COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Consideration of Budget Estimates

WEDNESDAY, 5 JUNE 2002

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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Wednesday, 5 June 2002

Members: Senator Knowles *(Chair)*, Senator Allison *(Deputy Chair)*, Senators Bishop, Denman, Herron and Tchen

Senators in attendance: Senators Allison, Buckland, Calvert, Crowley, Denman, Eggleston, Evans, Faulkner, Harradine, Herron, Knowles, McLucas, Tchen and West

Committee met at 9.06 a.m.

HEALTH AND AGEING PORTFOLIO

In Attendance

Senator Patterson, Minister for Health and Ageing

Whole of Portfolio

Executive

Ms Jane Halton, Secretary
Dr Louise Morauta, Deputy Secretary
Ms Mary Murnane, Deputy Secretary
Prof Richard Smallwood, Chief Medical Officer

Corporate Services Division

Mr Alan Law, Chief Operating Officer
Ms Wynne Hannon, Head, Legal Services
Ms Stephanie Gunn, Assistant Secretary, Corporate Activities Review
Ms Shirley Browne, Acting Assistant Secretary, Public Affairs and Parliamentary and Access Branch
Mr Peter Moran, Assistant Secretary ,Contestability
Ms Alison Larkins, Assistant Secretary, Staff Support and Development
Mr Tony Judge, Director, Corporate Development
Mr Chris Rosario, Director, Corporate Development

Portfolio Strategy Division

Dr Robert Wooding, Chief Information Officer
Ms Virginia Hart, Assistant Secretary, Budget Branch
Mr Paul Fitzgerald, Assistant Secretary, Health Information Policy and Projects Branch

Outcome 1: Population Health and Safety

Population Health Division

Ms Judy Blazow, Acting First Assistant Secretary, Population Health Division
Ms Marion Dunlop, Assistant Secretary, Strategic Planning
Ms Sue Gordon, Director Drug Strategy and Health Promotion Branch
Ms Sue Kerr, Assistant Secretary, Drug Strategy and Health Promotion
Prof John Mathews, Medical Director
Ms Sarah Major, Director, Preventive Health Services and Food Policy
Mr Greg Sam, Assistant Secretary Communicable Disease and Health Promotion

Ms Rae Scott, Director, Drug Strategy and Health Protection
Dr Judy Straton, Medical Advisor, Strategic Planning
Ms Carolyn M.Smith, Director, Preventive Health Services and Food Policy
Mr Steve Lowes, Financial Management Unit
Mr Rod Schreiber, Financial Management Unit
Ms Leanne Wells, Director, Drug Strategy and Health Promotion
Ms Jacqui Worsley, Research and Marketing Unit
Ms Laurie Van Veen, Director, Social Marketing Unit

Therapeutic Goods Administration

Mr Terry Slater, National Manager, Therapeutic Goods Administration
Dr Leonie Hunt, Assistant Secretary, Director Drug Safety Evaluation
Dr Brian Priestly, Director TGA Laboratories
Dr Fiona Cumming, Director, Office Complementary Medicines
Dr Sue Meek, Deputy Secretary, Gene Technology Regulator
Dr Margaret Hartley, Director, National Industrial Chemicals Notification and Assessment Scheme
Ms Elizabeth Flynn, Assistant Secretary, Office of Gene Technology Regulator
Dr John McEwen, Principal Medical Advisor
Ms Rita Maclachlan, Assistant Secretary, Conformity Assessment Branch

Health Insurance Commission

Dr Jeff Harmer, Managing Director, Health Insurance Commission
Mr John Lee, General Manager, Finance and Planning Division
Mr James Kelaher, Deputy Managing Director
Mr Lou Nulley, General Manager, Business Improvement
Mr Geoff Leeper, Executive General Manager, Business Improvement
Dr Janet Mould, General Manager, Professional Review
Mr David Num, Information Technology Services
Ms Ellen Dunne, Program Management Division
Ms Lyn O'Connell, Information Technology Services Division
Dr Brian Richards, Information Strategy and Business Development Division
Mr Lou Andreatta, Program Management Division
Mr Graham Mynott, Program Management Division
Mr Paul Fenton-Menzies, Legal Counsel
Ms Jeni Warbuton, Corporate Security
Mr Doug Marshall, Senior Pathology Officer
Ms Gayle Ginnane, Chief Executive, Private Health Insurance Association Council

Australia New Zealand Food Authority

Dr Marion Healy, Office of the Chief Scientist
Ms Clare Pontin, Strategy and Operations
Mr Peter Liehne, Standards
Mr Greg Roche, Safety, Legal and Evaluation

Outcome 2: Access to Medicare
Health Access and Financing Division
Mr Charles Maskell-Knight, First Assistant Secretary, Health Access and Financing Division
Ms Jennifer Badham, Assistant Secretary, Better Medication Management System Implementation Taskforce
Dr John Primrose, Medical Officer, Pharmaceutical Access and Quality
Mr Terry Barnes, Assistant Secretary, Financing and Analysis Branch
Mr Allan Rennie, Assistant Secretary, Pharmaceutical Access and Quality
Mr Brett Lennon, Assistant Secretary, Pharmaceutical Benefits
Dr Jane Cook, Medical Advisor, Medicare Benefits Branch
Ms Jennifer Campain, Director, Diagnostics and Technology
Dr Bernie Towler, Diagnostics and Technology
Dr David Barton, Medical Officer, Diagnostics and Technology
Mr Ian McRae, Assistant Secretary, Medicare Benefits Branch
Mr David Reddy, Director, Medicare Benefits
Ms Sarah Byrne, Assistant Secretary, Medical Indemnity Tasforce
Health Insurance Commission
See Outcome 1
Outcome 3: Enhanced Quality of Life for Older Australians
Aged and Community Care Division
Dr David Graham, First Assistant Secretary, Aged and Community Care Division
Dr David Cullen, Assistant Secretary, Policy and Evaluation
Ms Jane Bailey, Director, Quality Outcomes
Mr Warwick Bruen, Assistant Secretary, Community Care Branch
Mr Marcus James, Assistant Secretary, Residential program management
Mr Mark Thomann, Assistant Secretary, Office for Older Australians
Mr Stephen Taylor, Assistant Secretary, Legal Section
Aged Care Standards and Accreditation Agency
Mr Gerald Overton, Acting General Manager
Ms Kristina Vesk, Communications Manager, Aged Care Standards and Accreditation Agency
Outcome 4: Quality Health Care
Health Services Division
Mr Andrew Stuart, First Assistant Secretary, Health Services Division
Mr Dermot Casey, Assistant Secretary, Mental Health and Special Programs Branch
Mr Peter Broadhead, Assistant Secretary, Acute and Coordinated Care Branch
Dr Rob Pegram, Senior Medical Officer, General Practices Strategic Development Unit
Mr Peter DeGraaff, Assistant Secretary, Blood and Organ Donation Taskforce
Ms Leonie Smith, Assistant Secretary, General Practice Branch
Mr Richard Eccles, Assistant Secretary , Office of Rural Health
Outcome 5: Rural Health Care
Health Services Division
See Outcome 4

Outcome 6: Hearing Services
Aged and Community Care (Office of Hearing Services)
Ms Jenny Hefford, National Manager, Office of Hearing Services
Outcome 7: Aboriginal and Torres Strait Islander Health
Aboriginal and Torres Strait Island Division
Ms Helen Evans, First Assistant Secretary, Aboriginal and Torres Strait Islander Health
Ms Yael Cass, Assistant Secretary, Workforce, Information and Policy
Ms Mary McDonald, Assistant Secretary, Program Planning and Development
Ms Margaret Norington, Assistant Secretary, Health and Community Strategies
Dr Trish Fagan, Medical Adviser, Aboriginal and Torres Strait Islander Health
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, Assistant Secretary, Private Health Industry Branch
Dr Vin McLoughlin, Assistant Secretary, Priorities and Quality Branch
Ms Christianna Cobbold, Assistant Secretary, Health Capacity Development Branch
Medibank Private
Mr Steve Boomert, Corporate Development
Mr Peter Young, Manager, Corporate Affairs
Health Insurance Commission
See Outcome 1
Private Health Insurance Ombudsman
Mr Norman Branson, Private Health Insurance Ombudsman
Private Health Insurance Administration Council
Ms Gayle Ginnane, Commissioner
Outcome 9: Health Investment
Portfolio Strategies Division
See Whole of Portfolio
Health Industry and Investment Division
See Outcome 8
Office of the National Health and Medical Research Council
Prof Alan Pettigrew, Chief Executive Office, NHMRC
Ms Suzanne Northcott, Assistant Secretary, Centre for Research Management
Dr Clive Morris, Assistant Secretary, Centre for Health Advice Policy and Ethics
Mr Michel Lok, Assistant Secretary, Executive Support Branch
Ms Cathy Clutton, Assistant Secretary, Centre

CHAIR—Good morning everyone. I declare open this public hearing of the Senate Community Affairs Legislation Committee considering the budget estimates of the portfolio of Health and Ageing. Before commencing the outcomes, senators have advised that they do not require the Australian Institute of Health and Welfare, the Australian Radiation Protection and Nuclear Safety Agency, the Private Health Insurance Administration Council and the Professional Services Review. As there are no other areas of the portfolio for which senators do not have questions, I welcome the minister, Senator the Hon. Kay Patterson, the

departmental secretary, Ms Jane Halton, and, naturally enough, all the officers from Health and Ageing. It is good to have you back on board.

I draw witnesses' attention to the resolutions agreed to by the Senate on 25 February 1988, *Procedures to be observed by Senate Committees for the protection of witnesses*, and, in particular, to resolution 1(10) which states in part:

(10) Where a witness objects to answering any question put to the witness on any ground, including the ground that the question is not relevant or that the answer may incriminate the witness, the witness shall be invited to state the ground upon which objection to answering the question is taken.

I also remind officers that an officer of a department of the Commonwealth shall not be asked to give opinions on the matter of policy and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. Witnesses are further reminded that the giving of evidence to a committee is protected by parliamentary privilege and the giving of false or misleading evidence to a committee may constitute a contempt of the Senate. Finally, could I ask witnesses to clearly identify themselves when first called to answer a question to assist the Hansard reporters and to also ensure that all mobile phones are turned either off or down.

The committee will be working from the portfolio budget statements, and I propose to call on the estimates in the following outcome order: outcome 1, then outcomes 5 to 9. Before the committee commences with outcome 1 on page 43, I suggest that the committee begin with any questions on the portfolio overview on pages 7 to 31.

Senator McLUCAS—First of all, could we go to the questions on notice and thank the department for providing those in a timely way. There was one that came through late last night, and I wonder if we could deal with that quickly. It was an amendment to the question. I do not think any of us have had time to read the response. It was about funding to the Australian Divisions of General Practice. Could we have an explanation of that?

Ms Halton—My understanding is that there was a typographical error in collating the relevant table and a part of it got left off. I could be wrong and the relevant officers are not here. That was the explanation that was given to me. They offered their apologies for a clerical error, and were concerned to make sure the clerical error was corrected and then provided you with the correct and complete answer. I have now been given a copy of the correspondence from the First Assistant Secretary Andrew Stuart and it says, as I have indicated, that the amount which has now been included was inadvertently omitted from our original response. That is consistent with the advice that was given to me by the officers that it was quite simply a collating error. So our apologies for that.

Senator McLUCAS—We might move then to Outcome 1, if that is in order.

Senator WEST—Which outcome is the funding for practice nurses going to be in?

Ms Halton—Two, we think. We will just confirm that.

[9.11 a.m.]

CHAIR—Outcome 1, Population health and safety.

Senator DENMAN—What has been the total allocation of money under the Tough on Drugs program?

Ms Kerr—The total allocation is now $625 million which includes all initiatives for our department and a variety of other departments as well.

Senator DENMAN—Could you give me a breakdown on how much goes to law enforcement, treatment, prevention and research?

Ms Kerr—The demand reduction initiatives which cover this department and other departments is $407 million and the supply control initiatives is $217 million which gets us to the $625 million.

Senator DENMAN—Do you have a breakdown of each of those three programs?

Ms Kerr—Yes, I do. The $407 million is broken up as follows: $368 million for Health and Ageing; $27 million for DEST; $11 million—these are in round figures—for Family and Children Services; a small amount, $0.68 million for DOFA for evaluation, and that all adds to the total I have mentioned.

Senator DENMAN—What is the total allocation to drug programs outside the Commonwealth allocation to other programs?

Ms Kerr—It is not possible to answer that.

Senator DENMAN—Why?

Ms Kerr—Other programs provide funding for drugs that cannot be readily identified. Within the Commonwealth, for instance, some programs will have an impact on drugs, but are not directly drugs programs. Some of the programs that might be, say, in the families area will not be directly attributable to drugs, but they will have an impact on people's behaviour. Similarly, with the state governments, it is not possible to very clearly articulate exactly how much governments are spending in this area.

Senator DENMAN—Some of this Commonwealth money is going to the states for them to reallocate. Is that part of this?

Ms Kerr—Yes. Certainly, under the public health outcome funding agreements, the money for drugs is included in that overarching funding.

Senator DENMAN—What proportion of the total allocations to drugs by the Commonwealth government—outside the Tough on Drugs program—has been allocated to law enforcement, treatment, prevention and research?

Ms Kerr—It would be difficult to answer that. Looking at the research question, for example, we fund national research centres that do research on drugs, so we could give you the allocation that we give to those research centres.

Senator DENMAN—Yes, please.

Ms Kerr—I will give you that separately. In addition, from time to time, we have one-off projects that are funded in the research area, so we could give an estimate of recent funding in that area.

Senator DENMAN—Thank you. Can you do that now or will you take that on notice?

Ms Kerr—I will take that on notice.

Senator DENMAN—Of the allocation to drug treatment, what proportion has gone to the abstinence based programs?

Ms Kerr—I do not have that at my fingertips. I would have to take that on notice.

Senator DENMAN—Do you have at your fingertips what proportion has gone to public health evidence based programs, such as the pharmacological treatment programs?

Ms Kerr—I would prefer to take that on notice; that is quite a detailed question.

Senator DENMAN—How much of the treatment money was given to the Salvation Army?

Ms Kerr—Again, I do not have that at my fingertips, but I could certainly give that to you.

Senator DENMAN—Thank you. How many Australians are estimated to currently depend on heroin?

Ms Kerr—I will come back to that, Senator, if that is all right. I will get that information, and I will provide it to you in a moment.

Senator DENMAN—Does the government agree with the assessment of the National Crime Authority in 2001 that 'only 12 per cent of imported heroin is successfully intercepted, with 85 per cent passing through undetected?'

Ms Kerr—I am not in a position to comment on that.

Senator DENMAN—Who would I ask that of?

Ms Kerr—That would be an issue for the Federal Police and the customs portfolio.

Senator DENMAN—Are you in a position to answer any questions on those people dependent on heroin? Are you getting that information now, because I have some other questions.

Ms Kerr—I am getting the figures for you now.

Senator DENMAN—I will come back to those. How much has been allocated since the Tough on Drugs program to design the measures to divert selected drug offenders from the criminal justice system to the drug treatment programs?

Ms Kerr—Something in the order of $115 million has been allocated under the diversion program that the government, in consultation with the state governments, has put in place,.

Senator DENMAN—How can diversion of selected drug offenders from the criminal justice system to the drug treatment programs be reconciled with being tough on drugs?

Ms Halton—Senator, maybe I can answer that. I think there has been a concerted effort over the last few years. The diversion initiative that Ms Kerr has just talked about has been part of a campaign of recognising that, if you intercept people early in their drug use and give them effective treatment, you have a reasonable prospect of influencing their behaviour.

That has always been regarded as being completely consistent with the policy of being tough on drugs, and if you take the example of the New South Wales Drug Court, if you do not comply with the orders that are given, the full penalty that would have applied in any event will apply to you. But what it is doing is providing a treatment option for those people. The diversion initiative, which Ms Kerr has talked about as being rolled out right across the country, is part of that package of responses to not only apply appropriate criminal sanctions to people, but also to offer them a treatment option, particularly early in their drug offending.

Senator DENMAN—Have you given any more thought to safe injecting rooms?

Ms Halton—The government's policy on safe injecting rooms is well known and it would also be well known to you that there is a trial in operation in New South Wales.

Senator HERRON—What percentage of heroin drug addicts are drug free five years after diversion or treatment?

Ms Halton—Given that diversion has actually only been operating for a short period, I do not think we are in a position—

Senator HERRON—For two years.

Ms Halton—to answer that. I think you will find that even two years is too short a period. The diversion initiative is actually relatively new, and that will be evaluated. In fact, there has been a detailed evaluation set up as part of that initiative. Ms Kerr can correct me if I am wrong, but I do not think we have two-year data yet from the diversion initiative.

Ms Kerr—No. An evaluation is being carried out now into the diversion initiative, and some information will be available later this year. The Department of Finance and Administration is conducting that evaluation. I am sorry, Senator, I am still waiting for those figures on the number of users.

Senator DENMAN—Does the government have any estimate of the number of deaths, HIV infections, Hepatitis C infections or crimes that have been prevented by abstinence treatments of heroin dependent persons since the commencement of the Tough on Drugs program?

Ms Kerr—We have not collected that data.

Senator DENMAN—That is the same response as to Senator Herron. Is it too soon?

Ms Kerr—Yes, it is too soon, but I am not sure we would collect that data in that detail.

Ms Halton—Can I go to the point that you have asked about on abstinence programs, in particular. It is important to understand that in the approach we have taken on funding this has been in place for some time. We have a range of treatments that are funded and, yes, abstinence programs form a part of that but there are a variety of other programs as well. We would have to have a look to see whether we separately dealt with the abstinence programs as against the full range of programs and their effectiveness. It is important to understand—and certainly people in the field have told me—that different programs work in different contexts. So we have funded a variety of programs in recognition of that.

Senator DENMAN—What amounts of money have been spent on the National Illicit Drug Strategy since 1996?

Ms Kerr—Do you mean by the federal government?

Senator DENMAN—Yes.

Ms Kerr—The majority of new funding on illicit drugs has come under the National Illicit Drug Strategy, Tough on Drugs, but in addition to that there are other projects that have been funded from core funding.

Senator DENMAN—What are the categories, or sub-programs, and amounts in these categories for each of those years up to date from 1996?

Ms Kerr—Would you mind repeating the question?

Senator DENMAN—Yes. What are the categories, or sub-programs and amounts in those categories for each of the years from 1996 to now?

Ms Kerr—I would have to give further consideration to that and take that on notice. I assume by that that you mean what would have been spent on, say, research for each of those years in addition to what has been spent on the National Illicit Drug Strategy?

Senator DENMAN—Yes.

Ms Kerr—We would have to look at each of the categories in turn, and look at the programs that have been funded and collate that for you. As I said earlier, however, we do fund three research centres that cover research into illicit and licit drugs. We would have to make some estimates of those figures. That information would not be immediately available.

Senator DENMAN—How much funding has been allocated to the ANCD?

Ms Kerr—I can check how much there has been since it began, but it is in the region of $875,000 a year. We are currently negotiating a new contract with the new auspicing body, so I cannot be exactly sure of the final amount for the coming year.

Senator DENMAN—Have you any idea how much has been paid each year to the chairman and the deputy chairman?

Ms Kerr—I would have to ask the Australian National Council on Drugs for that information. The payments that would have been made would cover their sitting fees and travelling costs.

Senator DENMAN—I was going to ask for the travelling costs next.

Ms Kerr—The department does not have that information. We would have to obtain that from the Australian National Council on Drugs.

Senator McLUCAS—Just continuing on substance abuse issues, I understand that about $16 million is annually provided to non-government organisations for drug treatment services. What does the department do to assess and evaluate those programs in terms of their effectiveness?

Ms Kerr—Each contract with each of the programs that are funded under the Non-Government Organisation Treatment Grants Program requires the grantee to report to the department on outcomes. So at that level there is reporting by the individual programs. Secondly, we are presently negotiating with some key stakeholders on the terms of an overarching evaluation of the whole program.

Senator CROWLEY—What do you find when the states send you a report? What kind of data do you have?

Ms Kerr—They send us information on throughput, the number of clients they are seeing, the sorts of reasons they are seeing them, and male/female and age data, so that we get a picture of what is going on in that service.

Senator CROWLEY—Have you got that data aggregated?

Ms Kerr—We have some aggregation of that, yes, and we can provide that to you.

Senator CROWLEY—Would you be able to do that?

Ms Kerr—Yes, Senator.

Senator McLUCAS—So essentially it is about visitation, rather than effectiveness. Is that what the outcomes are being reported on?

Ms Kerr—From the individual services we are getting factual information, but in many of them—not all—we are getting information on effectiveness as well. It is quite difficult for some services to be able to evaluate that. That is the reason why we will be doing an overarching evaluation of effectiveness of the whole program.

Senator McLUCAS—You talk about key stakeholders coming together to devise an evaluation process; can you tell me some more about that?

Ms Kerr—We have been negotiating with the Australian National Council on Drugs and the ADCA—the Alcohol and other Drugs Council of Australia—on what might be the appropriate approach for that evaluation.

Senator McLUCAS—Are you looking to the issue of effectiveness of the programs?

Ms Kerr—Yes, we would expect that we would be able to do that.

Senator McLUCAS—Have you devised any terms of reference for that evaluation strategy to this point?

Ms Kerr—We have done some drafts, but since the budget and the announcement of the additional funding for the Non-Government Organisations Treatment Grants Program, we have decided that it would be better to have another look at the drafts that we had devised to take account of the new grants that will be rolling out under the new funding that has come through the budget. So it gives us an opportunity to refine the approach we had in mind.

Senator McLUCAS—Would the committee be able to have a copy of those terms of reference when they have been developed?

Ms Kerr—Certainly.

Senator CROWLEY—How will you know if you have refined it?

Ms Kerr—What we are doing is taking the draft that we have and looking at whether that it is still what we want to do, given that we will have a little more time now to do the evaluation. We want to take into account the new services that will likely be funded under the new funding. We will know because we will be able to take account of the new funding.

Senator CROWLEY—Will you be able to tell this committee, for example, how many people are being assisted with treatment for drugs—'treatment' used here loosely—against the number of staff being paid to provide that? Could you do a cost benefit of that sort, for example?

Ms Kerr—We will certainly be able to do some estimate of that but, of course, staff numbers and client numbers are constantly changing in services. So it will not be an exact measurement, but we will be able to have a look at that issue.

Senator CROWLEY—The numbers are a concern for me, and I think for my colleagues here. I think it is the question Senator Denman asked before: do we know how many people are doing heroin? We know the numbers will change from month to month or year to year, but when you actually check March 2002, or whatever, what is the score around Australia of people doing heroin?

Ms Kerr—Do you mean in terms of our own services? Or do you mean, generally, how many users are there of heroin?

Senator CROWLEY—I suspect that you might have to have an estimate of both, or perhaps an estimate of the people out there and a measurement of how many people your services are seeing.

Ms Kerr—The household survey estimates that 0.2 per cent of people are using heroin—that is the survey that was recently published by the Institute of Health and Welfare.

Senator HERRON—Is that broken down into intravenous use or smoking heroin, do you know?

Ms Kerr—I do not think it is broken down but the Institute of Health and Welfare would be able to advise us on that. They have released top line results, but not a lot of detail at this stage.

Senator CROWLEY—Have you got a number of what the 0.2 per cent actually is?

Ms Kerr—It works out to about 37,000 to 38,000.

Senator CROWLEY—What is the number who are in services or are brushing against the services?

Ms Kerr—I will give you that in a moment.

Senator McLUCAS—Coming back to the review of effectiveness of funds to non-government organisations, what funding is there, and where is it coming from, to do the evaluation that you are talking about?

Ms Kerr—Funding will be provided for the evaluation. We expect at this stage that it will be from one of the line items for which we received funding under the National Illicit Drug Strategy, and that is the best practice and evaluation line item. The exact amount will depend on the terms of reference that are devised in consultation with the stakeholders I mentioned.

Senator McLUCAS—Do you have a time frame for developing the terms of reference and then for completing that piece of evaluation?

Ms Kerr—We expect we would be in a position to have that evaluation completed in 2003.

Senator McLUCAS—By June? I am just trying to get an idea.

Ms Kerr—Perhaps towards the end of next year.

Senator DENMAN—Because there has been a shortage, supposedly, of heroin in Australia, have you got a percentage of the other drugs that are coming into the country like cocaine, ecstasy?

Ms Kerr—Again, the issues about supply of drugs are more appropriately answered by the Federal Police and the Australian Customs Service.

Senator DENMAN—So you would not have an idea of what proportion of drugs are being made in this country and what proportion are coming in?

Ms Kerr—It is very difficult to estimate how many are being made and how many are coming in. The Federal Police and Customs know how much they are seizing, so that information is in the public arena.

Senator CROWLEY—How do you get informed of that?

Ms Kerr—The Federal Police and the Australian Customs Service produce reports from time to time on that information and press releases are made.

Senator CROWLEY—Are you able to ring somebody or are the police required to ring you when they have data like this because presumably, this is a very important area of crossover information? What channels are there, if any, between the Department of Health and the AFP on this matter?

Ms Kerr—There are very close channels of communication. We work very closely with both those agencies through the National Drug Strategy. We exchange information both ways. We are constantly letting the Federal Police and Customs know of some of the demand reduction initiatives. It is not only at the federal government level, but at the national level we

work closely with state law enforcement and health departments, as well. So there is quite a partnership under the National Drug Strategy to share that information, because, as you say, having that intelligence assists us in knowing where to direct our resources.

Senator CROWLEY—So somewhere in the department it should be easy enough to find the last estimate of what are the alternative drugs, both made at home and coming in?

Ms Kerr—We certainly have the information about the seizures of drugs, but, as I said, it is harder to actually estimate how much is coming in. It is very difficult. But we could certainly ask the Federal Police and the Australian Customs Service to give us the latest information to provide to you.

Senator McLUCAS—I want to move to the program for retractable needles and syringes. I notice that $27.5 million was allocated to fund development and implementation of the introduction of retractable needles and syringes. Can you explain to the committee what progress we have had on this initiative to date?

Ms Halton—I think it is fair to say that the funding for this was only confirmed in the recent budget. Whilst people have started to think about it, I would not expect significant process in what is really only a matter of days. We can come to the technical answer, but it has only just been announced.

Mr Sam—I simply want to support that answer and say that we are now in the process of commencing an overall plan for this initiative.

Senator WEST—So you have no idea how you plan to implement this initiative?

Mr Sam—The initiative is clear in its objectives. We have been able to identify the fact that the initial phase of this will be a collection of the research to inform future developments within the initiative.

Senator WEST—But aren't there already significant manufacturers out there providing retractable needles—both for intramuscular and intravenous injections—and, in fact, intravenous cannulas? What communication and consultation has been had with them?

Mr Sam—The initiative is designed to address issues in health care settings, illicit drug use settings and also for insulin-dependent injecting diabetics. You are correct in saying that there are currently some technologies available, particularly in health care settings. We have already established a register of interest from those manufacturers who already have a product that they believe is suitable for this initiative.

Senator WEST—Is the issue the issue of product availability or is it the issue of encouraging facilities and individuals to actually use the product?

Mr Sam—I think there is an element of both, in terms of having a suitable standard in terms of the technology itself, but also looking at the factors that will be critical in acceptability in each of those three settings—that is, within diabetic use, health care settings and illicit drug use.

Senator WEST—With whom has the department already spoken or had consultations and contact about this?

Ms Blazow—We have actually done quite a bit of work already with the drugs area, because, as Mr Sam said, this covers a number of sectors—the health care sector, injecting drug users and also diabetics, for example. We have done quite a bit of work already in the illicit drug area, and the Ministerial Council on Drugs Strategy have considered the issue of

retractable syringes. They have already decided the sorts of questions that we should address in our preliminary research, so I will ask Ms Kerr to give you some information on the discussions there.

Ms Kerr—The Ministerial Council on Drugs Strategy, at its 2001 meeting, agreed that there should be a trial of retractable technology, to look at the possible benefits and costs of retractable needles and syringes introduced in needle and syringe programs. The ministerial council represents health and law enforcement ministers from all jurisdictions. The ministerial council asked officials to come back at the forthcoming meeting, this coming July, to report on that. In the meantime, the Commonwealth has come in with its initiative and its funding, so there will be further discussion on this issue and the roll-out of it, and the role of the states in it, at the forthcoming ministerial council meeting in July.

Senator WEST—So there is already work going on in terms of the illicit drug users. This money is not to subsidise or to support the facilities that use sharps—needles and syringes—in the purchase of the equipment, I take it. This money is to develop—

Ms Blazow—The first stage is examining all the issues around retractable needle and syringe. In fact, the initiative is to look at a strategy for development and implementation and to examine the issues around it. First of all has to come the research, the work to actually decide in what context retractables are useful, and what types of retractables, because there are also a number of products available. So the first stage is to do that work. No decision has been taken yet to subsidise retractables and their implementation in any particular context.

Senator WEST—Is there likely to be money to subsidise, to assist in the additional cost of the purchase of retractables?

Ms Blazow—That would be a decision that would need to be taken in light of the research, the work that is done around their usefulness, their cost-effectiveness and so forth.

Senator WEST—What research have we had done to date? Do we know? We know that needle-stick injury, particularly, is a danger both to the general public, when sharps are found where they should not be, and also to health professionals. What information are you after to go beyond that? I would have thought that it is fairly much a given, and well documented over a number of years, that there are people who contract hepatitis C and B, HIV and a whole series of other diseases from needle-stick injury.

Ms Blazow—Certainly is it those perceptions and those concerns that the government has responded to in this initiative.

Senator WEST—Perceptions of what?

Ms Blazow—Perceptions of danger and injury in all those sectors—

Senator WEST—Isn't it more than a perception?

Ms Blazow—and, of course, the reality as well.

Senator WEST—If you told me that you were trying to quantify the number of people who have, first, got a needle-stick injury and, second, contracted these diseases, I would be much happier than I am with the use of the word 'perception'.

Ms Blazow—We know that there are people who have contracted diseases. In fact, Mr Sam would be able to give you information on how many people in health care settings have contracted diseases as a result of needle-stick injuries. But the research will be around

introduction of the particular technologies, the type of technologies and whether or not those technologies would actually have major impact on those injury rates.

Senator WEST—Mr Sam, have you got some figures?

Mr Sam—I would take that on notice, Senator. Could I just add that the issue is around risk as well. The objective is clearly to reduce and minimise transmission of infections via needle-stick, but there are well-accepted risks around both use in those settings and particularly the discardment of used injection equipment, particularly outside of health care settings.

Senator CROWLEY—Have you got a figure on accepted risk? Might every 10th patient reasonably be expected to be hepatitis C? We are teasing you, Mr Sam. Help us.

Mr Sam—Let me qualify that. The known risks are around the fact that discarded injecting equipment does surface in appropriate places, in terms of both domestic settings and community settings. We know, for example, from surveys of injecting equipment that have been looked at, that blood-borne viruses have been found. So the risks are known.

Senator WEST—'Known' is a better word than 'accepted', I think.

Senator CROWLEY—I am not sure that explains what you mean by 'acceptable risk'.

Mr Sam—I do not believe I was trying to comment on an acceptable risk. It was a known risk.

Ms Halton—Senator, I think what the officer is trying to explain to you is that we need to do research in this area which balances up the full range of economic issues, costs et cetera. We need to look at the behavioural and social issues around product acceptability and disposal. I think the officer is trying to talk about issues around disposal—you would both understand very well the issues around needle disposal—and what are the issues around public disposal facilities and inappropriate disposal. You would both understand that this is a complicated area and that, in looking at retractable needles, we have to consider all of those issues before launching forth. So the research that will be done will balance and consider the issues that you have identified, plus a range of others.

Senator WEST—My concerns go to the health care workers. You used the word 'accepted' there. Certainly practice 25 or 30 years ago was, for example, 'Oh yes, you will cut yourself,' because these things were not known and these diseases were not around. It was accepted that, 'Oh yes, in the course of a week of shifts you are going to end up with cuts on your fingers.' That was accepted, and that is the reason, I suspect, for both Senator Crowley and me to home in on that word 'accepted', because it was practice that was accepted. It is practice today that is not acceptable, nor should it be accepted. But 'known' is a different story.

Ms Halton—We are acutely conscious that there are three really high-use groups who are particularly relevant to this initiative—health care workers, whom you have appropriately identified, and you are quite right about what we now consider to be acceptable; people with diabetes, who we know inject, in a large number of cases, regularly; and people who inject illicit drugs. We have talked about that as well. All those three groups are clearly relevant to this initiative, and the interests of each of those three groups need to be taken into account in undertaking the research.

CHAIR—Could I interrupt there. Am I right in saying that there is an allocation for funding for research for the industry, to ensure that there is a successful introduction of the

retractable program? I understood that there was a considerable amount being put aside for that type of research to be undertaken.

Ms Blazow—That is certainly a possibility, but we are going through the process of doing the preliminary research first, to have a look at the usefulness of the devices in actually reducing the rates of injury, prior to a second stage. If the first stage shows that there is usefulness, then we will go into a second stage of actually looking at, therefore, investing in developing the devices themselves and improving the technology.

Senator WEST—Who will the department be working with? Who is going to do this research and this work?

Mr Sam—There are a number of stakeholders, in terms of both the users of injecting equipment—diabetics and diabetes associations, for example—and the health care industry, particularly infection control. In terms of illicit drug use, Ms Kerr has already outlined the fact that the MCDS process has been considering this issue. Clearly there will also be liaison with industry and with industry groups.

Senator WEST—When you talk about the health care industry, who do you mean?

Mr Sam—Practitioners, primarily, and clinicians.

Senator WEST—You obviously cannot go and get every practitioner and ask them. Have you at this stage worked out what bodies you will be contacting and who you will be consulting with?

Mr Sam—There is not a defined list as yet, Senator, but the main users of this technology will be medical practitioners and nursing practitioners, and it fits within the policy framework of infection control and infection control practice in health care settings, in terms of use of these technologies through to the disposal and monitoring of needle-stick and other associated injuries.

Senator WEST—With the nursing one, I hope you are going to incorporate both the ANF and the two colleges of nursing, because one has the coverage of practice, procedure and the professional conduct standards, and the other one, the ANF, probably is the one that is going to be able to tell you more about incidence of needle-stick injury, because of the reporting by their workers. What is planned for the manufacturers and the distributors of this equipment? What benefits are in it for them?

Mr Sam—I think the primary benefit is in having a technology that is locally available and acceptable and that aids in minimising needle-stick injury and transmission of infection. The industry development and research component, again, as Ms Blazow pointed out, would be informed by the initial research. It is not simply a case of having any technology; it clearly has to be suitable for the purpose for which it is intended.

Senator WEST—Who is going to have the overall monitoring and driving role for this?

Ms Blazow—The Commonwealth will take that role, but in conjunction with states and territories and, as Mr Sam has said, the professional colleges and professional workers.

Senator WEST—Yes, but where within the Commonwealth? The Commonwealth is rather large.

Ms Blazow—The communicable diseases branch.

Senator WEST—Will this be receiving extra funding? How much of this $1.5 million for 2002-03 is going to be taken up in going to that particular branch for them to function? How much is going to be taken up in research?

Ms Blazow—I am not sure that we have done a breakdown yet of how much for research and how much for other functions. We are just looking at the figures here.

Senator WEST—It is $1.5 million for this coming financial year, then $6 million, $8 million and $12 million. I want to have some idea of what you are envisaging that you are going to spend that money on.

Ms Blazow—Yes. At page 25 of the yellow book—

Ms Halton—That was the technical description for the PBS, Senator.

Ms Blazow—we have a breakup there of the departmental allocation and the administered allocations for the retractable needles and syringes budget initiative, which shows a departmental $0.6 million for each of the four years of the initiative and, for administered funds, beginning with $0.9 million for the first year and growing to $5.4 million, $7.4 million and $11.4 million. That reflects the strategy of doing preliminary research and then looking in later years at the actual rollout of programs.

Senator WEST—What is going to be done to ensure that this equipment, when developed, is affordable? What is going to be done to encourage people to actually use the equipment that is available now?

Ms Blazow—No decisions have been taken yet on how any equipment would be funded. As I said, we would do the research first and have a look at the cost effectiveness and the benefits that can be gained from the particular devices before decisions are taken on particular funding methodologies.

Senator CROWLEY—Ms Blazow, do you know of any people currently using retractable needles?

Ms Blazow—I personally do not. I will ask Mr Sam.

Senator CROWLEY—We should finish our report soon, but we certainly do. There are significant numbers of hospitals who have already decided to introduce retractable needles, and I am concerned that we often find that what the states are doing seems to be something the Commonwealth pays for and does not know about. Let me urge you to look to the hospitals, because the next question I want to ask you is—and maybe I am jumping ahead here—whether you have any data yet of the benefits. We have been provided with evidence, for example, of the occupational health and safety hazards and consequences, and there are significant payouts for people who get stick injuries and diseases as a consequence. Do you have any of that yet?

Ms Blazow—We do not have that yet but, of course, we are starting our discussions with the states and territories and the colleges, so I am sure that information will be made available to us.

Senator WEST—I suggest you read the *Hansard* records of the nursing inquiry. You might find some valuable information already there.

CHAIR—What has been the response of the states and territories to the implementation of this technology since it was announced?

Senator CROWLEY—It is not implemented. That is the trouble.

CHAIR—That is what I am saying—the implementation of this technology since it was announced. It was announced only a couple of weeks ago.

Senator CROWLEY—It was quite a while back.

Ms Blazow—We have already had a positive response from a number of states that they are very keen to work with us in this initiative.

Ms Kerr—Could I just add to that, Senator Crowley. It was South Australia and Queensland ministers who put the whole discussion of retractables onto the MCDS agenda at the last meeting. It was as a result of those two state health ministers having an interest in this that MCDS considered it last year. So there has been some discussion and, as I said earlier, there will be further discussion at the forthcoming meeting. The initial reaction, from the contacts that I deal with in the state governments—the drugs people, the police and health people—has been quite positive.

Senator CROWLEY—Has anybody else written to you about it? For example, have the ambulance drivers of Australia written to the Commonwealth department and said, 'Retractable needles are the go; we've got to have them'?

Mr Sam—We have not received any correspondence from them, but clearly they would be a group that we would be consulting.

Senator WEST—What do we know of international research and use of retractable needles?

Mr Sam—We know that the research that has been done, particularly in illicit use, highlights the need for acceptability for the programs to be considered effective.

Senator WEST—Do we know what sort of technology is being used overseas?

Mr Sam—We do. We have gathered information on the types of technologies that are used overseas, and we have already received some application and expression of interest from overseas manufacturers of retractables.

Senator WEST—What is the usage rate over there?

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

Senator McLUCAS—This was an election commitment of the government at the last election. What has informed the allocation of $27½ million over four years?

Ms Halton—That was their election commitment.

Senator McLUCAS—How was that figure arrived at?

Ms Halton—I think you would have to ask the government.

Senator Patterson—It was a decision of the coalition that this was an issue that needed to be addressed. It does have some problems. You are indicating that the use of retractable needles in hospitals has benefits, but there is advice that I have been reading around the area, because of the commitment, that some retractable needles can be rejigged to be used again. That is a problem—not within a hospital but for use by people for illicit purposes. Drug users will tend to share needles amongst themselves because of the reduced supply of non-retractable needles. All those issues need to be looked at, and the technology needs to be looked at. That is why we are doing this research first. How the actual amount was arrived at, I was not involved in that, but I suppose it was an estimate from consultation with people about what would be required to get this up and running. You have obviously got an interest

in retractable needles, and the evidence is that apparently in hospitals they reduce needle-stick injuries, but there are other issues about what happens out in the community. That has all got to be looked at.

Senator McLUCAS—I am interested that the government could make an announcement that $27½ million is the appropriate amount, given that it would seem that we are now at least six months, and closer to eight months, past the election and we are still in a very early research phase.

Senator Patterson—Senator McLucas, when you make an election commitment, and there will be l-a-w taxes, sometimes they change and other times they are kept. You have to wait till the budget to get the money to start working. The department cannot initiate spending on a project for which there is not a budget allocation. The budget allocation is now there. They have been thinking and working on the way in which we are going to move forward. That is what will be done. It is a very difficult area because there are competing bits of evidence. In one area it can reduce transmission of disease and in another area it may increase it.

We have to look at what are the relative weights and which is the best technology. We have to look at what technology is more likely to be used, for example, by people who use drugs illicitly. If they are not going to use them and it increases sharing of needles and the transmission of disease in that community of people, you are actually defeating your purpose. You have to look at how you introduce it. They are the sorts of issues. We can go in and merrily get retractable needles and find people are not using them. They start trying to reconstruct them or to use non-retractable needles and increase sharing. With one area you would be defeating your purpose. You have to look at that whole range of things.

Senator CROWLEY—We could probably ask you questions about that if and when it ever happened, Minister, but the evidence so far is that using retractable needles in hospitals is an absolute winner. If you are using retractable needles for diabetics, who by and large are not sharing needles but just practising safety in their own administration or within a family—

Senator McLUCAS—The same goes for medical staff in hospitals.

Senator CROWLEY—Absolutely, within hospitals meaning all the users in and around hospitals. The fact that it may cause a behavioural change amongst drug addicts out in the real dirty world is a serious concern. I take your point on that. But that would seem to be minimal justification for not proceeding very rapidly within institutions, for example, where it is clearly a benefit.

Ms Halton—Can I just make a point there? At the end of the day states are at liberty now, if they wish, to provide that technology in hospitals. The hospitals are administered by the states and you have rightly made the point that in some states there is some of that practice. They can do that now if they wish. This is a broader investigation which I think the officers have tried to outline which will include issues around illicit drug use. The first 12 months—which we have not started yet, the money has not flowed yet—is only a research phase and that amount is only $900,000. I take your point about hospitals but that is a state government responsibility.

Senator CROWLEY—I would like to pursue some other questions on this matter. One, for example, is: has it been raised by the states in the drug abuse area? Has it also been raised by the states vis-a-vis Medicare agreements?

Ms Halton—We have only just started discussions with the states in relation to the forthcoming health care agreements. That has not been an issue that has been raised, but that is because we are at the very preliminary stages in our discussions with the states.

Senator Patterson—The states have had a 28 per cent real increase in funding over the period of the life of the last agreement. They have had $3 billion that was not clawed back. In the agreement if private health insurance membership went up we were to claw money back. That did not happen. So they have got a significant increase in funding. As Ms Halton said, they can use retractable needles in hospitals.

Senator CROWLEY—This is not the place to pursue this, Minister, but the independent assessor did say that the states were duded $600 million while all those other good things were happening to them. You are right; that is for another portfolio area.

Senator McLUCAS—I think we have finished on that matter.

Senator CROWLEY—I just want to ask how you made an assessment in the run-up to the election of about $27 million. How did you pick that figure?

Senator Patterson—Well, governments pick figures or oppositions pick figures. I suppose I could go through and look at the health policy of the opposition and there would have been figures written in there. You make an estimate about how much it will cost to do a certain thing and you try to get as close as possible to achieving your outcome with that estimate.

Senator CROWLEY—Looking at the way you have put the figures on page 25, it is quite clear that it is a small amount in the first 12 months to do some of the initial research, and so on. The estimate is out to $12 million by 2005-06. That sounds as though you are now spending money on something more than research. Is that a fair assessment? What is the estimation of expenditure administered? Does 'Administered' mean just paying people to run or supervise programs, and does it also take into account the costing of some of the needles?

Ms Blazow—The commitment clearly says that it is to look at both strategy for implementation and for product development. The decisions on the exact balance between those things is not yet decided because we have not done the preliminary work.

Senator CROWLEY—'Product development' here meaning?

Ms Blazow—Meaning improvement of the technology, if that is required.

Senator CROWLEY—Of the needles themselves?

Ms Blazow—Yes. There are a number of different types of technology, I understand, and they all have pluses and minuses. There are some technologies that could warrant some further development to make them more effective—the ones that can be tampered with, for example, for reuse.

Senator CROWLEY—I guess it is too early to be asking about Australian manufacturing as apart from overseas manufacturing?

Ms Blazow—It is too early. We have not made those decisions.

Senator CROWLEY—One question that I would like answered—if you have not got the answer now, that is good; I hope you look for it when you are doing all of this work—is about the little buckets that have got all the needles or the sharps stored in them. How will you get rid of these disposable containers that contain the thing to be destroyed? If you do not have an answer now, can you please find out that answer for me?

Ms Blazow—Certainly.

Senator HARRADINE—Can I ask a question about smoking. I noticed a survey recently—I do not remember where it came from—which said that there were an estimated 290,000 secondary school students now smoking. Is the department aware as to whether that figure is correct or at least a reasonable estimate?

Ms Kerr—I would have to check that figure. You have probably seen that in the press from a school survey, I imagine. What I can say is that the proportion of people who are smoking, as indicated in the recent Institute of Health and Welfare household survey, is falling and is now much lower than it was in the previous Institute of Health and Welfare report.

Senator HARRADINE—That is over the whole of the population. What about school students? Has the department made any assessment of that? This appears to me, in all events, to be a very crucial time.

Ms Kerr—The figures I have in relation to youth who have smoked—and assuming that most of these will be school students—is that the proportion of youth who are aged 14 to 17 who have smoked in the last week, in the year 2001, was 13.3. That is consistent with the overall figures that I have already quoted from the Institute of Health and Welfare and is a drop from the previous figures of 13.8 in 1998. Certainly, the numbers are showing a decrease.

Senator HARRADINE—The survey I referred to was a media release by ASH—Action on Smoking and Health. Is the department aware of that organisation?

Ms Kerr—Yes, we are.

Senator HARRADINE—Is it a reputable organisation in the respect that it is capable of undertaking such a survey?

Ms Kerr—Yes, it is.

Senator HARRADINE—It identified that 'new figures show 269,000 secondary school students are smoking.' If that is the case, what provisions are being made in this budget for initiatives or commitments to address the problem of smoking, particularly in school age students?

Ms Kerr—At page 52 of the PBS, there is a line item, investment in preventive health. It states that the government will be continuing to provide funding for a range of nationally significant public health programs, and that includes tobacco harm minimisation. So funding is ongoing for the department to continue its work in the tobacco harm minimisation area.

Senator HARRADINE—What types of activities are involved?

Ms Kerr—There is a range of activity that we will be rolling out. Some requires funding and some does not. An initiative announced by the minister last Friday on World No Tobacco Day provides funding of $1 million over three years to address the issue of indigenous smoking. That would be an example of one of the initiatives that we will be rolling out. An example of an initiative which will not require large amounts of money but which is very important is a review of the Tobacco Advertising Prohibition Act. That will be a significant piece of work over the next six months.

Senator HARRADINE—I was going to ask what action the government is proposing to increase pressure on tobacco companies. When is that review likely to be concluded? Who is undertaking that review?

Ms Kerr—It is likely to be concluded by the end of this calendar year. It is going to be undertaken by the department with significant input from a range of experts, including people who are experts in the health area, the legal area and so on. That is how it will be rolled out.

Senator HARRADINE—With a view to recommending to the minister certain changes to the legislation?

Ms Kerr—Certainly, it is time, after about 10 years of the Tobacco Advertising Prohibition Act, to have a look at whether it is still consistent with contemporary practice. The sorts of issues that the review will be considering will be whether the act has met its objectives of limiting the exposure of the public to messages that might encourage them to start smoking or to continue smoking. It will also look at whether the objectives of the act should be expanded to take into account new and emerging advertising practices and it will look at areas of the act which are not very effective.

Senator DENMAN—Some of these may have been answered. I could not quite hear what Senator Harradine was saying. The questions are on the tobacco advertising guidelines that the minister announced. Who will conduct this review?

Ms Kerr—The review will be conducted by the department with input from a range of experts.

Senator DENMAN—What sorts of experts?

Ms Kerr—People from the legal area and tobacco control areas. We are putting together a panel of people who can be on a committee that will be oversighting this work.

Senator DENMAN—Medical people as well?

Ms Kerr—Medical people as well. In addition, the review will be seeking opinions of a range of interested stakeholders, including medical people, industry broadcasters, publishers and so on—people who would be affected by any change to the legislation.

Senator DENMAN—People working within the industry in the drug and alcohol abuse field—for instance, there are a lot of people who come across tobacco problems in schools.

Ms Kerr—We have not yet set up the group to undertake this work. We are about to do that. We could certainly consider whether the opinions of schools ought to be taken into account in this review.

Senator DENMAN—I know from my own experience that, even at primary school level, tobacco smoking is becoming an issue.

Ms Kerr—We will certainly be encouraging the views from the public.

Senator DENMAN—You will advertise all this?

Ms Kerr—Again, the details of how that will be done are yet to be worked out, but I would expect that we would get the views of schools, or people who are engaged in school education, into the mix.

Senator DENMAN—What are the guidelines? If you have answered the same question from Senator Harradine, just say so.

Ms Kerr—I am not sure what you mean by 'guidelines'.

Senator DENMAN—What sorts of guidelines will be used for the review?

Ms Kerr—We are about to set up the committee, and we will then draw up terms of reference. As I have indicated, the government has already agreed to the general overview of the review, but we will look at how we will conduct that in more detail.

Senator DENMAN—What is the timetable for the review to report back?

Ms Kerr—We are expecting to have it completed by the end of this calendar year.

Senator DENMAN—In 2001-02, how many applications were received for exemption from the provisions of the Tobacco Advertising Prohibition Act 1992?

Ms Kerr—Four.

Senator DENMAN—How many exemptions were granted?

Ms Kerr—The minister decided to allow the sporting events to continue under certain conditions. So, in terms of granting, those events were allowed to continue, but under very strict guidelines.

Senator DENMAN—What were the guidelines?

Ms Kerr—It varied from event to event, but they were things like restrictions on advertising signage at the track for the Grand Prix, for instance, and those sorts of issues.

Senator DENMAN—How many breaches of the Tobacco Advertising Prohibition Act were reported?

Ms Kerr—In the last period for reporting—1 January to 31 December 2001—the Parliamentary Secretary to the Minister for Health and Ageing has reported to the parliament that there were no contraventions.

Senator DENMAN—Therefore, there would not have been breaches to be investigated, or prosecutions?

Ms Kerr—Yes, there were breaches to be investigated.

Senator DENMAN—How many?

Ms Kerr—In the calendar year 2001, there were 24 possible breaches of the act that were brought to the attention of the department.

Senator DENMAN—How many of those were prosecuted?

Ms Kerr—None have been prosecuted; there are still two under investigation.

Senator DENMAN—How long will that take?

Ms Kerr—With prosecution, we are very much in the hands of the Federal Police. If a complaint, breach or possible breach is considered to require in-depth investigation, it is referred by us to the Federal Police. The time frames are then in their hands.

Senator McLUCAS—Earlier, you said that $1 million has been spent on Aboriginal and Torres Strait Islander anti-smoking programs. Is that part of the overall allocation, or is that in addition?

Ms Kerr—One million dollars was announced last Friday as being earmarked to address issues of indigenous smoking, so that has not yet been spent. That is an example of the ongoing funding that is reported in the PBS for investment in preventive health.

Senator McLUCAS—Is it a part of the $2.3 million? I need to understand whether it is on top of or as a part of that allocation.

Ms Kerr—It is a part of the measures that involve funding of $22.8 million in 2002-03, as set out at page 52 of the PBS. That would be an example of the sorts of things that we would cover under the tobacco harm minimisation line. There are a number of initiatives in that item. The million dollars is spread over three projects over three years, so only a proportion of that would be taken out of that first year.

Senator McLUCAS—The government, in the Intergenerational Report, said that it was concerned about future health care and disability costs. Is there any recognition of the need for greater expenditure in anti-smoking programs?

Ms Kerr—I am not able to answer that, Senator. I am not familiar with the detail of the report.

Senator McLUCAS—I cannot find the anti-smoking allocation in that preventive health item. Can you explain to me, please, how much we are talking about for anti-smoking programs in 2002-03 and then the out years?

Ms Kerr—I can certainly give you an estimate of the sorts of activities that we will be undertaking this coming year, but there is a mix of issues involved in that investment in preventive health item and decisions about the break-up of that are yet to be made.

Senator CROWLEY—How many people attended family planning clinics last year?

Ms Blazow—Senator, we have been going through places we fund to put them on new contracts, with output based arrangements under their contracts. I think that at this stage, because we are only really in the first year into those new contracts, our information is still a little bit patchy and we may not be able to give you a national figure. I think we get figures from some states and not from all states. I will ask Carolyn if she is able to provide more detailed information.

Ms Smith—I think we could go back to our figures and get some data from around the states on number of clients, but I could not tell you that now. We can take that on notice.

Senator CROWLEY—I would appreciate that. Could you also could give us any subsections of what the people are visiting family planning for. I understand that people visit for education, for direct advice, for service provision, for counselling. I would very much appreciate those figures if you could provide them, because the word we get is that family planning centres are under considerable pressure.

Ms Blazow—Our agreements with them actually do identify a number of key areas where they are providing outputs, and you have identified many of those. For example, professional education is one of the areas where they are quite active, they provide some clinical services, they provide counselling, they provide education for young people on sexual health. We could provide on notice to you some information that we are already receiving from the organisations against those various categories of activity.

Senator CROWLEY—Is there any push for expanding the number of family planning clinics around Australia?

Ms Blazow—No. It is not an expanding network. In fact, it has been stable for many years now.

Senator CROWLEY—That was a very elegant word there, Ms Blazow, ‘stable’. That is probably the euphemism of the morning. I think they will be thrilled when they hear that is how it has been described. When I have been out talking with them I have heard words like

'despair' and 'We can't prise another dollar from anywhere,' but 'stable' will do beautifully, thank you.

Ms Blazow—We have just entered a three-year funding agreement with all the family planning affiliates.

Senator CROWLEY—Thank you. I am really appreciative of your answers because in times past when I have asked this question I have been given such beaut answers as, 'They are state matters, Senator, and we don't have the data.' So congratulations on an improvement on that. Did any of you get to see the television coverage of the coronial inquiry into deaths from petrol sniffing in South Australia?

Senator HARRADINE—Could I follow up, before you get onto that subject, on—

Senator CROWLEY—No, I am actually wanting to pursue the—

Senator HARRADINE—I just wanted an additional piece of information on the abortion issue while we are on family planning areas. Could you provide the committee also with details in regard to persons who present at family planning clinics who are pregnant and seeking counselling and who have been counselled by the family planning clinic? What percentage of those end up having an abortion?

Ms Blazow—We do not actually collect that as part of our data set that we have developed with family planning. We can certainly provide information on the number of counselling servers that are provided.

Senator HARRADINE—Where a person presents as being pregnant, is it not a fair question to ask, without detailing names of course, what percentage of those end up having an abortion? You are going to give the committee all sorts of other interesting information, but that seems to me to be a crucial piece of information.

Ms Blazow—I am not sure that the family planning people would actually know that, but we can certainly go back to them and ask what data they maintain under the data set that we have negotiated with them under our new agreements. We can take that on notice.

Senator HARRADINE—They would know the number of people that they have referred for an abortion. They would know that. If they know the number of people that they have counselled under those circumstances, surely they would know the number of people that they have referred? They may not know the total number of persons who have had an abortion, but then again they may. But they certainly would know what percentage of those that presented for counselling, under those circumstances, they have referred for an abortion.

Ms Blazow—We will go back to them and ask them whether they can provide us with any information on that particular aspect about referrals.

Senator HARRADINE—Thank you.

Senator CROWLEY—The department might be shocked to discover that I might be about to give them some praise—but I might not be able yet to do that. Did anybody see the coronial inquiry, as televised and as it made the news in South Australia?

Ms Halton—The coronial inquiry is a matter which is of particular interest to OATSIH. Those officers are not here at the moment. I think you will find the answer is probably yes, but I would not want to put words into the mouths of officers who are not here.

Senator CROWLEY—I raise it because one thing really shocked me and actually distressed me, apart from the distress about the number of people suffering and dying from

petrol sniffing and the way most of us face the evidence that we are totally inadequate to do much about it. There was a Commonwealth officer who was asked how many people in this country are petrol sniffers? 'I don't know.' How many people are dying from petrol sniffing? 'I don't know.' I cannot exactly paraphrase the questions, but the Commonwealth officer said, 'I don't know' in answer to goodness knows how many questions. I just want to say that that has been the response I have received to questions, particularly under this program 1 in the past. I must say that I was mortified, on behalf of the officer, and I hope she has recovered. It was not a pleasant piece of publicity, but it is really about a more general question and problem I have in this whole area, that under the new arrangements the Commonwealth is passing the money to the states and is often, I think, at arm's length from the outcome. These are precious Commonwealth dollars and in the estimates we properly have a right to know how many people go to family planning and how many people are on antidrug programs? Even just a basic head count is a start. The last few years have been sloppy as all get out, in terms of the data the Commonwealth could provide to us, or satisfy itself with. You are nodding, Ms Halton. Do I understand that that is your view?

Ms Halton—It is our view that, in return for funding that is provided by the Commonwealth, there should be as an absolute bare minimum level of accountability in relation to those kinds of information. You would understand well that it will take us some time in a number of our programs to arrive at arrangements that enable us to get what, in the first instance, would be basic information about what is provided and to whom. But yes, it is a fair comment. I think there is a view more broadly in government—and certainly it is an issue that I have discussed with some of my colleagues—that there is a need to ensure that we do have adequate information about where our funding goes.

I am not going to promise you that by the next estimates, Senator, every question you ask, about how many and which program, we are going to be able to answer. You understand that these are difficult issues and sometimes getting data, even where there is a huge willingness, can be quite difficult. But, yes, I take your point and it is something that we are conscious of.

Senator CROWLEY—Thank you.

Senator HERRON—It is not often that I find myself on the same side as Senator Crowley. A lot of that data, of course, would have to be obtained from the states, for example, deaths due to solvent misuse and so on, which would be recorded on death certificates, imperfect though they might be. It would purely be a time for us to get a database that we could have for future reference, if it is not there already. So I would support Senator Crowley in her request on all that data.

Ms Halton—Senator, you would also know that there are a number of things that we have been doing in respect of quality issues more broadly to help us look at how the whole system works. There is the question of data, particularly in relation to death certificates—and I think this particular coronial inquiry is looking at precisely that issue. We need to know and to have it properly attributed. If you think about it historically, we had this problem with suicide that there were a series of things that were never recorded. If you do not understand the dimension of the problem, you cannot begin to tackle it appropriately. So I take your point; I think it is absolutely right.

Senator HERRON—It is Commonwealth money, as Senator Crowley said. We have got a right to know what the outcome of that expenditure is.

CHAIR—Have such records ever been kept?

Ms Halton—In relation to petrol sniffing?

CHAIR—In relation to any of these programs where Senator Crowley is asking whether or not—

Ms Halton—I think it is fair to say that the arrangements in relation to data have been variable across programs. If I think of a particular example, Home and Community Care, we have been working on getting accurate data. There it was actually an accounting problem, not a willingness problem, for basically as long as I can remember. So I think Senator Crowley's point is fairly made and it is something we are working on across the portfolio. As I said to Senator Crowley, I am not promising by next estimates that I am going to have chapter and verse on every single program, but it is an issue that we are aware of and we are working on.

Senator CROWLEY—In fact, the data in some of these areas stands in marked contrast, for example the breast cancer screening program. The way that has been designed is that you have to be able to say that the actual number of breast cancer cases or deaths from breast cancer has fallen due to the numbers of early diagnosis to justify the whole screening program expenditure at all. But, even so, that data is significantly different, for example, from the stuff that is going through to family planning. The pap smears are the same; again, there is much better number counting. Outcome is a separate issue but at least we have a handle that there is better data. It is uneven from the different programs that you are funding here. You can tell us how many people are being immunised more or less and that is an important thing, but you cannot tell us about a number of the other areas funded under this portfolio.

Ms Halton—The point you make is reasonable. However, we have to acknowledge that it is much easier to measure discrete instances of something. Immunisation is a particular instance; it can be seen, counted et cetera. In some of these other areas, behaviours are more difficult to measure. Effects are more difficult to measure; people come in and out of treatment programs. So there are technical as well as other issues in relation to getting successful strategies on counting, but again the point you have made is fairly made.

Senator CROWLEY—The other important point on this area—and it follows the exchange of questions and answers from Senator Denman and Ms Kerr in particular—and it is the point that you just made, that it is hard in those areas to see an absolute outcome: this person was a heroin addict; this person is no longer one—that is not an easy thing to score or measure. One of the things in that area, though, is that a lot of people in the community will tell you what is going wrong. They will tell you the data; they will tell you the new drugs that are coming in. One of the things that concerns us is how that information gets to you, if it does at all. That is a little bit like the petrol sniffing stuff—there needs to be somebody, streetwise, on the ground so that there is no chance of broken data coming up here. People out there know about petrol sniffing; anybody who has ever visited an Aboriginal community can pretty much give you the head count as they walked through. It was a very shocking and perturbing piece of television for me—particularly the issue but, equally, the mortification of the public servant.

Ms Halton—We have a number of strategies which do not rely on us simply reacting to aggregate population statistics—death rates and things of that ilk. In the drugs area—Ms Kerr could give you more detail—we do have sources of information which are just not the top end of some bureaucratic stovepipe but are much more people on the ground. One of the things that the officers in the department have been doing, and I too have been doing this since I arrived in the portfolio, is going out and walking through services and talking to people.

People do tell you—you have had this experience yourself—what is happening. We try and factor those things into our policy development process.

Senator CROWLEY—So when they next come to me and say, 'Listen, we have got all this information. We would just love the Commonwealth health department to know about it,' who do I tell them to ring, Ms Halton?

Ms Halton—I am sure the minister's office or the minister will be fascinated. But, similarly, the relevant program managers do have a range of contacts in the community, and we encourage this. If people want to make those details and information known to us, they can approach relevant officers. If they have trouble doing this, you can always approach one of us.

Senator CROWLEY—In the end, your answer is right—the best thing to do is to tell a member of the House or the Senate and write letters to the minister, who can then see the chain of information is maintained. This is the last question from me at this time: the longitudinal study of women's health—is it still maintaining its funding? Is it still guaranteed to continue?

Ms Blazow—Yes, that is continuing.

Senator CROWLEY—And producing material?

Ms Blazow—Yes, data is starting to flow from that survey. I am not sure of the exact details. My colleague Marion Dunlop may be able to help.

Ms Dunlop—The funding is continuing. There is a current review underway which is under the auspices of the NHMRC, and that is expected towards the end of July.

Senator CROWLEY—Thank you.

Senator HERRON—Could you tell me how much funding that is.

Ms Dunlop—It is approximately $928,000 a year.

Senator CROWLEY—We are trying to get it over a million, Senator.

Senator McLUCAS—Getting back to the issue of information collection and sharing—I understand that the department used to publish on its web site a document which gave a whole range of health statistics by electorate. The last one published was in June 2000. Why have they been removed from the web site and whether or not it is intended that they be updated?

Ms Blazow—We are not sure which data you are talking about, but there is a program that the department has invested in called Health WIZ, which does publish a whole range of statistics by region—I think they are either local government areas or statistical local areas but not by electorates. That is available to everybody—the state governments can use it, the public can use it. It is readily available to give a full picture of health and other factors across the community. That is Health WIZ. I am not quite sure what data you are referring to.

Senator McLUCAS—Is Health WIZ on the web site?

Ms Dunlop—Yes. It is a tool for analysing data and it has a number of data sets included in it. It is being made available to state and territory governments, to divisions of general practice and it is widely used as an analytical tool and for planning purposes.

Senator McLUCAS—We will come back to it later; it is an issue that probably comes up in corporate.

Ms Halton—One of the officers can also make some comments, Senator.

Dr Wooding—What has happened is that we are exploring a range of ways of getting our data distributed and cut up into different geographical locations. In the health system, and in the way we fund our programs, I do not think electorates are really one of the most useful or helpful ways of doing it.

Senator McLUCAS—But we used to do that. Is that correct?

Dr Wooding—We put maybe one year's worth of electorate profiles on our web site. I think that was all.

Senator McLUCAS—Was that in 2000?

Dr Wooding—Yes. The electorate profiles information goes back to a period when it used to be done more on the community services side. We do not have community services programs any more. On the health side, most of our payments are made obviously to individuals through Medicare or to states. We tend to have state based information rather than electorate based information. Obviously there is a role for us to provide more useful information in some of the ways that Ms Blazow has been talking about, and it is not only electorate but geographical and other ways of splitting it up. We are continuing to look at that and find ways of getting that information distributed publicly, or put on the web site, which would be a useful source of information to the community.

Ms Halton—The reality is that people's information needs vary very much with their interest. Our information changes so regularly that trying to find a way of enabling people who want to access information to be able to manipulate that information, and produce what is their particular interest in some table or some map, or whatever it might be, is one of the challenges that every government department faces—ours particularly. Providing spatial geographic information is something which we have grappled with over many years and, as Dr Wooding and Ms Blazow have said, we have a number of tools which we do make available to people which we hope they will find more flexible in accessing and manipulating that data. As Dr Wooding just said, we are going to try to explore what we can do to supplement that. The web site is an obvious place that we can make that available, but we have not yet cracked the nut, if you like, about optimising people's access to information in a way which is sustainable and maintainable. That is a major issue because the costs of obviously maintaining those data sources can be extremely significant.

Senator McLUCAS—I would like to come back to this at an appropriate time to pursue that whole issue of sharing of health information.

Senator CROWLEY—I have one last question, I am sorry. I should have completed this. With regard to the review that comes out in July about the longitudinal women's study, would that be available to the senators?

Ms Dunlop—I would imagine when it is completed and it has been reviewed, yes.

Senator CROWLEY—Thank you.

Senator HARRADINE—Are you moving on to another matter?

CHAIR—Yes.

Senator HARRADINE—On the information sought, in respect of some family planning organisations, would you also ask them what percentage of that group which was mentioned have been referred to registered pregnancy support for counselling services?

Ms Blazow—Yes, we will include that in our request.

Senator HARRADINE—Thank you.

CHAIR—Are there any further questions?

Senator DENMAN—Yes. In 2000, there was an amount of $4 million allocated over four years for a national alcohol strategy. What proportion of the funding for this campaign has been allocated to advertising?

Ms Blazow—Would you like to repeat the question exactly?

Senator DENMAN—Yes. What proportion of the money allocated in the year 2000 to the alcohol program over four years has been allocated to advertising?

Ms Van Veen—I do not have a proportion, but what I can tell you is that on the National Youth Alcohol Campaign, since the campaign launched in February 2000 we have spent $7.4 million. We are currently planning another phase of youth activity on the campaign.

Senator DENMAN—So where has the remaining money gone that was allocated? Some has gone to advertising. Where has the rest of it gone?

Ms Kerr—We have also been doing some work around the implementation of the NHMRC guidelines on appropriate drinking levels, so we have allocated some of the funding to that as well.

Senator DENMAN—This program is specifically for the youth, isn't it? Is this program for young people?

Ms Kerr—Certainly the emphasis of the alcohol campaign has been on youth, but the guidelines and the education that will come out this year are about educating all people about appropriate levels of drinking.

Senator DENMAN—Have you begun evaluating the program?

Ms Van Veen—With respect to the campaign, we have conducted tracking research and evaluative research since the campaign's launch, and we have had very positive results in terms of attitudes and intentions amongst youth in response to the campaign.

Senator DENMAN—Where do you get your research information from?

Ms Van Veen—We undertake independent market research—we get research companies to go out and do quantitative studies with the target audiences. In this instance we would have been doing tracking evaluations—before the campaign launched we would undertake benchmark research to understand where parents and youth attitudes are on the issue, and then after the campaign has aired we go out to measure, against that benchmark research, what the campaign has achieved.

Senator BUCKLAND—You said 'the attitude and intentions of youth.' Where do you get that data from?

Ms Van Veen—In terms of the market research that is conducted, we go out and measure against the communications objectives, where we have objectives against attitudes, awareness, behaviour and intentional take-out on the campaign. It is very difficult to measure behaviour. The department has done some research very recently—we do not have the final report in—on a broader monitor on alcohol consumption. But generally what we are doing is going out, using these independent companies, to measure amongst the target audiences what we have achieved.

Senator BUCKLAND—But what age group are you targeting?

Ms Van Veen—With the youth campaign we are addressing the issue of under-age drinking and misuse of alcohol. We are targeting, in the first instance, 15- to 17-year-olds and their parents. So we are equipping parents with information to address the issue with their children.

Senator BUCKLAND—Is this done in schools or in community groups, or through churches? What is the—

Ms Van Veen—In the instance of the national campaign, we have a mass media campaign that is underpinned by below-the-line strategies using public relations strategies. The Department of Education, Science and Technology is also undertaking a range of drug education initiatives to back up what is going on in schools. We are also working with all the states and territories to ensure that what we do at a national level as agenda setting is able to be underpinned by localised activity.

Senator BUCKLAND—So you collect the data of intentions and attitudes from 15- to 17-year-olds, I think you said—I have got a short-term memory loss. If you do that, and you tell mum and dad about what you are all about, do you then go back in two years time to that same group, to see if those attitudes and intentions have changed at all?

Ms Van Veen—We do not go back to the same group. We undertake nationally representative surveys so that we can actually look with confidence at the numbers that we are sampling, to be able to apply them on a broader population base to see what is going on within that cohort. With respect to this campaign, the department has been undertaking youth alcohol campaigns over a number of years and we do roll out the campaigns and undertake regular research so that we get a true picture of what is occurring amongst this age group.

Senator CROWLEY—What is occurring in this age group?

Senator BUCKLAND—Exactly.

Ms Van Veen—In terms of the campaign, we certainly have seen a number of findings with respect to intentions in response to the campaign. The attitudes, the messages that they are taking on board are reflecting the campaign messages regarding drinking choices. I do not have the figures to quantify right now whether or not those choices are positive ones: whether youth are choosing not to drink or if they drink whether they are choosing to drink at risk levels. I am quite happy to provide copies of the evaluation reports on the campaign.

Senator CROWLEY—We might have to send Ms Halton and her political nose out onto the streets because the word around the place at the moment is that people are turning off drugs and turning back to alcohol at a rate of knots, and they are the people you are talking about. So it is a question of when that information gets back to you.

Senator BUCKLAND—I would like to see what you have got, if that can be provided. I am a bit concerned about doing surveys of groups without doing follow-up surveys of the same group. For instance, my son recently signed a document at school—it was two years ago, so he would have been 11 at the time—that said that he will not take part in any illicit drug activities, or a document to that effect, and he is very proud of that. It would be very interesting to follow up that same class of school children when they are 18 or 19 years old to see how many have stuck by the commitment that they have undertaken.

It worries me that we get commitments and we do surveys, but we do not do a follow-up survey to know the trends. A young person of 15 to 17 will have a different attitude when they are still at school or just leaving school from the one they will have after they have been

through university or once they are in the work environment, because their peer group changes. Is that being addressed; do you follow up?

Ms Halton—I would like to make a comment about that. It seems to me that there are two issues here. The initiative that you talk about—and I have heard about similar initiatives—is a very particular one and it pertains to a particular group of people. I think it is often appropriate in those cases to monitor those particular projects and follow up the individuals, as you have rightly said. I think Ms Van Veen is talking about the broader impacts that we have from broader campaigns and from looking across populations. She talked about benchmarking and monitoring a project to see what the benchmarks are in a community. For instance, after you have had a broad intervention to see whether that intervention has had an impact. So I think your point about a particular project being monitored, whether or not that is an effective strategy and whether that service should be used more broadly, is correct. But I think what Ms Van Veen is going to are those broader campaigns rather than a particular initiative in a particular place.

Senator BUCKLAND—I accept what you say, and I understand what was being said. It appears the broader campaigns are not giving us the correct result because there is a tendency now for young people—and this is coming through the health sector—to return to alcohol rather than to drugs. That can be found through industry when you talk to various industry groups about drug and alcohol programs within work sites as well as when you talk to hospital CEOs and the doctors et cetera. They are seeing the same thing, particularly in relation to road accidents. That is what is worrying me, yet the broad program is fine.

Ms Halton—Senator Crowley has made that point and we have had a sotto voce conversation here. Senator Crowley will have to go back and have a look at that particular issue. If there is any information you would like to pass to us through the minister's office, we would be appreciative of that.

Ms Van Veen—We will be happy to provide hard copies of the research on the campaign.

Senator BUCKLAND—Thank you.

Senator DENMAN—Is the National Alcohol Action Plan a public document?

Ms Kerr—Yes, it is, Senator.

Senator DENMAN—What was the response of the ministerial council on drugs to the draft national alcohol plan?

Ms Kerr—The National Alcohol Action Plan has been approved by the Ministerial Council on Drugs Strategy. I can provide a copy to you if you wish.

Senator DENMAN—Coming back to these kids who are turning to alcohol and not using drugs—I have had some experience in the community where I live of this—do you get information from youth street workers, homeless youth centres and those sorts of places?

Ms Kerr—Yes, we do.

Senator DENMAN—This is where I am getting a lot of my information.

Ms Kerr—Yes, we do. We fund the illicit drug reporting system, which is managed for us by the National Drug and Alcohol Research Centre in Sydney. That research looks at what is going on on the street. They are able to complement our other data sources, which are at a higher level—the household survey, for instance. They are able to complement those data sources by talking to users and workers in the field. It was through that source that we first

had information about cocaine and amphetamines beginning to appear on the streets. We certainly do take account of what is going on at street level.

Senator DENMAN—On the north-west coast of Tasmania, where I live—I am not asking for exact detail—do you get information from those sorts of centres? The income base is very low. Unemployment is high, so kids are turning from drugs to alcohol because it is cheaper. Do you have those sorts of stats from those areas? Not just the north-west of Tasmania, but that is an example of what is happening out there.

Ms Kerr—We do not have stats from right across the country. We have them mostly from capital cities. We do have some idea of what is going on in country towns, but there are limitations to just how big a sample we are able to collect. Your point is well made—that we do need to take account of what is going on in the smaller towns as well.

Senator DENMAN—Is that possible?

Ms Kerr—We could look, with appropriate funding, to extend some of our data collections. The issues about ongoing funding for these sorts of things is on the agenda for the ministerial council this July. It is very much a cooperative approach from the states and the Commonwealth to look at where the priorities are and how to allocate funding.

Senator McLUCAS—We will move on to the issue of the incident response capability measure that was announced in the budget. The budget announced that we were going to acquire and stockpile a whole range of antibiotics and antiviral medicine or whatever. Can you tell me how the range of drugs and vaccines will be determined?

Prof. Smallwood—The approach has really been to assess which are the likely starters as terrorist weapons. Smallpox and anthrax were on the top of the list—anthrax because clearly there has already been an incident in the US; smallpox because, although there is no evidence that the virus has got into the wrong hands, that possibility has been canvassed. Should the virus be used in a malevolent way, it could potentially have a devastating effect, with international implications. Every country has taken very seriously the possibility, albeit a small one, of smallpox being used as a weapon.

Senator McLUCAS—Do we have a committee that is making those decisions? How are we, as a government, making those decisions about which—

Prof. Smallwood—There is a group within the Commonwealth department chaired by the deputy secretary. I am on it, together with others from a range of areas. There is also very close networking through the national public health partnership and the communicable diseases network of Australia. So there is close linkage with states and territories on this issue. There is also close linkage with agencies outside Health: Emergency Management Australia, Attorney-General's and others. But on the specific bio, the carriage is mainly with Health.

Senator McLUCAS—How will the turnover of vaccines be managed given that many of them have a very short shelf life?

Prof. Smallwood—The initial budget, of course, is to establish the stockpile, and then there is funding coming over succeeding years to account for that turnover. The shelf life of the smallpox vaccine, as long as it is stored very carefully at minus 30 or thereabouts, is not short; it is many years.

Senator McLUCAS—And anthrax?

Prof. Smallwood—For anthrax, the main approach is not through vaccine but through antibiotic. The particular antibiotics are already available and used for other purposes but this is to put specific stockpiles to be held should there be an incident.

Senator McLUCAS—What sort of shelf life do those antibiotics have?

Prof. Smallwood—I cannot give you specific figures.

Ms Halton—But, Senator, in relation to things with a shelf life in this particular case the arrangement will be that we will rotate the stockpile. So, in other words, we will not have a batch which will expire. It will be a sort of a conveyor belt.

Senator McLUCAS—Thank you. Where will the drugs be stored? You were talking about making sure that they are kept in an appropriate state.

Prof. Smallwood—The vaccines will be stored at a facility in Victoria in the first instance. The notion ultimately is that the antibiotics and other antidotes will be available in jurisdictions.

Senator McLUCAS—So one location or a range?

Prof. Smallwood—I do not think that that has been finally decided. But a location in each jurisdiction at this point.

Senator Patterson—You can understand, Senator, that—

Senator McLUCAS—Of course I do not want the location, please. Where will we source our vaccine for smallpox?

Prof. Smallwood—At the moment in the first instance the approach is to have a supply of old vaccine that is now available from one of the international companies and, looking ahead, there would be an approach to companies developing new vaccine produced from cell cultures.

Senator McLUCAS—There has been some concern expressed in the US that they cannot be relied on for the sole supply of vaccine.

Prof. Smallwood—The companies cannot be relied on?

Senator McLUCAS—The US, generally, I understand.

Prof. Smallwood—I see what you are saying. The approach is to have vaccine here in the country rather than to indefinitely rely on the US, or some other country, providing us with vaccine should there be an incident. But in the short term, we have very strong assurances from WHO and the US that, should a smallpox incident occur here, there will be vaccine here within 48 hours. Should there be an incident it would be regarded as an international catastrophe, not just a problem peculiar to Australia.

Senator McLUCAS—Just moving off the stockpile to a broader question of response to bioterrorism events, what is to be done in terms of strengthening the ability of our public health system to detect and respond to a bioterrorism event?

Prof. Smallwood—I think it is fair to say, Senator, that there has already been considerable improvement in preparedness, which was begun before the Olympics—it certainly had a big kick forward in the Olympics. And then since September 11 there has been further activity. I think it goes to establishing links through the Public Health Laboratory Network and the Communicable Diseases Network of Australia as far as bioterrorism is concerned. Emergency Management Australia is another organisation; and the Australian Disaster Medicine Group.

The networking amongst these groups has become much tighter. There has been training of individuals in the sorts of responses that will be required, and I think that the Public Health Laboratory Network and CDNA, the Communicable Diseases Network, are on a much more alert footing. I think we can reasonably say that our public health infrastructure is reasonably placed. The question of how sophisticated our surveillance is, how effective our syndromic diagnosis capacities are, is one that is under active consideration. As to what sorts of alertings should be available to GPs and to others who might be the first to spot a smallpox case, these things are under continued and active consideration. An expert group to consider some of the scientific issues around smallpox, in particular, has been convened, and again it has a number of issues under very active consideration.

Senator McLUCAS—You have identified a whole range of networks. Who is taking the coordination role?

Prof. Smallwood—The group within the department has a major role. The National Public Health Partnership has also a major role in making sure that these networks are functioning well.

Senator McLUCAS—Will we end up with a disaster response plan? Is that a proposal?

Prof. Smallwood—There is that. There have been plans in the past, but there is one that is updated. Again it is what I think is termed a 'living document'. It is one that will not just sit there on a shelf without constant attention and revising as the situation evolves. We hope it will not evolve, but it may.

Senator McLUCAS—How much money has been allocated to the planning and development of all of that disaster response work, or is that absorbed within current allocations?

Prof. Smallwood—At the moment, I think, it is largely absorbed within current allocation. The money that was earmarked in the budget is specifically for the various stockpiles.

Senator McLUCAS—I have a couple of very quick questions on flu vaccines. There has been some reportage of the cost of unused flu vaccine. Can you estimate for me the amount of unused flu vaccine doses, and the cost of that since the inception of the program in 1999?

Mr Sam—We do not collect data specifically on unused vaccine. We have noted that the uptake in the over-65s program has increased since the inception of the program. In 2001, the coverage was 78 per cent; we are expecting that the coverage for 2002 will be over 80 per cent. We fund states and territories to 100 per cent of the eligible cohort. Our main indicators relate to leakage of the vaccine to non-eligible persons. The last survey showed that that had dropped to 16 per cent. Looking at the numbers, if the coverage rate is approximately 80 per cent and the leakage rate is 16 per cent, there remains four per cent, in effect, unaccounted for.

Senator McLUCAS—When you say the leakage rate has dropped to 16 per cent, what did it drop from?

Mr Sam—The first estimate, in 1999-2000, was 20 per cent.

Senator McLUCAS—So we were looking at probably about a four per cent unused in 2000-01. Is that right?

Mr Sam—To be clear, the issue is whether the vaccine was used appropriately or unused. We cannot differentiate that which was, in effect, wasted—that is, not used—from that which was used in persons other than those over 65.

Senator McLUCAS—There was a report that 150,000 vaccines were destroyed last year. If you put $22.40 on that, it comes to $3.36 million. What is your view on the veracity of those claims?

Mr Sam—I think the issue is that the Commonwealth does not purchase influenza vaccine at the retail price. I cannot give you the exact figure, but it is certainly closer to $10 per vial than it is to $22.

Senator McLUCAS—So with 150,000 vaccines being destroyed we are still looking at $1.5 million. Is that right?

Mr Sam—If those figures are correct.

Senator McLUCAS—Is there any way that we can find out whether or not these figures are correct?

Mr Sam—Yes, there is. Through the funding agreements with the states, we ask them to undertake quality assurance surveys on stock rotation and stock that is left in situ in the fridges of providers—GPs—and so on. As coverage increases, the amount available for wastage, by definition, will decrease. But the difficulty with this program has been ensuring that those who are eligible get access to the vaccine. The trade-off, in terms of the highest level of accountability, has been seeing that coverage increase. That is largely about provider behaviour, ensuring that general practitioners and other providers who have vaccines at their disposal use them appropriately.

Senator McLUCAS—There is a balance there, and I think you have described that well. But what would the department like to see as an appropriate level of wastage? We acknowledge that there will be, but what are you aiming for?

Mr Sam—The benchmark, in terms of wastage for vaccines within the childhood program, for example, is between five and eight per cent.

Senator McLUCAS—Depending on the shelf life?

Mr Sam—Depending on the shelf life and the nature of the vaccine itself. Just to reiterate: influenza vaccine is a little more difficult to manage to the same degree as those vaccines that have longer shelf lives. Demand varies from year to year, and supply varies from year to year. Getting the distribution of the vaccine to provide us nationally to match demand is not as predictable as it is with other vaccination programs. But we have seen an improvement in terms both of coverage and of reduction in wastage, and that was what we asked the states to address specifically.

Senator McLUCAS—Thank you.

Senator DENMAN—We have had 14 cases in Tasmania in the last few months, and I know that the problem is a worldwide shortage of vaccine. We cannot get vaccine. Can you give us an update on how that is being addressed? I know it is not this government's fault but a world problem.

Mr Sam—The vaccine you are referring to, Senator, I assume is the meningococcal C conjugate vaccine.

Senator DENMAN—Yes.

Mr Sam—That has been available privately in Australia now for some months.

Senator DENMAN—It is $70 a shot. That is the cost.

Mr Sam—I understand that is the retail cost of that vaccine. At the moment, there is only one supplier of that vaccine in the country. We are hopeful that that will not be the case, in terms of having other suppliers providing that vaccine to the market. We hope that would occur within the next six to 12 months.

In terms of what else we can do, I think the most important thing is that, as we do each year, we monitor the incidents of meningococcal C and other forms of meningococcal disease. It would appear at this stage that we are not experiencing epidemics or unusually high epidemics of the disease, but that is clearly an issue for us to watch. It should also be noted that there are other vaccines available that can be used to control outbreaks of this particular infection, should they be needed. So we are liaising with our state and territory colleagues just to maintain a higher level of alert, to identify outbreaks quickly and to ensure that the response occurs quickly. We will also maintain contact with the Therapeutic Goods Administration about any developments in other manufacturers applying to supply to the market here.

Senator DENMAN—In Tasmania they have undertaken an advertising campaign mainly aimed at young people in risky behaviour. Is that possible to look at nationally?

Mr Sam—Yes, it is. The Commonwealth facilitated a review of the meningococcal control guidelines under the auspices of the Communicable Diseases Network and promotional activities were a component of that. I think both in Tasmania and the ACT those programs will need to be evaluated in terms of their effectiveness. But I think there are general messages that are promulgated at the beginning of winter around the meningococcal vaccine and meningococcal disease. Risk behaviour is one component but the most important really is early identification of symptoms, particularly in young children.

Senator DENMAN—Where is this vaccine produced?

Mr Sam—I may have to defer to my TGA colleagues specifically to say where it is produced from.

Senator DENMAN—I just wonder why there is such a shortage worldwide.

Mr Sam—I cannot comment specifically; the only information that the manufacturer has supplied to us was that their production worldwide has been affected and that this was not peculiar to Australia. I will have to take that on notice.

Senator DENMAN—Thank you. I have finished that.

Senator CROWLEY—On the topic of pap smears, I really wanted to know a little bit more. Given the trouble that we have had and the anxiety and confusion that it has caused people, could you take us through the timeliness and/or the timelines of what happens when a pathology lab fails to meet the standards or is said to have failed to have met the appropriate standards?

Ms Blazow—That is more for outcome 2, because the pathology accreditation standards are actually part of the Medicare system and the way that that relates to Medicare eligibility. I know that a lot of attention has been put in just in recent months to actually review the current arrangements there so I would prefer if that could be deferred until my colleagues from outcome 2 are here.

Senator CROWLEY—Give me a minute to meditate on these questions to see whether some belong here or not. Are you saying the questions about public notification and informing patients of lapses, the timeliness and so on, belong in outcome 2?

Ms Blazow—Yes. The procedure for accreditation of labs as it relates to Medicare is actually part of Medicare and therefore covered by outcome 2. Certainly the cervical screening program has a great interest in that because it is part of our quality assurance for the program, but the actual logistics are undertaken as part of Medicare by the HIC, the College of Pathologists and NATA, the accreditation agency.

Senator CROWLEY—Would questions about how often we have to have pap smears be in your area?

Ms Blazow—Yes.

Senator CROWLEY—We will hold these questions to Medicare in section 2, but I thought I had read somewhere, Minister Patterson, that you were saying every three years will do.

Senator Patterson—I do not know where you read that. That would have meant that somebody put words in my mouth, Senator Crowley.

Senator CROWLEY—If I have got that wrong, Minister, please explain. I am sorry.

Senator Patterson—There was a report, I think about two weeks ago—do not hold me to that date—where somebody at an international conference was comparing across countries the pap screen rate.

Senator DENMAN—It was on 11 April.

Senator Patterson—I think it was reported in the newspapers in the last few days that two years was too short but that three years was adequate, and it compared other countries. If you would like a briefing on this, I am happy to go through it. There is conflicting evidence about whether that is right. There are some issues about the public relations exercise that would be required if we were to move to a three-year screening program. We need to evaluate, as a public health issue, whether we believe that it is two or three years. There will always be debate about it. I think the figure is that if it is three years you increase the risk of somebody dying of cervical cancer by a very small amount. People have to make that decision in terms of population health, whether you actually, by picking up more people by using the money saved by the three-year screening, encourage more people who have not had cervical screening to be included in the program. All those have to be weighed up. I think it was your government, in 1991, who brought in the two years and I think we would have to proceed carefully if we were to even consider three years. We have to look very carefully at the data. I have not said, at any stage, anywhere, that three years will do.

Senator CROWLEY—Thank you very much for the clarification. I guess from what you have just said that there is evidence that there would possibly be a small increase in the number of people who got cervical cancer.

Senator Patterson—You do not want to believe everything you read in the paper. I have only read in the paper the other day a report of this conference. I have not actually seen the original paper.

Senator CROWLEY—Even if it were the case, it would be a hard call to say, 'We reckon five or 10 women every three years is not worth worrying about.' I am not saying you are suggesting that at all, but I would have thought that if there was any hint of evidence that a few more women would die it would be a good case for not moving.

Senator Patterson—This fellow's argument was that you would save money by having it every three years and you could actually use that money to collect in the people who were not

having it at all, and that might save more lives. That all has to be looked at. I think it is a bit premature at the moment—

Senator CROWLEY—That is encouraging. Would you know, or is any work going to be done on, the costs saved by doing pap smears every three years, as apart from the costs outlaid to change the program to every three years, to say nothing of all the literature that says to come in every two years et cetera?

Senator Patterson—There has been an estimate that it would cost something like $10 million to publicise the change alone. I might be corrected on that figure. I read a briefing note yesterday or the day before.

Senator CROWLEY—That is departmental work that suggests there would be a significant increase in cost to change it?

Senator Patterson—Yes.

Ms Blazow—Actually, it is not only departmental work. As you would know, we have an advisory committee involving a number of experts also. A cost-effectiveness study of the possibilities for various intervals between screens has been commissioned. That study is in progress at the moment.

In addition, there are a number of other complex factors, as the minister has mentioned. As you would be aware, there are attitudinal issues about how often people believe they need to screen, and we already have data that about 35 or 36 per cent of women are screening more frequently than our recommended period of two years now. We are doing tandem research to work out how we could address that to work out how—if the cost-effectiveness study shows that we could extend the interval, achieve the mortality reductions and reduce the cost—we could then change the attitudes to get people who are already now screening more frequently than two years to change their behaviours to screen on a three-year or longer interval. That would be a significant issue we would need to address. It is not just a matter of changing the policy.

The third area of work that we are doing, which is very important, concerns new and emerging technologies in this area. You would be aware of the liquid based preparation, the role of human papilloma virus as a determinant of cervical cancer risk and so forth. So we are also doing work on what we can do about those new technologies, and we have got the Medicare advisory structures having a look at cost-effectiveness and the efficacy of those technologies for screening. So we have got three strands of work going on. We expect it will take 12 months or so before that comes together and we will be able to give advice to government on the best possible screening protocol for Australia and also the means of rolling that out. It is not just a matter of making the decision. We have to work out how we could implement it to get it working effectively.

Senator Patterson—The other thing is this, Senator Crowley. I know there are people who screen earlier, and that is a significant problem. But there are those of us who get the letter and do not go for three, four or six months. When you go for three years, that pushes it out even further. I think we have to make sure. The concern that I had when I looked at that suggestion was with regard to people's behaviour. People are busy—some have small children—and it is a matter of whether three years means three years or 3½ or nearly four. I thought it was very interesting. I think it was a man who made the suggestion; he most probably does not get a call-up letter. He would not get a call-up letter, but he might—I do not know. I presume he does not.

Senator CROWLEY—Do you have any evidence of the profile of the people who are having smears more often than every two years? For example, are they younger?

Ms Blazow—Yes, they tend to be younger. We believe that the view is that, because it is a good thing to do, the more often you do it the better therefore it is. People do not fully understand that screening does not necessarily mean you have to do it more to get the same outcome.

The other misconceptions we need to work on are that many women believe that the pap smear does a lot more than it actually does for checking a whole range of sexual health issues. We need to do quite a bit of work on explaining to people the purpose of the pap smear and that it is about detection of cervical abnormalities, not about a whole range of other conditions.

Senator CROWLEY—My experience is a bit similar. There are certainly younger girls, if I can call them that, and young women who are sexually active, who feel that this is one way in which they can check that something bad has not happened. I suppose if they have a message of behaving in a healthy way, even if it might be a bit wrong, it is hard to interrupt that message, wherever they have got it from. The question I wanted to pursue is how you would get that message out to such a category or cohort of women—or have you already planned for this?

Ms Blazow—Yes. We are working on that at the moment. We think another key to that is working with the GPs as well, so that the GPs are giving better information at the time that they are taking the pap smears, about the purpose of the pap smear and what it actually does, particularly if they are aware that the woman is presenting more regularly than the recommended protocol. The new cervical PIP, the practice incentive program, can also play a role there because the GPs will be getting slightly extra financial reward for undertaking those smears, which enables them to provide a bit more time.

Senator CROWLEY—How many smears would be done by the GPs compared to family planning, women's health centres or alternative health centres?

Ms Blazow—I cannot break it down to family planning in particular, but I can certainly break it down generally. We know that 80 per cent of smears in Australia are done by GPs. So 20 per cent are done in the other sectors—community health clinics and so forth.

Senator CROWLEY—The message would be well focused if it went through to GPs, who might also follow up.

Ms Blazow—Yes.

Senator HERRON—There are five female senators here and two males. I see six women and Professor Smallwood at the front. I want to put a word in for the males. There are 10,000 men diagnosed with prostate cancer every year. The department would be aware of an excellent book put out by the Australian Cancer Society on the management of prostate cancer. Is the department allocating any funds for the dissemination of that book throughout the nation; is it taking any interest in that booklet? I consider it to be an excellent booklet, given the difficulty of management of prostate cancer. I am not advocating screening for prostate cancer, because that is fraught with problems. Has the department allocated any funds to prostate cancer management?

Ms Blazow—In a number of ways we allocate funding for prostate cancer. As you rightly point out, we do not have a screening program for it and there are good reasons for that.

However, that does not mean that it is not recognised as a significant problem in the community. We fund a male reproductive health facility in Melbourne based at Monash University. One of their main aims is to disseminate better information to men on prostate disease, and they are doing a range of activities around that particular disease: forums for men in communities, written information, working with general practitioners to disseminate the messages and so forth. I am not aware of the Cancer Council booklet as such, but we could certainly find out. I know that another area in the department does work closely with the cancer councils; that is our Health Investment Division. They have cancer as a national health priority area under their responsibilities and they do quite a lot of work with the cancer councils. We also fund the national cancer control initiative, which has a whole range of cancers on its work program for both research type activities and promoting the dissemination of better information.

Senator HERRON—The booklet can be obtained from the Australian Cancer Society or any urologist. The National Seniors Association funded it for the Australian Cancer Society. It was launched in Canberra earlier this year. But I bring it to your attention. The prostate cancer support group, as I understand it, has requested a meeting with the minister. I do not know whether that has occurred.

Senator Patterson—The meeting has not occurred, no.

Senator HERRON—It has not occurred.

Senator Patterson—Senator Herron, every part of your body most probably has 50 disease processes and every organisation has a group. And I am trying to see them all.

Senator HERRON—You will be pleased to know, Senator Patterson, that I asked that they see your chief of staff to screen them out. Given that, apart from lung cancer and bowel cancer, prostate cancer is the biggest killer of men in society, I think it should be given a higher profile, that is all. I draw that to the attention of the department.

Ms Halton—Senator, thank you for drawing it to the attention of the department. Notwithstanding the gender balance which you have rightly drawn attention to, I would be remiss if I did not say to you that the first time I ever came to Senate estimates with the health portfolio I was one of only two women in a sea of grey suits. The senators on the other side of the table were a similarly replicated sea of grey suits. That said, we are as conscious of men's health issues as we are of women and we take your admonition very seriously. Thank you for drawing it to our attention.

Senator WEST—There are still a lot of grey suits behind you, Ms Halton.

Ms Blazow—On prostate cancer, in outcome 2 also there is some work proceeding under the Medicare banner around academic detailing of how prostate cancer is dealt with in practice in Australia. Perhaps that could be referred to them as well and they could provide the information about that program.

Senator HERRON—That is in the booklet.

Senator CROWLEY—For the record, I would like to suggest that good health policy did not get to cervical smears because there were finally women who knew the need for them, though the case is in fact that that is true, isn't it? But I would have thought that men ran the world for a long time. If they had not found out about their prostates during that time, we are pleased to assist them after the event.

Ms Halton—Well, perhaps not, Senator—not personally anyway.

Senator CROWLEY—Sorry, Senator Herron, I could not resist.

CHAIR—Any further questions on outcome 1?

Senator WEST—Can I turn to deep venous thrombosis, please. I understand that there is an international study being conducted on deep venous thrombosis. Is that correct?

Prof. Mathews—There is a study looking at deep venous thrombosis.

Senator WEST—I understand also that Australia did not decide to sign on to this research. Is that correct?

Prof. Mathews—There are two issues, Senator. The first, and the matter I think you are referring to, is an initiative through the World Health Organization to fund a number of interrelated studies, and it is true that Australia has not contributed to that program. The reason for that is that the department has sponsored a study in Australia to try to give a quick answer about the risk of deep venous thrombosis in air travellers arriving back in Australia. That study will tell us the magnitude of the risk more quickly, we believe, than the rather ambitious program of research that WHO has proposed.

Senator WEST—Why not sign up for the WHO one, though, if it is longer term and it is going to encompass a wider range of issues?

Prof. Mathews—It is basically a judgment of cost-benefit and timing. We believe that within a relatively few months the study the department is doing will give us an answer about the magnitude of the problem and provide a basis for any future work which might involve collaboration with the WHO program.

Senator WEST—What is the WHO one doing that we are not doing?

Prof. Mathews—There is a very large range of programs which are not only looking at the association, or argued association, between air travel and deep venous thrombosis but also trying to look at the mechanism. Our view is that any study looking at mechanisms should follow a study that shows, yes, there is a real risk, and a study looking at the mechanisms should also be looking at the effectiveness of interventions. That is the thinking that has guided the department.

Senator WEST—Are you implying that there is not an increased risk of DVT from economy travel?

Prof. Mathews—We believe it is very likely, but none of the data that are currently available give us a definitive estimate of how big the risk is. As you would be aware, all the airlines are providing advice to their passengers now to reduce the risk, on the assumption that it is causally related to travel, but nobody has a good estimate of what the magnitude of the risk is—nor, we believe, of the effectiveness of the intervention.

Senator WEST—Would Australia expect to be able to access the results of the WTO surveys and studies if we have not signed up to it?

Prof. Mathews—You would understand that most work that is publicly funded, whether it is by an individual country or an international program funded through WHO, would normally be published in the literature. That is one of the understandings. The only reasons that people would not publish information of that kind would be commercial-in-confidence reasons, and I would not expect there to be any of those in relation to the WHO study.

Senator WEST—So you expect to be able to utilise the results of the WTO surveys and research without paying any money?

Prof. Mathews—We are investing in Australia in the study I alluded to. We will, we hope and believe, have more definitive information available to WHO and other people through our own study at an earlier stage. We are certainly making an international contribution, as well as a contribution to knowledge in Australia.

Senator WEST—Who is undertaking the study in Australia?

Prof. Mathews—It is being organised through the department, through portfolio strategies; we have had, through population health, a role in helping with the design of the study and it is being done in conjunction with Western Australian researchers.

Senator WEST—Who?

Prof. Mathews—There is a group in Western Australia, and Professor D'Arcy Holman is involved. The basis of the study is to link the history of deep venous thrombosis to the time that people arrive in Australia after international travel.

Senator WEST—How were Professor Holman and his group decided upon as the group to undertake this research?

Prof. Mathews—The cost effectiveness of a study based on record linkage was one of the issues.

Senator WEST—Before you continue, could whoever has a mobile ringing switch it to 'silent' or 'meeting' so that it does not ring. It does help.

CHAIR—Can we proceed.

Senator WEST—I find it most distracting.

CHAIR—It is hardly interfering with what we are doing.

Senator WEST—I was finding it distracting. How was Professor Holman and his group decided upon?

Prof. Mathews—The group in Western Australia was involved in record linkage and had great expertise in the epidemiological skills required for this study. At the time this study was mooted, that was the only group which had the capacity to do a study of this kind.

Senator WEST—When was the study first mooted?

Prof. Mathews—I think it was—

Dr Wooding—I would probably need to check the information. Professor Mathews and I have been coordinating the study, and the study was first mooted last year. It was about the middle of last year that we first thought of the idea.

Senator WEST—So we are talking July or August last year?

Dr Wooding—Yes.

Senator WEST—What stage are we at now?

Dr Wooding—We expect the first results to appear by about September, Senator.

Senator WEST—By about September?

Dr Wooding—Yes.

Senator WEST—So how much is going into this particular study?

Dr Wooding—The costs are being absorbed within the operating costs of the department. We are also receiving some assistance from the Department of Immigration and Multicultural

and Indigenous Affairs, which is providing us with the data and helping us there. I could go away and see if I could give you a costing, but it is absorbed within our ongoing work.

Senator WEST—Has Transport got any involvement in it?

Dr Wooding—I think we have talked to Transport, but we are getting data from Immigration because that data is comprehensive and gives us what we require.

Senator WEST—Is it true that it is only $100,000 that it is costing?

Dr Wooding—That would be quite likely, I think. As I say, it is just a notional cost that is absorbed within our own ongoing expenses.

Senator WEST—Right. What do you expect to do with the research?

Dr Wooding—We are hoping, first of all, that it will need to be peer assessed as we will need to be certain about the outcomes. I think we would make it publicly available. As Professor Mathews said, I think we would try to feed it into the work that WHO is doing. It will provide very valuable early information about the actual association and the level of risk.

Senator WEST—So what is happening in September; what becomes available then?

Dr Wooding—That will be the first data that we will have been able to link and to be quality assured about. One of the issues we have is that it takes a lot of time to do this sort of data linking exercise and get absolutely high quality results—results that you can be certain enough to publish. Doing data linking is a time consuming process.

Senator WEST—Are courts already awarding compensation for this condition?

Dr Wooding—It is not my area.

Prof. Mathews—We would have to take that on notice. My understanding is that there may be some cases pending in Australia at the moment.

Ms Halton—I do not know that that is a question that we can actually answer.

Senator WEST—No, it has just occurred to me that you are saying, 'We are not sure there is a link. We are trying to do this to get some idea if there is a link and then we will look at possible treatment and if the treatment is working.' If the courts have already decided there is a link and your research comes up and says there is no link, if the courts have already given compensation, that would raise some interesting—

Dr Wooding—We are trying to establish the extent of the link. I think it has long been believed that there is a link but we have no hard statistical data that will show the percentage likelihood increase of having deep vein thrombosis after a long plane flight. What we are looking for here is evidence. It is a widely held view and it has been held for a long time.

Senator WEST—When will the first research and first material become public?

Dr Wooding—Until we are satisfied with the quality I cannot give an absolute assurance but we think we will have some definitive data on a preliminary basis by September; after the peer review and other processes have been gone through to make sure that we feel it is of sufficiently high quality, we would release it.

Senator WEST—My colleagues, when November comes around for the next round of estimates, will be able to follow up and ask what the situation is.

Dr Wooding—I expect we will have made a lot of progress by then.

Senator WEST—I hope you will have. I wonder what we are doing to our lower vascular flow sitting here with the stasis that occurs here.

Dr Wooding—Similar risks.

Senator WEST—I will leave DVT there.

Senator McLUCAS—I notice that you are working with DIMIA and obviously looking at information about international arrivals. Are we not looking at any of the long-haul flight domestic travel information or has that essentially been ruled out as a risk area. I am thinking of Cairns-Perth flights and Melbourne-Perth flights.

Dr Wooding—That is something we would look at once we had completed the international work. We will get some relatively short-haul international flights in any case because there are some flights of three to four hours to Australia internationally. First of all let us establish the information in relation to these long flights and then we could look further later.

Senator McLUCAS—Thank you.

Ms Blazow—Senator Knowles, can I just return to the discussion about meningococcal C.

CHAIR—You may.

Ms Blazow—We have obtained information about the question on the countries of manufacture of the meningococcal C vaccine. There are two main manufacturing plants, one in USA and one in Europe.

CHAIR—Thank you, Ms Blazow. Any further questions on 1.1?

Senator McLUCAS—Just some quick questions on the Community Partnerships Initiative Croc Eisteddfod festivals. I notice there is an extra $1.2 million in terms of the Croc Eisteddfod festivals. Can you tell us where that money is going to be allocated, please?

Ms Kerr—I beg your pardon, Senator. Was that the croc festivals you mentioned?

Senator McLUCAS—Yes.

Ms Kerr—Ms Van Veen will be able to talk about that but, yes, there is additional funding for the croc festivals.

Ms Blazow—Additional money for the croc festivals was provided in the budget context.

Senator McLUCAS—Yes, I am just looking at where that money is going to be allocated geographically. Thank you.

Ms Van Veen—The money is allocated over a period of four years to Indigenous Festivals Australia to stage the croc festivals in a number of rural and regional areas. In this calendar year, 2002, festivals will be held in Weipa, Nhulunbuy, Kununurra, Kalgoorlie, Port Augusta, Swan Hill and Moree. The $1.2 million is allocated over a period of four years.

Senator McLUCAS—Thank you. I understand that there has been an evaluation process commissioned through the National Drug Research Institute. Where are we up to with that evaluation report?

Ms Van Veen—I am not familiar with that one. Certainly we have done previous evaluation on the festivals, but it was not through the National Drug Research Institute. Is there another—

Ms Kerr—I think senators may be referring to the Community Partnerships Initiative, because the National Drug Research Institute in Perth is doing an evaluation of that.

Senator McLUCAS—Of the whole initiative?

Ms Kerr—Of the Community Partnerships Initiative, which is a separate initiative from the croc festivals. The Community Partnerships Initiative is the one that has received new money in the budget at page 50 of the PBS. There is currently an evaluation proceeding on the money that has already gone out in that program.

Senator McLUCAS—Going back to that point, in a question on notice from last estimates, Senator Evans was advised:

The Department will evaluate the effectiveness of the sponsorship provided to future Croc Festivals ...

Is there a formal evaluation occurring?

Ms Van Veen—At the moment, we are drafting a research brief to assess this year's festivals. We are planning on conducting an evaluation.

Senator McLUCAS—How long will that take?

Ms Van Veen—The festivals roll out from July through to September. We would be hoping to conduct it over that period of time. I would expect that towards the end of the calendar year we would have the evaluation results.

Senator McLUCAS—Thank you.

CHAIR—Are there any further questions before we move on to TGA?

Senator HARRADINE—Could I ask whether the Medical Services Advisory Committee comes within outcome 1 or outcome 2?

Ms Halton—It is within outcome 2, Senator.

Senator HARRADINE—Thank you. I want to raise questions about the abortifacient drug Postinor-2. Does that come under this outcome? It is probably a combination of TGA or 'Population health and safety'.

Ms Murnane—The officer is coming; he is next door.

Senator HARRADINE—I want to ask questions about this drug, particularly so that there is proper and full information available for those who may use the drug if it is approved for importation by the minister. The purpose of the drug is what?

Dr Hunt—The indication that was approved for the use of Postinor-2 was as an oral emergency contraceptive indicated for use within 72 hours of unprotected intercourse. It should only be used as an emergency measure. Women who present for repeated courses of emergency contraception should be advised to consider long-term methods of contraception.

Senator HARRADINE—Where did that come from?

Dr Hunt—That is the indication that was approved by the delegate of the secretary when the product was entered into the Australian Register of Therapeutic Goods.

Senator HARRADINE—Was that a description given by the manufacturer of the drug?

Dr Hunt—That indication is not only included on the Australian Register of Therapeutic Goods but is the indication contained within the prescribing information, which is the information which sets out information about the safe and effective use of the product for the

information of health professionals. In lay language, similar information is provided in the consumer medicine information document.

Mr Slater—The indication is not just the one that is proposed by the manufacturer. The approved indication is arrived at only after assessment by the Therapeutic Goods Administration and referral to the Australian Drug Evaluation Committee, which, in discussion with the TGA, gives recommendations about the approved indications. So it is not just what is proposed by the manufacturer.

Senator HARRADINE—Is it not a fact that the drug is intended to operate to render the lining of the uterus hostile to the implantation of an embryo?

Dr Hunt—I understand that is the main claimed mode of action of the product as an emergency contraception tool.

Senator HARRADINE—When does conception take place?

Dr Hunt—There are a number of arguments concerning when conception takes place.

Senator HARRADINE—No, scientifically, when does conception take place? Does not conception take place at the fusion of the sperm and the ovum?

Dr Hunt—I am aware that there are different opinions—

Senator HARRADINE—And is it not at that time that there is a new life—that there is an embryo formed?

Dr Hunt—My understanding is that the view currently held by a large number of people is that a life or a pregnancy is formed after implantation of an embryo.

Senator HARRADINE—I am sorry. I am talking about—

CHAIR—Just to interrupt here, Dr Hunt, you are not being asked for a personal definition. If you have a definition in answer to Senator Harradine's question that has been associated with the drug, you are able to give that definition. Please do not feel that you are being asked to give a personal opinion on this question.

Dr Hunt—Thank you, Senator. I am aware that there have been a number of opinions expressed over many years, but my understanding is that the scientific opinion that is used, and has been used for a number of years, is that pregnancy is said to occur after implantation and not before implantation.

Senator HARRADINE—I ask the question, and I want the answer from the department and the TGA—not your own personal answer: does the TGA say that conception does not take place at the fusion of a sperm and an ovum?

Mr Slater—The legal advice we have is that, for the purposes of defining what happens before implantation, we rely on the legal advice from Attorney-General's that fertilisation might take place on day one, as you say, but implantation takes place on day six or seven, and that is when a pregnancy is formed.

Senator HARRADINE—You are describing this drug to the women of Australia as an emergency contraception. Is it not a fact that, if conception takes place on day one, it is deceiving the women of Australia to describe this drug as an emergency contraception?

Mr Slater—With great respect, Senator, the woman involved does not know whether she is pregnant or not when she takes a postcoital contraceptive. She is making a decision about contraception rather than a decision about anything else.

Senator HARRADINE—I am talking about your description of the drug as a contraceptive. You, or Dr Hunt, told the committee just a moment ago that you agreed that the main purpose of the drug is to render the lining of the womb hostile to implantation of the embryo. If there is an embryo, then conception has already taken place.

Mr Slater—One of the main purposes of the contraceptive pill is to do just that. That is accepted by the medical profession, and by the community, as being contraception.

Senator HARRADINE—I am talking about the scientific term. I have been involved in another committee on the question of experimentation on human embryos for stem cells. There is no doubt in the minds of the scientists—you mentioned scientists—that conception takes place when there is a fusion of the sperm and the egg. I put it to you that to describe the main intended effect of this drug as contraceptive is to mislead Australian women.

Mr Slater—The Therapeutic Goods Administration relies on legal advice here. While there may be differences in scientific views, the legal advice that we have says that this is a contraceptive action, not an abortifacient action.

Senator HARRADINE—So you rely on some sort of tinpot legal advice instead of scientific advice? You go to a lawyer about a scientific matter?

Mr Slater—It is the view that would be likely to be upheld by courts in Australia.

Senator HARRADINE—Oh, yeah? Are you referring to a 1997 Attorney-General's Department opinion by a lawyer who was not a QC—not a senior counsel at all? Are you relying on that?

Mr Slater—No, I am relying on the latest advice from the Australian Government Solicitor, which is based on a decision handed down by the UK High Court. That decision supports the legal advice that you have in your hand, which we provided to you.

Senator HARRADINE—Can I have a look at that advice now?

Mr Slater—Certainly. We would be happy to provide that to you.

Senator HARRADINE—What was the judgment that you were talking about?

Mr Slater—It was the judgment by Munby J in a UK decision taken on 18 April.

Senator HARRADINE—What was that with respect to?

Mr Slater—I will just quote from it—it is in respect of the Smeaton case:

The issue in *Smeaton's case* arose out of an order made by the Secretary of State for Health which had the effect of making a progesterone-only morning-after pill a drug that could be supplied under the supervision of a registered pharmacist, rather than a prescription-only drug. The Society for the Protection of Unborn Children (SPUC) alleged that the order could involve or facilitate the commission of criminal offences under the Offences Against the Person Act 1861 (the 1861 Act). The effect of the 1861 Act, when read with the Abortion Act 1967, is that abortifacient substances may be administered only on the certification of two medical practitioners. SPUC's case was that this morning-after pill was an abortifacient.

And I think you will agree that it bears directly on the discussion we are having.

Senator HARRADINE—Are you saying to this committee, as you seem to be inferring, that the judge stated that conception does not take place at the fusion of the egg and the sperm—are you saying that?

Mr Slater—Sorry, Senator, I missed that last bit.

Senator HARRADINE—Are you telling this committee, as you seem to be inferring, that the judge stated that fertilisation/conception does not take place at the fusion of the ovum with the sperm?

Mr Slater—No, Senator—

Senator HARRADINE—Well, why did you raise it?

Mr Slater—I am saying that this legal advice that we have from the Australian Government Solicitor, having looked at the UK case, backs and supports exactly the legal advice that we had in 1996-97 that we have passed to you and that we have been relying on for making the decisions that we have.

Senator HARRADINE—And calling it a contraceptive when conception has already taken place? Are you saying that the judge in England is saying that?

Mr Slater—The judge is supporting the case that this is a contraceptive, not an abortifacient.

Senator HARRADINE—That it is a contraceptive? Does he say that?

Mr Slater—His finding was that this was not an abortifacient effect.

Senator HARRADINE—No. You seem to be very confused about this. You are suggesting that the judge said that conception does not take place when every scientist knows when it does take place. We are talking about being honest about these matters and giving full information and fully informed consent by the persons that may take them.

Mr Slater—I am happy to provide this legal advice to you, Senator, but if I can read the conclusion of the legal advice we had from the Australian Government Solicitor, it says:

In summary, we consider that an Australian court would adopt a similar approach to the approach taken by the UK High Court in *Smeaton's case* to the issue of whether the morning-after pill is an abortifacient. The approach taken in *Smeaton's case* is clearly supported by a considerable body of legal and medical opinion. We consider it is highly likely that an Australian court would also conclude that an abortion cannot occur before implantation and that the morning-after pill is not an abortifacient.

Senator HARRADINE—But that does not say that it is a contraceptive.

Mr Slater—It is not an abortifacient.

Senator HARRADINE—Are you saying it is a contraceptive?

Mr Slater—If it is not an abortifacient and it is taken by the individual who is not aware of whether they are pregnant or not, I say to you that they are taking a contraceptive decision, not any other decision.

Senator HARRADINE—You are describing the drug as a contraceptive, an emergency contraceptive. You say, do you not, that that advice from the Attorney-General's Department—by the way, who wrote that advice and what level was it?

Mr Slater—It was from the Australian Government Solicitor.

Senator HARRADINE—Who wrote it?

Mr Slater—The advice is from Henry Burmester QC. He is the Chief General Counsel, Australian Government Solicitor.

Senator HARRADINE—Are you saying that that advice supported what the advice was in 1997?

Mr Slater—Yes.

Senator HARRADINE—Can I go to that particular opinion. That particular opinion cited R v. Price as proof that 'prevention of implantation is not an abortion'. R v. Price was a case that involved a 10-week-old foetus. It had nothing to do with the reimplantation issue. That was one of the judgments that was relied upon by the 1997 opinion. You also cited statements made by a number of US Supreme Court judges in Webster v. Reproductive Health Services. Are you aware that none of those judges quoted was in the majority? The opinion that you rely on refers to the case of Young v. Northern Territory. Are you aware that that case does not even refer to the issue of abortifacients and that the case of the plaintiff was that the doctor was negligent?

Mr Slater—I have got to make it clear that the TGA relies on the opinion of the Attorney-General's Department and the Australian Government Solicitor; that is the legal advice that we have got. We sought follow-up advice, following the UK High Court decision, and that advice confirms the advice that we got in 1996-97, which we passed to you.

Senator HARRADINE—The answer is either 'yes' or 'no'; it is either a scientific fact or it is not.

Mr Slater—Just as there may be varying legal opinions and scientific opinions, the legal advice that the TGA relies on is the government legal counsel's advice.

Senator HARRADINE—And he says that conception does not take place in the fusion of the sperm and the egg?

Mr Slater—What they say is, as I read out to you, that this is not an abortifacient.

Senator HARRADINE—That is not what I asked you. I am talking about what you describe the pill to be. It is the drug companies that are misleading the women.

Mr Slater—The critical issue here is that we have approved the marketing of this product as a postcoital contraceptive, based on the fact that the individual making the decision to use the product is making that decision with the knowledge that they want to take a contraceptive decision, not an abortifacient decision.

Senator HARRADINE—Is that the basis on which you make your decisions—take a poll? Do you get around the community and just take a straw poll as to what the people think or may not think? Do you make those decisions in the department of health like that? You just do a survey—'What do you think about this?' Are we not talking about the fact of life?

Dr Hunt—Senator, could I just clarify one thing. You mentioned that a major mode of action of this product is the prevention of implantation, but I think it may be pertinent to the conversation between Mr Slater and you to mention that this product can also prevent ovulation and fertilisation. It is unlikely, given the period of its use, that you would know which it was doing in a particular instance. So it does not just have an action related to prevention of implantation.

Senator HARRADINE—If a person wanted to take a contraceptive, they would take a contraceptive. But the main purpose for taking this drug and its main action in that case would be to render the lining of the uterus hostile.

Dr Hunt—That is one of its actions, Senator. It can also prevent ovulation and fertilisation. It can have three possible actions.

Senator HARRADINE—But aren't there other drugs that do that, that have far fewer side effects or ill effects than this particular drug?

Dr Hunt—This product has three modes of action. It can prevent ovulation, fertilisation or implantation. Any product will have some side effects; even placebo as a product will have side effects. But this product was assessed by the TGA and considered by an expert advisory committee, the Australian Drug Evaluation Committee, in relation to its safety and effectiveness for its intended use as postcoital contraception. It was found to have an adequate profile in terms of safety and effectiveness. Information about side effects is contained in both the prescribing information for health professionals and the consumer medicine information for consumers. Both of those documents also contain information about the three modes of potential action of the product.

Senator HARRADINE—Are you saying that women who purchase this particular drug have it prescribed as a contraceptive?

Dr Hunt—I am sorry, I did not understand that question, Senator.

Senator HARRADINE—Are you suggesting, seriously, that the use of this drug as a contraceptive would be why it would be purchased?

Dr Hunt—It may be purchased as a postcoital contraceptive, and its actions to achieve that can involve a combination of prevention of ovulation, of fertilisation or of implantation.

Mr Slater—I think the critical thing here, Senator, is that an individual who seeks this product knows that they have got 72 hours. They want to take a contraceptive decision. So they seek after an incident of sexual contact, whether that sexual contact be consensual or otherwise, to make a decision about preventing pregnancy. That is a contraceptive decision. And this product is marketed with that indication as its approved indication.

Senator HARRADINE—That its main intended effect is not as a contraceptive?

Mr Slater—It is sought by the consumer as a contraceptive. They are making a contraceptive decision. They want to prevent pregnancy.

Senator HARRADINE—That is not a contraceptive decision. You are saying now that they want to prevent implantation. The drug operates on the basis that it would render the lining of the uterus hostile. Now could I just ask: have you had a look at the *Macquarie Dictionary*? Do you know what the *Macquarie Dictionary* says about 'abortion'? Among other things, 'abortion' is defined as 'the arrested development of an embryo or an organ at its more or less early stage'. Now there is 'planning'. We are talking about what people in Australia define as 'planning' in their interpretation of the English language. And isn't the *Macquarie Dictionary* quite frequently used for the purpose of looking up what the plain meanings of words are in Australia; I am talking about Australia? Is that right?

Mr Slater—Our legal advice goes to the definition used in the *Macquarie Dictionary* of abortifacient. It says that abortifacient is defined in the *Macquarie Dictionary* as something used to produce abortion. The key issue in considering whether morning-after pills are abortifacients is whether an abortion or induced miscarriage can take place after fertilisation but before implantation has occurred. Our legal advice goes to explore that question, Senator.

Senator HARRADINE—What does the legal advice say is in the *Macquarie Dictionary*?

Mr Slater—It says that abortifacient is defined in the *Macquarie Dictionary* as something used to produce abortion.

Senator HARRADINE—How then does it define abortion?

Mr Slater—This legal advice explores that.

Senator HARRADINE—I do not want to hear about the legal advice. I want to hear what the dictionary says. I am talking about what the plain language says.

Mr Slater—It says 'something used to produce abortion'.

Senator HARRADINE—Then, in defining abortion, the *Macquarie Dictionary* says, amongst other things, 'the arrested development of an embryo or an organ at its (more or less) early stage'. That is precisely what is happening here.

Mr Slater—The legal advice here goes to whether an abortion or induced miscarriage can take place after fertilisation but before implantation, which is the question I think you are getting at. Hence the TGA, in taking its decisions as to how this product is described, relies on the government legal adviser, and that legal advice is very clear.

Senator HARRADINE—But it does not rely on the plain English language that people understand. I am asking this question so that people are not deceived. I appeal to the government to take that into account. Could I go to the question of efficacy of the drug and the ill effects. Is it a fact that the ill effects include irregular bleeding, breast tenderness and nausea as the most common side effects?

Dr Hunt—I understand that is correct, Senator.

Senator HARRADINE—What is the estimated effectiveness of the drug?

Dr Hunt—I do not have the actual clinical trial section of the prescribing information in front of me. I am happy to take that question on notice and provide you with the information about the effectiveness seen in clinical trials, as published in the prescribing information.

Senator HARRADINE—What is the element in the drug which forces the shedding of the uterus's lining, preventing the embryo from implanting?

Dr Hunt—The active substance is levonorgestrel. It is thought to have three modes of action: to prevent ovulation, prevent fertilisation and prevent implantation.

Senator HARRADINE—I am talking about what is the effective element within the drug itself.

Dr Hunt—The active ingredient is called levonorgestrel.

Senator HARRADINE—That releases progesterone hormones, does it?

Dr Hunt—It is a progesterone hormone.

Senator HARRADINE—What does progesterone attack?

Dr Hunt—I am not sure what the question means, Senator Harradine—the physiological action of progesterone?

Senator HARRADINE—In the contraceptive pill, what is the main element?

Dr Hunt—In this particular pill, which contains levonorgestrel—

Senator HARRADINE—No, I am sorry, I am talking about the usual contraceptive pill.

Dr Hunt—There are a number of variations of contraceptive pills. There are oestrogen- and progesterone-containing contraceptive pills and there are progesterone-only-containing contraceptive pills.

Senator HARRADINE—I notice in the *Advertiser* of 3 June this week it said 'Vending machine push for morning-after pill':

A morning after pill drug company wants to sell its new "emergency contraceptive" in Australia through supermarkets and vending machines.

Mr Slater—Senator, the morning-after pill is a prescription-only product.

Senator HARRADINE—Is there any application in place by the company or anybody else to allow its sale without prescription?

Mr Slater—No.

Senator HARRADINE—What would you do if you received an application to allow this sale?

Mr Slater—There is an agreed national process for deciding on access restrictions to medicinal products, and that is the National Drugs and Poisons Schedule Committee, which is a Commonwealth, state and other stakeholding interest committee which looks at every application for any rescheduling or descheduling of the initial decision made by the Therapeutic Goods Administration.

Senator HARRADINE—I am not sure what that means in practical terms.

Mr Slater—It means that if a company wishes to apply for non-prescription use, for example, then they need to make an application to this national committee, which will evaluate the merits of that case and seek public submissions and make a decision about it.

Senator HARRADINE—What about the likelihood of higher percentages of ectopic pregnancy amongst users of the so-called postcoital contraceptive?

Dr Hunt—I understand the rate of ectopic pregnancy with the use of products like Postinor-2 is being looked at by the authorities in the UK. As yet there is no clear evidence that it is necessarily increased with the use of morning-after pills such as Postinor-2, but that is under review by the UK agency. We are awaiting the outcome of that review and then the availability of any new information on the true incidence.

Senator Patterson—Senator Harradine, while you are looking through your papers there, I would just like to make a short statement if I may, Madam Chairman, basically for the committee's benefit but also for the benefit of other people who happen to be watching estimates. Apparently the press is running a line that the government has withdrawn funding for retractable needles. I think the committee would all agree that that is not what has happened. We made a commitment of over $27 million that is to be spent in a staged way to ensure that we have the appropriate introduction of retractable needles and that we have the best technology. There is no resiling from that commitment by the government. For anything that happened here earlier this morning to be interpreted that way I think the committee would agree would be totally incorrect.

CHAIR—Thank you, Minister.

Senator HARRADINE—I do not think I have anything further than just to ask again the very interesting question as to whether the department of health says that conception does not take place at the fusion of the sperm and the egg.

Mr Slater—The discussion we have been having is about the legal advice that the Therapeutic Goods Administration has with regard to how to treat this particular product. That advice we have is clear: this product is not an abortifacient.

Senator HARRADINE—Oh dear! How can we get the facts from the department of health? Does it believe the scientifically proven fact that conception takes place at the fusion of the egg and the sperm? This is very vital when you are talking about being truthful to the public, to the taxpayers, and, most importantly, to the women. I just want an answer. The department of health, of all people, apparently do not believe that. You do not believe the facts of life. It is a fact of life. I have been in the other committee and the scientific evidence is absolutely overwhelming.

Mr Slater—I do not think there is any disputation that fertilisation takes place when the sperm meets the egg.

Senator HARRADINE—Well, why do you call this a contraceptive?

Mr Slater—Because, as I said to you, the decision taken by the individual here is a contraceptive decision, not any other decision.

Senator HARRADINE—Okay, I will leave it there.

Senator HERRON—I want to clarify it in my own mind, having listened to this interchange. As I understand it, a side effect of this particular drug is that it prevents implantation. Is that correct?

Mr Slater—It is one of three actions.

Senator HERRON—It is one of the three effects. You are saying that preventing implantation is not abortion.

Mr Slater—I think you would agree that the intra-uterine device is used by women to prevent pregnancy and it is a contraceptive decision that they—

Senator HERRON—That is getting into another field. Let us not confuse this.

Mr Slater—No, but it is a contraceptive decision that they are taking and its action is to prevent implantation.

Senator HERRON—That is correct. So it is used to prevent implantation. It is an abortifacient? You are not saying that they are not—

Mr Slater—It is a decision that they take as a contraceptive decision to use an IUD. And its action—

Senator HERRON—I find you are relying on semantics. I just find this quite bizarre. You have just agreed that when a sperm meets an egg, that fertilises the egg. Whether it be a human being, a monkey or a mouse it does not really matter. Are you disagreeing with that?

Mr Slater—No, you would know, Senator, that many times when the sperm meets the egg there is no pregnancy that is involved because it does not get to implantation, for whatever reasons. It might be the individual.

Senator HERRON—On what do you base that statement?

Mr Slater—On the fact that if we come to look at the term miscarriage, a miscarriage cannot take place—

Senator HERRON—I do not want to get into this argument with you.

Senator Patterson—Well, you have.

Senator HERRON—I have? I will pursue it then, if you wish. For example, we do know that some people produce antibodies to the sperm and therefore conception does not occur.

But you have not said that. That is habitual miscarriage. But we are getting into terminology here which I do not think can be sustained scientifically.

Mr Slater—Look, Senator, that is why we have been discussing the issue. We have tried to act very much with the legal advice given to us about the action of the postcoital contraceptive, and that legal advice is clear: it is not an abortifacient.

Senator HERRON—That is some advice that you have received. We all know that you can get lawyers on both sides of an argument—that is fairly easy to obtain. I can instance 10 advices that were given by the Attorney-General's Department in my portfolio, nine of which were lost in the High Court. So I do not rely on a particular advice.

Mr Slater—This was upheld in the British High Court, Senator.

Senator HERRON—We are not subject to the British High Court, with respect. We are subject to the High Court of Australia. That can be used in argument. But I do not want to get into that—I do not want to get sidetracked. I would like to know, now that this has been raised, where we are at in relation to this particular drug? Is it before the TGA?

Dr Hunt—Senator, the tablet was approved by the TGA in October 2001. I understand it is not yet available on the market, but it has been approved by the TGA.

Senator HERRON—What is the cost of the drug?

Dr Hunt—It is available by prescription. I am not sure how much they are charging. I believe it may be in the order of $20 for two tablets.

Senator HERRON—Twenty dollars. Is it subsidised?

Dr Hunt—I do not believe it is PBS listed, but I would have to seek the advice of the PBS in that regard.

Senator HERRON—Do we know how many prescriptions have been written?

Dr Hunt—Sorry, Senator.

Senator HARRADINE—Not any.

Senator HERRON—Not any yet. I was just trying to work that out. Thank you very much.

Senator HARRADINE—This is what it is all about, is it not? If it does have an abortifacient effect, then under the legislation it is a prohibited import, is it not?

Mr Slater—That is exactly right, Senator.

Senator HARRADINE—Yes, that is exactly right. All of the argument is designed, is it not, to ensure that the drug is not able to be characterised as per the definitions in the *Macquarie Dictionary* as having an abortifacient effect?

Mr Slater—That is incorrect, Senator. All of the advice and the discussion that we have had this morning are about the fact that the legal advice that we have is very important to us, as the Harradine amendments that you moved define abortifacients as restricted goods, and those are decisions that the TGA cannot take to accept an application. They are decisions that would be taken by the minister and hence it is most important that we get the legal advice right.

Senator HARRADINE—So you got the—

Mr Slater—If I may go on, Madam Chair, in that case it was absolutely critical that we got appropriate legal advice. The legal advice that we got in 1996 was to that effect and it has been confirmed by legal advice of 31 May 2002 which confirms that this is not a restricted good.

Senator HARRADINE—You are a client department of the Australian Government Solicitor. Would you provide to the committee the instructions that you gave in your request to the Australian Government Solicitor so we know what you said to the Australian Government Solicitor?

Mr Slater—We agree to pass that advice to you, Senator.

Senator HARRADINE—Thank you.

Mr Slater—And to the committee.

Senator HARRADINE—Who has made the decision, given the importance of this matter and the amendments to the Therapeutic Goods Act, that it does not need to go to the minister for health?

Mr Slater—That decision was taken by the Therapeutic Goods Administration based on legal advice.

Senator HARRADINE—Finally on this question, because it is an important question, the drug company Schering is trying its best to get this to be able to be sold in supermarkets and vending machines. I would want to know, in addition to what you have said to me, and I think the committee would be very interested to know, what action you propose to take when you receive an application from Schering to do just that?

Mr Slater—As I said, Senator, any application to that effect goes before the National Drugs and Poisons Schedule Committee. No decision can be made to change the current schedule without agreement by the majority of jurisdictions in Australia. So that means the Commonwealth and the states would need to, as a majority, agree that it was able to be—

Senator HARRADINE—What is the view of the Commonwealth?

Mr Slater—That would need to be considered.

Senator HARRADINE—Could you take that on notice?

Ms Halton—That is a hypothetical question. It is a question of government policy which, as I think the officer has said, has not been considered.

Mr Slater—We would also need to see the application.

Senator HARRADINE—It is a policy question. I will need to refer that to the minister in due course.

Mr Slater—Certainly we would not be forming a view until we had the application and saw the arguments.

Senator HARRADINE—But you mentioned it is a policy question, so it will be up to the government to make the decision in respect of that matter, not the TGA.

Mr Slater—It may well be that we might seek the minister's advice on that, but the application would need to be received and analysed before we took any decision.

Senator HARRADINE—There is really not much to analyse: either you are for it being sold in supermarkets and vending machines or you are not.

Mr Slater—The other thing that I should mention here is that any application is open to public submission, so we would expect the committee would be informed by the views of the community.

CHAIR—Are there any further questions of the TGA?

Senator McLUCAS—I have some questions for the Office of the Gene Technology Regulator.

CHAIR—There are no further questions of the TGA. Thank you very much.

Senator McLUCAS—Are you independent of the TGA?

Mr Slater—The head of the Office of the Gene Technology Regulator, Dr Sue Meek, is an independent statutory officeholder. The Office of the Gene Technology Regulator fits within the broad TGA structure.

Senator McLUCAS—How many licences for field trials of GM crops were granted in 2000-01 and to date in 2001-02?

Dr Meek—There would not have been any licences issued prior to 21 June 2001 because that is when the new Gene Technology Act came into effect. Since 21 June last year we have issued four licences for dealings involving intentional release to the environment. There are other dealings not involving intentional release as well. Are you interested in those or are you particularly interested in intentional releases to the environment?

Senator McLUCAS—We are talking about field trials?

Dr Meek—Yes, that is intentional releases. I have two types of licences I issue; one is for intentional and one is not intentional release to the environment. So there are four.

Senator McLUCAS—How many have been inspected for compliance with the conditions in their licence?

Dr Meek—It is a little early yet. The licences have only relatively recently been issued. I issued one in January this year and the others have only just been issued in the last month or so. So it is a little early. However there are very detailed monitoring compliance strategies included in the implementation of these licences and we will certainly be inspecting along the way. Indeed, the companies themselves are required to report against that strategy as time goes on.

Senator McLUCAS—So to this point we have not had any direct inspections but you expect that to occur?

Dr Meek—Yes, certainly.

Senator McLUCAS—To what level and how do you make a decision about which field trials will be inspected?

Dr Meek—We have a minimum target of 20 per cent of all field trials to be inspected on a rolling annual basis. The ones that we would select for inspection would probably be on a range of issues. We are trying to use our resources most effectively and so we would target inspection at times when there may be the greatest risk, for example, when the plants were flowering or during harvesting periods. We have introduced a risk profiling strategy to time and target monitoring visits to the greatest effect.

Senator McLUCAS—So it is not simply a random event?

Dr Meek—No, although we would include random just because it gives you a better base of information. As well as retaining monitoring we would also include spot checks which would be potentially random or targeted at specific times.

Senator McLUCAS—And how many inspectors do you have in your office?

Dr Meek—There are approximately 10 people in the monitoring and compliance and enforcement area in the office.

Senator McLUCAS—Thank you.

Senator WEST—Did you ask how many breaches had been reported in the last 12 months?

Dr Meek—Sorry, I have to do a mental calculation about when the act came into place and when it did not. Since the act came into effect, there have been some minor non-compliances but no actual breaches. Prior to the coming into effect of the legislation there were some breaches in relation to some GM canola trials in Tasmania.

Senator WEST—What is the difference between a breach and a non-compliance?

Dr Meek—It relates to the degree of severity, essentially. And non-compliances can be about areas of discussion about whether or not adequate measures are being taken to comply with licence conditions, whereas a breach would be an actual contravention of a licence condition.

Senator WEST—In relation to the non-compliances, I do not necessarily want to know the specific cases, because I would guess that you are not going to tell me that, but can you give me some indication as to what the non-compliances have been, where they have been—details like that?

Dr Meek—There is a process of reporting of non-compliances in the quarterly report. To date, we have issued two quarterly reports and they summarise the investigations that we have undertaken.

Senator WEST—How serious were the non-compliances?

Dr Meek—There have been no indications of risk to human health and safety and the environment as a result of any of them.

Senator DENMAN—The non-compliances are followed up again within a relatively short period?

Dr Meek—Yes. We may require companies or organisations to take further action as a result of any non-compliances that we might detect and then we would certainly confirm that those were followed up on and implemented.

Senator WEST—When you undertake the review of the non-compliances, how much warning do you give them, or do you actually just turn up on their doorstep to check?

Dr Meek—In the initial event of a non-compliance, if we have not detected it ourselves, when they would know that we found it, or if there may be certain circumstances where people actually advise us that they have had a non-compliance of some kind, then obviously they would know that we are going to turn up. We may or may not give them advance warning if we were going to check up, as the previous senator was just requesting information on.

Senator WEST—I would not want a situation where they were perpetually non-complying and that if they knew when you were coming they would straighten things up.

Dr Meek—In fact, that was the intention of introducing, as I mentioned earlier, this idea of spot checks when we would turn up unannounced and look around, yes.

Senator WEST—Thank you. That is all I have got for that. Can I turn to ANZFA in program 1, please?

ACTING CHAIR (Senator Tchen)—The Chair, before she left, suggested that if—

Senator WEST—I think I can get this completed by one o'clock. I have got a clear mission in life, Senator Tchen: lunch at one o'clock with the completion of program 1 is my mission. I think everyone will agree with that.

[12.50 p.m.]

Australia New Zealand Food Authority

ACTING CHAIR—I remind officers to identify themselves when they speak.

Senator WEST—I want to ask about some recent press coverage I have seen in relation to the use of antibiotics and growth promotants in animal husbandry and the view of ANZFA in relation to that—or the position of ANZFA would be more to the point?

Dr Healey—There are several agencies involved in the regulation of chemicals that might be used for agricultural and veterinary purposes. One of those agencies is the national registration authority, and their responsibility is for approving the use of the antibiotic and other chemicals. ANZFA's role is to ensure that, when there might be residues of those chemicals present in the food, those residues do not pose a risk to public health and safety. Our general approach is, firstly, that they do not pose a risk to public health and safety and, secondly, that they will be used at the minimum level required to achieve their purpose—what is called the ALARA principle.

Senator WEST—So you have no opposition in general to the use of antibiotics in animal husbandry particularly to facilitate growth promotion?

Dr Healey—That is not an issue for ANZFA to address except in terms of public health and safety and the impact that the residues may have, through the food supply, on health and safety.

Senator WEST—My concerns in relation to this relate to antibiotic resistance that might be built up within the product that the humans are then going to consume. Antibiotic resistant organisms are a major issue in the delivery of health care. In the last week, we have seen the closure in Prince of Wales in Sydney the intensive care unit and another ward—I presume it would have been the high dependency ward—while antibiotic resistant organisms were cleaned out and the place decontaminated. There is a very big health cost there, not only in terms of human life. Firstly, there is a cost in terms of the people who will die because you have not got an antibiotic to which the organisms are not resistant. Secondly, there is a cost in terms of the impact on a system such as Sydney of the closure of one of the major intensive care units in one of the major teaching hospitals in that city—a teaching hospital that is a feeder hospital: it is level 5; it has specialist areas of which there are a limited number in Australia. There is a cost there. I am wanting some feedback on that particular issue.

Dr Healey—In terms of looking at the residues in food, one of the pieces of advice that both the NRA and ANZFA require is from the EAGAR group—

Senator WEST—Is from?

Dr Healey—EAGAR, the Expert Advisory Group on Antibiotic Resistance, which is established under the auspices of the National Health and Medical Research Council. They are regarded as Australia's expert group in assessing the potential for resistance to particular antibiotics.

Senator WEST—So should I be asking the NHMRC some questions about it?

Prof. Smallwood—I would like to make a couple of comments. It is a major issue. The particular committee alluded to is one group that is looking at the whole issue of antibiotic resistance. There is a CMO report on communicable disease that will be coming out later in the year, I hope, which takes this up as an issue. I am aware that AFFA is also looking hard at the use of antibiotics in the way that you have indicated. There is also a departmental group looking at the government's response to the committee that looked at the use of antibiotics and antibiotic resistance. So it is a major concern and there is a lot of work going on in the area.

Senator WEST—With no disrespect to the agricultural sector, I do know it and come out of it. I can hear them now trumpeting to everybody that, if they actually were able to use these products, they would get X amount increase in productivity and they would get X amount of export dollars for this country, and those export dollars, they will claim, are probably going to be greater than what the cost in cash terms is of regularly cleaning out Prince of Wales intensive care and every other intensive care unit that there is in this country. So I have some concerns about—

Ms Halton—Can I make a comment about that, Senator? In fact, only a matter of a week or so ago the minister chaired the Food Standards Council. I think it is important to understand that this is an issue where, in fact, agriculture and health ministers come together. There is a very great awareness of the issues that you raised. In the meeting chaired by the minister, this issue was alluded to on a couple of occasions. To suggest—as you rightly say with due respect to the agricultural industry—that that industry will be in a position of being able to dictate, without any consideration of those issues, what can and cannot be used is not a reasonable reflection of the strategies and the structures that have been put in place to deal with these issues.

Senator WEST—That is fine, but I am just alerting people to the fact that there is going to be some serious pressure out there and it is going to be an interesting one for you. My replacement colleagues will await with interest the CMO's report on this issue, because it is something that I think is of grave concern to us all. The other question relates to the issue of caffeine in products. To go back to growth promotants and antibiotics, the other issue in relation to that is not just the antibiotic-resistant organisms but also, for people who have severe reactions to some of those products in their correct place, the lack of any labelling on a product to say, 'This product, organism or food'—usually meat—'has been treated this way.' Do we know how much residual of the antibiotic might be left in the product which could cause, in the most acute area, an anaphylactic reaction by somebody who has that sort of reaction to the antibiotic or the growth promotant?

Ms Halton—The ministers at their last meeting asked for a policy working group to look at these issues, so that issue has been referred to policy officials. That is not actually a TGA issue; it is a policy issue. It is going to be dealt with in that group.

Senator WEST—Minister, when are you going to have some good answers for me? It is in a ministerial group.

Senator Patterson—As Ms Halton has said, it is a high priority for the ministers across both portfolios, and it goes back to the council in November. With regard to caffeine—you were about to say something about caffeine—the health ministers again expressed concern that there was a need for a caffeine policy. We have asked for that issue to be addressed as well. I think that is also to come back for November, but I will not hold myself to that time.

Senator WEST—With the addressing of the caffeine issue, in the meantime what is going to be happening? Are there going to be any more products allowed on the market with caffeine or are some of the drink manufacturers going to be allowed to introduce caffeine while we are waiting for the policy?

Mr Liehne—We have a couple of applications before us looking at caffeine. One is an application seeking to permit caffeine at a relatively low level for flavour purposes in soft drinks. This would allow caffeine to the level of 145 milligrams per litre. This is the level that is associated with, or has traditionally been permitted for, cola based beverages where the caffeine is a critical factor in the flavour profile. There was a previous application on that issue which was subsequently withdrawn; a new application, essentially in similar terms, has been put to the authority.

It should be noted that we are developing standards that will apply both in Australia and in New Zealand. In New Zealand there is currently a general permission for caffeine in soft drinks at 200 milligrams per litre. We are addressing that issue and looking at caffeine in a much more detailed fashion.

The board of the authority have agreed to a set of principles that they would apply in relation to decisions on caffeine. These are three principles. The first of them is that, where there is uncertainty about the potential for adverse health effects, particularly in children, we should take an extremely cautious approach in terms of permissions for the addition of caffeine to foods.

The second is that, when caffeine is added to food other than one in which it occurs naturally, there has to be a labelling requirement to indicate that caffeine has been added, regardless of its source, and to give some indication of the amount of caffeine that is in that food.

The third principle is that, where caffeine is used for a stimulant effect—that is, above that 145 milligrams per litre or per kilogram which is generally accepted as the level for flavours—other restrictions and warning statements may apply. For instance, with the group of products known as the formulated caffeinated beverages, there are a number of advisory statements that are mandated on those products to indicate that they are not suitable for children or for pregnant women and to provide that advice to consumers so that they are aware of the higher levels of caffeine in those products.

Senator CROWLEY—Do you anticipate you will have to do something when New Zealand says 200 and we say 145—in other words, when the standards are different? Is this arm-wrestling or a gentle elegant discussion?

Mr Liehne—Under the treaty and the arrangements for developing a joint food standards code, there is a commitment for both Australia and New Zealand to have common standards. Within that framework, decisions are made that are the best regulatory decisions in the context that that applies. It means that in some circumstances the decisions of what is required

in Australia take precedence and in others we take account of the different decisions in other areas. For the purposes of caffeine in softdrinks the decisions or the principles that I espoused about particularly having a very conservative view on products that may be targeted at children would certainly loom large in the consideration of where this may go. At the same time, whilst the board have articulated three principles that they normally apply to the issue of caffeine in food regulatory decisions, the Food Regulation Standing Committee, which is the principal committee of officials that provides policy advice to the ministerial council, is also looking at the issue of caffeine in a broader context. I am not sure of the time frame for the development of that advice, but I expect that there will be some update of that to ministers in November as well.

Ms Halton—Senator, I chair the officials committee and we have got a very clear remit from ministers to look at the issue in a policy sense. Can I also make the point that the New Zealand minister is actually on that ministerial council, so I am sure there will be a very elegant discussion of those issues when relevant.

Senator CROWLEY—I am terribly chuffed that we have got to vote for elegant discussions. I am not clear at the end whether or not it is possible for Australia and New Zealand to settle for different standards, whether an agreement will have to be reached, and indeed how you win. That is all I really want to know. What is the process for dealing with it when there is a difference?

Mr Liehne—The terms of the treaty do provide for different standards in Australia and New Zealand in specific circumstances.

Senator CROWLEY—Is caffeine one of them?

Mr Liehne—Caffeine would not fit the circumstances that are currently espoused in the treaty.

Senator CROWLEY—Okay. So we can do it but not in this case. I just want to know how we do it in this case.

Mr Liehne—The decision will be one where the ministerial council will ultimately agree to the position that comes through. I expect that in this case, given the comments that have been made from ministers in relation to caffeine, a quite conservative position will be taken.

Senator CROWLEY—Thank you.

Mr Liehne—I am not suggesting in any way that I am speaking for the ministerial council in saying that.

Senator CROWLEY—I understand what you are saying.

Senator WEST—I am sure the minister is sitting here listening to our comments. I should have prefaced mine by saying that, as somebody who is very sensitive to caffeine, I am very aware of what it can do. For some people it can be an insidious drug.

CHAIR—Any further questions on outcome 1?

Senator WEST—No, I think it is lunchtime.

CHAIR—There being no further questions, the committee will adjourn until 2.15 p.m.

Proceedings suspended from 1.05 p.m. to 2.16 p.m.

CHAIR—I reconvene the meeting of the Senate Community Affairs Legislation Committee on the budget estimates. Dr Morauta has said that she would like to add some information to that given prior to lunch.

Dr Morauta—I will ask Ms Kerr to go first.

Ms Kerr—The answer to one of the questions you asked this morning in relation to the funding we provide to the national research centres on drugs is that the Commonwealth Department of Health and Ageing has provided a total of $3.5 million this financial year to the three national drug research centres to support their core programs.

CHAIR—Thank you, Ms Kerr.

Dr Wooding—I wish to add to the answer to Senator West's question about the costs of the deep vein thrombosis study. I neglected to mention that we actually have a contribution towards the project from the Department of Transport of $100,000, which is the $100,000 that Senator West was mentioning. The bulk of the expenditure is in-house costs; however, there is some money being expended on services provided by the University of Western Australia to a total of $13,500. That covers data extraction costs and some services provided by Professor Holman.

CHAIR—Thank you. We will now move to outcome 5. Senator McLucas has questions.

[2.18 p.m.]

Outcome 5: Rural health

Senator McLUCAS—Just going to the issue of rural GPs, could we have an indication of the total funds that have been spent on GP retention in rural and remote areas for 2000-01?

Mr Eccles—That is an issue that is best dealt with under outcome 4.

Senator WEST—What areas of rural health are you going to cover, then?

Mr Eccles—Essentially the programs that are listed under outcome 5 in the PBS, and perhaps issues of a broader rural nature.

Senator WEST—So GP numbers are going to be in outcome 4?

Mr Eccles—That is right.

Senator BUCKLAND—Is that going to cover the specialists in rural areas as well?

Mr Eccles—Yes, it will. It will be between outcome 5 and outcome 9, depending on the nature of the inquiry.

Senator BUCKLAND—Thank you.

Senator DENMAN—Does that incorporate the minister's announcement recently on dermatology and rheumatology services in Tasmania?

Mr Eccles—Yes.

Mr Stuart—I thought there was some ambiguity about the question and the answer just then. Questions in relation to medical specialists in rural areas under MSOAP are dealt with under outcome 5 now.

Senator DENMAN—The minister announced recently that Tasmanian rural areas are to benefit from a new visiting dermatology and rheumatology service. When will this program begin?

Mr Eccles—My understand is that services are ready to commence as soon as they have been able to recruit the appropriate specialists to provide those services.

Senator DENMAN—Have you any idea how many patients you expect to benefit from this program?

Mr Eccles—I do not have that information on hand but I can certainly—

Senator DENMAN—I am sure the minister would have had figures.

Mr Eccles—In terms of the service plan that would have been lodged leading to the consideration of that request for support, certainly that information would be there. It would not be hard at all for me to get it to you.

Senator DENMAN—Thank you. What other health services has the department identified as being needed in rural and remote areas in Tasmania? I have got lots.

Mr Eccles—Tasmania is benefiting from all the rural programs. I can talk in broad terms. Certainly there is a significant amount of activity under the regional health services program, where we are working directly with small rural communities to identify what the local area health priorities are. A number of those have been approved over the past two years, and several more are, I understand, coming up. The multipurpose service program is also set to expand in Tasmania, and we are working with a number of communities to finalise those services. As we mentioned, some specialist outreach funding has been announced recently and we expect that in Tasmania that is also going to grow over the coming years.

In terms of the specialist care activity, there are palliative care services, general psychiatry, rheumatology, dermatology—

Senator DENMAN—I am aware of all these, but my concern is that the programs are there but we are not attracting specialists: they will not work in Tasmania, particularly in remote areas like the West Coast, Queenstown and those places.

Mr Eccles—Yes. That is a challenge that we are seeing in a number of places.

Senator DENMAN—Yes, it certainly is.

Mr Eccles—In the development of the service plans that take place for each state and territory, quite a bit of emphasis is placed on what is feasible and what is likely. While the approval of the service plan, of course, does not guarantee that those services will flow, an appropriate analysis has been undertaken and so we expect that there is a significant likelihood that they will be able to get those visiting services. The Medical Specialist Outreach Assistance Program aims to deliver visiting services, particularly in those locations that are not able to sustain or attract a permanent specialist, for whatever reason.

Senator DENMAN—You would expect that some of these visiting specialists will not actually reside there. If they are visiting specialists, of course they will not reside in the area. There are problems with occupying families and living in those sorts of areas. Do you expect they will fly in from Melbourne? I am talking about the West Coast specifically at the moment. Will they fly from Hobart?

Mr Eccles—From either Hobart or Melbourne, predominantly. One of the key things that they will also be doing is working closely with the local GPs and other health workers.

Senator DENMAN—There aren't any.

Mr Eccles—Certainly they will work with the local health workers, so that there is some continuity, and also with other GPs who maybe providing visiting services in those areas.

Senator DENMAN—If these people fly in from, say, Hobart or Melbourne, how often would you expect that to happen? Once a month?

Mr Eccles—It varies on the nature of the speciality and the community need. It could well be once a fortnight, for a day. In some instances it may be once a month, for a day or two. It depends very much on what the particular needs of that community have been identified as.

Senator DENMAN—Thank you.

Senator HERRON—Is the department doing or about to do a medical work force survey?

Mr Eccles—Medical work force issues in general are best dealt with under outcome 9.

Senator HERRON—Thank you.

Senator BUCKLAND—Minister Anderson's statement says:

More medical specialists are visiting rural South Australia and providing services through the Medical Specialist Outreach Assistance Programme ...

This is, of course, enhancing the general practitioner's skills. Then he goes on to say:

The programme should become fully operational in 2002-03 and it is expected that more than 300 outreach services will be providing services in about 50 rural regions of Australia.

What new services will be established, can you tell us?

Mr Eccles—Across Australia?

Senator BUCKLAND—Yes.

Mr Eccles—As the paper you referred to indicated, there are some 300 new services planned. At this point in time, there are about 250 approved. The program was a bit slow to start. We will be fully subscribed by next year—there will be 300. I can certainly go through what the broad areas of support will be.

Senator BUCKLAND—That would be fine.

Mr Eccles—Why don't I do a snapshot for each state and territory?

Senator BUCKLAND—That would be very helpful, particularly for South Australia, but we would be interested in the total.

Mr Eccles—All right, I will start with South Australia. The main focus of the outreach services that have been approved in South Australia at this time—and there still is scope to grow in South Australia—is on visiting psychiatry services in rural areas and palliative care. Along with the palliative and the psychiatry services that are being delivered via outreach, there is a strong component of upskilling the local GPs as well—for example, in the far west region of New South Wales. Would you like me to read them out or table it? There is a list of 250.

Senator BUCKLAND—Certainly table it, but you were just going to give us a broad outline.

Mr Eccles—I will give a snapshot. In New South Wales, there are general physician, neurology, endocrinology, dermatology and rheumatology services being provided to Broken Hill. It is very much based on the particular priorities of the area that is being targeted. It does vary very much from region to region. For example, in the Hunter region—

Senator BUCKLAND—That is broad enough for my understanding of what you are saying. It would be particularly good if you could table the full list.

Mr Eccles—We will take that on notice.

Senator BUCKLAND—You said in part of that answer that, with psychiatry and palliative care, there would be general upskilling of GPs. How is that going to be done, given that GPs in country and rural areas are stretched to the limit now, such that they cannot visit capital cities for upskilling with their peers because they cannot leave their communities?

Mr Eccles—One of the things that we hoped to do by having visiting specialists go out to some of these communities is to relieve some of the burden on some of the GPs as well. The local arrangements will differ from community to community. A very important element of the program is to make sure that there is some continuity of care so that the patient does not feel that they are betwixt and between the specialist visits. An important element is to make sure that the local general practitioner or the other health service providers are aware of the situation to make sure there is some continuity of care. It does differ from region to region, Senator.

Senator BUCKLAND—Have the actual regions been identified? There are 50 regions, I think.

Mr Eccles—Yes, they have been identified.

Senator BUCKLAND—Perhaps you could table it rather than go through the list; that would help.

Mr Eccles—Yes. I do not have them here. I will certainly take that question and the other one on notice and get back to you.

Senator BUCKLAND—If you could take it on notice, I would appreciate that.

Mr Eccles—Sure.

Senator BUCKLAND—We still have questions unresolved with the medical indemnity problem. Is that likely to interrupt this program of introducing more services?

Mr Eccles—It has not been raised as an issue to date with the medical specialist outreach program.

Senator BUCKLAND—All right, I cannot really pursue that much. Are you saying that no-one has actually raised that?

Mr Eccles—Not in the context of this program because the specialist outreach assistance element of their work, if you like, is a relatively small part. It is not appropriate for me to comment on medical indemnity issues.

Senator BUCKLAND—I would not ask you to do that.

Mr Eccles—No, it has not. I suspect that the specialists who are providing the outreach assistance work are dealing with these issues as part of their mainstream practice, if you like.

Senator WEST—What about those that are outreaching into Aboriginal medical service centres?

Mr Eccles—Are you again talking about the indemnity issue, Senator?

Senator WEST—You are saying it has not been an issue, I am asking has it been—

Mr Eccles—I will clarify what I said. It has not been raised as an issue in the context of the medical specialist outreach assistance program, I am certainly not dismissing that it may be an issue in the context of their mainstream work life.

Ms Murnane—Aboriginal and Torres Strait Islander health will come on later this afternoon, or tonight probably, and Ms Evans will be able to tell you whether it has come up as an issue.

Senator WEST—You would be surprised if we did not have some questions for you about that, Ms Murnane.

Senator BUCKLAND—Going back to the program, how were the communities or regions identified?

Mr Eccles—In each state and territory we have state-based advisory committees and they are comprised of key interest groups, general practice groups, people from the health and medical workforce, rural service managers, there is indigenous service representation and other people. They advise the department on areas within the state that were considered priority and there was a range of data that assisted them to come to that decision and also a lot of local knowledge and consultation on the ground with a range of key stakeholders.

Senator BUCKLAND—So that would have been, as you say, done through consultation with the community.

Mr Eccles—That is right.

Senator BUCKLAND—How long does that process take if it was to be extended, and maybe I am going beyond the bounds of what this is? If this program was extended beyond the 50, because some regions have been left out, what is the period of consultation to develop that program?

Mr Eccles—It varies significantly. As we have discovered in all things rural, it is quite often the case that the communities with the highest need have the lowest capacity, if you like, to articulate their health needs so it does take quite a bit longer. It varies very much from community to community. Sometimes if they have a high level of capacity that can happen quite quickly, but other times the consultation process, it is the most important process and it does take some time, so there is no simple answer, Senator.

Senator BUCKLAND—You might just explain to me the quality improvement framework. Can you explain what this is?

Mr Eccles—Are you referring to something in particular?

Senator BUCKLAND—I am sorry but I cannot take you to the exact quote but there is reference to a quality improvement framework, which I guess this whole program is aimed at. What outcomes are you looking for from it, apart from improved medical services in rural areas?

Mr Eccles—I am not sure I have a complete understanding of the question. We certainly have quality improvement frameworks around a number of our programs which are all about making sure that everyone is clear that what we are trying to do is put in place a process of continuous improvement, regular review and reassessment and continuous focus on improving the way services are provided. That is built into a number of our programs.

Senator BUCKLAND—I cannot take that further because I cannot find the reference that I had for that and I apologise for that. There is also reference to 20 service delivery and seven service planning projects to be allocated. Can you explain those to us?

Mr Eccles—Sure. I think you are on the regional health services program there.

Mr Stuart—I think you may be dealing with an aspect of the after hours program. If that is the case then we can take those questions in outcome 4 tomorrow.

Senator BUCKLAND—All right then.

Senator Patterson—Senator Buckland, this is quite a complicated area. I am not trying to avoid the issue but if you would like the department to give you a briefing on the various programs and how it is decided where they will be I would be quite happy to offer that to you. You can ask questions about budget issues and things but if you sit down with the department they can take you through the rural health services, the specialist outreach program, the after hours service program—the various programs that have been put in place. That is not to avoid any questions about budget and budget things. You obviously have a very deep interest in it but you might be able to get more information from a briefing of the detail of it.

Senator WEST—If we do not get to you in outcome 5, Minister, we will get you in outcome 4!

Senator BUCKLAND—Minister, I appreciate that and I will take that offer up.

Senator Patterson—Thank you, Senator Buckland.

Senator BUCKLAND—Thank you very much for it. However, I will pursue with my questions. I also note that the remainder of what I have got here goes to outcome 4, so thank you, Chair.

Senator DENMAN—Is this where I ask about overseas trained doctors, because that does have an effect on rural programs as well?

Mr Eccles —No, that is outcome 4 as well, Senator.

Senator McLUCAS—I would like to move to the National Rural and Remote Health Support Services Program. Page 138 of the PBS describes 23 successful applicants who received funding in 2002 from the funding round 2001 and the next round will be 2003. Why wasn't there a funding round in 2002?

Mr Eccles —That is in outcome 5. You are absolutely correct that in 2001-02, 23 grants were funded. In 2002-03 a total of $500,000 will be provided through the program but there will be no grant funding round on the basis that the cycle for this program in the past has been taking in the order of 14 months. So we have found that it has crept up and over. At some point in time we have had to say we are just going slow for six months—or not going slow but getting it back into an appropriate cycle. We have got mechanisms in place so that it sticks to a 12-month cycle.

Senator McLUCAS—Why do they take 14 months? I am just looking for information.

Mr Eccles —It was just the standard process under the RHSET program of advertising and giving people a chance to apply. I do recall at least a couple of occasions where there were delays by the RHSET advisory committee, which is an external advisory body that advises the department on these things, in finalising their recommendations and then funding to flow. It turned from what was to be a 12-month process into a 14-month and sometimes 15-month cycle.

Senator McLUCAS—What strategies have you brought into play that will ensure that we do move to an actual 12-month program rather than getting into the same situation again somewhere down the track?

Mr Eccles —The whole operation of the RHSET program—the Rural Health Support Education Training program—has been streamlined and the process is such where the time-frames and the coordination and the entire framework of the way the program is going to be administered will be done on a far tighter timeframe, and we no longer have the advisory committee providing advice on every application.

Senator McLUCAS—So that delay will not occur because we do not get their advice any more.

Mr Eccles—No.

Senator McLUCAS—Is that going to hurt the operation of the program if we do not get advice from the committee?

Mr Eccles—There are still mechanisms for advice but it will not take as long.

Senator McLUCAS—Can you give me a bit of an understanding of the nature of those 23 successful applications. Do not run through them all but what is the general nature of those?

Mr Eccles —They are very much about local level capacity building projects, and I will just cover a couple of them. There is 'Overcoming isolation through knowledge'. The whole idea is that the RHSET program supports studies by people in the workforce usually who undertake research and develop resources to make rural practice easier or better for the people who are working out there. There are healthy lifestyle programs. There is research into managing challenging behaviour in older Australians in rural areas. A lot of it is research based.

Senator McLUCAS—Could we just get on notice a list of the successful programs?

Mr Eccles —Sure.

Senator McLUCAS—It might be useful to inform us about the 23 RHSET.

Mr Eccles —Yes.

Senator McLUCAS—That would be good.

Senator WEST—What was the total amount of money those 23 grants received? You set aside half a million for 2003.

Mr Eccles—It is $1.574 million for the twenty-three. that are currently being supported and that is being provided this financial year, $500,000 next financial year so I guess the total will be $2.074 for those over two years. RHSET grants are one-year duration usually.

Senator WEST—So that $1.574 million which was given 2000-01—

Mr Eccles—No, that is 2001-02.

Senator WEST—And in 2002-03 there is $500,000?

Mr Eccles—Yes.

Senator WEST—So my maths tells me that we are just about losing $1 million between this year and next year.

Mr Eccles—No, Senator. The RHSET in the 2000-2001 totalled $1 million. What we are actually doing is compressing two years' funding into one year's worth of grants on the basis that we had that difficulty due to the 14-month cycle. So we are funding more this year at a higher level than we did previously. So what we have got is a number of grants that, while they are 12 months in duration, they are spanning two years worth of funding. So the total

funding for those ones is in excess of $1 million dollars. The money allocated for RHSET grants this year and the next year—

Senator WEST—In 01-02.

Mr Eccles—Yes. So the current batch that are getting supported will receive $2 million all up which is $1.5 million this financial year and half a million next financial year. Compared to last year there was only $1 million worth. We are using two years' worth of funding for one year's worth of grants.

Senator WEST—And last year how many grants were given?

Mr Eccles—Twenty-three, but they were of smaller value obviously.

Senator WEST—I think you had better give us the details on notice so we can try and fathom some of this out because this is about as clear as mud. So in 2000-01 how much money was there?

Mr Eccles—I will read out the list. In 2000-01, 23 grants funded at a total of $934,000. In 2001-02, the current financial year, 23 grants funded for $1.5 million. Next financial year those grants will still be in operation because of the timing anomaly that I referred to earlier, and they will be receiving $500,000 from next year's allocation. And, then, a decision obviously has not been made as to how much money will be provided in the 2003-04 at this point in time.

Senator WEST—There is no forward program for 2003-04.

Mr Eccles—Between now and then, we will look closely at what the other elements are. The RHSET grants are just a relatively small component of the broader National Rural and Remote Health Services Program, which also includes the bush crisis line, funding for first line emergency care, funding for CRANA, the rural health alliance, midwifery upskilling and so on. So RHSET is only a small component of that larger program.

Senator WEST—Do I find somewhere a figure for that whole program, with it broken down so I can actually look at what each is going to get?

Mr Eccles—No, Senator, not in the PBS, but we can provide that. It is aggregated at a different level in the PBS.

Senator WEST—That might make our lives a bit simpler if you can give us the overall budget for that and then break it down into what elements are in that program and how much funding is going there. It probably was in last year's annual report, if it is not, it should be, but I would like to be able to look at what was spent in the last year's annual report and track that through in this somewhere.

Mr Eccles—We can certainly provide that, Senator.

Senator WEST—It will actually make some sense. I was having difficulty with it.

Mr Stuart—The point of confusion is the money is not necessarily spent in the year in which it is allocated.

Senator WEST—You will blame accrual accounting on that, I think justifiably.

Mr Stuart—There are accrual issues in this, yes. I just want to make a couple of points of clarification to make sure that we get the right questions at the right times. Overseas trained doctors were mentioned, and those questions should be under outcome 9, and I think we said outcome 4. We were briefly unclear whether the questions that you were asking, Senator

Buckland, were about after hours or about regional health services. If it is regional health services, then those questions are appropriate now. If it is after hours, then it is outcome 4. We have these issues because not everything rural that we do occurs under outcome 5. They occur under other programs.

Mr Eccles—The numbers you said twigged something, and certainly it seems you are referring to the regional health services program, and also when you mentioned the quality improvement framework I suspect that related to the regional health services program.

Senator WEST—That is good, we will talk about that. That is another one that has got me confused.

Senator McLUCAS—In terms of assisting us for next estimates, would it be appropriate to give the committee a list of all of the programs that fit under outcome 5 and the disaggregated budgets for those programs so we get the program name, subprogram headings and the budget allocation? That would actually assist us so that we know where to ask questions.

Mr Eccles—Certainly. That would be straightforward.

Senator McLUCAS—Thank you. Coming back to the Rural and Remote Health Support Services Program, are the recipients of those grants individual practitioners or are they the divisions?

Mr Eccles—The broader National Rural and Remote Health Support Services Program is comprised of several elements. With the RHSET grants, which were the 23, the recipients are either individuals or people who work within a peak organisation. It might be the Council of Remote Nurses, for example. Normally, they are people who are practising health professionals or people who might work in an academic area who are developing resources for health workers. With respect to other people who receive assistance under that program, more often than not the focus is on the non-medical element of the rural work force. There is activity there for first-line emergency care, as I mentioned earlier, and the bush crisis line, which is for rural and remote health workers who themselves may need counselling. The Rural Health Alliance is the peak body, which we deal with on a very regular basis on rural issues. There is midwifery upskilling, education programs and so on. It is quite a large program.

Senator McLUCAS—In terms of the other issue you identified earlier of the delay in uptake of programs in this particular line item, has that been experienced in any other programs in the rural health care outcome?

Mr Eccles—History will show that the regional health services program had a slower than anticipated uptake. It is the ones where we need to build a direct bridge and work with rural communities that often take a little bit longer. There are complexities to do with state governments as well, because we do need to dovetail our services in with the ones that state governments provide if we are going to optimise the use of our money. Essentially, there has been delay on a number of service focused rural programs, but all of them are certainly either on track this financial year, or will be on track next financial year. Certainly the regional health sservice program is very close to being on track at the moment.

Senator McLUCAS—That is good to hear.

Senator WEST—Can I go to page 139 of the PBS, and it might actually sort some things out for us here? I am quite confused when I read this because I cannot get a handle on the ac-

tual numbers. You say at the bottom of page 139 that there are 90 health services approved with 72 operational. Then you say that a further 73 planning projects have been supported, of which 32 are still in progress. Then over the page you say:

> … up to 20 service delivery projects and seven planning projects will be undertaken, bringing the total number of service delivery projects in rural Australia up to 120.

I am having difficulty getting the numbers to add up.

Mr Eccles—I think your confusion is justified, and there is much that is omitted from here that I hope will fill you in. I suspect the confusion arises from the fact that most of the planning projects, at some point in time, will result in the new service. So a number of planning projects that are currently being supported will result in a new health service, which will bring that 90 up to 100 and then the 20 new services will bring that to 120. Some planning projects take six months; others take over a year. I suspect that that is the reason for the apparent number issue.

Senator WEST—Ninety services have been approved. They have gone beyond the planning stage. So that is 90 that will be operational. At present, 72 of those are operational. You have got another 73 in the planning stage—

Mr Eccles—No; 32 are in progress.

Senator WEST—What happened to the other 41?

Mr Eccles—They all became either a regional health service in instances a couple of planning projects were, if you like, synergised and there might have been two or three planning projects that resulted in one more coordinated service. That happened on a couple of occasions.

Senator WEST—So is that 41 part of the 90 or the 72?

Mr Eccles—The 41 is part of the 90, and some of them could well be part of the 72, if they have made the transition and started to employ people. We consider them operational until they have been able to employ people and the funds start flowing.

Senator WEST—What is the status of the 32? Are they still in progress?

Mr Eccles—Thirty-two planning. We have moved along a little from there but, rather than confuse you and go with the figures as of today, we will go with the figures that are in here. The planning is still being undertaken and that will lead to the development. The planning is not just health service planning, it is actually consulting with the local community in developing a service plan submission. The service plan submission then goes to the advisory council for consideration. It is more than just planning; it is planning for action.

Senator WEST—Have you predicated your 2002-03 budget on up to 20 service delivery projects and seven planning projects being undertaken? Are you expecting the 20 service delivery projects to come out of the 32?

Mr Eccles—The significant majority will.

Senator WEST—Where are you expecting the seven to come from?

Mr Eccles—The process that we are going through at the moment with the regional health services program is we are now looking at areas of high need that for some reason or another have not been targeted at this point in time or have not made a submission. There are two way a community can get involved, they can either make a submission or high need areas are

targeted. At this point in time I think we are in the process of targeting the areas on the map that are not getting these services that we know may benefit from them.

Senator WEST—Who is doing the identification of the areas of high need?

Mr Eccles—Our state offices have planning processes and they work very closely with their state based advisory groups. The state based advisory groups, I mentioned the membership earlier, also include state government representation, which I think I forgot to mention. It is being undertaken at the state office level in consultation with these state groups.

Senator WEST—How many of the current 90 have come from that identification process?

Mr Eccles—The identification of priorities as opposed to the submissions?

Senator WEST—Yes.

Mr Eccles—I might need to clarify something, in that submissions that come from areas that are not considered by the state based advisory group as being of high need do not qualify for support. So we would expect that every service that is receiving funding under this program is in an area that the state based advisory group considers to be of high need.

Senator WEST—I would love to go back to the first estimates that we discussed this at, because I think I would have to say I told you so.

Mr Eccles—I recall that.

Senator WEST—I think I might have been right. Going back to this 90 and getting up to the 120, you have 90 and you have 20 that you expect out of the 32. I am still looking for another 10 to see how you are going to get to 120.

Mr Eccles—They could well be ones that maybe just have applications lodged. It is a target.

Senator WEST—So this is a target, a wish list or a guesstimate. I am not meaning that in any disparaging fashion.

Mr Eccles—I would say it is most likely that we will at least meet that number.

Senator WEST—As I say, I am not meaning that guesstimate stuff in any disparaging fashion.

Mr Eccles—No, sure.

Senator WEST—You think you can identify definitely 110 and you expect, on the previous history of the project, that you would probably pick up another five to 10 in the next financial year.

Mr Eccles—That is exactly right. It is an estimate based on past experience.

Senator WEST—I see that the office is also going to undertake a review. What form is the review going to take?

Mr Eccles—The regional health service program is now a few years old. Details are still being nutted out but, essentially, the aim of this review is to look at what the impediments may be at the local level to this program optimally reaching its goal. Things that may come up are the barriers to recruitment and retention and the reasons at the local and community level that this program may not be realising all its aims.

Senator WEST—I suppose you cannot tell me until you have done the review just how well some of these 72 are working.

Mr Eccles—Most of the feedback we get is directly from the communities or through the advisory groups. Where they are working well, they are absolutely exceptional. There are other areas that are having trouble in recruiting health professionals. As you know, the availability of money does not guarantee the availability of health workers.

Senator WEST—That is right.

Mr Eccles—It is varied but, on the whole, this program is realising some excellent results.

Senator WEST—So you could not tell us how many are having problems with recruitment or retention.

Mr Eccles—Not at this point in time, in that a lot of our regular reports are coming in as we speak. We will have a better idea of how each service is going when these reports come in.

Senator WEST—What sort of money are we talking about?

Mr Eccles—It is $25,118,000 this financial year, growing to $36 million next year and then plateauing the year later at a level in the order of $43.5 million.

Senator WEST—I could be confused here. Is long-term funding for these projects included in this or was there a time limit at which they had to become self funding or seek another alternative?

Mr Eccles—This is ongoing support. We do not expect the community to pick up the tab.

Senator WEST—Was that initially in the project or not? I cannot remember.

Mr Eccles—That has been the case since day one.

Senator WEST—Okay. I could not remember that clearly. Have we ever asked you for a list of the projects?

Mr Eccles—You have. I think we provided that to you at maybe this time last year.

Senator WEST—Is it worth having another look at? You can take that on notice.

Mr Eccles—Sure.

Senator WEST—Just so we can get some handle for who and where they are and what sort of spread they have.

Mr Stuart—This would be the accrued—

Senator WEST—Yes, I am not going to ask you to identify those that—

Mr Stuart—We will be able to provide you with approved and operating.

Senator WEST—That would be great.

Ms Murnane—On that map that we give you, we will also separately identify the multipurpose services that are managed by this program.

Senator WEST—What is the difference? I thought multipurpose services were where you had a combination of state and federal.

Ms Murnane—That is right. But they are in rural Australia.

Senator WEST—I know that. How are they linked to this regional health services program?

Mr Eccles—They operate in parallel. Indeed, a number of multipurpose services actually receive regional health service funding as well. The focus of regional health service funding is

on new primary health care. MPS is where the Commonwealth cashes out its aged care component, usually with the states' hospital funding so that it is in one pool, as I think you know.

Senator WEST—Yes. Some communities like MPSs and some do not. That is a very interesting situation on occasions.

Mr Eccles—Yes.

Senator WEST—You might also provide us with a list of where the 63 operational MPSs are, please.

Senator McLUCAS—Can I assume that through this we will get an understanding of which MPSs are getting money under the regional health services programs?

Mr Eccles—Yes. It will be clearly marked. We will asterisk those that are getting funding under both.

Senator McLUCAS—Thank you. That is fine.

Senator WEST—What is the funding split for MPSs?

Mr Stuart—Between what?

Senator WEST—Federal funding and state funding. What does the federal department pay for with an MPS?

Mr Stuart—The federal government pays for aged care flexible places, and the state government pays for hospital and related services. There is not a formulaic approach to that; it is agreed on a service by service basis.

Senator WEST—The states have to do all the buildings, don't they?

Mr Stuart—Yes.

Senator WEST—And all the capital works.

Mr Stuart—The Commonwealth provides substantial recurrent funding through the aged care funds.

Senator WEST—As you do to every other aged care facility in the country.

Mr Stuart—Yes, that is right.

Senator WEST—So it is no different in that respect, is it? The funding level is the same as for other aged care facilities—category 1 to category 8 and corresponding funding levels?

Mr Stuart—No. On average the MPS rates are higher, because they reflect the inclusion of rural viability funds, which are also available to other small rural services. So the MPSs are funded at the kind of higher rates that other rural services attract.

Senator WEST—Thank you.

Senator McLUCAS—Is the new general practitioner registrars program in this outcome?

Mr Stuart—It is in outcome 9, if we are talking about the outer urban initiative.

Senator McLUCAS—No. I am not talking about the new outer metro initiative in this budget.

Senator WEST—It is on page 139 of the PBS. Are we talking about the rural GP specialist training program, or the outer metropolitan doctor program?

Senator McLUCAS—'Access to GP services in regional Australia with rural emphasis in the allocation of registrar training.' That is what I am talking about.

Mr Stuart—I believe we are talking about outcome 4.

Senator Patterson—It is about the specialist training positions and the number of them that are out in rural areas.

Mr Eccles—If you give me a reference, I will be able to answer definitively.

Senator McLUCAS—I am sorry, I do not have a reference.

Mr Eccles—There are specialists that are funded through outcome 5.

Senator McLUCAS—No, this is not specialists. The announcement was about an increase in the number of registrar places to 450 registrars.

Senator Patterson—It is not registrar specialists; it is people on the GP specialist training program.

Senator WEST—You know why we are confused now. Thank you, minister. We are happy to deal with it wherever you want us to deal with it, Mr Eccles, if we just had some idea of—

Mr Eccles—If you can tell me the title of the program—

Senator WEST—No.

Senator McLUCAS—New general practitioner registrar.

Mr Eccles—It would be outcome 4 if it is new general practitioners.

Senator Patterson—It is outcome 4, and when you come to GPET that is where it will be.

Senator BUCKLAND—Going back to the national rural and remote health report, I have a few questions regarding midwifery. What steps have we taken—because there is talk of $600,000 for postgraduate and conference scholarships for professional development—to increase the level of midwifery skills in rural and remote areas?

Mr Eccles—We have done quite a bit. A total of 1,999 midwives have currently participated in upskilling training courses throughout the duration of the rural and remote midwifery upskilling program, which has exceeded the initial target of 1,500. That is a program where we work very closely with state governments.

Senator BUCKLAND—Is that in the $600,000 we are talking about?

Mr Eccles—Yes. Next financial year there is in the order of $600,000 to be provided for that. This financial year there is $1 million.

Senator BUCKLAND—What do you use to measure the success of the program that you are running for this?

Mr Eccles—The most obvious measure of success is the number of people who receive the training. The other measure of success, which is quite valid, I think, is that Commonwealth, state and Northern Territory representatives from this program met recently to discuss its future, and the evaluation of the program found that it had been successful and that it is going to be sustainable at the state level after the funding agreements we have in place expire.

Senator BUCKLAND—Does that $600,000 take into account the need for midwives to do refresher courses? Is that part of it?

Mr Eccles—Yes, the program is based on a payment of $3,000 per midwife to enable them to undertake a two-week upskilling or refresher course.

Senator BUCKLAND—What about providing the 400 rural and remote midwives that have been talked about? Where does the money for that come from?

Mr Eccles—That is in this.

Senator BUCKLAND—That is all within this?

Mr Eccles—Absolutely.

Senator BUCKLAND—So refresher courses and the provision of another 400 rural and remote midwives with refresher training are all within that $600,000.

Senator WEST—Can I follow on here. Are we talking about the same thing on page 138? In terms of the Commonwealth Remote and Rural Nurses Scholarship Program, the second dot point says that, from 2002, up to 400 nursing scholarships per annum will be made available to former nurses living in rural areas to undertake training for re-entry or upskilling. Is that the same thing?

Mr Eccles—No.

Senator WEST—It is a different 400.

Mr Eccles—That is a different one.

Senator BUCKLAND—Where does the money for that come from?

Mr Eccles—The money for that is from another program, the Remote and Rural Nursing Re-entry and Upskilling Scholarships Scheme, which is administered by the Royal College of Nursing.

Senator DENMAN—What is the uptake rate on that, particularly in rural and remote areas?

Mr Eccles—It is focused solely on rural and remote. There were 60 scholarships awarded earlier this year.

Senator DENMAN—And that is across the nation?

Senator WEST—Sixty scholarships out of how much money?

Senator DENMAN—And how many states?

Mr Eccles—I will need to put this into context. Initially funding was provided for 400 scholarships. Not long after the government announced this program, several state governments announced very generous upskilling programs. For example, the Queensland government recently announced a similar scheme, but rather than provide the level of funding we were, they would salary the nurses while they were—

Senator WEST—In New South Wales they announced much earlier this year that they were going to introduce a scheme whereby those coming back in came in at their previous departing salary.

Mr Eccles—That is right. New South Wales did that and Queensland did that, and that affected the number of people who applied for this program.

Senator WEST—How much is your scholarship?

Mr Eccles—Our scholarship was, up until very recently, $3,000. But in light of the lower than expected uptake, in light of what the states had done, we asked the Royal College of Nursing to work with us to review what could be done to optimise use of these funds. The decision has been made to increase the scholarships from $3,000 to $6,000, aiming for half the number. So we are doubling the value and halving the number, because we expect that that will go closer to filling the books—in light of the generous schemes that the states are increasingly coming on board with.

Senator DENMAN—So you are halving the number because the uptake was not there—

Mr Eccles—Yes, the uptake was not there, and we did an analysis as to why it was not there. There are a couple of reasons, but one of the main ones was that the states did introduce re-entry and cadet-style scholarship programs, but they had a greater benefit. So the pool of people who were interested in accessing our program were diminished. So we are looking at the best ways to fit in with what the states are doing now that they have come over the top and put their own in.

Senator WEST—Where were the 60 that were allocated?

Mr Eccles—Where in Australia?

Senator WEST—Yes.

Mr Eccles—I do not think I have that information in my notes.

Senator WEST—Even a state breakdown would be helpful.

Mr Eccles—We can get that to you, Senator. I do not have that information with me.

Senator WEST—That has cleared up one bit of confusion that I had. What are the criteria for the awarding of these?

Mr Eccles—The criteria to get an upskilling scholarship are: Australian citizenship or permanent residency; previous registration in an Australian state or territory, where the registration may have lapsed, or they could be enrolled nurses; eligibility to register or enrol in an Australian state or territory—except for the recency of practice; and the intention to undertake an accredited Australian nursing program that will qualify for application to register to return to nursing practice.

Senator WEST—What is an accredited program?

Mr Eccles—It varies from state to state. The nursing boards in each state have different programs of different lengths of time, which is one of the problems that we have had with this program, because the length of courses and the nature of courses differ quite significantly from state to state.

Senator WEST—I think in Western Australia if you have not practised for a certain number of years, you have got to re-register and basically almost restart—not quite from scratch; it varies from six weeks to months or years.

Mr Eccles—That is exactly right.

Senator WEST—Six thousand dollars is not going to go far if you happen to live in a state that is copping you years.

Mr Eccles—That is right.

Senator DENMAN—This does not take account overseas-trained nurses?

Mr Eccles—No.

Senator WEST—And previous registration with one of the state NRBs?

Mr Eccles—Are you asking about overseas-trained nurses who were previously registered but their registration had lapsed?

Senator WEST—No. To be eligible, you have to have previously been registered with one of the state nurses registration boards, or a territory nurses registration board.

Mr Eccles—That is right—or be an enrolled nurse.

Senator WEST—And the enrolled nurses have to register at a different level.

Mr Eccles—That is right.

Senator BUCKLAND—Is there a formula for working out who will be rural and regional and who will be city based in these programs?

Mr Eccles—Yes, it is based on the RRMA 3-7 geographic classification.

Senator WEST—It is where they live, not where they might go and work?

Mr Eccles—I think that is the case, but I am sure that if people wanted to do outreach work and that was in their submission then that would be reviewed accordingly. I do not think we would stop people from practising in a small town some way out of Orange, for example. But essentially the upskilling is for those.

Senator WEST—I was actually thinking of the borderlines there for RAMUS that you could well have somebody—the place that springs to mind is somewhere like Lithgow—who might live on the mountains. That could be classified as not eligible for RAMUS, but they could be closer to Lithgow or Portland facilities, rather than Katoomba facilities, and prefer to go there.

Mr Eccles—I suspect they would not qualify on the basis that, when this funding is provided, it is provided without any understanding of where these people are going to end up working. So I suspect it is based on where they live.

Senator WEST—There might be one or two who, because they live in New South Wales, will probably go and take up the New South Wales government's offer.

Mr Eccles—Yes.

Senator BUCKLAND—I seem to be bouncing around with this. I am having great difficulty following the program for this, and Senator McLucas's idea might be better for next time round. I still had a few questions on the midwives. I have asked the question before in another section with specialist outreach services. Medical indemnity for midwives is a concern. It is only in the last few days that I have read about how many are going out of midwifery because of the fear of not having insurance or indemnity. I do not know if you down tools when you are a midwife or you down the nappies—I am not sure which is the right term—but it is a real worry, particularly in rural and remote areas. A lot of people now are forced to travel to capital cities or major centres. That is bad enough, but even midwives are saying, 'Look, we fear this.' So what effect is this having in that area as well, and will it have any impact on the training of these people? It goes further than that even.

Mr Eccles—It will not, if they are in the public system.

Senator BUCKLAND—I understand that.

Mr Eccles—Are you referring to midwifery in general or in terms of this particular program? In terms of this particular program, because it is an upskilling program indemnity does not impact other than when they do the practical element of their training. Are you talking about midwifery in general and the issue of indemnity?

Senator BUCKLAND—In general, yes, but more particularly in the country regions. As I understand it, those I am referring to—I am not sure what newspaper I read that report in but it is only within the last week at least—are people acting in the public hospitals. That is what is worrying me.

Ms Halton—Can I try and answer that question. To the extent that someone is practising in a public hospital, issues around insurance cover for that practice have been and are an issue for the states. The issue of concern in relation to insurance in this area has been medical indemnity, which is an issue in respect of medical practitioners—so medical practitioners; the UMP/Amil issue, which of course is terribly well known.

Senator BUCKLAND—I understand all of that, but this is midwives that are raising the concern about their position.

Ms Halton—That is not a medical indemnity issue. There may be professional indemnity issues that they have which might be an issue in terms of broader insurance. I do not know that that has been raised with us. The issue that has been occupying us, as you probably well understand, is the medical indemnity issue. The Prime Minister's announcement in respect to that is also well known. Professional indemnity, if that is what it is, in respect of privately practising midwives is not something that I am aware has been raised with us as being a particular issue.

Senator Patterson—The midwives met with one of my staff members when the medical indemnity issue was raised. They wanted to come to the medical indemnity forum that we had on 23 April. As Ms Halton has said, that medical indemnity forum particularly focused on indemnity of medical practitioners. We had the state health ministers there, the chairmen and the presidents of all the colleges, representatives from the medical defence organisations and some legal people—a group of people like that—and the forum focused on the issue of indemnity of medical practitioners. It really was not appropriate for midwives to ask to be there. It was not about their issue. As Ms Halton has said, it is about professional indemnity. We do not actually—I will stand corrected—fund midwives. So it is a professional indemnity issue for them, as it is for other health professionals who work in health services.

Senator BUCKLAND—But it must be an issue for this program. If there is a difficulty there, surely it is going to impact on the uptake of this program—training, retraining and remaining in the system. If people are not prepared to do it—

Senator Patterson—Are you talking about nurses reskilling—the re-registration program?

Senator BUCKLAND—I said that I would come back to the question of midwifery. We have the nursing and midwifery education initiatives of $600,000. That is where I was and we went elsewhere; I have come back. If there is a lack of security in the minds of midwives or potential midwives or those seeking training or upskilling, if they cannot have that professional or medical indemnity, then surely that is going to have an impact.

Ms Murnane—That is something we monitor in terms of the impact on health. I would point out that of the nearly 2,000 midwives in Australia—I will check that figure—only 200 are privately employed, are independent. The vast majority of midwives in Australia are employed by the public system or by the private hospital system.

Ms Halton—That was the point I was making earlier. The reality is that midwifery tends to be practised in the public system. To the extent that there are issues in that respect—and the states, as you know, have dealt with insurance issues themselves; the Commonwealth has been dealing with the issues of medical indemnity—we are not aware that there is a particular issue.

Ms Murnane—The figures are 13,000 midwives, of whom 200 are independent operators. It may emerge as a problem—we will keep our eye on it. But it does not spring to mind that this is something the Commonwealth could do something about and it has not emerged as a significant issue at this stage.

Senator BUCKLAND—In relation to the upskilling, training and education initiatives that we are talking about, when a nurse or midwife in a rural or remote location applies, and is successful in gaining a place, for upskilling and training, what happens to the position that they currently fill?

Is there any contingency to replace that person if they have to leave site? I am talking South Australia here. They would go to Adelaide or perhaps Whyalla for their training. Are they replaced for the period of their absence, or is it a half-day session? Even that takes two to three days, because you have got travel to and from.

Mr Eccles—That is not relevant for one of the major programs, the nursing upskilling, because that is focused on those whose registration has lapsed. They are not currently in the work force. In terms of the midwifery one, they are refresher courses for those who are not currently working in that area. There are state funded locum arrangements that differ from state to state, but our programs do not cater for that. It has not been identified as a significant issue for our programs.

Senator McLUCAS—I understand that Dr Wooldridge signed an agreement in October last year with the Australian College of Rural and Remote Medicine to do with a professional development training program for rural and remote GPs. Does that fit in this section?

Mr Eccles—It is outcome 4.

Senator McLUCAS—I look forward to this document that tells me.

Mr Eccles—There is a guide in the PBS.

Senator WEST—Sometimes it does not work, though, especially in this area.

Mr Eccles—I agree.

Senator McLUCAS—Does RAMUS fit in this output?

Ms Murnane—Yes.

Senator WEST—Is it RAMUS scholarships?

Mr Eccles—No, RAMUS scholarships are in outcome 4.

Senator McLUCAS—Administered under the GP program?

Mr Eccles—I refer you to page 140 of the PBS. There is outcome 4—

Senator WEST—I suppose I was saying outcome 5 because it had previously been in outcome 5.

Mr Eccles—Yes.

Ms Murnane—We appreciate the difficulties here this afternoon. They are coming home starkly to us too. The issue is that, as in Aboriginal and Torres Strait Islander health, rural Australians avail themselves of general programs and of some special programs. Most, but not all, of those special programs are in the Rural Health Branch and come under the special rural health outcome. Some of them come under program 4 and some of them under program 9. As well as that, the whole picture of rural health is substantially augmented by more general funding which of course also reaches into rural Australia.

The secretary has pointed out that we need to do something to be able to draw this into at least a coherent picture when we talk about it. It would be impossible to have everything in the one administered area, but we do appreciate the difficulties that you are having this afternoon.

Senator McLUCAS—Thank you. There is a whole range of programs, just as you describe, that rural people access and that have a tag 'rural' somewhere in their name, but that do not fit in outcome 5. In that list that you provide to us, if there are other programs that a person coming across the PBS for the first time, and covering health issues for the first time, would assume sit in outcome 5, would you list them as well, with their allocation and where they fit in the outcome.

Ms Halton—As one who has recently had to reacquaint herself with the PBS, I have every sympathy with the problem you are expressing. We will give you the information we have promised to give you but I think we, internally, might have a look at whether we should have a novel notion of the index at the back, which tells you the name of the program and what it is under. So leave it with us because it is a trifle arcane and we will see if we can make it less so.

Senator PATTERSON—You might not give the page number because that might be changed when it is being put together but at least the program should be given.

Ms Halton—We will see what we can do.

Ms Murnane—Madam Chair, this is totally the prerogative of the committee but it would possibly help if programs 5, 4 and 9 were dealt with sequentially, so we would have all the people there. That does not mean they will capture everything that will impinge on health and ageing in rural Australia, but you will capture many of these special programs that you are talking about this afternoon.

CHAIR—Thank you, Ms Murnane. I think we will make a note of that for future estimates if that will facilitate a more even flow of events. Are there any further questions?

Senator WEST—Can I go to the University Department of Rural Health Program which is on page 137. It says that there have been 10 university departments established in regional locations.

Mr Eccles—That is right.

Senator WEST—Do you have a list of these universities?

Mr Eccles—Do you want me to run through them very quickly? In New South Wales it is the University of Sydney.

Senator WEST—Queensland, UQ?

Mr Eccles—Queensland is Queensland University and James Cook—a collaborative one at Mount Isa.

Senator WEST—So there are two universities there?

Mr Eccles—No, there is one. It is in Mount Isa, but as the recipient of funding, it goes through both Queensland Health and James Cook University. But there is one university in James Cook.

Senator WEST—UWA?

Mr Eccles—That is right, at Geraldton.

Senator WEST—Flinders?

Mr Eccles—Flinders is in Alice Springs.

Senator WEST—Monash?

Mr Eccles—Monash is not a university department of rural health. They may be receiving clinical school funding.

Senator WEST—Bairnsdale clinical school?

Mr Eccles—That is a clinical school; that is not a university.

Senator WEST—That is a different animal?

Mr Eccles—That is a different animal, related but different.

Ms Murnane—Outcome 9.

Senator WEST—Clinical schools are outcome 9 and university departments of rural health are outcome 5. The University of Melbourne?

Mr Eccles—The University of Melbourne is Shepparton.

Senator WEST—The University of Adelaide, Whyalla?

Mr Eccles—That is right.

Senator WEST—The University of Tasmania?

Mr Eccles—Launceston.

Senator WEST—Whom have I missed?

Mr Eccles—Flinders University has got the Greater Green Triangle which is in Warrnambool. The University of Newcastle has Tamworth and University of Sydney has Lismore.

Senator WEST—This says 10 university departments and it is looking at recruitment and retention of health professionals. It is talking about 10 university departments—and we have run through who the universities are—and the expansion of the program to build on its strengths. You have established the network, which comprises the directors of university departments of rural health and the head of Monash University School of Rural Health.

Mr Eccles—Monash is not a UDRH but does have a strong history in this sort of work so they have been invited to be part of the network.

Senator WEST—Tell me: are there any universities that are not listed there that do not offer medical training, medical courses? Those universities all offer medical undergraduate—

Mr Eccles—I think all the universities that are recipients of UDRH funding do have a medical school, but that is not a criterion for funding. The focus of UDRH is on the broad work force. Some of them do have medical activities. Clinical schools focus exclusively on medical students. The university departments of rural health are looking at the broader health

work force. There is a lot of nursing activity and a lot of allied health activity taking place in those.

Senator WEST—You have given us the list of universities, but it strikes me that you are actually missing universities that do not have a medical school but still have significant health schools. I suppose when I say 'health' everyone thinks of doctors, who have non-MBBS courses but have significant other health professional courses. I think of Charles Sturt which has, I think, three or four nursing campuses. It has social work; it has psychology; it has OT; it has medical imaging. I think of Wollongong University, which has significant health related courses. I think the UNE has probably got some as well. And UTS in Sydney, which certainly does outreach work as well, has a significant nursing course. What input are they having into this program?

Mr Eccles—I know that partnerships are being fostered at the local level between a number of the university departments, and certainly Charles Sturt is the example that I am aware of. I am not exactly—

Senator WEST—This has got a very medical model—'medical' as in doctor model.

Mr Eccles—No. The university departments of rural health are aimed very much at the non-medical aspects of health service training. It is about getting people to learn their craft—being a rural health service provider while in a rural location.

Senator WEST—That is still medical; it is still doctor.

Mr Eccles—Senator, there are an awful lot of nurses and allied health students that are being put through these institutions.

Senator WEST—In New South Wales I understand the only university that could not fill its nursing faculty numbers this year was Sydney University. All of the other universities did, with more to spare, yet it is Sydney University—not UTS and Wollongong and Western Sydney and CSU and all of those—that would appear to be the superior group.

Ms Murnane—Senator, could I say that our essential aim here was not to fund particular universities; it was to establish—and these were established over a number of four years—university departments of rural health to allow the training of health workers and to foster learning networks for health workers in rural Australia. So our primary focus was on where they were located. But, as Mr Eccles said, we are not deliberately ignoring any university. We would look at any sort of approach in relation to a partnership. In particular, I am sure the Charles Sturt University at Wagga has a close association with the clinical school that is established there.

Senator WEST—What is a 'clinical school'?

Ms Murnane—It is a generic term, Senator. It would involve allied health workers, so we would be talking about physiotherapists and podiatrists. We are, of course, talking about nurses. In the courses run by the university departments of rural health that I know best, the biggest take-up of those courses is from nurses who are already practising—for example, at the university department of rural health in Alice Springs and the university department of rural health in Central Australia—undertake courses which have a mixture of some residential periods and correspondence and other sorts of audiovisuals. Increasingly, hopefully, that will be able to be done electronically through IT.

Senator CROWLEY—I am not the only one, I am sure, who is confused by what on earth we mean by 'health worker'. In many cases I understand a 'health worker' to mean a person

less qualified than an enrolled nurse who is able to provide some kind of primary nursing type care.

Ms Murnane—I agree with you that it is loose, and that meaning can be assigned. That, however, was not the meaning I was assigning to it. The meaning I was assigning to it was people who already have a recognised qualification or who are pursuing a recognised qualification.

Senator CROWLEY—As low as a certificate 2 through TAFE?

Ms Murnane—I will let Mr Eccles come in here because I would not want to disenfranchise anybody who had availed themselves of the services offered by a university department of rural health.

Mr Eccles—Before I get on I would like to clarify something that I might have misled Senator West about earlier. While the recipient of funds is the university that we went through the list, for most of those—for example, the Whyalla UDRH—the collaborator is the University of South Australia. Other partners in the ventures include Curtin University, Edith Cowan, the University of Ballarat, the Northern Territory University, Deakin University, the University of New England, Southern Cross University. A number of those do not have medical schools.

Senator WEST—I am getting a bit confused. Maybe I am getting Alzheimer's and it is time to move on, but I have a recollection in the back of my brain that when the UDRHs were set up and were first advertised, it was specified that the money had to go to universities with medical schools. Am I right?

Mr Eccles—It precedes my involvement.

Senator WEST—It does not precede mine.

Senator PATTERSON—How is your corporate memory on this matter?

Ms Halton—I think it is in operation right now, Senator.

Senator PATTERSON—My corporate memory is that there were not a lot of rural programs to ask about when I used to ask questions.

Senator CROWLEY—That is very unkind of you, Senator Patterson. I am trying not to be nasty—but if you will provoke us. Senator Herron used to ask the same specious questions.

Senator HERRON—No comment.

Senator WEST—I think we have all done our fair share at one time or another. Have we got an answer?

Ms Murnane—I am sorry; I did not hear the question you just asked, but Mr Wells has just confirmed that there is, as I said, an association between the clinical school at Wagga and Charles Sturt University. In fact, Charles Sturt University sits on the management board.

Senator WEST—That is not the corporate knowledge I was after. I am after the corporate knowledge that can confirm for me that when the UDRH money was first advertised—

Ms Halton—The answer is that you had to include a university with a medical school, but it could be in some sort of consortia arrangement.

Senator WEST—My other recollection is that the primary focus at the UDRH has always been on rural medical practice.

Ms Murnane—That is not correct.

Ms Halton—Why don't we get the corporate memory?

Senator WEST—I think that would be great; thank you, Mr Wells.

Ms Halton—Can I just make the observation to you, Senator—you made the reference to dementia—that we all know the short-term memory has the problem with dementia; the long-term memory works nicely. So we will just pass to the long-term memory.

Senator WEST—It is the long-term memory that is working here.

Mr Wells—I do not know whether I am short-term or long-term in this context. We might depend on the answer. The original concept, when the university departments of rural health were initially announced, was that they would include facilities for training medical students and other students, be they nurses or other health workers. But there was no other capacity for medical students at the time.

Senator CROWLEY—What year are we talking about?

Mr Wells—We are talking about 1996-97. I am talking from memory now, and I do not have a factual brief with me. There was a requirement at the time that there would certainly be capacity to include facilities for medical students to get rotations through these rural areas because there was no other facility at the time. We had not started the program of rural clinical schools. That is why initially the requirement was that the consortiums must include at least one university with a medical school.

Senator WEST—I seem to recall the only argument I ever had about this was my concern that under this program doctors would become two-tiered and there would be those that would be trained in the rural medical schools would be disadvantaged vis-à-vis those trained in the teaching hospitals.

Mr Wells—The essential difference between the experience that students receive in a university department of rural health, as opposed to that in a rural clinical school is that university departments of rural health are designed for shorter term rotations—it could be four weeks to usually 13 weeks, or something of that order. The rural clinical schools require that the students spend half of their clinical teaching time in a rural clinical school—for example, for a four-year degree where the final two years are clinical experience, they have to spend one of those two years in a rural clinical school. It is a different concept, and the initial concept with the university departments of rural health was based around rotation and giving students an experience of rural medicine as opposed to having them based in a rural area being trained.

Senator WEST—I will have to go back and re-read something of six years ago, or whatever. Is Monash part of the 10 in the network, or is that 10 plus Monash?

Mr Eccles—The network is comprised of the 10 UDRHs plus Monash.

Senator WEST—That leads me to the question as to why Monash gets there when you have all admitted that there are a number of other universities that have significant rural and regional health training facilities that are based out there. How did Monash get a go and those ones did not?

Mr Eccles—Monash is recognised as a bit of a pioneer in the sphere of multidisciplinary studies in rural health. Many of the UDRHs base their model of activity on Monash. Monash

asked to be part of the network, and the university departments of rural health agreed that that was a good idea.

Senator WEST—If Charles Sturt had asked to be included, that would have been a good idea too, would it?

Mr Eccles—I cannot comment on that.

Senator WEST—It also talks about, on page 142 in indicator 2, increasing the numbers of students undertaking clinical rotation and training placements in rural areas. What are the implications of this? What does this, in fact, mean to the benchmark data to be collected in 2002-03?

Mr Eccles—We will be getting information from the university departments of rural health, as part of their standard reporting, to tell us how many students they are introducing to the benefits and interests of rural practice through the placements. Once we have that information, we will be able to use that as a benchmark and ask them to try to improve so that we are regularly increasing the number of people who are studying at universities who are given an opportunity to do a placement in a rural area.

Senator WEST—I have a concern about this. In New South Wales the key universities are Sydney university and New South Wales university—there is Newcastle university as well. New South Wales university does not offer any nursing training, as I understand it. The biggest nursing training courses in New South Wales would be at UTS, Western Sydney and then maybe Wollongong. What facility is there in here to enable UTS and Western Sydney to actually incorporate and allow rural experience for their students?

Mr Eccles—I will need to confirm this, but it is my understanding that the UDRHs do not restrict their flow-through of students to the contracted parent university, if you like. Certainly in a place like Tamworth there could be students from a range of campuses coming in through there, but I would need to check that.

Mr Stuart—I can confirm that that is correct. So the university departments of rural health take students from all schools, not just from those which are directly affiliated as part of the UDRH.

Senator WEST—But that can be a problem because none of them are operating on the same curriculum.

Mr Stuart—The UDRH experience becomes a part of the student's curriculum.

Mr Eccles—And it is a relatively short-term placement.

Senator WEST—What impact is this going to have upon those places that are not involved with the UDRH in terms of their access to some of those training positions, some of those clinical positions, because that is becoming an issue across the board too? Are you setting up a little group here that are going to have some elite access to clinical positions to the detriment of others?

Mr Eccles—I am not sure what you mean by 'clinical positions'.

Senator WEST—Clinical placements.

Mr Eccles—These are clinical rotations at the university, not so much placements. It is part of the learning; it is not part of the placement section of their program.

Senator WEST—Not entirely though.

Mr Eccles—No.

Senator WEST—My question still remains: what are you going to do to ensure that, by setting these up, you are not going to be disadvantaging another group in terms of access to facilities and placements?

Mr Eccles—It is certainly not the intention of this program to create an uneven playing field, and this has not been drawn to our attention, as far as I understand.

Senator WEST—You might like to take some of those questions on notice and have a think about them and get back to us—otherwise I am going to get us all totally confused.

Senator Patterson—Senator West, I think you need to clarify what that question is on notice. Do you want us to actually look at the other medical schools that are not attached to—

Senator WEST—I want you to be able to assure me that—

Senator Patterson—Can I clarify this—I am the one that has to sign off on the answer and I am not sure exactly what the question was. There are university departments of medicine that are not involved in the university departments of rural health. Do you want to know what access those students have to clinical placements in rural areas? That is a very big job, and it is not really something that the department has the actual information on. If you are a Monash student, for example, you can do a rotation in Warrnambool or at Wangaratta Hospital. Are you asking what rural opportunities students have in medical schools that do not have a university department of rural health? Is that the question you are asking?

Senator WEST—Can I first of all thank you for talking about medical schools and medical students because that is the point I have been trying to—

Senator Patterson—I thought you were talking about medical schools.

Senator WEST—Because I am being told here that it is all health students.

Senator Patterson—I thought you were talking medical students, and that is why I want to clarify the question.

Senator WEST—I do not know whether you have helped overcome my confusion or added to it. What I am wanting from the department, or from you, Minister, is an assurance that the impact of setting up and putting a group in one area is not going to have an unintended consequence of making access to that area by the people who have traditionally had access to it more difficult.

Senator Patterson—So you are saying that if you were in, for example, speech therapy at La Trobe and you used to do a rotation in, say, Shepparton, and now Shepparton has a university department of rural health—

Senator WEST—From somewhere else.

Senator Patterson—Yes—they then cannot have access to it because there is a reduced number of clinical places. That is a very hard question to answer, because—

Senator WEST—I know it is a hard question.

Senator Patterson—you have to say, 'What would have been the case had the university department of rural health not been there?' and you have to then go back and say, 'Did they have access to those places for clinical placements before the university department was there?'

Senator WEST—Minister, it is a real hard question but it is a hard question that a number of institutions are facing now. It was one that was brought to our attention when we were doing the nursing inquiry—that, because of some changing around within different universities and different alliances, it was impacting, quite probably unintentionally, on other facilities' ability to access clinical placements. That is what I am seeking—

Senator Patterson—With all due respect, that is anecdotal. The thing is that there are always difficulties. If you have ever had the responsibility of organising clinical placements, there is always difficulty in getting clinical placements and matching clinical placements with students, and it will ever be thus. As to whether you can tease out—and whether we can get you an answer that teases out—if university departments of rural health have affected that, I do not know how you quantify that. That is what I am saying. I do not know whether we can actually find the answer to that—Mr Eccles might have another view—because there are other things that change at the same time.

Senator WEST—But, maybe by just putting it here on the surface, some people might think about it and it might cause an appropriate reaction or thought patterns to occur.

Senator Patterson—It would be better if I indicated to you that, in setting these out, we ought to consider the effect on placements, rather than us trying to spend hours going back to the departments. I just do not think that we have that information. We would have to get information not even from the department of education but from the various universities. It would be incredibly time consuming. We will take on notice that you have raised an issue of concern and, when we set them up, we ought to be looking at whether they have an impact on other medical and allied health professional training institutions that are not involved and whether it impacts on their clinical placements.

Senator WEST—That is right. If you do that, Minister, I will be more than happy; I will be delighted.

Ms Halton—Senator, if you could give the minister's office the information that you have had about the adverse unintended consequences that you have already alluded to, that would assist us.

Senator WEST—It will be coming out in our inquiry report, I would think. It is in *Hansard*, so to say that it is anecdotal was a bit dismissive. It is evidence in *Hansard* from—

Senator Patterson—It is always an issue. Having been involved in teaching in the allied health professions, I have seen my colleagues anguish over finding clinical placements.

Senator WEST—And when they disappear out of sight because somebody has cut their throat and come in.

Mr Stuart—Nevertheless, I would say that the key effort of UDRHs—and I have now visited one that I was very impressed with—is in significant expansion of rural experience for medical and health professionals of all kinds. I think they are being very effective in that regard.

Senator WEST—Just as long as the other non-medical school universities get a look in and some major input into it, because they are often doing better health training than the sandstones. Regarding RFDS, there is a review and a consultative mechanism being set up. What is the story there, please?

Mr Stuart—I do not believe there is a review. The department has offered some funding to the RFDS for it to put itself in a good position to negotiate with the department about our future contract.

Mr Eccles—I would like to clarify something, Senator. Can you tell me where the review is referred to in the PBS?

Senator WEST—'A consultative mechanism will be established.' That is on page 140. If you are setting up a consultative mechanism, it would indicate to me that you actually think there is a problem.

Mr Eccles—No, there has always been an effort, which has been highlighted over recent years, to get clarity into the respective roles and responsibilities of the Commonwealth and states in supporting the RFDS. The RFDS do a range of things, including interhospital transfers—which are primarily the responsibility of the states—and emergency retrieval, as well as what we call traditional services, which are the primary care clinics. It is not so straightforward as to see that those things do not happen on the same trip. So we are trying to get a little bit more clarity with states and territories into the way that we support the RFDS.

Senator WEST—In this year's budget, you are providing an additional one-off $1 million. You have got three weeks and however many days to put an extra million dollars into their budget.

Ms Murnane—Yes. That offer was made to four operating sections, and it was made under certain conditions and for specific purposes. They have all written back now and agreed to that, so we will move the money along in the next week or so.

Senator WEST—What is the assistance for?

Ms Murnane—The assistance is for capital replenishment.

Senator WEST—Aircraft upgrades and—

Ms Murnane—Broadly, yes.

Senator WEST—That clears that up. Allied health professionals in rural areas: is that here?

Ms Murnane—Yes.

Mr Eccles—Is it the More Allied Health Services Program? If it is, that is outcome 4.

Senator WEST—Okay. It was $10.5 million last year and $11.4 million this year. We will try it in 4; if it is not in 4, I will cry.

Mr Eccles—It is, Senator.

Senator WEST—Okay. I think that has done rural health.

Senator BUCKLAND—I will talk to Senator Herron and see if we can do better. Could you explain the First Line Emergency Care Program to me?

Mr Eccles—Certainly. This is a program—$77,000 this financial year, and there will be $77,000 next financial year. It is all about upskilling remote health workers to training in first line emergency care, given the fact that health workers in rural areas are often first at the scene of trauma and require these skills.

Senator BUCKLAND—Does that go to ambulance services, ambulance officers and nurses that often go out with the ambulances in small areas?

Mr Eccles—My understanding is that ambulance training well and truly covers this sort of emergency care and first line activity. The focus of this is upskilling nurses. The program is administered through the Council of Remote Area Nurses of Australia and it is to provide their membership and other health workers with access to this sort of training. At this point in time there have been 14 courses held, and over 270 health workers have received training.

Senator BUCKLAND—Does 'health worker' take in the classification of ambulance service officers—and I understand they are quite distinct from hospitals? They are health workers in that sense, I think, if you compare them with some of the others that were mentioned. What about trauma counsellors who are called in after, for example, very bad road accidents, suicides and things like that. Are they health workers or are they defined as something different?

Mr Eccles—I think that in the broad definition of 'health workers', counsellors are certainly a very integral aspect of it. I would include them in my definition of a health worker.

Senator BUCKLAND—That is your definition. What about the department?

Mr Eccles—I would assume they are, and certainly under a number of our programs counsellors and trauma counsellors are one of the mainstays. Certainly under regional health services we are funding a significant number. I can clarify that this program is all about providing intensive weekend courses, mainly for nurses who are based in remote areas.

Senator BUCKLAND—I have a real difficulty with that definition if we are calling them 'first line emergency workers'. How do we put a nurse operating in a hospital as first line? Isn't the first line the person who goes to the actual scene? It may be just a definitional problem I have.

Mr Eccles—It might be a question of definition. The focus of this is the remote area nurses who, more often than not, do not work out of hospitals because of the nature of their practice, but because of the fact that they are often first on the scene or expected to deal with trauma and emergency situations, do require a different type of training to people who may be nurses in larger communities where other support workers, like ambulance personnel, may be more immediately available. The focus of this is on the people who practise in remote areas.

Senator BUCKLAND—So it could be bush nurses.

Mr Eccles—That is exactly it.

Senator BUCKLAND—Now I can equate to what you are talking about.

Ms Murnane—If there was a road accident in their community, they probably would be the first trained personnel on the scene. A lot of what they would get would be trauma coming to them in the clinic, through personal violence, community and domestic violence, and farm injuries.

Senator BUCKLAND—I appreciate that. That has cleared that up. There is $77,000 this year, and $77,000 next year. How long will it actually take to complete the program and are there intentions to—

Mr Eccles—We will look at it. No decision has been made as to whether to continue the funding beyond next year. But, in light of the very positive outcomes, I suspect that we will be looking at it. As I think I indicated earlier, it is part of the broader National Rural and Remote Health Services Support Program, the larger program. No firm decision has been made on how the funding within that allocation is going to be split in 2003-04 but we will certainly be looking at that within the next six to 12 months.

Senator BUCKLAND—You said that the training is done during weekends—I think you told us weekends. Whereabouts is that done?

Mr Eccles—This year at Coober Pedy, Alice Springs, Launceston, Katherine—those sorts of towns—Ballarat, Derby, Cairns.

Senator BUCKLAND—So the program goes to the front-line people.

Mr Eccles—Absolutely, as close as you can get to them.

Senator BUCKLAND—That is good.

[4.09 p.m.]

CHAIR—Can we move on to outcome 6, Hearing services.

Senator McLUCAS—I would like to start with some questions on cochlear implants and replacement processes. I understand that $1.4 million has been allocated to cochlear implants from this program. Is that right? I am having trouble finding that line in the PBS, so if you could direct me to that, that would be helpful.

Ms Hefford—The department provided to Australian Hearing Services an appropriation, known as community service obligations, of just over $28 million this year, and the $1.4 million, I think it was, for cochlear speech processors was one component of that. Australian Hearing are not limited by the smaller amount in terms of the resources available to them that they devote to speech processors. They can make decisions based on client demand and looking at the total of that $28 million.

Senator McLUCAS—So Australian Hearing Services makes that call internally?

Ms Hefford—Yes, they do.

Senator McLUCAS—But at the moment, they have allocated $1.4 million over four years? Is that your understanding?

Ms Hefford—They received some additional funding which was labelled specifically for cochlear speech processors, but they have access to their larger pool of funds and can make decisions based on client demand and the numbers of children presenting.

Senator McLUCAS—I know in any year about 200 children need a new processor. Is it appropriate for me to be asking you these questions, or should they be directed to Australian Hearing Services?

Ms Hefford—I would probably prefer to take on notice the question about the number of children presenting to Australian Hearing for a particular service and receive an answer from Australian Hearing. When you are talking about replacement processors, 'replacement' is the term that we use to cover a speech processor that has been lost or damaged beyond repair—it has fallen in the bath, for example. The number of those coming up in any one period of time is difficult to estimate or to predict.

Senator McLUCAS—If I said replacement, I did not mean that. I understand that about 200 children a year need a new processor.

Ms Hefford—That was the number for an upgrade?

Senator McLUCAS—For a new one.

Ms Murnane—I think that 200 is the number of new implants. This program does not cover that. That is covered by the states, who cover the first processor. The Commonwealth

made a commitment in 1996 to cover replacement processors, and that is what Ms Hefford is talking about. As Ms Hefford said, we will get you the numbers.

Senator McLUCAS—And it costs about $5,000 for a replacement processor—is that right?

Ms Hefford—The price varies. There are two or three different types. It can be as much as $8,000. It depends on the type of processor.

Senator McLUCAS—How many processors do we get out of $1.4 million over four years? You might want to take that on notice.

Ms Hefford—As I said, Australian Hearing are not limited to that amount of money. They would take any client coming forward with a child who had a cochlear implant and needed a replacement processor, and they would automatically provide that processor. There are no children on waiting lists for replacement processors. As soon as a child loses a processor and needs it replaced, they immediately order the replacement and organise a loan replacement from the nearest cochlear unit, so the child has a loan processor for the couple of weeks it takes to obtain the replacement.

Senator McLUCAS—With the changes in the private health industry and the inclusion of replacement implants on the schedule, has your branch done any assessment of what impact that will have on the Australian Hearing Services budget?

Ms Sperling—At the moment, cochlear implants, the initial speech processor and follow-up speech processors are still on the prostheses schedule, and therefore are paid for by private health funds for privately insured people.

Senator McLUCAS—Are the replacements still on the schedule?

Ms Sperling—They are.

Senator McLUCAS—That is different advice from what I have had from a range of people.

Ms Sperling—They are definitely still on the schedule. We can provide you with a copy of that schedule which includes that information. That is a tabled document.

Senator McLUCAS—I understood that there was a decision made in the meeting of April 2001 to remove replacement implants from the schedule.

Ms Sperling—There was consideration of that matter by the Private Health Industry Medical Devices Expert Committee. The committee's advice was that these devices did not fit the criteria to be included on the schedule. That advice was conveyed to the government, but any decision on acting on that advice has been deferred at this point, and those devices are still on the schedule.

Senator McLUCAS—Is that usual for the group to defer those sorts of decisions.

Ms Sperling—Most of the decisions that the committee makes are acted on, but there have been a range of devices where there will be a significant impact on health fund members. So consideration needs to be made of what other ways health funds might have of subsidising devices and how affected members might be notified before any action is taken. It is a ministerial decision as to what is and is not on the schedule.

Senator McLUCAS—What are the further considerations that have to be made?

Ms Sperling—At this point we are seeking some further information from private health funds as to how these items might be included on their ancillary tables and how affected members might be notified. We are also more generally reviewing the prostheses arrangements. No further action will be taken in relation to the listing of replacement speech processors while that review is in progress.

Senator McLUCAS—When do you expect that that will be finalised?

Ms Sperling—That particular issue will be considered, as I said, alongside the review of the whole prostheses issue. At this stage, the next list will be distributed in August. There is no intention to make any changes in relation to these items on the August 2000 list, either.

Senator McLUCAS—Are you aware of quite considerable concern amongst parents of children with cochlear implants about the removal of replacement implants from the list?

Ms Sperling—We have had some discussions with industry and we have received some letters expressing concern. We have done all we can to advise people of what the arrangements are, to ensure that health funds advise their members of what the arrangements are and to ensure that people know what the options are that are available to them, which, at the moment, are full cover under private health insurance or accessing a replacement speech processor under the Commonwealth program for children.

Senator McLUCAS—When you have done that assessment of impacts on Australian Hearing Services, if the replacement processor is removed from the list, can that analysis be made available to the committee?

Ms Sperling—Yes.

Senator McLUCAS—Will the government's review of private health insurance in general consider this issue as well?

Ms Sperling—It will certainly consider, in the broader sense, the way that prostheses arrangements operate. This is one item that is impacted by the prostheses arrangements.

Senator McLUCAS—Just coming back to the impact on Australian Hearing Services—have you done any analysis of the impact on Australian Hearing Services' ability to service its clients if it is removed from the list at the moment?

Ms Hefford—Australian Hearing Services have a responsibility to child clients at the moment, and that would be unchanged. Australian Hearing Services do not have a responsibility to provide services to adult clients.

Senator McLUCAS—It has been put to me by parents of those children who currently receive their first and any subsequent processor through their private health insurance—I am finding this interesting as to why they would do that, if they can get it through Australian Hearing Services. I will certainly go back and find that out—that if they cannot get their replacement processor through their private health insurance industry provider, they will go to Australian Hearing Services because they will not be able to afford to get any replacement processor privately, given that they are so expensive. Is that correct?

Ms Hefford—That is what I would expect to happen, that those parents would go to Australian Hearing Services.

Senator McLUCAS—Do we know how many children get their implants under private health insurance?

Ms Hefford—I do not have that information.

Senator McLUCAS—Is it possible to get that information from anywhere?

Ms Sperling—We do know that there are around 1,000 Australian children who have cochlear implants, but as to the separation of which ones get their services through private health insurance and which ones get their services through the Commonwealth program I do not have that information.

Senator McLUCAS—Surely we would know how many have been funded through the Commonwealth program, wouldn't we?

Ms Hefford—I can get that information for you.

Senator McLUCAS—Thank you. Then we can work out how many are privately provided.

Ms Hefford—There would still be some small number who would, for a range of reasons, be accessing a state government program through a public hospital, perhaps because the child has multiple disability.

Senator McLUCAS—Can we break those out as well?

Ms Hefford—We will try to do that.

Senator McLUCAS—If we move those children off the private providers into the public area, we will then know whether or not there is an impact on the ability of AHS to provide that service.

Ms Halton—I think we are saying that we will do our best endeavours—I do not know that it will be to the last decimal point of science—at least in the broad, to answer the question.

Senator McLUCAS—I will leave that and come back to it next time. Going to hearing services for indigenous children, how many indigenous children are being served by Australian Hearing Services? Do you keep data on indigenous and non-indigenous children who are being assisted?

Ms Hefford—Australian Hearing Services keep data on indigenous clients. The data is not perfect because it is based on self-identification and therefore probably under-reflects actual numbers. I do not have specific numbers with me, but I can ask Australian Hearing Services for numbers. Do you want numbers of indigenous children who have accessed a service from Australian Hearing Services for a particular period? I need to ask the question in a fairly specific way.

Senator McLUCAS—I understand. In the current year, and not numbers if a proportion is easier. I think we are trying to get a feel for the split between services provided to indigenous children and non-indigenous children. Do we have any data on Aboriginal and Torres Strait Islander children who are estimated to have a hearing problem that is significant enough that it will affect their schooling? Do we have that sort of population data?

Ms Hefford—We don't within the hearing program. It is collected in a number of different ways, often by state governments and often through education departments or through child health clinics, when indigenous children are having a check prior to commencing school, at which point sometimes a difficulty is identified. That is not something that we would do within the hearing services program. I am not quite sure how you would obtain that sort of data other than by asking education departments, perhaps, if they are aware of schooling or learning difficulties associated with indigenous children.

Senator McLUCAS—I thought that you may have that data, given that it might inform the intent of the program.

Ms Hefford—It is certainly true that hearing impairment can lead to difficulties in literacy and speech for small children.

Dr Graham—There have been some earlier surveys done. In surveys up to 1990 the incidence of significant hearing loss in Aboriginal children ranged between six and 70 per cent. So it can be very high.

Senator McLUCAS—Has that work been updated, Dr Graham?

Dr Graham—I am not aware that it has been.

Senator McLUCAS—Are there any specific indigenous programs that Australian Hearing Services operates that are addressing these horrific figures?

Ms Hefford—Australian Hearing Services provide hearing services to indigenous people, including children, in a number of remote communities, but it is particularly a remote indigenous issue. One of the difficulties is that it is very difficult to treat hearing loss while a child still has otitis media or a middle ear type infection. We come back to a primary health care problem. Australian Hearing Services are able to assess a child's hearing loss and they are able to fit hearing aids which will enable a child to receive amplified sound, but they are not able to address the primary care issues which are the cause of the problem. When we talk about Australian Hearing Services moving into those communities and trying to help those children, it is the remedial end of the problem. Unless you address the primary health care issues, those children's ears will become re-infected, the hearing aids will not be effective or not able to be worn and the cycle will repeat.

Ms Halton—The Office of Aboriginal and Torres Strait Islander Health will be appearing later. It is important to understand that there are a number of strategies in relation to the hearing issues that are particularly a problem for indigenous children, some of which go to the primary health issues that Ms Hefford just talked about, some of which involve a number of portfolios—for example, cooperation between ourselves and the education portfolio—and some of which involve, for example, the training of Aboriginal health workers. We might be able to pursue this in a little more detail with the office, but it is certainly something that we are particularly aware of. As Ms Hefford has said, there is certainly the tertiary end of this, which is the fitting of aids, but there are a number of other issues that we have been trying to focus on and deal with.

Senator McLUCAS—I appreciate that; thank you.

Senator WEST—I take the figures Dr Graham just gave. Did you say between six and 70 per cent?

Dr Graham—These are figures that were based on data before 1990, so there has been marked improvement since that time. But they also indicated that there was quite a bit of variation from community to community.

Senator WEST—My colleague Senator Crossin has certainly got a recent survey of 29 remote communities in the Northern Territory that showed that only seven per cent of Aboriginal children had normal middle ears.

Dr Graham—This is a significant hearing loss from one cause or another, which may be middle ear infection or for other reasons.

Senator WEST—I suppose there is a difference; we are not necessarily measuring apples with apples, are we?

[4.29 p.m.]

Senator WEST—I will move on to hearing problems of Aboriginal children. This is a crossover between outcome 6, Hearing services, and outcome 7, Aboriginal and Torres Strait Islander health. OATSIH, can you indicate what you think ear damage is among children in Aboriginal communities?

Dr Fagan—The information that has been presented already shows part of the picture. If I heard you correctly, Senator West, you said that a recent study in the Northern Territory showed that seven per cent of Aboriginal children had normal middle ears. That is fairly consistent with information given earlier. Not every child with an abnormal middle ear will necessarily have hearing loss. The picture varies very greatly from one community to another and between remote, urban and rural settings. What you will find in an urban setting will be different from desert or coastal situations. But there is no doubt that this is a very significant child health problem.

Senator WEST—Can you quantify or identify the differences between coastal and desert hearing issues?

Dr Fagan—I cannot provide you with any firm percentages. The best data you are liable to find is from specific remote settings, because you can get a number of children and you can also get a proportion of children. It is more difficult to get that kind of data for urban or rural locations, and the picture of hearing health is very different across those geographical and environmental settings.

Senator WEST—We heard in February that you had no system of formal data sharing on the number and location of children and adults with treatable hearing loss. We were also told that there was no outreach service to places like Lajamunu, which is a 480-kilometre round trip for which there is no travel subsidy available. If you have no formal data sharing arrangements, are you purely relying on referrals and existing customer numbers in assessing where and how many services you provide?

Ms Hefford—Australian Hearing Services have permanent sites in the larger centres, remote sites in smaller centres and visiting sites to quite a number of centres; but 'visiting sites' might mean they are there for only a half-day a month. They will come in, talk to the community, offer what assistance they can in terms of assessing children, and then come back at a later time. If a client needs to travel to another centre, Australian Hearing Services do not have funding to provide transport. I know that transport is sometimes able to be arranged with local health care workers who might be going that way or with other people in the community, but there is no formal arrangement through Australian Hearing Services to transport clients from one site to another or from one centre to another.

Senator WEST—What about access to IPTAS funding—Isolated Patients Travel Assistance Scheme? Is someone attending an Australian Hearing Services clinic eligible? Does anyone know?

Ms Hefford—Sorry, Senator; I do not know. I understood that you had to be going for medical treatment, but we can take that on notice.

Senator WEST—I am happy for you to do that. In the Northern Territory—and, I would guess, in western Queensland and even western New South Wales and Western Australia—we

are talking some long distances for people to travel, and not necessarily with the most reliable of vehicles, and there is no assistance. How are we going to improve access for these people? Is the demand for services one of the criteria to measure whether you are going to start taking a service out to a place?

Ms Hefford—Australian Hearing Services regularly visit a wide range of sites and talk to people in the communities to try to establish whether or not there is an interest in having a visiting site that might come through regularly. They do not always find a community that is ready to have a visiting site and ready to work to address hearing issues. For many communities there are other issues on which they would place a higher priority. They may be looking for some other kind of health service or health related service.

Senator WEST—Could somebody, in layman's language for those who are non-medical, explain the fact that only seven per cent of Aboriginal children in these 29 communities have normal middle ears, why that may not be an issue of major concern, and why it may not be impacting upon their hearing and, therefore, their education, speech and every other development?

Dr Fagan—I did not mean to minimise the problem—

Senator WEST—I realise that, but I am just wondering. If somebody said to somebody who did not understand that only seven per cent had normal middle ears, you might reach the conclusion that 93 per cent have abnormal middle ears and therefore a hearing defect.

Dr Fagan—And therefore some middle ear pathology.

Senator WEST—Or a pathology that is going to affect their hearing, yes.

Dr Fagan—And which very well may affect their hearing and their capacity to learn. Yes, it is a very significant issue.

Senator WEST—Can somebody explain simply: should they be concerned about only seven per cent being normal, or should they be not as concerned? Is there any other research that has been done that indicates that X per cent of people that you see with abnormal middle ears have no hearing loss, whereas another percentage have hearing loss to varying degrees?

Ms Evans—As Dr Fagan has said, middle ear infection—otitis media—and ear damage is a very major problem for Aboriginal children and a continuing problem for Aboriginal people. Treatment has to be done in a context of primary health care, and it is one of the reasons we have put a major focus on trying to strengthen appropriate care on the ground. It cannot be treated in isolation, as Ms Hefford has said. Hearing service comes in as a remedial service on top of that, and we have put considerable investment—and we continue to put investment—into strengthening primary health care. We also have a specific hearing program with a training program for Aboriginal health workers in terms of early identification and testing. Ms Norington might like to talk in more detail about it, but I would not want senators to think that we underestimate it as a problem.

Senator WEST—What is being undertaken to ensure that primary health care gets to those 93 per cent of the community?

Ms Evans—In the Northern Territory, it is the place where we have made most inroads working with the Territory health service to collaboratively strengthen and expand those services. The minister recently visited there. It is true that many of those remote services until quite recently had visiting services. What we have started on, and hope to expand, is permanent health services with trained workers in remote communities.

Senator Patterson—With our university department of rural health in Alice Springs, we will be able to facilitate that training, Senator West. We have a facility now to do that. One of the exciting things was to see in Danila Dilba in Darwin an indigenous health worker who is an audiologist doing some really interesting work; not only treating the children but training the parents in identification of ear infections so that they know when to present. It is very exciting. There is a long way to go, but there is some very interesting work being done.

Senator WEST—I know there is some interesting work being done, such as some simple remedies like teaching the kids how to blow their noses properly, which reduces the incidence or severity of middle ear infection.

Senator Patterson—There are two programs in Western Australia where they have swimming pools. It is a case of no pool, no school. The rate of ear infections has decreased significantly, as has that of scabies.

Ms Halton—I am aware from a conversation with Northern Territory health officers that very active consideration is being given to improving screening in the Northern Territory by ensuring that, before babies go home, they identify much earlier any child who starts life with a hearing deficiency. The point you are making is this may also develop later, and it is well made. There is a genuine acknowledgment that, the earlier you catch and deal with hearing deficiency, the greater chance a child has.

Senator WEST—Yes. That program has been taken up by many of the states and territories, but there is some concern that people think, if you are clear with no hearing defect at age two days or whatever, that means you are never going to get one. There is some work to be undertaken there. In relation to the stocktake at Australian Hearing Services of hearing services delivered to Aboriginal and Torres Strait Islander people as part of the review of the hearing strategy, can you provide details of all the providers as well as where each provider delivers services on the ground?

Ms Hefford—The review is being finalised within the department. The report is not yet complete. It is in the final stage of drafting and should be completed very soon.

Senator WEST—So I put on notice the question that, when that is complete, can the committee have a copy? Do we know how many audiologists serve indigenous communities in the Northern Territory?

Ms Hefford—Australian Hearing Services have a number of audiologists. I would not have the number that are currently located in the Northern Territory, but I am happy to take it on notice.

Senator WEST—Does Aboriginal Health fund any other audiologists or audiometrists?

Ms Norington—Testing is also undertaken up to a point, but not for audiometry, by Aboriginal health workers who are trained under the program that is run out of OATSIH relating to the hearing health.

Senator WEST—Are they fully qualified audiologists?

Ms Norington—No, they are not.

Senator WEST—And, therefore, not able to undertake the same range of treatments?

Ms Norington—No, they are not. To my knowledge there is one other audiologist who is employed by the Central Australian Aboriginal Congress, which is funded by OATSIH.

Senator McLUCAS—Can we get those figures not only for the Northern Territory but for all of the states?

Ms Norington—That is the number of audiologists?

Senator McLUCAS—Yes.

Ms Hefford—Is that the number of audiologists employed by Australian Hearing Services?

Senator McLUCAS—Yes.

Ms Hefford—I would not be able to give you the number of audiologists in private practice.

Senator McLUCAS—I understand that.

Senator WEST—Ms Murnane, in February you referred to training of indigenous health workers being undertaken by AHS. Can you provide the dates when AHS was contracted to undertake that work?

Ms Murnane—I cannot provide that. Can you, Margaret?

Ms Norington—My understanding is that AHS has been contracted to undertake that for some years now. That contract is renegotiated on an annual basis. We are in the throes of renegotiating for next financial year. Certainly the component that will be about training for Aboriginal health workers will be retained.

Senator WEST—So the training component of that has been going for a number of years?

Ms Norington—That is right. There are slightly different arrangements in place in the Northern Territory.

Senator WEST—It is the Northern Territory that my colleague is interested in. So the Northern Territory has been going for some time?

Ms Norington—Yes, that is right.

Senator WEST—Where is the training undertaken?

Ms Norington—My understanding is that the training is undertaken in regional centres. It is not always done in places like Darwin or Sydney. Quite often though they need to bring a number of them together at any one time. That makes sense in terms of the logistics of it and the opportunity for Aboriginal health workers to be trained together and share their experiences.

Ms Hefford—The contract that Ms Norington is talking about is a contract between OATSIH and Australian Hearing Services. Australian Hearing Services undertake that training on behalf of OATSIH and they use the existing locations of their hearing centres.

Senator WEST—Have you any idea how many health workers have been trained to date?

Ms Norington—I do not have that figure with me. We could probably get that figure. One of the reasons why we need to continually give the training is because Aboriginal health workers move on or they move into a different role in the AMS. So we always need to continue to be training as well as expanding the number. If you would like the figures for the last two years we could probably get them.

Senator WEST—That would be great. I would appreciate that. To what level are they trained? Is it just to the basic screening level?

Ms Norington—Pretty well. I think too, it is in order for them to recognise when they need the assistance of an audiologist or that other health workers need to be brought in, such as primary health care workers, doctors and ENTs. They work as part of a team.

Ms Evans—Senator, we can provide details of that.

Senator WEST—Have you followed up where the trainees have gone and watched how many are still working in the system or have moved out of the system altogether or moved up the health system as it has been part of their progression? That might have to go on notice.

Ms Norington—We could endeavour to find that out.

Senator WEST—Have you put in place any recurrent training?

Senator Patterson—Senator West, that is another one of those questions where we need to clarify exactly what you mean because the department could take a huge amount of time trying to find the answer to that question. It may be easily obtainable. I do not know whether they have kept tracking information. It may be that it is what we should be doing, but to go and try to find all the health workers ever trained or as of last year or people who have left being health workers is hard. That is a very broad question.

Senator WEST—The last couple of years would be helpful.

Senator Patterson—That means they have to locate them and find out what they were doing. The department does not have that information. To find it would just be very time consuming. I am not being obstructive or difficult. It is just that they do not have that information.

Senator WEST—No, but the reason I am asking the question is that every six months you are having to train up a whole lot of new people, because for some reason the other ones have disappeared or—

Senator Patterson—Can I make a suggestion that we take a sample of three of the larger health services, possibly in metropolitan areas like Townsville, and three in remote communities, and ask them to tell us, because they will have first-hand knowledge of Aboriginal health workers, how many have left in the last three years and where they are?

Senator WEST—It is those that have undertaken the hearing training that we are looking at.

Senator Patterson—I do not think we can cover them all, but we can take a sample of them, and try and find out where they are. It is a complication in the sense that we do not have a record of where all those people are.

Senator WEST—We do not need to know where they are but whether they are still utilising those skills; or is there, in fact, a big turnover in training?

Senator Patterson—If they have left a Commonwealth funded facility, we will not have a way of tracking them. But we will give you a picture that tries to give you the information you are wanting without having to spend more time than the officers have, when they could actually be working on developing programs—if you will accept that.

Senator WEST—I do accept that, Minister, and I accept there has to be a balance. There has to be some monitoring of what is happening down the track because, if they are only lasting two or three months, and you are having to redo the lot, then maybe there needs to be a review. That is where I am coming from.

Senator Patterson—Can I just correct something I said before about Danila Dilba? I said that the indigenous person was an audiologist. I have just checked with Helen Evans, and that person may be a health worker who is audiology trained. But I have to tell you, if she was audiology trained, she was very au fait with what she was doing. I would have looked on her as if she was behaving like an audiologist, but I think she may have been a health worker with audiology training.

Senator WEST—Has the department put in place any recurrent training programs, refreshers and upgrades on ear health, or you are just running the one-offs?

Ms Norington—For Aboriginal health workers? Yes, they do periodically have the opportunity to upgrade. And usually it can be done formally, but it is also done somewhat informally, say, when there is a visiting audiologist and there is some training done at the same time. The other thing I would like to add is that some of the trained Aboriginal health workers who have been trained as ear health workers are used in that capacity full-time, and sometimes they are used in a part-time capacity amidst a whole lot of other things. It really depends on the AMS and the decision that they make in relation to how they will use that health worker.

Senator WEST—It could well depend on the size of the community or the size of the AMS that there is not enough work for solely for doing one particular type of work.

Ms Norington—It is probably more to do with their view of not having a specialist health worker, for example, in ear health. But maybe they would have more of their Aboriginal health workers trained so that when a child presents it is looked at in a more holistic way.

Senator WEST—At any time of the day or night. They do not have to hang around. I understand that Senator Crossin has also placed on notice a question on details of the number and locations of hearing impaired persons. She has not received an answer to this question. I do not know whether it was a question on notice to estimates or a question on notice through parliament.

Ms Murnane—Every Senate estimates question on notice has been answered.

Senator WEST—That is what I thought. This must be a question that she has placed on notice in the chamber. I will get her to chase that one up herself.

Ms Murnane—It would be quite a test to answer that and give the location of every hearing impaired person in Australia.

Senator WEST—Numbers.

Ms Murnane—There are estimates, and those are based on certain studies and information that comes; but exactitude is impossible, as you would understand.

Ms Hefford—The Australian Institute of Health and Welfare's most recent report on this estimates that 17 per cent of the population have some level of hearing loss, but a smaller proportion or subset of that would have a treatable hearing loss; not all of that 17 per cent would be people who would need to be fitted with hearing aids or have some assisted listening device.

Senator WEST—Senator Crossin will no doubt read this *Hansard* and will be prompted to take the appropriate action.

Senator Patterson—If it is not already on notice Senator Crossin could put it on notice but she could just take into account the fact that the level of detail she might be asking for might

be impossible. The department will respond to her question with the information they have. It needs to be phrased in a way that it is possible for it to be answered.

Senator WEST—Thank you, Minister; that is fine. I have finished with hearing. We can go on to Aboriginal health.

CHAIR—This is outcome 7.

Senator McLUCAS—I want to ask some questions about Aboriginal health workers. Can you tell me the numbers of Aboriginal health workers we have, trained, in Australia? Is that something you could access information about?

Ms Cass—We can give you the numbers of Aboriginal health workers employed in Commonwealth funded Aboriginal medical services which would be a subset of all Aboriginal health workers because they are also employed by state governments.

Senator McLUCAS—Going back to that earlier conversation, we just do not know how many Aboriginal and Torres Islander people have been trained as Aboriginal health workers?

Ms Cass—We have undertaken some reviews of training for Aboriginal health workers. We are aware that there is great variability in the extent to which Aboriginal health workers are qualified. It varies from state to state. I can take that on notice and provide you with the data that we have.

Senator McLUCAS—Thank you. Could you also explain to us how the training is accredited? You might be able to do that now or you could do that on notice.

Ms Cass—Training for Aboriginal health workers is generally provided by RTOs, recognised training organisations in the VET—vocational education and training—system. The courses that they provide are accredited in that system. They are generally certificate level 3 or 4 qualifications.

Senator McLUCAS—Is OATSIH concerned about the retention levels of Aboriginal health workers? Is that an issue that has been brought to your attention?

Ms Cass—Retention in training or in the workplace?

Senator McLUCAS—Retention in work. It has been put to us that there are a lot of people who are trained—this goes back Senator West's questions earlier—but they do not stay in the profession.

Ms Cass—We are aware that access to training is an issue. There are issues about the size of the Aboriginal health worker work force. That has been put to us. The age profile of that work force is ageing and they are not necessarily being replaced.

Senator McLUCAS—It has been put to me, especially in the Torres Strait, that people move out of providing services that were provided by an Aboriginal health worker. That has not been put to you? The people do not stay in the profession.

Ms Cass—I can take that on notice and check for you, to see what information we have.

Dr Morauta—I believe there was an AIHW workforce survey which supported the sorts of trends you are talking about. We can find that information for you and provide it.

Senator McLUCAS—If it is simply a matter of providing that document and you think it might answer my question, in the interests of efficient use of departmental time it would suffice.

Dr Morauta—We can get that for you in the course of this hearing.

Senator McLUCAS—The other issue that you may have been made aware of is a career path for Aboriginal health workers. It has been put to me in many, many places that Aboriginal people and Torres Strait Islander people will go and undertake training, but, essentially, that is the end of the career. You get 'the job' as an Aboriginal health worker but the opportunities for promotion or professional development from that point in time are very limited. Has that issue been brought to the attention of the office?

Ms Cass—We are aware that the issue of the vocational training system and the career pathways for Aboriginal health workers is significant. It is an issue which the Commonwealth and the states have sought to address in agreeing on an Aboriginal and Torres Strait Islander health workforce national strategic framework which was endorsed by AHMAC—the Australian Health Ministers Advisory Council—at its recent meeting. One of the five objectives in that strategy is to address and reform the Aboriginal health worker training system and career pathways.

Senator McLUCAS—Can that framework be provided to the committee?

Ms Cass—It can.

Ms Evans—As Ms Cass has said, not only training but career opportunities for health workers is a big issue. Only in the Northern Territory is there registration of health workers and, now, an established career path. One of the recommendations in the report that Ms Cass has referred to, which has been endorsed, is that each state consider registration, which is a prerequisite, really, to a career path. If you have no accepted definition of a health worker—and that probably requires some sort of registration—it is very hard to develop a career path. I think it is a big problem for health workers.

The other problem for health workers, which I think you are alluding to, is looking at ways that they can articulate across to other training if, say, they have trained as a health worker and then wish to progress and maybe move to nursing. Some Aboriginal health workers are very happy to stay as health workers. They like that role. Some would like to progress to being nurses or to managing health services. One of the things that we want to look at is how educational facilities can facilitate that articulation: recognition of prior training and then movement across into other streams. So there is a whole package of things that we are starting to look at with our state colleagues.

Senator McLUCAS—Are the officers taking a lead role in providing that leadership to the states?

Ms Evans—Yes.

Ms Halton—Could I just emphasise that that question of articulation is a problem for us more broadly. Senator West has had a particular interest in that in the past in respect of nursing, and it is something which we are looking at more broadly, in conjunction with our colleagues in DEST.

Senator Patterson—I am just trying to remember in the recesses of my mind a development that is relevant to career paths for health workers, which I was just asking Dr Morauta about. A couple of months ago, I launched a harmonisation project—somebody behind me might be able to help—of people who work in hospitals, who spend time in hospitals and who develop skills for which they are never recognised when they move to another hospital in another state. The states harmonise those, I think through the health ministers conference—I am not sure; I will try to get a briefing on the detail. That project provided people within hospitals a career path that led on, if they wanted to, to their becoming an enrolled nurse or to do nurs-

ing. I think somebody mentioned to me the possibility of bringing the health workers into that harmonisation project so that if they moved across states their skills would be recognised in the other states rather than, say, their skills being recognised in Queensland, for instance, but not in the Northern Territory. There are a lot of programs, as you know. I will try to find out where that is and give you some information on that, because that is quite important in terms of some indigenous people who are working in hospitals and who would like to find a health path that is not just for health workers.

Senator McLUCAS—That would be useful. It does come back to recognised training, so that there can be movement across the states as well. In the development of the national strategic framework—I think you called it that; is that right?

Ms Evans—The work force framework.

Senator McLUCAS—What consultation did you have with indigenous health workers?

Ms Cass—Consultation occurred on several levels. There was consultation with NACCHO, which is the peak body for Aboriginal medical services. Consultation occurred at the health forum level, which is the jurisdiction level group where the NACCHO state affiliate, the Commonwealth and the ATSIC state representatives meet to work on Aboriginal health issues. We then consulted with state affiliates directly and, in some instances, I think in four states, funded consultation forums where they brought together services that make up their organisation and ran specific facilitated workshops on the draft document. In addition, there was a public consultation process where the document was sent out widely. We received about 60 written submissions. A significant attempt was made to consult with the Aboriginal health work force and services.

Senator McLUCAS—You talked about the forums that were brought together in terms of state affiliates. Did you move out of the capital cities—I know it is very expensive to do that but, with an issue like this, it is probably worthwhile to move to isolated places—or did you ensure that people from very remote places came to those forums?

Ms Cass—For those state affiliates where we funded an internal consultation process with their members, we gave them funding to bring delegates in from their services to the workshop.

Senator McLUCAS—I look forward to having a look at that work. The issue of career paths for indigenous health workers is an ongoing concern. I think the linkage between retention of skilled workers and providing them a career path is really important. You get a qualified person, a skilled person, as a health worker, they will be snapped by some other field unless we can give them a clear career path within the health field where I think a lot of them want to work, but if you see more money or reward for the work you are doing in another area, of course, we all would take that job.

Senator Patterson—My memory is now coming back to me. I launched that program for Dr Nelson. That is why the department will look blank, as if I have been off in some little frolic of my own, and I had. I got away from them one morning. They did not know what I was doing. When I think about that program, it is relevant and I think we should look at the program too to see whether there is a possibility to fit in there to get that harmonisation and not reinvent the wheel. We will chase that up. We will give you that information about that program when I have got it. The department suddenly realised that I was away from them for a morning.

Senator McLUCAS—Thanks for that. That is all I needed to talk about on indigenous health workers

Senator BUCKLAND—With respect to indigenous health, I have one area that that I want to address, regarding the growing problem with petrol sniffing in Aboriginal communities. I wonder whether you could be patient with me and work through this because it is a growing problem that I am getting more and more inquiries about. How many Aboriginal health workers, or health workers in general, are actually dedicated to the problem of petrol sniffing in Aboriginal communities?

Ms Evans—The issue of petrol sniffing, as you say, is of increasing concern, particularly in Central Australia. The numbers are not large but the impact on the communities where they are sniffing is very significant.

Senator BUCKLAND—Human life is important so it does not really matter if very small numbers or large numbers are involved.

Ms Evans—No, but I think petrol sniffing needs a range of approaches. As a funding body we have looked at preventive type activities such as funding Avgas, which does not have the same effect for sniffing, early activities around sport, recreation and social activities for kids that are bored, and then a range of activities that are needed for people who are chronic sniffers.

When you ask specifically about health workers dedicated to petrol sniffing, health workers would be working with sniffers and working with early intervention programs. I could not answer whether there were any dedicated staff; certainly there are youth workers who are funded predominantly because of the concern about petrol sniffing amongst young people. But I think it is probably unlikely that there are dedicated Aboriginal health workers for petrol sniffing.

Senator BUCKLAND—Page 163 of the PBS, under the heading 'Addressing Specific Health Issues', says:

- develop a national policy framework for the Aboriginal and Torres Strait Islander Substance Use Program, including program objectives, key result areas, monitoring and evaluation. Emphasis will be placed on intersectoral collaboration and regional planning processes. In addition, there will be a particular focus on petrol sniffing and alcohol;

How is this going to be done, and what are you really addressing there? Are you just going to look at it, because I understand there have been a number of studies now? I understand that coronial inquiries have been held. There are two notable ones, of course, going on at the moment—one in the Territory and one in South Australia. When are we going to stop looking at it and start addressing it? That is the worry. I am not being critical of the government in saying that it needs to be addressed. I fear that the department may continually be looking at the problem rather than getting out there and starting to address that problem.

Ms Norington—Senator, I think we could say that there are specific measures being undertaken, particularly at the Top End and in Central Australia, relating to petrol sniffing. There are programs that come under the National Illicit Drugs Strategy as well as under the Office of Aboriginal and Torres Strait Islander Health program, where we fund services that operate in those regions, either in their own right or as part of collaborative activity, to employ youth workers, to undertake a range of diversionary activity, to, in a collaborative way with sport and recreation departments and education departments, provide a range of programs that specifically address the needs of petrol sniffers, particularly at the point where we are wanting

to provide the appropriate activities to stop young people taking up petrol sniffing. So there are a range of programs. I could run through some of those with you, if you wish.

Senator BUCKLAND—I appreciate that you are prepared to do that, but I think I am aware of most of them. How were these programs developed, and who was involved in developing them?

Ms Norington—The programs are largely a combined effort between service providers—places such as the Nganampa Health Council, the NPY Women's Council in Central Australia and the Tangentyere Collaborative in Alice Springs, which pulls together about eight to 10 different organisations in Central Australia to work on programs that are related to youth generally but that also specifically target substance use, such as alcohol and petrol sniffing. The programs are often designed by a combination of Commonwealth and state and territory service providers and the community.

Senator BUCKLAND—At the end of the day, how much of a voice does the community actually have in the programs that are developed? Is it really left to the community workers at the state and federal government agencies?

Ms Norington—The communities have a significant role to play. It has been fairly well established that, if you impose a program, a project or a youth worker on a community that is not receptive, that is not going to be supported. So it is absolutely essential to have the right people in the community involved. That might be peer cohorts within the community. Equally, it has been shown in a number of cases that the role of elders in the community is particularly important. For example, if you are running a program which is providing some diversionary activities in a community but is also an out-station for the chronic petrol sniffer, the role of elders has been found, in a number of projects, to be particularly important to its success. We are funding some programs in the Northern Territory: Indulkana, Intjartnama and Yuendumu-Mount Theo. Evaluation of those programs—each of which uses a slightly different model—is about to be completed. We have gone back to the communities to make sure that they are happy with the presentation of things that have been said that might drift into privacy issues. I think that report will be available around the end of this month.

Senator BUCKLAND—How long was the evaluation period?

Ms Norington—It has been done over a couple of months. A preliminary report was done, it was taken back to the community by the consultants, and we are now in the finalisation stages of that.

Senator BUCKLAND—Are there any health workers working within Aboriginal communities who are specifically there to deal with drug abuse?

Ms Norington—Yes. Again, it is a bit like the ear health question. There are some who are almost specialising in that, and some for whom it is a shared responsibility with other Aboriginal health workers.

Senator BUCKLAND—So there are people dedicated to that?

Ms Norington—That would really be under the control of the Aboriginal Community Controlled Health Organisation. If it is a specific project, the project funding is probably attached to the employment of dedicated health workers and youth workers to assist with the project; and they would largely be Aboriginal people.

Senator BUCKLAND—I appreciate that. Does the department view petrol sniffing as an addiction, or just as a problem? There is a difference, isn't there?

Dr Fagan—Yes.

Senator BUCKLAND—If it is an addiction, you can treat it, or at least attempt to treat it. If it is just a problem, the best treatment seems to be that it will go away.

Dr Fagan—If you have a look at the limited data that we have available on the epidemiology of petrol sniffing, Nganampa Health Council has produced the most current and comprehensive data for that area. You will find that within a given community a proportion of the people who are sniffing will be chronic sniffers and a proportion will be intermittent or episodic or environmentally induced sniffers who may not sniff if the situation is different. But there will be a proportion who are both chronic and whose disabilities that have arisen from the sniffing mean that the type of care that needs to be provided for them is long term.

Senator BUCKLAND—I understand there will be a report handed down from the trial programs et cetera. Are there any views on the type of care that will be offered to petrol sniffing offenders? Will it be offered on site or will they be removed to a detox centre? Has the best way to deal with it been considered yet? Do you remove them and say, 'We'll bung you off to somewhere out of town for a while'?

Ms Norington—Among the experts in this area that have undertaken considerable studies in relation to particularly chronic petrol sniffers there is a range of views in relation to what is the most effective way of managing chronic petrol sniffers' needs. There would be some who would argue that what you need is a short-term safe place for that person to go to when they are very much under the influence of petrol. They may be sniffing, hallucinating, fitting—very seriously ill—and have some quite extreme behaviours which mean they may be a danger to themselves as well as others. One of the problems that you have with, in a way, forcing people into that are issues around detention.

Senator BUCKLAND—I am not recommending detention or suggesting that that is your view. I am just asking about removal.

Ms Norington—Yes. This in fact is part of some of the programs that we have been funding: the creation of what is commonly known as an out-station—so it is outside the community; it could be a couple of hundred kilometres away—where the person is encouraged, at times possibly coerced, into being removed from the community into a safer place with a range of activities. For example, they run a cattle station, they are given lots of activity and they are also, in a sense, educated about their addiction and their behaviour. There would be others, however, who would believe that it is better done in the community, given that the person needs to do re-enter the community, so you need to work with the community as well as with the person. There would be some who would say it is very important that you work with families; some would say that it is very important that you work with peer cohorts. There is a range. In some communities there is a preference for doing it a particular way. All that we can do is look at what the community's preferences are, what the research and the evidence would indicate to us, and try to come to some way in which the community feels comfortable about the way in which it is being managed.

There is no doubt that for some chronic petrol sniffers their rehabilitation requirements are quite extreme. They have an acquired brain injury and therefore it is not only their behaviour which is often dangerous to themselves and dangerous to others, they are physically incapacitated as well and, in many ways, unable to look after themselves—they are in wheel chairs.

Senator BUCKLAND—You mentioned the experts. Who are the experts?

Ms Norington—The key people who have written in this area are Dr Maggie Brady and Dr Peter Dabbs—he may be a professor, I am not sure about that.

Dr Fagan—Maggie Brady's knowledge of petrol sniffing would probably be the most extensive.

Ms Evans—We could provide you with some references, Senator, if you wish to follow up. Dr Brady has written quite extensively on it.

Senator BUCKLAND—That would be very helpful.

Ms Evans—We put a written submission in to the current coronial inquiry—

Senator BUCKLAND—Which inquiry is this? There are two, I think.

Ms Evans—There is the one going on at Umawa at the moment, the South Australian one. They requested we put in a written submission about the range of services we are funding. If you would like us to make that available to you, it outlines the current range of activities.

Senator BUCKLAND—I would very much appreciate that particular one. I guess there would not be statistics, and it might be an unfair question to ask, but I will ask anyway. Are there any statistics or indicators that would suggest that perhaps there are suicides linked to petrol sniffing—that is, that people have used excessive sniffing to terminate their lives?

Ms Norington—I am not aware of it. I am aware that this was certainly the subject of the coronial inquest in the Northern Territory a few years ago in which a young man died. The question was raised as to whether the cause of death was related to petrol sniffing per se and his hallucinating and so on. Here I am going to have to seek some technical advice, but there was some question about the fact that he was having difficulty with his breathing. The amount of oxygen that was coming into his system was insufficient, he panicked, and it led to his putting his arm through the window of a car and he bled to death. It clearly brings into play the emergency services and so on.

In relation to the coronial inquiry that is taking place in Umawa at the moment, there are three deaths that are being looked into there. The causes of death are quite different, but in the case of two of them they were found with petrol very close by. I suppose it will depend on what the coroner comes out with, but you would have to raise the question about whether it was suicide or whether it was accidental. I do not know.

Senator BUCKLAND—I deliberately asked that question because there was a report very recently in South Australia of a young man who was found with the container still to his face. I would think in circumstances such as you have previously described, where there is a lack of oxygen, one's natural reaction, if you want to do something about it, is to remove the source. Are there any thoughts on that? It may be too early to answer that.

Dr Fagan—I would just be giving an opinion. I could not say. I could not comment on that.

Senator BUCKLAND—I have looked at the budget papers and I cannot identify a specific funding line, but is there any funding line for addressing the problem of petrol sniffing?

Ms Norington—No, it is captured under substance use.

Senator BUCKLAND—So it all comes under that one line, 'substance use'?

Ms Norington—That's right.

Senator WEST—Is it possible to break down the information under the broad title of substance abuse? Petrol is not the only substance for which there is a program. I am interested in a breakdown of individual programs and state by state, if that is possible.

Ms Evans—We can provide on notice the information on the services funded. Many of the services are polysubstance services. We can certainly provide you with details on the services we fund.

Senator BUCKLAND—I have one more question—it is one that could be ambiguous at the moment. In the cities, and I refer specifically to Adelaide—being a South Australian, I generally like to promote our state, but we do have some problems. Chroming is the term for sniffing aerosol paint, and I am not sure how you relate chroming to paint, but it is happening—in fact, on the steps of Parliament House at one stage. Is that a problem within the indigenous communities?

Ms Norington—My understanding is that it is not at the moment, but it could become a problem, yes. It is something that seems to be more associated with urban environments but, no, we do not have any specific data on that.

Senator BUCKLAND—I appreciate that because I have heard nothing about it at all myself. Minister Anderson talked about croc festivals and support for indigenous youth. He said that, as part of the government's National Illicit Drug Strategy, $1.2 million in additional funding was being provided to the croc festivals over the next four years. I assume from a previous answer that some of that money will be going to this problem of petrol sniffing?

Ms Evans—Croc festivals are in remote communities, as Ms Kerr said earlier. The whole idea is to give the opportunity, through schools and then through the festival, for kids to focus on issues around substance abuse. I would imagine, without knowing the specific details, that the range of substance abuse issues are raised and discussed there.

Senator BUCKLAND—There is an additional $1.2 million specifically for this problem. Is that just going to be in educating or is it going to be in helping the communities?

Ms Evans—It is funding all aspects of the festival.

Senator BUCKLAND—So all aspects?

Ms Evans—Yes.

Senator BUCKLAND—Are there programs in the Aboriginal education curriculum to bring the dangers of petrol sniffing and substance abuse into that curriculum, into their health and education programs?

Ms Evans—I cannot answer that one specifically because that is actually more in the education area. However, there is an increasing focus of working between health services and schools, with substance abuse services and substance abuse workers going into schools. Certainly it would be something that we would hope is increasing in terms of health curriculums and approaches within schools. But I could not give you a specific answer on that.

Senator CROWLEY—Can you find out for us? It seems to me we have heard a lot of discussion today about the importance of health education. Ms Kerr was taking us through some of the programs vis-à-vis drugs and alcohol et cetera, for everybody in Australia, I presume. It might have included the odd Aboriginal person in passing. Why are we not so sure here?

Ms Halton—The reality is that, as Ms Evans has indicated, this is an issue that is dealt with principally in DEST. I am aware that a number of programs have been rolled out over the last few years which go particularly to tackling issues of drug use, through schools. For example, there was an initiative I know of which sought to provide education for principals so they could use that information in their schools. At one level, I suppose we could take it on notice, but essentially it is a question in detail for another portfolio. We can certainly get you the highlights, but they would be able to give you far greater detail than we can.

Senator CROWLEY—But from the evidence, we do not know how many people are dying from substance abuse. It would be good to know what we are doing to try to stop them dying.

Ms Halton—Of course.

Senator CROWLEY—So how do you inform yourself about what education is being provided? I presume you have an interest in knowing.

Ms Halton—Indeed, Senator, there is a high level interdepartmental committee which brings together all of the agencies that have an interest with respect to drug use—largely illicit drugs but in some cases licit, as we have just been discussing. That committee involves not only our colleagues in the education department but also the police, Customs and a whole range of other agencies, with the explicit intention of ensuring that the work that we do in this area is coordinated—enabling us, as you rightly say, to tackle some of the causes of dependency but also, hopefully, to militate against some deaths. As I say, we can talk with our colleagues and get you the pithy highlights and perhaps point you to where there are more details available. We would be happy to do that.

Senator CROWLEY—That is a help. Thank you. Being directed to where I can do some more finding out is very kind of you. I also like the efficiencies of coming in here with you having done that work so that I do not have to.

Ms Halton—My point is that we attempt to be able to answer, in forensic and vast detail, any question to do with our own portfolio, and we try to do our best. The reality is—

Senator CROWLEY—This is a process of education in both directions, is it not?

Ms Halton—Indeed.

Senator CROWLEY—But I actually worry a little bit, and I think this is terribly important. It is a bit like the questions on drugs this morning. You have a coordinating committee and there is a high level exchange of information between relevant departments, but when we ask, 'What is happening about education?' does that mean you would have to refer to the high level committee? Is there somebody in the department who actually knows the answers to those kinds of questions? I think the coordination is fantastic. What seems to happen, though, is that there is a gap between what is known there and what is provided to senators.

Ms Halton—I suppose this is a question of traditional practice. At the risk of straying into an area about controlling or dealing with other portfolios' information, I suppose our traditional practice in these committees has been to answer questions in respect of our portfolio, for which we have a direct responsibility and for which our minister has a direct responsibility. Your point was well made that what we do in a number of areas relates to other portfolios. We had the conversation about food earlier on, and I work very closely with my colleague who runs the department of agriculture. This is one of the areas where there probably are as

many portfolio intersections as you would find. My point is simply that, yes, we do know in broad terms what they are doing. They bring that information to those committees, and we provide advice—again, I say this with a wry smile—in a whole of government way on some of these issues.

Senator CROWLEY—Who chairs such a committee, Ms Halton?

Ms Halton—In this case, one of the deputy secretaries in our department is currently chairing that committee.

Senator CROWLEY—So the health department is the chair. Would I not presume that the health department then might have a bit of a handle on all the info coming and going?

Ms Halton—We do have a handle on that information and, certainly, in the advice we give to government in relation to progress or, more importantly, future directions, that committee has a job to pull together that information, to synthesise it and to provide integrated advice. That is precisely its role. My point is simply that we risk misleading you about the precise and specific detail in some areas, because it is not our day-to-day responsibility—in aggregate, certainly; but some of the questions this morning went to the specifics, and clearly we do not have a day-to-day responsibility and therefore we are unable to answer the day-to-day and specific detail.

Senator CROWLEY—I guess this becomes a matter of frustration for us, but it is a particular matter of frustration for the community who are really not at all interested that they have to be in Education or in Customs or up a tree. They just want to know. If their kids do not know about safe sex, or clean needles, or not petrol-sniffing, the main thing they want to know is how to get that stuff to the kids. They really do not want to be directed to this department or the other. Given that is traditional practice, is there any faint whiff of changing tradition?

Ms Halton—Senator, you would know that we have had variously over the years assorted administrative restructures which try and deal with these boundary problems and then we sort of discover we have created a new boundary. Let me just say that our attempt—and it is fair to say that in health chairing this particular committee, that was an initiative I took when I arrived in the portfolio—is fairly unusual. Normally a coordinating department again would take that responsibility. We thought it would be good for us as a line agency to work with our line agency colleagues in this respect. I take your point about people in the community, and we are trying to in effect coordinate information to people in the community, because they not only do not know what the acronyms stand for but they do not much care. Your point is quite reasonable. My point was simply that when you ask us for forensic detail in some of these areas, we may not be able to answer. But we will endeavour to do what we can.

Senator CROWLEY—On notice would be useful and I would ask your serious consideration of better ways in which you could anticipate the same questions next time and therefore different kinds of data might be available for us. I wanted to ask some other questions, for example in the area of the prevention of sexually transmitted diseases amongst Aboriginal communities, particularly in the Northern Territory. Again, who is responsible? I wanted to ask about the spread of AIDS, the spread of hep C, the whole business of the scarring and cicatrixing and the possibility of that transferring AIDS—to say nothing of—

Ms Halton—Senator, we can certainly talk about those things—

Senator CROWLEY—I just think that we are talking about very serious health issues—violence in the communities and so on. We have a Commonwealth program opposed to or trying to reduce domestic violence, for example—

Ms Halton—Run by the Office of the Status of Women.

Senator CROWLEY—Yes. But I would have thought that violence in the Aboriginal community—everybody is talking about it—

Ms Halton—Yes.

Senator CROWLEY—Again, I am quite sure it is an issue of concern for your department, but the health consequences are what we are actually talking about. I would be asking you to look at ways in which some of that cross-boundary or interdepartmental information which so impacts on the outcomes of health might be better provided to us.

Ms Halton—Senator, best endeavours. In respect of drugs, one of the things we can do—and we certainly will attempt to do this before the next estimates—is probably have a conversation with our colleague departments about a shared set of briefs which means that each of the agencies will have the same information in a number of these areas. We can certainly undertake to do that.

Senator CROWLEY—That sounds like a very useful initiative.

Ms Halton—Hopefully to reduce the level of frustration.

Senator CROWLEY—Because then you can tell us how all that money is being spent by Education and it is making no difference to the health outcome at all. Or perhaps it is. Can I ask you about trachoma?

Senator McLUCAS—Before you do—I had to leave the room for a minute—have we asked you how much money is currently being spent by the department on alcohol and substance abuse programs for indigenous peoples—as a global figure?

Ms Norington—We probably need to take that on notice because it is not just in our program. It would be across the population health division, outcome 1. We could certainly provide it.

Senator McLUCAS—Thank you, and you will provide it by state by state?

Ms Norington—Yes, we can do that. I am sorry, Senator, that was substance use including alcohol, was it?

Senator McLUCAS—Alcohol and substance abuse, yes.

Ms Norington—Tobacco as well? I am just trying to be quite clear about what it is.

Senator McLUCAS—Tobacco, yes.

Senator WEST—That is a substance. Some people have had to leave this room because of it!

Senator McLUCAS—I understand that $470,000 has been allocated to the indigenous substance abuse program through the petrol sniffing diversion pilot project. Is that correct? Is that within this office's purvey?

Ms Evans—The information we offered earlier to Senator Buckland—to table the details of programs and that—will include that.

Senator McLUCAS—Thank you. You will give a description of the project in that?

Ms Evans—Yes.

Senator McLUCAS—Can you tell us how many people that project will serve?

Ms Evans—That may be more difficult, Senator, but we will attempt to do that. There will be a target area—how many people it actually serves.

Senator McLUCAS—Right, instead of going to communities. Thank you.

Senator Patterson—When I look at a lot of the programs that were running, I wondered if a small group might be interested in people who are in OATSIH coming and doing a seminar on the various programs and how they are working, how they are being rolled out.

Senator McLUCAS—And how they interact with other agencies—that would be useful too.

Senator Patterson—It would be just for information. We would notify our backbench health committee, yours and this committee. It might not be a very large number. We could have a 1½-hour information session with all of these programs and some material.

Senator McLUCAS—Thank you; I think that would be useful.

Senator WEST—It would not be a huge number, but I think there would be half-a-dozen or so that would be very interested.

Senator CROWLEY—I am advised Australia is the only country in the developed world where blinding trachoma still exists. In 1997 the federal Minister for Health and Aged Care, Dr Wooldridge, promised to do 'whatever it takes' to address trachoma in Aboriginal communities. In 1998, the Prime Minister announced the provision of the antibiotic azithromycin to treat trachoma in indigenous communities. However, a paper last year in the *Medical Journal of Australia* outlined how nothing has changed. Can you comment on that information and tell me what funds, if any, are specifically earmarked for trachoma programs?

Dr Fagan—I can speak generally about the issue but cannot comment on the funds. Trachoma is an important issue in some indigenous settings. I think the information that we have the moment is that, while the disease is still common in some settings, it is not as severe as it was in the past. We see it as an issue to be addressed within the context of comprehensive primary health care, and there have been a number of initiatives directed at addressing it within that context. Ms Norington, would you like to comment on the availability of azithromycin?

Ms Norington—It is approved and made available under the section 100 arrangements to rural and remote Aboriginal community-controlled health organisations and other service providers.

Senator CROWLEY—Do you think we need to bring back Fred Hollows in this area? The health department would be loud in its protestations, I am sure.

Ms Evans—You may be aware that Professor Taylor did a report on indigenous eye health and recommended that there needed to be a regional approach to eye health; there are a range of eye health problems. As Dr Fagan said, these are issues that need to be dealt with by the primary health care services. The stand-alone Fred Hollows caravans, which undoubtedly were groundbreaking in their time, are probably now superseded by a recognition that it is much better to treat it on an ongoing basis within a primary health care setting.

In those areas where trachoma is still at very high levels—and there are undoubtedly areas, particularly in the desert areas—such as Katherine West Health Board, which was one of our

coordinated care sites, they have identified trachoma as one of their major initiatives. They are targeting it, working with schools and doing annual screening. So I think the short answer is no, we do not need another Fred Hollows, but we do need to recognise that it needs to be treated where it is a problem. The bigger problem for Aboriginal people and eye health is actually diabetic retinopathy. Once again, that is where primary health care is important. Early diagnosis of diabetes, regular monitoring and then treatment as necessary are really important.

Senator CROWLEY—How young is the youngest person with diabetic retinopathy?

Dr Fagan—I am afraid I could not answer that question.

Senator CROWLEY—Five?

Dr Fagan—That would be extremely unlikely.

Senator CROWLEY—I think it would be extremely unlikely too. What is the age group affected by trachoma?

Dr Fagan—Children are particularly affected by it.

Senator CROWLEY—My point being that trachoma is a disease that might indeed blind kids, or restrict their sight and, therefore, wreck their whole future. Diabetic retinopathy is very serious—I appreciate your point—but it is cutting it at a much older age group. You have been dealing with hearing in Aboriginal communities. A report of former senator, Bob Collins, said that some of the teachers in the Northern Territory regularly shout through loudhailers, because most of the kids in the classroom are deaf, as a result of those failed hearing problems. If we add blind as well, we are doing very well. I do not suggest—and I do not think you are suggesting, Ms Evans—that we should look at diabetic retinopathy in lieu of trachoma in kids.

Ms Evans—Absolutely not.

Senator CROWLEY—The concern I have is: are we seriously keeping an eye on it? According to this data, nothing much has changed. There are still patches of a high level of trachoma that is of major concern. My question is this: through primary health, GPs, Commonwealth funding for service delivery—whatever—in what way are you making sure that these figures are going to be lower in 12 months time?

Ms Evans—I would question that nothing has changed. I think that the rate of trachoma has been reduced. My understanding from current studies in central Australia—there is currently a research project with a PhD student going on on the AP lands—is that the trachoma is not as prevalent, but also it is not as severe. It is not blinding trachoma, and that is a very significant change. That is very important. It is very important that health workers, doctors and nurses in those areas where there is still a high prevalence are alert to it, and are able to pick it up and identify it earlier. With drugs like azithromycin, it can then be managed.

Dr Fagan—One of the lessons of the last 20 years of people's work in Aboriginal health is that it is through building the infrastructure for comprehensive primary health care that we should make the biggest investment if we are going to have the biggest impact. We have to keep our eye on issues such as trachoma where they are an issue, and an issue for the community. We need to work in partnership with the communities to do this. I believe that the approach that OATSIH has been developing over the last five years does attempt to take that forward.

Senator CROWLEY—I am pleased to hear that. I am interested though that the *Medical Journal of Australia* says that nothing has changed. It is not me. You are actually wanting to question those findings. Is that something you should take up with the MJA?

Dr Fagan—I am not sure which article you are referring to.

Senator CROWLEY—A paper last year. I must say that I do not have the date for that either. I do not know how many volumes of the MJA last year referred to trachoma. It might be something you could look at.

Dr Fagan—I would be happy to look at it.

Senator Patterson—With all due respect about papers, it depends on when that data was gathered. It was a year ago. It is likely it could have been sitting with the editor for a couple of months. It is likely that it was gathered six or 12 months before. One of the things that Ms Evans is saying is that, with the emphasis on primary care and funding, for example, coordinated care trials, we should start to see not just a one-off attack on particular disease processes but an ongoing, long-term systematic review. That is where we are going to see the long-term effects of the programs that are being put in place. We need to have a look at that. I did not actually see that article—it may have been before I became health minister—but I would really want to look at when that data was gathered, and I think, if you gathered it now, you might even see a difference in that period of time.

Senator CROWLEY—The point that Ms Evans made about people maybe having trachoma but that it is non-blinding is a very important point. I certainly acknowledge that. I wanted to know this: do I take it from what you are saying that there is no specifically earmarked funding for trachoma programs?

Ms Evans—There is specifically earmarked funding for eye health programs. We have implemented a program across the country with regional coordinators, and trachoma is part of that eye health program.

Senator CROWLEY—And the amount of that all up?

Ms Evans—I am hoping Ms Norington is going to be able to pull a figure out.

Ms Norington—The actual expenditure in 2000-01 was $2,685,230, and the planned funding coming up to 30 June this year is $3,912,000. It is likely we may not quite spend that amount, but that is the ballpark figure.

Senator CROWLEY—Is that money mainly spent through primary health?

Ms Norington—It is a range of activities that take place that that money is for. Regional coordination is one of them. Access to specialists is another. There is equipment, which is often extremely expensive and needs to be calibrated very regularly. There is training, in addition. There is the preparation of specialists guidelines. We have produced a very useful document—booklet—for specialists that does assist in diagnosis.

Senator CROWLEY—Is there any money for education?

Ms Norington—There is training money; is that what you mean?

Senator CROWLEY—I was just wondering whether Senator Buckland's cry of education in the schools was getting a guernsey under this boat too.

Ms Norington—Not specifically. It is very much directed to the clinical one.

Senator CROWLEY—Just as well; I will not ask what is the outcome. Could you provide for us some detail about whether there are any of those dollars going to education of the community as apart from educating the specialists or doctors.

Ms Norington—Yes.

Senator HERRON—Would Dr Fagan care to tell us how trachoma is transmitted?

Dr Fagan—Senator Herron, your information is probably as good as mine. By touching and by hand to mouth to eye.

Senator HERRON—It is a bug, in short—germs.

Dr Fagan—Yes, of course.

Senator HERRON—How do Aboriginal children in particular get trachoma? Surely somebody here in the health department knows.

Dr Fagan—It is from one person to another.

Senator Patterson—Contact.

Senator CROWLEY—Is it a contagious disease?

Senator HERRON—It is transmitted by flies. It is very interesting to hear this discussion, because the reality is that, until you get rid of the flies and you get the veterinarians to spray the dogs to stop the dogs—

Dr Fagan—The environmental health aspects are very important.

Senator HERRON—It is all very well to talk about this thing at this level in Canberra. The reality is that, until you fix the dogs, the faeces and the flies and keep the flies out of the eyes, you are not going to stop trachoma.

Dr Fagan—The environment health aspects are very important.

Senator Patterson—We have an ophthalmologist behind me and a surgeon over there. I think maybe we should just get the information and give it to you on notice, Senator Crowley. My ophthalmologist does not necessarily agree with the surgeon—

Senator CROWLEY—Actually, it is not my question.

Senator Patterson—And my ophthalmologist has worked in an Aboriginal community in the Northern Territory.

Senator CROWLEY—This is Senator Herron's question, Minister, and what he is asking is really very interesting. In a rhetorical sense, I think he is suggesting that there might be better ways of tackling this than through primary health care.

Senator HERRON—No, I am not at all.

Senator Patterson—If Senator Herron is right about the flies. There is a question about whether that is the method of transmission. I am not going to intervene in a discussion between an ophthalmologist who is sitting behind me and a surgeon who is sitting on the other side of the table. I think we should find out for all of you and we will get back to you. But that is not the advice we have.

Senator HERRON—I am aware of programs that are being done, Senator Crowley. Probably the best of all has been in Port Hedland, where Aboriginal women have been given laptops and, in their own language, with CD-ROMS, go into remote communities and speak in their own language, using the laptops and talking about hygiene. They are putting dispos-

able nappies in bins, eliminating the flies, keeping the dogs away from the food. Really, it is a matter of education, so I am supporting what you are saying.

Ms Evans—I would like to add, Senator Crowley, that I would be very distressed if we left with the impression that it is an 'either/or' approach. I think the environmental health aspects are incredibly important. WHO has what is called its SAFE strategy, which is surgery, azithromycin, facial cleanliness and environmental improvement. They all have a part to play; there is absolutely no doubt that overcrowding and a lack of water for washing faces, et cetera, are a big problem—and all the other aspects that lead to low hygiene. But I think needs a concerted approach on all fronts.

Senator CROWLEY—I am pleased that you raised that, Ms Evans. What is the current government commitment to the WHO SAFE strategy?

Ms Evans—The government has a commitment to it; I know that it is part of the Vision 2020 project. I think that it is a matter of hitting it on all fronts.

Senator CROWLEY—What is their dollar commitment to it?

Ms Evans—We talked about the health dollar commitment to it. The environmental health in terms of housing—dare I say it—is another portfolio. But, certainly, last year ministers endorsed an indigenous housing strategy which, for the first time, had a very strong commitment to maintenance and repair, which I think is a big issue in terms of hygiene and cleanliness.

Senator WEST—Minister, last week you launched a new report: *Tobacco: Time for action: National Aboriginal and Torres Strait Islander tobacco control policy*. I understand that that report says that Aboriginal and Torres Strait Islander smoking rates are twice as high as those in the overall Australian population and that smoking related illnesses are associated with almost 60 per cent of Aboriginal and Torres Strait Islander deaths. Is that correct?

Senator Patterson—I cannot remember the exact figures, but I think that those figures are correct. In some communities, it is as high as 80 per cent in terms of smoking. I did also announce an $80 million program for targeting indigenous communities, aimed at reducing smoking. It will first be targeted in some ways at groups which have found to be responsive, like pregnant women, but it will not be isolated to that group. There will be a rollout of this program over three years. This is the first time that there has been a program specifically directed at indigenous communities. The report was very thorough and will inform the rollout of the programs based on that funding.

Senator WEST—You said that it would be targeting particular groups. Who is going to be doing that, and how is the targeting going to be undertaken?

Senator Patterson—The report outlines some of the higher risk areas. Ms Evans might be able to give you more detail of the rollout of the program. There was discussion, in the brief that I signed off on, to the effect that it would look at where you get the most effective message through to the most responsive group. One of the most responsive groups—where you actually affect two people—is pregnant women. That is only one example of the way in which we target. The other group that we have targeted is health workers. One of the things the study found was a high incidence of smoking amongst health workers. Part of the program will be targeted towards them because, if we can get the message through to them, not only will we improve their health, but the fact that they are educated about it will, hopefully, encourage them. It is trying to get to the groups where you are going to have most effect.

Ms Evans—This project was funded out of our Population Health Division. It is a good example of mainstream programs picking up responsibility; not just seeing it as an Aboriginal health problem, but picking up on it within their tobacco strategy. As I say, I do not have the fine detail at my fingertips, but they contracted with NACCHO to do a study of attitudes.

One of the encouraging things out of that study and the focus groups was that, while the 1994 Aboriginal social health survey showed that a lot of Aboriginal people did not see smoking as a problem, the NACCHO study suggests that there has been quite a shift in attitude: Aboriginal people see it as a problem, recognise it as a problem and are keen to do something about it, but they do not know what to do. That is very positive progress. There are a number of recommendations, as Senator Patterson said. There is some initial funding: $1 million over three years. Part of it is going to target health workers because, apart from anything else, they are role models and they are right in the health setting. There is also a clearing house, as I understand it. There is a range of activities going on. Once again, there is often no sharing of what works and what does not work, so there will be a sharing of information. We could get you a copy of the NACCHO report.

Senator WEST—Yes, please. That will be much appreciated.

Ms Evans—There was a series of focus groups across the country—

Senator HERRON—In remote areas?

Ms Evans—Yes, I understand they went to remote areas.

Senator HERRON—How remote?

Ms Evans—I cannot tell you that.

Senator Patterson—It was over about an 18-month period, Senator Herron.

Senator HERRON—I would like a copy too.

Senator WEST—Your area does not have the details of what the program is going to be?

Ms Evans—No, but we can get them.

Senator WEST—If you can take that on notice from program 1. How much money is currently being spent on anti-tobacco programs for Aboriginal and Torres Strait Islander communities?

Ms Evans—We will take that one on notice too.

Senator McLUCAS—Can you tell us what the expected outcome of that program costing $1 million over three years will be? Have those objectives been identified?

Ms Evans—Yes, the broad objective, which is a reduction in smoking, but once again, we can get you the report on that.

Senator McLUCAS—And we will be able to measure those objectives?

Ms Halton—This is another one of these areas where I think, earlier this morning, Ms Van Veen was describing the benchmarking approach that is used in population health when they are looking to see whether there has been any shift in behaviours after interventions. Without going into the precise detail, clearly this is an issue that has now been looked at—there is a report which we will provide you with—and we do know what smoking rates are for Indigenous peoples. Clearly, whether or not you can expect a population-wide shift in this group in that period remains to be seen. But through targeting those particular groups, we should be able to look, for example, at health workers, to see whether there has been any

particular effect. I might say that this is an issue that has the very strong support of Pat Anderson, who is not only the chair of NACCHO but also the deputy chair of the Aboriginal and Torres Strait Islander Health Council. It is something she and I have discussed in detail, and it is something she is very keen to pursue.

Senator McLUCAS—If you have got $300,000 a year, an objective of reducing smoking in Indigenous people is a very large goal to be achieved with that small amount of money. It may be that the objective could have been targeted more tightly.

Ms Halton—I suppose we need to remember—and it is the point that Ms Evans was alluding to—that we do expect that our mainstream programs will also pick up Indigenous peoples. We should not have some very narrow focus and moneys only coming separately and in an identified way to target Indigenous peoples. This particular initiative will give us information about what works and what does not work. We can then target our information and campaigns through our mainstream programs in ways which will have a much broader impact than just through a particular, narrowly focused program. I think that is the important thing about this—that we try to appropriately meet the needs of Aboriginal and Torres Strait Islander people right across all of our programs. This is one of the ways we will try and do that.

Senator Patterson—The other thing, Senator McLucas, is that, as you beef-up and improve the primary health care—and Indigenous people are attending primary health care, which they were not doing—that message can then be conveyed by the health workers and by the primary caregivers. It is not just done in isolation; it is done in the whole context of Indigenous health.

Senator McLUCAS—I will be interested to see what the objectives say. I understand that last year the office released a draft National Aboriginal and Torres Strait Islander Health Strategy for comment. What was the feedback we received from that?

Ms Cass—The draft health strategy was released as a document for discussion in February last year. There was an extensive consultation process over the last 12 months. Since December last year health council has considered those comments and significantly rewritten that document. The principal changes are focusing it more tightly so that it is a framework for government action. There was endorsement of the key result areas in the draft document, but health council has also decided that it wanted to identify nine specific areas for immediate action. They have been included in the revised document which has now been distributed by health council to the four framework agreement partners I mentioned earlier—ATSIC, state and territory governments and NACCHO and its state affiliates—for an internal clearance process before it is endorsed through cabinets and signed by ministers.

Senator McLUCAS—So it is going through a second round of consultation.

Ms Cass—It is now an internal matter.

Senator McLUCAS—With a smaller group.

Ms Cass—That is right.

Senator McLUCAS—Why did you decide not to go to a broad consultation on a second stage, given that the document is significantly different?

Ms Cass—There was a 12-month consultation process which was extremely extensive. Those comments were very carefully considered by health council and taken on board in the revision process.

Ms Halton—Perhaps I can comment on that as I chair the health council. That document has been the subject of extensive consideration externally. As Ms Cass has said, all of those comments have been very carefully considered by the council. The council has sought, in reviewing and focusing down on that document, to balance up all of that input. There comes a point where the council feels we actually need to move forward and basically establish it as a framework for action.

One thing about the document now is it basically has two components, the first of which is a quite explicit framework for action. The council feels that we now need to go through this final process with those partners and then we will be able to move forward. If we had gone out to yet another very lengthy process, I do not know that it would significantly further improve the document and, secondly, it would have represented quite a significant delay in time. I think there is a desire now to move to the next stage and to get on with it.

Senator McLUCAS—Will the revised strategy have defined time frames attached to the actions that you are describing?

Ms Cass—It will. The revised document will have specific strategies for implementation and then it is intended that there will be agreement on implementation plans which will set time frames, performance indicators and the responsible jurisdiction or organisation.

Senator McLUCAS—And funding?

Ms Cass—There will have to be a commitment about who will implement what. In some instances that will involve funding for extended programs.

Senator McLUCAS—But the will Commonwealth's commitment—or that of any participant for that matter—be identified in the document and attributed to the strategies that are being developed?

Ms Halton—No. The intention is that this is a plan for action, not that it would necessarily on its release have a catalogue of funding attached to it. The reality is that we have a number of sources of funding, some of which now may be influenced by the document as it is eventually agreed. This would be the case with the state governments as well. Clearly government would be mindful of the recommendations in this document when considering future new policy considerations. But I think it is important to understand that in many instances we can marshal our resources more effectively and that is one of the things that we are trying to do. What it will do is provide that framework for action and then implementation will be by the various partners. In some cases that will include changes to how money is used and in some cases it may result in additional commitment.

Senator HERRON—Can I come back to the trachoma story. I recall a couple of budgets ago Minister Wooldridge announced an azithromycin program in the Northern Territory. Have you got the outcome of that program? It was over $1 million, if I recall.

Ms Evans—My understanding was that the azithromycin would be provided under section 100—which means free of charge—to clinics in remote areas, and that has happened. We do not have specific data on outcomes from that, but azithromycin has been made available, yes.

Senator HERRON—Is it still being made available?

Ms Evans—Yes, it is an ongoing commitment.

Senator HERRON—Yet we do not know the outcome. I get back to that original statement earlier today. Surely, if we are spending $1 million we should have some database, we should have some outcome. This is what Senator Crowley brought up this morning. I just

want to reinforce it. She triggered me with the trachoma story. Are we ever going to have an outcome?

Ms Evans—The collection of data, Senator Herron—as I know you are very familiar with—in these remote communities, particularly remote services, is a real problem. We have put quite a lot of investment into funding population health registers, computer systems, in AMSs so that they can actually get to square one, which is to have a population register that allows them to have profiles of their patients, and recall systems for diabetics, immunisation rates et cetera. That is pretty hard-core for some of those remote communities. We would like to have lots of health status data but I think we need to be realistic about how much these services can collect, particularly in remote areas.

Senator HERRON—I appreciate all of that, but the point which was made this morning, and which I want to reinforce, is that there is no point in throwing things at people if we do not know whether it is going to have any effect. In trachoma the best thing you can do is wash the child's face. That is why I was talking about education. That is where the money really should go—getting mothers to wash their kids' faces. It is a chlamydial bug that causes it. It is transmitted also by contact with flies. Then treatment is with Tetracycline and ultimately with surgery. But you are treating the end product. If you are going to prevent, you have to do those things. I think we really need to start thinking, after all these years, about databases and collection before we do anything. The point is made.

Senator CROWLEY—I suppose it is almost like ticking off on every point. The point Senator Herron has just made is terribly important. I looked at end-stage renal disease, visiting the Territory—although I do not think these Aboriginal ill-health problems are confined to the Territory. What is the Commonwealth department doing in recognition of the fact that in the Territory end-stage renal disease is about 18 times more prevalent in Aboriginal people than in non-Aboriginal people? That is a monstrously high figure. There is no guarantee that everyone will get on to dialysis, and even then the outcomes are pretty poor. Anyhow, what we are doing is dealing with the end stage. We need to back up and look at what is going to be a prevention in this case. What is the department doing? Is it leaving it to the local organisations, like hospitals and primary health care, or do you have a specific allocation and focus on this?

Ms Evans—Certainly it is an issue we are focusing on, Senator.

Dr Fagan—We are approaching this issue in a number of ways. Firstly, we acknowledge that end-stage renal disease for some Indigenous populations is a very significant problem. The pressure for improving access to renal replacement therapies is there right now. But we see it as very important to address the whole continuum of care and to try to develop and strengthen primary health care and early detection and early intervention programs so that we can reduce the future burden. To that end, we are in the process of developing a chronic disease framework. We have funded a number of pilot sites which are focusing on early detection and screening and early intervention and which are soon to be evaluated and to inform the development of the chronic disease framework. We are trying to develop a partnership with the states and territories to address improvements in access to renal dialysis.

Senator HERRON—We really should have Professor John Mathews answering this. He is a world pioneer and expert who did pioneering work at the Menzies School of Tropical Health and Hygiene in Darwin and has written extensively on this. He is in the department and was here earlier.

Ms Evans—Dr Wendy Hoy, who was working at the Menzies school with Professor Mathews and who, as I am sure you would be aware, Senator Herron, did some of that pioneering work on Tiwi in terms of early identification and management, has been funded to extend that program. That is the program that Dr Fagan was referring to, that we are about to evaluate. It has been running across a range of communities. That is early identification.

Senator HERRON—That is the use of antibiotics in babies?

Ms Evans—Yes.

Senator CROWLEY—I appreciate that things are being done, but the story is awful. The story is not showing much sign of improvement. Even though I think we now have OATSIH coming up with an Aboriginal health strategy to cover most of these things, I am interested to know—this is possibly a question to you, Minister—whether the time has come for us to get pretty aggressive about trying to see these Aboriginal health statistics change fairly dramatically, because they are still pretty awful.

Senator Patterson—Senator Crowley, I will refrain from being political, but you cannot turn the *Titanic* around overnight. We inherited some services that were less than satisfactory. I believe, having been out to have a look at them, that there have been some significant changes in the last five years with OATSIH. Already, for example, in Katherine West they were telling us that there are measurable differences: things like the number of emergency evacuations from Katherine West had gone down. They were giving us examples of those sorts of changes already, such as the number of people with diabetes being diagnosed and treated on a long term rather than being diagnosed and disappearing. That sort of change and those sorts of health outcomes are going to take a while to filter through for us to see that result in changes in numbers, for example in the delay of end-stage renal failure. Some people will still have end-stage renal failure. Hopefully that will be for a longer period.

One of the things that concerned me greatly as I moved around was the amount of Coca-Cola and sweets being consumed, and diet, in terms of diabetes in young children. There is some work being done in the Torres Strait Islands; they are going to do a survey of children. They told us that there were nine children aged 10—or 10 children aged nine, some awful figure—with stage 2 diabetes. That sort of change in health will take a long time in terms of education of parents about nutrition. I believe, though, that the changes that we have seen in primary health care will make a significant difference. People told us this all around the place. In Darwin, for example, at the health centre there, I was talking about it with the audiologist, who was saying that there are significant changes because they have been able to educate the mother and a child with an infection comes in much earlier, before there is damage, because the mother can identify it. But you are not going to see those results in public health data tomorrow.

Senator CROWLEY—I guess this is why, as Senator Herron said a couple of times, sometimes we can get depressed by the continuing, shocking story but sometimes it is very nice that there were 100 last and there are only 90 this year. Sometimes, just hard number data is a help, and it is also very interesting to know if was 100 last year and it is now 120. My goodness me, that sends a message too. I appreciate you are not being too political, Minister, but I also appreciate that this is not something that is your problem or ours. It has been a long-term problem, and we have got to cut across that whenever we can.

As I understand it, the infant mortality rate has dropped from five times the non-Aboriginal rate to about three times the non-Aboriginal rate. When we did a Senate inquiry into

childbirth, antenatal care for Aboriginal mums was making a big difference. I think the figures are already dropping at a big rate. I am not really here—it might surprise you, Minister—to point score at this time. I am terribly interested because visiting Aboriginal communities becomes depressing because people constantly tell you about the health problems, and they are pretty dreadful health problems. If we can get some more numbers counted it might give us some clear guidelines about what else we have to do and in which direction we go.

Senator HERRON—I would like to put something in the *Hansard*. This is reality: two-thirds of Aboriginal people smoke. All the surveys show that. One-third drink to excess. They are significant health factors that affect all of us. Until an educational program changes those statistics, I do not personally believe things will change. All of the other things can occur, but we need to get the rate down to that of the outside community, where less than 20 per cent now smoke cigarettes. One of the difficulties in the Torres Strait Islands is that it is difficult to exercise up there—it is as simple as that—because it is so hot. Of the 13 inhabited islands, you can walk around a lot of them in half an hour and you get very uncomfortable. There is a very high rate of incidence of diabetes. As Senator Patterson was saying, until we get back to basics, until education and behavioural modification occur, we are not going to see any statistical change.

Senator Patterson—Senator Crowley, one of the things I found heartening on this trip—I did a seven-day trip which was fairly intensive—was that, although it is patchy, there is progress. There are a number of young indigenous leaders who are really making a difference. There are people in both the Northern Territory department and in our department. One of them has a training and finance background and has a real desire to see people trained to be able to manage the sorts of programs we bring out like the coordinated care trials. I know that, when you visit, sometimes you have a sense of hopelessness, but I think there is real progress. It is slow and it requires capacity building and an approach that has long-term durable effects. We used to have a mentality—it was the same with overseas aid projects—of going in and doing something rather than building capacity in the local community. With these primary coordinated care programs we can see capacity building within the community to actually run their own programs and encourage their community to be involved. I was quite heartened by that. Having not been to the Northern Territory for some years, I thought there was significant change.

Senator CROWLEY—As it is getting towards the time when we should break, rather than go over the same questions, I will list a couple of areas in which I would like to put questions: rheumatic fever, the streptococcal infection rate, infant mortality and SIDS. Could you provide to the committee on notice whether there are any specific programs and, if so, what they are; what Commonwealth health funds have been allocated; whether those funds are directed specifically to a program or through a regional coordinated primary health or other kind of care arrangement; and whether there is any funding allocated to education about primary health issues in terms of prevention—early diet, hygiene et cetera. It is pretty clear that they are a critical part of it. I would be pleased to get that kind of breakdown. Thank you.

Senator WEST—Could we deal with the medical indemnity issues and AMSs—the impact that that is having on Aboriginal Medical Service facilities, and individual doctors working in those facilities.

Ms Halton—It depends on whether it is a medical or a professional indemnity question.

Senator WEST—Have any of the services been forced to close or reduce services because of the issue?

Ms Evans—We are not aware of any services closing or being forced to reduce levels of service. One service approached us with a problem they had around medical indemnity, because their insurer was going out of business, but they have now found another insurer. We are, however, working with NACCHO to collect some data on the costs around this area, and depending on what comes out of it, we will be looking at it. But no, certainly no services have closed and we are not aware of any reduction in levels of service.

Senator WEST—Are you aware of what has happened to services regarding the cost of obtaining medical indemnity cover?

Ms Evans—In collaboration with NACCHO, we are collecting information across the country about any increases that services have had to bear, and the size of those increases.

Senator WEST—What is going to happen to their funding, if they have had to bear quite a considerable increase in those particular costs?

Ms Evans—As you are probably aware, the AMSs have global budgeting, and our first-line approach is to expect services to absorb those costs. However, we also recognise that if these costs are very large, then it is something we will have to reassess.

Senator WEST—Given that in other areas the costs are trebling and quadrupling, are you going to look at those?

Ms Evans—That is exactly why we are trying to get a handle on it.

Senator WEST—At this stage you do not have a handle on the size, if there is a problem there?

Ms Evans—We have just started in the last two weeks in collaboration with NACCHO to collect that data.

Senator Patterson—It is different in different states, Senator West.

Senator WEST—I am very much aware of that, Minister, but we are trying to get a bit of a handle on it, like you are—I thought you might have had more of a handle. So it is a matter of waiting to see what NACCHO comes up with.

Ms Evans—We are working jointly with them on it and, in fact, I signed a letter to all services last week inviting them to provide information.

Senator WEST—When do you expect to have this information back?

Ms Evans—It will depend on how promptly services respond. But as I said, we prefer to do this in collaboration with NACCHO because they are keen to get that data too, and they will be pushing their services to provide it.

Senator WEST—And to date you only know of one that has had some difficultly in obtaining a renewal cover from another insurance company.

Ms Evans—I am only aware of one that has been brought to our attention.

Proceedings suspended from 6.33 p.m. to 7.48 p.m.

CHAIR—We are now on outcome 8, Choice through private health.

Senator CHRIS EVANS—Could someone take me through some of the costings on private health insurance.

Mr Wells—Senator, the estimates for the rebate?

Senator CHRIS EVANS—Yes.

Mr Wells—The total cost of the rebate for 2002-03 is estimated to be $2,276 million, of which $2,090 million will be in outlays administered through this department under the rebate, and $186 million will be administered through the ATO as the tax side of the rebate. This is $38 million or 1.6 per cent lower than the 2001-2002 additional estimate for this period.

Senator CHRIS EVANS—Where is that reflected in the PBS? I see it is in table C8.1 on 179, but that just has the total figure.

Mr Wells—That includes the funding for the rural hospitals.

Ms Sperling—On page 179, C8.1, under the heading 'Budget estimate 2002—2003', is a figure of $2,090,316,000. That represent the outlays which Mr Wells just explained would be the component of this program which would be administered through this portfolio in 2002-03.

Senator CHRIS EVANS—But for the cost of the rebate we have to add the tax. What is your estimate for that again?

Mr Wells—It is $186 million.

Senator CHRIS EVANS—What were the figures for this year? We are still working on estimates, I suppose, aren't we?

Mr Wells—The additional estimate figure for this year?

Senator CHRIS EVANS—Well, yes, I guess first of all the additional estimate figure, then some comment about whether that is likely to be met or whether it is likely to be—

Mr Wells—The figure at additional estimates for this year, for 2001-02, was $2,221 million.

Senator CHRIS EVANS—And that is again included in the tax rebate?

Mr Wells—Yes.

Senator CHRIS EVANS—That is the gross then?

Mr Wells—Yes.

Senator CHRIS EVANS—So you expect it to be less next year?

Mr Wells—Yes.

Senator CHRIS EVANS—And what is the rationale for that?

Mr Wells—The rationale for that is there are two main drivers. There is the impact of the 2002 premium increases. The effect of that was actually to increase the cost of the rebate by $11.6 million. The other main driver was a change in the ratio of people claiming the rebate through the tax system. The ratio of people claiming declined from 12.2 per cent to 8.6 per cent, and the net effect of that on the estimates for this year is $87 million, so that is why it went down.

Senator CHRIS EVANS—Because that means it does not—

Mr Wells—Fewer people claiming through the tax system. We had estimated at a rate of 12 per cent. It dropped down to 8.6 per cent. So the tax outlay component of it reduced.

Senator CHRIS EVANS—Doesn't that mean you spend more in the year? The tax outlay is delayed, isn't it?

Ms Sperling—Yes. The way the estimates are calculated is based separately. The outlays figure through the Health Insurance Commission and the tax figure through the ATO are both based on precedent of what the claiming rates are for both of those components. The 2000-01 financial year figures from the Australian Taxation Office have only just been finalised and it is those figures that we have used to estimate what the revenue component of this program will be next year, and it is about four per cent less than we had originally estimated, based on a lower claiming rate for this year.

Senator CHRIS EVANS—I understand that. So the rate you are claiming through the taxation system is dropping.

Ms Sperling—The actual numbers are dropping.

Mr Wells—But we did not have that information till just recently because of the way the tax system works.

Senator CHRIS EVANS—I understand that. Was that included in the budget figures?

Ms Sperling—Yes.

Senator CHRIS EVANS—But it was not in the previous additional estimates, okay. I am just trying to understand the impact that has on next year's budget. Does that increase or decrease the cost next year?

Ms Sperling—It decreases the revenue figures and therefore decreases the total figures for the program.

Senator CHRIS EVANS—Can you find another way of saying that so I understand it. It decreases the revenue figures?

Mr Wells—Which is the tax.

Senator CHRIS EVANS—Yes.

Mr Wells—The $87 million is each year. For the period 2000-02, for the five years, it is $375 million. For the period 2002-03 to 2005-06, the cumulative effect of that reduction in the tax profile is $375 million.

Ms Sperling—It does not have an impact on the outlays figure. It has a reduction effect on the revenue figures.

Senator CHRIS EVANS—Yes, I see. Where do I find the figures for the out years?

Ms Sperling—The figures for the out years for special appropriations are not in the budget papers. We can provide those figures.

Mr Wells—We can give you a table, Senator.

Senator CHRIS EVANS—I appreciate that. Why aren't they in the budget papers?

Ms Sperling—It is a standard presentational issue for special appropriations.

Senator CHRIS EVANS—It is like another table again?

Mr Wells—Would you like me to take you through the table?

Senator CHRIS EVANS—Yes, please. I just have a set of figures in front of me that does not seem to match.

Mr Wells—Table 1 shows the variation between the figures as at the additional estimates period. That is the first column. The column headed 2001-02 additional estimates shows the figures at that time estimated for each year, and the third column, 2002-03 budget estimates, shows the revised current estimate for each of those years.

Senator CHRIS EVANS—And when is that revised estimate from—I see, those are the figures for next year's budget. So you have revised them down quite substantially in the out years.

Mr Wells—Yes. There are two factors there. One is the effect of the changed ratio of tax claiming and the impact that has. The second one is that the figures which would reflect predicted premium growth are now not in these estimates. They are in the contingency estimate, the overall budgetary contingency reserve.

Senator CROWLEY—Are they a straight add-on?

Ms Sperling—They are counted into the bottom line.

Senator CHRIS EVANS—What you are telling me is the figures you give me here do not contain any provision for the increasing rate of premiums?

Mr Wells—What they contain is the effect of the 2002 actual premiums. They do not contain any projections of future premium growth.

Senator CHRIS EVANS—Why is that? Is that normal?

Mr Wells—That is consistent with government practice. Where there are estimates which are commercially sensitive, rather than have them in a place where they can be identified, they are put together in the contingency. That is set out in Budget Paper No. 1 at statement 6. The reference is 6-60.

Senator CHRIS EVANS—Yes, I have that. That does not tell me anything, though, does it?

Mr Wells—It tells you the basis on which figures are put into the contingency reserve, which categories of figures are in the contingency reserve—one of which is commercial-in-confidence—and that they are aggregated there.

Senator CHRIS EVANS—You didn't do this last year, though, did you?

Mr Wells—No. We have revised the practice, Senator.

Senator CHRIS EVANS—When you say it is common practice, it has not been common practice.

Mr Wells—It has been practice and we have now brought this program into practice with other similar programs.

Senator CHRIS EVANS—Normally we have this thing where you are a bit coy about the assumptions with me, we sort of skate around that for a while, and then we make a bit of a guesstimate.

Mr Wells—Yes. We have avoided that.

Senator CHRIS EVANS—We do not have to do that this year. You just say, 'No, they are not telling anything.'

Mr Wells—We are not being coy.

Senator CHRIS EVANS—You are just being unhelpful!

Ms Halton—This is consistent with standard practice.

Senator CHRIS EVANS—Next thing, Ms Halton, you will tell me it is all to do with accrual accounting.

Ms Halton—Senator, there are some things that predate accrual accounting, and contingency reserve and putting commercially-in-confidence things in the contingency reserve I know for a fact predates accrual accounting.

Senator CHRIS EVANS—I warn officers not to say 'accrual accounting'. I have had 2½ days of Defence saying 'accrual accounting' whenever they got into trouble, so I am about ready to leap across the table at the next one who uses that excuse. 'Why are we buying old helicopters?' 'Oh, accrual accounting.' 'Why is the weather bad?' 'Oh, accrual accounting.'

Ms Halton—It is all right, Senator. I can probably point you to several officers sitting behind me who, if you say 'accrual accounting', will start twitching and doing something.

Senator CROWLEY—Try it, Senator. I want to see.

Senator WEST—Mind you do not leap my way, Senator Evans.

Senator CHRIS EVANS—No. I am too old and tired to leap. Basically, you are not now providing any information on the growth in the costs. Without any factor, however inaccurate, in terms of the growth in premiums, that means the budget papers contain no real estimate of the ongoing cost of the rebate. Is that right?

Ms Sperling—The total cost of the program is factored into the bottom line because the contingency reserve is included in the total sum.

Senator CROWLEY—Can you give us that bottom line figure?

Ms Sperling—It is in Budget Paper No. 1.

Senator CROWLEY—Have you got one of them there?

Ms Sperling—Budget bills.

Senator CROWLEY—There is a big box over there. Is it in one of those boxes?

Senator CHRIS EVANS—It is the case that there is no separate line in that for the cost of private health insurance, isn't it?

Mr Wells—Senator, there is no line where you can identify our estimate of premium growth. The actual premium outcome is reflected and will be reflected each year as we update the estimates.

Ms Halton—The volume issues are reflected in the estimates that you see. That is the numbers of people who are covered. The issue that is not reflected is any change in the level of premium. That is because, as Mr Wells has explained, that issue is commercially sensitive information.

Senator CHRIS EVANS—It is also publicly interesting information.

Ms Halton—Indeed. That is probably one of the reasons it is commercially sensitive too.

Senator CHRIS EVANS—It is not just commercially sensitive; this is taxpayers' money.

Ms Halton—Indeed.

Senator CHRIS EVANS—You are asking us to approve the expenditure of it but you will not tell us how much it is.

Ms Halton—But, as the officers have pointed out, the aggregate of the amount is included in the contingency.

Senator CHRIS EVANS—I have to take your word for that because I cannot find it. It is not expressed.

Ms Halton—Indeed, together with a number of other things that are in the contingency and not separately expressed.

Senator CHRIS EVANS—But contingency, I thought, was to do with things that were unforeseen. I can look up what 'contingency' means in a dictionary.

Ms Halton—No, there are historically a number of things that are included in contingency. Senator, when I was in the department of finance at a time when there was a Labor government, we had a number of things that were in the contingency, including things of this type.

Senator CHRIS EVANS—No matter what previous governments did, all I know is that last year when we had this discussion it was here and now it is not. I do not know why it has been moved. If it was standard practice, it would have been standard practice last year.

Ms Halton—Senator, it should not have been included in the estimates last time.

Senator CHRIS EVANS—Why?

Ms Halton—Because it is commercially sensitive information.

Mr Wells—The standard practice has been that this sort of figure should have been in the contingency reserve and we have now brought ourselves in line with what is standard practice.

Senator CHRIS EVANS—Given that our standard practices have been discussed at every estimates round, I have difficulty believing that standard practice is not what we have been doing standardly but is now something else. Quite frankly, all I know is that we used to be able to work out how much this was going to cost us and now you cannot or will not tell us. From the Senate's point of view, that is the bottom line. This information is no longer available, so these figures for the out years are basically meaningless.

Mr Wells—No, Senator, they are not. They contain our best estimate of the participation rates and other variable factors in the program but they do not contain our estimate of premium growth. That is one point.

Senator CHRIS EVANS—Nothing, in my experience with private health insurance rebate, gives me any confidence that these figures, which show no growth in costs in the out years, are reliable. Tell me what the assumptions are that underpin these figures then.

Mr Wells—The assumptions are that participation rates will be fairly stable at the current level.

Senator CHRIS EVANS—As a percentage of the population?

Ms Sperling—No, numbers.

Senator CROWLEY—Mr Wells, did you say the assumption is that the participation rate will stay the same?

Ms Sperling—No, that the number of people covered by private health insurance at the moment will be the same.

Senator CROWLEY—Thank you. It is just a hearing problem.

Mr Wells—Senator, I will correct it. I did say 'participation rates' and I apologise. You did not mishear me.

Senator CHRIS EVANS—So what are you saying? Are you saying that the number of people will stay about the same and that you have no factor for growth in population?

Ms Sperling—That means the participation rate will decline slightly because of growth in the population. That question was raised last time and I gave the figures, which I am happy to give again, about what that means. In terms of the participation rate, it means that our estimates of participation in 2002-03 is 44.2 per cent; in 2003-04 it is 43.8 per cent; in 2004-05 it is 43.5 per cent; in 2005-06 it is 43.1 per cent, taking into account ABS population projections.

Senator CHRIS EVANS—Can you explain to me why you have that perspective? Why do you think the actual proportion will decline?

Ms Sperling—The actual participation figures over the last few quarters have moved around a little but not very much. We have not seen significant enough trends to make any assumptions other than those which I just outlined.

Senator CHRIS EVANS—Are you saying that the figures in the recent quarters have been stable?

Ms Sperling—Yes.

Senator CHRIS EVANS—And on the basis of that you are predicting ongoing stability.

Ms Sperling—That is correct. I have a graph here, if that would be useful, of the participation rates.

Senator CHRIS EVANS—Sure. Thanks for that. Does that mean, though, that you are predicting a longer-term ongoing decline and participation?

Ms Sperling—Participation as I outlined there. The estimates for this program go out to 2005-06, so the projections are as I have just outlined.

Senator CHRIS EVANS—What about in terms of a broader view about long-term participation? Is that signalling some view that the department has formed or was it just a reflection that it is a conservative estimation?

[8.08 p.m.]

Ms Sperling—The estimates for this program and other programs take into account precedents and statistical trends—statistical trends, as I have outlined and as are demonstrated in this graph, showing a reasonable amount of stability in the number of people with private health insurance and that is what we factored into our assumptions.

Senator CHRIS EVANS—But I think there was a discussion at the time—something advanced by the industry—that of course the impact of Lifetime Health Cover might well be to make it less attractive for those who have not joined to join later in life.

Ms Sperling—That is right.

Senator CHRIS EVANS—That might, in the longer term, have an impact on total participation rates.

Ms Sperling—At the moment, the trends are showing this stability and that includes approximately 90,000 people who are actually paying a loading under Lifetime Health Cover. There are still people joining private health insurance and they have been since the introduction of the lifetime health cover penalties.

Senator CHRIS EVANS—So 90,000 have joined and incurred a penalty?

Ms Sperling—Yes, 90,000 are currently incurring a penalty.

Senator CHRIS EVANS—Do you have an age breakdown on them? Have we done any analysis of those figures?

Ms Sperling—Yes, we do have that information. It is collected by PHIAC and we can certainly provide that on notice. It is quite a complex table.

Senator CHRIS EVANS—Thank you. Are you able to give me a summary of what that shows, so that I have a sense of that?

Ms Halton—Senator, we have a copy. We will see if we can get it photocopied and table it for you.

Senator CHRIS EVANS—Thank you for that. Is anyone at the table able to tell me, in a trend sense, what it means? It looks like a mass of figures.

Ms Sperling—Running my eyes down the figures here, Senator—

Senator CHRIS EVANS—If no-one has a real sense for it, I will leave it.

Mr Wells—We do not, Senator. It is a mass of figures for us at the moment as well.

Senator CHRIS EVANS—Yes, I thought if someone had a sense of what it was showing, it would be helpful for me to have that understanding. I will try and make sense of the figures. There is effectively in your projections no allowance for the suggestion that that might have an impact. What about the impact of price on membership levels? What does your experience tell you about that?

Ms Sperling—Senator, when we prepare the estimates, we discuss them with the Department of Finance and have to agree them with the department. We, as I said before, look at historic trends. We did not have any evidence at the time that these estimates were prepared that there had been any decrease in private health insurance participation as a result of any changes in price and, indeed, the figures for the March quarter, which were released a couple of weeks ago and are included in the graph which I gave you, show continued stabilisation of participation rates.

Mr Wells—Numbers participating.

Ms Sperling—Most of the premium increases will be introduced in the next quarter and we may see some trends then.

Senator CHRIS EVANS—I am not trying to be difficult. I think it is the case that predictions on these things have not generally been very accurate in the past, nor on the costings, so I am trying to test whether we are getting any better at it. It seems to me you have taken a fairly conservative view that they will stay much the same, with a small discount particularly for the out years. Is that fair?

Ms Sperling—That is what is reflected in the estimates at this point.

Senator CHRIS EVANS—That's very helpful!

Senator CROWLEY—The figure that you have given there for 2001-02—the first figure of $2,221, for example—is that post or pre last year's premium rise?

Mr Wells—This year's premium rise, Senator.

Senator CROWLEY—Before this recent rise?

Mr Wells—This figure has an allowance for that. The 2001-02 column, you are asking, Senator? It is the figure of $2,221 million. That was prepared before the actual premium increase for 2002, but it did include an estimate of what that might be.

Senator CROWLEY—Can you tell us what your estimate was?

Mr Wells—That is the coy discussion we used to have, Senator, where we preferred not to, because that sends a signal to the industry of where perhaps we might feel a reasonable outcome would be and that might encourage them to go to that level.

Senator CROWLEY—Far be it for me to take us back to where we have been before.

Senator CHRIS EVANS—For the interested viewers, the table seems to reflect an intuitive response, which is that the numbers joining in the earlier years, where the penalties are small, are higher and then they taper off to the older age groups. It seems to be on a sliding scale basically, looking at it. However, as you say, there are still significant numbers of people joining with reasonable penalty impositions. Is that a fair summary of it? Are there any other assumptions underlying these estimates?

Mr Wells—The other major assumption is the number who would claim through the tax system and the number who would claim through the rebate arrangements.

Senator CHRIS EVANS—What have you factored in there?

Mr Wells—We have revised that. The previous estimate was 12.2 per cent who claimed through the tax system and, based on the figures from the Taxation Office for the financial year 2000-01, that has been revised down to 8.6 per cent.

Senator CHRIS EVANS—You have used the 8.6 per cent to underpin the whole—

Mr Wells—For the estimates now, we are basing it as if that 8.6 per cent would continue.

Senator CHRIS EVANS—You do not expect it to fall further?

Mr Wells—We cannot anticipate that. Each year, we would revise that in the light of the latest available data from the ATO.

Senator CHRIS EVANS—It would seem that it is becoming more accepted that people pay for the funds et cetera.

Mr Wells—The figures suggest that, Senator.

Senator CHRIS EVANS—There might be hard core that still prefer to do it through the tax system. Do you have any information on what is happening inside the products, in terms of full cover versus hospital only and the trends and what is—

Ms Sperling—Again, it might be best if I invite my colleagues from PHIAC who collects those statistics to advise you on what data is available.

Ms Ginnane—The main trend is that there has been an increase in front-end deductibles for the hospital cover products. They are now about 57 per cent of the total hospital cover. There has been no other particularly obvious trend in products that I am able to observe.

Senator CHRIS EVANS—That is hospital only cover, is it?

Ms Ginnane—Hospital only cover.

Senator CHRIS EVANS—You now have 57 per cent who are using the front-end deductible option?

Ms Ginnane—Yes.

Senator CHRIS EVANS—Do you have any figures on the average—

Ms Ginnane—No, PHIAC does not collect data on what the deductible is

Senator CHRIS EVANS—So you have no idea whether it is $100 or $500?

Ms Ginnane—No, although it is limited. There are maximum limits for front-end deductibles of $500 for single persons and $1,000 for other forms of memberships.

Senator CHRIS EVANS—That is by regulation, is it?

Ms Ginnane—By regulation, yes.

Senator CHRIS EVANS—Are you intending to collect information on that or is there another way of gathering that information?

Ms Ginnane—We have considered looking at that information but we are not yet collecting it, but it is an issue that would be of interest and is one of the collection items that we are considering.

Senator CHRIS EVANS—What else can you tell us about patterns that are emerging?

Ms Ginnane—It is very difficult to identify any other particular patterns because we simply do not collect data around what is in the product mix. The major issue, though, is that there has also been a decrease in the number of people buying exclusionary products. They are where no cover is provided for particular types of services. There are very few products like that that appear to be being sold and very few are being purchased by consumers. They are preferring front-end deductibles as an alternative.

Senator CHRIS EVANS—In effect, taking out private health insurance, then self-insuring as part of the risk.

Senator CROWLEY—Do you have any breakdown on how many people are buying the extras?

Ms Ginnane—In terms of ancillary products, we only have total numbers of ancillary products and it is very difficult again to work out whether they have full cover products or a lower level of products because we simply cannot collect the data in that format. There are just too many products to start splitting them out in that way.

Senator CROWLEY—I have raised this before and I have certainly been reading of recent times some concern that private health insurance, particularly with the 30 per cent rebate, is going to help people buy sandshoes and golf sticks and so on. Are you able to distinguish ancillaries that add on golf sticks as apart from ancillaries that do not?

Ms Ginnane—If I could just get another document that I have, I can help you.

Senator CROWLEY—I am happy to wait.

CHAIR—While you are doing that, I would like to make some observations about ancillary tables because I pulled something off the net the other day about Western Australia, and I was amazed to look at the benefits paid from ancillary tables and, understandably, the largest beneficiary was dental and there was hardly anything that would go towards something

like sandshoes and walking sticks and umbrellas and everything else. It was absolutely minuscule. There is a huge list that I have here, and none of that looks at anything of that type, other than if you wanted to put it into something like podiatry or chiropody, where a podiatrist might suggest that a particular shoe is appropriate. I cannot see anything else in this entire list where such abuse would be taking place, so I would be interested to know if there is anything that you have that contradicts this information because it seems very comprehensive to me.

Ms Ginnane—The issue of fitness and lifestyle courses equipment, which is a subsection of the data that we collect, indicated that there were 305,000 services for the quarter ended 31 March this year, with a total cost of benefits of $20,955,000 that were paid. The total cost of the items was about $40 million. However, I also understand that a number of health funds are currently withdrawing products like that because of a concern that they may be misused or misinterpreted, but they were intended to be encouragements for people to stay healthy, and that is what they were aimed at, but I understand that some of them are now being withdrawn.

Senator CHRIS EVANS—They paid out $20 million—

Ms Ginnane—$20.9 million.

Senator CHRIS EVANS—In three months?

Ms Ginnane—In three months, yes.

CHAIR—But that is not all for sandshoes or umbrellas et cetera

Ms Ginnane—No, that is the total fitness, lifestyle, health—

CHAIR—That is the people who might be at risk of cardiovascular disease, or anything else, who have been taken into those programs to try and improve their health.

Ms Ginnane—Yes.

Ms Sperling—That is correct, and it also represents 1.3 per cent of the total benefits that were paid by funds in that period.

Senator CHRIS EVANS—What does it represent in terms of taxpayer subsidy?

Ms Sperling—I think we have been asked this question before and have made the point that there is no direct correlation between the amount that health funds pay out and the actual premiums that health funds charge, so it is not necessarily a one-to-one correlation.

Senator CHRIS EVANS—Mr Schneider says they are just benevolent societies.

Senator CROWLEY—I know there has been some concern in the community as the money becomes extremely real for more and more people that they might indeed be subsidising sandshoes or golf clubs for other folk. You have said some health organisations have withdrawn those products?

Ms Ginnane—My understanding is that some health funds are seeking to do that, Senator.

Senator CROWLEY—Do you know which ones?

Ms Ginnane—I am aware that MBF is withdrawing some products of that kind and I have been advised that others may be considering so as well. Not all health funds offer these products in the first place, Senator. It is a relatively small group that do.

Senator CROWLEY—If you could provide us with a list of any other funds that have decided to now withdraw those products, the committee would appreciate that.

CHAIR—And if there is a distinction between the withdrawal of the entire product or a withdrawal of things that may be claimed within that product, that would be helpful, because I think it would be sad if we were withdrawing all the fitness and lifestyle programs, if it is an encouragement for people to get better health.

Ms Ginnane—Yes.

Mr Branson—It might be useful if I just made a small comment here. I am not wanting to interfere, but I did in fact have some discussions with MBF with respect to the withdrawal of these products, to make sure that the remaining segments within the products—the quit smoking programs, the health and fitness sides of these programs—remained, so that the real health aspects of the product remained there. I have to say that we were not particularly concerned with golf clubs and walking sticks and things like that going out of it. That is not something that my office was concerned about, so long as there was reasonable notice given to the members that this product change was going to be made, and we did certainly make sure with MBF that they accepted their responsibility to continue with the real lifestyle aspects of it, and that is the quit smoking and the heart disease sides of the program.

CHAIR—It would be a pretty expensive way to get a pair of joggers, wouldn't it?

Mr Branson—I would rather not comment on that side of it.

CHAIR—No, but it is just an observation. To go and pay your private health insurance just to get a pair of joggers would be a bit preposterous, I would imagine.

Senator CHRIS EVANS—Mr Branson, on what basis you do that, though?

Mr Branson—On what basis I do it?

Senator CHRIS EVANS—Yes, in the sense that you make a judgment about what is and is not—I am not trying to be impertinent.

Mr Branson—No. I am quite happy to make that sort of statement because some of the comments that come to our office relate to, 'Why should I be denied benefits for going to this type of practitioner where the fund allows somebody else to have a set of golf sticks?' So if somebody is going to make a change to a set of products, which they are quite entitled to do, my discussion with them is such that I say, 'That seems to be a reasonable thing to do if you are going to withdraw it, but don't you think you should keep in the product those things which are going to assist in the maintenance of health of the member? After all, that is ultimately, isn't it, what health insurance is all about?' and I wanted to make sure that if they were going to withdraw something that they did not chuck out the baby with the bathwater.

Senator CHRIS EVANS—I am just wondering on what basis you do that.

Mr Branson—Commonsense is some of it.

Senator CHRIS EVANS—In terms of your authority, though—

Mr Branson—I do not have any authority for anything.

Senator CROWLEY—So why did you ring them up?

Mr Branson—I did not. They asked me.

Senator CROWLEY—They called you?

Mr Branson—Yes.

Senator CROWLEY—They said, 'We're thinking of doing this. What do you reckon?'

Mr Branson—Yes. I think that is a good idea, Senator—

Senator CROWLEY—Let us get it clear, Mr Branson.

Mr Branson—if they are concerned about what is going to happen—particularly if I have given them a roust from time to time about what they might be doing in the marketplace—that they then come to me and say, 'Look, we're going to have to do this. What do you think about it?' I am there to make sure that the consumers are protected. That is what my role in it is; purely and simply that.

Senator CHRIS EVANS—That is right. I understand your role in terms of consumer protection. I do not understand your role in terms of determining the policy of what is in an ad.

Mr Branson—I do not determine it; I give advice.

Senator CHRIS EVANS—Yes, I do not understand on what basis you give that advice even.

Mr Branson—We get a bit of feedback—probably more than most people—from consumers as to what they consider to be important aspects of their extras.

Senator CHRIS EVANS—Isn't that a decision for the funds?

Mr Branson—They do make it, obviously.

Senator CHRIS EVANS—When I have asked the government before about things I always thought the government had taken a clear position about that they were not going to judge it. Whenever I have raised concerns about these matters the government has refused to act because they say they do not make a—

Mr Branson—I am not the government, though, Senator.

Senator CHRIS EVANS—I know that. That is one of the reasons why I asked you on what basis you were doing it. I am a bit taken aback, to be honest. Is that still right?

Mr Wells—Senator, the policy is that the funds determine what items they will offer as ancillaries.

Senator CHRIS EVANS—Is that within the regulations that govern that? I presume this government draws the line somewhere. If it is a holiday in Fiji, it does not get approved.

Mr Wells—Yes.

Senator CHRIS EVANS—There are regulations that govern—

Senator CROWLEY—They did that for a while, too.

Senator WEST—Are you sure?

Senator CHRIS EVANS—I will be coming to that.

Mr Wells—It has to be health related. I am trying to find the regulation, Senator, so that we can read it. But it has to be health related and, within that, we cannot make a judgment or, in a sense, prioritise what we think would be good or what we think would be not so good.

Senator CROWLEY—Wouldn't we all feel better after a holiday in Fiji?

Senator CHRIS EVANS—It depends if one of the coups is in progress! So we think there might be a trend to move away from some of those products. Is that driven by pressure on their costs?

Ms Murnane—I suspect it is a combination of pressure on their costs and that health funds are not unintelligent and realise that there can be criticism of some of the issues and some of the products they are offering.

Senator CROWLEY—Has there been any that you know of?

Ms Murnane—I mentioned MBF that I am aware of, and I understand others are doing it. But I will take that on notice.

Senator CROWLEY—I meant are you aware of any criticism?

Ms Murnane—I am aware of criticism within this committee, Senator, and also there have been a number of articles in newspapers highlighting the issue of fitness related products.

CHAIR—I want to get something straight. The figures that you gave were 1.3 per cent of the total amount for lifestyle and fitness programs. Is that right?

Ms Sperling—No, the total benefits paid out by health insurance funds for everything they cover.

CHAIR—For everything that they cover?

Ms Sperling—The benefits they have paid for fitness and lifestyle type services represent 1.3 per cent of the total benefits that they pay out for all health services.

CHAIR—That is the point I am trying to get at—that is, 1.3 per cent of the total of the services. What percentage would be for a pair of joggers or a set of golf clubs? We are talking about an infinitesimal amount, one would suspect, aren't we? It is 1.3 per cent of the total and we are talking about a little chunk at the bottom.

Senator WEST—It depends where you sit on the socioeconomic spectrum, I would have thought.

Senator CROWLEY—It is sufficient to tax MBF's mind anyway—infinitesimal or not.

Ms Murnane—It is a very small amount, but it is not possible to deaggregate that any further.

CHAIR—That is right. I do not blame any of the funds, if someone is manipulating it to that extent where they want to get a set of golf clubs or a pair of joggers, cutting that element out, but do not throw the baby out with the bathwater if we are only talking about 1.3 per cent.

Senator CROWLEY—Far be it for me to disagree with you, Madam Chair, but I do not know that it was actually the purchasers of golf shoes that were doing the manipulating.

Senator CHRIS EVANS—As I understand it, the legal position is that providing it is a health related product under the regulations, they can list and pay out on services as they determine. Is that right?

Ms Sperling—On ancillary services, yes, Senator.

Mr Wells—They make commercial decisions about what they will include in their package to make it attractive or whatever for particular groups.

Senator CHRIS EVANS—The Commonwealth will pay the rebate on those ancillary services, as determined by the private health insurance?

Mr Wells—The Commonwealth pays the rebate on the premiums.

Senator CHRIS EVANS—Yes, but they pay that on the premium that covers those products.

Mr Wells—It covers the totality of the products of the health fund.

Senator CHRIS EVANS—While we are talking about private health insurance companies, are you aware of marketing that includes things like fee-free periods and other such enticements to join a particular fund? One of the funds in Perth is offering one month free membership or there are discounts on the pregnancy exclusions.

Ms Sperling—We are. I recall that Senator Crowley raised this issue at the last hearing. We discussed this briefly.

Senator CHRIS EVANS—One of the good things about this committee is that we keep raising it. As Senator Crowley will not be with us next time, I want to make sure we keep doing that.

Senator CROWLEY—Put it on the record. Good on you, Senator.

Senator CHRIS EVANS—I presume government is monitoring that. I do not want to go back to the evidence that I missed last time, but is there any government policy in relation to those?

Ms Sperling—There is a requirement for health funds not to discount greater than 12 per cent across the whole of their annual premiums. Within that limit, as long as any discount is not equivalent to more than 12 per cent of the premium, then it is a commercial marketing decision for the fund as to how they want to design their product to attract members.

Senator CHRIS EVANS—Have we regulated that they can only discount up to 12 per cent of the total premiums?

Ms Sperling—That is correct. That is to ensure that the principle of community rating is maintained across all members of all health funds.

Senator CHRIS EVANS—How does that work? Do you assess what the value of the discount to the customer is? Is that how it works?

Ms Sperling—Yes. At an aggregate level they need to give us an estimate of what the total value of that discount would be.

Senator CROWLEY—Does that mean that if somebody is going to pay $150 for the premium, they get 12 per cent off?

Ms Sperling—If the fund has calculated and given us evidence that there are some administrative savings that would be equivalent to up to 12 per cent of the premium, yes, that is correct. Those arrangements are offered in circumstances where, for example, an employment organisation might be offering private health insurance to all of its employees and therefore there are some administrative savings that go along with signing a lot of people up at the same time.

Senator CHRIS EVANS—I know that might be the case, but that is not what I am referring to. I am referring to people advertising against their competitors, trying to take members off them—competing for market share.

Mr Wells—They can do that up to that 12 per cent.

Senator CHRIS EVANS—Yes, I know. That is why I raised it. It seems to be more common, from what I have seen. I am trying to get an idea of what the policy framework is. We went through a similar problem with child-care centres a few years ago, as I recall—two kids for the price of one.

Ms Sperling—The policy, as supported by the legislation and regulations at the moment, is that they can make that commercial decision up to a limit of the value of 12 per cent.

Senator CHRIS EVANS—Yes, thank you for that. The example you used was about administrative savings et cetera. I can understand that context. I cannot understand, if they say you can have one month free, what savings are there.

Mr Wells—The savings for the consumer?

Senator CHRIS EVANS—Yes.

Ms Sperling—Basically we use the same framework and the same limits to apply to these fee-free periods, but it does not have to be justified in terms of savings. It is basically a commercial or marketing decision about how they want to design their products. That is the limit we have put on it.

Senator CHRIS EVANS—They can only offer them one month free, can they, because that is one-twelfth?

Mr Wells—It would depend what they are offering—it is 12 per cent—what they would calculate in their offer, as long as it was within that.

Senator CHRIS EVANS—I see.

Mr Wells—And it might be one month.

Senator CHRIS EVANS—So they have to seek approval for these offers, do they?

Mr Wells—No, only if they want to go above the 12 per cent.

Senator CHRIS EVANS—Can they get exemptions beyond the 12 per cent?

Mr Wells—They do not need to get approval, but they cannot offer discounts which, overall, are greater than 12 per cent.

Ms Sperling—Yes. We certainly are keeping an eye on those trends.

Senator CHRIS EVANS—But you implied, though, Mr Wells, that there was some potential for them to get exemption to offer more than that, or was that not so?

Mr Wells—I expect if they wanted to offer a product which gave further discounting, then they would have to come to us for approval. As a marketing exercise they can do these without coming to us for approval.

Senator CHRIS EVANS—If they can do it without incurring your wrath—

Mr Wells—Without coming for approval—

Senator CHRIS EVANS—for 11 per cent or 12 per cent, that is a question of whether or not you find out or check on them, I suppose. But, putting that to one side, were you suggesting there was an opportunity for people to get a greater discount facility with authority, or was it just a hypothetical?

Dr Morauta—Let me just check on the answer to that again, Senator.

Mr Wells—Can I correct my answer. The situation is that they cannot have more than 12 per cent worth of reductions of that nature. There is no opportunity for that.

Senator CHRIS EVANS—Yes, I thought what you were probably saying was that they would have to come to you to seek approval, but I was just checking and there is no facility for that, is there?

Mr Wells—There is no facility for that.

Senator CHRIS EVANS—You were saying that if they wanted to do that they would really have to come—

Mr Wells—They would have to change a product.

Senator CHRIS EVANS—Yes. Do we have any figures on the extent of this discounting?

Ms Ginnane—No, we cannot pick that up in our data at all, Senator.

Senator CHRIS EVANS—Is there any evidence that it might be targeted at particular groups which might undermine community rating principles?

Ms Sperling—We do not have any evidence of that.

Senator WEST—On the types of product being offered and with the last increase in premiums, have we seen changes in type of product, or reduction in some of the products being offered?

Mr Wells—I did not quite understand the question, Senator, sorry.

Senator WEST—We have had an increase in premiums but it has not been standard across the board. I am wondering if we have seen, with this increase probably in the lower end of the increase level, a change in product that is being made available. Are we seeing more restrictions or less product in some of those?

Ms Sperling—Health funds submit requests to change their products regularly throughout the year. We have certainly had a continuation of those applications over the last few months. The product change process is dealt with separately, at least by government, from the price change process, although some funds obviously want to consider both aspects of their business concurrently. We did have two health funds put in applications at the same time for changes of products—at the same time as changes of price—but only two funds.

Senator WEST—But were they popular products? Were they products for which the health fund actually had the bulk of their contributors being members?

Ms Sperling—There was quite a complex set of changes for both the two funds I am talking about.

Senator WEST—What were they and who were they?

Ms Sperling—Medibank Private had some product changes and MBF had some product changes.

Senator WEST—How did they change their products?

Mr Wells—Senator, I am advised products tend to stay much the same; it is the restrictions that might apply to how many times you can access a particular product, the number of services per unit.

Senator WEST—Yes, that is what I am after, Mr Wells. What were the changes and what was the product where there were changes or two?

Ms Sperling—The changes to Medibank Private involved changes to their Smart Choice and First Choice Saver products.

Senator WEST—Are they popular products?

Ms Sperling—Sorry, I do not have that information.

Mr Wells—We do not have the volume of products sold by the funds relative to other products which they sell.

Senator WEST—Okay. That was only two for Medibank Private, was it?

Ms Sperling—That is my understanding, Senator.

Senator WEST—What about MBF?

Ms Sperling—They had a range of changes including changes to their Lifestyle benefits, their HealthSmart arrangements and their FamilyFirst tables.

Senator WEST—What is FamilyFirst? Is that their basic table?

Mr Wells—Sorry, Senator, we do not have the detailed product information with us.

Senator WEST—I suppose I should ask the Ombudsman, following this, what reactions he has seen at the other end of the process in the number of people complaining about these changes and restrictions or changes to accessibility or product.

Mr Branson—There were a reasonable number of them, but we do not have anything to measure it against, so I cannot relate it back to what might have been in years past. Not a lot of activity has occurred of recent times so we have not been able to relate it. Product changes resulted in about 223 complaints. Of those, the majority were with respect to Medibank Private changes. Of course, one would expect that because they have the largest proportion of the market.

Senator WEST—Yes.

Senator CHRIS EVANS—Which particular changes were they largely related to, Mr Branson?

Mr Branson—I do not know the product names. I try to keep away from product names because they keep changing all the time as well.

Senator CHRIS EVANS—Was it one particular change or one—

Mr Branson—The biggest issue surrounded the benefits that were changed with respect to day-only procedures. That was the biggest level of complaint we received. I went into some reasonably high level dialogue with Medibank Private management with respect to this because there were some aspects of it that I was not particularly happy about. They made some changes to the way in which it was to be introduced which protected, to some extent, the consumers who were already on treatment regimes who would have been affected. You have to look at some of these things in perspective. 223 complaints sounds like a lot, but we are talking about three million people concerned with Medibank Private at that stage, so you have to look at it in perspective. It did affect people quite consistently across those ranges of products, but the number of complaints we received—obviously we did not just throw them aside—but they were small in number compared to the number of people who could have been affected.

Senator WEST—Given that the AIHW figures indicate that the day-only procedure is the growth area of all hospitalisations and all procedures done, that has potential to impact quite severely, doesn't it?

Mr Branson—That was the issue we took up with them, and the way in which they advised their members and gave them the opportunity to move to products which did not have those impediments.

Senator WEST—The total numbers of that were 223 for Medibank Private?

Mr Branson—No, 170 were rule changes out of the 223. That meant 53 other funds got complaints about rule changes as well.

Senator CHRIS EVANS—Is that the totality of your complaints?

Mr Branson—Of rule change?

Senator CHRIS EVANS—No, in total complaints.

Mr Branson—I have taken out some stats during the period February to June, which covered the rate increase period. All the rest of the stats are available through my quarterly bulletins. The stats then were that there were 529 complaints in total about premium increases.

Senator CHRIS EVANS—How does that compare with previous experiences?

Mr Branson—There were not any premium increases, so there is nothing to compare it with. There had not been premium increases in any real sense for the last three years. In the annual reports of the last two years I have reported that there have not been any complaints about cost because there were not any price rises of note.

Senator WEST—Have you had complaints about the action of one health fund—and I cannot remember the name of it—in actually removing a discount they had for payroll deductions or quarterly payments?

Mr Branson—Yes.

Senator WEST—How many complaints have you had about that?

Mr Branson—I do not know; not very many, because it is in the remaining 53 in that list.

Senator WEST—What is happening about that? Have you been able to take any action?

Mr Branson—We cannot take any action about a discount. It is the same thing that Bob Wells was talking about. So long as the discount falls within the realms of what discounts are allowed, then there is nothing that restricts them from saying that a discount is now four per cent or it is now six per cent or it is now eight per cent.

Senator WEST—Or it no longer exists.

Mr Branson—Yes. Obviously we take the issue up with the health fund but, in the end, if members have been the recipients of a discount in the past and that discount is deemed by the fund to be no longer appropriate, there is precious little we can do about it.

Senator WEST—What about the issue of private patients, in public hospitals possibly but certainly private patients, being charged a fee well above the scheduled fee by doctors, and no advice to the patient has been entered into before or after advising that the doctor charges a heck of a lot more?

Mr Branson—It is an issue that always comes up in our office, unfortunately. There are a large number of doctors, backed by the AMA, who actually provide very good information to patients. But there are some doctors who just do not bother to tell their patients anything, which creates a real problem. There is no legal requirement for them to do so, although the ACCC suggests that there may be—they would like to see some doctor perhaps who is continuously doing this. Unfortunately we do not get enough about an individual doctor to be able to take it up. It is an awfully difficult situation to do anything about. Doctors do not seem to take much notice of my office or anybody else when we write to them and say, 'You didn't bother to tell the patient.' The answer tends to be, 'They didn't ask.'

Senator WEST—So do you suggest it is probably easier for us to get into the chamber under parliamentary privilege and name the doctor?

Mr Branson—I do not know if I would be able to give you the name of the doctor for you to do it.

Senator WEST—I have one.

Mr Branson—Well, you can do what you like. Far be it for me to try and advise you what to do.

Mr Wells—Senator, could I add something on that very issue?

Senator WEST—Yes.

Mr Wells—The government has just gone through an extensive process of consulting around informed financial consent and this very issue about what doctors should tell patients and what they might be required to do, or what voluntary arrangements the profession might enter into. The government is considering that issue as a result of those consultations as to what might be an appropriate way of dealing with that very question.

Senator WEST—I have a constituent who received an $1,800 bill and is currently living on sickness benefits. The issue was not discussed and I am wondering what power the Ombudsman or anybody has to pull that bloke into line.

Mr Branson—Have they given it to us, Senator?

Senator WEST—Yes, I have; you have it.

Mr Branson—Maybe we will have a look at it.

Senator WEST—Yes, you have replied; a very speedy reply, too, I have to say, thank you very much. I am just wanting to make sure that the whole issue is—

Mr Wells—It is, Senator. As I say, we have gone through a very extensive period of consultation. The matter is being considered within the government.

Senator WEST—Thank you.

Senator McLUCAS—Can I turn to the issue of the Audit Office report into the administration of the 30 per cent private health insurance rebate. I understand the report found that the HIC reconciliation checks did not provide assurances that the funds have correctly calculated their premium reduction scheme reimbursement claims. Funds could have lodged incorrect claims and escaped detection. What procedures have been implemented by the HIC to address that deficiency?

Dr Harmer—We have been progressively improving our administration of that scheme over the period. When we first introduced it we were not able to effectively match the information and data from the private health insurers to our Medicare records. However, we were very confident that, having run Medibank Private, we knew what the problems were and we would eventually be able to put practices in place to fix them. We were also very confident that we were not making payments in respect of people who were not eligible.

As our audit procedure has taken up and we are now through the process of having audited probably over 70 per cent of the funds, we are finding that the payments in respect of the early years when we were not able to do the line by line matching were not made inappropriately, apart from a very tiny proportion.

Senator McLUCAS—Can you explain to me what line by line matching is?

Dr Harmer—When the program first started, the health funds were not able to provide information to us on individual patients who had been claiming. They claimed in respect of a bulk group of clients who were paying private health insurance. We made the payments on the base of their audited statements that these people had paid this amount of private health insurance. We would not be able to fully check each one of those until we had detailed information from the private health funds on each of the people. We have been progressively going through and auditing these statements and finding that the health funds in the earlier period were very accurate in the amount they were claiming in respect of the individuals who were paying the premiums.

Senator McLUCAS—Are you saying in the early days they were very accurate?

Dr Harmer—They were accurate right through but we were not able to demonstrate that they were accurate until we had completed all of our audits.

Senator McLUCAS—But the ANAO report says that funds could not substantiate $6 million of their line by line data.

Ms Dunne—That matter relates to the inability of the HIC to provide quality data in a timely fashion to the ATO so that they could check to see whether there had been any double dipping or not—in other words, access to the benefit, either via a cash benefit from the HIC or a premium reduction through the health fund, and then consequently lodging a claim on ATO—so we were unable to provide that information at a particular point in time. Since the ANAO audit we have been able to provide accurate data and in February this year we had received advice from the ATO that there were no rejections and that the quality of data was very good.

Senator McLUCAS—Did they quantify 'very good'?

Dr Harmer—Can I just add that the ATO have been able to recover, I think, $6.3 million of their early estimate of about $8 million that was double-dipped.

Senator McLUCAS—We have recovered $6.3 million of about $8 million?

Dr Harmer—Yes.

Senator McLUCAS—With ability to recover the $1.7 million?

Dr Harmer—The tax office made a decision on the basis of their normal administrative procedure that the $1.7 million, which consisted of something like 69,000 very tiny claims, all under $100, would be written off—their decision, not ours.

Senator CHRIS EVANS—I am a bit confused, Dr Harmer. Are you saying that, subsequent to the Audit Office report, you were able to reconcile all of them with line-by-line reconciliation or are you saying that subsequent to that report you have been able to introduce that system?

Dr Harmer—We have been provisionally improving the system over time, Senator, and we are at the point now where we can give Tax detailed line-by-line data which allows them to check to make sure that there is not double dipping between the scheme run by the Health Insurance Commission, which involves the vast majority of the payments under the rebate, and the scheme run by the tax office.

Senator CHRIS EVANS—What does that say, though, about the Audit Office findings about double dipping or claiming that was not justified? Are you saying that the tax office was able to successfully identify all of that in the end?

Dr Harmer—Most of it, yes.

Ms Dunne—Yes, that is true.

Senator CHRIS EVANS—So they were able to identify that, and that totalled $8 million worth.

Ms Dunne—In that first year there was $8 million identified through double dipping, so the benefit for 30 per cent had been claimed twice, once from HIC and once from the ATO. Out of that $8 million, $6.3 million was pursued and recovered.

Senator CHRIS EVANS—Was that pursued through people's tax returns or by individual action against them?

Ms Dunne—Whatever the ATO recovery processes are.

Dr Harmer—We do not know the answer to that, Senator.

Senator CHRIS EVANS—And the rest was written off?

Dr Harmer—Yes, under normal tax administration guidelines, as I understand. As I say, I think there were 69,000 claims which were under $100.

Senator CHRIS EVANS—That is the double-dipping issue. What about the issue they identified—the fact that the funds could not provide enough information to justify their claim?

Dr Harmer—That was the issue I dealt with with Senator McLucas initially. The ANAO claimed that when they looked at our administration of the scheme in that early period, they could not substantiate that we were paying accurately in respect of about $35 million worth of claims. That was in respect of—I am working from memory now—I think three funds in particular. We have now audited those funds, as well as most of the others, and as we have the detailed information line by line about individuals who were submitted initially in batch form from the private health insurers, we have discovered that we were right in our assumption that the funds would have been claiming accurately and appropriately for those people, and our audits have found that that was the case.

Senator CHRIS EVANS—Does that mean, though, you have gone back and done a line-by-line reconciliation as far back as the January to June 1999 period or that you just audited their systems?

Ms Dunne—We have gone back.

Senator CHRIS EVANS—So you have audited every entry?

Dr Harmer—Indeed.

Ms Dunne—Yes, 70 per cent of health funds.

Senator CHRIS EVANS—Every entry or 70 per cent of health funds? I am not sure which.

Dr Harmer—We are progressively doing it, Senator. We will have finished the line by line, right back to the beginning, by the end of this financial year. We are through 70 per cent, or a bit more, and our statistics so far indicate that we have no reason to believe that any substantial part of that $35 million picked up by the ANAO would have been incorrectly paid.

Senator CHRIS EVANS—Did you start with the problem children, as in the three or four funds that were identified, or are they still to be done?

Dr Harmer—Yes, we did.

Senator CHRIS EVANS—So the high-risk ones have already been dealt with?

Dr Harmer—Indeed.

Senator CHRIS EVANS—What does that cost you?

Dr Harmer—The Health Insurance Commission is a very efficient processing factory, Senator. About $1.7 million per year and $320,000 for auditing is included in that, and we pay out something of the order now of $1.4 million. The estimate is just over $2 million.

Senator CHRIS EVANS—Do you want to give those figures again with a bit more explanation. I was really after what the cost of auditing this particular issue was, and you were giving me your global budget, I think.

Dr Harmer—I was, yes.

Senator CHRIS EVANS—One of the issues we have discussed previously here is whether the tax option should be maintained or abandoned, and if you are having a lot of compliance costs, that is just something else in the mix.

Dr Harmer—The audit process I talked about—going back to the funds and checking for that $35 million that the ANAO thought it was possible we had inadvertently or incorrectly paid—cost us about $300,000.

Senator CHRIS EVANS—I thought $1.7 million sounded a bit high. Have you made any recommendations about how this might be done in the future?

Dr Harmer—This is a very complicated process. We believe we are now in a position where we have made most, if not all, of the legislative and other changes we need to make to be very confident about our payments and about minimal double dipping.

Senator CHRIS EVANS—Is there any ongoing consideration about whether the taxation option should be reconsidered?

Mr Wells—That is a matter of government policy. The policy at the moment is that both options are available.

Senator CHRIS EVANS—Often we set up departmental committees or inquiries to review whether there is anything driving that. There is nothing particularly driving the policy debate inside at the moment on that issue?

Ms Halton—I think the government, when it announced this, was quite clear about giving people choice, which is why these two options are available. There is no process internally at the moment reviewing that. You are right in saying that each policy in time is reviewed. No doubt that issue will be looked at at that time but, no, we are not considering any change to that at the moment.

Senator CHRIS EVANS—That is right. They gave them the choice, but it seems that they have voted with their feet for one option and then it is a question, I suspect, of whether the costs and the compliance issues outweigh the value of maintaining the choice. Can I ask some questions about Medibank Private.

Senator CROWLEY—Senator, I am sorry, I have one question on private health.

Senator CHRIS EVANS—Yes, that is all right.

Senator CROWLEY—I have a letter from a constituent here. He asks first of all: is it the case that there was a two-year period of grace or capacity to join private health insurance without incurring a penalty?

Mr Wells—We will explain the arrangements under the lifetime health cover. There was a two-year period for certain categories. Ms Sperling is getting the detail for you.

Ms Sperling—When the lifetime health cover legislation was implemented, the government recognised that there would be some circumstances that might have prevented a person from having hospital cover on 1 July 2000, which is when the policy came into place. Some transitional provisions, called hardship provisions, were included in the legislation. These cover circumstances in the period leading up to the introduction of lifetime health cover and they broadly cover three circumstances: firstly, persons in financial difficulty at 30 June 2000 who were unable to have hospital cover, but had shown a commitment to private insurance in the past; secondly, migrants who, broadly speaking, were in the process of obtaining a permanent visa; thirdly, persons who were experiencing exceptional circumstances at 30 June 2000 who, for those reasons, were unable to have hospital cover, but had shown a commitment to private insurance in the past.

A person meeting one of these criteria could make an application to the minister. The minister would then determine that they would be treated as having had hospital cover on 1 July 2000 and therefore not subject to lifetime health cover provisions. The issue in relation to the two years refers to the period of two years that people have had to make an application in respect of their circumstances at 30 June 2000 and people have until 1 July 2002 to make that application.

Senator CROWLEY—This is a case that perhaps does not fit under those conditions, but might. This is from a person who was the sole earner for a family and, at the time of the introduction of the private health insurance changes, because of the low level of income, was eligible for a health card. He has written:

One year later, my wife re-entered the workforce after 14 years away from it, primarily because we were unable to get by on just my income any more. As was only fair, we lost our health care card and proceeded to investigate private health cover. As I was at that time 43, we would have been penalised 26 per cent for life for joining so late.

Is it your estimation that a person who was on a health care card at the time because of low income would qualify under either financial or exceptional circumstances?

Mr Wells—The criteria are quite complex. Could you give us the detail of the case and we will get you an answer? I would not like to attempt to give an answer across the table.

Senator CROWLEY—Thank you. I raise it because he is not the only person who has asked me about it. We just do not know. We are not really clear about the conditions and, because this has very recently come to me, I thought I would bring it up here. I appreciate what you are saying. What you are really also saying is that perhaps the best thing is that, if there is any doubt, a senator or member might want to write in about the circumstances and get a reply back.

Mr Wells—Certainly.

Senator CROWLEY—I could also say to this person, 'You have until 1 July this year to make an application.'

Mr Wells—To make an application.

Senator CROWLEY—I will make sure that you sort this out for me/them. Thank you.

Senator CHRIS EVANS—I want to ask some questions about the Medibank Private scoping study.

Ms Halton—The scoping study is an initiative of the Department of Finance and Administration.

Senator CHRIS EVANS—Well, does health know about it? Are you assisting?

Senator Patterson—No, that is a scoping study initiated by the Department of Finance and Administration.

Mr Wells—We have already had some initial discussions with the Department of Finance and Administration. There will be issues in relation to the regulatory framework about which the scoping study will need to be informed. That will be part of the exercise and that will occur. The scoping study has not yet formally started, as I understand it.

Senator CHRIS EVANS—Are you assigning officers? Is the health department making an officer available as part of the team?

Ms Sperling—Nothing has been determined yet.

Mr Wells—No, it has not got to that, Senator.

Ms Halton—To my knowledge, we have not had any approach in that respect. Certainly we all stand ready to assist, particularly the coordinating agencies, but it would be standard practice that we provide advice as needed.

Senator CHRIS EVANS—Have you any idea on the timetable? Did they advise you as to the timetable?

Ms Sperling—They have not advised us of that yet either. I do not think it has been determined.

Senator CHRIS EVANS—Are you from Medibank Private?

Mr Young—That is correct, Senator.

Senator CHRIS EVANS—What can you tell us about the market share of Medibank Private in recent times?

Mr Young—Our market share in recent times has been steady at approximately 30.8 per cent.

Senator CHRIS EVANS—There has been no major movement in that share?

Mr Young—Not over the last 18 months or so, not since the lifetime health cover period. It has been pretty steady. It goes up and down a little.

Senator CHRIS EVANS—What about Medibank Private's profitability?

Mr Young—We reported a surplus of $105.9 million for the year ending June 2001 and we will be reporting our annual result for this year probably around about September-October.

Senator CHRIS EVANS—You reported your annual result in January, did you say?

Mr Young—No, we reported last year's annual result late last year. Our annual result was tabled by the Minister for Health and Aged Care, as it was then, late last year for the year ending June.

Senator CHRIS EVANS—That was a surplus of $105.9 million?

Mr Young—That is correct, for the financial year ending June 2001.

Senator CHRIS EVANS—When will you record your financial result for this financial year?

Mr Young—I do not have the details in front of me, but we report in September-October and then the results are tabled in parliament at the discretion of the minister.

Senator CHRIS EVANS—What, in general terms, can you tell us about Medibank Private's situation in relation to trading this year?

Mr Young—In general terms, the trading environment for Medibank Private is very difficult. The environment in which we are operating has changed significantly. I cannot report any data, but we have had a number of different impacts on our investment income and on our benefit outlays. On the benefit outlays front, we have had impact from an increase in the number of claims and an increase in the cost per claim.

Senator CHRIS EVANS—Are there any public figures available on those for this year?

Mr Young—Not at this stage. We report our results annually.

Senator CHRIS EVANS—That was behind your request to the government to raise the premiums by 13 per cent, was it?

Mr Young—We made a commercial-in-confidence rate application at the start of this year and there were a number of issues driving that, but the operating environment was the significant issue.

Senator CHRIS EVANS—You cannot confirm for me that the rate requested was a 13 per cent increase in premiums?

Mr Young—We treat our rate requests as being commercial-in-confidence, Senator.

Senator CHRIS EVANS—You read about them in the paper then, do you, like everybody else?

Mr Young—We read a lot about ourselves in the paper.

Senator CHRIS EVANS—I'll play your game then! We do not know what you applied for. What was the average premium increase granted to Medibank Private?

Mr Young—The average premium increase was 8.94 per cent.

Senator CHRIS EVANS—Was there much variation between different products?

Mr Young—Yes, there was. There was a range, which we announced at the time, of zero to 16.2 per cent.

Senator CHRIS EVANS—Can you give me some understanding of the rationale. I do not want you to take me through each of the rates but just the thinking that underpinned the different approaches.

Mr Young—In high level terms, we market a wide range of different products and those different products were performing differently in financial terms. So the rate increases that were applied varied according to the financial needs of the different products that we market.

Senator CHRIS EVANS—Do I take it that you try to return a profit on each of the products? Is that what you are saying to me?

Mr Young—We try to make our products sustainable and we try to avoid having some of our customers subsidise others of our customers.

Senator CHRIS EVANS—What were the major cost pressures on the higher end, the products you had to increase by the greater amounts?

Mr Young—The significant pressures were the impact on our investment income. Our investment income was significantly affected late last year, particularly by the events of 11 September. Traditionally Medibank has relied heavily on investment income to subsidise product. The other significant impacts were a dramatic increase in the number of claims and an increase in the cost of those claims above what we had expected.

Senator CHRIS EVANS—Can you explain the investment income? You have a range of investments held by Medibank Private. What are you investing in?

Mr Young—Our investment strategy varies from time to time. We invest in a range of international and Australian equities. We hold cash. We have a mixed portfolio approach. We have over the years had a mixed portfolio approach to managing our investments.

Senator CHRIS EVANS—Maybe I do not understand this properly. Are these investments of your cash at hand that are put into short-term investments or are these long-term surplus funds?

Mr Young—It is a combination. It is a balanced investment portfolio which has performed well over time but last year was significantly impacted by the downturn in international equities and particularly by the events of 11 September.

Senator CHRIS EVANS—I am trying to understand whether what you are doing is investing surplus cash or whether you have a couple of billion tucked away for a rainy day that you are earning investments on. Where does the investment come from originally? These are surplus funds you have reinvested over the years?

Mr Young—The investment comes from the funds that we generate through our trading and the funds that we generate as reserves over time.

Senator CHRIS EVANS—So you have had substantial reserves over time that have been invested and have been generating income as well?

Mr Young—That is correct.

Senator CHRIS EVANS—What is the extent of those reserves?

Mr Young—I am not sure whether we have published them. If we have, they will be in our annual report. I am not immediately familiar with the figures but I can check for you.

Senator CHRIS EVANS—That is fine. Do I take it that the investment income was subsidising payment of your benefits?

Mr Young—Medibank has been in existence for 26 years and traditionally investment income has been used to subsidise margin as part of a strategy to try and keep premiums low.

Senator CHRIS EVANS—What sort of contribution has it been making?

Mr Young—It has varied. I do not have the figures off the top of my head.

Senator CHRIS EVANS—I am just trying to get a sense of it, Mr Young.

Mr Young—The year ending last year it was in the mid-$20 millions, which was about a quarter of our surplus. In the previous year we generated about $90-odd million in investment income. Over the last five years we have generated returns on the assets invested averaging 9.9 per cent.

Senator CHRIS EVANS—The year before last you generated as much as $90 million from investment income.

Mr Young—That is correct.

Senator CHRIS EVANS—And that fell to $20 million last year.

Mr Young—It was in the mid-twenties. I will have to check. The data is in our annual report.

Senator CHRIS EVANS—Are we saying you expect it to be lower this year?

Mr Young—It has been significantly impacted this year.

Senator CHRIS EVANS—I see you have lost your chairman as well, or your managing director?

Mr Young—Our managing director, Mr Burrowes.

Senator CHRIS EVANS—When did he leave?

Mr Young—He left us in mid-April, I think on 18 April.

Senator CHRIS EVANS—When was that announced?

Mr Young—That was announced either that day or the day after.

Senator CHRIS EVANS—Was there a role for the government in approving that decision?

Ms Sperling—No.

Mr Wells—No. We notified the government.

Senator CHRIS EVANS—Notified the government that he had been terminated, that he had left, that he had resigned?

Mr Wells—I am not sure which of those words apply. Mr Young would perhaps have the text of the announcement. I think they mutually agreed or something like that. It is not a matter the government is involved in.

Senator CHRIS EVANS—That was what I was trying to clarify. It is more of a requirement—

Mr Wells—It is a matter between the managing director and the board.

Senator CHRIS EVANS—Yes.

Ms Sperling—The media statement at the time announced that Mr Burrowes was leaving his position at the end of April.

Senator CHRIS EVANS—I gather he went on the 18th. Is that right, Mr Young?

Mr Young—We appointed an interim managing director effective from 19 April and Mr Burrowes left the company. He was in the office for a number of days afterwards but he was no longer acting as the chief executive.

Senator CHRIS EVANS—His replacement started on the 19th, did he?

Mr Young—That is correct, Mr George Savvides.

Senator CHRIS EVANS—Was he with the company before? Was he an internal appointment or an external appointment?

Mr Young—He was asked to act as acting managing director by the board. He was a non-executive director of Medibank and subsequently we sought and obtained government approval for him to act as acting managing director.

Senator CHRIS EVANS—Is he still acting in that job?

Mr Young—He is.

Senator CHRIS EVANS—How long is that intended to continue?

Mr Young—He has been approved to act on an interim basis. There is no decision yet how long that will be or what the longer term arrangements will be.

Senator CHRIS EVANS—That is a matter for the board, I presume.

Mr Young—That is correct, in consultation with our owners.

Senator CHRIS EVANS—That therefore means, I presume, that the job has not been advertised or there is not a recruitment procedure in place.

Mr Young—I am not aware of a recruitment procedure. The issue would be determined between Mr Savvides and the board, and subsequently in consultation with our owners.

Senator CHRIS EVANS—He is continuing to act in the job for an unspecified period?

Mr Young—He has been approved to act in the job on an interim basis, subject to long-term recruitment of a permanent managing director.

Senator CHRIS EVANS—So there has been a decision to in the longer term recruit a new managing director.

[9.28 p.m.]

Mr Young—Eventually we will need a permanent managing director, yes.

Senator CHRIS EVANS—When was the contract for Mr Burrowes due to expire?

Mr Young—He was on a three—year contract which was due to expire later this year.

Senator CHRIS EVANS—Can you be a bit more specific than 'later this year'?

Mr Young—I believe he was originally appointed in September 1999 for a three—year period.

Senator CHRIS EVANS—Are you able to advise us whether the board paid out his contract?

Mr Young—The arrangements relating to his departure have been finalised within the terms of his contract. The arrangements involve a deed of release and a deed of confidentiality. I am not sure yet whether the payment has been made. The final details were organised a week or so ago.

Senator CHRIS EVANS—But essentially has his contract been paid out?

Mr Young—His exit arrangements are according to the terms of his contract. I am not familiar with the terms of his contract.

Senator CHRIS EVANS—But is the principle there that he is paid for the remaining period of the contract? Do you know?

Mr Young—I do not know the details of his contract, Senator. The arrangements are between him and the board and I am not familiar with them.

Senator CHRIS EVANS—Is the acting managing director remaining as a non-executive director of the board?

Mr Young—He is managing director so he acts in that capacity. If we recruit a permanent managing director then presumably he will resume his role as a non-executive director at that point.

Senator CHRIS EVANS—I presume he is there full-time and therefore has been employed on some sort of contractual arrangement as well, has he?

Mr Young—That is correct. He has been employed on a contractual arrangement which is a pro rata replica of the arrangements with the previous managing director, the remuneration tribunal advice being that remuneration is particular to the job, not to the person.

Senator CHRIS EVANS—Thank you for that. That does me for 8, I think.

Senator WEST—I cannot think of any more for outcome 8.

[9.31 p.m.]

CHAIR—All right, outcome 9, Health investment.

Senator DENMAN—This is where I was told to ask about overseas trained doctors. Is that right?

CHAIR—It was.

Senator DENMAN—There is a situation in Tasmania specifically that I want to ask about. What arrangements exist for an overseas doctor who has been offered employment in an area that has been unable to recruit an Australian doctor but is not classified as an area of need? There is a situation where there is a doctor from another country in Tasmania. He has fulfilled all the criteria. He has now been offered a job elsewhere, not in Tasmania, but it is not classified as an area of need, but that area cannot attract a doctor. What sorts of arrangements can be made there?

Mr Wells—It is the doctor's choice where the doctor works.

Senator DENMAN—He says it is not.

Mr Wells—He has been offered a job, presumably a salaried job elsewhere?

Senator DENMAN—Yes.

Mr Wells—That is not covered by our restrictions on access on Medicare. If he is offered a salaried job in a public hospital in another state, or elsewhere, he is free to take that job and the employer is free to employ him, but there is no provider number issued because that doctor would be on a salary in the public system and not billing Medicare. The area of need is still able to access whatever the relative schemes and entitlements are, which are available to attract another doctor into that area of need.

Senator DENMAN—That is not the information he has been given, but I will come back to that. What is the criteria for an area of need, or a district of working shortage?

Mr Wells—We use the term 'area of work force shortage'.

Senator DENMAN—Right.

Mr Wells—That is where the number of doctors relative to the population is below the national benchmark, which I think is one doctor per 1,400 population. That is one equivalent full-time. There might be, for example, three doctors working a third of the time each which

would add up to one. That area would then meet the benchmark, if you understand what I mean.

Senator DENMAN—How is the decision made that an area of need is unable to attract an Australian doctor?

Mr Wells—I am not sure of the question.

Senator DENMAN—Let us say the west coast of Tasmania—that is not where I am talking about at the moment—cannot attract an Australian doctor. Who determines that they can bring in a doctor from another country to practise there?

Mr Wells—We do, Senator.

Senator DENMAN—Do you make that decision purely on the fact that there is no Australian doctor available?

Mr Wells—Yes. They provide to us evidence of their attempts to recruit an Australian doctor and then they recruit the overseas doctor and, provided that doctor meets all the other criteria they need to meet, they can register in the state et cetera. That is when we then approve the provider number.

Senator DENMAN—So there is a provision that if an area is unable to attract an Australian trained doctor and an overseas trained doctor is willing to go there, that is possible.

Mr Wells—Yes, Senator.

Senator DENMAN—Thank you.

Mr Wells—So long as it is a defined area which meets that workforce shortage criterion that I referred to.

Senator DENMAN—Yes.

Senator McLUCAS—Page 80 of the PBS explains that there is going to be $80 million over four years. Can you explain the three outcomes and the rationale for the collecting of money from those three different outcomes into this program?

Mr Wells—There are three elements. First, there is a capacity to attract to practices in those areas people currently on specialist training programs. It would be doctors predominantly working in the public hospital sector who might want to work in outer urban areas, for example, part-time or weekends or, if they are in a period where they are leading up to an examination or some assessment, they might want to work for a week or two as part of taking a break from their normal hospital situation. The second category, encouraging other medical practitioners, is the OMPs category. These are doctors who do not have the vocational training qualification—for example, the Fellowship of the College of General Practitioners. It is about encouraging them, if they are prepared to work in outer urban areas, to sign up to a program which will lead them to get the vocational qualification and they can then access the higher Medicare rebate from the period they move. The third category relates to where there are appropriate training facilities available. A number of the stream of trainees who are non-rural—within the 450 there is a rural stream and a general stream and the general stream doctors can train in urban areas—and some of those would be encouraged to train in the outer metropolitan areas.

Senator McLUCAS—They are called the general stream. That is the differentiation: general stream as opposed to rural stream—those 450 rural and regional—are they called?

Mr Wells—The total intake for general practitioner training is 450, of which 200 is the rural stream and the remaining 250 is the general stream. It is within that 250 that we would attract trainees to the outer urban.

Senator McLUCAS—Are they registrars under the general pathway? Is that correct, or is that how they are described?

Mr Wells—There is one pathway, Senator. It is just that within the annual intake of 450, 200 pursue that pathway through rural training and 250 pursue that pathway essentially in urban training, but it is the same pathway. It leads to the same qualification, but they do it in different settings.

Senator McLUCAS—I will come back to that in a moment. Can you explain the high Medicare rebates? What outcome is that under?

Mr Wells—That is under outcome 2.

Senator McLUCAS—How much higher will the Medicare rebate be?

Mr Wells—I do not have that figure in my head. It is a standard figure, but I do not have those numbers. The people from outcome 2 will have what the rebate number is for the so-called A1 and A2. A1 is the vocational qualified doctor and A2 is the OMP, the other medical practitioner. I am not able to give you that exact figure at the moment.

Senator McLUCAS—Could we get that tomorrow?

Mr Wells—You will be able to get that from outcome 2.

Senator McLUCAS—The way you arrive at that figure, is that a percentage or a flat-rate increase?

Mr Wells—They are figures which apply across the country. It is the same for every doctor. If they are vocationally trained, they get whatever the rebate figure for a vocationally trained doctor is wherever they practise. If they are an OMP, they get the rebate figure for an OMP wherever they practise. That is standard. The people in outcome 2 will be able to tell you what the figure is and the basis of the difference.

Senator McLUCAS—I am now trying to understand why we are saying that this strategy will encourage people into the program if they are actually not getting paid a higher rate than they were getting paid anyway.

Mr Wells—No, they will be, Senator. If the OMPs—the other medical practitioners—remain in an inner urban area they will not be able to attract the higher rebate. If they move to an outer urban area and, at the same time, commit to a pathway, of which there are several available, which will lead to meeting the vocational training requirement, they can attract the higher rebate immediately they do that. They do not have to wait until they get their higher qualification.

Senator McLUCAS—Are those higher rebates are described as A1 and A2? I wonder if you could advise me when the appropriate time is to—

Mr Wells—I will alert the people.

Ms Halton—We will see if we can get them tonight.

Mr Wells—Yes, we will see if we can get them.

Ms Halton—We may not be able to, but we will certainly have it tomorrow.

Mr Wells—I do not have those numbers in my brief.

Senator McLUCAS—When those A1 and A2 higher Medicare rebates are determined—

Mr Wells—A1 is the higher. A2 is the lower.

Senator McLUCAS—What is the methodology to come to those?

Mr Wells—The officers from outcome 2 will tell you.

Senator McLUCAS—All right. Going back to the separation between rural and urban, advice from the department to the question, 'Who is eligible for the program?' was that all registrars undertaking the general pathway of the Australian general practice training program from 2003 will undertake a training placement in a designated outer metropolitan area. I understand that was for six months. How does that sentence exclude the 200 rural people?

Mr Wells—It says those undertaking the general stream.

Senator McLUCAS—That is general pathway and does that mean only the 250 urban doctors?

Mr Wells—Yes. The intention was not to take doctors who would otherwise go to rural areas—where there is already a need defined—but that they would not be diverted into outer urban areas.

Senator McLUCAS—Have you had a lot of contact from divisions, for example, or registrars around the country, especially in regional areas, expressing concern that they were going to lose their registrars to this program?

Mr Wells—It was only announced in the budget. I am advised that we started a process of consulting with divisions et cetera but there has not been enough discussion for that to occur. The scheme is designed so that cannot occur; that doctors in the rural stream will not be eligible for this outer urban rotation.

Senator McLUCAS—There has certainly been a lot of discussion amongst the divisions that I am aware of about losing their registrars out of regional areas to the outer metro. There is no clarity there.

Mr Wells—The design of the scheme is that the rural stream people are not eligible to access the outer urban places.

Senator McLUCAS—That is good to know. How are the boundaries of the outer metro areas described?

Ms Cobbold—To be eligible for programs under the more doctors for outer metropolitan areas measure practices, doctors must be located in districts of workforce shortage lying in the outer metropolitan zone. There are two elements to this definition: the outer metropolitan zone is defined as that part of the capital city's statistical division which lies outside the Australian Bureau of Statistics defined urban centre in 1991. The defined urban centre broadly corresponds to the central built-up area at that time. Choosing 1991 as the point of definition allows for the outer metropolitan area to include growth areas which have become built up since 1991, as well as the peri-urban and semirural localities within the metropolitan area. The programs will only be available in districts of workforce shortage which are outer metropolitan areas, as I have just defined, with a demonstrated shortage of general practitioners.

Senator McLUCAS—What is the demonstrated shortage?

Mr Wells—That is there one to 1,400.

Senator McLUCAS—The national benchmark of 1,400.

Mr Wells—The benchmark I referred to in the earlier answer to Senator Denman.

Senator McLUCAS—I think everyone recognises there is a problem there. I do not think there is any question about that. It has been put to me, though, that by putting effort into those outer metropolitan areas, it will once again put more strain on regional centres that would have similar workforce shortages. It will be more attractive to work in the outer metro areas than to spend time in the regional centres, especially regional centres that are quite close to outer metro areas.

Senator Patterson—Senator McLucas, are you suggesting we do not encourage any doctors to go and work in rural areas?

Senator McLUCAS—No, not at all. What I am trying to ascertain is whether or not an analysis of the impact of this program was made on centres quite close to the capital cities.

Mr Wells—Yes, Senator. We have been very attuned to the fact that this might be a more attractive proposition for some doctors. The way we have designed the scheme is that doctors who are eligible for rural locum relief—those sorts of measures—the pool of people we are making eligible for the outer urban is a different pool and that is the specialist trainees. They are not eligible for the rural locum and generally it would not be possible for them to do rural locums because, as I said, they are based in a city hospitals, whereas the junior doctors who have not yet started a specialist training program are not eligible for the outer urban scheme, but are eligible for the rural scheme, so it is a different pool there.

Senator McLUCAS—I understand that, yes.

Mr Wells—I explained the general practice pool as well. Again, the rural stream is not eligible to go into the outer urban. We have those figures for the scheduled fees. I will give you the scheduled fees and the rebate for each. For A1, which is higher, the scheduled fee is $28.75 and the rebate on that is $24.45. For A2, which is the OMP rate, the scheduled fee is $21 and the rebate is $17.85.

Senator McLUCAS—Minister, I understand you have had correspondence from the member for Herbert, suggesting a way of solving the doctor shortage in rural and regional Australia is to license premises rather than doctors. Is the government pursuing that policy option?

Senator Patterson—We get suggestions from lots of members, Senator McLucas. We look at them and evaluate them.

Senator McLUCAS—Have you evaluated that option yet?

Senator Patterson—We have looked at it. But there are always difficulties. When the Labor Party made changes to pharmacy, there were lots of difficulties with licensing issues.

Senator McLUCAS—We are talking about licensing of doctors' premises, or that is Mr Lindsay's proposal.

Senator Patterson—I know what you are talking about. Sometimes ideas seem good and then you have to look at the ramifications.

Senator McLUCAS—Are you saying that you have written back to Mr Lindsay, basically saying that it is not a good idea?

Senator Patterson—I did not say that at all.

Senator McLUCAS—Have you written back to Mr Lindsay? I know you write lots of letters, Minister. You cannot remember them all.

Senator Patterson—I write lots of letters. I think an answer has gone back to him, thanking him for his suggestion.

Senator McLUCAS—Are you not thinking of pursuing that suggestion?

Senator Patterson—You are as bad as a journalist, Senator McLucas.

Senator McLUCAS—I am representing my constituency.

Senator Patterson—Do you think it is a good idea? You would like to do it, would you?

Senator McLUCAS—I am only pursuing the proposal by Mr Lindsay.

Senator Patterson—As I said, there are a lot of proposals that come forward. We look at them all. We take ideas from some but you cannot implement all of them. I think I wrote back. I am trying to remember that particular letter. I will stand corrected, but I think I thanked him for the suggestion and left it at that. The department and I look at suggestions and evaluate them. We receive a lot of suggestions. Many of them are very good but sometimes they have to fit in with everything else that is going on. That does not devalue anybody's input.

Senator McLUCAS—Thank you. I have finished the out of metropolitan area doctors issue.

Senator ALLISON—I want to refer to the question of indemnity insurance for students in clinical placements. As I understand it, the UMP—now that it has collapsed—and other MDOs previously provided free indemnity insurance for medical students for clinical placements. Is that your understanding, too? Since the collapse of UMP it appears to be the case that medical and nursing training has been seriously curtailed, with some or all of the non-theoretical—in other words, practical—training being suspended. Is this the understanding?

Mr Wells—The situation with medical students undergoing clinical experience is that they are not providing treatment to patients; they are generally observing. Certainly when they are with the patients they are in the presence of a qualified doctor. Medical students are not qualified to provide treatment. The issue of medical indemnity for those students is not, so far as I am aware, an issue of concern. Some of the universities raised an issue about their own staff—that is, qualified doctors who are teaching—but that, we believe, is a matter between the university and the hospital. I am unaware of any issue about medical students.

Senator ALLISON—That is the information that we have been provided with—that medical and nursing schools and universities have had to cancel indefinitely some or all of their practical clinical placements.

Mr Wells—Senator, we are in regular contact with the deans of medical schools.

Senator ALLISON—Would you be surprised if that was the case?

Mr Wells—They certainly have not told me that, if that is what they are doing, and I expect they would.

Senator ALLISON—If it turns out to be the case, would you be concerned about that situation?

Mr Wells—That is hypothetical. We meet regularly with the deans of medicine as a group—in fact, we have a meeting coming up in a few weeks time. I am certainly prepared to raise that at the meeting, but I am unaware of any disruption to medical training around the medical indemnity crisis.

Senator ALLISON—You would expect those students, whether or not they are hands-on practising—

Mr Wells—They are not hands-on practising. That is the point. They are not allowed to put hands-on. They are not qualified; they are not registered as doctors.

Senator ALLISON—I understand that. But would you expect them, nonetheless, to be covered by indemnity insurance?

Mr Wells—No. What they would be covered by would be whatever insurance cover the university generally needs—public liability type insurance—if their students cause some problem as students. It would not be a medical type.

Senator ALLISON—All right. Even if it is public liability to cover those students, wouldn't that have been covered by UMP or the other MDOs?

Mr Wells—I would not think so.

Ms Halton—If I can perhaps intervene here. You made a comment about UMP AMIL having collapsed. I think it is important to put on the record that there is a provisional liquidator who is currently running the business of UMP AMIL. Demonstrably, it is still operating. The government's guarantee has enabled it to do that. There is an agreement that has been registered with the court in that respect. Secondly, UMP AMIL provides medical indemnity to registered practitioners. UMP AMIL is not a provider of, as I understand it, professional indemnity or any other variety of insurance.

Senator ALLISON—I understand the Prime Minister's commitment to that. It is my understanding that this had slipped through the cracks, as it were. I have just been handed a note that suggests Flinders nursing stopped practical training until state government intervention, and the same with Adelaide University; the University of Western Australia says it is a problem, as does the committee of deans of medical schools.

Mr Wells—Senator, that is news to us, but I will follow it up.

Ms Halton—In any event, if it is nursing, nursing is not a medical indemnity issue a la UMP AMIL.

Senator ALLISON—Nonetheless, we will have a problem if this is the case.

Ms Halton—Certainly, Senator. If you do have details—obviously you have information which we are not privy to—we would be very happy to look at it.

Senator ALLISON—Thank you.

Senator Patterson—That does not necessarily mean that it is a Commonwealth responsibility.

Mr Wells—No.

Ms Halton—No.

Senator Patterson—There are other allied health professionals—physiotherapy students, occupational therapy students; people who do procedures on patients—I mean, if an occupational therapy student put on a splint that was too tight. There are issues across the

whole of the allied health professions but it is not an area for which the Commonwealth has been responsible.

Senator ALLISON—I guess there are lots of insurance areas the Commonwealth is not responsible for but someone has to do something with some urgency at this point in time. Ms Halton, did you say you want us to give you information?

Ms Halton—As the minister says, it may or may not be in our area of responsibility. But unless we have the information, we cannot make a judgment. If you would like to provide it to perhaps the minister's office, we can look at it.

Senator ALLISON—I do not know that we have anything more than those names. That is all.

Ms Halton—We might follow it up with some universities.

Mr Wells—We will follow it up with DEST and we will also contact the universities that you mentioned.

Senator ALLISON—Thank you.

Senator CROWLEY—Madam Chair, that is an issue of considerable importance to a lot of us. When you have found the answer, could the information be provided to the committee for all of us?

CHAIR—Yes, that is routinely done.

[9.59 p.m.]

National Health and Medical Research Council

Senator HARRADINE—I want to ask a number of questions of the National Health and Medical Research Council. I thank you for the opportunity to ask these questions now. I am due in another part of the building as of now, so I will shorten my questions considerably. First of all, could I ask about the details of NHMRC grants to projects involving research in human adult stem cells.

Prof. Pettigrew—Currently in the year 2002 we are funding eight projects which involve the use of human adult stem cells. There are another 20-odd projects which involve the use of animal stem cells.

Senator HARRADINE—What about in regard to human embryonic stem cells and animal embryonic stem cells?

Prof. Pettigrew—The situation with respect to the use of human embryonic stem cell lines—that is, embryonic stem cells generated as you understand—there are two areas of funding which have recently received human ethics approval from the institution. Funding for those projects is commencing in June this year.

Senator HARRADINE—Could you provide us with the full details of those programs.

Prof. Pettigrew—I can provide you with some details now, Senator, if you wish, or we can take that on notice and provide it.

Senator HARRADINE—Unfortunately, as I say, I have to be elsewhere.

Prof. Pettigrew—We are happy to provide it.

Senator HARRADINE—Thank you. I refer to the statement on ethical conduct in research involving humans. Principle No. 1 of that statement reads:

The guiding value for researchers is integrity, which is expressed in a commitment to the search for knowledge, to recognised principles ... of ethical conduct of research and dissemination and communication of results.

How does the NHMRC ensure that that is the case in respect of programs which have been sought to be undertaken by applicants who may have a commercial interest in the outcome? In other words, to put it plainly, how do you cope with that principle? How do you ensure that that principle—particularly the dissemination of research results—squares with the attempt by some science technologists and commercial interests to obtain patents, for example, which result from the utilisation of taxpayers' funds?

Prof. Pettigrew—The researchers are very familiar with the ethical issues that they have to address when putting their applications for funding to us. They know that they have to receive institutional ethical committee approval before funds will flow, so they are aware of the principles there. But, in the generation of results from any research, there is an understanding that sometimes results will become apparent for which intellectual property value can be assigned and there is a normal practice that researchers will attempt to identify where that intellectual property is appropriately recognised in terms of patents. The publishing of a patent in a sense is also a public announcement that research results have been found in a particular area and that is now being accepted as one form of recognition of the outcomes of a research program.

Senator HARRADINE—Is that the normal course of events? I would have thought that dissemination of information would have related to the information that is gleaned from the program which has been funded by the taxpayer, by funding from NHMRC.

Prof. Pettigrew—That is correct, Senator, insofar as researchers do take note and they are very keen to publish their results in peer reviewed literature because that gives them a great deal of recognition for the work that they have produced. But there are occasions when there is value to be realised in a commercial sense from intellectual property, and our researchers are also conscious of that responsibility because, in receiving public funds to support their research, they also have the opportunity to capture intellectual property for commercial return. According to our policies, in the end that intellectual property value is returned to the community through the spin-offs which arise out of the dealings with that intellectual property.

Senator HARRADINE—Paragraph 1.18 of the statement says:

The results of research (whether publicly or privately funded) and the methods used should normally be published in ways which permit scrutiny and contribute to public knowledge. Normally, research results should be made available to research participants.

I am trying to see how the NHMRC squares that requirement with patenting which, in essence, does not enable public scrutiny because the information is not provided to the public—other than in peer reviewed journals, of course.

Prof. Pettigrew—You are quite correct, Senator, insofar as there is a tension in the way that you are expressing it. There is that tension and the decision has to be taken about when results are most valuably published in peer review literature. Might I say, my understanding is that that is more of the norm, but there is also the avenue for results, depending on the nature of those results, to be patented, and a patent is taken out on that intellectual property. But quite often researchers will publish their results for peer review scrutiny in the journals. The work which is published in a peer review journal is work which they are very happy to put into the public domain and a patent might be quite a specific issue to do with just a single

component of that research program for which they recognise potential value in the future under the terms of a patent.

Senator HARRADINE—I would have to have a look at the projects, but does NHMRC consider that, where there is a particular gene concerned or a particular aspect of early human life that is sought to be patented, that deserves greater attention in respect of patenting—patenting, say, a gene?

Prof. Pettigrew—I understand the problem you are alluding to, Senator. Indeed, I believe this is an international issue insofar as the whole matter of patenting of genes is a matter for quite a deal of debate and discussion in the scientific community, to my understanding.

Senator HARRADINE—I think Mountford has got a patent on cloning procedures, has he not?

Prof. Pettigrew—I am not aware of that, Senator.

Senator HARRADINE—Dr Mountford.

Prof. Pettigrew—I have no knowledge of his patent.

Senator HARRADINE—When you say it is an international matter, what discussions are taking place on that?

Prof. Pettigrew—I have no specific knowledge of actual discussions going on, Senator, but from reading the odd article in some of the more popular scientific journals, such as *New Scientist*, I have come across articles from time to time which raise the issue of patenting and where does this sit with the public good value which research also needs to bring through.

Senator HARRADINE—Yes. Chair, I will close it down there. Before I do, could I go to this question of the public consultations in respect of the legislation that is coming up on cloning and stem cell. Could you provide a list of individuals and groups, including representatives of or experts in artificial reproduction technology, medical research, consumer issues, ethics and the law, who have been invited to attend consultations on draft legislation to ban human cloning and other unacceptable practices and to regulate certain research involving excess embryos? Would you be able to provide the committee with a list of the people who have been invited and also advise the process for selecting those to participate in the presentations? Were selections made from a large list of all who may have an interest in participating? In effect, how were determinations made as to the length of time each party would be given to contribute their views on the draft legislation?

Prof. Pettigrew—Senator, there are quite a number of questions you have asked there. If you like, we will take that on notice and provide you with a detailed breakdown of all of those factors, but we can brief you on some of them now, quite specifically.

Senator HARRADINE—Thanks.

Dr Morris—Firstly, the consultation process was determined in consultation with each state and territory jurisdiction, taking into account the time available for consultations and the fact that considerable consultation had already occurred prior to COAG. The names of individuals to be consulted were provided to the NHMRC by each state and territory jurisdiction and the Prime Minister's office. The NHMRC did not seek to cull the lists of names provided. Therefore, the number of people consulted in each capital city has been dependent on the number of names provided to us for consultation. In some cases, that has required putting more people in one consultation session than in other consultation sessions, but we have endeavoured to balance the number of people put together in a consultation by

choosing key individuals for one-on-one consultations and attempting to balance the number of individuals, for example, from a bioethical perspective with the number of individuals from, say, an ART service provider perspective. We are happy to provide you with a list of people consulted in due course. We are currently in the middle of consultations which will finish this week.

Senator HARRADINE—When you say the state jurisdictions, are you in effect saying the departments of health?

Dr Morris—The state jurisdictions we are working from, Senator, are the departments of health and the departments of premier and cabinet or chief minister and cabinet.

Senator HARRADINE—I see.

Prof. Pettigrew—Senator, part of your question related to the time for consultation. We have allowed as much time as possible within the constraints of moving from 5 April decision through to the wish of the government to have legislation in the parliament by the end of June. That process takes a considerable amount of time and work. We have been running the consultations over a two-week period, covering every capital city of the country. We have been working very hard to accommodate as many people as possible in our consultations.

Senator HARRADINE—Chair, I will have to leave it there. I apologise, but it will have to wait until next time.

Senator McLUCAS—I want to ask some questions about the proposal by the United States National Institute of Health and their recent announcement through a paper entitled 'Planned modification of rights to subject inventions made through funding agreements to foreign entities'. Are you aware of that announcement?

Prof. Pettigrew—Yes, I am aware of it. I have emailed, but followed up in hard copy post today, a letter to the contact name that was provided with that notification, drawing to the NIH's attention the negative aspects of that potential ruling they have on their web site at the present time. I assume we are talking about the same issue.

Senator McLUCAS—The patenting issue.

Prof. Pettigrew—The patenting issue, yes. We have been in communication with DFAT. We have also been in communication with the Department of Education, Science and Training, and a number of other organisations, about this issue. My letter has been copied to both the ARC and the Australian Vice-Chancellors Committee and so on. We are working hard to bring to the attention of the Australian research community this issue which has only recently come to our attention.

Senator McLUCAS—Are you able to tell us what those negative impacts are? I think it is fairly self-evident.

Prof. Pettigrew—One of the problems we see is that it is not always easy to attribute intellectual property to any single funding agency. There are NIH grants in this country which are supporting research programs which also would contain a component of NHMRC funding, for example. We would not want the NIH policy to capture intellectual property generated using Australian taxpayers' dollars and only being lodged in the United States. That is quite clearly not to Australia's advantage. We are objecting to that and raising that concern with them. We have yet to hear their response.

Senator McLUCAS—Would it be appropriate for you to table that letter to the committee?

Prof. Pettigrew—It would be quite appropriate to table that letter to the committee.

Senator McLUCAS—Thank you. That would be good.

Senator Patterson—Senator McLucas, this issue has been raised in a number of quarters. I was at dinner with the directors of all the medical research institutes and it was raised there. The government is very aware of this issue. I know there are a number of ways in which that is being addressed and this is one of them. It is something we are very aware of and that concern has been expressed to us.

Senator McLUCAS—Do we know how many projects or institutions might be affected, with current pieces of work being done now that may have NIH funding as well as Australian funding?

Prof. Pettigrew—I do not know, Senator. Ms Northcott might be aware.

Ms Northcott—We are in the process of looking into that at the moment. We do not have the number of grants but we do know that two years ago there was about $US3 million coming in the form of NIH grants. That has now risen to about $US9 million. We will have that information shortly about the number of grants coming in. Our system takes some time to interrogate but people who lodge applications for NHMRC project grants have to declare whether they are getting money from other sources, but we will be able to provide that information shortly.

Prof. Pettigrew—There will, of course, be the possibility that there will be some NIH funding going to areas of research in Australia that we are unaware of.

Senator McLUCAS—I am aware of that.

Prof. Pettigrew—So that is another problem.

Senator CROWLEY—Do you mean like the defence department?

Prof. Pettigrew—Sorry?

Senator CROWLEY—It is all right.

Ms Northcott—I am aware of a vaccine CRC that is run out of the Queensland Institute of Medical Research which we do not provide funding to, but I think NIH funding goes into that.

Senator McLUCAS—Could we get a list of those?

Ms Northcott—We are in the process of gathering that at the moment, so we will pass it on.

Senator McLUCAS—That will be good. Thank you.

Senator CROWLEY—Do you think this should be argued in terms of the dollar damage potential to Australia?

Prof. Pettigrew—Senator, the line that comes through, I trust and hope, in my letter to the NIH, is that this move by the NIH potentially has the capacity to damage the collaborative research which is going on in a broad number of fields between American researchers and Australian researchers.

Senator CROWLEY—You are far too polite. I would have called it capital colonisation. Even before you worry about how offensive it is, it is singularly and unbelievably shocking. Do you know who is behind it? Presumably, so far it has not got Mr Bush's signature on it.

Prof. Pettigrew—I have no knowledge of whether there has been any instruction to the NIH, or whether it is an NIH developed policy of its own. I have no knowledge of that at this point.

Senator CROWLEY—Is it a policy yet or is it a proposal?

Prof. Pettigrew—It is a proposed policy which I understand is coming into effect later this year. We have been struggling to clarify exactly when.

Senator CROWLEY—It is coming into effect?

Prof. Pettigrew—This year.

Senator CROWLEY—Is proposed to come into effect.

Prof. Pettigrew—Proposed to come into effect this year.

Senator CROWLEY—Is it something that Congress will have a view about?

Ms Northcott—No. It is an NIH policy so, as with the NHMRC where we fund research, they fund research but they do not actually undertake it. They are not a direct research body of the American government. In the same way that we change policy about our grants without having to go to government and so forth, nor does the NIH; it can introduce policy of this nature.

Senator CROWLEY—Are you also talking to other countries who might have been recipients of this NIH beneficence in the past?

Prof. Pettigrew—Senator, our focus has been on protecting Australia's interests in the immediate term. But now that we have the letter sent off to the NIH, we can be in contact with our colleagues internationally. That could be done as soon as tomorrow. It is very easy for me to call the Health Research Council in New Zealand, for example, to bring it to their attention.

Senator CROWLEY—I would go to Europe, too.

Prof. Pettigrew—Certainly.

Ms Northcott—That depends probably on the response we get from the NIH. I am not sure we have lost the battle yet and that we need to bring in the big guns.

Senator CROWLEY—You are not sure that we have lost the battle?

Ms Northcott—The policy is not definitely going to go ahead. We do need to give the NIH an opportunity to think about the letter. When we table that you will see there are a number of concerns that are very clearly laid out. They do not just affect Australia. We point out that they might have quite a detrimental effect on US research as well. They introduced an act in 1980, I think, called the Bayh-Dole Act, which pointed out that research funding organisations are probably the worst place to vest IP, in terms of the administration costs of trying to exploit IP to improve health outcomes or whatever. Then you should vest that in the institutions that develop the IP, rather than in an organisation like the NHMRC or the NIH. So we pointed that out to them.

Senator CROWLEY—I suppose it is reasonable to take note of what you say, Ms Northcott. We ought to be polite and civil at the best of times. I think in the face of this, which happens to be one of the most breathtakingly horrible things I have heard of in a long time—and I am trying to think of words that are passing reasonable to describe it—I actually think it is plain obscene, to be honest. It is breathtaking, it is appalling, and I just wonder how long you are planning to wait.

Prof. Pettigrew—We will wait a reasonable time for a response back from the NIH.

Senator CROWLEY—About 24 hours, Professor?

Prof. Pettigrew—As short as you would like, Senator.

Senator McLUCAS—Minister, I use different words to Senator Crowley but I do agree, and I think you do, that it is quite a significant issue in terms of health research and ownership of patents and intellectual property. Is it something the Prime Minister could raise when he is over in the United States, given the potential effect that it does have?

Senator Patterson—Senator McLucas, with all due respect, I do not think you need to stress upon us how important we see it. I am sure the government will take every means possible to point out the effect it will have on Australia and the implications it has, especially when we have such a small market. You can be assured that everyone who needs to know about it is very aware of it.

Senator McLUCAS—Good. Thank you.

CHAIR—Any further questions on outcome 9?

Senator CROWLEY—Partly I think you were answering some of these questions to Senator Harradine but I honestly could not hear some of the conversation that was going on. Looking at your responsibilities under the proposed legislative and regulatory framework for stem cell research—this is in advance because I do not know whether the legislation is available or if you have seen it yet, certainly I do not believe it is available for us yet—

Prof. Pettigrew—I have seen the draft legislation. The draft legislation has been given to the people we have been consulting with as an exposure draft. We are consulting regularly with our state colleagues, as mentioned to Senator Harradine, with respect to changes to clauses in the act as a result of the consultations that we are undertaking. We are in communication with the minister's office.

Senator CROWLEY—If you have answered these questions, I beg your pardon; I simply could not hear what was going on. Do you have any sense yet of additional resources needed or already allocated?

Prof. Pettigrew—Senator, we have been working up a case for resources to carry out the regulatory functions that are required of this. There have been discussions between the NHMRC, the Office of Prime Minister and Cabinet and the department of finance with respect to proposals that will be required to fund the operation.

Senator CROWLEY—I did gather that you were talking with Senator Harradine about matters educational. If they answer these I will check the *Hansard*. I was just interested to know to what extent NHMRC is concerned with educational materials explaining new technologies like stem cell research to the public.

Prof. Pettigrew—Senator, we have put some very basic information on our web site, so there is accessibility there. But there is quite a level of work which is involved in producing documents that are highly accurate, peer reviewed, and have the best scientific evidence behind them. We just have not had the time or resources to put that information up and make it available yet, to the quality that we would wish to make it available.

Senator CROWLEY—But you propose to?

Prof. Pettigrew—There will be information on our web site. We have not yet had the planning meetings to decide exactly what information should be there. There is already information on our web site but it is quite preliminary information.

Senator CROWLEY—Do you have special funding allocation for this or is it part of your general educational role?

Prof. Pettigrew—The NHMRC Act does not specify that the NHMRC has an educational role in the sense that I think you are putting to us but we have a responsibility to communicate. Senator, I have been prompted to correct something I said. I am prompted that I said the Office of Prime Minister and Cabinet. What I am reminded to say is it was the Department of Prime Minister and Cabinet, but I will check with Dr Morris. He has also been involved closely with this.

Dr Morris—It was the Department of Prime Minister and Cabinet.

Senator CROWLEY—I am not sure what that point of scholarship is. Maybe it is late at night but I am just having terrible trouble hearing. If there are some really witty subtleties there, I will read them tomorrow. Thank you very much. That was just correcting something about the PM&C's role in all of this?

Prof. Pettigrew—Yes. You asked the question, Senator, about funding for our ability to regulate as proposed in the draft legislation. I understand that I said something about the Office of Prime Minister and Cabinet when I should have said that we are consulting with the Department of Prime Minister and Cabinet and the Department of Finance and Administration et cetera.

Senator CROWLEY—That is one of those earth-shattering corrections that will really make the world glow. Do you have any resources available through AHEC or any other line of funding that might assist you in the public education role that possibly confronts you?

Prof. Pettigrew—Senator, our resources are applied in accordance with the NHMRC Act. We provide guidelines and information to the human research ethics committees right around the country. There are more than 200 of those that we support with information. That forms part of our normal education role in the context of supporting the work of human research ethics committees.

Senator CROWLEY—Would you think of doing things like articles in the *Women's Weekly*?

Prof. Pettigrew—Probably not, Senator.

Senator CROWLEY—It is a bit of a question or a puzzle. I do not in any way want to be flippant. A lot of the conversations that go on in the *Women's Weekly* really are about terribly interesting issues like the challenge of cloning, for example, or surrogacy or in vitro fertilisation, or any of those latest technologies that are a matter of considerable importance and interest to the community. If we are now talking about a process that might indeed help cure people of things like Parkinson's or Alzheimer's or multiple sclerosis, the community has a huge interest in knowing how this might work. It is an area where maybe I could ask if there is anything further you could provide on notice about how you might want to up the ante in terms of a conversation with the public about these issues.

Prof. Pettigrew—Senator, I might say that is quite a difficult question to answer, simply because the COAG decision placed a responsibility on the NHMRC to be the body which brings forward legislation on behalf of the government. We are also charged with the

responsibility of regulating research on excess IVF embryos. I do not believe it is necessarily a position that I can adopt as the CEO of the organisation to be advocating one way or another on this particular issue. But there are certainly medical researchers within NHMRC circles who can provide advice which can be put into the public domain. There is also the Australian Health Ethics Committee, which has its membership which can also put information in the public domain. Just how we go about putting all that information together in an educative way, as you are suggesting, would have to be very carefully thought through.

Senator CROWLEY—I take your point on that. On the other hand, I hope you are not saying to us that if you are the promoters of the legislation you are then effectively hamstrung or limited in what you can then say by way of public education.

Prof. Pettigrew—It is important to draw a distinction, Senator, between the role of the officials who sit before you at this committee and the actual committee members and the council members who make up the NHMRC. That is a governance issue for the NHMRC to make a distinction on. That is a matter that we are considering at the present time. Your point is well taken, Senator. We will certainly take your comments on board, knowing the seriousness and the contentious issues that we are dealing with.

Senator CROWLEY—Thank you.

CHAIR—Any further questions? Senator Allison.

Senator ALLISON—Yes, I have some questions about the application by Bond and Notre Dame for accreditation for their proposed medical schools. Minister, has the Commonwealth indicated support for those medical schools?

Ms Halton—Senator, can I ask whether we have finished with the NHMRC?

Senator ALLISON—Maybe we will go on with the NHMRC. Sorry, Senator.

Senator WEST—I want to ask some questions in relation to chronic fatigue syndrome and what grants might have been allocated or given for research and work on that over the last few years. I am also trying to work out if the working group that was involved in or working for the Royal Australasian College of Physicians was funded by NHMRC, or funded through a Medicare grant.

Ms Northcott—I will answer both those questions. I am afraid I do not have in front of me the information on the grants, but we can get that to you tomorrow. We do have that to hand. As I recall, the money to the College of Physicians for the guidelines, which have recently been published, was through the department and not through the NHMRC.

Senator WEST—So they will be in program 2 tomorrow.

Ms Northcott—I am not sure. That might be program 9.

Senator WEST—Do we have any clarification? Is it 9 or 2?

Ms Northcott—Sorry, I am getting clarification on something else.

Senator WEST—It is 2. Thank you. I am trying to work out some questions about that. Will you take on notice for me the funding figure in NHMRC for that?

Ms Northcott—Yes, we will. We have answered a number of ministerials recently and it is very easy to obtain that information.

Senator WEST—I am sure you have. Thank you. I will pursue that tomorrow. That is all I have on that particular part of NHMRC. I am happy for that NHMRC grant money to come

on notice, because I will pursue under program 2 the other aspects of the issue. I am getting reports from people that there seems to be a difference between chronic fatigue and chronic fatigue syndrome and I want to know if that is recognised and accepted by even the NHMRC, as a difference, but certainly—

Ms Northcott—I have not heard of that issue. That has not been brought to our attention as an issue.

Senator WEST—It has been to me. I will pursue that tomorrow, though.

Senator HERRON—I apologise that I was not present when there were discussions in relation to stem cell research and the NHMRC advice to COAG. When NHMRC gave the advice to COAG did it investigate in any way, or was it your responsibility to investigate, any financial implications of advice you received from people advocating stem cell research to the NHMRC?

Prof. Pettigrew—The advice to COAG or the advice the NHMRC provided to assist the COAG implementation working group at that stage was advice based on the Australian Health Ethics Committee guidelines on assisted reproductive technology and other considerations by AHEC, as we call it.

Senator HERRON—You would be aware that there have been statements made in the Senate that there were financial interests involved in the advocacy of stem cell research by some of the people who were advocating that; they had a financial incentive to advocate that. Was that taken into consideration in AHEC?

Prof. Pettigrew—I was not party to AHEC's discussions, but Dr Morris presumably can answer that question, Senator.

Dr Morris—The NHMRC did not have carriage of preparing the report for COAG. The Australian Health Ethics Committee was consulted during the development of that report but only in relation to interpreting its own guidelines for assisted reproductive technologies.

Senator HERRON—Who took responsibility? AHEC or NHMRC, or neither, or both?

Dr Morris—AHEC provided advice to the COAG implementation working group, which, at the time, was supported by the TGA through the Office of the Gene Technology Regulator.

Senator HERRON—Is what you are saying that no consideration was given?

Dr Morris—Not—

Senator HERRON—Let us not fall into semantics.

Dr Morris—From the NHMRC's perspective those questions were not asked. NHMRC was asked to provide advice on AHEC's guidelines.

Senator HERRON—Yes, so no consideration or implications. Even though that allegation occurred, subsequently no consideration was given to that.

Prof. Pettigrew—Senator, we were not a party to the COAG implementation working group prior to 5 April apart from, as Dr Morris has explained, providing background and advice on AHEC's guidelines.

Senator HERRON—Yes. You appreciate this has come up in debate in the United States. I am not referring specifically to the Australian situation. It is something which has occurred recently in the United States for consideration. There would appear to be an analogy and I

think it probably will be pursued. But I wanted to ask you where you stood in that regard. Thank you very much.

Senator WEST—I have some questions which I think were put on notice about the NHMRC grant following the ABC *Science Show* report of 13 April. Can you give us a brief outline of where things stand with that, please?

Prof. Pettigrew—Can I just clarify that I personally am taking no role in the consideration of that issue. That matter is being handled by Ms Northcott, for reasons of potential perceived conflict of interest.

Senator WEST—Sure, because you have written some letters. Yes, Ms Northcott.

Ms Northcott—Yes, we issued a press release, which I presume you have seen, on 25 April.

Senator WEST—I do not have a copy of it here.

Ms Northcott—That was our last public statement. It was basically saying we had seen the UNSW report posted on their web site, I think on 17 April, about those investigations, that we still had a number of concerns in that report and that we welcomed their announcement about establishing an independent inquiry into the allegations. We are still waiting for word on the nature of that inquiry. I spoke to the university earlier this week. I have been speaking to them fairly regularly and I understand that an announcement about both the membership and the terms of reference will be made either at the end of this week or early next week.

Senator WEST—Thank you. I will leave it at that and we can continue later.

Senator CHRIS EVANS—You do not have any operating role in that?

Ms Northcott—No, it is an independent inquiry and the NHMRC is not represented, nor has it requested to be represented. What we have asked is that all of the allegations made by the complainants late last year are investigated. At one stage the press release by the university on, I think, 17 April said that it would investigate matters that it believed to be outstanding from its first investigation. We have said we feel very strongly that they start with the original complaints and proceed from there and we are very keen that there only be one inquiry from here and that it answers all the questions that we have.

Senator CHRIS EVANS—Thank you.

Senator WEST—Could you give us a copy of your press release?

Ms Northcott—Absolutely.

Senator WEST—Thank you. We will work out from there what other questions we want on notice.

Ms Northcott—Of course.

Senator WEST—Thank you.

CHAIR—Any further questions on NHMRC? No. Thank you. Senator Allison?

Senator ALLISON—I want to go back to the Bond and Notre Dame universities question, whether the Commonwealth has indicated its support for those medical schools.

Senator Patterson—I am aware that those two universities have indicated they would be interested in having medical schools, but as yet the government has not made any decision.

Senator ALLISON—What sort of considerations will the government have to think about with regard to that accreditation?

Senator Patterson—There are a number of considerations, Senator Allison. I will be in discussions with Dr Nelson about it. There are a very large number of considerations. A decision like that affects all the other universities' medical schools, it affects work force issues, and they all have to be taken into consideration.

Senator ALLISON—Has an application been made with regard to Commonwealth funding by those universities?

Senator Patterson—I have to say that this is the health portfolio, not the education portfolio. If you want to ask those questions, maybe you should direct them to the education portfolio. I do not know whether they have made an application.

Mr Wells—Senator, I could add to that. There has been correspondence from Notre Dame to Dr Nelson. As far as I am aware, there has been no request for funding and there has been no request for funding from Bond University. There have been no requests for funding as far as I am aware.

Senator ALLISON—Is the department, or are you, Minister, concerned about the proposed fee structures? I think it is the case for Notre Dame that, as part of their proposal, the offer is for medical courses at $16,000 per annum. I think that compares with $30,000, being the cost for a full-time placement in our other universities, or Australian medical schools charging $32,000 for overseas students. Is this an area of concern, that that level of fees might suggest something less than an appropriate course?

Senator Patterson—Senator Allison, this is a hypothetical question and it interests me as health minister, but it would be better directed to Dr Nelson and the education estimates.

Senator ALLISON—It goes to the question of how well those courses would be run, though, I would imagine, which is a health question as well as an education question.

Senator Patterson—As I said to you, it is a hypothetical question. We get requests all the time for various things and this is obviously a request that has gone to Dr Nelson. As I said to you, Dr Nelson and I had hoped to have a meeting the other day but we had to cancel; I think I actually could not meet with him. But there will be a lot that we will have to take into consideration.

Senator ALLISON—I was just asking if that was one of them.

Senator Patterson—There will be a lot of things we will take into consideration.

Senator ALLISON—Will you also have to consider whether or not additional provider numbers will be made available in Western Australia and Queensland?

Senator Patterson—I said to you that it has work force implications.

Senator ALLISON—So the answer is yes?

Senator Patterson—It is one of the things we have to take into consideration. When we look at any proposal, there will be a number of things we take into account, and one of them will be work force implications.

Senator ALLISON—Will you also need to consider clinical placements in Perth? I understand there is a fair amount of pressure on clinical placements already. How would that be resolved?

Senator Patterson—As I said, we will have to take into account a whole range of implications.

Senator ALLISON—Including that one?

Senator Patterson—I am not going to go through every single thing that would have to be considered, but of course we will consider the impact. It will have work force implications, it will have clinical placement implications, and it will have a range of other implications; they all have to be evaluated.

Senator ALLISON—Is there any idea at this stage about how long that decision-making process will take?

Senator Patterson—It will take us as long as it does to evaluate the implications of such a proposal.

Senator ALLISON—You do not have a time frame in mind at this stage? Is it likely to happen this year?

Senator Patterson—Dr Nelson would be the best person to answer that, because it is a more appropriate question for him, but I will discuss it with him because it has work force implications for health and financial implications in terms of provider numbers.

Senator ALLISON—Thank you.

CHAIR—Senator Tchen.

Senator TCHEN—I have a question for Mr Wells. I realise that trainee nurses registration is a matter for the states. However, registration for immigrant nurses who come through the immigration program would have something to do with the Commonwealth. The Commonwealth has recently announced that the immigration department has announced their labour market scoring. There are priority occupations, and a nurse is one of them. Can you tell me, Mr Wells, whether the Department of Immigration, Multicultural and Indigenous Affairs consulted with Health and Ageing before they drew up the marketing list, did they do it independently or did they consult with the states?

Mr Wells—Senator, they have consulted with the Commonwealth department, with us and with the states. I just want to clarify one statement that you made. The registration of nurses is a state responsibility, irrespective of where the nurse trains, so nurses recruited from overseas still have to be able to be registered with the relevant state or territory nursing registration board. The immigration process is about fast-tracking applications to recruit nurses generally into the public sector, which is largely what this is about. But those nurses still go through the registration process of the relevant nursing registration board.

Senator TCHEN—Nevertheless, DIMIA would still have received advice from Health and Aged Care regarding whether that particular occupation is a high demand occupation.

Mr Wells—Yes, they did, and it is.

Senator TCHEN—In terms of the qualifications of a prospective migrant nurse, there is no foreknowledge of whether those qualifications would be recognised.

Ms Cobbold—Senator Tchen, the recognition of the qualifications of overseas trained nurses is handled in the first instance by the Australian Nursing Council Inc., which is a body which brings together all of the registration bodies. They do the assessment of overseas trained nurses in the first instance, as part of the pre-employment and pre-immigration requirements. That is part of the immigration requirements for nurses to obtain those visas necessary for them to take up such things as employer sponsored nursing positions in the

public sector. They nevertheless are required to then be registered with individual state registration boards.

Senator TCHEN—Does the Department of Health and Aged Care monitor how the program is going or is that DIMIA's responsibility?

Mr Wells—That is a DIMIA responsibility, Senator. We were in close contact with DIMIA on this issue and also with the states and territories. If they have questions of us, they certainly come to us, but it is their program and they monitor its progress.

Senator TCHEN—In a hypothetical case, supposing a number of migrant nurses come into Australia under this scoring program and the state registration board says, 'We do not think you should be registered because you do not meet our standards X, Y and Z.' When these foreign trained nurses arrive in Australia and take up places under this skilled migration program, their skills are not recognised. That would affect our immigration program. Does the department monitor that?

Ms Cobbold—Senator Tchen, that actually cannot happen. Before they are able to immigrate here on that employer sponsored basis, they must have their qualifications recognised in an appropriate way. It cannot happen in the way you describe—not those who are actually overseas trained nurses who seek to come in to be sponsored in that way.

Senator TCHEN—I see.

Ms Cobbold—There may well be some overseas trained nurses who are already in Australia who came under other immigration classifications, but not on an employer sponsored work force requirement.

Senator TCHEN—Thank you for clarifying that. Information has come to me that one of the state registration boards actually has what appear to be discriminatory registration standards, depending on where the nurses come from, and the test is the same. Nurses from certain areas have to score higher on the test than those from other areas. I want to ensure that that does not have any flow-on consequential effects on our immigration program. I will pursue the other matter with the states. Thank you.

CHAIR—Senator Crowley?

Senator CROWLEY—I think this is to you, Minister. I am actually asking it here. If there is a place where it ought to be asked, I will come back and ask it tomorrow. One of the things we have learnt of recent times is the significantly higher costs of employing agency nurses; for the purpose of being under section 9, these are probably overseas nurses. It is not necessary to say so, but the Victorian government has forbidden the use of agency nurses in public hospitals, estimated to save about $20 million in a year. Is there any thought to move to stop the use of agency nurses in aged care for the purpose of saving dollars?

Senator Patterson—Ms Murnane can answer that. It is not a policy issue.

Ms Murnane—Senator, no, that is not something that lies within our jurisdiction at all. We do not directly employ. We do not control how the providers of aged care employ or who they employ. What we do is specify outcomes and specify that there needs to be an adequate level and mix of staffing in any aged care home.

Senator CROWLEY—Thank you.

CHAIR—Thank you very much. The meeting is adjourned until 9 a.m. in the morning.

Committee adjourned at 10.56 p.m.