COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

STANDING COMMITTEE ON COMMUNITY AFFAIRS

ESTIMATES

(Additional Budget Estimates)

TUESDAY, 13 FEBRUARY 2007

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SENATE STANDING COMMITTEE ON

COMMUNITY AFFAIRS

Tuesday, 13 February 2007

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

Senators in attendance: Senators Adams, Allison, Barnett, Carol Brown, Crossin, Hogg, Humphries, Lundy, McEwen, McLucas, Marshall, Moore, Nettle, Patterson, Polley, Siewert, Stephens, Stott Despoja and Webber

Committee met at 9.06 am

HEALTH AND AGEING PORTFOLIO

In Attendance

Senator Santoro, Minister for Ageing

Department of Health and Ageing
Whole of portfolio
Executive
Ms Jane Halton, Secretary
Mr Philip Davies, Deputy Secretary
Ms Mary Murnane, Deputy Secretary
Professor John Horvath, Chief Medical Officer
Ms Wynne Hannon, General Counsel, Legal Services Branch
Mr David Kalisch, Deputy Secretary
Mr David Learmonth, Deputy Secretary
Business Group
Ms Margaret Lyons, First Assistant Secretary
Ms Georgie Harman, Assistant Secretary, People Branch
Mr Stephen Sheehan, Chief Financial Officer, Finance Branch
Mr John Trabinger, Assistant Secretary, Information Technology Strategy and Service Delivery Branch
Ms Laurie Van Veen, Assistant Secretary, Communications Branch
Ms Tatiana Utkin, Assistant Secretary, Strategic Management Branch
Mr David Watts, Assistant Secretary, Legal Services
Mr Dean Herpen, Assistant Secretary, Corporate Support Branch
Portfolio Strategies Division
Mr Jamie Clout, First Assistant Secretary, Portfolio Strategies Division
Ms Shirley Browne, Assistant Secretary, Parliamentary and Portfolio Agencies Branch
Ms Julie Roediger, Assistant Secretary, Budget Branch
Mr Damian Coburn, Assistant Secretary, Policy Strategies Branch
Ms Jenny Hefford, Assistant Secretary, International Strategies Branch

Audit and Fraud Control

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

Outcome 1: Population health

Population Health Division

Ms Jennifer Bryant, First Assistant Secretary, Population Health Division
Ms Carolyn Smith, First Assistant Secretary, Office of Aged Care Quality and Compliance
Ms Jennifer McDonald, Assistant Secretary, Food and Healthy Living Branch
Ms Linda Powell, Assistant Secretary, Chronic Disease and Palliative Care Branch
Ms Virginia Hart, Departmental Officer, Drug Strategy Branch
Mr Peter Morris, Assistant Secretary, Strategic Planning Branch
Ms Andriana Koukari, Assistant Secretary, Targeted Prevention Branch

Therapeutic Goods Administration

Dr David Graham, National Manager
Dr Rohan Hammett, Principal Medical Officer
Dr Leonie Hunt, Director, Drug Safety and Evaluation Branch
Dr Sue Meek, Gene Technology Regulator
Dr Roshini Jayewardene, Acting Director, National Industrial Chemicals Notification and Assessment Scheme
Dr Margaret Hartley, Director, Office of Chemical Safety
Ms Shelley Tang, Acting Director, Office of Devices, Blood and Tissues

National Blood Authority

Dr Alison Turner, General Manager, National Blood Authority
Mr Gordon Lee Koo, Deputy General Manager, National Blood Authority
Ms Sandra Cochrane, Chief Financial Officer National Blood Authority

Professional Services Review

Dr Tony Webber
Ms Alison Millett

Cancer Australia

Professor Davis Currow, Chief Executive Officer, Cancer Australia

National Health and Medical Research Council

Professor Warwick Anderson, Chief Executive Officer
Dr Clive Morris, Acting Chief Operating Officer

Outcome 2: Access to pharmaceutical services

Pharmaceutical Benefits Division

Ms Rosemary Huxtable, First Assistant Secretary, Pharmaceutical Benefits Division
Ms Sarah Major, Assistant Secretary, Community Pharmacy Branch
Dr John Primrose, Medical Adviser, Pharmaceutical Benefits Branch
Mr Stephen Deller, Assistant Secretary, Pharmaceutical Evaluation Branch
Mr Declan O'Connor-Cox, Assistant Secretary. Access and Systems Branch
Ms Sue Campion, Assistant Secretary, Policy and Analysis Branch

Outcome 3: Access to medical services

Medical Benefits Division

Ms Megan Morris, First Assistant Secretary, Medical Benefits Division
Mr Tony Kingdon, National Manager, Office of Hearing Services

Mr Peter Woodley, Assistant Secretary, Diagnostics and Technology Branch
Ms Samantha Robertson, Assistant Secretary, Medicare Benefits Schedule Policy Implementation Branch
Mr Richard Juckes, Adviser, Medicare Benefits Schedule Policy Development 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
Ms Judy Daniel, Assistant Secretary, Chronic Disease and Better Health Pathways Branch
Ms Lisa McGlynn, Assistant Secretary, eHealth Branch
Ms Jennie Roe, Assistant Secretary, General Practice Divisions and Information Branch
Ms Sharon Appleyard, Assistant Secretary, Rural Health Branch
Ms Sallyann Ducker, Departmental Officer, Policy and Analysis Branch
Dr Brian Richards, Principal Medical Adviser, eHealth Branch
Mr Lou Andreatta, Assistant Secretary, Primary Care Financing Branch

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, First Assistant Secretary, Office of Aged Care Quality and Compliance
Ms Carolyn Scheetz, Assistant Secretary, Compliance Branch
Ms Mary McDonald, Assistant Secretary, Community Care Branch
Mr Peter Broadhead, Assistant Secretary, Policy and Evaluation Branch
Mr Iain Scott, Assistant Secretary, Prudential Regulation Branch
Ms Fiona Nicholls, Assistant Secretary Quality, Policy and Programs Branch
Ms Melinda Bromley, Assistant Secretary, Office for an Ageing Australia
Ms Allison Rosevear, Assistant Secretary, Residential Program Management Branch

Aged Care Standards and Accreditation Agency

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

Outcome 5: Primary care

Primary and Ambulatory Care Division

Mr Richard Eccles, First Assistant Secretary, Primary and Ambulatory Care Division
Mr Leo Kennedy, Assistant Secretary, Service Access Branch
Ms Judy Daniel, Assistant Secretary, Chronic Disease and Better Health Pathways Branch
Ms Lisa McGlynn, Assistant Secretary, eHealth Branch
Ms Jennie Roe, Assistant Secretary, General Practice Divisions and Information Branch
Ms Sharon Appleyard, Assistant Secretary, Rural Health Branch
Ms Sallyann Ducker, Departmental Officer, Policy and Analysis Branch
Dr Brian Richards, Principal Medical Adviser, eHealth Branch
Mr Lou Andreatta, Assistant Secretary, Primary Care Financing Branch

Outcome 6: Rural health

Primary and Ambulatory Care Division

Mr Richard Eccles, First Assistant Secretary, Primary and Ambulatory Care Division

Mr Leo Kennedy, Assistant Secretary, Service Access Branch
Ms Judy Daniel, Assistant Secretary, Chronic Disease and Better Health Pathways Branch
Ms Lisa McGlynn, Assistant Secretary, eHealth Branch
Ms Jennie Roe, Assistant Secretary, General Practice Divisions and Information Branch
Ms Sharon Appleyard, Assistant Secretary, Rural Health Branch
Ms Sallyann Ducker, Departmental Officer, Policy and Analysis Branch
Dr Brian Richards, Principal Medical Adviser, eHealth Branch
Mr Lou Andreatta, Assistant Secretary, Primary Care Financing Branch

Outcome 7: Hearing services

Medical Benefits Division

Ms Megan Morris, First Assistant Secretary, Medical Benefits Division
Mr Tony Kingdon, National Manager, Office of Hearing Services
Mr Peter Woodley, Assistant Secretary, Diagnostics and Technology Branch
Ms Samantha Robertson, Assistant Secretary, Medicare Benefits Schedule Policy Implementation Branch
Mr Richard Juckes, Adviser, Medicare Benefits Schedule Policy Development Branch

Outcome 8: Indigenous health

Office of Aboriginal and Torres Strait Islander Health

Ms Lesley Podesta, First Assistant Secretary, Office for Aboriginal and Torres Strait Islander Health
Mr Mark Thomann, Assistant Secretary, Program Planning ands Development Branch
Ms Joy McLaughlin, Assistant Secretary, Policy and Analysis Branch
Ms Rachel Balmanno, Assistant Secretary, Health Strategies Branch
Ms Haylene Grogan, Assistant Secretary, Services of Concern Taskforce
Dr Tim Williams, Senior Medical Advisor

Outcome 9: Private health

Acute Care Division

Ms Kerry Flanagan, First Assistant Secretary
Ms Bernie Towler, Senior Medical Adviser
Mr Charles Maskell-Knight, Principal Adviser, Medical Indemnity Branch
Ms Gail Yapp, Assistant Secretary, Acute Care Strategies Branch
Ms Yael Cass, Assistant Secretary, Acute Care Strategies Branch
Ms Penny Shakespeare, Assistant Secretary,Private Health Insurance Branch
Mr Brendan Gibson, Assistant Secretary, Healthcare Services and Financing Branch

Medibank Private

Mr George Savvides, Managing Director, Medibank Private

Private Health Insurance Ombudsman

Ms Samantha Gavel, Acting Private Health Insurance Ombudsman

Private Health Insurance Administration Council

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

Outcome 10: Health system capacity and quality

Primary and Ambulatory Care Division

Mr Richard Eccles, First Assistant Secretary, Primary and Ambulatory Care Division

Mr Leo Kennedy, Assistant Secretary, Service Access Branch
Ms Judy Daniel, Assistant Secretary, Chronic Disease and Better Health Pathways Branch
Ms Lisa McGlynn, Assistant Secretary, eHealth Branch
Ms Jennie Roe, Assistant Secretary, General Practice Divisions and Information Branch
Ms Sharon Appleyard, Assistant Secretary, Rural Health Branch
Ms Sallyann Ducker, Departmental Officer, Policy and Analysis Branch
Dr Brian Richards, Principal Medical Adviser, eHealth Branch
Mr Lou Andreatta, Assistant Secretary, Primary Care Financing Branch

Outcome 11: Mental health

Mental Health and Workforce Division

Professor Rosemary Calder, First Assistant Secretary, Mental Health and Workforce Division
Mr David Dennis, Assistant Secretary, Workforce Infrastructure Branch
Mr Allan Groth, Assistant Secretary, Council of Australian Governments Workforce Implementation Branch
Ms Maria Jolly, Acting Assistant Secretary, Education and Training Branch
Mr Nathan Smyth, Assistant Secretary, Mental Health Reform Branch
Mr Greg Poyser, Assistant Secretary, Mental Health and Suicide Prevention Branch
Ms Jan Bennett, Principal Adviser
Professor Harvey Whiteford, Principal Medical Adviser, Mental Health

Outcome 12: Health workforce capacity

Mental Health and Workforce Division

Professor Rosemary Calder, First Assistant Secretary, Mental Health and Workforce Division
Mr David Dennis, Assistant Secretary, Workforce Infrastructure Branch
Mr Allan Groth, Assistant Secretary, Council of Australian Governments Workforce Implementation Branch
Ms Maria Jolly, Acting Assistant Secretary, Education and Training Branch
Mr Nathan Smyth, Assistant Secretary, Mental Health Reform Branch
Mr Greg Poyser, Assistant Secretary, Mental Health and Suicide Prevention Branch
Ms Jan Bennett, Principal Adviser
Professor Harvey Whiteford, Principal Medical Adviser, Mental Health

Outcome 13: Acute care

Acute Care Division

Ms Kerry Flanagan, First Assistant Secretary
Ms Bernie Towler, Senior Medical Adviser
Mr Charles Maskell-Knight, Principal Adviser, Medical Indemnity Branch
Ms Gail Yapp, Assistant Secretary, Acute Care Strategies Branch
Ms Yael Cass, Assistant Secretary, Acute Care Strategies Branch
Ms Penny Shakespeare, Assistant Secretary,Private Health Insurance Branch
Mr Brendan Gibson, Assistant Secretary, Healthcare Services and Financing Branch

Outcome 14: Health and medical research

Regulatory Policy and Governance Division

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

Ms Teressa Ward, Assistant Secretary, Governance and Agency Relationships
Mr Paul McGlew, Assistant Secretary, Regulatory Policy Branch
Ms Kylie Jonasson, Assistant Secretary, Research Policy and Biotechnology Branch

Outcome 15: Biosecurity and emergency response

Office of Health Protection

Ms Cath Halbert, First Assistant Secretary, Office of Health Protection
Ms Raelene Thompson, Assistant Secretary, Surveillance Branch
Mr Simon Cotterell, Assistant Secretary, Health Protection and Policy Branch
Mr Rob Cameron, Acting Assistant Secretary, Health Emergency Planning and Response Branch
Dr Julie Hall, Medical Officer, Office of Health Protection

CHAIR (Senator Humphries)—Good morning. I declare open this hearing of the Senate Standing Committee on Community Affairs considering the additional estimates for the portfolio of Health and Ageing. Under standing order 26, the committee must take all evidence in public session. This includes answers to questions on notice. Officers and senators are well versed in the privilege protections and immunities and the scope of questioning for estimates. If you need reminding, the secretariat has a copy of the usual rules. I do not propose to read them out again now.

I welcome Senator Santo Santoro, the Minister for Ageing and the Minister representing the Minister for Health and Ageing, the departmental secretary, Ms Jane Halton, and all of the officers of the department. Before I invite the minister to make an opening statement, I have been advised that we do not have any questions to ask at the hearing in outcome 7, which is on hearing services. Therefore we will not be calling that particular program. If those officers wish to go off, they are free to do so. Before the committee commences with cost outcomes 1, we will go as usual to the whole of portfolio and corporate matters area of questioning. Minister, would you like to make an opening statement this morning?

Senator Santoro—Chair, just briefly: we are looking forward to a productive day and to being of every possible assistance to your committee.

CHAIR—Thank you very much, Minister. I hope that will be the case. We will start with questions in whole of portfolio or corporate matters. Are there any questions?

Senator McLUCAS—I first go to questions on notice. I understand that about half of the questions on notice were received by the due date, and I thank the department for that. Is there any reason why the other half were delayed?

Ms Halton—Actually, we thought we had done better this time than we had done previously.

Senator McLUCAS—Yes, I acknowledge that you have done better.

Ms Halton—Certainly there was a small trail at the very end. You will appreciate that, with the age care announcement, all of the ones that came in at the very end were age care relevant. You would know, given the content of those questions, that it seemed more sensible—that is probably the best way to put it—that we give an accurate answer based on the announcement.

Senator McLUCAS—So in November when I asked for the time frame for the introduction of ACFI, you knew that there was going to be this announcement that would change the rollout of ACFI?

Ms Halton—Essentially, the matter was under active consideration. Once the decision had been taken, the minister's view was that it was probably more sensible to provide the correct answer, so the question was delayed until that matter was in the public arena.

Senator McLUCAS—I do understand there was a political problem with answering that question, but the question still stands. In my view it should have been answered accurately at the time, inasmuch as to say that it was under review, because the sector was not informed that ACFI was not going to be rolled out or to be starting up in March. It is unfortunate, I think, that the opportunity was not afforded the community through that question on notice. It is not a big issue. It is just a matter of answering questions honestly and openly in the Senate estimates process.

Senator Santoro—It is fair to say that there were two strands of thought surrounding the ACFI situation. One was that there were matters before cabinet that were being finalised, but there was also my very strong willingness to continue to consult the industry about issues that were outstanding in relation to ACFI. The industry kept on providing me with advice, not all of which suggested that ACFI should be in fact postponed in respect of what was happening in cabinet. Obviously I was not able to be forthcoming until that cabinet process was finalised, but also I was very keen to hear the very specific technical advice that I was getting from the industry. They are very happy with—

Senator McLUCAS—That is not the issue. The issue is that there was a straight question asked in November last year. It should have had an answer, if only to inform the sector that the implementation date for ACFI was under active review. That was the honest answer, and that answer was not provided to this committee.

Senator Santoro—I stand by my answer. The industry, I can assure you, in terms of the consultation and their awareness of progress relating to ACFI, were happy. I did not receive complaints about the process. I can understand where you are coming from, but if you are advocating on behalf of the industry I can assure you that they were extremely—and I want to stress 'extremely'—happy with the level of consultation between the department, me and my office.

Senator McLUCAS—We will move right along. Would it be appropriate to ask questions about the Australian health care agreement negotiations in whole of portfolio or in another outcome?

Ms Halton—It depends on what you want to ask, Senator.

Senator McLUCAS—Questions about process and establishment: 'What is the process?' They are the sorts of questions I want to ask.

Ms Halton—If you want to do it now, I am happy to talk to you about it now. If you get into a lot more detail, I will need the relevant officers, but in terms of the broad process I am happy to talk about it now.

Senator McLUCAS—Has the department established any reference groups or any other kind of group to examine particular areas of reform that the Commonwealth wants to see pursued in the upcoming round of the health care agreement negotiations?

Ms Halton—You would appreciate that the health care agreements are not due for renewal until the middle of 2008. You would know, because we have discussed it in this committee on a number of occasions, that the operation of the health care agreements is something which we pay regular attention to. In terms of the establishment of negotiations with the states, the establishments of reference groups and things of that sort, no, we have not got any reference groups and we have not commenced discussions with the states. It would actually be a little early for that process to occur. I know from conversations with my state colleagues—indeed, I actually had this conversation with a couple of my state colleagues last week—that it is something that they are thinking about. There is indeed a discussion at AHMAC, which is the senior officials body, at the end of this month, where there is going to be a broad discussion about a range of issues, and I know that that is one of the things that they wish to raise. But there has been no formal discussion and there is no group yet established. It is a little early, to be fair.

Senator McLUCAS—You imagine, though, that there will be the establishment of reference groups, for want of a better word, to inform the process of the agreement?

Ms Halton—We have not even got that far in terms of a mud map of the process. Certainly you would know that last time—when Senator Patterson was the minister—there was a process set up with a whole slew of reference groups. This time, because we have had a COAG process around a number of these issues, I do not know what the decision will be about whether there are large numbers of reference groups or, indeed, what the process will be. It is a little hard to anticipate at this point what it might look like, but certainly I imagine about a year out or so you would be looking at getting the process kicked off.

Senator McLUCAS—Has the department commissioned any consultancies to conduct work on the forthcoming agreement?

Ms Halton—Again, we have a number of ongoing processes, including consultancies, where we are looking at the operations of health care agreements—hospital financing, et cetera. Mr Kalisch can tell me if there is something specific which I might not know about.

Mr Kalisch—We do have a couple of consultancies that are doing some work with us around this in a number of areas, broader health policy. One is KPMG and one is Banscott—I am not sure of the exact term.

Senator McLUCAS—What do KPMG do?

Mr Kalisch—I will have to get some details for you. I will take that on notice.

Senator McLUCAS—And the Banscott one as well.

Mr Kalisch—It is some broad advice around potential approaches and potential issues that we expect to come up within future negotiations. It is just some early thinking we are doing around some of the potential issues that we might take to the states as well.

Senator McLUCAS—Is it appropriate for us to have a copy of the terms of reference?

Mr Kalisch—I will see what we can provide. It is pretty general and we are just using them as sounding boards in particular areas of activity. As Ms Halton said, this is at a very early stage of development.

Senator McLUCAS—Okay. If you could provide us with those terms of reference that would be great.

Mr Kalisch—I will take it on notice.

Senator McLUCAS—Thank you, and also an understanding of the KPMG work. That is all I have on the health care agreements. I have a question around the COAG early childhood agenda. How was DOHA involved in that process?

Mr Kalisch—DOHA is part of an IDC that the Commonwealth has set up on human capital. It is being chaired by PM&C and we are one of a number of departments that are contributing to that process.

Senator McLUCAS—In what way?

Mr Kalisch—Providing perspectives and views on what could be in a package of measures that could be considered by COAG providing advice on some of the particular challenges in early childhood. It is really just contributing to an IDC that is a whole-of-government process.

Senator McLUCAS—I suppose it is too early to know whether any DOHA-specific measures will flow from the COAG agenda.

Mr Kalisch—It is probably best to direct those sorts of questions to Prime Minister and Cabinet or alternatively to Treasury. PM&C and Treasury are playing a bit of a double team on this, given it is a human capital agenda which has both a whole-of-government as well as a fairly strong economic flavour.

Ms Halton—It is important to emphasise, obviously from a portfolio perspective, that we have a particular interest in early childhood and a very specific interest, particularly in respect of Indigenous children, given the risks. Certainly we are contributing technical advice as well as a policy perspective. There is a strong view inside the portfolio about some of these issues and we are making sure that those views are known, but where that will end up—

Senator McLUCAS—Sure. This is a start.

Mr Kalisch—There are a few more processes to go through.

Ms Halton—Yes.

Senator McLUCAS—What topics is Doha progressing through that process? Indigenous children is one that you have indicated.

Mr Kalisch—Yes, Indigenous children. Certainly the antenatal and zero to three age ranges are the broad areas where we have particular interests. But there are other departments represented on that, including FaCSIA and DEST, which are also contributing ideas right up to age 5.

Senator McLUCAS—Nutrition?

Ms Halton—Nutrition is part of that, exactly.

Senator McLUCAS—I am just trying to get a feel for the thinking of the department.

Mr Kalisch—It is really hard. I do not want to divulge too much about the matters that are under active consideration.

Ms Halton—No. I think is fair to say that the conversation is wide-ranging and, I would say, fairly complete. It is a wide-ranging conversation that goes across the full range of issues.

Senator McLUCAS—Thank you. I want to ask a question about overseas development assistance, which is something that I found out about the other day.

Ms Halton—Yes, we heard that you are interested.

Senator McLUCAS—Yes. Is 'official development assistance' what it is called?

Ms Halton—Official development assistance—ODA. I had to find out about it too because I did not know it had that label.

Senator McLUCAS—It has been a learning experience for us all. Could you provide full details of the official development assistance, eligible expenditure and activities undertaken by the department since 2000-01 to date?

Ms Halton—Yes. I did not know that it had this label either. The majority of expenditure in this portfolio that qualifies under this category is in relation to our contributions to the World Health Organisation. I am told that, over the period, between 75 per cent and 95 per cent of the expenditure that qualifies in this category and this portfolio is all WHO relevant. It is either that or it has a particular aid perspective. You would know that we have taken particular interest in some South Pacific countries as a consequence of our leadership role in the region on health related issues. I have a table. I do not have multiple copies, but I am happy to table it. It does not all say, necessarily, WHO, but you will see that there is a large international organisation and that is basically where it goes.

Senator McLUCAS—What sort of expenditure is it?

Ms Halton—It is health related projects. For example, we have Papua New Guinea for 2005-06, $742,000. My understanding is that that will be HIV related. It is those kinds of things. I have it by country. WHO and HIV and those kinds of health related initiatives are largely what is comprehended here.

Senator MOORE—Is there anything in there about maternal and child health in the Pacific? That has been discussed a fair bit as well, both in the aid agencies and in general discussions. In the headings that you have there about our involvement in the Pacific, is there anything about—

Ms Halton—No, it does not do it by category. Essentially, remembering that we are not the aid agency, you would know that over the last few years we have been forging a closer link with AusAID. In particular, their recently published health agenda was something that we were much more instrumental in than perhaps we would have been previously. Obviously, the principal aid effort comes from AusAID. It shows you by country.

Senator MOORE—I take the point about the HIV focus, which we have had over many years. But somewhere in my mind I am sure that we have done some work around maternal—

Ms Halton—We have. Essentially, what you will see here is work that is relevant to our portfolio. Most of it is the contributions we will be giving as our core contribution to WHO.

You would know that the way we finance WHO is through what is called an assessed contribution. You would also probably know that I chair the WHO budget committee, so I count the pennies when I have that hat on.

Senator MOORE—I hope there are lots of pennies!

Ms Halton—Yes, they are not doing too badly. The assessed contribution does not grow, though. What has happened over the last few years is that the voluntary contributions have gone up significantly. Voluntary contributions enable countries to target their expenditure on things that are priorities. It means that, for us, we can actually put our voluntary contributions to the region into things like maternal and child health, HIV-AIDS et cetera. So, again, for us as a portfolio, while we are not, obviously, the key personnel on aid, that is where we are interested. I am happy to table this information.

Senator McLUCAS—Is any of the work that is being done in the Pacific being done on vector-borne diseases?

Ms Halton—We have done a number of things on vector-borne diseases—malaria, things we know about mosquitos.

Senator McLUCAS—Is it about service delivery or is it about research?

Ms Halton—Mostly service delivery. We have not done much in the research category. It depends on what the need is. We have a South Pacific health leaders forum, which we got money from AusAID for. We bring together the heads of health agencies right across the South Pacific. It is about capacity building for them, but also talking about the needs in their systems. Mostly their need is for practical and technical assistance; it is not necessarily for lots and lots of research. If there is a particular need for research, we will talk to them about it, but mostly it is about the health work force, it is about how you manage resources appropriately, it is where do you invest to get the maximum benefit, how do you manage issues around low birth weight, how do you minimise risk to mothers and babies, HIV transmission—all those sorts of things. It is a fairly predictable list. The Deputy Prime Minister of Tonga, Bill Tangi, who was originally an Australian trained surgeon, faces huge challenges as health minister. He is still runs two surgical lists a week because he is a surgeon—one of two surgeons. So he still gets to operate. If you talk to him about the kinds of practical challenges he has delivering a health system, it focuses the mind.

Senator McLUCAS—It is a bit different.

Ms Halton—It is a bit different. Anyway, we are happy to table this.

CHAIR—We have circulated an agenda with times allocated against each of the outcomes in this portfolio. As was the case yesterday, I propose to, with some latitude, stick to this agenda. If we run badly over time, I will begin to impose time limits. I would like to proceed now to outcome 1, population health.

Senator McLUCAS—Ms Halton, for each of the outcomes, I am going to ask a standard question, which I dare say you will take on notice. I would like to read it out now so that you know that for each of the 15 outcomes we will have the same question. Please provide a list of programs, current expense revenue and cash forward estimates for 2006-07, 2007-08, 2008-09 and 2009-10 under each of the outcomes.

Ms Halton—Sensator, before you go on, you will know that we publish—necessarily—forward estimates. Mr Clout can perhaps give you the standard form of words about what we have available, but if you have a standard question, we will take it on notice.

Senator McLUCAS—The second question is for those same years, identify the amounts obligated or forward committed under each of the outcomes.

Ms Halton—Yes.

Senator McLUCAS—If there is a problem with those words, I would prefer to know it today rather than get a letter back in a few weeks.

Ms Halton—Have you got that on a piece of paper? That way we can have the financial gurus look at it and we will tell you if there is an issue.

Senator WEBBER—Let us start with pregnancy counselling. First I place on record my thanks and, I am sure, the thanks of Senator Moore—she is briefly out of the room—for the briefing that the minister's office agreed to provide for us on the tender process Can someone take us through the process the department went through in awarding the tender, so that it is on the record?

Ms Smith—You would probably be aware that the RFT for the pregnancy support helpline was advertised in the *Australian* on 23 September. That tender documentation was prepared by the department with the advice of the expert advisory committee that we have discussed previously. The RFT process was also advertised on AusTender and on the Health tenders website. We held an information session for tenders on Wednesday, 11 October and a number of people attended that session. Applicants were able to seek clarification regarding the tender documentation up to one week prior to 30 October. Those tenders were then evaluated by a tender committee comprising senior departmental staff and Dr Andrew Pesce, the chair of the expert advisory committee. Two members of the expert advisory committee—two other members—were also asked to provide technical advice to the evaluation committee on some issues.

The evaluation committee was supported by a financial adviser, a probity adviser and a legal adviser. We completed our evaluation of the tenders and made a recommendation to the departmental delegate and that decision was taken in mid-December. We then entered into a process of negotiation with the successful tenderer and contracts were signed just before Christmas. Unsuccessful tenderers were notified and there was a public announcement in early January. Debriefs are in the process of being organised with unsuccessful tenderers.

Senator WEBBER—When do you anticipate you will finish the debrief sessions with the unsuccessful tenderers?

Ms Smith—I think they are scheduled for the first week of March.

Senator WEBBER—When we had our briefing we also talked about the monitoring and evaluation of the successful tender. Can you take us through the process the department set up for that?

Ms Smith—The department will be receiving quarterly reports from McKesson, who were the successful tenderer. They will be on qualitative and quantitative reports. We will also be having quarterly meetings with the successful tenderer to discuss any issues. There will also

be a process of quality auditing of the services. McKesson will arrange for an annual quality audit of the service.

Senator WEBBER—They will arrange for that?

Ms Smith—That will be provided to the department.

Senator WEBBER—Is the department going to do any independent evaluation or auditing of the way the service is provided, or is it all going to be organised by the tenderer?

Ms Smith—McKesson are required, under the contract, to arrange for an independent third party to audit. It will not be done by McKesson themselves. We also have the option, should we choose to exercise it, of organising our own third party audit. But that will be a matter for us to judge, based on the information that we get. There has also been an evaluation of the helpline scheduled for the first 12 months after operation.

Senator WEBBER—When the successful tenderer was announced, much play was made of their use of two other organisations: Centacare and the Caroline Chisholm Society. As I understand it, those two organisations are meant to be part of an advisory group or whatever. Are we any closer to knowing who else McKesson are going to use to advise them on the establishment and provision of this service?

Ms Smith—The contract, as you would be aware, is between the department and McKesson. McKesson, under the contract, are required to produce an information manual to help to support counsellors in undertaking that work. That information manual is required to provide evidence based information on all of the three options that are available to a woman facing an unintended pregnancy. That manual will need to cover proceeding with a pregnancy and either keeping the baby or considering adoption, and termination. This information manual will need to provide practical, evidence based information to be used as a resource by the counsellors when they are working with an individual client. McKesson have chosen to enlist some assistance in developing that manual. That is the role of Caroline Chisholm and Centacare. They are going to be on a small working party which will be helping them to develop the manual. The working party will also have clinical representatives from McKesson. When a first draft has been prepared, that manual will be reviewed by an independent psychiatrist and an independent O&G specialist. The manual will then be reviewed and approved by the expert advisory committee.

Senator WEBBER—I do not think that quite answers my question, though. Are we any closer to knowing who the rest of the working group is?

Ms Halton—We do know who they are.

Ms Smith—We have now received some advice from McKesson about the membership of that committee. I can read that out for you.

Senator WEBBER—That would be lovely.

Ms Smith—From the Caroline Chisolm Society it is Mary D'Elia, who is the CEO and has worked in pregnancy support for 13 years, and Denise Lee, who is their clinical services manager and a qualified social worker. From Centacare it is Gwen Bonett, who is the assistant director of family services and a registered psychologist, and Evelyn Picot, who is the director of policy planning and public relations and a social worker.

Senator STEPHENS—She is from Centacare as well?

Ms Smith—Yes. The representatives from McKesson_are the project manager, Katie Barwell, who has a Bachelor of Nursing; Dr Louise Gardiner, who is a GP and has a lot of experience in family medicine and family planning; and Suanne Hunt, who is a registered nurse. They are going to be producing a first draft, which will then be independently reviewed by two expert clinicians: Dr Stephen Coogan, who is an obstetrician and gynaecologist at the Royal Hospital for Women in Sydney and a member of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; and Dr Stephanie Bradstock, who is a psychiatrist in Sydney and also a fellow of the Royal Australian and New Zealand College of Psychiatrists.

Senator MOORE—Can you table that document? With my scrawled writing I have probably got all of their names wrong. If I could get that list, that would be great.

Ms Smith—We could certainly take that on notice and provide—

Ms Halton—We will get it typed up and we will table it.

Senator MOORE—That would be fabulous.

Ms Smith—Then I think we previously talked about the membership of the expert advisory committee and their fields of expertise.

Senator NETTLE—Can I just ask something on the McKesson project manager, the GP and the registered nurse. Are the GP and the registered nurse employees of McKesson?

Ms Smith—That is my understanding, yes.

Senator NETTLE—So you have three McKesson employees, then two from Caroline Chisholm and two from Centacare?

Ms Smith—Yes. The other thing is that McKesson have arranged a workshop with Family Planning WA, who are the providers of the training package. That is happening some time in the next week or so. The two organisations are going to discuss the training package and the information manual and make sure that there is a degree of consistency and sharing of information.

Senator STOTT DESPOJA—How many organisations applied for the tender?

Ms Smith—I have been advised by our legal adviser that that is commercial-in-confidence.

Ms Halton—We had a number.

Senator STOTT DESPOJA—Thank you, Ms Halton.

Ms Halton—I would not describe it as a small number. We did take some advice on this because we knew you would be interested.

Senator STOTT DESPOJA—How would you define a small number, out of curiosity?

Senator MOORE—A primary number.

Ms Halton—Yes. Do hand signals go into *Hansard*? Probably not.

Ms Smith—We had plenty of reading, Senator.

Ms Halton—Yes, there was a lot of reading material.

Senator STOTT DESPOJA—That has just ruled out my second question. My third question in relation to the tender would concern the debriefs that will be taking place. Ms Smith, how many organisations will receive debriefs? That is not supposed to be a trick so that you announce a number. Are all organisations that missed out on the tender eligible for these now they have been debriefed?

Ms Smith—Everyone who was unsuccessful was informed and they were invited to approach the department and request a debrief. I understand that all of those organisations are interested in a debrief and anyone who is interested will get one.

Senator STOTT DESPOJA—And that is a number.

Senator WEBBER—Does the successful tenderer have any plans to alleviate fears in the minds of people like me about the perception that perhaps it is not judgement free in terms of the counselling it is providing? We have all had the argument before in various stages about the values in the teachings that the Catholic Church provide to their social service delivery arms. When the public announcement was that it is McKesson, Centracare and Carolyn Chisholm, add to that the public statements of the minister when he was quoted in the *Sydney Morning Herald* as saying:

The Howard Government has overturned euthanasia laws, banned gay marriage, stopped the ACT heroin trial, encouraged independent schools, contracted Job Network services to church organisations, established pregnancy ... counselling—

Et cetera, talking about the role of the Catholic Church and the government. That was his opinion piece when the minister was launching the biography of Bob Santa Maria. Does McKesson have any plans to convince people like me and the wider community who are not followers of the Catholic Church that this is neutral territory and that we should all feel comfortable to approach them?

Ms Halton—Similarly I am not a follower of the Catholic Church. If I can make an observation, what is happening here is a process which ensures that there is independent scrutiny and when the material which Ms Smith has just been talking about is developed, that it has several processes of review. That review has to be able to satisfy the observers and the objectively—I think—balanced group that we have, the independent advisory group, that in fact that material is balanced. At the end of the day, the proof is going to be in the pudding here. We all know that the operation of the help line must be seen to be being delivered independently and to provide balanced advice. In terms of the particular view some people may have, I do not know that there is a lot we can do other than to continue what we are doing, which is to have a very open process in the development of the manual and to be quite scrupulous in monitoring what happens with the tender, making sure that the material that is produced is balanced. Certainly that is our objective. I am confident that McKesson understand very well that this is a difficult job. I am quite confident about that.

Senator WEBBER—I am sure they are well aware of some of the difficulties or have become increasingly aware since the announcement. What arrangements are in place once the service is up and running in terms of the security of the information that is provided to McKesson so it is not transferred on to anyone else? Are they going to solicit for clients? How is that going to be safeguarded?

Ms Smith—I might tackle the second part of your question first. There will be no soliciting of clients. The protocol is that people will ring the helpline if they wish to seek assistance. There is to be no cold calling. The contract provides quite a lot of assurances in terms of the privacy of clients who are ringing the helpline. No-one needs to give their name. If they feel that they might need to approach the helpline for further assistance and they do not want to have to give their story again they can give a de-identified nickname or some other unique identifier, but there will be no named records. The department will receive only de-identified data in any reporting. There are quite strict restrictions on access to records, particularly during any auditing processes. We believe that McKesson, as a very experienced operator in this field, knows only too well the importance of protecting clients' privacy. In this area, in particular, people are particularly sensitive, so the department put a lot of effort into in the contract negotiations.

Senator MOORE—All of us who were interested in the process knew that this was going on. We had had information. How exactly was the public announcement made?

Ms Murnane—The minister made a public announcement on, I think, 2 January.

Senator MOORE—My understanding is that that is the standard way your department operates. Every department has a different process for public announcements. The ministers always take it, but then some departments have their own processes of media releases.

Ms Halton—Yes. We do not, as a rule. You are probably aware—I could be corrected here—that in my time as secretary of the department we have only had about three press releases, maybe even less. We do not as a matter of course put press releases out. We do not think it is our business to have press releases unless there is a major issue. I think the closure of Pan Pharmaceuticals was one where we put out a press release, for example. So as a department we would not as a general rule put out press releases about tenders. We would notify a successful tenderer and people who had been unsuccessful. As you are well aware, in some cases ministers choose to make bigger announcements where there is a public interest in so doing. That can be everything from the awarding of age care places to whatever—other tender processes and the like. In this case the minister chose to put out a press release.

Senator MOORE—Were the unsuccessful tenderers aware of the result before that media coverage happened?

Ms Murnane—Yes.

Senator MOORE—So everybody knew who had got it before the media announcement?

Ms Murnane—Yes.

Senator MOORE—In terms of the process, we have talked about the sensitivity of this decision. We wanted to ensure that people got the same information at the same time. It seems to me that the media coverage engendered commentary that we have been catching up with ever since—trying to establish balanced arrangements and trying to establish the process. My quick look at the media on who was on panels only mentioned two names and got people's reaction. So the first two days of the announcement were difficult in terms of process. Does the department—with McKesson, because McKesson have to carry most of it because they

have been successful—have a reassurance process to keep the balance aspect in front of people from now on?

Ms Murnane—That is a particular reading of the media. We cannot control the way the media portrays something.

Senator MOORE—None of us can, Ms Murnane.

Ms Murnane—I know that. In terms of the information that McKesson themselves are putting out, that now includes the whole story. That is what is relevant here now. McKesson have—and this was upfront in their RFT—enlisted the assistance of Caroline Chisholm in Centacare. They also have their own experts involved. As well as that, there are two independent experts. Apart from that, when this manual is finished, it will go to the minister's expert advisory committee for assessment and, if there is a difference between McKesson and the expert advisory committee, the expert advisory committee will prevail. This is all very clear. We are making this very clear whenever we are called upon to do so. As Ms Smith said, there is going to be a debrief of all the applicants, and that will be another avenue through which we can make this clear.

Senator MOORE—It is all very clear to us, after having extensive discussion with officers from the department. They have gone to a great deal of trouble to point out that sequence of events to us very clearly. I am not convinced of that absolute clarity in the community, particularly in the community that is already asking questions about this process. Is there an expectation in the contract—it is confidential—about the community awareness campaign McKesson have? I know that the department has a process that it is not going to be a big splashy campaign; it is going to be more focussed around areas. That is fine. But in the expectation of McKesson, knowing the sensitivity of this process, was there anything in the contract or the deliberations of the contract about their role in community education and awareness?

Ms Smith—Certainly McKesson have been quite active in trying to speak to the media about this issue. Matthew Cullen has been interviewed, I think, on numerous occasions, and has talked about McKesson role in running the tender. He has also been proactive in arranging meetings with relevant interested members of parliament. I think he has offered to do that. Senator Stott Despoja is nodding. He has also arranged meetings with all the stakeholder groups, such as family planning, that you would expect to have an interest in this area. We believe McKesson are doing as much as possible to get out there and communicate with people who have an interest in this issue about how this service will operate.

Senator MOORE—Was there an expectation in the contract that they would have that role?

Ms Smith—It is not specified in the contract but it has been part of the discussions that we have had with McKesson that an important part of their building a credible service is to ensure that they have communicated with all relevant stakeholders.

Senator STOTT DESPOJA—Do you mind if I go back to a couple of comments, Ms Smith, that you made earlier? In regard to the issue of evaluation that Senator Webber was asking about you explained McKesson role in that process and how there was a departmental option of independent evaluation required. Under what circumstances would the department

exercise that option? What would trigger a departmental evaluation in addition to the McKesson instituted one, the independent one from McKesson?

Ms Smith—It is very difficult to pre-empt a decision that is in the future, and I do not want to go down a hypothetical path. But if we were seeing large numbers of complaints and issues identified in the quarterly reports that concerned us, those sorts of things would trigger such an audit.

Ms Halton—There is a contract and we expect them to produce consistent with the contract. If we see things that suggest to us that they are not doing as we have contracted them to do then we would have a conversation about how to manage that. I can assure you that, if we were concerned that they were not delivering what we had contracted them to deliver, which is independent and balanced advice, we would be exercising that option. I have given that undertaking to senators Moore and Webber and I can very happily put that on the public record. You can be absolutely assured that we will be monitoring this very carefully. If we are not happy then we will exercise that option.

Senator STOTT DESPOJA—I was not necessarily seeking to go down a hypothetical path. I was just curious in relation to the process—if there was a specific trigger in place. But basically that option is available to you and you can make that judgement given the circumstances?

Ms Halton—Yes, precisely. Essentially, it is a matter for our judgement. If our judgement is that this is not proceeding as we would wish it and we are unable to quickly rectify something we regard as being unacceptable then we will exercise that option.

Ms Murnane—The department will be having regular face-to-face meetings with representatives of McKesson. Any matters that come to our attention will be raised then. If they cannot be resolved, that might culminate in something else, as the secretary has said.

Senator STOTT DESPOJA—Does regular mean monthly or—

Ms Smith—In this implementation period from when the contract was signed through to the go-live date on 1 May they are to be at least monthly. In fact, I think the contact has been more frequent than that. Once the service is up and running, it is at least three-monthly, but we expect there will be telephone contact more regularly than that.

Senator STOTT DESPOJA—Ms Smith, you are right—Dr Cullen has been in touch with me. I had a very constructive phone discussion with him. He has been very upfront about the availability of briefings should we require them. Just on the issue then of Dr Cullen and the media, I notice that both in conversations with us and in the media he has been very upfront about the fact, in relation to the service and the issue of referrals:

We're not allowed under the contract to provide referrals to any provider,' says Cullen. 'We can say this is where you look for information.

Can I explore some of those issues, obviously, first of all, seeking clarification from the department. My understanding is that the hotline does not provide referrals. I am wondering what happens if someone requests information or a referral to a particular service—it may be adoption information or termination. What happens if that is requested by the caller? What happens then?

Ms Smith—We have obviously had this discussion on several occasions before. I think you would have seen what the RFT required in this area—that the helpline provider was expected to provide generic information about where clients can find information rather than specific contact details for individual agencies. We have discussed a number of times the difficulties in providing that specific information about ensuring that that information is accurate. It would be very difficult for McKesson to actually be able to provide local information for the whole of Australia so that they could be confident they were directing someone in the right direction. There will be generic information provided: 'You can go and talk to your GP or your family planning organisation and this is where you find them.' They would direct them to other agencies that could provide assistance at a broad and generic level, but they would not say, 'This is the phone number for this service in this suburb.'

Senator STOTT DESPOJA—On those generic agencies, you have mentioned family planning and GPs. I understand that we have had this discussion before. I guess we are now into the nuts and bolts of a service that is about to begin operating. I am genuinely interested in what happens. I have discussed this with Dr Cullen as well because I am genuinely interested in what happens when someone requests information. You have mentioned a list of possible generic services. Are they still to be developed in the working group and in the discussions about the manual or can you say with certainty that it will be GPs and family planning? Are there other organisations that are considered generic services for the purposes of someone requesting information?

Ms Smith—I think this is one of the issues that will need to be included in the information manual. It will be a resource for counsellors to actually be able to deal with those sorts of inquiries. I cannot tell you with great precision at this point because it is still being developed. All I can tell you is what the expectation of the department has been—that this will be generic information about the pathways people can follow to access services.

Ms Halton—It is worth reinforcing—I think we have discussed this previously—that this approach was based on the advice of the expert advisory committee. This is something they tussled with—I think that is a fair comment. So obviously when the manual goes back to the expert advisory committee to include whatever is proposed in this area we will have opinions, but it is my expectation that the expert advisory committee will be particularly scrutinising this part quite specifically to be comfortable that it meets the requirements that they recommended.

Senator STOTT DESPOJA—I will wait for those answers when the manual comes out.

Senator WEBBER—We may have to wait for the manual for this. What arrangements or protocol will be in place where it is obvious to the people working on the phone line that their client needs further in-depth counselling before they can make the decision on one of the three options? Is McKesson going to provide that further counselling or is there a referral process—in which case, who are they going to refer to?

Ms Smith—There will be protocols for how to handle situations in which, for example, you might get someone who rings up and then becomes very distressed. The counsellor on the end of the phone line might form a view that that person is so distressed that it is an emergency. There will be protocols for referral within McKesson, either to a more senior

counsellor or, if it seemed to be a crisis, to a psychiatrist who can handle that situation. Those protocols are well established in this area.

Senator WEBBER—Would that be a psychiatrist or a counselling service? Would Centacare be one of those generic services that they are allowed to refer to?

Ms Smith—No, this is within McKesson. To be clear and to put it on the record, all the people who are going to be answering the phone will have tertiary level qualifications in either psychology, social work or nursing. So they will have had relevant counselling experience when they start with McKesson, then they will receive the training package on issues around unplanned pregnancy. McKesson, being the operator of the helpline, will have a crisis protocol so that it will be referred either within McKesson to a counsellor who is more experienced or, if they felt someone was at risk of harming themselves, it would get immediately referred to a crisis line staffed by a psychiatrist. They have that within their organisation. But if the counsellor is counselling someone and the person is still feeling that they need more support to help them make that decision, the client will be referred in a generic way, as with other referrals, to where they can go for more assistance. For example, they could go and access the MBS item to receive face-to-face counselling.

Senator STOTT DESPOJA—So there would be referrals in emergencies only?

Ms Smith—And that is a process of escalation within McKesson. If someone needs in a short time frame a greater level of assistance, that call can be escalated. That happens with other providers such as Lifeline who operate in this area.

Ms Halton—McKesson is an experienced, already contracted, provider of health counselling to a number of the states. So this is an area it manifestly has experience in dealing with. It is a sad reality that sometimes you do get people who are extremely distressed, and McKesson currently has to manage that level of distress.

Senator STOTT DESPOJA—In relation to funding, how much money has been put aside for advertising the helpline?

Ms Smith—I think it is $2.4 million over four years.

Senator STOTT DESPOJA—How will that advertising be targeted? How will you seek to get that information across?

Ms Smith—We are currently in the process of working through those issues with our communication people in the department. The allocation for communication is $2.4 million. We are finalising the strategy at the moment. We are looking for low-key and targeted communication activity. There will not be any television advertising as part of that strategy. We are looking at getting information out through the internet and telephone listings and the range of organisations which are used by women in this area—GP clinics, family planning organisations, pharmacies.

Senator STOTT DESPOJA—I presume when you say ‘low key’ it does not include television and other broadcasts—radio and newspapers. That is not appropriate, not on the radar?

Ms Smith—Large-scale advertising is not on the radar, either on TV or radio.

Senator STOTT DESPOJA—Billboards?

Ms Smith—I don't imagine so.

Senator STOTT DESPOJA—I am not being facetious; billboards are often used for advertising services.

Ms Halton—You would be aware that our department has quite some experience in targeting communications campaigns. It is fair to say we have been doing this for quite some time. The advice we are getting in relation to this is that it is better to target information of this particular space at the kind of target group who may have need. The strategy currently being developed is precisely designed to target places and media that are appropriate and will be accessed by the relevant target audience.

Senator STOTT DESPOJA—Is there any consideration to any advertising making clear that this service does not provide referrals?

Ms Halton—I do not think we have gotten that far.

Senator STOTT DESPOJA—We ask you to bear that in mind if it is not providing referrals on all three options.

Senator NETTLE—How will complaints be handled?

Ms Smith—McKesson are required to have a process for managing complaints so people can make complaints through to the service. If they do wish to make a complaint, they will have to give enough information to enable McKesson to identify the call. So if they gave a unique name when they made the original call, they will have to provide that to enable some checking back of records. McKesson will investigate that complaint and McKesson will also be required to report to us quarterly on the number of complaints they receive and how they have been dealt with. People will also have the option to talk directly to the department if they wish.

Senator NETTLE—Will people be informed by McKesson that they have the capacity to talk to the department?

Ms Smith—We have not gone into that level of detail yet with McKesson, but I do not imagine that McKesson will have any problem with that sort of arrangement.

Senator NETTLE—What data will the department receive from McKesson about the individuals who access the service.

Ms Smith—It is things like age, if that has been provided, and gender, because this is a service that could be accessed by partners as well. I have a list of the data items, which it might be best if we put on notice. The broad reason for the call: is this seeking information about pregnancy generally or seeking information about unintended pregnancy? It is those sorts of issues. The list is: number of calls received, number of calls answered, the duration of the call, the origin of the call by state, the reason for the call, the number of crisis calls, the number of prank calls. They are the sorts of things that McKesson will be referring to us.

Senator NETTLE—Previously in discussion there have been proposals that there be information about, for example, how many weeks into the pregnancy somebody is, circumstances around it. Will any of that information be provided to the department?

Ms Smith—They were not proposals from the department and it is not an intention that those data items be collected.

Ms Halton—And I am not aware that we have had ever had that discussion in estimates, Senator.

Senator NETTLE—It has certainly been had in the parliament.

Ms Halton—In estimates, I am not aware that we have and certainly I am not aware of any discussion or suggestion from the department that that would be a data requirement. Those are not the data requirements.

Senator NETTLE—If you are able to table the list of the things that you are getting, that would be appreciated.

CHAIR—Senator Stott Despoja has a couple of questions as well.

Senator STOTT DESPOJA—Following up the issue of the records of calls—I understand we do not have much time; we will put some questions on notice—my understanding is that calls will be timed.

Ms Smith—Yes.

Senator STOTT DESPOJA—What information will be kept about the caller? I understand callers will be anonymous and obviously confidential. What information, if any, will be kept about the person who phones in?

Ms Smith—A counsellor will need to keep some sort of case summary, I suppose, of the call. That is important from both a follow-up point of view, if a person wishes to call again and get more counselling, or if there is a complaint, there needs to be a record of both the issues discussed and the broad nature of the advice given. There will be an option, but people will be told that when they ring.

Senator STOTT DESPOJA—So for the purposes of follow-up or what have you, there is the potential for that information to identify the caller, obviously if someone rings back and says, 'This is my case.'

Ms Smith—It is not a name.

Ms Halton—It is not a name, no. It is important to understand that if people ring they are under no obligation to provide their name or to provide identifying detail. If they wish to ring back at some time, they may choose to do so. I might ring up and say, 'I'm Mary'. There may be some code name you could be referred to as—'Fred Bloggs', whatever you want. Essentially, that will only enable you to ring back a second time and say, 'I rang before and I think I said I was "Fred Bloggs".'

Senator STOTT DESPOJA—So identify the case, not the caller, is a better way of describing it.

Ms Halton—Correct. That is precisely right. In other words, I can ring and say, 'I was talking to somebody. I found them really good to talk to. I said I was "Fred Bloggs" and I want to pick up on a couple of issues that I was talking to the person on the phone about.' You want to be able to say, 'When Fred Bloggs rang, here were the issues. Let's follow that through,' if that is what the caller wants. But if the caller rings and says, 'I just want to talk

this through and no, I don't want to tell you anything about myself and I don't want to give you an identifying name,' that is their choice.

Senator STOTT DESPOJA—That is what I did mean in terms of identification of the case, not the caller, and that information is held by, owned by, McKessons, not the department.

Ms Smith—Yes. We will not receive any of that information interest the quarterly reports. The sort of information we will receive will be at a completely aggregate level.

Ms Halton—It will be aggregate data. So there will be no way at all of us knowing even that someone rang and gave a code name 'Fred Bloggs'. We will simply know that 25 calls, 25,000 calls or however many calls were received.

Senator STOTT DESPOJA—What will happen with the funding arrangements for an organisation like Pregnancy Help Australia, now that this large amount of money has been dedicated to the helpline? Is there an intention by the department to continue the funding of Pregnancy Help Australia?

Ms Smith—Pregnancy Help Australia have a contract until the end of June. I think they are in the process of thinking about the direction of their organisation, now that the helpline tender has been awarded. The department will discuss those issues with them over the next couple of months.

Senator STOTT DESPOJA—I will look forward to updates.

Senator NETTLE—Will the information manual be released before the service goes live?

Ms Halton—It is not intended that the information manual be released publicly, but it will be available to the expert advisory committee. I have no doubt that, in that context, it will be seen by relevant experts and others, but it is not our intention to post it publicly.

Senator NETTLE—I will put my other questions on notice, including a question about what level of access we are able to have to the tender documents now that the tender has been awarded. I am just flagging that with you.

Ms Smith—Do you mean individual submissions, Senator Nettle?

Senator NETTLE—No. I mean the information provided to the tenders when they make the tender.

Ms Smith—Since the RFT documents were removed from the website—they are removed once the tender is no longer current—we have had a number of requests to see them, and we have been able to make those documents available.

Senator McLUCAS—I have three issues that I want to raise in population, health and ageing. They go to the Victorian government diabetes proposal, some data about dental health and some information about fluoridated water.

CHAIR—Will you put those on notice?

Senator McLUCAS—Yes. I also have questions about climate change, the use of crystal methamphetamine and the TGA, which I will put on notice.

Ms Halton—Thank you.

CHAIR—I thank officers in this area for answering questions. After the break will move to outcome 4, Aged care and population ageing.

Proceedings suspended from 10.19 am to 10.32 am

CHAIR—The Senate Standing Committee on Community Affairs hearing into additional estimates for 2006-07 is resumed. We will start with outcome 4, Aged care and population ageing, which includes the Aged Care Standards and Accreditation Agency.

Senator McLUCAS—I want to go to the announcement from the government this week about the funding of age care. The graph on page 19 of the document we could not open on Sunday—which made it very difficult to understand what the package is.

Ms Halton—What do you mean when you say you could not open it?

Senator McLUCAS—On the DOHA website.

Ms Halton—Just so that you are aware, that is because there was a fire at the Tuggeranong data centre.

Senator McLUCAS—But why could I open the fact sheets and not the substantive document?

Ms Halton—The fire took out not just us but a lot of others, and when they brought the systems back up they brought them back up progressively.

Senator Santoro—I became aware of that problem when one of the providers contacted me on the way back from the launch. By then we had it up on my personal website and we managed to direct something like 25 to 27 calls to that website. We tried to remedy the situation as quickly as we could by going electronic in other ways. There was a problem, and we are sorry about that.

Senator McLUCAS—The graph on page 19 shows resident payments from 2007-08 to 2010-11. What is the estimated number of new residents who will pay the higher fees when the new system comes into place?

Mr Stuart—About half of new high-care residents will pay higher accommodation fees, at an average of $1.74 per day, about one-fifth of new high-care residents will pay lower fees, at an average of $3.61 per day and about half of new low-care residents will pay lower fees, at an average of $7.92 per day.

Senator McLUCAS—Mr Stuart, could we turn those into figures? Is that possible? To do that I would essentially need to know the split of high and low care projected into the future.

Mr Stuart—About half of new high-care residents newly entering aged care—how many people is that?

Senator McLUCAS—Yes.

Mr Stuart—At the moment I would have to take that on notice. I do not have that figure in front of me.

Senator McLUCAS—But it is possible to find out, isn't it?

Mr Stuart—Yes.

Senator McLUCAS—That would be great.

Mr Stuart—We have to go back to projections of new entrants over that four-year period. It becomes, I should say, increasingly unreliable as you go further out, obviously.

Senator McLUCAS—The modelling would indicate, though.

Mr Stuart—We might be able to come back to you a little later in the aged care section of the hearing.

Senator McLUCAS—That would be good. What I am interested in knowing is not only the proportions but the projected growth in high care expected out of this package. That seems to be the underlying premise to the package, so I surmise that the modelling would indicate that there will be a growth in high-care places.

Mr Stuart—Actually, I do have that information. As part of the package, there is a rebalancing in the high care-low care ratio within residential care to 44 high-care places and 44 low-care places.

Senator McLUCAS—Just for the record, that is a move from 50, is it?

Mr Broadhead—Currently the ratio is 48 low and 40 high. It would be moving to 44 of each.

Senator McLUCAS—I will put a question on notice about the modelling that informs that. I dare say as part of the consultation that the department undertook in terms of the long-term response to Hogan that sort of work would have been done. Is it possible, Mr Broadhead, to provide that to the committee in a document form?

Mr Broadhead—Yes, we could certainly respond to the question.

Mr Stuart—I do not have quite the right numbers in front of me, Senator. We will have about 250,000 places in total by the end of the forward estimates period, but I do not have the flow. I have only got the number of places, not the number of people who will go through them in that period. So we will have to see if we can come back to that a bit later on.

Senator McLUCAS—Mr Stuart, can you answer the question: what is the proportion of growth in contributions from residents over that five-year period, as a global figure?

Mr Broadhead—In general terms do you mean the overall percentage that is contributed by residents in terms of the new funding?

Senator McLUCAS—Yes.

Mr Broadhead—Within the forward estimates period the government is contributing 64 per cent of the additional funding for accommodation.

Senator McLUCAS—And that is at 2010-11?

Mr Broadhead—Yes. It is within the period shown on that graph.

Senator McLUCAS—That graph then shows the growth in resident funding.

Mr Broadhead—Yes. The shaded in part of the bar at the bottom is the resident contribution. The lighter grey part of the bar is the government contribution.

Senator McLUCAS—And what is the likely average fee increase that the new residents will pay in both an absolute and a percentage term?

Mr Stuart—What time period are you referring to, Senator?

Senator McLUCAS—The period 2010-11.

Mr Broadhead—In 2010-11 or over the period to 2010-11?

Senator McLUCAS—In 2010-11.

Mr Broadhead—We will have to take that on notice.

Senator McLUCAS—Thank you. The graph is useful, but what is the current revenue split between resident contributions and government contributions for accommodation under the current operating model, including the drawdown on bonds?

Mr Broadhead—We are not sure that we have sufficiently reliable data on bonds to be able to answer the question across the sector as a whole. We have some data on bonds in particular in response to a survey, but it has a partial response rate. I do not think we could give a precise answer to the question. We do not have the data on every contribution made by every resident, particularly in low care.

Senator McLUCAS—Wouldn't you have that data out of the financial returns that were required under CAP?

Mr Broadhead—Not specifically, no. They give us more general information about the providers' financial circumstances but the data we tend to use in relation to bonds is particularly survey data and of course we now have about a year's worth of data that we have been collecting on bonds. But again, the coverage is partial. We do not have, for example, data going back. There will be people in care at the moment who paid a bond some time ago who may have reached the withdrawal limit and so on. It would be quite a complex question to try to answer.

Mr Stuart—A simpler way of coming at your question which does not require so much estimation on the basis of current data but is simply a statement about the future is that, as you will see, the public material makes it clear that under this new arrangement, after March 2010, the aged-care provider will receive the same amount of money in respect of every resident, whether the resident pays all of it themselves or the government pays all of it, or there is a mixed contribution—

Senator McLUCAS—I understand that. I am trying to understand the split.

Mr Stuart—such that by March 2012 they will be receiving $32.38, estimated, in respect of every resident, whether the resident pays a partial contribution or the government pays for all of it, in high care. The exact balance between resident contributions and government contributions then depends on the estimated asset position of the residents who are entering during that period. That is really the hardest part of the equation. Obviously it depends on estimation.

Senator McLUCAS—The total package was promulgated as a $1.5 billion funding commitment. Does that $1.5 billion include the resident contribution growth?

Mr Stuart—No, it does not.

Senator McLUCAS—So that is direct Commonwealth money.

Mr Stuart—That is direct Commonwealth funding.

Senator McLUCAS—What percentage increase in funding does the announcement represent on an annual basis?

Mr Stuart—It varies over the years because some things grow faster than others. Looking at the four years as a whole in terms of Australian government contribution, there is about $1 billion of additional Australian government expenditure into residential aged care during those four years against a base of about—someone can tell what the total is on residential.

Senator McLUCAS—I wonder whether someone could do that sum and come back to us a little later. It is not a very hard sum to do, I do not think.

Ms Halton—Yes, they will do it now, Senator.

Senator McLUCAS—We will come back to that. I need to confirm—it was a little bit difficult to tell from the fact sheet and, as I have already said, I did not get the substantive document until Monday—that bonds will continue in low care once these measures have been implemented.

Mr Broadhead—Correct.

Senator McLUCAS—When does low care begin and end under the ACFI?

Mr Stuart—There will be a later announcement about that. There is still a process of discussion with the sector about the detail of that. It should not be too long.

Senator McLUCAS—What happens to those residents who enter as low care then move to high care? Will the government pay the higher subsidies for those residents?

Mr Broadhead—The government will pay the new subsidy arrangements in respect of people in low and high care, where they qualify for a subsidy. So the revised subsidy arrangements apply in low care as well as high care. So if somebody entered as low care and was attracting a subsidy under the new arrangements, they would continue to attract that subsidy if they shifted to high care.

Mr Stuart—Let me just qualify that we are talking about care subsidies now under the Aged Care Funding Instrument.

Senator McLUCAS—No, I am talking about the capital subsidies—the accommodation subsidy.

Mr Broadhead—The answer I just gave was about the accommodation subsidy.

Senator McLUCAS—Just to be sure that I am right, the increased subsidy that will be paid by the Commonwealth will still be paid irrespective of whether the person has or has not paid a bond?

Mr Broadhead—For example, if you have assets below 2½ times the annual basic pension, at the moment you would be called concessional and you would receive a concessional supplement. Under the new arrangements you will receive the maximum subsidy that applies, which would be $26.88 from 20 March, if you are a new resident. That would be true whether you are in high care or low care. It works in that way because if you have assets

below that amount you are not permitted to pay a bond because you do not have sufficient assets to do so. So you would get the maximum subsidy as you entered care. That would be true whether you were in high care or low care and it would continue if you moved from low care to high care.

Mr Stuart—So, Senator, yes, the package does increase the Australian government's accommodation contribution into low care as well as into high care.

Senator McLUCAS—This question is aimed from a consumer's point of view. Currently a pensioner pays 85 per cent of their pension for their accommodation.

Mr Broadhead—No, that is the basic daily care fee.

Senator McLUCAS—From a consumer's point of view, they do not care if it is called 'care' or 'accommodation'.

Mr Broadhead—It is $29.98 per day, as we speak.

Senator McLUCAS—What will pensioners pay in the new arrangements?

Mr Broadhead—What pensioners pay for the basic daily care fee would remain as it is now.

Senator McLUCAS—There is no change?

Mr Broadhead—There is no change to the basic daily care fee. I am just being careful, because of course there are some changes to accommodation fees, but the basic daily care fee remains as it currently is in respect of pensioners.

Senator McLUCAS—Let me ask the question again, Mr Broadhead.

Mr Broadhead—There is an exception to that, but—

Senator McLUCAS—Pensioners do not care whether it is for care or accommodation. They know that they are paying money.

Mr Broadhead—But I want to be precise in my answer.

Senator McLUCAS—What does a pensioner pay now when they enter residential aged care?

Mr Broadhead—In respect of the basic daily care fee, they pay $29.98. In respect of their accommodation, that would depend on their assets, whether or not they are eligible to pay a bond and whether they go into low care or high care.

Senator McLUCAS—What about a pensioner with no assets?

Mr Broadhead—A pensioner with no assets would pay the $29.98 for their basic daily care fee and would rely on the government supplements for their accommodation payments.

Senator McLUCAS—And under the new regime?

Mr Broadhead—The same.

Senator McLUCAS—We might put some questions on notice that put in those variables, because we do need to understand how it will affect various components of the community. As I said, I think we will wait till budget estimates to look at this more fulsomely. I dare say there will be an inquiry of some sort to look at these issues a lot more closely. If those

questions that I have referred to could be answered, that would be helpful. I have some general questions on the outcome. We have spoken at length about the investigation of Mrs Kerry Bishop, who, I understand, was acting in a key role when she should not have been. Could I be informed of the progress of this case, please?

Mr Stuart—Yes, Senator. I think we informed you at the last hearing that an Australian Federal Police search was executed in relation to that case. Currently the evidence collected in that search is being assessed and there are ongoing discussions with the DPP.

Senator McLUCAS—Who assesses the evidence, Mr Stuart?

Mr Stuart—At the moment the department is assessing the evidence received from the AFP and we are in discussion with the DPP about that evidence.

Senator McLUCAS—Do we have a timeframe of when those discussions will conclude?

Mr Stuart—I am being told about a month or so.

Senator McLUCAS—Thank you for that. We spoke at the last estimates hearings about the knowledge of an aged-care bed licence application by a federal member of parliament. I thank you, Ms Halton, for the answer to my question. How was the investigation carried out within the department into how Mr Barresi knew that there had been an application for—

Ms Halton—I will ask the head of our audit area to explain that to you.

Mr Stuart—In addressing this question, we do need to be careful about some matters which are protected information under the act, which obviously relate to any issue about whether there was a particular application and what that application might have contained. If we start going into that area, perhaps we could have a short private briefing some time during the day.

Senator McLUCAS—A lot of this information is on the public record, but I do take your point. If we hit that barrier, we will have a little jump.

Mr Rennie—Officers of my branch visited Melbourne, interviewed staff, looked at processes down there, looked at files and made a decision from that which was relayed to you in the secretary's letter to you.

Senator McLUCAS—The staff you spoke to were staff of the Department of Health and Ageing?

Mr Rennie—Yes. The investigation was confined to people within the department.

Senator McLUCAS—Did you speak to Mr Dart?

Mr Rennie—No.

Senator McLUCAS—Why not?

Mr Rennie—The investigation was restricted to looking at departmental processes, looking at departmental files and interviewing departmental staff. There was no indication from that that we should go outside that area.

Senator McLUCAS—Did you talk to Mr Barresi?

Mr Rennie—No, we did not.

Senator McLUCAS—Why not?

Mr Rennie—It was felt that the investigation be confined to the information that was held on departmental files and talking to people within the department. There was no indication why we should take the investigation outside the department. We were looking at whether there was a leak of any information from within the department.

Ms Halton—Essentially, that investigation showed there was a plausible and perfectly explainable potential for a number of parties to have been aware of certain facts, which was demonstrated by the review of the documents.

Senator McLUCAS—Are you telling me that Mr Barresi wrote a letter of support for Mr Dart's application?

Ms Halton—I am not telling you that, Senator. I am saying that there were a number of parties who were manifestly aware of a number of matters who were not members of the department and therefore not restricted by the provisions of the act and a number of other things.

Senator McLUCAS—Did people in the minister's office know that Mr Dart had applied for bed licences?

Mr Stuart—I am unaware of any process from the department that would have brought that information to the knowledge of the minister's office.

Senator McLUCAS—Minister?

Senator Santoro—I am trying to think in the context of question time briefs that were advising me about the issue that was running in terms of the welfare of the residents. Within a question time brief—I do not have a clear recollection of that—there might have been reference to an application by the Darts in the context of what was happening in the general issue. My memory does not serve me well enough for me to be able to give you a definitive answer, but I can certainly assure you that there would have been no communications from either myself or anybody in my office to anybody else in relation to any knowledge of an application, if that knowledge was contained in the QTB. The department would have to check the QTBs to see whether that advice was there, but it was not fundamentally impactful to the point that I recall it now.

Senator McLUCAS—If the question time brief contained information that the Darts had applied for bed licences, is that not a contravention? This is protected information under the act, the application by the Darts. If that information was included in a question time brief, does that not contravene the protected information section of the act?

Mr Stuart—No, the minister is entitled to know a wide array of protected information. The issue with protected information is the use of discretion in how it is publicised, if that is the right word. In respect of protected information, the department is not generally at liberty to disclose it, except in very particular circumstances, and the minister is not at liberty to disclose it, except in particular circumstances. For the minister to be aware of it is certainly not a breach of protected information provisions.

Senator McLUCAS—But the minister's staff are not bound by the act in the same way that departmental staff are. For any ministerial staffer who has read a question time brief

which indicates that the Darts did apply for a bed licence and then provided that information to Mr Barresi, Mr Rennie's investigation would not pick up that fact, would it, Mr Rennie?

Mr Rennie—Our investigation was restricted to departmental officers. It did not extend to ministerial staff.

Senator McLUCAS—So we do not know whether the information was transferred to Mr Barresi by Senator Santoro's office.

Senator Santoro—Senator McLucas, I repeat what I just said to you: I am confident that my ministerial staff would not be divulging to anyone the details of my question time briefs. Obviously they have to come into contact with question time briefs because they are updated on a daily basis in order to satisfy the inquiries of senators such as yourself, but I would not want you to draw a conclusion from that, which I think would be a wrong conclusion, that my ministerial staff would have divulged the contents of any question time brief, including the one relating to the Darts.

What I can tell you is that knowledge of a provider's application for places is very widespread. I have had representations from Labor Party members and senators urging me to look favourably on the allocation of places to one of their providers. I can form a private opinion about their merit or otherwise—invariably I do not because I do not have the knowledge—but I cannot intervene. As I have stated to you in other places, I have no capacity to intervene but I do have knowledge. Other people, including Labor senators, have knowledge of applications because they write to me asking me to support them.

The Darts, I recall, participated in and convened many a public meeting or many a meeting—or at least several meetings, if I can be more precise—of residents and relatives and other people concerned about the issue. It would be highly unusual if they did not talk about their desire to continue operating in that facility and about what practical steps they had taken in order to continue their operations, including the application for places. I cannot say that with absolute certainty, but I would be surprised if a briefing note from the department or from somebody who attended a meeting like that would not indicate that applications for new places had been talked about.

I would not want anybody listening to this exchange to think that there is some conspiracy or lapse, either within the department or in my office, in terms of information that generally—and I think very possibly in this case—would have been very easily available.

Senator McLUCAS—Ms Halton, I think the investigation has been unsuccessful. Simply investigating the knowledge of staff in Victoria does not resolve the issue. It does not answer the question. We still do not know how Mr Barresi could say to the granddaughter of the oldest person in Australia, 'Don't worry, dear, the Darts have applied for bed licences.' He should not know that information, because it is protected. I do not know how he knows it and we should know that as a committee.

Ms Halton—Let us be clear, Senator. Information held by the department is protected. We cannot protect information which is disclosed by others, including—

Senator McLUCAS—Sure, but we still do not know how Mr Barresi knows it.

Ms Halton—the applicant. I think that the point the minister is making is that applicants themselves frequently disclose information. Indeed, we have evidence on our files of applicants having disclosed information. They can so do. It is the information that is held by the department that is protected. The review concluded that information held by the department had been appropriately protected by the department. Essentially, we cannot control what applicants themselves and, indeed, the referees for applicants say to others.

Senator McLUCAS—Sure, but we did not bother investigating how it is—

Ms Halton—I have no power. You also need to understand that I have no jurisdiction. I cannot ask internally—or, indeed, ask the ANAO, for that matter—to go and investigate somebody else in this space. All I can do is see whether the requirements that apply to us under the act have been observed. That is what I have done. If other people or applicants themselves have chosen to disclose, they are at liberty to so do. They do so all of the time.

Senator Santoro—For the record, I was in receipt in the last round, Senator, of at least dozens and dozens of letters from all sides of the political fence supporting applications. I say 'dozens and dozens' because, in the case of several providers, I literally received hundreds of representations in support of one or two individual applications. So the knowledge about applications by providers is very generally available in most instances.

Senator McLUCAS—In most instances, and that is the important difference.

Senator Santoro—But you are seeking to draw a very thin connection between a piece of knowledge by a local member that could have been gained exceptionally easily from discussions that he would have had with relatives or the providers themselves. We do not know. Maybe you should go and ask Mr Barresi how he got it.

Senator McLUCAS—I am sorry; I do not conduct investigations.

Senator Santoro—Then let me be absolutely, perfectly clear then. Mr Barresi did not get that information from my office and he did not get it from the department.

Senator McLUCAS—I am glad you are so confident, Minister.

CHAIR—Before we finish that issue, I want to ask a question. As a member of parliament I am often apprised of applications that are being made. Can I be clear: if I am informed of that fact by a provider for the purpose of securing a level of support or something of that sort, I take it that there is nothing irregular or no offence against the legislation in them telling me, subject to how they say it to me. If I tell other people about that, I am not committing any offence either, am I?

Ms Halton—No. Information that we hold under the act is protected but, if others have chosen to disclose that information—that is the point. The review we have done demonstrates clearly that this material has been disclosed by multiple others. There has not been a disclosure by the department—the evidence is pretty clear—but this information was broadly known. That is clear.

Senator McLUCAS—I think that is the issue in dispute.

Ms Halton—And on our files—

Senator McLUCAS—The investigation that you can only conduct—I take your point—will not resolve that.

Ms Halton—I am happy to talk to you—

Senator McLUCAS—That is in dispute: how broadly known it was that the Darts had applied for bed licences.

Ms Halton—The evidence we have on our files suggests that it was fairly broadly known.

Senator Santoro—If the Darts have put in a statutory declaration, to you or somebody else, that they have not revealed that information, you should provide it. It is of no use for you to leave the issue hanging out there when you say that there was a dispute. The facts show that there was no dispute. You may think that there was a dispute, but there was not a dispute. There is a thing in politics where you make a suggestion, throw out an innuendo and leave it hanging out there. If you think there is a dispute, you should produce your version, your side and your evidence as to why that dispute existed, because there is no dispute in the evidence that has been provided to you in very direct answers.

I believe it is not morally right to make an assertion about a piece of information that is so utterly and totally—particularly in those contentious circumstances—available. Now, if you have a statutory declaration from the providers or anybody else, particularly the providers, that they did not divulge that information, I think you may have a point of concern. But you do not have that and I suggest that you are being very disparaging of public servants and ministerial staff if you continue along that line of questioning.

Senator McLUCAS—We might revisit this issue next time around.

Senator Santoro—We are always at your disposal to hear your informed comments, Senator.

Senator McLUCAS—Thank you. Question EO 6059 was a response to a question in respect of the allegations of abuse in aged care facilities which went from July 2006 to November 2006. Is it possible to get an update on that question?

Ms Scheetz—That question was answered as of 30 November. Since that time, we have had six allegations.

Senator McLUCAS—So that makes 29 allegations in the financial year to date. Have any further charges been laid?

Ms Scheetz—In total, seven charges have been laid. One of those charges relates to the son of a resident and the other charges relate to staff.

Senator McLUCAS—Thank you. In the *Adelaide Advertiser* there was recently a reference to research that was undertaken by a Flinders University academic. When did the department become aware of that research?

Ms Smith—We became aware of that research when we read it in the *Adelaide Advertiser* on 7 February.

Senator McLUCAS—Did the minister's office receive information about the Flinders University research that was undertaken recently and was recently in the *Advertiser*?

Senator Santoro—My recollection of the order of events relating to this issue is exceptionally clear. My awareness of it commenced when I arrived in my office at about 7am, as I usually do every morning, and I had a clipping in front of me that was a photocopy of the front page of the *Advertiser*.

Senator McLUCAS—Did you not receive a letter from the academic?

Senator Santoro—I am not aware of receiving a letter from the academics. If you will allow me to continue, I will ask my office to check whether we have received any letters from the academics.

Senator McLUCAS—Thank you.

Senator Santoro—My awareness of it commenced on that morning. At that stage, I instructed one of my senior advisers to make contact with the department and to immediately make contact with the researchers with a view to obtaining further information specifically for the purpose of referring that information to the department and the agency for immediate investigation and any action if it were required in their professional opinion. Then I was informed of the facts that I gave the Senate when one of your colleagues asked me the questions—that is, the research that was referred to in the *Advertiser* was three to four years old and did not suggest that there was an endemic, widespread problem within a nursing home or, indeed, nursing homes across South Australia.

What particularly alarmed me was that the research findings, if I can describe them in that way, had not been reported to any of the authorities, including the department or agency. What I also did at that point—and we are in the process of formalising this—was let Flinders University know that we are very happy as a government and as a department to assist them to recognise what their moral responsibilities are in terms of reporting neglect. I was to use the word 'neglect' very deliberately here because it is not abuse as the word 'abuse' has commonly come to be understood in the last 12 months—that is, aggravated physical abuse or sexual abuse. They certainly were very regrettable instances of neglect that were observed and used within academic research to substantiate a situation that I do not think can be substantiated.

Senator McLUCAS—Minister, my question is very specific: I want to know when you were first informed of that research.

Senator Santoro—I became aware of it about 7am on the morning that the story appeared in the *Advertiser*.

Senator McLUCAS—Thank you. I understand you have agreed to have the department investigate the allegations that have been made. Can I get an update?

Senator Santoro—I do not agree. I refer issues—like this morning, for example, I received what to me seemed to be a serious complaint via my personal email. I do not agree; I simply refer it immediately to the department. Obviously I asked the department to have a look at the report in the paper and to seek to make contact with the researchers to get more details. At this stage it is my understanding—and the department can elaborate if they wish—that we have had considerable difficulty in obtaining more substantial information about that piece of academic work to the point where we can actually go into a specific facility. That was my

understanding as of last night, but the department is most welcome to correct me if that is necessary.

Ms Smith—The department has made contact with the academics in question on several occasions since the story in the *Adelaide Advertiser*, and on none of those occasions have the academics been able to provide any detail or identifying information that would enable the department to investigate any further.

Senator McLUCAS—Is that because they are not allowed to disclose their information, in an academic sense?

Ms Smith—We have been told that the observations that were in the research are based on one home from 2003 and three residents. The academic has not been prepared to give us the name of the home.

Senator McLUCAS—I do not think they can, because of their requirements and their academic obligations. I think that is the stalemate we are in.

Ms Halton—Actually, I do not know that that is true, Senator, I have to tell you.

Senator McLUCAS—I do not know either.

Ms Halton—I think that is not correct. When I worked in an academic institution doing research into older people's issues, if we came across a case of this sort, the first thing we would have been doing is reporting it, I can tell you right now. I think that is a very thin excuse if that is the excuse that has been given. When it comes to issues such as this, firstly, to put information in the public arena and say there is a major, systemic problem and it is founded on only one home with three residents and then to basically refuse to provide information that identifies it to enable us to follow it up quite frankly I think is scurrilous. It is appalling behaviour.

Senator Santoro—If I can add to that for the benefit of the committee, the department has offered to provide input into the training of aged care nurses at Flinders University to ensure that, in future, the Australian government's regulatory framework is well known to the students and to encourage them to report any cases of poor care to the complaints resolution scheme. I will be writing directly to the vice-chancellor of that university. I have asked for that letter to be drafted. It should be ready for signing if not today then tomorrow. I think we all have an obligation to take alleged or real cases of neglect that we have ascertained seriously.

Senator McLUCAS—I agree, Minister—absolutely.

Prof. Horvath—If I can add further to the secretary's comments, with which I totally concur, even if this was an academic research exercise, it is absolutely incumbent upon any academic when publishing any piece of research, if the facts around that are questioned, to be able to substantiate it with appropriate work books and appropriate identification by an appropriate authority. Clearly, the department is an appropriate authority to ask those questions. So the fact that the relevant academic is unable or unwilling to confirm any of the findings is an issue of major concern.

Senator McLUCAS—Certainly.

Ms Murnane—Clearly, important as the training and academic work might be, that is eclipsed by any adverse effect on residents. The fact that this had been going on for a number of years, allegedly, and they waited for publication until it was disclosed is something that we would be very worried about.

Senator McLUCAS—Yes. The concern I have is that it seems implicit in the work that that was almost expected. That is very troubling.

Senator Santoro—It is a cultural thing. On the whole issue of abuse, if there is one good thing that has come out of that terrible debate that the community indulged in through much of last year and which is culminating in the legislation that will be going through the lower house this week and Senate later on, it is that there is a much greater cultural awareness of the issue of abuse within the community, including within aged care facilities. If there is a silver lining to what has been a pretty dreadful story, it is that the community is a lot more aware of its obligations and its moral duty to report. Regrettably, this issue that has arisen courtesy of the *Adelaide Advertiser* and the research that accompanied or backed up that story—I use 'backed up' in a fairly loose way—has that silver lining. We are a lot more aware of our obligations to report. I stress that whenever I get something—and I get lots of emails on a daily basis about concerns—I do not even hesitate. We immediately refer them, because there is potentially a human being who is suffering.

Senator McLUCAS—I would be interested to know when your office first knew about it. I appreciate you taking that on notice.

Senator Santoro—I will take that on notice. If I can get you an answer before the end of the day I will. We will source the email.

Senator McLUCAS—Just on the issue of the point you have made about the community being more understanding about the nature of the abuse, can I put it to you that neglect is abuse in the technical sense.

Senator Santoro—Yes, I—

Senator McLUCAS—If we are going to have public education and a community understanding of what is acceptable in society, then neglect needs to be called abuse because that is what it is. To say that the sorts of things we read about in the *Adelaide Advertiser* are not that bad is the wrong message to be giving to our community about how to treat older people.

Senator Santoro—I want to say very strongly that a careful perusal of the *Hansard* of what I said a few minutes ago will clearly indicate that I sought to differentiate the treatment of residents as being, in this case, different from aggravated physical assault and sexual abuse. They are the words that I used. It was an issue of differentiating the treatment or experience of residents as it related to the cases reported in the *Advertiser* compared with the cases that were the subject of much spirited and heated debate at the beginning of last year. Nothing that I said should be misconstrued deliberately or otherwise. I regard as totally unacceptable the alleged experiences of those residents as reported in the *Advertiser*.

Senator McLUCAS—I want to go to an issue that has to do with the investigation of a complaint through the CRS. A woman by the name of Diane Bates made a complaint about

the care of her father, and a determination hearing was held in October 2006. After that determination hearing, a personal care worker indicated that they would like to give evidence. I understand, Minister, that you contacted Ms Bates in October of last year and you suggested that it would appropriate to leave everything until the findings of the determination hearing were made. Is that right?

Senator Santoro—From time to time, depending on what I would regard as the stress levels within or the severity of a representation, I ring a constituent. I do not have a clear recollection of that discussion. I would have to take that on notice.

Senator McLUCAS—Can you also take on notice whether or not you indicated to Ms Bates that you would have someone call her the following Monday and can you also advise me whether or not that has occurred. Can you also provide the committee with advice about what protections there are for workers in aged care providing evidence to a determination hearing.

Senator Santoro—I can take on notice the technical aspects of that question, but I can definitely state to you, without any fear of contradiction, that during any discussion that I would have had with anybody, including this person called Bates—and I will seek to refresh my memory of any contact that I had with this person called Bates—under no circumstance would I discourage that person from still pursuing full contact with the department and the agency in terms of any issue that they are concerned about. The only thing I would seek to do is to add more value to their representation to the department or to the agency through any further contact, either directly or through my ministerial staff members. I need to make it perfectly clear that I do not say, 'Put something on hold until either I speak to you further or somebody in my office speaks to you.' It is not a practice that I would want to have anybody—particularly me—implement. I can state that very confidently, because that is the way I treat each and any representation I receive in my office. It is immediately—and I stress 'immediately'—referred on to the department or the agency.

Senator McLUCAS—Thank you.

Senator Santoro—I will try to refresh my memory and, if I can come back to you with any further information, I will.

Senator McLUCAS—I have a technical question that someone might be able to answer immediately or take on notice. Ms Bates asked for a review of the final determination on 19 December but that application was refused because she was 24 hours late in applying for that review. What avenues are available for a person who wants a review of a determination in those circumstances?

Ms Scheetz—I think we will need to take that on notice because we are not familiar with that particular case.

Senator McLUCAS—Certainly. It is not necessarily that particular case; it is a more generic question. Sometimes you can appeal in certain ways for review under certain legislation. I was just wondering if there was an opportunity for her to pursue another path.

Ms Smith—We will take that on notice. I will also note that this is an area that is subject to reform under the new complaints investigation framework.

Senator McLUCAS—Yes, thank you. I want to go to the issue of the aged care approvals round.

Senator Santoro—Just to clarify an answer I provided to you in terms of the Darts and what the QTBs provided to me may or may not have contained—

Senator McLUCAS—We are talking about question time briefs?

Senator Santoro—Yes. I have just been advised—and I have not looked at them myself, but they are being carefully checked—that the QTBs provided to me did not contain any information regarding the Darts' application for additional places, which further—and I need to stress this—reinforces my contention that my staff did not and technically could not have provided that information to Mr Barresi about the application.

Senator McLUCAS—The department said that they had probably told you. The department has put that on the record, anyway. But it is neither here nor there, Senator.

Senator Santoro—You can gather from the answer that I gave you that I said, to the best of my recollection, it did not—but it might have. I do not want to mislead this committee, but I can now ascertain that it did not.

Senator McLUCAS—Okay, thank you. Going to the last aged care approvals round, which is the allocation of beds in our country, I understand that the minister approved the number of aged care places in February 2006 for last year's allocation. I need to confirm when the number of beds for the last round was approved.

Ms Rosevear—The number of beds approved at the end of the ACAR process was 7,771.

Senator McLUCAS—Sorry, Ms Rosevear, I am asking the question the wrong way.

Ms Rosevear—How many were released?

Senator McLUCAS—How many were released last year? It is really the date that I am interested in. Was it February last year as well? It was February this year.

Ms Rosevear—Yes, it was around February last year.

Senator McLUCAS—Okay, thank you. Wshat are the key criteria for the most recent round of bed allocations?

Mr Stuart—The criteria for assessing applications are on the public record in two places. There are some criteria mentioned in the act itself and there are also some criteria set out in the disallowable instrument subject to the act, under the act, which Allison will tell you about.

Senator McLUCAS—It might be quicker if I told you what I think it is and then, if that is not correct, you can tell me.

Ms Rosevear—Yes, certainly.

Senator McLUCAS—Improving access to aged care services for people with special needs; making places operational in a timely manner, which is commonly known as 'bed readiness'; provision of care for people living with dementia; and provision of residential respite care—were they the criteria that were in place for the last round of ACAR?

Mr Stuart—They are some of the criteria.

Senator McLUCAS—I need to understand further what the criteria are.

Ms Rosevear—I have all the criteria. There are three criteria around service planning. One will be a demonstrated need to restructure, which is not necessarily applicable to all places. There is making places operational in a timely manner, where premises are suitably planned and located. There is also the experience and expertise of those who will manage the service and the ability of the applicant to provide the appropriate level of care, measures to protect the rights of care recipients. You mentioned the provision of appropriate care for people from special needs groups, people with dementia and residential respite. There are the benefits to current and future care recipients, diversity of choice for current and future care recipients, continuity of care to current and future care recipients and past conduct as a provider of aged care.

Senator McLUCAS—What weight is given to each of those criteria in the application process?

Ms Rosevear—Each application is assessed against all criteria, so there is no particular weighting yet. It depends on the essential guide, which is released after the aged care planning advisory committees meet at the beginning of each ACAR process. It will determine what particular distribution of places will be within regions and whether any special needs groups are identified. For example, if an Indigenous special needs group was recommended for a particular planning region, then an application that met the needs of Indigenous people may have priority over one that does not. But it really depends on the criteria within a particular region at a particular time.

Senator McLUCAS—When you say 'region' you mean within a state, into a district or planning region?

Ms Rosevear—Yes, that is right.

Mr Stuart—Senator, there is no underlying weighting table or anything of that kind used in the allocation decision-making process.

Senator McLUCAS—The number of criteria you have given me, Ms Rosevear, is different to what I have been advised. Are there key criteria or criteria that are more important than others?

Ms Rosevear—All 13 criteria were set down in the legislation and they are all important criteria.

Senator McLUCAS—So, when a state planning committee comes together to make some assessments, on what basis do they judge one application against another?

Ms Rosevear—The applications are assessed by the department. The planning committees at the beginning of the process will make recommendations on priority, the number of places that should be allocated in particular areas and whether there are any special needs groups, for example. So they are not actually looking at applications.

Senator McLUCAS—So the department reviews the applications?

Ms Rosevear—Yes.

Senator McLUCAS—How does that process occur?

Ms Rosevear—They go through a competitive annual application process. The assessment framework follows the provisions of the act, so we will go through it and look at how each application meets the criteria in the legislation.

Senator McLUCAS—Is that just a 'yes' or 'no'? I am trying to understand how you judge two applications.

Ms Rosevear—There is a rating against each particular criteria, then we look at applications against each other if they are judged to be competitive.

Senator McLUCAS—The department officials will make an assessment of the applicants' success in meeting each of those 13 criteria—

Mr Stuart—That is correct, Senator.

Senator McLUCAS—and you add up the numbers?

Mr Stuart—There is no provision for concentrating on particular criteria or doing a shortlist on the basis of particular criteria. There is a process of looking at every application on its own merits against every criteria and then moving from that to a more comparative assessment.

Senator McLUCAS—I am trying to understand. Often when you have these processes you will have a list of criteria, you will give them a mark out of 10 and then the first cull is when you add up those numbers. Is that how it happens?

Ms Rosevear—We do not actually add up the numbers. If an application ranks very poorly against a couple of criteria—for example, the ability of the applicant to provide continuity of care to residents—they might receive a low score for those criteria even though they may have performed well against others. Unless they actually meet a minimum requirement and we are comfortable that they can meet the criteria, the application will not go forward.

Senator McLUCAS—I think you are telling me that there are some criteria that are more important than others.

Mr Stuart—I think Allison is saying that, if there are providers that score strongly in some areas but very poorly in others to such an extent that the department is not confident about their capacity to successfully deliver aged care, we will not allocate places to that provider. To allocate a numerical system across all criteria would seem to suggest that it is okay to be very strong in some areas but very poor in others as long as your overall score is okay. We do not use that kind of a system.

Senator McLUCAS—It has to be somewhat subjective.

Mr Stuart—It is judgement based and experience based.

Ms Halton—It weighs and balances all of the factors.

Senator McLUCAS—How is an applicant's financial situation assessed?

Ms Rosevear—The department contracts particular agencies to undertake financial assessment on their behalf.

Senator McLUCAS—So they are private financial services?

Ms Rosevear—Yes.

Senator McLUCAS—On what basis do you select private people? What sort of people do it? Accountants?

Ms Rosevear—They are generally firms that specialise in financial assessment. Bentleys is an example.

Senator McLUCAS—Every application has a financial assessment?

Ms Rosevear—The majority of applications have a financial assessment, especially if it is an applicant we have not seen before.

Senator McLUCAS—I am advised that the essential guide to the 2006 aged care approvals round said that the four key issues for the 2006 aged care approvals round are the four that I read out. How does that differ from the 13 that you read out?

Ms Rosevear—The 13 criteria are those that are in the act and principles against which every application is assessed. The priority criteria in the essential guide are the sorts of things that we may be looking for nationally and may have priority in particular areas, so that will be based on the assessment of needs in particular areas.

Senator McLUCAS—So, if an applicant focused on those four criteria, they would be more likely to be successful?

Ms Rosevear—If we had, for example, two applications that, against every criteria, were essentially the same but they were better in one of those particular areas that have been identified for that region, then, all other things being equal, they would probably be more likely to succeed.

Mr Stuart—The aim of this entire process is to identify the providers that will best meet the needs of the community rather than to select applicants who are the best at producing applications against particular criteria. It is run very similarly to a tender process in many ways, but we are attempting to fulfil policy purposes here—not to find someone who can sell the cheapest and best pencils to the department. So there is a process of introduction of policy goals, which we try to be very clear about; hence the quote from the guide that you are aware of.

Senator McLUCAS—I understand, Mr Stuart, that you have to use some sort of judgement in places to make an assessment of an application. I have heard that it costs quite a bit of money to put in an application for a bed licence and that some people opt to pay it and others do not; your task is to then sift through that to try to find the truth in the application.

Mr Stuart—Of course, we do not charge people to put in an application.

Senator McLUCAS—No, but others do.

Mr Stuart—There is of course a cost to providers in doing so.

Senator McLUCAS—I would like to go back to the process of assessing an applicant's financial situation. I understand the essential guide indicates that, if a financial analyst needs to clarify any financial information, the authorised contact person—that is, the applicant—will be contacted by an officer of the department and that any request for clarification is to allow consideration of the application. How often do analysts or consultants, through the department, contact people to clarify financial situations?

Ms Rosevear—I understand that only a handful are clarified every year and that they are generally the capital applications.

Senator McLUCAS—That is interesting; I will come back to that. The applications closed on 30 June last year, and I understand that the state office does the analysis. Can you tell me the time frame between the receipt of those applications—that is, 30 June—and the next stage in the process?

Ms Rosevear—Generally the assessment process takes around three months, during which time there will be an assessment. There will be a review by the more senior officers within the state or territory office, and they will then put together a list of recommendations that come to central office for the delegate to consider.

Senator McLUCAS—So that would be around September?

Ms Rosevear—Yes.

Senator McLUCAS—Do we have a date?

Ms Rosevear—We will have to take that on notice.

Senator McLUCAS—What happens after that, Ms Rosevear?

Ms Rosevear—There will be some quality assurance checking within central office, just to make sure that the information is correct, and then a package is prepared for the delegate's consideration.

Senator McLUCAS—How does the quality assurance work?

Ms Rosevear—Essentially we look to see whether the numbers add up and that the supporting information provided for each recommendation is sound. If it is not clear to central office then we will clarify with the state office as to what they mean. We are looking to see whether there is sound reasoning in the recommendation and we will clarify if there are issues.

Senator McLUCAS—I am concerned that you say 'the numbers adding up', because I am trying to ascertain whether it is a clinical process or whether it is a far more subjective process.

Ms Rosevear—It is generally a clinical process.

Senator McLUCAS—So there will be a sheet with marks on it as to how successful the applicant has been against each criteria?

Ms Rosevear—There will be a pile of folders that have details on every application, and there will be recommendations in relation to each application from the state or territory office.

Senator McLUCAS—When that quality assurance is done, how regularly does it show up oversights or different points of view from those at the state level?

Ms Rosevear—There are usually several each year. For example, we might go back to a state office and say, 'Why didn't you allocate all the places that were in the essential guide to the planning document to a particular region?' So we are looking to see the logic of their allocation process within particular regions. Those are the sorts of things we clarify.

Mr Stuart—We would be testing judgements.

Senator McLUCAS—Yes. Ms Rosevear, you seem to be talking about the allocation of places into regions, not the assessment of the applications for those places. Is it two processes?

Mr Stuart—No. What Allison is talking about is one of the issues in the kind of process of testing of logic. So if an ACPAC says, 'We need more places for Polish people in the west of Sydney,' but no places were allocated for Polish people in the west of Sydney in that particular round, then we would go back and say, 'What kinds of applications did you get? Tell us why you didn't think any of them were suitable.'

Senator McLUCAS—So it is a mixture of the two processes?

Ms Rosevear—Yes.

Mr Stuart—It is essentially testing and questioning.

Senator McLUCAS—So the QA testing takes about a month?

Ms Rosevear—Yes.

Senator McLUCAS—So that is October. Would it be completed at the beginning of October or at the end?

Mr Stuart—There are number of processes to step through. There is the place allocation process for both residential care and community care, and the state offices phase those to some extent and they come back together towards the end. There are also applications for extra service accompanying the round, which need separate consideration, and applications for capital. So when we have gone through a process of looking at aged care places, there is then further consideration of whether homes that have applied both for places and for capital ought to be successful in both. There would be people applying for places on the basis that they are only to provide them if they have a capital grant as well. So there are a number of threads that really have to come together in that latter part of the year.

Senator McLUCAS—When is the latter part of the year, Mr Stuart? When do we have a complete list of all of the elements agreed in the department?

Mr Stuart—I believe I was seeing some analysis in respect of residential places late in October, and I was seeing some analysis in relation to community care probably in late October or early November. But I do not think I saw analysis in relation to capital until mid to late November.

Senator McLUCAS—So the final list would be able to be compiled in late November?

Mr Stuart—It is of that sort of order, yes. Then there is a whole further process of logistics which involves obtaining reg 9 approval from the minister for finance.

Senator McLUCAS—What is reg 9 approval?

Mr Stuart—That is approval from the minister for finance to allocate funds, if you like, or a liability over multiple financial years, because obviously there is a very long expenditure tail on any allocation of aged care places.

Senator McLUCAS—What process do they go through?

Mr Stuart—Then there is preparation for public announcement and debriefing.

Senator McLUCAS—Do they go through some sort of assessment of the financial capability of each applicant?

Mr Stuart—I think I am being corrected. It is probably reg 10 approval.

Senator McLUCAS—Someone will get a gold star and you will lose yours, Mr Stuart!

Mr Stuart—The substance of what I have said is correct. What was your question?

Senator McLUCAS—What process does the Department of Finance and Administration undertake to get the regulation 10 approval?

Ms Rosevear—The minister needs to write to the minister for finance seeking approval for the capital expenditure and then the department will provide the information to the department of finance on the capital grants.

Senator McLUCAS—That is just on the capital grants?

Ms Rosevear—That is just on the capital grants.

Senator McLUCAS—This is only on capital grants?

Ms Rosevear—Yes, that is right.

Senator McLUCAS—So regulation 10 is only required on capital?

Ms Rosevear—That is right.

Senator McLUCAS—So the final list comes together in mid-November. Then what happens?

Mr Stuart—Then we go off, as I said, for approval from the minister for finance and we begin preparing for public announcement. I am just struggling to think the date on which I would have, as delegate, exercised my delegation on approval for the places. I believe it was in the second week of December.

Senator McLUCAS—What happens after that?

Mr Stuart—We have to get the minister for finance's approval before I can exercise that delegation.

Senator McLUCAS—Can the minister for finance's assessment change the outcome or recommendation that is made at that point from the department?

Mr Stuart—No, it is more in terms of an authority to expend the funds. I cannot exercise my delegation to allocate places until we have authority to expend the funds.

Senator McLUCAS—So it is the second week in December. What do you do at that point?

Mr Stuart—I sign a lot of paper.

Senator McLUCAS—What does the paper say?

Mr Stuart—There is a set of legal instruments saying, 'I hereby allocate places on behalf of the Australian government.' There are attachments listing all of the homes to which places are being allocated and listing all of the homes to which places are not being allocated. I initial every page.

Senator McLUCAS—When is the minister's office told of that?

Mr Stuart—During the preparation for announcement we start to work with the minister's office about the public information process that follows.

Senator McLUCAS—That is after the operation of your delegated authority?

Mr Stuart—That is right.

Senator McLUCAS—And that is what happened last year?

Mr Stuart—Yes, that is right.

Senator McLUCAS—When was the minister's office told?

Mr Stuart—As I recall, we were getting pretty close to business close-down in December and were pretty anxious to get the information across to the minister's office as soon as I had signed the legal instruments. So it would have been a matter of a day or two.

Senator McLUCAS—So you signed it in the second week of December. You sent a list of the approved places?

Mr Stuart—That is right.

Senator McLUCAS—And that is just for the minister's information?

Mr Stuart—That is right.

Senator McLUCAS—That would have been in the second week of December, plus a day? And what happens then?

Mr Stuart—There is then a fairly large process of notification, which I will let Allison explain.

Ms Rosevear—Once the announcement has been made, we will assist the minister by preparing media releases, for example. The minister writes to all successful applicants, advises them that they have been successful and that the department will be in touch with further information, such as with any conditions of allocation, for example.

Senator McLUCAS—What date did those letters go out?

Ms Rosevear—Those letters went out on 19 December, which was the announcement date.

Senator McLUCAS—Mr Stuart, do you write to the applicant or does the minister write to the applicant?

Ms Rosevear—The minister writes to the successful applicant.

Senator McLUCAS—So that was sent out on 19 December.

Ms Rosevear—Yes.

Senator McLUCAS—Was the letter posted on that date?

Ms Rosevear—I believe so.

Senator McLUCAS—The minister also contacts members and senators who may have an interest in who has been successful; what is the process for that?

Mr Stuart—There is a process inside the minister's office for preparing that documentation and using the information provided to the office by the department.

Senator McLUCAS—So the minister writes to all members and senators explaining which applicants in their various electorates have been successful?

Mr Stuart—I am unaware exactly of what happens in the minister's office.

Senator McLUCAS—That is a reasonable answer, Mr Stuart. Maybe the minister can answer that question.

Senator Santoro—That is one of the pleasant tasks of the minister: to write to people. I think from memory I do not sign all the letters. It is an electronic signature, isn't it, to the providers who have been successful?

Senator McLUCAS—You would say that.

Senator Santoro—But I do write to senators and members, Senator McLucas, letting them know what providers in their vicinity have been successful.

Senator McLUCAS—Which ones do you write to?

Senator Santoro—Senators and members.

Senator McLUCAS—Minister, please be specific.

Senator Santoro—Senators and members.

Senator McLUCAS—From which party, Minister?

Senator Santoro—I certainly write to coalition senators and members.

Senator McLUCAS—Yes, that is right. So you do not write to advise Labor members who have electorates in which there have been successful applications. You in fact write to a Liberal Party senator, or National Party senator perhaps, to advise them that an applicant has been successful.

Senator Santoro—That is correct.

Senator McLUCAS—Yes, that is right. Why do you do that, Minister?

Senator Santoro—I think it is established practice.

Senator McLUCAS—I think you might want to check that.

Senator Santoro—I will check that, if you like.

Senator McLUCAS—But why do you do it? Just because someone did it before you?

Senator Santoro—Just to clarify, as you have given me the opportunity, you would be aware that there has been no other minister who has been more consultative with the opposition than I have been.

Senator McLUCAS—That is not the question I am talking about, Minister. Just tell the committee whom you write to and when, and do you bother telling Labor members of parliament whether there has been a successful applicant in their electorates?

Senator Santoro—I write to duty senators also.

Senator McLUCAS—Do you write to Labor duty senators?

Senator Santoro—To coalition duty senators.

Senator McLUCAS—Only coalition duty senators.

Senator Santoro—That is correct.

Senator McLUCAS—You do not write to me, for example, to tell me which applications have been successful in Queensland.

Senator Santoro—I write you very often, as you know, and I extend to you much professional and personal courtesy. You should be gracious enough to acknowledge that.

Senator McLUCAS—I will take your advice when I want to, Minister.

Senator Santoro—I shall continue to do that too, Senator.

Senator McLUCAS—I look forward to it. In the 2006-07 ACAR round, how many approved providers applied for aged care places and how many approved providers were successful?

Ms Rosevear—I do not have the exact figure in front of me, but there were in the order of 1,800 applicants in the 2006 ACAR round and about one in four applicants were successful.

Senator McLUCAS—One out of four was successful?

Ms Rosevear—That is right.

Senator McLUCAS—It would be very helpful, Ms Rosevear, if you could provide me with a table by planning region that indicates the number of applicants—I am not talking about beds; I am talking about applications—and the number of successful applicants for each planning region. I think we would like to know that.

Ms Rosevear—There will be a number of applicants who apply across more than one planning region so we would actually have to look to see if we can put that together.

Senator McLUCAS—Don't they have to put in a separate application?

Ms Rosevear—Not necessarily, no.

Mr Stuart—Just to clarify, we will provide you on notice with an answer to the question that shows how many applications there were in each planning region and how many successful applications there were, acknowledging that there will be providers who apply in a number of areas and so will appear in more than one area.

Senator McLUCAS—How do you apply for beds in two planning regions with one application?

Mr Stuart—No, it is not with one application.

Senator McLUCAS—I thought that is what Ms Rosevear said.

Ms Rosevear—I am sorry—I thought you were asking about applicants. I can certainly get the information on applications.

Senator McLUCAS—No—for the south-west district in Queensland—

Mr Stuart—The number of applications—

Senator McLUCAS—how many applications you received—

Mr Stuart—and the number of successful applications?

Senator McLUCAS—and how many were successful.

Ms Rosevear—Yes, we can do that on notice.

Senator McLUCAS—Thank you. When you report back to an unsuccessful applicant, do you provide reasons for their lack of success?

Mr Stuart—Yes, we do. There is an issue underlying all of our discussions with individual providers which is that we can only talk to them about their application but our decisions are comparative—on the basis of comparative merit. It is often very difficult for an aged care—

Senator McLUCAS—Yes, you cannot tell them, 'You missed out because so-and-so was better than you.'

Mr Stuart—That is right—or why so-and-so was better than them.

Senator McLUCAS—But you can say, 'Your application was unsuccessful because you could not demonstrate bed readiness,' for example?

Mr Stuart—Sometimes it is as clear-cut as that. At other times it is simply that you can put in quite a good application or maybe a very good application but another provider is able to put in a slightly better one—one with a slightly better, longer and more compelling track record, for example. It is not always possible to point to a particular deficiency in an application. I can understand that providers sometimes scratch their heads about why they are unsuccessful in what appear to be perfectly adequate applications. But our decisions are comparative. We do try to tell providers that when we debrief them.

Senator McLUCAS—I daresay some of them are unsatisfied with your answer, but that is understandable.

Mr Stuart—Each applicant is the centre of their own concern, I would say.

Senator McLUCAS—I concur. Is the minister informed about the applications at any time during the ACAR process that you have described prior to the final recommendations being made?

Mr Stuart—I remember on occasion that we have advised ministers about the volume of applications, but there is never a process of advising ministers about particular applications or their merits.

Senator McLUCAS—Will the minister's office make contact not necessarily with you Mr Stuart but with members of your department, particularly in view of the comments of the minister earlier about the volume of representations in support of certain applications? Do you recall receiving any contact from the minister's office during this most recent round about particular applications?

Mr Stuart—We received the flow of correspondence that the minister has previously alluded to. That, of course, arrives in the minister's office and comes through to the department. But I have not been contacted by the minister's office about particulars of applicants in the course of exercising my delegation.

Senator McLUCAS—When was the final date—you might have to take this on notice—that the 2006-07 ACAR final list was sent to the minister's office? We have been talking about mid-December. I think we need to put a date on it.

Ms Rosevear—Yes. I believe it was around 14 December, but I will clarify that.

Senator McLUCAS—That is the date it is sent to the office?

Ms Rosevear—Yes.

Senator McLUCAS—And then I would like to know the date that the letters were sent.

Ms Rosevear—The date on which the letters were sent to successful providers?

Senator McLUCAS—Yes.

Ms Rosevear—The letters were sent to the successful providers on 19 December.

Senator McLUCAS—Thank you. I would also like to know the date that coalition members of parliament were advised of successful applicants in their electorates.

Ms Rosevear—I cannot answer that.

Senator McLUCAS—You may not be able to answer that yourself, Ms Rosevear, but the minister's office will be able to do that. Minister, I understand that there is a review underway into the aged care planning process. Could you explain what that is going to do?

Senator Santoro—Yes, there is. You will recall that I informed you of that review at the last estimates sittings of this committee. I did so unprompted and I did so before the last ACAR round had in fact concluded. It was a review that I decided I was going to undertake very early in the piece as Minister for Ageing. It was subsequent to I suppose anecdotal evidence and comment that was put to me, as I mentioned to you at the last sittings, by providers about the way the ACAR round was conducted. I think I invited comments about the process in my first major speech in Mildura in late February or early March in 2006. I thought the review was a good thing to do. I understand that is progressing.

Senator McLUCAS—Mr Stuart, could you outline how the review of the ACAR rounds is going to proceed, what the time lines are and when the reporting date is going to be?

Mr Stuart—I will refer that to Ms Rosevear for the detail.

Ms Rosevear—The review is being undertaken by an external consultant. That consultant is talking to various stakeholders. They have already spoken to state and territory officers and they will be speaking to various members of the aged care sector. The first meeting of the probity review reference group was last week. The reference group provides direction to the probity reviewer. We are expecting that, subject to people being available for a consultation process, the review will be able to provide at least some sort of preliminary report back by the end of March. The final report may follow thereafter, but there will be at least some preliminary report.

Senator McLUCAS—Can the committee have a copy of the terms of reference for that and the name of the external consultant?

Ms Rosevear—Yes. As to the external consultant, the successful tenderer was RSM Bird Cameron. They are undertaking the review. The terms of reference I would need to provide to you on notice.

Senator McLUCAS—The South Coast Aged Care Planning Region, understandably, has a particular shortage of aged care beds. We in Queensland recognise that is where the Mexicans

retire. So there is always going to be a higher proportion of older people in the South Coast Aged Care Planning Region. How does their ratio compare with other aged care planning regions in Queensland?

Ms Rosevear—As of 30 June 2006 the south coast operational ratio was 96.9.

Senator McLUCAS—Just for residential, please, Ms Rosevear.

Ms Rosevear—The residential was 78.8.

Senator McLUCAS—How does that compare with the rest of Queensland?

Ms Rosevear—It is lower. Queensland is 85.5.

Senator McLUCAS—On my understanding of the figures, it is the second worst in Queensland.

Ms Rosevear—I think it is the third or fourth worst in Queensland.

Senator McLUCAS—Really? I will go back and have a look at it. Given that and given the discussion earlier about having to make a judgement about applications, would bed readiness be an important criterion for applications for this particular region?

Ms Rosevear—The ability to have places online in a timely fashion is what the bed readiness criterion is about. All other things being equal, bed readiness would be an advantage.

Senator McLUCAS—Without going to specifics, were there any successful applications in that region from applicants which were bed ready—ready to start?

Mr Stuart—We would have to take it on notice.

Senator McLUCAS—There was an application from a provider that has an operational aged care facility that was unsuccessful. I am sure you know the one I am talking about.

Mr Stuart—Yes, we are aware of that application.

Senator McLUCAS—They would have gotten 10 out of 10 for bed readiness, you would imagine.

Ms Rosevear—Certainly they are bed ready, yes.

Senator McLUCAS—Tell me then if there were any other applications, particularly successful ones, that were as bed ready as Life Care.

Mr Stuart—We will have to take that on notice.

Senator McLUCAS—Thank you. Once aged care bed licences have been allocated, does the department have an ongoing monitoring of compliance, essentially, with what was said in the application?

Mr Stuart—Yes, we do. For the last few years we have been increasingly interested in seeing aged care places come online within a relatively short period of time. We have regular contact with providers, particularly where the process seems to slow down. We have regular contact with providers about getting those places going.s

Senator McLUCAS—Going to the other criteria—the dementia specific provision, for example—if one of the key criteria this year was dementia services, do you in two years time go along and make sure that they are providing dementia specific care?

Mr Stuart—We do put a condition of allocation on the places. If the provider wants to vary from that, they make an application through the department to vary from that.

Senator McLUCAS—How regularly does that occur?

Mr Stuart—It happens from time to time in the light, sometimes, of experience. Also, things do change over a period of years—if we allocate places for a particular ethnic group, for example, and that group becomes less evident in the age profile of a particular community.

Senator McLUCAS—We have spoken before about whether or not community aged care packages allocated to particular ethnic groups continue to be provided to those groups. I want to talk about the decision to award Mr Russell Egan 94 bed licences for a block of land on the Gold Coast. I understand that you have some constraints on talking about particular applications but, as you know, this has been the subject of some media scrutiny. How is an application for 94 bed licences approved for a block of land when an application for bed licences made by a firm that has a fully operational, functioning and partly Commonwealth used aged care facility was unsuccessful?

Mr Stuart—I am aware of the media about this allocation. I do not think it is particularly well informed. The issue about the minister's knowledge is an important issue to put to one side. Not once during the entire process was there any contact with the department from the minister's office about Mr Egan.

Senator McLUCAS—That is why we went through that process.

Mr Stuart—I did not myself know of Mr Egan's affiliation until after the approval, when the issue appeared in the press.

Senator McLUCAS—That is not the question I asked.

Mr Stuart—It was certainly implied in the question that you asked, Senator.

Senator McLUCAS—It was a straight question.

Mr Stuart—If I can interpret your question differently, we are in danger of comparing the comparative merits of two applications. There are 13 criteria involved in the comparative application. Attempting to make a general statement: where there are providers who have a long track record providing appropriate care and meeting our standards within our standards framework and who are assessed as being a very low risk of getting places going, those providers, as you could imagine, would generally be preferred to providers where there is not such a track record, where we have not previously been accrediting facilities, where there is no track record of any engagement with the complaint scheme and where there may be question marks about those providers against particular criteria. I think that is probably about as far as I can go in answering the question.

Senator McLUCAS—Does your comment about a track record mean that no-one who is in the business will ever get into the business?

Mr Stuart—That is not quite the case—not entirely the case. But certainly looking for providers who have an existing strong record of care is an important part of the approval process.

Senator McLUCAS—How does an applicant who has no strong record of care, given that they have not been approved bed licences in the past, prove that?

Mr Stuart—They hire key personnel who have such a track record in other aged care homes and they apply for places where applications are few and where others are not applying and things of that kind, essentially to obtain a foothold in the industry from which they can then develop a record to apply for more places in the future.

Senator McLUCAS—But you are telling me you have no processes to ascertain ability to deliver quality care outside track record?

Mr Stuart—We use proxies such as the key personnel but, as in all selection processes, an existing strong record is usually preferred to claims and promises.

Senator McLUCAS—We will use Life Care as an example; they are quite happy for us to be discussing this today. You would not go to the Life Care facility on the Gold Coast to have a look at the quality of care being delivered there? I do not mean you personally, Mr Stuart, but the department.

Mr Stuart—I would think that, in an area where there were a substantial number of applications from providers with strong track records, that would be an unnecessary expense on the part of the department. It is already a very large and expensive assessment process that we undertake, and the object of the policy is to obtain great quality care for older Australians. The object of the policy is not focussed on individual providers.

Ms Halton—Let us add to this that an applicant is at liberty—going to our original discussion about the third-party endorsement one gets in relation to applications—to tender or bring forward whatever information and supporting material they choose. As Mr Stuart indicated, in a case where you do not have an established track record—if there is an established track record all the applicants know we are going to go and look at their track record—you are at liberty to provide us, and in some cases we require you to provide us, with a series of pieces of information, including key personnel, and that is relevant. But if you have other matters that are relevant we expect those to be brought forward, and then we assess based on the application.

You are aware that in some cases people bring forward applications that are not successful and they have said later, 'Oh, but of course we can do that.' But if it is not demonstrated in the application upon which the decision is taken it is not demonstrated, and we take the evidence that is in front of us to assess those applications. That is what has happened in this process.

Senator McLUCAS—That does run counter, Ms Halton, to Mr Stuart's earlier evidence when he said that the job of the department is to sift through the data provided to work out what is important information—I am paraphrasing him.

Ms Halton—But that is entirely consistent with what Mr Stuart said. Mr Stuart said that we get a whole series of bits of information and, based on experience and the balance of that information, we weigh that and take a decision.

Senator McLUCAS—Therefore, in going through that process, do you ascertain whether a building approval has been provided for the block of land?

Mr Stuart—In assessing the criterion about which we are colloquially calling 'bed readiness' we look at all the information that the applicant provides, including the extent to which they have progressed building plans and council approval.

Senator McLUCAS—Do you know what the zoning is for the block of land owned by Mr Egan?

Mr Stuart—Not in front of me, no. I am not aware of that.

Senator McLUCAS—Would the department have ascertained that?

Mr Stuart—We may have.

Senator McLUCAS—You may have. It is not relevant to know whether the land is zoned for residential aged care? What you are saying there, Mr Stuart, is that you would not as a matter of course ascertain what the zoning of a particular block of land is.

Ms Rosevear—Part of assessing the criteria for making places operational in a timely manner would be to determine whether, for a particular block of land, it was likely that the applicant would be able to make the places operational in a timely manner. So we would be looking for them to provide evidence that that land can be used for that purpose.

Senator McLUCAS—So you would as a matter of course know what the zoning on the land is?

Ms Rosevear—I believe so, yes—certainly in the state and territory offices, and I can confirm with the Queensland office.

Senator McLUCAS—Would you as a matter of course require a development application to have been lodged?

Mr Stuart—Not necessarily, no.

Senator McLUCAS—So, in regard to bed readiness, we have a completely built, operational, functioning facility that is taking Commonwealth respite places already, and a block of land that does not even have a development application on it?

Mr Stuart—We are at this moment unaware whether there is or is not a development application.

Senator McLUCAS—You do not need to know that as part of the assessment?

Mr Stuart—I am not aware of that today. I am not certain what was in the application and what the Queensland department office subsequently might have asked for. I am sorry, but I cannot answer that question directly at this hearing today.

Senator McLUCAS—Minister, I understand you know Mr Egan—that is a straight question.

Senator Santoro—Yes.

Senator McLUCAS—Is Mr Egan an approved provider of residential aged care?

Senator Santoro—That is my understanding.

Senator McLUCAS—Have you seen Mr Egan's weblog?

Senator Santoro—I have seen extracts of it but I certainly have not visited the site by electronic means, no.

Senator McLUCAS—He has removed it from the website.

Senator Santoro—I am unaware of what he has done with it, but, during the time when some publicity was forthcoming as a result of the existence of that website, I have a vague recollection of some items being brought to my attention.

Senator McLUCAS—Have you been advised that Mr Egan's weblog has a connection to what I call a pornographic site?

Senator Santoro—I have a vague recollection that there was some suggestion put to me to that effect, but it was not what I would call a comprehensive briefing or any great detail imparted on my consciousness.

Senator McLUCAS—Do you think it is appropriate for an approved aged care provider to be providing a link to what I believe is a pornographic site?

Senator Santoro—On the surface that would not be a desirable link for an approved aged care provider to be providing, but I am not sure that was the case and I am also not sure that Mr Egan was portraying himself as an approved aged care provider.

Senator McLUCAS—On the same blog he is telling everyone that this was the best Christmas present that he had ever had, that he had hit the jackpot and that he can sell these bed licences for $3.7 million. This is what is talking about on his website, so he is clearly linking the fact that he is an approved aged care provider with that weblog.

Senator Santoro—What Mr Egan decides to do is his business. My business as minister is to administer the act. In terms of his boast that he can sell the aged care places that were allocated to him, you know that there is a very stringent, well-defined process.

Senator McLUCAS—So should he, Minister.

Senator Santoro—He probably—

Senator McLUCAS—He is telling the world that he has got a $3.7 million Christmas present.

Senator Santoro—What somebody claims and what is possible can often be two very distinct things. In this case, you would be aware that, for Mr Egan to be able to sell those places that were allocated to him, he would have to sell his whole company.

Senator McLUCAS—That is right. He can sell his whole company, with those places, and make about $3.7 million.

Senator Santoro—That is the current situation as it stands.

Senator McLUCAS—What action are you going to take on the information that you have that Mr Egan's weblog was connected to a pornographic site?

Senator Santoro—I do not know that I can do anything under the Aged Care Act, for which I have ministerial responsibility.

Senator McLUCAS—When a person is an approved provider and information comes to light that raises questions—and in my view it does—what action can you take?

Senator Santoro—I reiterate to you my advice that I do not believe there is anything I can do. If you believe there is something I can do, legally, you should inform me and this committee and I will consider your advice. But do not try to create some sense of drama or sense of obligation on my part, because I can only do what I can legally do, and your theatrics in what you are trying to suggest to the world that I can and should do just do not stack up against the law.

Senator McLUCAS—Can I ask Mr Stuart or Ms Halton—

Senator Santoro—No—

Senator McLUCAS—If someone has been given approved provider status and some information becomes evident that questions the suitability of that status, what does the act provide?

Mr Stuart—We have regulations in respect of key personnel. I think that would be the most relevant issue. The regulation states that aged care cannot be provided by a disqualified person.

Senator McLUCAS—That is not quite the question I asked, Mr Stuart. Information has come to light. I believe that the minister has to ethically question whether this person should remain as an approved provider. What action can be taken to investigate that, assess that and find out whether or not Mr Russell Egan should continue as an approved provider?

Ms Halton—Because we seem to be discussing a legal situation—and I am not confident that we have all of the information that you have—I am loathe to start offering specific advice in relation to a situation where we may have an unequal understanding of the circumstances. It is the case that, if someone has a conviction—and I am happy to get the lawyers to come up and give you a legal interpretation of these parts of the act—the issue is around the status of approved providers, as Mr Stuart has indicated. The role of key personnel is very important under the act, but again I am not necessarily confident that I have exactly the information that you have.

Senator McLUCAS—It is not the information that I have which is relevant; it is the information the minister has. The minister is aware that Mr Egan's weblog was connected to what in my view is a highly pornographic site. What has the minister done with that information? Has he referred the information to the department? Have you acted on your knowledge of Mr Egan's weblog?

Senator Santoro—I again stress to you that I do not have, in my view, any capacity to influence departmental processes in terms of the consideration and granting of approved provider status. The department, when considering applications under ACAR and when considering applications for approved provider status, will consider all the facts that are known to them, and I am sure that they will do a very professional job in doing that.

Senator McLUCAS—Yes, Minister. That is not what I am asking.

Senator Santoro—But I, unlike you, Senator McLucas, will not seek to interfere in either the allocation process or processes which should be beyond the prerogative of the minister.

Senator McLUCAS—I am not talking about better allocation; I am talking about the fact that you knew that there was this link to a pornographic site from Mr Egan's weblog and it would seem that you have done nothing about it.

Senator Santoro—Senator McLucas, I am—

Senator McLUCAS—Have you told the department?

Senator Santoro—I am under no—

Senator McLUCAS—Have you asked them to investigate whether it is appropriate?

CHAIR—Senator, can we hear the answer and then move to the questions. It is a bit hard when people are talking over each other—

Senator Santoro—It is my considered view that I am under no obligation to inform the department of people's—if I can put it this way—personal endeavours in terms of their personal websites. If there is any issue of impropriety that the department needs to consider in granting approved provider status, which Mr Egan has, it is up to the department, as it is up to the department to decide on the allocation of positions. I do not know that I can add to my answer.

Senator McLUCAS—I do not think you can either, Minister. You did nothing. You heard about it and you did nothing. I want to go back to the financial assessment processes. I think Mr Stuart indicated that a consultant is employed to do a financial assessment of an application. One of the directors of Life Care has expressed concern to me that there has been a breach of confidentiality during the process of assessment of their application. I am advised that he had a conversation with a mortgage provider who indicated to him that 'he was not sure about our submission because he had heard that the Department of Health and Ageing had serious concerns about Carrara's financial viability'. Is that a breach of the Aged Care Act? That is information that it would seem has gone from the consultant who has done the assessment of the financial viability to another party.

Mr Stuart—I would hate to speak hypothetically about whether it is a breach of the Aged Care Act. Firstly, I cannot confirm or deny whether the department actually has that view about Life Care's financial position. Secondly, I cannot at the moment answer how the mortgagee may have obtained such information, if it was correct. The department has received a letter from Life Care on this matter and the department has decided to conduct an investigation of this matter, which is something that we do whether or not we think there is a serious risk of a breach. We are currently investigating that matter.

Senator McLUCAS—Thank you. I appreciate that. Can I also ask you to investigate whether or not—I think it is 'not', and therefore why—a follow-up visit from the department, as we talked about earlier, was not undertaken, if there was this view held that Life Care had financial issues that should have been assessed—that mitigated against their being successful for licence approval?

Mr Stuart—I'm sorry?

Senator McLUCAS—That was a confusing question.

Mr Stuart—Could you clarify?

Senator McLUCAS—I want to know why the department, if it was of the view that there were financial issues with Life Care, did not request a follow-up visit from the department.

Mr Stuart—Again speaking hypothetically, the department makes allocation decisions in a way which is relatively risk averse. If there are particular criteria against which there is significant doubt, then it is not in the department's interests to pursue allocation of places to those providers. If that doubt is on—

Senator McLUCAS—That is on the basis that you have all of the information. I understand what you are saying, Mr Stuart. I know there are many unhappy unsuccessful applicants—I never hear from the successful ones—but when the applicant is of the view that you could not make a sound judgement because you did not have all the information, or you had incorrect information, that is of concern.

Mr Stuart—I think applicants must always feel that if only they could provide more information we would make a different judgement, but I am not sure that is necessarily always the case. We have very good standardised processes for obtaining comparative information on aged care providers, and there is really not a great deal of merit in departing from those standardised processes in individual cases, unless we are looking very hard to provide care in a place where it might otherwise be unavailable.

Senator McLUCAS—I understand that it is not a straightforward process, but the review will be interesting. I note that 97 bed licences went to Aged Care Services Australia Group, and that 37 of those were in Tasmania in this most recent round, and in the 2005-06 round the Aged Care Services Australia Group received 60 bed licences. If that is not correct I am sure you will come back to me. The director of that company is a gentleman by the name of Mr Arnan Rouse, who has been in the paper quite a lot, particularly in June and July. We have spoken about him here before, mainly because of his industrial matters with his staff. Do you recall Mr Rouse? We have questions on notice about him.

Mr Stuart—I am sorry, I personally do not.

Senator McLUCAS—I refer to question on notice No. 2763. Did the unannounced support contacts described in that question take place before or after the media reports around his staffing issues? Mr Brandon, you thought you were going to get away without any questions.

Mr Brandon—I am sorry, Senator, would you repeat the question?

Senator McLUCAS—I am asking about the support contacts you indicated in answer to question on notice No. 2763 about Mr Rouse's facilities. A lot of support contacts and spot checks were undertaken. How many of them were conducted after the stories about his sacking of his staff and replacing them with workers from 'the dole queue', as quoted in the Sunday *Herald*?

Mr Brandon—I do not have a table that sets out the date in relation to that media. I know the dates we visited each of the Aged Care Services Australia Group facilities, and we responded to question E06, No. 29, which went to whether we had undertaken unannounced spot checks at a number of homes since July 2006. That is what I have.

Senator McLUCAS—Can you recall whether those unannounced spot checks or side audits were as a result of the media reports?

Mr Brandon—We have undertaken a number of visits over the last year or so to all of the homes under Aged Care Services Group Australia. Some of them related to noncompliance in other homes. As part of our processes, if we find noncompliance somewhere we will go to look at other homes, so I cannot say that it was directly related to the media.

Senator McLUCAS—So there was some noncompliance found?

Mr Brandon—Over the last couple of years there has been some noncompliance in some of those homes.

Senator McLUCAS—Mr Stuart, how does that fit with a track record for a successful application? The words were that there was 'some noncompliance' at a number of homes; that is right, Mr Brandon?

Mr Brandon—Maybe I can clarify that. I am talking about residential aged care facilities, and some of these facilities may have had their noncompliance before Aged Care Services Group Australia took them over.

Senator McLUCAS—It is the same person, though; it is Mr Rouse?

Mr Brandon—Yes. I am looking at all of the homes going back—

Senator McLUCAS—Prior to purchase by ACSGA?

Mr Brandon—Yes. We deal with them as homes, not in relation to the approved provider.

Senator McLUCAS—Exactly. So we have to ascertain when they were purchased by Mr Rouse?

Mr Brandon—If you were to ask me that question about noncompliance since the purchase, I would have to take that on notice.

Senator McLUCAS—It would be helpful if you would do that.

Mr Stuart—It appears here that we have questions about a relationship between changes of ownership, an assessment process for places and compliance action, which I believe is going to be beyond us in the context of this hearing to answer with any clarity.

Senator McLUCAS—Yes, it probably would be in the time frame. If Mr Brandon can tell me the ownership of each of those facilities at the time of the spot checks—just go back to the question, Mr Brandon, and I think it will be straightforward—then I can make a further judgement. Minister, how much did the Liberal Party receive from Aged Care Service Australia Group, which sponsored the Liberal Party fundraiser in Launceston on 30 January this year?

CHAIR—I am sorry, Senator McLucas, that is not a question that is within the purview of the Minister for Ageing. It is a question to ask the Liberal Party.

Senator McLUCAS—I am sure the minister would know; he was there.

CHAIR—Whether he knows or not, it is not a proper question for the estimates committee. So if you want to ask the question of the minister, ask him over the lunchbreak.

Senator Santoro—I am not aware of any amount, Chair.

Senator McLUCAS—You were there, Minister; there is the invitation.

Senator Santoro—I might have been there, but I am answering your question: I am unaware of what sponsorship was forthcoming from anybody at that function.

Senator McLUCAS—Proudly supported by Aged Care Services Australia Group.

CHAIR—Senator, I am not going to enter into debate. This is not a matter for the estimates committee of the Senate.

Senator McLUCAS—I might pursue it elsewhere then.

CHAIR—You are welcome to do so.

Senator ADAMS—I notice that police checks for aged care workers will begin in March, and I have several queries. Firstly, will existing staff be required to undergo a retrospective police clearance?

Senator Santoro—Any existing staff member who does not have a police clearance certificate will have to apply for one.

Senator ADAMS—If one of these clearances indicated that a current employee had a conviction that would preclude them from holding their job, will they immediately be dismissed? If it happened years ago, how would they be situated?

Senator Santoro—There is some discretion built into the regulations, and it is really up to the provider to exercise some discretion. In exercising that discretion I think the provider would have to be fairly conscious of the fact that the accreditation agency and the department are able to make some judgements about key personnel. It is an issue that people have written to me about. If the conviction involved assaults or serious physical assault I think that the regulations in the act would be very clear.

Senator ADAMS—The other question I have is on the government doubling the assistance to those who have problems with incontinence. It is a great initiative. I have been asked why the scheme cuts off at 64 years? It goes from five years to 64 years. A number of people have asked me why this is happening.

Mr Stuart—In fact the government has just announced that it will no longer cut off at 64 but be extended beyond 64. This program was originally one that was managed by the employment department as a scheme to enable workforce participation for people who suffered from incontinence for neurological reasons. Some time ago it transferred into the Department of Health and Ageing. It has just appeared inappropriate to manage a scheme which excludes older people from a program which is managed through an aged-care area.

Senator ADAMS—Thank you. I thought I had better get it clarified. I was sure that it had, but I had been searching but could not find anything to tell me about it. The other thing concerns older Australians trying to find an appropriate aged-care facility for them to go to. Minister, could you tell me about the website and how they can access it?

Senator Santoro—That goes to the issue of a very fine aged-care website developed by the department and which I had the privilege of launching several months ago. The website was put together following the advice of an expert reference group working with very fine officers within the department. It enables people—prospective residents but particularly their carers and their relatives—to go about identifying aged-care facilities within their locality or

indeed anywhere beyond their immediate neighbourhood that they think may be suitable for the accommodation of their loved ones who may be ageing and becoming frail.

It is one of those initiatives that I think adds great value to the industry. The aged-care industry certainly appreciates a product such as the website, which of course will be maintained on a daily basis. The website will enable people to compare the quality of care that is available from one aged-care facility to another. It is easy to navigate. I do not have much expertise with computers but, when I was asked to trial it at the launch, even I had reasonable success in seeking out particular topics, such as location, size and other issues, which are of relevance when people are making decisions as to where to either go directly themselves or helping other people make decisions. It is a pretty good site.

Senator ADAMS—Thank you very much.

CHAIR—I have a couple of questions about the aged-care package that was announced on Sunday. I understand that as part of that package for community care places the ratio of places to people in the community aged over 70 is going to increase from 20 to 25. Is that correct?

Senator Santoro—What we have done there is actually increase the number of aged-care packages which will be available by 25 per cent—7,200 in total—over the next five years. Of those 7,200, 1,600 will be allocated to the dementia, high-care needs area. That recognises the fact that, as people stay in their own homes longer, many will eventually need the higher care that those packages will deliver, and that keeping people with dementia at home is highly desirable. Something which does disturb and disorient people with dementia is being put in a different location from that with which they have become familiar and having a multiplicity of carers who are unfamiliar to them. So the idea of keeping people with dementia in their familiar surrounds and being basically still cared for by people with whom they have great familiarity is a good thing from a care and clinical care point of view. It is a pretty significant step that recognises that the advent of dementia is increasing and that, until we find a cure, governments must seek to assist people to cope with the increasing incidence of dementia.

CHAIR—How many community care packages will be available altogether under this arrangement, taking into account those that are already there?

Senator Santoro—There are 1,600 new ones. How many in addition to the existing ones do we have?

Mr Stuart—There are 5,600 additional community aged-care packages over four years and 1,600 higher care.

Mr Broadhead—That is in addition to approximately 40,000 currently. So by the end of the forward estimates period there will be approximately 50,000 community aged-care places.

CHAIR—So that is about a 25 per cent increase?

Mr Broadhead—Yes.

CHAIR—There is additional money for assistance for care and housing for the aged. What is the target group?

Senator McLUCAS—There is a fact sheet.

CHAIR—I have looked at the fact sheet. I could download it when I got to it, but I could not see what it said about the target group for that particular program.

Mr Stuart—The target group for this program is the group of people who would not necessarily have the wherewithal to find their own aged-care accommodation. They are people who are homeless or sleeping rough or in otherwise insecure accommodation but who are nevertheless elderly and require care. We pay services that are contracted to the department essentially to assist in finding those people and linking them to aged-care services, whether they be community based or residentially based services.

CHAIR—Are you expecting that state based agencies like departments of community care and so on will identify people who might be eligible for those sorts of packages?

Mr Stuart—There are an existing array of community based providers that we are currently funding in the states. This funding will provide an opportunity to expand some of those and perhaps also to identify some new providers in places that we do not currently service. But I do not think we are ready to specify exactly what kinds of providers those will be.

CHAIR—I assume there will be a relatively high incidence of people with dementia and other forms of mental illness in that category of elderly homeless?

Mr Stuart—There could be.

Senator Santoro—Last year I opened premises for one such organisation, the name of which escapes me, but which I remember very clearly as providing very good care not just for people with some dementia onset conditions but people who basically had fallen on very bad times—homeless dropouts from mainstream society. There was this one organisation in particular—maybe one of my advisers can prompt me as to which one it was. It was a very touching experience to see people—including people who had experienced great success and had achieved great goals in life who had come across very bad times—who had been there for three, four or five years regain their confidence and their sense of self-esteem. It was a very worthwhile project. When the department suggested we should be looking at providing extra resources, it certainly met with very ready agreement from me. It is a small amount. I think it is about $2.6 million or $2.7 million, but that will go a long way to helping look after people that need very special care.

CHAIR—Congratulations. It sounds like a great program.

Ms Halton—I have a couple of matters to mention. In relation to the question you asked at the very outset about each program and the financial estimates, there has been a conferring with officers of the Department of Finance and Administration and I understand there is a blanket answer to your question which I am happy for Mr Clout to provide to you.

Mr Clout—As luck would have it, Finance are appearing right now in the room that we regularly appear in—

Ms Halton—And they are much smaller than us and they should be in here, in my humble opinion.

Mr Clout—This matter has come up in their committee as well this morning so they were quick to put their hands on the documents. The government's position on the publication of

budget estimates is that the four-year projections are published only at the functional level in statement 6 of Budget Paper No. 1. Our portfolio budget statements publish only one year of forward estimates—the current budget year. We publish ours also at the program level. So, in answer to your question for each of the outcomes for 2006-07, the budget estimates by program are published in our PBS. For the years beyond the budget year, the information is not published and we are not authorised to release that. The same goes for commitments against outcomes and programs.

Senator McLUCAS—Let us do the second part first—commitments that have already been made. Who makes that decision?

Mr Clout—The decision is recorded for us in a response from Senator Minchin to a question from Senator Evans in October 2005, and I am happy to table the response. Senator Evans's question was very similar to yours. It went to the program estimates over the forward years as well as commitments against those. Senator Minchin's response was that internal program information relating to the Australian general government sector is not publicly released.

Senator McLUCAS—All right. I might have a mull over that over lunch and we might talk further.

Ms Halton—That is fine, Senator. In relation to the matter you raised about security information and what matters we release in relation to the Darts' application I actually have had someone produce for me the material that we received from other parties in relation to that application. I can assure you that there were a number of letters from other parties demonstrating quite clearly that there were a significant number of others who were aware of their application, and they are both trivial—

Senator McLUCAS—I understand your point. There are a significant number of others who know about the application. It is not clear how Mr Barresi knew of the application.

Ms Halton—Maybe, but this does include members of parliament.

Senator McLUCAS—Thank you.

Proceedings suspended from 1.03 pm to 2.03 pm

CHAIR—We are going to attempt to restore the order and the integrity of our agenda, so we would appreciate it if we could move through reasonably quickly. We have agreed to return to outcome 4. Senator McLucas has the call.

Senator McLUCAS—I want to go to the issue of the Canterbury Multicultural Aged and Disability Support Services—a service that receives Commonwealth funding for 70 community aged-care packages. I think people generally call it CMADSS. Is the Commonwealth aware that the New South Wales government ordered an independent financial audit of the organisation which was handed down in May of last year?

Ms M McDonald—Yes, I am.

Senator McLUCAS—How were you advised of that audit? When I say 'you', I do not mean you personally; I mean the department.

Ms M McDonald—There had been a number of issues around CMADSS that had been raised with the department and the department has been working together with the New South Wales department in relation to that issue.

Senator McLUCAS—So you are aware that the Walter Turnbull report found instances where conflict of interest may not have been declared and examples of expenditure which could be perceived as being fraudulent.

Ms M McDonald—I do not have the details in relation to the finding of the report. Can I check whether someone else here is across that? I will have to take the question on notice. There is no-one here with that detailed knowledge.

Senator McLUCAS—Did the department receive a copy of the Walter Turnbull report?

Ms M McDonald—Yes.

Senator McLUCAS—Okay. The report noted that CMADSS has generated substantial cash reserves as a result of the funding—that funding being the Commonwealth CACP money—received significantly exceeding its expenditure in providing the related service to its direct clients. That was one of the findings. What action did the department take after receiving a copy of the Walter Turnbull report?

Ms M McDonald—I will need to take the question on notice. The part of that report that you are quoting I am not familiar with. I can tell you that there were some service issues with the CMADSS service the department was aware of and through a range of program management arrangements we have been working with the service identifying where there were issues involved and looking at how best to address those. The department has undertaken a quality reporting process for that service and looked into the issues of service delivery and a number of the allegations that have been made against the service.

Senator McLUCAS—Are you aware that CMADSS recorded an operating profit of $773,000 after provisions? Fifty-five per cent of that profit was generated from CACPS?

Ms M McDonald—Again, I would have to take on notice any questions relating to the specifics for that service.

Senator McLUCAS—Does that sound right, though?

Ms M McDonald—I am not aware of the details.

Senator McLUCAS—Is the department aware that Walter Turnbull found that some of the examples of expenditure that could be perceived as being fraudulent included tickets to political fundraising dinners?

Ms M McDonald—Again, I would need to take on notice any of the issues that you have there and respond back to you when I have the information. The day-to-day management around the service issues are managed by the New South Wales state office and I would need to speak to them to get the information that you are after.

Senator McLUCAS—But it would not be appropriate for Commonwealth money allocated to people receiving community aged-care packages to be used for Liberal Party fundraising dinners

Ms M McDonald—Again, I am not aware of the details of the allegations.

Senator McLUCAS—It is a question in principle. Would that be appropriate application of CACPS money—to send people to a Liberal Party fundraising dinner?

Mr Stuart—It is not the purpose for which we pay the money.

Senator McLUCAS—That is correct. So how do you monitor—this is now the policy question—appropriate expenditure on an ongoing basis.?

Ms M McDonald—The CACP program pays a subsidy in respect of care provided to particular approved service recipients. The monitoring that we undertake is in relation to the fact that a service recipient is receiving services under the program. They have been approved by an ACAT and they are in an approved place. We monitor the service levels and the quality that is provided. CACPs are a subsidy program, not a grant program. So there is not a requirement against a subsidy program to acquit in the same way that for a grant you have to acquit line by line your funding.

Senator McLUCAS—How do you monitor the service levels?

Ms M McDonald—The service providers are required to provide information to the department around the people they have in approved places. They need to have an ACAT assessment and then they are approved to be in that place. They then also have to report in terms of their service levels provided in terms of direct care for each of those clients through the payments system. That information is collected by the department and monitored. Then we have a quality reporting process by which the standards that apply for community care service providers have an assessment against those standards.

Senator McLUCAS—So for those four years, the period over which the audit has occurred—the period over which 55 per cent of profits, $773,000, can be directly related to Commonwealth money meant to be provided for the provision of care to these recipients—your monitoring system did not pick that up?

Mr Stuart—I think Mary has been fairly clear in saying that we are not in a position to confirm the facts that you are putting forward. So we would have to look to that in the first instance. But in terms of answering the policy issue that you are going to, community care packages started out as a fairly small experiment a decade ago and have subsequently grown very significantly. We have thought for a little while that in a fast-growing program with an increasing range of providers, there has been a need to do some of this quality and outcome checking a bit better. In that context, I would really like to draw your attention to a fairly small part of the overall package that was announced on Sunday but we are very pleased with.

There is an amount of $28 million made available for a quality package in relation to community care, for additional funding for the quality assurance framework, and for developing best-practice models and benchmarking as well. So, over the future as the program continues to grow very strongly, we are going to be putting a lot more effort into the kinds of issues that you are raising—checking of outcomes and looking at what we are getting for the dollar spent.

Ms M McDonald—Senator, there is one more thing that I can add. With regard to some of the claims that have been made against this organisation—I think you are probably aware that there has been a lot in the media about certain groups associated with the organisation making

a number of claims—about fraud against the Commonwealth were investigated by our audit and fraud area and I have here Allan Rennie who will be able to tell you the outcome of that investigation.

Senator McLUCAS—That was my next question. I need to know, Mr Rennie, when inquiries were undertaken by the fraud control unit into CMADSS.

Mr Rennie—Yes, Senator. I have not got the details of the actual dates with me but I can confirm that the investigators in my branch about 12 months ago undertook an investigation following a referral from the New South Wales office of the department. The conclusion of that investigation—I am sorry; I have not got the details here—was that there was no evidence of any offences against the Commonwealth or that services being paid for by the Commonwealth were not being provided. So basically the conclusion was that we were paying for services and those services were provided against that money. The investigation also found that there was some evidence that the organisation may not have been complying with some of the provisions of the contract with the Commonwealth, which is not a criminal offence, if you like, but it was something that we referred back to the policy area to further investigate. Ms McDonald was talking about the further work that her area and the New South Wales office particularly had been doing with that particular service.

Senator McLUCAS—Mr Rennie, you might have to take this on notice, but can you advise the committee in which areas CMADSS was not complying with its service agreement, if that is what it is called?

Mr Rennie—Certainly. I will have to take that on notice. I have not got those details with me, Senator.

Senator McLUCAS—No, that is fine. Could I also have the dates? Was it one investigation or more than one?

Mr Rennie—There was one investigation that went over a period of time. There will obviously be dates when it started, when interviews took place and conclusions. The conclusion was about May last year.

Senator McLUCAS—Around May?

Mr Rennie—Yes.

Senator McLUCAS—So your investigation happened prior to the handing down of the Walter Turnbull report?

Mr Rennie—I am not quite sure of the timing of the Walter Turnbull report. I have never seen that report.

Senator McLUCAS—You have never seen it?

Mr Rennie—I have not personally. Maybe my investigators did, but I have not seen it.

Senator McLUCAS—Could you confirm that your section has in fact read the Walter Turnbull report? I would also be interested in knowing where you differ with the conclusions of the Walter Turnbull report. I think that is useful to know.

Mr Rennie—Yes.

Senator McLUCAS—Coming back, Ms McDonald, to your comment about the acquittal process, does the acquittal process indicate from a provider of the CACP packages how many hours of service any particular client may receive?

Ms M McDonald—Senator, in terms of acquittal you mean the reports that the providers provide monthly in terms of their service levels, and they are against clients.

Senator McLUCAS—And they are. Have you gone back and confirmed that the information provided by CMADSS is in fact correct?

Ms M McDonald—That is part of the quality reporting process and I would need to check the details with our state office unit that went out to the service. The service hands back a report to our state office against a number of criteria. The state office then use information that they have, such as the reports that the organisation has provided, including hours of service for clients. They would generally verify that information as far as possible off the records. But I would need to check the details for what was done in this particular instance.

Senator McLUCAS—I suppose what I need to know is: how did your New South Wales office verify the information that CMADSS provided.

Ms M McDonald—Yes. We will take that on notice.

Senator McLUCAS—Could you provide the committee with a copy of a blank acquittal form so I can actually see what people are telling the department?

Ms M McDonald—Yes.

Senator McLUCAS—With regard to your report, Mr Rennie, you provide your report to Ms McDonald or to the secretary? I am just not sure of the process.

Mr Rennie—In terms of this particular one, I have not got the details of who the report was to. It depends where the report originated. I would suggest that this was referred from the New South Wales office of the department. We reported back to them through Ms McDonald's area.

Senator McLUCAS—Can you indicate whether or not you agree or disagree with the finding that Walter Turnbull has made that examples of expenditure that could be perceived as fraudulent included reimbursement of mobile telephone expenses, reimbursement for internet access of up to $100 a month, tickets to political fundraising dinners, tickets to an Australia Day dinner hosted by the Chinese Australian Celebration Committee and donations to the tsunami appeal via the CASS Charity Trust?

Mr Rennie—Senator, we will take that on notice and get back to you on that.

Senator McLUCAS—Thank you. Your report in this instance is an internal report.

Mr Rennie—That is right.

Senator McLUCAS—Can it be provided to the committee?

Mr Rennie—I would have to take advice on that.

Ms Halton—I will look at it, Senator. I have not seen it, but I will have a look at it and if it is able to be provided it will be, but I will have to have a look at it.

Senator McLUCAS—I have a final issue, and I think Mr Brandon might be required. Mr Brandon, Viewhills Manor had sanctions imposed on 19 January of this year. I understand that Viewhills Manor has previously had sanctions imposed. I do not know whether you will have this information with you but you very well might, but the first sanctions were imposed in 2004. Have you got a list in front of you of the visits that the agency has had to Viewhills Manor subsequent to that 8 October 2004 sanction being imposed?

Mr Brandon—I do not have a list that I could just read them off to you, but I can provide it.

Senator McLUCAS—Thank you. In terms of the period of time between the sanctions being imposed then lifted and then reimposed, do you imagine there would have been a series of visits in that time?

Mr Brandon—I believe there was a series of visits in that time. There certainly was.

Senator McLUCAS—What sorts of visits would have been undertaken?

Mr Brandon—Between October 2004 to date?

Senator McLUCAS—Yes.

Mr Brandon—There have been review audits, support contacts and an accreditation audit. So there have been review audits, an accreditation audit and a number of support contacts, some of which were announced and some of which were unannounced.

Senator McLUCAS—In terms of the accreditation audit, when was that?

Mr Brandon—There was an accreditation audit in March 2005.

Senator McLUCAS—And what did that find?

Mr Brandon—They were accredited for a period of one year.

Senator McLUCAS—And compliance?

Mr Brandon—The non-compliance of the previous six months had been corrected at that point in time. We gave them one year. We were of the view that the systems they had in place were new and not fully evaluated. However, they appointed a nurse adviser and we scheduled further visitors subsequent to that accreditation decision.

Senator McLUCAS—So they passed all 44 outcomes in March 2005.

Mr Brandon—That is correct.

Senator McLUCAS—What type of visit was the trigger that led to the sanctions being applied on 19 January this year?

Mr Brandon—The question about why sanctions were applied is one that the department can answer. I do not get involved in that.

Senator McLUCAS—What triggered the visit that then resulted in the imposition of sanctions?

Mr Brandon—Since the date we talked about earlier we had undertaken a number of visits and observed their progress. We did an announced visit in October 2006 where we identified non-compliance. That led us to our review audit in October 2006, and where there was non-

compliance we reduced their period of accreditation. Following that review audit in October 2006, we continued to monitor them and their compliance levels fell. We then did another review audit which led to the revocation of their accreditation.

Senator McLUCAS—On the 19th.

Mr Brandon—The decision to revoke the accreditation was on 15 January 2007.

Senator McLUCAS—And then sanctions were imposed on the 19th.

Ms Scheetz—Yes.

Senator McLUCAS—More in a policy sense, what is the next step for the department in dealing with facilities that are repeatedly non-compliant and where sanctions have now had to be applied twice in three years?

Ms Scheetz—Senator, you may be aware that the agency has made a decision to revoke the accreditation of that service. I understand that decision is under reconsideration. Their provider has applied for a reconsideration. In that case we would rely on the information provided to us from the agency. Essentially we take compliance action based on a range of information that is available to us through generally the agency visits and the agency findings of non-compliance. You would be aware in this case, and as Mr Brandon has already mentioned, that this home was fully compliant at some point and has now gone into a status of non-compliance. So we continue to monitor the homes, as the agency does, and we make a decision about action based on the results of that monitoring.

Senator McLUCAS—How many other facilities have had their accreditation revoked in the last 12 months, Mr Brandon?

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

Senator McLUCAS—Given that accreditation has been revoked, they have applied for a review of that revocation. What happens to them in the intervening period while the review occurs and how long does that take?

Mr Brandon—There is a period in which we have to review the accreditation. If we make a decision and they are not satisfied with that, they can then go to the Administrative Appeals Tribunal as set out in the legislation. In the meantime, until the revocation actually comes into effect, we continue to supervise and monitor their performance, particularly a home like this where we have revoked their accreditation. We keep a close eye on them. The department has things it does with them in regard to that, but that is outside our area.

Senator McLUCAS—And the period of time for the review of the revocation?

Mr Brandon—We have a maximum of 56 days in which to make the decision about the reconsideration. Following that, they have 28 days in which to apply to the AAT.

Senator McLUCAS—How many other facilities have had their accreditation revoked in the last 12 months?

Mr Brandon—During the last 12 months there were two homes for which original decisions were taken to revoke their accreditation and in each case the home requested reconsideration, which they could, and we decided not to revoke their accreditation.

Senator McLUCAS—So this is the only home in the last 12 months. Which 12 months we are talking about is a bit vague here.

Mr Brandon—I am talking about the financial year.

Senator McLUCAS—Yes.

Mr Brandon—Senator, I am advised that the only home that ended up without accreditation was Wyndham Manor, where we decided not to accredit the home as opposed to revoking its existing accreditation.

Senator McLUCAS—Thank you. There are a lot of questions on notice for you. I am sorry about that but time is of the essence. I thank the staff.

[2.31 pm]

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

Senator McLUCAS—I want to ask some questions about what knowledge the department has about the use of pharmaceuticals in hospitals. Can the department provide any data on the proportion of pharmaceuticals that are used in state and private hospitals that are not listed on the PBS and that are funded through the state and private hospital systems?

Ms Halton—With regard to specialised drugs, unless they are on the PBS—and you would be aware that there are some arrangements at the boundaries of hospital use in relation to the discharge of patients; obviously that is something we are aware of—in terms of what actually occurs in hospitals, we would not have any great familiarity with that.

Senator McLUCAS—I know you do not collect that data. It is not your expense, so you do not collect it.

Ms Halton—No.

Senator McLUCAS—But do you have an understanding of the proportion of pharmaceuticals that are prescribed through hospitals as opposed to those prescribed under the PBS?

Ms Halton—Only to the extent that health expenditures and the AIHW obviously collects data on totals of health expenditures, and obviously that is the basis upon which we say what proportion of GDP we are spending on health. I am aware of some breakdowns in relation to that data, but what they are I cannot tell you off the top of my head.

Senator McLUCAS—I did not expect you to.

Ms Halton—Thank you, Senator.

Senator McLUCAS—What I am trying to get to is what AIHW does collect information about. If I wrote to the AIHW, it might be able to indicate—

Ms Halton—The last time I looked at the health report—and somebody might even have it; I will see if we can fish out a copy—I am pretty confident that I saw somewhere that kind of information. Obviously in terms of the totals of expenditure people do get more disaggregated information but it is not something we collect and it is not something that we regularly analyse.

Senator McLUCAS—I think you understand the intent of the question.

Ms Halton—I do.

Senator McLUCAS—If there was some way you could provide an answer on notice to that that would be helpful.

Ms Halton—I am not promising.

Senator McLUCAS—Or even if you point us to the appropriate AIHW health—

Ms Halton—That is fine, Senator. How about we take that off line rather than do it on notice. We will just let you or your office know where we think you can find that.

Senator McLUCAS—Thank you. What are the current projections for the rate of growth in the PBS?

Ms Huxtable—The rate of growth for 2006-07 as published at additional estimates is 6.2 per cent. That is against the 2005-06 figure.

Senator McLUCAS—What was the 2005-06 figure?

Ms Huxtable—The actual rate of growth in 2005-06 was 2.7 per cent.

Senator McLUCAS—What was 2004-05?

Ms Huxtable—I will have to get out my brief. I think we did do a question on notice last time which set it all out in magnificent detail. The 2004-05 growth was seven per cent.

Senator McLUCAS—That is the actual 2006-07—

Ms Huxtable—No, the estimated 2006-07 figure because we are still in the 2006-07 year.

Senator McLUCAS—It is 6.2.

Ms Huxtable—Yes.

Senator McLUCAS—That is on current trends?

Ms Huxtable—Yes, that takes account of the annual model update finalised last year. It also takes into account new listings that the government has announced since budget 2006. It also takes into account variations to the estimates as a result of the PBS reform announcements in November 2006.

Senator McLUCAS—It is a big jump from 2005-06 to 2006-07. How can that be explained?

Ms Huxtable—There have been a number of things. In 2005-06 that figure was 2.7 per cent. It was quite low compared to figures in previous years. In some ways we are probably seeing a stabilisation in the estimate. Also there have been a number of new listings since August 2006, so that is since budget effectively. More than a billion dollars worth have been listed since the forward estimates period.

Senator McLUCAS—You said, Ms Huxtable, that the model update included new listings. The reasons for this increase in growth—

Ms Huxtable—We have talked before about the model and the way that it works. I think we have answered that. It probably goes into more detail than I can here. There is an annual model update that is undertaken. It is a very complicated task. It takes into account data on trends in the utilisation of prescription data from Medicare Australia. It also takes into account

updates on demographic information and finally it takes into account new listings. That process occurs once only because it is a large and complicated process. Then from time to time through budget and additional estimates and the midyear economic fiscal outlook, MYEFO, we will sometimes do variations to the current year estimate, so taking account of what has happened in that current year. We do not generally change the model. We do that annually because it is such a large task.

Senator McLUCAS—Am I right to think that new listings are the greater proportion of that increasing growth?

Ms Huxtable—I do not think that you could draw that conclusion. I would not know that myself. We would need to unpick some of that. I am not sure it is really open to being unpicked in that way. It is an integrated process that has a number of component parts and what comes out of that is some expectation about what the current year's growth will be and what the future growth will be.

Senator McLUCAS—There must be some assumptions that you put into the model before you press the button and ask it to run.

Ms Campion—There are two main things that drive the growth of the PBS. One is the underlying trends and utilisation for drugs that are already listed. We see growth in some drug groups and reductions over time in other drug groups. There is that underlying trend which is picked up in the model update that Ms Huxtable was referring to. The other major impact is the new listings for those expensive high-cost drugs. They are two components that drive the growth in the PBS.

Senator McLUCAS—So it is possible to get a notional split between the trend information which you tend to imagine is reasonably predictable and fairly constant—

Ms Huxtable—Not necessarily.

Senator McLUCAS—What makes it different?

Ms Huxtable—There are a number of factors that can change. One factor we have seen in recent years is what appears to be some long-term trend changes in GP prescribing behaviour. From recollection we have gone from around 94 prescriptions dispensed per 100 consults to about 83. That was some time last year.

Ms Halton—From recollection we have also told you under another item that that directly relates to an increase in the average consultation time—spend more time talking, less time prescribing.

Senator McLUCAS—That would indicate to me that you would have a downward trend in usage rather than an upward trend that we are predicting between 2.7 and 6.2 per cent.

Ms Huxtable—The PBS is a program that has for a fairly long period grown at a rate greater than CPI or the like. In the last 10 years the growth rate has been more around the average of 10 per cent rather than a lower figure. That takes account of factors like the ageing of the population, growth in the sophistication and use of different drugs and the introduction of what you would call blockbuster drugs to deal with things like hypertension or ulcers and the like. The other factor we have talked about—and you will recollect this—is that our figures capture a proportion of prescription activity that is occurring. There will be scripts

dispensed that are beneath the general copayment. From time to time there will be variations in that. That will also have an impact on our numbers.

It is not a very linear activity. There are a number of things happening. There are always new listings that have been introduced on to the PBS and they simply form part of a revised forward estimate that takes account of those new listings. You could not really disaggregate those over time from underlying activity in the PBS. They just form part of the PBS as it grows and moves forward.

Senator McLUCAS—Did the department conduct any sort of investigation into the very different growth rate in the 2005-06 year?

Ms Huxtable—I think that our analysis of 2005-06 we have discussed here before. We have certainly looked at the ATC classification level—that is, the anatomical therapeutic chemical group. We have looked at what we have projected with regard to various categories of drugs and then what occurred. Professor Horvath has spoken about some of the changes that we have seen where we thought, for example, that there would be a higher rate of take-up of lipid reducing drugs than there has been. That is not to say that they have not continued to grow but that they have grown at a lesser rate. We have seen that across several drug groups. Certainly we do analysis to understand better what the figures are telling us. The sort of analysis we have done we have probably described at length before.

Senator McLUCAS—Was there any assessment of whether the increase in copayments or the safety net thresholds impacted on the growth rate?

Ms Huxtable—We have not done any specific work on that that I am aware of, except to the degree that when you do analyse these figures you see quite a deal of variation in what is happening across individual drug groups. It is hard to conclude from that that there is a single underlying factor.

Senator McLUCAS—No, you would have to do a separate piece of work.

Ms Huxtable—If that were the case, you would expect to see a degree of consistency across all the drug groups, and that is not really what we see. We see quite a deal of variation. Some things are growing faster than we thought; others are growing less fast—if that is the way to say it.

Ms Halton—We have not done that analysis, but I have to say that it is not suggested by the data. Essentially, what we see in the data are, as Ms Huxtable said, highly variable, quite drug-specific effects—some rises, some declines—and we do not see a significant universal, across-the-board kind of effect which would then suggest that kind of analysis. On the contrary, we see far more complex what we think are behaviours around prescribing and also consumer demand.

Prof. Horvath—Senator, as I answered your question last time, and it compares with the current data, there were almost clinically predictable changes. Vioxx went off, and not only did Vioxx go off but it had a profound prescribing effect on that whole class of COX and also on the NSAIDS. People got concerned about their safety, so there was a very clear reduction in those scripts. There had been a lot of education over the previous five to seven years around statins and antihypertensive agents with a concomitant fall in strokes, a concomitant

fall in heart disease, and there was a lot of catch-up there. So it would be unrealistic to believe that the growth rate of statins and ACE inhibitors would continue into the forever. It was just very difficult to predict when it would flatten and grow with natural growth.

At the same time the NPS had done a lot of work around appropriate antibiotic prescribing in general practice, and there was an appropriate fall and then the antimalarials had been removed. At the same time there had been an uptake of some of the cancer drugs and other drugs that you would expect that were coming online. So, as the secretary said, there was a lot of variability in there. But the variability in that particular period, which I looked at quite carefully, was clinically quite explainable.

Senator McLUCAS—Thank you for that. I feel a bit of deja vu coming on every time we talk about the trends. I understand there is going to be a further round of reform to the PBS around the special patient contribution element; is that correct?

Ms Huxtable—I am looking blank. Could I have more explanation.

Ms Halton—More hints.

Senator McLUCAS—Is the current agreement with pharmaceutical companies around the special patient contributions ongoing, or does it expire and have to be renegotiated?

Ms Huxtable—I do not want to be too longwinded but there are different types of special patient contributions that are on the PBS. There are two types that have been fairly longstanding elements of the PBS—the brand premium and therapeutic group premium. Then there is another type which we have called special patient contribution but it is actually part of that broader group, which is where there is a failure to agree the price for listing purposes.

Senator McLUCAS—Yes.

Ms Huxtable—And as a result there is an additional charge which applies in respect of those scripts that is not met by the copayment. Nevertheless, if the prescribing doctor believes that this drug is clinically necessary, they can ring Medicare Australia and get a waiver in respect of that amount. There are currently six of those special patient contributions and that is an ongoing basis for listing. A company at any time can come and seek to have those SPCs removed. I think in fact recently—I might have to stop there, sorry.

Senator McLUCAS—There are six drugs with special patient contributions, so any pharmaceutical company can apply at any time?

Ms Huxtable—With those SPCs and the very small number of drugs that have those SPCs, in the majority of cases those have come about as part of the implementation of the 12½ per cent generic price reduction policy, and they are really quite special circumstances. The view of the minister in regard to those circumstances has been that it is necessary that those drugs remain listed, and therefore an SPC can apply, with that protection for patients that it can be waived in the event that that particular drug is clinically necessary.

Senator McLUCAS—And the doctor has to ring up and indicate what the implications are?

Ms Huxtable—That is right, but in respect of brand premiums, which are by far the largest numbers of listings that have some small additional charge associated with them, there has to

be a brand available at the benchmark price before there can be a brand premium, and that is sort of a safety mechanism. You will find, for example, with a drug like simvastatin there are 12 brands listed on the PBS and two of them have a brand premium, and 10 are available at the benchmark price so there are plenty of alternatives available for prescribers and for pharmacists in dispensing them.

Senator McLUCAS—Yes, I might come back to that later. Is the government going ahead with the public awareness campaign to promote the use of generic medicines?

Ms Huxtable—As part of the announcements on PBS reform I think there was an announcement that the government intended to undertake a public awareness campaign in respect of generics. We are working with industry and within government now to develop some of the parameters for that campaign so that work is ongoing. That announcement was in November and we are really working now to develop some of the thinking around that campaign, when it would roll out and the like.

Senator McLUCAS—Are there any details available at this point?

Ms Huxtable—Probably no more than what is already in the public domain. I think in the fact sheet that was posted on the website at the time PBS reforms were announced there was certainly a question about that and a response to that. I do not think there is any further information. We are still really working with industry to develop the thinking around that. There was a fact sheet in respect to PBS reform or an updated fact sheet that was put on the web site on, I think, 18 January—the beginning of February, I beg your pardon. There was a little more information there as to our expectations around the timing of the generics campaign, late 2007 or early 2008, but that is really the only additional information I would have.

Senator McLUCAS—Is there a cost? What is the total cost of the campaign?

Ms Huxtable—We are still developing the detail around the campaign. As you would understand, until we have really worked up the details of the campaign we would not have a figure around expenditure.

Senator McLUCAS—What is the likely success of initiatives like a public campaign to increase the use of generics? On what basis are we thinking that it is going to work?

Ms Huxtable—There would certainly be as part of the campaign an evaluation of its impact. In the past through the National Prescribing Service we have undertaken work to increase awareness of generic medicines—an evaluation is just starting.

Senator McLUCAS—I suppose I am asking the question at the other end, Ms Huxtable.

Ms Huxtable—It is a bit hard to say how effective it is going to be.

Senator McLUCAS—On what basis do we think it is going to be successful and therefore make the decision to expend the funds, other than gut feeling—and gut feeling sounds right to me, too.

Ms Huxtable—One of the issues that has been raised with us by the industry is a perception on the part of consumers that a generic medicine is not the same as or as good as a brand medicine. I think that is one of the issues that we want to address. Clearly it is a matter

more for the TGA, but the processes that are required to be gone through for listing of generic medicines are as rigorous, effectively, and so to give consumers a level of comfort and understanding around what their choices are as to patients fronting up to a pharmacy, that would be the flavour of the campaign. Certainly in respect of some pharmacists and how pharmacists talk to patients about generics you will often get information about generics and about their equivalent quality at the pharmacy, but it is about reinforcing some of those messages, I think, to consumers. Is John jumping in? No.

Senator McLUCAS—The professor and I have discussed earlier my concern that people go into a pharmacy and say, 'No, I do not want the brand one; I want the best one.' We have to explain to those people that the brand one—

Ms Huxtable—Is the same one.

Senator McLUCAS—is the same one, yes. I was just wondering on what basis we think it is going to work. I think you are saying, 'We reckon it will.'

Prof. Horvath—I think that is one of the things that has changed. Going back 10 years, the doctors who did the prescribing by and large were not convinced that generics were appropriate for all sorts of reasons, including convenience, because the drugs were largely introduced as brand names. So they understood what they were writing, but they were writing the brand name. I think there has been a lot of education at medical school going over a decade now about generic prescribing, so we are seeing a lot of graduates over the last 10 years who have been taught that generic prescribing is the way to go. Similarly, in most of the intern and PGY2 years there is encouragement to use appropriate pharmaceutical names in hospitals. By the time you get out into practice now, the whole issue of not using specific brand prescribing and generics is far more acceptable and used. So I am reasonably comfortable that it will not be in any way undermined by the medical profession writing scripts as it might have been doing 10 to 15 years ago.

Senator McLUCAS—Thank you. Still on the implementation of the PBS reforms, media reports have suggested that the savings arising from the forthcoming PBS reforms will be higher than expected—as much as $400 million in the first year. That was in a publication called *Pharma in Focus*. What is the government's view of that reporting?

Ms Huxtable—The savings that were announced as part of PBS reform were developed through a rigorous process that we undertook with the department of finance to validate our costings and scrutinise our costings.

Ms Halton—And can I say, Senator, with industry crawling all over it.

Ms Huxtable—That is very true.

Ms Halton—It is fair to say that there were vigorous discussions between industry and the department before we even got near the department of finance. To say that there was a triangular debate about the numbers—these numbers have been scrutinised up hill and down dale but, at end of the day, they are estimates. It does not surprise me in the slightest to see that commentary, to have people saying, 'We think it will be higher,' or, 'We think it will be lower.' All I can say to you is that I think our modelling, which has now been scrutinised by

Finance and was picked through by industry, is as good as you will get. Until we get there we will not actually know, but we are pretty confident.

Senator McLUCAS—So you are dubious about the claim of $400 million?

Ms Huxtable—Claims are often made.

Ms Halton—Claims are often made. While no doubt the people who have made them earnestly believe them to be true, I do not believe those claims have more solid ground on which they are grounded than we do for ours.

Senator McLUCAS—Under the PBS reforms, what is the government's projected estimate?

Ms Huxtable—The figure announced last year was $580 million over the four years of the forward estimates period.

Senator McLUCAS—Did you say $518 million?

Ms Huxtable—$580 million.

Senator McLUCAS—Over four years?

Ms Huxtable—Yes.

Senator McLUCAS—Could you break that down for us, Ms Huxtable, into the four outyears?

Ms Huxtable—There are two moving parts with the PBS reform. There is an amount which is the projected savings in respect of the pricing changes and then there is an adjustment package back to pharmacies, so the two things net off to be the $580 million. The gross savings that are projected, which I think were published in the MYEFO document last year, are $1.7 billion, and the adjustment package back to pharmacy and pharmaceutical wholesalers is $1.04 billion.

Senator McLUCAS—Is it possible to provide that to us in a disaggregated form over the four years?

Ms Huxtable—I can provide you with as much disaggregation as I am able. I am not sure I will be able to disaggregate too much more than that. I will need to go back and look at the published figures, but we will do what we can.

Senator McLUCAS—Thank you. And are those savings in the forward estimates?

Ms Huxtable—Yes.

Senator McLUCAS—How many drugs on the PBS now attract a patient payment in addition to the standard copayment? I think there are two elements: there is the special patient contribution—

Ms Huxtable—I would not want to be misleading. To say that they attract a copayment suggests that it is a mandatory charge or something. From memory, the number is 427. I am sorry, Senator, I had this figure in my head but I have lost it. I am sure the figure is 427 listings but I am beginning to doubt myself now. I cannot find the right bit of paper but I am pretty sure the number is 427 listings. I will correct that perhaps when we finish. I will go and find the right bit of paper because I am sure I have it here. There are 427 listings that have

some form of special patient contribution associated with that listing, whether it be a brand premium, therapeutic group premium or special patient contribution.

Senator McLUCAS—Can you give me those three categories again, Ms Huxtable?

Ms Huxtable—The brand premium—

Senator McLUCAS—The brand premium I understand.

Ms Huxtable—The therapeutic group premium are those groups—should I explain that one?

Senator McLUCAS—I think you have in the past.

Ms Huxtable—I have before. It is those groups which have been deemed by the PBAC to be interchangeable at the patient level, so there are groups together. There have been four therapeutic groups and recently two more were formed, so there are now six therapeutic groups. In respect of therapeutic groups, a manufacturer can elect to have a premium associated with that listing, provided there is at least one drug in that group that is listed at the benchmark price.

Senator McLUCAS—Yes.

Ms Huxtable—And then a special patient contribution is the one which is discussed—where there is a dispute in regards to the price at listing.

Senator McLUCAS—I wonder if you could provide for all patient payments, in addition to the standard co-payment, a breakdown of patient payments by concessional versus non-concessional status of the patient, a breakdown by the type of patient contribution, and information about the amount collected through each type of patient contribution.

Ms Huxtable—I would have to take that on notice. I will need to work through what information we have. I will take it away and do what we can.

Senator McLUCAS—And we will provide it to you in a written form as well.

Ms Huxtable—That would be very useful, thank you.

Senator McLUCAS—Can the department confirm that PBAC has recommended that the vaccine for rotavirus be included on the National Immunisation Program?

Ms Huxtable—Yes, that is correct.

Senator McLUCAS—Has cabinet approved the addition to this point?

Ms Huxtable—I do not believe there has yet been an announcement about a government decision in respect of rotavirus.

Senator McLUCAS—The process is PBAC makes the recommendation—

Ms Huxtable—That is right. In respect of a listing that is in excess of $10 million in any one year of the forward estimates period, the minister then takes the recommendation to cabinet.

Senator McLUCAS—When did PBAC make the recommendation for the rotavirus vaccine?

Ms Huxtable—It was the meeting in early November: 1 to 3 November 2006.

Senator McLUCAS—And then it is really out of your hands, is it not?

Ms Huxtable—No, it is very much in our hands.

Senator McLUCAS—But if it is over—

Ms Huxtable—It is out of our hands until then, sort of.

Senator McLUCAS—I understand. But, once that recommendation has been made, you provide that to your minister, if it is over $10 million.

Ms Huxtable—We often need to then go through a process of developing advice to the minister, which will need to include some engagement with the Department of Finance around projected costings, so a costing process. In respect of high-cost drugs, generally we also have a discussion with the company—sometimes quite a robust discussion with the company—around risk-sharing arrangements in respect of that listing. Those processes need to be finalised before government can really consider a listing.

Senator McLUCAS—Has that process been completed?

Ms Huxtable—The process is certainly well advanced.

Senator McLUCAS—I do not know if I am allowed to ask this: has the minister taken this issue to cabinet?

Ms Halton—You can ask, Senator, but we probably will not answer.

Senator McLUCAS—I will put it really nicely! Ms Huxtable, you are saying that the process is not complete yet.

Ms Huxtable—It has not been completed to the stage where there has been a public announcement of the government decision, but certainly the process is well advanced.

Senator McLUCAS—When you are talking about a public announcement, that would presume that it has been to cabinet, that the decision has been made and that the minister then can make the announcement. I suppose I am trying to break that time line into two parts.

Ms Halton—And we are going to neither confirm nor deny where in that process it is, Senator, because we are not at liberty to provide that level of detail.

Senator McLUCAS—You have in the past, I think.

Ms Halton—Not in terms of the cabinet timetable—when things are going to be considered.

Senator McLUCAS—No, you have never answered the question, 'Has the minister taken it to cabinet?' I agree with that, and that is quite proper. But I think you have indicated previously with other drugs the pricing arrangements and that process being completed. Are the pricing arrangements completed?

Ms Huxtable—I do not know, to be honest. We are still in the process of finalising all those arrangements, so I just cannot tell you. We do not know. We would have to take it on notice.

Senator McLUCAS—I understand that the PBAC has to move to full cost recovery. When was that announced?

Ms Huxtable—In a previous budget—I think it was the 2005 budget.

Ms Halton—Yes.

Senator McLUCAS—That is quite a big shift. What consultation has been undertaken with the medicine sector?

Ms Huxtable—I will just get the right brief. We have had some earlier discussions with industry. That occurred early last year; I think it was around May. We expect to commence a consultation process very soon—probably next month. I wrote to the main industry bodies in December alerting them to the fact that we would be consulting more thoroughly in March. The planning process is in train around that.

Senator McLUCAS—Have any details about how it will work been provided?

Ms Huxtable—No, that is really what we will be consulting with them on. We have been doing development work ourselves. We did some early development work around possible approaches. The way in which you could do cost recovery will be one of the things that we will be consulting with them on.

Senator McLUCAS—Has any analysis been done of what the estimate of the cost of taking an application to the PBAC would be?

Ms Huxtable—That is some of the work we have been doing. There has been a fairly detailed analysis within the division of the various costs associated with considering applications by the PBAC—not only the PBAC's operations itself but all the supporting operations that go to the analysis of applications, the provision of commentaries, and consideration by the expert committees. That is the work we have been doing. We will be sharing some of the results of that with industry when we consult with them. It is probably a little early for me to be talking about what our findings have been to date. We follow the Department of Finance guidelines in respect of cost recovery, so we have been doing the preliminary analysis work that we are required to by the Department of Finance in developing our approach.

Senator McLUCAS—What elements have been identified as being included in the cost recovery mechanism? Clearly, it includes the operation of the committee, but there has to be more than that. What are the costs that need to be recovered in the broad?

Ms Huxtable—I probably ran through quite a few of them there. The actual operational arrangement of the committee is one thing—their meeting, their airfares and the costs of the actual meeting—but supporting consideration of applications by the PBAC is a raft of other mechanisms, which include the secretariat function within the department. We have health economists on staff who do analysis of submissions and, with external evaluators, provide that analysis back to the PBAC to enable it to make its considerations.

The PBAC has two supporting committees: the Economic Subcommittee and the Drug Utilisation Subcommittee. They also analyse submissions, make their own commentary and provide their own advice in respect of those submissions. So there is a whole machine associated with the PBAC, and all the costs associated with that need to feed into our thinking around this one.

Ms Halton—The methodologies around cost recovery are pretty well established now. We do this in a couple of areas in the portfolio. The Therapeutic Goods Administration is a good example. The methodology that we apply—and we have been very much informed by the department of finance of this—goes to the full cost of the activity. So that is exactly what will occur here. Determining the full cost of the activity means drilling right through to the agency in terms of costs that should and can be attributed to that function, and that is what we will do.

Senator McLUCAS—Do we have to actually work out how much time we talk about the PBAC at estimates and attribute that cost as well?

Ms Halton—That is right. We will be costing your time as well, Senator.

Senator McLUCAS—That would be good. Do we have a notion of the quantum of the departmental cost on an annual basis to the PBAC to this point?

Ms Halton—Not really yet, no.

Ms Huxtable—No, certainly not off the top of my head anyway.

Senator McLUCAS—So that work has not been done. You have not come to a figure yet.

Ms Huxtable—There is work that has been done. I am not right across all the details, but that is the sort of information that we will be sharing with the industry and having a discussion with industry about.

Senator McLUCAS—I understand that there was some commentary in *Pharma in Focus* that a major submission to the PBAC could be as much as $100,000. What is your view? Is that reasonable?

Ms Halton—We cannot comment. In all seriousness, until we have actually done the numbers and had a good look at it, it is impossible to say whether that is wildly inaccurate or completely accurate. We just have to do the detail before we can answer that specifically. Again, do we go by the weight of the submission or by whether it is a small, medium or large one? There are all these issues that have to be dealt with. We do read those articles and sort of smile—

Ms Huxtable—Sometimes.

Ms Halton—wryly about the amount of work they potentially could save us.

Senator McLUCAS—Before a government makes a decision to go down the cost recovery road in any operation, you would have a notion of what the costs to business are going to be and whether or not they are manageable. I am not making any value judgement one way or the other, but that sort of analysis would have been required prior to the government coming to the decision to move to full cost recovery and apply that to the PBAC. Can you give me an understanding of what work the department did in that period and what analysis the department did about what the potential costs to industry might be?

Ms Halton—Not today. I am happy to go back and have a look at what was done at that time and see what we can find. Certainly there was some what I would describe as ballpark analysis done.

Senator McLUCAS—That is what I am looking for.

Ms Halton—But I do not think we have anyone here who can answer the question.

Ms Huxtable—There would have been an announcement at the time of the budget announcement about what the anticipated savings to government would be to go down this route. I suppose the counterfactual of that is the cost to industry.

Ms Halton—We will do it on notice.

Senator McLUCAS—Let us look at the anticipated cost to government, which is in the public arena, and then the next step—which I am sure would have been done—which is an analysis of the number of applications, the variety of applications and essentially what sorts of costs applicants are looking at.

Ms Halton—I am happy to do that.

Senator McLUCAS—Going back to the PBS reforms again very briefly, I want to ask about the special patient contributions in the category of drugs where the company has refused to accept the cuts in payment from the PBS. I think 'a failure to agree on the price' is probably the proper terminology. I think you indicated that they are on an 'as applied' basis. There is no round for those applications for exemption.

Ms Huxtable—They have emerged in the last few years, predominantly in five of the last six, in the course of negotiating with companies around pricing in respect of listings. So they would have applied in the normal scheduled points of April, August and December where there are price changes or price reductions that flow through. So they have emerged at those points. I am not sure of your direction of questioning, but we have certainly had questions on notice before which have listed those SPCs, as we call them.

Senator McLUCAS—I might leave it at that then. That is all I have on outcome 2. For the record, thank you, Ms Halton, for the information about pharmaceuticals in hospitals.

Ms Halton—It is a pleasure, Senator.

ACTING CHAIR (Senator Patterson)—Since Senator Humphries is away and Senator Moore is not here, I will take the chair. Are there any more questions on outcome 2, Access to pharmaceutical services? If not, I thank those officers.

[3.22 pm]

CHAIR—We now move to outcome 3, Access to medical services and professional services review. I welcome officers in that program.

Senator BARNETT—I thank my Senate colleagues for allowing me to go first in outcome 3. My questions relate to the Medicare funding of second-trimester abortions and late-term abortion. I wanted to ask whether the department was aware of the Consultative Council on Obstetric and Paediatric Mortality and Morbidity annual report for the year 2005, incorporating the 44th survey of peri-natal deaths in Victoria.

Ms Morris—I am personally not aware of the survey. I will just check with my colleagues.

Ms Robertson—Not that I am aware of. Can you repeat the title of it?

Senator BARNETT—Sure. It is the Consultative Council on Obstetric and Paediatric Mortality and Morbidity annual report for the year 2005. It incorporates the 44th survey of peri-natal deaths in Victoria.

Ms Halton—I am aware of that survey generally speaking. I am not sure whether the last version I saw was 2005. So perhaps you could go to the particular issue that you are referring to

Senator BARNETT—No problem at all. Is the department aware that, according to the survey, of the 309 abortions performed in Victoria in 2005 at over 20 weeks gestation, more than 180 of these were classified as 'terminations for psycho-social indications''?

Ms Halton—Yes, I seem to recall that this is a matter that has been discussed previously.

Senator BARNETT—Are abortions performed after 20 weeks of pregnancy for psycho-social indications eligible for a Medicare payment and, if so, under what conditions?

Ms Morris—Medicare benefits are only payable for the evacuation of the gravid uterus, which is only practical in the first trimester or, for the second trimester, terminations where there is gross foetal abnormality or life-threatening maternal disease.

Senator BARNETT—I am actually aware of that. You are referring in the latter case to Medicare item No. 16525.

Ms Morris—Yes.

Senator BARNETT—Is that correct?

Ms Morris—Yes.

Senator BARNETT—So can you answer the question in regard to psycho-social indications—as to whether that comes under that particular Medicare item number?

Ms Morris—I cannot, because we do not collect the reasons why women have that done.

Senator BARNETT—Is the department aware that, according to the survey, of 309 abortions performed in Victoria in 2005 at over 20 weeks of gestation, 47 of these abortions resulted in a live born baby who died shortly after birth? In terms of the report it was classified as a neonatal death—table 6, page 12.

Ms Halton—No, we cannot, because, as I have indicated previously, whilst we are aware in the general sense of that survey, this is not a matter which is a matter for our jurisdiction. Issues in relation to this area are a matter of state regulation, not for Commonwealth regulation and other than to the extent that Ms Morris has indicated, to wit the benefits that are payable in respect of the evacuation of the gravid uterus under the particular service, she has indicated that this is not a matter for our jurisdiction.

Senator BARNETT—I will ask it in another way. With those abortions performed after 20 weeks of pregnancy, which result in a live born child, it is possible then that they could be eligible for Medicare payment if they meet the criteria referred to by Ms Morris?

Ms Halton—I think it improbable, but without the particular circumstances, we could not comment. But I think it highly improbable.

Senator BARNETT—Highly improbable.

Ms Halton—Yes.

Senator BARNETT—I suppose my final question—and I might have to refer this to the minister for human services—is whether a woman who undergoes an abortion at 20 weeks gestation or more and has a live born child is eligible for any maternity payment? That might be a matter—

Ms Halton—That is not our business. We have no responsibility for that.

Senator BARNETT—I will need to refer that to the minister for human services, I would suspect.

Ms Halton—Yes.

Senator BARNETT—Is the department aware of the case of Dr Suman Sood, who has been convicted of performing illegal abortions and is the subject of complaints by the Medical Board of New South Wales? Dr Sood claims to have performed over 10,000 abortions. I am wondering whether Medicare has actually paid for any of those illegal abortions.

Ms Halton—Two things: firstly, issues in respect of medical registration and any prosecutions and other legal action are not, again, a matter for our jurisdiction. Whilst we read the newspapers as well, this is not something on which we can comment. In respect of particular payments in relation to medical procedures that are delivered by practitioners, we can talk to you about the policy parameters but, obviously, the actual payment of those benefits is something that is undertaken by Medicare Australia. That is no longer in this portfolio; it is a matter for the minister for human services.

Senator BARNETT—So it is possible that Medicare has funded those abortions performed by Dr Sood, even though he has subsequently been convicted of performing an illegal abortion?

Ms Halton—I cannot comment.

Senator BARNETT—Thank you.

CHAIR—Any further questions in outcome 3?

Senator CAROL BROWN—I would like to ask some questions about bulk-billing rates and particularly I would like to know whether you can supply data on bulk-billing rates for children.

Ms Morris—For children?

Senator CAROL BROWN—Yes.

Ms Morris—When you say bulk-billing rates for children, do you mean for under 16-year-olds?

Senator CAROL BROWN—Yes.

Ms Morris—For the under-16-years age group, bulk-billing as at the December quarter 2006 for non-referred GP services was 84.3 per cent.

Senator CAROL BROWN—Do you have that information by state?

Ms Morris—By state? I think we do.

Senator CAROL BROWN—I was hoping to get the information by state and territory and also by the broad type of service.

Ms Morris—You mean GP or pathology or whatever? I suspect we would have to take that on notice. We would not have that level of detail with us today.

Senator CAROL BROWN—All right. That is fine, if you could take that on notice.

Ms Morris—Thank you.

Senator McLUCAS—Would it be possible for you to provide us also the same information but by people over the age of 65?

Ms Morris—Yes, and I can give you the broad bulk-billing rate for over 65, but not the state breakdown or by type of service today.

Senator McLUCAS—Can you not do it by state?

Ms Morris—Not today.

Ms Halton—Not today. We do not have it with us. We can tell you now—what is the 65 rate?

Ms Morris—The 65 rate is 87.1 per cent.

Senator McLUCAS—But you could provide us on notice?

Ms Morris—Yes, that data is available.

Senator McLUCAS—Thank you.

Senator CAROL BROWN—Also last year I understand the bulk-billing rates were released by federal electorates of March last year. Would that be happening again this year?

Ms Halton—I think the minister made a decision that he would release in March of last year. I do not know that we have had the conversation with him, but no doubt we will have a conversation.

Senator CAROL BROWN—Can you confirm that or not on notice?

Ms Halton—On notice we can.

Senator CAROL BROWN—Thank you. I am also after the most recent data available on average patient contribution per service—this is patient billed services only—for unreferred GP attendances by federal electorate. If you want to take this on notice—

Ms Morris—Yes, if you want it by federal electorate.

Ms Halton—This falls into the category of what is produced by a federal electorate. The minister had decided that we were going to produce what we were going to produce once a year. So I am just not sure whether that is in that category. But we will take that question on notice.

Ms Morris—And as we have said, we have not yet had the conversation.

Senator CAROL BROWN—Sure, that is fine.

Ms Halton—Can I just make one comment about the data on patient copayments? It is a statistical artefact that, because there is a smaller number of people actually making a

copayment at the moment because the bulk-billing rates are quite high, they actually look higher because what has happened is that all the smaller copayments have basically disappeared. We will obviously be able to provide you with the national data, but the statistics of this are just worth keeping in mind when you look at them—counterintuitive; it is one of those.

Senator CAROL BROWN—Thank you. I will go on the to Medicare safety net. Can the department provide data on the numbers of people who registered for the safety net in 2004-2005 and 2005-06 compared to the numbers of people who were eligible to claim safety net benefits in these years but did not register?

Ms Morris—We cannot for 2006, Senator, because that data is not yet available.

Ms Halton—I actually think statistically that is very difficult to do. If they did not register, I am not sure whether we still know whether they were eligible. We will have to take that away and have a look at it.

Ms Morris—We will just get clarification of that.

Senator CAROL BROWN—If you cannot let me know those numbers compared to the number of people who have actually signed up as compared to those that are eligible, I will just take the numbers that are registered.

Ms Halton—I think what we can tell you, Senator, is how many registered and of the people who are registered how many became eligible. That we can do. We will happily give that to you.

Senator CAROL BROWN—When are the 2006 figures available?

Ms Morris—As the secretary has said, we have not yet had the conversation with the minister about what will be released in the electorate data, but last year the safety net figures were released along with the electorate data.

Ms Halton—Remember that one of the issues in this area—and I think you are aware of this—is the time in which claims actually come in. So even though a year is finished, our experience has always been that people hold on to their claims. I do not know about you, but I have a pile of bills that sit on the kitchen counter or are stuck on the fridge or somewhere. When there are so many of them and they fall off underneath the magnet, eventually you go and do something with them. That is not unusual. So people kind of go in with their claims progressively over a period.

Ms Morris—We are still getting claims for 2005.

Senator CAROL BROWN—For 2005?

Ms Halton—Yes.

Senator CAROL BROWN—I will ask this series of questions, and if you need to take them on notice or it needs to be confirmed that the information will be released by the minister just let me know. Can the department provide a breakdown of numbers of people who qualify for the safety net in 2006 by age group?

Ms Morris—No. We do not collect the data, but the data is not collected on that basis, I do not think, Senator. As I said, the 2006 data is not yet available. We have families that register,

and it would depend on the composition of the family and I do not think we can provide that. You can put it on notice and we can check what we can give you, but I am fairly sure we will not be able to answer that.

Senator CAROL BROWN—Okay. That is fine. Can the department confirm that data on the Medicare safety net by federal electorate will be released in March? Well, we will wait until the minister has had that chat with you. How is the Medicare safety net expenditure currently tracking against the revised expenditure projections?

Ms Morris—That is tracking as expected, Senator. We do not have 2006 data publicly available. As the secretary explained, you get two different or three different sorts of data with the safety net. You get families registered, you get families that qualify and then you get claims data which has a very long lag time. So expenditure and the safety net are a difficult concept to talk to in this context.

Senator CAROL BROWN—Do you do any sort of projections though? You must do some sort of projection on what sort of expenditure is going to be used.

Ms Halton—Yes—and to the extent that there are figures published in the budget in the forward estimates, but we do not talk about anything other than the forward estimates, and that is a standard practice. Senator McLucas usually asks us these things and we always give Senator McLucas the same answer, don't we, Senator? That is, we do not talk about the models that drive these things. Essentially, this is in the same category. We obviously have a process of modelling which takes account of the lag in claims and how many people we expect et cetera but the published data is basically the data that is published in MYEFO.

Senator CAROL BROWN—All right. That is fine. That is all I have on the Medicare safety net.

Senator McLUCAS—Can I just ask a question on that. Ms Morris, you said that there are families that are eligible, families that qualify and then families that get—

Ms Morris—Who have their claims processed.

Senator McLUCAS—That is right. What are the families that qualify? What is an explanation of that?

Ms Robertson—What Ms Morris was saying before is that the three categories are families who register as a family, because—and I think we have discussed this before at estimates—the Medicare database does not know that a particular individual belongs to a family until such time as you go into a Medicare office and you register as a family. So we have people registering as families in the first instance. Then we have those who have medical expenses such that they qualify once they reach the safety net thresholds. Then sometimes we have those who may not make a claim once they have reached the thresholds, but then there is that third category that do actually get a benefit once they have reached the threshold because they have those further claims.

Ms Morris—But those claims may be spread out. The people who are eligible for them may take a while to submit those claims.

Senator McLUCAS—So someone who has a really big fridge magnet is in the categories of families that qualify? Sorry, I am being silly but—

Ms Halton—I actually think those two categories are a nonsense category.

Senator McLUCAS—There is this group of people who qualify and they may eventually send in a claim or they may just not.

Ms Morris—That is right.

Ms Halton—Point (1): you have to be registered. I think really then the next two categories are not really two categories. Once you are registered, if you are going to qualify you have to have spent a certain amount. Basically until you have justified—validated—that expenditure, you do not technically qualify. We just know that some people are slower to claim and therefore to qualify but they are still qualified. I think it is a bit of a—

Ms Morris—It is the benefits beyond the qualification that have the long lag time.

Senator McLUCAS—Could you provide us, then, with a table that shows for 2004, 2005 and 2006 the number of people who have registered, the number of people who have claimed and then the number of—sorry, it is not people; it is families. It has to be families, and then the number of families that qualify.

Ms Morris—Yes.

Senator McLUCAS—The definition of 'qualify' in this context is people who have spent the appropriate amount of money to get into the threshold but have never sent the bill in.

Ms Halton—But you cannot do that.

Senator McLUCAS—Why not?

Ms Halton—We do not know that. This is the whole point. Basically, until we get a claim, we do not know that you are over the threshold. So essentially what you have is a family who have nominated. Say we are a family. We have all nominated as a family—odd-looking family, but there you go. I have all of the receipts under my fridge magnet. Until such time as I turn up with all of my receipts from under my fridge magnet, basically I have not claimed and therefore we cannot tell that we as a family are eligible. Once I have gone in with my first bundle of fridge magnet claims—and that has taken me over the threshold—I am now in the threshold and I am eligible. It may still be the case that I end up with two fridge magnets of receipts—I will have another bundle—and at some point later I will go in with my second bundle and obviously they will be reimbursed at a higher rate. Medicare already know that we are eligible because we have already gone in with our first bundle under the fridge magnets, but we do not know that the second bundle under the fridge magnet exists. I actually think the category is a bit of a furphy. I think this is a furphy. Essentially, there are two sorts of people, and that is people who are registered and people who are not—sorry, family. Once you are a registered family, you have either qualified or not. You may have qualified but not come in to substantiate that because you have fridge magnets.

Senator McLUCAS—So Medicare does not—

Senator WEBBER—They are going to start feeling discriminated against, those fridge magnets.

Senator McLUCAS—Let us talk about the Smith family—the Smith family register. You would not count the number of visits that they have that can be claimed through the MBS by family?

Ms Halton—If it were a bulk-bill service, so if it was a service that was—

Senator McLUCAS—So that is irrelevant for the purposes of the Medicare safety net?

Ms Halton—Exactly. So unless there is evidence brought forward to a Medicare office there is no way to know. Does that make sense?

Senator McLUCAS—Yes.

Ms Halton—And that is the point. As I said, I think this is a furphy. This is a dialogue about fridge magnets.

Senator CAROL BROWN—We can get that information for 2005 though, can't we?

Ms Halton—To the extent that the data on 2005 represents how many fridge magnets have come in. What I cannot tell you is whether there is a second lot of fridge magnets out there that have not come in.

Senator CAROL BROWN—Can you tell us what percentage of claims for the 2005 year came in in 2006? I would be interested to know how many are late.

Ms Halton—It would probably take a bit of effort but someone could probably do that.

Ms Robertson—Only to the extent that we know that we have captured all the claims for 2005 that exist because they will still come in.

Ms Morris—They will still be under fridge magnets.

Ms Halton—There is a tail on the distribution. There is a point at which you can say, 'I probably have most of the claims now.' You cannot ever be completely certain. Essentially what you see is a distribution of claims that come in quite quickly. Some people we know go from the doctor's surgery around the corner to Medicare. There are a proportion who will go in every week but there are whole bunch of people who do not.

Ms Morris—Some of the services that are claimed under the safety net are ART services and obstetrics. I remember that period in my life and the last thought I had on my mind was getting to a Medicare office. They are big expenses at a time in your life when you might have mobility difficulties or it might be difficult to get out or you might be waiting until you go back to work or something else. I can understand why they do have a long lag time.

Senator McLUCAS—How long can you wait before you claim?

Ms Robertson—My understanding is that it is generally two years. If somebody brought in a claim to a Medicare office beyond the two years I think Medicare Australia has its own procedures in that regard.

Ms Halton—I think next estimates I will bring you all Medicare Australia fridge magnets.

Senator CAROL BROWN—I want to ask some questions about the take-up of some new MBS items. I want to know how the items are tracking—whether there is a low or high take-up or what figures you have. The first one I am interested in is a cancer-care case conferencing item. I am happy if you have to take that on notice.

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

Senator CAROL BROWN—The items for the antenatal care provided by practice nurses and Aboriginal health workers—

Ms Robertson—As a general issue I point out that these items only came in on 1 November last year so we do not have a lot of data on those at the moment. We generally wait until we have a good full quarter of data before we start looking at those things.

Senator CAROL BROWN—Whatever you have will do. I will just keep going.

Ms Halton—If you would like to give us a list then probably the right thing to do—particularly for the early items—is for us to wait until we have a full quarter worth of data and then we will answer at that point.

Senator CAROL BROWN—I understand.

Ms Halton—If you give us the list of what you would like to know about—

Senator CAROL BROWN—I will provide that in written form on notice which will save us some time here.

Ms Halton—Not a problem.

Senator CAROL BROWN—I think that was it.

Senator WEBBER—Is this where I ask questions about the mental health MBS items or would you like them in mental health?

Ms Morris—We can talk about the specialist psychiatry ones.

Senator WEBBER—So just the psychiatry ones?

Ms Halton—Why not start and if we do not have the people here—

Ms Morris—Mental health is a bit later on and I will be around for that too.

Senator WEBBER—I am relaxed about that. You will probably have to take this on notice. Are you in a position to give us any of the breakdown on the take-up rates of the new MBS items for mental health?

Ms Morris—Yet again they are very new, Senator.

Senator WEBBER—I appreciate that.

Ms Morris—It is hard to get numbers. We do have the data here. Are you interested in all of them?

Senator WEBBER—Yes.

Ms Morris—Have you got your pen there?

Senator WEBBER—I do. And then I will probably completely confuse it and then ask again.

Ms Morris—The GP mental health care items are: item 2710, GP mental health care plan—in November there had been 27,303 claims processed and in December another 33,606. They are not cumulative. I will give you the full December figures.

Ms Halton—And if these look anomalous we will tell you. I think it will give you a fair indication of what is happening on a month-by-month basis.

Ms Morris—The figures are: GP mental health care review, item 2712, in December 529 claims; item 2713, GP mental health care consultation, in December 18,920; consultant psychiatrist initial consultation of a new patient, item 296, consulting rooms, in December 3,950; item 297, in hospital, 214; and item 299, home visit, 30. The next set is psychiatrist referred patient assessment and management plan: item 291, assessment and preparation of a plan, 482; and item 293, review of the management plan, 34. The next section is psychological therapy services by clinical psychologists, items 80000 and 80005, 114. The next one, which is for an at least 50-minute consultation, 80010 and 80015, 6,897, and item 80020, group psychotherapy of at least 60 minutes, 4. We are up to the last section—only another three to go. They are focused psychological strategy services by allied mental health providers, items 80100 to 80120, registered psychologist, 20,980; items 80125 to 80145, registered occupational therapist, 36; items 80150 to 80170, registered social worker, 678. I will just repeat that all the numbers I gave you were for the month of December only.

Senator WEBBER—The month of December only.

Ms Morris—I will make sure that that is checked carefully in *Hansard* to make sure that the numbers are right, because it was a lot to take down.

Senator WEBBER—It was. That would be most useful. Is this where I ask about the requirements for the mental health plan under item 2710?

Ms Morris—Yes.

Senator WEBBER—Or do you want to do that in mental health? What are the actual requirements for the plans? Does the department have a requirement for what that plan must consistent of before it pays?

Mr Andreatta—The requirements are set out in the MBS and I can go through them, if you wish.

Senator WEBBER—So would a handwritten letter of two lines meet the requirement of a plan to pay the benefit?

Mr Andreatta—There are two components of the plan. There is an assessment component and the preparation of a plan component. For the assessment, there are some guidelines on what the GP needs to undertake and I can go through those. It includes recording the patient's agreement to undertaking the plan, taking relevant history, conducting a mental state examination, assessing associated risk and any comorbidities, making a diagnosis and administering an outcome measurement tool. That is part of the assessment process. Then with the preparation of the plan there are guidelines. The GP is to discuss the assessment with the patient, identify and discuss referral and treatment options with the patient, agree goals with the patient, provide any psycho-education, any plan for crisis intervention, and the GP is required to document that plan and offer a copy to the patient.

Senator WEBBER—So when I know of patients who are wandering around with handwritten letters that go for about two sentences and they have been paid under the item number, that does not sound like it would fit those guidelines.

Mr Andreatta—The guidelines in the MBS?

Senator WEBBER—Yes.

Mr Andreatta—GPs are meant to follow those guidelines when claiming the item.

Senator WEBBER—What monitoring are we doing to make sure they do comply with these new guidelines before we pay?

Mr Andreatta—The GP is required to offer a copy of the plan to the patient. In some cases the patient may not take that offer up and the doctor will simply keep records of that plan in the patient's history at the practice itself.

Senator WEBBER—But this is a brave new world for GPs to come up with mental health assessment plans. Do we have any evaluations? Are we doing any monitoring?

Mr Andreatta—The items were introduced on 1 November. It is too early at the moment to undertake any auditing.

Senator WEBBER—But there have been an awful lot of them go through—27,303 in November and 33,606 in December. That is a lot.

Mr Andreatta—That is correct, and prior to the introduction of those items there was material posted on the website and material provided to GPs on how those plans are to be undertaken and those services performed. As well, the GP organisations provided to their members guidelines and instructions on the usage of those items. We will not undertake an audit of how doctors are using those items until possibly the first year of operation.

Senator WEBBER—Right.

Mr Andreatta—We have not heard of any inappropriate claiming of these items.

Senator WEBBER—I will therefore place on notice that that is something we do have to put some pretty vigorous effort into. Now that these new items are in—and far be it from me as the daughter of two psychologists to have a go at psychologists—

Ms Halton—There are a few over this side, too, Senator.

Senator WEBBER—I am sure there are. I certainly have had anecdotal feedback that as soon as these MBS items have come in, psychologists have put their fees up to a commensurate level. Across-the-board the fees have gone up $50. Is the department aware of anything like that? Have you looked into anything like that?

Mr Andreatta—We are not aware of any fee arrangements or any increases in fees. As I said, it is two months into the new items. Psychologists took a little while to start using the items because of the lag between a care plan and the referral process. We do not have any copayment data at the moment to make any assumptions like that.

Senator WEBBER—That is probably an issue that we need to be aware of and also any data on any exit of psychologists or psychiatrists from the public system now that the MBS items—

Mr Andreatta—I think after we get a quarter of data we will be able to make some more analysis.

Senator WEBBER—In that case we are going to have this discussion again in budget estimates.

Mr Andreatta—We will.

Senator WEBBER—I think that is pretty much all I have on the MBS.

CHAIR—Great. We need to finish this outcome as soon as we can.

Ms Halton—Can I ask Ms Huxtable to come back and provide those little matters on the PBS?

CHAIR—Sure.

Ms Huxtable—In response to a question in regard to the number of items that have an additional patient contribution, I was, I think, struggling to find the right figure and, as it turned out, I provided the wrong figure. Just to correct the record, as at December 2006, the total number of branded items which can require an additional patient contribution is 381. That is of a total of around 2,800 items on the PBS. I think I used the figure 427.

Senator McLUCAS—381, which included six that are—

Ms Huxtable—This is the reason for confusion. We need to be careful about an item, which is the form and strength of the molecule, and then the number of brands. So the SPC figure is in respect of the molecules. These figures are in respect of branded items. So there will be more branded items than there are molecules.

Senator McLUCAS—Thank you. I appreciate you using that language. I do understand it.

Ms Huxtable—It is apples and pears; it is quite difficult. The second element was in regard to cost recovery.

Senator McLUCAS—Yes.

Ms Huxtable—You asked a question about the anticipated revenue from cost recovery. I will read from the budget announcement in the 2005-06 budget for the record:

> ... the Government will recover the costs of the Pharmaceutical Benefits Advisory Committee's review of submissions for new listings on the Pharmaceutical Benefits Scheme, leading to additional revenue of $22.3 million over four years.

I think there are other elements of the question which we will take on notice, but that is the revenue figure.

Senator CAROL BROWN—How many GPs have completed non-directive pregnancy counselling training?

Mr Eccles—We do not have the figures on those who have completed the training. Training is the first step and then they need to register with Medicare Australia so that they are entitled to access the Medicare items. In the order of 179 GPs were registered with Medicare Australia at the beginning of this month.

Senator CAROL BROWN—So you do not know how many are currently undertaking training or how many have finished?

Mr Eccles—I do not think we have those figures. We would be able to get them from the providers of the training.

Senator CAROL BROWN—Do you have a breakdown of those 179 registered GPs by state? Can you give me a breakdown of that?

Mr Eccles—We do not have that with us at the moment, but I am sure that Medicare Australia will be able to get that information for us on notice.

Senator CAROL BROWN—Do you think I will have to ask them or can I just put it on notice now?

Mr Eccles—Yes, you could always ask them.

Senator CAROL BROWN—How many psychologists, counsellors and mental health nurses are registered?

Mr Eccles—At the beginning of the month there were nine psychologists, one mental health nurse and no social workers at this stage.

Senator CAROL BROWN—Thank you.

Senator McLUCAS—I want to ask some questions about the new MBS item for people with an intellectual disability to have a health check. We have spoken before about autism. The autism association has contacted me expressing concern that it has missed out in this measure. It has suggested that the presentation of the medical condition for people with autism is very similar to people with intellectual disabilities simply because they, like people with intellectual disabilities I am advised, have too severe and undiagnosed health conditions, particularly because of their inability to communicate that with their GP. When this measure was being worked up, was any consideration given to people with autism being included or having a similar MBS item?

Mr Eccles—The details of the item are still being worked through with the profession. We will be working with the usual stakeholders in developing the clinical parameters of this, and that is something we will certainly put on the table and make sure is discussed.

Senator McLUCAS—The way I read the press release is that intellectual disability will preclude people with development delay or autism or Asperger's syndrome.

Mr Eccles—Can you say that again, please?

Senator McLUCAS—The way I read the press release is that the rebate will be available for people with an intellectual disability, which by its definition will not include people with autism or Asperger's syndrome.

Mr Eccles—All I can say is that the parameters of the item are being discussed with the profession. The intention is to focus on people with an intellectual disability. The definition of 'intellectual disability' is something we will be working through, particularly with the clinicians.

Senator McLUCAS—I think you would agree, Mr Eccles, that intellectual disability as we know it does not include autism or Asperger's.

Mr Eccles—I think that is a fair comment.

Senator McLUCAS—In the discussion leading up to this, was there a broader discussion about all sorts of categories of people who have complex medical conditions and undiagnosed issues because of their inability to communicate that with their doctor?

Mr Andreatta—The representation that we got from the peak organisations, such as the National Council on Intellectual Disability and the New South Wales Council for Intellectual Disability, provided us with a strong case to have this item included. There was talk about what type of intellectual disabilities should be included in the item. As Mr Eccles said, the detail and the eligibility criteria around the item are yet to be finalised. I take your point that the media release actually included those two or excluded—I am not sure which media release you are talking about.

Senator McLUCAS—It was a media release by Assistant Minister Pyne dated 6 February 2006.

Mr Eccles—What were you referring to in the press release?

Senator McLUCAS—It says that a Medicare rebate will be available for people with an intellectual disability. The representation that I have received is that people with autism and Asperger's syndrome have the same presentations—that is, complex medical circumstances and a limited ability to communicate that with their GP and therefore go undiagnosed. The representation is why are they not included in this measure given that they do not have an intellectual disability but have the same presentations to the GP.

Ms Halton—Perhaps I can cover this. Essentially you would know that we have been developing progressively a series of items to enable a GP to work with a series of groups to look at their total health needs. We have done this for some of the health check items. We have done this for Aboriginal people and for particular ages. The representations that were received which led to the development of this item particularly went to the issues around intellectual disability. I am not disputing what you say about the people who are caring for people with autism et cetera and the developmental delay conditions that you have been outlining, but it is fair to say that the representations that were received were specific to the issues for people with intellectual disabilities. What I can say to you is that you have raised the issue and we are happy to have a look at it. We are happy to talk to the ministerial team about it. There will probably be other issues for this group. There were particular representations that led to this item, and that is consistent with what we have been doing in a number of areas. But we are happy to have a look at the issue.

Senator McLUCAS—Thank you.

Senator ADAMS—My question is about chronic disease and radiation oncology. It was a question I discussed at the last estimates or the estimates before regarding the Northern Territory and the status of its radiotherapy unit.

Mr Eccles—I am trying to think what outcome that would be best asked under.

Senator ADAMS—I just picked it up here because it says, 'Australians have access to cost-effective medical services.' That just jogged my memory. I am not sure whether radiation oncology comes under this outcome. There were some extra figures there.

Ms Halton—I think it is outcome 3. This is particularly in relation to the radiation oncology in Darwin?

Senator ADAMS—Yes.

Ms Halton—It is outcome 3. Can you tell us what you would like to know? We might be able to answer.

Senator ADAMS—All I wanted to know is where it is at. Does it exist yet or is it still on the way to existing?

Ms Halton—No, it does not exist yet. You know that we have to negotiate with our colleagues.

Senator ADAMS—You were doing that before.

Ms Halton—And we are still doing it.

Senator ADAMS—I am trying to catch up.

Ms Halton—We are still doing it but we are hopeful that that will lead to the turning of sods or the beginning of some form of construction this year. We have not yet completely resolved all of the issues in our negotiation with the Northern Territory, but it is close.

Senator ADAMS—Thank you.

CHAIR—There are no further questions on outcome 3.

Proceedings suspended from 4.13 pm to 4.32 pm

CHAIR—The Senate community affairs committee inquiry into additional estimates will resume. We have officers at the table for outcome 5, primary care.

Senator CAROL BROWN—I would like to ask some questions about the Round the Clock Medicare package. Has the department conducted any evaluations of the various measures included in the Round the Clock Medicare package?

Mr Eccles—It was only introduced towards the end of 2004, and no evaluation has taken place at this stage.

Senator CAROL BROWN—So when will you be looking to evaluate the measures?

Mr Eccles—It would be as part of any standard lapsing program review; we will be looking at the measures and looking at its success.

Senator CAROL BROWN—So after the completion of the program?

Mr Eccles—No, I think those reviews normally start some time before the finalisation. I will just check.

Mr Kennedy—I would expect that the evaluation would take place before the 2008-09 financial year so that if the program is reviewed any results can feed into that process.

Senator CAROL BROWN—So that includes the three new grants programs?

Mr Kennedy—Yes.

Senator CAROL BROWN—That is the operating subsidy, start-up grants and supplementary assistance?

Mr Kennedy—Yes, supplementary grants.

Senator CAROL BROWN—That will be carried out by the department at that time?

Mr Eccles—Yes. Initially, the department would contemplate the best way to do this evaluation. It could well be one that we do internally, or we might get external expertise brought in.

Senator CAROL BROWN—Of the grants that have been awarded, can you tell me who and what they are?

Mr Kennedy—There have been I think 73 services agreed to date. I am happy to run through them or perhaps provide it on notice.

Senator CAROL BROWN—If we could do it by program. Who has received operating subsidies to date, how many have there been and what is the amount?

Mr Kennedy—To date, in 2005-06, there have been eight operating subsidies approved and contracts executed. Do you want me to run through the list?

Senator CAROL BROWN—Yes, thank you.

Mr Kennedy—For the Adelaide Hills Division of General Practice, the Albury After Hours Clinic Pty Ltd, the Liverpool Division of General Practice, the Nepean Division of General Practice Inc., Southern Health in Victoria, Sunraysia Community Health Services, the Northern After Hours Clinic in Victoria and Wonthaggi Medical Group.

Senator CAROL BROWN—And how much were they?

Mr Kennedy—In the order that I just read them out, the first subsidy was for $478,515; for the Albury clinic, $382,100; for the Liverpool Division of General Practice, $550,000; for Nepean, $600,000; for Southern Health, $369,000; for Sunraysia, $453,109; for the Northern After Hours Clinic, $400,000; and for Wonthaggi, $500,000.

Senator CAROL BROWN—And those amounts are for over the four years.

Mr Kennedy—That is the full amount.

Mr Eccles—Up to three years.

Senator CAROL BROWN—Okay, up to three. When is the next round going to be awarded for the operating subsidy?

Mr Kennedy—We have just concluded a round; I think that was signed off late last year. We are currently in negotiation for operating subsidies with another 11 organisations in terms of trying to finalise funding agreements.

Senator CAROL BROWN—So it is yet to be announced.

Mr Kennedy—Yet to be announced.

Senator CAROL BROWN—When do you think they will be announced?

Mr Kennedy—It really depends on how quickly we can execute the funding agreements. Sometimes they can take a bit of time, but I would expect over the next couple of months.

Senator CAROL BROWN—Can you tell me what states they are in? Are you able to tell me that information? Can you tell me what electorates?

Mr Kennedy—I would not have it by electorate. Just by state and territory, there are four in Queensland, two in Western Australia, two in New South Wales and two in the Northern Territory. I think that gives 14. In listing those, I should say that the success of the negotiations will depend on whether those services are actually provided funding. I do not want to give any impression.

Senator CAROL BROWN—That is okay. Can we do the same again for the start-up grants? Can you give me some information on how many of those have been awarded and announced, who they are for and how much they are for?

Mr Kennedy—In 2004-05 for start-up grants, there were three awarded. One was for Chevron After Hours Service, one was for the Melbourne Medical Locum Staff Pty Ltd and one was for Adelaide Central and Eastern Division of General Practice. In 2005-06 for start-up grants, there was the After Hours Medical Care in Coolum, A Messieh in Burnie, the Cobram District Hospital, Eloirad Pty Ltd trading as Valewood Clinic, the Fremantle Regional Division of General Practice trading as GP Network, gpSolutions, four contracts awarded to primary health care, the Ramahyuck and District Aboriginal Corporation in Gippsland, RUR Investments Pty Ltd trading as Fountain Valley Medical Centre and Sunshine Health Care Trust in Victoria.

Senator CAROL BROWN—So when is the next round? How much does that add up to?

Mr Kennedy—All in all, there are 16.

Senator CAROL BROWN—Sorry, I meant money.

Mr Kennedy—The value of those?

Senator CAROL BROWN—Yes, the value of the grants.

Mr Kennedy—The bulk of them are for $220,000 over two years. There is only one exception to that, which is A Messieh in Burnie, Tasmania, which is for $217,000.

Senator CAROL BROWN—And the supplementary assistance?

Mr Kennedy—Some 50 of those contracts have been executed.

Senator CAROL BROWN—How many?

Mr Kennedy—Fifty of those in the 2005 round—sorry, 49, which have been contracts executed for start- up grants for supplementary grants.

Senator CAROL BROWN—Can you provide some information on notice on who received those and the value of those grants?

Mr Kennedy—Certainly.

Senator CAROL BROWN—To go back to the start-up grants, did I ask you when the next round of those was?

Mr Kennedy—In terms of the three grant types, the rounds are run at the same time.

Senator CAROL BROWN—So there will be another round of announcements, in the first six months of this year probably.

Mr Kennedy—Yes.

Senator CAROL BROWN—As I understand it, the government was also providing recurrent operating subsidies to a maximum of $200,000 a year and it indicated that from 2005 to 2007 it was going to have 25 new services. Are we on track for that?

Mr Kennedy—Sorry, 25 new services for?

Senator CAROL BROWN—Recurrent operating subsidies.

Mr Kennedy—Yes. We have 10 operating subsidies which have been agreed to date, with another 11 in the pipeline.

Senator CAROL BROWN—I think that is all for that. I just want to ask a couple of questions about improving access to primary care services in rural and remote areas.

Mr Eccles—If you can give us a little more detail we will be able to pinpoint the particular program down and ensure that it is in our area, not under the Office for Aboriginal and Torres Strait Islander Health.

Senator CAROL BROWN—It is a measure that was, I believe, in the last budget under rural and remote towns with less than 7,000 people regarding access to Medicare funding for non-admitted GP services.

Mr Eccles—That is in the acute care area.

Senator CAROL BROWN—Is it?

Mr Eccles—It is outcome 13 because it is about the hospital interface with communities.

Senator CAROL BROWN—All right. I will ask them then, thank you.

Senator McLUCAS—Thank you. That is all we have for acute care.

[4.47 pm]

CHAIR—We will now move to outcomes 6 and 8 relating to rural health and Indigenous health.

Senator McLUCAS—I know we are jumping here. I am actually waiting for Senator Crossin, who is going to manage this area. But can we start with an update on the COAG trials and the Department of Health and Ageing's involvement in the COAG trials.

Ms Podesta—Senator, I am happy to give you an update. Is there any particular aspect of the trials on the APY lands that you would like us to cover?

Senator McLUCAS—I will be very frank with you: we are waiting for Senator Crossin to walk in the room. But given that I have heard many of the conversations between Senator Crossin and you, maybe we could pick up from where you left off last time.

Ms Halton—Yes. We could talk till the cows come home on this, Senator. Not a problem.

Ms Podesta—We had a meeting at the trial site in October where we focused on an action plan for the next period of the trial. The action plan highlighted the priorities for the next period of time, and that is housing and infrastructure, policing and safety, governance and leadership, education and health. We are working towards a regional partnership around a number of those things. As we have said at a number of estimates, there are a number of key projects that were the original priorities of the trial which are being implemented as we speak.

The two key projects are the Mai Wiru stores policy project. There are a number of significant achievements of that project now that I would be happy to talk about. That project is around increasing the availability of nutritious and fresh foods on the lands. There is a healthy kids food pack that has been developed in association with Nganampa, the primary healthcare service there.

There is a new system for recording of healthy food items and nutrition advice. There is a public health nutritionist and retail manager who has been employed by Mai Wiru who is working with the stores on the lands. There have been six graduates in the retail certificate II course and the retail manager has been provided with additional training. It is a terrific achievement of the trial site and one that we have been very happy to be associated with given the linkage that we have all seen with regard to improvement of diet and exercise within the site.

The other critical project is the PY Ku project, and this is the initiative to increase services on the land through training and development opportunities through a network of transaction centres in the eight communities. There has been additional expenditure on that project with regard to accommodation purchased for the staff and for visitors as part of that project. The office furniture and the network server are now operational and we have 15 Anangu staff who have been trained and are working as part of the project.

Ms Halton—I have to say that the meeting that we had at the end of last year was a really positive meeting. We all know how hard it is to get momentum and to actually see things happen, but there was a really positive feeling. It was actually a very good meeting. There is lots to do. There is always lots to do, but it was good.

Ms Podesta—There have been some significant milestones achieved that everyone can see.

Ms Halton—We are actually getting some runs on the board, and I think that makes a huge difference.

Senator McLUCAS—Thank you for that, Ms Podesta.

Senator CROSSIN—Good afternoon. How are you? I have to admit that I do not have very much for you because I have been busy doing other stuff.

Ms Halton—We do not believe you, Senator Crossin.

Senator CROSSIN—So you can breathe a sigh of relief.

Senator McLUCAS—Can I interpose at that point. The reason this is tricky for both the department and those of us in the Senate is the shift in the time. It has thrown everybody. I know that that view is shared in this room. We will make representations about that. Things do have to change, we all recognise that. We should have been consulted before systems that have been in for a long time were changed. I will leave it at that.

CHAIR—I agree with you.

Senator CROSSIN—I am not sure whether we are doing outcome 6, 7 or 8.

Ms Halton—We are doing outcome 6 and outcome 8.

Senator CROSSIN—In terms of outcomes 6 and 8, I wanted to get a handle on what programs you are funding through your expenditure and forward estimates. I think it would be better if I put that on notice. I wanted to do a bit of a stocktake of exactly which programs you have going, how much you have allocated to them and how much you expect to spend. Rather than take up time now I will put those on notice.

I have just got a few questions about trachoma. That will not surprise you really, will it? I wanted to get an update on the National Trachoma Surveillance and Reporting Unit and where the allocation of $920,000 is going.

Ms Podesta—The Centre for Eye Research Australia has been awarded the contract to establish the National Trachoma Surveillance and Reporting Unit. The unit commenced activities in November 2006. We anticipate that the first trachoma surveillance report will be available by July 2007. Do you want further information?

Senator CROSSIN—How are they intending to go about that?

Ms Balmanno—The unit will be relying on data collected by the three states and territories that still have endemic trachoma, and this will be done through their public health units and their normal surveillance activities. That data will then be reported to the unit. At the moment we are finalising the core data elements that are consistent with what was in the CDNA guidelines and exactly how they will be defined. The data will be recorded in a centralised database that the states will have access to. They will be able to check and review their own data and make sure that it is showing up there correctly. Some of them are going to use that database as their main data tool within the jurisdiction. For others, there might be a transitional period where they have two sources of data running but they will be able to view it to check it.

The unit will then be able to publish and analyse that data on a regional level, a state level and a national level. They will have access to summary data for communities but that will not be published by the unit. The unit will not disclose that data. Any of the annual reports that we are looking to do will go back to a reference group that will include representatives from each of the states and territories as well as the Commonwealth and a number of expert representatives. They will review the reports before they are actually published to make sure that the data is presented appropriately, that the states are confident that it is being represented correctly and that it is the best data available.

Senator CROSSIN—Will the $920,000 be pushed out over more than three years now?

Ms Balmanno—It is still over three years. Roughly half of that money, $470,000, is going to the surveillance unit over a three-year period. The other $450,000 will be shared equally between Western Australia, Northern Territory and South Australia to enhance their existing trachoma surveillance effort. It is largely to train staff in the changes that have come about with the CDNA guidelines. In the Northern Territory, for example, they are using it to put in place a coordinator for their trachoma surveillance activities. One of the big issues has been coordinating the school based program that is run in the Northern Territory in a way that best uses the resources that are available. So they are using some of that money for that purpose.

Senator CROSSIN—It would seem that the Northern Territory is not actually going to start its program until 2008. That is my understanding from the answers you gave.

Ms Balmanno—They will be doing surveillance activities this year and they did do surveillance activities last year. It will be the 2006 surveillance activities that will be reported on in the middle of this year. Some of those activities are more consistent with the CDNA guidelines than others. This first report that we expect out of the unit in the middle of this year will still be a little transitional in terms of its compliance with the guidelines. The surveillance activities that are occurring during 2007 will be consistent with the guidelines, and the quality of the data and the report will improve each year.

Senator CROSSIN—I see that the training has commenced in Western Australia but not in the other two states yet.

Ms Balmanno—Western Australia is looking to do its surveillance activities a little earlier than the other states. They have actually managed to reach agreement to have quite a few of the regions do surveillance all at once within a couple of weeks through their public health units, which is a first. That will be fantastic in terms of being able to get a point in time picture of trachoma and not necessarily have families moving between communities or changes in those sorts of patterns. They just happened to strike upon a date in August. That is earlier than some of the others. They are just starting their training now and we will beef it up in July.

Ms Podesta—A significant number of the Northern Territory staff were involved in the pre-test of materials. The materials will form the majority of the training anyway. The Northern Territory staff have had access to some of the materials already. It is certainly true that the contract with the NT and the delivery of training is a little bit after WA.

Senator CROSSIN—Is there a unit that is actually going to do some research or monitoring of drug resistance?

Ms Balmanno—That will be one of the responsibilities of the surveillance unit. We have only had very preliminary discussions about how that will be done. We intend to get some further advice from the public health laboratories network about what activity is already going on around antibiotic resistance surveillance and see how we can work with them on that particular issue.

Senator CROSSIN—Is the Menzies School of Health Research involved in that in any way or subcontracted to get involved in any way?

Ms Balmanno—I could not say. We can follow that up.

Senator CROSSIN—When you talk about the national surveillance unit, what is that exactly?

Ms Podesta—Professor Hugh Taylor is one of the principals involved in that centre.

Senator CROSSIN—So the unit is going to be contained within the Centre for Eye Research, is that correct?

Ms Podesta—They were successful in the tender.

Senator CROSSIN—So the unit and the research centre are one in the same now?

Ms Podesta—Yes.

Senator CROSSIN—Do you have someone from a Commonwealth department on it?

Ms Podesta—Each state and territory has a public health unit with responsibility for trachoma screening but the contract that the Commonwealth tendered for, which the Centre for Eye Research Australia were responsible for, is also known colloquially as the unit but its formal name is the National Trachoma Surveillance and Reporting Unit.

Senator CROSSIN—I know who you are talking about.

Ms Balmanno—So the centre has broader responsibilities. This is one of the things that they will do. They do other research not funded by us.

Senator CROSSIN—I wanted to ask some questions about the ear and hearing programs funding. Just before I do that, though, you remember the issue about access to hearing aids and money actually being provided to allow people on CDEP access to hearing aids. Are they questions of Australian Hearing?

Ms Podesta—Yes, Senator.

Senator CROSSIN—I thought you were going to say that.

Ms Podesta—They are scheduled after OATSIH this time so you will be able to ask them the questions.

Senator CROSSIN—No, we did not call them. I wanted to clarify that. I give notice that I will have them for the budget estimates. We have not spoken to them for a while. So you would not have any idea how many they have given out or how it is going?

Ms Podesta—No.

Senator CROSSIN—Of the $1.9 million that was allocated in this budget, can you provide me with a breakdown of the ear and hearing health program? You allocated $1.9 million to Indigenous health services to target Indigenous children up to five years through screening and early intervention; this is in answer to E06_071.

Ms Podesta—We might have to take it on notice. We are very happy to give you details of the program.

Senator CROSSIN—Let us do that. I have not come all this way for nothing.

Ms Podesta—Is there anything specific you would like us to talk about?

Senator CROSSIN—I was really wanting to know whether there are different elements of the program to which the $1.9 million has been allocated.

Ms Podesta—We have just been given a copy of it, so do you mind if we have a quick look at it?

Senator CROSSIN—No.

Ms Podesta—As we said in June, we are in the middle of a transition phase around the OATSIH funding to health services. We have moved away from an input funding approach to an output based approach where services will be reporting to us in regard to their service development and reporting framework which will give us information on the number of episodes and types of care they provide. The $1.9 million is funding that has been rolled out to primary healthcare services and identified as money and input into hearing services as part of primary health care for children zero to five.

We certainly can report on the input in regard to the specific additional targeted projects but at this stage, as I think I indicated in June, we cannot give detail on each micro component of primary healthcare services. When we get the next service activity report, we will be able to give you very detailed information on the number and types of episodes of care. But, as I indicated in June, in the transition phase, services will no longer be asked to report to us by input—that is, 'You gave us this amount of money for hearing and therefore we did this in this period.' As I said in June, this was going to be a transition phase. We would not be able to then report specifically about the components because there is global funding provided to the primary healthcare services. We can certainly report on the specific targeted projects in addition to what is provided to primary healthcare services.

Senator CROSSIN—But not now, when you get your next report. Is that correct?

Ms Podesta—We cannot for the $1.9 million now but we can for the specific targeted projects which are over and above the primary healthcare delivery.

Senator CROSSIN—Let us go back a bit. When you say you have rolled it into the primary healthcare services, has it become part of the P-CAP money?

Ms Podesta—It is part of the Aboriginal and Torres Strait Islander primary healthcare funding—

Senator CROSSIN—Which has gone to states and territories.

Ms Podesta—which includes P-CAP and the Aboriginal and Torres Strait Islander health funds, yes.

Senator CROSSIN—So it is a bit hard to unravel it all. Is that what you are trying to tell me?

Ms Podesta—It is. We spoke about this in some detail in June. We decided after a lot of consultation with the sector that, rather than fund them on an input model where they had to report—and it really was a red tape issue from their point of view—against lots of little inputs, there would be a global figure provided to them and, through agreement with the sector, they would engage in service activity reporting where they tell us about their outputs. That is, for that global amount, they would tell us what level of services, types of services, types of clients they worked with.

As I said, there is going to be a transition phase where we will not be able to tell you precisely what happened for that individual little input. But when we get the next service activity reporting, we will be able to give you much more detailed information about the outcomes as a result of the money.

Senator CROSSIN—When is that reporting due?

Mr Thomann—We are in the final stages of implementing the service development reporting framework with services across Australia. That will be completed with most services in June of this year. In the next cycle in the next financial year, we will be hoping to have reports based on activities that the services themselves will define. Certainly, a number of organisations will be highlighting their activity around eye health, ear health, and maternal and child health. We will be hoping to get from that a much better picture of what the impact in terms of activity is of our total investment in organisations.

The purpose of this is to move away from what we were doing with organisations previously. Some organisations had funding inputs from umpteen funding programs. We were accounting for $1 million here and $3 million there at a national level and they were accounting for $50,000 here and $100,000 there. This was creating an enormous burden which was actually not giving us the information that we needed. So we are in a process of getting organisations to account for their activity and their outputs in terms of what they are actually doing rather than what they have been telling us they have been doing for the last 10 years. So there is quite a change for us and for them going on in the relationship between the department and the organisations.

Ms Podesta—One of the things I think you will find of interest is that the $1.9 million previously provided funding for about 30 sites, but we knew that there were other primary healthcare services providing other hearing services for children zero to five. For example, in the 2004-05 SAR approximately 70 per cent of services indicated that they provided hearing and hearing related services for children zero to five. What we will be able to now do through the SAR is roll in all of the information from the 30 sites and all of the other sites and be able to tell you in much greater detail precisely the numbers of children being assessed, the types of services et cetera.

Sorry, we will know the broad number of client contacts, not children. I am sorry. We have privacy issues about the number of clients. That will give us a much stronger policy framework to be able to identify potential gaps and where there needs to be additional investment around those services.

Mr Thomann—We are encouraging organisations to estimate of the total funds they receive from us from the total recurrent funds what proportion of the resources are going into certain aspects of service delivery—so what proportion of that overall allocation they get from us is going into eye health, drug and alcohol issues or mental health. So they are giving us an actual picture of what they are doing with the total money they receive from us rather than accounting for the inputs that they used to receive from us historically. This will change the incentives around giving organisations the opportunity to plan around what the needs are for their community and actually accounting for that.

Senator CROSSIN—Is it the same with the $640,000 and the hearing program, the $0.6 million that you talk about?

Ms Podesta—No. They are the specific projects over and above the money that has been rolled into primary healthcare services.

Senator CROSSIN—So that money is being targeted at Indigenous children and mothers up to eight years old. Is that right?

Ms Podesta—There is still an additional $0.6 million for a range of specific projects and they include the otitis media guidelines et cetera.

Senator CROSSIN—Okay. Can you give me a breakdown of what that money will be used for?

Ms Balmanno—For this financial year, we have $58,485 for the otitis media guidelines project that we have talked about before—the South Australian one—which is continuing. We

then have funding under three contracts for training for Aboriginal health workers in hearing activities. Those contracts are with Australian Hearing for $277,000—more or less $278,000; $277,978—with the Northern Territory for training in the top end of the Northern Territory for $186,363 and with Congress for training in central Australia for $74,080.

Senator CROSSIN—Can I just go back to that $1.9 million? Is that allocated by states and territories or organisations?

Ms Balmanno—It is provided to the services that were previously listed as the services that had the child health hearing sites.

Senator CROSSIN—So that might be—

Ms Balmanno—That is part of their core money now.

Senator CROSSIN—It might be state and territory health and it might be Aboriginal community controlled.

Ms Balmanno—Most of those would be Aboriginal community controlled organisations.

Senator CROSSIN—Okay. Can I take you to the Indigenous children's health check? Can I ask—and I think this was a question that Senator Evans asked; I do not have the number here, I am sorry—if the special health check teams have been formed?

Ms Podesta—That was a measure that was announced under the violence summit proposal. There has been recommended sites identified and we are waiting to finalise with the states and territories the agreement for the services to commence.

Senator CROSSIN—So you will then put these health check teams into those particular sites; is that right?

Ms Podesta—That is right.

Senator CROSSIN—And the teams will be made up of what?

Ms Podesta—They will be multidisciplinary teams. They will include doctors, nurses and Aboriginal health workers. There will also be a legacy team that will stay after the intensive child health checks have been undertaken in those regions to deal with the ongoing health issues that might be required. They will be supplementary resources available to the service and they will include, in most cases, a nurse and an Aboriginal worker.

Senator CROSSIN—How many sites are we looking at?

Ms Balmanno—Up to 10. We expect to move forward with probably five or six sites in the first instance, because trying to do 10 at once could be fun. The costing was based on doing up to 2,000 children going through the health check. So the exact number of sites will depend on how many children there are in the locations.

Senator CROSSIN—So 2,000 is still the target, then?

Ms Podesta—Yes.

Senator CROSSIN—So these will be specific doctor, nurses and health workers that you will employ that will go around to each of those sites?

Ms Balmanno—Probably not. We are going to go to open tender for someone to coordinate the health service teams. With some of the sites, we expect that they may already have partnership arrangements in place with the division of general practice, or a university that may be able to help with locum arrangements for the provision of teams and we would obviously work with that arrangement, if they have got something in place, and support that. With others, they will rely on us, I think, to identify and provide the additional health personnel. It will be a little dependent on the sites and what resources they already have in place and what they need to be able to do to undertake the health checks. We will do it in negotiation with each health service.

Ms Podesta—It is important to understand the difference. The child health check is available and increasingly being taken up as parents bring their children in or as doctors identify that it is a good option for children.

Senator CROSSIN—This is the Medicare rebatable initiative.

Ms Podesta—Precisely. So a number of the services will already be doing child health checks. The idea behind the violence summit was to identify some intensive delivery within communities of child health checks.

Senator CROSSIN—Which will supplement—

Ms Podesta—Precisely. 'Supplement' is exactly right.

Ms Balmanno—It would be the same health checks. It is it is not a separate check; it is the same check. The idea is to get services which perhaps have limited capacity to start doing those checks at the moment because of the systems they have in place or the personnel to be able to tip over into a more preventive way of dealing with child health.

Ms Podesta—We will be doing a lot of work within each community to give information, encouragement and support to families about the child health check. It is not a coercive measure; it is genuinely a public health measure and a population health measure.

Senator CROSSIN—I understand that. I have seen it operating.

Ms Podesta—You have seen the roadshow?

Senator CROSSIN—I have seen the roadshow, but I have also been into clinics in communities where it is happening. I have seen it happening. It would be unrealistic to expect the funds to be expended by 2006-07, surely.

Ms Balmanno—The funding was over two years.

Senator CROSSIN—Yes.

Ms Balmanno—So this financial year and next financial year.

Senator CROSSIN—So 2006-07 and—

Ms Balmanno—2007-08.

Senator CROSSIN—So that might mean something like Congress might just pick this up as part of their work.

Ms Podesta—They might well.

Ms Balmanno—And do those checks, anyway, without this additional support. Certainly, they have been quite proactive in doing health checks.

Ms Podesta—We do not want to pre-empt any outcomes, but because we will go to open tender they or another service might put their hand up to tender to be the provider.

Ms Balmanno—To help others.

Senator CROSSIN—This might not be a question that your area is able to help with, but in the case of a region like Tennant Creek and at Southern Barkley in a discussion I had with them just this morning I understand that they are struggling to get a doctor. What does your department do about that? In relation to these health checks, what happens there?

Ms Balmanno—For these health checks, a doctor would be part of the team that goes in.

Senator CROSSIN—So would you fly someone in in that instance.

Ms Balmanno—Yes, and they would be there for a period of weeks or however long it took, depending on the size of the community.

Senator CROSSIN—What does OATSIH do in general if they get alerted to the fact that there are no doctors going into certain regions, or you cannot mainly cannot get doctors to go into certain regions.?

Ms Podesta—We are acutely aware, particularly in remote services, of the challenges that they face in regard to the workforce. We have had a series of regular discussions with the peak body, AMSANT, in the Northern Territory around the challenges and the issues. We have certainly been looking at it on a case-by-case basis with services that are finding it difficult to attract and retain options and support. I think it is really important to note that there is no one single answer to this. It is not—

Senator CROSSIN—We know that.

Ms Podesta—It is not just an answer of, 'Give them another amount of money.' There are issues around governance, attractiveness, linkages professionally, the issues of why people will choose to work in certain locations—

Senator CROSSIN—Yes, I know all of that.

Ms Podesta—Mr Thomann might wish to give some additional information. It is an issue that exercises us.

Mr Thomann—We have had a number of discussions with AMSANT in the Northern Territory. AMSANT has a very good working relationship with the GPPHCNT, which is the rural workforce agency up there. When they first brought it to our attention in April last year, I think there were 18 vacancies in Aboriginal medical services. It is now down to six. The department has a number of rural and remote recruitment and retention programs with respect to GPs and the RWAs are able to bring them into places.

Where the Aboriginal medical service is struggling, OATSIH staff are able to give them assistance in terms of discussion around their activity plan, in terms of their ability to do business. If they are uncompetitive in the market, organisations are able to bill Medicare. Those revenues can also be applied to the kind of remuneration package that can be applied to attracting a GP into the area. AMSANT itself is looking at the kind of support it can give

organisations to enable those organisations to manage the package of arrangements that are necessary to attract GPs to work in certain locations. Certainly, I am aware that some organisations have changed the way they operate in order to make the conditions more attractive for GPs to work in their particular service and their particular locale.

Senator CROSSIN—I have some questions about the Opal fuel rollout but, before I do that, the OIPC has a strategic interventions unit now, and I am assuming that the Department of Health and Ageing is actually part of the workforce in that unit. Are representatives from OATSIH part of that strategic interventions unit or are they from the department in general?

Ms Podesta—We do not have staff in the strategic interventions unit. We certainly work very closely with OIPC as part of the whole-of-government approach to Indigenous affairs and we share information and work together, but the strategic interventions unit is staffed through FaCSIA, as OIPC is part of that department.

Senator CROSSIN—Yes, that is right, but they told us last night that they have one person from each department working with them. I wondered whether the person who comes from this department is from the general health area or from OATSIH.

Ms Podesta—We have staff who are located in Indigenous coordination centres but we do not have staff in the strategic interventions unit.

Senator CROSSIN—No. I am talking about the unit that Ms Kate Gumley heads up. It is called the strategic interventions unit. It has hundreds of millions of dollars to spend and there are four trial sites—about to be five trial sites. She told us last night that her unit interacts with someone from each of the major departments on a weekly basis. I am wondering who that is here. Come on, 'fess up.

Ms Podesta—We are talking about the difference between whether we are staffing the unit or whether we are a contact. We have a contact officer.

Senator CROSSIN—No, I do not think you staff the unit. She has 20 people in her division.

Ms Podesta—Yes.

Senator CROSSIN—It is called the strategic interventions unit under OIPC. It is like the COAG trials but hopefully will be more efficient and effective than the COAG trials. My really simple question is: does she liaise with someone in OATSIH or does she liaise with someone who is in the non-Indigenous part of Health?

Ms McLaughlin—The immediate contact for Kate Gumley's strategic interventions unit is in the Office for Aboriginal and Torres Strait Islander Health at the central office level in Canberra. It also has close working relationships with either our state or territory managers or our OATSIH director in the state and territory offices, but that varies from site to site.

Senator CROSSIN—Thanks. That is all I wanted to know. I am just trying to put the jigsaw puzzle together, and you have given me another piece, so thank you. I also wanted an update on the Opal fuel rollout. Have additional regions for the rollout been named besides Central Australia?

Ms Balmanno—Not at this stage.

Senator CROSSIN—Soon—is that what you are going to tell me?

Ms Balmanno—Very soon.

Senator CROSSIN—With OIPC last night everything was going to happen 'soon'. I take it then that there is going to be an announcement some time between now and the budget about further areas. Would that be not too far off the mark?

Ms Podesta—The two ministers are the two lead ministers on the petrol sniffing strategy.

Senator CROSSIN—It is all right. I do not want to put you—

Ms Balmanno—Very soon.

Ms Podesta—We cannot pre-empt when the government will announce—

Senator CROSSIN—And I would not want to pre-empt any of those boys either. Do we know how many additional regions there will be? Are we talking about two or 10?

Ms Balmanno—Two as per the budget decision.

Senator CROSSIN—But we do not know where those two regions are going to be.

Ms Podesta—It has not been announced yet.

Senator CROSSIN—Watch this space then. What is happening with the Opal communication strategy?

Ms Balmanno—It has started.

Senator CROSSIN—That is right. It must be February.

Ms Balmanno—The first press ad appeared on Friday to coincide with the action that Shell had undertaken to start to top up its tanks in Alice Springs with Opal. The regular unleaded tanks are gradually being replaced with Opal. It is a gradual process, rather than a take-it-all-out and put-it-all-in process.

Senator CROSSIN—Where was the ad?

Ms Balmanno—In the *Centralian Advocate* on Friday. It was a full-page ad on page 11, I think.

Ms Podesta—And it is in today's, Senator.

Senator CROSSIN—You are assuming that people in Alice Springs read the *Centralian Advocate*.

Ms Podesta—We have.

Ms Balmanno—I have just been corrected. It was on page 18 of the *Centralian Advocate* on Friday. That was the first ad. There will be a range of press ads and radio advertisements. There is also going to be a letterbox drop probably early next week to all residents.

Senator CROSSIN—So this is to encourage people in Alice Springs to buy Opal. Is that correct?

Ms Balmanno—It is actually to provide all of the information. We did some research in Alice Springs to find out what people's concerns and questions were about Opal fuel, and it is to respond to those.

Senator CROSSIN—Hopefully we have won the war on the mischief that was created about Opal.

Ms Balmanno—Hopefully.

Ms Podesta—We think so. The press coverage today was very balanced. It was very heart warming to see such balanced reporting today.

Senator CROSSIN—Is this in the Alice Springs media?

Ms Podesta—Yes, it was.

Senator CROSSIN—I will make sure they know you said that.

Ms Podesta—The communication campaign is very factually based. It is to give factual information about what cars can use Opal safely, the benefits to the general community of Opal and technical information about Opal. It is very straightforward information.

Senator CROSSIN—So you are running this on Imparja?

Ms Balmanno—We are not doing television ads for this.

Ms Podesta—Radio.

Senator CROSSIN—Just radio. I take it CAAMA Radio and ABC. What about 8HA?

Ms Balmanno—We would have to take that on notice and give you a list of the media buy.

Ms Podesta—We might well be able to have someone bring it in.

Ms Balmanno—We do not have it with us here.

Senator CROSSIN—I just urge you to have a look and make sure that 8HA is on there. It is like an FM station that I think most people would probably listen to.

Ms Balmanno—It is.

Senator CROSSIN—Are you pretty sure it is there?

Ms Podesta—We will take it on notice and we will give you a list.

Senator CROSSIN—So there will be a letterbox drop and radio information about it.

Ms Podesta—Radio ads, press ads, web based support, a technical brochure, a letterbox drop and an accompanying general brochure to all households.

Senator CROSSIN—So rather than me ask you what the features of the campaign are, can you provide the committee with copies of that?

Ms Balmanno—Yes.

Senator CROSSIN—In relation to the budget and projected expenditure, how much is budgeted and how much do you think you will spend?

Ms Podesta—Expenditure is based on fuel usage. Do you want to know about communication or the Opal measure?

Senator CROSSIN—Both if you can do it very quickly.

Ms Podesta—This is very much a demand driven expenditure. We are able to make an estimate of how much fuel will be used in the designated regions and therefore make an

estimate of the expenditure. But, as you understand, we pay upon receipt of fuel because we pay for the distribution costs and the subsidy of the fuel. So we will give you the figures on what we anticipate to be the fuel usage in the designated regions and therefore what we anticipate to be the expenditure.

Senator CROSSIN—Wasn't $10 million allocated as the subsidy? That much I know. Take it on notice if it is going to be easier.

Ms Podesta—We will take it on notice.

Senator CROSSIN—What was the budget for the communication campaign?

Ms Balmanno—So far we have spent nearly $124,000 on communication but we have committed a further $727,000. That includes, on the research that has been undertaken in Alice Springs, some of the additional technical analysis that we commissioned to make sure that we were confident in the messages that were included in the campaign and in the campaign material and in the media buy itself.

Senator CROSSIN—There was about $1 million allocated to that, was there not?

Ms Balmanno—At this stage it is about $900,000.

Senator CROSSIN—How long is the campaign to run for?

Ms Balmanno—The media campaign is to run for eight weeks at this stage. We will see how we are going and how it is being received in Alice Springs as we move along. We will be evaluating the campaign as we move through.

Senator CROSSIN—Are you getting an indication from BP that the rollout of Opal is being affected or is not being affected by their production capacity?

Ms Balmanno—It is not being affected at this stage.

Ms Podesta—It is interesting that we always focus on the sites et cetera, but the other thing that has been of incredible importance to us in the last month has been not only the anecdotal information that has come in about the number of sniffers that have been seen in the designated region but the information provided by—

Ms Halton—Or not seen is actually more to the point.

Ms Podesta—Yes. As opposed to previous periods where there had been particularly young people seen with cans on their faces, it is almost not seen now. The information that we received from Nganampa Health Service on the APY lands was particularly heartening. Over the last nearly two years now they have done their second survey. The incidence has dropped by nearly 80 per cent, and particularly with regard to young people it is almost nonexistent at this stage. We, like everyone in the area of health, are always cautious. You never say, 'It's been won'—never. But there is certainly enormously encouraging information now that shows that it is having a significant real and demonstrated impact.

I think, as we have spoken about in some detail previously here, we have always been very anxious about the issue of younger children emulating older teenagers who sniffed. It really does seem that that cycle has been broken in those communities. This is something many of us in this room have talked about in detail. It is hard in Aboriginal health, and we have always

appreciated the great interest that this committee has taken in it. It is wonderful to see a real and demonstrated improvement in an area of addiction.

Senator CROSSIN—That is good news. Can I just say in finishing that if your campaign is going for two months—this is just a bit of an advertisement here, so excuse me—there is a very big AFL match in Alice Springs on 9 March. It is part of what was the Wizard Home Loans match where the two losers will play off. The town will get thousands there. So if you are going to place an add, do it on that Thursday. You might even want to talk to the AFL about making your brochure available at the gates or at stands at the match.

Ms Halton—That is a good idea.

Ms Podesta—Senator, you know that the football was where there were young people who had previously been sniffers as well. It was terrific that they won one of the Aboriginal football competitions. We will certainly take that back.

Senator CROSSIN—If you want to get mass numbers, the town will be packed that Friday night, 9 March. The AFL will be on board, I am sure, if you want to actually distribute stuff at the ground or make it available at the ground.

Ms Podesta—That is great. One of the fantastic benefits of working in Aboriginal health is that I can genuinely go to AFL matches.

Ms Halton—It is work.

Senator CROSSIN—That is all I have. Thanks very much.

Ms Halton—On indulgence, we have a question on notice that we have discovered we actually had an error in. It was a $1 million error, so we would like to table a corrected version.

Senator McLUCAS—Was your version incorrect?

Ms Halton—Yes. It is EO6_68, but we have the revised version here.

Ms Podesta—We have 12 copies of the revised version.

Ms Halton—So we will table it and apologise. These things happen sometimes.

Senator CROSSIN—I did not pick it up.

Senator SIEWERT—I just want to ask a few questions about petrol-sniffing programs. There was the issue, as we know, with the false information that was going around Alice Springs from the middle to the end of last year. Are you now monitoring what media happens and countering that, because that was part of the problem last time in that no-one was countering the misinformation that was being put about? Are you actually now undertaking an active intervention program? Besides the advertising that is going on, are you now also responding?

Ms Balmanno—Yes. We have contracted a public relations firm that has an office in Alice Springs to be there on the ground and monitor the media sort of hourly for us and to help us prepare responses and to amend the materials if we need to or to use other strategies to make sure that the correct information is quickly within the public domain.

Senator SIEWERT—How long will you be doing that for? I appreciate that you can only run the campaign for a certain amount of time—the eight weeks—but, beyond the eight weeks, will you be continuing to do that monitoring?

Ms Podesta—We will check with our communications branch; they actually have the contract.

Ms Balmanno—At this stage I think we have only contracted for the initial period, but we will obviously see how that is progressing and we can always extend that contract if need be.

Senator SIEWERT—Okay. It would be unfortunate if misinformation started up again and we had to wait. We have had to wait since this first happened until this week. It would be unfortunate if that happened again.

Ms Balmanno—We certainly do not want to see that.

Ms Podesta—Obviously the department does its own media monitoring. We look to see what has been reported about our outcome. Obviously from our point of view, no-one anticipated the type of consumer backlash that was apparent in Alice Springs. We have now gone through it. We have seen it. We now have materials in place that give factual information to people. It came out of the blue to a large extent, because the program had been rolled out so successfully in remote Aboriginal communities, which had been the original intention obviously of the petrol sniffing program. We now have a lot more information about consumers. We know what is said and not said and, because we have the independent report and analysis done, we have factual information so that we can say that we know that this fuel is safe et cetera.

Senator SIEWERT—My understanding is that during that misinformation period a number of the petrol stations started not stocking Opal.

Ms Podesta—They made commercial decisions.

Senator SIEWERT—Yes. Can you tell me how many of the service stations are now stocking Opal?

Ms Balmanno—There are four petrol stations in Alice that have continued to stock it throughout the period. All of the petrol stations have committed to make the switch by the end of February. I think there are four Shell petrol stations that are in that transitional phase that I mentioned earlier where their tanks now have a mixture of regular, unleaded and Opal in them.

Senator SIEWERT—So all of them will be stocking Opal—

Ms Balmanno—By the end of February.

Senator SIEWERT—What is happening now with the sniffable fuel? How is that being regulated?

Ms Podesta—You mean the premium fuel that is still available?

Senator SIEWERT—The high-octane stuff will still be available. How is that being dealt with?

Ms Podesta—We have provided advice and information to all of the fuel outlets about additional security measures. That includes not only physical security around the bowsers but also—and Rachel can provide additional information—ID being provided at service stations when people purchase premium.

Ms Balmanno—I think some of the roadhouses have done that. They happen to be on community land so the community has been able to pass a by-law that means it requires adequate ID. The ones in Alice Springs are putting in place local policies around not providing premium in jerry cans, for example. It actually has to be to fill up a car.

Ms Podesta—We are just getting up to date on that. At one service station which was, as Rachel said, on community land the idea was to have additional security available on the bowser itself.

Senator SIEWERT—So does that mean you cannot just rock up and get petrol; it is not self-service? Is that what you mean by additional security? How is that being handled?

Ms Podesta—Our officer has been up there to every one of the service stations; he can tell us. It is still self-service but the staff have now been given additional training and information. They monitor from the console within the service station who is purchasing and what cars they are using to purchase the premium product. This is difficult because it is not illegal to buy premium fuel. It really is, as much as possible, about trying to influence consumer behaviour from the point of sale. There is no legislation. It is a voluntary action that the service stations are engaged in here. But they are genuinely coming on board. It is in everybody's interests up there to do the right thing. They have been providing training and information to their sales staff. They physically have a lot more security around their premium bowsers so that after hours you cannot get into them.

Senator SIEWERT—Once the switch is made and the rest of the stations are on board at the end of February do I understand correctly that there will be no sniffable non-premium, normal unleaded fuel available in Alice?

Ms Balmanno—That is correct.

Senator SIEWERT—Thank you very much.

CHAIR—That concludes outcomes 6 and 8. I thank the officers associated with that part of the proceedings.

[5.45 pm]

CHAIR—We now turn to outcome 9, Private health.

Ms Halton—For the record, you might be aware that the Ombudsman passed away. I think it would be appropriate to record here that he did an excellent job. He died very quickly and he was not an elderly man. Obviously people have expressed their condolences, but I think it is appropriate that we record here that we were very grateful for the work he did while he was in the portfolio.

CHAIR—The committee had noted the fact that he had passed away since our last meeting. I am sure I speak on behalf of all on this committee in saying that the committee greatly values the contribution he made over a large number of estimates hearings. Perhaps

Ms Gavel might pass back to Mr Powlay's family the comments that have been made here today.

Senator McLUCAS—I would like to concur with those remarks. I am going to be very quick with this because we are going to catch-up time. Can either the department or PHIAC provide any data on private health insurance coverage by electorate?

Mrs Ginnane—PHIAC does not collect the data by electorate, only by state.

Senator McLUCAS—Just by state?

Mrs Ginnane—Just by state.

Senator McLUCAS—And not by any smaller—

Mrs Ginnane—No.

Senator McLUCAS—Could you provide the data that you have? I think you might publish it.

Mrs Ginnane—We do; we publish it. I can certainly arrange for copies of the most recent annual report with all of that information to be distributed to the committee.

Senator McLUCAS—Thank you. In terms of the department's data collection, how does the department collect data on private health insurance coverage?

Ms Flanagan—We hold some data because of course we pay out the 30 per cent rebate but really the data is owned by the private health insurers themselves. We could look at the possibility of what we might be able to give you. We can take that on notice and see what we can actually provide.

Senator McLUCAS—So you can have a discussion with the private health insurer?

Ms Flanagan—We will see what we would be able to provide you, yes. I would need to speak to them.

Senator McLUCAS—I understand that the industry association does collect data but the industry association does not cover all providers of private health insurance. But it would be useful for us to get an understanding of the geographical spread of membership of private health. How many people have paid the Medicare levy surcharge in each of the last five years?

Ms Halton—That would be a Tax question. The Treasury portfolio would manage that. It is not our area.

Senator McLUCAS—So you do not have any relationship with Tax over that data?

Ms Halton—No, that is revenue.

Senator McLUCAS—It is totally—

Ms Halton—We spend it; they get it.

Mr Kalisch—That is processed through the annual tax return process and managed through that dimension.

Ms Flanagan—If you need that information it is best that you ask them directly.

Mr Kalisch—Certainly the Treasury portfolio publish some information in their regular tax statistics. It is an annual publication and I am sure that they would cover at least the amounts if not the number of people involved.

Senator McLUCAS—Does Treasury regularly provide you with any information about who is paying the surcharge or who is not, or is that information that you do not really require?

Ms Flanagan—We do not really require it.

Senator McLUCAS—I will put those questions through to the ATO then. Did the department undertake any modelling on the effects of the introduction of broader health cover on premiums?

Ms Flanagan—My understanding is that Access Economics was commissioned last year to develop a model to have a look at the various impacts on private health insurance. What we found from that was that, in effect, there will be a nil impact on premium increases.

Senator McLUCAS—So Access Economics provided you with a report. They ran the figures through a model.

Ms Flanagan—They provided us with a model and we used the model to do some analysis of what we thought the impacts would be. Overall we think there will be negligible impact on premium increases. That is because, by extending health cover, perhaps health insurers will be able to provide hospital substitute treatment, for example, which could be provided in the home, and that is a much more cost- effective way than providing it in a hospital. So overall we think there will be negligible impact.

Senator McLUCAS—Can you provide us with a copy of that model?

Ms Flanagan—This question has been asked before. It goes to the internal workings of government and it is not going to be released.

Senator McLUCAS—What you are suggesting is that on the application of the model there was a negligible increase in premiums.

Ms Flanagan—That is what the modelling is showing.

Senator McLUCAS—Is that in the short term or the long term?

Ms Flanagan—I think that possibly in the long term, with broader health cover, we will see private health insurers able to offer cover for chronic disease management which would cover more preventive sorts of care. You would then assume that you would actually see a downward impact in the longer term if private health insurers do offer chronic disease management programs and if they have the preventive effect that we hope and expect they might have.

Senator McLUCAS—The question I asked though was: are you suggesting that there will be limited or little change in the short term or the long term using the Access Economics model?

Ms Flanagan—I am suggesting that, yes. In the longer term though we might even see a better result than in the short term, depending again on how private insurers take up those

measures. We are trying to provide a platform on which they can offer these sorts of programs.

Senator McLUCAS—So that I have the record straight: you are saying that there will be negligible impact on premiums in the short term.

Ms Flanagan—Yes.

Senator McLUCAS—What evidence does the department have to suggest that the taking up of these so-called preventive measures will deliver better health outcomes?

Ms Flanagan—As I say, some chronic disease management programs are already offered. All we are doing in this legislation and in these changes is providing a platform, as I say, by which they can be offered. But one would make the assumption that with better disease management you are going to have more cost-effective and cheaper health expenditure in the long term.

Senator McLUCAS—I just want to pursue that for a second. You said it was an assumption. The question I was asking was: what clinical evidence do we have that says that increased uptake of these preventive health or chronic disease management measures will actually deliver improved health outcomes?

Prof. Horvath—There is a lot of data both here and overseas about chronic disease management. If we look at diabetes, there is extensive evidence that good out-of-hospital care reduces in-hospital care and reduces mortality and morbidity. Similarly, there are studies around cardiac failure, which is a very common presentation to emergency departments, that show that good chronic cardiac failure management out of hospital would reduce the number of hospital admissions and in fact prolong life considerably. So high-impact chronic diseases—such as respiratory, cardiac and diabetes-vascular—are the major emergency department acute admissions. There is a lot of data that shows that if you can get treatment programs into the community and their uptake is facilitated you will reduce hospital admissions and greatly improve clinical outcomes.

Senator McLUCAS—Professor, are we talking about the same thing? During the inquiry that we had just recently into the current legislation I do not think we were talking about that sort of direct, hands-on, tailored, personalised hospital exit health program. The products that I think the private health insurers are looking at are more generic. They are about walking more often, maybe going to the gym, eating better and stopping smoking—all of which we know is good. Where is the clinical evidence that says that a program introduced by an insurance company that encourages a population to be self-selecting will have a better health outcome? I want to see the clinical trial of that sort of package that would lead this committee to understand that there will be increased health outcomes as a result of this measure.

Mr Kalisch—I am certainly aware of some fairly dramatic interest by Dan Hook and his company, particularly around diabetes, which Professor Horvath was talking about. Mr Hook talked about not so much self-selection but about active encouragement and facilitation by the health fund not only for those who were at high risk of diabetes but certainly for those who were at low risk of diabetes. Mr Hook provided to the department a presentation that was fairly persuasive in saying that a broadly based program that also included those at low risk or at moderate risk of diabetes was also in the health fund's interest and had a considerable

financial pay-off. We can certainly get some of that information for the committee. Certainly from the department's perspective the presentation that Mr Hook provided, particularly on the aspect of diabetes, was very persuasive.

Senator McLUCAS—Mr Hook has provided that to the committee. I think the key difference is the active encouragement, because my understanding of the legislation does not allow a private health insurer to do anything other than offer a product. So where does active encouragement lie? Mrs Ginnane, you might like to comment on the issue of where do we stop offering a product and begin actively encouraging a product? And there is an element of perception in that as well.

Mrs Ginnane—I am not sure it is an area we can comment on. It is a policy area for the department around what health funds can actually do and what they can offer. Certainly my understanding is that they cannot force but they can certainly encourage. But at the end of the day it will be those people willing to take up that opportunity.

Senator McLUCAS—Ms Gavel, from the point of view of the Private Health Insurance Ombudsman, how many complaints do you receive from members who feel as though they are forced to take a certain action by a health insurer? Have I explained myself appropriately?

Ms Gavel—Yes. We would only have what I would call a handful of complaints around those sorts of issues. Occasionally people do complain that their fund has offered them something like a diabetes program and because they are already under the care of their doctor they do not want to take that up, but it is entirely voluntary and there is no requirement on them to take it up. We have very few complaints around those sorts of issues.

Senator McLUCAS—What is the nature of those complaints? An uncertainty about the right of the health insurer to offer the product? Could you give the committee an understanding of that?

Ms Gavel—I suppose people see it more related to privacy type issues. That would be the main issue.

Senator McLUCAS—'How do they know that I have diabetes?' for example.

Ms Gavel—Yes, that sort of thing.

Senator McLUCAS—We will come back to that. Do you get complaints about feeling pressured to do something, even though it is not explicit in the letter of offer that the insurer has provided the member?

Ms Gavel—As I said, we have had maybe one or two, but I would not say that they are in any way significant. They are such a small number.

Senator McLUCAS—There are not that many products out there, though.

Ms Gavel—Yes, but some people have very strong concerns about their privacy that are perhaps stronger than what the general public have. So they are probably the sort of people who would be more concerned about those sorts of issues.

Senator McLUCAS—Thank you. The new legislation removes 'minimising private health insurance premiums' in its objectives. What is the background to the removal of that objective in the new legislation?

Mr Maskell-Knight—The current requirements of the National Health Act say that in exercising its functions PHIAC is to achieve an appropriate balance between four things, one of which is minimising premiums. Under the current act, PHIAC has no powers to act over premiums. The new bill replicates that situation. We therefore thought it was a bit unfair to say that PHIAC should have an objective of minimising premiums when the control over premiums rests with someone else.

Senator McLUCAS—So the objective was in the PHIAC section of the new legislation, not in the—

Mr Maskell-Knight—Section 82BA, from memory

Senator McLUCAS—You amaze me, Mr Maskell-Knight. Did the department or PHIAC recommend that change in the policy development process?

Mr Maskell-Knight—It was part of the consultation we had with the Office of Parliamentary Counsel. PHIAC was certainly involved in those discussions at various times. I might step back a bit and say that our objective in framing the new legislation was to try to make it clear, workable and consistent, I suppose. As part of that objective, removing objectives from people who did not actually have any powers given to them to achieve that objective was consistent with our overall aim.

Senator McLUCAS—Thank you. What is the cost of the 35 per cent and 40 per cent rebate for older Australians, both in dollar terms and as a proportion of the total expenditure on the private health insurance rebate?

Ms Flanagan—I can take that on notice. I have not got that broken down into the 35 per cent and 40 per cent. So we can get that to you.

Senator McLUCAS—Thank you. Can the department provide any data on the number of older Australians who have taken out private health insurance since the higher rebates were introduced?

Ms Flanagan—We can take that on notice. I have data from the last year. If you want it back since the rebate was introduced, I would need to take it on notice.

Senator McLUCAS—That would be useful, thank you. So you can disaggregate it according to the two measures?

Ms Flanagan—Yes.

Senator McLUCAS—Over time.

Ms Flanagan—What do you mean by the two measures? The 35 per cent and the 40 per cent? The different age groups?

Senator McLUCAS—Yes.

Ms Flanagan—Yes, we can do that.

Senator McLUCAS—Thank you. That is great.

Senator MOORE—Can you do gender as well?

Ms Flanagan—We can look at whether we can do gender.

Senator MOORE—Or definitions or anything like that.

Ms Halton—The problem is going to be with the grouping.

Senator MOORE—We would like to find out exactly what your database can allow us to know.

Ms Flanagan—We will have a look at that as well.

Senator MOORE—That would be good.

Senator McLUCAS—I have a question about the relationship between the Department of Health and Ageing and the private health insurance sector and the public hospitals that their members are treated in. What role does the Department of Health and Ageing have in the setting or limiting of rates paid by the private health insurance sector to public hospitals?

Mr Maskell-Knight—The way the arrangements work is that there is something called the basic default benefit determined by the minister, which is the irreducible minimum an insurer must pay to a hospital, regardless of what sort it is, if one of their insured people goes into that hospital. As a matter of practice, that is what public hospitals charge and that is what private insurers pay.

Senator McLUCAS—Is that legislated? How does it work in a technical sense?

Mr Maskell-Knight—It is a determination made by the minister under paragraph (bj) of schedule 1 of the National Health Act. The reality is that there is nothing to stop insurers and hospitals coming to whatever agreement about rates they wish to. As a matter of fact, over many years public hospitals and health insurers have not chosen to enter into agreements to pay any more than what the basic minimum is.

Senator McLUCAS—Just say that last bit again. They have the option, but they do not use it.

Mr Maskell-Knight—Yes.

Senator McLUCAS—I think everyone would be aware of the issue about the HCF, which was raised during the inquiry into the private health insurance bills. Does either PHIAC or the Ombudsman's office have a view about whether this offer of the helping hand program is appropriate?

Mrs Ginnane—It is not an issue that I regulate.

Senator McLUCAS—Thank you.

Ms Gavel—We have not had any complaints about that issue at this stage. I have seen the information that HCF has put out about it and it seems to have a reasonable process for making sure that people were informed and able to give consent if they wanted to be part of it.

Senator McLUCAS—You are aware that one individual is alleged to have been contacted by the clinicians who are employed by HCF without giving consent.

Ms Gavel—Yes. Certainly, the information that I have seen from the fund is that it denies that is the case.

Ms Halton—My understanding is that McKesson, who I think was involved here, has actually contested that as well. The facts in this matter, as I understand it, are actually quite

hotly contested, and certainly I have heard people go on the public record saying they believe that not to be the case.

Senator McLUCAS—So you have not received other complaints?

Ms Gavel—No.

Senator McLUCAS—Similar to this one?

Ms Gavel—No, not at all.

Senator McLUCAS—Is the department aware how broad these types of offers are that the industry may have at this point in time?

Ms Flanagan—We understand that they are, I suppose, in their infancy. There are not that many around. There are some very good quality ones but they are not yet common—I think is what we have seen from the industry.

Senator McLUCAS—How do you regulate or assess these types of offers, given that the legislation is implicitly encouraging this sort of offer?

Ms Flanagan—It depends on what you want to regulate or assess them on. For example, if you were concerned about privacy, we have a lot of legislation around privacy and that would apply in these sorts of circumstances. We did not think it appropriate to have in our legislation issues of privacy because that is covered by other legislation.

Senator McLUCAS—So essentially you will react to complaints; you are not asking the private insurance sector to show their products prior to being promulgated. It is simply a matter of: you will act on complaints.

Ms Halton—I think it is probably important to make a distinction here. To the extent that there is an issue in relation to a PHI product, then obviously the approach to regulation is as we know it and people can make a complaint et cetera. If there is an issue in respect of clinical practice, and it seems to me that this is where this other issue has strayed into—that is, is it appropriate to have privacy rules for a breach et cetera?—then the arrangements that regulate clinical practice may be triggered. You are right in that it is a relatively new model. Our understanding of how these products are being offered is that they do involve consent, but to the extent that there are complaints and/or potentially problems in respect of the clinical side of those programs, obviously the clinical regulation that applies to any kind of practice would apply. Whilst we do not necessarily see ourselves having a role in that part of the process, I am actually quite confident that our regulatory framework does extend to cover all the aspects of these kinds of programs.

Senator McLUCAS—Do you intend running a public education program around what people should be able to expect under the new proposals? For example, it could be along the lines of, 'If you feel your privacy is being compromised, please go to the Private Health Insurance Ombudsman.'

Ms Halton—It is not something which at the moment we have focused on as being a particular need. I do think the point that you raise may be something which in the medium or short term the regulator might want to provide some guidance on the website for people who are perhaps looking out for information about these things. We know that access to

information about even products is something that certainly the Ombudsman was concerned about. It seems to me that it fits quite nicely into that package of information about which you would be trying to help consumers make informed choices as to products. But at the moment, I do not know that there is a particular need to go big in terms of communication.

Ms Flanagan—Just to add to that, one of the parts of these new initiatives is to set up a website which is exactly about providing people with information about products but it will have more than that. We are looking at informed financial consent in trying to give people a bit of an idea of what might be involved or how much they might have to pay if they do want to undertake heart surgery, for example. This will be administered by the Ombudsman. We are looking at what features we can put on it and engaging in consultation about what will be most helpful to people to have on that site. But it is starting off at least with the ability to be able to compare products and it can build from there.

Senator McLUCAS—We did say at the inquiry that we think it is a really good idea. When you fix it can you tell Telstra and all the other telecommunications providers, because I would love to be able to compare telecommunications packages as well? I think it is terrific. If you can do it you will get a gold star.

Ms Halton—The impossible we will manage, but the superhuman we struggle with.

Senator McLUCAS—I am very aware that people from Medibank Private are here and they will be called. Can you tell me how much the government has spent on subsidising dental services in 2005-06 through the PHI rebate?

Ms Flanagan—We can give you an estimate of that in that I think under ancillary services around 50 per cent is for dental. We might need to get a calculator quickly and give that to you in a few minutes.

Senator McLUCAS—Thank you. The latest ABS national health survey states that approximately 60 per cent of the top 20 per cent of Australian households by income have private health insurance ancillaries cover. Can you tell us the percentage of the total value of the Commonwealth private health insurance premium rebate expenditure in 2005-06 in respect of dental services cover that was paid to the highest 20 per cent of households by income?

Ms Flanagan—Not just at the moment.

Ms Halton—No.

Senator McLUCAS—Not just at the moment, or no?

Mr Maskell-Knight—No, ever. We do not collect information on cross-tabulated benefits paid by household income. The answer to the other question was $438 million, so 30-something per cent of the total benefits paid for dental treatment in 2005-06 was $438 million.

Senator McLUCAS—Thank you.

Senator MOORE—Is that an actual figure or a backdoor figure?

Mr Maskell-Knight—It is as close to an actual figure as you can get.

Senator MOORE—But you could not be absolutely accurate that that was dental. You are actually estimating on the basis—

Mr Maskell-Knight—No, we know what dental is. We know what the weighted average percentage rebate is. Multiply the first number by the second number.

Senator MOORE—So that is more secure?

Mr Maskell-Knight—Yes.

Senator McLUCAS—Mr Maskell-Knight, you could possibly extrapolate, then, that data into the split of—no, you probably could not.

Mr Maskell-Knight—I think I know what you were going to ask and we could not. We do not know what benefits are paid to what income.

Senator McLUCAS—That is right.

Ms Halton—There is a missing variable in the equation.

Senator McLUCAS—Which is: 'Who are you?' Thank you. I have one final question which you might be able to help me with. Of the $50 million or so included in the last budget for advertising the private health insurance extended choices program, how much was spent in 2005-06?

Ms Flanagan—Of the budget measures that were announced, how much of the $50-odd million was spent in 2005-06?

Senator McLUCAS—In the last budget, yes.

Ms Flanagan—We can probably find that for you.

Senator McLUCAS—Can you also indicate how much is committed in the forward estimates?

Ms Flanagan—That should be in the previous portfolio budget statements, so we can find that for you quickly.

Senator McLUCAS—How much is committed, not indicated.

Ms Flanagan—It will be difficult to do that because there are some elements of that that we have not yet decided on and there is money moving around between years and things like that. I will see whether there is anything firmly committed and try to get those figures, but we will have to take those on notice.

Senator McLUCAS—Certainly. Thank you. Good evening, Mr Savvides, sorry to keep you waiting. In the time that I have I want to focus on broader health cover from Medibank Private's point of view. What sorts of products is Medibank Private considering offering if the legislation passes in its current form?

Mr Savvides—The intervention initiatives are covered by the broader health legislation. Prior to that legislation the organisation has been developing product extensions and services for its membership. The benefit of the legislation is that we can gain the benefit of those costs in the reinsurance pool, so it is a much more incentivised environment for all health insurers to extend themselves and provide these extra services. So going forward, it is about being much more material about our investment in this area because the legislation makes that much more viable.

We provide a chronic disease management initiative. We have been working on some pilots and research to test the effectiveness of intervening, because it costs money to add more services and value to members, but does it actually return a benefit for the entire fund? They are the things that we want to research and discover. There are diabetes programs as well.

Our On Track Diabetes Program was a very successful pilot. It lowered the admission rate to hospital and improved the health status of the participants in the project and the claiming level on the funds. So all members benefit when that occurs, not just those who are targeted with the service. So it is in the spirit of that kind of intervention that we explore under the new legislation more freedom to offer substitutes to hospitalisation or extended services so that we are much more holistic in looking after members rather than having it demarcated as in the previous regime.

Senator McLUCAS—Can we just talk then about that diabetes program. You have measured increased health outcomes and decreased costs to Medibank Private out of the operation of that program?

Mr Savvides—That is right. We had 295 participates in the pilot, and we called it an on-track pilot. We gauged the assistance of the International Diabetes Institute to assist us in the design of the project, because they are experts in the area of intervention for diabetes. We also engage obviously with the college of general practice and other health professionals that are impacted by our involvement in this area. We do that before we enter these projects because we want to make sure all of the stakeholders are informed. What occurred out of it was that the pilot for diabetes saw a 16 per cent reduction in hospital admissions and an eight per cent reduction in benefit outlays for the health fund—that is, covering that 295 membership. Given that diabetes is much more pervasive than just 295 members, there is a very substantial health benefit if we were to roll that program out in a larger scale.

Senator McLUCAS—How did you select the participants?

Mr Savvides—I am not sure about the criteria of selection. It might have been geographic wrapped around the services that we could put around that geography and then we invite members to participate. They do a health risk assessment survey, which they are invited to do online. Out of that survey comes an invitation—because we learn from the profile—to members who have diabetes, because they will identify themselves voluntarily. If they identify themselves, we invite them to participate and ask if they would like that service provided for them. We enrol them in the project and provide some form of induction, obviously with the assistance of IDI—International Diabetes Institute—and then we launch the pilot.

Senator McLUCAS—Did you have a control group to compare them with?

Mr Savvides—The background control is the background claimants of our health funds, so we are able to do our own internal assessment as to whether we are actually moving forward as a fund or going backwards in terms of cost.

Senator McLUCAS—I do not know that that is right, Mr Savvides, because you are saying the background is the control unit but then you are identifying a group of people with certain indications. I am no epidemiologist, but my feeling is that that is not right.

Mr Savvides—I am not a health researcher either.

Senator McLUCAS—It sounds right in the gut, but I do not know whether it is right technically.

Mr Savvides—Not all of the respondents to the health risk assessment—the HRA—participated in the pilot. We understand the profile of diabetes in our population as—

Senator McLUCAS—I am wondering if it is those people who have minimal potential of getting diabetes who are probably pretty good anyway—

Mr Savvides—That is a fair point.

Senator McLUCAS—Those people may have put their hand up and said, 'I'll do the program because that's great and I'll feel even better when I go to the gym every other day anyway.'

Mr Savvides—I understand your point in that self-selection could create an adverse selection and distort the results. We know about the people who participated in the program, because they have to fill in a passport that keeps a record of various measures of their blood glucose et cetera and visitations to a GP. I think we were satisfied that we had a real and active sample of core disease engagement rather than a spurious sample of low and high intensity.

Senator McLUCAS—So these people self-select on the basis of them doing the health assessment?

Mr Savvides—Certainly. There is an invitation to participate. We do not force people into these programs or mandate it—not at all.

Senator McLUCAS—I am honestly trying to find the piece of clinical evidence that tells me that investment in this self-selecting type of program is worth the money that we will spend, because if it is then you cannot not support it really.

Mr Savvides—Senator, maybe if I could be adventurous enough to offer up another example. We also did a pilot for chronic complex conditions. Some 47 members were participating in this project. Their claiming history made it very evident to us that they were people suffering from complex conditions made more aggravated by a chronic disease. A 40 per cent decrease in hospital admissions took place. From beginning to end we saw a reduction. Their independent health assessment done by their doctor showed an improved health status, so they actually got better as a result of being assisted through that period of time. The claiming level on the health fund collectively of the 47 individuals dropped from $758,000 for the period that was monitored to $468,000.

So I guess roughly it is almost a 40 per cent reduction in health claiming costs, but the individuals were actually in a better health condition at the end of that pilot than they were. I cannot say to you that is a scientific study. I am not a scientist, so I cannot say that. It is just evidence of the work that we do in terms of trying to work out how we can help our members be better off in terms of their health condition by providing some form of assistance or intervention or assistance in navigating the complex health system, making sure they have regularity of diagnostic testing, GP visitation and medication compliance. These are our early endeavours in this area.

Senator McLUCAS—I turn now to premiums, Mr Savvides. As a result of the legislation that we have in front of us, have you done any modelling on premiums?

Mr Savvides—We obviously do not have a robust model to model the impact of a broader health cover. We do not have that kind of device. We want a much broader regulatory framework to work in. We felt rather truncated only being able to service at the hospital gate, if you like. So the challenge is there for the industry to use the expanded cover to provide a more holistic service to its membership—one that has a greater continuity of service delivery, especially for those who suffer chronic disease. Our task is to implement that in that framework in a way that improves the health status of our membership, attracts and retains people in private health insurance and does not challenge the viability of the health fund. We do not believe it will. In fact, there are opportunities to reduce the health-cost burden on the fund by pursuing this kind of intervention.

Senator McLUCAS—For example, you did not get a look at the Access Economics model that the department—

Mr Savvides—Our outlook is that there are more opportunities to improve the economics of the claiming cycle in health insurance by having this freedom to intervene and substitute for expensive care that does not provide a holistic service.

Senator McLUCAS—There has been some evidence put to us that there will be a spike in premium prices in the short term and then if it is then proven that chronic disease management or health promotion type products do in fact work there is potential for downward pressure on premiums, to coin a phrase. Is that your view as well?

Mr Savvides—I have not seen that. We have not seen any modelling that indicates a spike. We are not forecasting anything for ourselves in that area. We see opportunities to actually remove ourselves from being trapped into high-cost postoperative servicing activity which the step-down services can offer at a greater service and convenience to the member than the high-cost facilities can.

Senator McLUCAS—Is another value of the proposal a marketing opportunity for private health insurers like yourselves?

Mr Savvides—Absolutely. It does give us the opportunity to round off the product offering—the value proposition—and make us more holistic as a sector.

Senator McLUCAS—Have you done any assessment of where in the market these sorts of products would be best accepted?

Mr Savvides—It is likely to be more towards the aged end of the spectrum, because that is where the incidence of disease complexity occurs.

Senator McLUCAS—That cannot be good for your business, Mr Savvides.

Mr Savvides—We are a community rated sector anyway, so we have no choice in the matter.

Senator McLUCAS—I know, but would you go out there intentionally to attract older people with chronic disease?

Mr Savvides—But the reality is we have those people in our three million membership today.

Senator McLUCAS—Sorry; I am talking about a marketing opportunity. I do not know that any business operator would try to market an insurance product to a high-risk—

Mr Savvides—But there are many risks. There is the risk of technology uptake in health. There is the ageing population risk and the higher consumption of health as the community gets older. I just think the opportunity to intervene and provide services that could lower the cost burden on the fund by improving the assistance that we give members who are in need of assistance is more likely to alleviate those cost burdens than add to them.

Senator McLUCAS—Have you done any analysis of which part of the market would be more attracted to these types of products?

Mr Savvides—We have not done that as yet. Obviously we are focused on trying to grow our membership. Our marketing programs are designed to do that. They have been very successful. The ability to attract young people into private health insurance is obviously a very important objective for all health insurers in delivering the balance the community rating requires. In the last couple of years we have record growth in membership at Medibank Private. We do not think that is going to change going forward. I am talking about young membership and new to the industry—that is, people joining health insurance for the first time—as well as the ability to add value to the memberships of people who have been with the fund for some time and are experiencing complex illnesses.

Senator McLUCAS—I am not sure whether you will tell me I can have this information. Can you tell us what the growth in your young membership has been over time? This might compromise your business.

Mr Savvides—We actually do reporting on membership growth. I do not think we do it by age. I will have to ask my staff whether it is publicly available through the PHIAC reporting and whether there is any issue about commercial-in-confidence. If it is not then my marketers will give me a hard time because it is something that they would want to protect. Who we target and how successful we are is a competitive issue.

Senator McLUCAS—I understand that Mr Savvides. Finally, I turn to the quality and standards issue that we discussed in the inquiry. There is a 15-month lag between the implementation of broader health cover and the implementation of the quality assurance program. What is Medibank Private's view on that time lag?

Mr Savvides—We only engage providers who meet quality standards that are already in place in the health system. So we would not contract a non-compliant or non-standard-compliant provider that would put our quality product at risk. We are indifferent to that as a reality. When that overlay occurs in 18 or 12 months time we will not have to change any provider relationships because they are all accredited.

Senator McLUCAS—Is there a potential though that you could actually change products? For example, we were told by the physiotherapists that hardly anyone had any business QA. Everyone was registered of course but in terms of the operation of their—

Mr Savvides—Practice.

Senator McLUCAS—It is not just their practice; it is their practice in conjunction with others. So it is not just the QA on the practice itself; it is QA on the program. They said it would take a long time for that to be in place. I do not think I am doing them a disservice. If there is this lag time does it mean that you will have to rebadge and restart your product development if you can only get access to that kind of provider?

Mr Savvides—Unless there is an overlay in that period of time in the future which is very different to the quality standards that are in place today I do not believe that there will be a need to do any alterations. We are assuming that the standards which exist protect the patient consumer today as they would in the future. The regulatory overlay is just to cement that. We do not expect that that is going to be a change in the standard in terms of the severity of the standard.

Senator McLUCAS—I will leave it at that.

Senator MOORE—How does your company do age cohort in the marketing strategy? Is it in 10 years—is it 20 to 30, 30 to 40? I refer to the analysis of your membership and the processes used to attract and retain membership.

Mr Savvides—Are you saying: how do we project the age profile?

Senator MOORE—How do you actually define your memberships? When you are going for a young members marketing strategy, how many members do you look at—is it under 30s or is it the 20 to 30 or the 30 to 40 range? I cannot remember the forms that you fill in with your organisation.

Mr Savvides—We are going down a segmentation pathway which is not just age based; it is about whether an individual is a single or part of a couple, whether they are raising a family or likely to be in the way that they identify themselves.

Senator MOORE—The whole demographic thing.

Mr Savvides—Yes. It may be a young person just coming out of university and turning 25 and no longer covered under their parents cover. That is another segment that we would target to recruit. Then there is the empty nesters. There are a whole lot of segments. Our marketers attempt to understand the needs of those segments and then message product and price and promotion around those segments.

Senator MOORE—And actually analyse your membership on these bases? Do you actually count by family, by single, by couple and that kind of thing?

Mr Savvides—We do segment that way. We segment by states. That is a multidice and slice database.

CHAIR—That brings us to the end of outcome 9. I am not sure whether we will be seeing you again later in the year Mr Savvides. I am not quite sure what the status of the sale is.

Ms Halton—Unless you know something he does not, Senator, I think he is expecting he will see you later in the year.

CHAIR—That is a pleasure that we will look forward to.

Ms Halton—He may now feel very nervous. Perhaps you would like to assure him that there is no hidden message in that.

Mr Savvides—My contract has just been shrunk, has it?

CHAIR—In that case we have a date in May. I thank you and other officers associated with outcome 9.

Proceedings suspended from 6.41 pm to 7.40 pm

CHAIR—We will recommence proceedings for this evening's session of the Standing Committee on Community Affairs. We are up to outcome 10. I want to outline what the program will be, provisionally anyway, for the next few hours. Between now and eight o'clock we will attempt to deal with outcome 10. Between eight and nine we propose to deal with outcome 11, Mental health; from nine to 9.30, outcome 12, Health workforce capacity; 9.30 to 10.30, outcome 13, Acute care; and 10.30 to 11, outcomes 14 and 15 together. That is the plan. We will plunge straight into outcome 10, Health system capacity and quality.

Senator POLLEY—I would like to get an overview about the strength of the cancer care policy as far as the initiatives and an overview of where you are at with those.

Ms Halton—This is an outcome with multiple programs, so we have to now bring the relevant wave of troops to the front. So what particularly, Senator?

Senator POLLEY—Just give me a general overview, for a start, as to the sorts of programs, the initiatives and how things are tracking, and then we can go from there.

Ms Powell—Strengthening Cancer Care is a measure that has quite a large number of programs within it, so I will just run through those. It has a program related to bowel cancer screening. It funds the Breast Cancer Network; Cancer Australia; a number of programs that are run by Cancer Australia, including the cancer clinical trials; cancer research; cancer support networks; and developing training courses for cancer nurses. There was funding for grants to Camp Quality and the Make-A-Wish Foundation. There is funding for the Local Palliative Care Grants program, the National Breast Cancer Centre, Mentoring for Regional Hospitals and Cancer Professionals, the National Research Centre for Asbestos Related Diseases, a professional development package for cancer professionals, funding for the Royal Children's Hospital in Melbourne and the Sydney Children's Hospital, undergraduate places for radiation therapists evaluation, a 'Quit smoking when pregnant' program, and the skin cancer prevention program. Not all of those programs are actually administered by the Department of Health and Ageing. As you can see, it is a fully comprehensive cancer package.

Senator POLLEY—I want to get an overview of how the original estimates of expenditure are tracking now and whether they are running on budget, and could you give me a breakdown of the funding allocation.

Ms Powell—I can talk about two of those that are administered within outcome 10, my colleague Professor Currow can talk about those administered by Cancer Australia, and the others we will have to refer to other agencies or parts of the department, including the NHMRC.

Senator POLLEY—Thank you.

Ms Powell—The National Breast Cancer Centre funding is going out on budget. We expect to fully expend the appropriation for that this year. Similarly with the funding for the Breast

Cancer Network Australia, at the moment we have spent pretty much close to the budget that was allocated for that.

Senator POLLEY—Is all the money allocated just to breast cancer itself?

Ms Powell—The funding for the National Breast Cancer Centre includes funding for the ovarian cancer program.

Senator POLLEY—What is the breakdown of the money that is going to ovarian cancer?

Ms Powell—That is rolled up in a single grant to the National Breast Cancer Centre. It is a single funding arrangement.

Senator POLLEY—Are there any plans to change that allocation of funding?

Ms Powell—No. Funding was separate several years ago, and then it was just rolled in and the National Breast Cancer Centre determines how it spends those funds. It has a number of outcomes that it must meet for us, related to both breast cancer and the ovarian cancer program.

Ms Halton—As you know, the government is yet to respond to the committee's report on gynaecological cancers. You would be aware that there are a number of recommendations in that report, and I would be hopeful that we would have a response to that in the not-too-distant future. What is being relayed to you now are the at-present arrangements. It would be inappropriate for us to anticipate what would be the government's response to that particular report.

Senator POLLEY—Yes, I am aware of the report.

Ms Powell—They are the two programs that I can talk about. Perhaps Professor Currow would like to talk about the Cancer Australia programs.

Senator MOORE—Is this your first estimates in your job?

Prof. Currow—That is correct.

Senator MOORE—Welcome to your first estimates in this position.

Prof. Currow—Thank you, Senator. The other administered funds that have been outlined by my colleague include funding for building cancer support networks. As you would be aware, before Cancer Australia was established, two rounds of funding were made available through that to 27 projects across Australia. That is tracking on budget and on time. The next appropriation is in cancer research. Cancer Australia now has in place a process for assessing research applications, and moneys will be made available this year as a result of that process. With regard to clinical trials infrastructure, again the first round of moneys was made available before it was transferred from the department of health to Cancer Australia, and some $5 million was allocated to that in late 2005-06. We are looking at our processes there, not only for maintaining support for current clinical trials groups but for expanding that to other particular areas of cancer which do not enjoy a clinical trials group.

Developing training courses for cancer nurses is a project let to the Peter MacCallum institute in Melbourne. That is both on time and, indeed, on budget. The professional development package for cancer professionals was let to a consortium of four organisations, including the University of Sydney, the Cancer Council Australia, the Clinical Oncological

Society of Australia and the National Breast Cancer Centre. Again, that was before Cancer Australia came into being. Phase 2 of that program is being negotiated at the moment, and I would expect that contract negotiations will be finalised in the weeks ahead and that we will see the rollout of phase 2 of that program, again on time and within budget.

The next area is Mentoring for Regional Hospitals and Cancer Professionals. Again, before Cancer Australia was transferred from the department of health, some 21 grants were awarded in the 2005-06 and 2006-07 years. We are looking to consolidate that into a program which is called the Cancer Services Network national demonstration program. We have nominations from states and territories for linking regional and rural programs with relevant metropolitan cancer programs. The first meeting of that process will be at the end of February, in Adelaide. That again is on time and on budget. So, at the end of that, our administrative funds, with the exception of the priority-driven cancer research for which there is now a process, are very much on time and on budget.

Ms Powell—If I can add a bit more to some of the other measures. The grants to Camp Quality and Make-a-Wish Foundation have been made. The first round of funding for the Local Palliative Care Grants program was in 2005. We have had three rounds of that program and the fourth round was advertised earlier this month, so that is all progressing nicely.

Senator MOORE—That is on the website?

Ms Powell—I would expect so, yes.

Senator MOORE—So that is actually the fourth round that is on the website?

Ms Powell—Yes, that is right. The evaluation of the initiative will not be beginning until next year, and the campaign for the Skin Cancer Prevention Program has gone to air and is progressing as well.

Senator POLLEY—What was the budget for your advertising?

Ms Powell—The total budget for the Skin Cancer Prevention Program was $5.5 million. The bulk of that is for advertising. My communication colleague is not here at the moment. I will see if we can find that.

Senator POLLEY—Thanks.

Ms Powell—No, I am sorry. We will have to take that on notice.

Senator POLLEY—Yes, if you would.

Ms Powell—The bowel cancer screening program would be covered by outcome 1, so we would need to get back to you on that. There are a number of programs, such as undergraduate places for radiation therapists, that are run by other departments.

Senator MOORE—Can we get an update on the bowel cancer program? We ran out of time desperately this morning. I would just put that on notice because, if you noticed, we scrambled this morning with population health.

Ms Halton—Yes, that is fine.

Senator MOORE—We just did not get close to it. If we could get that, because that has been an ongoing issue for questions here. I think Senator Polley asked questions last night.

Ms Halton—Do you have a series of questions, or would you like a general briefing on where we are?

Senator MOORE—I think at the last estimates committee we talked about expenditure time frame.

Ms Halton—Yes, we did.

Senator MOORE—We got the kit and all those things.

Ms Halton—We will give you an update on the state of play.

Senator MOORE—Fabulous. I just want to know how it is going.

Ms Halton—Yes, fine. No problem.

Senator MOORE—Professor Currow, can we get an update on your administrative set-up, as you took up your position just before Christmas and you have had the first meeting of the board. Do you now have the full structure, as you expected, in place for Cancer Australia: the staffing, the allocation, the location; all those things?

Prof. Currow—Yes, we do. I took up my position at the beginning of October. Already the advisory council has met twice: once at the end of August/beginning of September and then again in early December. Supporting the advisory council and the structure of Cancer Australia are four national advisory groups: one in research; one in consumer interests and community participation; one in professional development and quality; and the last is a strategic forum which really brings together the jurisdictions and senior cancer clinicians from each state and territory. That group will meet for the first time at the end of February.

Senator MOORE—So each of those have been filled? I know the advisory board was, because of the ministerial appointment.

Prof. Currow—Yes.

Senator MOORE—I know the four separate ones are being filled.

Prof. Currow—We are finalising them at the moment. In terms of their constituency, it will include the span from prevention through to survivorship in each of those groups. It will ensure that any of the research issues will span from laboratory through to whole populations, and will include clinical trials. Each of those advisory groups will have at least two consumer representatives, and two members of the advisory council will also be on each of those.

Underpinning that will be 14 national reference groups. Three of those are age related: paediatrics, adolescents and young adults and cancer in the older person. There are 11 tumour-specific groups that we would hope we will meet. I understand that the invitations have gone out to the first of those groups, which is in gynaecological oncology.

Senator MOORE—That was very wise.

Prof. Currow—And prostate cancer will be very soon after that.

Senator MOORE—Were they ministerial appointments, Professor, in terms of filling all the way down?

Prof. Currow—No.

Senator MOORE—When the advisory committee was put together first there was media attention, and the CVs of all the people were made very public. It was a highly regarded group, as we all know. I do remember seeing the graphic that you provided to us for these kinds of structures. I have difficulty visualising without having the graphic. How did the people get appointed to the 14 and then the 11, or the other way around?

Prof. Currow—We have consulted widely, so that process has been to approach key national and state organisations with an interest in those particular cancers and consumers, professionals and the community more broadly. Importantly, for consumer participation we have gone through three processes to attract people to these groups. Firstly, there were advertisements, including in the national newspapers at the end of November, early December.

Senator MOORE—I saw those, yes.

Prof. Currow—Together with that we have asked for nominations from relevant cancer consumer organisations across the country. We have directly sourced from cancer consumer organisations some people with key expertise in areas that otherwise would not be attracted through the former two processes.

Senator MOORE—Is that appointment under your signature for the people who come through there?

Prof. Currow—Yes.

Senator MOORE—When you were first setting it up I know we had discussions about the structure and how this is going to operate, because of the pulling together of so many diverse and very dedicated groups. At this stage, the formal committees have met twice and you are about to have the others get into place and start talking to each about where they want to go. Is that right?

Prof. Currow—The advisory committee met in December. We also convened for the first time a cancer research roundtable in December, which is really bringing together community based cancer research funding organisations with Cancer Australia and the NHMRC. The first call for applications is now up on the NHMRC website. It will close in mid-March, with the other calls for applications under the National Health and Medical Research Council. The $5 million that Cancer Australia—

Senator MOORE—The special fund, yes.

Prof. Currow—had to administer has been doubled by that relationship.

Senator MOORE—The complementary relationship with NHMRC?

Prof. Currow—No, with community organisations that raise money for cancer research.

Senator MOORE—So the allocation through government for the estimates was $5 million, and that has reached double with community organisations?

Prof. Currow—And we have another $5 million to put into that.

Senator MOORE—That is impressive. It is very early, so questions we will be more detailed at the next hearings. We may use the process of asking the minister to have a briefing so we can just get information, because one of the things we did talk about was the allocation

of research moneys and how your organisation, with this dedicated funding, and the NHMRC are going to work together. We have seen over a number of years various issues about the dedication of research for cancer, which is one of the flagship issues for Cancer Australia. Once the first rounds have been allocated, perhaps it will be clearer and then we will be able to work through. Rather than working in theory, we will be able to see exactly how it happens.

Prof. Currow—Absolutely, Senator, but I just draw attention to the fact that our priorities were dictated for Cancer Australia in the budget.

Senator MOORE—Yes.

Prof. Currow—The call for applications has gone directly against those priorities.

Senator MOORE—Which were the ones that were widely publicised.

Prof. Currow—That is correct.

Senator MOORE—From my understanding, they have quite significant community support in terms of the priorities.

Prof. Currow—I think very broad support. It deals with major cancers. It deals with screening, prevention and indeed multidisciplinary care.

Senator MOORE—And it has also got the issue about community awareness too, hasn't it, in terms of the whole engagement?

Prof. Currow—The whole process at Cancer Australia is one of consultation and community engagement.

Senator MOORE—How many bodies are working in Cancer Australia now in a full-time capacity?

Prof. Currow—At the moment, as of today, we have our national managers in place so there are six positions there. Below that we have another six at executive level 1 and another five people in administrative support.

Senator MOORE—They are all based in Canberra?

Prof. Currow—No. We have people based in Sydney, Melbourne, Adelaide and in Launceston at the moment, as well as Canberra.

Senator MOORE—Is that on the website, that structural dispersion?

Prof. Currow—No, it is not.

Senator MOORE—This is to try and save duplicating effort. If it is on there I will find it. I had not seen that.

Prof. Currow—I hope the website will be up Friday week.

Senator POLLEY—If I can go back to care and talking about the funding allocation there, if you could give me the figures based state by state, and outline the program, please?

Ms Powell—For each of the three rounds?

Senator POLLEY—Just in the last financial year and what is in issue.

Ms Powell—I will have to take that on notice.

Senator POLLEY—If you could, that would be great.

Senator MOORE—Are there any full-time staff members of the department that work with Cancer Australia? Is there any ongoing link there? When you were first starting the department was providing set-up and process, but now that you are established what is your relationship with the department? I am not asking you whether it is good or not. I am asking what the formal relationship is.

Prof. Currow—Let me answer the question you have not asked. It is a very good working relationship. Staff were seconded across initially, Senator. Come mid-March we will be fully-fledged in terms of our ability to employ directly and so at that time those links will largely have been formalised into two separate organisations.

Senator MOORE—In terms of the various advisory bodies, is there any ongoing formal role for the department? Is there a departmental staff member who has ongoing linkages in terms of interdepartmental liaison with Cancer Australia?

Prof. Currow—At several levels within those groups. For the research advisory group, the chief medical officer is a member of that for the policy forum. The first assistant secretary is a member of that and on a day to day basis our senior adviser in policy and the departmental staff work closely together.

Senator MOORE—So on at least two levels there is a person from the department who is there not just for their own expertise, which they have, but because of their placement and structure in the department. Is that right?

Prof. Currow—That is correct.

Ms Halton—It is important to note that Professor Currow meets with the senior officers, as in the executive of the department, on a regular basis, just to make sure everything is working well.

Senator MOORE—One other thing is the role with Indigenous Australians. We have talked in terms of the whole process, but with Indigenous Australians in particular and the development of Cancer Australia is there a strategy process around that and are there any particular programs that acknowledge the need to have Indigenous people both involved and their issues taken into account in the various programs that you manage?

Prof. Currow—Every single one of our programs has specifically asked that there are issues around disparate outcomes in cancer, and they include the issues for people from Aboriginal and Torres Strait Islander backgrounds, people from culturally and linguistically diverse backgrounds and indeed the gap in outcomes between rural and metropolitan Australia. Every one of our programs asks that there be emphasis there. With regard to involvement, there are two projects to which I would draw your attention. The first is the rural and regional mentoring and one of those projects is under negotiation with the top end of the Northern Territory Health and Human Services, with the specific emphasis on issues related to the outcomes for people from an Aboriginal and Torres Strait Islander background.

The second thing to which I would draw your attention is that in our consultation, particularly in professional development and quality—that national advisory group—we have sought nominees from health professionals from Aboriginal and Torres Strait Islander

communities in nursing, medicine and social work so that their involvement is there from day one and, as we discussed when we last met, unless we have started to significantly decrease the disparity and outcomes across the community, Cancer Australia will not have delivered.

Senator ADAMS—Professor, as far as all the cancer organisations throughout Australia—there is an enormous number for very many different types of cancer—can you tell me, strategically, how you are going to be able to bring them together and get that information? How do we get on? They are all fighting one another for funding. Have you got any strategic thoughts on how you are going to do it?

Prof. Currow—Absolutely. Cancer Australia, even in the short period of time of its existence, has shown that it can be importantly a third party broker to find its way through some of the issues that you have alluded to; that we can bring parties together, both in funding, in the research organisations and more broadly across the consumer organisations in ways that can genuinely decrease the impact of cancer on the community. To do that we have already started a process of systematically consulting with groups across the country. We have invited nominees to our national advisory and our national reference groups that are both tumour-specific and specific to the other areas outlined in our budget papers. I believe that Cancer Australia can be a catalyst to bringing together the very large number of organisations that exist in our communities today and, through doing this, lessen the impact of cancer.

Senator ADAMS—Just one more question. This is my favourite hobby-horse—the travel schemes. Cancer patients are rural. I am from a rural area in Western Australia and it is something that I have been looking at for a long time and hopefully I will get a Senate inquiry up. This committee has agreed but we have to still go through the process of looking at access for rural patients to go to medical specialists. But the one group that really have problems are those suffering from cancer and especially those that have to go on and have radiotherapy or chemotherapy. Once again, I have been wondering how the Northern Territory—as I have asked the question before—are going with their radiotherapy service. But it is probably the single biggest issue for rural people, as to how they can, firstly, access a specialist and then the treatment that follows and accommodation, so there are all those issues. Is there any area within your organisation that would be able to look at that?

Prof. Currow—The issue of the Patient Assisted Travel Scheme is, as you point out, something that is very close to consumers' hearts and is of great concern in ensuring that we decrease the disparity and outcomes for people right across Australia affected by cancer. The challenge is that at the moment that sits within the state and territory jurisdictions and Cancer Australia, as such, has not been invested with the ability to change what is happening currently.

Ms Halton—Senator, I did ask the person in charge of Rural Health to be completely briefed on IPTAS and all those other things, including its whole history. He sat here next to me saying, 'Do you think she is going to ask me? I have got all this detail.'

Senator ADAMS—Look, it has been one of those days for me, unfortunately.

Ms Halton—I know. The point is absolutely accepted that there is an issue here. We have had some conversations inside the department within the current funding instruments that we have, in terms of the mechanisms that we have, what could we think about, but you have

rightly pointed to an issue which we are very aware of. I suspect this is a dialogue we will not conclude here.

Senator ADAMS—No, I do not think we will conclude it here and I hope that my other Senate colleagues, other than the ones on the committee, will agree that we can—it is very difficult because it is a state issue but it just keeps coming up and up and I have been involved in rural health for many years and it has always been a bone of contention. With the National Rural Health Alliance conference coming up very soon, once again it will be high on their agenda as well. I think that I am in a position now that I should be doing something about it. Having been a cancer sufferer myself and having to go through that, I know exactly how frustrating it was for me and I was very fortunate that I could cope with it. But for my colleagues living in rural and remote Australia, it is not an easy thing. They are denying themselves treatment because of the problem, and I do not want to see that.

Ms Halton—We acknowledge the issue, Senator. In fact, I have had about four conversations in my office about exactly this issue.

Senator ADAMS—I would love to talk to your office about that later.

ACTING CHAIR (Senator Moore)—We would hate to see that person's work go to waste, so if we could, through the minister, request a briefing so that that person's preparation on that issue can be put—

Ms Halton—Yes, we are happy to do that.

ACTING CHAIR—That would be very useful. We will progress that when we come back, Judith.

Senator ADAMS—Yes, that is fine.

ACTING CHAIR—It is all ready to go, so we will do that. Professor Currow, the first round funding with Cancer Australia is a five-year gig?

Prof. Currow—Absolutely.

ACTING CHAIR—And that is the planning program?

Prof. Currow—Yes.

ACTING CHAIR—Ms Powell, you listed all the programs from the book. Are any of those programs in their last 12 months?

Ms Powell—Many of those programs were over a number of different times—

ACTING CHAIR—Yes, they were.

Ms Powell—ranging from two years to five years. Some of them are completely finished. For example, skin cancer prevention will finish at the end of next financial year. We have already paid out the grant to Camp Quality et cetera. There is quite a bit of variation.

ACTING CHAIR—We will have a look at that, and if we have any other questions we will ask you about that, just in terms of those that are rolling towards their end. I would imagine that, in terms of future discussions about those things, Cancer Australia may well have a role in planning into the future and those kinds of things. We will see how that evolves. Any further questions? No? Thank you very much. We will move on to mental health.

[8.16 pm]

CHAIR—Thank you for looking after the shop, Senator Moore. We are on outcome 11, Mental health. Questions, Senator Moore?

Senator MOORE—We are at the stage with mental health where we want to really get an update on what is happening with the COAG program. We asked FaCSIA a range of questions last night on their part of the program. We want to see exactly what is happening with the various commitments that Health and Ageing have under COAG and also how they work with other established programs on the basis that it is not just the COAG stuff that is to do with mental health. Professor Calder, from your perspective in your branch, what is happening with the various mental health aspects under COAG?

Prof. Calder—We have a number of initiatives, and I might ask Mr Smyth, who branch manages all the COAG initiatives, to report on them overall. As you know, we have 13 measures under the COAG National Action Plan on Mental Health, and the Commonwealth budget in 2006 committed $1.9 billion over a number of years. We have a range of outcomes already, and I will particularly ask Mr Smyth to report on the better access measures. We now have data for two months, and it is a good news story so far but, as we are quick to say, it is very early. We cannot even really comment on trends, but so far the uptake has been very high.

Senator MOORE—What we are particularly interested in, Mr Smyth, now that you have set the program up—and they are new initiatives—is what data you are collecting. As you know, in these forums we are consistently asking for data. If we find out what you are collecting now, it will make it easier down the track to be told what we can and cannot get. We want to know what the program is, what the data you are collecting is, the evaluation mechanisms and the outcome processes. Is that clear?

Mr Smyth—That is clear, Senator.

Senator MOORE—It is achievable?

Mr Smyth—Yes, it certainly is.

Senator MOORE—Good.

Mr Smyth—The data relating to the uptake of the Better Access initiative has been detailed tonight by Ms Megan Morris. I do not know if you were in the room at the time, Senator.

Senator MOORE—I was not, but that does not matter. We can cross-reference that. That is fine.

Mr Smyth—I think that indicates a very positive uptake on the part of professions, meeting demand by consumers. Overall I think it is a very positive uptake, certainly in the first two months, although it is early data and we are going to have to look at trends over time in relation to that data.

We are tracking data in relation to all of the MBS related items, clearly, the registration of state registered psychologists onto the MBS, the registration of clinical psychologists through the APS accreditation process, occupational therapists and also social workers. In relation to

the other measures, it is still early days but each individual measure will have an evaluation and monitoring component built into it. I would like to talk a little bit about some of the overall monitoring.

Prof. Calder—In terms of evaluation, we are developing measures for each of the programs that the department administers. We will be working with the states and territories around common measures and we will then obviously use that base data to do an overall program evaluation over time.

Senator WEBBER—When you say you will be working with the states and territories, what work has been done to date?

Mr Smyth—At the moment, we are taking the lead, in conjunction with the states and territories, to support the process for annual reporting through the COAG. As you know, in the mental health action plan there is a requirement that health ministers report annually through the COAG. So we are taking the lead in progressing the work, and that is being done through the mental health standing committee and the information strategy subgroup of that committee. They have met on a number of occasions now and are putting a framework in place that will monitor, for the annual report, the 12 indicators. That is the overarching reporting mechanism that we are using. We are also in the process of developing a standard template. Some of the measures are still to come online obviously—

Senator MOORE—Yes, sure.

Mr Smyth—across Australian government departments, through our interdepartmental committee that has met on a number of occasions now to support that monitoring and evaluation process.

Senator MOORE—Are you on that committee, Mr Smyth?

Mr Smyth—I am on that committee.

Senator MOORE—I think it was easier to just check that first.

Mr Smyth—It is chaired by Mr Kalisch.

Senator MOORE—How many times has the IDC met?

Mr Kalisch—Quite a number of times, Senator.

Senator MOORE—You can take that on notice.

Mr Smyth—No, I do have—

Mr Kalisch—It meets very regularly.

Senator MOORE—So it is a regular format: monthly, six-weekly?

Mr Kalisch—It is probably about every six weeks. That is my recollection of how frequently it comes into my diary.

Mr Smyth—Five times, Senator, it has met. The last meeting was on 24 November last year.

Senator MOORE—Which departments are represented, Mr Smyth?

Mr Smyth—The departments that are represented on that are Prime Minister and Cabinet, Treasury, FaCSIA, DEWR, DEST, Veterans' Affairs and Attorney-General's. Certainly any of the departments that have a program that relates to the COAG measures are at the table, including central agencies like Treasury and PM&C.

Senator WEBBER—That is five times and it is six-weekly, except for Christmas, because otherwise that is the longest six weeks of my life.

Mr Kalisch—I think there is another meeting next week.

Mr Smyth—Yes, 27 February is the next meeting and then 4 May after that.

Senator MOORE—The template is part of that?

Mr Smyth—The template is part of that. We have a subgroup of the IDC that is working on the template for the monitoring and evaluation of the Commonwealth's measures, so that we can ensure consistency of data collection across government departments.

Senator WEBBER—When do we anticipate that we will have the template finalised and ready to go?

Mr Smyth—We certainly hope to have it endorsed by probably the 4 May meeting. But, again, it is dependent on some of the measures coming online. As you know, the drugs measure and the mental health nurses measure do not really start until 1 July of this year. We are certainly working to have that in place prior to the establishment or the uptake of some of those.

Senator MOORE—When is the first annual report due? Is it the anniversary of the COAG decision or does it go back into another sequence of reporting dates that fit into another corner?

Mr Smyth—That is a good question, Senator. We are asked to report annually following the COAG meeting. We are still in discussions with Prime Minister and Cabinet at the moment as to what the window there is, given that some measures will only start really as at 1 July. But it will certainly be before the end of this year that that report will be made.

Senator MOORE—The end of this calendar year?

Mr Smyth—End of this calendar year. That is right.

Senator MOORE—What was the actual date of the COAG?

Mr Smyth—14 July.

Senator MOORE—So it is actually into the new financial year.

Mr Smyth—That is right.

Senator MOORE—Are you able to provide us on notice, Mr Smyth, a short update on the programs up until now?

Mr Smyth—Certainly we can provide that on notice to you.

Senator MOORE—It would be useful, I think, if we had something from you, other than going through 13 programs and going tick, tick, tick; if we could get on notice the name of the

program, the status, what stage you are at with developing evaluation mechanisms and the anticipated process that you are going to use. That would seem to be a better use of the time.

Mr Smyth—No problem at all.

Senator MOORE—I know that Senator Webber has been through the MBS items and the process. Is that the most expensive item, the MBS?

Mr Smyth—Yes, it is—$538 million over the five years.

Senator WEBBER—Briefly, in terms of developing the monitoring and evaluation of those items, will that monitoring take into account outcomes rather than just uptake? I have been reassured today of the uptake figures but I am even more concerned about the outcomes.

Mr Smyth—There is an outcome measurement tool that is required as part of the mental health care plan, so that will look at the patient records.

Senator MOORE—What is going to be involved in the mental health care plan? How will it look and who is going to be involved? Have those issues been finalised?

Mr Smyth—That was discussed earlier.

Senator WEBBER—It was.

Senator MOORE—I do apologise.

Senator WEBBER—I would like to reiterate my concerns about that, because in the brief time that it has been there, certainly in some of them that I have seen, I do not think that a two-line letter really looks like a mental health plan. But I am not a mental health professional so I may be a little out of order.

Ms Halton—Senator, I think Mr Andreatta outlined to you what the schedule requirements are. You would know that Medicare Australia are responsible for the payment and enforcement of those arrangements. It goes without saying that, if you have got particular cases, by all means let us know and we will get them to have a look at. You would be quite aware, I am sure, that this is a matter that we think is quite important. These are very important items and they need to be used appropriately, but enforcement is Medicare Australia's business.

Senator WEBBER—Absolutely. Who was consulted about development of the guidelines for the plans? You're back!

Mr Andreatta—I am. With any Medicare items we consult with the GP profession, the various groups, the AMA, the royal college, Rural Doctors Association, the divisions of general practice and, in this case, the psychiatrists and allied providers.

Senator WEBBER—I'm the daughter of two psychologists: you've got to do better than that!

Mr Andreatta—The full range of providers that are currently using the items were consulted in the development of both the item description and obviously the rebate levels.

Senator MOORE—In discussion last night with FaCSIA on the responsibility that they have for their programs, because of the programs that are separate but complementary to those which Health and Ageing are responsible for, we had discussion around the definition

that was used for eligibility to access the programs in FaCSIA. The preliminary agreement was around a definition which I do not have with me.

Mr Smyth—The Wisconsin definition.

Senator MOORE—The Wisconsin definition. That was serving the purpose for the various programs in terms of mentoring and respite care and so on for which they are responsible as they work through further consultation. Is there any crossover with any of the programs for which you are responsible, where that definition either is called into play, is required or could be slightly different? Once again, in the whole area of mental health, definitions can become a difficulty in their own right. But if someone is looking at the definition of someone who fits the requirement for support because of their mental health process, is there anywhere where that would clash with anything that is going on in your agency, or has that been considered?

Mr Smyth—It has been considered certainly. There are probably two programs where it cuts across: one is the mental health nurses program, where we are targeting people with a severe mental disorder; and also the day to day living program is part of the COAG measure—people with high functional impairment.

Senator MOORE—Is there an issue in terms of the process or is it just part of a client based approach: you take each client as they come and work with them?

Mr Smyth—We do not really use the Wisconsin definition as such within our programs. But we certainly work in conjunction with FaCSIA to see that there is alignment with those programs. Our programs are more based on obviously a clinical diagnosis.

Senator MOORE—Very much, yes. I know it is early days but that is something that has been identified for ongoing monitoring?

Mr Smyth—It is certainly something that we are continuing to discuss at the IDC level and with FaCSIA.

Senator MOORE—Good.

Mr Kalisch—Senator, one point I should make clear at this stage is that certainly with the MBS items they are demand-driven. There are no budget constraints on them, unlike say the FaCSIA program which does have cash-limited resourcing that they need to try and work within. They do need to try and work out who should be eligible for the program and how to manage those resources fairly carefully.

Senator MOORE—It was just that, in terms of the build-up around the introduction of the COAG measures, after there had been a perception that there had not been a lot of services that were focused in this area, there was an expectation of demand and an expectation of service. What I am trying to work out is how to minimise any sense of being isolated from the services. To have a build-up, to think that you are going to get something, that you are going to have some service provided, and then find out that you are not, is a double-whammy: you build up and then you go backwards. We were talking all the way through the development of these programs about how we got the confidence of people to use them and to feel confident to retain that process. I am pleased that that definitional thing is being considered. It has not been raised particularly with me, but the consumer groups talk consistently about self-

identification and how they can feel isolated by other people telling them what their conditions are. I am sure you have had these discussions with them.

Mr Kalisch—Certainly the consumer groups have mentioned to us within the broader range of the package of measures that was announced by COAG the disappointment that there was not more placed on the accommodation side from the states.

Senator MOORE—Yes. The rural and remote initiative, which is one we have talked about at times. Is there anything in particular on that one, Mr Smyth?

Mr Smyth—Yes, Senator. Assistant Minister Pyne has signed off on potential auspicing bodies in geographical locations to implement that measure in phase 1, which is obviously for this financial year. Also, we have informed state and territory COAG groups of those decisions. At the moment we are under commercial arrangements because we have approached potential auspicing bodies in all jurisdictions and have sought proposals from them to implement that measure on the ground. So we are not in a position to be able to say what the dollars per jurisdiction are or which organisations we have approached, at this point in time.

Senator MOORE—Are the prospective auspicing bodies public yet?

Mr Smyth—No, they are not, Senator.

Senator MOORE—Mr Smyth, we had discussions with FaCSIA again and they talked about the process that they had in place of gathering information from states and territories and then using that information when they are forming their decisions about what is happening. Is there a similar interchange of information and issues with the states in the health and ageing areas of the mental health programs?

Mr Smyth—Yes, there is, Senator.

Senator MOORE—With the auspicing bodies for that one, were states and territories approached to give you information that could then be used?

Mr Smyth—We approached the states and territories as part of the COAG working groups to identify their areas of need. We then looked at where MBS uptake was lowest in those jurisdictions. Then we looked at the rurality and remoteness indexes of those areas as well so it met with the policy parameters of the actual program. Together with the states and territories, we identified what priority areas that measure would target. We consulted with the jurisdictions throughout that measure and informed them of what the decision was and they are quite comfortable with that decision.

Senator MOORE—When are you expecting that one to start?

Mr Smyth—We would hope to have contracts in place with the auspicing bodies in March of this year.

Senator MOORE—Before the end of financial year?

Mr Smyth—Absolutely.

Senator MOORE—How many?

Mr Smyth—It is about 18 or so in the first wave, Senator; phase 1.

Senator MOORE—And across all jurisdictions?

Mr Smyth—Except for the ACT.

Senator MOORE—I do not know; it can be remote. That was a straight comment; look at Belconnen. So we will be having at least some program under that particular area in every state and the Northern Territory?

Mr Smyth—That is correct, Senator.

Senator MOORE—Is that also going to be the area where some of the issues around Indigenous people are going to be picked up?

Mr Smyth—Yes, it will be.

Senator MOORE—We had particular issues about some of the mining towns and some of the areas there when we had the Senate committee. That fits remote.

Mr Smyth—Yes.

Senator MOORE—But it also has the other issue of the particular transient nature of the area. Was that one of the things that was looked at in that area?

Mr Smyth—It is. We are looking at some mining areas. Whether or not the organisations that we are auspicing there use hub and spoke model or a direct employment model is really up to the proposal that they can see will fit with the needs of that community and what is going to be viable for them to recruit into.

Senator WEBBER—With regard to rural and remote and the rollout of some of the programs, and we touched on it a bit with the MBS items earlier: one of the issues that has been raised with me by at least two states is a concern with the new items coming in and the transferral of the services from the public sector to the private sector, particularly psychology services. As people here know, I am concerned about towns like Port Hedland where there is the clear divide between the permanent residents and those that fly in and fly out and work at the different mine sites.

Is there any ongoing monitoring, evaluation or plan to ensure that we are still going to deliver the services to the people that most need them, that this MBS structure is not going to be the cure-all and that is it? I know we can say it is a state responsibility as well, which is what I was trying to hint at in terms of what work have you done with the states and territories; but I have a real concern that we are going to transfer the professionals out of the public sector and people are going to have the MBS item and that is good, but then there are going to be people that cannot afford to access that and they are going to miss out.

Mr Smyth—We acknowledge that there are some concerns at jurisdictional level that have been raised with us. The Australian Psychological Society does not share those concerns, I have to admit. They see that people will work across the public-private divide and there are certain people that are drawn to public related service and will probably stay there and others that are more interested in private practice. But we have two fund-holding programs that are the Better Outcomes in Mental Health and our Rural and Remote Measure that will specifically target isolated and remote communities to try and ensure that we maintain an allied health care presence in those areas. We do not have the ability to monitor the migration

of people out of the public sector into the private sector, in terms of the registration process as I understand it.

Senator MOORE—What about the MBS numbers?

Senator WEBBER—Yes, I would have thought the MBS numbers would be a good tool. I would have thought someone that used to work in the public sector, if all of a sudden they are giving you lots and lots of fees using the MBS number, it would seem to indicate—

Mr Smyth—They have to be in the private sector to provide that service.

Senator WEBBER—Yes, so if all of a sudden all sorts of—

Mr Smyth—It could be a new graduate that may have moved to that particular area or newly accredited or it could be somebody who has come in from overseas who has met the credentialling requirements as well and moved into that area. It is very difficult for us to tell whether that person may have previously worked in the public sector.

Senator MOORE—Is it one of the evaluation considerations, Mr Smyth? Even if it is not a flat figure— because of, as you say, the difficulty of working out exactly chasing a person—is one of the things to be considered in evaluating the whole program whether there has been a professional drain and to ask the auspicing bodies like the professional colleges, to see whether they would know?

Mr Smyth—We certainly do not have a formal mechanism but we can ask them in terms of our formal discussions with them, that we have on a regular basis.

Senator MOORE—It is in the various mechanisms you put in place to discuss what is happening in the programs. It was a particular issue that was raised particularly when the MBS items were being put up: that if you actually put this in place, which people did want to see, because it would give more access to services, it was raised consistently that it could mean that people would move en masse.

Mr Smyth—I think the government also recognises—and that is why there are new workforce measures that have been put in place, the 420 mental health nurses and the 200 clinical psychology places—that in any one year, as I understand it from discussions with the APS, there are 235 final year clinical psychology students in Australia, so that measure almost doubles the number moving into that area on a yearly basis. Professor Whiteford also wanted to raise an issue here.

Ms Halton—Can I make a point first, Senator? I think we just need to go back to the basics. The objective here was to increase accessibility to psychological services. That is the objective. I understand people's concerns. I think it is perfectly reasonable that people express those concerns, and, to be honest, we would be as worried as anyone else if that actually happened, because our objective is to increase accessibility of services. We do know that the geographic distribution of psychologists is pretty good compared to a number of the other professionals.

Senator MOORE—Absolutely.

Senator WEBBER—Compared to psychiatrists.

Ms Halton—That is absolutely right. There is something to be said for some of our profession, I have to say, unlike dear old Professor Whiteford's profession down the end there! But can I say that this is the kind of thing that we will be watching in the department. Our objective is to make sure that people get better access—end of story—and if there are things that we see that we are worried about—and it might not be just a concern about drift from public to private—those are the kinds of things we will be watching for. I can absolutely assure you that, if we see a stream of correspondence, or, when we are out and about talking to people, if people are raising those as concerns, they will be factored into the policy development process. This is not a static position. We are all about making sure that mental health services are more available, more accessible, nationally. We know we have got a big initiative. It is a really good initiative. We were not quite tap-dancing, but it was very close, and we need to make sure that the policy development process remains dynamic to ensure that there are not consequences. I do not think we should all sit here saying on day one, 'Oh, this is going to be terrible,' because it is not. It is not going to be terrible. It is a good thing. But we do have to stay alert and manage the implementation, and that is what we will be doing.

Senator WEBBER—I accept all of that. What I am trying to establish is how you will be watching it. You say you cannot track it through MBS.

Ms Halton—Yes, absolutely.

Senator WEBBER—I do not get any other feedback of what other formal mechanisms there are to watch this, and I do not know that you have that many people up in towns like Port Hedland to work out what is going on.

Ms Halton—No, you would be surprised.

Senator WEBBER—I doubt I would be. Not in Port Hedland.

Ms Halton—We are in and out of Port Hedland a lot.

Senator WEBBER—I know. I meet your people on planes.

Ms Halton—That is exactly my point. This is like any other number of programs that we run. Let us be clear: we have the big things like the Medical Benefits Schedule and pharmaceutical benefits. We also have small programs that we run, and you know that we are out talking to community providers and consumers the whole time. These are things that officers of the department will be very alert to. Occasionally even I get out and talk to people, and these are the kinds of things that people do raise if they have concerns about them. I can absolutely promise you that officers of the department are going to be very alert to these things. We will watch the data, the macro, but we will also watch the micro. We will watch the letters that we get from consumers; we will watch the stuff that we get told when we are out in community meetings; you sit down in an Aboriginal community and you talk to the community nurse. All these things are part of the process.

Senator MOORE—Is it part of the COAG discussion as well?

Ms Halton—Yes, absolutely.

Senator MOORE—It would seem to me that one of the most affected would be state governments if they are losing their state practitioners.

Ms Halton—Absolutely.

Senator MOORE—If it is on the COAG agenda, I think they are—

Mr Smyth—It is always the No. 1 item on the agenda.

Senator MOORE—I thought it might be.

Ms Halton—Yes, absolutely.

Mr Kalisch—The one other thing I would add is that state governments have for some time been talking about the difficulty of recruiting staff, as well, to these services, so we are not starting from a perfect situation. It is really trying to gauge how things have changed, whether for good or for bad in the future. That is the real challenge.

Mr Smyth—We do have regular formal meetings with divisions of general practice and, as you know, they have a very good network on the ground that advises us—who that division can refer to in terms of 'allied', as well; what is actually happening on the ground.

Senator MOORE—And they are still doing the Better Outcomes.

Mr Smyth—Better Outcomes. Also, the GPs will know what is happening in relation to the Better Access initiative as a result of these new measures. We have quarterly formal meetings with the Australian Psychological Society and the Royal Australian and New Zealand College of Psychiatrists, and we will start formal quarterly meetings with the College of Mental Health Nurses as well, and we still have these ongoing COAG meetings where, as I said, it is a key point of discussion.

Senator MOORE—Professor Whiteford, were you wanting to make a comment on the workforce or anything else?

Ms Halton—Or defend his profession, given we just all slagged it off!

Prof. Whiteford—Yes, I am catching a plane to Port Hedland tomorrow! To consolidate what my colleagues have said, in the evaluation the three areas we are looking at to answer the question about drift between public and private are: firstly, working with the state and territory governments, for them to advise us if they think their workforce is shifting; secondly, to work with the professional organisations—for example, the APS—who know about psychologists who are coming up for accreditation, who are being nominated to Medicare Australia to claim on these items; and, thirdly, whether in the evaluation we could actually sample divisions of general practice and get some qualitative and quantitative data within them to look at where the psychologists they are referring to or the nursing staff they might be employing are coming from, and aggregating that together to give us an overall picture in addition to the regular flow of information that would occur outside of a formal evaluation.

Senator MOORE—So we have got the psychologists and the nurses, who were already identified as being short, but they are being particularly picked up by the MBS item, so we should be able to look at those, and also the training packages that have been put there.

Ms Halton—And, Senator, can I just make one little point. The anecdotal feedback I am getting from people I either went to university with or know in the profession is fantastic. What they are saying is that, for the first time, there is a range of clients that they are seeing for counselling and other services who historically would never have accessed their services. I

have had this feedback consistently now from people who work way out in the bush and who work in the middle of the cities. I think it is worth just reminding ourselves of that. All these things are very important and we need to absolutely watch all of these things, but the on-the-ground feedback is really good.

Senator MOORE—That is the first round, isn't it?

Ms Halton—Absolutely.

Senator MOORE—Has the department done any projections or analysis of the expected demand for the new service? When you were putting it together did you have any goalposts in your plan, for how many services—under all of them but in particular, I think, under the Medicare ones?

Mr Andreatta—We do not have specific targets for the various MBS items. We do have uptake estimates that we use for costing purposes, demand driven. At the moment it is strong and very positive, but we are not tracking against any particular target.

Senator MOORE—Are any of those numbers public? I do not want to pluck a figure out of the air, because it is just stupid, but when you were looking at the first 12 months of the MBS number was there any plan in place for how many services would be accessible?

Mr Andreatta—Certainly that feeds into the funding model and our consultations with the Department of Finance and Administration. Those figures are confidential.

Senator MOORE—ATAPS—Access to Allied Psychological Services—is another program. I want to know how that fits in and whether they talk to each other.

Mr Poyser—Senator, you are asking what impact the Better Access measure has had on ATAPS?

Senator MOORE—Yes, with the other measure that was in place, because that is the other thing I am trying to get my head around. The department and the government already had some programs operating. The COAG ones came in over the top. I am asking how they are going now, whether there is liaison, whether they complement, whether they are being merged, all that kind of stuff, particularly psychological services.

Mr Poyser—It is very early days since Better Access has been introduced, obviously. The figures that we have, reported from the divisions of general practice, are similar to the previous three to four years of referrals, so at this point we do not have any data that shows—

Senator MOORE—It is very early, Mr Poyser.

Mr Poyser—It is very early, and none of the figures we have at the moment show that there is an impact.

Senator MOORE—Is it one of the things that you are looking at into the future as the program becomes more mature?

Mr Poyser—Yes.

Senator MOORE—Is that one thing that you are going to have a look at?

Mr Poyser—Yes.

Senator MOORE—That is all we can ask. I will make a note to ask you again in three months time. The intent of the question was to see whether these are the things that the department is looking at, so we can work together in the future.

Senator WEBBER—We have touched on a few issues. Mr Smyth, is there any other work you have done specifically with the states and territories? Is what you have told us in terms of the implementation the extent of it?

Mr Smyth—As you will recall, Senator, the two flagship measures out of the COAG action plan were the states and territories working together in those working groups—

Senator WEBBER—That is right.

Mr Smyth—and the establishment of a care coordination model. Across all of the jurisdictions, we have had extensive negotiations and discussions on the formulation of a care coordination model that meets the jurisdictional needs of the state or territory. We have a number of papers that are currently in the process of being endorsed by those groups. New South Wales is probably the most advanced in relation to that, and that paper is—

Senator WEBBER—So you do have a sense of urgency at the moment.

Mr Smyth—Yes. There is a lot of work that is taking place in terms of care coordination, and reports were due to senior officials on 2 February. We were asked to do a six-monthly report to senior officials, but because of the date of that senior officials meeting being moved to, I think, 23 February, reports from each of those jurisdictional working groups were due in the SOM secretariat on 2 February, and those reports were probably what we focused on at our last series of meetings at each of the jurisdictions.

Senator WEBBER—Is that it in terms of the development of the flagships?

Mr Smyth—There is obviously ongoing work in relation to care coordination and there are still ongoing discussions at the COAG working group level about the implementation of Commonwealth programs and the implementation of state programs. That is ongoing and will be ongoing for the foreseeable future.

Prof. Calder—Greg Poyser's branch has run the program of consultation with the states and territories on the day-to-day living program, which has been a very similar process.

Senator WEBBER—Where is that at?

Mr Poyser—We are hoping to advertise this weekend.

Senator WEBBER—We look forward to talking to you about how that goes in a few months time. There is not a lot you can say when you are going to advertise this weekend. Thank you.

[8.57 pm]

CHAIR—There being no further questions on outcome 11, we will press on to outcome 12, Health workforce capacity. I welcome officers associated with outcome 12 and invite questions.

Senator McLUCAS—How many districts of workforce shortage do we currently have?

Mr Dennis—Districts of workforce shortage are not static elements. Because they are based upon quarterly Medicare billing data, which changes four times a year, the districts of workforce shortage change. In essence, we have four maps in any year, with potentially four different sets of areas or districts of workforce shortage.

Senator McLUCAS—So in this current time that we are in now—

Mr Dennis—I am not sure at this particular point in time.

Senator McLUCAS—Are those maps published?

Mr Dennis—The information is available on the website. There is no mapping facility available, so there are no physical maps, but it is possible to get that information from the website at any particular time.

Senator McLUCAS—I do not know what the trigger for the change is, but on notice, could you give me a list of each of the areas of workforce shortage for 2006 so that I can work out where the changes are.

Mr Dennis—Yes. To clarify, do you want the final quarter for 2006 and the previous one, to measure the change from one to the other?

Senator McLUCAS—I was hoping to get the four quarters of 2006.

Mr Dennis—Certainly.

Senator McLUCAS—Are they done on a standard quarterly basis, so end of March and end of June et cetera? What are the trigger dates?

Mr Dennis—That is correct, and we have the December data which takes effect tomorrow. Yes, we can certainly provide that and we can probably provide it in a map form, if you would prefer it that way.

Senator McLUCAS—Can we have it in both forms?

Mr Dennis—Certainly.

Senator McLUCAS—If the next list is coming out tomorrow, could we have that list as well? Then we will get five quarters.

Mr Dennis—Certainly.

Senator McLUCAS—In relation to requests that are made outside of the standard reading of the Medicare billing data, how are they dealt with?

Mr Dennis—By that do you mean where, for instance, an applicant may make an application to practise in a particular area and finds that it is not a district of workforce shortage but then makes an application on the basis of other factors?

Senator McLUCAS—No, I am actually thinking a bit more from a community perspective, where perhaps a division of general practice, or a member of parliament, would write and ask for it to be considered as an area of workforce shortage. We have had many discussions in this place with former members of parliament about requests for their particular areas to be made areas of workforce shortage. I am thinking particularly of Tasmania. What is the process when you receive a representation for an area to be made an area of workforce shortage?

Mr Dennis—I should probably take this opportunity to clarify that a district of workforce shortage is defined as an area which has less than the average access to medical services, which means essentially they have a doctor-to-population ratio which means their access to medical services is less than the national average. Irrespective of individuals making representations, those statistics do not change and form the basis of determinations as to whether districts are in fact districts of workforce shortage or not.

Senator McLUCAS—When an area in the technical sense, because of the Medicare data, is deemed an area of workforce shortage, just through that straight mapping process, does that then allow a different application of the rules to be applied? I know some of it but I do not know all of it.

Mr Dennis—That is the primary consideration. In relation to the level of access to medical services in a particular statistical local area, the delegate has the opportunity to consider other factors in addition to simply that single measure.

Senator McLUCAS—Is that called an exemption?

Mr Dennis—No.

Senator McLUCAS—Or a determination?

Mr Dennis—An exemption pertains to an exemption from section 19AB of the Health Insurance Act 1973 which enables a doctor to practise in an area which they would not otherwise be. That is an exemption. A determination is essentially an assessment as to whether an area is in fact a district of workforce shortage and whether an application for an exemption will be granted or not.

Ms Halton—Mr Dennis has been understudying Mr Maskell-Knight!

Mr Dennis—I apologise.

Ms Halton—No, that is a compliment.

Senator McLUCAS—That was a compliment. Work that out.

Mr Dennis—It is a reasonably dense area and takes some time to unravel.

Senator McLUCAS—You are being very kind. So to get this in order, there is a counting of Medicare services in an area. You possibly, or someone in the department, come to a view that an area is undersupplied. Is that the determination?

Mr Dennis—It is probably better illustrated from the obverse angle where a doctor seeks to practise in a particular location. That doctor, who may be an overseas-trained doctor and hence subject to a 10-year moratorium—meaning that that doctor must serve 10 years in areas of workforce shortage prior to having unrestricted access to Medicare—wishes to practise in a particular location. So they make application and the team at the department make a determination as to whether that doctor should be granted an exemption, meaning that he should be allowed to practise where he would not otherwise be allowed to practise. That is an exemption to section 19AB. Whether that exemption is granted is based upon whether the area is a district of workforce shortage. Whether the area is a district of workforce shortage is determined by whether it has greater or lesser access to medical services than the national average.

Senator McLUCAS—Where a doctor seeks to practise in an area that technically is not an area of workforce shortage, that is when representations will be made to deem that area an area of workforce shortage?

Mr Dennis—That is where an exemption is required and they make application. Where that application is rejected that is typically the point where representations may be made.

Senator McLUCAS—How many of those applications for rejected exemptions do you receive every year?

Mr Kalisch—It might be useful to assess the numbers of applications that are made each year because they are very significant and it might help to just put it in context.

Senator McLUCAS—Yes. That would be good. Thank you, Mr Kalisch.

Mr Dennis—For the single year finishing January 2007—this year just gone—3,476 applications were received. That is approximately 450 applications per month. It is probably ideal to take that on notice and we can provide you with that data over a time series.

Senator McLUCAS—When you say the year ending January 2007, is that February 2006 to January 2007?

Mr Dennis—Yes, Senator.

Senator McLUCAS—And 3,476 applications for exemptions were received?

Mr Dennis—That is correct.

Senator McLUCAS—Then you can tell me, perhaps shortly or perhaps on notice, how many—

Mr Dennis—How many exemptions were granted—

Senator McLUCAS—Yes, granted and refused.

Mr Dennis—and how many exemptions were rejected.

Senator McLUCAS—That is fine. That is the raw data. What happens when an application is refused? What sort of recourse is allowed at that point?

Mr Dennis—We will perhaps simplify that somewhat for ease of explanation. An applicant may seek a preliminary assessment of area workforce shortage which is an indicative assessment which, without binding the department, provides them with some surety that if they go ahead and set up practice and incur costs associated with that, they will in fact be able to commence practice even if the district of workforce shortage status has changed in the interim. If either a preliminary area of workforce shortage determination or in fact a proper determination is rejected, then the applicant has the right to reapply, and we encourage applicants at that point to provide us with additional data which may assist.

As I alluded to earlier, whilst the district of workforce shortage is the primary method of determination, there are other factors which a delegate would consider. If that applicant is able to provide evidence attesting to these other factors, then it is certainly possible that the determination will be made favourably with that subsequent application.

Senator McLUCAS—I wonder, Mr Dennis, if you could further on notice subdivide the refused figure into refused and then refused again, and refused but then approved?

Mr Dennis—Certainly: the number of appeals, the number of appeals overturned and then the number of appeals that have been overturned and subsequently reinstated. Is that correct?

Senator McLUCAS—Yes. Is that possible?

Mr Dennis—Yes, I believe so.

Mr Kalisch—While we do not have the specific numbers with us tonight, I think from what Mr Dennis has said, and from my understanding as well, it is certainly clear that the vast majority of applicants do qualify for an exemption under the grounds that they are seeking to move to a district of workforce shortage. So the vast majority we think get through that first filter and are successful at that stage. So we are talking about a relatively smaller group but a relatively large number of applicants.

Senator McLUCAS—I suppose the difficulty in understanding it is that the community think of it in terms of a region and attracting a doctor. Your process is to think about it in terms of an individual application from an individual. I can see that is just the different way that we come at the issue.

Mr Kalisch—But I suppose the challenge here is that we want to use the workforce in the most effective and efficient way. And certainly the clarity around district workforce shortages is quite important to maintain, particularly in rural and remote areas as well as in some of the outer metro areas.

Senator McLUCAS—Mr Dennis, regarding the geographical size of these areas, I recall making representations on behalf of a doctor in my part of Australia who was making the case that the area was very large, in his view, and therefore—I will be specific; Palm Cove being a long way from Cairns—argued that Palm Cove could have been deemed an area of workforce shortage. We worked on that for quite some time. I am not sure what the result was. Do you get requests to subdivide areas from time to time?

Mr Dennis—We get a range of requests, including to subdivide statistical local areas, to consolidate statistical local areas, to move the boundaries of areas, to reclassify areas.

Senator McLUCAS—You would know Kenilworth, for example. Do you recall that one?

Mr Dennis—It is a common occurrence.

Mr Kalisch—Senator, I have seen a number of these cases as well. Certainly in a number of them, while there is this start around the metric indicator that is used as the first filter, once there is a rejection and further application is made, the department does seek to almost put a commonsense ruler across this where there are some specific points made and where in fact we consider and look at the maps and the various features. We take a commonsense approach to this.

Ms Halton—Senator, you know, because we have discussed it in this place I do not know how many times, the whole question of geographic classification cuts multiple ways. I seem to recall that we have had the RRMA drama and every other variety of drama around geographic classification and you have rightly pointed yourself to the fact that sometimes there are other reasons why you cannot attract a doctor into a particular microlocation or practice or whatever. As Mr Kalisch says, inevitably this is an emotional issue as well as a

practical issue, and we do try and apply a relatively commonsense ruler. But inevitably people are unhappy.

Senator McLUCAS—Mr Dennis, in terms of those applications that are initially refused and then approved, can you list those by each of the quarters that we are going to get the data on?

Ms Halton—I think that would be quite hard because that would require us to go back on a case-by-case basis through a whole bunch of files. I actually think that that would be quite difficult. We would have to go back and probably retrieve things through archives et cetera.

Mr Dennis—Most of this material is narrative so at that point it would be very difficult to do a search like that. It is not numerical in nature.

Ms Halton—We have got thousands of these cases. That is the problem.

Senator McLUCAS—Yes, I understand that. Townsville, for example, had a particular set of conditions applied to its status as an area of workforce shortage. My recollection—and you might confirm it, if you recall it yourself, Mr Dennis—is that there was a subdivision and then there was a condition applied that overseas-trained doctors could only work night duty at an after-hours medical practice. Are those sorts of conditions regularly applied? Is that the way it works?

Mr Dennis—I am not familiar with that particular instance. As the secretary has rightly said, we have thousands of these cases and I cannot recall each of them individually. The issue in relation to after-hours medical centres is a different one, insofar as in addition to geographical areas of workforce shortage there are also what are deemed temporal areas of workforce shortage, meaning that at points in time there are medical workforce shortages; hence, to a large extent, doctors who are otherwise restricted in practising during working hours receive an exemption to practise after hours, such that it augments the after-hours medical service in a particular area.

Ms Halton—My memory of the particular region that you are talking about is that you are right. My memory is that there was a case mounted in respect of the geography of Townsville, which I cannot profess intimate knowledge of. But having been there several times my memory is that, with that little part of the hinterland which was actually included in the geographic grouping called Townsville, there was a particular issue because in fact it was demonstrably different. I seem to recall that there was a pragmatic solution found in that particular area. That is going back a few years now.

Senator McLUCAS—Yes, it is back a fair while. Can you tell me if the Bay Islands Medical Service in Queensland is currently the subject of a workforce shortage determination?

Mr Dennis—Not without recourse to checking files. As we have indicated, we may have a hundred current applications under review and I am not able to provide you with individual details of any one of those without recourse to further information.

Senator McLUCAS—Could you take that one on notice for me? Given now I understand the process, where it is up to in travelling through the—

Ms Halton—Where is the Bay Islands, Senator?

Senator McLUCAS—In Moreton Bay.

Ms Halton—Thank you.

Senator McLUCAS—I just want a snapshot of where it is in the process.

Ms Halton—Subject to privacy considerations, we will take it on notice.

Senator McLUCAS—You collect GP to population ratios by SLA, I think you said, Mr Dennis.

Mr Dennis—We do not collect them directly, but the information that is used to form the basis of determinations in relation to districts of workforce shortage are determined by SLA—statistical local area. That is correct.

Senator McLUCAS—What is that data? Is it GP visits? What are you collecting?

Mr Dennis—It is the amount of Medicare billing compared to the amount of population, and the amount of Medicare billing is used to determine, I guess, a medical workforce quotient which is a full-time equivalent of a medical practitioner.

Mr Kalisch—Senator, would it help if we provided a little bit of detail on that specific aspect?

Senator McLUCAS—Yes, it would, I think. When you say 'Medicare billing', number of visits—

Mr Dennis—We do not, in the Mental Health and Workforce Division, manage the raw data at this stage. It is compiled, cleansed and calculated for us by our colleagues in Primary Care. They provide us with the information that forms the basis of our determinations.

Mr Kalisch—Some of this data is actually on our website. It is drawn from Medicare billing data and it is the workforce data that is on the department's website.

Ms Halton—We can give you the reference to the website to locate that.

Senator McLUCAS—Thank you.

Mr Kalisch—It is quite up to date, as we have mentioned.

Senator McLUCAS—Then you extrapolate from that, Mr Dennis, into a notion of GPs to population. Is that how you do it?

Mr Dennis—No. We are provided with the GP to population ratio and we make the determinations in relation to the applications that we receive on the basis of that.

Senator McLUCAS—Where do you get the GP to population ratio from?

Mr Dennis—From our colleagues in Primary Care.

Mr Kalisch—And the population data is drawn from ABS sources.

Mr Dennis—The ABS census; 2005 is the latest population data available.

Senator McLUCAS—Do you turn that GP to population ratio into federal electorates?

Mr Dennis—No.

Senator McLUCAS—We can do it. If you could provide us with a copy of SLAs in Australia and the GP-to-population ratio on each SLA, that would be useful.

Prof. Calder—We do not hold that data and it is not data that the department publishes. This division does not hold the data.

Senator McLUCAS—No, primary care does.

Prof. Calder—And it is not published.

Senator McLUCAS—I am asking if it could be provided to the committee.

Ms Halton—Again, that is one of these things that the minister has determined in the past about what will and will not be released. He has made the provision in terms of it being released annually. We will have to talk to him about that.

Senator McLUCAS—This is different from Medicare data.

Ms Halton—No, it is mainly based on Medicare data.

Senator McLUCAS—Yes, I realise that. We have had the discussion about whether or not the department has it, but it is clear that there is a set of data that shows by SLA in Australia the GP-to-population ratio held by the Department of Health and Ageing.

Ms Halton—There is a ranking of regions according to who is above the line and who is below the line in terms of provision.

Senator McLUCAS—You have to know the number before you ring so you must have that.

Ms Halton—It is not the number of GPs. But, anyway, we could argue about the semantics.

Mr Dennis—The SLA is not a subset of an electorate so you could not build up that information on an electorate basis from knowing SLAs.

Senator McLUCAS—On my understanding it was.

Mr Dennis—No, I do not believe so.

Ms Halton—We will take on notice what we can release.

Senator McLUCAS—We might draft a question so that we know we are asking the right thing.

Ms Halton—Yes, sure.

Senator McLUCAS—Dental workforce information: what data is kept on dental workforce populations?

Prof. Calder—Can you give me a moment, Senator?

Ms Halton—What we know is largely derived from information collected by the outposted unit which is located in South Australia. We do not, as you would understand, maintain databases of these sorts of things, so what we would rely on is largely information that is in the public arena in this case.

Prof. Calder—You are asking about the workforce entitlements?

Senator McLUCAS—I asked a very open question, Professor Calder. I said: what do we know about the dental workforce in Australia?

Prof. Calder—At the moment, according to the Australian Dental Association, which is derived from their website, there are approximately 10,000 dentists Australia-wide.

Senator McLUCAS—Do you have any understanding of their distribution across the country?

Prof. Calder—I do not hold that, Senator, no.

Senator McLUCAS—Does the department hold that sort of information at any level?

Prof. Calder—We could get further data for you, Senator. We can take that on notice.

Ms Halton—The short answer is, no, we do not.

Senator McLUCAS—You do not collect that data?

Ms Halton—No, we do not collect any of this data. We always rely on third party information so we are not primary data collectors on most of this stuff. In relation to the dental workforce and dental issues, the majority of what we would rely on inside the department comes from this sort of source and the outposted unit—I am sure they are an AIHW unit—which is located in South Australia.

Senator McLUCAS—If you could point us to appropriate places to look for that data, that would be helpful, thank you.

Ms Halton—Yes, absolutely.

Senator McLUCAS—I think this is in the right outcome: is the department aware of a proposal from Charles Sturt University for a new dental school?

Prof. Calder—Yes. I will ask Maria Jolly to answer that. Yes, there is information.

Ms Jolly—Yes.

Ms Halton—I have been made aware of it, Senator. It has been brought to my attention.

Senator McLUCAS—What recommendation process does the department of health have in that regard?

Ms Halton—It is a matter for DEST, principally.

Senator McLUCAS—I understand that.

Prof. Calder—We are aware of it but it is their matter.

Senator McLUCAS—Are you consulted in the approval process?

Ms Halton—It would be unusual in these sorts of areas if someone did not talk to somebody in the department. There is no technical requirement for us to be consulted but consistent with the people who are backing this proposition being completed—which is why I know about it because correspondence, I think, has come across my desk—similarly I would anticipate, in this area, that DEST would be having a conversation with us if and when they came to consider such a request.

Senator McLUCAS—But there is no requirement for DEST to talk to DoHA. They do not ask you for your submission or point of view.

Ms Halton—Yes.

Senator McLUCAS—But when new medical schools are established—

Ms Halton—Medical schools?

Senator McLUCAS—Yes.

Ms Halton—A different matter.

Senator McLUCAS—Can you tell me what the process for a medical school is?

Ms Halton—There is very close consultation between us and DEST and certainly the process of new medical places and indeed the establishment of new medical schools, principally, would be a matter for us. DEST might allocate, technically, but the question of whether there should be more or less medical schools would be principally a matter for the minister for health.

Senator McLUCAS—Thank you. We will then go to DEST and ask questions about that process of approval. I understand PricewaterhouseCoopers was engaged last year to do an evaluation of the More Doctors for Outer-Metro Areas program. Is that right?

Mr Dennis—Yes, that is correct.

Senator McLUCAS—Is that evaluation completed?

Mr Dennis—Yes, I believe so.

Senator McLUCAS—What were the results of that evaluation?

Mr Dennis—I understand that a comprehensive report was tendered, the content evaluated by the department and then—

Ms Halton—It was a lapsing program review. Lapsing programs are required to have—

Senator McLUCAS—Yes. Is it possible for the committee to have a copy of that review?

Ms Halton—We do not usually provide lapsing program reviews. I will take some advice on that.

Senator McLUCAS—Could we have an analysis of the findings?

Ms Halton—I will see what I can provide.

Senator McLUCAS—It is important for the committee to understand how successful that program was.

Ms Halton—Yes. Unless things have changed, because it is a budget process, those reviews are part of the budget process, but we will see what we can tell you about what we know about the effectiveness of that program based on the review.

Senator McLUCAS—Extrapolating from that, could the department provide a list of all reviews and analyses that it has done in the last 12 months on workforce programs, including if possible a summary of the results or major findings of each of those reviews?

Ms Halton—Sure.

Senator McLUCAS—On each of the various strands of the workforce programs.

Ms Halton—That might take us a little while.

Senator McLUCAS—There are that many reviews and analyses happening at present.

Ms Halton—It will have to be complete, Senator. Yes, that is fine.

Mr Kalisch—It is a very active area.

Ms Halton—It is very active.

Senator McLUCAS—That is all I have and I am a minute and a half over time. I apologise.

[9.33 pm]

CHAIR—Okay. We move onto outcome 13, acute care.

Senator CAROL BROWN—I would like to revisit my questions about improving access to primary care services in rural and remote areas. The last budget included a measure under which rural and remote towns with less than 7,000 people have access to Medicare funding for non-admitted GP services. How many towns have benefited from this measure?

Ms Yapp—At this stage, there are no approvals in place for any towns.

Senator CAROL BROWN—No approvals?

Ms Yapp—No.

Senator CAROL BROWN—Why is that?

Ms Yapp—Two states, WA and Queensland, are actively pursuing the initiative but they are still undertaking consultations with relevant stakeholders and consulting with the Commonwealth in terms of getting the initiative in place. Three states have indicated they do not have an interest in the initiative. Western Australia has a memorandum of understanding in place and they have an agreed implementation plan. They are in the process now of consulting with relevant stakeholders to get the initiative in place in nine towns in the initial tranche of implementation.

Senator CAROL BROWN—When will those negotiations be completed for those two states?

Ms Yapp—I imagine that it will be a staged process, so it is up to the states themselves as to how quickly they want to proceed. Queensland has been taking a different approach. They want to do a lot of consultation up-front, and have agreed guidelines in place. They have been having a lot of teleconferences, and the Commonwealth has been involved in some of those, in order to get agreement up-front as to how they will do it. Again, the feedback is that they are likely to pilot it. They will probably put it in place in three towns initially, see how it goes and learn from the experience before they look at rolling it out more widely.

Senator CAROL BROWN—With the three states that have declined, what reasons have they put forward?

Ms Yapp—Not all of the states have indicated why they have declined, but those that have have said that they have very limited numbers of emergency department services provided from their public hospitals in small rural towns, so they are small rural hospitals and they have limited availability. Therefore, they do not see that they would gain much from the initiative, so it is not really worth their while.

Senator CAROL BROWN—What about the other two? Has there been contact made with them?

Ms Yapp—Yes, we have been consulting with them. They have indicated they are not interested. This came out of a COAG initiative, so the sense there was that it was Queensland and WA that were particularly keen on the initiative, saw it could benefit them in terms of the sorts of arrangements that they had in place, and they are the ones that are actively pursuing it now.

Senator CAROL BROWN—Has any of the funding that was allocated been spent so far?

Ms Yapp—No. There is no billing against the MBS in any towns at this point in time.

Senator McLUCAS—I understand that DOHA engaged KPMG to provide policy advice on acute care funding. Can you tell us what that means? What was the scope of that request?

Ms Yapp—We have in place a panel arrangement for consultants to provide advice around acute care funding. As the current health care agreements expire, the provision that is in place is that they will give independent and expert advice to the department around current trends, operations and practices in state and territory hospitals and other health services, that they will provide advice around changes that might be implemented to improve the incentives and improve the efficiency and effectiveness of the acute care system and that they will provide comments on options and issues papers that the department itself has developed.

Senator McLUCAS—That is essentially a precis of their terms of reference, is it, Ms Yapp?

Ms Yapp—In terms of the panel contract, that is right.

Senator McLUCAS—And it is in the lead-up to the health care agreement?

Ms Yapp—That is right.

Senator McLUCAS—Your preparation internally prior to the formalised process.

Ms Yapp—Yes.

Senator McLUCAS—I dare say we cannot have a copy of that report. It is probably not finished yet.

Ms Yapp—The arrangements are that the contracts with the two suppliers are in place for three years. It is on a per diem basis, so they will be called on from time to time to provide advice.

Senator McLUCAS—Health Policy Analysis Pty Ltd was commissioned to develop a framework for measuring performance in the delivery of acute care hospital services in Australia. I understand that one was a bit more explanatory. Was that one discrete piece of work or an ongoing piece of work?

Mr Gibson—Yes.

Senator McLUCAS—Has that work been completed?

Mr Gibson—It has.

Senator McLUCAS—Is it in preparation for the negotiation of the next agreement?

Mr Gibson—It is preparatory work. It does not anticipate negotiations.

Senator McLUCAS—It is essentially data analysis. Is that a better way to describe it?

Mr Gibson—It is looking at the kinds of data that are available and how that might be improved to support indicators in areas of high priority.

Senator McLUCAS—What sort of performance measurement is it looking at?

Mr Gibson—It is developing, based on the national health performance framework domains. It is looking at how they might be expanded to develop indicators, particularly in the areas related to outpatient and emergency department care, quality and safety issues.

Senator McLUCAS—But only in outpatients and EDs or—

Mr Gibson—No, for the whole of the acute care sector.

Senator McLUCAS—There is a whole range of stuff that happens in hospitals, we know.

Mr Gibson—The quality and safety domains are areas of priority for the whole of the acute care sector. They are recognised as areas where we could improve our ability to measure performance, so quality and safety issues relating to the whole of the acute care sector. In terms of where indicators are underdeveloped in general, then emergency department and outpatient care are recognised as areas of underdevelopment.

Senator McLUCAS—That report is complete. Is it available to the committee?

Mr Gibson—It is advice to government at the moment. It would not be available to the committee.

Mr Kalisch—I think the answer is no.

Senator McLUCAS—I am compelled to ask the question.

Mr Kalisch—It is important to state at the outset that we are moving into a relatively sensitive phase and some of this information is necessarily quite confidential to government.

Senator McLUCAS—Thank you. The 2007 report on government services identifies the main conditions with the highest rate per population of hospital separations for potentially acute conditions and identifies dental conditions as having the highest rate among those. Can you explain that?

Mr Kalisch—Sorry, Senator, you did say dental?

Senator McLUCAS—I understand that is the case.

Ms Flanagan—Senator, we are a bit puzzled. It does not seem to resonate with us. Do you have a reference for that?

Senator McLUCAS—I am advised that the 2007 report on government services identifies the main conditions for hospital separations for potentially preventable—that is an important word—acute conditions, and it says that dental conditions were, at a rate of 2.57, potentially preventable acute conditions. Can someone tell me in English what that means? I had to have a debate with my adviser about what it might have meant.

Mr Gibson—A rate of 2.7 per what?

Senator McLUCAS—Preventable separations per 1,000 people in 2004-05.

Mr Maskell-Knight—I think we are all somewhat handicapped by not having the document in front of us, but in terms of what that means it seems as though it is saying that there are two point whatever separations per 1,000 people that could have been avoided if dental health care had been available.

Senator McLUCAS—That is what I understood.

Mr Maskell-Knight—That is what I understand it to mean without seeing the context.

Mr Kalisch—Perhaps we can also take that on notice and we will have a look at the ROGS report and, if there is an alternative answer, we will provide that to you.

Senator McLUCAS—Now I have a little bit of time to talk about blood, please.

Ms Halton—What would you like to know, Senator?

Senator McLUCAS—I understand that the Flood review, the plasma fractionation review report, was tabled in December?

Ms Cass—That is right. It was released on 15 December.

Senator McLUCAS—What were the recommendations of that report?

Ms Cass—There were a series of recommendations against the terms of reference set.

Senator McLUCAS—Let me be a bit more specific. What does it say about arrangements for plasma fractionation services?

Ms Cass—The gist of the independent committee's report was that overseas fractionation of plasma is not an advantageous option for Australia.

Senator McLUCAS—On what basis did Mr Flood come to that point of view?

Ms Cass—A range of issues were considered by Mr Flood. Principally his conclusion was that, though overseas fractionation would be feasible on the grounds of safety, quality and efficacy of the product, there were other issues relating to logistics and potential cost implications which counterbalanced it.

Senator McLUCAS—Logistics and cost? I have not read the report. Does it go to the question of safety?

Ms Cass—The balance of the report was not that there is a concern about safety, quality or efficacy of products as a result of options for overseas fractionation of Australian plasma.

Senator PATTERSON—There have been comments made by the Americans, for example, with free trade that they should have access to fractionation of blood. Was there any comment made about the fact that it is not a pure market situation, that people donate the blood?

Ms Cass—That was certainly a very strong issue in the report: that the Australian blood supply is predicated upon voluntary donation of blood by Australian citizens and there were community concerns about the implications of changing arrangements.

Senator McLUCAS—Do you mean, Ms Cass, that Mr Flood thought that it could limit the potential donor population?

Ms Cass—The report indicated that several submissions did make that point: that there may be an impact upon donation.

Senator McLUCAS—I think that is reasonable evidence given the experience of North Queensland. When people know that their blood is not being used wholly, they are less likely to donate, so there is some reasonable evidence to support that. The minister indicated, I think on that day, that he intended to continue with the obligations essentially under the USFTA and then went on to say that any change in policy concerning blood fractionation must be made jointly by all state and territory governments and the Commonwealth. What directs that? How does that work?

Ms Cass—The basis for the decision making is the National Blood Agreement, under which any decisions about the national blood supply must be made by all jurisdictions.

Senator McLUCAS—Is there one body that meets to talk about the National Blood Agreement?

Mr Kalisch—Ultimately, ministers come together as part of the Australian Health Ministers Council.

Senator McLUCAS—In a nutshell, what does that National Blood Agreement say?

Ms Cass—About the decision-making process for the national blood supply? Is that what you are asking?

Senator McLUCAS—More the principals, I think.

Ms Flanagan—First of all, the Commonwealth funds two-thirds of expenditure under the agreement and the states one third, so they are all stakeholders under the National Blood Agreement.

Ms Cass—The National Blood Agreement was signed in 2003.

Senator McLUCAS—It is only recent?

Ms Halton—It is a relatively new instrument. It has occurred in the time that I have been in the position. We came to recognise that blood is a particularly complex issue to manage. Indeed, the patchwork of arrangements that we had historically, in relation to managing and paying for the blood supply, was too fractured and did not reflect what had become a national system. So we took that patchwork, as it then was, and negotiated an agreement. It is a multilateral agreement effectively between the states and territories and us, the Commonwealth government. That agreement was reflected in the establishment of the National Blood Authority which is, again, a relatively new instrument. What that did was to strike an arrangement about how we would govern the supply of blood and blood products to Australians.

Senator McLUCAS—Do the health ministers have to agree to allow overseas plasma to come into Australia under that agreement?

Ms Halton—To alter the arrangements as they currently stand, recognising that we do have the input of some overseas product now—but put that issue to one side for a second.

Senator McLUCAS—Yes, I am aware of that.

Ms Halton—But the issues that you are going to, yes, there would have to be agreement from all of those parties.

Ms Cass—There is a clause in the National Blood Agreement which makes it clear that where any decision in relation to national blood supply arrangements has a material impact upon an individual jurisdiction, then that jurisdiction must agree to the change.

Ms Halton—In other words they all have to agree to the change.

Senator McLUCAS—Which gets to the point then of what happens if one of the states or territories does not agree?

Ms Halton—It is not agreed.

Senator McLUCAS—It is not agreed?

Ms Halton—No.

Mr Kalisch—And the change to the status quo remains.

Senator McLUCAS—How does that then fit with our obligations under the USFTA?

Ms Halton—We are discharging our obligations under the USFTA. The minister wrote to the states making a recommendation consistent with our obligations under the USFTA. He is currently awaiting a complete set of responses from those states and territories.

Senator McLUCAS—The minister wrote to the states?

Ms Halton—Yes.

Senator McLUCAS—When and what about?

Ms Cass—The minister wrote to the states on 15 December, the day of the release of the report, asking them to respond to the recommendations in the Flood report and to respond to the Commonwealth recommendation which is a commitment in the USFTA.

Senator McLUCAS—So to respond to the recommendations of the Flood report which is in fact the converse of the recommendation of the Commonwealth?

Ms Cass—Seeking the response of the states and territories on the full fit of recommendations.

Senator McLUCAS—What responses have you received, given that none of them went on holidays clearly? Have we received any responses back yet?

Ms Cass—The minister has received four responses to date.

Mr Kalisch—Senator, he asked for the responses back from the state and territory governments by 30 January.

Senator McLUCAS—30 January. He is a hard taskmaster, isn't he?

Mr Kalisch—It is an area that is dear to their hearts as well.

Senator McLUCAS—We have got four in. I dare say the others will come in shortly.

Mr Kalisch—I hope so.

Senator McLUCAS—Is it appropriate to ask what the contents of those responses are? Are they in the public arena yet?

Ms Flanagan—Senator, I think it is probably not appropriate for us to give the content—

Senator McLUCAS—I understand that.

Ms Flanagan—of those responses, but the states might be happy to indicate.

Mr Kalisch—I think a number of state ministers have made it well known.

Ms Halton—I think a number of them are already in the public arena indicating their view on this matter, Senator.

Senator McLUCAS—Senator Forshaw used to do blood, so I am a bit new to it. I will have to look up those papers and find out what they said. What is the next process? Will there be a meeting?

Ms Halton—If there is not a complete set of responses by the time the health ministers meet.

Senator McLUCAS—When is the next health ministers' meeting?

Mr Kalisch—Toward the end of March.

Ms Halton—The 30th? Anyway at the end of March.

Senator McLUCAS—On 30 March and it will be on the agenda for that meeting?

Mr Kalisch—Yes.

Senator McLUCAS—Is it expected that there be a resolution at that meeting or is there a time frame that we have to comply with; or 'when a decision is made, a decision will be made' sort of time frame?

Ms Halton—When the decision is made it will be made.

Senator McLUCAS—Can someone, very quickly, give me a medical explanation for platelet transfusion? What is a platelet transfusion?

Ms Halton—Professor Horvath loves it when you ask these things.

Prof. Horvath—Platelets are little, sticky things in the blood that literally stop you bleeding. When you cut yourself the platelets all stick together and the rest of the clotting factors, all 20-odd of them, stick to the platelets. So they form the architecture of the clot. So without platelets you bleed. There are a number of disorders where you can lose your platelets. Some of them are immune disorders, but the commonest is with aggressive chemotherapy, say for leukaemia, or after bone marrow transplantation.

The commonest, in fact the only therapy because there are no artificial platelets, is in fact after blood donation to harvest platelets, pool them and very rapidly—because they have got a very short half life—give them to the relevant person. They last usually two to three days. If you do not have your own platelets while you are in the business of remaking them you usually need platelet transfusions for some time. The other times you might use them is after an obstetric catastrophe where there is a lot of bleeding and you actually use up your platelets. Ordinary red cells that are given for transfusion do not have platelets, so that is what they do.

Ms Halton—Don't you love it? There are things that we just do not want to know and Professor Horvath insists that we hear about.

Senator McLUCAS—I am aware of the time so I will make this quick. Is there an issue for increased ability for platelets to carry bacteria and a screening system that has been recommended?

Prof. Horvath—Very simply, yes. There is a risk. The risk of contamination is twofold: (1) because they are pooled from multiple donors, there is multiple handling, and, (2), inherently, as we have said in other fora, blood and blood products are inherently dirty products. So there is a greater risk of platelets being bacterially contaminated than, say, a single unit of red blood cells.

Senator McLUCAS—I understand that the Red Cross has started doing a more expensive—is it a screening program or a cleaning program that they are undertaking?

Dr Turner—The governments and the Red Cross Blood Service have been talking about bacterial contamination for a couple of years now and there have been a couple of measures already introduced. The governments approved and the Red Cross introduced in 2004 improved skin disinfection from donors. There has now been another introduction of what they call 'diversion pouches' and that is when somebody has blood taken from them, the first little bit of blood that comes out, which contains a skin plug, is diverted into a different tube which then does not go into the blood bank for donation. So those two measures have been approved and have been implemented in the last couple of years. Governments are also now considering a third measure which is the question of actually testing platelets before they are released, to see whether they contain any bacteria. That is under active consideration by governments at the moment.

Senator McLUCAS—Who funds the first two measures that have been adopted? Who has funded those increased—

Dr Turner—That is done within the budget of the Australian Red Cross Blood Service and basically that is funded by governments under the cost-sharing arrangement through the National Blood Authority where the Commonwealth contributes two-thirds and the states contribute one-third of the funds to the blood service.

Senator McLUCAS—Just to finish this question, was there an overall increase to cover the cost of the implementation of those two measures?

Ms Halton—Yes. Senator, we had to get agreement from all the jurisdictions. Every time we increase the level of screening or implement a measure like this, we work out what it is going to cost and then we have to find our way to agree across all the jurisdictions to contribute the relevant amount of money. The truth of the matter is that we put in 67 per cent, so we are actually the majority funder but we still have to get the agreement of all the other parties.

Senator McLUCAS—Sorry. That was not the question I was asking. There would have been increased costs—

Ms Halton—Yes, it costs money.

Senator McLUCAS—to implement those two measures. Was the budget provided to Red Cross increased to cover that?

Dr Turner—Yes, the Red Cross Blood Service received an extra $1.4 million as a one-off cost to introduce diversion pouches. The rest of the costs were absorbed within their annual increases that they get from governments.

Mr Kalisch—This is all done within the national blood supply plan that ministers agree each year, which includes the budget and the relevant contribution, so it is done within a broader funding envelope as well.

Senator McLUCAS—Thank you. This third assessment process that you were speaking of, Dr Turner, could you explain that quickly? What is proposed under this third process?

Dr Turner—I am not a technical person but my understanding is that when the platelets are collected they are then incubated in a particular chamber for 24 hours, or possibly longer, depending on the methodology that is used, to see if bacteria grow or in some way show themselves in those platelets. The platelets are then held until the results of those tests before they are then released into the blood supply in the hospitals. There are different methods of doing it. There has been quite a big international debate about the best way to do that and really the best way has only probably become clear in the last 12 months. It is a very active area of international development.

Senator McLUCAS—Who does the risk analysis? Is it the department as the partial funder or the National Blood Authority or Red Cross? Who tries to work out what the risk is of not doing this new system of testing?

Dr Turner—Most of the advice that we get on risk comes from the TGA who are the experts on risk assessment. At this stage the regulatory requirement is only that five per cent of platelets are tested. That is the regulatory standard.

Senator McLUCAS—Is the TGA the body that is actively trying to think about the appropriate regulation, given the potential risk?

Ms Halton—We had the experience in the past of sometimes governments taking a decision to in fact improve the standard in relation to quality in front of a regulatory decision—in other words, before the regulator has decided something. Similarly, we have had examples of where the regulator, looking at international evidence in terms of the risk of particular kinds of technologies as evidence becomes available, has lifted the standard. They are the responsible regulator, and I think you know, from questions that we have dealt with here before, that the TGA are very active in the blood area. This is something that they take quite seriously, and they are internationally active as well. But certainly in respect of this particular issue, this is not being led by a change of regulation; this is being led by a debate inside the sector and inside government about whether there should be this change.

Senator McLUCAS—Is the department aware of any current or pending coronial inquests dealing with the issue of unscreened platelet transfusions?

Ms Cass—No, we are not aware of current coronial inquests.

Senator McLUCAS—But potentially?

Ms Cass—We are certainly aware from the ARCBS, who maintain a register of potential claims under the national managed fund in relation to bacterial contamination of quarterly data on potential incidences. We have advice from the Australian Red Cross Blood Service,

which has also been provided to other jurisdictions and to the NBA, that since September of 2006 there is a record of 18 potential cases, including two deaths. Whether they proceed to coronial investigation, I have not heard.

Senator McLUCAS—I understand that the decision can be made in March. Is it a little more urgent than that?

Prof. Horvath—Can I assist there for a moment, Senator. There is another side to this, as well as this third testing procedure. The clinical side of it is—which needs to be taken into the debate by the haematologists, and I am aware that they are a part of this decision making—that this third procedure does have the potential, as has been said by my colleague, to hold up the release of the platelets. Platelets are in short supply often and there are issues about delay when they may be clinically indicated and, similarly, the longer you hold the platelets in storage before usage—it is not a linear—there is quite a sharp drop-off in their activity. It is not just a straightforward, 'There is now a test. Why isn't it implemented in March?' There needs to be some other side of the risk equation for different clinical trade-offs. Once it becomes a regulatory issue, it becomes more difficult. So there is that part of the discussion that needs to be had as well.

Senator McLUCAS—Aren't all of those elements part of a decision that could be brought forward to, let us call it, an out-of-session ministers' meeting, if the TGA or the department or the Red Cross were of the view that, 'We are ready to implement this,' given all of the pros and cons, let us call them, that you have talked about, Professor?

Dr Turner—Senator, if I could answer that, but in a different way: if governments decide that that is what they want to do, Red Cross have indicated that it will take them about a year to implement the decision, because they will have to order equipment; they will have to put a whole lot of different processes in place. So making a decision a few weeks either side is not going to make any tangible difference to the speed of implementation. It will be when they can get the equipment from the suppliers and all of those sorts of things.

Senator McLUCAS—I was fortunate, or not, to chair the inquiry into hepatitis B in the blood supply. I think the key measure out of that was that the ARCBS did act appropriately and promptly on the information that it held. I am trying to understand if we are acting promptly enough on the information that we hold.

Mr Kalisch—I think it is fair to say that the broad judgment is that we are acting appropriately, expeditiously, but also trying to take account of all the factors. What Dr Turner said is certainly our understanding as well—that there are some constraints on the ARCBS in terms of them taking the next step of implementing, which will mean that any action around ministers making a decision in March will not overly influence the final implementation date.

Senator McLUCAS—Essentially, we could roll it out now and they will tick it in March.

Mr Kalisch—This is something that they will need to consider within the broader blood supply plan, the budget, and I suppose the extra cost burden on jurisdictions, which is something that we hear from a number of states and territories is not a small matter.

Senator McLUCAS—That has been useful. I am sure that we will talk about it more again.

Senator ALLISON—I have some questions in outcome 13. I will start by putting a question on notice, if I may, on the national survey of secondary school students and sexual health—I know that is program 1 and we have already passed it. But if I could put on notice a question about why it is that this five-year study was not funded again as I understand is the case for this year.

Ms Halton—It is still under consideration.

Senator ALLISON—A decision has not been made then?

Ms Halton—No. There were a number of issues with it, but it has not been resolved one way or the other.

Senator ALLISON—Can I ask why there is some doubt about it?

Ms Halton—The technical people are not here, but I can tell you that the issues—I am happy to take something on notice.

Senator ALLISON—Thanks. I wanted to ask about the issue that was raised a few weeks ago to do with the failure to refer those who attended emergency departments in public hospitals that were run by the Catholic Church health care group to do with rape. There were rape victims who apparently presented at emergency departments and were not referred to rape crisis centres because of the ethical code of conduct which is required by the Catholic Health Australia. Can you indicate how the Commonwealth views this situation? How are the Australian health care agreements effective in this respect?

Ms Halton—The Australian health care agreements—unless there is an addendum to it which I am not aware of—would not cover this matter. The requirements under the Australian health care agreements are particularly in respect of access to free public hospital treatment, and the requirements are well known. We do not get down into that level of detail, so we do not have a specification in relation to all of the service elements. I am aware of the matter that you raise, but it is not something which is a subject of the health care agreements.

Senator ALLISON—Isn't it the case that the health care agreements require the states to uphold Commonwealth objectives of equity and access? In fact, don't they spell out, if not in detail about particular services, that they require that some services continue to be provided?

Ms Halton—They require that services are provided according to medical need.

Senator ALLISON—And you do not think that a rape victim has a medical need to be referred to a rape crisis centre?

Ms Halton—I do not think one way or the other. I am just outlining to you what is in the healthcare agreements. That particular issue is something which has obviously been drawn to our attention, and we would be certainly making inquiries of our state colleagues, but it is not a matter that we can actually comment on at this point.

Senator ALLISON—So you are making inquiries with state colleagues?

Ms Halton—We have a meeting of the Australian Health Ministers Advisory Council coming up shortly, and we can raise that issue with our state colleagues when we meet with them.

Senator ALLISON—Does the Commonwealth have an interest in anything beyond rape crisis—for instance, surgical sterilisation, prescription contraception, prenatal and antenatal genetic testing?

Ms Halton—Those matters are not specified in the healthcare agreements. Obviously we have an interest in ensuring that the services that are provided are safe. We do not have a requirement that public hospital services provide the complete range of services because, as you would be aware, some hospitals do not provide brain surgery, some hospitals do not provide obstetrics et cetera; so there is no obligation on each hospital to provide a complete range of health and medical services. But the point that you have raised about those allegations obviously suggests that there might be issues in relation to appropriate treatment, and that is something we will talk to our state colleagues about.

Senator ALLISON—If, say, the Jehovah's Witnesses contracted to provide hospital services but clearly do not believe in blood transfusions, how would this sit with the Australian healthcare agreements?

Ms Halton—It is a hypothetical question and I think the longstanding practice is that we do not hypothesise. But certainly at the moment we know that public hospitals vary—

Senator ALLISON—Sorry, it is not a hypothetical question. You have indicated that the healthcare agreements do not cover the circumstances I have just referred to, and I am asking you about another circumstance. Would the Australian healthcare agreements also allow Jehovah's Witnesses to run hospitals that did not provide blood transfusions?

Ms Halton—Again, I do not want to answer a hypothetical question, because that is not a circumstance we are actually facing. The point I am making to you is that the services that are provided vary from hospital to hospital. I am not aware of any service that does not provide blood transfusions. Professor Horvath can correct me if I am wrong. Is there any hospital that does not provide blood transfusions?

Prof. Horvath—I would not like to say on record, but it is possible that some small district hospitals or community hospitals do not have blood banking facilities; therefore, they would in fact evacuate patients because it would be quicker.

Senator ALLISON—Getting back to this range of services that I referred to, if we leave aside blood transfusions, with the surgical sterilisation question, it has been the situation for some long time that—

Ms Halton—That is a regulatory requirement. Sorry, surgical sterilisation as in fertility?

Senator ALLISON—Tubal ligation.

Ms Halton—Not the sterilisation of surgical materials?

Senator ALLISON—No.

Ms Halton—I just want to be clear about what we are talking about. 'Sterilisation' can mean a couple of things.

Senator ALLISON—Sterilisation of a person.

Ms Halton—Got it!

Senator ALLISON—I know that in my home state those hospitals that have become part of the Catholic hospital system no longer do a service that was previously provided. It is a fairly simple procedure. It is not like brain surgery, or obstetrics even, but nonetheless patients are denied that service. Do you agree that that is the case?

Ms Halton—Some hospitals do not provide a full range of services, but other hospitals do provide that range of services.

Senator ALLISON—So the healthcare agreements make no distinction between the range of services provided related to the capacity to attract doctors to those positions or the size of the hospital or the demand—

Ms Halton—No.

Senator ALLISON—and codes of conduct based on religion?

Ms Halton—The state has an obligation to make sure a range of services are available. It is not required to make sure that the complete range of services is available at every institution, and it has ever been thus.

Senator ALLISON—Okay. Anyway, you are raising this matter with the health ministers?

Ms Halton—Yes. The particular issue that you raise is certainly something I am intending to talk to CEOs about.

Senator ALLISON—Will you also raise the question of surgical sterilisation and prescription contraception and genetic testing?

Ms Halton—No, because that is as it was ever. Some of these services have never been provided in some of these hospitals.

Senator ALLISON—Even a hospital that provides obstetrics but does not do tubal ligations is not a problem as far as the Commonwealth is concerned?

Ms Halton—I am saying that it is not inconsistent with the healthcare agreements. At some point we will get into a conversation with the states about the funding of the healthcare agreements. At that point a whole range of conversations can occur, but in terms of the current healthcare agreements those arrangements are consistent with the healthcare agreements. They have been in place in many states and in many facilities for many years, so, no, that is not something we are intending to raise in the near future. The issue in relation to appropriate support for patients in particular circumstances I think is a different question.

Senator ALLISON—What is different about the emergency department treatment of rape victims and other kinds of services which are not provided on the basis of a code of ethics?

Ms Halton—The suggestion is, as I understand, that there was not necessarily clinically appropriate treatment of patients in a particular circumstance. That may in fact not be an accurate allegation, but it is appropriate to raise that issue. However, the range of services provided by a hospital is known. That is a longstanding practice and that is not something that we will be raising.

Senator ALLISON—So, in terms of appropriate clinical outcomes, you do not think that tubal ligation fits into that category somehow?

Ms Halton—Services are quite clear about what services they provide. If you are seeking a different kind of service then you will go to another facility.

Senator ALLISON—And if you are in a country town where the only public hospital is the one that does not provide this service?

Ms Halton—That is a matter for the state to organise.

Senator ALLISON—The healthcare agreements are silent on the matter is what you are saying?

Ms Halton—Yes.

Senator CAROL BROWN—I want to ask questions about organ donation. Can I have the organ donation rate for 2006?

Mr Gibson—We might have to take that on notice, Senator. I am not sure I have that with me.

Ms Flanagan—Senator, I think that we have given organ donation rates before. I thought we had given a fairly up-to-date answer, but it might not include 2006.

Senator CAROL BROWN—It does not include 2006.

Ms Flanagan—Okay. We will take that on notice.

Senator CAROL BROWN—I can tell you all the others, if you like.

Ms Flanagan—I think I can probably tell you, too, if I turn to the right page. We will get you the rate for 2006.

Senator CAROL BROWN—You do not have the rate and you will not have the raw figure?

Mr Gibson—The rate is pretty much unchanged from 2005, and it is around 200 organ donors in 2006.

Senator CAROL BROWN—The rate in 2005 was 10.1. You believe that to be around the same?

Mr Gibson—Around the same, yes.

Senator CAROL BROWN—And the raw figures for deceased donors were 2004 figures?

Mr Gibson—Yes. It has been pretty much the same now for quite a few years.

Senator CAROL BROWN—Yes, I know. I know there has been a lot of effort put into upping the donation rate and there have been quite a lot of initiatives put forward. I think there were seven put forward last year to make the public aware of organ donation. Have you been doing any evaluation of those initiatives?

Ms Flanagan—As you would see, the package was only agreed very recently and so we do not do evaluation. In effect, we are in start-up mode to get some of those up and running. For example, the minister has set up a national clinical task force to advise him on what can be done. Some money has been set aside to raise community awareness. In fact, we had a meeting in Sydney on Monday to talk with key stakeholders about how we do that. I do not

think we can say that anything has been evaluated from this latest range of programs yet. We are getting them up and running.

Senator CAROL BROWN—It has been about eight months. Has the expert task force been established?

Ms Flanagan—Yes, and it has met a number of times.

Senator CAROL BROWN—Who is on that task force?

Ms Flanagan—It is chaired by Professor Jeremy Chapman, who is a renal—

Prof. Horvath—He is professor of renal transplantation at Westmead and he is the incoming president of the International Transplant Society.

Ms Flanagan—I was wondering whether we had a list of the members of the task force that we can give you.

Mr Gibson—I can read them out to you: Associate Professor Philip O'Connell, who is the president of the Transplant Society of Australia and New Zealand; Ian Jenkins from the Australian and New Zealand Intensive Care Society; Sally McCarthy from the College of Emergency Medicine; Russell Stitz from the Royal College of Surgeons; Napier Thomson from the Royal College of Physicians; Russell Strong from Queenslanders Donate; Patrick Coghlan from the national transplantation service with the ARCBS; Steven Nailer from the Australian Tissue Banking Forum; Jennifer Gillott from the Australasian Donor Awareness Program; Graeme Russ from the Australia and New Zealand Dialysis and Transplant Registry; Stephen Lynch from the Australian and New Zealand Liver Transport Registry; Peter MacDonald, a cardiothoracic transplanter; Tina Kendrick, President of the Australian College of Critical Care Nurses; Keith McNeill, cardiothoracic transplanter; Trish Wills from the national managers group of the state based donation agencies; Marcia Coleman, who is the chair of Australians Donate; Mark Cocks from Transplant Australia; and Ashley Eccles, who is a state-territory government observer. Several of those have proxies who also attend.

Senator CAROL BROWN—They have met, obviously.

Ms Flanagan—Yes, they have met.

Senator CAROL BROWN—When did they first meet?

Mr Gibson—24 October. They have another meeting on 28 February.

Senator CAROL BROWN—They are responsible for overseeing the initiatives that were announced in the last budget. Is that right?

Ms Flanagan—No. In effect, funding is provided to set up this national clinical task force to advise the minister. As I say, they are looking at a number of things, such as raising community awareness, which is one of the top priorities, and I think the other is to work better in hospitals. Mr Gibson attended a workshop last week.

Mr Gibson—That was looking at how we might improve the processes for the notification of potential organ donors. A lot of the interest is around how we can make sure we do not miss potential organ donors at that critical point. Obviously, it is a very sensitive time. It occurs in intensive care units, where people are dying.

Senator CAROL BROWN—We had this discussion about specialist hospital coordinators in June last year. Is that the sort of thing that they would be looking at?

Mr Gibson—No. They are more looking at the processes by which the intensive care specialists communicate with the state based agencies that are responsible for coordinating organ donation. Whether or not the intensivists have a particular designated role, like an organ donation coordinator, can vary from hospital to hospital, as I understand it. The discussion that we had with the national clinical task force last week was about whether or not we should have an agreed national protocol that is consistent across the country, which would enable a consistent approach in relation to the circumstances in which you contact a state based organ donation coordination agency, what information you would pass on and how that information is collected and collated.

One of the big unknowns we have at the moment is that we do not have our denominator figure—the number of potential organ donors in Australia each year. At the moment we know we are only getting around 200 each year, and it has been that static for some time. What we do not know is the number that we are missing, either because of something that does not work within the process within the hospital or because of the consent procedure not working effectively.

Senator CAROL BROWN—So you do not know how many we are missing. Obviously, there are some people that, whilst they may be on the organ donation register, may not present in the way that you need to be able to harvest organs.

Prof. Horvath—Senator, perhaps I can help. I have been involved in this for all of my professional life, and it is very complex. The reason we do not know is that a large number of people actually die in other circumstances: in rural settings, in intensive care units. When in individual institutions an audit is done, the number of missed donors is considerably less than the purported figure. One of the things that is coming out of the task force—and I have been in part to two of their meetings—is that, most probably, the target figure we are working towards is somewhat ambitious.

We have the other problem in our community that we keep getting compared to, say, Spain. Spain is a reasonably homogenous society. We have a very multicultural society, with a very large ethnic mix and with a fair number of religious groups who have serious objections to donation. So there are already groups where there are donors lost. Mr Gibson is correct—we do not know the true potential lost donors because we have not been able to account for all of those facts. I think we could waste a lot of time trying to get the denominator right. What we have to do is maximise where we can get to. Professor Chapman's first thoughts are to put some realistic figures, but we are not going to double the donation rate. We need to look at a realistic target and a stretch target.

Ms Flanagan—One of the other key things that seem to be in evidence is that you often lose people at the point of death because the families are not aware of what they might want to do.

Ms Halton—Absolutely.

Ms Flanagan—So there are target areas that can be clearly identified to try and get better outcomes than currently, and that is certainly one that is universally identified as being a real area that we need to work on.

Senator CAROL BROWN—I agree entirely. I think we had seven measures introduced in the last budget, including community awareness of organ donation, expanding of the organ donation register, improving clinical data on organ donation and transplantation and so on. Yet we have not moved forward.

Prof. Horvath—Senator, can I assist there. Even if the best-case scenario happened and all of those factors were successful—if within a year we implemented all of them—we may not see an increase in donor rate for a decade.

Senator CAROL BROWN—I understand that.

Prof. Horvath—That is one of the frustrating issues in trying to measure success. Hopefully, the people who are affected by our very effective programs do not die as donors for a long time.

Senator CAROL BROWN—I understand that. We have Organ Donation Awareness Week, which is coming up next week, and we have peak periods when a celebrity or someone of a high profile donates, yet we really do not move from around that 200 mark, and we have not in the last 10 years, so that is the decade you are talking about.

Are these measures sufficient? I am not from the medical field, but it seems to me that one of the biggest impediments is that even though you give consent—we now have a register that goes to consent—you still have family consent at the end of the day. That means talking to your family, and it is a big ask for people going through that trauma. The best thing that I can see is to have a specialist in the field in your hospital talking to the family and relatives of the potential donor. Some hospitals have organ donation coordinators, and what I would be interested to see is what their donation rates look like compared to the national average.

Mr Gibson—There are some states that perform particularly well. South Australia is a stand-out state.

Senator CAROL BROWN—And they have coordinators?

Mr Gibson—There are also some hospitals in other jurisdictions that perform particularly well. I am not sure whether they have people in the designated coordinator's role, but I think the statistics vary quite a bit. You can have a 30 per cent consent rate from potential organ donors in some hospitals. It can go up as high as 70 per cent in other hospitals, where people consent to donation from a potential organ donor. There are several projects where we are trying to understand how this dynamic works. I think you are right. What the clinical task force is telling us is that the expertise of the people involved in the donation process does make a difference. That is why one of the programs that is funded is the Adapt program, which is about training people who are involved in organ donation within hospitals, and the proportion of staff who are receiving training is increasing every year. That is a recognised area of priority work.

Ms Flanagan—But I do not think there is a magic bullet in this area, otherwise we, hopefully, would have found it over the last 10 years.

Senator CAROL BROWN—I support—

CHAIR—Senator Brown, I am sorry to interrupt, but we do have another two programs to do in the next 25 minutes. There are a number of senators wanting to ask questions in those other areas. Is it possible for you to put the remainder of your questions on notice?

Senator CAROL BROWN—Very sadly, but, yes, I will.

CHAIR—I appreciate that. Thank you very much. I am sure you can express your feelings very well in your questions on notice.

Senator CAROL BROWN—I really did want to know how many extra people had registered.

[10.37 pm]

CHAIR—I am sure you will be able to find out with a question on notice. Thank you very much. Can I invite officers associated with outcomes 14 and 15 to the table, please.

Senator McLUCAS—Chair, I just want to put on record that we did want to ask some questions about Operation Cumpston to the biosecurity and emergency response people, and also some advice about stockpiling or purchasing a pre-primer vaccine for a flu pandemic, but, given that I know that Senator Patterson is very keen to ask some questions of the NHMRC, I just want to say thank you to the people from biosecurity and emergency response. We do value the work you do and we will put those questions on notice.

CHAIR—Thanks, Senator McLucas, I appreciate that. We have no further requirement for biosecurity and emergency response. We do thank you for your appearance here tonight. Do we have any questions of anybody other than NHMRC? There being no questions, anybody not associated with NHMRC is free to go, and we will proceed now with questions of NHMRC.

Senator PATTERSON—Thank you, Senator McLucas, for giving me time to ask these questions. The Prohibition of Human Cloning for Reproduction and the Regulation of Human Embryo Research Amendment Bill requires implementation of the Lockhart committee's recommendations regarding the current guidelines for the use of excess ART embryos in research, including a review by the NHMRC into consent procedures. Could you tell me what stage the review is at and when you expect it to be completed?

Prof. Anderson—As you are aware, the matter that you refer to is part of the overall framework for implementation of the Prohibition of Human Cloning for Reproduction Act—which I will probably call 'the Patterson Act' after this—and we have been undertaking a great deal of work to make sure we are ready to proceed with licensing procedures from 12 June, when the act comes into being.

On the matter that you raise around consent, we are working very actively on that. We believe that the draft nearing completion, the 'Statement on human experimentation' or the 'National statement on ethical conduct in research involving humans', which is referred to in the ART guidelines and vice versa, will cover a number of these consent issues, and we are preparing our papers for the very shortly forthcoming Australian Health Ethics Committee to get their advice on this particular matter.

Senator PATTERSON—Who is involved in the review?

Prof. Anderson—We are undertaking that in the office of NHMRC to prepare for the meeting of the Australian Health Ethics Committee.

Senator PATTERSON—Have there been appropriate forms developed for consent for embryos which have been declared excess?

Prof. Anderson—Yes, we are undertaking quite a deal of work around the—I should not perhaps use the word 'technical' issues, but it is work to make sure that we are ready to proceed with the licensing procedure. As you will be very aware, we had quite a lot of experience in this in the implementation of the previous 2002 acts, and we have very active work under way which we also will take to our licensing committee, which meets also very shortly, to get their advice on how we are going with that and whether what we are planning to do there meets the requirements of the act.

Senator PATTERSON—What about dealing with the issue where researchers need not ask for further consent to use embryos already declared excess? Where will that fit in and who is looking at that?

Prof. Anderson—I will seek advice from Dr Morris on that.

Dr Morris—Senator Patterson, can you please clarify your question. Are you referring to a Lockhart review recommendation?

Senator PATTERSON—No, I am referring to the fact that there was a recommendation that the researcher need not ask for further consent to use embryos already declared excess. Where will that be covered and who is working on that?

Dr Morris—That is already covered in the framework which we are administering. Implementation of the revisions to the act will not change those particular procedures.

Senator PATTERSON—And that will all be finished by 12 June?

Dr Morris—Yes.

Senator PATTERSON—Similarly, have you clarified the issue of whether those who donate embryos or gametes for the creation of ART embryos may express preference for the type of research for which the tissue will be used once the embryo is declared excess? Is that being dealt with as well?

Dr Morris—Yes. As you indicate, that goes to the issue of consent, therefore ensuring that the Human Research Ethics Committee, which is the first step in the process, tackles that and makes sure that it is tackled in accord with our national statement and the ART guidelines, and then the licensing committee also has of course to satisfy itself that that has occurred.

Senator PATTERSON—You are saying that I could advise the people who are interested in putting in a research licence application that you will be ready by 12 June, when the act comes into effect?

Dr Morris—That is certainly our strong belief, and we are working very actively to make sure that that can occur.

Senator PATTERSON—Egg donation is different from ART. What is being done about the guidelines for egg donation?

Prof. Anderson—This is a very important issue. On looking at our current ethical guidelines in assisted reproductive technology, this issue of the donation of gametes generally—or embryos; but gametes, male or female—is covered in some detail, but we believe we ought to be providing assistance to ethics committees by drawing those together in some way. They are covered in there. They are covered in the national statement as well. We believe it is part of our more general obligation to make sure that researchers and patients and clinics and everybody else involved understands the new legislation, what their responsibilities are and what the sanctions are, and we will be undertaking an education program around that.

Senator PATTERSON—There was money allocated for the 2002 bill for public education and awareness. Do you remember how much that was?

Prof. Anderson—I might need to seek assistance—it was before I was appointed—from the department on that.

Dr Morris—I think I can answer that. I may need to clarify and take it on notice, but I do not believe there was money specifically allocated for public education as part of implementing the 2002 legislation.

Senator PATTERSON—I thought there was.

Dr Morris—I will clarify that for you, Senator.

Senator PATTERSON—Okay. Can you give that to me on notice, and, if there was, how much has been spent and what it has been spent on.

Dr Morris—Sure.

Ms Halton—Does this bring the committee to a conclusion, Senator Humphries?

CHAIR—It does, yes. We have no further questions of NHMRC and they are the only ones left. I thank the officers involved in the hearing today. Thank you, Ms Halton, for your administration of their coming before us in circumstances that are less than ideal, and I hope that we will be able to get to the other room on the other side for the hearings in May. That is our intention. I thank the senators for their cooperation today and we thank the staff of the committee, and I want to thank Hansard for their ongoing assistance in this difficult process.

Senator McLUCAS—I want to communicate my request that the committee formally request to go back to the other room, but I think Ms Halton's request to revert to the other group is probably more important. Ms Halton did indicate that the World Health Assembly will be meeting in the week that we are scheduled to have estimates, and I think that should have been taken into consideration prior to moving our committee out of whatever group we were in to the other one without any consultation. So I think we should formally write. I cannot move that, but I urge the committee to formally write to whomever.

CHAIR—May I make the suggestion that we will see if we can sort this out without having to do that.

Senator McLUCAS—Okay.

CHAIR—If we cannot, then certainly a letter will be written. As the secretary reminds me, it is actually a decision of the Senate as to what days we run on, but needless to say it is a matter that we can discuss informally with members of the government.

Senator Santoro—Chair, can I add my own thanks to those that have already been expressed to the senior management of the department, and also to all to other officers who so ably assisted them, and I also thank you and your committee for the professional and personal courtesies that have been extended to us.

Committee adjourned at 10.50 pm