COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Consideration of Additional Estimates

MONDAY, 19 FEBRUARY 2001

CANBERRA

BY AUTHORITY OF THE SENATE

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Monday, 19 February 2001

Members: Senator Knowles *(Chair)*, Senator Allison *(Deputy Chair)*, Senators Brandis, Denman, Evans and Tchen

Senators in attendance: Senators Brandis, Gibbs, Conroy, Collins, Crowley, Denman, Evans, Forshaw, Harradine, Knowles, Lundy, Tchen and West

Committee met at 9.08 a.m.

HEALTH AND AGED CARE PORTFOLIO

In Attendance

Senator Vanstone, Minister for Family and Community Services

Executive
- Mr Andrew Podger, Secretary
- Prof John Mathews, Head—National Centre for Disease Control
- Mr David Borthwick, Deputy Secretary
- Ms Mary Murnane, Deputy Secretary
- Prof Richard Smallwood, Chief Medical Officer

Portfolio Strategy Division
- Ms Chris Harrington, Director, Policy
- Dr Robert Wooding, First Assistant Secretary
- Ms Virginia Hart, Assistant Director, Budget Branch
- Ms Robyn Forster, Senior Manager, Budget Branch
- Mr Paul Fitzgerald, Assistant Secretary, Information and Research Branch
- Mr Bob Eckhardt, A/g Assistant Secretary, Policy and International Branch & International Branch

Corporate Services Division
- Mr Neville Tomkins, First Assistant Secretary
- Ms Wynne Hannon, Head, Legal Services
- Ms Jan Feneley, Assistant Secretary, Public Affairs, Parliamentary and Access
- Mr Peter Moran, Assistant Secretary, Contestability Branch
- Mr Vipan Mahajan, Director, Contract Management Unit
- Mr Phillip Jones, Assistant Secretary A/g, Business Systems Branch
- Mr Andrew Wood, Assistant Secretary, Staff Support & Development Branch
- Mr John Littler, A/g Assistant Secretary, Financial Management Branch
- Ms Julie Fox, Legal Services

Outcome 1 – Population Health and Safety

Population Health Division
- Mr Brian Corcoran, First Assistant Secretary, Population Health Division
- Prof John Mathews, Head, National Centre for Disease Control

Mr Greg Sam, Assistant Secretary, Communicable Diseases & Environmental
Ms Judy Blazow, Assistant Secretary, Primary Prevention & Early Detection Branch
Ms Sue Kerr, Assistant Secretary, Drug Strategy & Population Health Social Marketing
Ms Marion Dunlop, Assistant Secretary, National Population Health Planning Branch
Ms Laurie Van Veen, Director, Population. Health Social Marketing Unit
Mr Peter Brooks, A/g Director, Immunisation and Vaccine Preventable Diseases
Mr Paul Lehmann, Director, HIV/AIDS and Hep C Section
Ms Leanne Wells, Director, Tobacco and Alcohol Strategies Section
Ms Cheryl Wilson, Director, Illicit Drugs Section
Mr Paul Cramer, Research Manager, Research & Marketing Group
Ms Georgia Tarjan, Director, Primary Prevention Section
Mr Stephen Lowes, Director, Financial Management Unit
Ms Sarah Major, Director, Bowel Cancer Screening Taskforce
Mr Rod Schreiber, Financial Management Unit
Ms Carolyn M. Smith, Director, Food Policy Section

Therapeutic Goods Administration
Mr Terry Slater, National Manager
Ms Rita MacLachlan, Director, Conformity Assessment Branch
Mr Pio Cesarin, A/g Director, Chemicals & Non Prescription Medicines Branch
Ms Liz Cain, Director, Interim Office of Gene Technology Regulator
Dr Leonie Hunt, Director, Drug Safety Evaluation Branch
Dr Albert Farrugia, Manager, Blood and Tissue Services
Dr Susan Alder, Principal Medical Advisor
Brian Priestly, Scientific Director, Chemicals and Non Prescription Medicines
Dr Fiona Cumming, Director, Office Complimentary Medicines
Dr John McEwen, Director, Adverse Drug Reaction
Ms Elizabeth Flynn, Director, Legal and Policy Unit
Mr Neil Ellis, A/g Director, Monitoring and Surveillance Unit
Dr Peter Thygesen, Assistant Director, Evaluation Unit

Australia New Zealand Food Authority
Mr Ian Lindenmayer, Managing Director
Dr Marion Healy, Chief Scientist
Mr Peter Liehne, General Manager, Standards
Ms Claire Pontin, General Manager, Strategy and Operations
Mr Greg Roche, General Manager, Safety, Legal and Evaluation

Australian Radiation Protection and Nuclear Safety Authority
Dr John Loy, ARPANSA

Health Insurance Commission
Dr Brian Richards, General Manager, Information Management Division
Ms Lisa Paul, Deputy Managing Director, Health Insurance Commission
Mr Lou Nulley, General Manager, Better Medication Management System
Mr John Lee, General Manager, Finance and Planning Division
Mr Geoff Leeper, General Manager, Program Management Division
Mr Ralph Watzlaff, General Manager, Professional Review Division

Dr Janet Mould, Medical Director, Professional Review Division
Mr Bob Thomas, Executive Director Vendor Management Division

Outcome 2 – Access to Medicare

Health Access & Financing Division
Dr Louise Morauta, First Assistant Secretary
Mr Alan Keith, Assistant Secretary, Diagnostic & Technology Branch
Mr Charles Maskell-Knight, Assistant Secretary, Financing & Analysis Branch
Ms Jennifer Badham, A/g Assistant Secretary, Better Medication Management System Taskforce
Mr Ian McRae, Assistant Secretary, Medicare Benefits Branch
Mr Alan Stevens, A/g Assistant Secretary, Pharmaceutical Benefits Branch
Dr John Primrose, Medical Officer, Diagnostics & Technology Branch
Dr Jane Cook, Medical Officer, Medicare Benefits Branch
Ms Diana Macdonell, Director PBAC Secretariat & Listings
Mr Allan Rennie, Assistant Secretary, Medicare Schedule Review Taskforce

Health Insurance Commission

See Outcome 1

Outcome 3 – Enhanced Quality of Life for Older Australians

Aged & Community Care Division
Dr David Graham, First Assistant Secretary,
Mr Andrew Stuart, Assistant Secretary, Policy and Evaluation Branch
Mr Marcus James, Assistant Secretary, Residential Program Management Branch
Ms Lana Racic, A/g Assistant Secretary, Office for Older Australians
Mr Raino Perring, A/g Assistant Secretary, Accountability and Quality Assurance Branch
Mr Peter DeGraaff, Assistant Secretary, Office of Hearing Services
Mr Warwick Bruen, Assistant Secretary, Community Care Branch
Ms Jenny Hefford, A/g Assistant Secretary, Complaints and Compliance Taskforce
Mr Stephen Goggs, Legal Officer, Complaints and Compliance Taskforce

Aged Care Standards & Accreditation Agency
Mr Tim Burns, General Manager, Aged Care Standards & Accreditation Agency
Ms Kristina Vesk, Communications Manager, Aged Care Standards & Accreditation Agriculture

Outcome 4 – Quality Health Care

Health Services Division
Ms Lynelle Briggs, First Assistant Secretary, Health Services Division
Mr Peter Broadhead, Assistant Secretary, Acute & Coordinated Care Branch
Mr Dermot Casey, Assistant Secretary, Mental Health & Special Programs Branch
Mr Andrew Tongue, Assistant Secretary, General Practice Branch
Dr Rob Pegram, Senior Medical Adviser, General Practice Strategic Development Unit
Mr Jonathan Benyei, A/g Assistant Secretary, Blood and Organ Donation Taskforce
Ms Joanna Davidson, National Manager, Office of Rural Health

Outcome 5 – Rural Health Care
Health Services Division
See Outcome 4
Outcome 6 – Hearing Services
Aged & Community Care
See Outcome 3
Outcome 7 – Aboriginal and Torres Strait Islander Health
Aboriginal and Torres Strait Island Division
Ms Helen Evans, First Assistant Secretary
Ms Mary McDonald, Assistant Secretary, Program Planning and Development Branch
Outcome 8 – Choice through Private Health Insurance
Health Industry and Investment Division
Mr Robert Wells, First Assistant Secretary, Health Industry and Investment Division
Ms Perry Sperling, Acting Assistant Secretary, Private Health Industry Branch
Mr Stanford Harrison, Director, Workforce Regulation Section, Health Capacity Development Branch
Ms Vin McLoughlan, Assistant Secretary, National Health Priorities & Quality Branch
Medibank Private
Ms Di Jay, Company Secretary, Medibank Private
Private Health Insurance Administration Council
Ms Gayle Ginnane, Chief Executive Officer, PHIAC
Health Insurance Commission
See Outcome 1
Outcome 9 – Health Investment
Health Industry and Investment Division
See Outcome 8
Office of the National Health & Medical Research Council
Prof Alan Pettigrew, Chief Executive Officer
Prof Elspeth McLachlan, Head, Centre for Research Management
Dr Clive Morris, Assistant Secretary, Centre for Health Advice Policy and Ethics
Mr David Clarkson, Director, Research Development Section
Mr Robert Wells, First Assistant Secretary
Australian Institute of Health and Welfare
Mr Richard Madden, AIHW

CHAIR—I declare open this hearing of the Senate Community Affairs Legislation Committee considering the additional estimates for the portfolio of Health and Aged Care. On 30 November 2000, the Senate referred to this committee the particulars of proposed additional expenditure for the year ending 30 June 2001 for the portfolios of Health and Aged Care and Family and Community Services. The committee will now commence examination of the Health and Aged Care portfolio.

Before commencing the outcomes, senators have advised that they do not require the Private Health Insurance Ombudsman or officers from ARPANZA, HAS, PHIAC and AIHW. Are there any other areas of the portfolio for which senators do not have questions so that those officers do not have to remain? No.

I welcome for the first time the Minister representing the Minister for Health and Aged Care, Senator Amanda Vanstone; the departmental secretary, Mr Andrew Podger; and officers of Health and Aged Care. Minister, do you wish to make any opening statement?

Senator Vanstone—Thank you, Senator Knowles. I offer an apology for being late and holding you up for 10 minutes, which I hope not to do again. I am pleased to be here, so let us get on with it.

CHAIR—Thank you. The committee will be working from the portfolio additional estimates statements and I propose to call on the additional estimates by outcome order. Before the committee commences with outcome 1 on page 27, I suggest that the committee commence with any questions on the portfolio overview on pages 3 to 24. We have already advised Mr Podger that corporate matters will be held at the end of today's hearing. Any questions?

Senator CHRIS EVANS—It is nice to see the minister back before estimates; I have not seen you since Employment estimates. Mr Podger, first of all, I suppose I have to thank you for the improvement in performance on responses to questions. I think we have been having a bit of a battle over that for the last year or so, but I think there was a much more timely response this time and I appreciate that. I would like to thank the department for that. Maybe it is a sign of the new minister driving things, but I think that it was actually preceding her appointment.

Senator Vanstone—I can assure you that that is the case. I have not had to raise that with the department. We did have a constant problem in AG's and we tried to fix it. Any positive news you have got so far is entirely a function of either the previous minister or the department alone.

Senator WEST—I would be claiming the credit, Minister, while you can be ahead.

Senator CHRIS EVANS—I thought the rule of estimates was that the minister took the credit and the department took the blame.

Senator Vanstone—I have actually had the reverse experience, Senator Evans.

Senator CHRIS EVANS—Do not get bitter and twisted, Minister. Thank you, Mr Podger, for that. As I say, it was much appreciated—a much more timely response. I think the one issue that I have not had feedback on is the one we discussed a couple of times about the response to reports on research. You were going to give me a considered response on when one thought it was appropriate to release that information.

Mr Podger—The short answer is that, consistent with the guidelines I have in the department for release, it would not be appropriate to release the market research material on private health insurance at this time, that it could be counterproductive to the work being done in the program area, particularly the work on gaps. The reason you have not got an answer is—as I agreed with you the last time, that I would have a look at my guidelines—I have not settled that yet. That is why you have not got an answer. I am still looking at the guidelines—whether there are other ways in which we ought to be handling this matter.

Senator CHRIS EVANS—Some of this is a couple of years old now, isn't it?

Mr Podger—I understand that, but the material on private health insurance from the market research was important at that time for the work we were doing, the measures coming in—the 30 per cent rebate—and then with Lifetime Cover last year. It is also still pertinent to the work that we are doing on gaps. The issue is whether release of it could be counterproductive to what we are trying to use it for.

Senator CHRIS EVANS—Counterproductive to whom, Mr Podger? I do not understand that argument about counterproductiveness.

Mr Podger—The first matter in our guidelines is that any market research must be related to the goals of the program or the ease of implementation of a new initiative. Clearly, that is what the whole purpose of any market research funded by the department is. There is always a risk that release of a more detailed market research should actually be counter to the smooth operation of the program in the implementation of government initiatives.

Senator CHRIS EVANS—So in terms of a policy, you are not able to tell me what that policy is other than I cannot have that stuff currently.

Mr Podger—I have a policy which I have passed to the committee before, I believe. I am reviewing whether there are some changes at the edges of that policy that might be appropriate.

Senator CHRIS EVANS—I am not sure that I saw that, but I may have. A lot of paperwork goes up and back. I have not been able to ascertain what the current policy is that you are reviewing.

Mr Podger—The policy is one page of points. It sets out that any market research that the department funds has to be related to program objectives, or objectives that are related to government initiatives. It talks about that, as a general principle, such market research at some point should be made public, but it also says that the timing of that release should be such that it would not be counterproductive to the general aim of the market research, that is, the program's objectives and the implementation of particular initiatives. It is around that area that we have been asking questions.

Senator CHRIS EVANS—So the decision on their release is one for you, Mr Podger?

Mr Podger—It is essentially one for me. You will understand that the process of authorising market research is one that goes beyond the department. We have talked before about the ministerial committee that is involved in those things. We do not have a process of going right through that committee, but there would be, on controversial things, things I would discuss with my minister or his office.

Senator CHRIS EVANS—So have you discussed with the minister the release of this particular information?

Mr Podger—I have had some preliminary discussions on that, but it is my decision that I think the release at this point of the market research would not be appropriate.

Senator CHRIS EVANS—So, as I understand it then, subject to your review of the policy, effectively you are telling me that the decision about when it is released will be made by you when you think it is no longer counterproductive.

Mr Podger—That is correct. What is not in the guidelines is some clarification around those issues. All it says in my guidelines at the moment is that the timing should take into account those factors. You have raised with me an important issue about keeping decisions where we have just declined access under active review, and that is the area that I am looking at.

Senator CHRIS EVANS—All right. So when do you think you will be in a position to advise us what those deliberations lead to?

Mr Podger—I would hope to be able to give an answer to your question in the next couple of weeks.

Senator CHRIS EVANS—One is the issue of wanting access to the research, but second is the question about your review of the policy, which has been dragging on for a while as well. So, reading between the lines, I suspect that I am not going to see it shortly, but I am interested in what policy is going to drive that as well.

Mr Podger—If it would help, I will table—I have not got it right here—the existing guidelines, which might clarify the principles we are currently using.

Senator CHRIS EVANS—I would appreciate that. As I say, you may have handed it up before, but I do not remember seeing it. But you are, in fact, reviewing those and you say that you will be in a position within a few weeks to advise me what the review of those guidelines leads to.

Mr Podger—Once I have finished the review of any change in the guidelines, I would issue the guidelines. They will be publicly available and they would be made available to this committee, of course.

Senator CHRIS EVANS—Okay. Thank you for that, Mr Podger.

Mr Podger—I have a copy of the existing guidelines.

Senator CHRIS EVANS—Yes. As part of the overview, could someone explain in more general terms some of the issues surrounding the additional estimates statements, in particular, what seems to be some quite large underspending and the phrase 'reversal of rephasing' and what that actually means?

Ms Hart—I may be able to answer those questions in terms of the overall adjustments to estimates. Did you have a specific question on the tables at the front or just a general question about reversal of rephasing?

Senator CHRIS EVANS—First of all, I would like to know what that term means. It is used a number of times in the documents and it is a bit of a mystery to me. So perhaps you could start by explaining that.

Ms Hart—It is generally explained for each of the outcomes that that relates to under the individual outcome tables, but it is to do with a phasing of pattern of expenditure that was agreed at the 2000-01 budget and for reasons of changes in expenditure—either underspending or identified areas of spends—it has now been reversed. So it is a way of indicating on the books that that pattern of phasing of the money has changed.

Senator CHRIS EVANS—What does that mean in real terms, then—'reversal'? Does that mean that it is not going to be spent in this budget year?

Ms Hart—No. It depends. It is hard for me to answer that question in the abstract, but it depends on the actual funds that have been rephased. Sometimes rephasing has occurred because there has been delayed expenditure and the money has been held over for expenditure, and sometimes it has actually been brought back into the current year because there have been identified projects for it to be spent on.

Senator CHRIS EVANS—So in that instance it would be spent this year but not on the item approved for in the budget? Is that what you are saying?

Mr Wooding—What you have to sort of appreciate with this is that it is very early in the year that you need to make decisions about rephasing. Rephasing is perhaps comparable to what used to be called 'carryover' under the old budgeting arrangements. It is basically that you think you are not going to spend some money this year so you put it forward to next year or vice versa. You think maybe you can spend the money this year so you bring it forward.

These decisions have to be made often many months before the end of the financial year. Then, for example, it may become possible to spend the money in the existing financial year so that the decision to rephase needs to be reversed. So in fact in some of these cases where the rephasing has been reversed it may be that the money was spent towards the end of the financial year, so in fact it has already been spent.

Senator CHRIS EVANS—So first of all we have a rephase and then we have a reversal of a rephase?

Mr Wooding—That is right.

Senator CHRIS EVANS—So for instance on page 31, table C1.2, we have a $9.5 million reverse rephasing approval approved during the 2000-01 budget process.

Mr Wooding—Yes.

Senator CHRIS EVANS—What does that figure represent?

Mr Wooding—I think that represents that the money was spent during 1999-2000. It ended up being spent in 1999-2000, even though at the time of budget 2000, which, as you recall, was before the end of the financial year, there was a feeling that it wouldn't be spent in that financial year. But in fact in the end it was.

Senator CHRIS EVANS—So you are saying to me that we had the budget in May and you did not think it would be spent by the end of June but it was?

Mr Wooding—Yes. But, because of the way these processes work, it was probably at the end of February that the decision to rephase was made. The budget process within government takes a long time to work through, so in fact the deadline for deciding on rephasing is, as you see, only eight months into the financial year. So it is a bit early to be 100 per cent certain.

Senator CHRIS EVANS—So that figure represents $9.5 million that you thought you were going to carry over to 2000-01 but in fact didn't and spent in the previous financial year?

Mr Wooding—That is correct.

Senator CHRIS EVANS—And that is the same under Appropriation Bill (No. 4) for $4.8 million?

Mr Wooding—Yes. That is correct.

Senator CHRIS EVANS—I see there are a number of underspends. Is that usual?

Mr Wooding—Once again, because of the end of February deadline it may be that a need to rephase becomes apparent after that, that in fact you are not going to spend all the money in a particular year, and for that reason you have missed the budget for having that rephasing. So effectively that is a rephasing that has been done in AEs because the budget deadline was missed.

Mr Podger—You asked whether this is unusual. No, it is not unusual. I think the levels of underspends are not particularly unusual this year. I think in fact they are a little bit less than they have been in other years.

Senator CHRIS EVANS— So a reverse of rephasing alters the budget figures for 1999-2000; is that right?

Mr Wooding—The final end of year figures for the actual expenditure—not the budget figures as such.

Senator CHRIS EVANS—But we do not find those figures obviously in these estimates.

Mr Wooding—No. You would have to find them elsewhere.

Senator CHRIS EVANS—And where do we find those?

Mr Wooding—In the annual report.

Senator CHRIS EVANS—So the annual report will reflect a figure that is $9.5 million different on Appropriation Bill (No. 3) than we would have anticipated for the last budget figure.

Mr Wooding—That is correct. The budget figure would show a figure $9.5 million lower and then the annual report would show the actual figure that was spent.

Mr Podger—I suspect it is slightly more complicated than that, and I apologise for that. The annual report will reflect 1999-2000 and we will be referring back to the 1999-2000 budget—that is, May 1999. In May 2000, in that budget for 2000-01, the government announced a rephasing which included some changes in spending in 1999-2000, which affected 2000-01. So our annual report may not pick up what happened in May 2000. It will be referring to the May 1999 budget. So the actual tracking of every decision may not be exactly in the annual report. But what you are seeing is a tracking from the May budget last year to the additional estimates, and we are trying to make sure that the tracking is right in those documents.

Senator CHRIS EVANS—In a different portfolio, in Family and Community Services, I have had a lot of difficulty working this out in terms of what we actually spent in any particular year. I had an argument with the previous minister about child-care spending because every figure was different. I am just trying to be clear in my own mind. Where do we find what we finally spent in 1999-2000?

Mr Podger—In the annual report.

Ms Hart—In the appendix of the financial statements. That is the actual expenditure for 1999-2000.

Senator CHRIS EVANS—And that is in the 2001 annual report?

Ms Hart—It is in the 1999-2000 report—the current report.

Senator CHRIS EVANS—So that will reflect and include the reverse rephasing?

Mr Podger—Effectively, yes, it does. But it will not actually talk about that.

Senator CHRIS EVANS—I am just asking whether the end result of that will show up in the 1999-2000 report. That will include the final figures?

Mr Podger—Yes.

Senator CHRIS EVANS—I think that is clear. We will be able to read the *Hansard*, I am sure. I see there was an ad in the weekend's papers for SES band 2 vacancies. Mr Podger, can you just explain to me what is happening there? You talked about several extra level 2 positions being made available.

Mr Podger—No, we have one vacancy at the moment. One of my officers has left to join the general practitioners college.

Senator CHRIS EVANS—That is Ms Furler, is it?

Mr Podger—That was Ms Furler. Ms Briggs, who was in charge of the Portfolio Strategies Division, has transferred across to Ms Furler's old position and, as you know, Dr Wooding is

acting in that job at the moment. That job has been advertised. On the weekend we put in an advertisement of a more generic nature. I am expecting at least one other vacancy to occur over the next six months or so and I am therefore looking out for possible candidates.

Senator CHRIS EVANS—You do not have another—

Mr Podger—There are no new positions, but I am expecting at least one other vacancy over the next period.

Senator CHRIS EVANS—And is that as a result of a resignation you have already received?

Mr Podger—It is advice of an impending retirement, a resignation.

Senator CHRIS EVANS—So the actual numbers of SES officers inside the department will not change?

Mr Podger—The numbers of divisional heads will not change. The number of branch heads is always moving about, up and down, but there is no overall expansion or decline. We shift jobs according to priorities as they occur. We always have a number of projects going.

Senator CHRIS EVANS—Thank you for that

[9.29 a.m.]

CHAIR—We move on to outcome 1, population health and safety.

Senator DENMAN—Can you tell me if there are any replacements mooted for the ANCD?

Ms Kerr—The current terms of appointment of ANCD members expire in March this year and consideration is currently being given within government to the future composition of the ANCD.

Senator DENMAN—So you cannot tell me which members will be replaced if they are changing over?

Ms Kerr—No, I cannot.

Senator DENMAN—Will the replacements be chosen by the state?

Ms Kerr—I would not expect so. That has not been done that way in the past. But, again, I do not have information on how the final composition of the new council will be determined.

Senator DENMAN—Will you call for nominations?

Ms Kerr—Again, this is a decision of the government. I do not have that information.

Senator DENMAN—Is there any appeals mechanism? Do you know that?

Ms Kerr—Again, it is unusual to have an appeals mechanism for appointments of this kind to government boards. And I would not expect so. But, again, I do not have that information.

Senator DENMAN—I think I have brought this up before. In 1964 there were six deaths from heroin overdose. In 1999 there were 958. Do you think those results suggest that young people are being adequately protected?

Ms Kerr—There are very complex issues around heroin deaths. This is a trend that we are seeing around the world. Governments are taking a range of initiatives, both Commonwealth and state, to address the whole area of heroin overdose. Most recently, the Ministerial Council on Drugs Strategy asked the Commonwealth and the states to develop as a matter of priority a

heroin overdose approach. We are expecting that that will go to ministers out of session very soon.

Senator DENMAN—Do you know whether they are looking at the Swiss trials? Within six years they brought their death rate down quite substantially. It was halved.

Ms Kerr—What we are doing is pulling together a whole range of information from a whole range of organisations and individuals who have an interest in this area; the national policy will reflect a number of views.

Senator DENMAN—Where are you getting those opinions from? What range of people?

Ms Kerr—Initially we have taken advice from all state governments, because state governments in many jurisdictions have their own overdose strategies already. We have taken advice from the Australian National Council on Drugs, which has already released a document on overdose and what it believes should be the approach to that. And we have brought together a range of players who have an interest in this area—people like ambulance officers and others who are at the front line of seeing overdose deaths—to seek their views on how best to address this issue.

Senator DENMAN—During 2001, in the early part of this year, in Melbourne and Sydney street heroin became scarce so the demand for treatment increased. Why did this scarcity develop, do you think?

Senator Vanstone—I do not want to try and interfere in estimates—it was my experience in opposition that the more ministers did that, the longer the estimates took. But Senator Denman's first question made my ears open up, and so does this one. The first one was a statement possibly of fact—I am not sure if the figures are right; I am sure they are not very far wrong—in relation to heroin deaths, asking basically for a personal view of a public servant as to whether she thought people were appropriately catered for and protected. This second one does the same thing. It is a personal view not within the sphere of knowledge of public servants. Estimates and additional estimates and especially supplementary ones are meant to go to government expenditure. Senator Denman, the rest of your questions, up until this last one, I thought were fair questions. But we do have to be fair to the public servants. It is not their position to offer personal views on generalised statements or facts. It is their job to be able to tell you what the government is expending money on.

Senator DENMAN—Thank you, Minister. Is there any research to show why this scarcity developed?

Ms Kerr—I do not have that research, although the National Drug and Alcohol Research Centre does try to track movements in heroin and other drugs on the streets.

Senator DENMAN—Could you find out for me, if I put this on notice, whether the heroin price also increased and whether property crime increased during this period? Is that possible?

Ms Kerr—I think we could certainly look at the issue around price. But, of course, that varies from time to time so we would probably have to pick a point in time. But I think it would be very difficult to provide information on property crime within a short period of time.

Senator Vanstone—I can help you. It will be extremely difficult in relation to the sort of property crime that might have an association. Those figures do not come down to, I think, census collector districts, for example, and they take a long time to come out. It is one of the great problems in trying to look at crime prevention strategies, for example, and getting them targeted at specific geographic areas. There is a bit of geographic mapping. If you want to ask

some questions in the A-G's estimates, whenever they are, the Institute of Criminology is starting to produce information in relation to geographic distribution of crime to, I think, census collector areas. But there is always quite a significant delay.

Senator DENMAN—Is any research being conducted in Australia into naltrexone implants amongst heroin injectors?

Ms Kerr—Not that I am aware of.

Senator DENMAN—Could you find out for me, because I have information that would say there are naltrexone implants being used but not legally? Can we check that?

Ms Kerr—Yes.

Senator DENMAN—In many parts of Australia demand for all forms of drug treatment far outstrips the supply of such treatment. Does the government believe that the arrangements between the Commonwealth and states should result in treatment being more available, or more readily available?

Ms Kerr—What the federal government did was to put a lot more money into drug treatment and rehabilitation through its Tough on Drugs strategy. That was always intended to enhance what the states had already in place. It is primarily a matter for states. The federal government came in and topped that up.

Senator DENMAN—We still have problems in Tasmania. We had a very short supply of drug treatment programs. Would the Commonwealth still be opposed to medically supervised injecting rooms if the trial in Sydney's Kings Cross, which is currently subject to a legal challenge, suggests that lives have been saved or could be saved?

Ms Kerr—I do not have the answer to that. That is a matter for the government. But the government position is that it does not support these trials and that this is primarily a matter for state governments.

Senator DENMAN—Thank you. That is all I have got. I have got a couple of other questions, but I will put them on notice because they are asking for statistics.

Senator GIBBS—I have a few. How many states and territories have implemented diversion programs under the national diversion scheme, which was announced in April 1999?

Ms Kerr—Currently four states have signed funding agreements with the Commonwealth.

Senator GIBBS—Which are those states?

Ms Kerr—Tasmania, New South Wales, Victoria and Western Australia.

Senator GIBBS—New South Wales, Victoria and South Australia—

Ms Kerr—Western Australia.

Senator GIBBS—Western Australia. Obviously agreements have been signed with those states?

Ms Kerr—Agreements have been signed with those states.

Senator GIBBS—So that leaves Queensland—

Ms Kerr—South Australia, ACT and the Northern Territory.

Senator GIBBS—And they have not—

Ms Kerr—They have not at this stage signed agreements but negotiations are very well advanced. We expect we should be in a position to get agreement very soon.

Senator GIBBS—So there are no problems with those states? They are definitely going to sign agreements?.

Ms Kerr—There is definitely a lot of goodwill in the negotiations to come to an agreement so they can be signed.

Senator GIBBS—Was there some time frame within which these agreements were to be agreed to, to come to some agreement?

Ms Kerr—We had left it fairly open. I must say we had anticipated we would have had them all signed up by now. But in the nature of Commonwealth-state issues, these things do take a little longer and we had to seek advice from a range of players.

Senator GIBBS—Were there any problems? For instance, did different states have various problems? Did they want to implement other things, not agree—

Ms Kerr—It varied considerably from state to state. That is one of the reasons it has taken so long in that we have accommodated the individual circumstances of individual jurisdictions.

Senator GIBBS—Thank you. Obviously we have talked about the differences between the states and territories in implementing these schemes. How will these programs be evaluated at a national level, bearing in mind that there are different workings in each state?

Ms Kerr—The Department of Finance and Administration received funding as part of this initiative to undertake the evaluation of the whole initiative, and we have been on a committee assisting the Department of Finance and Administration in setting up the arrangements for that evaluation.

Senator GIBBS—So you will obviously evaluate that state by state by different evaluations?

Ms Kerr—Yes, there will be individual evaluations in each jurisdiction as well as the department of finance will do an overarching evaluation.

Senator GIBBS—When will those evaluations be available?

Ms Kerr—Again, it will vary according to when the agreements were signed. We will be, of course, getting early information from each of the states as they sign up as to how many clients and so on have already gone through the program. So it will be a sequential arrangement. We will be getting information as the program rolls out as well as at the end of the funding period.

Senator GIBBS—And those evaluations will be made public?

Ms Kerr—Yes, I would expect so.

Senator GIBBS—How many states and territories have implemented programs under the supporting measures package of the COAG agreement on illicit drugs of April 1999?

Ms Kerr—There are a range of initiatives in the supporting programs, as you would be aware, that go across a number of portfolios. Off the top of my head I would not know exactly the answer to that question, but I know that supporting measures have been implemented across the board not only by us in our portfolio but by other portfolios. But that would be information I would need to collect from other agencies as well as our own department.

Senator GIBBS—So they have not reported to you yet; is that what you are saying?

Ms Kerr—We work closely with other departments so that we try to keep abreast of what they are doing in these supporting initiatives. Certainly the Department of Finance and Administration will be collecting information from all those portfolios on their supporting initiatives as part of their overarching evaluation. We are aware, but in answer strictly to your question I would need to collect that information.

Senator GIBBS—When will the National Illicit Drugs Campaign commence?

Ms Kerr—That is a decision for the government.

Senator GIBBS—There has obviously been a delay. You do not know?

Ms Kerr—We have previously said that we would expect it to be early in this year—

Senator GIBBS—Early this year?

Ms Kerr—and that is still my expectation.

Senator GIBBS—When do you think we and the population of Australia might find out when this happens—when they announce it, I suppose, whenever they feel like it. How and when are we going to know when this is going to start? Is there some time frame here?

Ms Kerr—I expect there will be an announcement made by the government.

Senator GIBBS—I do not suppose you know, Minister, when that will be?

Senator Vanstone—No. You are quite right; I do not.

Senator GIBBS—I am sure you will let us know.

Senator Vanstone—I think Minister Wooldridge will.

Senator GIBBS—When will the National Heroin Overdose Strategy, which the Ministerial Council on Drugs Strategy agreed in July 2000 would be developed as a matter of urgency, be made publicly available?

Ms Kerr—It will be publicly available as soon as the Ministerial Council on Drugs Strategy has signed off on it. They asked us to give it to them out of session and we expect that to go to them fairly shortly. So we will get agreement from all those Commonwealth and state ministers out of session. I would expect that would then be available before their next scheduled meeting in the middle of the year.

Senator GIBBS—Great. When will the national alcohol action plan and the national illicit drugs action plan, which were first mentioned in the November 1998 National Drug Strategy framework, be made publicly available?

Ms Kerr—They are in the same category. Again, we are working on them now. We expect they will go to ministers out of session to sign off on before their next scheduled meeting. However, ministers did retain the right at the meeting if any one of them wished to delay consideration of it until they had a face-to-face meeting. They recorded that that was their right. So we will give it to them out of session, we expect, but it will be their decision as to whether they wish to actually discuss it at a meeting or agree to both those national action plans out of session.

Senator GIBBS—So that could be in the next couple of months?

Ms Kerr—Yes.

Senator GIBBS—How often do they have their scheduled meetings?

Ms Kerr—They meet once a year generally.

Senator GIBBS—In January?

Ms Kerr—Generally. I would expect the next meeting would be either June or July, but the actual meeting date has not been firmed yet.

Senator DENMAN—I have another question which I overlooked. You will have seen the publicity recently about the injecting use of Temazepam and Normison in gel form. Is that being monitored? Is there any move to make sure those products are in tablet form? I think it is the gel form that is causing problems. People are injecting it and becoming gangrenous or having limbs amputated.

Ms Kerr—That would be a question better directed at the officers in outcome 2.

Senator DENMAN—Thank you.

Senator CHRIS EVANS—I want to ask about the funding issues and my fascination with reverse rephasing. Can someone explain to me what is going on with the methadone funding? It is detailed on page 31 of the additional estimates statement. Can someone take me through what is happening?

Mr Corcoran—The methadone funding program has been put on hold while we wait for further information. That has been a continual rephasing until such time as the government makes a firm decision as to whether it wants to proceed with that program or not.

Senator CHRIS EVANS—What does 'put on hold' mean? You are not funding any methadone at the moment?

Mr Corcoran—As a result of the national illicit drug campaign and diversion strategy, there is a whole new wave of over $300 million of treatment programs. Methadone is a very substantial proportion of that. So there is considerable methadone treatment provision already being made.

Senator CHRIS EVANS—I am not quite sure I understand. Why is the $13.9 million rephasing of methadone funding occurring? Is that money you thought you were going to spend but you are not now going to spend?

Mr Corcoran—The provision of methadone is actually provided under the PBS and through the MBS. This was money to perhaps do that in an alternative way through centralised clinics, but issues of national access and national distribution suggested that may not be the way we proceed.

Senator CHRIS EVANS—So there was a proposition to provide methadone to centralised clinics. Did we allocate $13.9 million to fund that in the 1999-2000 budget or the 2000-01 budget?

Mr Corcoran—It actually goes back a budget or two before that. It was a complex arrangement of perhaps swapping private expenditures for a public clinic program but, as I say, that approach is under review.

Senator CHRIS EVANS—You tell me it goes back at least two budgets. Do you have the exact year that was originally funded?

Mr Corcoran—I think the initial idea was promulgated in the 1997 budget.

Senator CHRIS EVANS—And this money is all from that budget just carried forward?

Mr Corcoran—There has been some money annually carried forward.

Senator CHRIS EVANS—In relation to the $13.9 million, is that all from 1997? Where did the $13.9 million come from?

Mr Corcoran—That money has been allocated on an annual basis. So this would be the carryover from last year.

Senator CHRIS EVANS—Have you spent any of the moneys allocated in the previous budgets on that program?

Mr Corcoran—No, we have not on the methadone program because the private expenditures still continue.

Senator CHRIS EVANS—Yes. Are you telling me that that $13.9 million figure is an annual figure, or is that the sum of the previous three budgets carried forward?

Mr Corcoran—No, that is more an annual figure.

Senator CHRIS EVANS—So you have had about $13 million each year allocated for this program since 1997 but none of it has ever been spent. Is that right?

Mr Corcoran—That is right, because the private expenditures still continue.

Senator CHRIS EVANS—That raises the question: why do we allocate it every year then?

Mr Corcoran—That has been an arrangement of the government.

Senator CHRIS EVANS—So every year we allocate $13 million or so for a methadone program we have no intention of funding?

Mr Corcoran—I want to stress that we are still funding methadone treatment services.

Senator CHRIS EVANS—I accept that. I am really trying to get at this budget item and understand why you have not decided to proceed with the program yet keep allocating money for it since 1997. It gives the impression that we are going to spend $13.9 million a year on a centralised clinic methadone program and we are not, and we have not every year since 1997 apparently. Why not? Why do we keep allocating it if we are not going to do it?

Mr Corcoran—We have been continuing with NDARC costing studies and we have been conducting a trial in South Australia to look at the efficacy of the new arrangements. Until such time as the government has decided one way or the other, it has continued to have that line item in the budget.

Senator CHRIS EVANS—In relation to the trial in South Australia, is that funded out of that budget item?

Mr Corcoran—Yes, it has been.

Senator CHRIS EVANS—What is the expenditure?

Mr Corcoran—It is a very small amount of money. It is more in the amount of administrative funds. It is only $140,000.

Senator CHRIS EVANS—Is that an annual figure? Has this been recurring?

Mr Corcoran—No, that was a one-off expenditure. That was just to provide for the administration of the trial.

Senator CHRIS EVANS—So is that all you have spent out of this program since 1997?

Mr Corcoran—We also paid for the NDARC costing study, but again that was a very small amount.

Senator CHRIS EVANS—You paid for what? Sorry, I did not quite hear you.

Mr Corcoran—The NDARC costing study, which again looked at the per capita cost of a centralised clinic versus individual treatment.

Senator CHRIS EVANS—Has that study been completed?

Mr Corcoran—Not yet.

Senator CHRIS EVANS—How much has that cost you?

Mr Corcoran—I do not have that figure, Senator. It is a relatively small amount.

Senator CHRIS EVANS—Is that done within departmental resources as a consultancy? Is the costing study done internally?

Mr Corcoran—The moneys go into the National Drug and Alcohol Research Centre. So it is out of this money. We are not doing it internally.

Senator CHRIS EVANS—Returning to the funding for the methadone program, could someone give me the figures for each budget from 1997 onwards? Does someone have those handy?

Dr Wooding—We do not have those with us. We will give them to you on notice.

Senator CHRIS EVANS—I appreciate that. Can someone give me a rough idea then? Has it been around $12 million or $13 million each year? I am not going to hold you to it; I am just trying to get a feel for it.

Mr Podger—I think you are asking a question about the spending through the MBS and PBS arrangements in this area.

Senator CHRIS EVANS—No, I am talking about this centralised clinic proposition.

Dr Wooding—I think it has been in the order of that, but we would have to look at the exact figures. It may be more in some years.

Senator CHRIS EVANS—So what has happened each year to that money?

Mr Podger—Effectively, that money has not been spent. What has happened is that we have continued to spend money through MBS and PBS, which are both of course special appropriations in this field. That program has not switched from a private program to a publicly—

Senator CHRIS EVANS—I accept that, and Mr Corcoran made that clear. I think that is established. In Appropriation Bill (No. 4) you have got an appropriation each year—I will check the figures—of the order of $13 million for this centralised clinic program. I am told it has not happened and the only expenditures have been small amounts on trials, et cetera. What has happened each year to the $13 million? Has that gone back into the drug strategy or is it carried over?

Mr Wooding—We will take it on notice. I think in the first year or two it may have been returned to the budget bottom line. Last year's has been rolled over and has been rephased into this year and will be used for the purposes described in AEs. But we will give you an answer on notice for all of that.

Senator CHRIS EVANS—What happened to the money in the 1999-2000 budget?

Dr Wooding—It was rephased into 2000-01 as the $13 million as described there.

Senator CHRIS EVANS—How much was allocated in the 2000-01 budget?

Dr Wooding—I believe about $18 million.

Senator CHRIS EVANS—So you have a total of about $32 million or so allocated for that program in a sense?

Dr Wooding—The $13 million is being used for the other purposes described—the related purposes. I do not have the document in front of me that actually tells you that they are being used for international drug strategy initiatives. So that money is not being used for methadone as such.

Senator CHRIS EVANS—So the money from last year is being used, you say, for international drug strategy—

Dr Wooding—No, for the national drug strategy.

Senator CHRIS EVANS—So what does that mean? That $13 million has been transferred from where it was allocated?

Dr Wooding—It has been redirected to the non-government organisations treatment of grants program and the illicit drug diversion initiative.

Senator CHRIS EVANS—What about the $18 million from this years budget?

Dr Wooding—I do not think we are in a position—

Mr Corcoran—It has not been allocated yet.

Senator CHRIS EVANS—But you are fairly clear it is not going to be spent in this financial year on the methadone clinic program?

Mr Corcoran—It is unlikely.

Senator CHRIS EVANS—So the $3 million you transferred to the national drug strategy have added to the funds you would have allocated under those initiatives?

Dr Wooding—The money is appropriated under outcome 1, which is the population health and safety outcome. It is part of the overall funding for that outcome.

Senator CHRIS EVANS—What I am saying is: is there a net increase in the programs you describe the money being diverted to or has that money been used to fund what was already allocated?

Mr Corcoran—No. There has been a net increase in the funds available under program 1 with a one-line appropriation.

Senator CHRIS EVANS—That is not the question I am asking, I suppose. Dr Wooding described two programs to which the money had been diverted. I am asking whether that resulted in a net increase in those moneys available to those programs or not?

Mr Corcoran—We have undertaken to come back to you with the information. I do not think the funds have all gone into drugs. It has been across a range of issues in program 1 under the one-line appropriation.

Senator CHRIS EVANS—I would appreciate it if you could give me a breakdown of where that $13 million has been allocated and to what programs. Could you do that for the budgets from 1997 onwards, too? I would be interested to trace what has happened to that money. I gather, Mr Corcoran, that you say it is unlikely that it will be spent on this methadone clinic program this financial year, either. Where are we at with a decision on this issue?

Mr Corcoran—It is under consideration at the present time.

Senator CHRIS EVANS—Consideration by whom?

Mr Corcoran—By the government.

Senator CHRIS EVANS—So it is with the minister for decision? I am not trying to be clever; I am just trying to work out where the process is at. It is with the minister in the sense that he has to make a decision about whether we go ahead or not?

Mr Corcoran—It is in the government's decision making arena at the present time.

Dr Wooding—Under these outcome funding arrangements there is an opportunity for money to be redirected within the same outcome.

Senator CHRIS EVANS—I appreciate that, but I would have thought that if you had been funding a program since 1997 you would have made up your mind by now whether or not you are going to spend it on that. That is all. I am just interested to know when we are going to make that decision, who is going to make that decision and when we will know about it. That seems to be a reasonable question. I do not know that 'it is within the realm of government decision making' is a terribly helpful answer. I suspect I would have got that answer any time from 1997 onwards. Without being rude, where are we at with this?

Mr Corcoran—I have given you all the information I can. It is with ministers.

Senator CHRIS EVANS—So basically the methadone program since 1997 has been unchanged in the sense that it is funded through the PBS and this initiative has not gotten off the ground. So there has been no change: is that a fair summary?

Mr Corcoran—With the exception that with the flow of funds under the National Illicit Drug Strategy, there has been a substantial increase in funding for methadone programs. There already were some—I am retracting that statement. I will refer to Ms Kerr.

Ms Kerr—This issue about methadone is only about the possible restructuring of funding of private methadone services. So it does not impact generally on the methadone funding that is provided to the states.

Senator CHRIS EVANS—Perhaps you could give me a couple of minutes on what the structure for funding for methadone is and how that has changed in the last couple of years. I am just trying to get a feel for this. You are obviously saying it is funded through the PBS.

Ms Kerr—I think the easiest way is just to describe what this measure was about. It was about looking at possibly funding methadone services as part of the public health outcome funding arrangements—the PHOFAs. So instead of funding through Medicare for private methadone services in Australia, the funding would go to the states as an annualised allocation per private patient and then the states would handle the money that they would otherwise have got through the Commonwealth, and that would cover consultations and urinalysis relating to methadone patients. So it was a different way of providing the funding to the states. The reason for the costing study was to work out what would be the level of that funding, because it was always an estimate as to what that value would be. That is why it has been very time consuming and very difficult to do. A trial was undertaken in South Australia and in addition the National Alcohol Drug and Research Centre asked to do a costing study. So those issues have been quite complex.

Senator CHRIS EVANS—In relation to the $14 million or so, what are those figures based on? Are they rough guesstimates as to what it would cost to fund the states directly?

Mr Corcoran—They were extremely rough estimates.

Senator CHRIS EVANS—So why was it $13 million last year and $18 million this year?

Mr Corcoran—The $13 million is the rollover from last year of funds not spent.

Senator CHRIS EVANS—But you told me you only spent $140,000 last year, didn't you?

Mr Corcoran—We spent only $140,000 out of the methadone money on methadone. But as Dr Wooding has already described, it does go into a one-line appropriation and the minister has the authority to spend that one-line appropriation as he sees fit.

Senator CHRIS EVANS—I am not disputing that; I am just trying to get a feel for what we spent on methadone. I thought from the evidence you gave me that of the $13 million or so allocated in the budget last year you only spent $140,000 on a related project. Is that not right, or is that right?

Mr Corcoran—That is correct.

Senator CHRIS EVANS—So why did you think you were going to spend $13 million last year and then think that you were going to spend $18 million this year? That is what I am trying to understand.

Mr Corcoran—The issue has been a complex one. The decision making on it and the gathering of information have been very slow. There had been a range of other developments in states that run methadone clinics. For example, Victoria and New South Wales have put substantial additional sums in. So it has been a changing environment in which to make decisions and ahead of that decision the funds have stayed in the one-line appropriation.

Senator CHRIS EVANS—Ms Kerr, you have explained what the proposal was for. Can you just explain to me what else the Commonwealth spends on methadone—how else you fund it?

Ms Kerr—I think it might be best if that is answered as part of this question on notice that sets up the detail of the figures. I do not have those at my fingertips.

Senator CHRIS EVANS—I am not so much interested in the money; I am interested in the overview of how the Commonwealth funds methadone programs. I have heard you saying to me that this is about an initiative that was to replace the current system. I am trying to understand how the current system works.

Ms Kerr—At the moment, methadone services for private methadone patients are funded through Medicare, and that is the consultations and the urine analysis. This proposal was about stopping doing that and instead funding the states—once we knew what the per capita amount for patients would be—on an annualised allocation per private patient. Then Medicare benefits would no longer be available. So that was what the proposal was about.

Senator CHRIS EVANS—Do you have any figures or an understanding of how much it costs through the Medicare program currently?

Ms Kerr—Those are the sorts of issues that have had to be looked at essentially in the costing study and in the trials.

Senator CHRIS EVANS—So have you got a handle on that or not?

Ms Kerr—We are still waiting for that input.

Senator CHRIS EVANS—So do you not know how much methadone programs cost you through Medicare?

Ms Kerr—I will know a lot more about that, I think, once we see the results of the National Drug and Alcohol Research Centre work.

Senator CHRIS EVANS—But there is no way of currently assessing how much it costs you; is that what you are telling me?

Ms Kerr—The original budget figures a couple of years ago were an estimate and this whole process has been to get a better handle on what the actual cost is.

Mr Podger—I think in terms that this is a question we have taken on notice, we will provide some estimates of what is being spent on MBS and PBS. We are able to estimate that. Whether we can give a very precise answer, yes—

Senator CHRIS EVANS—That is what I am trying get at. Basically, you do not know. You cannot hit a button and pull out how much methadone related Medicare claims cost you, basically, at the moment?

Mr Podger—You can get an estimate. You can certainly get a figure from the PBS, but the MBS figure would be more of an estimate.

Senator CHRIS EVANS—And do you know what the PBS figure is?

Mr Podger—No, I have not got those yet. I think that we have taken it on notice that we will provide you some material around that.

Senator CHRIS EVANS—All right.

Mr Podger—When this proposal was put forward and was mentioned in the budget—and I cannot remember exactly which budget—it was presented as a transfer across from the MBS, PBS, and there were some estimates at that time.

Senator CHRIS EVANS—I assume, though, that where you have got an appropriation under Appropriation Bill (No. 4) there would also be a savings measure under another measure. Is that not wrong?

Mr Podger—There will be an offset, but it is a special appropriation. It will not appear in the bills because it is a special appropriation.

Senator CHRIS EVANS—So what offsets have you calculated for this financial year from Medicare for this measure?

Mr Podger—I suspect we do not have a current year estimate of that. That is not what we would have had at the time of the measure. There would have been estimates, including through to the forward estimates, of both the cost to the population health program and the savings to the Medicare program.

Senator CHRIS EVANS—But I think that it is fair to assume that there have been no savings on the Medicare program in these four budgets because the measure has not gone ahead; is that fair?

Mr Podger—I assume that is correct, but again when we come to those details we can confirm that.

Senator CHRIS EVANS—All right. I appreciate your giving me what you could on that because I am just trying to get my head around what has happened there. Can someone tell me what has happened with the 'COAG Illicit Drug Diversion Package'—the next item on page 31?

Mr Corcoran—You are looking under Appropriation Bill (No. 4)?

Senator CHRIS EVANS—Yes.

Mr Corcoran—As that notes, because of delays in reaching agreement with all the states in the last financial year—there were four of them that were still to be signed up, as Ms Kerr said before—there are small amounts of money which were not spent last year also on the supporting measures such as hep C education. So there is $740,000 which was not spent in two states—or one state and one territory—last year under those supporting programs.

Senator CHRIS EVANS—So what? That has been carried over?

Mr Corcoran—Yes, so it is not lost. It can be spent. You can give it to them to be spent this year.

Senator CHRIS EVANS—So what does the $4.8 million reversal of rephasing money consist of?

Mr Corcoran—That was money which we, as Dr Wooding said before, expected not to spend last year. Ultimately, it was spent. So we had expected not to spend it. We had it rolled over. It was then spent. So that has been a reversal of that entry.

Senator CHRIS EVANS—I think I have finally got my head around it, but what was the $4.8 million for?

Dr Wooding—I can answer that. The $4.8 million and the $9 million under bill No. 3, basically, are the money that was used to pay for the research Bio 21 initiative, which is in the list of measures under outcome 1. Where we have said we have absorbed it with existing funding, that is more or less—it is a little bit more complicated than that, but in the broad that is the existing funding in which that measure has been absorbed.

Senator CHRIS EVANS—So, basically, the money you thought you were going to save you spent on the Bio 21 technology project last year?

Dr Wooding—That is correct.

Senator CHRIS EVANS—So that was what—$15 million?

Dr Wooding—That is correct.

Senator CHRIS EVANS—So that all came out of last year's budget?

Dr Wooding—I think it is a little bit more complicated than that.

Senator CHRIS EVANS—It always is, Dr Wooding.

Dr Wooding—Because there is a certain amount of activity over all the different years, but I think in the broad that is how the money was found.

Mr Podger—As a challenge in terms of this new outcome basis of appropriations, it is designed to give the government more flexibility within an outcome structure. How we report within that, some rejigging of spending becomes a little bit complicated.

Senator CHRIS EVANS—It is a challenge that I am obviously failing, Mr Podger.

Mr Podger—Our presentation is a challenge, which we are obviously not getting right.

Senator CHRIS EVANS—No, no. I was going to ask you about Bio 21 and I finally got to where the money came from to pay for it. So I feel like I am making progress. Basically, the $15 million—give or take—which you used to fund Bio 21 came out of the reverse rephasing moneys reflected in the additional estimates; is that a fair, rough summary?

Dr Wooding—I think in the broad—

Senator CHRIS EVANS—Okay. Is that because you had not allocated funds for Bio 21 originally in the budget?

Dr Wooding—That is correct.

Senator CHRIS EVANS—So when did that initiative get approved?

Dr Wooding—We will have to wait for Mr Wells.

Mr Wells—The Bio 21 was the result of a submission. Bio 21 is a consortium of Victorian universities, research institutes and some private sector organisations which is designed to be one of these critical mass type research centres where you have a number of research institutes or research centres collaborating, and they also have industry involved in the research, to get from the basic research through to the possible industrial applications.

It is a local Victorian initiative. A proposal came to the government. I think it would have been—I would have to check the dates—probably around early 2000 or late 1999; I can't remember exactly. It had the support of the Victorian government. Subsequently, the Victorian government contributed, I think, of the order of $15 million. It could have been more and, again, I would have to check the figures on that. The Commonwealth government decided to support it as well, and that is where the $15 million came up. So it is a matter that arose after the budget for the year in question, and the government decided to support it on its merits.

Senator CHRIS EVANS—So how do you do that? What assessment took place, or is there a budget that these sorts of things are normally funded from?

Mr Wells—No. That is why it had to be funded from a redirection of existing funds.

Senator CHRIS EVANS—How did the Commonwealth provide the assessment or decide to fund this particular project? No doubt you have people knocking on your door all the time with brilliant ideas; they just need $15 million to get started. How did you make this assessment? What was the process?

Mr Wells—There is no standard funding package for this sort of initiative, so there is not a process that you can simply refer it to. This was a measure that had considerable support from the University of Melbourne, Monash University, Walter and Eliza Hall Institute, AMRAD, which is the private sector linkage, plus others; so it had considerable, if you like, academic and scientific support behind it from institutions which receive considerable funding, for example, through the National Health & Medical Research Council in the normal peer reviewed research processes. It had the strong support of the Victorian government—the Victorian government both then and now—and it was consistent with the sort of development that was outlined in the Wills review of health and medical research, that Australia should try to develop these so-called critical mass centres of research with links to industry. So it met all those sorts of criteria, and it did have, as I said, actual considerable funding support from Victoria. On that basis the government decided to support it.

Senator CHRIS EVANS—What are you actually paying for?

Mr Wells—Some of the funds will go for capital developments. For example, Monash is aggregating some of its activities in a Monash Institute of Health facility. Some of it will go for recurrent type expenditure—for example, recruiting staff or whatever. But it was a one-off grant, so most of our funds would in fact go for capital developments associated with the project.

Senator CHRIS EVANS—So there have been no performance criteria set against the money.

Mr Wells—The grants went to Monash University and Melbourne University. There are specific requirements in their contracts, but they are of a nature of completing a building or a facility rather than performance against research criteria.

Senator CHRIS EVANS—How much did each university get?

Mr Wells—Could I take that on notice? I do not have the break-up with me.

Senator CHRIS EVANS—Okay. Thanks for that.

Senator GIBBS—I have a few HIV questions. The HIV-AIDS awareness program in the past was extremely successful, and we saw a significant fall, from a peak of 1,276 in 1990 to 663 in 1998, of people who were diagnosed with HIV-AIDS, which is extremely significant. Why has the government put at risk the past achievements in HIV-AIDS awareness and prevention by removing key conditions of HIV-AIDS funding that were previously in place? The two main ones are: firstly, that in providing funding, a condition that half the money be spent on HIV prevention/education programs; and, secondly, that the states match Commonwealth funding on a dollar for dollar basis.

Mr Sam—The relationship between the Commonwealth and the states in relation to the provision of prevention and education services is within the context of the PHOFA agreements.

Senator CHRIS EVANS—It is under item 5, questions on that.

Mr Sam—The relationship between the Commonwealth as the funder for these initiatives and the states and territories as providers of education prevention services is within the context of the public health outcomes funding agreements. Within these agreements, the Commonwealth specifies specific outcomes in terms of deliverables that will show interruption of transmission. The change was to provide for greater flexibility. So there is still a requirement for states to report to the Commonwealth on what has been achieved with the fundings directed through that process.

Senator GIBBS—In other words, the guidelines have totally changed. They do not have to spend a certain amount of money on education.

Mr Sam—There is an agreement through these funding agreements that the priorities and tasks as outlined in the fourth national strategy will be adhered to.

Senator GIBBS—Do you think that these agreements are working, and do you think it is wise to remove the strategies that were put in place before, because in the government's own national HIV-AIDS strategy publication of 1999, it is noted that approximately 5,700 Australians have died, and a further 16,700 are living with chronic HIV infection.

Mr Corcoran—There are two issues. One is that, as a result of extensive consultation, including with all the states and territories, there is now in place the fourth national HIV-AIDS strategy, to which everybody has signed up. Under the public health output funding agreements, while there is a broad banding, there is an overall maintenance of effort clause in there, and state and territory governments are very much in touch with their local communities in terms of their needs. So we have no reason to believe that there is any serious weakening of the HIV-AIDS effort.

Senator GIBBS—So you do not think these figures are serious?

Mr Corcoran—Of course they are serious.

Mr Podger—I think the issue is that there has not been a diminution of effort in this area. We have also set out in the annual report, on pages 49 and 50, substantial gains over the last few years arising out of the efforts in the HIV-AIDS area, but there is a new stage of agreement with the states to take those efforts further.

Senator GIBBS—Thank you, Mr Podger. Do you think that the battle with AIDS is acceptable? Are we getting somewhere? When the program started it was extremely successful and it was reducing the numbers of infections through the use of condoms, education and so on. Are we still proceeding down the track of limiting infections? Are they becoming less and less and might we eventually be able to totally eliminate it from Australian society?

Mr Podger—I do not think it would be right for me to give a general opinion.

Senator GIBBS—Okay. But what about from the data that you are collecting?

Mr Podger—From the data we are collecting there has been over the last 10 years a very substantial improvement. The number, for example, of HIV diagnoses has declined from a peak of 2,500 to about 679 in the last full year of calculation. Having said that, the issue is not one which we are then saying is over. It is not over. There are still issues, including things such as safe sexual practices by people, that are of continuing concern.

Senator GIBBS—There were views expressed by the Queensland AIDS Council that the 'internationally recognised success of the Australian partnership between government and non-government organisations and those directly affected may be jeopardised by a growing complacency'. Would you agree with those comments? These are also expressed by community groups. This is what people are saying.

Mr Corcoran—Certainly the community groups who are responsible for delivery of the education programs are aware that from time to time issues of complacency can emerge. But overall we continue to maintain this as a notifiable disease. We continue the research. We continue the education programs. We have a new strategy. We have the Australian National AIDS Committee, which brings together all the players to talk on a continual basis to the Commonwealth government. What the Queensland AIDS Council is expressing is the need for continual vigilance in the area.

Senator GIBBS—That is right. What measures can the department and the government implement to reverse this worrying trend?

Mr Corcoran—There is no reversal of a worrying trend. But the community groups who deliver the direct education programs are saying that they need to revise their methodologies. It is no different as in the tobacco arena, where a message becomes tired or is not appropriate for a new generation of people who were not in the risk group at the time the AIDS epidemic emerged. So it is a question of refreshing people's memories and adopting new education approaches. That is why the money is with the community groups who are best placed to do that.

Senator GIBBS—Maybe we should have a resurgence of the program that we had before. Is it not true that AIDS is also now becoming a worry not only with the homosexual community but also with the heterosexual community? It is passing over. It is quite a public health risk.

Mr Corcoran—We have an ongoing program of social research around the AIDS issue. The research is not just in the virology area, it is also in the social area. That research program continues.

Senator DENMAN—I have a question on FIT packs. Is this the place to ask it? FIT packs are the things they dispose their needles in—that is, users put their needles in them. There is a GST on those. This is a health issue and a community issue. Do you know why there is a GST on the FIT packs?

Mr Corcoran—I imagine that the government has looked at all these issues and—

Senator DENMAN—But it is a health issue. There was not a GST on health issues.

Mr Corcoran—I am not aware that this has been brought to the government's attention.

Senator DENMAN—Thank you.

Senator HARRADINE—I want to ask a question about the *Rocking the cradle* report. I have asked questions on notice on that previously. The government and the department responded and, of course, has tabled a response to that report. There have been recent reviews of state legislation under the Commonwealth's competition policy review. What has been the outcome of those reviews? Perhaps I could elaborate. As you would know, the Australian Association of Midwives Inc. has been making representations about that. It gave good evidence to the committee, as you know, Madam Chair. Medicare funding and the arrangements for in-patient hospital care actually exclude midwives from acting as providers of primary maternity care. It excludes recognition of them under Medicare funding. What I am asking really is: why is the department continuing not to recognise the work of midwives and not to recognise the fact that many, many women prefer midwives to a doctor? Perhaps the department could take it on notice.

Senator Vanstone—I have a niece who is a midwife. I will be very interested in that answer.

Senator HARRADINE—Thank you.

Mr Podger—I am sorry. This issue, I think, goes to our rules around the medical benefits scheme. Of course, for those who are in public hospitals it is a matter for the state arrangements. But as you say, particularly for those who go to private hospitals we pay the medical benefits. The medical benefits are restricted to payment to doctors rather than to allied professionals. That is the design of the medical benefits scheme. Can I take it on notice? I am not quite sure whether I can answer anything more than that at the moment. But I am not aware of the competition issues you have raised. I would have to follow that up to see whether there has been any action on that side.

Senator HARRADINE—Also, could the department follow up the clear desire and preference of many women for a midwife as opposed to a doctor? That is so in a number of country areas, too—since country areas are the topic of the day.

Mr Corcoran—Under the budget last year there was a very considerable allocation under the rural health initiative for allied health professionals. That money was not explicitly allocated for midwives, but it was allocated for decision in local areas as to what their priorities were but, by and large, as the government's response to the *Rocking the cradle* report noted, most of these areas of activity were those directly funded by state governments.

Senator HARRADINE—Could you take on notice that question?

Mr Podger—I will take that on notice, Senator. I suspect that my answer is a broadly correct one; that is, that this is related to the rules around the medical benefits scheme which restricts benefits to services provided by doctors. On the issue of midwives, there are a

number of professional health workers who are not doctors who are not provided with access direct to medical—

Senator HARRADINE—But it is a closed shop, isn't it? The medical profession is a closed shop and the rules in respect of Medicare are binding you to the views of that closed shop. The question of clinical relevance there—

Mr Podger—I think it is not as simple as that. The design of the MBS has always been around services provided by doctors' medical services. It has always been an issue whether there are other ways to fund particular parts of the health system, including work done by allied health professionals, but it has always been a government policy from the beginning—not just this government, the previous government—that the MBS is essentially a program of reimbursing patients for medical services performed by doctors.

Senator HARRADINE—Could I remind you of the questions that I asked the department relating to the abortion of that child with suspected dwarfism.

Mr Podger—Sorry, I am not understanding what the question is.

Senator HARRADINE—Your response to that question was that Medicare payments would be available provided it was a clinically relevant procedure, or words to that effect. I think it is important to get the actual words. I cannot quite pick up the actual wording, but what is the basis for Medicare payments?

Mr Podger—Well, Medicare in broad consists of the MBS, the PBS and now payments to the states for public hospitals. MBS generally is a scheme for reimbursing patients for particular medical costs relating to services provided by doctors. In the case of obstetrics, the majority of women who are giving birth do so in public hospitals. That is handled through the state public hospital arrangements funded by the Commonwealth. In the case of those who go to private hospitals, the Commonwealth provides some support by way of medical benefits scheme arrangements. It also provides support indirectly through the 30 per cent rebate, but the move to change the MBS to being a broader program to reimburse people for a range of other entirely important and legitimate health services would be a very expensive way to go about it.

Senator HARRADINE—The question is: would the same fee be charged by a midwife as compared with a doctor? What if it was lower than a doctor? Under the competition area—the government is keen on competition policy—surely the midwife's account would be less than a doctor's and, if that was so, then why not pay the midwife under Medicare? I raised that question of competition in the question that I asked.

Mr Podger—Senator, I—

Senator HARRADINE—Or is it a closed shop?

Mr Podger—I do not believe that to describe it as a closed shop gives the correct situation. Such issues as this do arise from time to time in a range of areas. We get it, for example, in the area of nurse practitioners, we get it in the areas of other health professionals who, at the margin, may be able to provide an alternative to what the medical doctor does.

Senator WEST—I do not think that it is only at the margin, because there are some areas in the health services where, in the prime, other health professionals are able to deliver a more appropriate service than medical practitioners.

Mr Podger—I am sorry if you took offence. What I was trying to indicate was that these issues are not simple issues of alternatives where it would be easy to design the MBS to

handle things differently. The MBS has, from the beginning, been directed to reimbursing people for services provided by doctors.

Senator WEST—As far as the delivery of health services across the board goes, the fount of all knowledge does not rest in one profession.

Mr Podger—I do not believe I have given any such suggestion here.

Senator WEST—I am a bit sensitive. That is probably why Senator Harradine is better asking these questions and not me. Senator Harradine, I am sorry about that. My professional biases are showing.

Senator HARRADINE—I was going to say that your knowledge would be far more useful to the committee than mine, which is pretty—

Senator WEST—I am seen as being too biased, so please continue.

Mr Podger—Senator, I think I have got the question you asked on notice and our answer. You asked about how 'clinically relevant services' is defined and we answered:

> The legislation provides that Medicare rebates are payable in respect of clinically relevant professional services that are contained in the Medicare Benefits Schedule and performed by registered medical practitioners.

We go on a little bit further than that but that is the first sentence of our reply.

Senator HARRADINE—I understand the fact of what is happening, but my question to you is based on the competition policy of the government and, I might say, fairness as well.

Mr Podger—I understand the point you are raising. You are raising a policy issue, which is going beyond my capacity to answer. I am answering to you the way we are managing things at the moment and the legislative basis for that.

Senator HARRADINE—I understand that, but surely the department considers matters against the background of government policy in this broad area.

Mr Podger—Certainly we do, and we have discussions, for example, with the ACCC about issues on a regular basis also, including issues to do with the operations of the colleges and so on, and issues of the work force which the ACCC is interested in.

Senator HARRADINE—Will you discuss this matter with the ACCC?

Mr Podger—I cannot recall the specific issue coming up in our discussions with the ACCC, but we have had a range of other work force issues come up with the ACCC, yes.

Senator HARRADINE—Do you know what the ACCC's views are about competition in the health area, or is it a closed shop?

Mr Podger—Senator, it is not as simple as that because the ACCC is not a policy organisation; it operates within its arrangements under the Trade Practices Act. It talks to us about the action it is taking under that but it cannot, in doing so, contravene other pieces of legislation, but we do talk about the way we manage the legislation we have.

Senator HARRADINE—Yes. Well, when is your next meeting with them on that and would this matter be a subject item on the agenda?

Mr Podger—I guess after this discussion it may be on the agenda, but I had not expected it to be on the agenda. I am not too sure when our next meeting will be. We normally meet about every six months with the ACCC.

Senator HARRADINE—Going back to your definition and the answer that you gave me to question EO13 on the topic of clinically relevant services, I referred there to the question of the abortion of the baby with suspected dwarfism. I also raised the question of sex selection abortion. Now, in neither case did you respond directly and say, 'No. One is discrimination clear and simple and the other, of course, should in no way be supported.' You then defined 'clinically relevant services' as meaning 'a service rendered by a medical practitioner that is accepted in the medical profession as being necessary for the appropriate treatment of the patient to whom it is rendered'. If ever I have seen a closed shop, that is it. Ask somebody whether they want to be reimbursed for some services by the government and they will say yes. Here you are asking the doctors whether they agree to be paid or not. Is that not a very strange way of handling the very big budget in respect of this area?

Mr Podger—The medical benefits schedule is a very detailed schedule listing the items that we will reimburse and the payments we will make in reimbursement. That is a general bible, if you like, that we in the Health Insurance Commission use for making payments. When there is an issue to do with whether a particular service which appears to fit one of those items may not in fact be clinically appropriate, that is in the first instance an issue for the regulation of the medical profession by the state governments through their medical board arrangements and so on, and we abide very much by state law and state regulation arrangements on that. In certain cases the HIC will intervene because it believes there has been a series of practices by a doctor which has given rise to questions about their entitlement to MBS payments. In terms of a question of detail about whether something is clinically relevant, that may well involve an issue at state law and state regulation arrangements. I think we have discussed some of these issues before, particularly in the abortion area, about the way we operate.

Senator HARRADINE—You are talking about payment by the HIC for Medicare services. That is what I am talking about, too. These questions emerged from discussion about midwives and doctors performing a service. One gets the Medicare payment; the other does not. Here was another issue—that is what I am trying to get at—about what is appropriate and what is clinically relevant. Clinically relevant here says that it is performed by a registered medical practitioner. That is immediately a closed shop, isn't it?

Mr Podger—Under the law of the MBS we are required only to make payments in respect of services that are performed by registered medical practitioners. You may disagree with that, but that is the boundary for our operation. And then we go on there to say that a clinically relevant service means rendered by a medical practitioner. It is consistent with our law that we require that. We rely very much on the profession in determining what is acceptable services.

Senator HARRADINE—The AMA?

Mr Podger—No, the profession. Generally the royal colleges would be the—

Senator WEST—The midwives?

Mr Podger—I am sorry. We are talking about medical practitioners, Senator. The regulation of medical services is handled at the state level. Medical boards and so on—that paraphernalia of regulation of the medical profession—are managed at the state level.

Senator HARRADINE—I asked a question on notice about the abortion of a child—I think it was something like two weeks before the child was due—on the grounds of suspected dwarfism. In answer to that, and also in answer to the sex selection matter, you say that the department states that Medicare benefits are only payable for clinically relevant services. I was asking about what was meant by clinically relevant services, and you say 'those that are

generally accepted in the medical profession as being necessary for the appropriate treatment of a patient'. The medical profession. That is why I am talking about a closed shop. What does it take? Is it a vote of the AMA? How do you determine what procedures are generally accepted in the medical profession?

Senator Vanstone—Would it be of help if I take the questions that you have asked, put them on notice and ask Dr Wooldridge to respond? The reason I suggest that is that I think it is very difficult for public servants sometimes to respond to these sorts of issues, which are of a nature often considered sensitive. Dr Wooldridge is the minister. If you would be happy with that, I would be happy to do that.

Senator HARRADINE—I am happy, if it is okay by other members of the committee. I refer to question EOO9. The TGA referred to the 12 reports of fatal outcomes as a result of the use of methatrexate as reported to the Adverse Drug Reactions Advisory Committee. Were these in relation to its use in pregnancy termination or for other purposes?

Dr McEwen—My understanding is that no report that we have had of the use of methatrexate has involved the termination of pregnancy.

Senator HARRADINE—Methatrexate is an off-label application, is it not, in the latter case?

Mr Slater—For procuring an abortion?

Senator HARRADINE—Yes.

Mr Slater—The answer to that is yes, it is off label.

Senator HARRADINE—Could you provide the committee with what were the uses of methatrexate which involved a fatal outcome? What were they used for?

Dr McEwen—Yes, we can provide that. Could I just say that we are again reviewing our reporting on methatrexate, so that if there has very recently been a report, we will of course inform you of that—in relation to termination of pregnancy. But our understanding this morning was that there had not been.

Senator HARRADINE—What is the status of the application to the TGA for approval of a new morning-after pill, the Postinor 2?

Mr Slater—The TGA, for commercial-in-confidence reasons, normally would not disclose whether it received an application or not.

Senator HARRADINE—Why?

Mr Slater—For commercial-in-confidence reasons. It may mean another company which was wanting to put in an application may know the status of the fact that there was another application with the TGA already.

Senator HARRADINE—But in the public interest, aren't matters in these areas somewhat different from commercial-in-confidence matters that go to other areas, the engineering designs or whatever?

Mr Slater—It has been established practice that we do not reveal whether we have received an application or not. It is an important guarantee that the TGA provides to applicants, that their applications are made in confidence. That has been accepted practice over the years.

Senator HARRADINE—But in this respect: does the applicant want the pill to be sold over the counter? That is a very serious question.

Mr Slater—I am not in a position to answer that. What I can undertake to do for you is to seek information from any companies that you might be interested in pursuing on your behalf. If you think that there is an application around, I am happy to approach a company to ask whether they would be prepared to release any information about any potential applications or applications they may have with the TGA.

Senator HARRADINE—Does the TGA have a view about the over-the-counter sale of drugs of this nature?

Mr Slater—The role of the TGA, which you know very well, is to assess the safety, efficacy and quality of applications, and we do that applying our normal risk assessment processes. We do not have a view about individual applications other than their scientific and medical merit.

Senator HARRADINE—Could the TGA supply a copy of the patient information pamphlet which would be provided with such a drug? Doesn't the TGA have information that makes it aware of the ill-effects?

Mr Slater—If the TGA approves for marketing a particular medication, yes, we would make available product information and consumer medicines information that would contain any adverse concerns or contra indications that would come with that application.

Senator HARRADINE—Do you expect to receive from the applicant details of the ill-effects, which may indeed lead to effects such as nausea, vomiting, fatigue, headache, dizziness, breast tenderness, irregular bleeding, etc?

Mr Slater—The TGA, as part of its assessment of an application, goes into these matters in great detail, requiring of the company the results of all clinical trials that may have been undertaken in relation to the medicine which details adverse events. The TGA assesses these. It then places its assessment for scrutiny from the Australian Drug Evaluation Committee, which comprises the foremost clinical experts in Australia, for assessment of the TGA's thinking on this. So those matters are taken most seriously in the assessment of the application and whether a marketing approval decision is made.

Senator HARRADINE—How are the assessments made and -

Mr Slater—I will ask Dr Hunt, who is in charge of the Drug Safety Evaluation Branch, to take you through that.

Dr Hunt—When we receive an application, we do an initial filtering to see if the data is sufficient to enable an evaluation to proceed. Once it is established an evaluation can proceed, the application is accepted for evaluation. At this point, the data is divided into three main areas: data relating to chemistry and quality control; data relating to animal pharmacology and toxicology; and data relating to clinical use. Scientific evaluations are then performed on the data. These may be in-house or done externally by consultants with particular expertise in the area. The evaluation reports are checked by a senior officer, whether done in-house or externally, to see if they are adequate for our purposes, in that they have looked at all the data submitted and considered all the issues.

All the evaluation reports then come together for a senior medical officer within the clinical evaluation unit to prepare what we call an overview, which is a summary of the main issues raised by the evaluation reports. Edited copies of all the evaluation reports go to the sponsor companies, so if there are any errors of fact or omissions, the sponsor company can point them out. Copies of the overview, of the company's reaction to the overview and the evaluation reports and the full set of evaluation reports are then provided to the Australian

Drug Evaluation Committee. The Australian Drug Evaluation Committee considers this and provides advice to the delegates of the secretary in respect of whether they believe the application should be approved or rejected.

Senator HARRADINE—You mentioned animal experimentation. I suppose that was not the word you used, but they were going to be the guinea pigs. In this particular one, does that apply, or who are the guinea pigs in that sense?

Dr Hunt—With any application, without referring to a specific application, if it is an application for a new chemical entity or for a new extensive patient group that the drug hasn't previously been used in, there would be clinical data in the patient group in which it was intended to be used as well as supporting animal data. For a new chemical entity, you would expect significant data to have been generated in animals or in in vitro tests to elucidate the basic pharmacology and toxicology of the compound, and you would expect those studies to have commenced well before the clinical trial program.

Senator HARRADINE—Mr Slater, under the Therapeutic Goods Act 1989, the TGA can evaluate and assess products that 'influence, control or prevent conception'. Is it within the TGA's jurisdiction to approve drugs which operate as abortifacients?

Mr Slater—No. As a result of an amendment to the TGA Act that went through the Parliament in 1996, from memory those decisions about accepting an application for registration of an abortifacient rest with the minister—that amendment commonly known as the Harradine amendment.

Senator HARRADINE—Thank you for reminding me! How does Postinor 2 work?

Dr Hunt—Postinor 2, I understand, is a drug that is used as a morning-after pill, as a drug that essentially prevents implantation.

Senator HARRADINE—Pardon? That essentially—

Dr Hunt—I understand it prevents implantation.

Senator HARRADINE—Thank you for that. Could I go to another area altogether and it is to do with an answer that I received to question EO10 on the national sexual health strategy project. Who appointed the Sexual Health Reference Group? What were the criteria for membership of that group, or what are the criteria?

Senator CROWLEY—Can you just run that past me again? Mr Corcoran has got it, but I would like to get it, too.

Senator HARRADINE—Who appointed the Sexual Health Reference Group?

Mr Corcoran—The initiative was a decision of the national population health partnership, which represents all states and territory governments and the Commonwealth. Whilst it calls itself a national sexual health strategy project, it was really, if you like, a working group established under the partnership to examine the feasibility or the merits of having a separate national sexual health strategy. So the answer is that it was a range of nominations coming from state and territory governments plus the Commonwealth at the bureaucratic level, not at ministerial level.

Senator HARRADINE—Yes. What are the criteria for membership?

Mr Corcoran—By and large that group represented people who were well connected with communities who would be at risk of sexual health diseases.

Senator HARRADINE—Could I ask you directly then: why were only those known for their advocacy of abortion, involvement in abortion provision, selected for the group and not one person involved in 'advocacy—provision of other options'?

Mr Corcoran—I suspect the answer is that they were people who are most associated with areas of sexual health disease, or sexual health risk.

Senator HARRADINE—All of us are associated with that matter of policy, aren't we?

Mr Corcoran—Some are directly more at risk than others.

Senator HARRADINE—I do not think that is the question that I asked you. I am asking the question: who appointed the group?

Mr Corcoran—Again, it was a group—despite the title; it does not and never had a formal status such as we would have with, say, the national alcohol action plan, or the like. It was a group appointed by the national population health partnership and it was a working party to look at the issues of the prevalence of sexually transmitted diseases and the like to see whether there was a case to be made for a proposal to the government for a separate strategy.

Senator HARRADINE—You have not answered my question as to why there is not one person on that Sexual Health Reference Group involved in the advocacy of provision of other programs which attempt to address and which do address the areas for which this group are concerned.

Mr Corcoran—I do not wish to be difficult, but, as I say, it was a mutual decision of the state and territory governments plus the Commonwealth at bureaucratic level.

Senator HARRADINE—I am asking you. You are at the Commonwealth bureaucratic level. You did this on your bureaucratic own. Now tell me why.

Mr Corcoran—What I am saying was that it was a consensus decision and it looked at those areas where there were issues of most risk.

Mr Podger—I am not too sure we are going to be able to answer that further.

Senator HARRADINE—I intend to follow it up because this is clearly a view expressed bureaucratically by the department. Mr Corcoran has said so. No group or individual, no matter how expert in this particular area, will get a look in unless they are pro abortion. That is what you are saying.

Mr Podger—Sorry, I want to say I have heard the comments you have made. This has been a very low-level arrangement at this stage. If and when it gets to a point of putting proposals to the minister in this area, I am sure he will want to be assured of the breadth of input into such a strategy.

Senator HARRADINE—But you are starting off on the wrong foot, aren't you? This is the whole point. This group, apparently appointed by no-one, is going to be the group, the Sexual Health Reference Group, that is going to prepare a report for the minister.

Mr Podger—There may or may not be a report for the minister.

Senator HARRADINE—Could you provide the committee with material developed thus far by this group?

Mr Corcoran—I suspect the group was put together—drawn from existing groups who are working in the area. You may well have a point that it could have been broader in its composition. I do not think that there is any question that there is always scope for nominating or identifying alternative or broader approaches. What I can say is that I do not

believe that the project is going to go anywhere. Indeed, the consultant's report—it is a working party and the view of that group is, I think, that there is no compelling case for a separate proposal for a national sexual health strategy. So I do not believe that the interests that you are supporting have been harmed in this way because there are no—

Senator HARRADINE—Excuse me. You are suggesting that I am doing one thing. I am asking a question to you as a bureaucrat and you have admitted it is the bureaucracy's decision to exclude these people from the group.

Senator Vanstone—Senator, as you know, I am new to looking after these estimates, so I am not as familiar with these issues as I might be in other areas. I have not heard Mr Corcoran say that, and I wanted to raise this a few minutes ago when you said 'you have admitted as much'. I have not heard that. I do not believe the transcript will show that Mr Corcoran said that at all. So, while I appreciate the position you put, we all have to be very careful not to paraphrase what we believe someone is telling us as being the evidence. I think that is unfair to Mr Corcoran and to other people.

Senator HARRADINE—I accept that, Minister. I regret if there has been any inference, but I thought I heard Mr Corcoran say that this matter had been determined at bureaucratic level and that the Commonwealth was involved.

Mr Corcoran—That is correct, Senator.

Senator Vanstone—That is correct.

Senator HARRADINE—I then asked: since you are here, let's have the answer.

Mr Podger—A low level area of the bureaucracy in both the Commonwealth and state has suggested a group of people to help give them some guidance. You have suggested, as I understand it, that that particular group is a very biased group, or a biased group. That is an issue I will take on board and have a look at to make sure that we are careful around those. What we have said to you, however, is that, before anything would go to the minister for any proposals from there, I am sure he would insist on having a breadth of views contained within the material that comes forward. At this stage Mr Corcoran has also said that he does not believe that the material that has come forward so far is of a quality that ought to be going to the minister.

Senator HARRADINE—Who are the members of the national strategy's coordination working group?

Mr Corcoran—I am sorry: I do not have that list here with me, but we will certainly get that for you. I am certainly not trying to be unhelpful or disrespectful. What I am trying to say is that there was no decision to exclude any one particular group. I think the people who put the group together just built upon those people who work with existing Commonwealth funded initiatives in the area. So it really was not a full-blown broader strategic view. It was just to see how existing programs might be able to work more effectively. So it did have a significant focus, and that certainly was a limitation, but it was because they were not trying to create a new visionary strategy covering all aspects. They were simply looking at existing activities and whether they were working.

Senator HARRADINE—So, Mr Corcoran, you will provide the list of who is on both groups?

Mr Corcoran—You want the list of national—

Senator HARRADINE—Members of the Sexual Health Reference Group and the national strategy's coordination working group.

Mr Corcoran—Yes.

Senator HARRADINE—In respect of the answer you gave me to question EO10, as far as I can recall there was reference to the fact that the Sexual Health Reference Group would be giving advice and recommendations to a February 2001 meeting. I suspect that refers to the working group. Would you provide the committee with a copy of that advice and those recommendations?

Mr Corcoran—Yes. I think it is more likely to be in the nature of an oral report by the strategy's coordination working group. We are meeting in Hobart at the end of this month. I shall certainly make sure you get a copy of the considerations.

Senator HARRADINE—Thank you.

Senator CROWLEY—I will start by asking about funding for the Aboriginal health centre alternative birthing at Moree. It is the Moree community midwifery service, Aboriginal maternity services in the New England area.

Ms Blazow—I am not aware of that individual service, but the nature of your question depends on whether it is a service funded by the state government through the public health outcome of funding agreements under the alternative birthing component or whether it is an Aboriginal service funded direct by the Commonwealth through the Office of Aboriginal and Torres Strait Islander Health.

Senator CROWLEY—It is the former. My question is only to put some discussion into the air about how the Commonwealth, which provides money to the states under the public health agreements, satisfies itself that that money is being appropriately spent. I wrote and asked a number of people and I am very interested in the answers I got about whether or not there could be funding. Somebody wrote to me and said, 'We are desperately short of money. We were funded under the Commonwealth alternative birthing program. That money is about to run out. What do we do next, because we have already shown that Aboriginal antenatal care is making a difference in terms of better outcomes for mother and baby.' Good service. You would tick off on it. You would like it to continue. I got a number of letters, and I am just interested in how I make sense of the Commonwealth's interest in this area, when all the letters from the Commonwealth level say, 'There's nothing we can do about it—not our responsibility. We give the money to the states and then we wash our hands of it.' I really want to explore this.

I wrote to Minister Herron to get clear that it was not part of Aboriginal health and that he as the Aboriginal minister had no say. He pointed out that it was a mainstream health service, and that is fine. I got a letter from Grant Tambling, on behalf of the minister, pointing out that it was originally funded as an alternative birthing service initiative. It states:

> Alternative birthing services are funded through the Department of Health and Aged Care's public health outcome funding agreement with New South Wales. The current PHOFA broadbanded funding provides New South Wales with approximately $200 million over the period of the agreement (1999-2000 to 2003-04) to provide a range of population health programs. I understand since you've started writing letters, Senator, that the New South Wales health department has come to the party and funding is continuing.

I got a letter from Dr Lisa Studdert, who said, 'Unfortunately, there is nothing we can do about this situation. Positions in New South Wales public hospitals are funded by the New

South Wales government with contributions.' My question is: how do you satisfy yourself that Commonwealth dollars, 200 million of them, are actually being spent on national health outcomes in this area, seeing none of you apparently could tell me that it had anything to do with you?

Mr Corcoran—There is a joint parliamentary committee report—I think in 1996—which recommended, in relation to the administration of special purpose payments, that the Commonwealth get out of the detailed administration of these programs, go back to a strategic overview oversight which concentrated on statewide outcomes and leave the states themselves to be responsible for the administration of those programs. So we receive information on outcomes from states at the statewide level.

Senator CROWLEY—How often, Mr Corcoran? How often?

Mr Corcoran—On an annual basis.

Senator CROWLEY— Annually, right. I am down there in Moree; you are waiting to get an annual report; my funding has run out: is there any point in talking to you?

Mr Corcoran—We would not get information at the Moree level; we would get information at the state level.

Senator CROWLEY—So how do you satisfy yourself that New South Wales is delivering what you want with Commonwealth dollars?

Mr Podger—Senator, I think we have been through this argument a number of times before about—

Senator CROWLEY—Indeed, Mr Podger, but I have never had such good letters—

Mr Podger—I was going to make two points. First of all, the point about the broadbanding arrangements and our performance measures.

Senator CROWLEY—I remember these, because instead of a three per cent efficiency you gave them a 10 per cent efficiency—

Mr Podger—We actually have far more substantial reports these days on the performance under these agreements than we had in the past. They are not into the individual project level or anything of that sort, but we do have very substantial annual reporting arrangements with the states on the outcome funding agreements.

The second point I wanted to raise was related to Aboriginal services, that we have framework agreements with the states around Aboriginal services, and we are trying to move to joint regional planning with the states between the Commonwealth, the states, Aboriginal and Torres Strait Islander Commission and the community controlled health sector. Those framework agreements in the regional planning will require within regions clear identification of who is spending what and detailed services and where the gaps lie. Those agreements are also intended to lock in what the states are spending and so we have confidence, when we are putting more money in, that it is not being offset by reductions by states. So we are moving to a quite comprehensive joint regional planning regime for Aboriginal health services under the framework agreements.

Senator CROWLEY—Well, that is all fine, Mr Podger, but it does not answer my question. How do you know that the Commonwealth Government's outcomes for increasing services for antenatal care to Aboriginal women in New South Wales is being done—and I would think that you would also be very interested to know whether it was all in the north-west corner and none in the south-east—and do you actually have to wait each year till a

report comes in and then somebody reviews that and then you would say, 'Well, look at this. They are only getting Aboriginal care in the north west and none in the south east?' I can understand what you are saying—it is theoretically fine—but how are you assuring yourself that New South Wales is delivering? Framework agreements are fine, but when I asked about continuing a good service at Moree the Commonwealth said, 'That is nothing to do with us.'

Senator Vanstone—Senator, perhaps if I can be of some assistance here, and I know no more about this than what I have simply heard in response to the answers to questions you have put today, but if I understand what Mr Corcoran and Mr Podger have said, it is that individual grants to individual services are handled by the states. The Commonwealth has an overarching broad-based agreement which has some indicators that the states report on. I do not know the detail of those; whether, for example, they cover the distribution as well as the outcomes—outcomes in a health sense as well as geographic distribution of services, but I think the officers have made it very clear that they do not handle individual requests for grants; that that is handled by the states. And, with respect, I am not sure that it is an appropriate paraphrasing to simply say, 'Oh well, the Commonwealth says it is not to do with them.' What the Commonwealth says is, 'We give the money to the states. The states handle those individual grants and we get reporting on the broader outcomes.' I think that is what they have said.

Senator CROWLEY—Well indeed they have, and so I was saying: how are you sure that the $200 million that you have sent off to the states is being spent in the right place at the right time? Mr Podger, would it be possible to provide me with a copy of the framework agreements?

Mr Podger—We certainly can.

Mr Corcoran—There are two sets of agreements; there are agreements within the public health area, the outcome funding agreements. There are the framework agreements for Aboriginal health which are signed by four parties. We can give you copies of both those.

Senator CROWLEY—I appreciate those, and could I have maybe the last couple of years data from New South Wales, for example, that satisfies you on this? I have asked questions about this in the past and I have been told such good answers as, 'If you want to know, for example, Senator, how many people attended family planning, you can look up the family planning annual reports', which I do still believe is an unsatisfactory answer from Commonwealth bureaucrats. I could indeed look up the report, but so could you. I would like to know how you are satisfying yourself that if they are the best reports you have got to go on—here moving to family planning—that you are satisfied. But if we come back to this, how long after the event do you know where the money is being spent?

Mr Podger—I think, Senator, we can provide you with copies of recent reports from New South Wales under the public health outcome agreement.

Senator CROWLEY—That would be good, thank you.

Mr Podger—To give you clear information on a range of information that we collect from the states on that.

Senator CROWLEY—And what would you say to people from Moree or another hypothetical New South Wales town who are very anxious about continuing funding—ongoing funding—for their service? It is called, 'Well, don't speak to us, speak to New South Wales.' I am really interested in that. It may not be quite Pontius Pilate hand washing, but it is very like that; 'Don't speak to us. Contact New South Wales.' Now, what happens if you

would support it—because it is very much one of your outcomes, it is part of the framework agreement—but New South Wales has got a bee in its bonnet and it is not going to spend the money there or it did not, or something. Is it at the end of the year when you get the data in that you can actually say to New South Wales, 'We're not happy with the outcomes'?

Mr Corcoran—Senator, we get reports at the statewide level. We do not get reports which go to Commonwealth assistance for programs at the local level. The joint committee report was actually in 1995, and I suspect that was a look at whether there was duplication of bureaucratic effort in managing programs—often at the local level—so they are very small dollar contents and so the focus has been framed within that framework of the COAG agreement on the relationship between the Commonwealth government and state governments around the administration of SP2s. So we do not have bureaucratic duplication of programs at the local level.

Senator CROWLEY—I think that most of us might tick off on that. All of those things seem reasonable. What I want to know is: how does the Commonwealth satisfy itself? To what level do you go? Do you go down to a health area level or do you go to the five major subdivisions of New South Wales?

Mr Podger—In terms of the public health agreements, Mr Corcoran has said that we do it on a statewide level, but I have also said that across the whole of Aboriginal health under the framework agreements we deal with joint regional planning at a much more localised level and we have, not so much in New South Wales but in some other jurisdictions, increased our funding in particular regions associated with assurances from the state of the money they will be putting into it as well as ourselves and we do detailed planning about services in those regions. Now, in New South Wales we have made some advance on that, but I think we have probably got further to go yet on our regional planning arrangements.

Mr Corcoran—Senator, may I put this into context. The Commonwealth government's expenditure and contributions to public health comprise a very small proportion of overall governmental expenditure on public health. It is about 20 per cent. So we are just a little bit on the top, basically. One could argue that it is logical in those circumstances that the 20 per cent does not distort the overall, and certainly we do not have control over the other 80 per cent. The current arrangements would seem to reflect the balance of funding responsibilities between the state and the Commonwealth governments for public health activities.

Senator CROWLEY—All of this is fine, but I am just interested in this book here, these program portfolio budget statements, that spend a lot of time telling me about—if I read program 1—outcomes, better quality, this, that and the other thing. I have two questions. Are you satisfied on an annual report at a statewide level from New South Wales that Commonwealth dollars spent on public health are delivering the sort of outcome that you can tick off on and say, 'Yes, that is quality health being delivered in New South Wales'?

Mr Podger—As a general rule the answer is yes. At the high level that Senator Vanstone argued was a Commonwealth responsibility, yes: through the reports we get we can show in a number of areas steadily increasing benefits from the public health dollars we are spending.

Senator CROWLEY—I will keep an eye on that, Mr Podger, thank you. On the other level, I am interested because a lot of the initiatives that are now rolled over and given to the states came from the Commonwealth because the states did not do it, would not do it, had not thought of it. The alternative birthing program was a Commonwealth initiative. A number of those public health areas were Commonwealth initiatives. They were actually funded under specific purpose programs, and now we have given away the responsibility for them to the

states. I am just very concerned that people will ring me and say, 'Help us lobby to continue this very good service.' I am just interested in knowing: is there nobody in the Commonwealth department who has any interest in this until the report comes in at the end of the year? for example, what report do you get? Do you get a report that says 5,000 people wrote letters asking for more money there and none happened, or do you just get a sense that we sent $200 million and $200 million can be ticked off on? Or should I give them your name, Ms Blazow, and tell them to ring you if they are trying to lobby for more money?

Senator Vanstone—That is a bit rough.

Senator CROWLEY—I do not think it is, necessarily. I want to know who in the department is the person to speak to?

Senator Vanstone—These agreements are made by the Commonwealth government with the states. The suggestion that you will refer people who are unhappy with decisions that these states make to a Commonwealth public servant to answer for the nature of the general agreement and, in particular, for the nature of the decision made by a state government is not your usual charming self.

Senator CROWLEY—I am glad you think that is suitably provocative.

Senator Vanstone—I was trying to be gracious.

Senator CROWLEY—I am just terribly concerned that people would write and say, 'We are in trouble. A previous Commonwealth source of funding is in the process of coming to the end and we want that service to continue.' What I learn here again and again apparently is that there is no point in speaking to the Commonwealth. That is the concern people have.

Mr Podger—I think that is not quite right. What we have said is that the decision for a specific individual service is not one for the Commonwealth where it has been funded under the outcomes agreement. That does not mean that in our monitoring of the situation we do not take into account the fact that there are letters that come to us. We will talk to the state about issues that arise. But the state in the end will be the one who will take the decision on the specific service. We have focused primarily on monitoring how the program is going on these annual reports, which are very substantial reports, and we satisfy ourselves whether, in fact, we are getting improvement, for example, in the issues, such as screening rates and so on, against the target we have set. Those are the sorts of the things that an outcomes agreement focuses upon. And we do satisfy ourselves that there is improvement over the years against the benchmarks we have set.

Senator CROWLEY—Are you suggesting that it is reasonable for people who are concerned about funding for their service to write a letter to the Commonwealth?

Mr Podger—I am saying that their primary focus should be the state. But I see no difficulty if they wish to keep us informed so that that can be on our agenda when we are dealing with the state, but it is not going to be a matter for us to determine.

Senator CROWLEY—Is it a matter for you to speak to the state minister about?

Mr Podger—Under certain circumstances it might be, but as a general rule, probably not.

Mr Corcoran—Senator, you used the phrase before 'funded by the Commonwealth'. The Commonwealth makes a contribution—and it is not the majority contribution—to this range of programs. So I think it would be better to talk about 'a Commonwealth contribution' rather than 'Commonwealth funding'. The Commonwealth contribution is not coming to an end. There is a five-year agreement, which finishes in 2004. Funding is not being ceased. If there

are decisions being made at the state and local level, that would be as a consequence of the state balancing off its planning and its demands for these funds. But we have not directly funded any one individual program. We simply make a contribution.

Senator CROWLEY—But you previously did.

Mr Corcoran—And therefore our leverage on a state minister is a very small leverage.

Senator CROWLEY—But the alternative birthing service was a Commonwealth initiative with Commonwealth dollars—all of it. The states were not doing that. So it was entirely Commonwealth money. You might understand the anxiety out there when that Commonwealth money for programs for two years, three years, five years is now running out across the country. They are writing to people like me saying, 'Please guarantee that this money will continue, that the service will continue.' It is well and good for you to say that it has now passed to the states and it is not just Commonwealth money, but it was the only money going into alternative birthing services for some many years.

Mr Corcoran—All I can say is that the Commonwealth money is not running out. It is a five-year agreement, which finishes at the end of 2004.

Senator CROWLEY—That is the health agreement, but the alternative birthing money has ceased in many places or has been rolled over or called something else. But programs in the states were actually funded to cease over the last few years. People are writing to me concerned about a continuation of the funding for their alternative birthing service. I am assisted with some of the answers today. If you can provide me with those framework agreements as well as the state agreement, that would be a very big help. But I am also interested in how you satisfy yourself about alternative birthing services, which you thought were good enough to fund in the beginning. Do you actually have an interest in looking at an item like that or just at the whole package of the public health agreement?

Mr Corcoran—Again, without wishing to pass the buck, I think the Commonwealth role in public health is more regarded as one of commencing innovation rather than long-term sustainable proposals. We do not have the knowledge at the local level of the range of health services being provided in the private sector, in the public sector, at the state level, at the community level. So the Commonwealth role in public health is generally to initiate something and then let it work its way through into the system. It then becomes a decision at the local level, and that might be by an area health service in New South Wales, that this is the priority for that particular region. Generally under the partnership, the MOU there gives the Commonwealth an acknowledged role in innovation but generally not in funding long-term sustained programs. They then come within the decision making framework and the service support framework of the states and territories.

Senator CROWLEY—Will the report from the governments tell you a breakdown of this funding into, for example, alternative birthing allocations?

Mr Corcoran—Yes, they do.

Senator CROWLEY—If you could provide me with that breakdown of the public health—

Mr Corcoran—We will provide you with a full report for New South Wales as we have undertaken.

Senator CROWLEY—That would be for all the items under that public health agreement?

Mr Corcoran—Yes.

Senator CROWLEY—That would be helpful. I think the point you make is interesting, Mr Corcoran, but a few years ago the Commonwealth government handed much of the responsibility for immunisation to the states, and we watched that become a disaster as the kids in this country were not immunised. It took the initiative from the Commonwealth to put its imprimatur on that to see that the process was delivered. That is why some of us are very nervous about handing national programs and initiatives over to the states and then waiting for a report at the end of the year.

Mr Podger—There are issues here of trying to get the balance right. You are quite right. There are concerns from time to time.

Senator CROWLEY—Absolutely.

Mr Podger—There are concerns that that level of responsibility is being abrogated by handing things over. It is quite true also that part of the Commonwealth's leadership role is to promote innovation in particular fields. However, there is an equally major problem if you end up with lots and lots of little programs innovated in different years of the past and continuing exactly as they were and not allowing the flexibility that those who are trying to manage the whole health system need to have. Getting that balance right is a continuing challenge for all of us.

Senator CROWLEY—I have a final question in this area. One of the things about this particular project is that it has turned out in the short life that it has had to show clear evidence that it has improved the health status of Aboriginal women and their babies. That sort of data seems to me to be too precious to interrupt with a possible unfunding of the service and then refunding later down the track. Is it the sort of data that you look at—that is, that there is an improvement in the health status of people working through these services?

Mr Podger—It is data we look at. It is looked at by the population health people and also by the Aboriginal health program area. As I mentioned to you, under the framework agreements we are looking for ways to increase investments into improving Aboriginal health but in a way that works jointly with states, ATSIC and the community control sector. Amongst those considerations have been issues such as what has been working in which areas of the country, and this issue of alternative birthing has not just been in Moree. There have been a number of other places where there is some evidence of improvements arising, and we would take that into account in our discussions with the services, particularly in regional planning arrangements.

Senator CROWLEY—I am interested in what the additional estimates statement says on page 32, under the heading 'Quality' for the first output group. It states:

> High level of satisfaction of the Ministers, Parliamentary Secretary and Ministers' Offices with the relevance, quality and timeliness of policy advice, Question Time Briefs, Parliamentary Questions on Notice and Ministerial requests for briefings provided.

I presume that if I read on I will eventually come to number of Aboriginal women now better off. I am glad that we have a quality measure that talks about the satisfaction of ministers, but I am really much more interested in whether precious Commonwealth dollars are being measured as delivering better health care for Aboriginal people.

Mr Podger—To be fair, that particular item is under output group 1—services to the ministers in the parliament. Of course we do a lot of evaluation of the performance of our programs.

Senator CROWLEY—I now have questions—and I guess it is still in program 1—on the Office of the Gene Technology Regulator. The Office of the Gene Technology Regulator was expected to be operational in January 2001. Can you tell us now when it is expected to be operational?

Ms Cain—The act that was passed by parliament at the end of last year will take effect from 21 June this year and the office will be operational from that date.

Senator CROWLEY—Is there any reason why that date was chosen, apart from the fact that it is the winter solstice?

Ms Cain—That was six months from the date parliament passed the legislation.

Senator FORSHAW—Was that laid down in the legislation? I can certainly remember it was passed late last year. It could be said it was passed very early last year—in the morning at about 5 o'clock. Are you saying that it could not be set up any earlier than six months after the legislation was passed?

Ms Cain—In practical terms, we needed time after the legislation was passed to go through the process that we are in the midst of at the moment—that is, consulting on the development of the regulations under the bill, getting them made before parliament, going through the recruitment process for the gene technology regulator and establishing a reserve fund under the legislation. Those things in the project plan that we are working to will take that period of six months; so it is 21 June.

Senator FORSHAW—There was an interim office in existence.

Ms Cain—There still is, Senator.

Senator CROWLEY—Are you still operating?

Ms Cain—Yes, Senator.

Senator CROWLEY—I thought that was right, but as far as I can see there seems to be no additional funding available and you were supposed to cease in December. How are you getting funding now?

Ms Cain—When the interim office was established, we were given funding for a period of two financial years. That funding will take us through to the end of the current financial year. So there is funding available.

Senator CROWLEY—There was an over allowance, if you like, in the first place?

Ms Cain—The original start-up date set for the office was in fact 1 July 2001. On that basis, two years funding allocation was made available. We had hoped to be able to implement the office six months earlier than that at the beginning of this year so there would have been a saving there, but we had enough money to keep on going until the end of this financial year.

Senator CROWLEY—Do you have an adequate budget to continue to do all the things that are required? Do you have to make any cuts to fit within that budget?

Ms Cain—No. The budget allocation is adequate for the requirements of the interim office.

Senator CROWLEY—Can you assure us that the monitoring and auditing that was previously being done is continuing despite all the other calls on your time?

Ms Cain—Yes, Senator. In fact, I can report that while we have given a commitment to do a 20 per cent monitoring program we are exceeding that at the moment. Of the five per cent

monitoring we would have undertaken in the previous quarter, we were able to undertake monitoring of 11 per cent of field trials.

Senator FORSHAW—Where are the funds associated with establishing the new office coming from?

Ms Cain—There was a budget allocation the budget before last.

Senator FORSHAW—So the 1999 budget. I do not have that budget with me, but are you saying there was an allocation for the funding for two years for the interim office? I assume that ran from the 1999-2000 and 2000-01 financial years. Was there a separation allocation for establishing the new office in the 1999 budget? Is that what you are telling me?

Ms Cain—In the 1999 budget a two-year allocation was made to establish the Office of the Gene Technology Regulator and to fund the operation of the interim office.

Senator FORSHAW—So it was rolled all into one. Just so I have this clear, what you are saying is that the funds that have been allocated up until the end of this financial year are sufficient to do both—that is, to continue the monitoring and everything that the interim office has been doing and is expected to do as well as all of the work to establish the new office. I am taking the nodding as a yes.

Mr Slater—You will remember in debate on the bill that the government's initial decision for budget funding in 1999-2000 was premised on the basis that there would be 100 per cent cost recovery for the office. You will remember that that was a recommendation of the Senate select committee, that the funding be provided by government for the office and that that proposal be dealt with in the budget process. In the meantime, there were funds allocated for two years operation of the interim office. So funding will be made available through the budget from 1 July 2001 for the ongoing office.

Senator FORSHAW—No doubt we will be able to ascertain just what the establishment costs are for the new office at that time. Thank you.

Senator CROWLEY—What was KPMG's reported assessed annual cost of running the GTR?

Mr Slater—About $8 million.

Senator CROWLEY—And what is the budget that you have got?

Mr Slater—We had $7.5 million allocated for the interim office.

Senator CROWLEY—Per annum?

Mr Slater—Over the two-year period.

Senator CROWLEY—KPMG was putting an $8 million assessment on the costs per annum.

Mr Slater—Per annum, yes.

Senator CROWLEY—So that is actually what happens to the cost when you take out full cost recovery.

Mr Slater—That is the assessed full cost of the operations of the office.

Senator CROWLEY—And that is not to do with the extra cost of the assessment you would have to do?

Mr Slater—Yes, it includes all of the costs to do with the assessment.

Senator FORSHAW—Just remind me. Is that the net cost or is that a cost—just explain that $8 million cost from KPMG. How does that sit alongside the original position to use cost recovery?

Ms Cain—To inform the government's consideration of whether the office should be fully cost recovered from day one, we commissioned KPMG to establish the costs that the GTR would incur against the legislation as it was drafted at that point in time. KPMG came up and advised that the annual cost would be $7.8 million in their estimates and that would cover all of the requirements that the GTR would have in terms of staffing and program costs to give effect to the legislative system.

Senator CROWLEY—That presumably is the allocation, or a large part of it, of what you will be expecting in this year's budget?

Ms Cain—Yes.

Senator CROWLEY—And do we have any idea yet of whether or not that figure will be agreed? I know you cannot expect answers from the budget, but—

Mr Slater—Its budget had to be considered in the budget.

Senator CROWLEY—Thank you. I guess this area, as we discovered during the inquiry and during discussions, is terribly important for the Australian community. They certainly want an assurance that there will be adequate funding to do all of those reviews, examination, testings, et cetera, that will be necessary. I guess we have to wait and see what the budget figure is, but the assurance for the community is going to be very important. What kind of assurance can you give them at this time?

Mr Slater—The KPMG study looked at all the requirements to meet the legislative responsibilities of the office. That will sit alongside other bids in the budget context and we remain ever optimistic that it will receive a high priority of consideration.

Senator CROWLEY—Thank you. In the September quarterly report, you had monitored 20 per cent of field sites during July and September.

Ms Cain—The commitment in the quarterly report is to monitor 20 per cent over a 12-month period. That target was set in consultation with the states and territories. Broken down on a quarterly basis, that would be five per cent per quarter. In the previous quarter—the quarter just completed—we were able to monitor 11 per cent rather than five per cent.

Senator CROWLEY—And how many sites does 11 per cent represent?

Ms Cain—I will have to take that one on notice.

Senator CROWLEY—And are there big sites and little sites, messy ones and easy ones?

Ms Cain—There are both big sites and little sites and ones that are easier than others.

Senator CROWLEY—Could you give us a sense of whether you have just done 11 per cent of the easy ones—and I will presume that you have not—but I would like to know whether that is the case? Which ones have you done?

Ms Cain—What we have is a plan that identifies the high risk periods for each field trial. The high risk periods would be, for example, when a trial is flowering, because that is when there is the potential for pollen dissemination. So in each quarter we target at least five per cent of trials, all of which are during a high risk period.

Senator CROWLEY—How many of those sites were Aventis sites?

Ms Cain—I will have to get back to you on that.

Senator CROWLEY—Some were?

Ms Cain—I know that what we try to do is cover a range of companies or organisations dealing with GMOs. So I would assume that there would have been Aventis sites, together with CSIRO sites and Monsanto sites and so on.

Senator CROWLEY—Could you also provide us with a list of all the companies or organisations who have sites? Of that 11 per cent, how many sites caused concern?

Ms Cain—There were some sites that required some remedial action. There were not any sites that presented a significant risk to the environment or to human health and safety. I will get back to you with the details of those investigation reports.

Senator CROWLEY—And that would include what was meant by 'remedial action'?

Ms Cain—Yes.

Senator CROWLEY—I would appreciate that. Can you tell us whether all of the sites that caused concern were Aventis sites?

Ms Cain—No, I cannot.

Senator CROWLEY—Could you tell us which were Aventis sites or which were the sites that caused concern? Can you put a name on them when you give us our report?

Ms Cain—Yes.

Senator CROWLEY—Thank you. How many breaches of GMAC guidelines has Aventis now made, including those in Mount Gambier?

Ms Cain—Because we keep up a rolling program of monitoring and inspection, including some, for example, that were conducted as recently as last week, I cannot give you a figure that is current as of this moment in time, but in terms of completed investigation reports of that particular company, we can give you that information on notice.

Senator CROWLEY—Thank you. Could you also provide us with the answer as to which other sponsors have breached GMAC and how many breaches have been made?

Ms Cain—Yes.

Senator CROWLEY—And how many sites were spot checked and how many were given notice that you were coming?

Ms Cain—Under the current voluntary system, natural justice and due diligence dictates that we always provide advance notice of a monitoring visit. As you know, under the legislation, the gene technology regulator will have the capacity to conduct unannounced visits but, under the voluntary system, that is not an appropriate way for us to operate. So all of them would have been given some advance notice of the visit.

Senator FORSHAW—What happens when they actually visit the site? What is involved in this monitoring? You might want to take that on notice and give us an outline of what they do. Do they just turn up, have a look and go home, conduct experiments, or what?

Ms Cain—The visits are always conducted by at least one official from the interim office and by at least one external expert contracted to the office with appropriate expertise—so an expert in brassica weeds or an expert in whatever is appropriate to the particular monitoring visit. What happens in each monitoring visit depends on the nature of the trial that is being conducted—whether the trial is current or whether it is in the post trial monitoring period. But

things would include a physical examination for weed species that were not supposed to be in the area, a consideration of whether the future of buffer zones had been established, a consideration of what other crops are being grown in the vicinity. But each visit is, of necessity, tailored to a particular site under inspection.

Senator CROWLEY—And you check which crops are now being ploughed up waiting for the garbage to collect them?

Ms Cain—That does not happen anymore, I believe.

Senator CROWLEY—I am very glad. Do you check?

Ms Cain—We do check.

Senator FORSHAW—Written reports are prepared, no doubt.

Ms Cain—They are.

Senator FORSHAW—They would presumably be then held by the interim office or the new office?

Ms Cain—That is right.

Senator CROWLEY—How much notice is 'notice'?

Ms Cain—The notice can range from 24 hours to a week to 10 days.

Senator CROWLEY—I guess natural justice for the company is reasonable, but protection or natural justice for the community is a balancing question. I guess that is something you have considered.

Ms Cain—It is. There are two things that we are conscious of. One is that under the new legislation there will be that capacity to conduct spot checks. But the other one is that the results of our monitoring and inspection to date have not identified any breach that has resulted in a significant harm to either people or the environment. I think, generally speaking, what we have found is a reasonably good level of compliance with the recommendations, albeit there are cases where we would prefer compliance to be of a higher level.

Senator CROWLEY—The report states that experts were contracted to conduct the monitoring. How many experts and at what cost?

Ms Cain—I will take the cost part on notice. In terms of the number, there is always at least one independent expert accompanying somebody from the office at each monitoring visit.

Senator CROWLEY—It would be appreciated if you could give us the cost of those experts. Is it based on a daily cost or is it based on qualification? Does a professor for weeds get more money than a professor for garbage?

Ms Cain—I will provide you with some information on that.

Senator FORSHAW—I want to know, when you are having spot checks, whether you actually looking for spots. Certainly in some industries you would.

Senator CROWLEY—According to the report, Luminus Consulting, attached to Adelaide University, was contracted to conduct investigations. Is that group still being used and at what cost?

Ms Cain—We do use that group from time to time. They have a particular expertise of relevance to canola, which is one of the crops that we have been doing a fair bit of monitoring in relation to recently. As I said, we will get back to you on the cost side of things.

Senator CROWLEY—Who within GMAC recommended that group?

Ms Cain—We sought advice from Professor Nancy Millis, who is chair of the Genetic Manipulation Advisory Committee. I believe that there was a discussion within a GMAC release subcommittee meeting which would have involved all members of the release subcommittee about appropriate qualifications of people to undertake monitoring with us.

Senator CROWLEY—Is Professor Rick Broush associated with this consultancy in any way?

Ms Cain—Yes, he is.

Senator CROWLEY—Is he in a position to gain financially from a consultancy?

Ms Cain—The consultancy is with Luminus. Professor Broush is associated with Luminus. It was Professor Broush that we originally approached to provide the services because of his considerable expertise in the area. So I would imagine there is a financial arrangement in place between the Commonwealth and that company.

Senator CROWLEY—Your September report states that the interim office was made aware of two other alleged breaches of GMAC guidelines during the reporting period. What were the breaches?

Ms Cain—The reports on those breaches are yet to be finalised. As with other breaches that we have discussed, there will be disclosure of the details once the breach investigation is completed, but I cannot give you that information now.

Senator CROWLEY—On notice?

Ms Cain—On notice, and as soon as the investigation is completed.

Senator CROWLEY—And what were the outcomes of the investigation? Could you take that on notice, too? Thank you. How many trial sites have been monitored? That is essentially what you are going to tell us; is that right?

Ms Cain—That is right.

Senator CROWLEY—So 11 per cent of X equals whatever.

Ms Cain—Yes.

Senator CROWLEY—Do you know whether in that quarter you have identified further breaches or issues of concern?

Ms Cain—I believe that during the quarter there were four sites that were identified with a need for some remedial action. But as I said earlier, none of the issues of non-compliance that we identified resulted in any significant risk to the environment or to human health and safety.

Senator CROWLEY—How many of those additional sites were spot checked, if any?

Ms Cain—All of them were part of the 20 per cent monitoring program. I think, as we have discussed, your definition of 'spot check' has to take into account the prior notice.

Senator CROWLEY—That is one definition. Did you have any other alleged breaches reported to you in the December quarter apart from those that you investigated and found?

Ms Cain—I believe not. I believe that the activity and investigation resulted from the proactive monitoring we undertake. But I will double-check that and confirm it.

Senator CROWLEY—As you think there were none, it is not likely that these were complaints reported by the public and then found to be a valid criticism. So what you are

saying is that over the last three months and possibly six months the main breaches have been identified by monitoring as opposed to the public complaining?

Ms Cain—No, they are primarily as a result of monitoring. But, of course, any organisation dealing with a genetically modified organism that finds a non-compliance issue is required to notify us of that non-compliance issue. There may have been some instances of that sort of notification from companies or organisations.

Senator CROWLEY—Could you check that for us?

Ms Cain—Sure.

Senator CROWLEY—According to the September reports, the interim office went into contract with Mr Bill Harris regarding an inquiry into a complaint made by an individual about the conduct of GMAC's general business. Can you tell us what Mr Bill Harris's occupation is?

Mr Slater—Mr Harris is a consultant.

Senator CROWLEY—For what specific reason was his expertise required?

Mr Slater—Mr Harris was investigating a complaint made to the Prime Minister about irregularities in a GMAC steering committee meeting. The minister wanted those irregularities investigated. They were also the subject of questions on notice in the parliament. Mr Harris was chosen because of his high standing and expertise in public sector matters. Mr Harris was a former commissioner of the public service board and head of the chief minister's department in the ACT and had impeccable credentials for undertaking the investigation.

Senator CROWLEY—What was the cost of his consultancy?

Mr Slater—Approximately $20,000.

Senator CROWLEY—Can you give us more detail about the nature of the complaint?

Mr Slater—The complaints were also the subject of questions on notice in the parliament and therefore in the *Hansard*. We are very happy to dig those out for you. That will give you a sense of the background to it. Because the report is yet to be released, I would prefer not to comment on the questions that were raised in it. I would rather point you to that as a general background to the nature of the complaint.

Senator FORSHAW—Were the costs of Mr Harris's consultancy paid for by the funds allocated for the interim office?

Mr Slater—Yes.

Senator FORSHAW—You might need to take this on notice. Could you give us details of the number of times and the costs and who was engaged as consultants by the interim office?

Mr Slater—Certainly, we can take that on notice.

Mr Podger—That would normally become available in our annual report, of course.

Senator FORSHAW—Has it been a regular practice for the interim office to use consultants or was this a one-off?

Mr Slater—I do not think the—

Senator FORSHAW—I did not think it was, but—

Mr Slater—This particular investigation is a one-off. The interim office used a range of consultants, such as KPMG, as you would expect, to do studies.

Senator FORSHAW—I am aware of that.

Mr Slater—The majority of the consultancies were about setting up the office and giving specialist advice where it was much more cost effective to get that advice externally rather than to try to deliver it from internal resources.

Senator FORSHAW—What about in the usual work of the interim office, the monitoring and that type of work? Would all of the expert staff be within the office or the department, or would you bring in outside consultants for that?

Ms Cain—We use a twofold process. We have experts within the office, and we are in the process of building up that expertise, bringing on board people with an agronomy background or particular public health experience. So that is one job of work for the interim office—to make sure that the gene technology regulated by June has access to good internal capacity. But I think that we would continue to also contract in external expertise, because when you are looking at something like the sexual compatibility of brassica weeds with canola, that is a fairly specialised—

Senator FORSHAW—Which I do all the time!

Ms Cain—And it is very interesting, but it is a particular expertise, and there will be a continued need to keep on buying in that expertise.

Senator FORSHAW—I appreciate that, and I can imagine there may well be occasions where you would want to access expertise within state departments—lab culture. But anyway, if you could give us the details that I requested a moment ago, that would assist. Thank you.

Senator CROWLEY—I just wanted to follow up the Monsanto Roundup Ready cottonseed breach. According to the September report, you have reported that, and you indicate a failure of Monsanto to maintain full control of the material used in the field trials of genetically modified cotton. I think it is probably exactly the same as what happened in the US with Aventis StarLink corn. The report says that this failure did not result in increased risks and it would not necessarily be the case if the same failure were to occur for other genetically modified crops. As has happened with StarLink corn, this has not been cleared for human consumption, but you were not able to assure us, when we asked questions, that it had not got into the food chain. What has been the response of the regulators to this Monsanto breach and its processes?

Ms Cain—One of the key differences between the Monsanto breach and the breach that you reference from the US was the fact that while a general-release approval had not been granted at that point in time for Roundup Ready cotton, Roundup Ready cotton had been subject to extensive field trialling over many, many years in Australia, and so a considerable amount of data was available to the Genetic Manipulation Advisory Committee and to the interim office as well as to states and territories, and a sensible assessment was able to be made on the basis of that information about the risks to human health and safety and to the environment. As you would recall, Roundup Ready cotton has subsequently been approved for general release in Australia. So I think that that is one of the key differences between the Roundup Ready breach.

What we did in response to the breach was conduct that risk assessment, calling on the data that was available to us through those many years of field trials. We also conducted an audit of Monsanto's internal control processes to identify why the breakdown in control had occurred to make sure that it did not happen at some future point with some alternative crop.

Senator CROWLEY—What research did you draw on to assure you that contaminated cotton oil, as eaten by cows or humans, is of no harm to either?

Ms Cain—I believe one of the things that we did was look to the risk assessment of such cottonseed oil conducted by the Australia New Zealand Food Authority, and I understand that that oil has been approved for human consumption in Australia. I could check that with the Australia New Zealand Food Authority, but from memory, that is the case.

Senator CROWLEY—If you could, that would be useful. Could you also provide us with the articles or copies of the research done to show that it was safe and/or copies of the risk assessment. Maybe not now, but if you could tell me: what is risk assessment research as apart from 'eat this and see if you get sick' research?

Ms Cain—We would be happy to provide the full risk assessment on Roundup Ready cotton. We released that risk assessment, as you would recall, for public consultation in draft form, and then again when the risk assessment was finalised. So all of that information is in the public domain, and we would be happy to provide it.

Senator CROWLEY—Thank you.

Mr Podger—I would be a bit concerned about the extent to which the interim office or the final office is able to provide details of absolutely everything. I think, as the officers explained, we do make a lot of information available around the investigations and so on. I simply say that an issue is the amount of work involved to follow up with all the research papers and so on that back a particular expert view taken within the office.

CHAIR—May I just make a general inquiry. We are now going over the debate that happened in the committee inquiry and also the chamber debate for the bill, and I am just interested to know where this actually relates now to the budget estimates as opposed to general questions which—

Senator CROWLEY—I appreciate your point. This is really essentially within the ambit of the budget requirements, since the interim office is continuing to exist up until—

CHAIR—Yes, it is, but this is a repeat of both debates, and I am just wondering, seeing we are still only on outcome 1 and I plan to break for lunch at 12.45, whether we can proceed.

Senator CROWLEY—I am just about finished on this, Madam Chair.

Senator FORSHAW—Can I just quickly go back to the Senate inquiry. Monsanto did indicate that it had no idea where the contaminated cotton oil had gone. Has anybody been able to confirm whether the contaminated oil has been exported?

Ms Cain—I believe that was an issue that was canvassed in the audit into Monsanto's procedures. There is a public report of the result of that audit, and we can provide you with a copy of that.

Senator FORSHAW—If you would not mind, yes. The other questions really depend upon the answer to that one. If you can provide us with the report, I have two other questions that I will put on notice. The first is: if it was exported, was it labelled as being genetically modified? The second is: were there any risks associated, effectively, with our international reputation? That is probably a general question that we can follow up at another time.

CHAIR—Just while Mr Slater is there, I will put a couple of questions on chelation therapy. I made further inquiries only late last year about any progress on chelation therapy. As you probably know, it is something that I have been inquiring about for about 14 or 15 years, and we seem not one millimetre ahead of where we were 14 or 15 years ago. I am just

inquiring as to whether or not this is an open and shut case of 'no' as far as the TGA is concerned, or whether there is some possibility of progress in this area. I think from memory—and, unfortunately, I do not have the correspondence here in front of me—the last suggestion that was given to me was that there had not been double blind trials done, and until such time as such trials were done, there would be further correspondence entered into. That is my paraphrasing, not precisely as it appears in the correspondence.

You may appreciate, of course, that when we are dealing with people with arteriosclerosis and requiring bypass surgery and so forth, these are the people who are utilising chelation, but it is pretty rich to suggest to them, 'Sorry sport, but you can hang on till you've got a double blind trial and, if you croak it, that is stiff, but the next person might live.'

I really have a problem with this, because I have a number of constituents over many, many years who have written to me. Literally I have filing cabinet drawers full of people who are saying, 'This is not anecdotal. This is actual. I was ready for a foot or leg amputation through loss of circulation. I was not able to work,' and so forth and so on. The list just goes on. 'I am now back playing golf, tennis and leading a full working life.' There is also the cost differential—the cost of chelation vis-a-vis invasive surgery. I am just wondering where we are at, where we are likely to go and how we are likely to get there.

Dr Hunt—In relation to chelation therapy, EDTA is included on the Australian register of therapeutic goods in two forms, disodium edetate and sodium calciumedetate. Treatments are not approved for use in arteriosclerotic disease. In order for the TGA to specifically approve that as an indication, we would need to have an application from a sponsor who would usually be a pharmaceutical company.

CHAIR—With all due respect, I know all that. That is the answer that I have been given for many, many years.

Dr Hunt—We would expect the application to be accompanied by supporting data. The gold standard trial would be a double blind randomised trial, but that is not the only trial that would necessarily be accepted. But, in the absence of an application and any evidence, the TGA is unable to approve the extension of indications. However, whether an individual doctor can use what are already registered products for an off-level indication is a matter of medical practice and not within the jurisdiction of the Therapeutic Goods Administration.

CHAIR—I know all of that. That is what is frustrating me, because that is the same answer that I have been getting for years and years and years. In other words, I inquire as to where we go from here and I get a letter back saying, 'Go and suck eggs.' It is very frustrating from my point of view when I have constituents who are paying for this treatment out of their own pocket, sometimes up to $2,500, and they are back leading a full working life and their alternative was to go and cost the collective taxpayers $40,000, $50,000, $60,000, $70,000 or $100,000. I am just finding it incredibly frustrating to write to these constituents and say, 'Nick off. We don't care.' We have now been told again and again and again that we have to have the double blind trials. If I write to these constituents with a copy of today's *Hansard* and say, 'I've been told yet again we've got to have double blind trials,' they will just go berserk.

Dr Hunt—Perhaps I can explain. Under the Therapeutic Goods Act it is a requirement that we have an application from a company before we can approve a product for an extension of indications.

CHAIR—I understand that. But then the attachment to that is always with double blinds.

Dr Hunt—No, I did not say that, with all due respect. It also is a requirement under the act that there be sufficient information concerning the quality, safety and efficacy of the product. It has to be examined by the delegate of the secretary. I said double blind was a gold standard, but certainly other forms of trials can be done and can be performed and may be appropriate. But, at the present time, if we have no application and no evidence at all, we are unable under the act to extend the indications for these products.

CHAIR—I understand that. The companies involved are at their wits' end because they know what the answer is going to be. They are going to be told to go off and do double blind trials. If we are wanting evidence of people—just out of my filing cabinet I could get people to join hands and run rings around this place about five times as evidence of saying, 'Here I am,' but that does not seem to be adequate. What I am worried about from an expenditure point of view is that we keep on spending money on invasive surgery while there is a possibility of therapy on this side at a very low cost and having a very beneficial effect.

Mr Slater—No, I think what Dr Hunt is saying is critically that we cannot initiate an application.

CHAIR—I realise that.

Mr Slater—And, hence, we need an application, and it is up to the company to provide what evidence they have to support that application.

CHAIR—But I want to know what type of evidence you are going to accept, because every response that I get is 'this is a bit of witch doctoring' or 'it is only anecdotal' or 'there was someone who died in 1930 from an overdose when they got EDTA for lead poisoning'. I just keep getting the same old answers. What I am really asking is: if the company does put in an application, how do we do it without setting people up in a double blind trial where we are literally playing with people's lives? If they are in need of bypass surgery—I tell you what, I would not want to be a candidate and wondering whether I am just getting a bit of saline stuck into my arm.

Mr Slater—I think it is up to the company to assess what evidence they believe is required to be put forward to demonstrate the safety and the efficacy, given whatever risks are known about a product, and the TGA will assess that. I think it is important to recognise that we cannot initiate an application and we cannot state what evidence is required.

CHAIR—I do recognise that.

Mr Slater—Our role is to assess that evidence and to make a decision then about the safety, quality and efficacy of that product. We, as Dr Hunt said, are willing to take whatever evidence is available to support the application.

CHAIR—But, with all due respect, it does not seem to me as though the TGA is willing to accept evidence, because each time I have inquired about this over many, many years I have got the same answer back again and again and again. I have to tell you that when I got the first answer last year I just literally went into orbit. I could have pulled out the first letter I wrote umpteen years ago and compared the two. They were virtually identical. I thought we had actually progressed along the way from that.

Mr Slater—One of the important aspects that we would have to pay credence to here is that, where pharmaceutical companies have taken an enormous venture capital risk, often in the order of $US500 million, to research and put forward applications for products that deal with high risk illnesses, there is a requirement on regulatory authorities to ensure that there is a level playing field and that, where we are dealing with serious illnesses with high risk

outcomes, there is across-the-board comparable evidence of safety and quality and efficacy to support that marketing application. That is a very important role of the regulator. Hence, it is up to the company to judge what evidence they believe is necessary to support an application, and they do that in their judgment about the assessment of the risk.

CHAIR—I do not deny any of that. I think that is why Australia has one of the best systems in the world in terms of safety and efficacy. What I look at is this huge waste of money and costs to an individual. We do not seem to have learnt from our near neighbours in New Zealand, who look at this rather favourably, or many other countries overseas where, in fact, people have to undergo chelation therapy before they are allowed to have bypass surgery.

Mr Slater—What I can offer you is that the TGA is most willing to sit down with any applicant in a pre-application meeting to talk through the types of evidence that might be necessary to support an indication. We more than willingly extend that offer to the company that may be involved here. That is a new change that has been brought about under this government in the regulation of therapeutic goods. Perhaps that is the way forward so that we can sit down and talk through what evidence they have, whether that evidence would be sufficient to support an application, and what other evidence they might need to get. I think that discussion might be the way forward on this.

CHAIR—All right. We will proceed on that basis. Are there any further questions on program 1?

Senator CROWLEY—I think we have a few.

Senator FORSHAW—We have questions for ANZFA. Some of those go to the BSE issue. I might indicate that we have some questions which also relate to the ramifications of the BSE issue but which are more properly directed at the NHMRC, which has established a special committee. I imagine it would be more appropriate to deal with those questions when they come on later.

CHAIR—How would you like to handle that, Mr Podger?

Mr Podger—I think we can have the NHMRC people here when you are dealing with ANZFA so that we can pick up those things. The chief medical officer will be here as well, who is also very much involved in that. So it might make it easier if you could do it in one go.

Senator FORSHAW—We could get those out of the road.

Senator WEST—Is ANZFA in outcome 1?

Mr Podger—Yes, ANZFA is in outcome 1. I am saying that we do not have to wait for the NHMRC. It might be easier to deal with the BSE issues in one go rather than to find at the end of the day you actually have some questions of ANZFA again.

Senator WEST—I do not have any BSE questions, but I have got questions for ANZFA.

Senator FORSHAW—What time are we breaking?

CHAIR—I wanted to break at 12.45 p.m. Senator Harradine has a couple of quick questions. Would you like to handle those now?

Senator FORSHAW—Then we can come back to these after lunch.

CHAIR—Then we can come back to that. Is that satisfactory?

Senator FORSHAW—Because we will probably be at least half an hour or more with ANZFA.

CHAIR—That is fine.

Senator HARRADINE—This goes back to a question I asked Mr Corcoran. It goes to the title of the groups. I am referring to answer EO10, which states that the Sexual Health Reference Group was established in August 1999 and that membership of the Sexual Health Reference Group includes representatives of a wide range of community and professional groups. I want you to take that on notice. For example, what about the youth program—a fine program amongst peers—about true love waits? Is there anybody in that area that promotes that view?

Mr Corcoran—I should have put it in the context that the purpose of the group was to look at the efficacy of existing programs that were being funded by governments. I suppose that was a natural and, in your view, unfortunate limit upon the scope of the group. But it was a narrowly conceived study of how well existing programs were working. That was the reason why there was not that broad a range. When we respond to you on the membership of that group I will attempt to draw the connection to the existing programs which they represented, if that would help.

Senator HARRADINE—I said I would only just deal with the question of the clarification of what groups are what. There has been a consultant's report. I would like to know how much this Sexual Health Reference Group has cost thus far, including the consultant's fee. There was a consultant's report in September 2000. The report has been referred to the National Public Health Partnership for consideration and further action. Who are they?

Mr Corcoran—The National Public Health Partnership comprises the heads of public health divisions at Commonwealth, state and territory levels. We are brought together under a memorandum of understanding to pursue a national approach to a range of public health issues. I can give you the composition of that group as well, which changes membership.

Senator HARRADINE—Thank you.

Mr Corcoran—It is ex officio representation.

Senator HARRADINE—Could you give me the membership of the partnership's national strategy coordination working group, which is actually examining the report and will provide advice and recommendations to the partnership at its meeting in 2001? You were going to give us a copy of that outcome as well for the meeting.

Mr Corcoran—Yes.

CHAIR—Thank you very much.

Proceedings suspended from 12.43 p.m. to 1.49 p.m.

CHAIR—I reconvene the meeting of the Community Affairs Legislation Committee.

Senator FORSHAW—We have representatives from the NHMRC at the table, do we? I will start with them. These are questions in relation to the Special Expert Committee on Transmissible Spongiform Encephalopathies—TSE. As I understand it, the minister set up the committee in response to the growing crisis in Europe with BSC. What was the consultation process that took place leading to the appointment of the consumer representative, Professor Trang Thomas, to the expert committee?

Dr Morris—Professor Trang Thomas is a member of the National Health and Medical Research Council. It was felt that having her on the committee would provide a link with the council, as well as with consumer issues.

Senator FORSHAW—Is her membership of the council itself as a representative of consumer interests?

Dr Morris—No.

Senator FORSHAW—As I understand it, there are a whole range of appointments representing state governments, state ministers, et cetera, and various professional groups. What is Professor Thomas's representative role, if I can term it that, on the council itself?

Dr Morris—I will have to take that on notice. I know she is not there as a consumer representative.

Senator FORSHAW—Is she on the expert committee representing consumer interests?

Dr Morris—I believe that is how she has been represented. I can check that for you.

Senator FORSHAW—That is what I understand and I am now trying to ascertain what processes occurred and what consultation took place in arriving at the decision to appoint Professor Thomas as representing consumers or consumer interests on the expert committee and, without reflecting on Professor Thomas and her qualifications personally, to ensure that she is there as a representative of consumers.

Dr Morris—In relation to these issues, she is a lay person. Everyone else on the committee is an expert.

Senator FORSHAW—Who made the appointment?

Dr Morris—The NHMRC made the appointment.

Senator FORSHAW—The council?

Dr Morris—The council, yes.

Senator FORSHAW—Was it decided to appoint a member of the council to the expert committee?

Dr Morris—It was decided to have a member of council on the committee, yes.

Senator FORSHAW—Who else is on the special expert committee?

Dr Morris—I have a list here.

Senator FORSHAW—Could you provide that?

Dr Morris—Would you like me to read it out or to table it?

Senator FORSHAW—Could you read them out and identify where they are from.

Dr Morris—We have the chair, Professor Graeme Ryan from Melbourne; an expert in quarantine and risk analysis, Dr Kevin Doyle of the Australian Veterinary Association; an expert in food safety, Dr Amanda Hill; an expert in communicable diseases and diagnostic testing, Professor Lyn Gilbert from Westmead Hospital; an expert in communicable diseases, Professor Peter McDonald from Flinders Medical Centre; an expert in blood transfusion Dr Tony Keller from Perth; an expert in prions and transmissible spongiform encephalophies, Professor Colin Masters from Melbourne University; an expert in neurology, Dr Steven Collins from the Department of Pathology, University of Melbourne; an expert in surgery and neurosurgery, Associate Professor Peter Rowley from Royal Adelaide Hospital; an expert in medical epidemiology, Professor Adele Green from Queensland Institute of Medical Resesarch; an expert in human risk assessment, Professor John Caldor from the National Centre for HIV Epidemiology and Clinical Research; an expert in human ethics, Associate Professor Paul McNeill from the University of New South Wales; an expert in health

economics, Dr Terry Jackson from Monash University; an expert in agricultural and veterinary epidemiology, Dr Chris Baldock from Queensland and a representative of consumer interests, Professor Trang Thomas from the Department of Psychology, Royal Melbourne Institute of Technology.

Senator FORSHAW—Other than Ms Thomas, how many persons on that committee are also members of the council?

Dr Morris—Professor Adele Green is also a member of council. She is the chair of the Health Advisory Committee of council.

Senator FORSHAW—So there are two persons from the council on the expert committee. Everyone else has been co-opted or brought in from outside because of their particular expertise. I will go back to my first question. How was Professor Thomas appointed to represent consumer interests on this expert committee when she does not represent the consumer interests on the council?

Dr Morris—This was decided by the council, which includes the consumer representative on council.

Senator FORSHAW—Who is that?

Dr Morris—That is Michele Kosky from Western Australia. She was part of that decision-making process. The reason there are two members from council is that Adele Green is there as an expert in epidemiology rather than as a lay person—

Senator FORSHAW—Yes, I understand that.

Dr Morris—And Trang Thomas, as a psychologist, was seen to be a lay person in relation to these issues.

Senator FORSHAW—Was there any consideration given to appointing somebody from outside the council to represent the consumer interests? Effectively, everyone else on that committee is not a member of the council. One person is, and that person has specialist knowledge in this area.

Dr Morris—Senator, I would have to check the minutes of the meeting. I am afraid I was not at that meeting, but I think one of the issues may have been the time available. It was felt the committee should be set up as quickly as possible and, although it was quite evident through professional links who the experts were, to seek a specific consumer representative may have been seen to delay things.

Senator FORSHAW—I would suggest, Dr Morris, that it would not take that long to consult with major consumer groups and find a suitable appointment. Was there any consultation with any major consumer interest groups?

Dr Morris—I am afraid I do not know.

Prof. Smallwood—Senator, as I recall, there was a degree of urgency in setting up the committee and the consumer rep on the executive of council, Michele Kosky, was instrumental in the decision-making. As I understand it, there was not consultation with consumer groups outside the council.

Senator FORSHAW—There was not?

Prof. Smallwood—As I recall it.

Senator FORSHAW—Is there a consultation process with other outside experts and consumer representatives as part of the deliberations of the expert committee? I appreciate

you have quite a range of experts from various fields on the committee, but what consultation does the committee have with consumer groups and other interested bodies?

Dr Morris—Senator, at the first meeting of the committee at the end of January it was decided that the committee would consult widely with all relevant groups on each particular issue. That would include consumers, industry groups and other relevant groups.

Senator FORSHAW—State governments?

Dr Morris—State governments, et cetera.

Senator FORSHAW—Does that mean setting meetings around the country? Is that what you are talking about?

Dr Morris—If necessary, meetings; initially correspondence. The committee already has a long list of industry groups and other interested people who have approached the secretariat. The first contact will be through correspondence leading possibly to meetings.

Senator FORSHAW—What is the committee intending to come up with ultimately? A report? How long is the committee intending to deliberate for? What is it aiming to actually end up doing?

Dr Morris—The life of the committee is yet to be decided. The committee will provide advice to the government on issues as they arise. The government has already specifically asked for advice on a range of issues and it is going to be addressing each of those issues, providing that advice.

Prof. Smallwood—It is conceived as functioning in an analogous way to SEAC, which is the UK committee, the Spongiform Encephalography Advisory Committee, where it is monitoring the changes and evolution in the BSE epidemic and the variant CJD epidemic and all the issues around it. The life of these committees will be presumably as long as the issues keep coming.

Senator FORSHAW—It is an advisory expert body. It is not charged necessarily with bringing down some major final report, if you like, as Lord Phillips did in the UK.

Prof. Smallwood—That is the understanding I would have.

Senator FORSHAW—As I understand it, the committee has resolved to publicise the outcomes of its meetings up to two weeks after their conclusion via press release. Is that correct?

Prof. Smallwood—That is correct, Senator.

Senator FORSHAW—Will the committee or the NHMRC be looking at other ways of communicating the outcomes of its meetings in a more immediate fashion, posting them on the web site?

Dr Morris—I believe there are plans to place the outcomes of each meeting on the web site as well.

Senator FORSHAW—Do you have any proposals for getting information to the public, other than press release and possible web site?

Dr Morris—Not at this stage, but one of the issues we discussed would be public education matters. It may well be that there are other strategies employed in the future.

Senator FORSHAW—Am I correct in understanding that following the committee's initial meeting there was a press release issued but it was some days after the conclusion of

the meeting and, indeed, it was late in the day after the usual deadline for press releases to have any opportunity to get into the paper or onto the news that night?

Dr Morris—I do not think that was intentional, Senator.

Senator FORSHAW—It was a Friday, wasn't it?

Dr Morris—It was on a Friday following the meeting. It was within 10 days of the meeting.

Senator FORSHAW—So the meeting took place and then 10 days later, late on a Friday, the media release was issued.

Dr Morris—I am not sure if it was the Friday immediately after the meeting or another week following that. I would need to check the dates for you.

Senator FORSHAW—Has the special expert committee considered the findings of Lord Phillips's report in the UK, particularly those aspects that went to the government's handling of the problem?

Dr Morris—The Lord Phillips report is part of designated reading material for all members of the committee.

Senator FORSHAW—That would mean that you have considered or will consider the comments and recommendations regarding government secrecy—I think to use the word 'paternalism' would be appropriate—to adequately address identified risk factors and public confidence.

Dr Morris—Yes, Senator.

Senator FORSHAW—What risk factors will the committee be considering? Maybe you want to take that on notice.

Dr Morris—The committee has a range of issues to consider and it is a bit early to talk about which risk factors in particular it is going to be looking at.

Senator FORSHAW—Could you take that on notice and, if you are able to, respond appropriately. One issue that comes to mind, for instance, is will you be considering the risks associated with other beef food products such as gelatine, tallow, milk? Will you be? You cannot just nod, I am sorry. It is a 'yes' or 'no'.

Dr Morris—The committee, as I said, has been given a range of issues, including issues of beef and other beef related products in the food chain. It is a question over the next few meetings of the group to prioritise the workload in order to determine which ones have the greatest priority in terms of public health.

Senator FORSHAW—How many meetings have taken place so far? Just the one?

Dr Morris—There has been one meeting in December 2000 by telephone, which was more in the way of a briefing session, and a face-to-face meeting on 30 January this year.

Senator FORSHAW—But at this stage you cannot say specifically that they will be looking at the risks associated with other products. That is something that has to be considered, is it?

Dr Morris—That is fair to say.

Senator FORSHAW—I appreciate you said this is an ongoing advisory body to provide advice to the minister and to government, et cetera. Do you have any time lines at this stage for your considerations?

Dr Morris—The issue at the moment is defining priorities and defining what information is easily obtainable for the committee to provide its advice. At this stage I do not think time frames have been put in place for any one piece of advice.

Senator FORSHAW—It is just that you and Professor Smallwood said earlier that there was a degree of urgency to get the expert committee established. I would have thought that you would also be, very early in the piece, identifying some time lines by which time you would be able to provide reports or advice to the government on some of the high priority issues. I would have thought they were pretty clear by now.

Dr Morris—The issues are fairly clear but the committee is still seeing what information is going to take some time to gather and which information is readily available.

Senator FORSHAW—You do not have any time lines at the moment?

Dr Morris—No.

Senator FORSHAW—What type of risk assessment analysis will the committee be undertaking?

Dr Morris—Can you be more specific?

Senator FORSHAW—I am trying to find out what process you see as being involved in risk assessment. Is it just the gathering of material or information that is on the public record and from overseas?

Dr Morris—No.

Senator FORSHAW—Is it more in-depth than that?

Dr Morris—It is more in-depth than that in terms of risk assessment. It is a question of taking the particular issue in the Australian context. For example, if we are looking at consumption of foreign canned beef, one would need to know who is eating it in Australia and what the consumption is in order to start a risk assessment.

Senator FORSHAW—You would want to know what was in it, wouldn't you?

Senator CROWLEY—I would have thought so.

Dr Morris—Of course.

Senator FORSHAW—That would involve, or should involve, somebody doing some testing and some analysis, or was it done overseas?

Dr Morris—That would be an issue for the National Food Authority to establish.

Senator FORSHAW—So you would be relying upon ANZFA to advise you in that regard.

Dr Morris—I imagine so. ANZFA in terms of its regulatory processes, and what it allows into the country, would be doing our risk assessment.

Senator CROWLEY—Will you be using epidemiological studies?

Dr Morris—Epidemiological studies would be included, yes.

Senator CROWLEY—Will you be doing anything more factual or objective than that?

Dr Morris—If there is an urgent need for information then there will be some information gathering beyond simple epidemiology.

Prof. Mathews—We will be working with Professor Smallwood coordinating the departmental response in the light of the advice that comes from the National Health and Medical Research Council. I think it is important to emphasise that the expert committee, as

well as bringing together the best brains in the country, has access to emerging information from overseas. Professor Colin Masters, who is the deputy chair of the expert committee, NHMRC, is a member of the committee in the UK. He has access to the informal networks. All the other expert people on the committee are able to alert us to unforeseen hazards. Clearly the issues in terms of the Australian food supply in the short term are pretty reassuring. There is no reason to suppose that Australian herds are infected with BSE. The obvious risks that we have asked for advice about relate to the identified hazards, the risk of variant CJD entering Australia through someone who has previously lived and eaten food in Britain. There are other potential threats related to the fact that the bone and meat meal that spread the BSE in Britain did not come to Australia but the precise destination of the bone and meat meal from Britain around the world remains to be determined. That is one of the issues that the expert committee will be providing advice on.

Senator CROWLEY—We do not know where it went, but we know it did not come from Australia.

Prof. Mathews—That is our current understanding, Senator.

Senator FORSHAW—I am sure you would understand that when people refer to experts overseas on this issue, there is a great deal of scepticism about just how expert they ultimately are, or were, given what they seem to be finding out increasingly about the spread of the disease in Europe.

Prof. Mathews—Yes.

Senator FORSHAW—Despite their early assurances. Just back to the membership of the expert committee, you said there is a representative on there with respect to quarantine. Who was that person? Have you checked that? Is there someone on there from AQIS, or Biosecurity, as the other arm is now called.

Dr Morris—I think we have Bob Biddle, from AQIS, on the committee.

Senator FORSHAW—So there is an AQIS person on the committee?

Dr Morris—There is, yes.

Senator FORSHAW—The questions I now have on this are directed mainly at ANZFA. We can proceed to those. What scientific assessment process will ANZFA be employing to determine whether the currently banned European beef products are safe under the new food standards code?

Mr Lindenmayer—Essentially we will be going through what we see as the whole gamut of our standard scientific risk assessment process which involves the gathering of information—and I have to say that information will certainly include material, with both hard data and professional advice drawn from not only the expert group advising in HMRC, but also from regulatory and scientific authorities in a number of other countries. We will also be doing some consultation with stakeholders within Australia and New Zealand and with all of the jurisdictions within Australia and New Zealand.

Senator FORSHAW—The actual prohibition or ban that was put on the importation of the products I think was announced in January, was it?

Mr Lindenmayer—On 5 January, yes.

Senator FORSHAW—I obviously read about it in the press. You may well have provided this through the usual sources, but if not would you provide the committee with documentation or details of just what actually has been banned? Can you do that?

Mr Lindenmayer—I can tell you right now.

Senator FORSHAW—All right.

Mr Lindenmayer—We are referring to it not as a ban so much as a withholding from entry. Essentially what we have done is advised AQIS—and we have a role of advising AQIS on the risk assessment for foods proposed for entry to Australia—to prevent the entry to Australia of all foods originating in the 30 countries of Europe. Although I know the boundaries of Europe are a little bit fuzzy it is the 30 countries that are deemed by most people to be the countries of Europe—with the exception of those products which are in about four groups: milk and milk products, collagen, tallows in related fats, and gelatin.

Senator FORSHAW—They are exempt.

Mr Lindenmayer—They are, at this stage, exempt. We have since then written to the NHMRC expert committee seeking advice from them about the appropriateness of an exemption for those groups. We have also sought advice about the level of risk entailed in the importation of sheep and goats as well.

Senator FORSHAW—What you are saying is you have a concern about those products but at this point in time they are still able to be imported.

Mr Lindenmayer—No, I would put it a different way. I would say at this stage the scientific evidence available to us indicates no cause for concern. While it is our view that the probability of any individual eating such a product, or indeed any beef product from Europe, is extremely small, at the same time the consequences in the event of contracting vCJD are so serious as to justify erring on the grounds of caution. For that reason we are saying that in addition to all other beef derived foods, it is desirable that we seek confirmation in relation to those four classes of product. We have very close contact with regulatory authorities in North America and in Europe and we understand further scientific work on some of those things has been undertaken or is in the process of being undertaken. We want to tap into that information as well.

Senator FORSHAW—The report I saw was along the lines you have just outlined. Has there been prepared an actual list of products, or is that not possible—the ones that you describe as being essentially products that are manufactured in Europe from beef? Is that able to be expanded into a list?

Mr Lindenmayer—Within reason. The problem is that there is no national database that identifies by brand and by other characteristics, including date of manufacture, every last subset of that huge and diverse range of products. What we did do, however, was to get the customs tariff information on all foods containing beef that had originated from Britain over the preceding two years. In most cases, that list was not specific to a particular brand but, rather, descriptives such as 'beef cubes', although beef cubes were an exception where a particular brand name had been appended. We provided that information to the retail sector around Australia, as well as to importers, and indicated that this represented, we believed, a fairly comprehensive list of the classes of food but that the respective importers and retailers would need then to do their own homework from their own records to identify which foods needed to be removed from the shelves.

Senator FORSHAW—Product that is already in Australia is also picked up in this decision, is it, as best it can be?

Mr Lindenmayer—It is a somewhat different decision, to the extent that, whereas there is a power to require the withdrawal under law of foods which are either contrary to the food

standards code or are otherwise unsafe for human consumption, it is not possible with this class of food to say, yes, this particular brand, this particular type of product, manufactured in this particular location, is in fact dangerous to the consumer. Because the probability of there being a BSE prion in any particular food is very low, and because it is scientifically not possible to establish the presence of BSE infected material in any beef product once it has been processed, we simply were not able to do that. What in fact we did was to go to all of the retail and import industry organisations on 5 January and ask them to institute a voluntary withdrawal. There was agreement that this should occur and that they would do it forthwith and there has been, I have to say, a commendable level of compliance with that undertaking.

Senator FORSHAW—I appreciate the sort of position that you have just outlined but, as you know—and as I know, as one who sat on the CJD inquiry of this committee, as I think other members here did—what has occurred in Europe is that the disease, particularly if it is CJD, does not manifest itself until many years later. People have been given assurances in Europe and in Britain that the product was free of contamination or free of the disease and subsequently that has been proven to be wrong, which would suggest that you have to err on the side of caution rather than necessarily low probability.

Mr Lindenmayer—We are very conscious of that. In fact, we are at this stage examining the desirability of putting in place, under the food standards code, a general requirement that all foods containing bovine material are made from cattle that are BSE free.

Senator FORSHAW—How will the risk assessment process that is going to be undertaken be funded? Is industry going to have to pick up the cost?

Mr Lindenmayer—We have an extremely limited capacity to charge for our services and there is certainly no capacity under the legislation to charge industry for doing so. The costs will, therefore, be met from the ANZFA budget.

Senator FORSHAW—Will you or AQIS be requiring independent testing from the Australian government laboratories or, as it often does or as I understand ANZFA does—and certainly this happens with the GM area—is it essentially relying upon the scientific work being done by the industry itself?

Mr Lindenmayer—In this case, as I was saying earlier, there is no scientific test available which will identify BSE infected material in processed beef products. For that reason, the processes that are now being developed by ANZFA in conjunction with AQIS for Australia, and with the Ministry of Health and others in New Zealand for the purposes of New Zealand, would involve a certification system, with that certification system having regard to the intrinsic level of risk of the country. It would follow from that that it would be very stringent indeed for those countries where there have been outbreaks and cases of vCJD in the population and, of course, far less stringent for the few countries which, like Australia, are in the top category in terms of a low probability of their beef having BSE infected material in them.

Senator FORSHAW—You said earlier that you are not able to produce a list of all of the products and brands, but are you able to require companies or the industry to provide consumers, and particularly retailers, with information about which of the products they are importing are sourced from European beef?

Mr Lindenmayer—As I was saying, we did produce a list based on the last two years Customs information. That list went into considerable detail but, in almost all cases—not literally all, but almost all cases—it stopped short of identifying the brand name or the name of the manufacturer, which means that the retail sector has had a great deal of guidance in

knowing which products to look at, but they needed to go beyond just the list in order to establish whether or not the product did contain bovine material. A classic example of how that list needed other information is a popular brand of beef cubes. The manufacturer provided certification that these beef cubes contained absolutely no bovine material. It was a beef flavour but had nothing derived from something on four legs that went 'Moo!'

Senator FORSHAW—I can imagine consumers having a beef about that! That was terrible. How do the consumers, then, know whether a product that is on the shelf is sourced from European beef or not?

Mr Lindenmayer—They cannot be absolutely certain, but there are two things that assist them greatly in differentiating. One is the requirement for country of origin labelling and the other is the requirement for ingredient labelling on foods. We acknowledge, however, that there are difficulties to the extent that products are made in one country but with beef products drawn from others. In many of those cases, the retailers have been seeking advice from their suppliers about the source of the beef in their products in order to establish whether it was European beef or Argentinian beef or, for that matter, even Australian beef.

Senator FORSHAW—You have mentioned the country of origin labelling requirements. ANZFA is conducting a review this year, isn't it, of those requirements?

Mr Lindenmayer—Yes.

Senator FORSHAW—Will there be an opportunity for public submissions and public consultation in that process?

Mr Lindenmayer—Yes, there certainly will be.

Senator FORSHAW—Has ANZFA met its work program commitments for the year? I appreciate that there are a few months to go.

Mr Lindenmayer—It is virtually impossible to answer that question, with almost half of the year still to go—

Senator FORSHAW—That means no, doesn't it, because if you had, you would be quickly saying, 'Yes.' Sorry, go on.

Mr Lindenmayer—I would need to check with one of my colleagues. We are going to meet it? Yes. I am assured that the relevant general manager expects that we will meet all of our work program commitments.

Senator FORSHAW—Do you have sufficient resources to deal with these major issues that have arisen? Whilst they have been around for a while, they have arisen in the last 12 months or so, particularly the BSE issue again and one which we are going to turn to in a moment—StarLink corn. Does your current funding enable you to do all the things you want to do in that area or are you looking for more resources?

Mr Lindenmayer—Our budget was substantially increased in the last budget. I believe this year we will manage within that budget. We undertook a fundamental review of how we are going against the budget in the last two weeks. We have been able to reallocate resources in order to cover what we believe will be the costs of the major risk assessment and other work on BSE.

Senator FORSHAW—I am sure we can have another look at that and give you another chance in a few months' time after the next budget. Can I just ask some questions regarding StarLink corn, which I am sure is well known to everybody in the room. Senator Evans tells me he is dying to ask these questions but he is happy for me to proceed. As I am advised,

ANZFA is required to advise AQIS on issues of compliance with the food standards code. What particular corn products has ANZFA advised AQIS to monitor for suspected contamination of the unapproved StarLink corn under the AQIS imported food program?

Dr Healy—We have been actively monitoring and evaluating the StarLink situation. You would be aware that StarLink was detected in various corn products. It has been detected at the DNA level. There are no cases that we are aware of where it has been detected at the protein level. Of course the DNA itself is not unsafe. The first point to make on enforcement is that StarLink has not been approved for use in Australia and there is no application for it to be used. We do not expect an application and in fact Aventis has asked for the registration to be withdrawn in the US.

Senator CROWLEY—Will it make much difference now that it is all over the country and completely out of control?

Dr Healy—My understanding is that StarLink represents a very small proportion of the crop, notwithstanding the fact that it had been commingled and has been broadly distributed. We have been having discussions with AQIS about monitoring for StarLink. AQIS and the Australian government laboratories have also been looking at the sorts of products and the sorts of testing regimes that are necessary.

Senator CROWLEY—You say the DNA has tested positive in some samples. Are those samples—

Dr Healy—Not as far as we are aware in Australia.

Senator CROWLEY—That is the question; not in Australia?

Dr Healy—As far as we are aware.

Senator CROWLEY—At some stage could you perhaps provide me with a little bit of paper that tells me why it is safe to find DNA but not protein, which I understood you to say.

Dr Healy—That is correct. We can certainly provide you with some discussion on that point. DNA itself is not inherently unsafe. The safety of StarLink has been called into question because of the protein product that it produces, not the DNA itself. Perhaps I should add that it is a question of potential allergenicity of the protein where concerns have been raised.

Senator CROWLEY—You might also in that little bit of paper tell me how the protein produced by DNA differs from the DNA and what is the element where it is differently safe?

Dr Healy—We can do that.

Senator FORSHAW—Are we only talking about imports from the USA here or are we talking about from other countries as well?

Mr Lindenmayer—In relation to StarLink?

Senator FORSHAW—Yes, and the corn products that ANZFA has asked AQIS to monitor.

Mr Lindenmayer—The food standards code applies to product from all sources. While the United States is of course the major producer of GM commodities, a number of these commodities are produced in a number of other countries. The standard applies everywhere, whatever the source. Therefore, an inspection regime will not differentiate between a particular approved commodity—or non-approved commodity, for that matter—coming from one country as against that same commodity coming from another.

Senator FORSHAW—The monitor would include or should include corn products from other than the United States?

Mr Lindenmayer—Yes.

Senator FORSHAW—Do these products include material imported for feed stock?

Mr Lindenmayer—Our role relates only to food for human consumption. We advise AQIS, therefore, on such classes of product. AQIS itself gets advice from elsewhere, including Biosecurity Australia in relation to other things.

Senator CROWLEY—Do you have any concern about feed stock? Do you talk to food and agricultural colleagues about it? For example, food stock for cows, that might give them BSE, should focus the mind.

Mr Lindenmayer—We most certainly talk extensively with them about those animal feeds which are likely to have deleterious effects on the safety of the food.

Senator FORSHAW—What assessment has ANZFA undertaken to ascertain the presence of StarLink in Australia? You may have touched on this in your earlier answers.

Dr Healy—There is a number of activities that we have been engaged in. The first is to ascertain, at least to the extent that we can on the available information, the health risk that is posed by the StarLink protein; to get some level of reassurance from manufacturers of various products about where their corn going into those products that seem to be most susceptible to the presence of StarLink was coming from; and also then to be having ongoing discussions with AQIS about looking at incoming products, as well as taking into consideration the proportion of the corn crop in the United States that consists of the StarLink crop.

Senator CROWLEY—What is the nature of the hazard? Is it only an allergic response or is it something more?

Dr Healy—There is no demonstrated allergic response. In undertaking safety assessments of these types of proteins there is a battery of tests that are done to try and gauge the likelihood that a particular protein will lead to an allergenic response for those proteins that have not been in the food supply previously. The StarLink protein is one of those. On that battery of tests, on one parameter in particular, there was some indication that there was some potential for this protein to be allergenic but there is no demonstrated allergenicity.

Senator FORSHAW—Part of that process of assessment, I take it, was to contact the major food manufacturers.

Dr Healy—We have been in touch with several of the manufacturers, especially for those products that have been implicated in contamination by StarLink.

Senator FORSHAW—That would include Taco Bell and Kelloggs?

Dr Healy—Taco Bell in particular.

Senator FORSHAW—What information did you receive back from, say, those companies regarding—

Dr Healy—Taco Bell assured us that their products were sourced locally and that they had a certification system in place that indicated the products were not made from GMOs.

Senator FORSHAW—Did the documentation include claiming that they had tested for the presence of the StarLink corn?

Dr Healy—No, it did not. It claimed that their corn was sourced from crops that had been produced in Australia, and StarLink is not authorised for production in Australia.

Senator CROWLEY—Articles did suggest that the taco manufacturers in the States were up in arms about this, though. Was Taco Bell one that managed not to get caught up in this corn co-mingling? How did they manage to keep it unco-mingled?

Mr Lindenmayer—As I understand it, no tacos or taco raw materials—or at least the corn raw materials—are imported anyway. This is a fairly low value per unit volume food and it is therefore very unlikely that this will be imported from the other side of the world when local equivalents are cheaply available.

Senator FORSHAW—Are you able to provide the responses or the information that was provided to you by those companies? You may want to take that on notice.

Mr Lindenmayer—Senator, we will need to take this on notice. There is a fairly strong chance it will be commercial-in-confidence material, but let us see whether we can—

Senator FORSHAW—We are concerned about public confidence here. Commercial-in-confidence is sort of in inverse proportion to public confidence. I appreciate that you will have to take it on notice.

Mr Lindenmayer—Yes. We are, as you would appreciate, under certain obligations to protect those things that have legitimately been provided as commercial-in-confidence to us. We will need to establish the facts, but we will do what we can.

Senator FORSHAW—Are you aware of whether the manufacturers or food suppliers or indeed ANZFA have undertaken any PCR technology to ascertain the presence of StarLink corn in Australia?

Dr Healy—I can answer that. No, those tests would not have been undertaken. As far as I am aware, there is no testing laboratory in Australia that currently has the ability to do those tests. The main reason is that the primers that you need to do the PCR are proprietary information of the company. My understanding also is that AGAL is having negotiations with the company to get access.

Senator FORSHAW—Thank you. Good luck.

Senator CROWLEY—I will perhaps put some questions to you following that one when I get my head around it—like who owns that and who they are in cahoots with. The United States Environmental Protection Agency's FIFRA Scientific Panel concluded that Cry9C has a medium likelihood of being an allergin. Is that the one you have been talking about?

Dr Healy—That is right.

Senator CROWLEY—ANZFA has not done any testing to determine whether it is?

Dr Healy—We have not received an application for the Cry9C to be used in food, so we have not undertaken a full evaluation. However, once we became aware that Cry9C had leaked into the food supply in the United States, we did what I would say is a preliminary evaluation of the information that was supplied to the United States EPA, which is very similar to the sort of information that we are used to evaluating for other products. We can certainly see where their concerns have arisen.

Senator CROWLEY—I am not sure that this question is strictly to you, Mr Lindenmayer, but I wonder if you can help me with it. ANZFA is required to advise AQIS on issues of

compliance with food standards: do you have any say or contribution to the requirements under customs of importing genetically modified food?

Mr Lindenmayer—Customs act as the agent of AQIS under the Imported Food Control Program, Senator. We, as the advisers on risk assessment in relation to imported food, therefore do have some link with that matter.

Senator CROWLEY—Are all of the imports of genetically modified food restricted imports and therefore does a form need to be filled in and ticked by some minister?

Mr Lindenmayer—No. There is a requirement that all genetically modified foods, before they are released to go on the market, satisfy the rigorous safety assessment that we take them through and then be approved by the ministerial council. There are at the moment only seven such commodities so approved. When foods are imported, a form of documentation is completed by the importer, based on material provided by the supplier, and among the questions asked is a question about whether or not the food contains genetically modified material. If the answer is yes, then it is necessary for the importer to be able to demonstrate that the material is one, or maybe several, of the approved ones. If any genetically modified food other than the approved commodities is present, then that food cannot lawfully be imported.

Senator CROWLEY—Who says it cannot—you or AQIS?

Mr Lindenmayer—In effect, the law says it cannot. The decision is taken by Customs as the agent of AQIS, and AQIS act on our advice.

Senator CROWLEY—What about genetically modified material for research? As opposed to the genetically modified crop that might be imported in large amounts, what about the small bags of seed that somebody might be bringing in to do a research trial in Mount Gambier?

Mr Lindenmayer—That is a matter for regulation by the Interim Office of the Gene Technology Regulator. It is an issue of release into the environment, not an issue of marketing to the public for human consumption.

Senator CROWLEY—Thank you for that. I will note down those distinctions. I am beginning to think it is a nightmare to get through, but things come in through customs under many different hats. I should ask you, Minister, under your previous guise. I will try to seek some further information, because I think it is very confusing for the community and I have been asked to chase up these questions—how things get through customs and who acts on behalf of who? Thank you very much.

Senator FORSHAW—I want to ask one final question. Currently there is an import risk assessment, or a draft has been produced by Biosecurity with respect to an application by New Zealand to export apples into Australia, which are currently banned because of the danger of fire blight. There is also a similar situation—it is not in the application stage, as I understand it—regarding bananas from the Philippines. Is ANZFA consulted as part of that import risk assessment process in regard to those two products?

Mr Lindenmayer—If there is any question that the health and safety of the consumer is at risk, then most certainly we are consulted. Indeed, we would have a major input to such an assessment. In neither of the examples you have cited is there any cause—at least to the best of my knowledge—to believe that public health and safety is at risk.

Dr Healy—I do not recall myself that we have looked at the bananas from the Philippines example but we certainly have looked at the apples from New Zealand, which I think is what you are referring to.

Senator FORSHAW—Yes, that is right.

Dr Healy—We have made some comments largely in relation to proposed mitigation measures for fire blight, which relates mainly to permissions for MRLs in the food standards code.

Senator FORSHAW—I understand fully that you are charged with food safety, as the name implies, and your New Zealand counterparts are part of the organisation. But whilst the fire blight issue is one which is of major concern obviously to the agricultural sector, the growers, the fact is that fire blight can destroy the apple and you may not even know that it is infected until you cut it open. Then it is not fit, obviously, for human consumption.

Secondly, some of the processes that have been identified as treating the apples before they come into Australia, such as chlorine dipping and the use of chemicals, I would have thought may at least raise issues about fitness for human consumption. In that context I would have thought ANZFA had a role to play, even though the primary focus is on trying to keep the disease out of Australia as distinct from whether the apples are safe to eat or not.

Mr Lindenmayer—Yes, the use of materials of that sort or, for that matter, processes in order to de-infest or decontaminate a food, is very much part of our bailiwick. There is a substantial array of what are called processing aids, some of which have that purpose. All of those, in order to be lawful, or to have residues lawfully in a food, have first to be subject to a risk assessment we undertake and then approval. In regard to processes like irradiation, in each case—and by case I mean each type of application—in terms of the nature of the irradiation process and the classes of foods to be irradiated, again it is necessary to get prior approval before foods that have been irradiated can be marketed within Australia, or for that matter imported into Australia from another country.

Senator FORSHAW—That is fine. We will pursue it in another place.

Senator Vanstone—I wanted to make a point about the supplementary estimates to the additional estimates. As interesting as this conversation has been there are limits.

Senator FORSHAW—Thank you, Minister, but this is work that is actually being undertaken right at this moment by Biosecurity, AQIS and, as I understand it, ANZFA. It is a matter of major importance to a lot of Australians.

Senator Vanstone—I appreciate that.

Senator FORSHAW—I just took the opportunity to ask about it.

Senator Vanstone—I agree with you entirely. I am simply making the point, Madam Chairman, that there is a lot of interesting work that goes on. Work in the government does not stop when estimates are not on. Of course it is always going on. The question is: when do we ask questions about it?

CHAIR—I think the important thing is that things are getting a little out of control, because we are still on outcome 1, if some of these important issues are to be discussed—

Senator FORSHAW—I have finished. I did say that was my final question.

CHAIR—I am just making the statement generally that I am sure if the committee members would like to discuss these issue in more detail the minister would be more than

likely responsive to a request by the committee for a special briefing, as opposed to using the estimates time to do it.

Senator FORSHAW—I do not want to drag it on, Chair. My question was whether or not ANZFA had a role in the process. I would have thought it was appropriate to ask here. I have asked it and I have the answer and I am satisfied.

CHAIR—I am just talking generally. I am trying to be helpful in terms of saying that if you want to have some of these debates I am sure we can arrange briefings.

Senator FORSHAW—We just had a week of it through the rest of the country.

CHAIR—I am sure we can arrange briefings if the committee would so desire. Any further questions on outcome 1?

Senator DENMAN—Is this where I ask my question on Temazepam and Normison, or is that in the next program? I was told to come back to it because I asked it in the wrong place before.

Mr Podger—Outcome 2.

Senator WEST—This is not in the PAS but, given this is the first opportunity I have had to ask it: with respect to the annual report from the advisory panel on the marketing in Australia of infant formula, along with all other annual reports, when are they due?

Mr Lindenmayer—No, Senator, it is not one of the reports required under the relevant legislation to be tabled by whatever the date is in October.

Senator WEST—When do you normally expect it to be ready? When in 1999-2000 was this report tabled?

Mr Lindenmayer—When was it completed?

Senator WEST—Yes.

Mr Lindenmayer—It was completed in early 2000.

Senator WEST—I know when it was presented here because I was the Presiding Officer who enabled it some presentation out of session.

Mr Lindenmayer—December 2000.

Senator WEST—It was the previous one to this that I was interested in as well. This report raises a lot of concerns, because it talks about working with the industry and the need to identify the specific sources of influence and research that are going to be undertaken. There are three objectives there. It would seem to me that those were the sorts of objectives, the sort of pieces of information that infant formula manufacturers would have been dearly wanting to know. It is asking to identify the specific sources of influence on a mother's choice of infant feeding to establish mothers' understanding of attitudes on information available regarding the issue of breastfeeding versus infant formula substitutes, and to correlate breastfeeding rates with mothers' perceptions and attitudes. I just have some concerns about that particular piece of research which the industry, it would appear, to be wanting the government to provide the money for. Would that be correct?

Ms Pontin—IFMAA, the industry body, has actually offered to jointly partner with government in undertaking this research.

Senator WEST—What is happening in relation to that?

Ms Pontin—In relation to the research?

Senator WEST—Yes.

Ms Pontin—We have relayed that information to the department. ANZFA's role in supporting APMAIF is to supply the secretariat services. The department has responsibility for the policy framework surrounding it.

Senator WEST—So no-one can tell me what sort of ethics committee might be set up and what oversighting might be done of any research then? No-one can tell me if there has been a decision made whether to go ahead with this particular research. I did give warning to the committee secretariat that I was going to ask questions about this report.

Mr Corcoran—We have done nothing about this research at this point, Senator. We have commissioned independent advice into the operation of the panel, the effectiveness of the panel in achieving the objectives of the WHO agreement, and in that context we would be looking at the merits of research which might further those objectives. At this point we do not have that independent report and so we have taken no action in relation to this research as yet.

Senator WEST—If I understand you correctly there is in fact a consultant undertaking a report on the workings of this advisory panel.

Mr Corcoran—That is correct, Senator.

Senator WEST—Because I have concerns here. The panel has been discussing various concerns regarding the transparency and the activities associated with the disputes resolution process, as well as avenues of reporting alleged breaches and other information to the panel. I was wanting to pursue what other avenues there were for reporting alleged breaches; how many cases had gone through the disputes resolution process; how many had been reported and what the results of those were.

Ms Pontin—Senator, we do not have the information on the number of disputes that have been sorted out by the intercompany process. All we have been able to observe—and the panel has itself observed this—is that the number of reports of alleged breaches going to the panel has decreased.

Senator WEST—Yes, but then it goes on in other areas to indicate that there are differing views on the matter, ongoing discussions, and there were breaches found under clause 7(d) and the provision of samples. It says it found two breaches against signatories under clause 7(d) and that, due to ongoing discussions and differing views on this matter, the panel has decided to withhold the names of the subject companies pending the further deliberation of IFMAA, ANZFA and DHAC regarding the distribution of samples. There is a grave area of concern in here that people must have in relation to the sample issue. What is the latest on the particular breaches of 7(d)?

Ms Pontin—Those two issues are situations that the panel itself is continuing to debate. There is disagreement amongst the panel.

Senator WEST—Who are the two signatories that have breached?

Ms Pontin—I can give you the names of those two companies, but I would like to restate that the panel itself is having a great deal of difficulty dealing with this issue and has undertaken to look at it again through this year and report in its annual report at the end of this year.

Senator WEST—Are those two breaches included in the number of breaches that are in the table on the previous page, page 16?

Ms Pontin—I understand that the number of breaches in total is seven this year. There are five recorded in that table and there are two other unnamed companies.

Senator WEST—They are ones that are in breach of 7(d). Who are the two companies?

Ms Pontin—The two companies involved there were Bristol-Myers group and Wyeth Australia.

Senator WEST—In fact, instead of having two breaches, they have actually got three each. They would have to be the two major companies as far as product goes, wouldn't they?

Ms Pontin—I cannot answer that, I am afraid.

Senator WEST—I see that Amcal has also withdrawn as a signatory to the MAIF. Why did they withdraw?

Ms Pontin—I do not have that information either, I am sorry.

Senator WEST—Can you take that on notice please?

Ms Pontin—Yes.

Senator WEST—What were the penalties for the seven breaches? Obviously two you are still arguing about.

Ms Pontin—Not us, the panel. The panel is certainly in disagreement about those remaining two, but for the other five the process of the panel is to write a letter to the manufacturers concerned, bringing the breach to their attention and asking for it to be rectified in some way.

Senator WEST—What have the companies done in relation to those two breaches each?

Ms Pontin—The two disputed breaches?

Senator WEST—No, the two breaches that are actually in the table. They have had a letter written to them. What have they done in relation to those breaches? Have they ceased what they were doing or have they just thumbed their nose?

Ms Pontin—I am not aware of whether they have replied or what they have done about that.

Senator WEST—So we do not know what they have done. We do not know whether those two companies have actually taken action to remedy the breaches that they have been found to be in breach of.

Ms Pontin—They are not recorded as an ongoing breach, so I am assuming that whatever action was taken was satisfactory to the panel.

Senator WEST—Does the department have an opinion on the issue of samples?

Mr Corcoran—Senator, it is precisely for these sorts of reasons—the controversy over the issue of samples—that we have commissioned the independent report. That was commissioned as a sense of urgency at the request of the minister to try to get to the bottom of these sorts of issues and come to a situation where the panel does operate effectively and there are clearer practices, procedures and outcomes.

Senator WEST—It would seem to me on the sampling issue, from the way this report is written, that most of the companies would in fact like to be, if they are not already, in breach of the WHO code article 7.4.

Mr Corcoran—That is one particular view, yes.

Senator WEST—I suppose that is a view coming out of an old early childhood nurse. I am wondering if and how we are policing clause 7(c), on page 23, which states:

Manufacturers and importers of infant formulas should not offer any financial or material inducement to health care professionals or members of their families to promote infant formulas, nor should such inducements be accepted by health care professionals or members of their families.

That is WHO code article 7.3. I am wondering how that is policed, if it is policed.

Mr Corcoran—I know this must be very confusing for you, Senator. At the present time the panel is supported by ANZFA, so questions about—

Senator WEST—Thank you, Mr Lindenmayer. How is that being policed?

Mr Lindenmayer—The role of ANZFA in this is to provide a secretariat service to the panel. The panel receives complaints and acts on those complaints and that is the extent of the ANZFA role in this matter.

Senator WEST—So nobody has the policing role of inducements that the manufacturers or importers might offer to health professionals.

Ms Pontin—Senator, this is a voluntary agreement signed by a number of manufacturers, and it is reliant on people taking a complaint to the panel. I am not aware if there have been any recent complaints against 7(c).

Senator WEST—What is your reaction to the fact that now we are seeing on infant formula shelves in supermarkets, and I presume in pharmacies as well, formula for toddlers? Are you aware of what I am talking about here?

Mr Lindenmayer—Follow-on formula?

Senator WEST—Follow-on formula, yes—the 12-month plus. I want to know why it is there and how it got there. I want to know whether any evidence or research has come to bear of late that would indicate that cows milk is not suitable for children over the age of 12 months. This is what one would tend to believe. No-one can answer that question?

Senator Vanstone—Is your question: is there research that indicates that?

Senator WEST—Yes. Does ANZFA or the panel have any research that indicates—

Mr Lindenmayer—There is research, Senator. It is certainly the view of the World Health Organisation that for children under 12 months it is inappropriate for cows milk to be the sole—

Senator WEST—Without modification.

Mr Lindenmayer—or principal source of nutrition.

Senator WEST—That is right.

Mr Lindenmayer—Beyond that age, we believe that it is primarily children who have a lactose intolerance who ought not be fed cows milk. But for other children, children without such an intolerance or a similar condition, cows milk is a desirable part of the diet.

Senator WEST—And full strength cows milk, not low fat.

Mr Lindenmayer—Indeed, full strength cows milk. We have maintained in the new joint food standards code a requirement that milks that have been modified to reduce the milk fat be labelled as not an appropriate source of nutrition for children.

Senator WEST—Reading the label of the follow-on formula, it is not particularly clear that it is a low fat based formula. I want to know if there is research that backs up the sale of

this to well, normal 12-month-old plus. The information I have had from my former professional colleagues indicates there is no research that they are aware of.

Mr Liehne—My understanding is that the industry has segmented the market quite significantly. There are a number of formulae which are specifically targeted at different age groups or different subpopulations within the population. The matter is further complicated by the fact that we now have a joint market between Australia and New Zealand. The New Zealand products can equally be sold on the Australian market under the trans-Tasman mutual recognition arrangement. My understanding is that the New Zealand requirements in relation to the WHO code, particularly the approach that is evident in APMAIF, is simply not at the same level of scrutiny, nor the same level of government control. All of those factors are working together to create opportunities for this segmentation in the marketplace. The review of infant formula requirements or infant formula standards for the joint food standards code was not completed in time for deliberation by ministers when they met in November. It is expected that that will be completed within the next 12 months so that there in fact will be a joint standard for infant formula and formula products for both countries. That should resolve the anomalies that exist between the Australian and New Zealand markets.

Senator Vanstone—Senator, if I understood what has been said, the short and direct answer to your question—are we aware of any research that says normal cows milk is not suitable for over 12s?—is no.

Senator WEST—I think that is correct, Minister. That leads me to ask in relation to some types of this particular formula—and I have actually taken to scouring the infant formula sections of the supermarket and having to explain to people it is not for my child

Senator Vanstone—You better watch it; they might think you are trying to tamper with it. You'll find your picture up in supermarkets: 'If you see this woman, notify the cops!'

Senator WEST—Quite possible. But I am concerned though because of the energy component and the difference in the energy component between the formula that is for the under 12-monthers for some of the products and the post 12-monthers. In some of the products there is an increase in the energy or calorific content of the milk that is going to the post 12-monthers. Presumably it has to be through some sorts of sugars. We have a problem with obesity in this country and the problem of younger obesity is getting bigger. I have grave concerns about infant formula companies selling product that is sweeter than it needs to be, because children will develop a sweet tooth pretty quickly without any encouragement from anybody else. One of the companies actually gave recipes for incorporating this particular product with milk to make smoothies and things. Why is it in the infant formula section? Why isn't it in the normal milk section? I want to know what you are going to do about it, because I have grave concerns about the way this is being retailed. What is happening with it?

Mr Liehne—There are obviously very different views from sectors in the public health profession and others compared with the views that may be coming forward from industry in this area.

Senator WEST—My word.

Mr Liehne—Indeed, this has been one of the reasons why the draft standard has not been resolved at this stage, because there is indeed a significant difference of view about the utility and the value of different formulas within the marketplace. The authority is seeking to ensure that a framework will be developed in the new standard which will, in fact, provide a consistent and scientifically based evaluation of the safety of these products so that we do have the best standard that is available.

Mr Lindenmayer—The nutrition labelling requirements which were decided upon at the end of last year and which become mandatory at the end of next year will require the identification not only of energy levels but also of sugar in all foods. This will at least provide a means by which parents can do a comparative examination of products on the shelf.

Senator WEST—At present it is very difficult to do a comparison between the under 12-month and the post 12-month product.

Mr Lindenmayer—Yes.

Senator WEST—I have grave concerns about it. I warn you that that is one that I will be pursuing at the next estimates. I will ask TGA about pseudoephedrine sales. What is happening with the sale of pseudoephedrine in pharmacies in this country in various formulations, formulae, products? Is it still schedule 2?

Dr Alder—Last year there were a number of proposals that were put to the National Drugs and Poisons Scheduling Committee, of which I am chair, to look at the scheduling of the different pack sizes for pseudoephedrine. Following a fairly extensive public consultation process, a number of decisions were made that look at different schedules for the different sized packs. The large pack was a 90s pack and there were concerns that this product, which was sold as a schedule 2 product, was being inappropriately bought and abused in terms of manufacturing amphetamine from it. That product was withdrawn from the market. There was a move for the 60-pack size from schedule 2 to schedule 4, I think—and only the smaller pack size, which was a pack of 30, was allowed to remain. I would have to check. There was a move from the large pack size to prescription only and the smaller pack size, I think, from schedule 2 to schedule 3, so that it actually had to be handed over by the pharmacist. But I would have to check and provide for you the exact details.

Senator WEST—I would appreciate it if you did do that checking. The complaints to me have come from pharmacists. They are concerned about what appears to be a lack of monitoring of the sales of pseudoephedrine products or products containing pseudoephedrine. The police departments in all of the states and nationally are very concerned, because we are now getting the amphetamines onto the black market by the distillation of that already pure product. In fact, it is easier to distil and you are probably getting a safer product at the end of it. With the work of the police force and customs at the borders, the products coming in through the borders are negligible now. The concern is with what is already legally available here. I am wondering what we are doing to monitor the sales of pseudoephedrine products. Is there any mechanism whereby large sales trigger alarms to do further investigation?

Dr Alder—It is my understanding from the members of the scheduling committee who come from the state and territory health authorities who have jurisdiction in this area that they are acutely aware of this product. There were representations made through those state members to the committee relating to concerns of the relevant police areas. That was what was prompting the recommendation for the rescheduling, and it is my understanding that the states are all continuing to monitor the process. The recommendation that was made by the committee is not binding on the states. Each state has to look at that decision and make recommendations within the state as to whether they adopt it. I would have to check with those members to see in fact what has been the outcome. I am aware that at least one state indicated at the time of the decision that they would not be implementing the recommendation.

Senator WEST—Is there a role here for federal monitoring if one of the states is going to be a bit recalcitrant in not wanting to do anything about monitoring the sale of pseudoephedrine?

Dr Alder—My understanding is that it has also been an issue that has been taken up by the state pharmacy boards. Where there have been issues brought to their attention by the state health authority or the police about inappropriate sales of pseudoephedrine products, it is an issue that a number of the state boards have taken up in terms of taking disciplinary action against the pharmacists involved.

Senator WEST—You have just told me that one state indicated it was not going to come on board. Is that right?

Dr Alder—That is what they indicated at the time. I would have to go back and check whether they in fact did implement the recommendation or not.

Senator WEST—Which state was that?

Dr Alder—South Australia.

Senator WEST—If I understand you correctly, South Australia is not going to implement any restrictions on pseudoephedrine sales or not going to implement any monitoring?

Dr Alder—They were not going to implement the recommendation for the change to the scheduling of the product that was recommended by the committee last year.

Senator WEST—That leaves one state that is going to be providing a very easy source of a 90-pack pseudoephedrine product.

Dr Alder—My understanding is that the 90s pack was actually withdrawn by the manufacturer. It is not available at all in Australia.

Senator WEST—Then what was South Australia not going to do?

Dr Alder—They were not going to move the product from schedule 2 to schedule 3 and from schedule 3 to schedule 4.

Senator WEST—It is not going to do anything to make it harder for people to get a pseudoephedrine product?

Dr Alder—I would have to check with the state whether that was the outcome. That is what they indicated at the meeting.

Senator WEST—I am likely to pursue it at the next round to see what precisely has happened. If you can take those questions on notice, I would appreciate that. What is happening with the review of drugs, poisons and controlled substances being done for the Council of Australian Governments?

Mr Slater—That report is now with the government. It is to be referred to the Australian health ministers for initial consideration. Agricultural ministers will also be involved. When those two ministerial councils have considered the report they will be making recommendations to the Council of Australian Governments.

Senator WEST—Is it a public report?

Mr Slater—No.

Senator WEST—When will it be made public?

Mr Slater—When the Council of Australian Governments agree to release it.

Senator WEST—Thank you. I think I will leave my TGA questions there. I think we have finished outcome 1.

[3.21 p.m.]

CHAIR—We move to outcome 2—access to Medicare.

Senator DENMAN—My question is on Temazepam and Normison. You will probably be aware of the publicity recently on this issue of injecting the gel from those two drugs and amputations and gangrene that occur as a result of it. Is any work being done on these products being sold only as tablets rather than in gel form?

Dr Morauta—Senator, there is a subcommittee of the Australian Pharmaceutical Advisory Committee specifically dealing with the question of intentional misuse of pharmaceuticals. They are currently looking at this issue. When they resolve what they believe should be done, it will then be taken up by the appropriate place—the Pharmaceutical Benefits Advisory Committee or wherever. So the matter is under review at the moment.

Senator DENMAN—Good. Do we have any statistics on the numbers of people who have had this happen to them—gangrene or an amputation—or is that pure media hype?

Dr Morauta—I believe that part of the process that is going on now is to try to collect such information to place it in context.

Senator DENMAN—Can you let us have the information when the process has been completed?

Dr Morauta—I am just waiting for somebody who knows a bit more on this. I think when the material is available it should be available in the form you are describing.

Senator CHRIS EVANS—I want to ask a series of questions about PBAC related matters. I want to start, first of all, with changes to the PBAC. Could you tell me what the process was formally for those people whose terms were terminated?

Dr Morauta—I will ask Mr Stevens to confirm this. Basically there was a change in legislation late last year, which you may recall. That legislation brought to an end the terms of all the members who were members last year as of the last day of December 2000. On the last day of December 2000 the membership of all those people lapsed. The new legislation took over, and the process has moved on into that environment.

Senator CHRIS EVANS—It was necessary, therefore, to appoint everybody new under the new legislation. Is that right?

Dr Morauta—New or anew, yes. People have to be either reappointed or appointed.

Senator CHRIS EVANS—Yes. Effectively nobody—

Dr Morauta—Nobody was there.

Senator CHRIS EVANS—Yes. As of the new legislation coming into existence, there were no continuing appointments. Is that correct?

Dr Morauta—That is right, yes.

Senator CHRIS EVANS—For some of those members who had previously held positions, their terms had not expired but their terms were terminated by virtue of the legislative effect: is that right?

Dr Morauta—That is right, Senator.

Senator CHRIS EVANS—How was the selection process conducted for the new appointments?

Dr Morauta—The new legislation provided a different arrangement from the previous legislation. The legislation provided for at least eight members of the committee to be drawn from nominations that were provided from the sector and the regulations said which groups would provide the nominations. So the process was that people were invited to provide nominations from these different colleges and different groups who were nominated in the regulations. From that, there was a list of names for government to consider in each of the categories that were specified. Do you have the brief in front of you, Alan? Just read out the categories, if you like.

Mr Stevens—The categories were consumer, health economists, pharmacists, general practitioners, clinical pharmacologists and specialists.

Senator CHRIS EVANS—Yes, I remember the bill. Did you get more than one nomination from nominating bodies or did you have more than one nominating body?

Dr Morauta—Yes and yes, really. More than one nomination in each category emerged and there was more than one nominating body for each category, I think.

Senator CHRIS EVANS—For instance, did the AMA nominate a number of GPs?

Dr Morauta—I am not sure that it is appropriate for us to give you the details of the nominations in that form, Senator.

Senator CHRIS EVANS—Sorry, I was not necessarily after the specifics. I was trying to get a feel for the process. Did each organisation nominate one person or could they have thrown up more than one?

Dr Morauta—They could throw up more than one.

Senator CHRIS EVANS—As I recall, the legislation did not actually specify the nominating body. It was more of a generic term.

Mr Stevens—It was in the regulations, Senator.

Senator CHRIS EVANS—The actual nominating bodies are listed in the regulations?

Mr Stevens—They are, yes.

Senator CHRIS EVANS—When was that?

Mr Stevens—It was a matter of a day or two after the legislation was passed in the Senate.

Senator CHRIS EVANS—That the regulations were tabled?

Mr Stevens—Yes.

Senator CHRIS EVANS—So for instance for a consumer—

Mr Stevens—If I take the consumer category as an example, that listed three organisations that would nominate a consumer person for the PBAC and those bodies were the Consumer Health Forum, the Australian Federation of AIDS Organisations and the Australian Consumers Association. Each of those organisations nominated three individuals.

Senator CHRIS EVANS—I see. Did you ask them to nominate three?

Mr Stevens—In the paperwork that we gave them, yes—up to three.

Senator CHRIS EVANS—That is not in the regulations, though?

Mr Stevens—That is not in the regulations.

Senator CHRIS EVANS—We did not pass the legislation until just before Christmas, was it, as I recall? It was one of the last bills through, I think. When was the legislation passed?

Dr Morauta—Let us take that on notice. I do not think we have the detail here, have we? We will take it on notice, Senator, and give you a reply on that. We do not have the details here.

Senator CHRIS EVANS—When were the regulations gazetted?

Mr Stevens—Just a point of clarification, Senator. The number of nominations is in the regulations.

Dr Morauta—I am sorry. I have just had a conversation while you were talking. I said we would provide the detail of when the regulations were tabled in parliament and so on.

Senator CHRIS EVANS—You are not sure of that?

Dr Morauta—We do not have it with us. It is not in front of us now.

Senator CHRIS EVANS—But that was also in December, was it?

Mr Stevens—In December, yes.

Senator CHRIS EVANS—How long were the groups given to nominate?

Mr Stevens—They were approached immediately the legislation was proclaimed and they were given until early January to provide nominations. From memory, it was about 5 January.

Senator CHRIS EVANS—Your recollection was that the regulations were gazetted within days of the legislation being passed?

Mr Stevens—That is right.

Senator CHRIS EVANS—So you received those nominations and then there was a ministerial appointment to choose those?

Dr Morauta—Yes. There were nominations available for the minister to make a selection from in the categories concerned.

Senator CHRIS EVANS—The specific memberships were listed to eight. There are 12 in total, aren't there? Where did the other four names come from?

Dr Morauta—They came out in discussion between the department and the minister.

Senator CHRIS EVANS—Were there other groups, other than those specified, invited to submit nominations?

Dr Morauta—No.

Senator CHRIS EVANS—So this is the roundtable, I think the minister described, is it?

Dr Morauta—It was an iterative process between the department and the minister over quite a period to look at this.

Senator CHRIS EVANS—No, but this is the process which the minister described as a round table, is it?

Dr Morauta—Yes. There was a round table in the middle of it, yes.

Mr Podger—There was a roundtable discussion at one point, yes.

Senator CHRIS EVANS—It was as a result of that discussion that the other four nominations came up—and the decision on the eight, was it? I am just trying to understand the process.

Mr Podger—The process, so you can understand, is that the extra four are ministerial additional ones. The minister does not settle those until he has a clear idea of which of the other eight are going to be filled out of this process. We need to get a reasonably firm picture on those and then the minister looks at the other four appointments to round out the committee.

Senator CHRIS EVANS—Did he notify you which of those eight were being nominated before that? Was it a two-stage process, or was it just part of the one process?

Dr Morauta—I think it was over a period of time. There was a roundtable during this process but it is an iterative process trying to work out how to proceed, Senator.

Senator CHRIS EVANS—All right. Is that how you normally do appointments of this nature?

Mr Podger—That is a reasonably common way of doing it. There will be some formal processes and then trying to complete the process with the minister there will be some informal iterative arrangements to get the total package right.

Senator CHRIS EVANS—Can you provide us with the information on who the nominating organisation was in each case for those who were selected? I am conscious you were concerned about not providing those who were selected.

Dr Morauta—Yes, I would also like to take advice on that one, Senator, because I feel that there may be issues there about the privacy of the people concerned. I would like to take it on notice.

Senator CHRIS EVANS—I understood there might be some privacy concerns of those who were not selected. I just wondered about those who were selected.

Mr Podger—I would rather have a look at that just in case there are sensitivities, Senator.

Senator CHRIS EVANS—All right. Have there been background notes on those new members released publicly?

Dr Morauta—Attached to the media release was a short biodata: three or four lines on each of the members, yes, Senator.

Senator CHRIS EVANS—Thank you. What procedures were applied to those people in terms of any potential conflicts of interest they might have in taking up the appointment? We have discussed before departmental procedures. Can you just tell me which ones apply in terms of these appointments, or whether they do, given it is not a departmental position as such?

Dr Morauta—The process was, Senator, that when people were nominated we contacted them to see if there was a conflict of interest that related to the PABC. Then when they were in serious contention they were asked to send in a form.

Mr Podger—There is a cabinet requirement for these sorts of appointments, quite aside from the department's arrangement for handling conflict of interest. If their appointment is to be made through the cabinet process, the cabinet requires from the people being nominated a letter to give reassurance around the conflict of interest issue.

Senator CHRIS EVANS—So you first of all discussed with each of them whether or not they had any potential conflict of interest and then, when they got to the stage of being in the starter's gate or being looked at seriously, you actually then asked them for a letter—or could that be a form?

Dr Morauta—It is a form letter that we send to them and they send back to us.

Senator CHRIS EVANS—What is the nature of that form letter?

Dr Morauta—I think in that letter the minister tabled in the House, Senator, there was a fairly good description of that, but we can certainly provide you with a copy of the form letter. We will take that on notice. We do not have it here.

Senator CHRIS EVANS—Do you send them a letter that says to fill in your name and sign it at the bottom, a sort of statement declaration, or is it a suggestion as to things they might cover in a letter?

Dr Morauta—No, it is a form letter.

Mr Podger—There is a form letter where an individual has to sign up to a reassurance that there is no conflict of interest expected. Also, when we get the CV, we would look at that to see whether there are any obvious questions to be considered.

Dr Morauta—Senator, we have not quite finished the conflict of interest statement process for these people yet. There is another more detailed one that Mr Stevens might describe to you.

Mr Stevens—At each meeting of the Pharmaceutical Benefits Advisory Committee each member is required to provide a statement of any conflicts of interest that they would have on any item that is listed for discussion at that meeting. The process is much more detailed when they get to the actual PBAC meeting itself. They need to state very specifically if there is anything in the agenda which would give rise to a conflict of interest.

Mr Podger—So in addition, Senator, to the processes around appointment and the handling of that, which are basically laid down by the cabinet process for appointments, we have within the department rules about the management of conflict of interest which apply to committees. Each committee sets its own, consistent with that, detailed ways to manage that and that is the way the PBAC manages it.

Senator CHRIS EVANS—What guidance do you give to the new appointees when you are talking to them about conflict of interest? What would constitute a conflict of interest?

Mr Stevens—Essentially with new members of the PBAC we get a legal adviser to brief them on such issues.

Senator CHRIS EVANS—So you did that with each of—

Dr Morauta—No, that is after they are members.

Mr Stevens—That is after they are appointed as members and that process would precede their actual signing of any declaration at the meeting.

Senator CHRIS EVANS—Is that different from the form letter you send them?

Mr Podger—It is a process around appointments which includes a form letter that the individual has to sign; that they believe their appointment does not raise concerns about conflict of interest. Having been through the appointment process we then have the management—there may be, in particular instances of issues coming up before a committee, a particular conflict of interest, which is not a generic one which would preclude them from being on the committee. Those issues are then handled in the committee arrangements, but new members are given counselling before their first meeting around the management of those processes and what the issues involved are.

Senator CHRIS EVANS—But in terms of identifying what might be, as you describe it, a generic conflict of interest, there is no legal advice or discussion with them about that prior to the—

Dr Morauta—Sorry, there was a discussion with each of these people by phone prior to them being given the form, in which a departmental officer outlined the sorts of things they might be considering and having to address. In some cases they were quite long discussions.

Senator CHRIS EVANS—Right. What issues do they go to? What advice do you provide to them about that?

Dr Morauta—We talk about whether they are receiving funding, perhaps, from a pharmaceutical company, because a lot of the people are academics and their research organisations might be receiving money. We talk about that to them and if they want to think that through. They are the sort of questions. We tailor it to the people concerned.

Senator CHRIS EVANS—Did that sort of discussion occur in relation to Mr Clear?

Dr Morauta—Yes.

Senator CHRIS EVANS—What attitude did the department take to him in terms of whether there might be a generic conflict of interest?

Dr Morauta—We believed there was not one.

Senator CHRIS EVANS—And you told him that.

Dr Morauta—Yes, following discussion.

Senator CHRIS EVANS—Was that based on any advice?

Dr Morauta—No, I think it was just part of the process.

Senator CHRIS EVANS—So you did not get any particular advice about whether or not Mr Clear had a generic conflict of interest?

Dr Morauta—No specific legal advice, no.

Senator CHRIS EVANS—No. How did you form the view that he did not have one?

Dr Morauta—By discussion with him about the nature of the activities he was involved in. We had his CV and all that already.

Senator CHRIS EVANS—Yes. But you did not seek any particular advice about the nature of any conflict of interest that might arise in his case?

Dr Morauta—No.

Senator CHRIS EVANS—So you just had a general discussion about what constituted conflict of interest and how that might affect him. Why did you take the view that there was no generic conflict of interest if he had an ongoing interest in the industry?

Dr Morauta—I think for the reasons that have already been publicised; the company concerned did not have a pharmaceutical interest.

Senator CHRIS EVANS—Right. So that was the department's view, was it?

Dr Morauta—Yes.

Senator CHRIS EVANS—Yes, sorry, I have only read what the minister said. This departmental process—I am just trying to get clear what—

Mr Podger—Yes, it was a department view, Senator.

Senator CHRIS EVANS—All right. But as I say, you did not take any particular advice about his appointment; it was just your general way of treating all applications and discussing with each of them their potential conflicts of interest.

Dr Morauta—Yes.

Mr Podger—That is correct.

Senator CHRIS EVANS—You did not think that an ongoing interest or involvement in the pharmaceutical industry was, potentially, a conflict of interest?

Dr Morauta—I do not believe he had ongoing involvement, Senator.

Senator CHRIS EVANS—I am not trying to put words in your mouth. You do not think that his appointment raised any particular issues that were not raised with other applicants?

Senator Vanstone—With respect, I am not sure that what a senior bureaucrat thinks about someone's capacity is an appropriate question for this estimates committee. In the end, this person is not the decision maker. I understand what you are trying to get to, but I think you can phrase it in another way.

Senator CHRIS EVANS—Quite frankly, Minister, the evidence of the department is that they have been the decision makers. That is why I was following it up. It seems the department did take the position of briefing people on what constituted a conflict of interest or not prior to the appointment.

Senator Vanstone—Briefing them, yes.

Senator CHRIS EVANS—Yes, and discussing it with them, and the department have indicated that they made a judgment that there was not one. I am trying to ascertain what the basis of that was. I was a bit surprised that the department had done that. Nevertheless, it seems the department does do that. The department, I gather, Dr Morauta, did form a view about what did and did not constitute a conflict of interest in this area. Is that fair, or not?

Dr Morauta—I think that is right, for advice to government, Senator.

Senator CHRIS EVANS—I thought your evidence was that you did not seek any advice about conflict of interest matters regarding these appointments.

Mr Podger—I think Dr Morauta's answer to that question was that we form a view. We provide advice to the minister who takes the decisions. It was not that we had sought further advice. We give advice in this area.

Senator CHRIS EVANS—I presume that would mean, though, in practice that there would only be an issue if you formed a view that there was a conflict of interest. Is that right? These are people who are already basically about to be appointed, who you then brief about conflict of interest issues, as I understand it.

Dr Morauta—In order for them to fill in a form, Senator. They are given a form to fill in. This is a government-wide form. People naturally enough say, 'What does this form mean?' and we attempt to explain it to them, in order that they make an informed decision about signing it.

Senator CHRIS EVANS—Yes. It seems to me that that raises the question about what constitutes a conflict of interest. Someone has to provide some advice on that. I am wondering who provides that advice. I thought from your evidence that you were saying you did, the department.

Mr Podger—The department does give advice throughout appointments on whether there is a conflict of interest, but it also is a matter for the person who has been nominated to give assurances themselves about that matter. It is not totally the department's responsibility but the department does take responsibility for advising government on those things. It is unlikely, the department having advised and the individual having advised that they believe the conflict of interest, if there is any, can be managed, that somebody at the political level will take a different view. But they are always able to do so.

Senator CHRIS EVANS—You use the term whether the conflict of interest can be managed. I guess that anticipates that there are different degrees of concern.

Mr Podger—There are some committees where a degree of conflict of interest is inevitable and there is an issue of managing it—that the people will all be on the board. For example, the HIC board has various medical practitioners and specialists and pharmacists and so on on it. Each has a potential, in particular circumstances, for conflict of interest. But there is a process of managing that on the board. This is not an unusual thing where there can be instances of conflict of interest which have to be managed, but overall you will say that the appointment should proceed.

Senator CHRIS EVANS—So no conflicts of interest caused concern on this occasion in the PBAC appointments and they all proceeded. Is that correct?

Mr Stevens—That is correct, yes.

Dr Morauta—There was no issue with the members who have been appointed.

Senator CHRIS EVANS—Was there any industry input into these appointments? Were their views sought as part of that process?

Dr Morauta—It is not provided in the regulations, Senator.

Senator CHRIS EVANS—I know that. That was not really the question, though.

Dr Morauta—No.

Senator CHRIS EVANS—I understand that the legislation provides for those particular appointments to be from specified groups. I did not realise the regulations had moved with such speed so I missed them leading up to Christmas, but they obviously provided the organisations that could nominate. I am asking, more generally, was there any other industry involvement in the nomination process or in nominating people or discussing nominations?

Dr Morauta—Not that we are aware of, Senator.

Senator CHRIS EVANS—Who in the department does liaison with the pharmaceutical industry?

Dr Morauta—Largely the Pharmaceutical Benefits Branch, Senator.

Mr Podger—It does go beyond that, Senator, but that is the main area. Of course, Therapeutic Goods Administration has a very major interaction with the industry and, indeed, the Health Industry and Investment Division has dealings with them from time to time, as would the Portfolio Strategies Division. The main areas would be the PBS branch area and the TGA.

Senator CHRIS EVANS—What is the nature of their involvement? You say the PBS branch. Is it a very hands-on involvement? Are there representations?

Dr Morauta—The primary relationship is into applications for PBS listing. That gets you into daily contact with the industry, working on those applications and putting them forward.

Then there is a whole series of other areas in which they come forward and have discussions with us about processes. For example, they were engaged in that process in the Tambling review. They sit on a number of things we are doing like that.

Senator CHRIS EVANS—What sort of protocols does the department have for departmental officers dealing with the pharmaceutical industry or other industries for that matter—I presume they are more general—but in terms of what is appropriate or not appropriate for functions, gifts, relationships.

Mr Podger—First of all, the chief executive instructions set out the issues of management of conflict of interest and there is also, beneath the CEIs, some guidance given to officers around issues such as gifts and entertainment, et cetera.

Senator CHRIS EVANS—Those are standard across department structures?

Mr Podger—They apply across the department. We also have substantial training right across the department on ethical issues. We have a program of training on that which we have covered across the whole of the organisation over the last two years. The issues in the pharmaceutical industry are particularly pertinent for those involved in the regulation—that is, TGA and the pharmaceutical branch area of Dr Morauta's division.

Senator CHRIS EVANS—Are there any arrangements for declaration of such matters?

Mr Podger—There is a process of declaration of interests. There is also meant to be a declaration of gifts. We do not keep a direct register of everything, but there is a process where officers are meant to talk to their division heads or whatever if there is anything in particular in the way of functions or whatever that need to be brought to attention.

Senator CHRIS EVANS—I know parliamentarians think there are financial limits on gifts and stuff.

Mr Podger—There is guidance on that, yes, Senator. In the guidelines there is guidance about limits on that. These things are not absolutes, but there is quite clear guidance around those sorts of things, yes.

Senator CHRIS EVANS—What sort of level of gift or hospitality would that sort of thing cut in at?

Mr Podger—I would have to get the guidelines. I do not have them in front of me. I think we deal with $50 for a gift as a general guidance—where there is a problem is if it is more than $50—across the organisation. On entertainment it is a more generic one; it needs to be related to the business. I actually apply a general rule that, if it would be embarrassing before this committee in a particular instance, the staff ought to be cautious. If it is embarrassing, they should not do it.

Senator CHRIS EVANS—It is a good rule. I used to have a rule when I was a union official: if I was not happy explaining it to 700 firefighters at a general meeting, it was not a good thing to do.

Mr Podger—It is very much the same rule that we apply in the department and, indeed, that is specifically used in our training exercises.

Senator CHRIS EVANS—Can I ask you a couple of questions about these meetings with the so-called Bennelong group. Was the department at that meeting on 10 November with the Prime Minister?

Dr Morauta—No.

Senator CHRIS EVANS—Did you prepare briefing papers for that meeting?

Dr Morauta—Yes.

Senator CHRIS EVANS—Was the question of appointments to the PBAC among those briefing papers?

Dr Morauta—No.

Senator CHRIS EVANS—So the briefing papers were about what: general pharmaceutical issues?

Dr Morauta—Yes.

Mr Stevens—There was no agenda. We just briefed on general issues, that was all—current issues in the branch basically.

Senator CHRIS EVANS—Did you get any feedback after the meeting; any approaches regarding issues raised at the meeting?

Mr Stevens—There was no feedback that we received, Senator.

Senator CHRIS EVANS—Did you get any notes or minutes from that meeting?

Mr Stevens—No, Senator.

Senator Vanstone—Sounds like one and the same question: did you get any feedback? No. Did you get any notes? If the answer to the second one was yes, the answer to the first one was incorrect.

Senator CHRIS EVANS—I think if you go back over *Hansard* for the last year or so you will understand why I asked both questions, Senator Vanstone.

Senator Vanstone—I was going to mention that this matter has been exhaustively raised and when you consider that you had dragged the rake over every piece of that garden—

Senator CHRIS EVANS—I was off that week from parliament, Senator Vanstone, so I missed all that.

Senator Vanstone—*Hansard* is online now.

Senator CHRIS EVANS—I am not usually, but I do take the opportunity to ask the public servants for their feedback.

Senator Vanstone—That is fair enough. I think those questions are all perfectly fair, except for the last two which were repetitive.

Senator CHRIS EVANS—As I said, if you had been through the MRI thing. I learnt to ask more exact questions sometimes. There was no feedback from that meeting. You mentioned earlier that the Consumer Health Forum was one of those groups who were in the regulations as one of the three consumer groups to nominate people for the PBAC. Is that right?

Mr Stevens—That is correct, yes.

Senator CHRIS EVANS—Did you receive nominations from them?

Mr Stevens—Yes, we did.

Senator CHRIS EVANS—Was that organised by writing to them saying they were able to nominate up to three persons for consideration? Is that how it worked?

Mr Stevens—That is correct, Senator, yes, specifically relating to a consumer person. They were not able to nominate in other categories—for a health economist, for example.

Senator CHRIS EVANS—But they were able to nominate who they chose in the sense of—did they have to hold any particular qualifications, for instance?

Dr Morauta—No, it was our choice, Senator.

Senator CHRIS EVANS—Are there any other requirements on the forum to provide appointments to government regulatory committees? Are they one of the groups that provide other nominations, the Consumer Health Forum?

Mr Podger—I am pretty sure they do, Senator, but I do not have that right here. I think we have used them on other ones for nominations.

Senator CHRIS EVANS—What were the other two you mentioned, Mr Stevens?

Dr Morauta—The Federation of AIDS Organisations and the Australian Consumers Association.

Mr Stevens—Yes.

Senator CHRIS EVANS—I see the minister has made some comments about the old PBAC being too adversarial towards industry. Is anyone able to help me as to what that criticism is based on and how this new committee is structured to be less adversarial to industry needs?

Dr Morauta—I do not know that it would be appropriate for us to comment on that, Senator.

Mr Stevens—I do not think we can answer that. All I can do, Senator, is repeat the minister's comments that he felt there were a number of members of the previous committee who had been there too long and we did not have a good process of turnover after a period.

Senator CHRIS EVANS—All right.

Mr Stevens—And also that we had not drawn on enough nominating groups; that some groups had dominated in the process before.

Senator CHRIS EVANS—Obviously there the reference to too adversarial indicates that there might have been in his mind increasing friction. Have the number of legal actions taken by pharmaceutical companies against the PBAC increased in recent times?

Mr Stevens—Yes, they have, Senator.

Senator CHRIS EVANS—What is the extent of the movement there, Mr Stevens?

Mr Stevens—Basically we have had two cases taken to the Federal Court and a few—I could not say exactly how many—requests for statements of reasons under the AD(JR) Act.

Senator CHRIS EVANS—You had not had proceedings in the Federal Court previously? What were the two recent ones?

Mr Stevens—One was Naltraxone and the other one was the Viagra case.

Senator CHRIS EVANS—Was that the first time that occurred?

Mr Stevens—To my recollection, Senator.

Senator CHRIS EVANS—What about requests for statement of reasons?

Mr Stevens—They have been present since I have ever been involved in the scheme and much before that. That is not a new issue.

Senator CHRIS EVANS—Has the volume or the frequency of those increased dramatically?

Mr Stevens—They are very spasmodic. They seem to come in fits and starts. I would not say that they have specifically increased or decreased. You get long periods of time when you get nothing in that area.

Senator CHRIS EVANS—All right. What is the question about liability of PBAC members if a decision is successfully appealed in the courts? Is there any personal liability on the PBAC members?

Mr Stevens—Basically a member of the PBAC who is working on government business, on PBAC business, would be covered the same as an officer in a department would be.

Senator CHRIS EVANS—So basically the department is liable, not the individual?

Mr Stevens—That is right.

Senator CHRIS EVANS—Is that right?

Mr Stevens—Yes.

Senator CHRIS EVANS—How many of the old committee members were asked to serve on the new PBAC?

Mr Stevens—I am not able to answer that question, Senator.

Dr Morauta—No, I do not think we have the detail.

Senator Vanstone—I think that was all dealt with perhaps in the Senate and in the Reps in their question time. It was indicated a number were invited and declined. I cannot remember the number.

Senator CHRIS EVANS—Neither can I. That is why I am asking.

CHAIR—It is all in the *Hansard* from then.

Senator CHRIS EVANS—With respect, Madam Chair, I do not think what the minister says in the chambers is necessarily the same as an answer you get from the department. This is our opportunity to ask the department. I am not saying there is a conflict there.

Mr Podger—Senator, I guess there is a sensitivity here about the details of the process we have under the legislation, under six different headings, a nomination process with three or more under each organisation nominating. Out of that the minister considers which ones he might wish to take on. He will speak to some of those himself. There will be all sorts of arrangements around that. I do not think it is normal for us to go through what happened in the middle of that process, about who was approached and who said no, or what other things happened in that area. That is not a usual thing for us to divulge.

Senator CHRIS EVANS—All right. Can someone explain to me what the PBAC's role is in price setting and its relationship with the pricing authority, just in a general sense to start with?

Dr Morauta—The minister provided quite detailed information in the House recently, Senator, which we can provide again for you. There is quite a good statement in the PBPA annual report, for example, on how the two things come together.

Senator CHRIS EVANS—Yes.

Dr Morauta—Senator, do you want us to go through this chapter 2 from the annual report of the PBPA. It sets out, I think, quite clearly how the two things come together.

Senator CHRIS EVANS—Maybe just go through that summary, Dr Morauta. I just wanted to have an understanding of how it worked; that was all.

Mr Stevens—Basically, Senator, the PBAC receives applications from pharmaceutical sponsors of drugs and they are charged with the responsibility of assessing those applications for individual medications, for their clinical effectiveness and cost-effectiveness. They will provide recommendations to the minister, if they consider it appropriate, on the listing of those drugs, for what indications they should be listed and the quantity for listing. At the same time they will provide advice to the Pharmaceutical Benefits Pricing Authority on issues such as cost-effectiveness. The pricing authority itself is the body that is armed with the responsibility for recommending an appropriate price for listing, and in recommending that price it will take advice from the PBAC on issues such as clinical effectiveness and cost-effectiveness but the actual price itself is a matter for the pricing authority.

Senator CHRIS EVANS—So they can take the advice and do with it as they will in a sense but the authority for the decision is with the pricing authority, is it?

Mr Stevens—The advice from the PBAC is basically one of nine factors that the pricing authority will take into account in recommending an appropriate price to government.

Senator CHRIS EVANS—One of nine.

Mr Stevens—Yes.

Senator CHRIS EVANS—The others are all specified as well, are they?

Mr Stevens—They are listed in the annual report of the pricing authority, yes.

Senator CHRIS EVANS—What is the general way this is treated then? Does the pricing authority generally take the PBAC's recommendations

Dr Morauta—The PBAC does not usually make recommendations with respect to price, Senator. It just goes to the cost-effectiveness and I suppose that is really how it works.

Mr Stevens—That is right.

Senator CHRIS EVANS—They are all about pricing conditions, are they, or they are recommendations?

Mr Stevens—The PBAC recommends on the basis of whether a drug is considered to be of acceptable cost-effectiveness in terms of providing benefits over and above alternative therapies, whether they be other drugs, hospitalisation or whatever.

Senator CHRIS EVANS—How does that work? The question of cost-effectiveness obviously comes down to an assessment of the cost. You cannot work out whether something is cost-effective if you do not know what it is going to cost or what is going to be charged.

Mr Stevens—Basically, in assessing that, they would take into account the price that the sponsor has applied for and that is part of the application to the PBAC.

Senator CHRIS EVANS—So the PBAC works out the cost-effectiveness discussion, or argument, in their own minds based on what the application from the pharmaceutical company is as to price.

Mr Stevens—They would do a detailed evaluation of the application from the sponsor. That evaluation would take into account the actual benefits of the drug over alternative therapy and the actual cost of providing those benefits. So that is where you get the cost-effectiveness aspect.

Senator CHRIS EVANS—So they basically rely on what the sponsors applied for in terms of the price.

Mr Stevens—They have got nothing else to relate to, yes.

Senator CHRIS EVANS—So they do not actually say, 'That ought to be $2 more.' They do not get into that sort of debate about it.

Mr Stevens—No.

Senator CHRIS EVANS—They are guided in the cost-effectiveness by the sponsors.

Mr Stevens—By the sponsors' application.

Senator CHRIS EVANS—So effectively then, if the pricing authority comes up with a different price, the PBAC has not effectively provided any guidance on that issue in the sense that the PBAC do not say, 'Well, it's good value at $5 but it's overpriced at $7.' They do not do that sort of consideration. It is just that at the price suggested it is either cost-effective or it is not. Is that it?

Mr Stevens—Usually they provide general advice to the pricing authority. In rare instances they do provide some specific advice but that more specific advice is to provide a better guidance to the pricing authority where the cost-effectiveness in their view may be tight.

Senator CHRIS EVANS—Have there been instances where the pricing authority has not accepted PBAC recommendations when they have made specific recommendations in relation to price?

Mr Stevens—Yes, there have been situations.

Senator CHRIS EVANS—Was Celebrex one of them?

Mr Stevens—In the case of Celebrex the PBAC made its recommendations in regard to clinical effectiveness and cost-effectiveness and provided more specific advice on the cost-effectiveness side. The pricing authority in turn took that advice into account but also took into account other factors as its charter evolved.

Senator CHRIS EVANS—The next step is the PBAC's recommendation in relation to price.

Mr Stevens—It was not the PBAC's role to make a recommendation on price; that was a pricing authority role.

Senator CHRIS EVANS—I accept what you are saying to me, Mr Stevens. You were explaining the relationship; I am not taking argument with that. But I think you said to me that on this occasion they did make a recommendation in relation to price. Is that not right?

Mr Stevens—No, they did not make a specific recommendation on price; they provided more guidance to the authority than normally would be the case but it was not a specific price.

Senator CHRIS EVANS—Is it fair to say the pricing authority did not take that guidance?

Mr Stevens—No, I do not think it is fair to say that at all. It did take into account the PBAC advice plus other factors.

Senator CHRIS EVANS—No, I am not saying it did not take it into account. Is it fair to say their final decision did not follow that advice?

Dr Morauta—It did not have the form of, 'It should be X.'

Mr Podger—The short answer to your question is that you are wrong. To say the pricing authority did not follow it is not right, but to say that they did follow it was also not necessarily entirely right.

Senator CHRIS EVANS—Yes, all right, Mr Podger.

Senator Vanstone—Perhaps they have got law degrees. I do not know.

Senator CROWLEY—In times past, though, I remember on a couple of occasions brawls between the health minister and whoever about the price of a medication, and often PBAC was the focus where recommendations to keep the price down were coming from, and pressure to keep the price up was also being brought to bear.

Mr Stevens—It would be the advice that the minister or the government would have received from the department, taking into account the advice from both the pricing authority and the PBAC.

Senator CROWLEY—I am not sure what that means.

Dr Morauta—Sorry, can we just clarify your question, Senator Crowley?

Senator CROWLEY—That is pretty good. I did not understand you and you did not understand me.

Dr Morauta—No, I am trying to help. I thought if I could just get it a bit clearer.

Senator CROWLEY—Possibly my memory may not be accurate but I remember occasions, when Neil Blewett was the minister, when there were recommendations to accept drug X at price Y, and the minister would say, 'We all want drug X but there is no way we will do it at price Y. We have to go back and argue for price Y to be reduced.' That advice, as I understood it, came through to the minister from PBAC.

Senator Vanstone—What is your question?

Senator CROWLEY—My question is: is that the case?

Dr Morauta—It is more likely that it was the advice of the PBPA that was being questioned by the government.

Mr Stevens—That is right.

Dr Morauta—We cannot comment because we do not have a particular example but it would be a price not from the PBAC, because I do not think it has had that role, but from the PBPA.

Mr Podger—More generally, the PBAC provides for the Australian system. It has a better grasp of cost-effectiveness than any other system around the world has got, and yes, we do use that to pressure our companies to come up with more modest prices but I do not think it is exactly the way that you have described it in terms of the specific operations for a specific case of the PBAC setting prices.

Senator CROWLEY—We know a lot of the arm-wrestling happens offstage but we know arm-wrestling goes on.

Mr Stevens—Yes.

Senator CHRIS EVANS—Can I just ask about Celebrex. Have you got figures on how much Celebrex has cost in the first five months of listing?

Senator Vanstone—Just while we are getting that, Senator, you might like to have a look at the *Hansard* for, I think it was the 8th of this month, where Dr Wooldridge took the

opportunity to highlight just how difficult it is to estimate what the costs in the first month or so will be. He used the example of a drug called Zoloft. The estimate for the first year then, which was 1994-95, was $2.5 million. It ended up costing $35 million, so the estimates are not always right on track. On that particular occasion they were 14 times out. The advice I have is that this is not a particularly uncommon phenomenon because it is so terribly hard to make those predictions. I am sure there are other examples like that.

Dr Morauta—The answer is, from 1 August 2000 to 31 January 2001, $97.5 million.

Senator CHRIS EVANS—That is a five-month figure. Have you done revised project figures for the full financial year?

Dr Morauta—Yes, we are in the process of doing that.

Senator CHRIS EVANS—I think we had an estimate of $217 million over four years, didn't we, and $36.7 million in 2000-01? You have not as yet done a revised annual figure?

Dr Morauta—For this year, Senator?

Senator CHRIS EVANS—Yes.

Dr Morauta—It comes through in the next set of estimates, I think.

Senator CHRIS EVANS—But you do not have one currently?

Mr Stevens—No.

Senator CHRIS EVANS—Even though you have five months worth of figures, there has not been any attempt to revise the—

Dr Morauta—No, we are doing it, Senator, but we have to agree it with the department of finance and all that kind of thing, and that is all going on at the moment.

Senator CHRIS EVANS—Have you got a rough guess yet? Senator Vanstone made the point that these things are often wrong in terms of projections and I think that is a fair enough point to make. The next question, though, is: this is clearly one of those that is going gangbusters at the moment, well above estimations. We have now had five months experience. In terms of the budget estimates I think it is reasonable to ask what the most reasonable guesstimation is currently.

Dr Morauta—Sorry, we do not have a figure on it at the moment, Senator. We are trying to work out what the acceleration is in this matter and we cannot pick an annual figure yet. We are just working on it.

Mr Podger—It does take a little bit of modelling to do this and, as Dr Morauta said, we would need to discuss it with Finance. I would be reluctant to give a general figure here without having been through that process. That will be in the budget papers when we get to that point.

Senator CHRIS EVANS—I assume, therefore, that you have no revised estimates for the out years either, as a result.

Mr Podger—That is correct.

Senator CHRIS EVANS—From the briefing they have given me, I was going to ask about Vioxx.

Mr Stevens—That is an alternative to celecoxib. That was listed on the Pharmaceutical Benefits Scheme on 1 February.

Senator CHRIS EVANS—Do you think that will have an impact on the Celebrex costings?

Mr Stevens—I certainly believe so, Senator. Being in the alternative, one would expect that they are going to share the same market.

Senator CHRIS EVANS—Do you have any projections on what you think is going to happen with Vioxx?

Mr Stevens—Rofecoxib is the generic term for Vioxx.

Senator CHRIS EVANS—Sorry?

Mr Stevens—Rofecoxib, the same as celecoxib.

Senator CHRIS EVANS—I think I will stick to 'Vioxx'! Do you have a costing estimation on Vioxx?

Mr Stevens—Specifically on Vioxx, no. We expect that the total market will be shared by the two drugs at present. What market share Vioxx takes will be a matter of how doctors prescribe.

Senator CHRIS EVANS—Do you think of it as a zero sum game between the two? It is the same market, basically?

Mr Stevens—Normally, in this kind of situation you get a bit of a rise in the total.

Dr Morauta—However, there is another effect going on, which is a replacement effect with the other non-steroidal anti-inflammatory drugs, and that is another part of the estimate. These things are replacing other things for a number of patients. That also has to be worked through, for a net effect.

Senator CHRIS EVANS—What were your estimates on those? Was that original estimate of $36.7 million a net?

Mr Stevens—That was a net figure, Senator, yes.

Senator CHRIS EVANS—That was the net increase, you would have thought, with the savings on some of those other drugs plus the use of these?

Mr Stevens—That is correct, yes.

Senator CHRIS EVANS—Clearly it is going to be, you think, driving a higher cost in total, in net, rather than the savings offsetting the increased costs?

Dr Morauta—Yes, Senator, but that is another element in the arithmetic—not just Vioxx but what it is offsetting.

Senator CHRIS EVANS—I think we have established that these original estimates are difficult, but what sorts of factors do you take into account when making those estimates?

Mr Stevens—We take into account advice from the sponsor company, to start with. It is basically their drug and they provide some estimates to us. We look at what the alternatives are that may or may not be listed on the Pharmaceutical Benefits Scheme, if we can get a handle on those, and specific advice, where we can obtain it, from the user groups.

Senator CHRIS EVANS—There is no secret modelling or anything on this sort of stuff?

Mr Stevens—It is very difficult to do these kinds of things, especially when you get a new class of drug.

Senator CHRIS EVANS—The minister made the point that some of the previous drugs have had quite different results or much larger take-ups, et cetera. Is this because pharmaceutical companies tended to underestimate the size of the market?

Mr Stevens—It would vary considerably. In some cases, yes, they do underestimate the size of the market. In other cases they overestimate. It is not a one-way issue. Quite often the individual drug estimates from a company are excessive compared to what comes out actually.

Senator CHRIS EVANS—The original estimates for Celebrex, I gather, were based on having an authority listing or having certain price-volume agreements in place. Could the absence of some of those things have affected the take-up?

Mr Stevens—It is difficult to say. Certainly one may expect that an authority listing may restrict it to some extent, but I am not too sure to what extent. It is the advice on that kind of thing that we take the advice from the PBAC on—how the listing would compare with the alternative therapy that is currently available.

Senator CHRIS EVANS—Have you any idea how many people are now subscribing to Celebrex?

Dr Morauta—We have the number of prescriptions, Senator, for that first period that I gave you. It is around two million.

Senator CHRIS EVANS—In the five months there have been two million prescriptions?

Dr Morauta—Yes, but that does not mean it is two million Australians, because of all the repeats and things like that. We do not have the number of people.

Senator CHRIS EVANS—You are not able to break that down to the number of persons, the number of people, using the drug?

Mr Stevens—No. It would depend on the actual usage of the drug. Quite often, the actual usage varies considerably, depending on what dosage the prescriber has put the patient on. It can depend on how many tablets a day they are being prescribed.

Senator CHRIS EVANS—It is fair to say we have no idea, basically, of how many people are now on the drug?

Mr Stevens—No, but we will certainly be asking for research to be done into that. Certainly we will be getting the drug utilisation subcommittee of the Pharmaceutical Benefits Advisory Committee to look at such factors. That is a normal thing for that committee to do.

Senator CHRIS EVANS—Is that obtainable, though? If you cannot get it, is it easily obtainable, or is a relatively accurate guide able to be achieved or not?

Mr Stevens—It can be obtained but it is not readily available. You cannot just go and pluck it off statistics that are available.

Senator CHRIS EVANS—Even with the Medicare numbers on the PBS now?

Mr Podger—It will be easier in the future.

Senator CHRIS EVANS—I had to hand over my Medicare card the other day when I got a script, so I thought you would know everything about me now, Mr Podger—what drugs I was on!

Mr Podger—That will be so, but it is not there yet. We are in stage 1 of that process.

Senator CHRIS EVANS—What avenues are available to address issues if you think there is a massive cost blowout caused by these drugs coming on the market? Do you have any way of controlling that?

Mr Stevens—There are a number of areas that can be addressed, Senator. As I say, one of the normal functions of the drug utilisation subcommittee is to monitor the usage of new drugs and provide some feedback to the PBAC where that usage is somewhat out of line with original predictions. The PBAC can have a look at that to see whether the drug is being targeted appropriately to the correct population, whether it needs to be further restricted, and sometimes we may need to look at pricing issues. We would certainly be asking the sponsor company itself to provide us with more details about why the usage is so high compared to original estimates. That is a process going on at present.

Senator CHRIS EVANS—Can you advise whether or not there have been some reports of quite large adverse drug reactions to Celebrex?

Dr Morauta—That is actually in TGA, Senator.

Dr McEwen—To the end of January we had had about 2,300 Australian reports of suspected adverse reactions to Celebrex, Celecoxib.

Senator CHRIS EVANS—It strikes me as being a large number. Is that right, Dr McEwen?

Dr McEwen—Yes, it is the largest number of reports to a single new drug in that sort of period since it was marketed, which is now going towards a year, for any medicine in Australia.

Senator CROWLEY—Over what period were those 2,300 complaints?

Dr McEwen—Marketing started in October 1999.

Senator CROWLEY—So what is that? About a year?

Dr McEwen—It is a year and three or four months.

Senator CHRIS EVANS—What sorts of adverse reactions are they reporting? I am sorry, Dr McEwen; I do not know much about this area. How are they reported and what sort of information has been coming back to you?

Dr McEwen—We operate a reporting scheme that has two parts to it. The major part, the longest existing historic part, is to ask doctors and dentists and pharmacists to send us individual case reports of patients who have had suspected adverse reactions. We widely distribute a prepaid mailer card. In addition to that, pharmaceutical sponsors, the manufacturers of the drugs, are under an obligation to report to us any reports that they get.

Concerning Celebrex, approximately half of the reports came from the pharmaceutical company. We published in a bulletin that was sent to doctors, dentists and pharmacists in June of last year a breakdown. About a third of the reports involved skin reactions, about a third of the reports involved gastrointestinal reactions—principally minor gastrointestinal reactions—and the other third approximately were spread over all the other areas.

Senator CROWLEY—How much renal disease?

Dr McEwen—Relatively small, but I have not mentioned that all the serious reports are reviewed by the Adverse Drug Reactions Advisory Committee. We had picked up in that early stage, which was to the end of April, that we had had nine reports of either acute renal failure or worsening of chronic renal disease, and we have given quite a deal of publicity to

that. I think in that respect Celebrex is no different from any other nonsteroidal anti-inflammatory agent in respect of renal effects, or not markedly. The particular problem we highlighted was in elderly patients who are prescribed Celebrex, along with a diuretic and an ACE inhibitor. That combination of three drugs has a great propensity to worsen their renal function.

CHAIR—Could we have a copy of the adverse reaction bulletin?

Dr McEwen—We are in the midst of doing a repeat analysis of that. My impression is that that proportionate breakdown remains roughly the same. I had earlier done an analysis. Because of the nature of these spontaneous reporting schemes, there are many potential biases, so to compare between drugs is something which you need to do with very great caution, if at all. But at about the time of the publication of that bulletin, our sense was that we had had fewer severe gastrointestinal reactions—in other words, bleeds or perforated ulcers—with Celecoxib than with earlier drugs. That is a pretty rubbery comparison, though, on this data. You need better data.

Senator CHRIS EVANS—I think your starting point was that you had had by far the largest number of reports with this drug compared to other drugs. Is that right?

Dr McEwen—Yes.

Senator CHRIS EVANS—In a total sense, and the majority of those reactions were to do with skin complaints and gastrointestinal reactions.

Dr McEwen—Approximately a third involved skin reactions, a third gastrointestinal reactions and a third for the rest.

Senator CHRIS EVANS—When you get what seems to be an unprecedented number of reports, what then happens? What action is put in place when you get that report?

Dr McEwen—The committee meets every six weeks. It has reviewed that reporting and has sought to explain why we might have had that number. I think the committee's view is that there are a number of factors here. This is a drug that was heavily promoted from the start, it was a drug for which many expectations were created at or about the time it was marketed, and it is a drug which has achieved an extraordinarily high usage, both before and after its pharmaceutical benefits listing. It is probably explicable in those terms that we have had such a high reporting.

Senator CROWLEY—Which of those matters most? Would you be able to break down whether the heavy promotion or the high expectations or the high usage contributed more?

Dr McEwen—No. I think they are all factors. It would be almost impossible to put a percentage on any of them.

CHAIR—Could we still have a copy of that bulletin, please?

Dr McEwen—Yes.

Senator CHRIS EVANS—Dr McEwen, forgive my ignorance, but if you get reports saying there are a lot of reactions—and you say you have analysed what they are and what might have caused the large number—what do you do to actually deal with the fact that people are having adverse reactions?

Dr McEwen—One has to think about whether there is something worrying about this or whether this is in fact what one would expect with what one knew from the clinical trials and having regard to the very high usage of the drug. If we know that one in every 100 patients

has a certain adverse reaction and one million people are taking it, there is the potential to get 10,000 reports. I think that, in this instance, what we are doing is observing those reports and asking: do they fit with the experience that was generated from the clinical trials, which is reflected in the product information and reflected in the information that goes to consumers, or are there things outside that? To date, as we have said, we have highlighted in that bulletin the combination of the drug with an ACE inhibitor and with a diuretic, particularly in elderly patients, as a difficulty. We have highlighted that there seems to be quite a high proportion of skin reactions, though none of them very nasty.

CHAIR—What types of skin reactions are you talking about?

Dr McEwen—They are rashes and itches and a sort of hive-like reaction. We are contrasting that with a drug reaction like a Stevens-Johnson syndrome which affects eyes and causes mouth blistering and severe lesions. We have had very few reports of that.

Senator DENMAN—Could you tell me what proportion of adverse reactions you have to get before the drug—not that particular drug, but any drug—is withdrawn from the market?

Dr McEwen—That is a difficult question to answer. Perhaps I can answer it this way: we have had instances in Australia in the past where in the early part of marketing we have had a serious reaction which was not picked up in the clinical trial and that has led to certainly issuing a warning and perhaps modifying the use of the drug in Australia. A serious blood disorder with an anti-depressant is one example. Another example was a nonsteroidal anti-inflammatory drug where we got 40 or 50 reports of it causing haemorrhagic cystitis, a haemorrhaging within the bladder. In both of those instances it was not taken from the market but there were warnings and modifications.

Prof. Smallwood—Senator, it might be helpful if I add some comments on Celebrex and Vioxx over and above what has been said to date. I think on the published data there are a couple of things that are worth saying. In the clinical trials, the number of ulcers dropped from 20 per cent to about two per cent to three per cent. That is one clear benefit in the trials which has led to this expectation that there will be considerably less harm. Theoretically, that was what should have happened seeing that they are selective COX-2 inhibitors rather than the non-selective inhibitors which hit COX-1 as well as COX-2.

Senator WEST—You might like to explain that in simple language, because that has even got me confused.

Prof. Smallwood—Okay. The problem with the nonsteroidal anti-inflammatory drugs that have been around for a long time is that they are non-specific inhibitors of an enzyme called cyclooxygenase or COX for short. There are two forms of that enzyme—COX-1 and COX-2. COX-1 is important in preserving the integrity of the lining of the stomach and also kidney function, whereas COX-2 is a bit of a rogue enzyme which produces these prostaglandins which come in areas of inflammation and cause pain and general distress.

If you can target the COX-2, theoretically you should be able to deal with the pain and distress and inflammation and not harm the stomach or the kidney. That, in effect, in the trials as far as the stomach was concerned, was borne out in terms of the number of ulcers. A larger outcome study that has attracted some notice is called the class study, which was undertaken in about 300 or 400 different centres in Canada and the US and involved about 8,000 patients. Again, the study was very encouraging in showing a reduction in more serious outcomes such as symptomatic ulcers or bleeding or perforation, unless those patients were also taking aspirin.

You have to worry about other drugs. You worry about Warfarin; that is another concern that has come up—bleeding. In terms of those major published studies, the expectation that these medications, the COX-2 inhibitors, would cause less serious harm to the stomach are certainly borne out. In this class study, as opposed to what John is concerned about in the reports that he is getting, there was much less kidney problem as well. It is not surprising that there was a great expectation amongst practitioners, and indeed consumers, that these would be much less hazardous drugs for those with severe arthritis.

Senator CHRIS EVANS—But I suppose the issue is that we do not know then from these adverse reactions whether we are getting the beneficial effects as well. Is your point in part—

Prof. Smallwood—My point is that they have been very effective drugs in terms of symptom relief and the published data—as I said, unless you are on aspirin as well—was also very encouraging. I think the issue of keeping an eye on what is going on beyond the clinical trials is what is also at issue here.

Senator CHRIS EVANS—I may have missed the point, but I assume you are saying that the adverse reaction figures obviously do not give you feedback on the points you are making in the sense of positive reactions. Is that right?

Prof. Smallwood—No, they do not go to efficacy. What goes to ADRAC is just a potential harm from that, attributable to the medication.

Senator CHRIS EVANS—So how do we make a judgment on balance then?

Prof. Smallwood—I guess it is a difficult issue. It has to be reflected back to the users. The harm that is documented by ADRAC is done in the way he described. It may be that you have to be more cautious with older people, or certainly cautious with other drugs. Aspirin is a good case in point.

Senator DENMAN—The practitioner prescribing this would hopefully have the patient's case history, so they would whether there were any previous occurrences of, say, ulcer or whatever that is likely to be aggravated.

Prof. Smallwood—I think that has been a standard risk factor for the older nonsteroidals and it would be a brave person who would ignore it, even with these.

Senator CHRIS EVANS—Dr McEwen, you said that half of the complaints or adverse reactions were reported by the manufacturer. Is that right?

Dr McEwen—Approximately, yes.

Senator CHRIS EVANS—How do they come to report them?

Dr McEwen—They are required under their condition of approval. They may have a direct contact from a doctor or from a patient or one of their sales representative staff when they call on doctors are told, 'I had a patient who had X or Y.' They are required to send us a case report about that.

Senator CHRIS EVANS—Right. This adverse drug reactions bulletin went out in June 2000.

Dr McEwen—Yes.

Senator CHRIS EVANS—So that information has been available since then. Is that right?

Dr McEwen—Yes.

Senator CHRIS EVANS—So that was available even before the product was listed on the PBS.

Dr McEwen—Yes.

Senator CHRIS EVANS—Since this bulletin you have put out further information?

Dr McEwen—We mentioned Celebrex in a more recent bulletin which has just gone out, but that addresses a specific issue—that is, the interaction of Celecoxib with Warfarin. In terms of that pie chart, we are in the process of redoing it at the moment, going through all the reports and updating it.

Senator CHRIS EVANS—But I presume this goes to practitioners and interested parties, does it?

Dr McEwen—It piggybacks with the *Australian Prescriber*—so all the doctors, dentists and pharmacists in Australia.

Senator CHRIS EVANS—So you put this out in June 2000. So is this publication going out now, or has there been something in between?

Dr McEwen—We have had in between publications but we have not dealt with Celebrex in those.

Senator CHRIS EVANS—No. That is what I am saying. In terms of providing information on Celebrex, those are the two—

Dr McEwen—They are the two.

Senator DENMAN—In the case of trialling these things, you obviously—I do not know whether it is obvious or not—choose people that have arthritis but are relatively healthy otherwise and these side effects occur. Is that how it happens?

Dr McEwen—The populations for clinical trials are certainly selected. When the drug is marketed, one of the things that we look for is a series of reports of reactions, particularly a serious or unexpected reaction in a population that was not in the clinical trials. Essentially, we have not seen it.

Senator DENMAN—How do you choose the people in the clinical trials?

Dr McEwen—In brief, they are selected by the sponsors of the trials who want to demonstrate the efficacy of their drug. To some extent they are chosen to optimise the results. I think Professor Smallwood was talking about the initial trials. The patients selected were free of ulcer at the start of the trial.

Senator WEST—We do not have a system, I understand, like Canada does, where there has to be some gender differentiation and mixtures in those trials. Am I right?

Dr McEwen—I do not know of the Canadian practice.

Senator WEST—Given that there was a report in the media last week about gender differences in reactions to particular types of analgesics, I would have thought it would have been an appropriate thing to be doing when we are doing trials of new drugs.

Mr Podger—Can we take that on notice? We have not got the right people here and we are also not aware of the Canadian arrangement.

Senator WEST—It was something put to me last week. As always happens, I pricked up my ears. Sorry, I should not have.

Senator CHRIS EVANS—I am just a bit unclear, Dr McEwen—and maybe Mr Stevens or Professor Smallwood are more appropriate to answer this question. You get an unprecedented number of reports and you, quite rightly, analyse those, but I am just not clear in my own mind who makes an assessment about whether the adverse reaction is worse than the positive effects, or what reaction in terms of public health issues or approvals then comes into play if you get a large adverse reaction.

Dr Morauta—The superior committee for the registration is ADEC. This committee that Dr McEwen looks after reports to ADEC. When it believes there is a matter of concern, it would raise it with ADEC and the question would be then raised as to its listing in Australia, its registration in Australia—whether it needed some more conditions on it or whether it needed to be deregistered. That is the sort of way the process generally works.

Senator CHRIS EVANS—So you are saying the Adverse Drug Reactions Advisory Committee provides advice to the department then if they have got serious concerns.

Dr McEwen—Yes.

Senator CHRIS EVANS—Have you done that, Dr McEwen?

Dr McEwen—We report to the main drug evaluation committee. The advice that has been provided consistently out of the ADRAC meetings in looking at this is that the pattern of reactions is consistent with what is seen in the clinical trials and that the reason for the high number of reports is not certain. It is probably for the reasons I have already indicated: the very high usage, the very high expectations created and the aggressive promotion.

Senator WEST—Is the creation of expectations a concern to you?

Dr McEwen—I am not sure that I can answer.

Mr Podger—They can be, yes.

Senator WEST—Is it because it can raise unrealistic expectations or it can be raising—

Mr Podger—That is the role in particular of things like *Australian Prescriber*, which are trying to get to doctors a very independent view of these sorts of things and educate them and try to avoid a hype, if you like, that can be created. Can I just add one thing about the adverse effects? If, in fact, it does raise questions, it ought to go back to the Australian Drug Evaluation Committee about safety. Equally, if it raised questions about clinical effectiveness or cost effectiveness, at some point it could come back into a reconsideration by the PBAC. That would have to have gone through the committee that John has been talking about.

Senator CHRIS EVANS—I am just trying to get clear in my own mind what happens. I am not saying this has happened, but if people were dropping dead as a result of a drug, it would go back to Dr McEwen. I am just trying to work out what happens then in the sense of does he write a very good report that is circulated and hopefully has some effect or does someone do something a bit more serious about it?

Mr Podger—It can go back to the Australian Drug Evaluation Committee and the TGA therefore may review whether the drug ought to be listed. It may in fact not be an issue so much of safety as of clinical effectiveness and cost effectiveness, which may still allow it to be listed but raise questions about our arrangements with the PBS. Under certain circumstances that would come back and be revisited by the PBAC.

Senator CHRIS EVANS—Dr McEwen's committee would also be the one responsible for raising questions about effectiveness and—

Mr Podger—No, what I am saying is that he is raising issues about adverse events, which is essentially a safety issue but it may give rise to questions for a revisiting by the PBAC as well as by the ADEC.

Senator CHRIS EVANS—Would that also go through Dr McEwen's committee or is that a more separate process?

Dr McEwen—No, it would be considered by the PBAC. Cost effectiveness is PBAC's role. Registration is ADEC's role. So if there was a substantial issue that a drug was unsafe it would be up to ADEC to say, 'This must come off the market.' That is not an issue here.

Senator CHRIS EVANS—Given that it is not unsafe, as it were, what happens in the sense of what I was pursuing with Professor Smallwood—that is, who makes the assessment about where the balance lies with the adverse reactions versus the positive reactions? You approve the drug and you put it on the list based on trials. If you get a response that indicates behaviour that might be a bit different from what you got in the trials, who then considers that and what action are they able to take?

Dr Morauta—The PBAC receives ADRAC reports from this committee and it can also have a matter referred to it from ADEC. So there are a number of ways the PBAC keeps abreast of this.

Prof. Smallwood—Perhaps it would help if I gave an account of two still commonly used antibiotics—Augmentin and flucloxacillin—which are commonly used. Flucloxacillin is used against staphylococcal infections and Augmentin is used against a range of infections.

Senator CHRIS EVANS—A week never went by when my kids were small when they were not on Augmentin, so I know that one well.

Prof. Smallwood—This is the cautionary tale. It was not clear from clinical trials whether or not these caused harm to the liver. When they were generally marketed and then went onto the Pharmaceutical Benefits Scheme the prescriptions went up. Then reports started coming through of serious jaundice and, in some cases, liver failure.

There was interaction between ADRAC and senior people in the community, particularly those with an interest in liver disease, in liver failure, and with ADEC. It became clear that a little more needed to be known about who was vulnerable. It turned out, for example, that with both flucloxacillin and Augmentin, older people were affected, particularly if they were put on the medication for a longer period of time—a term of about two weeks. It became clear then that those directions were to be promulgated—to be particularly cautious with older people. But the benefit of those drugs was such that they were not considered, as I understand it, to be withdrawn from the market. So they are still out there and they are still doing a lot of good things. But there were safety issues with these rare but serious events which only came up when they were being prescribed in large amounts.

Mr Podger—The key point we are raising is that there are due processes to keep an eye on these things and feed them back to our committees. But on Celebrex, nobody is suggesting at the moment that the department is thinking about delisting or taking it off the PBS or anything like that. We are monitoring the adverse events.

Senator CHRIS EVANS—I am sure you would have told me if that was the case. As I say, I was interested in what the process was once we had the drug on the market—if we get a large drug reaction, how does it feed into the other processes. Thank you for that.

Senator DENMAN—When a recommendation comes from a trial elsewhere, do we trial them here as well or do we just go ahead and monitor them, as you have said?

Dr McEwen—There is no requirement to stage trials?

Senator DENMAN—That is fine. Thank you.

Senator HARRADINE—I have a question on the MBS, following the department's answer to my question E015. I had asked a question on the fact that the medical benefits schedule provides benefits to be paid for the management of second trimester labour with or without induction for, amongst other things, gross foetal abnormality. I asked you whether the department had a definition of 'gross foetal abnormality' and, if not, who in fact defines it? The answer to that question was: 'No, the department hasn't a definition of gross foetal abnormality; it is a clinical decision for a practitioner.' My question is: how does that relate to the answers you gave this morning that Medicare rebates are payable in respect of clinical relevant professional services and that such a service means a service rendered by a medical practitioner that is 'generally accepted in the medical profession as being necessary'? Isn't there a contradiction in what you put to me in the answer there compared to what you said this morning? Here you are saying that gross foetal abnormality is a clinical decision for the practitioner.

Mr Podger—I am not sure that there is a conflict between those two answers, Senator. The answer here is that it is a clinical decision for the practitioner. The answer to your other question went a bit further and talked about what were the standard professional arrangements accepted in the profession. I would argue that that was implied by this answer but not set out in this answer. I do not fully understand the conflict that you are detecting between the two answers.

Senator HARRADINE—I want to know whether or not MBS payments are triggered by the abortion of a person with gross foetal abnormality—for example, dwarfism, and I will come to that in a minute. You have said, in answer to my question, that MBS payments are triggered by the 'clinical decision' of a practitioner. But this morning you talked about what is 'generally accepted in the medical profession as being necessary'.

Dr Morauta—I am not sure how much of a distinction there is, Senator, and where the conflict lies. Obviously any doctor in clinical decision making will bear in mind the views of other members of his profession, and the broad standards of the profession and the specific standards of the profession with respect to the matter in hand.

Senator HARRADINE—Take the issue of dwarfism. Does the department consider dwarfism a gross foetal abnormality?

Dr Morauta—I think our answer is: were the doctor to make that as a clinical decision, that would be appropriate. But it is up to the doctor to decide whether that is his view of it or not.

Mr Podger—It is an issue for the doctor in line with the professional standards; it is not an issue that we would separately set a standard for in the department.

Senator HARRADINE—In other words, one doctor could say that dwarfism is a gross foetal abnormality, such as the doctor in Melbourne—there was a great outcry about that. Another doctor could say, 'Oh, no—definitely not. Who is abnormal? What about the anti-discrimination laws of this country?'

Mr Podger—Senator, we will not pay MBS payments for a service that is illegal in any state.

Senator HARRADINE—Mr Podger, I know that.

Mr Podger—This answer here is saying that we rely on the doctor. In saying that, we also rely on the doctor abiding by the professional standards set by the colleges or whatever else there and abide by the regulation of the medical profession by the states through medical boards and other processes. We do not have a departmental position on this—a definition or anything like that within our departmental processes.

Senator HARRADINE—You do not have a definition of what is a gross foetal abnormality? Do you agree or don't you agree as a department—and this answer was from you as a department—that dwarfism is a gross foetal abnormality? Surely that is a simple question.

Mr Podger—Our answer to the first question you asked then is: no, as we set out in the answer here, we do not have such a definition. You are asking for views. The department does not have views, because the department does not have a definition. The department relies on these things in terms of professional standards and the process of regulation of those at the state level.

Senator HARRADINE—But the department and the HIC are spending millions of dollars of taxpayers' money through the MBS. As a representative of the people—particularly people who are grossly outraged at what could occur in respect of persons who have dwarfism—who am I to ask? You are saying that it is up to the individual clinical practitioner.

Mr Podger—No, that is not what we have said, Senator.

Senator HARRADINE—I quote what you have said:

The department considers the question of whether a patient's condition constitutes gross foetal abnormality as a clinical decision for the practitioner.

Does that not mean you could have one practitioner saying, 'Yes, it is', and another saying, 'No, it isn't'?

Mr Podger—We would expect the clinical decisions of practitioners to be in line with the professional standards set by the relevant colleges and that they would be subject to the state laws. The issue of discrimination, as we said in part (d) to that answer, is a matter for the Attorney-General, in particular the Victorian Attorney-General.

Senator HARRADINE—But you are quite happy to pay out, on the basis of something that comes to the HIC with gross foetal abnormality, dwarfism.

Mr Podger—Senator, we have been through some of these things before. I am not sure I can add more to my answer. We are a health insurance organisation. We do not set all the standards. We do not determine exactly the efficacy or whatever of the services that we are funding. We are an insurance organisation and that is the way it operates.

Senator HARRADINE—But where is the accountability, Mr Podger? Where is the accountability of the expenditure of taxpayers' money? What you are really saying is that if the individual practitioner says that dwarfism is a gross foetal abnormality then you will pay for it.

Mr Podger—No. First of all, the issue of concern you have raised, as to whether it is an issue of discrimination or appropriate medical practice, is a matter for state governments and for the professions, and that is where the accountability around that lies. If there are particular services that you believe are inappropriate, the accountability around that lies with those processes of regulation of the professions.

Senator HARRADINE—Is that so? You will expend taxpayers' money if you get a claim for reimbursement of a doctor under the MBS for that doctor performing an abortion on the person because that person carries a foetus, an unborn child, with dwarfism. I specifically ask you because that is what is likely to happen. I am asking: where is the accountability? Where do you begin and where do you end? Is the absence of two fingers on a foetus a gross foetal abnormality? Where do you start and where do you end? The absence of a hand, the absence of an arm—how far do you go?

Mr Podger—Senator, the answer to the question was that we do not have a definition of that in the department. That is an issue for professional standards and state legislation.

Senator HARRADINE—That is a cop-out.

Mr Podger—I understand your view, Senator. I am simply advising on what the government policy—

Senator HARRADINE—Madam Chair, I am raising these matters because of a very strong reaction amongst the disabled community to what occurred—that is to say, the abortion of a person with dwarfism. What you are saying here is that you are not prepared to say that dwarfism is not a gross foetal abnormality.

CHAIR—Senator Harradine, may I just seek clarification? Are you actually asking the department to be judge and jury on a clinical decision made by a doctor in consultation with a patient? I am at a little bit of a loss to understand what further can be usefully pursued by—

Senator HARRADINE—Yes. Certainly I am asking the department how the department and the HIC administer the MBS. We are talking about millions of dollars here.

CHAIR—Does the department interfere in any other procedure of deciding a tick or cross in terms of payment?

Mr Podger—No, Senator. I have described the processes we operate, which is in line with our legislation and government policy and in line with policy that has been there for a number of years. It is not expressing any view whatsoever on the precise operation the senator is talking about. That is not my job. I am not giving a view one way or the other; I am simply saying that the processes of the MBS is, as we have set out there, that we do not have a departmental definition. It is an issue for the doctor, but of course not written in that is that the doctor is then obliged to abide by the professional standards and abide by the law of Victoria in those processes.

CHAIR—But the department has no capacity whatsoever to make a judgment on someone else's clinical assessment.

Mr Podger—We would not make such a judgment, no, Senator.

Senator HARRADINE—So you just pay up on the say-so of a doctor.

Mr Podger—Senator, I do not think there is anything further I can say in answer to the question.

Senator HARRADINE—This is a very important matter. We are talking about dwarfism and how dwarfism is perceived throughout the community. I am raising these questions at the specific request of a number of people in the disabled area. We are paying out money for what you give a tick to.

Mr Podger—Senator, with all respect, I think the issue of paying the money is in some respects a second order issue. The issue you are raising is a concern about the operation. The

operation without MBS would still be of concern, and it is an issue that would need to be addressed by the profession or the Victorian regulation arrangements to see whether or not it is appropriate. That having been from us, unless there is an issue raised directly there, we will pay. We will not make a second judgment on those issues. That is not the way our responsibilities under the law and under government policy apply.

Senator HARRADINE—We are talking about money in this committee and it is not a second order matter; it is a very important matter for people to know how their taxpayers' dollars are spent. What are the accountability procedures? Is there separate information in respect of gross foetal abnormalities? Is there a separate listing of the amounts that have been paid out through MBS on that particular ground?

Dr Morauta—No.

Mr Podger—Madam Chair, I do not think there is anything further I can add to my answers this afternoon.

Senator HARRADINE—I am asking a question. Do you have any accountability procedures? Do you have within the department or within the HIC a listing of the payments made in respect of abortion for 'gross foetal abnormality'?

Mr Podger—We would not have data on that, no.

Mr McRae—You would be aware that the Medicare item that we are referring to contains management of second trimester labour in the context of intra-uterine foetal death, gross foetal abnormality or life-threatening disease. All we can do in our system is count how many times that item is claimed. We have no information coming through to tell us what the components of that may be.

Senator HARRADINE—You have no way of examining the accountability or otherwise—just take the word of the individual doctor?

Mr Podger—Senator, I do not think there is anything further I can add to my answers already. We do have lines of accountability for our health insurance arrangements but you are suggesting a process which is not written into our legislative processes or government policy arrangements for us to have a second layer of decisions and judgments over the appropriateness of particular procedures.

Senator HARRADINE—But you do make a judgment on the question of clinical relevance. That judgment, you have said to me this morning, is based on what is generally accepted in the medical profession as being necessary.

Mr Podger—I do not think anything I have said this afternoon is in conflict with that statement either.

Senator HARRADINE—What you have said here, in answer to my question, confirmed this afternoon that it really depends on an individual, the treating doctor.

Mr Podger—No, Senator, I added to that and said that in answering the question that is a clinical decision for the practitioner. Not written into that answer but implied, as far as we were concerned, was that would have to be in line with professional practice and would have to be in line with state legislation.

Senator HARRADINE—How do you assess professional practice? What is in line with professional practice? At least, how do you assess that?

Mr Podger—In general the issue would arise when there are questions about whether a particular practice is not acceptable. That would normally go through a college arrangement unless it was an issue directly in state legislation about an inappropriate practice.

Senator HARRADINE—You make a decision there and then that either this is or this is not generally accepted in the medical profession. How do you go about that?

Mr Podger—The issues you are raising are issues that might be put to the professions and raised at—if it would require change in the standards of the profession or perhaps an issue for state law. It is not for us to second-guess that.

Senator HARRADINE—But you have said you have defined a clinically relevant service which included what is generally accepted in the medical profession. That triggers a payment of money. All I am asking you is how do you go about finding out whether the service is generally accepted in the medical profession as being necessary? What procedures have you got in the HIC for that case? Or do you leave it to the medical profession; it is a closed shop again? You are asking me to ask them; they are not here and they are a law unto themselves.

Mr Podger—It is the medical profession that sets the professional standards. It is not the department or any bureaucracy that sets that. The medical profession sets those standards through those colleges. Some sensitive issues also go to the law and that is particularly handled at the state law.

Senator HARRADINE—But you accept, in the ultimate, the say-so of the individual medical person.

Mr Podger—There are a number of processes, if there is a suggestion that particular procedures are not in line. There is a professional services review and other processes which allow that to be pursued. I am not too sure I can answer any more than I have done, Senator.

Senator HARRADINE—Okay, but you have been given the opportunity, Mr Podger, on behalf of the department to say whether or not you consider dwarfism as a gross foetal abnormality.

Mr Podger—I have tried to very carefully say it is not the responsibility of the department to determine that. It should not be seen as a reflection in any way on my view or the view of individuals around this room at the moment or anywhere else in the department.

Senator HARRADINE—We are not talking about individuals.

Mr Podger—It is not a responsibility that the department has.

Senator HARRADINE—Madam Chair, I am not impugning anybody.

CHAIR—Mr Podger has answered your question a number of times. I do not think he has got anything more to add, Senator.

Senator HARRADINE—I understand, but his inference a moment ago that I was reflecting somehow about officers' personal views in the department is, with due respect, unwarranted.

Mr Podger—Thank you, Senator.

Senator HARRADINE—I am sorry if that message was getting over. It was not meant to get over.

Mr Podger—I appreciate that.

Senator HARRADINE—I was really asking it in respect of the department and Mr Podger, being in the position that he holds.

CHAIR—Thank you. Any further questions on outcome 2?

Dr Morauta—Madam Chair, could I add a couple of things to things we did before?

CHAIR—Certainly, Doctor.

Dr Morauta—We got something wrong. We do have a note of the meeting with the pharmaceutical manufacturers. We have found one on file. I am sorry, Senator, I was very emphatic that we did not have such a thing. I have now found it, so we do have such a thing and we have the regulations to table for you here, which I believe you were asking for in relation to the pharmaceutical benefits amendment.

Senator CHRIS EVANS—Thank you for the regulations, Dr Morauta. Could you be a bit clearer on which particular subject matter you are clarifying? You said you had a meeting with the pharmaceutical industry; you did not refer to what?

Dr Morauta—The question was, did we have a note of the meeting that the Prime Minister had with the pharmaceutical manufacturers. We said no, and people in the department who are watching us have decided that we got it wrong and that there was something on file. I am correcting it now, Senator.

Senator CHRIS EVANS—I expect the minister, therefore, to apologise to me for accusing me of being persistent.

Senator Vanstone—All I said to you, Senator, was that if the answer to the second question was different from the first, then the first was an incorrect answer. You have to get the same answer to both.

Senator CHRIS EVANS—Yes, but you learn the value of persisting sometimes.

Senator Vanstone—No, I feel quite sure the public servants who have been listening and watching would have picked up the answer to, 'Did you get any feedback?' with the single question. They are pretty good, you know.

Mr Podger—The correction was to both questions.

Senator CHRIS EVANS——Can you go back and maybe explain to me what it is you are now offering me?

Dr Morauta—I was offering you information, Senator.

Senator CHRIS EVANS——Yes, but I thought you were about to give me the file notes. You were waving at me, facing me and I thought—

Dr Morauta—No, I was reassuring myself that it was there, Senator.

Senator CHRIS EVANS——You are saying to me that the meeting the Prime Minister had with the Bennelong group on 10 November—you got, what, a report of that meeting?

Dr Morauta—Yes, a file note, Senator.

Senator CHRIS EVANS——Who provided that to you?

Dr Morauta—It was from the Prime Minister's office but I am not quite sure how it arrived to us—through the parliamentary secretary's office.

Senator CHRIS EVANS——There was a file note from the Prime Minister's office reporting on the meeting, which was forwarded to the parliamentary secretary's office.

Dr Morauta—Yes, Senator.

Senator CHRIS EVANS——Whose parliamentary secretary?

Dr Morauta—Senator Tambling's.

Senator CHRIS EVANS——Was it copied to the minister?

Dr Morauta—It is not obvious from the paper before me that it was, Senator.

Senator CHRIS EVANS——Why would it go to the parliamentary secretary of Senator Tambling?

Mr Podger—Senator Tambling takes responsibility in the portfolio for PBS matters.

Senator CHRIS EVANS——Of course. Senator Tambling got the file note at the same time you got it or did he send it on to you?

Dr Morauta—No, he sent it on to us.

Senator CHRIS EVANS——The Prime Minister's office sent it to him and he copied it to you?

Dr Morauta—Yes.

Senator CHRIS EVANS——You are not able to tell me whether the minister got one as well?

Dr Morauta—No, I cannot.

Senator CHRIS EVANS——Will you take that question on notice for me, please, as to whether or not it was copied to the minister as well.

Dr Morauta—Yes.

Senator CHRIS EVANS——What is the date of that file note?

Dr Morauta—14 November.

Senator CHRIS EVANS——When was it received by the department?

Dr Morauta—Again, not obvious from the document in front of me, Senator. It may not be possible to establish that.

Senator CHRIS EVANS——You don't date stamp them or anything?

Dr Morauta—I would like to say we did but this one does not appear to be blessed with such a thing, so I cannot pretend otherwise.

Senator CHRIS EVANS——I should have thought, with the MRI thing, all this stuff would be in order by now.

Senator WEST—I would not have thought anything would have escaped your department without a—

Senator CHRIS EVANS——It is dated 14 November but we do not know when you received it.

Dr Morauta—It is out of the parliamentary secretary's office on 14 November. What I do not have is when we actually got it.

Senator CHRIS EVANS——What is the date on the document?

Dr Morauta—It says 'Dated 14th of November' and the parliamentary secretary's office stamp is 14 November too.

Senator CHRIS EVANS——But the origin of the note is somebody in the Prime Minister's office.

Dr Morauta—Yes.

Senator CHRIS EVANS——Are you able to tell me who?

Senator Vanstone—Is that relevant?

Senator CHRIS EVANS——I would like to know. It is just a question of whether people are going to tell me or not.

Senator Vanstone—You might like to know, but what hangs on it? If I say to you the person's name is Mary Smith and then I say, 'Oh, no, it's John Black' or 'Fred Nerk', what does it matter other than a desire to personalise things? I understand you are interested in the issue generally, but to personalise things, either for bureaucrats or people who work for members of parliament, is very unattractive. It neither adds value nor detracts value from the note, depending on who wrote it.

Senator CHRIS EVANS—While I am always interested in your views, Minister, I really wanted to know whether or not you were going to tell me.

Senator Vanstone—I would not tell you, no.

Mr Podger—With that guidance, I do not intend to tell you either, Senator.

Senator CHRIS EVANS—I am sure those dismissed staffers will be pleased to know that you have such an interest in not personalising such matters. I should formally ask: are you prepared to make the note available to the committee?

Mr Podger—I will take that on notice, Senator.

Senator CHRIS EVANS—Why do you take it on notice?

Mr Podger—The paper originates from the Prime Minister's office and elsewhere. I do not think it would be appropriate for me to unilaterally decide to release it.

Senator CHRIS EVANS—I would appreciate it if you could get back to us when you are in a position to provide advice on that, Mr Podger. Dr Morauta, why didn't we know about this when I asked earlier?

Dr Morauta—I think we forgot, Senator, or something like that. The detail escaped us.

Senator CHRIS EVANS—Were you aware beforehand?

Dr Morauta—No. It has just been drawn to my attention. I immediately drew it to your attention.

Senator CHRIS EVANS—Yes, I appreciate that. I was wondering whether it was something that escaped your memory or whether it was not known to you.

Dr Morauta—I would not personally have known, Senator.

Senator CHRIS EVANS—Are we confident that that is the only involvement the department has had with this meeting, apart from the briefing note prepared for the Prime Minister's guidance?

Mr Podger—I believe so, Senator.

Senator CHRIS EVANS—No minutes, no notes, no further correspondence?

Mr Podger—We were not there, Senator.

Senator CHRIS EVANS—I am just making sure I have asked the right question, Mr Podger.

Senator Vanstone—Twice.

Senator CHRIS EVANS—Well, there you go! Sometimes the third time you get lucky. So there is no other material which you think is relevant to that meeting held by the department?

Dr Morauta—We will certainly let you know if anything turns up, Senator.

Senator CHRIS EVANS—Thank you for that. Where were we?

CHAIR—Anything further on outcome 2?

Senator CHRIS EVANS—Yes, I wanted to ask about a couple of drug related PBS matters. I am sorry to the officer involved. Senator Harradine has another committee and asked if he could have a commercial interlude. I want to ask about Halotestin, which is manufactured by Pharmacia. I gather it was removed from the PBS in November. Can anybody tell me why?

Mr Stevens—It was removed at the request of the manufacturer.

Senator CHRIS EVANS—Why was that?

Mr Stevens—I would imagine because of low volume, but that would be a matter for the manufacturer.

Senator CHRIS EVANS—You don't ask them?

Mr Stevens—They provide us with general information. But the volume of that product was low and they have requested that it be withdrawn from the PBS.

Senator CHRIS EVANS—So that we are clear, Mr Stevens, was it because of low volume? Do they provide you with a reason or don't you know?

Mr Stevens—I know the volume was low. I cannot recall a reason being offered by the manufacturer.

Senator WEST—Is that normal?

Mr Stevens—They would write to us and write to the PBAC seeking removal from the scheme. They would offer a reason, but I do not have that reason with me.

Senator CHRIS EVANS—Could you take that on notice, Mr Stevens, to find the reason why Halotestin was removed. In such circumstances, do you automatically follow the request of the supplier?

Mr Stevens—Senator, we cannot force drug sponsors to remain listed on the scheme. Certainly if there is advice from the PBAC that the drug is of need and the sponsor has withdrawn it from the market for some reason, we try to seek alternative sources.

Senator CHRIS EVANS—You do not try and encourage them to leave it on the market?

Mr Stevens—We certainly do that. That would depend on the advice of the PBAC at the time.

Senator CHRIS EVANS—What advice did you receive regarding Halotestin?

Mr Stevens—I would have to take that on notice, Senator.

Senator CHRIS EVANS—Yes, if you would, please. So someone could effectively write to you seeking its removal. Basically, you say that you do not have any power to keep a drug

on the market. If they say to you, 'We don't want it on,' you can talk to them about it, but you have no power to force them to keep a drug on the market.

Mr Stevens—That is a fair summation. Under the legislation we cannot force a company to have a drug listed on the scheme.

Senator CHRIS EVANS—You might want to talk to them and encourage them if you think there are no alternative replacements, but at the end of the day if they want it off it comes off.

Mr Stevens—That is basically it. Sometimes we have no option, because the product has been withdrawn from sale by the sponsor's source of supply.

Senator CHRIS EVANS—What happens to those patients who are on that particular product?

Mr Stevens—The normal practice for a drug to be removed from the scheme is that we have advanced notice of a removal and we put advanced notice in the schedule of benefits to alert prescribers of that. It is normal in most cases for the sponsors to put a note around themselves to prescribers.

Senator CHRIS EVANS—Did that happen with Halotestin?

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

Senator CHRIS EVANS—Are there readily available replacements, similar products, for Halotestin?

Mr Stevens—Again, I would have to take that on notice.

Senator CHRIS EVANS—Could you provide me with some information on the process by which Halotestin was removed, why it was removed, and what alternatives were available to those patients on Halotestin? You think it is probably to do with low volume. How many products would come off annually, on average, Mr Stevens? I will not hold you to a figure. It is just so that I have an idea.

Mr Stevens—Generally a number of products come off the scheme each year, and you will find in the front of the schedule of benefits at each time products that are being removed. In the majority of cases they may be brands of a particular item where there are alternative brands still remaining, or there may be an item where there are a number of competing products.

Senator CHRIS EVANS—Are we talking about 10 a year or 20 or 100?

Mr Stevens—I would have thought of the order of 60 to 100 a year.

Senator CHRIS EVANS—Quite a large number.

Mr Stevens—If you equate product equal to a brand—that is an individual product for a company.

Senator CHRIS EVANS—Could somebody tell me about the anti-smoking product Zyban? I gather that is now on the PBS listing.

Mr Stevens—It was listed with effect from 1 February.

Senator CHRIS EVANS—It was around for a while before that.

Mr Stevens—It received marketing approval before that.

Senator CHRIS EVANS—Do you have any idea of the volume that is being consumed?

Mr Stevens—Not at this stage, no. It is a bit too early to get data.

Senator CHRIS EVANS—What about before listing?

Mr Stevens—I do not have that data available.

Senator WEST—Has it been subject to an extensive advertising campaign?

Mr Stevens—The sponsor has certainly been promoting it. That would be normal for any new item, whether it is PBS listed or non-PBS listed.

Senator CHRIS EVANS—What estimates have you done for Zyban? What are the budget estimates for Zyban?

Mr Stevens—Our estimates in relation to volume are of the order of 30,000 scripts in the first year.

Senator CHRIS EVANS—Thirty thousand prescriptions expected in the first year. Do you have any data yet on how many have been written?

Mr Stevens—No data on how many have been dispensed at this stage. It is a bit early.

Senator CHRIS EVANS—I have a note here suggesting that the HIC have said 90,000 prescriptions have been written so far. Is that not right?

Mr Stevens—That would relate to the number of authorities requested, but we do not know whether it actually it resulted in scripts being dispensed or not.

Senator CHRIS EVANS—Can you explain that point to me, please, Mr Stevens? I do not think I understand that.

Mr Stevens—The product is listed with an authority required restriction and the prescriber needs to get prior approval from the Health Insurance Commission prior to writing the prescription and handing that to the patient. We are aware that the HIC has a number of requests for authorities but we do not have the information on whether the patient after receiving the prescription has physically got that dispensed from a pharmacist or not.

Senator CHRIS EVANS—So the patient has to apply?

Mr Stevens—No, the prescriber.

Senator CHRIS EVANS—The prescriber, who is the doctor.

Mr Stevens—That is the doctor, yes.

Senator CHRIS EVANS—The doctor has to get the authority to be able to prescribe the drug. Is that right?

Mr Stevens—That is right—prior approval.

Senator CHRIS EVANS—What steps do they have to go through to get that approval?

Mr Stevens—Basically a mechanism through the Health Insurance Commission. They can either contact by telephone or by written application. A great majority of course are by telephone.

Dr Morauta—Senator, obviously as a result of the authority which has been given, there would be a very large number of prescriptions dispensed in relation to the number of authorities. We just do not have the figures yet on the claims coming through because it is very early days.

Senator CHRIS EVANS—I think my level of understanding needs me to go back a step even before that, though, just to be sure. What does the doctor have to do to get the authority?

Do they have to prove anything? You have that leap in the sense that they have to do something in contact but what do they have to establish in order to get the authority?

Mr Stevens—They have to establish that the patient meets the criteria set down in the schedule of benefits.

Senator CHRIS EVANS—I see. They have to apply in respect of each individual patient.

Mr Stevens—Each individual patient. That is right, Senator.

Senator CHRIS EVANS—What criteria apply for Zyban? Perhaps you could take it on notice but just give me a general idea of what sort of requirements there are.

Mr Stevens—Basically they need to be participating in a scheme that is related to smoking cessation. In effect, what the doctor is actually saying to the HIC is that the patient will be participating in a program relating to the drug.

Senator CHRIS EVANS—So there is a more holistic approach to the cessation of smoking other than just the drug. Is that it?

Mr Stevens—That is right.

Senator CHRIS EVANS—They do not have to provide any evidence. The doctor verifies that that is the case.

Mr Stevens—That is right.

Senator CHRIS EVANS—So it is a simple phone call. Are you aware of this 90,000 figure? I do not want to put words into your mouth. Someone gave this to me as being an HIC figure.

Dr Morauta—Perhaps the HIC could come and talk about the authority numbers.

Senator CHRIS EVANS—I might be burbling then. It may not be. It could be 9,000 or nine.

Ms Paul—Senator, since 1 February, the department is exactly right. We have received over 90,000 calls from doctors to get their authority. The system is as Dr Morauta describes but, as they say, it is not an indicator yet of how many would have actually been dispensed.

Senator CHRIS EVANS—If I am wrong, correct me, but I presume they would not be going to the trouble of ringing you unless they had already spoken to the patient and had some prospect of the patient engaging in the—

Ms Paul—That is right.

Senator CHRIS EVANS—These are not spec calls; they actually have to name the patient when they ring you.

Ms Paul—That is exactly right. In fact usually they will ring us during the consultation, so the patient is usually there in front of them.

Senator CHRIS EVANS—So what has your previous experience been with these authorities—that there has been quite a large take-up compared to the authorities given or not?

Ms Paul—We would expect so. It varies but, usually, as I say, the patient is there; the doctor is doing it over the phone. We are giving an authority on the spot against the criteria that were described, so you would expect a reasonably high take-up but we will not know that for some time.

Senator CHRIS EVANS—But, if you have had 90,000 authorities, you would expect to get a good number of those actually seeking then to avail themselves of a prescription.

Ms Paul—We would expect so.

Senator CHRIS EVANS—When will you have figures on that? When will you get a feel for how that is going?

Ms Paul—We will know when our PBS claiming figures are next pooled together. But of course there may well be lag times too, of course, between when a patient actually gets a script and when they go and have it filled and so on. So it will be a rolling collection of information.

Mr Podger—You would also expect some other things to emerge over time. You get on to this for a year and we will not know for a while what will happen in the coming months, whether we have got a whole lot of people on it or whether we will continue to get new people coming on it or not. So it looks as if we have got a spurt considerably higher than we had expected, but it will take not only figures on whether those turn into prescriptions which are then taken forward but also what will happen over the following months.

Senator CHRIS EVANS—There is always an element that this might be the latest greatest cure for smokers and they all try it and then go back to what they normally do. But, as you say, Mr Podger, it seems like the initial interest might well be quite strong. Are there any conditions attached to the listing of Zyban by the PBAC?

Mr Stevens—There is, Senator. They are listed in the schedule of benefits and one is, as I mentioned before, that it needs to be part of a program. Also there is only one prescription allowed per annum.

Senator CHRIS EVANS—How long would a script last for?

Mr Stevens—For most patients the script would last for a two-month period.

Mr Podger—What it means is we are unwilling to pay a second time following a first time within a 12-month period.

Senator GIBBS—The program is a two-month program and, if one sticks with the drug and the program, is there a reasonable chance that one could be cured of smoking?

Mr Stevens—I think with any smoking cessation program there are always relapses but that has been the recommended period of going on the program and taking this drug.

Senator CHRIS EVANS—Mr Stevens, you should see all the smokers behind you looking at their feet at the moment. You can tell the smokers by the ones who are not looking up at the moment.

Senator GIBBS—I am very interested in this. So it is a two-month program and there is a good chance that one could be cured in two months.

Mr Stevens—It is an expectation that you are going to achieve a result in that period. Not everyone is going to achieve cessation of smoking in that period. Drugs generally are not 100 per cent effective in all cases, but the trials have indicated that this drug gives better results than alternative therapies such as nicotine patches.

Senator CHRIS EVANS—Can I just ask: have you set down what constitutes a comprehensive treatment program as a guidance for doctors as to what has to be done that surrounds the prescription of the drug?

Mr Stevens—We have not issued any particular guidelines from the pharmaceutical benefits area.

Senator CHRIS EVANS—How do the HIC give approval then if they do not know what the guidelines are?

Ms Paul—We ask the doctor, when they ring for an authority, whether the patient is also going to undertake a comprehensive cessation program. As you would know, there are any number available to people through state bodies and other bodies, and the doctor would confirm that with us and we would go through the other conditions and then give the authority. It is our interaction with the doctor who is recommending or deciding on the cessation program, the treatment program.

Senator CHRIS EVANS—But there will be some guidelines produced which give information to doctors as to what that will be, will there?

Mr Stevens—No, we are not producing any guidelines ourselves.

Senator CHRIS EVANS—I got the impression from what you said that they were on their way, but that is not right?

Mr Stevens—No.

Senator CHRIS EVANS—It is purely at the discretion of the HIC as to what constitutes a comprehensive treatment program. Is that correct?

Ms Paul—Sorry, Senator?

Senator CHRIS EVANS—It is purely on the advice of the HIC as to what constitutes a comprehensive treatment program.

Ms Paul—We take the advice from the doctor, so we would expect the doctors in their professional capacity to have a good knowledge. There would be an enormous amount in their professional literature, Senator, about what comprises a comprehensive treatment program and any numbers of offers of treatment programs and so on, so we rely on the doctors' judgment.

Senator CHRIS EVANS—Mr Stevens, given that there might be a high take-up on Zyban, is there any trigger that makes you review the listing or the control if there is a huge uptake?

Mr Stevens—As we stated earlier, there is a process where the drug utilisation subcommittee of the PBAC would monitor usage of any new drug that is listed to see how its uptake is in line with expectations and report back to the PBAC for further consideration. We would also seek comments from the sponsor themselves as to why such a variation from our original estimates.

Senator CHRIS EVANS—But what about from a cost point of view? If you find there is a huge take-up, does someone assess that and what the implications of that are?

Mr Stevens—You need to assess that as part of an ongoing review. If a drug is proved to be of acceptable cost-effectiveness, if there is a high take-up rate that may still be providing considerable benefits to the community—

Senator CHRIS EVANS—Yes, I am not suggesting that is not the case, but I am saying that, clearly, if you have budgeted for something to cost $10 million a year and the first six months it is $200 million, surely someone in the bureaucracy says, 'Hang on a secretary; there goes the Commonwealth budget.' What mechanism is in place—

Dr Morauta—That is what Mr Stevens has said. There is a process whereby these things are looked at and referred back to the PBAC for further advice.

Mr Podger—As you know, the PBS is a special appropriation and therefore the money will flow, but we just do not take a hands-off approach. In that case, if there is a major expansion, we will have a look at whether or not it is cost-effective, whether the consideration the PBAC had in making its recommendations for listing on cost-effectiveness grounds still holds. If it does still hold, we will say we are quite happy about the higher costs because it actually is delivering cost-effectiveness in line with the policy of the program.

Senator CHRIS EVANS—Is there a particular trigger on that or is it just something you monitor and provide advice on?

Mr Stevens—That is a normal occurrence through our drug utilisation subcommittee to monitor that and provide regular advice to PBAC. If PBAC feel there is a concern, they will make recommendations to the government on that.

Senator CHRIS EVANS—Thanks for that.

CHAIR—Any further questions on outcome 2? Outcome 4.

Senator CHRIS EVANS—I have a couple of issues on outcome 4 but I think, given the way we are going, I would rather put those on notice. They are more factual information, Mr Podger. I do not know how other senators are placed but I was going to suggest we actually get on with 5 just to make some progress, basically.

CHAIR—Okay then. We will move to outcome 5, Rural Health Care. Just for domestic arrangements, I was planning to break at 6 p.m. but Senator West advises that she does not have a lot on rural health so we will just continue until rural health is finished.

Senator WEST—Thanks, Madam Chair. To start off, I want to raise doctor numbers, and assertions by the minister that doctor numbers are rising. I asked a question last time in estimates, which was E038, about numbers, and I thank the department for the comprehensive answer, which indicated in table 1 that general practitioners in rural and remote areas had gone from 3,231 to 3,886, and this was full-time equivalents, so we are actually talking working times, not bodies, which is the important bit. That shows, if my maths is correct, that that is an increase of 55 doctors across Australia or 55 FTEs. Does this indicate that the various efforts to get doctors into rural areas have not had a great deal of effect?

Mr Tongue—Senator, what we are finding is that we are being quite successful in getting the headcount by number of doctors into rural areas. We are doing quite well at that. But what is happening is that practice patterns amongst doctors in rural areas are changing, such that the old style male GP who might do 55 or 60 hours a week is now being replaced by both male and female younger GPs who are not working as hard, and that is what we are capturing in that FTE measure.

Senator WEST—Also in that answer you then go on to tell me that there are currently 79 overseas trained doctors practising in Queensland, Western Australia and Victoria, and the scheme is currently being implemented in other states. So far 16 doctors working on these schemes have been awarded permanent residency or citizenship. When I pick up the 79, I know I am not quite measuring apples with apples, but it would appear to me that, if they have been approved to work in the bush on a permanent basis, we are having a net loss of Australian trained doctors in rural Australia.

Mr Tongue—Senator, it depends whether you are talking about long-term doctors or short-term doctors, if you like. We need to find about 300 doctors a year to merely stand still

in rural areas and we are now emerging with a pattern of short-term measures—the overseas trained doctor initiative, temporary resident doctor initiative, which is about locum support for periods under 12 months, the rural locum relief program and so on—

Senator WEST—I have just been asking those who have permanent residency and are becoming Australian citizens.

Mr Tongue—I have to say, Senator, that I have not picked up a trend that we are replacing Australian doctors in that intermediate to long term with overseas trained doctors.

Senator WEST—You do not know, though? You do not have figures?

Mr Tongue—I would have to really go away and analyse the data, I think.

Senator WEST—I would appreciate it if you would actually go away and analyse the data, please, to see that in fact we are not bringing in doctors from overseas and we are going to end up with a two-tiered system: doctors who have trained overseas being given permanent residency to come into this country and work in rural and regional areas, and in the cities there will be the Australian trained doctors.

Mr Tongue—Under our new rural training stream that we are introducing under the More Doctors Better Services package, we are increasing, we are doubling, the number of Australian trained doctors that will be vocationally trained in those RAMA 4 to 7, so genuinely rural and remote areas, over the next three years.

Senator WEST—Yes, but we have to see if they stay there. I could be dead and buried before that gets working.

Mr Tongue—Certainly.

Senator WEST—Can I also turn to table 4 under the answer from last time, showing the number of temporary exemptions nearly doubled last year. This represented 685 temporary doctors being approved for rural areas. When you have those numbers of people temporarily coming to the country, you tell me you need to find about 300 a year to replace natural attrition. We know that the FTEs have increased by 55. That still leaves me with about 330. What have you done with those? Isn't this further evidence that Australian-trained doctors are being lost and they are not there?

Mr Tongue—A lot of our early efforts in trying to address the rural doctor problem have focused on trying to provide particularly locum support. One of the things that we find is that, particularly in towns with, say, three doctors, if we lose one doctor the other two then start doing a much bigger after-hours workload and leave. So what we try and do is find temporary resident doctors to plug the gap until we can get a permanent replacement in a particular time. We are using those TRDs as short-term work force relief to buy us a bit of time to fix the problem.

Senator WEST—What figures do you have to show how long the TRDs are spending in particular locations?

Mr Tongue—Usually TRDs stay for 12 months or less.

Senator WEST—In the country?

Mr Tongue—In Australia.

Senator WEST—But how many of them are spending that whole 12 months in one particular location?

Mr Tongue—I would have to look at the survival curves.

Mr Wells—Senator, we do not have that information. Most of them, as Mr Tongue said, are here for a maximum of 12 months but some are here for relatively short periods of one or two months, and we certainly do not have those figures. We only know of them when they apply for a provider number. If they are here for periods outside that period when they apply for a provider number, we do not have that information, so we do not know how long they are staying in the country or what proportion of their stay in the country is service in rural areas.

Senator WEST—How clear is the picture that you have of the whole situation?

Mr Wells—In terms of temporary resident doctors?

Senator WEST—Temporary resident doctors, doctors going to rural areas, types of doctors, the length of stay, the number of overseas-trained doctors who have been given permanent residency and are becoming Australian citizens and who are going to stay here: do we know with that group how long they are actually staying in rural areas?

Mr Wells—Senator, for that group the latest figure I have is as at 7 December when it was 79. They are recruited from overseas with a qualification equivalent to or nearly equivalent to an Australian general practitioner. They come on the condition that they serve for a minimum of five years in a rural location. The scheme has been running now for a little over 12 months so we do not have any history of what they will do. But in order to come they have to go through those streamlined immigration procedures and they have to sign a contract for service of five years.

Senator WEST—How many requests for exemptions have been received to date? Presumably there is some mechanism whereby, if there is a problem such as somebody in the family requires—

Mr Wells—I see, how many of those 79 have applied?

Senator WEST—How many of the 79 have sought exemptions or release from the contract because of some particular problem?

Mr Wells—I will take that on notice. I do not have that in my brief. It could be zero, but I will take that on notice and get back to you.

Senator DENMAN—Do those long-term people, those who stay five years and are obligated to do so, stay in the same community for the five years? Or are they able to move from one community to another?

Mr Wells—Senator, they can only move to another rural community within the five-year period.

Senator DENMAN—I have had complaints about that, about people, particularly on the west coast of Tasmania, only staying a short time and then moving, so the community does not have any consistency of medical care. A report is about to be released, I believe.

Mr Wells—Senator, a report on?

Senator DENMAN—There has been a report into health care on the west coast of Tasmania, a general report. I think it is by the state government. That is one of the points in the report.

Mr Wells—Senator, I will follow that up.

Senator DENMAN—Yes, thank you.

Mr Wells—I have not heard of those particular cases.

Senator WEST—Can we also look at table 2 in that answer that you gave me; that is, the number of general practitioners bulk-billing—sorry, not bulk-billing; that would be wishful thinking, getting GPs to bulk-bill in rural areas—

Senator DENMAN—That is right.

Senator WEST—the number of GPs billing Medicare in RAMA 3 to 7 by type of practitioner from 1996-1997 to 1999-2000. The interesting one for me is that the percentage change over the three years for vocation registered GPs has been an increase of six per cent; for general practice registrars it is 5.1 per cent; and for other non-specialist medical practitioners there has been an increase from 1,201 to 1,600, which is an increase of 33.2 per cent. This indicates, to my reading, that what we are seeing in the number of general practitioners going into the bush is a greater predominance of non vocationally trained GPs. Am I correct in my assessment and reading of that table?

Mr Tongue—Senator, you are correct. The reason for that is that the majority of those people coming in as temporary resident doctors or under the Rural Locum Relief Program are classified as 'other medical practitioners' and that is because many of them have not yet achieved full recognition by the RACGP.

Senator WEST—But there are only 79 coming in permanently from overseas.

Mr Tongue—Yes.

Senator WEST—Where do the rest of them, the 321, come from?

Mr Tongue—Many of those, Senator, are Australian doctors who are allowed to practice in rural areas, for example under the Rural Locum Relief Program, pending recognition by the RACGP.

Senator WEST—Doesn't this go back to my point about two levels of general practice care in this country? We are seeing a big increase over three years of non vocationally registered GPs. They might be good doctors—I am not going to be critical or to stand in judgment there—but they have not undertaken the general practice vocational training and they are therefore trained to a lesser level and receive a lesser repayment from Medicare. This, to my mind, is leading to a two-tier system.

Mr Tongue—Senator, as a result of a decision taken in November last year, from 1 January those other medical practitioners billing patients in RAMA 4 to 7 were allowed access to the higher Medicare rebate so that we could address the inequity for rural Australians. In an urban area you could choose between a vocationally recognised doctor and another medical practitioner. You have a choice. In a rural area we were conscious that there were some Australians who do not have access other than to OMPs, and were therefore disadvantaged with regard to the rebate. We have done two things. First of all, we have increased that rebate for OMPs, and we are also engaged with the medical profession in talking about what we call an alternative pathway so that we can draw those other medical practitioners who are out there into a quality regime where they reach the standard of equivalent to Fellow of the Royal Australasian College.

Senator WEST—You have helped the OMPs, as you call them; you have helped their hip pocket. You have not helped the standard being practised on the patient. You are talking about 'We are talking with them.' What incentives are you going to be able to introduce now that you have upped the income for them—this 33.2 per cent increase for the rest of them as well?

Mr Tongue—Senator, the only way that they can obtain access to the higher rebate is if, up until August, they register their interest in participating in this alternative pathway. Then, after

August, to maintain access to the higher rebate they must be practising in the alternative pathway. They must have access to continuing medical education to upgrade their skills and qualifications such that they reach that standard of FRACGP.

Senator WEST—How is this going to be done?

Mr Tongue—We are engaged in negotiations with the profession at the moment about building the alternative pathways. Work is well under way by a consortium involving the RACGP and a number of universities to build a modularised system that would cost other medical practitioners about $9,000 over four years to access and would result in them being assessed by a committee with regard to their skills and then having access to the various modules that they need to get them up to standard.

Senator WEST—Who is going to foot the bill for this? The doctors? Will the $9,000 over four years cover this?

Mr Tongue—We argue that, because of the benefit that has been conferred on the OMPs, they should foot the bill but we have underwritten the cost of developing the modules.

Senator WEST—Sixteen hundred times $9,000 will be adequate income to run this program?

Mr Tongue—Yes. The proposal has been fully costed by the consortium. We are in the stages now of negotiating the price down a little bit if we can.

Senator WEST—Was this a bit of an indication that the college's numbers are not adequate; that there needs to be more space provided in the colleges?

Mr Tongue—It is an indication, Senator, that we need to ensure that in working with the medical profession we encompass these alternative pathways; that there are ways we can get doctors with good skills into rural areas and then, if those skills need sharpening up, provide that and also, for those doctors who are out there, ensure they maintain their skills—particularly those GPs with procedural qualifications.

Senator WEST—Talking of GPs with procedural qualifications, I will not go into the row about the medical indemnity that is going on at present, beyond asking: does the Commonwealth think it has a role in that? I bet the short answer is no.

Mr Tongue—That is correct, Senator.

Senator WEST—Why doesn't it think it has a role?

Mr Podger—I do not think it is appropriate for us to answer that question, Senator.

Senator WEST—Fine. If it is not appropriate to answer the question I will pursue it on another occasion. I am sure my state minister already is pursuing it. Can I also look at the method of calculating what is a full-time equivalent, because I understand you used a method of capping the calculated workloads. Is that right?

Mr Tongue—Yes, that is correct. What we do is look at what is considered to be a full-time workload, then divide that into the level of billing in a particular RAMA. We set the count at one, so a GP who is billing more than the full-time count is still considered to be one GP. This is why we prefer the full-time workload equivalent measure where we allow one GP who is working more than the capped amount to be counted as, say, 1½ GPs. We think that is a more realistic measure of actual workload out on the ground.

Senator WEST—The new figure for 1998-99 of 3,231 FTE GPs working in rural and remote areas is 10 per cent below the figure of 3,563 which was given to me last year on

question 233 in the December 1999 estimates. I am going to be comparing apples with oranges here if you do not give me the figures for 1996-97 and 1997-98 on the same basis as the calculation given in the last answer, so we can do a proper comparison.

Mr Tongue—I must admit, Senator, I thought we had given you comparable data but I will go away and check that. If we have not I will correct it.

Senator WEST—Please. That is the information as I understand it. I might be wrong. I have been known to be wrong before but that is the way I understand it. Now can I ask about regional health centres? What is the story there?

Ms Davidson—Senator, I am not sure what you mean?

Senator WEST—What is going on? Are there any delays?

Ms Davidson—As you might recall, last year there were some delays but this year we have managed to make substantial progress. We have approved 85 regional health services. Some of those are for planning purposes and some of them are actual service delivery. Quite a lot of the regional health services have a process, before we approve services, of doing some planning with the community.

Senator CHRIS EVANS—What are you funding, Ms Davidson? When you say you have this process in place you are funding the consultation process?

Ms Davidson—We will fund people to do a development of a proposal because the Regional and Health Services Program is supposed to ensure that it is meeting the community's needs. Often communities cannot necessarily on their own, without some support, identify what their needs are.

Senator WEST—That is how I got into a fight in a conference a couple of years ago.

Ms Davidson—That is right. Some of the proposals we get need initial funding in order to do the planning and then develop a full-blown proposal for services. We have approved 48 of the 85 for ongoing service delivery and 37 are planning projects at this stage.

Senator WEST—What recurrent funding are these going to get once they are approved?

Ms Davidson—I do not think I can tell you how much of the funding is for ones that we have approved as recurrent versus how much is for new ones.

Senator WEST—I am happy for you to take it on notice but I am interested in knowing what recurrent funding is going into these. Unless there is recurrent funding going into this program there is going to be grave danger of some of these projects not staying afloat.

Ms Davidson—Sorry, Senator, once a service is approved then the funding is recurrent. All I was saying was that, because some of them are just planning projects, until they have done—

Senator WEST—That may in fact not get off the ground.

Ms Davidson—That is right.

Senator CHRIS EVANS——How many have you physically got operating?

Ms Davidson—We have got 48 physically operating. They have a guarantee of recurrent funding, provided that they continue to meet the—

Senator CHRIS EVANS——Some of those were operating last year, weren't they?

Ms Davidson—Last year I think we only had two operating by the end of the year.

Senator WEST—It was not many. How many applications have you had? How many have been successful?

Ms Davidson—That is difficult because what often happens is we have got proposals that are being developed, even to the stage of putting an application in. Our state officers are handling those in the earlier stages, so we periodically ask them about new projects they are working on with communities. We know about the ones that then come to us for approval. I am not sure if we have got data on how many applications—

Senator WEST—I am just interested to know the number of applications and the number of expressions of interest that you might have received that go on to be part of that 48. Is it that you have had 48 applications and 48 have got the tick, or is it 480 that have put their hands up and 48 have got the tick? If so, where have the other ones failed?

Ms Davidson—I would have to go back and look at it. Often what happens, Senator, is that the ones that fail—some of them we can go back and work with some more and develop the proposal to a point where it could succeed.

Senator WEST—A realistic proposal.

Ms Davidson—There are some others we do not think fit within what the program is about. They might be for acute cure, whereas our emphasis is primary care. There are quite a few where we go back and help people do further work on in order for them to succeed. I could see what we could provide you with in terms of—

Senator WEST—I would be interested to know, please. It would be very helpful. Can I ask about the Rural Communication Strategy. There was $4 million allocated for Rural Communication Strategy from the administered expenses to departmental expenses to allow it to deliver the strategy directly. What is the reason for this $4 million being reclassified?

Ms Davidson—Senator, we sought to have it reclassified because a lot of the work is being done within the department. Some of it is going to be used on our own departmental staff in our public affairs area. Other funds are being used to produce a newsletter, to develop a web site and for printing of pamphlets and information materials. That is more appropriately classified as departmental funds.

Senator WEST—Who instigated the change?

Ms Davidson—The department instigated the change.

Senator WEST—What does it reflect in terms of content for the proposed programs? What are you changing from to, or to from?

Ms Davidson—Sorry, Senator, I am not sure that I—

Senator WEST—It has always been a communication strategy but it has been moved. What does that indicate in terms of content change?

Ms Davidson—In the budget process it was allocated as administered funds. I am not sure on what basis it was originally allocated to administered—

Senator WEST—That was the next question.

Ms Davidson—I am not sure what the process was with Department of Finance and Administration.

Ms Hart—I might be able to shed some light on the general approach to classification of departmental as opposed to administered funds. Originally, when we put in for new policy funding, we made an estimate of how much would be departmental and how much was

required in administered funds. What Ms Davidson is saying is that, as the implementation of the policy was refined, we realised that some of that activity around the newsletter and public affairs was more appropriately classified as departmental activity. The department initiated that reclassification but it is based around guidelines that Department of Finance and Administration provide to departments about appropriate classification of funding.

Senator WEST—In other words, it is the old pea and thimble trick with money: that Finance, when they think we have just got on top of it, will change it all so that we are totally confused. This is eye-glazing stuff, this blinking administered thing. I think you have told me what you plan to include in the program. How will the department ensure that the communication program is not used to sell political messages? We are coming up to a sensitive time in the next half-year or so.

Ms Davidson—We have been quite careful, Senator, that the material we are producing is about providing information to people about the programs that the department runs and how they can access those programs.

Senator WEST—Maybe you can, on notice, send us a copy of all the sorts of pamphlets and material that you have produced, please, so that I can put my beady eye over it. You might want to take this next one on notice, and I am quite happy for you to do so. The Bush Nursing, Small Communities and Regional Private Hospitals Program, $30.3 million over four years 'to assist community hospitals in rural areas to identify the need for and implement refurbishment or reorganisation, business re-engineering or restructuring': I would like a bit of a progress report on what is happening with that.

Ms Briggs—At the moment, Senator, that program is under outcome 8, but I can give you some initial information and that may well satisfy your needs. To date, contracts for service planning have been completed for five small not-for-profit hospitals in the Darling Downs area of Queensland. The contracts provide for operational and financial assessment services. Implementation plans are currently being developed around those arrangements, and negotiations are taking place with three other groups of hospitals in Queensland as well.

In South Australia strategic service planning has begun for five small not-for-profit hospitals. In Victoria consultants have been selected to undertake the service planning and negotiations are under way for most private bush nursing hospitals. In Tasmania discussions have commenced with North West Private Hospital to undertake service planning. In Western Australia the minister has approved the establishment of a visiting specialist trial to improve patient services at St John of God Hospital in Geraldton, and that will begin shortly.

Senator WEST—Nothing in New South Wales?

Ms Briggs—Nothing at this stage, Senator, but I am sure that, under outcome 8, the officers there may well be able to provide to you some information.

Senator WEST—I am happy to leave it to outcome 8. Do MPSs come under yours as well?

Ms Briggs—Yes, they do, Senator.

Senator WEST—What is the latest with them? How many more do we have? Lots and lots?

Ms Davidson—Senator, there are 64 MPSs approved to date. Of those, 10 are approved but not yet operational.

Senator WEST—Maybe you can give me a breakdown of where they are and what stages they are at. Perhaps that could go on notice too. Have there been any changes in the administration or regulations regarding the administration of MPSs?

Senator DENMAN—I have a question on rural health. Again I use the west coast of Tasmania as an example because it is close to my electorate office. There are problems with travel costs for people on the west coast when they are referred by their GPs to specialists in other areas. Quite often the pensioners, the unemployed and the working poor are out of pocket because they have to stay overnight and so on. Are there any plans to help alleviate that cost for them?

Ms Davidson—The state government, Senator, is responsible for the Isolated Patients Travel Assistance Scheme.

Senator WEST—What is the accreditation process that is needed for MPSs?

Ms Davidson—They are not subject to the aged care accreditation arrangements but they do have to meet accreditation through agencies like the Quality Improvement Council and the Australian Council on Health Care Standards. It varies slightly from state to state, and the Commonwealth and the states have agreed to do some work on trying to develop some national principles. They all have some quality assurance arrangements but we want to make sure there is some better national consistency than at present.

Senator CHRIS EVANS—Are you applying the certification requirements to MPSs?

Ms Davidson—The aged care certification arrangements?

Senator CHRIS EVANS—Yes.

Ms Davidson—I am not sure, Senator. In terms of the MPS program, we work with Aged Care on it, and I am not sure about it. We would need to ask Aged Care.

Mr Podger—Can I confirm the situation on that when we deal with program 3 tomorrow morning?

Senator CHRIS EVANS—Yes. It is an issue also, I think, of an interface between hospitals and nursing homes as well, with different accreditation agencies but particularly with the MPS.

Ms Briggs—Senator, it is my understanding we are not applying those certification arrangements. If I am found to be wrong, I will update that tomorrow, but that is my understanding.

Senator WEST—The question that arose in my mind was: how appropriate is it to use hospital-type health accreditation for aged care facilities? There is a very great difference in the provision of care in those two areas: one is a health provider and a health facility; the other is aged care, which can be about—well, you have all heard me rave, and Senator Evans rage, about this. The question that next comes into my mind is the fact that when I looked at the aged care accreditation information, I saw there have been a number of hostels that I know of in small communities that are in the process of going across to MPSs that have only been given 12 months accreditation. What do you, as those who are responsible for the MPS side of it, have to say about that? What are you comments about that side of it?

Ms Davidson—I understand that until it has been approved as an MPS it actually has to meet the aged care accreditation arrangements.

Senator WEST—What is the reason for it not having to reach the aged care accreditation standards after it becomes an MPS?

Ms Davidson—I think, Senator, that people have recognised that, for the multipurpose services, there is a need for some more flexible arrangements, because it is combining aged care and hospital arrangements under the one roof. But prior to approval that is not actually happening, so that we believe the separate accreditation processes make sense.

Senator WEST—That just about expires my aged care questions for tonight. Thank you.

CHAIR—Thank you very much.

Mr Podger—Is that the end of outcome 5?

CHAIR—That is the end of outcome 5. Thank you very much.

Proceedings suspended from 6.19 p.m. to 7.35 p.m.

CHAIR—We are on outcome 7—Aboriginal and Torres Strait Islander health. I call Senator Evans.

Senator CHRIS EVANS—Thank you. Could someone outline to me the process for revising the National Aboriginal Health Strategy—what processes are in place?

Ms Evans—The National Aboriginal and Torres Strait Islander Health Advisory Committee, which is an advisory committee to Minister Wooldridge, was reviewed and restructured about 18 months ago. In the revised terms of reference, the first term of reference asks the council to advise on a strategy to essentially—I cannot remember the exact wording, which I could get for you—take Aboriginal health into the next century. It was discussed in some detail at the first meeting of the restructured Aboriginal council, which Mr Podger chairs, and council agreed that there had been a significant amount of consultation, reviews et cetera around Aboriginal health. They took on board the reference. They decided as a process they did not wish to have a preliminary large round of consultation. What they wanted was, as a council, to develop a draft document to then go out for extensive consultation. So over the last 12 months the council—and with a number of workshops of expanded council members—have workshopped this draft strategy document and at the last meeting of council that was held about 10 days ago council members agreed that that document should go out for extensive consultation on the clear understanding that none of the members of council or none of the organisations or governments they represent endorse the draft as it goes out. It is simply a draft for consultation.

Senator CHRIS EVANS—Is that the first time that draft has been released?

Ms Evans—Yes, that is the first time it has been released to broader than the council members and those members of the workshop.

Senator CHRIS EVANS—This is the one that caused the upset last year, is that the one? Is it the same draft?

Ms Evans—This was the draft that NACCHO expressed some concern about. NACCHO are members of council and had been involved in council and on the workshops throughout the development process.

Senator CHRIS EVANS—They withdrew for a while, didn't they?

Ms Evans—They did, yes.

Senator CHRIS EVANS—Are they back in?

Ms Evans—They are, yes, Senator.

Senator CHRIS EVANS—So they resigned from the council for a period. Without putting words in your mouth, can you describe what happened to—

Mr Podger—They wrote to the minister saying that they were going to withdraw from the council—this followed a motion at their annual general meeting—citing their concerns about the draft strategy document. The minister wrote to them after that saying he was disappointed with their decision, bearing in mind that they had been involved all the way through the process and the importance of getting a strategy that could be signed up. Subsequently, NACCHO have then come back after some discussions that I have had with them and asked to be reconsidered to come back onto the council, but they now accept that the draft strategy is reasonable to go out as a basis for consultation, that nobody has endorsed it at this point, and that there is room, through the consultation processes, for any concerns about it to be considered and pulled together into the process. So they have now also agreed that the executive of NACCHO will put to the next annual general meeting a rescission of their motion to say they felt that they got that wrong.

Senator CHRIS EVANS—So has there been any change in the draft between these two occurrences?

Mr Podger—Minimal changes and certainly nothing coming out of that particular process. For example, at the last meeting we agreed that we needed to highlight the caveats that it has not been endorsed by everybody and so on, but there has been no other drafting changes in response to those sorts of comments.

Senator CHRIS EVANS—Did the minister's letter to them threaten their funding?

Mr Podger—The minister's letter to them raised that he was concerned about the representation of various Aboriginal health groups that were coming through NACCHO, that there was very substantial funding through NACCHO for that, that he wanted a consultation about future arrangements for the way in which advice is given to him from the sector, and that the department be asked to reconsider the way we handle that money. He gave an assurance that there would be no cut in total money, but he wanted to look at the way in which those funds are provided.

Senator CHRIS EVANS—Is that occurring?

Mr Podger—That is still continuing. The minister has made clear in his reply to NACCHO in the most recent round that he intends to proceed with that review.

Senator CHRIS EVANS—What is the status of that review?

Mr Podger—It is still early days on that. We are still working out the detailed arrangements, but it will be a consultation managed by the Office of Aboriginal and Torres Strait Islander Health within the department, under Ms Evans. We are still finalising the details of how to manage that consultation process. There are issues here to do with a number of people involved in Aboriginal health who do not currently have direct access to the consultation processes—for example, Aboriginal doctors and other health workers, things of that sort. We need to have a look at what is the best way of drawing those views into the system. There is also an issue about what is the best way of funding a peak organisation in the community controlled sector. For example, the issue raised in some of the discussions by the Senate committee a year or so ago was whether that money ought to go direct to the people or to go via the members. For issues of that sort we will need to have consultations around. If

you like, we can table the correspondence, Senator. We are happy to table the correspondence between the minister and NACCHO from last year and most recently.

Senator CHRIS EVANS—I always worry when you were so keen to table correspondence, Mr Podger.

Mr Podger—I am simply saying that because, as chair of the council, I have tabled it to all members of council and indeed provided it to the states as well so they understand the arrangements.

Senator CHRIS EVANS—Mr Podger, far be it for me to look a gift horse in the mouth. I appreciate that and I thank you for that. I hope it sets a precedent for some of the other stuff I would like to see.

Mr Podger—I think I should make clear that the minister and I, as chair, have welcomed NACCHO coming back. I think, if we are going to achieve a national strategy that can be widely endorsed both by jurisdictions and by other stakeholders, it would be difficult to do that without NACCHO being a party to the process.

Senator CHRIS EVANS—You are saying to me that the sections that they found offensive in the draft are still contained in the draft that is going out for consultation.

Mr Podger—That is so. They have agreed that the consultation process will allow those things to be exposed. As I have highlighted to them, there are a lot of issues here which need to be balanced with different viewpoints if we are going to get everybody to sign up.

Senator CHRIS EVANS—Who else is represented on the council, Mr Podger?

Mr Podger—The council is essentially the four key parties to the framework agreements; that is, the Commonwealth, the states—the states being represented by somebody from the Australian Health Ministers Advisory Council and from the heads of the Aboriginal health units in the states—ATSIC and the community controlled sector. The minister also has a number of—I think it is five—appointments of his own. He has chosen that two of those up until now have been on the nomination of NACCHO as well. There are two members from each of the four stakeholder parties to the framework agreements plus these five and, as I say, for two of those five he has accepted nominations from NACCHO for those.

Senator CHRIS EVANS—Are they formally representing NACCHO or are they just nominations—

Mr Podger—They are effectively the minister's nominees. They are therefore in their own right rather than NACCHO, but he has accepted the NACCHO appointments as two of his nominees.

Senator CHRIS EVANS—Are the other three selected by the minister?

Ms Evans—Perhaps I could also add that the chair of the NHMRC sits on the council as an ex officio member as well. The three other members were appointed in their own right. One is an indigenous doctor, Dr Mark Wenetong. The other two are Aboriginal women who have extensive experience working in Aboriginal health in the community, Barbara Flick and Kerry Arabena.

Senator CHRIS EVANS—They are both nominations at the discretion of the minister; they are not nominated by—

Mr Podger—That is correct, yes.

Senator CHRIS EVANS—When do those positions fall due?

Mr Podger—At the end of this financial year they come up for reconsideration.

Senator CHRIS EVANS—But all five appointments are effectively at ministerial discretion?

Mr Podger—Yes, that is correct.

Senator CHRIS EVANS—You are saying one of the aspects of this review of funding is to look at what mechanisms you can use to consult Aboriginal people about health issues?

Ms Evans—I think what the minister has asked the office to do is to consult widely on the range of advice and expertise that should be available to him and to the office in Aboriginal health, whether that is currently available, and also to look at whether the current funding arrangements achieve that to the best degree possible—the wording in the letter. I could actually read you the wording if you like.

Senator CHRIS EVANS—Yes, I would not mind. It is just so I can get the nuance right.

Ms Evans—In the third last paragraph the minister says:

In light of NACCHO's resignation from Council and the growing number of Aboriginal Medical Services who have chosen to withdraw from membership of NACCHO I believe the current arrangements between the Commonwealth and NACCHO have become untenable. I am therefore writing to advise you that I have asked OATSIH to consider the extent and adequacy of the coverage of the current national representation arrangements. In doing this, I have asked OATSIH to consult with a wide range of bodies involved in Aboriginal health including community controlled services, state/territory based representation bodies, substance misuse services, indigenous doctors, nurses and health workers and ATSIC as to what the best national representation arrangements might be. In this context I should advise you that I cannot guarantee continuing direct Commonwealth funding of NACCHO at the end of this process and ask you to make arrangements for the organisation accordingly. To help you however, I will guarantee present arrangements until 30 June, 2001.

In instigating this process, I want to assure you that I am committed to maintaining, at a minimum, the same level of funding for national representation services that is currently provided. However, to which body or bodies this funding might be provided will be considered in the light of these consultations.

Senator CHRIS EVANS—That is helpful. Is there any chance of your review being completed by 30 June?

Ms Evans—I think it is essential that it be completed ahead of 30 June because I think it is important for everybody to know where they stand, and we would hope to have a report to the minister by early May.

Senator CHRIS EVANS—Have you started the consultation process?

Ms Evans—We are just in the very early stages of sorting that out.

Senator CHRIS EVANS—Effectively you have not started consulting anyone yet?

Ms Evans—No, that would be true, although we have had a certain amount of unsolicited comments.

Senator CHRIS EVANS—You would hope to have a report on the review to the minister by May so he can advise people whether or not their funding is going to continue beyond 30 June, basically?

Ms Evans—Yes.

Senator CHRIS EVANS—I know in the FACS portfolio we have had a number of instances where that has not happened and people have been hanging on, laying off staff in

anticipation, et cetera—similar reviews. What do you currently fund NACCHO for both in terms of amount and function?

Ms Evans—They are currently funded on four core services, which is to provide advocacy and representation. I am just looking at my colleague to see whether we have got the actual figures here. The secretariat for this financial year is funded. I can actually table this figure if you like. The total amount of funding they received in this financial year is a combination of secretariat funding for their advocacy representation. Then there is a series of project officers that are funded in particular areas such as work force, population, health, and substance abuse. The overall figure—I am just making sure I get this absolutely correct—for the policy officer positions for the year 2000-01 is $727,030. There is also an additional project officer position funded through the GP branch for $120,000, and they are funded also for a tobacco control project for $217,000. Their secretariat funding amounts to $617,000. Overall, their current level of funding is $1,179,530 for this financial year.

Senator CHRIS EVANS—Are there any other peak Aboriginal organisations that receive funding currently?

Ms Evans—We currently provide some funding for secretariat support for the Indigenous Doctors Association and also for indigenous nurses.

Senator CHRIS EVANS—What amount is that?

Ms Evans—I will have to take that on notice. It is not anything of the order—

Senator CHRIS EVANS—It is just merely some secretariat funding?

Ms Evans—Yes.

Senator CHRIS EVANS—It is quite small in comparison, I suspect.

Ms Evans—Yes.

Senator CHRIS EVANS—Clearly they are currently the major organisations you fund that provide representation services and advocacy for Aboriginal health groups?

Ms Evans—That is correct, yes. Can I just make a correction? I am sorry, the total I had here was not correct. When you add the secretariat funding and the project officer funding it comes to a little over $2 million.

Senator CHRIS EVANS—I had a feeling that it was a bit more than that.

Ms Evans—Yes, it did not add up. I am sorry about that.

Senator CHRIS EVANS—That is all right. What does it finally add up to?

Ms Evans—It is a little over $2 million. Can I table the exact figures for the committee?

Senator CHRIS EVANS—Yes, sure.

Ms Evans—Would you like the figures on the other two organisations as well?

Senator CHRIS EVANS—If you have got them, yes. That would be good, thanks. At this moment they are back on the council, but the question of their funding is subject to this review, and that will be a decision for the minister in May?

Mr Podger—Correct.

Ms Evans—I think it is important to note that the minister has made it quite clear he wants to maintain at least the level of funding that goes to facilitate representation at the national level.

Senator CHRIS EVANS—I refer to the budget item about indigenous renal dialysis units in the Kimberley and Cape York regions. Can someone explain to me what the delay is in the rephasing of those funds?

Ms Evans—In relation to the Kimberley region, yes, it has been a long process because we have been working closely in negotiation with the community sector and Western Australian state health. Up until the last 18 months or so, renal dialysis was only provided out of Royal Perth Hospital. Western Australian Health were keen to try to regionalise that. We agreed jointly—the three parties—to fund essentially a project that looked at costs, appropriateness, et cetera. That has taken some time. There has then been a negotiation with relocation of recurrent costs from Royal Perth. So essentially it has been the consulting and the planning that has taken that time, which is why the money has been rephased.

Senator CHRIS EVANS—That is true at Cape York as well, is it?

Ms Evans—At Cape York there have been similar issues; that is right. Queensland Health contracted for a North Queensland renal services assessment for their overall renal services. So we agreed to wait for the outcome of that to make sure we were all coordinating and working together on it.

Senator CHRIS EVANS—Is there any confidence that we will get them up and running this year?

Ms Evans—We would be hopeful, yes. I can get you a current progress report on it. My understanding is that the Broome centre is about to go ahead with construction and the Weipa one has been agreed to.

Senator CHRIS EVANS—Under whose auspices is the Kimberley one occurring?

Ms Evans—The Kimberley service is being run by BRAMS, the Broome Aboriginal Medical Service. It is a facility that is going to be built onto the AMS there.

Senator CHRIS EVANS—So they are actually having to construct the capital works.

Ms Evans—Yes.

Senator CHRIS EVANS—What has happened in the interim, then? Patients are still being flown down to Royal Perth from Broome?

Ms Evans—Yes. The arrangements that currently are in place are for them to go to Royal Perth, yes.

Senator CHRIS EVANS—There must be some savings, obviously, in terms of transportation issues in having a centre located in Broome and Cape York as well. Were any savings measures included in the budget as well?

Ms Evans—I cannot tell you the exact figuring, but I would be surprised if there were any savings, because of the cost of providing services in remote areas, attracting and retaining staff, et cetera. There is a considerable increased cost for any remote area delivery.

Senator CHRIS EVANS—A Broome-Perth return air ticket is pretty expensive, too. I suspect there is quite a lot going on that.

Mr Podger—There are some offsets. This issue also arose in the context of the Tiwi Islands arrangement. Yes, there were some offsets in not having to have people go to Darwin across the water, but there are substantial costs in managing a service there.

Senator CHRIS EVANS—I am not saying it offset it; I just assumed there would be some actual savings as well.

Mr Podger—There is no doubt there are offsets, but it does not make up the full cost.

Senator CHRIS EVANS—Okay. How many dental facilities are there in Commonwealth funded Aboriginal health services? Have you got them all fully in use?

Ms Evans—We will have to take that one on notice. I do not have the figure. Certainly some of the Aboriginal medical services have dental services, but I cannot give you a figure.

Senator CHRIS EVANS—A problem has been raised with us that apparently they have been funded but they have not been able to get dentists in a range of these centres. I had some representations about that. Is that an issue or not?

Ms Evans—I think recruitment of dentists is an issue. That is my understanding, but I cannot give you any exact figures.

Senator CHRIS EVANS—Perhaps I might place on notice some questions about dental health services in Aboriginal medical services. A suggestion has been put to me that a range of facilities are available but they are not operating effectively because of the inability to attract staff to them. I was just trying to tease that out and find out how widespread that problem was, but if you cannot help me I will put those on notice. Could someone explain to me the Army-ATSIC Community Assistance Program? It has been cancelled or postponed due to the war, I gather.

Ms McDonald—The Army-ATSIC Community Assistance Program, AACAP, has been rephased. The East Timor crisis reduced the Army's capacity to put teams out on the ground in some of the remote communities. So it has been rephased from a four-year program to a six-year program. The money has just been spread across those additional years.

Senator CHRIS EVANS—So there is no additional money; it is just that you have spread the money over a longer period. Is that right?

Ms McDonald—That is correct.

Senator CHRIS EVANS—What does that mean for the program? Does that mean that there has been no activity this year, for instance, or that the activity has been significantly curtailed?

Ms McDonald—No. The Army did have some capacity. They had some units they were able to put out in some areas. So they started, but it was at a much slower pace than when the decision was first made to run the program. They would have had more teams out in more remote communities. But certainly there have been a number of areas where the program has commenced.

Senator CHRIS EVANS—When you refer to them having fewer teams than what they would have planned—I think there was an announcement of the initial trial or something and then there was a four-year commitment, wasn't there?

Ms McDonald—That is right. There was an initial program and then, following that, there was an announcement of a four-year expanded program. That was prior to the situation in East Timor. There were some plans at that stage to do around four remote communities a year. That was dropped back in the first year to two.

Senator CHRIS EVANS—Are you able to give me a schedule on which communities will be got to and when—a sort of revised schedule?

Ms McDonald—Are you after both the first AACAP program and the revised one, or are you only after the second stage?

Senator CHRIS EVANS—I am really after what you are going to do now, basically. I am happy for you to take it on notice and table the information. I am just interested in what you are now planning to do in which communities and when.

Ms McDonald—We can take that on notice and provide a schedule.

Senator CHRIS EVANS—Thanks for that. Has any consideration been given to enlisting more private involvement, I suppose, to replace the Army to keep it at the current rate?

Ms McDonald—There certainly has been some consideration of contracting out some of the work, and some of the projects that were undertaken while the Timor situation was in place drew on some private sector involvement as well, where Army did not have the capacity in particular areas.

Senator CHRIS EVANS—Will that continue or is it reverting to a solely Army program?

Ms McDonald—It is being considered on a case-by-case basis, depending on availability of expertise.

Senator CHRIS EVANS—So who makes that decision about whether Army does it? Is that an Army decision, or is somebody else coordinating it?

Ms McDonald—A lot of the work that takes place in communities are things that are linked with the Army-ATSIC program that may be done by private contractors or other people as well—for example, the upgrade of clinics which might have been contracted out privately. When Army comes in to a community and the work is scoped, there are some things that Army would have done as part of AACAP, but quite often the scope of that work is broadened by linking in with some of the other work. So it is very much on a case-by-case basis in terms of what the opportunities in each community are.

Senator CHRIS EVANS—Thanks for that.

[8.03 p.m.]

CHAIR—There being no further questions on outcome 7, we move to outcome 8—choice through private health insurance.

Senator JACINTA COLLINS—Please bear with me if you have covered some of this ground with Senator Evans previously. I have just been handed a similar question that you have dealt with on previous occasions with Senator Evans. I will go firstly to page 93 of the additional estimates statements. I am interested in the cost of direct delivery of services of the rebate. You indicate here an increase in price at 2000-01 additional estimates of $1.787 million. If I go back to what you have outlined at table C8.1, am I correct that that is roughly a 10 per cent increase in cost—slightly higher?

Dr Wooding—This is money for the Australian Taxation Office. What had happened was that within government there was not a price agreed for the work the tax office was doing in terms of the rebate.

Senator JACINTA COLLINS—I have seen that that has been outlined on page 89.

Senator CHRIS EVANS—Can I ask you about that later? So hold that answer.

Senator JACINTA COLLINS—I am at another area. I am at page 93 under output group 6, where you indicate an increase in the price—that is, the direct delivery of services.

Dr Wooding—That is the same area. The direct delivery of these services for outcome 8 is the delivery of the rebate.

Senator JACINTA COLLINS—Yes.

Dr Wooding—That is delivered through two organisations—the Health Insurance Commission and the Australian Taxation Office.

Senator JACINTA COLLINS—I appreciate that, but I am sure you would not be double counting the additional payments that go to the tax office, which you have already outlined here at page 89.

Dr Wooding—No. They are mentioned twice, because this section here is basically allocating the additional money asked for in the additional estimates by output.

Senator JACINTA COLLINS—Sorry, we are in different tables.

Dr Wooding—It is the same figure, effectively.

Senator JACINTA COLLINS—Okay, and that is the only explanation for the variation?

Dr Wooding—Yes. There is also some information on page 12 of the additional estimates statement, which I could direct you to. You see footnote 3 on page 12, which also talks about a capital injection of $1.84 million. So that is just some more information on the same subject. But, basically, that is the only additional money that we have received this year in relation to that output.

Senator JACINTA COLLINS—If we go back to the total on page 88 where we look at direct delivery of services, can you explain for me the changeover time from 1999-2000 to these additional estimates?

Dr Wooding—I think the figure in the 1999-2000 budget, which was the first budget we had ever done in this output group allocation of departmental expenses, was still a very early sort of notional split of money. I think you will find that the 2000-01 budget much more closely reflects the amount of the cost of delivering the rebate through the HIC. I think the 1999-2000 budget figure was probably not as accurate.

Senator JACINTA COLLINS—Take me through these figures. Am I wrong in looking solely at output group 6 where you have the $5.474 million for 1999-2000 and then $1.51 million in 2000-01? Why is that so low?

Dr Wooding—As I said, it is not low. I think that reflects more accurately the correct attribution of costs to that output group. I think the 1999-2000 figure was the first year we had ever done this particular task of attributing departmental expenses to output groups. As I said, I think also in that year there were possibly some more start-up costs, because that was the first effective year of the rebate.

Senator JACINTA COLLINS—So why is that then revised up to $3.3 million?

Dr Wooding—Because now the Taxation Office money has come in as well.

Senator JACINTA COLLINS—Okay.

Dr Wooding—So what has happened is that the 2000-01 budget reflects the money paid for administering the rebate through the Health Insurance Commission and then in the revised estimate—now that we have also been appropriated some money for the costs from the tax office—that is, I suppose, effectively the full cost of delivering the 30 per cent rebate.

Senator JACINTA COLLINS—Okay, and then these additional estimates of $1.7 million do not include any revision in terms of revised estimates of costs?

Dr Wooding—No, the revised column is basically an addition of the additional estimates figure in the 2000-01 budget figure. So that $3.297 is the total of the numbers on either side of it.

Senator JACINTA COLLINS—I have now moved to the $1.7 million.

Senator CHRIS EVANS—I think what Senator Collins is asking is: was the $1.7 million solely accounted for by the taxation figure?

Dr Wooding—Yes, that is correct.

Senator CHRIS EVANS—Or did you alter the estimates for the other—

Dr Wooding—No, it is only the taxation figure.

Senator JACINTA COLLINS—Okay. So have you looked at forecasting potential changes in costs for the 30 per cent health rebate? I am particularly interested in a potential blow-out in relation to ancillary benefits.

Dr Wooding—Ancillary benefits would be appearing under the administered expenses for the rebate. This is the cost of actual public servants who are employed to deliver the rebate—

Senator JACINTA COLLINS—Okay. Let us go to that area.

Dr Wooding—To the rebate? We have some estimates in the additional estimates for the increased cost of the rebate on page 87. They have risen by $387 million on page 87.

Senator CHRIS EVANS—Are they still current?

Dr Wooding—I think they are current at the moment, yes. That is correct.

Mr Wells—That is correct.

Senator JACINTA COLLINS—That is the current forecast. What proportion of your total outlay in relation to the 30 per cent rebate would take into account people with ancillary benefits?

Dr Wooding—We can get you an exact figure on notice because it changes, obviously, every time—and it would be an estimate, because we will have to take the FIAC figures and estimate something on the rebate, but it is somewhere between 35 per cent and 40 per cent.

Senator JACINTA COLLINS—Thirty-five per cent and 40 per cent of the total cost.

Dr Wooding—Yes, I think that is correct. That is about how much of the private health insurance expenditure is on ancillary benefits.

Senator JACINTA COLLINS—Can you give me those figures over time?

Dr Wooding—We can give you historical figures from FIAC. That is correct.

Senator JACINTA COLLINS—Can you take a rough stab at it at the moment?

Dr Wooding—No, and I am actually not sure. That 35 per cent to 40 per cent was before Lifetime Health Cover. So it may have fallen somewhat, too, because Lifetime Health Cover mainly led to an increase in hospital rather than ancillary. So I suspect that it would have even fallen somewhat in recent times.

Senator JACINTA COLLINS—Were you aware of the growing practice of some health insurance funds to directly compete with state ambulance services by moving away from rebating ambulance subscriptions?

Dr Wooding—I have had some discussion with people about that. Many health funds still offer an ambulance-only product. I have had some complaints from some of the state

ambulance subscription schemes that they are not eligible for the 30 per cent rebate. I think that is the concern that I have had expressed to me. Because they are not registered health funds, they are not eligible for the 30 per cent rebate. I believe that the ambulance-only cover has existed for many years in the private health insurance area, and I am not aware that it is growing or changing in any particular way at the moment.

Senator JACINTA COLLINS—It seems as if some health funds—not all—are adjusting their products post the rebate and current policy. It seems that is having a significant impact on some state ambulance services in terms of them losing large numbers of subscribers and the funding base there associated.

Dr Wooding—I suspect that is the problem of not getting the 30 per cent rebate on the state ambulance services. So they are moving to the health funds, which have a 30 per cent rebate payable on them.

Senator JACINTA COLLINS—There are a couple of issues here which I will go to in a minute, but in relation to the rebate itself, and your responsibility here, you are aware of this problem.

Dr Wooding—I have had it raised with me just once. I am no longer in the job, but in the 18 months that I was there, I think it was raised with me once by somebody whom I cannot recall.

Senator JACINTA COLLINS—Okay.

Dr Wooding—But it seemed a reasonable point—the state subscription programs are not eligible for the rebate. So that certainly makes them less competitive, less attractive, than the health insurance fund products.

Senator JACINTA COLLINS—I am curious whether you have looked at this issue in terms of future forecasting in relation to ancillary services. I note from my own experience—yesterday or the day before—Australian Unity is now advertising not only ambulance-type extra cover but after-care products such as home help, child care, and I think the ad said 'even child care'. I am curious whether the department has done any work on a potential blow-out in relation to ancillary benefits.

Dr Wooding—I do not know how long Australian Unity have offered the ambulance-only product. We can take that on notice. The after-hospital care—which is not on ancillary; it is actually part of the hospital product—has been offered for a number of years now, as I understand.

Senator JACINTA COLLINS—Does that include child care?

Dr Wooding—I think it includes any costs that enable people to get home from hospital quicker.

Senator JACINTA COLLINS—Yes.

Dr Wooding—And that is seen by the fund as a saving from their total payout on hospital, because they have shortened the length of stay.

Senator CHRIS EVANS—I thought that if they provided child care you would stay in hospital longer.

Dr Wooding—I am not sure about the child care, but they do offer a lot of home help and that sort of thing with that aim in mind. I must say that that is the first I have heard of the child-care issue.

Senator JACINTA COLLINS—This was in the ad. I just happened to prick up my ears.

Dr Wooding—Okay.

Senator JACINTA COLLINS—Firstly, you are not particularly aware of a move by the health funds away from rebating subscriptions to reimbursing emergency ambulance services, apart from one complaint?

Dr Wooding—Sorry, that issue I am not aware of at all. That is a new issue. I think they have always reimbursed emergency ambulance.

Senator JACINTA COLLINS—That is right. Different funds have done a variety of things.

Dr Wooding—Okay.

Senator JACINTA COLLINS—But they now seem to be moving towards telling you to go and pay your ambulance bill and they will reimburse you for it in relation to, unfortunately, it appears only emergency ambulance services, which has created quite a number of other problems, because most state ambulance services fully cover you for emergency and non-emergency ambulance services.

Mr Wells—We will take that on notice. But that has not been brought to our attention. We will have to look at that and come back.

Senator CHRIS EVANS—There has clearly been some movement. I am one of the few ideologues left; I do not have private health insurance. But I found myself a member of the HBF scheme by default this year, because I was a member of the St John Ambulance in Western Australia for ambulance cover. Suddenly, my correspondence was not from St John Ambulance but from HBF, offering me the rebate on my St John Ambulance cover.

Dr Wooding—I suspect that must have been what was behind it.

Senator CHRIS EVANS—I suspect it was. That is what Senator Collins is asking you about, Dr Wooding. It seems to me there are some public policy issues here. I am surprised—

Mr Podger—There will be a number of things that arise from a 30 per cent rebate, as the industry responds—for example, change the relativities for people to cover themselves for private hospital or go through private health insurance. Clearly, the policy is having a shift there towards a private health insurance product because of the 30 per cent rebate. There will be a number of things which will flow from the rebate through the industry and industry practice.

Senator JACINTA COLLINS—I suppose what I am questioning here, though, is what you say is the industry response. What is the industry response? Does it or does it not include ambulance services? If it does include them, aren't they at an uncompetitive position in relation to the 30 per cent rebate?

Senator CHRIS EVANS—Your reply, Mr Podger, implies that it does not matter to you what they do; this is about market forces. This is something that is subsidised 30 per cent by the taxpayer so surely we have a public policy position on what we are subsidising and what we are not, don't we?

Dr Wooding—We have always favoured ambulance services being— and they have been—part of private health insurance for a long time.

Senator JACINTA COLLINS—But not with the 30 per cent Commonwealth subsidy?

Mr Podger—The government's policy has been to introduce a 30 per cent subsidy to encourage people to take out private health insurance. When you do that you change the relative prices and you will get things changing at the margins. Some of those things, yes, we do wish to monitor those. But to say that there has been a change in relative prices is not in itself a bad thing. You will get a number of responses, such as you have, where an ambulance service has decided to move into the private health insurance ambit by changing its arrangements.

Senator CHRIS EVANS—But are you telling me you do not have any public policy interest if they suddenly tell you that child care is partly rebatable because the child-care centre has joined private health insurance?

Mr Podger—It depends on the bounds of the change. At some point, yes, we would be concerned.

Senator CHRIS EVANS—I guess we are trying to tease out of you what interest you are taking in such matters and what the policy is.

Dr Wooding—I can give you some advice there. For example, with that Australian Unity scheme and similar schemes where they are offering home help and they are paying it from hospital, the money they spend there is not eligible for reinsurance under the hospital cover reinsurance arrangements. So in that sense it is outside the hospital cover system. In some ways we do have various regulatory rules there, but if a health fund wants to provide services that they think get people home from hospital quicker and can see a saving, I think that is reasonable.

Senator CHRIS EVANS—Is that a personal opinion or is that a public policy position of the government?

Dr Wooding—The government has been interested in trying to find ways—as we have seen with the bill that has recently been through the House of Representatives—of promoting the same sort of access to post hospital and hospital in the home services for privately insured people that have been available to public patients for a number of years. That policy, I think, is established. We are interested to hear about other issues. We will take them on notice and have a look at them.

Senator JACINTA COLLINS—Let me try to tie this up, because you will probably have to take most of this on notice, by the looks of it. What precludes the ambulance services getting access to the rebate?

Dr Wooding—They are not registered health insurance funds.

Senator JACINTA COLLINS—What precludes them becoming such?

Dr Wooding—There is a whole range of regulatory rules about becoming a registered health insurance fund. I suppose there is nothing in theory, but there would be a lot of issues they would have to consider before they wanted to do that.

Senator JACINTA COLLINS—I understand, from a Mr Peter Callinan, that the Victorian, South Australian and Queensland ambulance services were told that they were precluded by the Commonwealth-state agreement?

Dr Wooding—That might be something I would have to take on notice. That may well be correct. That is a different issue to do with the ambulance services. Anyone can start a health fund in Australia if they meet the rules, but there may be some other rules in relation to Commonwealth-state agreements that might cut across that.

Senator CHRIS EVANS—Would that be because they are partly government funded?

Dr Wooding—Yes.

Senator CHRIS EVANS—Are those services government funded?

Senator JACINTA COLLINS—The Victorian service's funding base is made up of about 50 per cent state grants, which from a public policy perspective makes it even more concerning if this practice is allowing the health funds to cream off, in some instances. I will give you the case of AXA, which makes a distinction between different age groups and creams off the better actuarial risk in relation to, in a sense, self-insuring for ambulance services. So to people under the age of 50 they say, 'We will reimburse you once you get an ambulance bill.' To people over the age of 50 they say, 'No, go back to the ambulance service and get them to cover you and we'll reimburse you for the subscription.' In a sense, they are creaming off the ambulance service ultimately to a state government disadvantage, because they are footing at least 50 per cent of the bill—and potentially higher—if they are destroying the subscription base of the ambulance service.

Dr Wooding—I think we can only take that on notice. There is a range of issues that we would need to look at, including the arrangements for the health care agreements and what the obligations are on the state, anyway. If in fact there are practices which are circumventing the principles of community rating, including the community rating for lifetime cover, we would certainly have an interest in those.

Senator JACINTA COLLINS—Further to that, I would also like you to look at what you have available to you perhaps from the ombudsperson in relation to consumers' experience. As I understand it, you have had a significant level of reporting of complaints from consumers. For instance, at the moment, to get full ambulance cover in Victoria—emergency and non-emergency—you essentially have to pay twice. When you raise the issue of non-emergency cover with your health fund they say, 'Yes, you should still go and get a subscription.' To get a subscription you have to pay a full subscription, when you are already covered for emergency services. So at the moment consumers in the health industry are being asked to pay twice for a service because of the state of flux of the market in response to the implementation of the health rebate.

Dr Wooding—I think we have to take that on notice as well. That is not an issue I have been aware of previously.

Senator JACINTA COLLINS—I have one further issue. Medibank Private is not here, is it?

Mr Podger—No.

Senator JACINTA COLLINS—It has been reported to me that of all the health funds Medibank Private, ironically, is actually the most aggressive at this practice.

Dr Wooding—We will have to take that on notice as well.

Senator CHRIS EVANS—I have a few on private health insurance issues. Dr Wooding, are we sticking with the assessment at the moment on the private health insurance rebate costs? You are the man now as well?

Mr Wells—I am now the new man. That is the current estimate. As you are aware, estimates are being revised. There are steps in the budget process where they are revised and we are going through those steps. But the estimate we gave you at the last hearings and which is in the previous document—

Senator CHRIS EVANS—Is still current?

Mr Wells—is the current estimate.

Senator CHRIS EVANS—I saw there were some figures the other day on a slight drop-off—about 50,000—in the private health participation rate.

Mr Wells—In participation.

Senator CHRIS EVANS—I know it is not a huge amount in terms of the overall number.

Mr Podger—It is basically in line with our expectations. It does not change anything significant on our expectations since the big increase has come through. We had expected there will be some small drop-off as things proceed through.

Senator CHRIS EVANS—Have you done any work yet on assessing—we were talking earlier about this with Dr Wooding—the percentage of the rebate that is funding ancillary cover? He mentioned something I raised with you on a number of occasions, that is, the increase in what is seen to be hospital-only cover and gap—not gap, what is the word—

Mr Podger—Front-end deductibles.

Senator CHRIS EVANS—front-end deductibles and things. Have you done any work on assessing those trends in terms of the percentage of products that have been sold with those features and whether there are any conclusions to be drawn and whether there is going to be any policy response to those movements?

Ms Sperling—We will be working with the industry on a range of issues related to front-end deductible products. At this point we have not done a thorough assessment of changes to products over the recent time, but we recognise that there are issues related to front-end deductibles which we will be working with the industry on over the next few months.

Senator CHRIS EVANS—Have you got any figures on the prevalence of these products and of hospital only cover? Are you able to, for instance, track since the rebate came in what percentage of people are taking hospital only cover as compared with before and what percentage are buying front-end deductible products compared with before?

Ms Sperling—I can take that on notice. Those figures are readily available in the regular PHIAC reports, but I do not have them on hand. I would be happy to provide them for you.

Senator CHRIS EVANS—If you could give me a summary of what is happening in terms of those products since the advent of the rebate, I would appreciate that.

Ms Sperling—Certainly.

Senator CHRIS EVANS—We have had this discussion a number of times about just trying to get a feel for what is happening in terms of the response to the rebate. In terms of a policy response or managing that, you say that you have been working with the industry. Towards what end?

Ms Sperling—To have a look at the appropriateness of front-end deductible products, to look at the acceptability of those products and any consumer issues surrounding those, and to assess whether there needs to be either some voluntary industry agreement on reforming those products or some government regulation related to them, depending on the nature of any concerns that we might have.

Senator CHRIS EVANS—Is that discussion only going to be with industry, or is it going to be with a wider group?

Ms Sperling—Industry, consumers and other relevant stakeholders.

Dr Wooding—Just to clarify, I think the particular products of most interest are what are called exclusionary products, which are often combined with front-end deductible products.

Senator CHRIS EVANS—I know that they are the ones that have been attracting some media interest, but they are not the only ones of interest to me. I am actually interested in what we are funding through the Commonwealth. I think there is a public policy interest in what it is we actually are funding now. We have raised this with you a number of times. I am a bit concerned about, to be honest, what seems to be a lack of interest in the topic. I raised earlier not only whether other products have been offered that perhaps are not appropriate to be funded by the rebate but also the trends that have emerged as a result of quite a changed market stimulus—I do not think anyone denies this—in the sense of the 30 per cent rebate. We ought to be monitoring what that is doing in the market. Obviously it is much broader than the insurance funds themselves.

Dr Wooding—I think it is fair to say that we are looking at these things. It is not a matter of not being interested. We are looking at issues to do with any of the products becoming artificial rather than genuine health insurance products. That goes to questions such as the degree of a front-end deductible, exclusionary products and those sorts of things. There comes a point at which that would be of significant concern to us.

Senator CHRIS EVANS—Not only artificial but whether or not they have any impact on reducing demand on public hospitals, which is one of the prime objectives of the program.

Dr Wooding—That is really what I was getting at in terms of 'artificial'—that they are not actually designed to provide general health insurance.

Senator CHRIS EVANS—So you will be able to give me some information as to comparison over time of those products?

Ms Sperling—Yes.

Senator CHRIS EVANS—Thanks for that. Can I ask, then, where we are at with this gap cover advertising campaign—the $10 million campaign? Is that about to start?

Mr Wells—That is still in the various processes within government of approval of the nature of the campaign and issues around timing, et cetera. So we cannot foreshadow when that will occur or what it will look like. It is still going through that process.

Senator CHRIS EVANS—You cannot tell me when. Can you tell me what sort of campaign? Is it TV? Is it radio?

Mr Wells—We have not really been determined what the elements would be and what the mix would be. That is part of that process.

Senator CHRIS EVANS—What is the objective of the campaign?

Mr Wells—It is basically an information campaign to raise awareness of the availability of no or known gap schemes, to encourage people who have taken out insurance to be aware and to take advantage of any new schemes that are on offer, and also to encourage the funds to themselves make available and actively promote their own particular schemes. So it is essentially an information campaign to make sure the public is aware of what is on offer and that they follow up their rights—

Senator CHRIS EVANS—What other private organisation has the government advertise their products for them?

Mr Wells—We are not advertising a product; we are advertising the availability of these products for consumers.

Senator CHRIS EVANS—They are not your products. You are advertising on behalf of a third party.

Mr Wells—We are not advertising any particular products. I would not think the purpose of the campaign—

Senator CHRIS EVANS—Aren't you advertising gap-free products?

Mr Wells—We would not be advertising product A, product B or product C. That would be a matter for particular funds to advertise. Our campaign would be of the nature of, 'These products are now on offer and you should think about taking advantage of them'. But we will not be advertising a particular product. That would not be our role.

Senator CHRIS EVANS—So are the private health funds contributing to this campaign?

Mr Wells—Not at the moment, because we are still working through the detail of the campaign.

Senator CHRIS EVANS—In the budget for the campaign, is it intended that the private health insurances will contribute to the advertising campaign?

Mr Wells—Not that I am aware of. We would be funding it from funds available to the department.

Senator CHRIS EVANS—Which budget are you funding it out of?

Ms Sperling—Outcome 8 funding.

Dr Wooding—You will find on page 89 where it is being funded from. It is an appropriation bill No. 3 outcome.

Senator CHRIS EVANS—So there is no additional estimate change? That was funded in the original estimates, was it, Dr Wooding?

Dr Wooding—When we first started to think about it we thought we might seek additional funding through the budget, but we have discovered that we have had money set aside for simplified billing. It became increasingly apparent in the second half of last year that the best way to promote simplified billing was to promote gap cover, because the gap cover arrangements, which are increasingly also involving e-commerce that is being run by the funds, actually achieve all the objectives of simplified billing—that is, that the patients do not have to collect a whole pile of bills, receive a whole lot of different rebate payments from different sources and end up with out-of-pocket costs. So we have decided to put our energies into promoting the gap cover concept for the time being.

Senator CHRIS EVANS—I see you have some money being brought forward on simplified billing. Was that money you were going to spend on advertising?

Dr Wooding—It is money that we will now spend on this campaign, yes.

Senator CHRIS EVANS—So that $4 million that was brought forward from 2002-03 to fund simplified billing is actually going to be rolled into the advertising campaign for gap cover?

Dr Wooding—That is correct.

Senator CHRIS EVANS—You do not see the need to fund the simplified billing campaign down the track?

Dr Wooding—There is still some money left in the estimates for simplified billing. I think this is the simplified billing campaign. I think the objectives of the two processes have come together as gap cover has become more successful. As I say, it is achieving the objectives of simplified billing.

Senator CHRIS EVANS—You are going to put $10 million this financial year into funding the gap cover advertisements for private health insurance; is that right? It is effectively spent in this year? Is that still the intention?

Ms Sperling—The final amount and nature of the information campaign in relation to gap cover have not yet been determined.

Senator CHRIS EVANS—Where do they get that $10 million figure from? Was that not here last time, or was that somewhere else?

Ms Sperling—I do not think we have ever been in a position to specify an exact amount of money.

Dr Wooding—That may have been in a newspaper article, as I recall.

Senator CHRIS EVANS—Authoritative sources, then? I knew I had a good source! So there is no truth to the $10 million campaign? It could be more or it could be less; is that right?

Mr Wells—Correct. The final budget has not been determined. It will not be until the shape of the campaign is clearer.

Senator CHRIS EVANS—Has the department got any attitude to the sort of advertising that the funds are conducting now, which seems to be aimed at taking members off each other? A lot of the fund advertising now, certainly in Western Australia, is about market share. They seem to be encouraging people to swap funds.

Dr Wooding—I think it was very much what we expected after Lifetime Health Cover.

Senator CHRIS EVANS—Do you fund the general advertising or do they have to fight among themselves?

Mr Podger—I think you would expect that there would always be an argument about market share in terms of competition. I guess one of the things we were concerned about two years ago was that lifetime cover should not get in the way of mobility. It is rather pleasing to see it has not got in the way of mobility. It does seem that it is being handled. But, I had never portrayed it the way you just have—that is, the government pays for attraction to get people in and the funds pay for the market share. In the campaigning, the funds have substantially paid for their own advertising to get people into private health insurance. It has done a bit of both.

Senator CHRIS EVANS—I think we have funded a fair bit of it too, have we not, Mr Podger?

Mr Podger—We have indeed.

Senator CHRIS EVANS—What is the Lifetime Health Cover fund advertising budget?

Mr Podger—It is a substantial amount of money, which is not entirely surprising. Given that we are spending nearly $2 billion on the rebate, it is reasonable for the government to try to ensure that, as it was introducing lifetime cover and so on, it would be explaining that to the public.

Senator CHRIS EVANS—The more you advertise it, the more the rebate costs you. I am one of those taxpayers who gets a bit angry when I see the government funding the general advertising and then the companies spend their time fighting over market share. It struck me as being a little concerning as to why we were going to fund another advertising campaign to promote the industry, especially when you tell me that they are not contributing at all to that campaign.

Dr Wooding—I think the gap cover campaign is a completely different sort of campaign to Lifetime Health Cover. I would not personally see it as promoting the industry. As I think I said at the last estimates hearing, it is about empowering consumers in the industry to take advantage of something and to try to get critical mass in terms of participation of doctors, funds and consumers in gap cover. So it is not trying to attract people in so much as trying to transform the existing industry, including the people who are already in it.

Mr Podger—I think it is fair to say that for many years governments have been concerned about the lack of cover of gap issues. That has been a continuing sore. We have taken a number of measures to try to address the obstacles to that, including the attitudes taken by some doctors and professions, as well as the roles of the health insurers. The advertising is part of the array of measures to address those difficulties.

Senator CHRIS EVANS—I would have thought that as we were spending $2 billion of taxpayers' money per annum on it we would have had a bit of leverage; but, no, we have to go and pay for the advertising as well. It seems to me that you should have bought yourself a fair bit of leverage with $2 billion.

Mr Podger—I think you are now expressing a view of the policy.

Senator CHRIS EVANS—I am.

Mr Podger—Yes, and it is not appropriate for me to respond.

Senator CHRIS EVANS—I was just expressing a view about us spending more on advertising it. Dr Wooding, you were going to tell us about the Taxation Office increased cost item. When Senator Collins got you onto it you found the answer but not to the issue she was raising. I think you started to explain it, and I want to understand. Is this money you are going to pay the tax office?

Dr Wooding—Yes, Senator.

Senator CHRIS EVANS—Is it a fee for service?

Dr Wooding—Yes. It is an amount paid in relation to the work they have to do to deliver the rebate as a tax rebate for the 10 to 15 per cent of people who claim it that way.

Senator CHRIS EVANS—I thought last time we discussed it you were telling me that the actual number claiming it was quite small and dropping.

Dr Wooding—In absolute numbers, it is still quite a large number of people. Our initial estimates as to how many were going to claim it through the tax side were based on the proportion of people claiming it through the old FIS scheme. Under that scheme, there was an important element of determining what your income was, which sort of encouraged people to go down the tax route. Now that there is no means test, I think people are switching to claiming through the health fund rather than through the tax side.

Senator CHRIS EVANS—What is your latest estimate of the percentage who will be claiming it through the tax system?

Dr Wooding—I think it is around 13 per cent.

Ms Sperling—Yes, 11 to 13 per cent.

Senator CHRIS EVANS—Has there been any discussion about removing that option?

Dr Wooding—That is a policy matter for the government, Senator.

Senator CHRIS EVANS—Has there been any active consideration given to that policy? It is costing you more money now to service what seems to be a diminishing market. I just thought I would raise the issue about whether or not that is a possibility.

Dr Wooding—It was introduced under the new tax system measures. It was tied into the system there. That is the government policy, Senator.

Senator CHRIS EVANS—Thanks for that.

CHAIR—If there are no further questions on outcome 8, we will move to outcome 9, health investment.

[8.41 p.m.]

Senator WEST—I want to ask a few questions about the rural medical schools. As I understand it, these are for teaching undergraduates while university departments of rural health focus on research and postgraduate training. Is that right in relation to rural clinical schools?

Mr Wells—Yes, Senator, that is right. The rural clinical schools are for the medical undergraduates in their clinical years to undertake a period of time in a rural location.

Senator WEST—We have had some announcements from Minister Wooldridge about nine new clinical schools. Is that correct?

Mr Wells—That is correct, Senator.

Senator WEST—They are Coffs Harbour, Dubbo, Rockhampton, Kalgoorlie, Riverland in the Northern Territory—I do not know what that means—Bairnsdale, Shepparton, Whyalla and Burnie; and the two new university departments at Tamworth and Lismore. The press release listed eight existing university departments. Is that correct?

Mr Wells—I think that is correct. That is to bring the number up to 10. I think there were actually seven existing. An eighth had been announced in the last budget—

Senator WEST—Is that Mount Gambier and Warrnambool?

Mr Wells—The other two were announced along with the clinical schools the other week.

Senator WEST—The total funding for all centres is $117.6 million. Is that correct?

Mr Wells—Over four years, yes.

Senator WEST—How many applications were received by the department for the clinical schools and the university departments?

Mr Wells—With the clinical schools, which is the process I was involved in, we invited each of the medical schools to bring forward a submission against set criteria, which they did. We then met with the universities and with the state health authorities involved in the various proposals. We then made recommendations to the minister and the minister subsequently made the announcements. So I suppose there were nine submissions. We did not advertise. Because they had to have medical undergraduates, only those universities with medical schools would be affected, so we went directly to them.

Senator WEST—So basically all of the existing nine universities got a guernsey in the clinical schools?

Mr Wells—Basically. In relation to the new university medical school at James Cook, we have set aside some money for them with a view to some further planning down the track.

Senator WEST—Have you at some stage provided us with the criteria and the guidelines you used to assess them?

Mr Wells—I think we have, Senator. I am happy to provide them again. I will take that on notice.

Senator WEST—I cannot remember if you have or not. What steps were taken in relation to conflicts of interest in the declaration of pecuniary interests in this process? If the nine of them all got a guernsey, were they given a map of Australia to sort of say, 'I'd like this bit and I'll have that bit'?

Mr Wells—No, Senator. As I said, they had to frame their proposals around criteria which were publicly available before they submitted their proposals. They all had to frame them around the same criteria. There were not individual criteria for each university. I am not sure where the conflict of interest arises, Senator.

Senator WEST—When everyone's snout was in the trough, how did they resolve it? They seem to have all had a win here because the nine existing universities had a clinical school.

Mr Wells—I think that was the intention. There would be capacity for each university, the policy intention being to get 25 per cent of the medical students in their clinical years undertaking half their clinical experience in a rural area. So in order to achieve that, each medical school would have to have some involvement. From a policy perspective we are keen to get all the medical schools with some focus on rural activity, not just some.

Senator WEST—So where is Sydney university going to have its clinical school?

Mr Wells—At Dubbo.

Senator WEST—Where is Hunter? Maybe you can give me a list so I can look at the nine universities and the nine clinical schools and say, 'Right. They got this and they got that.'

Mr Wells—I can provide you with that.

Senator WEST—How wonderful. How similar were the proposals as to the clinical streaming that would go on, because I have expressed concerns here before that I did not want to see there being two tiers of doctors coming out at the end. I do not want one group of students just being consigned to the rural clinical schools, albeit I know that they will get a good, broad experience at Dubbo with the clinical stream. What I want to see is the professorial students also out in those rural clinical schools. How have the proposals been arranged so that you can actually ensure that all of the students spend time in the rural clinical schools?

Mr Wells—Not all of the students will be able to spend half their time in the clinical schools because there just is not the capacity to do that.

Senator WEST—No, it is basically 25 per cent of them.

Mr Wells—It is 25 per cent of them. We will specify in our contracting with each of the universities that each of those universities will have 25 per cent of their students getting half their time. But, in addition to that, we will encourage the universities to have other students

go into the rural areas with the clinical schools and spend shorter periods of time throughout. A minimum of 25 per cent will be required to do it that way.

Senator WEST—How are you going to ensure that the bottom 25 per cent are not sent out to the clinical schools in the rural areas to do half their clinical schools there?

Mr Wells—The model we have where that has worked is the one at Wagga, which has now been running for a year. That university has actually called for students to put their hand up. The dean there tells me that they have been oversubscribed—in other words, more students want to go to the rural school than they actually have places for. If the other universities follow the same model, which we would be encouraging them strongly to do, that should not occur. In other words, you should get a reasonable spread of the students, not just, if you like, the lower end of the class. Do not forget, you are talking here about people who are in the top one per cent or less of the high school graduates, et cetera.

Senator WEST—Maybe not if you actually now have postgraduate entry into medicine.

Mr Wells—But you are still getting high achievers.

Senator WEST—You are talking about bright people, but there is a difference between the bottom 25 per cent and the professorial students.

Mr Wells—All I can say is that the experience at Wagga—and again we are talking of one year's experience—is that it is not the second prize.

Senator WEST—I am just wanting to make sure, I suppose as a bushy, that we are actually educating the professorial, the cream, those who are going to be doing the research, who are going to be the leaders in the profession in 10 or 15 years time, who will be the professors, the top elite band, and that they also are going to be compelled, if necessary, to have that clinical experience in a rural and regional teaching hospital and centre. They will get a totally different variety of cases. They will get a broader experience. I do not have to sell the virtues of what is available for them in those category 5 base hospitals, but I want to make sure that everybody gets that access.

Mr Wells—Yes, I understand that. As I say, our experience to date has been to the contrary.

Senator WEST—When we were talking about this before, I asked about the involvement of Dr Jack Best in doing work for some of the universities as they ran up their proposals. Can you outline what his involvement was in the process, please? In what way was he involved?

Mr Wells—In terms of our process he had no role. As I have explained previously, we have handled this internally within the department. In other words, we conducted the discussions with the universities and with the state health authorities. We then internally prepared the advice for the minister, had the discussions with the minister and prepared the advice that was released. Dr Best, I understand, did work with some of the universities, but that was not at a level—

Senator WEST—Which ones?

Mr Wells—I do not have that because that was not a matter between him and us; it was a matter between him and the universities. We dealt only with the principals at the universities, that is, the deans or a subdean or some employee of the university. We did not deal with Dr Best and the universities.

Senator WEST—But he had had an involvement—and correct me if my memory is failing me—with this process and this program for some time, hadn't he?

Mr Wells—Not with this program.

Senator WEST—With rural medicine?

Mr Wells—He certainly has had some involvement with rural issues and did some work around the *Rural Stocktake*, but he has not had involvement with this program from our end. He clearly has had involvement with some of the universities, but not in terms of informing us or negotiations with us. There was one meeting with one of the deans where Dr Best was present at the invitation of the dean. As far as I know, that was the only one.

Senator WEST—Since the *Rural Stocktake* was completed, have you received any payments from the department for work carried out?

Mr Wells—Not from our area. The other officers are not here. We would have to take that on notice.

Senator WEST—What contact did Dr Best have with the assessment panel, officers of the department, the minister's office or the minister himself. Minister, you may have to take some of those questions on notice.

Senator Vanstone—That might be a better idea.

Senator WEST—Did any of the proponents not submit a valid proposal by the due date?

Mr Wells—From recollection, no, but can I take that on notice?

Senator WEST—Certainly.

Mr Wells—They certainly all submitted valid proposals, but I am not sure about the due dates.

Senator WEST—There were some invalid proposals?

Mr Wells—No, I said they all submitted valid proposals, but I am not sure about the dates.

Senator WEST—None of them had to go back and redo their proposals or modify them?

Mr Wells—We have had discussions, as I said, with each of the universities, and the result of that—what you have here in the announcement—would not be exactly what those universities would have proposed whenever it was last year. That has been a process of iteration between us and the universities, but no-one was told, 'Your proposal is out of court. Go back and try again.'

Senator WEST—The Coffs Harbour rural clinical school, part of the New South Wales university, is a new node of the Wagga Wagga clinical school based at Coffs Harbour extending to Port Macquarie and surrounds. What was the origin of the Coffs Harbour proposal for a clinical school as the new node of the Wagga Wagga school?

Mr Wells—The University of New South Wales, which will be managing both, indicated to us that they would prefer to run it as one entity with, if you like, two campuses—one at Wagga, one at Coffs Harbour. The next step in the process is that we are actually going around now negotiating the detail, funding and conditions with each of the universities. Just how that will operate will be part of our discussions with the University of New South Wales, but that is based on their preferred model.

Senator WEST—So you are not sure how it is going to work at this stage?

Mr Wells—Not at this stage.

Senator WEST—Did Coffs Harbour make a submission?

Mr Wells—No.

Senator WEST—UNSW did?

Mr Wells—UNSW made a submission, and that was one of the ones that, in further discussions, was modified. They were seeking, I think, slightly different coverage within New South Wales, but in a process of negotiation with the three universities in New South Wales we came to this solution.

Senator WEST—So it is not possible to see it being given these proposals?

Mr Wells—I do not think so, because they were, as I said, initial proposals and we have moved on from there in discussions with them.

Senator WEST—So where did UNSW initially want their second node to be?

Mr Wells—They did want some coverage in the northern part of New South Wales along the coast, but I think they also wanted some expansion in the western part of the state.

Senator WEST—Is it true that the rebuilding of the Coffs Harbour hospital does not make provision for teaching facilities?

Mr Wells—I cannot answer that. That is a matter for New South Wales. I understand the New South Wales government is happy, in a sense, with our proposals. They have not come to us and said, 'You can't put one at Coffs Harbour,' for example. My advice is that they are quite happy with that proposal.

Senator WEST—What about the Port Macquarie hospital, because that is the main Health owned hospital where they contract out the provision of public services to the state. It is a very nice profit to themselves, I would add as a sideline. What benefits will flow to them as a result of this deal?

Mr Wells—To Port Macquarie—

Senator WEST—To main Health.

Mr Wells—I cannot comment on that.

Senator WEST—The Port Macquarie hospital one—

Mr Wells—What these clinical schools will do is place undergraduate students in the local hospitals but also in local GP practices, in community settings. So I suppose at some point at Port Macquarie hospital, along with other hospitals in that area, there will be some support from the University of New South Wales by way of academic support for those students who are in that hospital. That would be the nature of the support, but again I cannot comment in detail because we have not had those detailed discussions with UNSW.

Senator WEST—So there are still discussions yet to be had.

Mr Wells—Very much so.

Senator WEST—Was there a competing bid for a clinical school from Lismore?

Mr Wells—The original proposal from the University of Sydney was for a clinical school at Dubbo and a clinical school at Lismore.

Senator WEST—Why did Coffs win and Lismore not win?

Mr Wells—Sorry, there are two different aspects. Sydney University's original proposal did not extend down the coast; it was around Lismore.

Senator WEST—So is there a comparative evaluation of the proposals? Can I see why Lismore lost out on the clinical school as opposed to Coffs Harbour?

Mr Wells—Lismore did not lose out. What it got was a university department of rural health, which will be a collaborative venture between the University of Sydney and the Southern Cross University. So it will provide training and facilities for more than just medical undergraduates; it will cover other health care workers as well. That was the model that in the end Sydney University, in a sense, opted for.

Senator WEST—How much funding in broad terms has been allocated to each centre?

Mr Wells—We have not done that yet. What we have is a formula that will be in two parts. The first part of the formula will be a per student loading; so the larger universities will get proportionally more because it will require each of them to have 25 per cent of their students go through for a year. So that will be relatively straightforward. But the second part of the formula will make allowances for things like distance, remoteness, the need to upgrade infrastructure of some of the facilities and so on. So, for example, places like Kalgoorlie will need more support in that regard than places like Coffs Harbour.

Senator WEST—So you do not have even an estimate of what the funding is going to be to each centre?

Mr Wells—We can calculate the first part but it would be, I think, misleading for us to be giving out those figures until we have had the negotiations with the university around the whole package.

Senator WEST—What is the relative size of a clinical school compared to a university department?

Mr Wells—I am not sure that that is a question that can be answered. We want to base medical students in the town or the locality, whereas university departments tend to have students on a rotation through for a 12-week or whatever period of time. So it is a bit like apples and pears, I think, in that regard.

Senator WEST—I am trying to get in my mind some comparison of the numbers of teaching undergraduates that you would expect at a clinical school and what you would expect the size of the departments of rural health to be, or even what has been put in the proposals.

Mr Wells—For a university with an annual intake of, say, 100 students into its medical school—and say it is a four-year program—when those 100 students reach year three, 25 of those would be expected to spend a year, either year 3 or year 4, at the clinical school for that university. So you can quantify then what staff support et cetera would be required in that locality depending on the student load. For a university department of rural health, I think the calculations are different, but I do not have those. I would have to take that on notice; it is not my area. That is under the Office of Rural Health.

Senator WEST—What is to say that Tamworth or Lismore is not just going to have one office and a computer and somebody there making fleeting visits?

Mr Wells—I think the models you already have suggest that would be otherwise. Places like Broken Hill and Mount Isa all have a resident director; they all have support academic staff resident in the town and those staff usually also have clinical appointments or provide private services in the district; so it is of that nature.

Senator WEST—I just have to wait and see is the answer to that. You tell me that no funding allocation has been made at this stage?

Mr Wells—That is right.

Senator WEST—If I were to tell you that Southern Cross at Tweed Heads and Lismore is expected to receive $3 million a year for the next four years, would you tell me that that was over the top and not accurate?

Mr Wells—I think there is an issue there that the university departments of rural health, as I understand it, are funded around about a $1 million to $1½ million a year from the department, but they also attract other funding by way of research grants, funding from state health departments et cetera. So I could not tell you what the actual budget for Lismore would end up being once they get fully operational, because we would expect that the Commonwealth funding is not the only direct source of funding.

Senator WEST—So we do not know how much that particular one is going to receive for four years?

Mr Wells—That could well be based on an estimate of the experience at other schools. I would have to take that on notice. Again, it is not my particular area.

Senator WEST—The reason I am asking is that Mr Anthony, the local member for Richmond, which covers the Tweed Heads area, put out a press release on the 6th of this month saying:

Southern Cross University at Tweed Heads and Lismore will receive $3 million a year for the next four years to play a key role in the new Lismore University Department of Rural Health.

I am just wanting to get some idea because I was under the impression that some people knew how much funding there was, but you tell me that that is not the case.

Mr Wells—There was no announcement of funding by school or department in the minister's announcement.

Senator WEST—So you do not know where this $3 million has come from?

Mr Wells—I cannot comment on that particular figure but, as I say, these departments do have sources of funding other than the department's funding. The more successful they are the more we would expect they would attract other funding.

Senator WEST—But this would be a new move for Southern Cross University, wouldn't it?

Mr Wells—The one at Lismore is a joint venture between the University of Sydney—

Senator WEST—And Southern Cross?

Mr Wells—and Southern Cross. The University of Sydney, of course, has extensive experience from its Broken Hill university department.

Senator CHRIS EVANS—But you are saying you have not actually announced what funding will go to them; is that right?

Mr Wells—It has not been announced.

Senator CHRIS EVANS—So you cannot verify those figures?

Mr Wells—No, I cannot verify those figures. But they might not be out of the ballpark. I am not saying those figures are wrong. I am saying there has been no announcement.

Senator WEST—And therefore there has been no calculation as to how much would go to Tweed Heads and how much would go to Lismore?

Mr Wells—I would not think so, no, certainly not at our level.

Senator WEST—Can I turn to rural bonded scholarships, please? The funding for those was increased by nearly $1 million over four years; is that correct?

Mr Wells—Yes. That was an adjustment to the estimate.

Senator WEST—What brought about the increase?

Mr Wells—I think it was just one of those adjustments based on further consideration of the numbers and those sorts of things. It is more a technical adjustment. It is not for more places or anything like that.

Senator WEST—That leads me to my next question: how many applications have been received for bonded scholarships, given that most of them are in O week this week, last week or next week?

Mr Wells—The numbers are still being finalised with some of the universities. I am confident all the places will be filled. Some universities were well and truly oversubscribed. Other universities were able to fill their places but were not as oversubscribed. But overall—

Senator WEST—When you say 'fill their places', this is fill their—

Mr Wells—Quota. The 100 places were shared out among all the medical schools.

Senator WEST—How did that get shared out—just on a pro rata basis on the number of students they have?

Mr Wells—Partly on a pro rata basis—the bigger universities obviously can take more places—and partly on—

Senator WEST—What—Newcastle would get more than Sydney because Newcastle tends to attract—

Mr Wells—No, Newcastle would get fewer than Sydney because Newcastle is a far smaller medical school than Sydney. I can give you the numbers.

Senator WEST—Yes, I would appreciate that. So you do not know how many applications have been received for the scholarships at this stage?

Mr Wells—Could I take that on notice and give you the final figure when we have had them all confirmed?

Senator WEST—Sure. I am interested to know how many offers have gone out given that the academic year is now starting and the students—

Mr Wells—The number of offers that would have gone out would have exceeded the number of places available.

Senator WEST—Will exceed the number of places?

Mr Wells—Yes, because some people will get an offer and then reject so another offer goes out to another person.

Senator WEST—You are doing several rounds of offers?

Mr Wells—Yes, I think there have been about three rounds altogether. This is part of their normal university academic intake.

Senator WEST—As they go round with the first round of offers for places into the universities—

Mr Wells—Some students change their mind and go to a different university, for example. They get another offer. So the number of offers made will exceed the number of places available, for that reason.

Senator WEST—I will bear that in mind when you give me the figures. I am happy for them to come on notice as well. Do you have any idea how many who applied for bonded scholarships—this probably carries on from the last conversation—have won a place at medical school on the basis of their own results, without—

Mr Wells—Without being the next after the quota?

Senator WEST—Yes.

Mr Wells—That is a difficult question. I know some have, but I could not answer that. We will be doing a review of the operation of the scheme probably in March or April when the final numbers are in. I think universities get their first report to DETYA in March or something—so after that. That would be one of the factors we are looking at.

Senator WEST—I am interested to know if people have been required to relinquish their HECS places in order to accept a bonded scholarship.

Mr Wells—No-one has been required to. Some might have volunteered, but no-one has been required to take up these scholarships. They are voluntary. In fact, we have gone to great pains to ensure that the students understand the conditions of the bonding, et cetera. So they are all voluntary. That situation would not have arisen unless you have complaints.

Senator WEST—Can I ask about the RAMUS scholarships? Is that $10,000 a year with no bond?

Mr Wells—I am sorry, they are the Office of Rural Health. I do not administer those.

Senator WEST—I suppose they have gone?

Mr Wells—I suspect they have gone.

Senator WEST—Can I put on notice for them—perhaps somebody could alert them to this—that I am wanting to know how many offers of RAMUS scholarships have been made for this academic year, how many have been accepted, how many recipients have also received a bonded scholarship offer, and what has been the pattern in terms of which scholarship people accept.

Mr Wells—If they have a choice?

Senator WEST—Yes, if there is a RAMUS choice or a bonded choice. Do you have any idea?

Mr Wells—I do not.

Senator WEST—I think that would be a significant and interesting question.

Mr Wells—We will take that on notice. That might well have to wait till the outcome of our review. But we will certainly get you that information when we can.

Senator WEST—I think that is about all I have got on that.

Senator LUNDY—I have some questions on IT outsourcing. I understand they are in this section?

CHAIR—Yes, they are. Senator Harradine has just got some on NHMRC.

[9.12 p.m.]

Office of the National Health and Medical Research Council

Senator HARRADINE—Mr Wells, I refer you to a response to me in late November to my question E017 on a draft report relating to the termination of pregnancy. I asked:

> When is the new abortion report likely to be finished? When will the NHMRC meet to discuss the new report? Is the NHMRC or any of its committees doing any other particular work relating to abortion at the present time? If so, please provide details.

The NHMRC responded:

> There is no new abortion report being prepared by the NHMRC. There is no new abortion report. No other projects relating to termination of pregnancy are being undertaken at the present time.

Mr Wells—I will ask Dr Morris to answer that. But, before he does, could I just make a statement? I would like to introduce Professor Alan Pettigrew, who since 2 January has been the chief executive officer of the NHMRC. So we are now in a handover situation. I just wanted to explain that. I will ask Dr Morris to answer that question for you.

Senator HARRADINE—This is the first committee that you have attended?

Prof. Pettigrew—That is correct.

Senator HARRADINE—Your response to my questions, which were threefold, was:

> There is no new abortion report being prepared by the NHMRC. There is no new abortion report. No other projects relating to termination of pregnancy are being undertaken at the present time.

Is that the fact? Have we been told the truth?

Dr Morris—The NHMRC met in August 2000 and discussed a report that had previously been in preparation in the previous triennium, which had been released once without council endorsement in, I think, late 1997 and was subsequently withdrawn. Council decided not to proceed with that report, given that they felt it had not met the original terms of reference provided to the working party and that, although the working party had revised the report, it still contained some factual errors and they felt that it was somewhat out of date. So the council decided not to proceed with this report. However, council did decide that there was a need for objective, factual information on the issue and they requested that the Health Advisory Committee of the NHMRC proceed with the preparation of information pamphlets for health professionals and for women.

Senator HARRADINE—When did the NHMRC decide this?

Dr Morris—In, I think, August last year.

Senator HARRADINE—But the NHMRC told this committee, 'There is no other project in relation to termination of pregnancy being undertaken at the present time.' Why didn't you say that there was a decision made in August 2000?

Dr Morris—I need some help here.

Mr Podger—I think in the processes of this answer, unfortunately, the final answer was not entirely complete, for which I apologise. There are no new projects, but you are quite right: the answer did not clarify that there is some further work that the NHMRC has asked from August to do a bit more on. But there is no new project as such or any new report being prepared as such, as I understand it.

Dr Morris—There is—

Senator HARRADINE—Are you seriously saying that? The impression that anyone who has been involved in it would gain from your response is that the information paper was dead in the water. This is a serious matter. These are questions asked at the committee, or in association with the committee, and the response being given clearly was inaccurate.

Mr Podger—Can I take that on notice? We will be providing you with a revised answer on that question. I am sorry if the answer we have provided has been misleading.

Senator HARRADINE—Who is heading up that committee? Is there such a body as the NHMRC termination of pregnancy working party?

Dr Morris—There is no such body. The Health Advisory Committee has put together a group of people to prepare some information pamphlets. There is no termination of pregnancy working party.

Senator HARRADINE—I am sorry, Dr Morris. Did a body entitled the NHMRC termination of pregnancy working party have a working party meeting between 10.35 a.m. to 3.40 p.m. on Friday, 10 November 2000?

Dr Morris—2000? In that case, yes. That is an internal name for the working party. I am sorry, I did not realise that they had given it a title. My understanding was that a group of people had been put together from within the Health Advisory Committee and council with some experts to prepare a specific set of information papers providing factual information.

Senator HARRADINE—Will you provide the committee with a copy of the minutes of that meeting?

Dr Morris—Certainly.

Senator HARRADINE—Will you advise the committee as to who heads up that working party?

Dr Morris—The group is being co-chaired by two members of the Health Advisory Committee, Dr Rosemary Aldrich and Dr Robert Grenfell. They are co-chairing the committee, I think, or co-chairing the group.

Senator HARRADINE—Is it not a fact that a report is being 'updated' by Dr Margie Ripper?

Dr Morris—I am afraid I do not have that information.

Senator HARRADINE—It is clear that you did not read the Adelaide *Advertiser* of 12 February 2000. Was the Adelaide *Advertiser* wrong in stating that the Health Advisory Committee—

Mr Podger—Could I perhaps comment on that? The history of this, as you know, goes back some years of the report—the document that you have. There was some work done on that document in the previous several years and I suspect—I would have to check and get back to you—that might well have been part of that process of attempting to revise that document. That process has since ceased. As I understand it, there was no further work being done on that document that you have. So, if it was February 2000, that could well be consistent with the answer that Dr Morris gave. That was a year ago.

Dr Morris—You referred to a committee which met in November 2000.

Senator HARRADINE—Yes.

Dr Morris—And I was telling you who was on that committee.

Senator HARRADINE—Yes.

Dr Morris—I am afraid I do not know about a meeting in February 2000, but I am sure that we could find out for you.

Senator HARRADINE—Who constitutes the working party?

Dr Morris—I have a list of the people here.

Senator HARRADINE—Thank you. Could you read that into the record?

Dr Morris—The co-chairs are Dr Rosemary Aldrich and Dr Robert Grenfell. There is also Dr Christine Bayly, from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; Ms Michele Kosky, from the NHMRC and also from Health Consumers WA; Dr Julia Shelley, epidemiologist, La Trobe University, Victoria; and Dr Edith Weisberg, Director of Research, Family Planning, Australia Health NSW.

Senator HARRADINE—So you are able to give me the list of names of a working group, the existence of which you did not know.

Dr Morris—You are referring to a group that met in February 2000.

Senator HARRADINE—No, I am referring to a group that met on 10 November 2000.

Dr Morris—I did not know of it by the title that you used. I did not—you—

Senator HARRADINE—Has that got the heading, the title?

Dr Morris—'Working Party Membership' is my title. It is not known as the termination of pregnancy working group—the words I think you used.

Senator HARRADINE—Yes, but what is it working on?

Dr Morris—It is working on information pamphlets. The title that you used was obviously used for internal purposes. I am afraid that I did not realise that it was the same committee, I am sorry.

Senator HARRADINE—Could you advise who of that committee were also members of the original committee?

Dr Morris—I do not believe any of them are. I am sure that you could cross-reference. We can take that on notice if you prefer.

Senator HARRADINE—I am raising the question of Dr Edith Weisberg. Was she a member of the original committee, and why is she on it?

Dr Morris—It is decided by the Health Advisory Committee.

Mr Wells—Dr Weisberg is from New South Wales. I understood—I will check this—that the original working party was all Adelaide based.

Senator HARRADINE—Dr Weisberg was a corresponding member of the committee.

Mr Wells—Is that indicated in the document?

Senator HARRADINE—Yes. The document that we have in front of us contained serious errors and this was completely withdrawn in 1998. Are you aware of the comment by the minister, Dr Wooldridge? In talking about the original draft he said:

... the draft imposes one particular point of view in considering issues surrounding the termination of pregnancies, at the expense of giving a fully balanced consideration to what is a complex medical and ethical problem ...

Was it not withdrawn on that basis and on the basis that it contained serious errors? What action is being taken to ensure that there is a balance, if there is going to be such a report? What steps are being taken to ensure that there is a proper balance in the membership of that committee, if there is going to be a new paper issued?

Mr Wells—I was involved in that original decision to withdraw the document. As you will recall, the document was only ever released as an information paper. It was never endorsed as an NHMRC report.

Senator HARRADINE—In fact it did come out originally, did it not, with the NHMRC flag and it was immediately withdrawn?

Mr Wells—That was corrected. Then a factual error in the document was brought to our attention and we withdrew it immediately at that time. The then Health Advisory Committee of the NHMRC decided that the report should be reviewed with a view to checking that error and correcting it and checking for other errors. Also, elements of the document were seen by the then Health Advisory Committee, which to that point had not been involved in the preparation of the document, as not evidence based. You might recall that this occurred at the changeover of the triennium with the NHMRC, so we had a new Health Advisory Committee. They thought there were elements of the content of the report which were perhaps not evidence based or did not meet current criteria for evidence assessment. So attempts were made to review the document and revise it in that context. It was decided by the now NHMRC last year that that was not possible, that no further work should be put into trying to revise the document to make it acceptable for release. So that document has now been abandoned.

As I understand the process, the issue of information for women about termination of pregnancy was still seen as an important matter for the NHMRC, and it was decided that a new process should be undertaken and that that process should focus on evidence based information rather than on the sort of information that was included in the previous report.

Senator HARRADINE—So on this committee where is there a person who is familiar with the pain, suffering and trauma and with post-abortion stress? Where is the person that is involved and familiar with that?

Mr Wells—I am not aware of all of the members of that working party. We will take it on notice and provide you with a short CV and area of expertise of the various members of the working party.

Senator HARRADINE—Did the minister have—I do not think it is appropriate to ask a member of the National Health and Medical Research Council—

Mr Wells—I think that is as far as I can go. The question I think you are raising is that this issue is being handled by the NHMRC itself. The NHMRC is independent of the minister on this one. The actions taken have not involved the minister in the last few months.

Senator HARRADINE—So what is this committee doing? Is it issuing another information paper? Who is going to do the audit on that paper?

Dr Morris—The objective of the Health Advisory Committee as requested by the National Health and Medical Research Council was to provide evidence based information on the

methods and the risks of termination of pregnancy, to health professionals and to women. There is an information pamphlet on the evidence based methods and risks.

Senator HARRADINE—That was what this was supposed to be, too, only it was an information paper, not just a pamphlet. Yet there were substantial errors in this. It had to be withdrawn. Again I ask the question: where on this committee—

Senator Vanstone—Senator, I am not wanting to interrupt, because I understand your interest, but you have asked that question and Mr Wells indicated that he would be happy to get you the CV of the people who are participating in this group, or working party or whatever you want to call it, but he is not familiar with their personal expertise. So you can peruse that. You have asked that question; it has been answered. I do not know that officers can help you more with that aspect of it tonight.

Senator HARRADINE—I am asking a question. Where is the person or persons that have a very intimate knowledge of post-abortion trauma and who have been involved in counselling persons with post-abortion trauma?

Senator Vanstone—I think that is the same question. I think Mr Wells has indicated to you that he is not familiar with the experience of each of these people, and what he is happy to do is get a CV of each of these people so that that can be assessed. That was the question you asked and that was his response. I do not know anything about these people—I certainly cannot help you—but I understand that Mr Wells has offered to help you in that way. I cannot see that he can help you much more if he does not have personal knowledge of their expertise.

Senator HARRADINE—And if their expertise happens not to include that, what then? What action will be taken?

Senator Vanstone—That probably needs to be assessed, and you need to consider what you want to say as a consequence of the CVs when we get them for you.

Senator HARRADINE—We know that at least one of the panel is a pro-abortion activist. Do you have others of other views on that committee?

Mr Podger—I do not think we are going to be able to answer that any further this evening. I could say that obviously Professor Pettigrew, who is here, is hearing the issues you are raising and I am sure he will be raising back with the council the issues you have raised for them to reflect on the matter.

Senator HARRADINE—I go to the question of cloning. The Australian Health Ethics Committee—I think it was in 1998—recommended strongly to government:

> ... that you urge remaining States and Territories ... which have not legislated in this area to introduce legislation prohibiting the application of techniques to clone a new human individual. This legislation should not, however, interfere with those cloning techniques which do not involve human embryos.

What is the situation in regard to the various states at this present point of time?

Dr Morris—There is legislation in three states, as you know, and the Australian health ministers conference has asked the NHMRC to facilitate a process with the states to ensure that all states put in place complementary legislation on a national basis to ban the cloning of human beings.

Senator HARRADINE—What is the current situation? What is the state of play at the present moment?

Dr Morris—At the present moment, the NHMRC has held two meetings with representatives of each state health department and is currently working to prepare a report on the consultations.

Senator HARRADINE—Who comprised those meetings and when did the meetings take place?

Dr Morris—The meetings have taken place in Melbourne on 15 December 2000 and 31 January 2001.

Senator HARRADINE—Who prepared the report for the meeting? Did the NHMRC prepare a report for those particular meetings?

Dr Morris—Yes, the office of NHMRC prepared some briefing material for the meetings and provided the secretariat support to the meetings.

Senator HARRADINE—Would you provide the committee with a copy of the document that you presented to the states?

Dr Morris—There are several documents. We can provide them all if you prefer. There was one set of briefing notes that went out in, I believe, early to mid November 2000 to all states and territories, and there was a clarifying statement handed out on 15 December and 31 January 2001.

Mr Podger—Can I just clarify? In providing such information, you will understand that these are just materials provided to the committees. They have no status from the NHMRC. They would have to go through further processes. So we can provide you with the material, but I wish to underline that such documents are input to considerations; they do not have any particular status of their own.

Senator HARRADINE—What was the outcome of those meetings?

Dr Morris—As I said, there is a report in preparation. I can say that the meetings ended with fairly good agreement on the part of all states as to where the process was going, but each state has its own legislative problems and legislative time frames.

Senator HARRADINE—Has each of the states that have not as yet any legislation in place, for example, on the ART question, decided to legislate in the area?

Dr Morris—I think that two of those states are going through consultation processes, and the third, I am not sure. I think we should really wait to see the report when it comes out.

Senator HARRADINE—Who is that report—

Dr Morris—The report is being prepared by council. It will be a report of the NHMRC.

Senator HARRADINE—I see.

Mr Wells—The process of pursuing that recommendation, as you are aware, is being conducted through the health ministers conference, and Dr Wooldridge in fact took it to the health ministers conference and initiated the current action. The Commonwealth, through Dr Wooldridge, has been strongly encouraging of the states to adopt national uniform legislation. The purpose of this process, as I understand it, was not so much to consider if but to consider how national uniform legislation might be introduced and what form it might take and what process—it was more how to make it happen rather than to examine the question of whether it should happen or not. Certainly, as I understand it, the feeling from health ministers was that, yes, it should happen, but there were process issues to be looked at.

Senator HARRADINE—What should happen?

Mr Wells—There should be national uniform legislation.

Senator HARRADINE—On what?

Mr Wells—On the issue as recommended, on that issue of assisted reproductive technology from the report.

Senator HARRADINE—In the debate in the chamber last year, a document was tabled in the Senate which I picked up out of the papers. It was a briefing note from Dr Clive Morris of the Centre for Health Advice, Policy and Ethics, Office of the NHMRC, dated 1 November. It included background information on the decision by health ministers to ban the cloning of 'whole' human beings. What is meant by 'whole human beings'?

Dr Morris—I think that was the term used by the Australian Health Ethics Committee in their 1998 report.

Senator HARRADINE—Are you certain of that? I said in the debate last year:

The background information includes a report about the Australian Health Ethics Committee 1998 advice to the Minister for Health and Aged Care on human cloning. Dr Morris's report states that the Australian Health Ethics Committee identified a distinction between the cloning of whole human beings and therapeutic cloning.

That is a very important point. I went on to say:

I have in my hand a document which I obtained through the Australian Parliamentary Library entitled *Australian Health Ethics Committee—National Health and Medical Research Council: position on cloning and related technologies* and dated 15 December 2000.

The document stated:

The NHMRC's position on the use of cloning and stem cell technologies was inadvertently misstated—

they use the word 'inadvertently', and no doubt that is correct—

in Appendix 1 (Background Information) of the invitation from the NHMRC to the Head of each State and Territory Health Authority -

AHEC says:

That appendix—

that is, your advice to state ministers—

incorrectly stated that, in its report entitled Scientific, Ethical and Regulatory Considerations Relevant to Cloning of Human Beings (1998) (Cloning Report), AHEC had identified a number of key issues which included the need to draw a basic distinction between the cloning of whole human beings and therapeutic cloning. In fact, in the Cloning Report AHEC specifically rejected the distinction between so-called 'therapeutic' and so-called 'reproductive' cloning.

With respect, Dr Morris, that is diametrically opposed to what the heads of the state departments or authorities were told by the NHMRC, is it not?

Dr Morris—As outlined in the document you are referring to, there was a misstatement in some background material to the states. When this was detected, the situation was rectified through production of that clarifying statement. The issue was the statement by AHEC, which said, 'A basic distinction should be drawn between the cloning of a whole human individual and the copying, also referred to as cloning, of the component parts of a human.' This was paraphrased and used the unfortunate term 'therapeutic cloning'. That has since been withdrawn.

Senator HARRADINE—Just so I get it clear, have you now given further advice to the state authorities?

Dr Morris—Dr Kerry Breen, the chair of AHEC, tabled that position statement at each of the meetings we have had with the states.

Senator HARRADINE—So that, which could have been a very serious slip-up if it was not picked up, has now been rectified?

Dr Morris—Yes.

Senator HARRADINE—Thank you.

[9.50 p.m.]

CHAIR—Do you have questions, Senator Lundy?

Senator LUNDY—I have questions relating to the IT outsourcing contract in the department of health. Depending on how I go, I might need to put some questions on notice as well. Within the department of Health and Aged Care, who was responsible for evaluating the tenders?

Mr Moran—The structure of the evaluation process in the OASITO model had several, shall we say, tiers of committee. Within the Department of Health and Aged Care we were represented on the steering committee. The immediately subordinate committee to that was the evaluation committee, on which various officers were represented. If you want the names, I can provide those. Subordinate to the evaluation committee were three other committees. They were, respectively, the corporate evaluation committee, which looked at the general legal requirements of the contract, a financial evaluation subcommittee and a technical subcommittee. Each of those three reported in name at least to the evaluation committee, which in turn reported to the steering committee. Do you want the names of those people?

Senator LUNDY—If you could take that on notice, that would be fine.

Mr Moran—Sure.

Senator LUNDY—In terms of the steering committee, what was that committee's specific role in the final evaluation of tenders?

Mr Moran—The steering committee compromised officers of each of the group agencies. I should expand on that. In the case of the Health Insurance Commission, there was a board member also on the steering committee and officers of OASITO. At all steering committees there was also the corporate counsel to OASITO, Blake Dawson Waldron—but to be honest I would need to take on notice whether they were actually members of the steering committee; I suspect not—and also Stephen Marks, who was the probity auditor retained by OASITO. Again, I suspect that he was not a member of the steering committee, but he was present.

Senator LUNDY—Because it is a health group, you mentioned that an evaluation committee was subordinate to the steering committee. Was that evaluation committee made up of only health and community care representatives or was that joined across the whole health group?

Mr Moran—No. From what I have said in terms of the evaluation committee and each of the three subordinate evaluation committees, they also contained officers who were contracted employees of each of the group agencies.

Senator LUNDY—So all of those committees were part of the whole health group?

Mr Moran—Yes.

Senator LUNDY—Could you provide me with your department's representation on each of those committees? What I am interested in is the position, if you like, or the status of the officer who was represented.

Mr Moran—Sure.

Senator LUNDY—If not in this committee but in other committees we have discussed the process for the evaluation of tenders. Can you describe to me the relationship between the evaluation committee and the steering committee and any knowledge you have of subsequent evaluation following the steering committee recommendation?

Mr Moran—Can I first go back and add to my answer in that there was in fact another committee which was comprised I think of agency heads. Mr Podger was a member of that committee, which was referred to as the options committee and which looked at the final recommendations of the steering committee and brought into that the recommendations of the industry evaluation committee, on which the department of health was represented but only on a consultative basis. I understand that, except for Mr Podger, the department and indeed none of the other agencies, with the possible exception of OASITO, had representation on the industry development part of the evaluation. Sorry, was your question what happened to the evaluation report once it left the steering committee?

Senator LUNDY—Yes. It obviously went to the options committee.

Mr Moran—I understand it went to the options committee for it to consider the findings of the steering committee, whose job I should remind you was to look at the combination of technical, legal and financial bids quite exclusive of the industry bid. The options committee then looked at those parts of the bid which were to do with industry development and then passed its recommendation to the minister for finance.

Senator LUNDY—Let me start with the evaluation committee. In relation to the evaluation committee's recommendation to the steering committee, did it identify a specific tenderer as being a preferred option at that evaluation committee level?

Mr Moran—As I recall it, the evaluation report as produced by the evaluation committee, and I may need to take guidance from my colleagues, presented to the steering committee its findings in terms of compliance—and I use the word loosely—with the conditions of the tender for each of the bidders, their final price and a finding on whether or not their technical solution met the business needs of each of the agencies or the group as a whole. If you can bear with me for five seconds—

Senator LUNDY—Certainly.

Mr Moran—I will confirm whether the evaluation committee made a specific recommendation as to a preferred tenderer to the steering committee.

Mr Moran—The answer is no, it did not. It ranked them in accordance with their compliance with the financial threshold and the technical threshold and the compliance with the legal requirements of the contract.

Senator LUNDY—And did it rank them collectively, that is, take into account all of those issues and gave them a ranking of one to three, or did it make a different assessment on the different aspects, that is, a ranking in corporate, a ranking in financial and a ranking in technical.

Mr Moran—It did do the latter but, as I recall it, it distilled an overall ranking of one, two and three.

Senator LUNDY—So it did the separate ones and then it did an overall analysis and provided an overall ranking?

Mr Moran—I need to qualify that answer. What I said was accurate only in respect of—or in other words, it was inaccurate in the other two—it was accurate in respect of the financial ratings. It made a specific one, two and three in terms of the cost of the bids and simply said that it had crossed those two thresholds that I referred to in terms of technical and corporate, or corporate—

Senator LUNDY—So you did not actually rank them in terms of corporate or technical?

Mr Moran—Simply that they complied.

Senator LUNDY—Okay. So the evaluation committee produced an evaluation report containing that information?

Mr Moran—That is correct.

Senator LUNDY—That evaluation report was handed on to the steering committee?

Mr Moran—That is correct.

Senator LUNDY—What was the product of the steering committee's considerations that was passed on to the options committee?

Mr Moran—As I recall it, it was a finding or a set of recommendations which were referred to the evaluation committee and then it produced a final recommendation as to the preferred, in all the circumstances, tenderer.

Senator LUNDY—Right. So it was the steering committee that made that assessment about the combination of the financial, technical and corporate?

Mr Moran—Effectively, yes.

Senator LUNDY—In terms of the evaluation report produced by the evaluation committee, was that modified or updated or redrafted in any way as a result of the steering committee's considerations to then be passed on to the options committee or was the original evaluation committee report passed on to the options committee with additional recommendations from the steering committee?

Mr Moran—I do not know.

Mr Podger—There were some questions raised, as I recall, about the precision on some of the advice on the financial side of things and that was referred back to the evaluation committee for clarification.

Mr Moran—I think you are suggesting that once the evaluation was effectively signed off by the steering committee, did anything else happen to it.

Senator LUNDY—No. Sorry, I must not have made myself clear. The evaluation report considered by the steering committee—

Mr Moran—Yes.

Senator LUNDY—I am just trying to ascertain what they actually passed on to the options committee. Did they then perhaps build on the original evaluation report with subsequent considerations and recommendations?

Mr Moran—Yes.

Senator LUNDY—Or did they create a separate report and pass that on in conjunction with the evaluation report?

Mr Moran—They drew together the findings of the evaluation report.

Senator LUNDY—Right.

Mr Moran—Summarised those, in a sense, and made a final and specific recommendation and stated the number of reasons as to why that was the preferred tenderer.

Senator LUNDY—Right.

Mr Moran—That is what went forward to the options committee.

Senator LUNDY—So in terms of asking the right questions, there are actually two reports: there is the report produced by the evaluation committee and then a subsequent, expanded report, or perhaps a structured different report produced by the steering committee; is that a fair enough interpretation?

Mr Moran—No, I think what the steering committee did was understand and accept the recommendations and the findings of the evaluation committee and say that, in all of the considerations, this, for a number of reasons—which were then outlined—is the preferred tenderer. And effectively that, in a short summary, in a sense—

Senator LUNDY—Like an addendum to the evaluation?

Mr Moran—Something of that order, yes.

Senator LUNDY—Can you tell me, in terms of the steering committee's consideration, what tests were applied to make that determination? I am asking about the decision-making process of the steering committee.

Mr Moran—Sure. Having established that there were a number of evaluation criteria and subcriteria, which were ground over in some detail by the evaluation teams and hence subsequently the evaluation committee, the steering committee, I guess—I can be fairly certain—made its own assessment that the process had been followed according to that process which had been advised to tenderers in terms of what was important and what criteria and subcriteria would be used. They formed a judgment then on the basis of, in a sense, the policy direction of the outsourcing initiative, which was to derive savings among other things and determined that a particular one—and in our case, IBMGSA—met most closely those various considerations that I had outlined.

Senator LUNDY—You mentioned before that the original evaluation report identified a ranking as far as the financials went.

Mr Moran—Yes.

Senator LUNDY—And the evaluation committee supplied all of that to the steering committee. Did the steering committee select at that point the tenderer that had the lowest price?

Mr Moran—Yes. I will take on notice and correct that if I am wrong, but I can perhaps, without having to do that, confirm that now. Yes. I am sorry, I should not have had to confirm that at all. For the group as a whole, yes. I am sort of opening up the question beyond the Department of Health and Aged Care now to the group. Yes, IBMGSA was the lowest price at that point.

Senator LUNDY—And in terms of the steering committee's recommendation, was that the recommendation put up to the options committee?

Mr Moran—Yes.

Senator LUNDY—Given we are talking about a multiagency exercise here, in terms of the department of health and community care, at any stage were you excluded from any of the stages that you have described? I have not worded that very well. As an individual department, were there any stages in this process that you were not able to participate fully in or were excluded from?

Mr Moran—There was no stage that I was aware of from which we were excluded.

Senator LUNDY—Right.

Mr Moran—We were, I suppose it is fair to say, a fairly vigorous and vocal participant. It is possible that there were stages that I do not know about that we were involved in, but I think that unlikely.

Senator LUNDY—With reference now to the options committee—and Mr Podger might be able to refresh my memory—you were a member of the options committee?

Mr Podger—That is correct.

Senator LUNDY—And other heads of departments, or other heads of agencies?

Mr Podger—I actually think that it was slightly unusual in our case that the head of the department was on the options committee. I think we were the first case where somebody from within the cluster itself was on the options committee. It was an issue that we pressed very hard on.

Senator LUNDY—And on my understanding of that options committee structure, you mentioned that it involved, I think, OASITO, Shaw Pitman—

Mr Podger—I would have to go back and check whether some of those people, like Shaw Pitman, were actually a member of the committee or they were privy to the process and able to give advice. I suspect that it is probably the latter rather than the former, but I would have to check.

Senator LUNDY—As with Blake Dawson Waldron?

Mr Podger—Yes. I would have to check with just exactly what that role was. They were certainly fully involved but I suspect that they were not formally a member of the committee.

Senator LUNDY—If you could take that on notice to provide precisely the structure of the options committee, that would be terrific, including anyone who may not have been a formal part of the committee but was privy to the committee's considerations. In terms of the options committee's participating members, were members of the private sector involved in that?

Mr Podger—Not that I recall. But again I would have to check that out. I do not recall any external person or that sort of thing being involved. There might have been a consultant to OASITO involved in the process. I am going to have to check that aspect, as I said, of it. But essentially it was OASITO and myself and DITAC. Because the basic role of the options committee was to draw together the material from the committees that Mr Moran has talked about and the work done on the industry side, which was coordinated through the industry department.

Senator LUNDY—So up to that point, you mentioned you were the first agency head to participate on an options committee. So I guess I can draw from that the conclusion that up to that point—up to the health group contract—heads of departments from other agencies had not been involved in that final consideration?

Mr Podger—That is my understanding, yes.

Senator LUNDY—That is certainly the finding that reflects the recommendations and the subsequent Humphry review.

Mr Podger—I think there are a number of things in our particular cluster which in fact followed the sorts of things that Mr Humphry picked up, that we were able to get in place in our own situation. The fact that we had a cluster, which was the health cluster, meant that we could concentrate on our business interests.

Senator LUNDY—You had some synergy with the other departments and agencies, in other words?

Mr Podger—There was a lot of synergy between the players in our cluster and we were able, therefore, to ensure that the process took a great deal of account of our business interests.

Senator LUNDY—With respect to the options committee's consideration of the industry development matters, I presume at that point you were in a position to consider the industry development submissions from each of the short-listed tenderers, or was it just for the IBMGSA, the one the steering committee had recommended to the options committee?

Mr Podger—I had access to an overview report. I did not have access to the detailed material from the tenderers on that.

Senator LUNDY—But from the three short-listed tenderers? Were there three short-listed or two?

Mr Podger—Three. There was an assessment done. As I say, it was coordinated by the industry department.

Senator LUNDY—Was it industry or DITAC?

Mr Podger—It is the communications—

Senator LUNDY—Yes, Senator Alston's department.

Mr Podger—That industry department, if you want to put it that way.

Senator LUNDY—I know exactly what you mean.

Mr Podger—I had access to a summary reported from that. My key interest was to satisfy myself that the process we had been involved in would not be dramatically turned over by a report around the industry one unless there was very good reason for doing so. As it turned out, that report suggested that there was no reason to overturn the recommendations coming out of the other process that we had been intimately involved in.

Senator LUNDY—But you did not actually see the detail, you just saw the summary?

Mr Podger—I had not seen the detailed bid put in by each of the tenderers, no.

Senator LUNDY—Would you have been able to, if you had asked?

Mr Podger—I might have been able to if I asked. I do not know, but I did not test that. I just used the summary report. As I said, my main concern was that, if that process had raised questions about the recommendations from all the processes we had been through, I would wish to have gone into a lot more detail to find out why and whether it was a matter of concern, and whether I felt the balance around that was reasonable. But that did not arise in that process.

Senator LUNDY—Did you have as an agency head on this options committee the right of veto in that process of offsetting the industry development aspects against it?

Mr Podger—No, I did not have a right of veto. But clearly I had a chance, because I was actually on the options committee, that should the industry report have suggested a different final tenderer I would have been able to pursue that in some detail as to why and what the trade-offs were. I would not have had a final veto on it, but my views would have been passed on to the minister and so on.

Senator LUNDY—You would have had a fight on your hands, in other words?

Mr Podger—I would have had a fight on my hands. But my views would then have been passed on to the ministers before the final decision. By being on the options committee I had the capacity to ensure that the department was able to give a view to ministers on the overall picture, not only on part of the picture.

Senator LUNDY—I have a general question: how were you advised by your minister, the minister for finance, or the Prime Minister about what your role was, what OASITO's and the other agencies' and departments' roles were as part of this process? Were you provided with some sort of brief so you knew what your rights were as an agency in the scheme of things?

Mr Podger—I do not think it was provided in quite that way. OASITO's role was always set out and there were cabinet decisions and so on setting out what the responsibilities were. I think it is fair to say that in our cluster we took active interest in this from the beginning to pursue our business interests.

Senator LUNDY—I guess what I am asking for is whether there is any documentation you are able to provide the committee that specified your role and OASITO's role in this whole evaluation process? I ask the question in the context that discussion in other committee forums has traversed this issue of precisely what OASITO's role was in driving this policy forward and how much it was in fact governed by the agencies and departments by virtue of their own minister's directions to proceed with outsourcing.

Mr Podger—OASITO was given a responsibility by the government for whole-of-government objectives. That went through a cabinet process. There was correspondence from the Prime Minister clarifying that process. At all times we abided by that. But within those processes we took a lot of steps to pursue our business interests and make sure that those were entirely looked after within the context of the whole-of-government objectives. This started from right back, as I recall, in 1997 with discussions I had with the then head of OASITO about the structure of our cluster. I reached agreement then with him that the cluster would be a health cluster. I think that was made easier by the fact that the HIC and the department together represented a pretty large-scale exercise which met the whole-of-government objectives of having large-scale groups put together. But OASITO at that time accepted that this cluster could meet its objectives while addressing ours.

Senator LUNDY—The Prime Minister wrote a letter in December 1998 to all ministers, as I understand it—I am not sure if he actually wrote to departments as well—advising of, I guess, an upgrade in the test for IT outsourcing in that he specified there had to be a whole-of-government reason not to. Did you, firstly, as an agency head receive any correspondence either from the Prime Minister or your own minister that specified the terms upon which you should continue embarking down the outsourcing path?

Mr Podger—As I recall—and if I may I will reflect on these answers afterwards to see if there is anything else I need to add to this—yes, we got that letter from the Prime Minister to

our minister, who passed it on to us. I think there might have been a supplementary letter at departmental level also at that time.

Senator LUNDY—Sorry, from Minister Fahey or from the department of finance?

Mr Podger—I suspect it was from OASITO, but I would have to check that. I have to say that we were reasonably well progressed on ours and we did not find that that particular letter changed our course particularly.

Senator LUNDY—If you could take on notice the provision of that correspondence and also tell me if there were any changes to your process that were initiated by the receipt of that letter.

Mr Moran—It is my recollection that the letter was more of a reaffirmation rather than a change in policy or change in direction. Perhaps we should take on notice if in fact we changed things.

Senator LUNDY—Yes. Thank you.

Mr Podger—I think the letter was primarily to do with making clear to those who were a little bit behind the process that they needed to hurry up and that the thing was very firmly coming from the Prime Minister. But in our case I think we were reasonably on track at that point.

Senator LUNDY—Could you also provide the committee with any information you received from OASITO, the Department of Finance, the Prime Minister or another minister relating to roles and responsibilities for both agencies and OASITO as part of the IT outsourcing initiative?

Mr Podger—I will take that on board. There were issues around the margins all the time. Let me give an example on that for the HIC. The HIC board took this process extremely seriously in terms of its own responsibilities under the CAC Act to ensure that the process met its business objectives, and there were some communications from time to time around that process as well. I am assuming that your question is essentially about the overall process and roles rather than issues of detail from time to time that we would naturally pursue.

Senator LUNDY—If you sought clarification at any point in time because of the CAC Act or FMA or anything else, I would appreciate that correspondence and responses as well. I am trying to get an insight, as I explained before, into just what the roles and responsibilities were of both OASITO and yourselves as a participant in the health group.

Mr Podger—I will take that on notice and check the various communications on that. I think some aspects of these also led to some advice we provided to ministers on aspects to do with the responsibilities of the HIC under the CAC Act. I am not quite sure about the appropriateness of release of all of that documentation. I guess all I am trying to say is that I think in our cluster we were able to use those various levers to ensure our business interests dominated.

Senator LUNDY—Mr Podger, I am sure you are aware of the basis upon which you cannot provide the committee any information, so I ask you to provide whatever you have got, and if you choose not to provide something, to provide an appropriate explanation on what grounds.

Mr Podger—Yes, certainly. I do understand that.

Senator LUNDY—Thank you. At any time of the tender evaluation processes did the cluster or the health group make a recommendation on a particular course of action on a

particular tender which did not conform with OASITO's views, as opposed to the overall committee?

Mr Moran—About 100 times, to my recollection, but it was largely at the tactical level about how something should be adjusted financially, how a particular aspect of a negotiation ought to be conducted or whether something was particularly important to ourselves and the HIC and not to OASITO. There was, as I suggested earlier, vigorous disagreement right throughout the process about a range of things, but having been involved in these sorts of things primarily in the Department of Defence, that is not unusual. The idea is to put a group of largely like-minded people together and attempt to get the result that is within the framework we are working in. But I do not recall any fundamental split between the agencies wishing to go one way in the final analysis—not during the evaluation—and OASITO going another way. Certainly my recollection is that the technical team in particular, as you might expect from technical teams, had quite vigorous disagreements about elements of each of bids—saying, 'This is much better obviously', and so on—but I do not recall a fundamental split between the agencies or even, indeed, between the agencies once all that evaluation and analysis had been done.

Senator LUNDY—Thank you for that. I would like now to just refer to some responses to questions on notice that you provided to the committee. I think it goes towards this issue. I asked for a description of the changes that did occur to the specification for the contract. There is a list of changes that occurred. Were the changes referred to in that question part of the negotiations and toing and froing at the steering committee level?

Mr Moran—As I recall in respect of the department of health, we answered a question on notice to the effect that the only material change to what we went to contract with, compared with what we went to the market with, was the removal of voice management from the Department of Health and Aged Care's requirements. The reason was that, having evaluated the bids from each of the three bidders, we were able to maintain our then current arrangements more cheaply. It is also the case that we withdrew—I guess I would hide behind the issue of material change—IT training for the same reason, but it was a very small element of the overall bid. I mean, it was a fraction of the prices we were talking about. I am speaking now for the Department of Health and Aged Care. I am not able to recall what may or may not have happened in respect of the other agencies.

Senator LUNDY—The answer to the question on notice relates to another agency, HIC, within the health group. Perhaps, Mr Podger, you are in the best position to answer this, although, Mr Moran, were you on the evaluation committee?

Mr Moran—Yes.

Senator LUNDY—You might be able to help me out here.

Mr Podger—We have the Health Insurance Commission present as well.

Senator LUNDY—That would be useful, because I am just looking at the response to questions. The answer reads, 'The substantive changes to the specification were as follows'. It has quite a long list of changes to, I guess, the specification that resulted ultimately as forming part of the health contract. I wanted to discuss a couple of them specifically. Could we have some officers from the HIC at the table? Do you know the answer to the question on notice I am referring to? I will read it out, just in case it is helpful. I asked:

You said there were no substantial changes to specification to the outsourcing contract with IBMGSA. Can you describe perhaps the changes that did occur?

So you were asserting there were no major ones, but in the answer to that question you state:

The substantive changes to the specification were as follows:

1. The lease of the data centre was removed as a condition precedent to the contract.

2. The notion of compensation for the removal from the services of a major segment of HIC's business was introduced.

It goes on. Do you recall what I am talking about now?

Dr Harmer—Yes, I do. I remember that. I remember giving the answer and then going back, as I indicated I would need to, to check with my people. There was some debate within the Health Insurance Commission about whether some of those changes were actually substantial or not. It was felt that some of them were, so we listed them like that. There were changes that we had all agreed to. There were issues that came up as we went through the contract—obviously it took some time—so we were reassessing our needs, and most of those changes reflected decisions that we in the organisation had taken and negotiated with OASITO to leave out of the contract.

Senator LUNDY—So these changes were largely ones that you pursued in that environment?

Dr Harmer—Yes, correct.

Senator LUNDY—Were all of the agencies in a position to pursue specific changes relevant to their agency?

Dr Harmer—I believe so. I suspect the primary difference is our internal definition of what was substantial. It is a moot point.

Senator LUNDY—Sure. The answer to the question on notice concludes:

In addition there were a number of changes of a non-substantive nature.

So I presume there were more changes after that, too.

Dr Harmer—It was an operational definition for the Health Insurance Commission about what was substantial and what was not.

Senator LUNDY—Yes. I should not qualify any questions I ask and not even use words like 'substantial'. That is the lesson I have learnt out of this. Next time I will ask: what were the changes? I seek clarification of a couple of points. Referring directly to that answer to a question on notice, point 2 states:

The notion of compensation for the removal from services of a major segment of HIC's business was introduced.

Can you give an example of what a major segment might be?

Dr Harmer—I cannot. Could I take that on notice to give you an example of that, please?

Senator LUNDY—Sure. I have to say that I am interpreting that as being if for some reason there was a diminution in the requirements by the outsourcer they would be compensated in some way?

Dr Harmer—Yes. I am fairly sure that is the case, but I would like to be doubly certain.

Senator LUNDY—And then if you could tell me whether that is something that you advocated for or whether that was something that OASITO was advocating?

Dr Harmer—As Mr Podger said, my board, as a board of a CAC Act body, took extremely seriously our responsibilities. So we might, as Mr Moran has suggested, have quite

a stoush with OASITO from time to time over these things. But in the end, if we had agreed to it, then we agreed.

Senator LUNDY—Yes. So you might have lost one there?

Dr Harmer—We would have perhaps negotiated on some of these as well.

Senator LUNDY—Another point further down the page states:

An independent event report was introduced which allows the HIC to withhold 20 per cent of invoice charges pending adequate clarification of any issues that resulted in a degradation of performance where service levels have not been met.

My question, which does not seek clarification, is: has there ever been an independent event report and have you ever had cause to withhold up to 20 per cent of invoice charges?

Dr Harmer—The answer to that question is: yes, there has been and, yes, that was the reason for the withholding that I mentioned last time.

Senator LUNDY—So it is relating to service credits and the treatment of service credits?

Dr Harmer—Yes, and performance against that.

Senator LUNDY—Thank you. The next point states, in relation to end to end reporting:

The RFT required that 95 per cent of entries have a three-second response time for Medicare officers to the mainframe and back. This requirement was removed as it would have required IBMGSA to provide data telecommunications carriage at an additional cost to the HIC of $3.1 million per annum. This is because IBMGSA is not entitled to the offers of government on-line discounts available to the HIC. As the HIC did not have guaranteed service levels prior to the RFT, the additional cost was not determined to be cost-effective.

That is reasonably self-explanatory as well. Obviously, it relates to the removal of—let me clarify this—the telecommunication aspect of the HIC?

Dr Harmer—Yes, voice.

Senator LUNDY—Yes, voice was out. This related to voice? Or are we talking about something similar?

Dr Harmer—We would need to check that, but I think it relates to data transfer.

Senator LUNDY—But the implication here is that that would have required telecommunications carriage and hence what was actually removed from the tender with regard to the voice requirement, or is this completely separate to the voice requirement?

Dr Harmer—No, I think it is separate. I am almost certain it is separate.

Senator LUNDY—That is an important point of clarification. My question is: for a reduced cost of $3.1 million you agreed to degrade services on the basis that you had not previously specified levels prior to the RFT?

Dr Harmer—That is correct. I will correct this if I have this wrong. I am told that is correct.

Senator LUNDY—In terms of identifying that three-second response time from Medicare officers to the mainframe and back, had it not been outsourced, that is, had the department maintained their eligibility for the government online discounts, would that saving have been achieved?

Dr Harmer—I do not believe we were meeting that service level fully in advance of IT outsourcing. So it would have cost us some money to get that additional security response time.

Senator LUNDY—The implication of this answer is that, had you wanted that response time, you would have got it at a cheaper price had it not been outsourced, because you would have been able to access the government discount.

Dr Harmer—Can I take that on notice? I suspect that is possibly true, but I would like to take that on notice.

Senator LUNDY—Could you also take on notice what was the saving to government if it remained in-house for that particular service level, that three-second response time service level? Finally, just the second last point—and I will read it for the benefit of the committee:

Call pick up times were extended to include an Interactive Voice Recognition (IVR) system. The RFT—

the request for tender—

stated that calls were to be picked up by a help desk operator—

presumably that means a person—

within 30 seconds. IBM-GSA requested that an IVR be used at the 15 second mark and at an additional 30 seconds from the IVR—

that is the interactive voice recognition—

to pick up by a help desk operator. The impact was to add 15 seconds to the maximum time allowable before a help desk operator was to answer the call, but to introduce a message within 15 seconds to the caller.

Does that mean that people have to wait 15 seconds longer before a real person answers the phone?

Dr Harmer—I believe the answer is 'not always', but I would like to again take that on notice.

Senator LUNDY—But that is the service level that you have deemed for the purposes of the contract?

Dr Harmer—Yes, and the HIC call response time is pretty good—it has always been—and I think it benchmarked probably better than most comparable organisations of our size for the complexity. But I will take that on notice. We did not see that as a major issue detracting from our service. I think in most cases the pick-up was very close to immediate.

Senator LUNDY—Can you tell me what, if any, trade-off there was in terms of costs or the ability to make perhaps greater savings as a result of making that difference or responding to that request from IBM-GSA to make that change?

Dr Harmer—I will take that on notice.

Senator LUNDY—I will just follow a point on that same sheet. The third point says:

Benchmarking provisions were changed to allow for the release of information to other agencies and parliament. The HIC agreed to pay the costs of any benchmarking for the purposes of retaining control over the process.

Can you explain that? I did not quite understand it.

Dr Harmer—I am told that we elected to pay in the event of benchmarking because we wanted to control who was doing the benchmarking.

Senator LUNDY—Sorry, who was doing it?

Dr Harmer—We wanted to select the agency or organisation that would do benchmarking. So we agreed that that control was worth paying for.

Senator LUNDY—So who was your competing benchmarker? Who else was going to do it that made it worth while paying to keep control of?

Dr Harmer—I think the issue was whether the organisation would be able to select the benchmark as opposed to it being selected by OASITO.

Senator LUNDY—Really?

Dr Harmer—Or by the vendor.

Senator LUNDY—Why would the vendor be involved in benchmarking? Wasn't that done during the evaluation process?

Dr Harmer—This is ongoing benchmarking.

Senator LUNDY—I see. So through the operation—

Dr Harmer—We will want to do benchmarking as we go along. As the agency letting the contract, we want to be able to control and select who is doing the benchmarking, even if it means we do not share the benchmarking costs with the vendor. That is the issue.

Senator LUNDY—I am astounded because I would have presumed that to be the case. You are suggesting that perhaps in other contracts it is the position—at least the starting position—of OASITO to allow that to be outsourced as well.

Dr Harmer—I do not know the answer to that.

Senator LUNDY—I will try to ask OASITO. How much did you have to pay for that privilege of benchmarking your own service levels?

Dr Harmer—We have not done any yet, so it is not an issue.

Senator LUNDY—But it will be.

Dr Harmer—It will be an issue, yes.

Senator LUNDY—At what point will it be an issue for you?

Dr Harmer—Sometime after the end of the first 12 months of operations, which will be coming up at the end of March.

Senator LUNDY—I have to say I am very relieved to know that you actually have some control of the process of benchmarking and evaluating the process of your contracts. I find that somewhat reassuring. I would like to turn now to a response to a question on notice that I presume does relate to the Department of Health and Aged Care. Their answer was in respect of savings by the department. In the last point in response to that question you say:

Health's experience in the last 12 months of the contract is that the contract management costs are considerably higher than the DOFA estimate. If these costs were not able to be materially reduced, there will be no direct savings to Health and Aged Care.

Can you elaborate on that, because certainly the answer does mention competitive neutrality considerations. I guess I am looking, Mr Podger, for an explanation as to what those competitive neutrality considerations are and what your current assessment is of realising any saving whatsoever.

Mr Podger—The answer starts off talking about competitive neutrality elements, but your question was about direct savings. That is why we went through and clarified in the process—

Senator LUNDY—I am trying not to take it out of context. That is why I am giving you the opportunity to explain.

Mr Podger—In relation to the final point about saying that these costs are not able to be materially reduced, there will be no direct savings to health and aged care. There would still be savings in terms of the competitive neutrality issues which do not accrue to the department. They accrue to government, but not to the department.

Senator LUNDY—Certainly.

Mr Podger—But as you can see in the department's case in this arrangement, the direct savings are very small. Three and a half million over five years was the estimate coming out of the evaluation process, but that was on the assumption that Finance had made of the estimates of our management costs, and our contract management costs at this stage would be higher than—that interprets them as being somewhere around $700,000 a year. We would be higher than that.

Senator LUNDY—So you would be in the red?

Mr Podger—The Health estimate of the contract management costs is more like $8.9 million. That was the sort of figure we were dealing with. Finance's view was that we ought to be able to get it down to about $3.7 million but, as you can see, that difference is more than $3.5 million over five years. This is an issue we are still looking at, and indeed we are now going through an output pricing review with the department of finance, and they are asking us in this area to benchmark ourselves with other people who have outsourced IT, such as the insurance industry and so on, and we will go through that process. But I hasten to say that we are naturally taking a somewhat cautious view, because a minor saving in this part of administrative costs could have a big cost to us in terms of business outcomes for the rest of it. So we are being very careful about this, I have to say.

Senator LUNDY—Thank you. To go a step further—you just stated that the competitive neutrality considerations were not a direct benefit to the department; that they were a benefit to the government: can you put a finer point on that and explain precisely what you mean by that to me, please?

Mr Podger—The competitive neutrality issues are essentially to do with the fact that, because of IT outsourcing and dealing with private companies, there are taxation issues associated with the operation of private companies. That is the dominant issue in the competitive neutrality, which would not occur when you have an in-house arrangement.

Senator LUNDY—So we are talking about GST and payroll tax.

Mr Podger—And company tax.

Senator LUNDY—And company tax. Just let me get this crystal clear. Out of the $16.75 million savings that were identified originally by DOFA as your proportion of the $54 million savings of the health group, excluding taxation realised as a result of outsourcing, including GST, payroll tax and company tax, the balance was $3.51 million.

Mr Podger—That is right.

Senator LUNDY—Right. But in addition to that, you have estimated your contract management costs as being $8.9 million.

Mr Podger—That was the estimate we had a while back. We are still obviously looking at what our ongoing costs will be, and that is an issue we have not yet settled.

Senator LUNDY—Right.

Mr Podger—But at the sort of level of costs we have currently, the estimate we gave to Finance some time ago would still prevail, that is, about $8.9 million over the five years.

Senator LUNDY—And you said Finance had given the figure of about $3.7 million.

Mr Podger—Finance's view was—on their assumption of what the benchmark ought to be, what an overhead cost of contract management should be—three per cent of the value of the contract.

Senator LUNDY—Right. So even on the best-case scenario, after everything that you have described, based on Finance's own estimations of what the contract management should cost, the impact on the department is that you are still effectively $200,000 in the red in terms of your own operational budget. I think I am stating the bleeding obvious, actually.

Mr Podger—I think you are adding a few things that you did not mention before that are elsewhere. In terms of the arrangements that Finance made for the department, that is broadly correct.

Senator LUNDY—It is a long way from the implication in the ministerial statement—perhaps this is one for you, Minister—of $16.75 million.

Mr Podger—The competitive neutrality savings are real. I cannot measure exactly what has actually been achieved in that area. But for the department's part of this arrangement, the minister's statement said that the major savings would be in respect of the competitive neutrality area, and that still is true. Nothing has changed on that.

Senator LUNDY—I am not suggesting it has changed. I am just clarifying where the savings are found.

Mr Podger—But there has been nothing wrong in what the minister for finance said on that. The issue that has been raised is the direct savings to the department, leaving aside the competitive tendering. As we have said in our answer to you, on the basis of our current costs of contract management, there are no direct savings. If that does come down to the sorts of order on the benchmarking financiers, there will be some very small savings directly to the department.

Senator LUNDY—Just generally, the independent review by Richard Humphry into the IT outsourcing initiative came up with a series of recommendations, several of which are directly relevant to both the health group and the Department of Health and Aged Care, particularly about future plans, if you like, post the culmination of this five-year contract in which you are currently engaged. I was wondering if you could respond generally to the recommendations in the Humphry report that are relevant to health, and I guess any observations you have about the impact on your IT outsourcing contract.

Mr Moran—It was our view generally—and you have asked for a general response; I may have to do more—that the great thrust or the major thrust of the Humphry report was in fact about transition and implementation. As we had already—and I would claim successfully—transitioned and implemented, most of the recommendations were not relevant to us. The specific question you ask about what might happen at or towards the end of this particular arrangement—and I guess, by implication, would we seek to separate ourselves from the Health Insurance Commission—frankly, I just think it is too early to say. There is certainly no

agenda that I am aware of to do so. There are definite, albeit slightly intangible, benefits—that is at this early stage; I suspect more to come—in having the same outsourcer. But that would be my general response to the question that you ask.

Mr Podger—In terms of the Humphry report, I think it is fair to say that he has drawn very heavily on some of the material we used for our transition arrangements. For example, his advice to people around risk assessment and so on draws almost directly from our own documentation. So not surprisingly, we feel reasonably comfortable with the Humphry report.

Senator LUNDY—The recommendation that we are referring to, about what happens at the end of the contract, basically implies that if there is no business case, there should not be continued outsourcing in the way that it is currently structured, either in the group or as an agency or department. It really opens the door to those sorts of options. My question goes to an issue that was raised in the Auditor-General's report about the treatment of assets and how that affected the various evaluations and savings estimates. Can you tell me, at the conclusion of your existing contract, what the status of the IT assets will be?

Mr Moran—I think we had this conversation a while ago. In the case of the Department of Health and Aged Care, the lease that we have entered into with IBM-GSA and therefore IBM global finance is in fact an operating lease, not a finance lease, and we have the sole option of determining at the end of the contract whether we wish to keep the assets and treat them for accounting purposes in a particular way, or whether we in fact do not want to keep the assets and treat them therefore in a different way, and that is at our sole discretion.

Senator LUNDY—Right. So again just to clarify: in that regard, the financial methodology used to make those assessments at least by OASITO differs from that with respect to the leases used for cluster 3, 5 and tax.

Mr Moran—I cannot comment on that. I was not privy to that evaluation—the other evaluation, I am talking about.

Senator LUNDY—Could you take it on notice, because the differences between the two types—the operating lease and the finance lease—are documented and reported upon quite comprehensively in the Audit Office report.

Mr Podger—Our understanding is that the Auditor-General's report raising questions about this did not raise issues of particular pertinence to us in our cluster.

Senator LUNDY—No, it certainly did not raise any questions in relation to the health group, which is why I am asking: if the Audit Office did make that assessment in the way that they compared the different financial methodologies prepared by OASITO on the other groups and clusters, where would you sit? Are you like the rest of them or are you different? Do you see what I mean?

Mr Podger—The point I was making is that I think we are different in that we have an operating lease. I believe it has been accepted by all the accounting people that we have an operating lease. There was a debate about that in respect of some other clusters, and we have a ruling from ANAO to that effect.

Senator LUNDY—Could you provide that to the committee?

Mr Podger—Certainly.

Senator LUNDY—Thank you.

Mr Podger—You asked a question about the freedom we have at the end of this process to go separately from the rest of the cluster and so on. As a matter of speculation, we will

certainly look at it at the time. I think we would expect Medibank Private to go their own way. We would see no particular advantage to them remaining within the process, but there will be considerable arguments in favour of retaining the arrangements with the HIC. There may be arguments to go separate as well, but there would be considerable arguments in favour of us retaining a common outsourcer, given the sorts of developments happening in the health information area.

Senator LUNDY—Are you able to give an indication to the committee about the degree to which your department feels captured by the outsourcing process, or do you feel that you have a capability as a department at the end of this contract to walk away without any disadvantage?

Mr Podger—I think it is fair to say that we do not feel 'captured', to use your word, by this. There will be issues at the end of the contract process about new competitive processes and the risks associated with any such processes. I think it is fair to say that our view was that IT outsourcing could serve the department and the HIC benefits. For example, as a member of the HIC board, the HIC board got some independent assessment of best practice around the world around IT outsourcing, the scope of IT outsourcing, and was comforted that the scope of this particular IT outsourcing was generally in line. There were suggestions about different ways we might have done it but we felt comfort that we had the scope of it right.

Senator LUNDY—You mentioned before that IT training was pulled out and the voice stuff as well. Can you take this on notice and provide the committee with details about how IT training is currently managed and how that would have compared if it had been included in the tender—just more information generally about that decision?

Mr Moran—In summary, IT training in the Department of Health is delivered in the same way as it was before. We did put it into the tender. We found that the bids were not competitive and basically it has gone back to the way it was, but we can summarise that.

Senator LUNDY—Thank you. Has the contract been varied in a way that has resulted in greater expenditure by the department on information technology?

Mr Moran—No. Inevitably in a services agreement of this size there are contract variations, but there have been no variations to the contract that have led to overall unit price increases.

Senator LUNDY—Can you provide the committee with a copy of your contract with IBMGSA?

Mr Moran—Yes. I understand that we have provided that document to another committee under certain conditions. I will need to consult, I suppose, with the legal people in the department and also possibly that other committee.

Senator LUNDY—If that is the case, then you do not have to provide it here. I am just covering my bases.

Mr Podger—We have responded to OASITO, who was asked by that other committee, and we have provided material through that process.

Senator LUNDY—Then I will ask you to take the question on notice because there is some difficulty with OASITO in getting information. I also ask you, on notice, to provide to this committee the evaluation report as prepared by both the evaluation committee and the steering committee and also any final analysis or evaluation report as prepared by the options committee.

I have one final question relating to what could be described as the legacy systems or the underlying information technology architecture within your department and also the Health Insurance Commission. To what degree or what proportion of the costs associated with your IT outsourcing contract with IBMGSA goes towards maintaining your existing legacy systems within your information technology architecture?

Mr Moran—For the Department of Health, that is not how the actual services agreement is constructed. It is about the provision of certain platforms and bits within the platform by volume by unit rate. Forgive my non-technical answer, but I think it might be possible—

Senator LUNDY—Forgive my non-technical question.

Mr Moran—to disaggregate—

Senator Vanstone—The rest of us will just excuse ourselves.

Senator LUNDY—It is all right. It is nearly 11 o'clock.

Mr Moran—It may be possible to answer your question with reference to the services agreement and that part of it that we are paying to IBM which supports legacy systems. It might not, I guess, is the best I can say.

Senator LUNDY—Can you give me a general idea of to what degree the contract addresses the issue of sustaining the legacy systems as opposed to any policies or plans there may be to upgrade some of that underlying architecture?

Mr Moran—The contract is not directed at any particular set of systems that it would maintain. IBM has extensive obligations to us to support applications and therefore systems and applications development and maintenance. They also have extensive obligations in other parts of the services agreement to work with us and to point to other ways and better ways of doing business. So there is no sense that we or they are locked into an arrangement which maintains older or legacy systems. In fact, the intent of various parts of the agreement is to the contrary.

Senator LUNDY—Is that the same with respect to HIC?

Dr Harmer—We have contracted IBMGSA to run our operations, not maintain them. Most of the maintenance and upgrades—

Senator LUNDY—IBM did provide the mainframe prior to this contract being let. Is that not the case?

Dr Harmer—I will take that on notice, but IBM was a major supplier for the HIC's mainframe equipment, yes, and that is the equipment they are still operating.

Senator LUNDY—So just on that point, what proportion of the contract I guess either in percentage or even value terms is going to maintaining that existing mainframe system?

Dr Harmer—I do not want to give you a figure now, but I can give you that figure. I will take it in on notice.

Senator LUNDY—It really goes to the position of legacy systems in the context of these outsourcing contracts. Is there any provision in the contract to look at the upgrade of those legacy systems?

Mr Moran—In respect of applications or systems, that would be a business decision that the department, and I assume the Health Insurance Commission, would take. It would certainly seek advice from IBMGSA in terms of the right way to do that. In terms of operating software—underlying base software—there are obligations on IBM to us and I understand the

Health Insurance Commission to maintain software at certainly current or near to current levels as part of their contractual obligation to us, but that is a separate discussion to the actual applications which reside on that software.

CHAIR—It is now after 11 o'clock, so I propose to draw the hearing to a close. Do you have further questions that you would care to put on notice?

Senator LUNDY—I do, and I will have to prepare them for the committee. I will place them on notice.

CHAIR—Thank you. Thank you, Mr Podger and the officers.

Mr Podger—Are we focusing only on outcome 3?

CHAIR—Yes, that is right—only on aged care tomorrow. That is right, Senator Evans?

Senator CHRIS EVANS—About 12 hours worth.

CHAIR—I look forward to seeing you on the show at 9 o'clock in the morning. Thank you.

Committee adjourned at 11.02 p.m.