not have that information with me. We might be able to get that for you.

Senator McLUCAS—That would be great. Minister, I am trying to understand what you mean when you say that the target is for 2008. I think you said in a press release that comparing June 2005 figures with a target for 2008 was not reasonable, or something to that effect. I do not understand where this target for 2008 has come from.

Mr Dellar—The 2004 budget reset the ratio from 100 to 108. The PBS of that year, and I think in subsequent years, has reflected that the intention is to reach that 108 target by the end of December 2007. So the target in 2008 will be 108.

Senator McLUCAS—That is the total number of residential aged care beds and CACPS and EACH packages.

Mr Dellar—That is correct.

Senator McLUCAS—So it is community care services along with residential services.

Mr Dellar—That is correct.

Senator McLUCAS—I just do not understand the relevance of this target, given we are actually talking about the application of residential aged care beds. According to a ratio which has changed a little—it has gone down—it is now fewer beds per 1,000 people over 70 than there were three years ago that we are aiming to achieve. So I just do not know where this notion of a target comes into that.

Mr Stuart—Mr Dellar has advised that the portfolio budget statements of that year, 2004, in making the announcement about an overall target ratio of 108 places, said that the objective was to meet that target of 108 operational places by the end of December 2007. So that is essentially what we are referring to.

Senator McLUCAS—Does that mean now that currently we have a ratio that does not indicate anything to the department because we have the end of 2007 as a target?

Mr Stuart—We are moving towards that year by year. Obviously we are charting our progress towards that year by year.

Senator Santoro—Perhaps I could elaborate on that answer. Obviously the government, prior to the last election, set a target. The target has been explained. The debate and the discussion that we have been having both within and outside of the Senate relates to what is the definition of 'operational places'. As I have suggested to you in responses to some of your questions, by media release and perhaps also in response to some of the statements that you have made outside of the Senate, the government considers operational places to include those that are available via the community care programs that the federal government funds.

I suppose it is a matter of policy how we regard funding the capacity of a person who otherwise would be within a residential aged care facility to enjoy—as I have mentioned to you in the Senate—his or her own bed at home. So I suppose it is not even semantics; it is just a very strong preference by the government, and certainly also by me as the minister, to look

at the availability of aged care within a community context as being very much a desirable aspect of government policy. We set a target, we put it out there in the community and we are doing our very best, obviously, to meet it. As I have said to you in the Senate, and also in the other public statements that I have made, we are confident that we will achieve that target.

Senator McLUCAS—Minister, I think you have misunderstood me. The Labor Party invented community aged care packages. We understand and know the acceptance by the community of community aged care packages. We welcome EACH and EACHD, but that is not my question—it is the decline in real terms in the number of residential aged care beds. Along with that, Productivity Commission information shows that waiting times for residential aged care have grown. I watched *Four Corners* on Monday night—I think most of the people in this room did. It was very hard to watch someone waiting three months to get into residential aged care. Those figures are growing. Community aged care services are extremely welcome, but we are talking about residential aged care. In this six months—I accept Mr Dellar's comment—we have seen a reduction in the number of beds for the group of people who will potentially take it up. That is why my colleagues get increasing numbers of people ringing up trying to find a residential aged care bed for their frail relative.

Senator Santoro—There is no doubt that, depending on the location of a person who may be seeking to enter into residential aged care, there could be a waiting time. There will be regions throughout Australia where the waiting time will be nowhere near the three months you have just quoted in terms of one incident that has come to your attention. We acknowledge that there are waiting times. The government will continue to do everything possible to match the availability of beds with the demand that exists in a particular region. We are committed to doing that. We are as concerned as anybody else about waiting times. I refer you back to the commitments that were made by the government when it first came to office in 1996. We set targets which were greater than the situation that existed when the Howard government came to office. We are confident of meeting those targets. Within the planning processes we have an eye on trying to match places with the demand that is obvious from the process the department has in place to monitor and ascertain demand.

Senator McLUCAS—Do you agree that waiting times are growing for residential aged care?

Mr Dellar—The report of the operations of the Aged Care Act publication as at June 2005 has an aged profile of the amount of time that has elapsed between an ACAT assessment and entry into care. It shows that 8½ per cent are admitted within two days, another 20 per cent within seven days, another 45 per cent in a month or less and 71 per cent within three months. We do not, however, put a lot of weight on waiting times. The way people move into aged care is complex. Just because a person has an ACAT assessment does not necessarily mean that they wish to take up a place in a residential service. We generally do not rely on it a great deal in planning or allocating places.

Senator McLUCAS—You would be aware of the Productivity Commission work in this area. Do you think their methodology is flawed?

Mr Dellar—I could not venture an opinion on that. I do not think the question is whether their information is accurate but whether it is a useful tool to determine how to allocate places.

Senator McLUCAS—Are you saying the department does not know whether waiting times are growing?

Mr Broadhead—We do not measure waiting times as such. We have data on the period between an ACAT assessment and people's entry to care. That cannot strictly be called waiting time—

Senator McLUCAS—No, I agree with that.

Mr Broadhead—because people get assessed for a variety of reasons, including against the day, as it were. The Australian Institute of Health and Welfare has specifically commented that entry periods are not a proxy for waiting times. So we do not have data on waiting times as such.

Senator McLUCAS—Have you looked at the Productivity Commission's methodology, then?

Mr Broadhead—I have not specifically looked at it, no. But I am sure it has been examined by people in the department.

Senator McLUCAS—I take your point that you think ACAT assessment to entry is not a proxy for a waiting time, but can you compare that trend information and get any realistic understanding of what is happening out there?

Mr Stuart—Not necessarily.

Senator McLUCAS—Why not?

Mr Stuart—There are phenomena within this data which include people waiting for a particular home of their choice. There is a distribution within the entry period data which is very highly left-skewed towards short periods. What proportion access within three months?

Mr Broadhead—It is 71.4 per cent.

Mr Stuart—So it is possible in fact for the average entry period to go up a little bit while most people most of the time are getting their preferences and entering aged care when they need to.

Senator McLUCAS—The world is not changing in such an amazing way, Mr Stuart. I am trying to ascertain why you think in one year those realities would change so dramatically.

Mr Broadhead—The Institute of Health and Welfare's report also found that the biggest predictor of entry periods was not the availability of aged care in that particular locale but the use of a community aged care package and/or use of respite. Also, where somebody was assessed tended to be a predictor of entry period—for example, if they were assessed in hospital then they tended to go in much more quickly than if they were not assessed in hospital. So there are a bunch of variables here that impact on entry periods but, as my colleagues have been saying, they are not an accurate proxy for waiting time as such.

Senator McLUCAS—But it is the best that we have got.

Mr Broadhead—But it is not the same as.

Senator McLUCAS—I understand that, but where we are trying to compare one year's period of time that people wait to get into residential aged care with another I think it is probably feasible to look at that measure because it has not changed.

Mr Broadhead—But one of the things that does affect the entry period is the use of community aged care. During the time the use of community aged care has increased because the availability of places has increased. People who have community care actually take longer to get into residential care; and, indeed, we think that, by and large, is a good thing. So there are things here which may be evidence of good outcomes—that is, that people are able to remain in the community for longer periods prior to entry into residential care—rather than bad outcomes.

Ms Halton—I would like to add a comment here. I think I answered the first question I was ever asked at a Senate estimates committee about waiting periods for residential care a little over 20 years ago. That is sad but true. The whole debate about what is a measure for this has gone around and around and the reality is that it is incredibly hard to measure. The reason we actually worked with the AIHW on the piece of work that has been referred to is that it is very hard to disentangle the detail here.

Exactly as Mr Broadhead is saying, we know that there are a number of factors that actually moderate and influence what happens in terms of people's decisions and the choices that they make. And, exactly as he says, there has been a significant increase in the number of community aged care packages in a short period. So I think it is a large jump to basically say there has been no change in this field. Certainly we know, because they are telling us this, that some of the providers actually have vacant beds because people are actively choosing to stay in those community aged care packages with community services for a little longer. So I do think this is quite a complex field.

Mr Stuart—I would like to add to our earlier answer about having 108 places by the end of December 2007. Within that there is also an expectation of reaching the 88 residential places by that date, and we are on target do so.

Senator WATSON—I have a series of questions about departmental disregard to what I would call due process in relation to licence holder providers. Following a complaint received by the Aged Care Complaints Resolution Scheme and a referral by the department of the complaint to the agency, the Department of Health and Ageing requested that the Aged Care Standards and Accreditation Agency conduct a review of Aldersgate Village. So far so good. This is my first question: does the law or good business practice allow agency staff to leapfrog the home licensed provider and deal unilaterally with any other party, especially in a non-threatening environment? Is there an agency person who can answer that?

Ms Halton—Could you re-express that question in slightly less emotional terminology and go to the substance of it? That question as it is currently put is a little hard to answer. I think the officers are going to have a great deal of trouble answering the specifics of that question. If you can give us the specifics we can answer it.

Senator WATSON—I gave you the background. It is not the responsibility of a bureaucrat to tell me how I am going to ask my questions.

Ms Halton—I think the officers are going to have trouble answering your question. If you could give us some specifics then they will be able to answer your question.

Senator WATSON—My specifics were: does the law, or does good business practice, encourage agency staff to leapfrog a home licensed provider and deal unilaterally with another party? In my experience your government agency has always, in the first instance, contacted a licence holder provider. Why not in this instance?

Ms Halton—Can you go to the specifics? As Senator Humphries said at the beginning of this hearing, the officers cannot answer speculative questions. If you have a particular instance you would like to raise with us then the officers can probably deal with it.

Senator WATSON—The specific question is in relation to a problem at Aldersgate Village. And I prefaced my question by saying that. I cannot be more specific than that, unless you would like to paraphrase the question for me, which would be setting something of a precedent, with respect.

Ms Halton—It is important to be completely clear about what question you are asking and which particular instance so that the officers can answer your question. And they will now attempt to do so.

Mr Brandon—The answer to the question is that the agency does not become involved with third parties other than with the agreement or the consent of the approved provider.

Senator WATSON—In this case there was no consent; they just acted quite unilaterally and bypassed the CEO and the board. Is that good business practice?

Mr Brandon—I do not understand that anyone from the agency bypassed the CEO or the board. I imagine you are talking about Aldersgate Village.

Senator WATSON—They did in this case.

Mr Brandon—That is not my view.

Senator WATSON—You believe that they were not bypassed.

Mr Brandon—That is correct.

Senator WATSON—I move on to my next question. Aldersgate homes in Tasmania is the licensed service provider, or was at the time, to operate the aged care facility. Is it the usual practice of the Aged Care Standards Accreditation Agency to fail to communicate concerns with the CEO, the director of care or the director of nursing in an aged care facility before communicating such concerns to another industry body, in this case Uniting Care Melbourne? Why was the holder of the licence bypassed?

Mr Brandon—I do not believe that the holder of the licence was bypassed.

Senator WATSON—Can you tell me why? Factually they were bypassed. You are saying that they were not bypassed. Tell me the nature of your communication with the licence holder provider.

Mr Brandon—I do not understand which particular interaction you are talking about. If you are talking about the one on or around 31 March, then there was an assessment team at the home and they were talking with the management of the home at that particular time.

There had been previous involvement with the management of the home and I believe with the CEO of the region back on 18 March when she was present and involved in the acquisition of resources and the direction of what actions were to be taken to address their substantial noncompliance. She too was contacted at the same time as the team was talking to the staff and management on the ground at Aldersgate Village on 31 March.

Senator WATSON—Are you aware that, following an inspection of the home by the agency, a subsequent debriefing was initiated and the staff and the board were not provided with the normal opportunity to respond to the issues raised by the agency? Again, is that normal practice? In other words, there was insufficient time, and inadequate opportunity was given.

Mr Brandon—If you are referring to the review that was conducted on 18 March, where substantial noncompliance was identified, at the exit meeting the CEO of the agency was there to hear the comments, as was Dr Corrigan, who is, I understand, the CEO of Uniting Aged Care Victoria and Tasmania. At that exit interview, which is part of our normal process, the assessors told the people present what their concerns were. I also understand that, at that meeting, the home, including Mr Forshaw, the CEO, and Dr Corrigan, developed together a plan for immediate action. Subsequent to that, following the receipt of our report, Mr Forshaw made a submission to the agency consistent with the requirements under the Aged Care Act and the accreditation grant principles. We then acted on his submission following the exit meeting at which he was present and came to the decision that we did concerning Aldersgate Village.

Senator WATSON—It does seem surprising that in the so-called debrief not only was inadequate time given but also the chair and the CEO were not notified of an earlier commencement of that debrief session. Consequently, the CEO was not present for the early part of that debrief.

Mr Brandon—That may well be the case.

Senator WATSON—It comes back to what I call the jackboots handling of this whole issue by the accreditation agency.

Mr Brandon—The process is that we deal with the management of the home. They are on the ground at the particular time. My understanding is that the decision to bring the exit interview forward was actually discussed and arranged with the director of care of the home. Our assessment staff do not deal directly with board members as a matter of course, particularly if there is a senior member of the staff of the home present. In this particular case, the director of care was the person with whom they negotiated the time for the debriefing.

Senator WATSON—Part of that debriefing, I understand, was the essential issue of medication. This major concern was not discussed at the debriefing. There was merely a passing remark as your agency representative, Sue Dockrell, rushed out to meet a plane commitment. The nature of the communication was misunderstood by the person to whom the remarks were addressed. Would you like to comment?

Mr Brandon—I have no personal knowledge of that. I can tell you that following the exit interview, which was attended by Mr Forshaw and Dr Corrigan, the agency sent a

comprehensive report to the home and Mr Forshaw responded to that comprehensive report. It was that report plus his response which input into the decision making.

Senator WATSON—The dismissal of the CEO and the board is claimed by Uniting Care Melbourne as having taken place within minutes of the federal government imposing sanctions on Aldersgate Village. Is that so?

Mr Brandon—I have no knowledge of that.

Senator WATSON—Could you find out?

Mr Brandon—I am not in a position to find out when the decision to dismiss the board or the CEO was made.

Mr Stuart—Senator, that is obviously a matter for action by the people to whom the board and the CEO were accountable at that time. The matter of the timing is not something that we are involved in.

Senator WATSON—Okay. What sanctions did the agency have in mind in such a situation? You certainly raised the question of sanctions and it was those threats that led to the sackings.

Mr Brandon—The agency does not impose sanctions.

Senator WATSON—And you did not suggest the appointment of a commissioner to resolve the situation?

Mr Brandon—I am sorry; I do not understand the question.

Senator WATSON—You say that you do not impose sanctions and that no sanctions were suggested. What about the suggestion from the staff that the agency threatened the appointment of a commissioner. Is that correct?

Mr Brandon—To my knowledge there is no such position of commissioner.

Senator WATSON—The appointment of a commissioner from outside; I do not know.

Ms Halton—We do not know to what that refers. It has no meaning under the terms of our act.

Senator WATSON—I presume it was an outside independent body or person to look into the activities.

Mr Stuart—The department notified a notification of noncompliance to the home.

Ms Scheetz—That notice of noncompliance was issued on 7 April as a result of the agency's findings of noncompliance.

Senator WATSON—There was no threat of the appointment of an outside body to run the home or to take over control of the home?

Ms Scheetz—That is correct.

Senator WATSON—Are you aware that the state manager of aged care in Victoria and Tasmania, David Cooper, failed to return the phone calls of the chair of Aldersgate following the decision to stand down both the CEO and the board and therefore denied the chair any chance to discuss the situation at Aldersgate with him? This was a discourtesy and, as far as I

am concerned, it appears to endorse the overbearing authority without recourse to natural justice by your agency.

Mr Stuart—The senior management in the line of responsibility took a decision which may have been consequent on what it observed in terms of care being provided or standards being met. That was not a decision of either the agency or the department; it was a matter for the senior management of the home to whom the chair and the CEO were accountable. The department at all times dealt with the approved provider of the day and does not wish to introduce itself into a dispute of any kind between factions within the management of an aged care home, especially where particular parties are no longer, due to actions of senior management, effectively responsible for the management of that aged care home.

Senator WATSON—Do you believe that David Cooper, the state aged care manager for Victoria and Tasmania, was quite right in failing to return any calls from the CEO?

Senator Santoro—I do not think that is a question that can be answered by the officers. As Mr Stuart has explained to you, the internal processes regarding recruitment or dismissals for an aged care facility are purely within the jurisdiction of the internal arrangements for that organisation, in this case the Uniting Church. It seems to me that what you are suggesting is that the agency and perhaps even the department failed to provide to the approved provider semblances or realities of natural justice once they were found to be noncompliant with 19 of the 44 standards.

You will acknowledge that I have given you an extensive letter explaining the sequence and the nature of the events. For the record, the non-compliance standards included clinical care and medication management, pain management, palliative care, nutrition and hydration, skincare and behavioural management. The agency also found serious deficiencies in education and staff development, human resource management and information systems.

The most relevant part of my advice to you, Senator, would be that when the debrief occurred—and, as I understand it, prior to the approved provider being provided with the opportunity to respond to the outline of the findings—Mr Forshaw was a little late for the exit debrief. It must be borne in mind that the appointment time was arranged, as I understand it, by the then most identifiable senior officer. So the home and the most senior responsible officer were given the task of assisting with the arrangement of the specific appointment time.

Senator WATSON—Bringing forward the agreed time. That is the problem.

Senator Santoro—Even if there was, at a later stage, an alteration to the appointment time—I am not saying that occurred; the officers will be able to provide that specific advice—and Mr Forshaw was a little late, I have been advised that he was indeed present long enough to hear and comment on the findings of the audit. Subsequent to the agency then issuing orders—I can be corrected here publicly on the record by the agency or the department if I have not got the story right—it was then that the senior management of the Uniting Church organisation in Victoria, whose jurisdiction also covers Tasmania, then made the management decisions which obviously are of concern to you, and in relation to which the department and the agency had no jurisdiction over whatsoever in terms of any intent—if there ever was going to be intent—to interfere with that process. What we need to establish, given that you have raised the issue in estimates—and of course you are totally entitled to raise the issue—is

whether to everybody's reasonable satisfaction the approved provider had reasonable opportunity to put its side of the story.

Senator WATSON—Absolutely. And that was denied on the basis that they were told to get on and fix the problems rather than challenge the authority's comments.

Senator Santoro—The agency gave them advice as to what they had to do to remedy the breaches—I repeat that they were found noncompliant in 19 of the 44 standards. The agency is required to suggest a course of remedial action. The agency did that and it was then up to the internal management of Uniting Aged Care in Victoria to decide how they go about it. In terms of undertaking remedial actions, if that body decides, as it seems to me by looking at all of the information before me, to include a change of management in order to effect that remedial action, I do not think the agency or the department can be held responsible for that action.

Again—and I am not conceding this—the people being dismissed may have reasons to feel aggrieved about the way the process has been undertaken. I am not sure that that is the case and I do not want to take sides, as the agency and the department do not want to take sides. But that is a matter, as the officers have stated, of the local management being affected by a decision of the central management. We cannot do anything about that. As the minister—

Senator WATSON—My concerns are over the inadequate time for it and a lack of a comprehensive debrief—and, in the first instance, not dealing with the licensed provider.

Mr Brandon—I will try to bring this together to give some clarity to it. The review audit was conducted between 14 and 18 March. On 18 March an exit interview was conducted, which included the assessors, management of the home, Mr Forshaw, who arrived late, and Dr Corrigan from Melbourne. At that meeting the assessors broadly outlined what issues they had discussed and what concerns they had. Dr Corrigan and Mr Forshaw and other people from the home agreed on a course of immediate action because they understood the seriousness of what was going on. Some days later we gave them a full and comprehensive report. They then had two weeks within which to respond to that report in writing. Mr Forshaw responded. Subsequent to his response we asked the home for further clarification. So we had two submissions, Mr Forshaw's submission and another one, clarifying that. We then made the decision. The home then had the opportunity to seek reconsideration of the decision.

CHAIR—It is now time to break for lunch.

Senator WATSON—I am just concerned at the behavioural pattern and what sort of message that is going to send to other homes.

Proceedings suspended from 1.10 pm to 2.11 pm

CHAIR—We are in the midst of outcome 4, and Senator McLucas has more questions.

Senator McLUCAS—There is an Aged Care Planning Advisory Committee in every state. I have asked you before for the names of the people on the committees, and I cannot recall what the answer was.

Mr Dellar—I do not recall you asking the names of the committee members. I do not have their names with me. There are typically about eight members in each state and territory and they represent a range of experiences and knowledge. For example, there will be people who

know about the needs of culturally and linguistically diverse people, there will be those who know about veterans, those who know about planning, and people with experience in aged care. However, we do not have members of actual provider organisations.

Senator McLUCAS—Can we get on notice the names of those who are on the committees?

Mr Dellar—Yes, we can provide that for you.

Senator McLUCAS—They change over time. Could you go back to, say, around 2000 and just indicate who has been on the committees from 2000 to now?

Mr Dellar—I am not certain whether we have that information.

Ms Halton—It will be quite a big job to go back through all the files. Is there a particular thing that you are looking for, to narrow it down a bit?

Senator McLUCAS—You would have minutes, wouldn't you?

Mr Dellar—Yes, we would have the minutes.

Senator McLUCAS—You could go back and look through the minutes.

Mr Dellar—It would take a little while to reconstruct that information. We would not have it in a single place.

Ms Halton—No.

Senator McLUCAS—It goes to the question of potential conflict of interest. I understand that there will be current approved providers who are on those committees.

Mr Dellar—I do not think that there are any current approved providers on the committees.

Senator McLUCAS—Are there people who have financial associations with approved providers who might be on those committees?

Mr Dellar—As with probably all the committees in the department, we have conflict of interest provisions and we require members to declare those conflicts. If any discussion comes to a point where that conflict becomes live then they are not permitted to take part in the discussion.

Senator McLUCAS—An allegation has been put to me. And it is an allegation; I am testing it. The allegation is about one person but potentially it is broader. Information gained while working as a member of a planning advisory committee can be quite significant and it could benefit future applications. How do you deal with that issue?

Mr Dellar—That essentially is the issue of conflict of interest, and the way we deal with it is that we have quite rigorous and well-developed arrangements that require people to declare conflicts of interest, and they are dealt with at the time. Probably something else to mention is that Senator Santoro has announced that there will be a review of ACAR probity. We are able to start that process, and in due course there will be an examination of ACPACs, along with all other aspects of the aged care approval round.

Senator McLUCAS—We will go to that in a second. What are the arrangements that you have in place now to protect conflict of interest questions?

Mr Dellar—Every member of the committee is required to provide information about any potential conflicts of interest and provide a declaration in relation to those interests or lack of them.

Senator McLUCAS—If a person sits on one of those planning committees who has a financial association connection with a company that is an approved provider, how do you manage the broader question of the gaining of knowledge across the sector, rather than dealing, say, with an application by that individual entity?

Mr Dellar—There is an air of speculation about this, because I am not yet sure that we do have an example where there is a member of the committee—

Ms Halton—Can I make a suggestion? If you have had an issue raised with you and it is obviously of concern to you, if you are happy to tell me or one of the officers in confidence who this person is, we will have a look at the issue.

Senator McLUCAS—I do not really want to progress that allegation. I am trying to look at the broader policy question of ensuring that conflict of interest questions have been dealt with. That is why I am trying to understand what the arrangements are that Mr Dellar is talking about.

Mr Stuart—From what you have said, am I right to understand that the particular case is one where someone was a member of an aged care advisory committee and then subsequently engaged in activity within the sector or was it while they were still a member of an aged care advisory committee?

Senator McLUCAS—Subsequent to their being a member of an aged care advisory committee, it is alleged that they were very successful in bed allocations.

Mr Stuart—There would be a question mark about whether that is a current conflict of interest or simply an opportunity for the individual to have learned about the processes.

Senator McLUCAS—I take your point.

Mr Stuart—There is not necessarily insider information involved in that. There are other people in the industry who have had an opportunity to learn about the processes by having been formerly involved as members of the department or by being consultants with a long track record. It would be difficult to distinguish this as a particular issue.

Mr Dellar—The other point is that when the Aged Care Planning Advisory Committee has completed its work it makes a recommendation to the secretary, which is subsequently acted upon and then the results are published in our approval round booklets, which tell anyone who cares to read them what our priorities are for the year and what our priorities are for the following two years. Once the work is completed there is really not much that an ACPAC member would know that no-one else knows.

Ms Halton—What I am struggling to think of is what you could have gained by contributing to that process that would give you an inside track, because essentially what we do is we put in the public arena the outcome of that process. The reality is that people in the sector have expertise, so you might have no financial relationship with an approved provider but you have probably been around the sector for some time. Whether a person of that kind has been on a committee at some point later and is associated with a provider, it may just be

that they are good at what they do. But I am really struggling to think about what you could learn.

Senator McLUCAS—What you could learn is who you are potentially competing with in the future.

Ms Halton—I do not know that you learn that in this process, because you are not privy to information about who is likely to apply.

Mr Dellar—That is correct. The Aged Care Planning Advisory Committees provide advice on priorities. They do not ever see applications and have no part in the application process at all.

Senator McLUCAS—This is a higher level. What is their role?

Mr Dellar—To provide advice and priorities.

Senator McLUCAS—Prioritise allocations to regions by state?

Ms Halton—Absolutely.

Mr Dellar—Yes, and in addition things such as that Aboriginal people need extra places here—that sort of thing.

Senator McLUCAS—How is the review that you are about to undertake into the probity of the ACAR round going to operate?

Mr Dellar—There will be a consultant who will conduct the review and will consult with the people who wish to make submissions to that, and we will review our papers, documents and processes and eventually produce a report.

Senator McLUCAS—Is the motivation from the minister?

Senator Santoro—Yes. Just like you, some people who are clearly dissatisfied with the outcomes of the ACAR have come to me. There have not been many but there has been a number who say that something is not right and they think that they are better than the other person. They might have been in the sector for much longer and they are demonstrably competent in delivering aged care, and they think there has been something fishy. Whenever I ask for evidence, it has not been forthcoming to any extent that I would be concerned. Nevertheless, I was sufficiently cognisant of an impression—I will not even call it a worry—out there that some undue influence could be exercised. I have just said, 'Let's have a look at it. Let's do a review by an independent consultant.' I did not have to do that. I did not feel under pressure. I want to stress that I have every confidence in the process that is undertaken and oversighted by the department. I do not expect the review to come up with anything untoward, but in terms of accountability it is a reasonable thing to do. Obviously I will inform the parliament and the public when that review is completed.

Senator McLUCAS—Who is conducting that?

Mr Dellar—I have a recommendation from my team about the selection of the consultant, but that has not been completed.

Senator McLUCAS—We could give them the good news now!

Mr Dellar—The consultant will be chosen by the end of this week.

Senator McLUCAS—Is it competitive or are you going to just select somebody to undertake that?

Mr Dellar—No. We went for a tender based on a standing committee within the department. There were people offered the opportunity—various people applied and various companies applied.

Senator McLUCAS—It would be quite inappropriate for you to announce that here.

Ms Halton—It has been managed with suitable probity.

Mr Dellar—It has not been settled.

Senator McLUCAS—Could you provide the committee with the terms of reference for that piece of work?

Mr Dellar—Yes. I might be able to get it for you in the next—

Senator Santoro—Perhaps I can help. The review will examine the probity and ethics guidelines and associated training, management of conflict of interest registers, confidentiality and security, the decision-making process, and feedback to applicants. I have had some opinion in terms of the feedback process so we have included that also.

Senator McLUCAS—I do not get any complaints from successful people, as you would imagine. Ms Halton, I do accept that it might be a bit tricky to go back over time to get the memberships of those committees, but, without pushing too hard, if you could go back into what is very readily available, that would be very helpful.

Ms Halton—Yes.

Mr Stuart—We are happy to do that. While we are still talking about planning, could we add to our previous answer in relation to the residential care ratios over time?

Senator McLUCAS—Yes.

Mr Stuart—We had a June and December comparison which we said was not apples and apples but probably more of an apples and oranges comparison. To get a real apples and apples comparison we have data for 30 June 2004, 2005 and 2006. As to the ratios over that time: 30 June 2004 has a ratio of 84; 30 June 2005 has a ratio of 85.1; and 30 June 2006 has a ratio of 85.6. You can see that there is growth towards our target of 88 by the end of 2007 using those comparable data points.

Mr Dellar—You asked for the population denominator.

Senator McLUCAS—Yes.

Mr Dellar—For 30 June 2005 the population figure that we used is 1,892,756, and this is the population 70-plus. And for 30 June 2006 the population base that we used is 1,936,548.

Senator McLUCAS—I might get from you, on notice, the same thing for the December stock-take figures as well.

Mr Stuart—I am happy to take that on notice.

Senator McLUCAS—It is noted from AIHW that 67 per cent of all residents are high-care residents. I am trying to understand why the government continues with a planning allocation

ratio of 48 low-care beds and 40 high-care beds? It is not just ageing in place. You cannot say that.

Mr Stuart—There is obviously a factor of ageing in place, and you have mentioned the impact of that. Over time there are more high-care residents entered into places that are designated low care, and that is because they entered care at a low-care level when they first entered care. That is the benefit of retaining a ratio between high care and low care, which is that it ensures that when people first enter care there are places which are designated low-care places for them to enter and in which they then, in particular places, are enabled to age in place.

Senator McLUCAS—If you look at the RCS level of people entering residential aged care, it is increasingly at the higher end.

Mr Stuart—That is also true.

Senator McLUCAS—I am trying to get the logic.

Mr Stuart—We have a population which is increasingly frail and dependent. In part that is due to the success of community care, as we were discussing before; in part it is also due to our ageing population. The government's policy of ageing in place allows individuals to enter care at a lower level of care and then remain where they are as their care needs increase. But that does not mean that we do not still need provision for people to enter at low care. We still need provision for people to enter at low care, and that is the benefit of the ratio and what enables that to occur.

Ms Halton—It is probably important to remind ourselves that, when the ratio came in in the 1980s—the 40-60, as it was at that particular point—I think the ratio of high-care to low-care residents was probably about the same. It was of that order. It was of the order of 60-something.

Senator McLUCAS—That is what people said.

Ms Halton—It was categorically of that order. Your question is a fair question, but this has been the case and, as Mr Stuart said, it was always about ensuring that you could get into the system as a low-care resident.

Mr Broadhead—As you said, two-thirds of people in care are high care. The majority of people entering care are actually low care. About 60 per cent of people coming into care are low care.

Senator McLUCAS—What is the split on entry, then, of high care to low care?

Mr Broadhead—Roughly 60-40.

Senator McLUCAS—Sixty low care and 40 high care?

Mr Broadhead—Yes. I can get you the exact figures.

Senator McLUCAS—We have also talked about why people enter as low-care res: because there is a low-care bed. That skews those figures as well.

Mr Broadhead—I am not sure I understood that.

Senator McLUCAS—We have talked before with Mr Mersiades about how often the ACAT assessment meets the vacancy. You did talk about vacancy rates earlier.

Ms Halton—Yes.

Senator McLUCAS—You have provided me with information in the past on current vacancy levels. Could we get an update on the current vacancy rates? I cannot recall the last date that we had a question on notice on that one.

Mr Stuart—I will just look for that information.

Senator McLUCAS—Do we have vacancy rates by planning regions?

Mr Stuart—Planning regions?

Ms Halton—That would be such a volatile figure.

Mr Broadhead—We have answered the question previously. I will find that answer on 'occupancy', as we would call it. There has been a very slight decline nationally from 96 per cent to about 95-and-a-bit per cent in terms of occupancy, but there is a deal of regional variation.

Senator McLUCAS—Is it possible to get a vacancy rate by planning region tabled? Can that be constructed?

Mr Broadhead—Yes.

Mr Stuart—It is possible to do, but I would caution about a particular factor that has a big play on the occupancy rates regionally, and that is that occupancy rates will always fall temporarily when a new home opens in a particular region. That can be a very significant factor in a small planning region. So there will be in the data particular planning regions where the occupancy rates look particularly low because we have just been allocating places in that area.

Senator McLUCAS—That is interesting. I would still like to receive that, though, if that is possible. Is the department observing what seems to be slight increases each quarter on vacancy levels, and is it at a point where we have to start changing policy settings around that?

Mr Broadhead—We do monitor occupancy. We are aware of fluctuations. As I have said, it is a small fluctuation at the national level. As Andrew Stuart has just outlined, there are a number of things that affect occupancy, particularly at the local level. Refurbishments are one example. Residents will move out of a building while changes to that building are made or buildings are replaced and so on. The lead time to fill a new aged care home is around six to 12 months. Where there are new facilities coming online, because you count the beds that are available from the time that the place opens, as it were, you will get an impact on occupancy levels due to new places being opened. We believe from the analysis that we have done in the last year or so that the minor dip that we have had in occupancy is largely the effect of refurbishments and of the large number of new places that are coming on stream due to the expansions in the last few rounds. We do not believe there is any evidence of a long-term trend downwards in occupancy. As I say, at the national level it is about 95 per cent to 96 and a bit per cent.

Senator McLUCAS—I am not suggesting that it is a huge shift. You are aware that parts of the sector are concerned about what seems to be a trend in occupancy. I believe the former minister used to talk about occupancy and vacancy.

Mr Stuart—We are aware of the issue being raised. There is an interesting relationship between the matter you raised earlier, access by individuals, and the issue of vacancy rates. Occupancy rates in the 95 per cent to 96 per cent area reflect very low rates of vacancy and fairly slow turnover. Of course, a policy objective is to provide access and to provide for choice. I would just point out that there is a relationship between occupancy levels, access and choice, which we need to be cognisant of.

Senator McLUCAS—Is there an appropriate vacancy figure that the department is comfortable with?

Mr Stuart—There is no policy about a vacancy figure.

Senator Santoro—It is interesting that we are having this exchange now in view of some of the previous exchanges before lunchtime. I intuitively think that if there is a reasonable level of vacancies, to take up the points being made by Mr Stuart, it is good for the consumer. Like you, I do get representations from the sector saying that there is an increasing number of vacancies. I have pasted speeches on my website that clearly tell the sector that I do not see anything wrong with a reasonable number of vacancies existing, because it does provide the consumer with a greater level of choice and competitive advantage. What this discussion reinforces, without in any way wanting to put words in your mouth, is that—

Senator McLUCAS—You would not be.

Senator Santoro—I know I would not, but I wanted to stress that that is not what I was trying to do. It does emphasise the locational nature of the issues that we have been discussing in terms of vacancies and also in terms of waiting times. I think that it is all tied in with ageing in place. It is tied in with community care being made available in increasing amounts. You were quick to jump in when you said before that it was the Labor Party that initiated the trend towards community care packages. I have openly given credit to the previous administration for that. We thought it was a good idea. I think we are providing close to 40,000 community care packages, up very substantially from about 3,800 back in 1996. I think that we are all on the same wavelength. I will not take up anymore of your time. It is interesting how the discussion has come around full circle. I want to stress the locational component of waiting lists and vacancies. In terms of waiting lists, I appreciated the evidence this morning; I have a better perspective of just how uncertain a concept that can be.

Mr Broadhead—In terms of percentages figures, if I could add to my earlier answer, the figures I have is that occupancy was 95 per cent in 2005-06; and 95.3 per cent—this is nationally—in 2004-05; and 95.8 per cent in 2003-04.

Senator McLUCAS—It is sitting at around the same level.

Mr Broadhead—There is a slight drift downward.

Senator McLUCAS—You made the point about choice. Is there any intention to increase that vacancy level?

Senator Santoro—As you would be aware, the government at the moment are very seriously considering how we further respond to various representations that are being put to the government over time. We received the Hogan report and we are looking forward to making a further response. There could well be some initiatives that will come forward that will look at the supply side of the equation with a view to possibly increasing supply. I do not wish to sound disrespectful, but we might even listen very favourably to the sorts of things that you were saying this morning in terms of extra places. But the government's policy is to keep on making provision, providing extra places particularly to meet the end of 2007 target, which will become fully operational on 1 January 2008.

Senator McLUCAS—We'll see.

Senator Santoro—I want to stress that I take your point that 'we'll see'. However, we are confident of achieving that. We will come pretty close, if we do not, but I am confident that we will achieve it.

Senator McLUCAS—I turn to the investigation into Mrs Kerry Bishop. Thank you for the answer to question No. 2112, which goes to this question. The answer to that question says that there are two individuals who have been investigated for acting in a key role when they were not allowed to. One of those people is Mrs Kerry Bishop. Can I assume that the other person is her husband?

Mr Dellar—You cannot assume that.

Senator McLUCAS—Then let us go on with Mrs Bishop. Is that investigation ongoing?

Mr Stuart—What is probably best for us to say here is that the department, through its fraud control area, has a little while ago concluded its work and investigation in this area and has handed the matter on to the appropriate authorities, and there it rests.

Senator McLUCAS—And the 'appropriate authorities' being DPP?

Mr Dellar—That is correct.

Senator McLUCAS—Can you tell me who the other investigation is being conducted into?

Mr Dellar—It is not a current matter. The question I think we have answered is that the investigation was conducted over time.

Senator McLUCAS—Yes.

Mr Dellar—The matter relates to something from one or two years ago.

Mr Stuart—I am sorry. I think what we are looking for is clarification of your question. Your question is entirely about the case of the Bishops, is it not?

Senator McLUCAS—I asked a question on notice, No. 2112, and I asked how many individuals have been investigated for acting in a key role when they were not entitled to. Your answer to that was that there were two. I imagine from that that one of those investigations is the investigation that is now just completed into Mrs Bishop. I am seeking to know who the other investigation was conducted into.

Mr Dellar—There was another individual, but it is several years ago. However, it is a matter that is still under review—that is, the individual concerned is being monitored by the department, and if we form the view that that individual was acting as a key personnel we would again take action.

Senator McLUCAS—So the investigation was undertaken by the Department of Health and Ageing?

Mr Dellar—Some time ago, yes.

Senator McLUCAS—Was it found that it was appropriate to send that information across to the DPP?

Mr Dellar—No, the decision at the time was that there was not evidence that would allow us to take it to that step.

Senator McLUCAS—I will not ask any more questions about that. I turn to the Blackburn aged-care facility in Melbourne, which I understand is now closed.

Mr Dellar—That is correct.

Senator McLUCAS—That was a very difficult circumstance. We had the oldest person in Australia in that facility. The local member, Mr Barresi, became involved in the transfer of that elderly lady. You will recall that the operators were very well regarded people. It was an internal dispute between the operators and the owner of the building. It was a very distressing time for those residents and they were eventually moved. Mr Barresi, I understand, offered to provide a limousine to transfer one of the residents to her new place of living, and that was refused by the family. But during that conversation, Mr Barresi indicated that the Darts, the very good providers who were operating Blackburn, would be all right because they have an application in for more beds. How would Mr Barresi know that?

Mr Dellar—I do not know what Mr Barresi said, but what I would say is that the only source of information that he could have would be the Darts.

Senator McLUCAS—Yes, and the Darts have indicated to me that they have not told Mr Barresi that. So how would Mr Barresi have known that information?

Mr Dellar—You are going to the issue of probity of the aged care approvals round. What I would say—and I am not saying whether Mr and Mrs Dart have submitted an application or not—is that we do run those processes very tightly and very carefully.

Senator McLUCAS—Yes, I am aware of that.

Mr Dellar—We have probity arrangements, we have conflict of interest arrangements and, more than that, we separate knowledge within the department's officers—that is, only selected people are permitted to know who has applied for what. It is not a matter of general knowledge in the office.

Senator McLUCAS—I am aware of that, Mr Dellar. It should be highly protected information.

Senator Santoro—Not necessarily, if I can interrupt. I am in receipt of literally hundreds of letters, including from members of the Labor Party who represent the Labor Party and their electorates in this place, supporting applications by providers. I suppose I do look at who they

have come from, I scan them, and I just immediately send them off to the departments. I think that once it hits the department the probity safeguards are such that, whatever else happens, once it hits the department and the planning committees, or whatever they are called, obviously probity and discretion kicks in.

Senator McLUCAS—So you told Mr Barresi?

Senator Santoro—No, I have not. I cannot recall having any discussions with Mr Barresi at all. I want to be emphatic about that. I cannot recall in fact whether I have received any communications from the Darts in terms of applications other than communications in relation to Blackburn, and obviously many from the Darts and from supporters of the Darts who, as you quite correctly stated, are very highly regarded.

Senator McLUCAS—I am trying to work out how Mr Barresi might know, because this is protected information under the Aged Care Act.

Senator Santoro—It is an assumption that Mr Barresi did say that; you might have to check that with Mr Barresi. You might want to ask him whether or not he in fact said that. If you want me to speculate, let me give you one: the Darts might have told somebody else, who then mentioned it to Mr Barresi. I do not know to whom the Darts have spoken.

Mr Stuart—I think the general point being made is that, yes, it is protected information from the point of view of the behaviour of the department, but there are often other parties involved.

Senator Santoro—Yes.

Mr Stuart—Nevertheless, Senator, given what you have told us today, I would like to take this away and ask some questions of the staff involved and follow up that matter.

Senator McLUCAS—Good. That is my next question. I think an investigation into what has occurred is required, given the very strict protection of that information that should happen.

Ms Halton—I will make sure that that report comes to me and I will examine it.

Senator McLUCAS—Thank you. Has Mr Devlet been granted approved provider status?

Mr Dellar—I will take some advice in a moment, but I think that is protected information under the Aged Care Act. I think I am not permitted to tell you the answer to that question.

Senator McLUCAS—All right.

Ms Halton—We would have to shoot you!

Mr Dellar—I will just confer.

Mr Stuart—We will come back to you.

Mr Dellar—It has been confirmed with me that that would be protected information under the act.

Senator McLUCAS—I think I need to talk to Mr Brandon now, please. Mr Brandon, the minister and I have had a discussion in the chamber, which you would be aware of, I am sure, about the number of spot checks that have been undertaken. I do not have the actual numbers

with me, but I know what the May and the June figures are. Can you tell me the number of spot checks that have been undertaken from July to now, please?

Mr Brandon—The number of unannounced visits for the first quarter—I have actually got the first quarter plus a few days of October, because it is too early—

Senator McLUCAS—First quarter of this financial year?

Mr Brandon—For the first quarter of this financial year. There were 382 support contacts in the first quarter—unannounced visits. In the 28 days of October we have done 336.

Senator McLUCAS—That 336 was in how many days?

Mr Brandon—From 1 to 28 October.

Senator Santoro—So 28 days.

Mr Brandon—About 28 days.

Senator McLUCAS—How is the figure of 382 for July, August and September broken down?

Mr Brandon—They are unannounced visits. 'Support contacts' is unannounced visits.

Senator McLUCAS—Yes. So for each month?

Mr Brandon—I am sorry. I do not have that figure with me.

Senator McLUCAS—Could you get that for me, Mr Brandon, please?

Mr Brandon—Could I take that on notice?

Senator McLUCAS—That will be fine.

Mr Brandon—I might make the observation by way of explanation that you would be aware that this is the period of the year where we are in a high-level of accreditation audits. In this calendar year to date we have been doing a lot of site audits.

Senator McLUCAS—Yes.

Mr Brandon—As the number of site audits decline, which they do substantially, the number of support contacts goes up. That is why over the next few months we will have an increased capacity to do unannounced visits.

Senator McLUCAS—That is what I want to go to. We have had a discussion before, Mr Brandon, about the nomenclature of the visits that you have. We have site audits, and some of them are announced and some of them are unannounced.

Mr Brandon—No.

Senator McLUCAS—No; pardon me. That is another one.

Mr Brandon—If I might help—

Senator McLUCAS—A site audit is just a standard every-three-year audit?

Mr Brandon—That is correct.

Senator McLUCAS—How many of those have you done in this financial year?

Mr Brandon—I do not have the figures for this month but for the first quarter we did 759.

Senator McLUCAS—That is because this is the third rolling—

Mr Brandon—That is correct.

Senator McLUCAS—This is the big year?

Mr Brandon—Yes.

Senator McLUCAS—What is the support contact?

Mr Brandon—Review audit.

Senator McLUCAS—Review audit. How many of those have you done?

Mr Brandon—We have done 15 in the quarter. We did 64 last year and we have done 15 in this quarter.

Senator McLUCAS—Support contacts?

Mr Brandon—If I could just use the quarter to 30 September, we have done 787 support contacts, of which 382 were unannounced, which is a total of 1,561 visits for the quarter.

Senator McLUCAS—Of all three types?

Mr Brandon—Of all three types.

Senator McLUCAS—So there have been 405 announced support contacts. How does that compare with what you would usually do for a quarter?

Mr Brandon—It is a hard, if not impossible, task to realistically compare with history, because until last year the target figure was 1.25 visits per home per year. Commencing 1 July the target is 1.75. The May Commonwealth budget increased the funding and the volume of activity. We would expect in this financial year to do at least 5,200 visits, whereas last year we actually did 4,900, which included a large number of site audits, of course.

Senator McLUCAS—Can you disaggregate that for me over the last financial year?

Mr Brandon—Last financial year we did 1,743 site audits, 64 review audits and 3,190 support contacts, which totals 4,997. Of the 3,190 support contacts, 886 were unannounced.

Senator McLUCAS—The Aged and Community Services newsletter of 26 October stated:

> One result of the increased spot checks has been that in some areas agency support visits have been put on the backburner, with some planned visits even cancelled. The agency indicated to Aged Care Queensland that, if facilities have received correspondence about a schedule of support contacts following accreditation, these no longer applied.

Is that correct—that with the increased activity in spot checks you have had to decrease your activity in support contacts?

Mr Brandon—No, that is not generally correct. As you would be aware, we advised homes in advance of support contacts. When we changed the arrangements such that we are doing more visits than we did previously—and of course we are now doing more unannounced visits; every home will get at least one unannounced visit this year—it meant that we had to revise the whole schedule. So it is more visits; that is the total. We said to homes, in a letter to each aged-care provider: 'We had told you we would be out there in December as part of a routine visit. That is no longer on. We are recasting our whole

schedule.' The end point of that is that every home will get at least one unannounced visit during the financial year. We can do at least 5,200 visits, which is an average of 1.75 visits per home.

Senator McLUCAS—Did you have a projected program for support contacts, or is that something that has to be a bit more dynamic than that?

Mr Brandon—Internally?

Senator McLUCAS—Yes.

Mr Brandon—We had a schedule of announced and unannounced, and with the change to every home having an unannounced visit we just rejigged the schedule.

Senator McLUCAS—Have you reduced the number of announced support contacts because of the rejigging of the schedule?

Mr Brandon—Because of the hiatus or the ups and downs, if you will, in the accreditation cycle, what I can tell you is that next year we will do at least 5,200 visits, of which 3,000 will be unannounced support contacts, and approximately 1,800 will be potentially announced support contacts and the rest will be site audits.

Senator McLUCAS—So that is a decrease in the number of announced support contacts?

Mr Brandon—That is correct. The total number of support contacts will increase. There will be a small decrease in announced and, of course, a significant increase in unannounced.

Senator McLUCAS—What is the decrease in the announced support contacts?

Mr Brandon—I do not have the figure with me. The 3,000 visits, which is part of the national program of unannounced visits that the minister announced earlier, is embedded in our structure. The other support contacts will be a mix of announced and unannounced. I cannot guarantee that all the others will be announced. In fact, what I would say to you on balance is that some of those others will also be unannounced.

Senator McLUCAS—Because of the nature of the business they are in?

Mr Brandon—Because of the nature of the business and what we are looking for.

Senator McLUCAS—Going to the procedure for identifying which outcomes will be assessed at a spot check, how do you undertake that process?

Mr Brandon—In each state office we have a case management committee and a national case management committee. The role of the state case management committee is to identify what actions we should take in relation to a particular home and also to review what actions have been taken and to review the plan. That is what I would describe as a normal case management process. With the introduction of the budget initiative we developed what we called a national program of unannounced visits, the objective of which is to make sure that when we go out to a home we are actually looking widely enough so that we can find indicators of non-compliance if, of course, there is non-compliance. So we have developed some, and we are in the process of developing more, of what we call assessment modules, which are detailed instructions to assessors on which systems and processes to look for, which expected outcomes to look at and how those systems and processes interact. As you would appreciate, by looking at our results and processes guide, which is on our website, most of the

expected outcomes—in fact all of them—interact with others. It is not just a matter of going out and looking at one expected outcome. The national program of unannounced visits has assessment modules. We are trying to bring that all together. When the state case management committee decides the schedule of homes and which homes they are going to visit, they provide for the assessors advice on which national modules to look at and what else to look at, which is based on information we might have from the home, our understanding of previous non-compliance and basically any other concerns or, in fact, interests we have or knowledge we have of the home.

Senator McLUCAS—The Aged and Community Services newsletter says that—and I am paraphrasing it—if you look back at what your last audit showed as being potentially non-compliant, or not as good as you would like it to be, that is probably the area the agency is going to focus on.

Mr Brandon—No. I am familiar with the article. To be honest, if I were an aged-care provider and I had non-compliance or an area of concern from a previous audit, I would be looking very closely at that. However, the point I was making before—and maybe I did not make it clearly enough—is that these national modules sit outside that. There are two parts to the visit. There are the issues and concerns we have about what we know, and then the broader thing, which could be looking at how they do incident management and all the things that are attached to that. So, yes, if you own a home, I would suggest that providers should be looking very carefully at any previously identified non-compliance, but they should not believe that that is all we are going to look at, because a substantial part of the assessment will be these national modules, which are designed to find out if there are problems.

Senator McLUCAS—So the national modules sit outside the 42 expected outcomes?

Mr Brandon—They address expected outcomes. They are underpinned by the expected outcomes, but they are an approach we developed to ensure that we had the best possible chance of identifying non-compliance if it existed.

Senator McLUCAS—Has that just recently been developed?

Mr Brandon—We had what I describe as a rudimentary process under our old arrangements, but with the introduction of the new arrangements it was very important that we actually got out there and we were using the resources sensibly to make sure that, if there was stuff to be found, it was found. It was not just a bit of a, dare I say it, cursory look. That is why we developed our more rigorous and robust assessment modules.

Senator McLUCAS—Essentially, then, how many outcomes do they cover?

Mr Brandon—Collectively they will cover the 44. We are developing 12 modules. They will cross over; they will cover a number. The important thing about the national programs of unannounced visits is that the instructions we have given to our officers and our staff are that, if the assessor is on site and identifies a potential issue, the idea is to go off down that path and look. If you have an unannounced visit, the possible outcomes are that at the end you get a 'thank you very much—no worries', the unannounced visit gets extended in time, you get another visit which may or may not be unannounced or, alternatively, you get a review audit.

Senator McLUCAS—You said that you were developing these national modules. Are you currently using them?

Mr Brandon—We have developed some. We intend to develop 12. We have two absolutely finalised. We have three working and another nine well under development, about half of which are ready for sign-off.

Senator McLUCAS—Have you consulted with the sector in the development of those modules?

Mr Brandon—We discussed with the peak industry bodies the national program of unannounced visits. We did not discuss how we would do them and, particularly, we did not discuss the modules because we thought that that runs the risk of undoing the value that will come from having unannounced visits.

Senator McLUCAS—How would that happen?

Mr Brandon—Part of the instructions to the assessors will be a modus operandi. Basically, the message that we have given to the sector is: we are doing unannounced visits; you need to be fully compliant with the standards at all times. It is a reflection of the legislation.

Senator McLUCAS—That is the purpose of having them.

Mr Brandon—But that is the message we need to get to them. My concern is that if we were to go out and say, 'This is what we're going to do,' people may well take the view that they will just take a bit of a risk here and there. We are saying to the sector quite clearly that the purpose of these is to focus on the care standards, which I think was the subject to the minister's press release on 9 May or thereabouts.

Senator McLUCAS—You have two modules rolled out now—

Mr Brandon—Three.

Senator McLUCAS—I am trying to understand how the modules are constructed. Are they around specific elements of care? For example, does module 1 involve, say, medication management and module 2 deal with nutrition and hydration?

Mr Brandon—The assessment modules are not about a particular expected outcome, because that is too narrow. They are broader. The one I have here is called 'Assessment module 2006/02'.

Mr Stuart—A revealing title?

Mr Brandon—A revealing title because it is so broad that a title would not help us. But in this one, there are instructions to the assessors that have headings 'Aspects', 'What to look at', 'The process to take', and 'Consider the implications for the following expected outcomes'. This one actually addresses about 12 outcomes. There is another part of it which tells them what to observe, how to talk to residents and relatives, staff interviews and what documentation to look for and then has further information, some of which is lifted from our *Results and Processes Handbook*. These are detailed instructions to assessors on the systems and processes to look at and how to look at them. If problems or issues are identified, they then go off looking for that.

Senator McLUCAS—What did you do prior to this rollout with conducting spot checks?

Mr Brandon—The focus previously had largely been on expected outcomes, some of which you touched on before, such as looking at medication management. We used to advise the assessors to look at a number of expected outcomes, and it worked reasonably well under the circumstances. I think what the introduction of the new program has done has just accelerated some of our internal continuous improvement work, where we just continue to look at how we do things and how we, hopefully, create value.

Senator McLUCAS—I take your point that we do not really want to tell everyone what we are going to check people on, so I am a bit loath to ask you to table that document. Is there some way you could give me an understanding, without tabling the various modules, what outcomes each module seeks? Let me put it this way: What is the number of outcomes that each module is addressing in that principal earlier part of the document you described to me?

Senator Santoro—I just had a quick word with Mr Stuart and we would be more than happy to provide you with a briefing on the issue that is of interest to you.

Senator McLUCAS—I thank you for that. I would not mind knowing—and I think the public needs to know—the number of outcomes each module is going to address.

Mr Brandon—All the 44 are covered by the complete—

Senator McLUCAS—Yes, I understand that.

Mr Brandon—Each one within the set covers a range of expected outcomes. However, the point to be made is that, in covering that range, it then opens doors to other expected outcomes—what I would describe as core outcomes and then they open doors to others. If I could explain what I mean, you mentioned medication management before. The expected outcome talks about safe and effective medication management systems. That could actually lead to another expectation on staff training and privacy and dignity. I could go on. I am not an assessor, but there are a whole range of areas where one would simply say it is an expected outcome called 'safe and effective medication management', but it opens the door to a number of other expected outcomes.

Senator McLUCAS—Is it possible, though, for you to identify not the names of them but the number of principal outcomes that each module is addressing?

Mr Brandon—If I could take the question on notice, I can probably come up with some solution.

Senator McLUCAS—Terrific. And, yes, I will take up the offer of a briefing on that issue, thank you. Very quickly, Minister, you talked earlier about the long-term response to Hogan. When is that expected to be released?

Senator Santoro—As I have mentioned to you before, it is under active consideration. I expect that a further response will be forthcoming sometime in the near future.

Senator McLUCAS—You said that to me in February.

Senator Santoro—I am more confident that the future is nearer now than it was in February, but it is under very active consideration.

Senator McLUCAS—I wonder how active your department can get.

Senator Santoro—It is active at all levels, including the department and my office. As you know, I continue to consult with the sector. Even though it is under active consideration, I keep on benefiting from advice and opinion from the sector.

Senator McLUCAS—Do you imagine we will have the document before Christmas?

Senator Santoro—I said to someone else who asked the same question that my name is Santo, not Santa, so I will not say anything beyond that. Christmas is almost upon us.

Senator McLUCAS—Professor Hogan brought down his report in May of 2004, if I recall correctly—quite some time ago.

Senator Santoro—Yes. As you would appreciate, the government in fact responded quite substantially to that report, including with the announcement of the funding of a $2.2 billion investment, Investing in Australia's Aged Care: More Places, Better Care package in the 2004 budget. That package did respond, as you would be aware, to all of the review's immediate recommendations and most of its medium-term recommendations.

Senator McLUCAS—When the document does arrive, is it going to explain the government policy for a long-term strategy for residential aged care funding, or is it going to provide a range of options? What are we going to deal with when it comes?

Senator Santoro—I think that eventually the document and the expression of policy that will be discernible in it will be determined by cabinet. At this point, I am really not in a position to outline in any great detail the nature of the further response to the Hogan report. I think it would be fair to say that the further response that will be forthcoming some time in the near future will be pretty descriptive of the government's long-term policy direction.

Senator McLUCAS—It will not be an options paper, a discussion paper or something of that nature?

Senator Santoro—Even options papers, if that were to be the nature of the document—of course, I am not confirming either way whether that will be the case—can be pretty educational as to what the government is thinking in terms of policy. I am not trying to be difficult. It is just that, as I have explained on a number of occasions to the sector and to you, we have not been resting on our laurels. We have been consulting very extensively, and it is under very active consideration within the government.

Senator McLUCAS—We have heard that before; so has the sector.

Senator Santoro—They understand that we are trying to get it as right as we can for them, and we intend to keep on consulting until the very end of the process.

Senator McLUCAS—Either in estimates or in response to a question on notice you said earlier that the agency makes out-of-hours visits to aged care facilities. What proportion of visits is out of regular hours?

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

Senator McLUCAS—Have you seen the Commissioner for Complaints annual report?

Mr Brandon—Yes.

Senator McLUCAS—In his opening comments the commissioner makes his observations of internal complaints systems in residential aged care. Essentially he is saying that they are there more in principle than in practice. When you read that, what did you think?

Mr Brandon—I do not recall reading that, but I am sure it is there.

Senator McLUCAS—One of your expected outcomes is that people will have an internal complaints resolution process?

Mr Brandon—That is correct.

Senator McLUCAS—I looked back over about 100 of the most recent reports, and very few identified that there was any problem with the complaints systems operation, according to the reviews that your teams have done. Do you have any comments about that?

Mr Brandon—Those 100 reports would reflect what we found and, as you are aware, as part of the site audit process we are required to interview at least 10 per cent of residents and relatives. The actual interview rates are much higher than that. Comments and questions such as, 'How well does the complaints system operate and does the home react to your complaints?' are part and parcel of the assessment. Of those 100 that you have read, my take would be that the residents interviewed were satisfied with the complaints management system in place in their home.

Senator McLUCAS—There is obviously, though, a disjuncture between what Mr Knowles is seeing and what your assessors are seeing.

Senator Santoro—Could I intervene here and give you a view that may be acceptable to you. What the complaints commissioner, I believe, is saying in that report is that the current complaints system can be improved on. In fact, he reported to the government and we have discussed—

Senator McLUCAS—That is about a different issue, though.

Senator Santoro—Is the paragraph you are reading from that report referring to the way the agency specifically handles complaints?

Senator McLUCAS—No, internally within an aged care facility. Every aged care facility has to have an internal complaints mechanism/process. Mr Knowles makes the observation that they are more on paper than in practice.

Senator Santoro—He is right, to a considerable extent. That is why the government has responded in terms of compulsory reporting, in terms of eventually wanting aged care facilities to have in place systems. I suspect that that government requirement will be pushed via the accreditation system. That is why we are introducing whistleblower legislation. In order to create an internal complaints reporting mechanism, which is compulsory and is assisted by whistleblower legislation, which is also assisted by other initiatives that will enhance the culture of reporting, suspected or—

Senator McLUCAS—I am sorry to interrupt; this is actually not about high-level abhorrent sexual offences. He is talking about the need for systems to be in operation in each aged care facility that militate against having to use the higher level complaints resolution scheme/system, however it might be structured.

Senator Santoro—You are talking about food or complaints about—

Senator McLUCAS—If I have a complaint about where my mum is staying, I should be able to go through the internal process in the facility. His observation is that they are there on paper, but they are not in practice and, as a result, the CRS and his office end up having to deal with a much higher level type of complaint. The point I am making is that one of the expected outcomes that the agency is meant to assess is whether or not a facility has an internal complaints resolution system. My assessment is that it is very rarely identified as a problem through the assessment process.

Senator Santoro—I see where you are coming from.

Mr Brandon—I can advise you that in the September quarter, the first quarter of this year, we did 795 site audits, and nine of those complaints and comments were found to be non-compliant.

Senator McLUCAS—It is very small number, isn't it—nine out of 759 where that was identified?

Mr Brandon—The expected outcome that relates to complaints and comments is that each resident or his representative and other interested parties has access to an internal/external complaints mechanism. There is a lot of detail behind that. My take on it is that the assessors in those 759 site audits spoke to at least 10 per cent of the residents in each home and reported what the residents told them.

Senator McLUCAS—I understand that. I am asking whether or not it is an effective system, because the complaints commissioner has a different view about how effective complaints resolution is in the sector.

Senator Santoro—I think I have the paragraph that is of interest to you.

Senator McLUCAS—Can you tell me which page it is? I have lost it.

Senator Santoro—It is page II—it is a Roman numeral. What he says is that the best of these organisations use information from complaints to seek out problems and improve services, but we are yet to reach a stage where the industry as a whole accepts complaints as a legitimate element of quality assurance. What he is saying is that there is a trend within the industry to deal seriously with complaints of the sort you are talking about. I suppose what he is also reflecting upon is that there are people within the industry—and I do not think they are the majority. As I am sure you would appreciate, I visit many aged care facilities these days, and the commitment to care is very palpable. I think the majority would treat a complaint on its merits and without taking it personally. The commissioner does say that it is important for providers to overcome the perception that all complaints are a personal attack on the integrity of the staff and the services provided. I do not think he is saying that it is most—

Senator McLUCAS—I have just found the quote. It is on page 17, the third last point. It says:

> Committees are increasingly confronting situations where facilities have an internal complaint mechanism in theory but not in practice.

Given that Mr Brandon's agency has a responsibility to ensure that facilities have an operational and effective internal complaints scheme, for the commissioner to make that

comment, I think, is somewhat at odds. I will not progress that any more given the time. The final question goes to the Community Partners Program. Mr Dellar, can you explain to the committee the process by which funds are allocated within the Community Partners Program?

Mr Dellar—It was the equivalent of a tender process. The program was advertised, applications were received and assessed, and grants were awarded to those judged to be the most competitive.

Senator McLUCAS—Was that done totally in house?

Mr Dellar—It is done totally in house, yes.

Senator McLUCAS—There has been quite a big shift in the Community Partners Program funding in the last round. Is that a reasonable observation?

Mr Dellar—Not really. Going back in history, the Community Partners Program is a new program which is actually in it first full year of operation. We took on that program after a review of the department of immigration settlement scheme. It was decided by the government that the department of immigration would no longer fund services for settled immigrant groups. The decision was made as part of the 2004 budget to create a new program called the Community Partners Program. Its intent and goal is to provide funding to organisations from a non-English-speaking background that have significant numbers of people who will need support or would benefit from additional support in gaining access to residential and other forms of aged care. For the first six months of the program, we actually rolled over the grants that were formally provided to those organisations by the department of immigration. But it is not the case that every one of those had the focus on aged-care services that this new program has.

Senator McLUCAS—If I am comparing 2005-06 funding with 2006-07 I am actually comparing DIMIA money?

Mr Dellar—No, you are not doing that. What I am saying is that we moved from a process where DIMIA was the funder to a process where the Aged Care Division within the Department of Health and Ageing was the funder.

Senator McLUCAS—So 2004-05 was DIMIA?

Mr Dellar—I have actually missed a year here. From memory, the department commenced funding from 1 January 2005. I will check that. Then in 2005-06, or in that six months, there was a funding round, and in the round this current year there has been further funding. Programs have been funded essentially for one year each time.

Senator McLUCAS—So the principle that you may have inherited from DIMIA, to fund services that are providing aged-care assistance, referral, whatever—is that for newly arrived migrant groups? What is the rationale?

Mr Dellar—There is really one program that has been replaced by another program. The original program was for migrant communities. In the review, those communities were divided up into different kinds of communities. Those that are essentially representing new groups of people coming to the country, where the issues are about employment and housing and training and learning English, remained with the department of immigration and other related entities. Where the funding had become one of supporting communities that have been

in Australia for a long time, the need had quite often changed from one of, on arrival, 'What is it you need?' to, 'We've been here a long time now. What are our needs now?' We took over funding. 'Took over' is not quite the right word, because Immigration ceased and we commenced. However, for the first little while we continued to fund those organisations, but then chose to advertise the funding and select organisations that were serving or proposing to serve communities where the need for ageing support became most acute.

Mr Stuart—I think it would be fair to say there was a process of clarifying the objectives involved in all of that.

Senator McLUCAS—There has been a lot of consternation about the change in funding and the essential debate-funding of a number of organisations.

Mr Dellar—It is true that some organisations that were not successful have not been happy about that.

Senator McLUCAS—Yes.

Mr Dellar—However, the services that are being funded are using all of the money that is available and presumably benefiting the communities that they are serving.

Senator McLUCAS—In terms of making a judgement about which areas receive the funding—I am looking particularly at Victoria—there has been quite a growth in funding in areas that, if you look at the demographics, would indicate that there are not high numbers at all of people from culturally and linguistically diverse communities. How do you make a judgement about putting services into the eastern area of Victoria with two per cent and three per cent of people who are migrants and removing significant funds out of north-western Melbourne, which has, as we know, huge numbers of migrants?

Mr Dellar—The demographics are definitely part of it, and we would certainly have the view that we should not fund organisations that do not have people with the developing needs for aged care. It is not only that. It is also about the application and whether the applicant is prepared and wishes to deliver the kinds of services that are envisaged under the Community Partners Program.

Senator McLUCAS—In terms of the internal process that you went through, you then make a recommendation to the minister?

Mr Dellar—That is correct.

Senator McLUCAS—Did the minister change any of those recommendations?

Mr Dellar—Not to my knowledge.

Senator McLUCAS—Thank you.

Proceedings suspended from 3.29 pm to 3.41 pm

CHAIR—The committee will resume its public hearings into the estimates for the Department of Health and Ageing. We have completed outcome 4 and we are now jointly on outcome 3, Access to Medical Services, and outcome 11, Mental Health.

Senator MOORE—We have some general questions on the Medicare safety net and then, as you would probably expect, we have a series of questions on the mental health process.

Ms Halton—As a consequence, you have the heavyweight team. I do not think I have ever had so many deputy secretaries and division heads at the table with me at one time.

Senator MOORE—We are very used to dealing with a whole bunch of professors. We have some standard questions about the Medicare safety net. We will see how many of these we can get answers to and how many we will need to put on notice, but you will be unsurprised by them. We want an update of the spending on the Medicare safety net—actual spending for 2005-06, budget estimate for 2005-06 and the variation. Do you have that in graphic form?

Ms Morris—Do you want actual spending?

Senator MOORE—The actual spending for 2005-06—it may well be in the annual report but I have not read it—the budget estimate for 2005-06 and the variation.

Ms Morris—The budget estimate for 2005-06?

Senator MOORE—Yes.

Ms Morris—The extended Medicare safety net is effectively a calendar year program. We do not look at financial year estimates. It obscures understanding of it to look at it in the sense of a financial year.

Senator MOORE—Your data is as of December last year; is that right?

Ms Morris—Yes.

Senator MOORE—Do you do half-year calculations as of June-July, or is the focus mainly on December-January?

Ms Morris—Mainly on December-January.

Senator MOORE—Can we get the December-January 2005 figures, which would be the latest that you keep? Is that correct?

Ms Morris—Yes.

Senator MOORE—What was the actual spending as opposed to the estimate spending?

Ms Morris—The actual spend was $272.2 million in the last calendar year. It was very close to the estimate. It was within an expected variance of that.

Senator MOORE—Was it an underspend, an overspend or very close?

Ms Morris—It was a very close underspend. The estimate was $274.8 million. So it was a $2.6 million variance.

Senator MOORE—What was the reason for the discrepancy, although it was close? Has that been analysed?

Ms Morris—It is demand driven, as is the MBS in total. We usually come in pretty close on estimates in the MBS as a whole, and I think this is a pretty good outcome for this too.

Senator MOORE—I understand that the stimulant is demand, but were there any areas of demand that surprised you or did not meet expectations? Are there any particular areas in the MBS process where you can say it was due to underspend in these areas? Can you do the same thing with the safety net?

Ms Morris—I do not think we have done that sort of analysis to answer your question adequately. It is demand driven and also we are finding that there is a lag time in people making claims. The patterns are changing over time.

Senator MOORE—Have those patterns been consistent over a number of years? Have they settled into any kind of historical process?

Ms Morris—Yes.

Senator MOORE—Has there been any analysis of that?

Ms Morris—Yes. We keep an eye on it.

Ms Robertson—We look at where the expenditure is greatest within a particular calendar year. As you would expect, as people accrue towards their thresholds throughout the calendar year, the bulk of the payment is made towards the end of that calendar year.

Senator MOORE—In the past we have talked about seasonal variability, because of people getting unwell at different times. Can you trace that?

Ms Robertson—We have not done any analysis.

Senator MOORE—You have not done any analysis?

Ms Robertson—No.

Senator MOORE—Do the figures reflect that kind of change?

Ms Robertson—With the MBS as a whole, obviously when we are looking at expenditure across a particular year we see that there are peaks and troughs and the expenditure varies quite erratically. I would say that a lot of that is to do with when people claim as well, but there has been no specific analysis to look at whether or not there is a link between particular times of year and expenditure on the safety net, simply because we are seeing the bulk of that expense coming towards the end of the calendar year.

Senator MOORE—Can you give us expenditure in this calendar year to date? Do you do monthly figures?

Ms Morris—Expenditure is tracking how we expected it would this year. We keep an eye on it, but it is a different program to the MBS as a whole. We look at it differently. We monitor it, but there is a retrospective submission of claims and it takes off throughout the year.

Senator MOORE—What is the expenditure under the Medicare safety net as of the end of October? Is that a public figure?

Ms Robertson—We do not have that yet, given that October ended only yesterday.

Senator MOORE—I just want to know if you keep records of that expenditure and if can you give me those figures or not.

Ms Morris—No, I do not think that we can. They are not yet available.

Senator MOORE—When was the last available figure?

Ms Morris—The end of the last calendar year.

Senator MOORE—Realistically, you have no public expenditure figures?

Ms Morris—Yes.

Senator MOORE—Can you tell me how many times the department has had to revise its estimates for the Medicare safety net since the program was introduced in January 2004?

Ms Morris—Only once.

Senator MOORE—What was the reason for that variation?

Ms Robertson—There have been two occasions. Once was in relation to PEFO, the Pre-Election Fiscal Outlook, and the second one was when the thresholds were raised in last year's budget.

Senator MOORE—They were not retrospective changes, they were changes for the future? Is that right?

Ms Robertson—Yes.

Senator MOORE—They are the only two times that you have had to revise them?

Ms Morris—Yes.

Senator MOORE—I refer to a targeted figure for the Medicare safety net on page 64 of the annual report. I am sure you know this figure. We want to know why and to what extent the increase in the Medicare safety net threshold has been responsible for this result. There are three parts to the same question. I will get ask them and see what you can and cannot answer. Can you give us updated numbers of how many families and individuals are missing out under the new thresholds as compared with the original thresholds? Modelling was done with the old thresholds. The new ones came in and, as you said, you had to revise the process, and we want to know what the difference has been as a result. We have had that figure in the past. After they were changed we got that data very quickly.

Ms Robertson—That is right.

Senator MOORE—It is really an update particularly focused on the second pink box there.

Ms Robertson—These figures in here refer to the calendar year 2005. The thresholds did not actually change until 1 January 2006. These are not affected by the changing thresholds.

Senator MOORE—That is the answer to point two.

Ms Morris—Yes.

Ms Robertson—As Ms Morris said before, what we find is that people are not always claiming their rebates on the exact day that they have had the service. One of the reasons that we have the explanation in here is to say that, as at the end of June, which is when the period of the annual report is, we had 622,000 families and 117,000-odd singles who had qualified for safety net. As more people claim for 2005 during the 2006 calendar year, those figures continue to rise. We are still attaining the thresholds, if you like, or the targets in the annual report.

Senator MOORE—Is that a reflection of the process that is being undertaken?

Ms Robertson—That is right.

Senator MOORE—You are reporting on a calendar year basis and a financial year basis in your annual report.

Ms Robertson—For this particular target, yes.

Senator MOORE—Is there any way of standardising the reporting? The system, as you have explained, is clearly on a calendar year basis. Has there been any discussion of changing the year of process to a financial year?

Ms Morris—No.

Senator MOORE—The second one is about the data as opposed to updated numbers on families that were claiming under the old thresholds and reaching the safety net target, as opposed to families under the new one. The change came in on 1 January.

Ms Robertson—2006.

Senator MOORE—Yes. So you do not have figures?

Ms Robertson—No. There is a published figure that says it is estimated that around one million people will no longer qualify as a result of the changes to the thresholds.

Senator MOORE—Where did the estimate come from? Was that based on best knowledge?

Ms Robertson—That was based on an estimate that was done at the time the thresholds were changed.

Senator MOORE—In terms of us getting some clarity on how that is tracking, just on what you said to us now—

Ms Robertson—We would have to wait until well into 2007 before we could get the numbers on that.

Ms Morris—Until you get actual spend on the extended Medicare safety net everything is an estimate. There is a long lag time.

Senator MOORE—You have told me that the first public figures will be available in December 2006, which will only be in the system some time after that, and that will be the first time we will be able to get a clear evidence based comparison between the two threshold amounts; is that right?

Ms Robertson—Even then, because of claims lags, you will still find that even after the end of 2006 and well into 2007 the numbers of people benefiting will continue to rise.

Ms Morris—Which is what we are finding this calendar year with last year's services that are still coming in for claiming.

Senator MOORE—I am trying desperately to compare the systems.

Ms Morris—We try too.

Ms Robertson—We have had to wait a long time.

Senator MOORE—The same lag in claims occurred under the previous thresholds. I expect that the tendency not to put in claims straightaway has not only been there since the new arrangement?

Ms Morris—That is right.

Senator MOORE—If we are trying to take a point in comparing A with B—correct me if I am wrong—it would as fair a comparison to say under the old threshold rates at this date this was what was happening; under the new threshold rates, with the same process of individuals and families not submitting claims immediately they reach the point, then that would be a fair comparison?

Ms Robertson—It is an interesting issue and one that we have been grappling with internally as well. What you find with the program is that you have got a very long tail throughout the year and then it kicks up at the end with expenditure. That little kick towards the end of the calendar year is now moved further towards the end of that calendar year, so you are still going to have to wait a bit longer for those claims to come through the system.

Senator MOORE—Have you analysed why the kick is taking longer?

Ms Robertson—It is because of the change to the threshold.

Senator MOORE—So they reach the point later?

Ms Robertson—Because the threshold has changed from effectively $300, $700 and $500 to $1,000, it is taking people that little bit longer to accrue towards the thresholds.

Senator MOORE—I can see that, but I still think in an attempt to have a look at it you cannot just keep changing the date if it is a January-December program.

Ms Morris—When it comes out we will look at it, and when it is publicly available you can look at it too, and then we can draw our respective comparisons.

Senator MOORE—That is all that we can ask. When we have something to look at, we will.

Ms Morris—Yes.

Senator MOORE—Thank you for that. I want to put on notice one of the mega questions, which you responded to previously, and that is the issue of underspend/overspend. I put on notice a question for the department to update the underspend information it provided at the last estimates hearing, which was: 'In particular, can you please provide updated year-to-date figures of the top 10 underspending programs that you provided to the committee at the last estimates?' That is definitely a notice question.

Ms Morris—Yes.

Senator MOORE—Now we would like to ask some questions on mental health. I will kick off and then Senator Webber is going to take over with some specific questions. What I want to get on record, just to start with, is exactly the relationship between the Health and Ageing programs in the mental health process and the FaCSIA program; how do the departments work together and what is the arrangement? I know that Health and Ageing have particular programs in mental health that predate the COAG arrangement, but in terms of what we worked for towards the end of last year it was definitely leading up to the COAG announcement and where we were going into the future. If we can get on record exactly how that is working, what the interaction is and, moving into the future, how we can track its progress.

Mr Kalisch—Once the COAG Mental Health initiatives were announced by the Prime Minister and then also finalised by COAG in its July meeting, this department chaired an interdepartmental committee.

Senator MOORE—Are you the chair?

Mr Kalisch—I am the chair of that group.

Senator MOORE—So Health and Ageing has the chair?

Mr Kalisch—Health and Ageing is chairing that group. It involves FaCSIA and the Department of Education, Science and Training. It involves the Department of Employment Workplace Relations, Attorney-General's, Prime Minister and Cabinet, Treasury and Human Services, given some of the Centrelink links.

Senator MOORE—Is that all?

Mr Kalisch—It is a relatively large group, but it comprises those that have an interest in this and reflects the fact that there are a number of portfolios with initiatives. Of the $1.9 billion total Commonwealth contribution to the package, this department has $1.2 billion worth of programs, and then other departments are responsible for their particular initiatives and we get together to make sure that we collaborate to the extent possible so that everyone is aware of the major milestones and we are not tripping over each other in the implementation stage.

Senator MOORE—Is that interdepartmental working group focusing exclusively on COAG issues, or does it have a wider remit to look generally at the issue of mental health in Australia?

Mr Kalisch—When we get together we are taking the opportunity to consider some of the other issues that we are all dealing with in the mental health space to make use of that time.

Senator MOORE—That seems reasonable when you are all together.

Mr Kalisch—Yes.

Senator MOORE—You have got representatives from all those people. How often does that group meet? Is it that formal?

Mr Kalisch—There are formal meetings and minutes. It meets about every four to six weeks.

Senator MOORE—In terms of interdepartmental groups, that is quite a strong schedule of meetings.

Mr Kalisch—It has a number of milestones that we have been looking at as well as the need to establish effective monitoring and evaluation processes across the whole package. There is a need to get going on that pretty quickly. The imperative is that we all see the need to implement this on time.

Senator MOORE—Is that at the FAS level?

Mr Kalisch—It varies according to department. FAS and assistant secretary is not an uncommon level of representation of agencies.

Senator MOORE—So it is a senior committee?

Mr Kalisch—Yes.

Senator WEBBER—I will start with some questions about the new access regime. How many people in Australia are estimated to have a mental health disorder? We have got these lovely fact sheets that tell us all about it. How many people that have a mental health disorder will be picked up by the new program?

Prof. Calder—Can you repeat that?

Senator WEBBER—How many people in Australia are estimated to have a mental health disorder in need of treatment at any one time? How many people do we think we can pick up with this new, better access to mental health care program?

Prof. Calder—The estimates are about six per cent of the population at any one time.

Senator WEBBER—For the purposes of the mental health care Medicare items, we have the list of mental disorders and they go through. I take it perinatal depression is a 'mental disorder not otherwise specified', because it does not fit in to schizophrenia, bipolar or eating disorders.

Prof. Whiteford—The percentage of the population in a 12-month period who have a diagnosable mental disorder and substance abuse is 16.6 per cent. That excludes dementia. Perinatal depression would come under any of the depressive categories, which could be major depression or it could be dysthymic disorder. We are talking about depression in infants here, not depression in the mothers.

Senator WEBBER—Yes. I have a nice list here of the conditions for the purposes of accessing the mental health care items, and then I have the list of things to which it does not apply, and dementia is mentioned. What about postnatal depression? Is that a 'mental disorder not otherwise specified'?

Prof. Whiteford—No. There are several hundred mental disorders in the DSM4. Most of those would be in, and they are not all listed in the MBS schedule. So that was to give an indication of the type of mental disorder which would be covered, not to be an exhaustive list of only the mental disorders which would be covered.

Senator WEBBER—Do GPs know that?

Prof. Whiteford—Yes.

Senator MOORE—It seems odd, Professor. We have had this discussion before in different places with the mental health committee. It is very difficult to get an exhaustive list in this area, and trying to is a difficulty in itself. Certainly one of the things that came out in the mental health committee was particular concern from people who were working in the field of postnatal depression and also with small children. We have such a long list on the fact sheet but one of the things that we have heard is that there is a concern that that particular area has not been identified. I know that with any condition if you do not find your own listed, people do tend to feel dismissed, but there has been such a range of things put on the public fact sheet. The reason we are pushing it is that these are the public products that people are looking at to see what is happening in the community post the mental health expenditure and what they hope is going to be this new phase of awareness. We have things like panic disorders and adjustment disorders which are also quite wide. We had, as Senator Webber

knows having worked with us on that mental health committee, quite graphic evidence during that process from people who are working through those and have their own support groups. We were interested when we saw this, because we are watching it closely, as to why that particular group was not mentioned. There is no particular fact sheet that picks up that area in particular, so what is the rationale?

Prof. Whiteford—The rationale would be that postnatal depression is not a classification in the DSM4.

Senator MOORE—Are all these others?

Prof. Whiteford—Yes, they are.

Senator MOORE—All of these are straight from DSM4.

Prof. Whiteford—I would have to look at the list again to be sure. Depression in old age, depression in children, depression in postnatal periods would all come under the heading of depression.

Senator WEBBER—Right.

Prof. Whiteford—The issue would certainly be for some populations a lack of clinicians in that area, and certainly for children. That is a particular issue and would be the reason they may be having difficulty accessing treatment. There is certainly no intention to exclude various mental disorders. Having said that, the issue always comes up about substance abuse, and substance abuse is in the mental health program where it is comorbid with mental illness.

Senator WEBBER—Sure.

Prof. Whiteford—And substance abuse that is not comorbid is handled under a separate alcohol and drug strategy. Similarly, that is the case with aged care. Uncomplicated dementia is in the aged care program, not in the mental disorders program.

Senator WEBBER—Because we do have alcohol use disorders and drug use disorders on the list.

Senator MOORE—Tobacco users are specifically excluded. Senator Allison is not here, so we will not go into that.

Senator WEBBER—We do not need to go there!

Senator MOORE—It is interesting that drugs and alcohol are listed but tobacco use is one of the four that are specifically excluded at the bottom.

Prof. Whiteford—Usually tobacco use is not treated as a mental disorder. We will undertake to have another look at that list next time we do it.

Senator WEBBER—If only not to arouse our curiosity.

Prof. Whiteford—I will check it personally.

Senator WEBBER—With the new access arrangements to psychologists and psychiatrists, in the fifth year of operation of the program the government says it expects 35,000 people will see a psychiatrist. How many psychiatric services will be provided to those 35,000 people? Is there a maximum number of consultations?

Prof. Whiteford—There is no maximum number of consultations. Most people see a psychiatrist only two or three times; and some see the psychiatrist many times, some more than 50 times in a year. That is very uncommon, but it does happen. So the decision is left with the clinician and the patient about how often consultation takes place.

Senator WEBBER—How does that then fit in with what the fact sheet says. It says 'These psychiatric services will be provided to patients with severe mental illness.' I would have thought that, if you have a severe mental illness, you would need to see a psychiatrist more than once or twice.

Prof. Whiteford—You can have a severe mental illness which recovers completely.

Senator WEBBER—That is the aim.

Prof. Whiteford—That is the aim and that is what happens. So the person may see a psychiatrist two or three times. In that time they are also managed by their GP. Under the new arrangements, we expect that psychologists and later mental health nurses will be involved, and the treatment would result in them not needing to continue to see a psychiatrist, but perhaps needing to continue to see a general practitioner.

Senator WEBBER—Then the government says that it expects 400,000 Medicare services will be provided by psychologists, so how many patients is that? I want to place on record I am the daughter of two clinical psychologists. I am going to be very sensitive about this.

Mr Smyth—Again, we have not looked at specific patients there, because the number of consultations with phychologists varies between patients. Under the measures there are two levels of psychology that are receiving Medicare rebates, obviously clinical psychology and also state-registered psychologists.

Senator WEBBER—Yes.

Mr Smyth—Any patient can see a psychologist for 12 individual sessions and 12 group sessions in a calendar year. There is the ATAPS component of the Better Outcomes in Mental Health program as well. I understand it was approximately a year ago the figures indicated that it was less than four on average consultations per patient with a psychologist.

Senator WEBBER—Again, it is one of those things that arouses the curiosity of people like me in that you talk about the number of patients for psychiatrists and the number of sessions for psychologists. There either has to be a straightforward formula, it is a bit confusing, or I am not getting it.

Prof. Whiteford—The psychiatrist measures have been around for longer, so we have more data on how many patients are seeing a psychiatrist and how long they see them for. The change to the psychologists' measure is a modelling exercise because we are not sure just how many people will use psychologists and how many psychologists may choose to go into private practice once these new measures come in. We hope that psychologists will be well distributed across Australia and that many people will access them. But until the measure starts, which is today, as you are aware, we will not know, but we will collect the data and we hope our modelling and our costings are not too far out.

Mr Kalisch—Aside from the constraints that Mr Smyth talked about in the terms of sessions per patient, this is really a demand driven program. If there are more people seeking

to access the service and taking it up then we will see more people getting access to that MBS rebate through this program. So we look forward to providing you with further information.

Senator WEBBER—That would be good. I think having a rebate so people can see psychologists is an excellent initiative. As I say, I have to declare an interest. It is one I fully support. What is the current rate of bulk-billing for psychiatry?

Prof. Whiteford—Just under 36 per cent.

Senator WEBBER—What is the current average patient out-of-pocket cost, say, for a patient to see a psychiatrist who does not bulk-bill?

Ms Halton—We will see if we have it here.

Senator WEBBER—While you are checking: do we expect any change to either of those under the new mental health package?

Mr Smyth—To either of what, Senator?

Senator WEBBER—The current rate of bulk-billing or the average patient out-of-pocket costs for a patient to see a psychiatrist who does not bulk-bill.

Mr Smyth—We certainly expect that rates of bulk-billing will increase and the out-of-pocket costs will decrease. There have been some significant increases in item numbers for attendances with psychiatrists for consumers, so we would certainly hope that those numbers actually move up and down accordingly.

Senator WEBBER—Is there a current annual limit on the number of psychiatry visits Medicare will cover?

Mr Smyth—Under item 319 it is up to 160 in a calendar year.

Senator MOORE—In terms of the first round of questions that I asked and linking it in with the mental health process, has there been any modelling done on the potential impact of these mental health changes to the Medicare safety net? My understanding of the whole idea of this extension of availability of services was to give people the chance to access services which we believe they may not have been taking up before these changes were brought in. Some of the evidence we had in the inquiry was that a lot of the people did not access medical services for a whole range of reasons, so the government has announced these changes. The expectation I would imagine would be that people would access them now, and the system has just started. Has there been modelling done to see whether the greater access to services by people who were not using them before may then have an impact on the safety net that will mean that people using the services will get to the limited amount more quickly? Has that modelling been done?

Ms Halton—Certainly, in assessing the financial impact of any measure, we take account of any potential impact on everything that is relevant, the safety net being one of them—pharmaceutical benefits et cetera.

Senator MOORE—Which is all linked in, yes.

Ms Halton—We canvassed the entire range.

Senator MOORE—So there has been modelling done on that basis.

Ms Halton—Yes. Our colleagues in the Department of Finance and Administration would expect no less.

Senator MOORE—Sure. And we will ask them. Is the modelling public?

Ms Morris—No.

Senator MOORE—Was the work done by Finance with information from Health?

Mr Kalisch—It would have been the other way round. The health department would have done it, and they would have verified it and agreed with it.

Senator WEBBER—Do we have any information on the current average charges for psychology services that will now be covered by Medicare?

Mr Kalisch—Do you want the rebates?

Senator WEBBER—Yes.

Prof. Whiteford—The rebate is $110 for a clinical psychologist and $75 for an eligible psychologist, which is a state- or territory-registered psychologist.

Senator MOORE—Is that market rate?

Prof. Whiteford—It is less than the APS rate, but it is the rate which, when discussed with the profession, would lead us to believe that the co-pay would be small or negligible.

Senator WEBBER—Is that the same rate that Medicare pays for psychology services under the Chronic Disease Management Program?

Prof. Whiteford—No, it is higher.

Senator WEBBER—Why?

Prof. Whiteford—Because of the skill level that we are expecting those psychologists to have—the high level of qualifications.

Senator WEBBER—Even the $75 ones, to use a very shorthand term.

Prof. Whiteford—Yes. And it is also because we are allowing referrals from psychiatrists and paediatricians as well as GPs to those psychologists, and we would be therefore expecting some substitution to occur there. For that level of substitution we would want to ensure that we have high-quality care being delivered to patients.

Senator WEBBER—Do we have an expected rate of bulk-billing for these new psychology services? If we do, what is it?

Prof. Whiteford—We would hope that the majority of patients would be bulk-billed. The co-pays would be, as I said before, small or nil.

Senator WEBBER—For those who are not, what do we expect the out-of-pocket cost for a visit will be?

Ms Halton—We do not know that. You would be asking us for speculation. Once we get the ranges, obviously David will know.

Senator MOORE—One of the things we talked about during the inquiry was other allied medical health, apart from psychologists, being involved in the mental health program, and

mental health nurses came up in discussion quite a lot. It is my understanding that the mental health nurse initiative has been postponed. Is that right?

Prof. Whiteford—No. It was always due to come in on 1 July 2007.

Senator MOORE—So it had a different implementation date?

Ms Halton—Yes.

Prof. Whiteford—Yes.

Senator MOORE—Because everything else was coming in—I know there is a program—but why in particular were mental health nurses later? Is there a rationale for that?

Prof. Whiteford—It was just a staggering. I think the issue was to do the MBS measures which came in on 1 November. There was also the setting up of a different payment mechanism for the nurses. They are on sessions or salaried.

Ms Halton—It was not identified whether—

Prof. Whiteford—That is right. It had to do with the type of patient population they are going to look after and the fact that we are looking at them working in the practices of private psychiatrists who are not used to employing nurses, as GPs are. That meant there was more development that had to be done for that measure, that patient population. There was also the matter of mental health nurses' level of skill and experience. We had to work with the College of Mental Health Nurses to ensure we got the right nurses into those practices.

Senator MOORE—So it is systemic reasons more than anything else?

Prof. Whiteford—Yes.

Senator MOORE—And also the ongoing workforce issues—which I know belong to another branch.

Prof. Whiteford—That is correct.

Mr Kalisch—It really is important to understand that this is a new initiative, and obviously, with new initiatives where you have to set up new structures, new arrangements and new funding mechanisms, it is quite different to augmenting an existing program.

Senator WEBBER—Under the new program with access to psychologists and psychiatrists, who develops the patient's management plan? Is it the psychiatrist, the psychologist or the GP?

Prof. Whiteford—There are two types of plans. There is a plan developed by the general practitioner which has been introduced the MBS on today, which is the GP Mental Health Care Plan. Referral to a clinical psychologist, an eligible psychologist or a social worker or occupational therapist requires the development of that plan. There is another plan which the psychiatrist develops on referral from the GP. The GP refers the patient to the psychiatrist and the psychiatrist sees the patient between one and three times but refers the patient back to the GP for management. Under that plan also the GP can refer to a psychologist, social worker or OT.

Senator WEBBER—Does the GP need to have any training for that?

Prof. Whiteford—The OT and social worker both have specialist mental health expertise. It is not every OT and every social worker.

Senator WEBBER—With access to these new item numbers, have there been or will there be any changes made to the budget for the Better Outcomes in Mental Health program?

Prof. Calder—There are no changes.

Ms Halton—I will check that.

Ms Morris—While that is being checked, I would like to correct an answer that was given earlier. Mr Smyth was correct in saying that for item 319 it could not exceed 160 attendances in a calendar year. That is correct. Then I think there was a follow-up answer asking if there were restrictions on any other psychiatry items. Looking through the schedule and the psychiatry items, most of them have a limit of 50 attendances in a calendar year.

Senator MOORE—This is clearly one of those numbers.

Ms Morris—That is clearly in the schedule for those item numbers.

Senator MOORE—Thank you.

Ms Krestensen—There are no changes to spending under the Better Outcomes Program, particularly the ATAPS program, and the GP psych support projects are all on course to continue up to June 2009.

Senator WEBBER—This is something that you can take on notice. Can we have the forward estimates of budget allocations for Better Outcomes for Mental Health?

Ms Halton—Yes. We will do that.

Senator WEBBER—What have we done to provide access to psychiatric services for patients in rural and remote areas as part of this package? We can have an item number, and that is a good idea, but, to return to my usual bugbear, you cannot find a psychiatrist—

Prof. Calder—We do apologise. Maybe the table needed to be bigger.

Senator WEBBER—It would make more sense.

Prof. Calder—Let me apologise. I have only been in this role three weeks so I am relying heavily on my colleagues for some of the detail.

Mr Kalisch—There are a number of initiatives in this package that talk about providing extra support for people in rural and remote areas. There is in fact a specific subcomponent of the package which looks at providing services in rural and remote areas really to look at providing services where there are no doctors and psychiatrists.

Senator WEBBER—Are these specifically psychiatric?

Mr Kalisch—It is providing a whole range of services. There was an announcement, I think, in mental health work around that specific initiative. It is just over $50 million over four years.

Senator WEBBER—Is that the $51.7 million?

Mr Kalisch—That is the one.

Senator WEBBER—That is for mental health services in rural and remote areas?

Mr Kalisch—That is the one. Perhaps Mr Smyth or Ms Bennett can provide a bit more information about that.

Senator WEBBER—I want to know what we are going to do to ensure that you do have access to psychiatric services. It is my constant bugbear. I can find a psychiatrist in Geraldton but after that there is nothing. I can find psychologists in the north-west but I cannot find psychiatrists. So I want to know what we are going to do. How is the $51.7 million going to be provided? Will that be done through Better Outcomes in Mental Health or separately—what is the story?

Mr Kalisch—That will be a separate program.

Ms Halton—Can I make one point? Your point is absolutely well made about the difficulty of accessing psychiatrists, because we all know the sort of geographic distribution of psychiatrists. When we talked to the profession, one of the things that they were keen on, particularly with this broader range of professionals who we can access, is that they might actually be able to expand the number of people they see in their practice, and I think that probably includes being able to do more outreach into the bush. If they basically can see somebody a couple of times, then ensure that their care is being managed either through a nurse or through a psychologist—through that broader range of professionals—it will enable them to have a larger practice, more people, including a broader geographic distribution.

This particular issue is something that Professor Horvath and I discussed explicitly with the profession, being very mindful of exactly those concerns. We are going to have to see how it rolls out and we will continue to talk to the profession about precisely those concerns, but I think it is important to be aware that we are very mindful of that issue. It is something we are talking to the profession about. I do not think I can force them to move to Halls Creek or wherever.

Senator WEBBER—No. I find it hard to force them into the northern suburbs of Perth—except the nice ones.

Ms Halton—It is a bit the same in Sydney, let us be honest. But the issue of whether or not they can have more outreach in their practice once we enable them not to have to see every single patient they have, so that they can actually delegate some of that care, I think that capacity is expanded through these arrangements.

Senator WEBBER—Okay.

Mr Smyth—The Medical Specialist Outreach Assistance Program also obviously provides psychiatric services into rural and remote Australia. We are also working with the College of Psychiatrists at the moment in trying to increase the uptake of tele-psychiatry as well.

Senator WEBBER—So how is the $51.7 million going to be rolled out? Is that going to be funded through—

Ms Bennett—This measure is not particularly for psychiatry, it is for a range of other allied health services. It is being rolled out. At the moment we have a state-based COAG implementation group in each state and territory. The purpose of those groups is to work cooperatively with the states and territories in implementing our parts of this package and the parts of the package that states are responsible for. Under those committees we have

established a process to work closely with the states and territories in identifying the areas of greatest need in the rural and remote areas. We have also done modelling ourselves of areas where MBS is not well serviced, and we are working with our own state and territory offices to help identify priority areas in each state and territory. So that is the first part of the process.

We will then listen to, or take on board, the advice of our state officers and of states and territories and make recommendations to our minister on areas where we ought to start rolling this measure out. The measure will be rolled out through a number of auspices, divisions of General Practice being one and also Aboriginal medical services or the Royal Flying Doctor Service. So we have some flexibility about who we use as an auspice for this measure.

Prof. Horvath—If I may follow on from what Jan Bennett and the Secretary have been saying, I think if you take all the measures rolled up together then what this has done is actually increase the capacity of the whole system. Regarding your description of Geraldton, it may not be possible to get a resident psychiatrist there—

Senator WEBBER—We have one there.

Prof. Horvath—Oh, you have one there? You may be able to get a second one on the MSO program, but you may well be able to get them working with mental health nurses in the area and with psychologists in the area, where you get a transfer of skills and a sharing of patients. So if you roll the whole lot together and work with the industry as a whole, the capacity of the industry will be greatly expanded, and that is our hope.

Senator WEBBER—It is an admirable hope and it is one that I am sure we all agree with, because I have got to say, just by looking at the $51.7 million, we are at last getting to a point of expenditure that vaguely relates to the disease burden. I think that is a mighty fine aim in life, although we are going to have to wait for the mental health nurses before we see how that works. But the cynic in me would also say I am probably more likely to get some cooperation from them because they are about to get a bit of competition in terms of people's ability to access other mental health professionals immediately. We have been looking at auspices, but when will the rollout on the $51.7 million start?

Ms Bennett—It will start very soon. We are deeply engrossed in discussions with states and territories to help them map current service gaps to identify likely auspice groups for those areas of greatest need. We have asked most of them, as we have been dealing in these state and territory meetings, to have their preferred areas to us within the next two to three weeks. We will then take our own decision on whether those areas best meet the needs of the Commonwealth and its assessment of where it wants to put these new services, but we have asked for that information to be with us in the next couple of weeks.

Senator MOORE—Thank you. We are getting very close to time. We do apologise. What we may do is ask for a briefing from the department. We have done that with FaCSIA in this program area.

Senator WEBBER—Yes.

Senator MOORE—We may do that to keep going.

Ms Halton—We would welcome that.

Senator MOORE—I think that would be useful at this stage of the development, so we will put that on notice. We will put it in writing as well so that we can actually get that done. Then we can work together as much as we can as it goes through. Chair, I have a couple of questions on MSAC that I really want to get on notice before we finish this section.

CHAIR—Please do so.

Senator MOORE—I am just going to check with the others.

CHAIR—We do need to move on to Indigenous health, but if you want to put questions on notice, please go ahead.

Senator MOORE—I will run through the questions on MSAC and then we will see what we can get and what we have to put on notice. What about cancer services? Is that in this area or not?

Ms Halton—Yes, it is one.

Senator MOORE—We will put those on notice. We want some figures on the funding for the operation of MSAC for each financial year since its inception. How many full-time equivalent staff does MSAC currently have? What financial reimbursements do members of MSAC receive? Who appoints the members?

I just want to get these on record so you can see where they are coming from. When were the current members appointed? How often does MSAC meet? Who decides which submissions will be assessed?

I do not expect you to give these answers now. What is the average time for the completion of such as assessment? What is the longest time such an assessment has taken? I am not expecting you to give me the answers—

Ms Halton—We can answer some of this now.

Senator MOORE—We are under time constraints. I dare not take any more time than I have to. I am just going to run through them but when I get to something that you cannot answer, even on notice, could you just let me know?

Ms Halton—One that you have already come to, that I would just like to put a flag over is: what is the longest time that anything has taken?

Senator MOORE—Longest time, yes.

Ms Halton—This is a bit of a 'how do you define it' question, because obviously some things go in and out of MSAC. They may have gone in in a particular configuration and come out; then the sponsor could put it back in or there could be more evidence. To define the stop and start on some of these things does not necessarily give you a valid measure.

Senator MOORE—I accept that. How is a decision made that a submission is ineligible? What is the basis for that? For each financial year since the inception of MSAC can you please provide a list of submissions received, submissions accepted and assessments of submissions published?

Ms Halton—I do not think we will be able to do that one.

Senator MOORE—Can you do any of it?

Ms Halton—Probably not.

Senator MOORE—I will come back to that. The others are for each financial year. I am just going to put them on notice. This is not an effective way of doing this.

Ms Halton—We will do what we can but I think you will find that some of it would require a kind of major archaeological exercise in the archives. We will do what we can. We will take it on notice and we will see what we can give you.

Senator WEBBER—Thank you for that. I just want to place on record that it is good to see that we now have an MDC item for cancer, as promised. It was part of the Peter Cook inquiry. It has been a long time coming.

Ms Halton—I would just like to clarify one of the answers given earlier today, if that is acceptable?

CHAIR—Certainly.

Mr Eccles—Senator McLucas, earlier you asked about the GPII, the general practice immunisation incentive, and whether or not there were plans afoot to expand it into pneumococcal. I mentioned that it was not on my work program and indeed it is not, but our Population Health Division has been talking to some of the professions about that.

Ms Halton—That is about pneumococcal and meningococcal?

Mr Eccles—Yes, I think it is, but that is probably best covered under outcome 1. I just wanted to clarify that. I did not want to mislead you into saying that that was a closed shop.

Ms Halton—I think it is also fair to say that the fact that people lower down in the organisation might have been considering options does not mean that actual decisions have been taken. I did not have any visibility of it either.

Senator McLUCAS—I omitted to ask a question of Mr Brandon. Ms Halton, when a spot check is undertaken, what happens to that information once the assessment and the spot check occurs?

Ms Halton—Thank you for that question. Essentially, if there is an adverse consequence from that spot check, that would feed its way into the information systems, the websites and the public information. At the moment there is not any systematic way of providing information about the fact that there have been, for example, three spot checks in this particular home or none in that.

I think the minister has indicated a preparedness to have a look at the whole question of making sure that that information is transparent to people. So, at the moment it is not available, but I think there is an undertaking that we will go away and have a look at that, because the general principle is that it is fair that residents, and indeed families and consumers, would be concerned to know these things. We will have a look at that issue.

Senator McLUCAS—If an adverse finding is found in a spot check, Mr Brandon indicated that that would trigger either another spot check or a review audit. The process starts again.

Ms Halton—Yes, exactly.

Senator McLUCAS—What would the timeframe be from the time of a spot check with an adverse finding to the point when the community would know that there was an issue?

Ms Halton—I would not want to give a precise answer on that. I will check that for you but, as you rightly say, it depends on what process has been triggered and the timetable that follows that. But it could potentially be a matter of some weeks. It depends on the outcome. As you know, if there is serious imminent risk people would be moving with a great deal of speed.

Senator McLUCAS—I will put a question to Mr Brandon on notice about what has been found in the 382—or whatever number it is—that have occurred.

[4.38 pm]

Office for Aboriginal and Torres Strait Islander Health

Senator CHRIS EVANS—Could I start by asking about the financial table on expenditure, at the back of outcome 7—which I understand it was; it is now outcome 8—in the annual report. It seems to reflect a $40 million underspend in Indigenous health. Is that right, or am I misinterpreting that?

Ms Podesta—We sought a rephasing within the program largely as a result of a need to rephase funds to meet capital works commitments, primarily in remote and regional areas.

Senator CHRIS EVANS—I know what rephasing means, but can you just explain what capital works, and why?

Ms Podesta—Certainly. We have a very extensive capital works program within the Aboriginal health program. As you would appreciate, the capacity to attract and retain talented and committed staff, particularly in remote and regional Australia, requires both clinics and housing.

We have a very extensive program. We have nearly 126 capital works projects that are in varying stages across the program. The current estimate is nearly $110 million committed through contracts in regard to capital works projects. They are guided to some degree by our national Indigenous health infrastructure plan, and we make payments against the contracts to varying degrees of completion targets within those projects.

As you would be aware, the boom in industry, in the mining industry in particular, has sucked out of regional Australia trades people who are available to undertake projects of that type. We have recognised in the last year that there has been a significant lull in the capacity to deliver against the original contracts, because of the non-availability of trades people as a result of that boom, and also because of the climatic conditions in parts of Australia. At different times we have roads that are impassable so that goods are not able to get there. All of those contracts are committed funds; the difference is that we did not expend some of those funds in the financial year so we have rephased the capital works money.

Senator CHRIS EVANS—That has all been rolled over into the next financial year?

Ms Podesta—Yes, it has.

Senator CHRIS EVANS—Are there consequential knock-ons for the later years or do you expect to be able to—

Ms Podesta—It will depend on the building schedule and the capacity of the builders to meet the timeframes within the contracts.

Senator CHRIS EVANS—Is this mainly housing or is it new medical facilities?

Ms Podesta—It is a mixture of both. The greater delays tend to be in remote areas. They really move between the construction of new clinics and housing, but there are also upgrades and renovations. As I said, there are 126 building projects. The nature of those projects really varies but some of them include the construction of completely new clinics.

Senator CHRIS EVANS—Thank you for that. On the face of it, it looks like you spent an extra $21 million on policy advice and $22 million less on program management?

Ms Podesta—Do you mean with regard to capital as opposed to—

Senator CHRIS EVANS—Yes, sorry, the next column down.

Mr Thomann—You are talking about the table in the annual report?

Senator CHRIS EVANS—I am on the same table and on the next line—I have not moved far or fast!

Ms Podesta—In terms of what was expended last year?

Senator CHRIS EVANS—Yes. Is there an explanation there?

Ms Podesta—The program has expanded significantly over the last six to eight years and there has been an increase in departmental expenses associated with the expansion of the program. Certainly there has been a significant expansion in the rollout of the administered funds through the program as well.

Senator CHRIS EVANS—On the face of it you spent less of the money on programs. You had a budget of $11 million and you have spent $32 million, so it is a 200 per cent increase.

Mr Thomann—I think we have got an old-fashioned stuff-up here in terms of the transposition of numbers in the publishing process.

Senator CHRIS EVANS—I will always back the stuff-up over the conspiracy.

Mr Thomann—I think if we swap the lines for those two numbers we would have the accurate position. They have been incorrectly published. It is a publishing error.

Ms Halton—There needs to be an corrigendum, by the sounds of it.

Senator CHRIS EVANS—Can someone tell me then what they should say?

Mr Thomann—The two lines need to be swapped.

Senator CHRIS EVANS—Let us be more specific. You are not saying all of the line.

Mr Thomann—No.

Senator CHRIS EVANS—So just talk me through it. Output group 1, policy advice.

Mr Thomann—With relation to policy advice, the budget estimate was $11.064 million. The actual result was $10.915 million. For program management, the estimate was $33.188 million and the actual result was $32.745 million.

Senator CHRIS EVANS—Thank you for that.

Mr Thomann—Then I think the mathematics will flow through from there.

Senator CHRIS EVANS—Whoever is responsible for reading the report has just ducked for cover in the back row there somewhere.

Ms Halton—There was a bit of a sweepstakes about how long it will take for someone to find the first error in the report, and I think maybe you just won.

Senator CHRIS EVANS—If I found it it must be very obvious, which I suspect means you had better have a close look at the rest of it.

Ms Halton—People have been looking at it, I can promise you.

Senator CHRIS EVANS—So, basically, there are no differences there. I should really now take you through all the tables but, given the pressing time, I will let Senator Crossin have a go.

Senator CROSSIN—I have some clarification on figures from estimates in June. The 2006 OATSIH budget initiatives were $39.5 million for two new initiatives, the brokerage and the additional health places. Am I correct in reading that $12.63 million is set aside for the five broker services?

Mr Thomann—That is correct.

Senator CROSSIN—And the remainder of the money is for the additional 40 health professionals?

Mr Thomann—That is correct.

Ms Podesta—That is correct.

Senator CROSSIN—Where are we up to, then, with the brokerage?

Mr Thomann—We have received expressions of interest for funding and we are in the process of assessing those submissions.

Senator CROSSIN—How many expressions of interest did you receive?

Mr Thomann—We received a total of eight submissions.

Senator CROSSIN—My understanding is there is an intention to put the money into five services—is that correct?

Mr Thomann—Over four years.

Senator CROSSIN—The same five services over four years, or might it possibly—

Mr Thomann—No, five different locations in Australia.

Senator CROSSIN—Can I ask where the locations of the eight are from which you received expressions of interest?

Mr Thomann—At this stage we have received three submissions from New South Wales, two from Queensland, two from Victoria and one from Western Australia.

Senator CROSSIN—Is it predominantly for rural and remote areas?

Mr Thomann—No, it is predominantly for urban and larger regional areas where there is a good supply of health workforce.

Senator CROSSIN—Have you got an idea of how that money will be split between the five services?

Mr Thomann—This is the first stage of the process. We will be choosing those which have the best prospect of providing a quality service and we will be going back to them to seek a detailed tender. That will then obviously set out both the price and the level of services to be provided. Then we will make some decisions on value for money and other criteria.

Senator CROSSIN—When are you expecting to make an announcement about who will be the five?

Mr Thomann—We will be making announcements early next calendar year. We may not be making announcements about the whole five. We are certainly committed to getting the first brokerage service up this financial year. It will depend upon the quality of the applications and the outcome of the negotiations.

Senator CROSSIN—Briefly, what services will they be expected to provide?

Mr Thomann—They will be expected to provide a linkage service between Aboriginal and Torres Strait Islander residents of the region that they have contracted to serve and linking those people in with a range of primary and allied health care professionals who register with a brokerage scheme in that area.

Senator CROSSIN—With the additional 40 health professionals, funds were to be provided to states and territories on the resource model allocation?

Ms Podesta—That is correct.

Senator CROSSIN—Has the funding been allocated as yet?

Mr Thomann—We have actually been discussing with our state and territory offices area priorities. They have been looking at priority areas on the basis of areas which are underfunded and which manifestly need more health professionals to be working within the Indigenous health organisations that are out there, or possibly looking at new projects. We are in the process of assessing the priorities against funds available and the submissions that have been prepared by the state and territories offices—

Senator CROSSIN—Have all states and territories offices responded to your request for priorities?

Mr Thomann—Yes, our state and territory offices have been developing this in conjunction with the sector and our partners in each jurisdiction.

Senator CROSSIN—There is no predetermined amount of money per state and territory?

Mr Thomann—No, we have not predetermined that amount. It really is a needs based approach.

Ms Podesta—It will be rolled out as part of the enhancement and expansion process in PHCAP, as we discussed at the last estimates.

Senator CROSSIN—But it is only a reportable item under PHCAP? It is not part of the PHCAP money though, is it?

Mr Thomann—Yes.

Ms Podesta—Yes, it will be.

Senator CROSSIN—Is it part of the new $30 million of the PHCAP money?

Mr Thomann—As I explained at the last hearing, I think, this is being accounted for through the PHCAP budget reporting entity. We see it as the next instalment of PHCAP, if you like.

Senator CROSSIN—I have got here that you suggested to me the new measures will be reported under the PCAP reporting element?

Mr Thomann—That is right.

Senator CROSSIN—But it is not part of the PHCAP formula for distribution to Aboriginal medical services, is it?

Mr Thomann—We will be using that formula to identify those regions which are underresourced. At the last hearing I provided a map which shows the relationship of the regions between their OATSIH funding to the PHCAP benchmark. We will certainly be looking at those regions which are most underfunded according to that methodology and we will be trying obviously to get more resources into those regions where the organisations identified have the capacity to use those funds effectively.

Senator CROSSIN—I am sorry; I am just a bit confused here. The additional 40 health professionals will be going to Aboriginal services, or will the money be going to states and territories?

Mr Thomann—The intention is that the money will be going to Indigenous health organisations, wherever possible.

Senator CROSSIN—Through states and territories?

Mr Thomann—No, it will be a contract directly with Indigenous health organisations, wherever possible.

Senator CROSSIN—I have a note here that at the last estimates you indicated the funds would be going to the states and territories on a resource model allocation. I think I see the difference now; it is not state and territory governments.

Ms Podesta—That is correct.

Mr Thomann—Not state and territory governments.

Ms Podesta—We work under our strategic framework with state based partnership arrangements, which do include the state and territory governments, but they also include the Aboriginal community controlled health sector and us. So when we talk about states and territories we talk about partnership arrangements that exist at the state level.

Senator CROSSIN—You are currently assessing the level of need and resources prior to allocating this money?

Mr Thomann—And the capacity to deliver quality service and the need for additional health professionals as part of a multidisciplinary approach delivering comprehensive primary health care.

Senator CROSSIN—What is the timeline for this budget outcome?

Mr Thomann—At this stage we are getting those proposals finalised and we will be making decisions on the basis of capacity to benefit and the amount of money that we have available.

Ms Podesta—Organisations will be notified before the end of this calendar year to enable them to recruit from the beginning of 2007.

Senator CROSSIN—I see. I will follow that up in February.

Senator CHRIS EVANS—I would like to ask about the Healthy for Life program. I would like a quick update. I have got a few questions about sites et cetera that I will put on notice given the shortage of time. I just wanted to get a sense of how it is going, the scope and basically a short update on where it is at.

Ms Podesta—In November 2005 the minister announced the first round of the 27 successful applications. On 19 May the minister approved a further 26 Healthy for Life applications and they are now rolling out as we speak. They are undertaking stage 1 and stage 2 planning and implementation of their programs.

Senator CHRIS EVANS—Are these existing organisations providing similar services in the main or are they new services starting from the ground up?

Ms Balmanno—They are all existing primary health care organisations. Most of them are Indigenous community controlled organisations, but some are mainstream organisations that serve a large number of Indigenous clients. They are all existing primary care providers.

Senator CHRIS EVANS—What are you providing extra to them or what do you demand of them in terms of extra performance?

Ms Balmanno—The first stage lasts approximately six months. We are flexible with services, recognising that some can do it more quickly and some more slowly. It is an assessment of their starting point in terms of the quality of their chronic disease care and their child maternal health. They do a range of activities including clinical audits and other sorts of assessments of the care that is currently being provided by their service. They then look at the extent to which that care complies with best practice and they develop a plan about how to improve the quality of care within the service. They are provided with funding for a project officer for that period to undertake those activities with all the service personnel and the service management. Once they have submitted their plans about what they propose to do through the implementation of Healthy for Life, which can involve bringing on additional staff, running additional clinical activities, implementing different quality improvement activities within their services specifically targeted at improving their chronic disease and child health indicators and the quality of their care there, we then fund them for those activities. So some of the first round of services that Ms Podesta mentioned have now moved into that second stage and are now receiving their funding for implementation of their plans.

Senator CHRIS EVANS—What sort of emphasis are you seeking from them?

Ms Balmanno—It varies quite a lot from one service to the next, depending on where they are starting from. As was published when Healthy for Life was announced, a range of key outcomes has been set around Healthy for Life in relation to low birth weight, smoking rates and so on. The services will all be measured against those outcomes. We have agreed a set of

eight basic outcomes that all services participating in Healthy for Life will be measured against, and their progress over time in getting closer to their own targets in terms of those outcomes and seeing some improvements.

Senator CHRIS EVANS—Does that cover the population that they are servicing or the people who access their services?

Ms Balmanno—It will be the people who access their services. It will be based on their client records.

Senator CHRIS EVANS—What sort of interventions are you encouraging?

Ms Podesta—They vary depending on the focus of the Healthy for Life application, but they include things such as an increase in attendance for antenatal care in the first trimester. We are all conscious of the lag that currently exists for Aboriginal and Torres Strait Islander mothers, particularly first-time mothers in terms of the comparison between Aboriginal and non-Aboriginal people attending antenatal care, so we have set targets regarding an increase in antenatal care. They also include an increase in the number of adult and child health checks that might be undertaken by the service and the associated plans for follow-up, and an increase in best practice arrangements regarding chronic disease. And the longer term includes targets with regard to birth weight to try to increase the birth weight of Indigenous babies to within 200 grams of non-Indigenous babies—a decrease in low birth weight by at least 10 per cent. We have a range of clinical and practice indicators that we have set for the program as a whole. Not every service will meet every one of those, but across the program we will have collected data to be able to report against those.

Senator CHRIS EVANS—That is encouraging. The point of my earlier question was: what is in place to ensure that? Part of the problem is getting people to attend and utilise the service. What aspect of the program seeks to address the fact that so many Aboriginals do not access services that might have been available already but have not been utilised?

Ms Podesta—There is a range of activities in place and we can talk about those as well. We have a significant communication program associated with Healthy for Life, and I will just talk briefly around the introduction of the child health check.

Senator CHRIS EVANS—Yes.

Ms Podesta—We are very conscious of the need to increase the usage and demand rate for child health checks so that we do not just rely on those people who traditionally have come into clinics but also that we increase demand by parents, grandparents and children themselves. In the last three months we have been conducting a communication campaign and attending a range of community events to promote the child health check. That has been extremely successful in raising awareness and knowledge of the child health check. What we expect to see from that is a significant increase in the number of parents—particularly first-time parents—presenting children and babies for child health checks at the clinics. It is an important first step from our point of view.

There is a range of other activities within Healthy for Life, but we are very conscious of the need to work closely with communities to encourage a sense of acceptance, trust and relationship between communities and between health care practitioners. I have to say that we

have seen in the more established services that that certainly that does increase over time. One of the things that we know about primary health care in Aboriginal health is that longevity of the service significantly increases the relationship between the community provider and the community.

Senator CHRIS EVANS—There are a range of very good programs that have been running for a while now that provide good models.

Ms Podesta—That is right. The longer established services have very high numbers now, and it is one of the trends that we are acutely aware of in Aboriginal health. You do not do it overnight. It needs to be built slowly. It is like any type of growth: you cannot just make the perfect apple tomorrow; you need to be able to develop it over time.

Ms Halton—The other thing about this is that, where we can manage continuity of staff, that makes a huge difference as well. It is very pleasing in a service like Nganampa in the APY lands that we have a number of staff who have been with that service for 20 years. Some of the nurses have been out there for years and years. That makes a real difference. You know the people and they trust you. It makes an enormous difference.

Senator CHRIS EVANS—That is why staff stability in a lot of these remote areas is a real issue.

Ms Halton—A crucial issue.

Senator CHRIS EVANS—I wanted to follow on with the child health check, because it is obviously a related measure. You introduced the Medicare number in March, was it?

Ms Podesta—On 1 May this year.

Senator CHRIS EVANS—Do you have any idea of the take-up or any early figures?

Ms Podesta—Yes, we do. As of 30 September there have been 1,721 child health checks undertaken.

Senator CHRIS EVANS—That does not seem a huge number. What were your targets like?

Senator CROSSIN—Is this the full check? Is it correct that it takes two or three hours to do each one and it is being promoted by Nova Peris-Kneebone?

Ms Podesta—Nova Peris has been employed by OATSIH as part of the communication process. There is a minicheck that is conducted in communications. We do not count that in these numbers. This is the full health check, which is a Medicare funded item.

Senator CHRIS EVANS—What were your targets? That is only five months, but what were you expecting in the way of take-up? Does it meet expectations? Are you pleased or is it slower than you thought?

Ms Podesta—I do not think we have a target.

Ms Balmanno—It would be a target based on the costing. The primary care division would need to answer that. From May to June, the numbers doubled and then from July to August, the numbers per month doubled again. We are seeing the monthly number of checks being done growing quite quickly.

Senator CHRIS EVANS—As you say, you must have had a target to get funded, otherwise the bean counters would not let you do this.

Ms Podesta—I am sorry if we look a little bit dumbfounded. Even though it is an Aboriginal health check, it is not part of our outcome; it is primary health care, so we do not have the target that might have been in the original. We know the impact on our client group, but we do not manage it. It is a Medicare funded item.

Senator CHRIS EVANS—Would you mind taking that on notice for me?

Ms Podesta—Certainly.

Senator CHRIS EVANS—Obviously it is a part of assessing whether it is working or whether we are getting enough reach.

Senator CROSSIN—Who does the health checks in remote communities? Is it a Medicare item that is able to be done by the clinic sister or the health worker?

Dr Williams—A doctor is required to be involved in the conduct of the health check, but the doctor does not need to do the entire health check. Any other member of the multidisciplinary team in the Aboriginal health service can assist with parts of the health check, such as taking the history and perhaps performing some examinations. Aboriginal health workers and nurses would be involved in that. Doctors are required to ensure that the process is done properly and also make an assessment, make the appropriate referrals that might be required and make a future plan for that client. In answer to your question a little bit earlier, probably the timeframe for doing that in a comprehensive fashion would be about an hour. The doctor may not be required to spend the complete hour because some of the other health workers may be assisting with part of the process. Some would take longer than that, but, on average, about an hour.

Senator CHRIS EVANS—With respect to the COAG program following the summit on family violence and child abuse, one of the initiatives was rolling out health checks in a particular region. Can someone tell me if that has started, what region has been selected and why that will work differently from the other measure?

Ms Balmanno—The regions have not been selected yet. There are bilateral negotiations happening with each of the state and territory governments post COAG.

Senator CHRIS EVANS—Are you using 'regions' in the plural?

Ms Balmanno—Yes. We are looking at possibly 10 locations. The costing has been based on 2,000 children being checked, so it may be fewer larger communities or multiple smaller communities. We are seeking input from state and territory governments at the moment in terms of suitable locations from their points of view. We will consider those within the Commonwealth and a final decision will be made in the context of the COAG meeting next February.

Senator CHRIS EVANS—How is this different from general availability?

Ms Podesta—They differ in that it is an intensive roll-out and the health service who will be asked to do that will be provided with additional resources. There will also be communication strategies within the community to encourage as close as possible to a

universal take-up of the opportunity. There will be a range of communication barbecues and other things to encourage people to bring their children in. To be able to do every child within a specified period of time, the health service will be provided with additional resources for that period and also for the follow-up period. We know that they will identify a range of hitherto undiagnosed conditions and the health service will be provided with additional resources to do the follow-up work with the children and their families.

Senator CHRIS EVANS—Have you identified the additional resources that you are providing as part of the program?

Ms Podesta—The costing includes additional resources for health services.

Senator CHRIS EVANS—What sorts of resources?

Ms Podesta—Additional doctor, nurse and Aboriginal health worker support, if that is what they require.

Dr Williams—It is an additional team initially and then follow-up staff to come afterwards, so that after that team has left there are nursing staff available who can follow through with those plans as required. It is expected that some of the sites chosen may be sites that do not usually have a lot of access to medical practitioners on a constant basis. It is recommended that a child health check is done by the usual practitioner for the client—that is, the doctor who has provided most of the services in the previous 12 months or will in the next 12 months—but in some remote locations there is no usual doctor. There is no doctor on site. They are flying in and out and they are on rosters. Those locations will be considered for the intensive check.

Senator CHRIS EVANS—Isn't the difficulty going to be the same sort of difficulty that you expressed earlier about housing in remote communities?

Ms Podesta—Potentially.

Senator CHRIS EVANS—What is the roll-out of this? I am not being critical, but getting doctors and getting housing sounds to me like it is a longer term plan?

Ms Podesta—It will vary and that is part of the reason for the consultation at the moment. We are talking with states and territories around the logistics of being able to do an intensive community-wide rollout. Some communities do have additional housing. We anticipate that the backup and support team might well be centrally contracted to then be available on a rolling basis to the clinics as identified. It will really depend on the particular circumstances of the communities identified. As Ms Balmanno indicated, at the moment there is no final decision. We know that we are going to aim for about 2,000 children, but whether that ends up being five communities or three or 10 has not been finalised yet.

Senator CHRIS EVANS—I will not hold you to this because it sounds like quite a task, but when would you hope to be delivering services on the ground?

Ms Podesta—We anticipate that it will commence this financial year; we would anticipate early next calendar year that will commence.

Senator CHRIS EVANS—I thought you were not finalising it until COAG in February?

Ms Podesta—That is early in the calendar year.

Senator CHRIS EVANS—That is when you get a decision, and all of a sudden it is March.

Ms Podesta—We are used to running things out fairly quickly. We are doing the preparatory work now.

Ms Balmanno—The decision will be based on obviously all the lead-up consultation that has already happened with jurisdictions and with communities before they have been put into the decision that is going to go to COAG. It will not come as a surprise to any of the major stakeholders at that point.

Ms Podesta—We do not imagine that it will be one of the controversial decisions that suddenly changed—

Senator CHRIS EVANS—Are you trying to indicate that the ministers do not make these decisions?

Ms Podesta—No, but we have faith in the sensible nature of our colleagues.

Senator CHRIS EVANS—In following your advice, yes.

Ms Podesta—We try to get on with everyone.

Senator CHRIS EVANS—'We're from the federal government and we're here to help.'

Ms Podesta—In the case of OATSIH, I think most people would agree that is correct. We are the cherries of the department.

Senator CHRIS EVANS—I bet you didn't use to say that in your former life.

Ms Podesta—The sweet fruit of the department.

Senator McLUCAS—Chair, can I suggest that Indigenous Health go through till 6 o'clock.

CHAIR—We would do Health workforce capacity from 6.00 to 6.30 and then resume our program on Rural health at 7.30. That is agreed. Please proceed.

Senator CROSSIN—While we are feeling so good about ourselves, I have to tell you that the cheapest cherries ever get in Darwin is $12.99 a kilo.

Ms Podesta—I am intensely aware of the price of fruit in rural and remote communities.

Ms Halton—She is going to get onto bananas next, just be warned.

Ms Podesta—I would be very happy to be able to discuss the price of tomatoes in the Torres Strait, the price of oranges in Manapa and the price of bananas everywhere but Queensland. The secretary has just been to the APY Lands where she handed out oranges.

Ms Halton—Yes, I did.

Ms Podesta—I can tell you that we are acutely aware of the prices of fruit and vegetables.

Senator CROSSIN—I could make you all envious and tell you that mangoes are selling for only 50c each in Darwin.

Ms Podesta—It depends—in the tropical areas where we work there are an enormous range of fruits.

Senator CROSSIN—Can I take you to the *7.30 Report* on 11 October, 'Good news on the Indigenous health front'. It was an ABC report regarding Indigenous outcomes at Utopia.

Ms Podesta—Yes.

Senator CROSSIN—You would be aware of that news?

Ms Podesta—I saw the report.

Senator CROSSIN—Just for the *Hansard*, the report goes to the good outcomes at Utopia based on the outstation model. Utopia is a hub and it services predominantly Indigenous people who live on outstations. Given the current statements by the federal Minister Brough and others about outstations, has there been any work done by your department specifically on health outcomes in relation to models of delivery that include outstations as best practice?

Ms Podesta—We have not undertaken any work regarding that. A number of the health services that OATSIH funds provide outreach and health services to outstations across the country.

Senator CROSSIN—I am aware of that, but this is an exceptional outcome here in terms of the health of people at Utopia in and around the outstations. Is there any intention to look at health benefits with respect to Indigenous people at outstations in light of some of the current public comments?

Ms Halton—We would probably take a different look at this, which is: what are the issues around diet, medical intervention, income and education? There is a whole series of things that we would consider germane to health outcomes. We are not intending to take one particular variable, disaggregate that and have a particular study of it. However, we are constantly looking at the kinds of things that we think will make a collective difference. I am well known now for lecturing my secretarial colleagues on health services being a necessary but not sufficient condition for improving health. There are certainly some factors in this particular area that are collectively unique and collectively have generated a particular outcome. But it would not be our intention to extract one particular thing and focus on that specifically.

Senator CROSSIN—It is not one particular thing; it goes to all of the things that you are talking about. This is about 16 family groups living in 16 different locations, where there is, for example, no petrol sniffing, no sexually transmitted diseases, and the mortality rate is almost 40 per cent lower than for any other Indigenous people in the Territory. If it is so significantly good in relation to the use of outstations and the link between that and the health of Indigenous people, does this draw any specific attention to your department?

Ms Halton—No is the short answer, because at the end of the day there is very little point in our prescribing a particular approach in terms of living arrangements; that is not a practical thing for us to prescribe for everybody else. What we have to do is look to see how our services can assist with exactly the issues you raised—reducing the incidence of sexually transmitted diseases, ensuring a proper diet, dealing with a whole series of issues in relation to communicable disease to get that same kind of outcome for people regardless of where they live.

Senator CROSSIN—Have you brought this news item and this reporting to the attention of the minister?

Ms Podesta—We certainly briefed the minister on the existence of the items and what was included in the news item. As we indicated, we did not do any particular analysis about the factors that may or may not have contributed to the health status of the people within that community.

Senator CHRIS EVANS—This is important, because you say you cannot change the living arrangements, and that is right. But all sorts of government policies contribute to how living arrangements are structured. One of the things I found interesting is some of the Telethon Institute work seems to indicate that some of the health and education profiles are better for some of the people in remote areas than in urban areas, which was counterintuitive for me. Maybe it just showed my ignorance. It seems to me that is the sort of evidence that ought to be informing government policy, albeit within your own little silo. Given that we are now no longer in silos and we have a whole-of-government approach—although we will cover later whether that means anything other than rhetoric—surely that should be informing the policy process. I was a bit concerned by that answer, which indicated that you were almost still in the silo.

Ms Halton—Let us be very clear about this. Firstly, we are proactively not siloed. But, more importantly than that, we have an obligation to try to deliver those good health outcomes to people. In a sense, living arrangements or indeed employment are not things that we have a responsibility to deliver. As I said, I regularly give my colleagues lectures on this issue. We do have a very real concern to ensure that our contribution to improving the living circumstances of Indigenous peoples has the best chance of getting a really good outcome. But in terms of whether it is our policy responsibility to go out and work out whether there is a correlative or causative link in some of the data that has been seen—from Fiona Stanley, for example—no, that is not our policy responsibility. You are quite right that—I do not know what the 'not siloed' verb is—

Senator CHRIS EVANS—Joined up.

Ms Halton—In our joined-up government role we make a very active contribution on issues that go to good outcomes, but we do not take responsibility for things such as the line responsibility for other portfolios. Just as I do not expect people to start talking to me and telling me exactly how I should be rolling out immunisation programs, similarly we take an interest in healthy housing but that is what it is.

Senator CHRIS EVANS—In terms of Utopia, what evidence/assessment is available to the department on the health outcomes and the possible driving factors for those better health outcomes in that community?

Ms Podesta—Every one of the OATSIH funded health services provides data to us in terms of service activity reporting, so we are able to ascertain the level of services and the types of services. The service itself maintains the clinical records of its clients, and we are not able to—as there is an ethical issue—and nor do we seek to read or access the clinical records of the clients. What we do as a system is collect data regarding the health performance framework, which looks at performance across governments, across the country regarding a

range of factors, programs and activities that are undertaken and what impact may or may not have taken place regarding the health status of the population as a whole.

Senator CHRIS EVANS—With all due respect to that explanation, do you know whether they are more sick or less sick than the people in the community down the road? You are talking about a health performance framework, levels and types of services, but what really cheered me about your approach on the earlier program that we were talking about is that we were trying to work out whether people were getting better and having better health outcomes. It seems to me that whether Utopia is utopia or not, I would like to think you knew, and you could tell me, whether that was accurate in reflecting the health outcomes for that community and that you knew why they were better if they were better. That is what I want to find out. Do you know that?

Ms Podesta—We do not know at an individual service level the clinical presentation and characteristics of the clients by individual service within OATSIH. We do not control the information and the data. What we do know is the number of clients who present, the prevailing conditions that they present with and the types of treatment undertaken. At a system level, we do a range of evaluations that look at a system level about characteristics, trends and the performance of those services.

Ms Halton—We need to make a distinction between what happens at the practitioner/patient level with what happens at the population or community level. Essentially, nowhere in our health system that I am aware of do we actually collect information at the patient level from practitioners and feed it into a statistical system that enables us to make judgements about the health of that population. We do not get it through MBS. We do not get it through PBS. We do not get it through the hospital system. What we do is we look at the range of health interventions of a particular community. We look at how many people are immunised. We can pick that up from the data. We look at the utilisation of particular kinds of pharmaceuticals. We can actually plot that across communities. Then we look at other data. It is fair to say that in Western Australia, particularly with the work of Professor Stanley, there is a process of data matching that is quite unique in this country and that does enable some of those things to be followed in a more complete way statistically. Regrettably, the protocols that enable that to happen are not present elsewhere. What we have to do is look at the population-wide data, which we pick up from a number of other collections, to make those kinds of assessments.

One of the things that we do is take expert clinical advice, together with research and a number of other sources of information, and make judgements about the kinds of interventions that we think are going to make a difference. I mentioned immunisation. We have the evidence to suggest that, if we get almost complete immunisation of children, we are going to get better outcomes. We also know the same things in relation to achieving good birth weight, for example. In addition to providing a general improvement to population health and the availability of primary care, we have had particular focuses on the kinds of interventions that we know will make a difference. We do not collect—and, as I said, I am not aware of this being collected—a specific snapshot of all the people dealt with by those services. When we have the opportunity to do what has been done in Western Australia, that might be different. However, at the moment that is not the case.

Senator CHRIS EVANS—I understand what you are saying. I must be a simple soul. I would have thought the Office for Aboriginal and Torres Strait Islander Health would be able to tell me where they are getting better health outcomes and why.

Ms Halton—Yes, and exactly as I said, we can—

Senator CHRIS EVANS—You said you could not tell me that.

Ms Halton—No. What I am saying to you is that we can see the benefits of those policies in terms of things like immunisation and some particular conditions, such as rheumatic heart disease. I can go on. What we do not collect is the patient-by-patient data that enables you to aggregate across a particular geographic location the specific outcomes in a particular community. It would be a bit like saying that there is a medical service in Parliament House and we are going to do a regular data collection on the health of senators and members of the House of Representatives.

Senator CHRIS EVANS—It only feels like we live here!

Ms Halton—Mostly.

Senator CROSSIN—With all due respect, we should not labour on this; we have other issues. We do know that delivery of medical services through AMSs has proved to be successful.

Ms Halton—Absolutely.

Senator CROSSIN—We do know that, if we can move 20 people out of a house, the level and incidence of things like trachoma will reduce.

Ms Halton—Exactly.

Senator CROSSIN—Given that there are some people in this current government who are talking about not supporting and resourcing outstations and suggesting that Indigenous people should not live there, I would have thought that Kevin Rowley's research in relation to Utopia would show us that outstations are working in terms of improved outcomes for Indigenous people. Is this not now a new field of research that perhaps ought to be looked at?

Ms Halton—You are asking us to take on a research function, which is not our job.

Senator CROSSIN—No. I am just suggesting you should look at the research.

Ms Halton—We will look at the research. There is no contention about that. Essentially, all of the things that you raise about the particular things we know about trachoma and crowding et cetera are acknowledged, and that is exactly my point. By taking that evidence and translating those kinds of messages into the health services that we provide, we believe we can demonstrate that we have actually had an impact.

Senator CROSSIN—I suppose the reason I have raised it is that I believe the *7.30 Report* and the research at Utopia adds another layer of looking at improved outcomes to the services you are providing. It may well complement it.

Ms Podesta—It was certainly interesting. It was similar to other anecdotal information that has been provided to us, and it is contrary to some anecdotal information provided to us by health services. The evidence as to whether outstation living contributes or does not

contribute to health status is still an open question to some degree. There is research being undertaken that may or may not indicate that. I wanted to talk a bit about those factors, because the national strategic framework that we operate under works very closely with our state and territory governments. One of the important things that we do in OATSIH as part of the partnership arrangements we do have with state and territory governments is that we seek to identify those factors over which states and territories have primary responsibility, to seek to get them to improve their effort and concentration of effort in areas where there is a need to improve health outcomes. As the secretary indicated, whilst we do not have direct control over all of the factors that have an impact on people's health status, we certainly are able to influence through the partnership agreements we have where effort needs to be made. For example, dust abatement—and I know we have spoken about this at length in previous estimates—access to better sanitation and water services, all of which are regularly discussed at our state- and territory-level partnership forum to especially identify what we can do to make it better. We are all about health. We do not all have just responsibility for health. What other factors can be improved?

Senator CHRIS EVANS—I still remain worried by the response in the sense that I really do think we have to learn from what works. While I accept Ms Halton's answer about immunisation rates et cetera—that is all true—one of the real failings, it seems to me, in Indigenous policy is the failure to grow success. What I would like to know from you, and what I hoped you would have known, is whether the claims about Utopia are right. It seems to me that that is the first step. I do not necessarily believe everything I have seen on TV, but I am not doubting it. However, I would like to have some sort of an authoritative response about those health outcomes in that community. Then I would really like to see some effort to try and analyse, if they are much better health outcomes, how we can replicate those in other communities. I am a bit concerned that we are driven by these wider systems without trying to get to terms with those issues.

Ms Halton—I should be quite clear: the point that you make is a good point, and I agree entirely. When we identify things that have had particular traction, we do want to know about them, and we do want to use that information to improve health status right across the country. What we have to be mindful of, though, is that something which occurs in a particular environment is not always immediately replicable in every other environment. Therefore it behoves us, particularly when we have charge of a large amount of money, to make sure that we deploy those funds in a way that is going to get good outcomes. I do not dispute your general point at all. We do need to know what happens where, and, if we can work out why, that is a good thing.

Senator CHRIS EVANS—The first way of getting there is to actually measure the outcomes, not just the processes.

Ms Halton—Yes, and let us be clear: measuring outcomes in health can be a very difficult and indeed contested space.

Senator CHRIS EVANS—The only advantage of living in a very small community in outback Australia is that it is a much more confined sample than trying to measure everyone who moves through Parliament House in a week.

Ms Halton—Indeed. But let us also be clear that there are issues here about replicability. There are also issues here about personal privacy and intrusion. My point earlier about the fact that we tend to look at these things on a population basis is that people start to feel a bit like caged guinea pigs who get studied every five minutes. That does not mean we do not want to know. We do want to know, but I do think we have to balance off the privacy issues as well.

Ms Podesta—OATSIH invests as a partner in the CRC for Aboriginal Health, which undertakes peer reviewed research into health. We are a very active partner in the CRC. We will seek to discuss with the CRC what research they are undertaking, the qualitative research they are undertaking at the moment. I believe that Utopia is more than likely part of their research program.

Senator CROSSIN—Can I move on to the issue of privacy and clause 8 of the standard Department of Health and Ageing ATSI health programs funding agreements. Am I in the right area, or is this cross-portfolio?

Ms Halton—No, this will be us.

Ms Podesta—I do not think I am particularly familiar with every clause of the contract, but I will do my best.

Senator CROSSIN—Perhaps this one might jog your memory. I understand that this new clause 8, 'Access to premises and records', was in fact inserted into the funding agreements in the last funding round without any consultation. Is that correct? Can you tell me when clause 8 was actually put into the standard health program funding agreements?

Mr Thomann—Are we talking about the OATSIH standard funding agreement, the OIPC funding agreement or the standard department of health funding agreement?

Senator CROSSIN—I think it is the Department of Health and Ageing ATSI health programs funding agreements. That is the name I have been given.

Mr Thomann—We have not made any major changes of that nature to that OATSIH standard funding agreement.

Senator CROSSIN—This is another clause, 'Access to premises and records'. It states that it must give the department, the National Audit Office, the Office of Evaluation and Audit and the Office of the Privacy Commission any and all records associated with the funding.

Mr Thomann—We made some minor changes to the wording of that particular provision. It was not a new provision. From memory, we added in the OEA, the Office of Evaluation and Audit, Indigenous programs.

Ms Podesta—Because it did not exist when we wrote the original one.

Ms Halton—That is right. This is not actually a privacy issue. Let us be clear, I was talking about individual personal privacy.

Senator CROSSIN—Just on the record, that is what I want to clarify. This is not about the department of health having access to individual personal medical records—is that correct?

Ms Halton—No.

Mr Thomann—That is correct.

Senator CROSSIN—What would it be in relation to then?

Ms Halton—Financial accountability in relation to the Commonwealth moneys that we actually provide organisations. As Mr Thomann was saying, you would be aware that the Office of Evaluation and Audit has recently been given coverage of services in this area, and it is therefore incumbent on us to make sure that they can have access. Indeed, they have as part of their processes been accessing the services that we fund. Certainly we have an obligation to ensure that we can access records in relation to the use of the funding that is provided by us and therefore by the taxpayer.

Mr Thomann—I might add that we have had 10 organisations audited by OEA, and their investigation was entirely constrained and confined to the matters of their funding agreement and of the use of Australian government funds.

Ms Podesta—We have had no instances of client records being sought or accessed by the Department of Health and Ageing. The privacy of the client records has been maintained in Aboriginal Medical Services.

Senator CROSSIN—Can I take you to the Mutitjulu clinic. Would that clause have been in any agreement that had been signed by the Mutitjulu clinic?

Ms Grogan—The Mutitjulu Health Service Clinic is currently under funds administration, so any contractual arrangements with that clinic would have the standard contractual arrangements that we have with all of our organisations that we fund.

Senator CROSSIN—Prior to the clinic being put under administration, would that clause have been present in any agreement that was signed?

Ms Podesta—I would imagine so. It was a standard clause within our funding contract, as Mr Thomann indicated. It may not have included the OEA reference, depending on the timing of that change, but otherwise it is our standard funding agreement.

Senator CROSSIN—Can you tell me the circumstances of the Mutitjulu clinic being placed under administration in January?

Ms Podesta—In December 2005 we commissioned a consultancy to undertake an operational review of the organisation and to provide assistance to address the immediate issues of concern relating to clinical service delivery.

Senator CROSSIN—What were they in particular?

Ms Podesta—I am just going to find out. This was a little before my time. Prior to 2005?

Senator CROSSIN—Yes.

Ms Podesta—No, I cannot give you the details at the moment. I do not have the details prior to December 2005.

Senator CROSSIN—You said to me at the start of your explanation that in December 2005 there was an investigation into the clinic because there were service delivery issues. What were the issues?

Ms Podesta—As I have indicated, I do not have the detail. I have all of the detail of what came after that, but I do not have the detail of what started that.

Senator CROSSIN—You might take that on notice.

Ms Podesta—I will. Mutitjulu Community Health Service has been under ORAC administration since 13 March 2006. We continue to provide funding to that service through the administrator for the delivery of primary care and aged-care services. The administrator's report, which we received on 26 June, highlighted the following concerns: the current standard service delivery is unsatisfactory, there is major conflict amongst the staff that is virtually irresolvable, the members and the community will not engage with the administrator unless they are paid for their services, and service provision cannot be guaranteed under the current structure. The administrator formed the view that it would not be possible within the short term to rectify these problems and return the service to the control of members, and the administrator presented a number of options for the future governance and management of the health service. We have entered into a short-term funding agreement until the end of November 2006 through the administrator to ensure ongoing delivery of primary health care while transition arrangements are negotiated over that period.

Senator CROSSIN—Who are those transitional arrangements being negotiated with?

Ms Grogan—We are currently talking with a couple of alternative providers, including the Northern Territory health department, as well as potentially another community controlled organisation within the Northern Territory.

Senator CROSSIN—Congress?

Ms Grogan—Congress is one that has indicated a very recent interest, as of this week.

Senator CROSSIN—Who was the other one prior to that?

Ms Halton—As a normal rule we would not provide details of who we are having these discussions with. They are discussions that have not actually reached fruition. I do not think it helps to start indicating who these discussions are with.

Senator CROSSIN—May I ask you who initiated the process of placing the clinic under administration?

Ms Podesta—After the consultancy review, we initiated that the service needed to be under an administrator.

Senator CROSSIN—Is it currently fully staffed and open during normal hours?

Ms Podesta—The service is providing health care services. I believe that the service has continued to have problems in attracting staff.

Senator CROSSIN—Is it open in normal trading hours or normal hours?

Ms Podesta—This health service has not been open on a regular 9 to 5 basis for some time. That is part of reason why we needed to initiate the review of the services.

Senator CROSSIN—Yet it has been in your care since at least March of this year. Is that correct?

Ms Podesta—There has been an administrator running the health service.

Senator CHRIS EVANS—Where is that administrator based?

Ms Podesta—I do not have the detail of that. I will have to take that on notice.

Senator CHRIS EVANS—One of them is in Perth and one of them in is Brisbane, I think, depending on which one. Do you know whether yours is the Perth or the Brisbane one?

Ms Podesta—I am sorry, I do not have the detail.

Senator CHRIS EVANS—I would like you to take that on notice. Can you also tell me how many times the administrator has actually visited the community?

Ms Podesta—I do not have those details.

Senator CHRIS EVANS—Maybe you can take that on notice as well.

Ms Podesta—I will.

Ms Grogan—I would also like to point out that the administrator is actually an ORAC appointed administrator.

Ms Podesta—It is not a Department of Health administrator.

Senator CROSSIN—At this point in time though you are totally responsible for the operation of that clinic—is that correct?

Ms Halton—No, we are not.

Ms Podesta—No, we are not. ORAC are administrators.

Senator CROSSIN—Using your funds.

Ms Podesta—We are providing funding through the administrator for the provision of health services in that community, but the Department of Health has not employed the administrator, ORAC has.

Senator CHRIS EVANS—Do you help with the recruitment of staff, et cetera?

Ms Podesta—No, we do not.

Senator CHRIS EVANS—You do not play any support in that?

Ms Podesta—The territory office in the Northern Territory has certainly been acutely aware of the difficulties and has been identifying alternative options and discussions with alternative providers. So, for example, the GP at Yallara was asked to provide services on a short-term basis, and that has continued, I believe. There have been discussions with the Royal Flying Doctor Service to try to increase the contact visits with doctors into that community. We have put a lot of effort through our state and territory office into ensuring that doctors and nurses will be made available to the community, and those services will continue to be sought. There has been, as Ms Grogan indicated, ongoing discussions with the Department of Health in the Northern Territory to try to get some more permanent arrangement. From our point of view it is not a desirable situation to have an administrator running a health service, and we do as much as possible to try to get some stability. Referring to our previous discussion, our strong belief is that a stable health service is incredibly important, but a poorly run one is worse than anything.

Senator CROSSIN—ORAC is actually an arm of the federal government so at this point in time let me rephrase my question: the federal government then is responsible for the health service at Mutijulu through ORAC?

Ms Podesta—At this stage the ORAC administrator is running the health service there.

Senator CROSSIN—And the ORAC administrator is answerable to ORAC, which is then answerable to OIPC through to the federal government.

Ms Podesta—That is correct.

Senator CROSSIN—It is not a private externally run operation at this point in time—is that correct?

Ms Podesta—That is correct.

Senator CROSSIN—It is being controlled by the federal government in one shape or form or another.

Ms Podesta—There is an administrator that has been appointed to run that service at this stage.

Senator CROSSIN—Through ORAC, through to the federal government. Have you had a role in investigating allegations of child sexual abuse or STIs in children at Mutijulu?

Ms Podesta—No, we have not investigated claims.

Senator CROSSIN—No, I said: have you had a role in those allegations? Have you been consulted about them, asked about previous incidences or records or funding? Have you had any role at all?

Ms Podesta—No.

Dr Williams—The monitoring and surveillance of sexually transmitted infections is mainly a state responsibility and would go through the Public Health Unit, the Centre for Disease Control, in Darwin.

Senator CROSSIN—When Mutijulu health clinic is actually under administration, who then is responsible for the privacy of the medical records in that clinic?

Ms Halton—That is not a question we can answer. We do not have a direct relationship with the administrator. The administrator puts in place administrative and other arrangements in respect of the operation of that service. That is a question that is more appropriately directed to the administrator or those who have instructed the administrator.

Senator CROSSIN—Given though that you obviously know about the Department of Health and Ageing and the funding agreement that is signed and given you have made comments about privacy of records, who would be responsible for the privacy of those records? If it is under administration, would it be the administrator?

Ms Halton—Records are a kind of complicated issue here. At the end of the day the service provider basically would, I think, be the owner of those records. In the event that a provider is a medical practitioner that is where the ownership would rest, and certainly those records would remain the responsibility of the provider.

Senator CROSSIN—But at this stage this clinic is actually running with funds generated from your department. Is that correct?

Ms Podesta—That is correct.

Senator CROSSIN—At a Mutijulu meeting I attended in August of this year the community officers alleged that there had been an unauthorised access of medical records in 2005. Are you aware of those complaints?

Ms Podesta—There has been no complaint made to us about that.

Senator CROSSIN—No complaint made to you formally about that?

Ms Podesta—No, there has not.

Senator CROSSIN—Are you aware of any action taken to underinvestigate the allegations of unauthorised access to medical services?

Ms Podesta—We are not aware of those.

Ms Halton—No.

Senator CROSSIN—So no-one has made a formal complaint to you at all?

Ms Podesta—No, they have not.

Ms Halton—No.

Senator CROSSIN—Can you take it on notice whether anyone has made a formal complaint to the minister about this, please.

Ms Podesta—Yes, certainly.

Ms Halton—We certainly will.

Senator CROSSIN—When OIPC announced it was freezing federal government funding to Mutijulu in July, were you informed of this decision?

Ms Podesta—As we have indicated, we do work closely with our colleagues. We were aware that other action was being taken at Mutijulu. Our funding had already been placed under an administrator at that stage so it was of little consequence to us at that point because we had already had issues regarding the health service in that community.

Senator CROSSIN—The administrator is funded until the end of November—is that correct?

Ms Podesta—That is correct.

Senator CROSSIN—What are the plans come 30 November?

Ms Grogan—We intend to maintain the current arrangements to ensure that services continue to be delivered while we negotiate with alternative service providers. The registrar indicated to us yesterday that they are prepared to keep that administration arrangement until the full transitional arrangements are fully negotiated and finalised.

Ms Podesta—We currently offered an extension to the end of December. That has not been agreed at this stage formally, but informally there has been an indication that that will be agreed.

Senator CROSSIN—I have two other questions on this, then we can move on. You said that your department conducted a review of the clinic in December 2005.

Ms Podesta—We had a consultancy to undertake a review of that service.

Senator CROSSIN—Who was that consultancy? Can you take it on notice?

Ms Podesta—Yes. We can probably give you the answer before we finish, but I cannot tell you off the top of my head.

Senator CROSSIN—Is that consultant's report public?

Ms Podesta—No, it has not been publicly released.

Senator CROSSIN—Can you take on notice for me when that report was finalised and how much it cost?

Ms Podesta—I will.

Senator CROSSIN—Can you also take on notice for me whether or not there is any mention in that report of claims that there was unauthorised access to medical records at that health clinic, seeing the allegation is that those records were accessed without authorisation during 2005, which must have been prior to your investigation occurring?

Senator FIERRAVANTI-WELLS—The administrator that you are referring to is an administrator appointed under Commonwealth legislation?

Ms Podesta—Under the Office of Registrar of Aboriginal Corporations.

Senator FIERRAVANTI-WELLS—And the proceedings go through basically the insolvency area of the Supreme Court in the Northern Territory?

Senator CROSSIN—No. It is an automatic right under ORAC to appoint an administrator into mainly Aboriginal controlled organisations. The Office of Registrar of Aboriginal Corporations has the power to do that.

Senator FIERRAVANTI-WELLS—Yes, I appreciate that. I used to do their work when I was in the AGS in Sydney, but we used to do some of their work in winding up proceedings.

Senator CROSSIN—Yes. It is not through the NT Supreme Court.

Senator FIERRAVANTI-WELLS—That is what I was asking. Was this some sort of winding-up proceedings?

Ms Halton—I do not think we are in a position to comment on that.

Senator FIERRAVANTI-WELLS—Fine. That is all I wanted.

Ms Halton—It is not in my portfolio; it is in another portfolio.

Senator FIERRAVANTI-WELLS—That is all right. I was just asking.

Ms Podesta—There is one thing I would like to clarify. I am aware through the media of claims about the confidentiality of patient files. I apologise because you asked if we had been formally notified and, no, we have not.

Senator CROSSIN—I am sorry. Just to clarify where I am coming from: I did not quote any media article; I quoted a meeting that I attended with people at Mutijulu in August when this was raised.

Ms Podesta—We certainly saw some media about that, but we have not had a formal complaint about it.

Senator CROSSIN—Thank you.

Senator CHRIS EVANS—Mr Chairman, could I ask a couple of questions about the APY lands COAG trial?

CHAIR—Indeed.

Senator CHRIS EVANS—First of all, given OIPC has been taking responsibility for a number of the other trials, I wanted to understand whether or not there was any suggestion or plans that Health and Ageing hand over responsibility for the APY lands COAG trial to OIPC.

Ms Halton—There are two things to say here. Firstly, the trials of course will come to a natural end at some point, but in terms of the work that we are doing as a portfolio on the APY lands, no, we have not had any reduction in that effort, and certainly OIPC and we are both very active in that region.

Senator CHRIS EVANS—No. The question was about key responsibility, though. You might know that a number of the other departments have handed back primary responsibilities.

Ms Halton—No. I have not handed it back.

Senator CHRIS EVANS—There are no negotiations or discussions about doing that?

Ms Halton—There will be an actual negotiation about what we do when the trial ends, but in terms of whether it is our intention to reduce our involvement, no.

Senator CHRIS EVANS—You are going to stay the course.

Ms Halton—Absolutely. In fact, I was out there last week.

Senator CHRIS EVANS—I see in your consultancies in the annual report you paid about 130-odd grand to Nicholls Consulting for consultancy services for the trial. Was that for some sort of assessment or evaluation of the trial?

Ms Podesta—No.

Senator CHRIS EVANS—What was that for?

Ms Podesta—That is for the officer who has been working with PYQ, the media service and transaction centre that will be established and is about ready to go.

Senator CHRIS EVANS—So have you done an evaluation of the trial?

Ms Halton—There is an evaluation of all of the trials. I do not know if it actually has been released yet.

Ms Podesta—It has not been released.

Ms Halton—No. But there is an evaluation.

Senator CHRIS EVANS—I understand there are separate evaluations of the trial.

Ms Halton—Yes. That is correct.

Senator CHRIS EVANS—So has the evaluation of your trial been completed?

Ms Halton—It has.

Senator CHRIS EVANS—Who did that for you?

Ms Podesta—Urbis Keys Young.

Senator CHRIS EVANS—The names get more exotic all the time. Has that been presented to the minister?

Ms Podesta—We have seen a copy of it.

Ms Halton—Yes. For the formal presentation to government, the answer is probably no. Have drafts and copies of it been seen by a good number of people? Yes.

Senator CHRIS EVANS—Will the report be released publicly?

Ms Halton—That is my understanding.

Senator CHRIS EVANS—Do you know when that will happen?

Ms Halton—No, because it is a decision for government.

Ms Podesta—OIPC are looking after the evaluation of the COAG trials, and they are currently doing a synopsis review of all of the trials, which they commenced in mid-October.

Senator CHRIS EVANS—A synopsis review—a review of the review.

Ms Podesta—They are doing an overall synopsis review of all of the trial evaluations.

Senator CROSSIN—They are only going to release the bits they like, in other words.

Senator CHRIS EVANS—I am glad we do not have to rely on them for all our source material then. Perhaps you could take on notice a question to the minister on whether or not he will release the report and when.

Ms Halton—I do not think it is a matter for him. I think it is actually a matter for the Minister for Families, Community Services and Indigenous Affairs.

Ms Podesta—And COAG.

Ms Halton—And COAG, yes. That is quite right.

Senator CHRIS EVANS—So one minute you are telling me you are still running the show, and the next minute you are telling me—

Ms Halton—No, no.

Senator CHRIS EVANS—They seem a bit confused, that is all. That is why I ask now. If I go to OIPC they will say, 'Oh, no—that's the Department of Health and Ageing's responsibility.'

Ms Halton—Let me see if I can be as clear as humanly possible. The COAG trials were commissioned by COAG, and the COAG processes mean the evaluation, I think, has to be considered by COAG. That can probably be done out of session. In terms of the process, the

process has been coordinated by OIPC. There have been individual analyses of each individual trial site because they are all quite different. So there are separate bodies of work on each trial site, and they will stand as separate reports. Our understanding is that they will be released once they have been through the appropriate protocols, given this is a COAG initiated process. Our understanding is that OIPC are going to try and bring together a sort of meta-analysis of the COAG trial sites, which I think is what Ms Podesta was referring to, and it is our understanding that all of that will be released publicly. Yes, Minister Abbott is aware of the evaluation of our trial site. Yes, we have seen drafts of it and provided comments on it and input and all that stuff, but it is not a matter for him to decide its release because it came out of the COAG decision.

Senator CHRIS EVANS—Can you tell me whether or not you have done any evaluation of the additional funding you provided under the improved primary health care initiative for four sites, including Wadeye in the Northern Territory? You have provided that funding in the 2005-06 year to auspicing organisations for additional infrastructure to support additional services. Are you able to tell us whether you have done an evaluation of that measure?

Ms Podesta—The measure is still being rolled out. They are very significant. Mr Thomann will give the detail about this, but the new services are significantly enhanced services and they are being rolled out now. They are not being evaluated because they are not fully operational yet.

Senator CHRIS EVANS—Yes. I thought you were supplementing existing services, but you are talking about new services.

Ms Podesta—It varies. There are four in that new policy proposal. Some of them are new greenfield sites and some of them are significant enhancements to existing clinics and services. We can give you the detail of that.

Senator CHRIS EVANS—Given the chairman has to bring down the guillotine soon, I will put those on notice, if that is all right.

Ms Halton—He's going to gong you.

CHAIR—Alright.

Senator CROSSIN—In response to a question that I asked, E06186.

Ms Podesta—Yes. That was the benchmarking.

Senator CROSSIN—We do not have the luxury of colourful maps.

Ms Podesta—This is the benchmarking for primary health care?

Senator CROSSIN—Yes, that is correct. It actually relates to the 10 new mental health workers. That is E06186. That map also relates to the relative disadvantage compared to the rest of Australia. It provides a percentage of the OATSIH benchmark. I think you know the map I am talking about.

Ms Podesta—I do, yes.

Senator CROSSIN—According to the map provided to me with the answer it seems that in fact Mutitjulu and Uluru national park is one of the worst funded regions against the OATSIH benchmark of anywhere in Australia. Would that be a fair statement?

Ms Podesta—It is in a region which is significantly below the benchmark at the moment. That is certainly correct.

Senator CROSSIN—It is much worse off than the surrounding regions. Why is that?

Ms Podesta—There are a number of reasons that we can describe.

Senator CROSSIN—Just do it briefly.

Ms Podesta—It partly depends on history and current infrastructure and what services had been established in the past and what services are able to grow and be developed now. As you are aware, as part of OATSIH's responsibilities we develop infrastructure in greenfields and enhance the capacity to be able to take up and increase the provision of primary care. That is why we have, and we are very open about, the need to grow services in areas which are currently under benchmark. One of the things that is important to note is that it can sometimes be a little bit misleading, particularly when you get down to small areas.

Senator CROSSIN—It is a pretty big area on this map behind us.

Ms Podesta—I know that. It can be misleading because it measures where services are currently provided from, not necessarily where the people reside. People do cross over, so some of the over-benchmark is accounted for in the fact that some regions contain regional hubs which provide a lot of services to scarcely populated regions.

Senator CROSSIN—But this area does not have that. It is a pretty significant dark red area on this map.

Ms Podesta—It is adjacent, though, to some of the regions that do contain that.

Senator CROSSIN—Like Alice Springs, but that is 800 kilometres away.

Ms Podesta—Yes, I know, but Alice Springs does get additional resources in recognition of the fact that it draws clients from a number of surrounding areas. Be that as it may, we have an agreement and we are working towards increasing the resourcing, the infrastructure and the capacity of primary health care for Aboriginal and Torres Strait Islander people to work towards meeting the benchmark across Australia.

Senator CROSSIN—Just quickly in finishing, though, the map actually was provided as a tool for determining where, as a part of the COAG mental health package, 10 additional mental health workers might be placed. Is that correct?

Ms Podesta—No, that is not correct.

Mr Thomann—My recollection was we were talking about the four sites, the improved primary health care initiative which Senator Evans has just mentioned—

Senator CROSSIN—So it is not related to the 10 additional mental health workers?

Mr Thomann—No. The question you asked in the last hearing was about the basis on which we chose sites such as Wadeye and Cape York, and I used this map as an indication that we are trying to target the additional resources to areas which were underfunded.

Senator CROSSIN—And one of those would be Mutitjulu.

Mr Thomann—There are a number, as you can see from this map.

Senator CROSSIN—But one of those is an area that includes Mutitjulu.

Ms Halton—We also have to be aware, and we have been doing this consistently under PHCAP, that there also has to be a service capacity to actually deliver those services. As for the conversation we have just had about the problems of the service at Mutitjulu, there is—and we do this quite consciously—limited point in putting additional funding into services that do not have a capacity to utilise that funding to deliver improved health services.

Senator CROSSIN—Technically, though, that health service has been delivered by the Commonwealth government through ORAC, through an administrator, since March of this year. I would have thought that is pretty high-capacity delivery of service.

Ms Halton—Let us be clear. In rural and remote areas attracting and retaining staff can sometimes take a considerable amount of time, where building the service infrastructure and capability of all the staff takes a considerable amount of time. I made a reference before to Nganampa Health, where it has taken 20 years to build up capability. This service has had considerable difficulties for a good number of years. It is not enough to say, 'Right. There is an administrator in there from March. Therefore, it is all hunky-dory.' That is just not the reality. We absolutely agree with you; we want to improve the range of services to people in those communities, but we cannot put money into a service that cannot use it effectively, and that is what has to be built on.

Senator CROSSIN—But the Mutitjulu service is not a service run by the Northern Territory government. It is not a service that has been run by an Aboriginal medical service. For the last 10 years it has been run by the Commonwealth government.

Mr Thomann—Can I just clarify? It is an organisation that has been a community based organisation for several years.

Ms Halton—That is right.

Mr Thomann—It is an independently incorporated organisation like any other community based organisation that might be incorporated under ASIC or under the state government associations incorporation legislation. In this case, this organisation has been incorporated under the ORAC legislation. The fact that an ORAC administrator had to be appointed in March is an admission that this organisation has failed as an organisation.

Ms Podesta—It was unable to manage itself.

Mr Thomann—One of the indicators of that is that you had very little functioning capacity left in that organisation due to lack of management capacity. The ORAC administrator has, for the last eight months, been managing what has been left of that organisation.

Ms Halton—We need to be clear. You know better than we do, actually, that many of these communities have expressed a very strong preference for a community controlled organisation to deliver health services. Wherever we have been able to work with those community controlled organisations to deliver an effective service, that is what we have done. So the Commonwealth has not been 'running this service'. A community controlled organisation has been. It got to the point where an administrator had to be appointed.

Senator CROSSIN—I think it is the local community council, actually.

Ms Halton—Well, whatever. It has been run by the local community, and essentially what Ms Grogan is doing is actually working to ensure that we put in place a sustainable arrangement so that the people of that community have access to a high-quality and functioning health service. That is our objective.

Senator CROSSIN—Thank you.

CHAIR—Are there further questions on this outcome? Actually, we had decided we would finish at that point, so can I thank officers in outcome 8.

Ms Halton—Senator McLucas asked what were the components of the primary care practice incentives appropriation, the list of acronyms and things that are in that, and we will table it.

[6.06 pm]

CHAIR—We are now dealing with outcome 12, Health workforce capacity.

Senator MOORE—How many Medicare provider numbers have been issued to GPs in designated areas of need?

Prof. Calder—Areas of need, I am advised, is a state classification. We use areas of workforce shortage. Is that what you mean?

Senator MOORE—Are they the same?

Prof. Calder—No, not necessarily.

Senator MOORE—So the areas that you would use in the way you would designate doctors would be areas of workforce shortage. Since July 2004, how many Medicare provider numbers have been issued to GPs in designated areas of workforce shortages?

Prof. Calder—We can give you the numbers of doctors. I do not have that information about Medicare provider numbers.

Senator MOORE—Can you get that for us, Professor Calder?

Prof. Calder—Are we able to procure that today?

Senator MOORE—So you will take that on notice?

Prof. Calder—Yes. We possibly could provide it shortly.

Senator MOORE—Thank you. This will probably be similar in terms of the data you would be gathering. How many of these GPs were overseas-trained doctors who would not be eligible to work outside such designated areas? Could we have—and I believe we have had this in the past—this data broken down by state and RAMA?

Prof. Calder—We will need to take that one on notice.

Senator MOORE—Absolutely. If there is a problem with any of these just let us know, but if we can take those threshold numbers—

Prof. Calder—Yes.

Senator MOORE—this is the kind of data I have asked for before and there has not been a problem.

Prof. Calder—Yes.

Senator MOORE—How many—and this has been highlighted—special cases have been considered for provision of a Medicare provider number to a GP in an area not officially recognised as an area of workforce shortage, and how many provider numbers have been issued?

Prof. Calder—We will need to do that one as well. It might take a little while.

Senator MOORE—Are there any plans to reconsider the currently designated areas of workforce shortage? Has any consideration been given to this? We regularly ask this. I know that you do get lobbied by people, regions and divisions of GPs. Has any consideration been given to doing a review of the current status across the board?

Mr Kalisch—It is probably worthwhile noting that those areas of workforce shortage are reviewed every six months.

Senator MOORE—A standard review process?

Mr Kalisch—Standard review.

Senator MOORE—Who does that?

Mr Kalisch—We do that.

Senator MOORE—Your branch, your department?

Mr Kalisch—It would be in Mr Dennis's branch, but it is done on the basis of the data that is available from Medicare Australia, looking at the average number of doctors per 1,000 head of population within a particular SLA.

Senator MOORE—Mr Dennis, either you or Mr Kalisch, is there a possibility of seeing the overlay of what is an area of workplace shortage and what is a state area of need? In Queensland, for instance, I do not know what areas of need have been determined by the state government. I take it from the previous answer the state government has what it calls areas of need. I would like to be aware of what the differences are.

Mr Dennis—I believe we could provide fairly readily the—

Senator MOORE—I am sure you must get asked this.

Mr Dennis—We get asked repeatedly. As Mr Kalisch has reported, districts of workforce shortage, so designated, change on a regular basis—in fact, on a quarterly basis—with each set of new Medicare billing statistics, because it is that billing data that determines the basis for designation. In effect, the districts of workforce shortage change on a quarterly basis. Not all, of course, change but there is potential for each to change on a quarterly basis. We could provide fairly in-depth information regarding the current districts of workforce shortage. The areas of need may take a little longer because, as you have highlighted—

Senator MOORE—You would have to go to each of your—

Mr Dennis——each of the states is responsible for that information.

Senator MOORE—If you could do that, it would be very useful just to look at how they line up and in terms of the lobbying that is done.

Mr Dennis—Yes.

Senator MOORE—When are those reviews done? When you say every six months, is it a standard time that that review cycle is done?

Mr Dennis—It is as the Medicare billing data becomes available, which is quarterly.

Senator MOORE—Okay, so that when would be: March? Is it twice a year?

Mr Kalisch—It is quarterly.

Senator MOORE—Quarterly, and—

Mr Kalisch—I can find out.

Senator MOORE—It would just be useful to look at the cycle. You would have to plan your work around that as well, I would imagine?

Mr Kalisch—It does not implicitly change the way in which we do our work, but it changes the way in which we deal with particular requests at a point in time.

Senator MOORE—Can you take that on notice, that standard kind of information?

Mr Kalisch—We will try to get that to you quite quickly.

Senator MOORE—Can you tell us why the ACT as a geographic area is not determined as an area of workforce shortage?

Mr Kalisch—My understanding is that it has areas of workforce shortage within it.

Senator MOORE—So the whole area of it is not, but segments of it are.

Mr Kalisch—A district of workforce shortage is based on an SLA, which is a statistical local area, so it does not necessarily concord to any other boundaries that may be there.

Senator MOORE—One of the joys of the system is that nothing matches up.

Mr Kalisch—One example, as I understand it, is that the Belconnen area of the ACT is an area of workforce shortage.

Senator MOORE—Belconnen as a regional area?

Mr Kalisch—As a regional area it is, and probably the inner-south area of Canberra is not.

Senator MOORE—When we get the information we may have to come back with some more questions about the things that come up. That is what we wanted on that particular issue. I know that Senator Webber has some questions on something else but still on workforce.

Senator WEBBER—It is overseas trained doctors. I notice that Medicare provides $10,000 scholarships to help these doctors pass their exams and move into the workforce. How many overseas trained doctors have been awarded scholarships under this provision?

Prof. Calder—Just give me a moment, while we scramble through our papers.

Ms Jolly—Could you just repeat the question?

Senator WEBBER—How many overseas trained doctors have been awarded the $10,000 scholarships that are awarded under Medicare?

Ms Jolly—I am just getting that figure.

Senator WEBBER—There are more figures I want as part of that program, too.

Ms Jolly—Just over 300.

Senator WEBBER—And how many of the 300 have sat the clinical exams?

Ms Jolly—I would need to take that question on notice.

Senator WEBBER—In that case, could you also take on notice how many have sat exams, how many have passed the exams, and—you may actually know this—how long are doctors with the scholarships given to sit the exam?

Ms Jolly—I can supply that information quite quickly.

Senator WEBBER—What happens if they do not sit the exams? How much was budgeted for this program, too, while you are there?

Ms Jolly—The overall measure that you are referring to has a number of components, so I am just confirming the component that I have here. The $5 million under that particular initiative—

Senator WEBBER—That is what was budgeted?

Ms Jolly—Yes, that is correct.

Senator WEBBER—And how much has been spent?

Ms Jolly—All bar $500,000.

Senator WEBBER—Will it continue? I gather it is due to expire in June next year.

Ms Halton—When there is a lapse in the program, we cannot make an equivocal statement on that. It is subject to budget processes.

Senator WEBBER—If you could get back to us with those other ones, that would be good.

Senator MOORE—As a lapsing program it is under review. Is that right?

Ms Halton—All lapsing programs are reviewed, yes.

Senator MOORE—The review process would be in the next six months?

Mr Kalisch—As the cycle comes into the next budget.

Senator MOORE—When we gather next time will we find out how that review is going? Is it a standard lapse in program?

Ms Halton—Yes, it is.

Senator MOORE—I have a couple of questions on doctors in outer metropolitan areas which leads on, really, from the previous one. Because we have talked here a few times about how the scheme was operating, we want to know how many GPs, full-time equivalent GPs, specialists, full-time equivalent specialists or practices have relocated under the scheme. And that is that particular scheme: More Doctors for Outer Metropolitan Areas.

Prof. Calder—I have this information. Since the inception of the measure in 2002 to 30 June 2006, 250 doctors have relocated to or significantly increased their work in outer metropolitan areas.

Senator MOORE—Do you have any more data on that?

Prof. Calder—I do not have any in front of me. We do not have it here.

Senator MOORE—But you can. You already keep those figures in terms of reviewing the scheme. Can you tell us what was originally budgeted per financial year for the scheme, because it has been going since 2002?

Prof. Calder—I can give you funding for this year: it is $6.8 million. I do not have the forward years.

Senator MOORE—If you could get that for us in terms of an historical snapshot of what was budgeted, how much was spent each year, the success rate in terms of what I asked for—that is, how many doctors or practices moved. The option was there for them to move individually or for a whole practice to move, wasn't it? But have there been particular changes to the scheme in its short life span? Is there anything that comes to mind? I know you have been looking at it closely to see how it is going. Have there been changes to the way it works to make it more attractive?

Mr Dennis—Yes, certainly. In recent times the flagship of the initiative, which is the incentive grant, has been increased and that has, in fact, encouraged five further doctors to move, with a further three making enquiries about moving since 1 July this year. So it is continuing to provide an incentive force to have doctors move from inner metropolitan to outer metropolitan areas and, as we have said, that has been 250 to date, with the extension seeking to have a further 250 move over the ensuing four years.

Ms Halton—Unless I am mistaken, the question was: 'Have we extended it?' My memory is that we only had this with GPs to begin with, and we have actually extended the range to include specialists.

Senator MOORE—That was one of the enhancements to the scheme since it came in.

Ms Halton—That is right.

Senator MOORE—I know that the process is based on advertisement. I have seen advertisements in the major papers. Is there any other form of PR that is done to advertise this program?

Mr Dennis—Yes, we have undertaken a major launch recently where a number of colleges and other appropriate bodies were targeted. We have recently sent a mail-out of 900 targeted letters to individuals who are currently inner metropolitan doctors apprising them of the opportunities that presently exist under the scheme.

Senator MOORE—So it is specifically targeted at getting doctors in the inner city areas to move out—not necessarily doctors relocating from one outer metropolitan area to another or even doctors relocating from one country practice to another. To get the incentive you have to be a practising GP or specialist, or practice those things I read out before, in an inner metropolitan region who is prepared to look at moving to what is defined as an outer metropolitan practice. That is right, is it not?

Mr Dennis—That is correct, yes.

Senator MOORE—Can you tell us how much of the $80.797 million underspend in 2004-05 was due to underspending in this particular program, the More Doctors for Outer Metropolitan Areas program? What was the underspend in this particular program, the More Doctors for Outer Metropolitan Areas program? Over the period there have been years when there has been underspending, which has stimulated more work in the program. Can you take on notice, when you are giving us that other data, what a historical snapshot of the underspends would be?

Prof. Calder—Thank you. We will.

Senator MOORE—That is it.

Prof. Calder—We could clarify one of the answers, if that would be appropriate now?

CHAIR—Certainly.

Ms Jolly—I just wanted to come back to you on the scholarships. There were 338 scholarships—90 of those candidates were eligible to sit the clinical exam; five of those have now passed, and they are continuing on with their learning plan and other things. Also, of those scholarships, 49 have passed the MCQ.

Senator McLUCAS—Does that mean that a large number failed their exams?

Ms Jolly—The remainder have not sat the test yet. They sit the test when they are ready. They are working through their individual learning plans as part of the program.

Senator McLUCAS—Do we know how many have not been successful?

Ms Jolly—No, I do not have that information. Candidates are able to re-sit these exams.

Senator McLUCAS—Yes, I know that. And that can happen on a number of occasions?

Ms Jolly—Yes.

Senator McLUCAS—But we do not know how many may have been unsuccessful at their first attempt?

Ms Jolly—No, we do not.

Proceedings suspended from 6.26 pm to 7.31 pm

Senator McLUCAS—I want to ask some questions about the Medical Specialist Outreach Assistance Program. Is that called MSOAP?

Mr Eccles—Yes.

Senator McLUCAS—How long has it been operating?

Ms Appleyard—Since 1999.

Senator McLUCAS—What does it pay for?

Ms Appleyard—It pays for travel expenses and allowances like meals to enable specialists to be able to travel to remote areas and provide services. The services themselves are funded under Medicare.

Senator McLUCAS—How does that work?

Ms Appleyard—Do you mean how do they get reimbursed?

Senator McLUCAS—Yes. How do they tell you, 'I want to go to Bullamakanka'?

Ms Appleyard—An MSOAP advisory forum, instituted on a state basis, generally consists of representatives of all of the peak type specialists and doctors groups, as well as consumer groups, state health and our department. They come up with a prioritised list of services and encourage specialists to apply to be able to provide MSOAP services, and the list of services is then approved by the department on an annual basis.

Senator McLUCAS—You have the list of services and then various specialists apply to deliver the service that you have identified?

Mr Eccles—Or they are recruited to do so. They could be approached. For example, if they are providing outreach psychiatry services, psychiatrists will be actively encouraged to consider being part of the scheme.

Senator McLUCAS—Do the advisory forums meet annually?

Ms Appleyard—They can meet more frequently in order to consider proposals, which can come in on an ad hoc basis, but the decision to approve the plan is done annually.

Senator McLUCAS—Is there a top-down planning approach but proposals are then received as well?

Ms Appleyard—It is a bit of both. It is bottom-up as well because if a specialist would like to participate in it they are always welcome to submit an application at any time.

Senator McLUCAS—What is the split between those who want to be part of the program and indicate—that is, 'How long is a piece of string?'—

Mr Eccles—It is hard. Sometimes it is a bit of both. The reason members of the committee might suggest providing an outreach dermatological service to a particular town could well be that they are aware that there is an interest by a specialist, a capacity or a need. To say that these were generated from the ground up and generated by the advisory committee would be very difficult. In fact, one of the reasons we created the state based approach was to make sure that we had a good mixture of things that were consistent with the national framework and that they were grown from the bottom up.

Senator McLUCAS—What is the average cost per service delivered?

Ms Appleyard—That really does fluctuate because it depends on the number of services that the particular specialist is providing, what the service is and where they have to go to. Obviously, the more remote, the more expensive it is. It would be very difficult to give an average cost. Even in the list I have here it ranges from anything from a few thousand dollars to anything up to $60,000 for an individual service. It could be any range.

Senator McLUCAS—For a single service?

Ms Appleyard—For instance, if you were to say that a particular specialist was providing an obstetric service to a town, if that specialist was going back frequently, the cost of that service—which you would call one service because it was provided by one specialist—would be that—

Senator McLUCAS—We are talking at cross-purposes in terms of what the service is. So a service is a particular specialist visiting a particular location?

Ms Appleyard—Yes.

Senator McLUCAS—Is it possible for us to get a list of the service types?

Ms Appleyard—Yes, definitely.

Senator McLUCAS—Is it reasonable to ask for that by geographic area?

Ms Appleyard—Yes—by state? Would that suit?

Senator McLUCAS—Can you break that down even further?

Ms Appleyard—Yes. For 2005-06 we can give you a breakdown. We can do it by town or the location visited.

Senator McLUCAS—Could give me the service types for Dirranbandi?

Mr Eccles—It might be all the Queensland towns that benefit, what service they get and the value of the service.

Senator McLUCAS—That would be fantastic; thank you. From a question on notice we read that there were 1,079 MSOAP services. That is 1,079 specialists who undertook a visit program. Is that right?

Ms Appleyard—Sort of. For instance, if you had the same specialist providing a dermatology service to two different towns or two different regions, that could be called two services. The services, as I would call them—it is hard to use a word other than service—would be a particular type of outcome to that town, be it in a certain type of specialist—

Senator McLUCAS—Let us call it a clinic.

Ms Appleyard—It seems to me that, if we want to call them clinics, there would be over 1,000 different types of those offered under the outreach program.

Senator McLUCAS—How does that figure compare to those over the last five years of the program's operation?

Ms Appleyard—It has been steadily increasing, but the thing to remember about MSOAP is that it does have a capped, or finite, funding source. It is about $17 million for 2006-07. MSOAP is always very popular and there is always more demand for it than there is funding, hence we have to prioritise the approved services.

Senator McLUCAS—So an application for a dermatologist to go town X may be refused?

Ms Appleyard—It may be, yes.

Senator McLUCAS—Who makes that decision?

Ms Appleyard—The MSOAP advisory board.

Mr Eccles—The department makes the decision, but it is based on the advice of the local advisory committees. One of the things that they are charged with is the prioritisation and giving of advice on relative need and capacity to meet that need.

Senator MOORE—Taking into account their budget?

Ms Appleyard—Absolutely.

Senator McLUCAS—Was the $17 million for 2005-06?

Ms Appleyard—It is for 2006-07. It would be the approximate allocation.

Senator McLUCAS—Since 1999, since the program has been operating, what funding has been allocated for each year and what spending has occurred? For 2005-06 what was the allocation?

Ms Appleyard—I can get you the exact figure, but it was around $15 million and the spend was around the same. I will get that for you. It is always in the last page in the financials.

Senator MOORE—Can you also find out if any of them got knocked back?

Ms Appleyard—Under the cut-off, yes.

Senator MOORE—The budget and then the expenditure was very similar. The scheme is obviously popular so I would like to get some idea of who—not necessarily who but how many—missed out.

Ms Appleyard—Yes. The budget for 2005-06 was $15.49 million and the expenditure was $15.4 million.

Senator McLUCAS—It may not be possible but, if we are talking about clinics and then services—service being a specialist delivering a service to an individual—

Ms Appleyard—Yes.

Senator McLUCAS—is it possible to identify the number of services that have been delivered through MSOAP?

Ms Appleyard—I am sure that it is. I think that is a definitional issue that I would like to explore for you too. Are you talking about, for example, if we have a dermatologist providing a service and if they do it once a month then that is 12 services? Is that the kind of thing that you mean?

Senator McLUCAS—No. I am talking about a dermatologist who goes to Bullamakanka and sees three people. I am calling each of those events a service.

Mr Eccles—A patient episode?

Senator McLUCAS—Yes. We will talk about clinics and patient episodes.

Ms Appleyard—All right.

Senator MOORE—Could you get that through Medicare records?

Mr Eccles—I am not sure whether or not Medicare drills down to tying it in to MSOAP. We would need to check. I cannot imagine that we would be able to interrogate the MBS to find out whether Dr Smith provided six services in Bullamakanka on a particular day.

Ms Appleyard—I doubt it.

Mr Eccles—I have a feeling that they do have to report on volumes. Professor Horvath has gone down that MSOAP road in a former life.

Senator MOORE—What forms did you have to fill in?

Mr Eccles—I missed out, because in the former life of MSOAP the area had to ask for you. It means that you would have to get a new provider number for that particular area for

them to sort it out, otherwise it would just appear as part of your ordinary Medicare billing. I do not think the question is answerable.

Senator McLUCAS—You do not think it is answerable?

Mr Eccles—No, unless they actually received a provider number for that location.

Senator McLUCAS—Unless they are reporting by the number of episodes?

Mr Eccles—It probably would be generalities as in estimated volumes or at the end of each 15 they need to advise the committee of volumes and things. We will see what is possible.

Senator McLUCAS—Thank you. I have some questions now about rural procedural GP's.

Ms Appleyard—The rural procedural GP program is another outcome.

Senator McLUCAS—Which one is that?

Ms Appleyard—That would have been outcome 5.

Mr Eccles—If you ask the questions I might be able to answer, because I have a general familiarity with the program but I am not sure. It is in another outcome.

Senator McLUCAS—If you can tell me which outcome it is, that would be helpful so that we do not make the mistake again.

Ms Appleyard—Yes.

Senator McLUCAS—Ms Halton, I have to say that you do provide us with quite a good summary of where rural stuff actually fits, so it is our error.

Ms Appleyard—It is the rural procedural GP program.

Senator McLUCAS—It is funding for training.

Ms Appleyard—It is definitely outcome 5.

Mr Eccles—It is in the workforce area.

Senator McLUCAS—They are very statistical type questions. I can put them on notice.

Mr Eccles—That would be great. Thank you.

CHAIR—Thank you very much to the officers concerned with rural health. We are a little early for Health System Capacity and Quality. Ms Halton, do you know whether you have officers available to deal with that area now?

Ms Halton—With outcome 10?

CHAIR—Yes.

Ms Halton—Some of it is for Mr Eccles.

Senator MOORE—We have questions on the Broadband for Health Program and Health Connect, if we have time. Are they both yours?

Ms Halton—Yes. What we might do is pull a few people forward, if you like.

CHAIR—Yes.

Senator MOORE—We want to know the about the funding provided to Broadband for Health and its component programs, such as Managed Health Networks, since the program's inception. When did it commence?

Mr Eccles—This is Broadband for Health?

Senator MOORE—Broadband for Health.

Mr Eccles—2004-05.

Senator MOORE—There have been two completed financial years?

Mr Eccles—Yes, 2004-05. That is right.

Senator MOORE—And 2005-06?

Mr Eccles—Yes.

Senator MOORE—Can we get the details of the funds that were provided each year and the actual spending on the program against the estimates in each year?

Mr Eccles—You would like that for each year?

Senator MOORE—The actual spend and the estimates. Have you got that?

Mr Eccles—I am just checking. If you are happy for us to take it on notice, then we will do that.

Senator MOORE—Yes. Do you know how many practices or GPs have taken up this particular program each year?

Ms McGlynn—As at May 2006, 50 per cent of eligible practices, 88 per cent of Aboriginal community controlled health organisations, 80 per cent of community pharmacies and 100 per cent of the Royal Flying Doctor Service had signed up for the broadband initiative. We would expect those figures to rise, given that was the May 2006 data. That is the latest we have, and we have signed off many more applications since then.

Senator MOORE—That is May 2006?

Ms McGlynn—Yes.

Senator MOORE—You would have knocked off the end of that financial year and you are into the third?

Ms McGlynn—Yes.

Senator MOORE—Is the goal to get 100 per cent across the board?

Mr Eccles—I am not sure if there is a stated goal, but it is to get as close to 100 per cent as is practicable.

Senator MOORE—I am just wondering whether you had a business plan.

Mr Eccles—We have set targets in annual reports.

Ms Halton—Yes, we have. Someone asked me this question just recently, and I said to them that ideally in the medium and longer term you would have all practices on this system recognising—and Professor Horvath can throw something at me at this point if he does not

like what I say—that there will be some specialists who, because of the nature of their practice and their attachment to their ways of working, may never come on to the program.

Prof. Horvath—I agree.

Senator MOORE—Is that a cultural issue?

Prof. Horvath—Yes. A lot of them have their own peculiar computing systems for which they think they are self-styled experts. I agree with Ms Halton; they are going to be the difficult ones to get onboard.

Senator MOORE—I cannot see that far, but you did give me those percentages. Did you actually include specialists separately? You went for GPs, community health services and community Aboriginal services—

Ms McGlynn—Community pharmacies.

Senator MOORE—community pharmacies and Royal Flying Doctor Services?

Ms McGlynn—Yes.

Senator MOORE—Specialists as such do not get their own jersey; is that right?

Ms McGlynn—Not in the scope of this program.

Senator MOORE—So we are looking particularly at GPs and GP practices?

Ms McGlynn—That is right.

Mr Eccles—Practices, yes.

Senator MOORE—Is there a geographical area where these practices, in particular, have not taken up the service? Is there any particular geography base?

Ms McGlynn—The services are awarded by RAMA, so we can look at the breakdown by RAMA.

Senator MOORE—That would be good, because that would show that. Every time we talk about broadband services the issues of access and ISP come up. Is that something that you can give us any information about? Has physical access been a deterrent in some places?

Ms McGlynn—There are a number of things that we can talk about in terms of the ISPs. At the moment there are 63 broadband providers. We have also gone out to request that providers who may like to sign up do so. Also, some providers are providing services that would be eligible, but for whatever reason they have not signed up to the program. There are some big providers that would meet our requirements, but they have not signed up.

Senator MOORE—The providers themselves sign up to the program and then other people sign up. Do you have an active role in linking up the individual medical practices with ISPs?

Ms McGlynn—We would not say which providers they needed to choose, but we would make sure that those that were eligible met certain standards and that we have an audit in place to check that they meet the speeds and the requirements that we have set.

Senator MOORE—Who does the assessment of that?

Ms McGlynn—The company's name escapes me. I can provide that to you on notice.

Senator MOORE—That would be good. So the department contracts an organisation just to look at their credibility or integrity?

Ms McGlynn—Yes. Can I also add that right across Australia people have access to at least two providers. There is not always just a sole provider.

Senator MOORE—To the best of your knowledge, there is no medical person who is eligible for this service who could not access it because of inaccessibility to an ISP?

Mr Eccles—It is important to bear in mind that this can be done through the standard broadband landline but also through satellite, particularly the harder to reach areas. I think the entire country is covered by satellite access.

Senator MOORE—Can we get information about that?

Mr Eccles—How many are signed up for the landline and how many for satellite?

Senator MOORE—Yes, the varying forms of it. I think that is really interesting because of the other interest about e-health and the access to satellite. Do all the pharmacists get the same amount of money to come onto the system? Is there the same incentive for doctors, pharmacists and the Royal Flying Doctor Service? Is it a flat rate?

Mr Eccles—It is, but you get more in more remote areas and you get more if it is a satellite based service.

Senator MOORE—Because of the cost?

Mr Eccles—Because of the cost associated with it.

Senator MOORE—How does this program link in to the IMIT PIP? Can you get both? With my very basic knowledge of technology, I am just wondering if a doctor can access this scheme and also the particular PIP?

Mr Eccles—Absolutely.

Senator MOORE—They can get both?

Mr Eccles—Yes. We have now got a situation in Australia where well over 90 per cent of doctors are computerised. They have computers on their desks.

Senator MOORE—Doctors or their practice?

Mr Eccles—Yes, that is right. I have the figures here somewhere, but a significant proportion of them have signed up for the IMIT.

Senator MOORE—Can I get that as well? That would be really useful—

Mr Eccles—Yes.

Senator MOORE—particularly if the move is towards this form of service delivery, to see the attraction to a medical practice of going that way. You have already told me how many ISPs are involved.

Ms McGlynn—We do know the number of PIP practices who have claimed both up until the end of May, so we can give you that.

Senator MOORE—That would be good. Do you have a percentage for that as well?

Ms McGlynn—Percentage of total?

Senator MOORE—Yes.

Ms McGlynn—We can do that for you.

Senator MOORE—I would like the numbers as well. You did give me percentages but I would like to know the numbers that that reflects as well. Can you tell us how the $10 million allocated in December 2005 to Managed Health Networks is being spent? There was a media release at that time talking about the expenditure program. What was the actual intent of the Managed Health Networks expenditure of $10 million?

Ms McGlynn—The Managed Health Networks grants were building on the Broadband for Health Program. This was about allowing people to get established with more advanced broadband health services so that we could get secure messaging between service providers that was high speed and all of those things. This was looking at the privacy and security of information that was of a higher quality.

Senator MOORE—The expectation was that people who already had stage 1 would get extra funding to go to another level. Was that the idea?

Ms McGlynn—Not necessarily. There are three kinds of grants. There are seeding grants, which are looking at developing a business case, and then there are development grants, which are looking at putting together Managed Health Networks, so linking up services. Then there are service provider grants, which are looking at people like software developers and system people who could add value to the broadband connectivity that already exists.

Senator MOORE—Do those expenditures all come out of the one bucket?

Ms McGlynn—Yes.

Senator MOORE—It is not divided internally into thirds?

Ms McGlynn—No.

Mr Eccles—At the risk of bouncing around, can I go back and answer your question from earlier?

Senator MOORE—Of course. Which one?

Mr Eccles—In August 2006 there were around 4,760 general practices participating in PIP. Of those, around 91 per cent, which is 4,300, were meeting the IMIT requirements. It is a very significant proportion of practices.

Senator MOORE—That is very high. Has there been an internal review of this program to find out why it is working?

Mr Eccles—This is the IMIT?

Senator MOORE—Probably both, because it is all part of the same expectation, but for the sake of the question I will not ask you PIP because that was a previous program. So on the Broadband for Health scheme, has there been an internal review?

Ms McGlynn—That will happen in 2006-07. We are looking at a framework for that now.

Senator MOORE—And now for a question we love so dearly. In 2005-06, the Broadband for Health Program was underspent by $2.575 million due to delays in assessing grants. That was the rationale given. That was obviously identified as an issue. What has been done now and do you have outstanding grants?

Ms McGlynn—In the Broadband for Health Program there was a lag in payments partly because practices did not submit their claims or they were incomplete, so we have worked very closely with Medicare Australia to look at how we can improve those or encourage general practices to submit their claims. I know that there have been follow-up calls about incomplete information. We have processed a lot of claims. Medicare Australia submit their claims for sign-off to the branch and we have processed a lot of those in the last several weeks. We have also communicated through the Australian Divisions of General Practice and others to look at how they can facilitate their claims by completing those forms more accurately. In terms of the Managed Health Networks grants, we have had an overwhelming response that was much higher than we would have expected and we are currently assessing those proposals. We hope to award those grants in November.

Senator MOORE—Is that the expected time frame?

Mr Eccles—Yes.

Senator MOORE—So that is running to schedule?

Ms McGlynn—Yes.

Senator MOORE—So the November expectation was there. The other one was the ongoing issue about submitting your paperwork.

Ms McGlynn—Yes, in Broadband for Health.

Senator MOORE—Is this being done electronically?

Ms McGlynn—They can fax it through.

Senator MOORE—It is faxed, is it?

Ms McGlynn—Yes.

Senator MOORE—This program still relies on paper?

Mr Eccles—I am not sure of the question. How do we receive the compliance reports from the practices? Essentially: do we receive them electronically?

Senator MOORE—Yes.

Mr Eccles—I am advised that it is by fax to Medicare Australia.

Senator MOORE—At this stage?

Mr Eccles—Yes, but do not forget many faxes can be sent from a desktop computer.

Senator MOORE—Yes. So, from the branch's perspective, you comfortable with the current grant-processing processes?

Ms McGlynn—Yes.

Senator MOORE—In June 2006 an advertisement, of which we have a copy, indicated that the Broadband for Health Program had been extended to 30 June 2007. When was it

originally expected to end? It says that it has been extended, but when was it supposed to cease?

Mr Eccles—We are just finding out.

Senator MOORE—It does not say in the ad. The headline is very clear. It is a standard one that says it has been extended, but I am just checking from what to what?

Mr Eccles—It was always expected to be in that time frame, but that had not been confirmed exactly. I think there was always funding available, but we did not have a clear idea of the way that we were going to advance the program.

Senator MOORE—Was it budgeted through until July 2007 always?

Mr Eccles—Yes.

Senator MOORE—Is it due to lapse in July 2007?

Ms McGlynn—It terminates in 2006-07.

Senator MOORE—Any decision to extend or not will be in the normal process of review and then reapply—the budget cycle?

Ms Halton—Recognising that terminating is, by definition, a different thing to elapsing.

Senator MOORE—We have had information—and I am sure that you have heard it as well—that some GPs are waiting four to five months for the broadband subsidy once they have signed up. We understand that in October there were some subsidies that had payments that were still outstanding. Do you have any data about how many payments were still outstanding as of October?

Ms McGlynn—I referred to my previous answer. My advice from Medicare Australia would indicate that they have processed until the end of 2005-06 and that doctors will be receiving those payments. There has been a great effort in Medicare Australia to get those payments out. We do not have the data, but we would expect that soon.

Senator MOORE—Medicare Australia pays their subsidy payments?

Mr Eccles—Yes.

Ms McGlynn—Yes.

Senator MOORE—Does the department have any control over the Medicare payment cycle?

Mr Eccles—It depends what you mean by 'control'. We are in constant discussions with our colleagues in Medicare Australia.

Senator MOORE—It seems to be a long time. You gave answers before that one of the problems was the people getting their claims in.

Mr Eccles—In on time, yes.

Senator MOORE—However, the information that we have had is they get their claims in and there is still a significant delay in getting the payment. Is that something that has been brought to your attention?

Ms Halton—I think the short answer is probably no. Essentially, as you understand, this is where there is a split between portfolios.

Senator MOORE—Absolutely.

Ms Halton—We will pursue it.

Senator MOORE—Can you have a look at that?

Mr Eccles—We will look at it.

Ms Halton—Absolutely.

Senator MOORE—Can you check if it is accurate and, if it is, why? I will just throw that to you. Are there delays, why, and what are you going to do about it, if you know?

Ms Halton—The specifics on that might best be put on notice. We will chase it from the other end.

Senator MOORE—It has also been said that perhaps one of the issues is that the grant is not paid until the ISP gives a statement of supply.

Mr Eccles—That could be.

Senator MOORE—Sometimes there is a feeling that the ISP is reluctant to do so. Have you heard that? That is another thing to be followed up.

Mr Eccles—I have not heard it, partly because my involvement in the e-health world is relatively new. We will look at that, and we will also provide you with advice about the current status of payments. My understanding is that there has been a significant effort by Medicare Australia and the people in the e-health branch to ensure that we are as up to date as possible on making payments. I am vaguely confident that I will be able to give you some very satisfying figures in that regard.

Senator MOORE—I appreciate that you will have at that and get back to us. It is always difficult when you own the policy of the program but someone else does the payment. Certainly within the broadband telephone services industry there have been general concerns in some parts of regional Australia about service. Are you aware of whether broadband, once people get that service operating, can help with telephone access as well? Is that something that has come to your attention—if they work through this process it improves their whole communications?

Mr Eccles—I would imagine. I will seek technical advice from the people behind it.

Senator MOORE—It will be useful in terms of the credibility of the system.

Mr Eccles—However, I would imagine that, once you are hooked up via satellite to Broadband for Health for your computing needs, it would also have an impact on your telephony, much like it does for standard home based systems.

Ms McGlynn—I have just been advised that they can use that broadband connection for voice over internet, for example.

Senator MOORE—Yes, once again the whole range of services that go through. One of things you mentioned earlier was security of systems. Is the department aware of GP concerns that firewall protection offered by ISPs could be inadequate for the protection of patient

records? Has that been raised with you—medical concerns about the security of this system to protect medical data?

Mr Eccles—Not specifically that, certainly not in my time there. The whole issue of privacy of patient information is something that is very foremost.

Ms Halton—I have seen a number of reports in some of the medical press about this issue. I feel that there is a small amount of Jekyll and Hyde, because on the one hand I have seen various people complaining vociferously about the extra requirements that we are putting on people in relation to the conditions for them receiving some of the PIP components. At the same time, I have heard people expressing concerns about privacy and security of records. At the end of the day, we all absolutely agree that security of patient records is a fundamental provision of medical practice, be they in manila folders slung behind the receptionists—and we can all conjure up an imagine of that; I would venture to suggest that that is not hugely secure—or be they located on a computer somewhere. We have to be a little wary that some of the things one hears about this are perhaps a little overblown depending on the perspective, be it the Jekyll or the Hyde perspective. One of the things we are very conscious of—and I believe the IT industry is conscious of—is the need to make sure that these things are held securely. It is something that we will continue to pursue.

Senator MOORE—So security is one of the issues the company that is looking at the ISP provision is addressing. The media comment, which I know that you would have seen, was about this very issue and it related particularly to one that is called McAfee firewall and a concern about the security of that. From the department's point of view, in the process you have in place, is one of things that you take into account the privacy aspect?

Ms Halton—Exactly. At the end of day, what we are actually attempting to do is to incentivise, push, prod, and encourage practices to, firstly, not only to become far more IT literate but to have IT permeate the way that they practice. Secondly, they can start to offer patients the advantage that will come from this. This is, in a sense, a bit like the days when there was one terminal in the corner of every office that was the internet enabled terminal. It was all a bit of a mystery. I think really that is the phase we are going through with this. We are, in a way, just starting down this path. A lot of people do not necessarily understand what we are doing, and I think it is important that we continue to talk about the importance of privacy and making sure that they all understand the need to have the technology that delivers that.

Senator MOORE—It has only been going for two years, as you have explained. In that time, has there been an issue about privacy?

Ms Halton—No.

Senator MOORE—It is one thing for people to make claims. Has there been an actual—

Ms Halton—No, not that I am aware of.

Mr Eccles—We are continually ramping up and making the expectations for privacy greater and greater and more consistent with—

Senator MOORE—In line with medical practices.

Mr Eccles—Exactly.

Ms Halton—Absolutely.

Mr Eccles—It needs to grow.

Senator MOORE—I have some fairly straightforward questions on HealthConnect. You may wish to take them on notice, but I will at least get them on the record. Can I have the information for the 2006-07 year to date? How many HealthConnect funds have been distributed?

Mr Eccles—I do not think we have the year-to-date figures at this point.

Senator MOORE—When do you have a look at that? At what period? Six monthly?

Mr Eccles—I would have to check. I am not sure how useful it would be to do year-to-date on something like the HealthConnect project. I am not sure whether it is something that is in equal—

Senator MOORE—Can I just read the questions, Mr Eccles, and you can take them on notice and get back to me.

Mr Eccles—Yes. Let us do that.

Senator MOORE—If it is not feasible or not helpful, you can let me know.

Mr Eccles—Okay.

Senator MOORE—How many Health Connect funds have been distributed? What projects did they go to? How does the actual expenditure balance against the expected expenditure for that period of time? What new funding agreements have been delivered in that period? What new projects have been agreed? That is all I have for that section.

CHAIR—Are there any other further questions on outcome 10?

Senator MOORE—Regarding the marketing program, we have seen one ad, and I know that you have had relatively good success, particularly with the smaller groups of pharmacists and the flying doctor services. The figure for GPs is still around 50. You said that you are looking at promoting it. Can we get some information about your marketing strategy and what processes you intend to use to do that? That can go on notice.

Mr Eccles—Through divisions of general practice.

Senator MOORE—Just the chosen method on this particular program, because it has such ramifications for other services.

CHAIR—Thank you very much to officers involved in outcome 10. If we have officers on outcome 1 available, we will call them to the table.

[8.11 pm]

CHAIR—We are now on outcome 1—Population health.

Senator McLUCAS—The questions I want to ask go to a visit from Mr Jan Bult, from the Plasma Protein Therapeutics Association, to Australia.

Ms Halton—Is this an anticipated visit?

Senator McLUCAS—No, it is a visit that occurred in August.

Ms Halton—This is a visit to which there was a press reference?

Senator McLUCAS—There was a small story in the *Age*.

Ms Halton—Yes, I think I know the one you are talking about. Apparently the officers are not here yet.

Senator McLUCAS—I might leave that until the TGA comes.

Senator MOORE—I have some questions on the bowel cancer program and also the cervical cancer screening programs. On the bowel cancer program we are following up on questions we have asked before. Can you tell us as of now which states and territories have signed up to participate in the National Bowel Cancer Screening Program?

Ms Lyons—As of now, Queensland, New South Wales, the ACT and South Australia have signed up and commenced. At the AHMAC meeting that was held last week all of the other CEOs of the other states gave an undertaking that they would commence by 1 January next year.

Senator MOORE—You are waiting for that to be confirmed in writing?

Ms Lyons—Yes.

Senator MOORE—Do you have any idea why they had not signed to that stage? We have been talking about this for a while.

Ms Lyons—No. This is a state-by-state program rollout, as you know. As with each of the states there are exigencies and idiosyncratic problems that seem to emerge in each of them that are all different. It has been a process of trying to overcome some of those different problems.

Ms Halton—I think, to be fair, there was a discussion amongst the CEOs last Friday.

Senator MOORE—Is that AHMAC meeting—

Ms Halton—Yes, AHMAC. There was a CEOs discussion before the formal meeting, where I think there was a willingness on all of the jurisdictions' part expressed to actually get it moving, if that is not a terrible pun given the earlier conversation.

Senator MOORE—Can you give us a breakdown of how the $43 million committed to the program is currently being spent? Have you got an expenditure to date; for example, in terms of publicity, pathology, data collection and that kind of thing?

Ms Lyons—We might have to take that on notice because we do not have that breakdown here with us.

Senator MOORE—You know what I am after?

Ms Lyons—Yes, I know exactly what you are after.

Senator MOORE—When you do that breakdown, can you advise as to the funds being provided to each state and territory and what you know those funds are being used for?

Ms Lyons—Yes.

Senator MOORE—So for the ones that have already started in the program, to the best of what they have told you, how they are going and what they are spending their money on. Can you tell us how many FOBT kits have been mailed out?

Ms Koukari—As at 30 October the registrar had sent out 52,500 kits.

Senator MOORE—That is across the four states that are currently signed up?

Ms Koukari—That is right.

Senator MOORE—Is that to plan? Fifty-two thousand sounds like a lot. I do not know what to judge it by.

Ms Lyons—It is approximately five per cent of the total population.

Senator MOORE—Can we find out where they went to, not to whom but by state breakdown?

Ms Lyons—We would have to take the breakdown on notice.

Senator MOORE—Sure. Can you give me a breakdown of where these went by state and territory, and how many went to people who were involved in the pilot program?

Ms Lyons—That is something we could have.

Senator MOORE—What is the expected participation rate, the number of returned FOBT kits, as a percentage of those sent out? To get what you want you have sent out 52,000 kits at this stage. It may not be 52,000 that you do the assessment on. But what is the hit rate that you actually require to make this an effective program?

Ms Koukari—That is one of things that we are looking at. I think it would be part of the evaluation of the program to look at the participation rate. However, looking at the bowel cancer screening pilot, we had a participation rate of just over 40 per cent.

Senator MOORE—In terms of the people who were assessing that, that was a good result? Unless you actually are in the business, it is hard to know what is good.

Ms Koukari—With cervical screening, the participation rate is about 60 per cent with a 15-year program.

Senator MOORE—Do you have any evidence to date about the number of positive FOBT kits?

Ms Koukari—Yes. The number of positive test results, as at 30 October, is 695, which is a positivity rate of 6.5 per cent.

Senator MOORE—In terms of medical processes, is that too early to say?

Ms Koukari—It is too early at this stage.

Senator MOORE—Some 695 people have actually found out through this process that they should get some help?

Ms Koukari—That is right.

Senator MOORE—Have you done any work on the estimated cost of the service per participant? Is that something that you have modelled at this stage?

Ms Koukari—That is one of things that we are going to assess as part of the evaluation program. There will be a cost study as well as a cost effectiveness study completed.

Senator MOORE—Can you refresh my memory on the time frame of this particular program? It has just started.

Ms Koukari—We commenced screening in August. Screening will continue until June 2008.

Senator MOORE—That is the initial phase: 2006-08?

Ms Koukari—That is right.

Senator MOORE—And you would be doing an assessment through the latter half of that period?

Ms Koukari—That is right.

Senator MOORE—So when we come back next time and if you are into the process, we will have a little bit more data, but you still would not have started your formal evaluation stage?

Ms Koukari—No, although we will have made steps towards it.

Senator MOORE—In terms of promotion, how are you actually telling people about it? We asked about the expenditure on the kits. Can we get a little kit?

Ms Koukari—We have some here.

Senator MOORE—There has been genuine interest in this program.

Ms Koukari—We can hand out goodies.

Senator MOORE—That is lovely. Thank you.

Ms Lyons—This is the package that participants are sent.

Senator MOORE—In terms of statistics, I have straightforward questions on the cervical cancer project. We had the AIHW report on cervical cancer screening in Australia. The report said that about 61 per cent of women in the specialised target group had pap smears in 2003-04. Allowing that that was two years ago, that is still what I would consider to be a fairly low result. I just want to get some feedback on whether that is what the department considers—

Ms Powell—The participation rate in the cervical screening program has been steady for the last few years. It was 61 per cent in 1996-97, and it is still around that. There are no formal targets set for participation in the program.

Senator MOORE—Certainly in some of the discussions we have had in other places—in the gynaecological cancer inquiry—we talked about the issue of participation rates in cervical screening in 2006 after so much publicity in this area over so many years. We had a general discussion that we thought 60 per cent was not great, and particularly as it was steady. There was not any growth in it. Can we get a breakdown of Commonwealth funding spent on cervical cancer screening programs together with the uptake rate as it has been reported each financial year from 1996-97? Is that data that you would have?

Ms Powell—The funding for the cervical screening program is rolled up in the public health outcome funding agreements, so we cannot separate out the precise amount of funding.

Senator MOORE—Can you give indicative amounts?

Ms Powell—We can give you estimated amounts.

Senator MOORE—In terms of getting some idea about where it is going and the funding, I take the point.

Ms Powell—I cannot be sure about the degree of confidence in the accuracy, but we can give you estimates.

Senator MOORE—Can you make that statement when you give us the figures?

Ms Powell—Absolutely.

Senator MOORE—I am sure you would, so that when we look at it we can then go—

Ms Powell—Yes—we will qualify it as we need to.

Senator MOORE—The most recent PHOFAs allow broadbanding of funding. Are there requirements or targets set under the PHOFAs with respect to the amount that must be spent on cervical cancer screening and the number of eligible women that must be screened annually?

Ms Powell—I do not believe there are targets on the number of women because there is no formal target for participation.

Mr Morris—There are no formal targets set under the PHOFAs. The PHOFAs are outcome oriented.

Ms Powell—However, there are indicators for the program. They require jurisdictions to provide annual data to the AIHW about participation rates, early rescreening, low-grade abnormality detection and high-grade abnormality detection. All states and territories meet this indicator.

Senator MOORE—What about the amount that must be spent? Is there no direction given to the states about that?

Mr Morris—No, there is no direction given to the states on how to allocate their funds to specific activities under PHOFAs.

Ms Powell—States and territories also have the report on the strategies that they use to target both screened and unscreened women to participate in the program.

Senator MOORE—They do that on an annual basis?

Mr Morris—Yes.

Ms Powell—Yes.

Senator MOORE—What Commonwealth funds are currently available to target women of non-English-speaking backgrounds and Indigenous women?

Ms Powell—In the cervical cancer screening program, in terms of states reporting on their strategies, they have to specifically talk about focusing on Aboriginal and Torres Strait Islander women. I do not think there is one particularly for women from other backgrounds.

Senator MOORE—That issue came out strongly in our committee inquiry as well. Even with the AIHW stuff, there seemed to be an even lower participation rate for women from non-English-speaking backgrounds. Senator Adams is looking at that issue. There is particularly worrying evidence from Aboriginal and Torres Strait Islander medical centres about that area. With their report they have to indicate their strategies around Aboriginal and Torres Strait Islander women but not at this stage about non-English speaking women?

Ms Powell—No. They have to target unscreened and underscreened women particularly from Aboriginal and Torres Strait Island—

Senator MOORE—They do not further define what 'underscreened' means. It is self-assessment. Can you tell us anything about the consideration being given to the role of HPV testing in cervical cancer screening? I realise it is relatively new, but it has caused a great deal of debate.

Ms Powell—There has been a policy statement from the National Cervical Screening Program which recommends that all women aged 18 to 69 who have ever been sexually active, whether vaccinated or unvaccinated, should have cervical screening by pap smears. That has very recently been reconfirmed.

Senator MOORE—In terms of publicity programs to encourage women to take up screening, do you have any information? Is the publicity of these programs a state responsibility? Secondly, in view of the statement about needing to maintain screening even if people take up vaccination, which is another concern, how do you actually get that message to the community?

Ms Powell—In terms of the need for continued screening, we would expect that the screening programs will continue to encourage women to be screened, because it will be a long time before any impact from the vaccine will be available. In terms of encouraging uptake from the vaccine, I would need to—

Senator MOORE—I am interested in that, but I am also interested in whether there will be a program around that, which is really in its early stages, in terms of encouraging women to have cervical cancer screens.

Ms Powell—Are you talking about promotion of the HPV vaccine?

Senator MOORE—Not at this stage, but I want to know that as well. I am actually interested in the promotional programs to encourage women to have cervical cancer screening—the current programs. I am still unhappy with 60 per cent. I think that is really low.

Ms Powell—We would expect that the jurisdictions would continue with their current programs.

Senator MOORE—It is a state responsibility?

Ms Powell—Yes.

Senator MOORE—Promotion is a state responsibility?

Ms Halton—May I just add to that? Recognising that in relation to cancer more broadly, with the establishment of Cancer Australia and all the work that has been done around

gynaecological cancers et cetera—and of course we have just had the recent report that has come out—I think it is fair to say that the specific programs targeting women, with respect to the particular screening program, we would expect the states to continue. However, you would not want to ignore the greater activity by us in this space, particularly with the establishment of Cancer Australia.

Senator MOORE—Sure. And there is the expectation that Cancer Australia will have a role.

Ms Powell—I think so. At the end of the day, Cancer Australia's job is a broad one, but part of it is about raising the profile around these kinds of issues and the particular importance of screening where this is relevant.

Mr Eccles—That is on the agenda of new the Australian health development policy committee, which is the new AHMAC committee, which is looking at the whole roll-up of chronic diseases and some of the other issues around the formal screening advisory committee. It is well aware of these issues. From talking with my counterparts in the other states, they are well aware of the underscreening of migrant groups and poorer groups. This is certainly on the agenda and these are discussions that I have already had with David Currow, the CEO of Cancer Australia. So I think there is a lot of energy at Commonwealth, AHMAC and state levels.

Senator MOORE—I think that is a really important step. Ms Halton, I deliberately have not asked questions about Cancer Australia at these estimates because of its very recent implementation. It will be the subject of considerable questioning in the future. So it is not because we are not interested that we have not put them on the agenda this time. It is just that we thought it was a bit early to go through the kinds of questions we had. Do you want to go on to something else? Do you want to do immunisation?

Senator McLUCAS—Do the immunisation. I think TGA is here, but I think you have the right people at the desk, that is all.

Senator MOORE—I have some very straightforward questions on immunisation which I would imagine you would have to take on notice, so I will just throw them out there. I want to deal with the key sexually transmitted diseases and other diseases. The ones that I have here—HIV-AIDS, gonorrhoea, syphilis, chlamydia and hepatitis C—are the conditions we are interested in getting information on, and I want information from the financial years 1996-97 to 2005-06. We will give this to you on notice.

Ms Lyons—Yes. I want to clarify whether this is about immunisation for those things, or is this about—

Senator MOORE—I have gone to the wrong page. It is STDs.

Ms Lyons—Okay.

Senator MOORE—I read the wrong page. I do apologise. Have I got the right people?

Ms Lyons—Yes.

Senator MOORE—Do you have a note of the conditions?

Ms Lyons—Yes.

Senator MOORE—I also want the number of reported infections, the infection rate, the particular infection rate in the Indigenous community, federal funding excluding PBS funds, and PBS funds in their own right. That is from the 1996-97 financial year until now.

Prof. Horvath—I think to extract the PBS funds would be almost impossible because the drugs used for treatment of some of these conditions are used across the board for other conditions.

Senator MOORE—So it would be impossible to extract them and get federal funds excluding PBS, or would it be possible just to tell us what the PBS funds were?

Prof. Horvath—I do not think you could look at the PBS and extract from the PBS what necessarily relates to those infectious diseases.

Senator MOORE—So we could get the funding excluding PBS.

Prof. Horvath—Correct.

Senator MOORE—But it would be questionable whether we could get it for each of the conditions separately?

Prof. Horvath—You could not get the PBS funding.

Senator MOORE—If we can just get that in the answer then we will be able to take that as the rationale for that.

Senator McLUCAS—I think we could get the new range of HIV drugs, could we not, because they are specifically for HIV?

Prof. Horvath—Most probably for HIV alone.

Senator McLUCAS—Yes. It is the only one I could think of that is that specific.

Prof. Horvath—Well, it is not all of them. You could get the antiretrovirals but not the other drugs used. So it is partial.

Senator McLUCAS—That is right. It would only be partial.

Prof. Horvath—It would only be partial and it would be misleading.

Senator McLUCAS—Yes, you are right.

Senator MOORE—We will try immunisations now that I have found the right page. What data is available about the effectiveness of the catch-up program for pneumococcal immunisation?

Ms Lyons—We might need to take that on notice, because I am not sure about the level of information we have on that.

Senator MOORE—You are clear about the question, so that is fine.

Ms Lyons—Yes.

Senator MOORE—What percentage of the eligible population is now vaccinated?

Ms Lyons—We will have to take that on notice, too.

Senator MOORE—Do you know the target that you aimed for? Will you take that on notice?

Ms Lyons—Yes.

Senator MOORE—Was the catch-up program for pneumococcal immunisation extended beyond December 2005?

Ms Lyons—Yes, that is correct.

Senator MOORE—That is correct?

Ms Lyons—Yes.

Senator MOORE—Can you tell us what the costs associated with the catch-up program were? The kinds of things we expect they would be are the advertising, doctors' information, the actual vaccines used and consultancies.

Ms Lyons—We will have to take that on notice.

Senator MOORE—Yes, but we are wanting to know the break-up. It is both the use and the administrative funds.

Ms Lyons—Yes, we should be able to get that.

Senator MOORE—Information in my favourite question, E06-260, shows that the vaccine program was over budget by $32.65 million in 2005-06. It was stated in the explanation box:

Increased expenditure is due to greater than anticipated uptake in both the newborn and time-limited catch-up cohorts under the Childhood Pneumococcal Vaccination Program

What does it mean that uptake was greater than anticipated?

Ms Koukari—That we had expected a particular uptake and there were a number of reasons behind that greater than anticipated uptake, including growth in population, that we had not anticipated—

Senator MOORE—I missed that bit; I am sorry.

Ms Koukari—Sorry.

Senator MOORE—We got the first sentence fairly well. The middle bit faded out.

Ms Koukari—I was saying that one of the difficulties that we had was that we did not have accurate population figures, and we do now with new ABS data. But it is also quite difficult to estimate what the impact of a catch-up program will be, and in this instance it was just more successful than we had anticipated.

Senator MOORE—What was the anticipated uptake for newborns and for catch-up? So there would be the two: newborn children, which would be determined by how many children are born, and the catch-up period to get the people who missed out.

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

Senator MOORE—Sure. Can we get the actual uptake?

Ms Koukari—Yes.

Senator MOORE—We know it was overdone, but what was the figure? How does that fit with the news reports that were widely in the media that in December only 75 per cent of eligible toddlers had received the vaccine? Is that a figure of which you are aware?

Ms Koukari—No.

Senator MOORE—We often do quote from media because we know that you have a very good media monitoring service to see when health issues come up. I refer to the *Daily Telegraph* of 26 September this year. Basically, what is your understanding of the percentage of eligible toddlers that has received the vaccine? The media is claiming 75 per cent. Does the department have a figure?

Ms Koukari—That is an accurate figure at the end of the catch-up program.

Senator McLUCAS—When will the catch-up program be complete? It was to finish in December 2005 and then it was extended.

Ms Koukari—No, it has not been extended. It was due to cease in December 2005, and it was not extended.

Senator MOORE—When I asked if the catch-up program was extended beyond December 2005 for pneumococcal immunisation, you said yes.

Senator McLUCAS—I thought you said yes.

Senator MOORE—You did. You said yes.

Ms Koukari—I am sorry. I thought you meant: did it cease?

Senator MOORE—No. Sorry.

Ms Koukari—I am sorry.

Senator MOORE—So it did cease in December 2005. Okay. I will just change that to 'No'.

Ms Koukari—I apologise.

Senator MOORE—So it did finish in December 2005. That was the catch-up process. And 75 per cent of eligible toddlers, on the basis of the figures that you had, had received the vaccination.

Ms Koukari—That is right, at the end of that period.

Senator MOORE—Professor Horvath, is 75 per cent good?

Prof. Horvath—Yes. Considering the anxiety some people have about vaccinations in general, any catch-up is considerably less than a primary where you catch them early. We certainly have not had any concerns from the profession about the 75 per cent that I am aware of.

Senator MOORE—What data is available about the effectiveness of the catch-up program for meningococcal C immunisation? Has there been an evaluation of the effectiveness of the catch-up program for that one?

Ms Koukari—As a result of the program there has been an 80 per cent decrease in cases and an 85 per cent decrease in deaths.

Senator MOORE—Do you have any idea what the percentage of the eligible population is now vaccinated?

Ms Koukari—The immunisation register does not capture data to that age limit, so we do not have reliable data on that.

Senator MOORE—Can we put on notice what data it does keep?

Ms Koukari—Yes.

Senator MOORE—So we have this and then we can come back to it.

Ms Koukari—Certainly.

Senator MOORE—Can we find out what data it does keep, what figures are extracted from that, what was the target for the catch-up program for meningococcal C immunisation and whether the catch-up program was extended beyond June 2006 and, if so, why, and the cost? We would like the same kinds of costs as we had before—the costs around the catch-up program, advertising, vaccine, information to doctors, consultancies, and, if the program was extended beyond June 2006, the additional costs of extending the program beyond that period. We will give this to you in writing, but are those questions clear?

Ms Koukari—Yes.

Senator McLUCAS—I would like to ask some questions of the TGA.

CHAIR—We will move on to the Therapeutic Goods Administration.

[8.44 pm]

Therapeutic Goods Administratiion

Senator McLUCAS—I understand that Mr Jan Bult from the Plasma Protein Therapeutics Association was in Australia around August of this year. I know the National Blood Authority is not here, but did the TGA or, to your knowledge, the NBA have any involvement in his visit to Australia?

Dr Graham—Yes, we have very strong links with international regulators and international organisations dealing with biologicals, and there was in effect just a standing offer for that person to visit Australia when they had a chance in their schedule, which they did. I was overseas at the time but they did visit the TGA. I think he also visited the NBA at the same time.

Senator McLUCAS—Did TGA or NBA pay for any part of Mr Bult's visit?

Prof. Farrugia—No.

Senator McLUCAS—No.

Prof. Farrugia—I in fact invited Mr Bult and organised the visit and was the chief interface with him during his visit to the TGA. As to payment—certainly not, no. He and a colleague of his were not paid for by the TGA for the visit.

Senator McLUCAS—Not paid for at all?

Prof. Farrugia—No.

Senator McLUCAS—But you hosted him, so to speak.

Prof. Farrugia—We had the meeting under our roof with him and Dr Gustafson, the regulatory affairs manager of the Plasma Protein Therapeutics Association.

Senator McLUCAS—Did you arrange meetings for him with other people in Australia?

Prof. Farrugia—No. These meetings were arranged, but they were not through our leadership. It was known that we had invited him.

Senator McLUCAS—When he was at the TGA, did he meet with you, Professor Farrugia—is that correct?

Prof. Farrugia—Yes—and a number of other colleagues.

Senator McLUCAS—Who else did he meet with?

Prof. Farrugia—They were the people involved in blood regulation across the various parts of the TGA. Offhand I think they were Dr McGuiness from the Drug Safety and Evaluation Branch, Dr Harrison, Dr Whitbread, Dr Poulis and other officers evaluating the safety and quality of plasma derivatives.

Senator McLUCAS—What was the purpose of those meetings?

Prof. Farrugia—It is the standard purpose whenever we interact with the industry. The Plasma Protein Therapeutics Association is an extremely important international organisation. It is the umbrella organisation of the vast bulk of the international plasma products industry, the so-called for-profit sector. They are well recognised internationally. They hold regular meetings with peer agencies such as the Food and Drug Administration and the European Medicines Agency. We, like these agencies, feel that it is appropriate that we interact with them in our consultative process for these therapeutic goods.

Senator McLUCAS—*The Age* article of 29 August indicates that Mr Bult was in Australia to lobby for overseas companies who want Australia's blood supply opened to competition. Is that an accurate assessment of his visit?

Prof. Farrugia—I am afraid I do not read *The Age*. I read other newspapers. But in relation to his interaction with the TGA, it was to discuss matters of mutual interest in terms of the scientific framework for plasma products standards. Mr Bult's presentation was in fact made available to us, as was that of Dr Gustafson, and at no time did he lobby for anybody. He made us aware of what his organisation was because, unlike me, many members of my organisation had not yet heard Mr Bult speak internationally. He is a very well known international speaker, so he made us aware of what his organisation was, but it was not in the context of lobbying per se.

Senator McLUCAS—But he may have been lobbying other entities.

Prof. Farrugia—He may well have, but I was not there.

Senator McLUCAS—Do you know if Mr Bult met with Minister Abbott or Minister Pyne?

Ms Halton—No, I am not aware that he did.

Senator McLUCAS—Professor Farrugia, you spoke, I understand, at an annual scientific meeting in Hobart. Is that correct?

Prof. Farrugia—I did indeed. I speak at many meetings.

Senator McLUCAS—What sort of meeting was that?

Prof. Farrugia—It was the annual scientific meeting of a number of scientific organisations in this country, including the Haematology Society of Australia, the Australia New Zealand Society of Blood Transfusion, the Australasian Society of Thrombosis and Haemostasis and some other groups like that. These societies generally meet together, in order to economise, once per year. Since it is the major scientific meeting involving the sectors in blood which we regulate, we are generally present at these meetings and we hold various events.

Senator McLUCAS—Did you seek, or did you need to seek, approval from the department to speak at that meeting?

Prof. Farrugia—Every time I attend a meeting on TGA time, I need to seek approval, of course.

Senator McLUCAS—Whom do you seek that from?

Prof. Farrugia—I sought it from the agency as usual, yes.

Senator McLUCAS—From you, Mr Graham?

Dr Graham—Not necessarily. It would have been from the branch head of that area.

Senator McLUCAS—What sort of process do you go through to ascertain the appropriateness of speaking at wherever it might be, not just for Professor Farrugia but for anybody for that matter?

Dr Graham—We would look at what is in the program, what is the relevance to the TGA and to the department. With scientific discussions such as those, it is very relevant. We just recently put out a discussion paper on blood and blood regulation as part of the trans-Tasman process, so that sort of interaction with the industry and also with other governments of Australia is particularly important at this point in time.

Senator McLUCAS—Do you look at who sponsors the meeting?

Prof. Farrugia—Scientific meetings are always sponsored by commercial companies, many of whom we regulate ourselves, but we certainly accept absolutely no support for these. I make it a point to specify whenever I speak that I am not supported by anybody. It is necessary for us to attend. There is no scientific meeting internationally or domestically that I am aware of that does not involve some level of sponsorship by regulated entities.

Dr Graham—It is a fairly small biologicals community in this country, so if we did not go to any of these seminars because they might be supported in one way or another by the industry that would mean we probably would not go to any.

Ms Halton—I also think it is important to understand that we, as a matter of practice, would not accept airfares, accommodation or any of those sorts of things. When anyone in the department is invited to speak at something, which people are—things sponsored by the *Financial Review* and assorted other things—if there is merit in ensuring people understand what we do, we attend but we do not accept airfares or any of those sorts of things.

Senator McLUCAS—Thank you for that. It is also a matter of perception. I understand, Professor, you shared a platform with Professor Bjarte Solheim, who had been brought to

Australia by Octapharma specifically to tell conference delegates how Octapharma secured the contract to fractionate Norwegian plasma offshore. Is that true?

Prof. Farrugia—I actually was a co-speaker amongst three speakers, one of whom was Professor Solheim, who is an old and valued colleague and an eminent authority in blood transfusion as well as a co-member of the Council of Europe committee of experts, on which I represent Australia. Another was Professor Naomi Luban, who is an eminent American authority in blood transfusion who, it is my distinct recollection, had no association whatsoever with the company of which you speak. Yes, I did speak at that seminar and it was one of various engagements which I had, and I can definitely remember that I made it a point to specify that I myself was not sponsored by the agency you have mentioned.

Ms Halton—Can I make a particular point here? I asked the question earlier on, when you asked if the TGA was here, about whether it referred to that particular newspaper article. I saw that newspaper article at the time. It is important to understand that the review of Australia's blood fractionation arrangements is not being conducted by the TGA. It is being conducted by an independent group led by Phillip Flood, an eminent former secretary of the Department of Foreign Affairs and Trade, supported by a small secretariat located in the Acute Care Division of the department. It is fair to say that there is a propensity for people to over-read and then use some of these things to suggest that things are afoot—for example, when Professor Farrugia appeared at a scientific meeting. If we go to the core of this matter, which is people's concern about inappropriate lobbying in relation to the security of Australia's blood supply—let us go to what we are actually talking about here—

Senator McLUCAS—That is right: the public perception of that.

Ms Halton—Absolutely. The review is the important thing here. The review is being conducted in a way I am absolutely confident has complete probity, and with a group of eminent Australians who are actually doing that review. The review will be handed to the minister at some point towards the end of the year. Then the minister obviously will have to consider that report, and the government will consider it. It is a little unfair for external people who want to make some issues perhaps where there are not any to point to the fact that what has been a fairly standard practice, which is that people do appear at scientific meetings to discuss the science, implies something. As I have said, we are quite careful that we do not accept sponsorship, particularly in these sorts of circumstances, fully recognising, as you rightly say, there might be a public perception. But I do think we have to ask ourselves how sometimes this public perception is generated: some people are actually out there stirring it up.

I understand the concern that you are raising, which is about security of our blood supply. Be assured it is something I am personally, as the head of the department, very worried about as well, because at the end of the day I need to be confident that we have a secure and safe blood supply. You do not have to go back very far in years to look at what has happened internationally in some of those respects. We do not have to go too far back to see some things in relation to overseas experience with blood supply that we would not wish to replicate. I can tell you that that review is being conducted in a way which I am absolutely confident has appropriate probity associated with it.

Prof. Farrugia—May I also add, for your comfort, that the seminar in which I had the honour to appear along with my good friend Professor Solheim had absolutely nothing to do with plasma fractionation arrangements. It was on transfusion related acute lung injury, and that is what I and Professor Luban, as well as Professor Solheim, spoke about. Professor Solheim spoke about the issue which you are referring to in another symposium, which included as co-speakers people who, I can assure you, were not sponsored by Octapharma either.

Ms Halton—In relation to that particular article which alleged, I think, from memory, that the individual concerned was meeting with the minister—

Senator McLUCAS—Yes.

Ms Halton—I inquired, having seen that, because it was the first I had heard of it, and I can assure you I was assured by the office it was the first they had heard of it as well, and it was indeed not the case.

Senator McLUCAS—This is a different article, which I think must be from the *Australian*. It states that Mr Solheim has also been invited to speak with health minister Mr Tony Abbott.

Ms Halton—No. As I say, when I saw that, I asked precisely that question and I was told, no, that that indeed was not the case. In fact, I was involved in the conversation with the minister where that conversation occurred.

Senator McLUCAS—Professor Farr, you shared a platform with Professor Solheim. Did you have any other meetings with him in your capacity as medical adviser—and that is probably the wrong term—of the TGA?

Prof. Farrugia—As I said, I have the honour of representing Australia on the Council of Europe committee of experts on quality in blood transfusion. Prior to his retirement earlier this year, Professor Solheim was equally honoured to represent his country, which is Norway. In that capacity I have had interactions with Professor Solheim extensively. As I said, Professor Solheim is an old, valued colleague and an eminent authority in the field in which I work, and so my interactions with him are frequent.

Senator McLUCAS—Is it true to say, though, that he came to Australia essentially to explain how Octapharma secured the fractionation contract in Norway?

Prof. Farrugia—I am afraid you will have to ask him or Octapharma. My interactions with him in the context of the scientific meeting in Hobart were in relation to other issues that had very peripheral involvement with the issue which you are referring to. As I said, Professor Solheim is an eminent authority in many aspects of the field.

Senator McLUCAS—During his visit, similar to Mr Bult, did he also visit the TGA?

Prof. Farrugia—No, I am afraid not. He did not have the time. We would have loved to have had him there to give us a lecture on one his many areas of expertise. I can tell you that in fact we did invite him and he spoke at another seminar during the conference on the issue of iron deficiency in blood donors, which is a well-recognised medical problem worldwide, on which he is also an authority.

Senator McLUCAS—The issue is around confidence in the decision that we have made with the US free trade agreement, and confidence in our excellent blood supply, based on the fact that there is no payment for donors. Yes, there is a lot of concern in the community.

Ms Halton—Yes.

Senator McLUCAS—I do not think I am understating it.

Ms Halton—I am very aware of that concern. It will not surprise you to know that there have been a number of people who have raised that issue with me and, as I have done with you, I have assured them that we have been absolutely scrupulous in ensuring that the review that is currently under way is being conducted absolutely properly. I have had several discussions with Mr Flood myself, and I know that others have also been talking with Mr Flood and he is being supported by a very good team from the department. He is on time to provide his report and we are awaiting that report from him.

Senator McLUCAS—The annual report shows a payment of over $134,000 to Banscott Health Consulting for the provision of strategic policy and communications advice for the review of Australia's plasma fractionation arrangements. Then there is $478,000 to Royce Victoria for the provision of a communications consultancy and advice for the review of Australia's plasma fractionation arrangements. They are two quite significant consultancies. Could we get an understanding of the purpose of them and why that contract was undertaken?

Ms Halton—Yes. I think actually we have canvassed this somewhat at a previous estimates, but Ms Cass is happy to go through that with you.

Ms Cass—You have asked about two consultancies for the plasma fractionation review. The first is in relation to Banscott Consulting. Under the Banscott Consulting contract a total of $134,000 has been committed and $114,000 has been spent. The purpose is very broadly to provide strategic policy support to the department in the conduct of the review, to advise on the framework for the national consultation process, and to assist in providing advice to the review committee as required.

Senator McLUCAS—Let us go through those three elements. The first was strategic policy advice. What sort of advice would that be? I do not know the company. I do not know what their skills are.

Ms Cass—The consultant is a gentleman called Alan Bansemer, who has provided strategic advice to the department in the conduct of the review.

Ms Halton—Mr Bansemer is a former deputy secretary of the department. He is also a former Commissioner for Health in Western Australia. He has very longstanding expertise in the health system, formerly of—

Senator McLUCAS—This advice is to the department?

Ms Cass—To the department in the conduct of research and preparing advice for the review committee. He has strong expertise across the health sector in understanding the operations of the health sector, including the blood sector, from the point of view of state and territory governments.

Mr Kalisch—It is probably an indication of the extent of the thoroughness with which we feel that the review committee has to deal with this issue, and the level of expertise that we are seeking from people like Mr Bansemer who are very expert in this field, as well as drawing on the resources and expertise of the department.

Senator McLUCAS—Your point earlier, Ms Halton, was that this is an independent process. I am trying to understand what the relationship with the department or with this consultancy is—between the department and an independent review.

Ms Halton—As you would understand, when we do these types of reviews a committee is constituted. That committee brings with it some expertise, some of it quite broad, some of it quite specific, and it is important, also acknowledging that some of the people in the department may not have as much depth in this matter, that we have furnished the committee with a broad range of advice and ability on which to draw. Mr Bansemer is more steeped in health than I think most of us could aspire to be and has experience in the Commonwealth government and also across a number of states. We were conscious of putting together the best support that we could for the review team. At the end of the day the review team has its independence, and I can promise you that Mr Flood is fiercely independent, which he rightly asserts. This will be his report with his name on it. But in terms of ensuring that he has access to people both on his committee and as a resource, that was part of this process.

Mr Kalisch—The committee has very clear expectations and ideas about the sorts of issues it wants covered in the report, and expects us to be able to provide information that they will be able to use in that process.

Senator McLUCAS—Ms Cass, you were about to tell me about Royce Victoria Pty Ltd.

Ms Cass—That is right. The second consultancy contract that you mentioned was in relation to Royce Pty Ltd. A total amount of $478,000 was committed but in 2005-06 $349,000 was spent under that contract. The main deliverables under the contract were to assist the department in identifying the 170 stakeholders to be engaged in the consultation process for the conduct of the review, to help us in developing a stakeholder communications strategy, and to provide support to us in preparing the public material for the consultation process, which included the drafting of fact sheets, questions and answers which we prepared but that provided some support to us and that went onto the plasma fractionation review website.

Senator McLUCAS—That is a lot of money to develop a stakeholder list. I am not trying to be critical, but I would imagine that the department would have the capacity to do that, surely?

Ms Cass—The department certainly had some very good base knowledge about the blood sector. They have provided support to us. We have a very small review team. Having some of these experts on hand to provide support was useful.

Ms Halton—In emergency terms we describe this as ‘surge capacity’. In terms of the base capability of the department, we do not maintain teams of these sizes other than when we actually need to do this kind of work. This was a particular job of work that needed to be done in a short amount of time, and the decision was made that given the people inside the

department were fully committed on a range of other things it was best to buy in this expertise at this time.

Senator McLUCAS—Were there any other consultancies let around the whole Flood review process?

Ms Cass—There were, and I can advise you of them if you wish.

Senator McLUCAS—Please.

Ms Cass—Apart from the two that we have discussed, there were three others. Two of those consultancies went to the Allen Consulting Group to provide actuarial indemnity insurance and demographic advice for the research material that went into the conduct of the review, and the second contract for Allen Consulting Group was for business research and analysis, particularly in relation to the demand projections for various products. The third consultancy was to Transfusion Services, which is to a clinician to assist us in providing expert advice of a clinical capacity in the research.

Senator McLUCAS—What was the value of those three contracts?

Ms Cass—For Allen Consulting Group, the value was $185,000 and $177,000; and for Transfusion Services, the value is $36,000.

Senator McLUCAS—What was the role of Mr Flood in selecting the various contractors?

Ms Cass—The consultancies were run as procurement processes by the department, and were engaged by the department to provide support. Mr Flood was not a decision maker as a delegate in that process.

Senator McLUCAS—I am just trying to understand this notion of a fiercely independent review process.

Ms Halton—I think it is important to understand that basically he has no authority under the various provisions under which we operate. Of course, at any point if he was unsatisfied with the technical work that had been provided to him, he was quite within his rights to reject it and tell us to do it again. At the end of the day, the process of selecting the consultancies to do this work is rightly and properly a decision taken inside the department by a duly appointed delegate.

Mr Kalisch—As I understand it, the review committee was looking for certain pieces of work—certain information—and we could source this only by these external sources.

Senator McLUCAS—There are a few more questions that we will put on notice to do with the Flood review. They are lists of meetings and whatever. They will go on notice. Thank you.

Senator BARNETT—I have some questions for the TGA regarding the review of the application by Professor Caroline de Costa for authorised prescriber status to import and administer mifepristone. I have asked questions in the past about this. I wanted to follow up on some of those questions, and specifically on the protocol that applies to the use of the licence. I have asked about that previously, and you were seeking further information from Professor de Costa as to whether she is happy to make that available. The initial response was no, so my question is: have you had any further discussions about the availability of the protocol that would apply to the use of that drug by Professor Caroline de Costa?

Dr Hammett—At the last estimates hearing we committed to let you know whether this was a matter of commercial-in-confidence and committed to seek Professor de Costa's indications about whether she was willing for this protocol to be released. Our advice is that it is to be regarded as a matter of confidence, and Professor de Costa's wish is that it not be released to this hearing.

Senator BARNETT—In light of the many and various public statements by Professor de Costa in the newspapers and elsewhere as to the success of the various usages of the RU486 drug and advising the public of that, do you have any further advice or would that matter be reconsidered? Secondly, do you have any evidence within your sphere that you could advise the committee as to whether these particular abortions were successful or otherwise?

Dr Hammett—There is nothing in the public statements made by Professor de Costa that would alter our advice that this is a matter of confidence that we are not at liberty to release to the committee. Should Professor de Costa wish to do so in her public utterances is a different matter. The TGA, in approving the special access provision of RU486 in the authorised prescriber status for Professor de Costa, ensured that the use of the product was monitored closely by the Cairns Base Hospital Ethics Committee, with a number of requirements that were consistent with the guidelines for ethics committee activities set out by the NHMRC. That committee is charged with monitoring the appropriateness and the outcomes of the use of that product and of certifying the ongoing appropriateness of that. The TGA does not have any data or any further information about the effect of the use or indeed of the existence of the use of the product.

Senator BARNETT—Are you aware, then, of the Cairns Base Hospital Ethics Committee protocol that they apply and the criteria that they apply to Professor de Costa's use of the drug?

Dr Hammett—The protocol that was applied by the Cairns Base Hospital Ethics Committee was the same protocol that is set out in the NHMRC guidelines for review by clinical ethics committees. The only difference between that and the standard committee guidelines was that the committee was asked, and in fact agreed, to review the use of this product on a six-monthly rather than on an annual basis.

Senator BARNETT—That they would review the use of it?

Dr Hammett—They would review the appropriateness and the other criteria.

Senator BARNETT—Have they done that as yet?

Dr Hammett—They have. They were requested and agreed to report to the TGA on a six-monthly basis, and we have received one report from them.

Senator BARNETT—Can you advise us of that report and its contents?

Dr Hammett—The report informs the TGA that the clinical ethics committee has done what it undertook to do, which was to oversight the use of that product, and we have been advised that they have done what they agreed to do.

Senator BARNETT—Is that report available?

Dr Hammett—I would need to seek advice on that.

Senator BARNETT—I am happy for you to take it on notice.

Dr Hammett—We would have to take that on notice.

Senator BARNETT—Thank you. Professor de Costa has said that the use of RU486 has been confined to women living in Cairns who met stringent federal licensing criteria by having a life-threatening or otherwise serious condition exacerbated by pregnancy. Can you describe in any further and better detail the actual federal licensing criteria, or is it as you have just described?

Dr Hammett—I assume that the criteria she is referring to are the criteria for approval of an SAS use under an authorised prescriber program, which specifically stipulates under the Therapeutic Goods Regulations that you should be in that context, and hence that is the context in which it is being utilised.

Dr Graham—She was also required to comply with state or territory law. In this case it would have been Queensland law.

Senator BARNETT—I understand Queensland law is different from some other state laws with respect to abortion, so in that regard can I just ask: does the approval that she has authorise Professor de Costa to use mifepristone to procure the abortion of women suffering from severe depression?

Dr Hammett—Severe depression is not specifically listed. The criteria that have been applied are the criteria required under the legislation. As you enunciated, it has to be a life-threatening or serious condition. We have not listed every severe, life-threatening or serious condition. We rely on medical practitioners to have an understanding of severe, life-threatening and serious conditions. In addition, there is a level of oversight provided by the ethics committee of the appropriateness of that medical practitioner's decision-making around that issue.

Senator BARNETT—Is there any conflict with the Queensland law in that regard?

Dr Hammett—I am unaware of any conflict. The onus is clearly on Professor de Costa to comply with Queensland law as well as the requirements of the authorised prescriber approval.

Senator BARNETT—With respect to her application for approval to import and administer mifepristone, did she provide any evidence that abortion is an appropriate therapy for women suffering from severe depression?

Dr Hammett—I would need to go back and look at the actual application to answer that question specifically. In general terms what is required, as I believe we discussed at the last estimates hearing, is data showing that the particular product that is being applied to be used is used elsewhere, has not been withdrawn elsewhere for any safety reasons and is effective in the condition that it is being used for.

Senator BARNETT—You mentioned the Cairns Base Hospital. Is the administration of the mifepristone required to be carried out at that hospital?

Dr Hammett—Without wishing to breach confidentiality requirements, the administration is stipulated to occur in certain settings according to an agreed protocol.

Senator BARNETT—Are you aware of the procedures that she has carried out, and have they been carried out at the Cairns Base Hospital?

Dr Hammett—The ethics committee is charged with the oversight of compliance with the protocol and the appropriate use of the medication. The TGA is not monitoring the use of that product on a daily basis. The ethics committee has been charged with that and agreed to do that.

Senator BARNETT—Is Professor de Costa a private consultant or is she a member of the staff of the Cairns Base Hospital?

Dr Hammett—That is not an issue I have knowledge of.

Senator BARNETT—Are the procedures carried out under an approval covered by Medicare?

Dr Hammett—I think the question goes to a matter of the professional practice and the relationship that exists between a practitioner and a patient. I am unaware of the mechanisms by which Professor de Costa and her patients have arranged payment for any services rendered, and that is not something the TGA has control of or any oversight of.

Senator BARNETT—So we are not aware whether Professor de Costa's patients are using Medicare funded services or whether she is using a public hospital?

Dr Hammett—I am unaware of that.

Dr Graham—The TGA is not aware of that.

Senator BARNETT—Are there any other licences that have been approved similar to Professor de Costa's approval?

Dr Hammett—Yes. As we mentioned at the last estimates committee hearing, there were two approvals granted at that time. There have been no further ones granted since then.

Senator BARNETT—Can you advise any further and better particulars since the last time we met in regard to those two further licences?

Dr Hammett—Sorry. It is only one other than Professor de Costa. There were two approvals that were made at the same time. As we answered last time, there are no further details that we are able to give because of the confidentiality requirement.

Senator BARNETT—So it still sits at two?

Dr Hammett—It does.

Senator BARNETT—Thank you.

Senator ADAMS—I have three questions, but two fairly short ones. On the evaluation of BreastScreen Australia—and I asked this question last time—could I have a progress report on where it has got to? The evaluation was apparently to report on the first stage and be provided to AHMAC late in 2006.

Ms Powell—The evaluation of BreastScreen Australia has indeed begun. We have commissioned the National Breast Cancer Centre to do the first project for that, and we are anticipating that the project will continue on schedule and report in 2008.

Senator ADAMS—It says here that the report on the first stage will be provided to AHMAC late in 2006, which is now.

Ms Powell—Sorry. I was referring to the end of the evaluation.

Senator ADAMS—So where are we at with the first stage? Is that a public statement or not?

Ms Powell—We have commissioned the NBCC to do a mortality feasibility study. They have begun that. It is not finished yet. We have had discussions through the screening subcommittee of the Australian Public Health Development Principal Committee, which is an AHMAC subcommittee, to agree on the way forward of that evaluation.

Senator ADAMS—So there is nothing more you can tell me on that?

Ms Powell—There is nothing more at this stage, no.

Senator ADAMS—Speaking of Mr Bansemer, I think my memory was jogged because I was not going to raise the Patient Assisted Travel Scheme, but maybe I will have to. Thank you for that. This committee has been doing a number of inquiries that have involved a lot of rural consultation. In my diligence I have asked this question about the Patient Assisted Travel Scheme in every state I have travelled to, and that has been backwards and forwards and everywhere. It is still a huge problem. Our latest inquiry was about gynaecological cancer in Australia. A lot of rural women, of course, are having to go to the city for radiotherapy and their chemo. Lymphoedema was another thing that was a problem. The Patient Assisted Travel Scheme for those long treatments and accommodation is still a huge problem. I have spoken to the minister about it and hopefully it will be on the agenda for COAG. I bring Mr Bansemer into this because he has to sit next to me on the plane going to Western Australia. Guess what the topic is? In 1987 he was the one who took it from the Commonwealth and gave it to the states and, unfortunately, it has not worked since.

Ms Halton—In Mr Bansemer's defence—and as I look around this room I see a couple of us who were around at the same time—I do not know that this was necessarily his idea, nor necessarily a good one, but it is the reality.

Senator ADAMS—Are we moving forward in that direction to COAG as an agenda item?

Ms Halton—I cannot say with any clarity, because we do not control the COAG agenda.

Senator ADAMS—I realise that.

Ms Halton—I think people are aware that this is an issue, and certainly I have had a conversation about it with a number of people inside government. The concern has been loudly put not just to you but also to a number of other people. As to whether it will end up on the COAG agenda, I cannot give you any firm answer on that.

Senator ADAMS—Another inquiry I have just thought about is the Commonwealth, state and territory disability plan. We are also doing that, and it is coming up a lot in that as well.

Ms Halton—Yes, I am aware of that.

Senator ADAMS—This is a problem for people with disabilities.

Mr Kalisch—Perhaps I can add something about the Patient Assisted Travel Scheme and COAG. There was, as you might be aware, a COAG decision from its last meeting that there would be further work on both service delivery and education and training initiatives related to rural people. That work is under way at the moment and we would like to see the states and territories doing more in some of these areas. That is one of the issues that has been put on the table. It is still subject to further consideration, but we expect COAG to look at the issue of rural service delivery at its next meeting.

Senator ADAMS—Our biggest problem with it is that, of course, as services diminish in the rural, remote and regional areas, with specialist services especially, most people are now having unfortunately to travel to the metropolitan areas, which is just getting so hard. Speaking for the people where I live, down in the south of Western Australia, we are almost becoming second-class citizens. The access and the accommodation in the city that people are getting is just not good enough in this day and age. They just cannot do it. People are just not going for treatment, and that is what I hate. I just hate to see my neighbours suffering and having a much shorter life because they cannot get their treatment. That is unfair.

The other main issue I was going to raise tonight is from a rural perspective as well. That has come from our inquiry into transparency in advertising on the pregnancy counselling bill. I note that the non-directive pregnancy support counselling service as an MBS item is starting today. Could someone answer some questions on the counselling service, please.

Ms Halton—Recognising that the MBS item should have been done long since, but as it happens the officer is still here.

Senator ADAMS—That is fine. I wanted to ask about the tender.

Ms Halton—The tender process is with the Medicare items.

Senator ADAMS—My question is contained within schedule 3, the statement of requirement for the pregnancy counselling tender. The information provision, 5.8, reads:

> The service provider is not expected to provide referrals to specific service provider agencies but is expected to provide generic information about where clients can find such information.

I know the referral issue was a huge debate within our inquiry. I will give you an example of a country JP who is faced with domestic violence issues. Let us see where we can go with this example of a pregnant woman experiencing domestic violence and looking for information on both pregnancy options and escaping the domestic violence situation. Should the provider be expected to provide the client with relevant support services, shelter/police support, rather than be told to look in the phone book, as this clause suggests? This has been a debate that has gone backwards and forwards. It really is very difficult.

This goes back to the issue raised in the recent pregnancy counselling and advertising bill inquiry, of which I and a number of other people here were members, where an anti-choice pregnancy counselling service refused to assist a women looking for a termination of pregnancy service and referred them to the phonebook. This, I was told, was going to help rural women. A lot of rural women do not have a GP. Because of confidentiality they are not prepared to go to the GP in their town, so they rely completely on their phone book. If the helpline just tells them to go and look up the phone book again, then what are you going to do under my scenario of a domestic violence issue, which is something that the police should

deal with, and this woman is also pregnant, which may have been part of the problem with the domestic violence issue? Where do we go with this? I am a practical person. I am a midwife, I live in the country. Lots of people I know have been in a situation of trying to get help, and the telephone has not helped them. This is supposed to help.

Ms Murnane—This is a counselling service and not simply an information service. Things have to be weighed here. As you said, there has been extensive discussion about it, and there has been. In terms of a specific referral, it would be absolutely impossible for the service funded through this tender to have up-to-date specific referrals and to know that they were accredited. There would be all sorts of dangers of liability. In terms of referral to a generic service, as I said before in this committee and in the hearing of the Senate Standing Committee on Community Affairs, we would envisage that the sorts of places they would tell people about would be family planning associations, GPs—and you have ruled that out in the particular example that you are giving—and also public hospitals.

Telling somebody to look in the phone book and hanging up the phone is one thing; it is another thing to say to somebody: 'If you look up the *White Pages*, you will find the Family Planning Association. If you call them, they will be able to tell you what specific options you have in relation to a termination.' That is presumably what you are referring to. The non-directive counselling, the helping and assisting of the woman to work through the issues, will happen on the phone. It is not just a gruff, 'Go away, there is nothing more we can do for you.' We are not expecting them to do this. If they were to say: 'Look, you are in a rural area. This is your state. We can help you and give you the phone number of the nearest public hospital', for example, that would not be an unreasonable thing for them to do and that would not be ruled out by the requirements of the tender. The sad fact is that people in rural and remote areas, although a lot is done to try to compensate for this, do not have and will never have exactly the same access to facilities in the same time that people living in one of the capital cities or even in one of the large provincial towns will have. What we try to do in a range of programs here is to mitigate that but we cannot eliminate it.

Senator ADAMS—It really is worrying me. Under the ruling in the tender, the three options must be discussed. I really do hope that those women are going to be helped. They are my concern. As you say, we do not expect to have a Rolls-Royce service like everyone else has, but it has to somehow be made easier for them. At the moment it is pretty terrible.

Senator WEBBER—I am sorry to interrupt you, although we both do share the same concerns about these issues. Within the tender process for the help line, we talk about non-directive counselling. This committee, in consultation with a lot of others, has had a debate about that definition and what that means. I note that to the tenderers you have given a definition of what that means. Suppose you have been through that process and you live in rural and regional Western Australia. If the woman concerned has made the decision that a termination is for her, I am not sure then whether this service actually gives them any assistance. You cannot get a termination in many public hospitals outside Perth. I am not sure that saying, 'Here is the closest local public hospital' will help.

Ms Murnane—It is a phone number. That is presumably how they will get in contact, or they could visit. The service cannot provide and is not expected to provide services or to assist people in getting fast access to services. What it is meant to do is to assist them to sort out in

their mind, if they have a pregnancy that was unintended and unwanted, what they are going to do, whether they are going to go ahead with it and investigate options to adopt the child or whether they want to have a termination.

Senator WEBBER—What do you mean that it is not meant to assist them with getting fast access? What does that mean?

Ms Murnane—It means that there are not going to be specific referrals for services.

Senator WEBBER—If I ring up and I am at that critical point in terms of when a termination is legally available in my state, I am going to need fast access, if that is the decision I make. Just saying, 'Here is the phone number of the local public hospital, which does not provide that option,' is not making that option available to me. Logically, it seems to me that there is less time available for one of the three options, particularly in Western Australia.

Ms Halton—There is an expert advisory committee for this process. I am advised that the expert advisory committee talked about this issue at some considerable length. The terms of the requirement reflect the advice of that committee. They did wrestle with this issue, but that is where the advice—

Senator WEBBER—Is there anyone on that expert advisory committee with experience in service provision in rural, regional and remote?

Ms Halton—I have not got the list in front of me. I will have to check.

Senator WEBBER—Can you take that on notice?

Ms Halton—Yes.

Senator WEBBER—If you are living up in the north-west and you do not have much money, it can take you over a week to get to Perth.

Ms Murnane—The issue of women living in rural and remote areas did come up at the expert committee and it was very high on people's minds. But we have to look at purposes, as I said. This is not a specific service provision.

Senator WEBBER—The purpose of this is to provide non-directive counselling and that is it?

Ms Murnane—That is correct, yes.

Senator WEBBER—Therefore, are we going to ensure that appropriate personnel staff this?

Ms Murnane—Yes, we are. Ms Smith can talk in more detail about that.

Ms Smith—The RFT specifies the level of qualifications of the counsellors that we would be seeking.

Senator WEBBER—Can you give me a rough idea?

Ms Smith—The tender says that it is desirable that the counsellors have tertiary qualifications and that, at a minimum, they would need qualifications in counselling from a registered training organisation.

Senator MOORE—Desirable as opposed to mandatory?

Ms Smith—It is mandatory that they would have qualifications from a registered training organisation and desirable that they have tertiary-level qualifications.

Senator WEBBER—Therefore, that would be the key difference between people accessing this service and availing themselves of other MBS mental health counselling type services that we now have. It would seem to me that the sorts of women struggling with this decision would have some psychological issues, as most women do when they confront an unplanned pregnancy. This is just going to let people other than psychologists and psychiatrists assist you in making that decision.

Ms Halton—Let us make a distinction here. Psychological issues go to issues of mental health. At the end of the day, this is about providing non-directive counselling. Whilst there may be a coincidence with respect to mental health issues for some people who find themselves in this circumstance, this is not primarily a mental health issue. It is a question of ensuring that the people who provide the non-directive counselling are appropriately qualified and do provide genuinely non-directive counselling.

Senator WEBBER—If this service is just about providing that non-directive counselling and providing all of the options in that way, given what you have told us about the kinds of personnel that would then be employed, how do those people then form a view about the risk to health of the client on the end of the phone?

Ms Murnane—It depends on what you are talking about. Obviously, if they believe that somebody was in danger of harming themselves immediately, built into the system there is a way of getting in touch with an appropriate person and a way of tracing the call if an address is not given. That has been taken account of, and Ms Smith can talk more about that. But if what you are saying is providing health advice, it is not the role of this service to provide health advice. The health advice is provided through the GP or through a person qualified to do that.

Senator WEBBER—I understand that. As I understand it, in the tender process it says that the counsellor must keep a summary of the advice given and their view on the risk to health of the client. Given what you have said about the people it will be permissible to employ to provide this service, do we have a definition of what 'risk to health' means and how they are likely to interpret that?

Ms Smith—I am not wanting to be unhelpful here, but we have to be very cognisant of the fact that we are in the middle of a tender process. We have been communicating with tenderers only in writing, other than through a formal information session that we held with prospective tenderers, and it was attended by our probity adviser to make sure that the process was appropriate. It is quite difficult for me to be speculating in a public forum about the tender documents, because that means that some tenderers may be able to get a level of information that is different from others.

Senator WEBBER—I understand that.

Ms Smith—Tenders do not close until 6 November.

Senator WEBBER—You say that counselling can be from a registered training organisation or what have you. We have gone through that process and talked about the variety of places we can get these people from. I am concerned about the definition of 'risk for health', because it will have an impact on the quality of people employed and the quality of service. Then, if you look at phone calls and how you deal with that if they are anonymous and what have you, it seems to me that it is more important to have professionals at the upper end, in which case there will be the conflict with the MBS items.

Ms Halton—We do not want to be unhelpful, but it is really important to put on the record that we have quite clear advice from our probity advisers that we should not discuss the content of the tender document in this forum, because it potentially compromises the operation of the tender. I do not want to be unhelpful, but the advice from the probity adviser is quite clear.

Senator MOORE—I would like to ask about the tender process. We are aware of the processes put in place surrounding the sensitivity of this particular tender. Is this a standard process for health tenders? I am aware of the process used a few years ago to give out the tender for Lifeline domestic violence counselling. It seems that this one has greater secrecy around it. I am not questioning whether it should or should not, but I just want to make sure that the tender process used in terms of the way people access the information, the time frames, the information sessions and all those things are standard. If that is standard then that is fine.

Ms Smith—This is a process that is entirely consistent with the Commonwealth Procurement Guidelines.

Senator MOORE—I have read them.

Ms Smith—They were upgraded quite significantly at the beginning of 2005.

Senator MOORE—As a result of audit activity, they were boosted up. So this particular process has been determined in line with that standard process?

Ms Smith—Yes.

Senator MOORE—It is not a special process?

Ms Smith—No.

Senator MOORE—This is a standard tender process?

Ms Smith—Yes.

Ms Murnane—If we went through all of the records of past hearings we would find that, for example, for the seasonal immunisation tender we said exactly the same things. Every tender that I have been involved in over the last two years has had a legal adviser and a probity adviser.

Senator MOORE—It must have. It is the standard process. The second thing is the role of the advisory committee, which we have discussed before. That role is very important. Will it continue to have a role after the tender is let? The whole way this operates is something that caused discomfort and interest about exactly how this would operate. The choice of the advisory committee was quite detailed in terms of getting personnel involved who had a range

of skills and who were able to work together to advise on how it was going to operate. Is the expectation from the minister and the department that this group will continue to have a role in just watching the whole program evolve, as opposed to just the introductory element?

Ms Murnane—There is an expectation that there would be an ongoing role and there is reference to that in some instances in the RFT.

Senator MOORE—I saw that. The other point is what is the process for approval. Who has the delegation to determine who is successful on this basis?

Ms Murnane—I chair the tender panel, so another deputy secretary in the department will have the approval.

Ms Halton—It is a departmental decision.

Senator MOORE—Does it close in early November?

Ms Smith—It closes on 6 November at two o'clock.

Senator MOORE—Two o'clock Canberra time?

Ms Smith—Two o'clock Canberra; eastern daylight saving time.

Senator MOORE—What is the expectation about the decision being made public?

Ms Smith—We are working towards a decision and an announcement by the end of the year.

Senator MOORE—The end of the calendar year?

Ms Smith—Yes, the calendar year.

Senator MOORE—With an expectation for the program to be operational when?

Ms Smith—Early in 2007.

Senator MOORE—Are we still working on the term 'early' as being the first half of 2007? These are things that we have been talking about for a while.

Ms Smith—We would very much be hoping the first half, yes, if not earlier.

Senator MOORE—Is it fair to say that this will be in place by the next round of estimates—

Ms Halton—Absolutely.

Senator MOORE—and we will have a greater ability to work through the details and understand the process.

Senator ADAMS—Coming back to the at-risk person, how do tenderers find out? Have you had your orientation day for tenderers? What is the process there? If I have a query and I am putting a tender in and want to know a detail like that, what is that definition? What do you expect?

Ms Smith—The process was that potential tenderers had to register on the website to download the documents, and a number of them did that. Everyone who had registered to download the documents was then invited to an information session, which was held in Canberra on 11 October. Potential tenderers were also able to send questions to an email

address on the website, and they have all been responded to. Those answers are posted on the website and sent to all people who have registered so that everyone gets the same information.

Senator ADAMS—Has anyone asked that question?

Ms Smith—Not that I recall.

Senator ADAMS—I was going to ask Professor Horvath to give me a definition, but as it is in the tender I had better not. I am very interested and I will be watching very carefully.

Senator NETTLE—I had some questions about the blood fractionation, which you were talking about before.

Ms Halton—The review?

Senator NETTLE—Yes.

Ms Halton—Does that mean that we are going to outcome 13? The review is technically under outcome 13. Have we finished with population health?

Senator NETTLE—I have one question for the TGA and then I have questions about blood.

Ms Halton—If everyone else has finished on population health, we could do the TGA question first.

CHAIR—Yes, that is a good idea.

Senator NETTLE—I gave some notification about this question. I am asking about a particular product that is called the DivaCup. It is a menstrual cup. It is a Canadian product and there are a number of places in Australia that were importing it from Canada. They have been told that they are not able to get it imported at the moment. The company is saying that it is because the TGA is doing a review. I just want to find out what is going on.

Ms Maclachlan—The situation is that this is one of several menstrual collection cups that have been available in Australia. This particular one is not currently available because it has got to go through the TGA's approval process. My understanding is that the manufacturer in Canada has been in contact with the TGA over a period of about two years and we currently do not have an application to supply the product generally in Australia. We require an Australian entity or sponsor to sponsor the product here in Australia and make an application to the TGA. I am aware that the product has been supplied in Australia and generally it was sourced through the internet, but that was deemed to be an illegal supply. There are alternative products on the Australian market that are approved by the TGA and are on the Australian Register of Therapeutic Goods. I am aware of at least two or three that are very similar to the DivaCup.

Senator NETTLE—If you could make the names of the other products available, that would be appreciated, either now or on notice.

Ms Maclachlan—To you?

Senator NETTLE—Yes.

Ms Maclachlan—I will provide those to you on notice. I do have the names here, but it is probably better that I do it later.

Senator NETTLE—All right. So the hold-up is that there is an Australian company that needs to make an application to the TGA in order to go through that process?

Ms Maclachlan—That is right. But there are alternative products available in Australia and they have gone through the appropriate safety evaluations.

Senator NETTLE—Thank you. That was all I wanted to ask.

CHAIR—We are going back to the blood authority now.

Senator NETTLE—Has consideration been given to the issue of national security implications for blood fractionation with regard to natural disasters and terrorist attacks occurring offshore—difficulties which could hamper international transportation and cause contaminated supply and so on?

Ms Cass—Term of reference 4 of the plasma fractionation review, released on 17 February, includes assessing the issues raised in the three earlier terms of reference against the evaluation criteria of safety, quality, efficacy, security of supply and potential impact on expenditure under the National Blood Agreement. Certainly the evaluation criteria of security of supply encompasses all issues relating to ensuring the security of the supply of those products.

Senator NETTLE—Are all the ones that I mentioned covered by that?

Ms Cass—That is encompassed within that evaluation criteria.

Senator NETTLE—This may be the same. Are there any implications that we would permanently lose blood fractionation infrastructure from Australia if activities were occurring and there were implications for that in terms of supplies?

Ms Cass—That is also encompassed within the terms of reference.

Senator NETTLE—CSL does that now. Presumably it operates in such a way that it puts funding into other research and development. What would be the implications for on any other research and development that they do if their main source of revenue is removed?

Ms Halton—You are asking us to make a comment in relation to a commercial operator. We are not in a position to answer that question. The terms of reference of the review that Ms Cass has been referring to go to the issues that you have talked about—security or supply et cetera—and they are properly a matter for the committee to consider. Obviously the committee will consider that in whatever way it thinks appropriate and we will be privy to that when the review is received and then released publicly. But in terms of the operation of CSL as a commercial provider, that is not something that we can comment on.

Senator NETTLE—Perhaps this is about what interaction the department and the government have with the other parts of CSL—for example, the biotech research that they are doing, where there is an interaction between them and the government. Without going into the issue of whether there are implications if their revenue is taken away, just what interaction occurs?

Ms Halton—We have interactions with CSL on a whole range of issues—on everything from vaccines to what have you. It would be inappropriate for us, in those other dealings, to indulge in speculation. Essentially we would view our interactions with CSL on that range of

issues as being in a sense separate and independent, but obviously the issues that are germane to the review, which go to the security of the blood supply, are things that the review committee will consider.

Senator NETTLE—Maybe I should just ask on notice about what other interactions you have with CSL. I am not doing it related to that, but what interactions do you have with CSL on other areas apart from blood?

Ms Halton—We would be happy to tell you the nature of the dealings that we have with CSL across the portfolio. That is fine. It does go across a range of issues, principally vaccines. I can provide that as a catalogue.

Senator NETTLE—Given that people in Australia donate blood out of goodwill, is any assessment being done about whether the attitude of people donating blood will change if it is a fully commercialised operation? Is there any assessment of the implications for people donating?

Ms Cass—The key response to that is that the terms of reference themselves made it clear that the work of the review is to be consistent with the policy objectives and aims of the National Blood Agreement. One of the aims of the National Blood Agreement is that Australia continues to support voluntary non-remunerated blood donation.

Ms Halton—It is important to understand that not only is this a position that we have taken domestically but we have actually supported it internationally. There have been resolutions at the World Health Assembly with respect to this matter, which Australia has been an active supporter of.

Senator NETTLE—If the blood fractionation occurs offshore, is there any concern that Australia's blood supply may be siphoned off into overseas markets as a highly valued low-risk product from non-remunerated donors? What is the interaction there? Is that something that is being considered or has an assessment been done on that?

Ms Cass—That is one of the issues that is encompassed under term of reference 2, which relates to the safety, quality and efficacy of products and services for Australia. As the review committee has not finalised nor provided its report, it is difficult for me to provide more information on the substantive issues that they are considering. Certainly that is an issue encompassed under term of reference 2.

Senator NETTLE—Does that also encompass the issue of blood supplied in Australia but how that then might be used internationally? Does it deal with both of those two components of it?

Ms Cass—The current regulatory framework, which is overseen by the TGA, goes to those issues of safety, quality and efficacy of product, and that includes issues of the integrity of the source plasma and regulation of the manufacture of the product.

Senator NETTLE—I am not so much asking about the product here in Australia. I am asking about people who might donate here in Australia, with the blood or the blood product then being used overseas. I am asking: has that issue been looked at?

Ms Cass—Term of reference 2 specifically says to identify requirements to be met by producers of plasma products or suppliers of the plasma fractionation services to ensure the safety, quality and efficacy of such products or services.

Senator NETTLE—Do you mean here in Australia and overseas?

Ms Cass—Yes.

Senator NETTLE—That is covered by that?

Ms Cass—As part of the review process that is being considered.

Senator NETTLE—That covers the questions that I wanted to ask you.

CHAIR—If there are no further questions in outcome 1, we will move to outcome 13.

Senator McLUCAS—I want to talk about the Australian health care agreements. I have to be honest and say that I have not asked questions on this topic before. I do not know how I have got out of that in 4½ years of doing this. Some of these questions might seem a little banal. I would like to get an understanding of the total Commonwealth funds by state and by financial year for the previous agreement and the current agreement.

Ms Flanagan—We can take that on notice, because you would appreciate that, if we are breaking it down by year and by state, there are quite a lot of figures. Is that all right?

Senator McLUCAS—Yes. I wanted to get a bit of a notion of it so that we could have a conversation, but given the quantum of data it is not possible to do that. If you could take that on notice, that would be good. Does the funding include mental health funds?

Ms Yapp—Yes.

Senator McLUCAS—How does that work?

Mr Kalisch—Some extra funding is provided for the states and territories as part of that agreement.

Ms Halton—It is important to understand that basically the Australian Health Care Agreement comprises an aggregate of money provided for a broad range of purposes—basically acute care and other services. Attached to each agreement, over the last however many years I have been involved with them, we have often tended to have a pool of money provided as incentives or an additional stream that is more particularly identified than the general pool of funding. That is around stimulating particular activity or encouraging reform or development. The last agreement was no different, and there were some separately identified funds as part of that agreement in this particular area.

Senator McLUCAS—When you provide me with the annual funding by state and by agreement, could you disaggregate—can we call it 'core' funding? Is that a reasonable word?

Ms Halton—We can show you the bulk of funding together with the additional incentives. What we will have to check is actual expenditure, remembering that the last agreements as against the current agreements had a slightly different structure and a different pattern of expenditure over the agreements, all of which there is a history to. Obviously, next year if you are interested we can talk this through in terms of the detail. Yes, we can do that.

Senator McLUCAS—The other incentive payments include mental health funds, but what other components are there to the Australian Health Care Agreements that I should understand?

Ms Flanagan—In the table I have here, there is separate funding for palliative care; safety and quality; mental health, which we have already talked about; Torres Strait; and Woomera, but I think they are just one year—

Senator McLUCAS—Now I am interested. What is the Torres Strait money?

Ms Yapp—The Torres Strait Islander money is money that is specifically for Queensland in recognition of the treaty that is there.

Senator McLUCAS—That is the $300,000 for us to take people at TI Hospital who are Papua New Guineans?

Ms Yapp—Over five years it is $15.5 million for Queensland in recognition of the movement of Torres Strait Islanders.

Senator McLUCAS—What is the Woomera money?

Ms Yapp—The Woomera money is for South Australia: $5.7 million in recognition of the healthcare costs that South Australia is bearing.

Ms Halton—It was the historical health impacts of testing.

Senator McLUCAS—It is about $3 million a year for the Torres Strait?

Mr Kalisch—Yes.

Senator McLUCAS—Does it include DVA money?

Ms Yapp—No, it does not.

Senator McLUCAS—There is no DVA money included in the Health Care Agreement?

Ms Yapp—No.

Ms Halton—You would be aware that veterans are treated as private patients and that those funding arrangements are managed separately.

Senator McLUCAS—When a DVA recipient gets a service in a public hospital, how does that work?

Ms Halton—They are treated as an insured patient and the reimbursement is provided by Veterans' Affairs.

Senator McLUCAS—Directly to the state?

Ms Halton—I cannot comment about the detail, because obviously that is not something that we administer. There is an arrangement between the Department of Veterans' Affairs and each of the states or, as it happens in this particular case, against some of those hospitals.

Senator McLUCAS—Does the Health Care Agreement acknowledge in any way the position of private patients in public hospitals? It is indicated here that it may include the 30 per cent rebate paid to funds of private patients treated in public hospitals.

Mr Maskell-Knight—The agreements provide for patients to elect to be treated privately, and there are procedures set out for how that election process is to work.

Senator McLUCAS—How does that appear in the numbers in the agreement?

Mr Maskell-Knight—There is no financial implication for that.

Senator McLUCAS—There is no recognition of that cost in the agreement?

Ms Halton—It is not a cost.

Mr Maskell-Knight—It is not a cost; it is a revenue.

Senator McLUCAS—If you could provide us with the disaggregated cost by state and by financial year across the two agreements we will get an understanding. That will then provide us with an understanding of the mental health components by state as well?

Ms Halton—Yes.

Ms Yapp—I have the mental health figures for this agreement by state, if you were wanting that, but if you would rather wait until we can see it across—

Senator McLUCAS—I am happy to wait. Does the data on Commonwealth hospital spending that is published by the AIHW—and I am not sure which data I am referring to here—include mental health money, DVA funds and—

Ms Halton—If it is the figures that come out of the publication *Australia's health*, it would be all-source Commonwealth expenditure, so it would include veterans—without knowing the particular table, but I would stake money on it. They usually publish all-source Commonwealth financing when they put in those totals. For example, it would include veterans' money.

Senator McLUCAS—What else would be included in those AIHW tables?

Ms Halton—For example, it would include mental health.

Mr Maskell-Knight—It would include all the Health Care Agreement funding, which includes Veterans' Affairs, I suspect. To the extent to which it is possible to identify Defence health spending that goes into the public sector, it would include that. I believe it also includes an estimate of the amount of the private health insurance rebate that ultimately finds its way into the public hospitals.

Senator McLUCAS—That is where this question about the private health insurance rebate comes from. If I compare your information to the AIHW data, it will not match, will it?

Ms Halton—No, it will not. Do you know what publication this table has come from?

Senator McLUCAS—No.

Ms Halton—You will need to speak to the person who found it for you, because in brackets somewhere you will usually find that there is an explanatory commentary somewhere with those tables.

Senator McLUCAS—If we get your data, that will be the clean data?

Ms Halton—Yes, in terms of our Health Care Agreement funding.

Mr Kalisch—I also understand that, apart from the methodological issues, there are also sometimes differences in timing. The AIHW data may refer to a different point of time each year compared with the data that we publish. Again, if your researcher can look to the detailed source details that would be available—

Senator McLUCAS—Will the data that I get from you be financial year data?

Mr Maskell-Knight—Yes.

Ms Flanagan—Yes.

Senator McLUCAS—In our favourite question on notice—

Ms Halton—Which one is that? I would love to know which your favourite question on notice is!

Senator McLUCAS—In 2004-05 there was a $22.8 million underspend in the demand driven subprograms included in this program structure. Who is the winner? Who can answer this question?

Ms Flanagan—Did we take that question on notice the last time? We obviously did. We might have to do it again.

Ms Halton—We do not know, we will have to find out. We have had everything up here from Darwin emergency to bone marrow as a possible explanation. The answer is we do not know; we will find out.

Senator McLUCAS—That would be good.

Ms Halton—We should not be speculating, but we have had funding for emergencies—the Bali bombings and things of that sort—and that included actually paying the states for hospital treatment. I reckon that is actually the most likely explanation, but we will come back to you on notice.

Senator McLUCAS—I will submit this question on notice as well.

Ms Halton—Yes, okay.

Senator McLUCAS—I am looking for what subprograms they were. I will put it on notice; that is the easiest thing to do.

Ms Halton—Okay, thank you.

Senator McLUCAS—We will read with interest the table that you provide. Thank you. That is all I have for Outcome 13.

CHAIR—Thank you very much for taking part in Outcome 13. I call now officers in Outcome 14, Health and medical research.

[10.20 pm]

Senator MOORE—I want to apologise for you being the last witnesses because it is always tough. We were particularly keen to have the NHMRC along tonight because this is the first real Senate estimates since the act changed and became operational. We did not call you last time because that was way too soon. We thought it would probably be useful to get into the habit of, where possible, having the NHMRC here. So, I do apologise for you having

to be the last witnesses, but someone has to be. I want to start with some general questions about the fact that the act has changed and the new appointments have been made. You would all be aware that this committee did have a look at the legislation that changed that, and issues were raised about the new legislation. The key point was raised with us all the way through was the expectation that the new legislation, the new appointment and the new committee structure would lead to greater accountability. I am looking directly at you, Professor—I do apologise—but as the CEO I thought that it might be appropriate. I would like you to talk about what, in terms of this accountability process and the fact that the new committees are set up now, is the internal process to publicly reinforce the accountability element which was the key driving force for the change?

Prof. Anderson—I am new too, so I hope you will be gentle with me. It is my understanding—I was only acting at the time—that one of the purposes of the act was to clarify the accountability, including of the CEO. As you are no doubt aware, the CEO is now directly accountable to the minister. I have spent much of my time since I have been appointed making sure that we put in place under there clear pathways for our principal committees to advise council and then for council to advise me through, I guess, simple administrative processes.

Senator MOORE—It is also that we would expect that the relationship between the NHMRC and the Senate estimates process, regardless of who is in government or opposition, will keep looking at these issues of accountability and the process. It is to really get that kicked off, in many ways. You would be aware that once the original committee was set up there were changes in the groupings that led to the core committee of the NHMRC. There were debates about whether that would happen or not. I just want to clarify that all the positions are filled?

Prof. Anderson—That is the council of the NHMRC?

Senator MOORE—Yes, the council.

Prof. Anderson—Yes, all positions are filled.

Senator MOORE—And the various feeding committees that go off from that, such as the ethics committee, AHEC, and all those?

Prof. Anderson—Yes, that is right.

Senator MOORE—Are all those positions substantively filled at the moment?

Prof. Anderson—There are five principal committees and I believe that they are all filled, yes.

Senator MOORE—You would be aware, because you gave evidence to the Lockhart review committee, that the Lockhart review has a number of comments about the NHMRC in it, most of them positive, but one that it did make was about the 'lengthy delays in filling vacancies on the MVO Research Licensing Committee'. That is stated in the text of the committee. I was just wanting to know from your perspective, even though you are new, what was the basis of that particular statement, whether there were lengthy delays in filling those positions and, if there were, what will the process in the future be to ensure that it does not happen again?

Ms Halton—I have to say I do not actually think this is something that Professor Anderson can comment on. Essentially, the Lockhart commentary was, in fact, in relation to the previous arrangements. We have canvassed this very briefly, but we have canvassed in the past the reason for changing the structure and the relationship. I am almost loath to use this terminology again, given the conversation we have just had, but I think I have in the past described the previous government's arrangements leaving me as feeling sort of half-pregnant, that I as CEO actually had a series of responsibilities but that the previous occupant of the previous position had responsibilities and reconciling those, given our very statutory roles, was actually quite difficult. But the reality of the appointments process is that, obviously, those things are managed by the minister and, indeed, recommendations would come from a variety of sources. So I think it is hard for Professor Anderson, firstly, to comment on that history but, secondly, I think we would all rightly agree that the process going forward is that everyone is now endeavouring to ensure that the committees are fully populated.

Senator MOORE—I want to deal with the process going forward then, in terms of the fact that that was stated in an historical context, and no-one denies that. The annual report talks about the role and the actions of the embryo licensing committee and the human genetics and the ethics committee; nowhere in there does it talk about whether all the jobs are filled and what the process is for filling them. So, that is fine. But from this time forward, if vacancies occur in any of those committees, what happens?

Ms Halton—It is probably important to understand that in the departmental restructure you would be aware that we have actually set up a new area to actually provide greater oversight and greater servicing to the various portfolio bodies. Ms Addison, who is sitting down there is in charge of that area.

Senator MOORE—That is a new position?

Ms Addison—Yes, it is.

Senator MOORE—You escaped from the other area?

Ms Addison— I am not sure 'escaped' is the word I would use.

Ms Halton—Essentially her role and this new division's role is right across the, sort of, regulatory and governance side of the portfolio, precisely to make sure that timely activity occurs in this area. Obviously, ministers get to make these decisions; we do not. But it would be endeavouring to both support the NHMRC in its new role; its new structure would also support the ministerial team to ensure that we minimise those vacancies.

Senator Santoro—Perhaps if I could just add to that answer, when I was appointed minister in late January, obviously I noticed that there were some vacancies on some of the committees that you are interested in—

Senator MOORE—I am interested in all of them.

Senator Santoro—But with the vacancies that became obvious to me, I acted as expeditiously as possible to fill them. Yes, there were some delays, but I also draw to your attention, and possibly unnecessarily so, the complex nature, or the complex qualifications, that are required of appointees. I think that the government took the appointment process

seriously and cast around with a view to attracting the attention in terms of those vacancies of well-qualified people. There is also quite an elaborate process of consultation with the states. Again, we took that responsibility seriously. Where possible, we sought to engage the states in a meaningful way with a view to coming up with a decision that had broad support across the jurisdictions. But the committees are now—

Senator MOORE—Fully staffed?

Senator Santoro—Certainly, yes. The appointments have been made and we are very happy with the calibre of the appointees. They have been generally well received, including across state jurisdictions. If you are looking for an undertaking that we will act expeditiously in the future, you know the government always acts as expeditiously as it possibly can.

Senator MOORE—On that point, one of the documents that we went into in depth during the process of the review of the legislation to change the act was looking at the detailed documents that people going onto the committees had to sign about conflict of interest, pecuniary interest, and all those things, particularly because of, as you pointed out, the complex nature of the people that you are seeking to fill these jobs. Since the new committees started, has anyone had to fill in one of those things and state that they had any conflict or difference?

Senator Santoro—I will ask the officers if they could help with that.

Prof. Anderson—Yes, we are very rigorous about that and all the members of our committees have done that.

Senator MOORE—They fill them out and give them to you?

Prof. Anderson—Yes, to the NHMRC.

Senator MOORE—This is another mechanical aspect, but when the new major committee and the AHEC were formed a number of people who were on the previous committee were not reappointed for various reasons, and there was media comment about that. That was possibly good, that people are interested enough to comment about it. Could we get some information because I have seen on the website the new ones on the current committees and the people that were reappointed, or who are going again? Is that possible?

Prof. Anderson—I guess if it is on our website, we could certainly supply that.

Senator MOORE—It does not actually say 'new person'.

Prof. Anderson—No, so we could give you the last committees—

Senator MOORE—Just to say who was there, because people come in and out in their three-year terms, and things like that.

Ms Halton—Should we give you the list just of memberships with an asterisk on who is a reappointment?

Senator MOORE—That would be really useful. My other question is not particularly to the NHMRC but it includes you because it is about a ministerial release about increased funding for research that came out on 9 May, which has some particular reference to the NHMRC and also to a range of others. I just want to find where they all fit within the budget and whether they are—

Ms Halton—Can you give me a bit more information?

Senator MOORE—It is 9 May 2006, 'Funding Research for Future Health' media release. It came out from the minister and states:

The Government is tonight announcing the allocation of an additional $905 million for Australian health and medical research as a major investment in our future health.

It is a very detailed media release. I am wanting to find out where all the processes go with the funding. I know about the NHMRC, but there is a whole bunch of other things and I do not know whether they are yours or—

Ms Halton—Is it under this item?

Senator MOORE—Yes. I want to find out where they all are. The first one was the $500 million boost to the NHMRC, so we know that one. Then we have already seen on your website the added research grants that are in that area, so that is another one. We will keep watching those with particular interest. If I had time I would ask questions about diabetes because of the big process today in the House, but I will not.

Prof. Anderson—I wish you would.

Senator MOORE—Does the $170 million for new research fellowships come under this portfolio?

Prof. Anderson—Yes, that is by the NHMRC. That is for a new Australian fellowships scheme, a senior fellowships scheme, which we advertised two or three weeks ago—I can give you the exact dates—and which closes shortly. We will set up normal NHMRC peer review processes to select, we are hoping, 10 successful candidates.

Senator MOORE—This particular funding is for a nine-year period.

Prof. Anderson—Correct. Each fellowship will be for five years. There will be a rolling program over nine years.

Senator MOORE—The next one is $22million for stem cell research. That is going to the National Adult Stem Cell Research Centre at Griffith University. We have been able to meet with Professor Mackay-Sims and hear about what he does. Where does that allocation come from? Is that your portfolio?

Ms Addison—It is. It would have appeared in the supplementary estimates.

Senator MOORE—Sorry, I was looking at this and that and did not see it. In terms of that, was there a process for selection in the same way the NHMRC process operates?

Ms Halton—That was a decision of government.

Senator MOORE—The government provided an extra $50 million to the Walter and Eliza Hall Institute of Medical Research in 2005-06.

Ms Addison—Yes; that was a decision of government.

Senator MOORE—But once it is a decision of government, does that money come into this area that you oversight?

Ms Addison—I can explain.

Senator MOORE—Thank you. It is a lot of money and it is something we have not asked questions about before.

Ms Addison—Apart from the $22 million that is going to the Australian Stem Cell Centre, all of that money has been expended. It was all expended by 30 June of this year.

Senator MOORE—So, the $22 million has not been, but the $50 million to the Walter and Eliza Institute has been?

Ms Addison—Yes.

Senator MOORE—That has all gone in last year's lot? Because some of that was actually contributing to a seven-storey extension of the institute, so it was bricks and mortar stuff?

Ms Addison—Yes, that is right.

Senator MOORE—And then there is a whole bunch: medical research facilities and grants for development and expansion. It states:

The government will provide $163 million in grants to medical research facilities for a variety of development and expansion projects.

Then it lists a whole bunch. The biggest is $37 million and there are a couple at $5 million and there is everything in between. So, how does that work?

Ms Addison—Those funding agreements have already been executed in the funds we paid out, and they were paid out before 30 June this year.

Senator MOORE—And it was a decision of government as well?

Ms Addison—Yes.

Senator MOORE—So, that has been and gone. In terms of ongoing review of what is happening with that money, all of which is spent and gone except for the Griffith University one, what responsibility is there after they get that amount of money by government decision to report back on what has gone on?

Ms Halton—They are capital contributions, so you have to—

Senator MOORE—You would see a seven-storey building—

Ms Halton—Yes, precisely.

Senator MOORE—$10 million for the Queensland Brain Institute—

Ms Halton—We get the building or the equipment, or whatever it was that we were funding. The point about these is that they are capital injections.

Senator MOORE—The only ones that are not capital are the NHMRC, the fellowships and the stem cell research equipment?

Ms Halton—These moneys are dispensed according to appropriate processes. It is just because these were capital amounts that were to be expended—all signed, sealed, delivered, paid and sorted.

Senator MOORE—Executed.

Ms Halton—That is the one.

Ms Addison—We have funding agreements for each of those, and those funding agreements have reporting obligations within them for each of those line items that we referred to. Part of my team's responsibility is monitoring them and following up with the organisations in terms of the expenditure, making sure the building is there.

Senator MOORE—That is for the capital stuff. What about the Griffith stem cell research? Do you have an ongoing relationship with them?

Ms Addison—We will have an ongoing relationship with them. We are in the process of finalising the funding agreement for them. Once the funding agreement is in place, then the funding will flow over the period of time that it is being provided.

Senator MOORE—Will the fellowships come to you and will you oversee those?

Prof. Anderson—Yes, in the normal oversight process with reports and so on.

Senator PATTERSON—Why do the NHRMC grants for research institutes appear separately. Why was that not in the—

Prof. Anderson—The Australian Fellowships?

Senator PATTERSON—No, I was talking about the stem cell centre.

Ms Addison—I might be able to answer that. It was not funded through the NHMRC. They were funding arrangements that were funded through the department.

Senator PATTERSON—Would it have passed the NHMRC test for funding of institutions if it had applied under the normal—

Ms Halton—It was a decision of government.

Senator PATTERSON—That is not the answer to my question, Ms Halton.

Ms Halton—No.

Senator PATTERSON—Would it have passed the various rounds you have to go through to be funded under the NHMRC?

Ms Halton—We cannot answer that question.

Senator PATTERSON—Why can you not answer that question?

Ms Halton—Because it was not a test that was applied.

Senator PATTERSON—Did NHMRC do any preliminary work on whether the test had been applied?

Ms Halton—No.

Ms Murnane—That is speculative.

Senator PATTERSON—Was there any work done by the NHMRC on whether that institute would have got a grant, yes or no?

Prof. Anderson—Not to my knowledge.

Senator PATTERSON—I think you should take that on notice, Professor Anderson, and answer at a later time. I want to know if there was any work done in any way by NHMRC as to the status of whether it would have been included—

Ms Halton—We will find that out. I am not aware of it, but we will find that out.

Senator MOORE—In terms of the appointment, I know that for the major committee—I forget the term.

Prof. Anderson—It is the council.

Senator MOORE—That is appointed by the minister. Are all of the subcommittees appointed by the minister as well?

Prof. Anderson—Indeed.

Senator MOORE—They are all ministerial appointments. Is it you, Minister, or Minister Abbott who does those appointments? We heard this morning about the differentiation with the act, as to which minister has responsibility for this particular process.

Senator Santoro—Those committees that operate under the jurisdiction of those two pieces of legislation that I am responsible for, I have responsibility for.

Senator MOORE—So it is you.

Senator Santoro—It is me, yes.

Senator MOORE—Thank you.

Senator FIERRAVANTI-WELLS—Senator Patterson asked you about research that may fall into a particular category that she was referring to. In regard to the question that Senator Patterson asked, whilst she was looking at it from that perspective there could be other areas of research and other funding that could have occurred. Therefore, do not look specifically at just what Senator Patterson is asking you, look at others that may fall in that same category.

Ms Halton—That was a very wide question.

Senator FIERRAVANTI-WELLS—Senator Patterson asked you a question about assessment.

Ms Halton—She asked a specific question about whether or not the NHMRC had done any work on this particular proposal in respect of the decision that was ultimately taken, and that is what I have undertaken to have a look at.

Senator FIERRAVANTI-WELLS—In relation to the particular funding to Griffith University, were there other areas that may have been funded or were funded under this same umbrella.

Ms Halton—Which umbrella?

Senator FIERRAVANTI-WELLS—The sort of funding that has gone from—

Ms Halton—I genuinely do not understand your question.

Senator FIERRAVANTI-WELLS—What you are saying is that was the only funding that occurred. That was the question that I was asking.

Ms Halton—That is right.

Senator FIERRAVANTI-WELLS—I was asking that, if there was any other funding, please give it the same consideration.

Ms Halton—No. There is a press release. We have just gone through basically each item on the press release. Senator Patterson has now asked me about one particular decision, which is a separate item in the decision, and we are happy to answer the question.

CHAIR—Senator Moore, you had a question.

Senator MOORE—One of key issues that came up in our discussion about the new structure of the NHMRC was the change in the relationship with the states. Under the previous historical arrangements, each state got to nominate their nominee on the committee. You gave in your answer, quite appropriately, the comment that a wide ranging consultation process has to go through with the states. Would you care to take on notice or answer straightaway what you consider to be the appropriate consultation process with the states? As you realise, it is a sensitive issue in terms of the changed arrangements, but I am happy for you to take that on notice if you would like to.

Senator Santoro—I will try to give you some indication now, bearing in mind that my experience has been limited to date. As I mentioned when I became minister, there were vacancies that needed to be filled. We wrote to the states inviting them to provide us with suggestions and nominations. When I was ready to let them know what my preferences were, we wrote back to them. That is quite a formal process.

Senator MOORE—Did they all respond?

Senator Santoro—To the best of my recollection, I believe all of them did respond. If it was not all, the vast majority of the states did. In terms of additional consultation, in my travels I had occasion to speak to several of the responsible ministers within state jurisdictions, and some discussions were had of a very informal nature—it could even be described as a casual nature—and that assisted me in formulating my final views and making recommendations. I might try to get you a more detailed description of the consultation process.

Senator MOORE—Thank you.

CHAIR—Senator McLucas.

Senator McLUCAS—Following on from Senator Moore's question about the change on 1 July of the membership of the committees, I think, Ms Halton, you indicated that you might asterisk some committee members that are—

Ms Halton—I think the question we were asked was who was a continuing member. We can do whichever way you like. We will indicate who was there and who was not there that is there now.

Senator McLUCAS—Of those members who did not continue, can you indicate on what basis they left. Was their tenure just over?

Ms Halton—No. Basically it is a decision of the minister—the government—who is appointed. Essentially some people continued and some people did not.

Senator McLUCAS—Basically their tenure was not reinstituted?

Senator Santoro—There were a couple of instances where members became unavailable because of commitments. There was one case where one of the members took on extended

responsibilities overseas; therefore, that person was finding it difficult to be in attendance at meetings and was unavailable for consideration for reappointment. There is a variety of reasons. I have to be honest with you, I cannot recall making a decision that said, 'That person is off and this person is on.' There were vacancies. We cast the net, consulted and the appointments were eventually made. If you are saying was anybody heavied off a committee, the answer to that is no. As I said, I was dealing with vacancies mainly of the licensing committee.

Senator MOORE—I do not think you were talking about the licensing committee.

Senator McLUCAS—No, I was talking about the five committees of the NHMRC.

Senator Santoro—That will give you at least an indication of the way that it happened in my part of the world.

Senator McLUCAS—You appoint the membership of those committees, as well, is that right?

Prof. Anderson—No. The Minister for Health and Ageing appoints the council and four of its five principal committees.

Senator McLUCAS—Minister Abbott appoints the membership of the five standing committees.

Prof. Anderson—They are called principal committees. There are five of those, one of which is the licensing committee, which Senator Santoro does. Then there is council. The membership of council is specified in the act as the chief medical officers from each state.

Senator McLUCAS—So could we have the information for Senator Moore for the five principal committees.

Ms Halton—That is what we seem to be doing. We seem to be doing that for all of them. Who is a continuing member and who is a new member?

Senator PATTERSON—Are the states required to support the appointment.

Ms Addison—My understanding is that the majority of states and territories are required to support the licensing committee.

Senator PATTERSON—It is different from the others now?

Ms Addison—Yes, it is. It has its own legislation.

Ms Murnane—That committee is covered under the human embryo research.

Senator PATTERSON—The implication was that it was the minister at the table whose responsibility it is, but for that committee there is a requirement of the majority of states and territories, so it is different now from all of the other committees that the senator is asking questions about. That was not made clear, I do not think, in the answers.

Senator McLUCAS—The consultation process that Senator Santoro undertook—sorry to be talking about you in front of you, Senator—was just with respect to the licensing committee.

Ms Halton—Yes, it was in respect of the licensing committee.

Senator McLUCAS—So what consultation was undertaken with the states by Minister Abbott, I imagine, in terms of filling of the positions on the principal committees?

Ms Murnane—With the Australian Health Ethics Committee the legislation specifies that the minister must consult with the states on filling that position.

Senator McLUCAS—I am trying to understand what he did to fulfil that requirement?

Ms Murnane—The minister talks about the names that he is considering and seeks agreement.

Ms Addison—One of the things that I should probably make clear is that the current appointments were all processed under the old legislation. They all started before July, so the process has started under the old legislation and they followed the prescribed rules under the legislation as it was at the time. If we start with council, the legislation previously had requirements about consultation and so Minister Abbott followed those requirements. As Ms Murnane was saying, in terms of the ethics committee, letters were sent out to all of the prescribed organisations seeking nominations. Once those were received, advice was provided to the minister and it went through the normal processes.

Senator McLUCAS—Is that under the old act?

Ms Addison—It was commenced under the old act, so the processes for all of the appointments were completed in accordance with the old act's provisions.

Senator McLUCAS—We have covered off on that now. I just have to whinge about not asking anything about Q fever! I forgot.

Ms Halton—I nearly mentioned Q fever earlier. I was half way through an answer that Senator Nettle asked me about the CSL and I nearly said vaccines, including Q fever, and I restrained myself. Q fever has been sorted out, if that is what you wanted to know.

Senator McLUCAS—I do understand that.

Ms Halton—We have signed documents with them.

Senator McLUCAS—What did we end up doing?

Ms Halton—I would not want to be drawn on the detail, but we have a signature on the contract.

Senator McLUCAS—I have no further questions. Thank you.

CHAIR—That being the case, we have finished outcome 14 and today's hearings into the Department of Health and Ageing. Minister, we had some criticism of you on an earlier occasion, so I am very thankful for your appearance and attendance here today. Thank you, Ms Halton, and your officers for your time today. I thank you in advance for the answers to the questions on notice.

Senator Santoro—Before we conclude, I would like to thank Ms Halton, her senior officers and the other officers who have been here throughout most of the day and available to assist the committee. Their expertise has been made available to the committee in a very earnest and straightforward way. From my point of view as minister and, I am sure, the senators on the other side who were asking the questions, we appreciate their assistance.

Thank you, Chair, and your committee and supporting staff for your assistance and professional courtesies.

CHAIR—The committee stands adjourned.

Committee adjourned at 10.52 pm