COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Estimates

TUESDAY, 31 MAY 2011

CANBERRA

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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Tuesday, 31 May 2011

Senators in attendance: Senators Adams, Boyce, Crossin, Fierravanti-Wells, Furner, McEwen, McLucas, Moore, Nash and Xenophon

HEALTH AND AGEING PORTFOLIO

In Attendance

Senator McLucas, Parliamentary Secretary for Disabilities and Carers

Department of Health and Ageing

Executive

Ms Jane Halton, Secretary

Ms Rosemary Huxtable, Deputy Secretary

Ms Megan Morris, Acting Deputy Secretary

Professor Chris Baggoley, Acting Chief Medical Officer

Mr David Learmonth, Deputy Secretary

Mr Chris Reid, General Counsel

Ms Rosemary Bryant, Chief Nurse and Midwifery Officer

Ms Kerry Flanagan, Acting Deputy Secretary

Mr Paul Madden, Chief Information and Knowledge Officer

Mr Andrew Stuart, Acting Deputy Secretary, DoHA National Alignment

Business Group

Ms Margaret Lyons, Chief Operating Officer

Ms Samantha Palmer, General Manager, Communication and People Strategy

Mr Joseph Colbert, Assistant Secretary, People Branch

Mr David Paull, Acting Secretary, Corporate Support Branch

Ms April Purry, Acting Secretary, Legal Services Branch

Mr Gary Davis, Assistant Secretary, IT Solutions Development Branch

Ms Kerrie Reyn, Assistant Secretary, IT Strategy and Service Delivery Branch

Mr Adam Davey, Assistant Secretary, Health Campaigns Branch

Ms Julie Schneller, Acting Secretary, Online, Services and External Relations Branch

Mr Gary Aisbitt, Principal Client and Technical Services Adviser

Ms Susan Parker, Director, Health Campaigns Branch

Portfolio Strategies Division

Mr Peter Morris, First Assistant Secretary

Ms Kylie Jonasson, Assistant Secretary, Budget Branch

Ms Debbie Morrison, Acting Assistant Secretary, Ministerial and Parliamentary Support Branch

Mrs Susan Azmi, Acting Assistant Secretary, Policy Strategies Branch

Ms Alice Creelman, Assistant Secretary, International Strategies Branch

Mr Greg Coombs, Assistant Secretary, Economic and Statistical Analysis Branch

Transition Office

Mr Graeme Head, Chief Executive Officer

Dr Tony Sherbon, Deputy Chief Executive Officer

Mr Peter Broadhead, Acting First Assistant Secretary

Mr David Mackay, Assistant Secretary, Implementation, Systems and Reporting

Ms Shirley Browne, Assistant Secretary, Stakeholder Engagement and Communications

Professor Richard Marshall, Assistant Secretary, Hospital Financing and Reforms

Audit and Fraud Control

Mr Colin Cronin, Assistant Secretary, Audit and Fraud Control Branch

Strategic Review Taskforce

Mr Ben Vincent, Acting Assistant Secretary, DoHA National Alignment

Office of the Chief Financial Officer

Mr John Barbeler, Chief Financial Officer

Mr Malcolm Bowditch, Director, Finance Branch

Outcome 1–Population health

Population Health Division

Mr Nathan Smyth, First Assistant Secretary

Ms Melinda Bromley, Assistant Secretary

Ms Janet Quigley, Assistant Secretary, Healthy Living Branch

Mr Damian Coburn, Assistant Secretary, Population Health Strategy Unit

Regulatory Policy and Governance Division

Ms Mary McDonald, First Assistant Secretary, Regulatory Policy and Governance Division

Ms Donna Burton, Assistant Secretary, Blood Organ and Regulatory Policy Branch

Ms Kathy Dennis, Assistant Secretary, Research Regulation and Food Branch

Ms Teressa Ward, Assistant Secretary, Office of Hearing Services

Ms Anne Kingdon, Assistant Secretary, Governance, Safety and Quality Branch

Mental Health and Chronic Disease Division

Ms Georgie Harman, First Assistant Secretary, Mental Health and Chronic Disease Division

Mr Alan Singh, Assistant Secretary, Mental Health Reform Taskforce

Ms Virginia Hart, Assistant Secretary, Mental Health Reform Branch

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

Mr Simon Cotterell, Assistant Secretary, Drug Strategy Branch

Mr Leo Kennedy, Assistant Secretary, Chronic Disease and Alcohol Branch

Mr Michael Culhane, Assistant Secretary, Cancer Services Branch

Associate Professor Rosemary Knight, Principal Adviser, Cancer and Chronic Disease

Therapeutic Goods Administration

Dr Rohan Hammett, National Manager

Dr Megan Keaney, Principal Medical Adviser

Mr Stephen Dellar, Principal Adviser, Regulatory Reform

Ms Jenny Hefford, Chief Regulatory Officer

Ms Philippa Horner, Principal Legal Adviser

Dr Larry Kelly, Group Coordinator, Monitoring and Compliance Group

Ms Judy Develin, Group Coordinator, Market Authorisation Group

Mr Peter Bickerton, Acting Principal Adviser (Operations)

Australian Institute of Health and Welfare

Mr David Kalisch, Director

Mr Andrew Kettle, Group Head, Business Group

National Industrial Chemicals Notification and Assessment Scheme

Dr Marion Healy, Director

Food Standards Australia New Zealand

Mr Steve McCutcheon, Chief Executive Officer

Dr Robyn Cleland, Acting General Manager, Food Standards (Canberra)

Dr Andrew Bartholomaeus, General Manager, Risk Assessment

Dr Paul Brent, Chief Scientist

Mr Peter May, General Manager, Legal and Regulatory Affairs

Australian Radiation Protection and Nuclear Safety Agency

Professor Peter Johnston, Acting Chief Executive Officer

Mr George Savvides, Chief Financial Officer, Corporate Office

Office of the Gene Technology Regulator

Dr Joe Smith, Regulator

Dr Michael Dornbusch, Assistant Secretary

Australian National Preventive Health Agency

Dr Rhonda Galbally, Chief Executive Officer

Dr Lisa Studdert, Manager, Policy and Programs

Mr John Kalokerinos, Manager, Operations and Knowledge

Outcome 2–Access to pharmaceutical services

Pharmaceutical Benefits Division

Ms Felicity McNeill, Acting First Assistant Secretary

Dr John Primrose, Medical Adviser

Mr Kim Bessell, Principal Pharmacy Adviser

Ms Adriana Platona, Assistant Secretary, Pharmaceutical Evaluation Branch

Mr Nick Henderson, Acting Assistant Secretary, Policy and Analysis Branch

Mr David Reddy, Acting Assistant Secretary, Access and Systems Branch

Ms Beryl Janz, Assistant Secretary, Community Pharmacy Branch

Outcome 3–Access to medical services

Medical Benefits Division

Mr Richard Bartlett, First Assistant Secretary

Mr Peter Woodley, Assistant Secretary, Private Health Insurance Branch

Ms Penny Shakespeare, Assistant Secretary, Medicare Benefits Branch

Ms Elizabeth Hoole, Acting Assistant Secretary, Health Technology and Medical Services Group

Mr Shane Porter, Acting Assistant Secretary, Medicare Financing and Analysis Branch

Ms Fifine Cahill, Acting Assistant Secretary, Diagnostic Services

Professional Services Review

Dr Tony Webber, Director

Mr Luke Twyford, Acting Executive Officer

Outcome 4–Aged care and population ageing

Ageing and Aged Care Division

Ms Carolyn Smith, First Assistant Secretary

Mr Russell de Burgh, Assistant Secretary, Office for an Ageing Australia

Mr Keith Tracey-Patte, Assistant Secretary, Budget Finance and Information Branch

Ms Kate McCauley, Assistant Secretary, Policy and Evaluation Branch

Prof. David Cullen, Assistant Secretary, Policy and Evaluation Branch

Ms Samantha Robertson, Assistant Secretary, Residential Program Management Branch

Ms Tracy Mackey, Assistant Secretary, Community Programs and Carers Branch

Ms Rachel Balmanno, Assistant Secretary, Home and Community Care Reform Branch

Office of Aged Care, Quality and Compliance

Mr Iain Scott, First Assistant Secretary

Ms Lucelle Veneros, Assistant Secretary, CIS Operations Branch

Ms Fiona Nicholls, Assistant Secretary, Aged Care Workforce and Better Practice Programs Branch

Ms Violeta Stefanoska, Assistant Secretary, Prudential and Approved Provider Regulation Branch

Ms Lyn Murphy, Assistant Secretary, Quality and Monitoring Branch

Dr Sue Hunt, Senior Nurse Advisor

Outcome 5–Primary care
Primary and Ambulatory Care Division
Mr Mark Booth, Acting First Assistant Secretary
Ms Sharon Appleyard, Assistant Secretary, Policy Development
Mr Lou Andreatta, Assistant Secretary, Workforce Distribution
Ms Meredeth Taylor, Assistant Secretary, GP Super Clinics
Mr Rob Cameron, Assistant Secretary, Rural Health Services and Policy
Ms Vicki Murphy, Assistant Secretary, Service Access Programs
Ms Jennie Roe, Assistant Secretary, Practice Support
Outcome 6–Rural health
Primary and Ambulatory Care Division
See Outcome 5
Outcome 7–Hearing services
Regulatory Policy and Governance Division
See Outcome 1
Outcome 9–Private Health
Medical Benefits Division
See Outcome 3
Outcome 10–Health system capacity and quality
eHealth Division
Ms Fionna Granger, First Assistant Secretary, eHealth Division
Ms Liz Forman, Assistant Secretary, eHealth Strategy
Ms Sharon McCarter, Assistant Secretary, eHealth Systems
National e-Health Transition Authority
Mr Peter Fleming, Chief Executive Officer
Regulatory Policy and Governance Division
See Outcome 1
Mental Health and Chronic Disease Division
See Outcome 1
National Breast and Ovarian Cancer Centre
Dr Helen Zorbas, Chief Executive Officer
Cancer Australia
Dr Helen Zorbas, Chief Executive Officer
National Health and Medical Research Council
Professor Warwick Anderson, Chief Executive Officer
Mr Tony Kingdon, General Manager and Head, Planning and Operations Group

Dr Clive Morris, Head, Research Group

Professor John McCallum, Head, Research Translation Group

Outcome 11–Mental health

Mental Health and Chronic Disease Division

See Outcome 1

Outcome 12–Health workforce capacity

Health Workforce Division

Ms Maria Jolly, Acting First Assistant Secretary

Mr David Hallinan, Assistant Secretary, Medical Education and Training Branch

Ms Bernadette Walker, Acting Assistant Secretary, Nursing, Allied and Indigenous Workforce Branch

Ms Gay Santiago, Assistant Secretary, Workforce Development Branch

Health Workforce Australia

Mr Mark Cormack, Chief Executive Officer

Mr Roberto Bria, Executive Director, Corporate and Finance

Professor Liz Framer, Executive Director, Workforce Innovation and Reform

Outcome 13–Acute care

Acute Care Division

Mr Mark Thomann, First Assistant Secretary

Dr Andrew Singer, Principal Medical Adviser

Mr Charles Maskell-Knight, Principal Adviser

Ms Gillian Shaw, Acting Assistant Secretary, Hospital Policy Branch

Ms Veronica Hancock, Assistant Secretary, Hospital Development, Indemnity and Dental

Dr David Martin, Acting Assistant Secretary, Healthcare Services Information

Ms Ann Smith, Assistant Secretary, National Partnership Agreement

Australian Organ and Tissue Donation and Transplant Authority

Ms Yael Cass, Chief Executive Officer

Dr Gerry O'Callaghan, National Medical Director

Ms Judy Harrison, Acting Chief Financial Officer

Ms Elizabeth Flynn, Acting General Manager

Outcome 14–Biosecurity and emergency response

Office of Health Protection

Ms Jennifer Bryant, First Assistant Secretary

Ms Fay Holden, Assistant Secretary, Health Protection Policy Branch

Ms Sally Goodspeed, Assistant Secretary, Communicable Disease and Surveillance Branch

Dr Gary Lum, Assistant Secretary, Health Emergency Management Branch

Mr Graeme Barden, Assistant Secretary, Office of Chemical Safety and Environmental Health

Ms Julianne Quaine, Assistant Secretary, Immunisation Branch

Dr Jenny Firman, Medical Officer, Office of Health Protection

Committee met at 09:00

Department of Health and Ageing

CHAIR (Senator Moore): Good morning everyone. I declare open this hearing of the meeting of the Senate Community Affairs Legislation Committee. We are continuing our examination of estimates for the Health and Ageing portfolio. We welcome parliamentary secretary Senator Jan McLucas, Ms Jane Halton and the Department of Health and Ageing staff members. We are going into the second day, you have got the program and we are going to begin with outcome 5, Primary care. We are scheduled to go through until 10.30 am when there will be a break, and everyone looks forward to that. We are continuing primary care after that, just so you know, scheduling to 11.45 am. Senator Fierravanti-Wells is starting off with primary care.

Senator FIERRAVANTI-WELLS: Yesterday in aged care I asked a question about medical workforce attraction and retention within aged care and we have said that we would deal with it today. I was told it would come in primary care. My question was about how many additional GPs have been attracted into aged care as a result of the enhanced rebate initiative announced in the 2010 budget.

Ms Morris: The Aged Care Access Initiative that was announced last year?

Mr Booth: I think was there were two aged care access initiatives. The one that we have been talking about is the GP component and allied health component, and that is giving access to primary care services for residential aged care facilities. This gives incentive payments to GPs through the Practice Incentives Program, or PIP, and also for clinical care for allied health professionals. Under the allied health side, divisions of general practice at the moment manage the purchase of allied health through this directly or through the divisions of general practice. That is right, is it not?

Ms Roe: Yes. The take-up of the Aged Care Access Incentive under the Practice Incentives Program is that in 2009-10 around 4,800 GPs were paid for reaching the tier 1 target and around 3,300 GPs were paid for reaching the tier 2 target. Both represent almost a two per cent improvement on 2008-09. There is a four per cent improvement on the number of GPs reaching tier 2. It also represents an increase of 7.2 per cent in MBS items for services provided in residential aged care facilities.

Senator FIERRAVANTI-WELLS: Are you able to track where those increases are—whether they are in metropolitan aged care facilities or regional and rural ones?

Ms Roe: I do not have that data with me.

Senator FIERRAVANTI-WELLS: Could you just take it on notice and give me a breakdown of where that was. The provider peak groups and the AMA have been calling for a range of initiatives to help to make it more attractive. Are you talking with stakeholders in relation to this issue? It has been an ongoing issue about getting more doctors into aged care.

Ms Morris: I am happy to answer that, because I had quite a long conversation about it with Brian Morton—whose title I am not sure of, but he was from the GP Council of the AMA, the New South Wales GP chairman. I undertook to follow up with him and have a longer meeting and go through some—

Senator FIERRAVANTI-WELLS: It is a perennial problem, Ms Morris and—

Ms Morris: It is a big problem. It is one of the real fault lines in primary care.

Senator FIERRAVANTI-WELLS: Suffice it to say it has been an ongoing issue for some time.

Ms Morris: We recognise it as such, and I would not say that in the last few months we have actively sought out relevant stakeholders, but we have certainly engaged with them whenever we have been able to and will continue to do so.

Senator FIERRAVANTI-WELLS: I am paraphrasing, but I talk to the doctors and they say, 'We are available,' but as I go to aged care facilities people just shake their heads and have trouble getting a doctor there. There are some arrangements that the odd aged care facility has with a doctor that works. I saw one instance where a doctor in Queensland had Friday as his treating day. He would be there and he would do 40 or whatever number he did on a particular day and that seemed to work. Could you just take that on notice. I would be very interested to see the breakdown in terms of both the doctors and the allied professionals as to whether we have actually had some progress in relation to this. That would be good.

Ms Morris: Thank you, Senator.

Senator FIERRAVANTI-WELLS: Perhaps we can just get some guidance. I have a question on the capitated payment for coordinated diabetes care. Is that here in 5.1?

Ms Morris: I am not sure if it is 5.1 but it is definitely under 5. It is under outcome 5. I do not have the breakdown.

Senator FIERRAVANTI-WELLS: Just out of interest, which is it: 5.1, 2 or 3? I will study my table before the next estimates.

Ms Morris: It is probably 5.3, I would say, Primary care policy innovations.

CHAIR: That is the diabetes question?

Senator FIERRAVANTI-WELLS: Yes, the diabetes question. I will wait until there.

CHAIR: There is no problem if it is all the same officers. If across those outcomes in 5 it is generally the same officers, we can let it flow. It is just that constantly moving back and forth is a problem. Senator, you have free range.

Senator FIERRAVANTI-WELLS: There has been a rationalisation of the COAG diabetes grant in favour of the coordinated diabetes care pilot program. Is there an expectation that this pilot program will prove successful?

Ms Morris: I think you are asking for an opinion there?

Senator FIERRAVANTI-WELLS: Am I? I will retract my question, but tell me how the pilot is going.

Ms Morris: Do you want to answer that, Mark?

Mr Booth: We can just say that the invitation to tender was put out in May and we are expecting responses back to that on 6 June I believe, which is next Monday. We have

obviously got a process then for assessing the applications as they come in with a view to getting the pilot started on 1 July. That is where it is at.

Senator FIERRAVANTI-WELLS: I suppose this is hypothetical, but have you got a plan B if the pilot is not successful and the grants are not reinstated, or have you not thought ahead?

Mr Booth: We are moving ahead with the pilot and we—

Senator FIERRAVANTI-WELLS: No, I appreciate you are moving ahead with the pilot, but if it proves not to be successful will you then reinstate the diabetes grants funding?

Ms Morris: I do not think that is a question for us.

Senator FIERRAVANTI-WELLS: Yes, I appreciate that. I will leave diabetes. I have questions left in this section on Medicare Locals and GP superclinics, but they are big topics so I thought we could get the little things out of the way first.

CHAIR: Senator Boyce or Senator Adams, do you have anything else?

Senator BOYCE: Apart from GP superclinics and Medicare Locals, my other question was around 5.4, the primary care Practice Incentives Program, and it was to ask further around what work has been done on incentives for doctors getting into e-health. What payments, if any, are currently being made and what is proposed?

Ms Roe: That question normally would be addressed under e-health.

Senator BOYCE: Yes, I did ask it there ,but there was not much response. Can you go on, Ms Roe.

Ms Roe: There are some discussions with NEHTA, the National E-Health Transition Authority, at the moment about reformatting the health incentive, but they have not been concluded at this stage.

Senator BOYCE: Will they come into this program if and when they are?

Ms Roe: You might be aware there is a new fund for practice incentives that has been announced in the budget. It is a collapsing of all the PIP incentives. We are currently looking at developing new funding guidelines and e-health will be a part of that. There will be a discussion paper and new guidelines developed with the profession over the coming months.

Senator BOYCE: It is just a collection of what is there now, is it not?

Ms Morris: We have had an e-health incentive in place under PIP for some time. I would not remember how long.

Ms Roe: Over 10 years.

Ms Morris: Well over a billion dollars over those years has been spent on e-health incentives through PIP, and there is an incentive in place now. Every PIP incentive gets changed over time. I think I am repeating what I probably said a few years ago here: that if you leave the incentive the same then it does not achieve anything and you have met your targets.

Senator BOYCE: It is about pushing innovation, is it not?

Ms Morris: Over time we push the boundaries, we ask for a bit more. I think what Ms Roe was saying is that we are currently working with NEHTA on refashioning the e-health incentive we currently have so that it is appropriate to reach the targets that are needed to

accompany the rollout of a personally controlled electronic health program. So it is an ongoing process.

Senator BOYCE: Yes, thank you.

CHAIR: After Senator Adams' question I think we should go into the general questions around Medicare Locals and see where that goes. We will then end with the GP superclinics and that will take us through until morning tea, I would think.

Senator ADAMS: Does the maternity services review come into this particular one?

Ms Morris: Yes.

Mr Booth: The review does, yes.

CHAIR: Congratulations, Senator Adams.

Senator ADAMS: Yes, I finally got it right. Can you provide some further information on the follow-up to the maternity services review and what progress has been made with the states and territories on funding for maternity units in rural areas? There are several other questions that I want to ask as well, but we will start with that one.

Mr Booth: The review came to its conclusions late last year and the maternity services plan was introduced. That was actually formally released just a few weeks ago. We have copies of it here which we can certainly forward.

CHAIR: Have you got enough copies for all of us, Mr Booth?

Mr Booth: We have got one, but we can certainly arrange to have more copies brought over.

CHAIR: That would be lovely, because I do not remember getting it and I know we were waiting for it. But, if we could get copies for all the committee, that would be very useful.

Mr Booth: Yes, we will certainly put a call in and get copies for everybody. Within the Maternity Services Plan there is quite a large section on taking the plan forward and what is going to be achieved in the first year. The plan was agreed, as I say, at the end of last year and as soon as it was agreed the initiatives underneath the plan were starting to be put into motion. Work has been carrying on since November of last year, although the plan itself was officially put out in printed format about a month ago.

Senator ADAMS: Within the review, did you deal with the collaboration between the midwives and GPs as far as deliveries go? Was that included with it or not?

Mr Booth: That would have been looked at.

Ms Appleyard: There has been work undertaken on collaborative arrangements, as you know, in our Medicare benefits division, and they will be able to answer any questions that you may have specifically in respect of those arrangements.

Senator ADAMS: I am just worried about the registration and the problems. I have been told that there are only 20 midwives that actually have collaborative arrangements. I am just wondering where the maternity review is going to sit if you cannot get the work force organised.

Ms Morris: I think Rosemary Bryant, who is the chief nurse and who has been involved with the Maternity Services Review and plan since the beginning, might want to talk to that. I would just say this is very new territory and it will take a while for the arrangements to come

into effect. It will be proof of concept, I think, for a lot of people in all the professions—although Andrew Pesce very proudly told me a few weeks ago that he had delivered, I think, two or three collaborative babies.

Senator ADAMS: Collaborative babies?

Ms Morris: Collaborative babies—he was very proud of this.

Senator ADAMS: I thought most babies were the result of collaboration.

Senator BOYCE: Of one form or another.

Ms Morris: I think we would like to see more arrangements in place. I am not surprised that it is slow to start. Rosemary Bryant, do you want to comment on that?

Ms R Bryant: I would agree with Ms Morris's comments. We never expected that there would be a huge rush of midwives wanting to get eligibility status. It is slow, but we have had some progress and we know that there are pockets throughout the states where there is progress, but we know that in some areas there is not so much progress. It is a bit of a mixed bag at this point.

Senator ADAMS: How are you going to move forward on this particular issue? I know that you are probably going to have to mediate, just about, in some of the areas between the GPs and the midwives. It is not an easy area. Have you got a plan to actually help guide both parties through?

Ms Appleyard: Both the Australian College of Midwives and RANZCOG, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, have collaborative arrangements guidelines in place. One of the actions under the plan is to look at perhaps bringing those collaborative arrangements together into a common set of guidelines. This is activity that we are very much looking at advancing, but note that there are guidelines in place, so we do not have a vacuum in this area. Bringing them together would be an important piece of work.

Senator ADAMS: Thank you for that. The second question I had was: what progress has been made with the states and territories on funding for maternity units in rural areas?

Ms Appleyard: When you see the maternity services plan you will see outlined fairly clearly what the activities are under the plan and who was responsible. Jurisdictions do have individual responsibility for what you are talking about—birthing units, particularly in rural areas. As Ms Bryant has said, the jurisdictions are up to various stages in terms of implementation. It is very much an issue for them, though, in terms of how they organise their public hospital systems and their service delivery. They most certainly have a requirement under the first year of the plan to report on how they are implementing these arrangements, and that is something that they have to report on to AHMAC through the Maternity Services Inter-Jurisdictional Committee. That is something that we are working on together. As far as jurisdictions are concerned, it is their area of responsibility and they will be responsible for reporting on it to AHMAC.

Senator ADAMS: Let us just hope that this does not happen, but unfortunately maternity services do tend to be in the limelight if there is a problem or an underperformance or if something goes wrong. Can you tell me how these issues would be dealt with by the National Health Performance Authority? You are saying that it is the states' and territories' area, they

have to fund it and they have to deal with it. Yesterday we were told that the local network boards would be dealing with the issue of poor performance. Yet where would the state come into this, because it is a state issue?

Ms Morris: I will try and answer that for you. I do not think there is one simple, clear answer but there are a few points I would make. Firstly, the maternity services plan has a lot more in it than most of us had hoped in our wildest dreams we would be able to get agreement on. I think it was a real breakthrough in dealing with the states on this. I would just like to credit Ms Rosemary Huxtable, who is probably sitting behind me somewhere, who led the negotiations. They were hard and they took a long time and I think we all surprised ourselves on how good an outcome we got. It is not just a plan that is out there published and that is it, we will wash our hands of it; it is the basis of continuing to work collaboratively with the states on maternity services and with the major professional groupings over the next five or ten years, however long it runs.

Ms Appleyard: Five years.

Ms Morris: In terms of rural maternity services, anyone who knows anything about health is aware of what the issues are there. You have been raising them consistently here for some time, I know. I think there are several potential things in play that would look at that. Firstly, courtesy of the COAG agreement from February this year, we are meant to develop a national primary care strategy with the states. I know that my colleagues Mr Booth and Ms Appleyard have been engaged in negotiations on that. I would be surprised if rural maternity services did not come up in some form in that context. Secondly, the performance authority would have to look at a whole range of health outcomes. I cannot personally comment on whether rural birthing is in there; I do not know, but I will talk to my colleagues in the transition office about that and how that is being addressed. In the area of health reform and all the mechanisms in place, there will be a lot more public reporting and public accountability about health outcomes for everyone within communities. So, if things are not working particularly well for groups in whatever part of the country, it is going to be obvious and there will be an expectation that something will be done to address that.

Senator ADAMS: Coming back to the review, does that include how those services are going to interact with the local network boards or Medicare Locals?

Ms Appleyard: The review was undertaken and the budget measures undertaken before some of the more explicit details of health reform were agreed. Very clearly, as you know, rural birthing units, rural hospitals, multipurpose services will be part of local hospital networks. It will be absolutely critical that there is a link there and that as far as planning goes, local hospital networks are very mindful of needs in respect of birthing services and maternity.

Senator ADAMS: Mr Booth, you obviously know what the content of the review is. The idea of these Medicare Locals and network boards has been around for a while, so would it not—

Mr Booth: This probably gets into the discussion around Medicare Locals and the role of Medicare Locals. One of the key things that a Medicare Local will need to do is to assess the health needs of the population that it is looking after—that is, in its geographical area. That is going to be across the board. One of the key things it needs to do is to look at those health

needs, look at the services that are available, try to identify any gaps in services that are there and then try to facilitate where to actually meet those gaps. Clearly in rural areas where maternity services are an issue we would expect that Medicare Locals would be looking at what services were needed to try and fill those gaps. So it does fit within the Medicare Local context.

Senator ADAMS: But it is not in the review?

Mr Booth: It is not specifically in the review, no, because, as Ms Appleyard said, the review started a few years ago—about three or four years ago—before the Medicare Locals—

Senator ADAMS: Yes, but it has only just been published, so I would think that surely—

Mr Booth: This is a plan which is the result of the review that was undertaken in 2008.

Ms Morris: I take your point, but no; the new governance arrangements under the health reform framework are not explicitly articulated in the maternity services plan. Those governance arrangements apply now to health services in and out of hospitals. I would actually say you do not need to explicitly mention them, because health services will be delivered in the new framework of public accountability and governance and better allocation of resources between tertiary and primary health care. I understand what you are saying, but I am not sure that it is something that is cause for concern in terms of how the plan will be progressed. I am sure you will ask it next estimates though.

Senator ADAMS: I certainly will.

Ms Morris: We will be ready.

Senator ADAMS: I am very appreciative of the fact that the review has been done; that is great. It really annoys me that it has just been published and yet the planning for health with the Medicare Locals and the local network boards just has to be part of it. I cannot see why it is not even mentioned as forward thinking.

Ms Morris: Think of it as principles and subordinate legislation or something; whatever is in there will be governed by the broader framework of health reform.

Senator ADAMS: In October I will certainly be returning to the subject.

Ms Morris: We will look forward to it.

Senator ADAMS: I have another question on the Maternity Services Review and what may be happening. How many additional scholarships have been provided to GPs and midwives to provide maternity services in rural and remote Australia? Have we got any increase there? Would you like me to ask that in rural?

Ms Morris: Yes, we will have to take that on notice. It is from another area, sorry.

Senator ADAMS: Coming back to the midwives, what is the process for review or appeal for midwives who cannot get a collaborative arrangement? If there are no doctors prepared in that region, what happens? Probably the wheat belt of Western Australia would have been a good example, but now, because of the generosity of the Barnett government, they have certainly come up with a lot of money to actually rectify that situation. It is great having you there, Ms Bryant, because this is one of your areas of expertise, I know. Really, the collaborative arrangements are a problem. If you have not got a doctor who is prepared to do it, what is going to happen to the midwife?

Ms Bryant: Yes, I agree that there are some areas of difficulty. There is no formal process; in fact on the ground the process is for the midwife to approach the hospital administration and try and get the hospital administrator or the management to broker an arrangement with the local doctors. That is the first port of call. If there is no satisfactory outcome to that, then the state health departments have midwifery advisors within each of the states. Those midwifery advisors are kept very busy with providing information around how the collaborative arrangements can be implemented. So, that is the next port of call for a midwife. In fact, the midwives are very aware of the structures within their states and where they can go for advice around that. There is no actual formal process as such, but the informal arrangements are as I have outlined.

Senator ADAMS: There is no appeal mechanism? Do they have to go to the state midwifery area and to try and work it through?

Ms Bryant: The state health departments control the public hospitals in one way or another, which may be in a different way depending on the state, of course. Some have a more interventionist approach than others. It is up to the state health department to try and resolve those problems. As I have said before, we know that there is resistance to collaborative arrangements being put in place. To a degree, one of the ways of overcoming this is to demonstrate successful arrangements in other geographical locations, hopefully within the same state. But, it is a slow process.

Senator ADAMS: Therefore that midwife's living really is affected because someone else is saying no, I am not going to be responsible; I am not going to go into a collaborative arrangement with you. How is that person going to be registered? Also, what would be the insurance arrangements?

Ms Bryant: As I said before, the midwife can have a collaborative arrangement with the hospital. I have not got the act with me, but under the act the hospital has to ensure that there are medical practitioners working in that hospital who are able to enter into that collaboration. The collaboration is with the hospital but the hospital does have to have a medical practitioner who provides obstetric services.

Senator ADAMS: I am fully aware of that. That is where the whole thing breaks down. I am just very concerned about the midwife who is a highly skilled professional person actually being held back and not able to practice because of somebody else who is a professional who is saying no, and there is nobody else. It may be in an area where there are one or perhaps two GP obstetricians, and neither will help. I think that unfortunately it is going to be a problem that is going to take quite a lot of solving. Thank you for that.

Ms Morris: Senator, before you leave it I would just add that I think over time we will see increasing patient pressure asking for these collaborative arrangements. That applies to any consumers in health. They will hear about what is available, what happens in other areas, and will be asking for this. Is that a fair enough comment, Rosemary?

Senator BOYCE: We can certainly see from all the nodding going on at the table that the department would like this to happen faster than it currently is.

Senator ADAMS: We hope the power of the consumer can win through then.

Senator BOYCE: Can I just ask one question in this area? I was going to ask it later, but I might get told it was the wrong spot. In terms of the maternity review, are you looking at the

question of indemnity insurance and who it should be applied to? I am thinking particularly in terms of midwives who assist with home births. Is this the right place or the wrong place?

Mr Booth: That would be dealing with the indemnity.

Senator BOYCE: Ask that in indemnity? Is it within the review or not?

Mr Booth: No.

Senator BOYCE: No, okay.

CHAIR: I think if you put that on notice, they can get a detailed response back from all the responsible areas. That might be the way to go.

Ms Morris: The maternity services review is coordinated with the primary and ambulatory care division but it actually crosses nearly every part of the department, quite frankly.

CHAIR: Thank you. Are we moving now to Medicare Locals?

Senator FIERRAVANTI-WELLS: Yes we are. We had a bit of a discussion yesterday about Medicare Locals and funding. I will come back to some issues, but I first want to just take you to a transcript of a joint press conference between Minister Roxon and the Prime Minister.

Ms Halton: Which we do not have, Senator.

Senator FIERRAVANTI-WELLS: If you are happy to take it with my scrawling on the side.

CHAIR: Can we go to something else while we get that?

Senator FIERRAVANTI-WELLS: Yes. It goes to the issue of patients not actually seeing a Medicare Local. In that transcript that the Prime Minister was asked to talk about, she alluded to the fact that patients would never actually see a Medicare Local. I will get that for you. She also made comments in that transcript that Medicare Locals would be fund holding organisations. How does that fit in, in terms of them providing services directly?

Ms Morris: I will talk about fund holding because fund holding can be interpreted in many ways. I think I am fairly confident that I understand the way in which the Prime Minister meant it. I also understand that it was taken to mean something quite different by some parts of the medical profession. What the Prime Minister and the minister would have been referring to with fund holding is that the Medicare Locals will hold program funding provided by the Commonwealth, and probably by state governments too. Over time, that program funding may actually be amalgamated into one funding agreement only or a series of funding agreements grouped around particular needs of patients. It is to do with the service provision that complements and supplements the mainstream funding of primary health care through the MBS and the PBS. It is not the Medicare Locals holding the MBS rebates for a patient. I know that you understand that they will not be seeing individual patients, but their responsibility is to do with primary healthcare needs at an aggregate level for a population. Clinicians, in particular GPs, will still be responsible for determining the health care needs of individual patients. The Medicare Local will not say, 'You saw Dr Fierravanti-Wells and she said you only need three physiotherapy appointments but we think you need four and you need to see a dietician twice.' That is not the territory they will get into.

Rather, for example, it may be something like, we are getting this much funding for allied health services in this area, and we are getting this much for residential aged care facilities, et cetera, but when we actually look at the health needs of the population here we have got more young adolescents and higher mental health needs; we do not have a lot of residential aged care facilities. Therefore we are going to make a case for how we think we can address those outstanding primary health care needs within this area and better support the healthcare providers in the area to deliver those services. Does that make sense?

Senator FIERRAVANTI-WELLS: In the context of what you have just said to me, it seems to be an intention for them not to actually provide services themselves.

Ms Morris: Some will, because some divisions of general practice already do. Usually those divisions are in more rural and remote areas, and they are the service provider of last resort. But, they are not divisions now. Even if they are delivering services, the patients do not come to the door of the division and walk through and see people who are located in the division offices. They are usually directly contracting services but working together with the local GPs around the patient needs.

Senator FIERRAVANTI-WELLS: I have left the Medicare Local component of access to allied psychological services for this component of it because it is a structural question. How does budget paper page 232 fit into Medicare Locals receiving funding to employ part-time child liaison officers who will liaise with specialist child allied mental health professionals? Will these offices be located in the Medicare Local office? How does that work? That is a shop front implication to that sort of provision. That is where I was asking you questions yesterday, Ms Morris, in relation to putting the shingle up.

Ms Halton: Perhaps I can deal with this. It is quite confusing because we know at the moment that divisions do fund activities and, in fact, do employ people who actually deliver real things, as against administer plan, encourage, facilitate. Those particular positions are actually no different. The issue is the locus of their delivery. For example, if you look at how we manage the mental health needs of communities where they are quite sparse or there are not a lot of private providers, we put money into the divisions and those individuals then go out to practices to provide the service. That particular program is new, as you know, so we do have to do some work on how it will be rolled out. It is not our expectation that the Medicare Local will have a public face. Whilst they may be employing or contracting or assisting in delivery, exactly as the divisions do now, as a place to go to get something, we do not think that is likely. They might have a conference room where they bring in local doctors where they have some professional development activity but it is not the same as a public face.

Ms Morris: Or treatment rooms?

Ms Halton: Yes, exactly.

Senator FIERRAVANTI-WELLS: Medicare Locals will not see patients or see people. That was the context in which Ms Morris was responding. I have given you a copy of it but the Prime Minister was asked the question: are you saying that a patient will never actually see anybody working in these Medicare Locals. Her response was: of course. It is not very clear what the answer to that was.

Ms Morris: Patients will not see the administrative staff located in Medicare Locals who are doing the population health planning, the needs based assessment or whatever. Medicare

Locals will employ people under particular programs, but they will not deliver those services in Medicare Locals. That said, there might be a branch office of a Medicare Local in far west Queensland, and because of the needs of space or whatever they have a room there where treatment happens. But, as a general rule, they are not a shop front to people.

Senator FIERRAVANTI-WELLS: I would read into that, Ms Morris, that they will also do research on what the community needs are, what the community shortages are, have responsibility for distributing funds.

Ms Morris: Health planning. The funds that they will have are the funds that divisions already get. Most of our programs delivered to patients out of hospital now—and I say most because I cannot give you a figure—are actually run through divisions of general practice. They are, as I said, supplementary to, complementary to the mainstream MBS and PBS programs. They will be rolled over to Medicare Locals. There are some things that were announced in the budget, such as new mental health measures, which will be run out through Medicare Locals. But, they are about services to address, I suppose you would say, areas of market failure or extra need around mainstream MBS services.

Senator FIERRAVANTI-WELLS: Yesterday I asked the question whether we were seeing a shift away from fee for service.

Ms Morris: I think you asked that last time too.

Senator FIERRAVANTI-WELLS: I did. I have got a thing about this, Ms Morris.

Ms Morris: Ms Halton and I shook our heads a lot.

Ms Halton: Again, I understand that some people think this is the thin end of the wedge. I think I made this comment yesterday and I have certainly made it on multiple occasions in the past, let us be clear that our fee for service system works incredibly well in most places and most of the time. We know, particularly in Senator Adams' favourite stomping ground of regional and remote Australia, that it does not tend to be as effective.

Senator ADAMS: Aged care facilities.

Ms Halton: The point is that we know that there are some areas of failure. What we have done with divisions of general practice in the past is put resources in their hands so they can address the gap. It is about gap filling. It is not about fundamentally shifting the paradigm. It is about making sure that those individuals in those communities get a fair crack in terms of access to service.

Ms Morris: Medicare Locals would have to actually present data on what the health needs of a population within a defined geographic area is, so that if they have a case to make for a shift in that program funding, a shift in the balance, whatever, that case can be made to the government. Initially, the programs that you know that divisions run will still be run out from Medicare Locals rather than divisions, as Medicare Locals are set up. That is purely and simply what the reference to funds holding is. It is not about holding MBS payments.

Senator FIERRAVANTI-WELLS: I guess this goes to the practice incentives, and that is 5.4. Can I ask my question in relation to Medicare Locals and how they interact? As I said, there was this budget measure in relation to dealing with children, the part-time liaison officers. There is also, under the mental health area, the better access program and some of the stuff that is going to happen there. For those aspects in the budget that referred to programs

being run through the Medicare Local framework, what happens to those areas that do not have a Medicare Locals? I do not want to go into ATAPS, but I understand, for example, there is funding in the 2011-12 budget that is going to be run through the Medicare Locals. What happens to the ones that do not have Medicare Locals, 75 to 80 per cent of the country? What happens there?

Ms Halton: It depends on the program. Some of the programs that we have are phased in. What you would most likely see is the phasing will coincide with the roll out of Medicare Locals. Where they are not phased, as we have already indicated, divisions of general practice actually do already have a role of this kind, and we do have them as a vehicle. I think it is a question of case by case, depending on the program.

As you know, if you look at a number of the mental health measures, capacity will limit the speed at which we roll some of those programs out. We will try and coincide wherever we can with Medicare Locals.

Senator FIERRAVANTI-WELLS: Take an instance where those running ATAPS that do not fall within a Medicare Local, will they cease to have ATAPS? That is just an example.

Ms Harman: The short answer to your question is no. ATAPS services will continue uninterrupted. We have a very careful transition plan that we are starting to work on now, subject obviously to the first 15 Medicare Locals being announced, so that we can ensure that there is a careful transition from divisions of general practice to Medicare Locals in respect of ATAPS services.

Senator FIERRAVANTI-WELLS: Going back to some of the questioning yesterday, it is really going to depend very much on the agreement that you have with each of the Medicare Locals. It comes back down to some of the issues—

Ms Morris: Your question is around just what do we mean by that flexibility; what is core and what is flexible?

Senator FIERRAVANTI-WELLS: We now have to look at the funding formula for Medicare Locals. We know that the first Medicare Locals are meant to come online on 1 July, four weeks away. The finalisation of this funding formula and the distribution of the funds to the Medicare Locals picks up the point that I was making yesterday that we do not know yet—

Ms Morris: I think there are probably up to about 26 different programs that we currently run out through divisions and there will be more now following this budget. Those programs have money appropriated and they are delivered on a national basis. Where there is a Medicare Local in place it will be run through the Medicare Local; pending a Medicare Local covering a geographic area, it will be run through the division of general practice. The imperative is to get the services to patients and make sure the money is out there. It will be a period of change and change management, but I think we are quite painfully aware of the challenges there. It is not just our division; as you can see, Ms Harman is here and there are many divisions in the department that are going through this process at present.

The flexibility that was referred to yesterday is around particular unmet needs in an area that might be identified through the needs based assessment that will be done. But programs are programs: money is appropriated for them, they are government priorities and we make sure that they are actually run effectively.

Senator FIERRAVANTI-WELLS: In effect it does not matter that the Medicare Locals' fund and the structure around it is not established formally. What you are saying is the money will roll out—

Ms Morris: The money will roll out and we will manage change management and transition to Medicare Locals throughout that.

Senator FIERRAVANTI-WELLS: You might have the global fund, but each Medicare Local will have its own specific contract, if I can put it that way?

Ms Morris: Yes.

Senator FIERRAVANTI-WELLS: It will be a contract?

Ms Morris: Yes.

Senator FIERRAVANTI-WELLS: It will start with a standard template and then the schedule will be varied according to whatever it is that they are going to deliver?

Ms Morris: Yes.

Senator FIERRAVANTI-WELLS: You might start under your new framework on 1 July, but your contract might be dated July 30, or something like that.

Ms Morris: I think that is correct.

Senator FIERRAVANTI-WELLS: Legally, is that okay under the current arrangements?

Ms Halton: Let us be clear about this, and I think we said this very clearly yesterday. We have a draft sitting ready to roll. It is our objective that those contracts for the first 15 are actually in place by 1 July. It is true that they may be supplemented by extra things we will add on as we roll out additional bits and pieces, but it is our objective to have those first 15contracted.

Senator FIERRAVANTI-WELLS: In terms of the guidelines for this fund, the intention is also to roll out the guidelines and the 'legal framework' for this fund by 1 July?

Ms Halton: When you say this fund, what do you mean by that?

Senator FIERRAVANTI-WELLS: The Medicare Locals fund.

Ms Halton: Okay, so the base funding?

Senator FIERRAVANTI-WELLS: Yes.

Ms Morris: The guidelines for Medicare Locals are the guidelines that were issued in February.

Senator FIERRAVANTI-WELLS: And they will not vary?

Ms Morris: They may, like all guidelines, be amended over time, but they are not going to be reissued for the contracts for the first tranche.

Senator FIERRAVANTI-WELLS: Those guidelines will form effectively a schedule, or a part of the funding for the contract that you have with each of those Medicare Locals?

Ms Morris: I will have to defer my colleague.

Mr Booth: Yes, there will be a core contract with the Medicare Locals to deliver that core funding and the other program funding that we have been discussing here. Are you referring to the Medicare Locals fund?

Senator FIERRAVANTI-WELLS: Yes.

Mr Booth: In common with the other funds that the department is looking at, we are going to be developing guidelines for the fund in conjunction with key stakeholders. For the Medicare Locals fund, because of the transitioned roll out of the Medicare Locals we cannot do that instantly, because obviously there is going to be a first tranche, a second tranche and then a third tranche. The guidelines will be developed in conjunction with Medicare Locals and other stakeholders as they come on board. However the core funding will start from 1 July this year.

Senator FIERRAVANTI-WELLS: In other words the guidelines for the operation of the fund will be a moving feat?

Ms Morris: I was confusing you.

Senator FIERRAVANTI-WELLS: I am confused now, Ms Morris.

Ms Morris: I was leading you down the garden path. I thought you were asking about the core funding for Medicare Locals, that is core funding as we provide to divisions, and there is no separate fund for that. What Mr Booth correctly understood you to be asking about was that, as with the other funds that were announced in the budget and are being set up, there will be a fund called a Medicare Locals fund. The guidelines for that are yet to be developed.

Senator FIERRAVANTI-WELLS: That is what I am asking. I have understood the flow of the money, and I have understood that as at 1 July you anticipate having contracts in place for the first 15. You have a template, and it is just a matter of cutting and pasting depending on what the Medicare Local is going to do. Is that it in a nutshell?

Ms Halton: Put in its basic, that is a nice summary.

Senator FIERRAVANTI-WELLS: Thank you. However, the Medicare Locals fund which is referred to at page 212 to 212 of the yellow book is what you are talking about, and that is the one that has the evolving guidelines that from time to time will be varied as the Medicare Locals will come on. Your 15 at the moment might be subject to, say, a guideline which contains 50 clauses. Next week it could be 55. That is simplification but is that what you are telling me?

Mr Booth: I think in common with the other funds that are being developed, the intent is to move a number of streams into a single fund so we can simplify it.

Senator FIERRAVANTI-WELLS: Okay, so from time to time the—

Mr Booth: As with all the funds there is a process of consultation in developing guidelines.

Senator FIERRAVANTI-WELLS: I am not questioning that. From time to time the obligations of Medicare Locals will vary depending on the global guidelines of the fund?

Ms Halton: Can I make an analogy here? In common with all other bodies that we fund, we have a contract with them, say, in respect of a particular program. They might have two contracts, one in respect of program 1 and one in respect of program 2. For policy reasons, government changes the approach to program 2. Because we have the capacity to do this, we vary the arrangement we have with that organisation with respect to the delivery of program 2. This is exactly the same.

Senator FIERRAVANTI-WELLS: It is like an insurance contract? You still have an insurance contract, and from time to time the NRMA will send you a booklet that tells you the new conditions of your contract.

Ms Halton: Correct.

Senator FIERRAVANTI-WELLS: The funding of your contract does not change; it is just that from time to time those guidelines can vary.

Ms Halton: Correct, and to extend the analogy, say you have a boat and they send you a letter saying, 'We have changed the principles on your boat but have not changed anything on your car.' Now, the car is probably the larger of your insurances, I do not know. In this particular case we have the core funding; we set that up, and we are not anticipating significant changes to that in the near future. You never know, but we are not. At the same time we now have these funds—which they probably are already receiving some moneys from—we are solidifying, simplifying and, exactly the same as your boat insurance policy, we may change some of those deals.

Senator FIERRAVANTI-WELLS: When do you anticipate that the fund itself will start? 1 July?

Mr Booth: 1 July, 2012.

Senator FIERRAVANTI-WELLS: And it will start with a basic set of guidelines?

Mr Booth: We will be developing the guidelines over the next few months.

Senator FIERRAVANTI-WELLS: It is likely that it could be set up with no guidelines?

Ms Morris: 1 July 2012, you said?

Mr Booth: 1 July 2012 is when the fund will start.

Ms Morris: Next year, Senator, by which time all Medicare Locals will be in place.

Senator BOYCE: What do you mean by 'in place'?

Ms Halton: This is the whole point about extending people's contracts until 1 July 2012. People have moneys coming out of funds. We have created the administrative structure, but in each case there will be new guidelines for the integrated fund. There are, as you know, a number of funds. They will be consulted on, developed and promulgated during the course of this year in order that for any grants, for example, which would have expired during the course of this year which now expire at the end of June 2012, those normal funding processes can then apply using those new guidelines.

Senator FIERRAVANTI-WELLS: I was going to ask some questions in relation to widening the role of Medicare Locals vis-a-vis general practitioners. It is more practice incentive questions. Will I leave those to 5.4?

Ms Morris: Whatever suits you.

Senator FIERRAVANTI-WELLS: Okay, I will let Senator Boyce go now.

Senator BOYCE: I just had one question at this stage. The focus on preventative health in Medicare Locals: can you talk about the priority that will have or not have?

Mr Booth: Certainly Medicare Locals will have a focus on preventative health. There is a very clear intent that, in line with looking at population health needs and looking at what is

needed across the population, preventative health is very strongly within that framework. That is certainly going to be a key.

Senator BOYCE: I will leave that there. I will probably chase it next time.

Senator ADAMS: As far as the applications go, how many applications were received for this round?

Mr Booth: We received 59 in total.

Senator ADAMS: Fifty-nine in total for 15 Medicare Locals?

Mr Booth: For the first tranche, that is correct, yes.

Senator ADAMS: With the department and the administration of Medicare Locals, has a separate section been set up for this?

Ms Halton: No.

Senator ADAMS: It is being done by departmental people?

Ms Halton: Yes.

Senator ADAMS: So there will not be a Medicare Locals section?

Ms Halton: No. There will be my multiskilled primary care people. We are flexible.

Senator ADAMS: Very flexible. I was just going to ask how many people have been appointed to manage the contracts and what expertise you had in managing contracts of this nature.

Ms Morris: We already have an area within one branch that manages the divisions of general practice. We are well experienced at managing contracts. The Medicare Locals will be required to do more than divisions of general practice, but it is ongoing work for the division, really. Our policy area has been involved in the development of them and we have many very experienced contract managers within the division. It is a continuation of existing work once they are up and running, by and large.

Senator ADAMS: Coming back to the divisions, how many do we have now, 119?

Ms Morris: We have 111.

Senator ADAMS: I am a bit out of date.

Ms Morris: I think you were probably adding all the state based organisations, and people often use one figure or the other. I am sure you were right, Senator. You were just counting in the SBOs.

Senator ADAMS: So we are looking at 111. You are going to end up with 30 Medicare Locals eventually, or more?

Mr Booth: The original announcement was for 57 Medicare Locals.

Senator ADAMS: That is still half the number of divisions?

Mr Booth: Yes.

Ms Morris: Yes, there will be significantly less.

Senator ADAMS: With these divisions, how much longer are they going to be funded? As Medicare Locals establish, what happens to the divisions?

Ms Morris: The funding for divisions of general practice expires at 30 June 2012.

Senator ADAMS: I do not know whether this should be asked in rural, but I will have a go and see where we end up. It is about the savings that were realised through last year's decision not to further fund the regional health service programs. Will those savings be allocated to the Medicare Locals?

Mr Booth: That is within rural health.

Senator ADAMS: I am coming down to communities under 7,000 and that sort of area, so will I leave that for rural health?

Ms Halton: It depends on what the specific question is.

Senator ADAMS: Okay, I will keep going. In last year's budget decision, the funding to regional health services was described as 'realigning services' in rural and remote areas of less than 7,000 population in anticipation of the work of the rural Medicare Locals. What I want to know is where that funding has gone. Is it going to Medicare Locals or has it just disappeared into somewhere and has not gone to rural areas?

Ms Halton: We would need a bit more detail.

Ms Morris: I can tell you that the offset used for Medicare Locals was the divisions of general practice program and there was new money on top of that. I am not sure that it is a straight quid pro quo, but we would need to check.

Ms Halton: We have worked out what it is. It was the 2006 COAG measure, which I do remember, and it was the departmental money that was around the proposal and I think it was communities below 7,000.

Senator ADAMS: I know, because I can remember commenting on it.

Ms Halton: Do you remember that essentially states had an option to look at applying for almost like a cashing-out arrangement if the town was a very small one. The resource that we had was actually the departmental money to implement that, but it did not get any traction. It was not a service out there that was cancelled. That is why I was looking puzzled, I was trying to work out what it was; but I know exactly what it was.

Senator ADAMS: Did that funding stay in rural?

Ms Halton: No, it was departmental money. It was a terminating measure and it has disappeared. It was not service delivery money out there at all.

Senator ADAMS: How will the department ensure that Medicare Locals established to serve rural and remote communities are funded to address existing shortfalls in health service delivery and the higher establishment costs and the costs for coordination of health care that they face? What sort of rural and remote weightings will there be for the funding of Medicare Locals in these areas?

Ms Morris: We cannot yet tell you what the funding formula will be, but I can assure you that rural and remote issues have been taken into account in the development of the funding formula. I cannot at this stage give you the details of it.

Ms Halton: The minister has to make a decision, obviously, about these things. We cannot preview details which are not in the public arena yet, but what I can say is that the factors that you would expect which would reflect things like rurality, Indigeneity—

Senator ADAMS: I was just going to ask about Indigenous areas.

Ms Halton: The things which traditionally add to the cost base, and obviously that is disproportionately felt in the bush, are well known to us and certainly I would anticipate would be features. As to the actual services that are provided, as we have already indicated, our initial priority is to get these established and to transition the programs that exist and some of these new programs which we have already talked about this morning into Medicare Locals. Their planning responsibility, which is to really look at what those deficiencies are, will then in time assist governments in making decisions about where priorities should be made in terms of the allocation of resources. But what I am not expecting to see is a huge bucket of money tipped into each of those rural and remote services to address a particular deficiency, because we have to actually go through a proper process of looking at all of those issues first. Our challenge is to get them established, to transition the existing programs in and then to implement the new programs and get them to have that planning function. That will then, working with the LHN, give us a much more rich view, I suppose I could say, about what actually is needed and what goes on in those areas. Does that make sense?

Senator ADAMS: Yes, it does. I think my frustration is probably the fact that I need a map and I need to know where these boundaries go.

Ms Halton: Yes, absolutely.

Senator ADAMS: I know about the services that really could be improved. I am just worried that during the establishment of these bodies and with the state of flux that the divisions of general practice are in, everyone is going to be concentrating on how Medicare Locals are going to work and all the rest of it. What is going to happen to the poor consumer out there at the end of all of this? Are they going to be looked after or are we going to lose health services while all this happens?

Ms Halton: That is exactly our concern. This is the point I think Ms Harman made when she used the words 'careful transition plans'.

Senator ADAMS: Yes, I noted that, but I thought: well, that is fine, but—

Ms Halton: We all know that change can be disruptive and that is why we are very conscious of the need, exactly as I just said, to transition the existing without losing the important services that are being funded and provided, to add the new ones in and get that settled, and then build on these new functions.

Senator ADAMS: Who is going to be the watchdog? This is where I get confused with state health and with Medicare Locals as they are established. Who is going to be the watchdog to make sure that these services are not falling through the cracks while all this transition is going on?

Ms Halton: I actually think a number of people have that responsibility. Obviously from the department's perspective we will be watching this incredibly closely; but, as is ever the case, we will not only be relying on our officers, including our officers in state and territories who of course, as you know, visit areas quite regularly and go out and talk to people on the ground, but we will also be relying on feedback from people like you who have got those contacts. We get told things by the AMA, the ANF, by individuals who ring us or write to us et cetera. We will be watching this and we will be looking to all sorts of feedback about what is happening on the ground. As you know, if you see something particularly in WA that you are not happy with or you are concerned about—

Senator ADAMS: I will be doing that, don't worry!

Ms Halton: That is good, and that is what we rely on as well.

Senator BOYCE: I just have a couple of questions on that. Ms Morris, you said that the funding for all the divisions of general practice will cease in June 2012?

Ms Morris: That is right.

Senator BOYCE: There will be 30 Medicare Locals that will replace all the divisions?

Ms Morris: No, 57—

Senator BOYCE: We will not have 57 ready to go.

Ms Morris: The first tranche are expected to be rolled out from 1 July this year, the second tranche from 1 January 2012 and the remainder from 1 July 2012. It is a planned transition.

Senator BOYCE: I thought you were asked earlier about whether Medicare Locals would be set up without guidelines, and we were told, no, they would not happen until—

Ms Morris: No, this is the confusion between—

Ms Halton: This is the two insurance products.

Ms Morris: We have got the boat and the car analogy.

Ms Halton: Medicare Locals, when they start, will have Medicare Locals guidelines. They are already out. In our analogy, Senator Fierravanti-Wells already has her car insurance policy. That policy is out. It is the Medicare Locals guideline. Because we keep using the word 'fund' it gets confusing. Medicare Locals have their guidelines. They are already published; everyone knows what they look like. In addition, there are other moneys that they get, not just from the Medicare Locals base funding. They might get funding from other of our now streamlined funds. It is those streamlined funds, it is Senator Fierravanti-Wells' s boat licence fund, and the money that they attract which will transition in. The existing arrangements will apply until these new funds have their guidelines finalised, which will come after consultation. Then there will be a new policy booklet about the boat, or about mental health, ATAPS, whatever the service might be, and then those new guidelines. Effectively, there will be the base, guidelines already known, and the old services being transitioned, which will change the guidelines over the next 12 months.

Ms Morris: But the services will continue to be delivered?

Ms Halton: The services will continue.

Ms Morris: As I said earlier, the services that divisions run and that Medicare Locals run are really about where people are missing out on mainstream assistance. The last thing we or the government would want is that those services get disrupted.

Senator BOYCE: Thank you.

CHAIR: Any more on Medicare Locals?

Senator FIERRAVANTI-WELLS: Yes, I just have some questions generally.

CHAIR: We will go through until 10.30 on Medicare Locals and then reassess.

Senator FIERRAVANTI-WELLS: I just want to put into context practice incentives and Medicare Locals. In the yellow book we talk about program 5.3, Primary care practice

incentives and the practice incentives general practice fund. Dotted throughout the literature there is a reference to filling gaps in primary care and incentives being run through Medicare Locals, for example the afterhours care and transfer in relation to ageing and other incentive payments. Are we going to see those incentive payments that are currently there being transferred financially over to Medicare Locals? Is it going to happen in a budget context? Sorry the question is a bit confused. Do you understand?

Ms Morris: I will try and answer. I am presuming that I know where you are heading. We have already gone through MBS and the fact that MBS will continue as the mainstream funding for private primary care. The Practice Incentive Program will also continue. It is seen as the only way we really have of paying for actual outcomes in primary care, and we are, as with other funds in the department, setting up a practice incentives fund. However, there are a couple of specific measures that were announced back in 2010 where some of the PIP payments have actually been converted over to measures that will be run through Medicare Locals.

Correct me if I am wrong, Jennie Roe, but it is not all the PIP afterhours payment; it is PIP tiers 1 and 2, I think, which will be changing. I will let Ms Roe explain what they are, but within afterhours it is a many layered PIP program. My understanding of those first two is that they had fairly low compliance requirements and I think the recent audit confirmed that they had fairly low compliance outcomes. Jennie, would you like to talk a bit more about that?

Senator BOYCE: Low compliance outcomes? People weren't doing it?

Ms Morris: In some instances it was a fairly token afterhours coverage, I think, but Jennie will talk about the PIP afterhours ones.

Ms Roe: I am quite confused about what I am answering but I will start with what I think I am answering. The PIP afterhours incentive, although it was due to stop earlier, has now been extended up until July 2013, at which point there is some block funding being available for afterhours going to Medicare Locals. The process from then on will be in consultation with the Medicare Locals and their own afterhours plans. As you heard earlier, one of the responsibilities of Medicare Locals is to look at services planning in their district. Where they have determined what the processes will be, the practices will be able to access block grants through the Medicare Locals. So it is just a different funding mechanism.

Senator FIERRAVANTI-WELLS: Does this budget contain measures that will transfer those incentive payments that currently go to GPs and allied health professionals to Medicare Locals? It is a structural question I was asking.

Ms Roe: My understanding is it is not meant to move across to Medicare Locals until 2013.

Senator FIERRAVANTI-WELLS: So it will not be until the 2013 budget?

Ms Roe: That is right. That is for afterhours. The aged-care access is different again and that will be transferring across from 1 July 2012.

Senator FIERRAVANTI-WELLS: It might be helpful at this point if you take on notice and tell me about these incentive payments without us going through it all because it is obviously a bit confusing to do. Give me the list of all those incentive payments and tell me

when they are moving across to Medicare Locals and, if there are budget measures associated with it, which budget they are likely to be contained in?

Ms Morris: The point I was trying to make is that with the PIP afterhours incentives there are several tiers and it is only two of those tiers that are moving.

Senator FIERRAVANTI-WELLS: On a more general question, looking ahead, at this point you cannot really ascertain what the total funding for Medicare Locals will be over the forward estimates?

Ms Morris: There is a number in the budget; I think it is $492 million.

Mr Booth: It is $493 million over four years.

Ms Morris: And in a full year of funding I think that they will get $175 million a year in core funding.

Senator FIERRAVANTI-WELLS: That is on top of amounts that are redirected from that?

Ms Morris: Yes, the program funding is on top of that.

Senator FIERRAVANTI-WELLS: So on top of the amounts that are redirected from the divisions of general practice as they wind up?

Mr Booth: No, the $177 million is the core funding and that builds upon what the current divisions get. I think at the moment the current divisions get around $85 million.

Ms Morris: It is $85 million and they will get $175 million in a full year of funding. That will be the funding base for the Medicare Locals network in a full year of funding once the divisions funding ceases.

Senator FIERRAVANTI-WELLS: That includes a component for staff that the Medicare Locals will employ?

Mr Booth: Yes.

Senator FIERRAVANTI-WELLS: Do you envisage that Medicare Locals and the role of Medicare Locals will expand over time? Will there be more bits and pieces added on? The guidelines will float, does that mean the responsibilities will change?

Ms Halton: I think we should not speculate on that. I think the challenge with Medicare Locals now is to get them established, get the things transitioned and to get them working with the LHNs to actually provide a more integrated health service for people living in local communities. I think that is the thing, rather than getting into some sort of hypothetical about where they may end up.

Senator FIERRAVANTI-WELLS: The framework is there based on what we have heard earlier for additional responsibilities to be added to Medicare Locals?

Ms Morris: That is the divisions now.

Senator FIERRAVANTI-WELLS: No, I am not making a point of it, Ms Morris, I am just simply saying that the framework is already there if you wish to add?

Ms Halton: It certainly provides us with a platform.

Senator FIERRAVANTI-WELLS: Yes, that was my question.

Ms Halton: There is a platform there but what that platform might entail—

Senator FIERRAVANTI-WELLS: May be in two or three year's time we do not know; it depends on decisions of government.

Ms Halton: And how successful they are in doing the functions that I have outlined.

Senator FIERRAVANTI-WELLS: On that point, is there a planned evaluation at some stage? Obviously you have not set a date for it but I would envisage at some stage there would be an evaluation program.

Ms Halton: It is inconceivable that if we do not evaluate this someone else will not. I think we can say with complete confidence this will be evaluated, probably to the back teeth.

Senator FIERRAVANTI-WELLS: I might just stop there.

CHAIR: We know that Senator Adams has a lot of questions and there will be ones on notice in this area. If you do not want to take the opportunity for further questions now we will break for morning tea and when we come back we will go into GP superclinics.

Proceedings suspended from 10:26 to 10:48

CHAIR: We will reconvene and go to GP super clinics. I know that Senator Furner has some questions, so we will start with him and then we will go there.

Senator FURNER: Thank you, Chair. I might start with the budget commitments for the super clinics. I understand there is $355 million allocated to building 23 new and 425 upgraded clinics. Is there any opportunity to understand where those new allocations might be going to?

Mr Booth: In terms of the sites?

Senator FURNER: That is correct.

Mr Booth: We can certainly run through where things are in terms of the super clinics that are currently operational or where other ones are.

Senator FURNER: I think we are aware where the current ones are but could you give some undertaking of where the proposed ones might be?

Mr Booth: At the moment we are running through the invitation to apply process. We are running through a process of getting those applications in, going through the assessments and all that kind of thing. I can certainly run through the listing of the different areas, where they have come from. The listing is: Blacktown, Broken Hill, Coffs Harbour, Hume region, Lismore, Liverpool, Nowra, Port Macquarie, Southern Central Coast, Tweed Heads, western Melbourne, Adelaide, Caboolture, Canberra, Darwin, Emerald, Gold Coast, Lower Hunter, Mackay, Mount Barker, Sunshine Coast, Townsville, West Pilbara, Wynnum, Cobram, Jindabyne, Northam and Rockingham.

Senator FURNER: Is that Mount Barker in South Australia?

Mr Booth: It is.

Senator FURNER: Is there any feedback at this point on what burden has been removed from local hospitals as a result of the introduction of the GP super clinics?

Mr Booth: In terms of reductions in emergency departments and those kinds of areas?

Senator FURNER: That is right.

Mr Booth: We have not got an overall look at that at the moment but certainly as the super clinics are developed, we have a kind of score card that we look at that has various indicators within it. We have not got a specific one that looks at reduction in burden on local hospitals, although we do hope that that is something that occurs as a result of the super clinics being constructed.

Senator FURNER: What are the variables of the score card? What do they relate to?

Mr Booth: We can have a look.

Ms Taylor: The sorts of things that we look at are the types of clinics that are run by the individual super clinics in terms of keeping people well and out of hospital—things like diabetes clinics, clinics for asthmatics and preventive health activity. In addition, we look at preventative measures such as screening activities that each super clinic will run.

Senator FURNER: Any mental health at all?

Ms Taylor: Many of the super clinics will run mental health services, yes.

Senator BOYCE: Can I come in there with a follow-up question?

Senator FURNER: I do not want to break this line of questioning at present. In general the super clinics model has a far reaching multipurpose scope in terms of those types of—

Ms Taylor: They do. Each clinic will have a very specific focus on preventive health measures targeted at their local population. It is fair to say that there are a lot of communities around Australia that have very similar needs, so you do get quite similar clinics and processes and services in many of the super clinics. They focus on asthma, obesity, smoking cessation programs and exercise programs. It is fairly broad and wide-ranging across the super clinics.

Senator FURNER: A super clinic in my back yard, the Strathpine GP super clinic, has consultations with a mental health nurse, a chronic disease nurse, a dietician, podiatry, exercise, pathology and physiotherapy. Is that a standard model in terms of most super clinics or is that reasonably unique to the Strathpine super clinic?

Ms Taylor: Each super clinic is unique. As I said, there are a number of services that will be common to clinics, but certainly Strathpine has a very broad array of services. In particular, their Indigenous health services are something that many of the other clinics do not do. That is partly for reasons of demographics and partly because they have not actually developed those services at the moment. That is a big feature and focus of the Strathpine super clinic.

Senator FURNER: I understand they were successful recently in being awarded some recognition for their services. I understand it was the workforce innovation award; is that correct?

Ms Taylor: Yes, they were finalists in the Queensland state collaborative workforce awards, which is a pretty impressive achievement for a super clinic.

Senator FURNER: Is that the first?

Ms Taylor: That is the first, yes.

Senator FURNER: Maybe the first of many?

Ms Taylor: Hopefully.

Senator FURNER: Turning to Caboolture, you have mentioned that as being in the target group of forthcoming super clinics. I have had some discussions with locals up there, with Indigenous communities in particular, regarding the need for a clinic up there. Where are we at in terms of the consultations in respect of a Caboolture GP super clinic?

Ms Taylor: The public consultation was held on 16 March. I am just checking my notes. I am pretty sure that the invitation to apply process is open at the moment. I will just confirm that.

Ms Halton: Meanwhile, with regard to the information that Senator Fierravanti-Wells asked for, we have now got a number of copies and we can email it to the secretariat in a word version for distribution. I am happy to table that in hard copy and it will be provided electronically.

Ms Taylor: I can now tell you about Caboolture. The competitive ITA process was advertised on Saturday, 16 April. It has been extended by one week to 6 June. There is an offer of land from the Queensland government associated with that particular invitation to apply process, so to ensure that potential applicants were aware of that offer we extended the process by an extra week.

Senator FURNER: The offer of land was based on the extension in terms of the reasons why there was a need to extend?

Ms Taylor: Yes, that is correct.

Senator FURNER: Are you aware if the land is close to the hub of Caboolture?

Ms Taylor: As far as I am aware the land is closely associated with the hospital, but I could not tell you exactly where it is.

Senator FURNER: What sort of feedback did you get from the consultations that you held on 16 March? Is it possible to give an example of what sort of feedback occurred?

Ms Taylor: I do not have the consultation paper here with me at the moment but I could take that on notice. It is mixed. In each instance where we do consultations, you do get a mix of views. Generally the local population is very keen and supportive, allied health professionals are usually very keen and supportive of super clinics, and the reaction from the local GP fraternity is quite often mixed. We do have some support, and there was support expressed on that night from a number of local GPs interested in the idea, but it is fair to say that there was also a little bit of discomfort from some of the local GPs as well.

Senator FURNER: I take it that would be generally from other consultations with people not familiar with what they deliver and concerns about their local practices?

Ms Taylor: Exactly, but it is very clear from the consultations that, by and large, he general public do see the need for additional services in their local areas.

Senator FURNER: Would you be able to indicate whether this is going to be another multidisciplinary model such as say Strathpine as an example?

Ms Taylor: It will be. All super clinics will feature multidisciplinary workforce. That is a feature of the model, as is very close integration between the services. They will work closely in a team environment to make sure that people who need integrated care across a range of multidisciplinary practitioners can get it in the one centre.

Senator FURNER: There will be a focus on mental illness, for example?

Ms Taylor: Potentially.

Senator FURNER: With a reasonably large Indigenous population around Caboolture, there will no doubt be a focus on that as well?

Ms Taylor: That is right. When we put out the call for invitations to apply we put out some data that indicates the type of services that we would like to see in each individual location. That information is based on the health demographics of the area. We do look to see how the applications have addressed those particular criteria.

Senator FURNER: Going back to your response in respect of the comments at the public consultation, I am aware that some practitioners, one locally and one from Wamuran, raised some concerns about the effect on their private business and practices. That was certainly replicated as well by the local federal member for Longman, Wyatt Roy, in terms of expressing concerns. Once again, is that the general response from people who are unfamiliar with what GP super clinics deliver and are fearful of them having some impact on their business overall? Is it that they are unaware of what they primarily deliver on the ground?

Ms Taylor: That is true. I think that is a fair comment in terms of the general worry in many places by local practitioners of what the implications of the super clinic are, without necessarily understanding how patients in their practices can actually benefit from those GP Super Clinic services as well. Because there is absolutely nothing to stop patients of practice A seeing a practitioner in the super clinic and then coming back to their home practice; it is not like it is exclusive for the patients in a particular super clinic.

Senator FURNER: I think one of the unreasonable comments was made by a doctor indicating they were a glorified practice operating nine to five. Certainly based on my experience with Strathpine, that is not the case. They operate into the long hours of the evening and also on both Saturday and Sunday and provide excellent services. I take it that is what your expectations would be of Caboolture as well?

Ms Taylor: Yes, they are expected to operate extended hours of services. Very clearly that is in the guidelines.

Senator BOYCE: I asked before about the Caboolture Super Clinic which I could not find in this update. Is it there or not? Can you give me the page number?

Ms Taylor: Page 28. That table is actually about the original 36 super clinics.

Senator BOYCE: Would it be possible to update this table including the new ones?

Ms Taylor: We can do that, yes, certainly Senator.

Senator BOYCE: You mentioned a score card used for each super clinic. Can we have that made available please?

Ms Taylor: A score card is probably slightly misleading in terminology. What we actually do is on a quarterly basis we compare the implementation arrangements in each super clinic against the 10 program objectives because that is actually looking at what we are tracking them against. As a rule that is just an internal tracking document. I am not sure that we would necessarily—

Senator BOYCE: What would be the problem with making that publicly available?

Mr Booth: Certainly in terms of the 10 objectives that is publicly available. I think what we are saying is that we use that as a kind of internal project management tool almost to check that things are on time and that things are being delivered as they should be.

CHAIR: Go back, take it on notice, get clearance and get back in contact with us.

Mr Booth: Yes, certainly we can do that.

Senator BOYCE: Yes, because that would be useful to know. You mentioned before the scope of practice and how do you evaluate whether clinics are meeting the guidelines you have set for them?

Ms Taylor: As I mentioned we do a quarterly catch up with each clinic in terms of the services they were originally designed to, and under our funding agreements, had agreed to deliver. The purpose of the quarterly report cards is to actually look at how they are tracking against those services.

Senator BOYCE: What happens if they are not tracking?

Ms Taylor: We certainly ask questions as to why not. We have not had an issue with that at this point in time given the range of services that the clinics are delivering.

Senator BOYCE: We have got this new tranche to come in Queensland but how many services are actually operating in Queensland at the moment?

Mr Booth: In terms of the 10 super clinics that are currently operational we have Ipswich in Queensland and we have Brisbane Southside. So in terms of the 10 Super Clinics—

Senator BOYCE: Brisbane South is not fully operational, is it?

Mr Booth: Yes. We have got Brisbane Southside, we have got Ipswich and we have Strathpine. That is three that are fully operational at the moment.

Ms Taylor: Can I just make one comment there? The Annerley hub of Brisbane's Southside which is basically a standalone super clinic is fully operational, yes.

Senator BOYCE: But the spokes are not, is that how it works? The Logan hub is not operational?

Ms Taylor: It is a slightly different model to everywhere else. Each super clinic is its own individual clinic and that particular model has two stand alone hubs which are essentially two super clinics for the price of one.

Senator BOYCE: I am pleased to hear that we are getting some economies of scale here even if we do not have one of it seeing patients as yet. Going back to the comments that Senator Furner was making about the I think quite realistic concerns of local private practices as to whether a Medicare clinic is going to impact on their own business, do you assess what happens to their businesses after the opening of a super clinic?

Mr Booth: We would not formally go in and do a review of other practices, no.

Senator BOYCE: I am not suggesting that you would formally go in and review their practice but you might ring them and ask them if business is down?

Mr Booth: We would not do that as a matter of course, no.

Senator BOYCE: So you really have no idea if they are affecting the local business?

Ms Morris: From time to time and often in this forum here this question is asked and sometimes comments are made. Ms Taylor can correct me if I am wrong but I do not think we have actually had any formal complaints from any existing practices.

Ms Taylor: That is correct, Ms Morris. We do get some commentary particularly in the media about claims of practices going out of business. We certainly have not had any formal advice or any evidence to suggest that there has been that type of an impact on a local practice. Part of our evaluation process that will be undertaken in the second half of this year will actually have a survey part process to it. In this, the evaluators will ask questions in each of the super clinics of the patients, to actually get a feel for how they may have moved from other local practices in the area, what drew them to the super clinic, how they actually continue now to seek their services across the area now that the super clinic is there as a choice.

Senator BOYCE: Just intuitively you would think that if I am going to get two or three services from one place then I would perhaps see the GP in that place as well?

Ms Taylor: Possibly. People seek GP services for all sorts of reasons. If I am happy in my service I will stay with my GP. If I cannot get in on a day I might go to the super clinic if they happen to have a vacancy spare but that does not mean I will not go back to my home practice. That is the sort of information we will try and get through the evaluation to see how people source their health care.

Senator BOYCE: I would think there is some sort of responsibility here of the department to see what effect super clinics have had, if there is truth to the comments made by local practitioners on the effect or potential effects on their business.

Ms Taylor: As I said, we will certainly survey patients to see what they can tell us about their health seeking activities.

Senator BOYCE: In terms of the super clinics running on time in Queensland, can you tell me how up-to-date you are with meeting the objectives that you have?

Ms Taylor: In terms of the time frame of the roll out for the remainder of the clinics?

Senator BOYCE: Yes.

Mr Booth: In terms of sites that have commenced construction activities and offering early services, Cairns falls in to that category.

Senator BOYCE: You have commenced construction activities there?

Mr Booth: Yes, and they are offering some early services.

Senator BOYCE: What does that mean?

Mr Booth: That they have started building.

Senator BOYCE: Okay.

Ms Taylor: In the case of Cairns in fact we have completed the upgrade of a spoke site. The site for the hub in Cairns has actually just been finalised in terms of the subdivision arrangements and they do hope to start the construction of a hub fairly soon.

Senator BOYCE: So you have not actually started building there?

Ms Taylor: The hub site, no that is correct, but we have a number of subspoke sites that are operational.

Mr Booth: In terms of being constructed, we have Bundaberg and Redcliffe in Queensland as well. Those are being constructed.

Senator BOYCE: I note that Redcliffe is going to open in mid-2011. Does that mean this month?

Ms Taylor: At the moment the time frame for Redcliffe is late July, I believe, July-August.

Senator BOYCE: The update did say mid-2011?

Ms Taylor: Yes, that is right and our time frames for mid are from April through to July-August. It is not a June thing; there is a window. We have done that to just divide the year into early, mid, late so we have got a window for each.

Senator BOYCE: I actually had some photographs taken last Friday of the Redcliffe site, of which I have copies here for you. It has got a lot of scaffolding and some concrete floors.

We have scaffolding; we have a few concrete floors, and nothing else. This does not look to me like a building that is going to be finished within six months. What are your views on that?

Ms Taylor: I am reporting what the operators tell us, and that is that they expect to be finished the construction in July-August.

Senator BOYCE: All right.

Senator ADAMS: They will be busy.

Senator BOYCE: As Senator Adams says, they are going to be very busy.

Ms Taylor: Absolutely, and that is what we like to see.

Senator BOYCE: There are no walls, there are no windows, and there are no carpets. It certainly will not be there by 30 June, which is what I took to be mid-2011, but even by 30 August, it will be a stretch to get there. How many other super clinics are in that situation? Certainly if you look at the list that we have, the guidelines have crept out and out. In many cases the deadlines have crept out. How many others are like this where the probability of it being finished in time is moot?

Mr Booth: I just emphasise what Ms Taylor was saying. These are quite large construction projects. We follow them and track progress on them very closely. The contractors in the local area give us information and assurances as to when things will be completed, and in the terms of this particular one, that is the information that they have given to us.

Senator BOYCE: Are there penalties if it is not?

Mr Booth: We certainly keep a very close eye on what is happening, and want to know if there are major delays or anything has happened that might impact on time frames. These are quite large construction projects, and inevitably things either speed up or slow down, as on any construction activity.

Senator BOYCE: One assumes that the people doing it are quite used to undertaking large construction projects.

Mr Booth: Yes, and we have the 10 operational; we have a number that are expected to be completed fairly soon. We are moving through them and they are being built, and they are delivering services.

Senator BOYCE: Given that people thought they were going to have 30 of these a couple of years ago, it is still a bit of an issue. Can you tell me about Townsville?

Ms Taylor: Townsville commenced construction last week.

Senator BOYCE: Last week?

Ms Taylor: Last week.

Senator BOYCE: When will it be completed?

Ms Taylor: It is mainly a refurbishment of an existing site, so the expectation at this point is that construction work will be finished at the very end of this year, with services to start early in the new year.

Senator BOYCE: What will the services be?

Ms Taylor: The Townsville Super Clinic will have GPs, specialist services such as orthopaedics, gastroenterology and cardiology, a range of allied health professionals including physiotherapists, mental health counsellors, psychologists and dieticians. There will be a pharmacy. They will take pathology, and radiology services will also be co-located. I would point out that in Townsville a number of those services have already started as early services, and that staff will transition into the super clinic. They have quite advanced efforts around their workforce. I do not anticipate that there will be an issue between the finish of construction at the end of the year and actually having the workforce to go in there in early February.

Senator BOYCE: Indigenous health services?

Ms Taylor: They will have Indigenous health services, specialist services in conjunction with TAIHS, which is the local Aboriginal and Islander service.

Senator BOYCE: You said that this is a refurbishment in Townsville. How long has this refurbishment taken?

Ms Taylor: As I said, construction started last week on the refurbishment. There have been some issues around the site in Townsville. The original plan was to actually have it go into a larger multistorey complex with which the developer did not go ahead. For a period of time after that, our funding recipient sought a new site to go to. There was a bit of toing and froing. There were some issues around contamination on the site that they had to get fixed up, so it has been a bit of a challenge in terms of getting to this point.

But we are there now. Construction has started, and we believe we will be in there in early 2012.

CHAIR: What is the site?

Ms Taylor: The site is in Charters Towers Road. It is an old car yard.

CHAIR: Charters Towers Road in Mundingburra?

Ms Taylor: As an ex-Townsville resident, I could not actually tell you, but yes, Mundingburra is essentially along that stretch.

Senator BOYCE: It has taken us three-and-a-half years to get there, really, I guess?

Ms Taylor: As I explained, there have been a number of situations beyond the funding recipient's control in terms of the site.

Senator BOYCE: But I am told it was 27 January 2009 that the tenders closed for Townsville, so we will be three years in the making. Back to your evaluation, when do you plan to complete the evaluation of the operating super clinics? Will that be a national evaluation?

Ms Taylor: It will be a national evaluation of clinics that have been open for 12 months or longer.

Senator BOYCE: How many is that?

Ms Taylor: From memory, that is six or seven of the current 10, and they will also look at all of the other sites as well, but focusing on the operational ones, because we are interested in how they are achieving against the objectives.

Senator BOYCE: For a scheme that was going to give us a great big bang in 2008, we have six that have been operating for more than 12 months. Thank you.

Senator FIERRAVANTI-WELLS: In relation to the funding agreements for the GP Super Clinics, will you be monitoring the funding agreements for the next 20 years to ensure that there is no breach? These funding agreements go for 20 years. What do you have in place to ensure that there is no breach of funding agreements?

Ms Taylor: The agreements will be monitored over the next 20 years as we monitor them now. Each year there will be an assessment against their annual plans, and if there are breaches at that point, they will be dealt with as the program unfolds.

Senator FIERRAVANTI-WELLS: The resources for that are within the GP Super Clinics budget?

Ms Taylor: My understanding is the resources will continue within the division.

Senator FIERRAVANTI-WELLS: Going back to the original allocation of the program, it was stated that there would be an assumed amount for MBS, PBS and DVA. In relation to each of those areas—I will put this question on notice because it is a bit more technical. In relation to these primary care infrastructure grants, at page 216 of the yellow book, you propose to go a second round of those infrastructure grants. Given you have your GP Super Clinics program, why are you doing a second round? If your GP Super Clinics program was successful, why do you need a second round of the infrastructure grants? Can you explain why you have both?

Mr Booth: It was always intended to have two rounds with the primary care infrastructure grants. When the measure was introduced, it was for two rounds.

Senator FIERRAVANTI-WELLS: Notwithstanding what has happened with the GP Super Clinics, you have just decided to go ahead with the second round?

Ms Morris: This was a government decision, and we are implementing that decision.

Senator FIERRAVANTI-WELLS: All right. I might put some other question on notice in relation to that.

Ms Taylor: Just to make it really clear, you are talking about the small infrastructure grants for general practices around Australia?

Senator FIERRAVANTI-WELLS: Yes.

Ms Taylor: The 425-odd grants?

Senator FIERRAVANTI-WELLS: I am talking about the ones that go from pages 214 to 216.

Ms Taylor: Essentially it is a different target group, but yes, if you would like to put questions on notice, that is fine.

Senator FIERRAVANTI-WELLS: Thank you.

Senator McEWEN: I wanted to follow up on the primary care infrastructure grants. You said that there were two rounds, and it was the government's announcement in the 2010-11 budget that there would be two rounds?

Ms Taylor: Yes.

Senator McEWEN: In the first round, approximately $64 million worth of grants were made available?

Mr Booth: Yes, $64 million.

Senator McEWEN: Some of those have been announced out of that first grant, is that right?

Mr Booth: Out of the first grants, yes.

Ms Taylor: Some 245 applicants were shortlisted for grants, and of that we have 98 funding agreements proceeding.

Senator McEWEN: Were they across the three streams—A, B and C?

Ms Taylor: They were.

Senator McEWEN: Do you know how many of those 98 were in each of the three streams?

Mr Booth: Yes. In stream A, which was up to $150,000, there were 115 applications. In stream B, which was up to $300,000, there were 61 applications. In stream C, which was up to $500,000, there were 64 applications.

Senator McEWEN: They are the applications, but of the 98 successful applicants, which streams did they fit into?

Ms Taylor: They were the shortlisted applicants. We are just progressing the 98 as part of that 240-odd as we worked through. I do not have the detail of which stream they were in.

Senator McEWEN: Did that expend the $64 million?

Ms Taylor: Yes. We have a scenario where the odd grant recipient drops off and we replace it, so the amount is around the $64.5 million, but we still have $64.5 million to spend, irrespective of whether the total is slightly below that or not.

Senator McEWEN: The second round is, I understand, an additional $50 million?

Ms Taylor: Yes.

Mr Booth: Yes, $52.5 million.

Senator McEWEN: Have applications been sought for that round?

Mr Booth: Yes, applications were advertised on 16 April, and they close on 10 June.

Senator McEWEN: They will be allocated on the three streams again—$150,000, $300,000 and $500,000?

Mr Booth: Yes.

Senator McEWEN: Is that money primarily to assist existing practices to improve their facilities for clients?

Mr Booth: That is correct. They are small scale grants for improvement of facilities.

Senator McEWEN: Give me an example of what they might be used for, or are being used for, in fact?

Ms Taylor: The sorts of things they are being used for are to build additional consulting rooms, offices for staff, particularly nursing staff, additional rooms for allied health professionals, occasionally pathology collection rooms, treatment rooms for nurses and allied health workers to work out of. There is a fair range of things they are actually being used for.

Ms Morris: It might enable them to undertake teaching—

Ms Taylor: That is right, for the larger grants, absolutely. That is what we are looking for.

Senator McEWEN: Were there any criteria about where they should be allocated?

Ms Taylor: No.

Senator McEWEN: Did the applicants have to demonstrate where the community was not able to have the service because the facility was not available in the centre?

Ms Taylor: With the number of grants available, it is a broad scale approach. If your general practice could show cause, effectively, through the criteria, then the eligibility was met.

Senator McEWEN: Are we confident that the second round of $52.5 million will be fully expended?

Ms Taylor: Absolutely.

Senator McEWEN: I take it that it has been a very popular program with general practices?

Ms Taylor: It has been an extremely popular program, yes.

Senator McEWEN: Okay, thank you very much.

Senator FIERRAVANTI-WELLS: In relation to the 10 super clinics that are currently operational, do we know how many of these were actually GP services before they became GP Super Clinics, and how many were allied health care services? In other words, of the 10, do we know how many were existing GP services?

Ms Taylor: None of them were allied health practitioners. Ballan was an existing small bush nursing hospital that was expanded through the grant. Strathpine was brand new. Port Stephens was brand new. Devonport was an extension of an existing site. Geelong was a brand new purpose built centre, as was Palmerston. Ipswich was brand new. Southern Lake Macquarie was quite a significant extension of an existing practice. The Brisbane Southside Annerley Hub was a lease arrangement in a new building, and Burnie was a new building as well.

Senator FIERRAVANTI-WELLS: What about the GPs in those clinics? Were they already operating in the area?

Ms Taylor: There are 70-odd GPs currently working in the super clinics. A few of them were existing in those areas, but the large majority were not.

Senator FIERRAVANTI-WELLS: Can I infer that the large majority are new to the area?

Ms Taylor: Yes, a large number of them were, including overseas trained doctors (OTDs).

Senator FIERRAVANTI-WELLS: I will put some questions on notice in relation to that. I want to provide you with a copy of an answer to a question that was provided to Dr Southcott by Minister Roxon on 11 May in relation to super clinics. Whilst that is being copied, perhaps Senator Adams could ask her couple of questions.

Senator ADAMS: Can I have a progress report on the Western Australian GP Super Clinics?

Ms Taylor: There were three GP Super Clinics in the original tranche for WA. They were at Cockburn, Midland and Wanneroo. The Midland super clinic started construction on 18 April, so that is all systems go. We understand from the operator there that they believe they will be operational by early 2012. The Cockburn GP Super Clinic is part of a significant health precinct being developed by the Cockburn City Council. That one will be part of a $40 million precinct which will have a somewhat extended timeframe given the scale of the exercise. Again, we believe that that will be late 2012. Despite our best efforts, the council has a timeframe of its own for that precinct and the super clinic is part of that health precinct. The third site in WA was Wanneroo. It has not started construction at the moment. We are in negotiations around a second stage funding agreement with the funding recipients on the Wanneroo super clinic at the moment. We hope that we will have that signed in the very near future. They have proceeded under an interim funding agreement to do so early work around establishing the business arrangements for the clinic, so the second part of the funding agreement will look to see construction commence.

Senator ADAMS: I have not been as proactive as Senator Boyce to go and take some photos of Midland, but I do not really think there is too much progress going on. I will certainly check it out when I get back.

Ms Taylor: It certainly has faced a number of challenges in the local area, with the local council authorities, but as I said, it is up and going now, and it is moving along.

Senator ADAMS: Would you like to tell me about the applications for the proposed GP Super Clinics for WA?

Ms Taylor: The three additional sites in WA are Northam, Rockingham and the West Pilbara. The West Pilbara consultation was completed on 31 January. We have recently assessed that application, and the Northam and Rockingham assessments have also been concluded. Those reports are in the write-up stage at the moment.

Senator ADAMS: Is it confidential, or can you say when you think they will start building?

Ms Taylor: As I said, the reports are being written up in terms of the outcomes of the assessment processes for those at the moment. I do not have dates for anticipated openings.

Senator ADAMS: Overall, Western Australia was one of the first areas to have these announced almost five years ago, but nothing has happened. We are getting there slowly. Do you have any comment as to why it has taken so long?

Mr Booth: As we said earlier on, some of these are quite large construction projects. As I understand it, some of these sites have had issues around consent and different areas that they have had to get through. Some of those processes just take quite a bit of time to work through. I think that is one of those examples.

Senator ADAMS: With respect to primary health care and GP super clinics, how will Medicare Locals interact and what will happen?

Mr Booth: Super clinics in a Medicare Local area will be one of the providers within that Medicare Local area. As we said earlier on, in terms of what Medicare Locals do, they have this responsibility for looking at the health needs and planning health services for their population. The super clinics in a particular area will be one of the providers that they will need to take account of and include in their planning.

Senator ADAMS: If the super clinics are not performing, do they come under the health performance agency? Where do they fit in? If Medicare Locals are trying to make sure that they do what they have said they will do, but cannot because of a lack of personnel, what happens? We could use as an example Karratha, in the north-west of Western Australia, which is almost a city. Trying to get health professionals up there is not easy. The GP super clinics have allied health services and they have this and they have that, but if they are not performing because they cannot get staff or the staff are overstressed and things are not going right, where does that monitoring come from?

Ms Megan Morris: GP super clinics employ privately billing health professionals as per any other private GP or integrated practice in the country. The national performance authority will be looking at the healthy community reports, which look at health outcomes in aggregate for an area. If they are showing up outcomes that you might not expect, or do not tally with the number of service providers and your understanding of the health needs of a population, you would expect the Medicare Local to drill down and work with local service providers to try to identify the issues. As the secretary has said previously, there are many layers to the health performance framework. The department will also have a role in there. We monitor the individual super clinics regularly, but there will also be the Medicare Locals working with local service providers.

In summary, the system in future will have a lot more transparency about health outcomes, and there will be many avenues to respond to where there are problems.

Senator ADAMS: The transparency is getting very blurred as to who is responsible and how it will work. Mental health services would probably be a great example, once again, out in those sorts of areas. If the GP super clinic does not have a psychologist or a psychiatrist available, how do they provide the mental health services?

Ms Megan Morris: Medicare Locals will have a responsibility for trying to work with the existing local workforce and identify ways to address gaps in the primary health care workforce, which they might do by organising to get someone in on a sessional basis. They may be able to get someone to move. They may be able to strike a deal with the local hospital

network and work with state employed professionals, as some divisions of general practice do now, where there are workforce gaps.

Senator ADAMS: Good. That was my next question. How do the local network boards fit into this little scenario?

Ms Megan Morris: I thought we were still on GP super clinics. You are confusing me, Senator.

Senator ADAMS: Practically, it has become a nightmare.

Senator McLucas: I do not know that we can say that. I think the infrastructure is very clear that we have the Medicare Locals—

Senator ADAMS: It is not clear. I do not want to contradict you, but unfortunately it is not clear. I would not be asking these questions if it was clear.

Senator BOYCE: When you have half of us ringing you regularly asking what is going on, it cannot be clear.

Senator McLucas: We are here to help make that clear if we can. The relationship between a Medicare Local and a GP super clinic is the same as that between a Medicare Local and existing private practice. They are not different at all. It is just another point of service delivery in a geographical area.

Senator ADAMS: Unfortunately there is a lot more bureaucracy as well, which is a pity.

Senator McLucas: I do not think so, Senator, and I do not know that—

Senator ADAMS: Primary care is very important, and in a regional and rural area it is even more important because there are fewer health professionals.

Senator McLucas: Absolutely, and that is why we are putting in this infrastructure to support better service delivery to your constituency and mine, which are the ones that are currently underserviced.

Senator ADAMS: Okay.

Senator BOYCE: I am getting a little perplexed here. When you said there had been a refurbishment just started in Townsville, what is the address that that is being done at?

Ms Taylor: I believe it is 87 Charters Towers Road.

Senator BOYCE: Was that the former GP practice?

Ms Taylor: No, that was a former car yard.

Senator BOYCE: I have just had an email through from someone in Charters Towers telling me that the former car yard is vacant, the old buildings have been removed and there is nothing happening there.

Ms Halton: It is not in Charters Towers; it is in Townsville.

Senator BOYCE: Charters Towers Road, sorry. There is the Ross River Road, Mundingburra site, where nothing has happened, but that is not on the radar yet, is that right? That was announced in 2007, but nothing has actually happened there.

Ms Taylor: No, that was the site where the developer was to build the building, and the developer did not go ahead with that development.

Senator BOYCE: Okay. The car yard is—

Ms Taylor: On part of the car yard, there are a number of buildings, as I understand it. There is a main workshop showroom area that is undergoing some refurbishment, and there are a number of outlying small buildings on the site that are being pulled down or removed.

Senator BOYCE: So you are not refurbishing?

Ms Taylor: The larger showroom area is being refurbished, yes. It is having various renovations done to it. I do not know how else you would describe it. The showroom part of it is being refurbished. There are roof works and things planned for it. It is a staged process. I understand there are some buildings being pulled down. This started last week. As to whether there are men up ladders, I do not know.

Senator BOYCE: Apparently the old buildings have been removed.

Ms Taylor: Yes, that is part of what is happening at the site.

Senator BOYCE: That is a start, but the site is apparently completely vacant.

Senator McLucas: Yes, that is why we are refurbishing it.

Senator BOYCE: How do you refurbish a vacant block of land?

Ms Taylor: It is not a vacant block of land, Senator. You will find that it is an unused car yard.

Senator BOYCE: That is not the information I am receiving from someone who has just walked across the road to have a look.

Senator McLucas: There are no cars in the car yard, is that right?

Senator BOYCE: No. They are saying there is nothing there. The site is vacant.

Ms Halton: What do they mean by vacant? Do they mean every building has been bulldozed, or do they mean that the site that was the showroom remains there? That is our understanding. That building is being refurbished, and other buildings were being removed.

Senator BOYCE: But you told me that the refurbishment had started last week.

Ms Taylor: The refurbishment, as I said, is part of the internal works. There are also roof works. It is a staged process. When I say a refurbishment, there is an entire—

Senator BOYCE: But does that not mean people on site doing stuff?

Ms Taylor: I can only tell you what they reported to us. They have said that this is the work going on. As to whether they are inside, or whether it is a lay day for the builders up there, I am sorry but I do not know.

Senator BOYCE: But if nothing has been done since last week, do you feel misled?

Senator McLucas: You have a view and the officers have a report. Your view is coming from someone who has walked across the road—

Senator BOYCE: And is standing outside Charters Towers Road. I went and took these photos of something that is clearly not going to be functioning in two months or so. How many examples of this do we need, Minister?

Senator McLucas: I cannot predict what the builder is doing today. As you would know, having undoubtedly gone through building events, we cannot expect to know whether the builder will be ripping up floorboards today or what. We have been advised that these works have started.

Senator BOYCE: You may well have been advised that these works have started, and none of this would be quite the issue it is if it had not been advised by the then Prime Minister in 2007 that there would be 30 of these within a year or two. None of it has happened, and what is going on right now is a classic example of why it is so slow in happening.

Senator McLucas: Be very clear, this is a five-year program, which is a considerable build around the country. You pointed to a February date in 2009. As you may remember, the other thing that happened in the Townsville instance was that the global financial crisis hit big time around then. The proponent was going to be part of a larger development directly over the road from Stockland, on the corner of Ross River Road and the road to the university. That construction did not occur. You can attribute that to the fact that the global financial crisis hit right then.

Senator BOYCE: Perhaps we could use the floods as well?

Senator McLucas: Don't be silly, Senator.

Senator BOYCE: Well, this is fact.

Senator FIERRAVANTI-WELLS: I want to pick up on a report in the *NT News* on comments made by the director of GP super clinics within the department, Ms Anne Thorpe. Is Ms Thorpe here?

Ms Taylor: She is on leave.

Ms Megan Morris: Not because of Senate estimates. It has been planned for some time.

Senator FIERRAVANTI-WELLS: Okay. I am happy to provide you with a copy of this article once I have quoted it. I only have the one copy. The article in the *NT News* states:

> Director of GP Super-clinics within the Department of Health and Ageing Anne Thorpe said that there are clinics within the country that are struggling. 'Some other clinics are finding it challenging providing the services that were set up to deliver,' she said. 'We've got clinics that are struggling. The patients who are walking in the door are not the sort of patients who have the sort of chronic disease that they think they should be focused on.'

It is an article about a new GP super clinic proposed for Darwin's northern suburbs which will not be offering bulk billing. Ms Thorpe has obviously made this comment on the record, and I wanted to ask Ms Thorpe why GP super clinics are struggling—like this one in Darwin, for instance. Are they in the wrong place? Are they duplicating services? What sorts of patients do super clinics intend to treat if that is the sort of comment that Ms Thorpe is making on the record?

Ms Halton: Let us be very clear about this. To start with, Ms Thorpe is on leave. But, in anticipation of this, there are absolutely clear rules in the department that officers basically do not speak to the press unless they have my authorisation. I can tell you that Ms Thorpe is a very, very, very good officer, somebody whom we value highly. Ms Thorpe is not known to flout the chief executive's instructions and go talking to the press. To start with, she did not provide comments on the record to a journalist. I will leave it to my colleague to go to the content.

Senator FIERRAVANTI-WELLS: I am going on a report which has her comment in inverted commas. I appreciate your comments, but I am just going on what I have in front of me.

Ms Halton: And I am saying to you—

Senator FIERRAVANTI-WELLS: Are you saying that she did not make those comments on the record?

Ms Halton: Yes.

Senator FIERRAVANTI-WELLS: Okay, right.

Mr Booth: At any of the super clinic consultations, there is an open forum in terms of discussion where members of the public and interested parties come along and talk to different groups of people. Certainly no quotes were given to the press at this time. In terms of what Ms Thorpe was talking about at the consultation, there was a general discussion around chronic conditions. Comments were made by people in attendance about general practice and primary care in general and about the movement from a kind of acute based model of primary care, where people go along to clinics just because of an acute episode, as opposed to seeing clinics and general practice more with a chronic condition.

Senator FIERRAVANTI-WELLS: Can I just interrupt. I have a couple of very specific questions. Did she make the comments or did she not make the comments?

Mr Booth: As to the comments that were quoted here, my understanding is that they were taken out of context.

Senator FIERRAVANTI-WELLS: So she did make the comments?

Mr Booth: No.

CHAIR: I am sorry, senators—

Senator FIERRAVANTI-WELLS: Can I get the witness to say she either made them or she did not? You have obviously come prepared.

CHAIR: You have asked the question. They have the question. We are actually over time in this session, as you well know. You have asked the question. In response to Senator Fierravanti-Wells' question, did Ms Thorpe make those comments or not?

Mr Booth: Not in that context.

Senator CROSSIN: I am hoping that you can provide some assistance here. I know that Ms Thorpe is on leave. I think you will find that that article is derived from the public consultations that were held in Darwin regarding the proposed northern suburbs GP super clinic, to which that reporter from the *NT News* turned up unannounced and unregistered and proceeded to record all of the comments that were made in that two-hour session.

Senator FIERRAVANTI-WELLS: So she did make them?

Senator CROSSIN: Did she make those comments? I do not remember exactly word for word whether she did. I do not—

Senator FIERRAVANTI-WELLS: You just said they were recorded.

CHAIR: Excuse me. Senator Crossin, I am speaking, and in the normal process of order—

Senator FIERRAVANTI-WELLS: Can I raise a point of order?

CHAIR: When I am finished, Senator. What I am actually going to say is that Senator Crossin has made a comment. She was not allowed to finish making her comment. When that

has concluded, Senator Fierravanti-Wells, you will be able to make a comment or question that, but not while I am speaking. Senator Crossin, what was the end of your comment?

Senator CROSSIN: Let me just try to clarify it for you.

Senator FIERRAVANTI-WELLS: You have not heard my point of order.

CHAIR: Senator—

Senator FIERRAVANTI-WELLS: You did not hear me on the point of order.

CHAIR: Senator Fierravanti-Wells.

Senator FIERRAVANTI-WELLS: I was questioning the witness. Senator Crossin turns up, you give her the call in the middle of my asking questions, and now you are shutting me down because I am trying to pursue something.

CHAIR: Senator Fierravanti-Wells, I actually take your comment. There is no point of order. In terms of the way this process operates, we actually listen to the people who are actually given the call at the time. You asked a question. The officers were responding. Senator Crossin actually asked whether she could comment because she was there. The secretary actually referred to that. I accepted Senator Crossin's comment.

Senator FIERRAVANTI-WELLS: I hope you continue to give me time to pursue it.

Senator CROSSIN: Let me just clarify this really clearly, point by point. When you hold consultations for super clinics, you are requested to register and you usually let people know you are coming. The *NT News* journalist turned up unannounced and was there for all of the night. She probably took notes on her notebook, or however print journalists make a record of what is said or not said during the night. I do not think they record it digitally; they make handwritten comments. Through the course of that night, Ms Thorpe probably answered over 200 questions. Those comments may or may not have been recorded accurately in a response to many hundreds of questions she was asked to take that night on behalf of the department. She also gave a half-hour PowerPoint presentation and assisted in clarifying questions that people in the audience had. That is the context in which that newspaper report was written.

You would probably need to ask Ms Thorpe whether she actually said those words or not. I was there for the two hours. I do not remember word for word every single answer that she gave.

CHAIR: Thank you, Senator Crossin. Senator Fierravanti-Wells.

Senator FIERRAVANTI-WELLS: Does the department prepare a summary of each of the meetings?

Mr Booth: Yes.

Senator FIERRAVANTI-WELLS: Are you prepared to provide the committee with a copy of the departmental summary of the meeting outcomes for that meeting? They are not on the public website, so are you prepared to provide us with that?

Mr Booth: The summaries that are done tend not to go into specific comments and quotes.

Senator FIERRAVANTI-WELLS: As I understand it, and correct me if I am wrong, we did request Ms Thorpe's attendance here today. Were we advised beforehand that Ms Thorpe was not available to attend today?

CHAIR: Yes, you were, Senator.

Senator FIERRAVANTI-WELLS: Senator Boyce has some further information.

Senator BOYCE: I just wanted to make the point that this was the second time that the director of the GP super clinics department was not able to attend estimates. We queried why this was so, and we were told there would be no issue because the officers here could answer every question that was asked. We are not getting an answer to this question.

Ms Halton: Actually, if I could get a word in, I might be—

Senator FURNER: That is not true. One of the—

CHAIR: Senator Furner!

Ms Halton: If I could get a word in, I might be prepared to tell you what the director actually said in relation to the misquoting of her, which I will be happy to read into the record. Can I also make the point that EL2 officers are not normally expected to give evidence at estimates. It is not my practice. SES officers, who are management, are responsible for answering questions, and you have the senior officers who are responsible for this program. EL2s do not expect to be interrogated at estimates. It is not part of their brief. However, the officers—

Senator BOYCE: We can pursue that at another time, Ms Halton.

Ms Halton: Yes, but, at the end of the day, it is not necessarily a reasonable thing to ask junior officers to sit at the table in relation to these matters. Let me tell you what she indicated, before her planned leave, had transpired at this particular event. She indicates that she was talking about the necessity to understand what an integrated multidisciplinary team based approach to care means. That is half the picture. 'None of this works if a GP super clinic is not relevant to its local situation, and I know that that is tough'—and this is where I think she has used the word 'struggling' which, at the end of the day, is able to be misinterpreted. I think she has learnt a very important lesson out of this. We have all learnt those lessons in our careers, me included. She said, 'We've got clinics that are, you know, struggling with the issue that patients walking in the door are not the patients that have the chronic disease that we think they should be focused on. So, what are they going to do about that?' She then went on to describe the use of population health data and the process by which the clinic could look at the strategies for developing services targeted at attracting patients with chronic disease et cetera.

I am told that the journalist Senator Crossin referred to, who arrived unannounced and uninvited, asked Ms Thorpe whether Palmerston was one of those clinics that were struggling. According to my advice, Ms Thorpe very clearly clarified the use of the term 'struggling' to explain that she was talking about the challenge of integration across privately provided and publicly provided services and the things that I have just outlined. The suggestion is that the context and the way in which this word was used is not accurately reflected in this article.

Clearly Ms Thorpe has learnt a lesson about the use of a particular word, but she was talking about a much broader context. Senator Crossin was there. I do not know whether she can make a comment about whether this is consistent.

CHAIR: I think Senator Crossin is on record now. The call is with Senator Fierravanti-Wells. Do you have anything to add on the basis that we are 10 minutes over time? You were fully advised that we were going to finish at 11.45 am. I have allowed it to continue, so could you complete this issue.

Senator FIERRAVANTI-WELLS: Ms Halton, can you table the document that you have quoted from?

Ms Halton: I cannot table the whole document because there is a series of other things in there.

Senator FIERRAVANTI-WELLS: Can you table the relevant extract?

Ms Halton: We will give you an extract, yes.

Senator FIERRAVANTI-WELLS: At the end of all of this, short of getting a copy of the tape, we do not know that Ms Thorpe actually said the words as quoted in the article. Does denies that she used them in that way?

Ms Halton: No. I think what you are hearing here is that she does not believe that this is an accurate reflection of the broad context of the remarks she made. She makes the point that, when asked explicitly about the word 'struggle', she clarified what she meant. Therefore, this particular reporting is not an accurate reflection of the sentiment but focuses on the word, which is not fair or reasonable.

CHAIR: Thank you, Senator Fierravanti-Wells. I am going to close it down there. We are now completed with the officers from outcome 5. Thank you very much. We now move to Population Health, Outcome 1, and we will start with the TGA.

Senator XENOPHON: *Four Corners* recently had an episode relating to the failure of the DePuy ASR hip replacement device. During the program, Professor Stephen Graves, from the National Joint Replacement Registry, stated that the NJRR had notified DePuy of a high revision rate for the device in 2006, 2007 and 2008. Was the TGA aware of these reports and, if so, what action was taken?

Dr Hammett: The TGA is very aware of the ASR hip issue and has worked very closely with the National Joint Replacement Registry to respond to data arising from that registry demonstrating a problem with that device. In fact, just to be clear, there are two types of ASR hip: one is a resurfacing hip; the other is the conventional XL femoral head hip. The problem that was identified in the 2006 data related to the resurfacing hip device. It was thought at the time by the experts, including Professor Graves from the joint registry, that higher than expected rates of revision of the ASR resurfacing hip were due to the technical difficulty of implanting that particular device. As a result of that and a formal review by the TGA and its expert working group, which consists of orthopaedic experts, advice was given to the surgical community of the need to improve training in the implantation of that particular device. A training program was commenced that led to enhanced levels of understanding of the importance of inserting it and a reduction in the use of that particular hip in Australia.

Senator XENOPHON: Do you see the problem as one of insertion or a problem in terms of the device itself?

Dr Hammett: These things are always easier in retrospect. At the time, the best advice available to the Australian public, to the Australian regulators and to the clinical community was that it was a difficult technical insertion. So a program was set up to train surgeons in the specifics of that and the data continued to be monitored to check whether that training program was in fact working.

Senator XENOPHON: But that advice was subsequently shown to be wrong?

Dr Hammett: No, I am not sure that that is true. In fact, it is a difficult hip prosthesis to insert. Indeed, there are additional issues with the second type of hip that relate not to the technical insertion but to problems with wear in the hip joint. That is the ASR XL.

Senator XENOPHON: And cobalt toxicity is a real issue?

Dr Hammett: The issue around cobalt toxicity is, at this stage, largely an anecdotal and putative issue. It has not yet been confirmed by the scientific literature. But yes, there is a problem with wear—

Senator XENOPHON: I have seen my constituent Catherine Sullivan's results of the cobalt toxicity, and it is quite astounding. It is just off the scale in terms of what it is and what it ought to be. Could we just go to that? When was the TGA aware of the research being carried out by Tom Joyce from Newcastle University in the UK and his colleagues at the University Hospital of North Tees?

Dr Hammett: I became aware of it during the *Four Corners* program a couple of Mondays ago, but certainly our orthopaedic expert working group has been monitoring closely emerging data around the issues of the ASR hip and the data that is arising from not only the Australian regulatory database but databases around the world.

Senator XENOPHON: I am surprised that you were not aware of the research out of Newcastle University in the UK. The research undertaken by that group discovered that in Newcastle there was a failure rate of 26 per cent in patients where the hips were resurfaced, and 49 per cent in those who had full replacements. Australia's revision rates are not as high. Is that because doctors and surgeons are not on the lookout for device failures? Are you aware of those extraordinarily high failure rates in the UK for the same device?

Dr Hammett: I am aware that the *Four Corners* program reported those rates. I have not seen those published. I am also aware that the National Joint Replacement Registry captures better than almost any registry in the world the entire rate of revision of these sorts of devices in the Australian context. Australians need to be aware that we have the ability in Australia, perhaps better than anywhere else in the world, to pick up when these sorts of devices are running into problems. That is why action arising from the ASR hip failures occurred in Australia faster than anywhere else in the world.

Senator XENOPHON: It was portrayed as a 'voluntary' recall, and it was in quotation marks in terms of the answers to estimates of over a year ago. Does it not mislead consumers? In fact, you told them to take it off the market, but you gave DePuy an opportunity to take it off the market so-called voluntarily. Doesn't that in a sense not tell the full story in terms of the concerns about this particular device?

Dr Hammett: What we have sought to do is to make sure that both the clinical community and the patients who might have had these devices inserted are aware of the problems with the device and the appropriate ongoing clinical management. We have done that via a variety of mechanisms. We have written to the peak clinical bodies. They have promulgated that information to surgeons throughout the country. We have had the company actually send out alerts to the surgeons and the hospitals where they were implanted, and we have public information on our website. We have in fact sought to ensure that people who might be affected are aware of the issue.

Senator XENOPHON: Just by portraying it as 'voluntary', although it was in quotation marks in the answer that was given by the TGA last year, does that not inherently mislead consumers about the true status of the recall?

Dr Hammett: I am not sure that that is right.

Senator XENOPHON: Why was it in quotation marks?

Dr Hammett: The important fact in this is that the TGA, through bringing the company to a point where it understood that the data was showing that there was a problem, achieved removal of this device from the Australian marketplace 10 months before it had been removed anywhere else in the world. The practical reality is that the vast majority of recalls that occur in Australia and, indeed, elsewhere around the world are voluntary recalls. The reason for that is that, if companies can be encouraged to understand that there is a need for a recall, it is far less likely to result in protracted legal action that could delay the public health benefits of removing the product from the market. Our concern is to make sure that the product is removed. However, we can—

Senator XENOPHON: Can we just look at DePuy's conduct? Back in September 2007, DePuy Orthopaedics agreed to pay $84.7 million to the US government as part of an agreement to avoid criminal prosecution over financial inducements the company paid to surgeons for the use of their products. In addition, there was a recent UK case in the Southwark Crown Court on 14 April this year where a judgment was given and they paid £4.8 million after their director of marketing was convicted of paying bribes to secure contracts in Greece. Judge Bean said, 'Corruption was in effect a company policy. The corruption was systemic and long term.' If this company has that record, in the US, in the UK and in Europe, is that something that would subject it to greater degrees of scrutiny by the TGA?

Dr Hammett: Our role under the Therapeutic Goods Act 1989 is to regulate products, so we regulate medicines, we regulate medical devices—

Senator XENOPHON: But if a company that manufactures a product has real issues with corruption and has been convicted, or you have a judge in the UK saying that there is a systemic level of corruption in that organisation—that company that is manufacturing these devices—is that something that the TGA ought to be aware of and ought to follow up?

Dr Hammett: I am not sure I can answer that. The TGA in no way would condone that sort of activity.

Senator XENOPHON: I am not suggesting that. I accept that fully. I accept fully that you do not condone it, but does it mean that if you are aware of UK cases, European cases and US cases involving this company and dodgy dealings—out and out corruption—that is something that means you should more carefully, and perhaps more cynically, view any material they provide you?

Dr Hammett: What I would like to have in operation in Australia, which I believe we do have, is a way of monitoring very closely the performance of all joint prostheses.

Senator XENOPHON: That is not my question.

Dr Hammett: Let me finish. I will try to link it directly to your question. The reason why it becomes important to have a framework in place for monitoring all of them is that we would not have the information about any particular company that might be engaging in that

sort of conduct until long after the event. In fact, the matters that you have described presumably have come out in court hearings several years after the event. What is important at a public health level is that we have the mechanism to be able to detect when these problems are happening in real time.

Senator XENOPHON: Sure; I get that. But finally on this, and I will put some questions on notice: if that was in the US in 2007, and in the UK it was earlier this year, does that not set alarm bells ringing in the TGA to say that this company has been in the courts, it has been part of settlements and it has been part of findings by the court about systemic levels of corruption? Would you not be more wary of your dealings with DePuy as a result of those court findings?

Dr Hammett: We are wary of our dealings with all companies, and we have requirements about the probity of those dealings, and we would expect all companies in the Australian context to deal with the regulatory framework honestly and appropriately.

Senator XENOPHON: They have not in the US, the UK and Greece. I will put some further questions on notice. Thank you.

CHAIR: Any further questions of the TGA?

Senator FIERRAVANTI-WELLS: I am happy to hand you a copy of a news article by Shine Lawyers entitled, 'Law suit against manufacturer heats up'. Could you have a look at that, please? DePuy is actually in the Johnson and Johnson group of companies. It states:

The legal battle against a unit of the pharmaceutical giant Johnson & Johnson is heating up with existing participants in the legal action urging other people affected by the company's conduct to, join the fight.

Shine Lawyers is leading the joint US law suit against Depuy (Pron: DA-PEW) Orthopaedics, which engaged in a widespread recall of two of its products in August 2010 due to the products' high early failure rate.

Unfortunately, the product recall came too late for many people …

At the time the TGA approved its use, did you give it qualified approval? You obviously must have taken into account advice in relation to intended use, levels of risk and degree of invasiveness. A range of other criteria were taken into account.

Dr Hammett: Let me provide some context around this. For any medical device, there is a set of regulatory requirements about the long-term safety and performance of that device that the company that markets it is required to meet. That applies to any type of medical device. It is important that the committee understand, and the Australian people understand, that it is not possible to build a device or a medicine or any other therapeutic product that is completely risk free. The point of having a regulator and a premarket approval process is to try to identify what some of those risks are and minimise them. But there will always be a balance between the benefits of a particular thing and its risks. Joint prostheses are in fact incredibly beneficial to people. Of all the operations that are undertaken in Australia, behind cataracts, joint replacement surgery is regarded as the most beneficial in terms of patient outcome benefits, in terms of their quality of life. It takes away their pain.

Ms Halton: And improves their mobility.

Dr Hammett: That is right. Clearly what we have to do is balance an appropriate level of regulatory oversight to determine the risks of a particular product while, at the same time,

acknowledging that these things really do improve people's health. It just is not possible to foresee all of the potential complications that can occur with a joint prosthesis. This particular prosthesis was approved initially through a European notified body. The framework in Australia creates the ability for devices that are made overseas to be approved by these things called notified bodies that do the assessment. That approval was done in Europe by the British Standards Institution back in 2004, I think.

Senator FIERRAVANTI-WELLS: Which Johnson and Johnson got through the British system?

Dr Hammett: Correct. That then allows access to our marketplace. One of the things Australia has done, and done very well, is recognising that you cannot remove all the risk before something gets on to the market. So what you have to do is monitor things once they are on the market and respond quickly. That is where the joint registry data comes in, and our interactions with the joint registry.

Senator FIERRAVANTI-WELLS: Part of my question was: when it was approved for usage in Australia, was it approved with any conditions attached to it? That is not the technical jargon, but you understand my question. Were there any conditions placed on the usage of these devices in Australia?

Dr Hammett: I think the answer to that is no, but I will get back to you when I check the approval on whether there were any specific conditions. There are standard conditions of approval.

Senator FIERRAVANTI-WELLS: I think you should. Correct me if I am wrong, but I understand you were the principal medical adviser to the TGA at the time of this approval?

Dr Hammett: I do not believe I was. I think it was approved in 2004.

Senator FIERRAVANTI-WELLS: If you could take that on notice, I would be most interested to know the risk-based classification process and what the risk base was there, and the various criteria. If you could provide me with that, that would be very good. How many Australian patients have had the device implanted?

Dr Hammett: About 5,500. In fact, that is the two types of ASR hip. It is about 1,000 or so for one and about 4,500 for the other.

Senator FIERRAVANTI-WELLS: When did you first become aware of the problems?

Dr Hammett: The TGA became aware following release of the 2007 Joint Replacement Registry data, and worked with the experts at the time to develop appropriate risk mitigation strategies. We have followed that data and then took up the issue in 2009 with the company that led to its withdrawal from the Australian marketplace.

Senator FIERRAVANTI-WELLS: Were you in discussions with Johnson and Johnson about that?

Dr Hammett: Johnson and Johnson receive, as do all companies who are covered by the Joint Replacement Registry data, information from the Joint Replacement Registry about the performance of their particular hips. In addition, the TGA, following the release of that information, also had communication with J&J about the higher than anticipated revision rates.

Senator FIERRAVANTI-WELLS: Could you direct me to where that is available, on notice? I assume it is not available on the public record?

Dr Hammett: I would have to check on that.

Senator FIERRAVANTI-WELLS: Could you take it on notice when that occurred.

Dr Hammett: If we can make that communication directly available to you, we would be happy to do so.

Senator FIERRAVANTI-WELLS: Thank you. Obviously your purpose is to protect public health and safety by regulating therapeutic goods that are supplied, imported, manufactured or exported from Australia. Why did the TGA not recall the product?

Dr Hammett: As I alluded to with Senator Xenophon, the vast majority of recalls that occur in Australia and, indeed, in other similar regulatory environments are done as voluntary recalls. I think the practical reality is that regulators have a choice: we can engage in lengthy, time-consuming and costly legal battles in front of the courts to effect recalls; or, where we are able to demonstrate through rigorous exposition of the data that there is a problem, we can sometimes—indeed often—get companies to take that action themselves. As you say, our interest is in protecting public health. The fastest way that we can do that, in the most cost-effective manner for the Australian taxpayer, seems to be an appropriate way to do that.

Senator FIERRAVANTI-WELLS: As a consequence now of this lawsuit, do you envisage any liability issues from the Commonwealth's perspective, or have you taken advice in relation to any potential liability that the Commonwealth may have in relation to the legal matters on foot?

Dr Hammett: My understanding is that the liability for any product failure rests with the manufacturer. The class action has involved the manufacturer. I do not envisage that there would be liability for the Commonwealth as a result of our having a regulatory framework for these particular devices.

Senator FIERRAVANTI-WELLS: Nothing perhaps going back to the decision-making process when the product was approved for use? Have you taken advice in relation to that?

Dr Hammett: I have not, but there are proceedings underway. These class actions are under way, and we have not been joined in any of those currently.

Senator FIERRAVANTI-WELLS: I am not asking you what the advice is; I am just asking if you have taken legal advice.

Ms Halton: You know the issues around legal professional privilege.

Senator FIERRAVANTI-WELLS: I am not asking for the advice; I am just asking Dr Hammett if at this point in time he has sought legal advice in relation to the proceedings on foot.

Dr Hammett: No, I have not, as we have not been joined in any of those. Should the need arise, we will take legal advice.

Senator FIERRAVANTI-WELLS: Okay. Thank you; I think I will leave that there and put further questions on notice.

Senator ADAMS: Thank you for appearing. I think you probably know what I am going to ask about. First, with respect to TGA's review of the breast-imaging devices, has that been finished?

Dr Hammett: There is still one outstanding breast-imaging device that is under review. As you will recall, there were seven devices. Six were removed from the market. There is one that evidence has been provided to us about and we are currently working through that last device.

Senator ADAMS: You were actually doing a report, were you not?

Dr Hammett: No. We were reviewing the individual devices to see if they met regulatory requirements and could remain on the register.

Senator ADAMS: I thought you were going to do a report at the end.

Dr Hammett: No, I am sorry.

Senator ADAMS: How unfortunate. What is worrying me is that it has been reported back that a number of the devices that you have had removed are still being used. I know I have asked this question previously, but do we have a watchdog or someone to see that these people are not using things that you have already removed?

Dr Hammett: There are watchdogs there that oversight professional practice of people who might be using these. In addition, there are fair trading laws that are monitored by the ACCC about misleading conduct for consumers. We have in fact written to the relevant professional bodies alerting them to this issue. We have also written to those commercial entities that purchased these devices to inform them of the fact that they were no longer legal therapeutic devices. Ultimately the oversight of the ongoing use of those devices does not rest with the TGA. We have gone to significant lengths to make the relevant authorities aware that there may be an issue that they need to continue to watch or to take action on.

Senator ADAMS: Last time we talked about the colleges, which unfortunately caused a bit of a problem. A lot of these people that are actually performing the service are not registered. They are not health professionals, not having trained as health professionals. They have been trained to use the device. What is coming back to me is the fact that these devices are still being used, so just getting to the professionals is not going to help. How do we deal with this?

Ms Halton: This is consumer law.

Senator ADAMS: Right.

Ms Halton: If you think about it, Senator, if there is no professional body who can apply a sanction to the individual because they are not a professional, we talked previously about where professionals sometimes are involved and how sanctions can be applied. But, where someone is operating outside of that frame, essentially it is deceptive and misleading conduct from a consumer perspective.

Dr Hammett: I have just been advised that we are actively and currently working with the ACCC in relation to three of these particular devices.

Senator ADAMS: That is good to know. We now have BreastLogic, a South Australian organisation now appearing in New South Wales in Tweed Heads. They are out there with very exciting advertising, and then more exciting news: 'BreastLogic Tweed Heads opening

12/5/11. Make an appointment and you win a fabulous gift basket.' Really and truly, what they have gone on to describe is, I would think, going to cause problems for BreastScreen Australia.

Dr Hammett: I do not know if you are able to provide us with the information that you have there, but we will certainly be very keen to follow it up.

Senator ADAMS: Yes, I will table it. It was actually in the *Daily News* on Friday, 13 May 2011, so I am very happy to provide that. It is alive and well, and I know that in Western Australia it certainly is still. Unfortunately, we have a lot of people who think it is okay because it is pain free, and they pay $145 in this instance with BreastLogic to have whatever it is, a screening scan, and there is no rebate, of course, and no guarantee with what is found or where they go from there. It is very worrying. The fact that you are working with the ACCC helps, because I know that they were investigating that. Thank you very much for that.

Senator SIEWERT: I refer to the TGA transparency review, which I understand has been delayed until this month—is that right?

Dr Hammett: It is due to finalise its activity on 30 June.

Senator SIEWERT: What happens from there? Does it move to implementation?

Dr Hammett: The review panel, as I am sure you are aware, is chaired by Professor Dennis Pearce and contains consumers, health professionals and industry representatives. They will come up with a set of recommendations about how we might enhance the transparency of our regulatory processes and decision making. Those recommendations will then be presented to the secretary and considered by the secretary and subsequently by government as to which of those recommendations they might wish to see implemented. Following that consideration, I am sure we will be asked to implement those. I hope that happens in the near future.

Senator SIEWERT: Do you expect that the implementation would require additional funding and, if so, do you have enough funding in next financial year's budget to do that, or would you require additional funding?

Dr Hammett: Currently all of TGA's funding comes through the cost recovery arrangements, consistent with the Commonwealth's cost recovery guidelines. Depending on the nature of the recommendations, there may well be a requirement for additional resources to implement those recommendations. If, for instance, we are asked to publish new information about all of our regulatory processes, premarket and postmarket, that will require resources to do that. One of my hopes is that the transparency panel, in considering their recommendations, will give due attention to the quantum of resources that are required to implement those recommendations to meet the objectives of the transparency review. I think then there comes a question about where that money comes from.

Senator SIEWERT: That was going to be my next question.

Dr Hammett: Ultimately that is a matter for government. It will need to make a decision about that.

Senator SIEWERT: In that case—and if I am putting words in your mouth or misinterpreting, please correct me—if the panel will provide advice about resources as well,

is it expected that they would then provide advice on the source of those funds and how that funding is achieved?

Dr Hammett: I think that will be up to the chair of the panel, or indeed the entire panel, as to whether they want to go to a specific recommendation about where those funds are sourced from, or whether they simply want to attempt to quantify how much resource is needed and then leave it to government as it accepts or rejects particular recommendations to identify the source of those funds.

Senator SIEWERT: I refer to the issue around advertising. At the last estimates, I was asking about the consultation and advertising arrangements. We found out that the submissions closed on 27 August last year. The response from my last lot of questions was, 'Recommendations on future advertising arrangements will be made by the government after due consideration of the submissions.' We are now quite a way down the track. Where is that process up to?

Dr Hammett: You are right: the initial advertising consultations closed last August. The submissions, of which there were 77, were published on our website in October last year. Following that, the parliamentary secretary, Ms King, convened a workshop here at Parliament House with relevant stakeholders. That workshop identified that suggestions for reform in advertising fell into three broad groups: those relating to the preapproval process for advertisements for therapeutic goods; those relating to the complaints resolution panel and its processes, its workload and its efficiency; and those relating to sanctions that were available for breaches of the advertising requirements. Following that workshop, the parliamentary secretary asked that the TGA establish working groups on each of those three areas, and to come back to her with advice around specific options for improving the advertising arrangements in those three areas. The timeline for providing that further advice links very closely to the transparency panel, and indeed many of these issues have come up in the transparency review.

Senator SIEWERT: I am not surprised.

Dr Hammett: What we are hoping to do is to have advice coming to Ms King at about the same time as the transparency panel so that she can consider a coherent package of potential measures to improve the situation.

Senator SIEWERT: Okay. What is the time line for that again?

Dr Hammett: The transparency panel finishes its work on 30 June.

Senator SIEWERT: So the two of them will be together?

Dr Hammett: Yes. I would hope we would be able to update you on progress at the next estimates.

Senator SIEWERT: I will not even ask about when that will be made publicly available, because I know I will get the stock standard answer. With respect to labelling compliance for complementary medicines, I would like to follow up on an update as to where you are now with that process after the random reviews that were conducted in December. Do you think that the level of postlisting compliance by complementary medicines is acceptable? It has found that 15 medicines had labelling issues such as noncompliance with requirements and breaches which may mislead customers. I will not go through the list, because we are running out of time.

Dr Hammett: We would like full compliance with the regulatory framework. We need to be absolutely clear on that. Our expectation is that the complementary medicines industry should be fully compliant with the requirements of the act. On that small sample from which you have reported figures, there were high rates of non-compliance. We are working with a group, again, of the key stakeholders, including consumers, health professionals and the complementary medicines industry, to try to identify ways of ensuring that their compliance improves. We are quite determined that we will see better rates of compliance within this sector. That will potentially require some enhancements to the current regulatory arrangements to incentivise that compliance or improve that compliance.

Senator SIEWERT: It is in the interests of the good operators in that sector that we have a good regulatory process. Is that understood by the broader sector? In terms of engagement with the TGA, how do you find that engagement?

Dr Hammett: Certainly, within the working group that has been established, there is very active and constructive participation from all the stakeholder groups involved, including the industry. I think there is certainly an awareness from those parts of the complementary medicines industry that are involved that there is a need to improve these results.

Senator SIEWERT: You said there may be a need for improvements in regulatory process. Do I take it that that means that, if you cannot get improvements through the process you are engaging in now, you will go to maybe regulatory improvements, or are you considering both at the same time?

Dr Hammett: The working group is being asked to look at the issues that have arisen from this compliance data to try to understand what factors are contributing to that and come up with potential solutions. Some of those may not involve any regulatory change. Some of them may be about educating the industry better about what the regulatory requirements are or clarifying our regulatory guidelines to make them easier to understand—those sorts of things. Some of them may go to more fundamental matters of how we inform the public about the nature of our regulatory activity for these low-risk medicines. As you, and I hope the rest of the committee, are aware, the TGA evaluates these medicines for their quality, whether they are made according to good manufacturing practice, and their safety. They can contain only low-risk ingredients. But we do not evaluate them in terms of the effectiveness of the individual medicine. There is a need for us to make the community aware of that.

Senator SIEWERT: Thank you.

CHAIR: Thank you to the office of the TGA. Ms Halton, under chronic disease, I want to ask you a question about the Swap program. We are in the situation that the clerk has determined that no one in a costume is able to be in the room during the set period. I know that you wish to show us what is happening with the Swap program, so we will invite him in. I would like you to actually give us a quick overview of the Swap program and the importance of it, and then we will adjourn, and then we will actually meet the mascot.

Ms Halton: Thank you, Senator. This is an opportunity for the senators to be apprised of one of our latest public health campaigns, which is in our collective personal health interests.

Mr Davey: You may have seen Eric, a blue balloon man, as part of our new 'Measure Up' campaign, which is called the 'Swap It, Don't Stop It' campaign. This campaign aims to actively encourage adult Australians to make positive healthy changes in behaviour to

contribute to a reduction in the prevalence and impact of chronic disease. We are focusing on physical activity and nutrition, as we did in the first phase of the 'Measure Up' campaign. Evaluation research from the first phase of the campaign recommended that we incorporate strategies helping people understand how they can make changes. There is a very high understanding of why you should make changes, and broadly speaking, what you should do—exercise more and eat better. We are doing this through what is called a swapping framework that people can apply to their daily lives. For example, swap sitting for moving, which might be to swap sitting in front of the TV for going outside and doing some gardening. In developing the campaign, research showed that the Eric character works well to communicate the messages as he is engaging, non-threatening and also, importantly, non-judgmental.

Ms Halton: Apparently he is threatening to the security guards in Parliament House, but we will just put all of that to one side for a second.

CHAIR: I believe he is extraordinarily threatening to the security guards.

Ms Halton: He has actually run around Parliament House previously and never, apparently, caused a threat, but today he is making people nervous.

CHAIR: We will follow up on those issues. Mr Davey, in terms of the reasons and the assessment you just made, that is done through focus groups and people providing that information?

Mr Davey: Yes. We have actually undertaken 129 qualitative groups in the development of this campaign.

Ms Halton: You will have seen a lot of the material, and in fact, after we come back, I actually have some of the material that we are using in a number of the campaigns which I would actually like to share with senators. We will do that after lunch, just so that we can talk about what the purpose of those is in actually delivering these public health measures.

Senator FIERRAVANTI-WELLS: So this is your attempt to stop us eating chocolate; I know it is.

Ms Halton: No, you are allowed a small piece, but you are not allowed the entire block. You have to swap the whole block for something else. It is interesting because, when we tested this campaign, the character actually has very high resonance with people. That is because he does not necessarily look like any one of us. I am not looking at anyone as I say that, can you all notice, but the point about it is: swap part of your drive by parking somewhere and then walking for part of the distance. It does not have to be a difficult thing to just swap one activity for another. You do not have to stop everything you love, and that is really the message.

CHAIR: After the break, we will follow up, but you will be able to give us the costings of the program over the period of time?

Ms Halton: Yes.

CHAIR: And also the TV component where he has been introduced to the public.

Ms Halton: That is correct.

CHAIR: On that basis, we will formally adjourn for the lunch break, and we will welcome in the Swap character. We are formally adjourning the session.

Proceedings suspended from 12:35 to 13:21

CHAIR: We will now continue with the questioning. Ms Halton, at the break you were going to give more information about the Swap It campaign, the process that is now in place regarding expenditure and the term of this campaign. I am particularly interested in the TV aspects because I know that is the largest buy. Can you tell us how long you expect those advertisements to be on and what evaluation process will be in place?

Mr Davey: The total allocation for the campaign is $41 million over four years, which was approved by COAG under the National Partnership agreement in November 2008, so we are coming up to the final two years of funding for that campaign. The current media buy includes TV, as you pointed out, and all media activity under the current buy, which launched on 13 March, is due to cease on 30 June.

CHAIR: This year?

Mr Davey: Yes. That is for that burst of media activity. There is a range of local level community activities. We work in consultation with state and territory health departments to deliver and those activities will continue. There is a range of social media such as the Facebook site, iPhone applications and those sorts of things which will continue outside the life of the media buy itself. At this stage there is no further media booked. We would anticipate, based on previous phases of the campaign, that we would look to continue media buys in the spring and autumn phase.

Evaluation for this Swap It campaign that started on 13 March will commence after the buy finishes, so I would expect the evaluation to begin in mid-June, but we will not expect to see results for a short while after that as it needs to be written up.

The current media buy is approximately $10.3 million in terms of our budget. I note that we have not paid all the invoices yet because they have not all been sent in and they can vary depending on what media was achieved in terms of the buy, itself. You indicated that you wanted a sense of the breakdown.

CHAIR: Yes.

Mr Davey: The TV component of the $10.3 million for this burst is approximately $4.5 million. We have radio with approximately $1 million; digital, which is online advertising, of approximately $1 million; out-of-home advertising, which includes billboards, bus shelters, shopping centre advertising, floor advertising near shopping centres where you go in and those sorts of things, at approximately $2.4 million; magazines at just over $600,000; cinema at about $160,000; and in terms of our media activities targeting culturally and linguistically diverse audiences, it is about $321,000. There is also some Indigenous or Aboriginal and Torres Strait Islander specific advertising, which is about $150,000 for this phase of activity.

Ms Halton: I can give the senators an idea of what material we are using to give people information. You have all met the character and obviously it is very strongly branded as we go through the campaign. I have the material for the senators because I thought you might be interested. You get your little black bag which shows you what tips it gives people to put into action and the advice about what kind of things you are swapping. You can take it home and read it later. It contains the fact sheets that people can access. You have an example of the shopping list. I have also included in here, for your information, because I know that we will get on to it later and I thought rather than tabling things serially, the current information about the smoking campaign that we are indulging in. We will, no doubt, come to that later on, but I

thought it would be interesting for people to take this back to electorate offices and places like that so that you can see what it is that we are using and the messages that we are giving about some of these public health issues.

On smoking, you can see this one 'Stop Smoking, Start Saving.' The whole point about this is that it costs you an awful lot of money to smoke and you can start to save some money. You will find in here the Eric material. There is also a small condom box in here. When I look around this room I suspect that it is maybe not entirely relevant, but when Senator Furner comes back we will give him the packet as well. I can tell you that in here there are his and hers condom tins.

CHAIR: Where are these bags normally given out?

Mr Davey: The bags are quite often handed out at events. If we are targeting youth then it might be at a youth event, so it could be a music festival and those sorts of things.

CHAIR: Is that all in the department's budget?

Ms Halton: Yes.

Mr Davey: That is right.

Ms Halton: These are obviously relevant to the particular target market that we are interested in. This bag contains the big pack with all the Swap It material, the information sheets and so on, which I think will be quite useful, but as I said there will be a number of other campaigns which we will be running which you might be interested in. It is a grab bag of things that we are currently doing.

Senator Furner, we were just discussing condoms.

Mr Davey: I might point out that those two condom tins were designed by our target audience, by young people, in a competition that we ran during the last phase of the campaign. They were voted on by their peers and they were the successful designs.

CHAIR: Are there any other questions in this particular area of population health? Thank you, Mr Davey, and good luck with the campaign.

Mr Davey: Thank you.

CHAIR: We have until 2.30 on the issues around population health and then we will start with the agency.

Senator BOYCE: Where do questions around plain packaging go?

Senator FIERRAVANTI-WELLS: Is it 1.3?

Ms Halton: The people are here.

CHAIR: Senator Siewert has questions about alcohol as well.

Senator SIEWERT: I appreciate that some of these questions may go to the agency. There are two places to ask those questions, which is the agency and here.

Ms Halton: To be fair, because the agency is just starting, I suspect a lot of it will be here. Also, we are doing some of the campaigns on their behalf. The agency people are here and obviously very willing to take your questions. Plain packaging is definitely us.

CHAIR: Senator Fierravanti-Wells.

Senator FIERRAVANTI-WELLS: I will start on the national bowel cancer screening. How long was it that the kits were not supplied under the bowel cancer screening program?

Mr Smyth: The kits are still being sent out. Are you talking about the suspension of the program or the current program as it is running?

Senator FIERRAVANTI-WELLS: My question was: for how long did you stop supplying the kits?

Mr Smyth: The suspension was between May 2009 and November 2009. The kits continued to be sent out following the reinstatement of the program in November 2009.

Senator FIERRAVANTI-WELLS: Is that when the kits started to be provided again?

Mr Smyth: Yes, that is correct.

Senator FIERRAVANTI-WELLS: Has any consideration or recommendation been made to expand the program to biennial screening?

Mr Smyth: Anything in relation to that would be considered as advice to government and taken in the context of a budget and cabinet decision, so unfortunately I would not be able to answer that.

Senator FIERRAVANTI-WELLS: Clearly there would be some component of clinical evidence that would need to be provided. I will rephrase the question. Is there any clinical evidence or reason why it has not been expanded?

Mr Smyth: Minister Roxon made a statement in the House that the NHMRC gold standard guidelines recommenced biennial screening for people aged over 50.

Senator FIERRAVANTI-WELLS: But that is not what is happening.

Mr Smyth: What is happening is a continuation of the program as it is currently running. Any decisions relating to an expansion of the program are decisions for government.

Senator ADAMS: What about repeat screening for Australians over 50? Have you done any work as to the costings for that?

Mr Smyth: They are considered as budget and cabinet-in-confidence decisions, work that I would not be able to share with the committee.

Senator ADAMS: Have you given consideration to any cost estimates? You have continued to fund the program for the future. With the scientific evidence that has come forward about bowel screening, the cost to health services later on and all of those sorts of things, if you were going to do repeat biennial screening of those age groups then surely—

Mr Smyth: There was some work done by a fellow from the United States who came out and did an analysis of the program. That was Dr Michael Pignone. That information was published in the *Medical Journal of Australia*.

Senator ADAMS: I saw that.

Mr Smyth: That gives a range of costings as to any potential expansion of the program.

Senator FIERRAVANTI-WELLS: I would like to ask some questions in relation to the plain packaging.

Ms Halton: While we are changing the officers at the table I would like to give Senator Boyce some information about the Townsville GP Super Clinic. I have had advice regarding the Townsville GP Super Clinic at 87 Towers Road, Hyde Park, Townsville—

Senator BOYCE: Is that Charters Towers Road?

Ms Halton: We are told Towers Road, but I am sure that is the shortened version. As you know, advice has been given that the works entailed a major refurbishment which is a significant conversion package of a car yard. It is correct that no-one is on the site today. We found out why that is the case. It is because the project manager and builders are in a safety and risk management meeting which is expected to last for six hours. Given this is a major refurbishment, the occupational health and safety issues in compliance with the national code of practice are considered crucial, so they have been working on the site and that is where they are today.

Senator BOYCE: Thank you. Risk management would be a good thing for them to learn about.

Senator FIERRAVANTI-WELLS: In relation to tobacco, are you aware of an article which appeared in the *Sydney Morning Herald* on Saturday, 28 May? I have a copy of it for the committee.

Ms Halton: While that copy is coming, I have not got copies I can leave with senators but I have brought examples of the plain packs which I thought we might just circulate around to the senators to actually look at in case anyone has not seen them. We will just pass them around, but we need them back, please.

Senator FIERRAVANTI-WELLS: There is just one paragraph there, The article states:

> Documents obtained through the freedom-of-information process show the government will spend more than $10 million on legal fees to defend plain packaging. This does not include billions in potential compensation to the tobacco industry.

That is the quote I wanted to use. Can you confirm that that is the case—that you have budgeted or that there is an amount of over $10 million set aside to defend proceedings?

Mr Cotterell: The document that you are referring to that was released was a draft costing document. It was not agreed to by the department of finance and no funding has been provided for that purpose.

Senator FIERRAVANTI-WELLS: So there is nothing in the budget papers? Okay, thank you. I wanted to ask some other questions in relation to the improved services initiative in that program. I think it is under 1.3. When I raised it as part of what is left over from COAG, there was a program called Improved Services for People with Drug and Alcohol Problems and Mental Illness. I understand that originally there was $73.9 million, was there? Yesterday when we were having a discussion about mental health I understood that those programs were being rolled over.

Ms Harman: That is correct. That is a program that is managed in another part of my division under outcome 1.3.

Senator FIERRAVANTI-WELLS: What has happened with that? Did we do that program and did we use all the money that was set aside?

Ms Harman: That is a program that has been very successful. It is performing very well. All the money is out there. We have had a strong history of spending the full allocated amount under the program. Currently the improved services initiative provides funding to 122 drug and alcohol treatment services, peak bodies and expert organisations to improve the capacity of drug and alcohol services to manage clients and improve outcomes for clients with comorbid drug and alcohol and mental health issues.

Senator FIERRAVANTI-WELLS: Are you doing an evaluation or is there an evaluation being done?

Ms Harman: I will refer that one to my colleague.

Mr Cotterell: There has not been a formal evaluation of the program. There was a forum for participating organisations that was held in 2010. It was hosted by the National Centre for Education and Training on Addiction. That forum was very well attended and we received very good feedback on the program. As part of the changes to the grants arrangements going forward right across the department, this program will be amalgamated and consolidated into a broader grants program on substance misuse service delivery. It will be another matter with our other similar programs in this area. The intention is that the guidelines will continue to specify that services are able to deliver for patients who have co-occurring substance misuse and mental health issues.

Senator BOYCE: I have a question under 1.1 which relates to the Institute of Health and Welfare's 2001 data, believe it or not, which apparently is the latest we have. It said $11 million was spent on 12 chronic diseases. Apparently this data has not been collected since then in that way. The diseases are heart, stroke, lung, colorectal, depression, type 2 diabetes, arthritis, osteoporosis, asthma, chronic obstructed pulmonary disease, chronic kidney disease and oral disease. What are the latest figures for expenditure on those chronic diseases? I realise this may not be something you can just give me off the top of your head.

Ms Halton: No, we cannot. We will have to take it on notice. As you rightly say, there was some work done by AIHW looking at a number of data sources. This is quite a complex piece of work. I actually do not know whether we are going to be able to generate an answer to this question for you, because, unless AIHW is going to do another exercise, it may be very difficult to do.

Senator BOYCE: In which case my next question would be: how are we going about measuring the cost of those chronic diseases now?

Ms Halton: We know they cost a lot and we have those previous estimates, but in terms of updating those estimates we will go away and have a look to see what work we have done on that without completely replicating what work—

Senator BOYCE: Absolutely. I am not suggesting you undertake an AIHW survey.

Ms Halton: We will take it on notice.

Senator BOYCE: Mr Smyth, did you have something to add there?

Mr Smyth: Part of my area looks at the schedule with the AIHW, so I was just coming to the table to see if there was something I could add, but the secretary has covered it all off.

Senator BOYCE: My other question there would be: what funding does the department currently have in a convenient way, whether it is last year's or this year's or forward or whatever, for prevention programs in those 12 chronic disease areas?

Ms Halton: Let me take that on notice. It is hard to give you a segmented number. It may well be that we have to have an aggregate, but we will have a look.

Senator BOYCE: Hopefully not an aggregate of the lot but an aggregate of some of them. Is that what you are saying?

Ms Halton: My problem is that a lot of what we do crosses some of those categories, so we will have to have a look—

Senator BOYCE: You could end up with double counting; is that what you are saying?

Ms Halton: Correct, so we will have to have a look at it.

Senator SIEWERT: I just wanted to quickly follow up the questions that I asked last time around sudden cardiac death. We did not get very far last time.

Ms Halton: I think Dr Singer answered some of these questions last time but I do not know that I see him, so Professor Baggoley is going to give it his best shot.

Senator SIEWERT: It was actually Professor Bishop and Dr Singer who answered some questions last time. I just want to follow up and ask: is there any official data on this? Because I asked questions about it last time, I continue to get quite a lot of emails about it. Are there any statistics or is there any way of getting a better understanding of the extent or prevalence of sudden cardiac deaths?

Prof. Baggoley: This is my big moment, Senator.

Senator SIEWERT: See, you sit there for a day and a half!

Prof. Baggoley: In fact, I do not have access to the data. I am sorry; it is like waiting for a day and a half while a cricket partnership has been going on setting a world record and then you come in and go out quickly. I do not have the data in relation to sudden cardiac death. Andrew Singer advised me this was a question from last Senate estimates. He will be here this evening. Nonetheless, in my role as an emergency physician, in my 25 years experience I have been involved with care or resuscitation of patients on a very infrequent basis, so it is certainly not a common problem, but when it does occur it is devastating as it can occur in young people for whom there was no knowledge of there being a clinical problem. Often even after autopsy you may not find the cause. I have just been handed a note from the Australian Bureau of Statistics that there were 268 registered deaths from all circulatory events for Australians aged 34 and younger in 2007, with sudden cardiac deaths accounting for an unknown proportion of these deaths. In addition a further 356 in this age group were from ill-defined causes, a small proportion of which may have been from sudden cardiac deaths.

When deaths are recorded nationally by cause, it is not usually noted whether death was sudden, so that does provide a bit of difficulty in relation to the data. That is the information that has been provided. I can certainly note that it is a tragic event when it occurs, obviously particularly for families.

Senator SIEWERT: Thank you for the figures. Is there a reason why if it is sudden it is not noted on the death certificate? I presume that is on the death certificate.

Prof. Baggoley: Having filled in death certificates over many years, I know that what is usually required is the cause of death, which could be cardiac arrest due to maybe a cardiac abnormality or so on, so the word 'sudden' may not be required or necessarily be scripted, if you like, or prompted by the death certificate.

Senator SIEWERT: In terms of a number of the deaths that have been reported to me that have occurred in association with sporting activities or vigorous exercise, I wonder whether that is just because they are the ones that I have heard about and been reported to me, or does that reflect a trend from your experience?

Prof. Baggoley: In my experience, all the cases I have seen—and in my 25 years they would be still less than a handful—have occurred in an exercise situation. Some have suffered a knock to the chest and others have just collapsed. So the speculation is whether a blow to the chest which has been transmitted through to the heart has prompted a rhythm disturbance or whether in vigorous exercise the increased adrenaline that occurs when exercising has also prompted a rhythm disturbance. But they are the circumstances in which I have seen sudden cardiac death.

Senator SIEWERT: When we discussed it at the last estimates I was asking whether there was a possibility of letting GPs know about this, particularly for young people who are associated with sports. I have the transcript here but, without reading that, we were having a discussion about how GPs should know about it already. I have since had it fed back to me that in fact that may not be the case. I wonder whether that would help, particularly for GPs who are associated with sports and high performing sports.

Prof. Baggoley: It is a question of what you can do to screen for the likelihood of this occurring. Right now there is no universally endorsed screening strategy to identify those at risk, which is what makes it all the more puzzling and tragic.

Senator SIEWERT: I understood from our last estimates that it would be very difficult to do a screening test. Is that your opinion?

Prof. Baggoley: Yes.

Senator SIEWERT: Are there things that we could put in place that would actually alert parents to get their kids checked or keep an eye on their children?

Prof. Baggoley: Probably and sadly, those who are family relatives of someone who has died of a sudden cardiac would be wise to get a full cardiac check. Even there it may not be possible to find evidence of a structural or electrophysiological abnormality that would cause this. But there is advice that with sudden cardiac deaths it is certainly worth evaluating surviving relatives or even have post-mortem genetic testing, because it is not just that there would be the one cause for such a sudden event; it is a very broad diagnosis which can encompass a range of underlying issues. Certainly those who are related to someone who has had a sudden cardiac death should be fully evaluated but, given the incidence, the cost to the population of such a full work-up would not appear to be warranted. You might not necessarily even find any cause and someone could still have an evaluation and—

Senator SIEWERT: And not be picked up?

Prof. Baggoley: Yes.

Senator SIEWERT: It has also been suggested to me that there is some connection or confusion between sudden cardiac death and sudden unexpected death with epilepsy. Have you noticed or been aware of any association there?

Prof. Baggoley: I would not have thought there would be an association. It is possible to concede that someone could have a major heart rhythm disturbance and then with a lack of flow of oxygen to the brain could have a seizure. That is a way they could be linked, in which case the underlying issue would still be a cardiac one. Mostly people who have death relating to seizures have an underlying epileptic disorder, so the two are not connected.

Senator ADAMS: I would like to go on to ask some questions about TB and the closure of the Saibai TB clinic. Is this the right place to ask that?

Ms Halton: Yes.

Senator ADAMS: With the PNG TB infection rates running at two per cent in the Papua New Guinea population and 50,000 cross-border arrivals from Papua New Guinea into the Torres Strait islands each year, why is the TB clinic on Saibai and Boigu being closed on 30 June 2011?

Ms Halton: To start with, it is a state facility. The officers can make reference to what we know about what the state activity is in this respect, but obviously it is not something that we control.

Senator BOYCE: Did the state take up funding it when the federal government ceased to fund it one or two years ago?

Ms J Bryant: I am sorry—what was the question?

Senator BOYCE: I understood that it had been funded by the federal government but they stopped funding it in the recent past.

Ms J Bryant: The Commonwealth has provided funding for the clinic—I am sorry, the clinics on Saibai and Boigu are Queensland Health facilities.

Senator BOYCE: I realise that. I have visited them.

Ms J Bryant: The Commonwealth recognises that Queensland provides services on public health and humanitarian grounds to PNG nationals who cross, often under the guise of crossing for traditional purposes under the provisions of the Torres Strait—

Senator BOYCE: Or they just flat out cross because they are sick and need treatment and cannot get it at home.

Ms J Bryant: We make a contribution of close to $4 million per year. That has been continuous and is ongoing.

Senator BOYCE: I do not understand the previous answer that the state has stopped funding it. It was a state decision to close it down.

Ms Halton: Yes. We have seen press reports and we have had some conversation with our Queensland colleagues about this, but it is their choice as to how they manage that particular issue. Obviously issues at the border are their issues to manage.

Ms J Bryant: We do not direct Queensland in the provision of services. We do not ask them to provide particular services and we do not direct how much or what nature of services they make available. We have been in discussion with Queensland and indeed with our

colleagues in AusAID, the Department of Foreign Affairs and Trade and the Department of Immigration and Citizenship about the situation on the islands and the provision of services to PNG nationals. Our strong view—and I believe it is a shared view on the part of Queensland, us and the other Commonwealth agencies—is that at any given point in time Queensland is treating approximately 60 people in the TB clinics. That is a very, very small proportion of people in the Western Province of PNG who, it would seem, have TB on the available data.

The approach to treatment being taken on the islands is that it reaches a very small proportion of people. It is not able to be provided given the nature of the clinics, which are every several weeks, in accordance with best practice, which is directly observed treatment. Consequently people are given supplies of medication. They take them back to PNG. The level of compliance with their treatment is uncertain. There is some anecdotal evidence that they share it. When they feel better they share it with their relatives rather than completing their treatment. Whilst some individual patients who are treated in the clinics by Queensland Health authorities get excellent results, at a population level we are not making headway. The discussions we have had seek to improve services on the PNG side of the border, so we are working with our colleagues in AusAID who are seeking to set up a number of clinic services in PNG so that treatment can be administered on that side of the border in accordance with the WHO treatment protocols and we can reach a broader population.

We have also found that sustainability of treatment on the Queensland side of the border is very fragile. Last year, for example, we had outbreaks of cholera in Daru, where movement under the treaty provisions was temporarily suspended, and similarly after an outbreak of malaria. On those occasions, of course, people cannot come at the times when they would normally come to the clinic. The issues of them trying to maintain continuity have been very difficult.

Senator BOYCE: Most of these issues were gone through very carefully by the inquiry that was held by the Senate Standing Committee on Foreign Affairs, Defence and Trade about 12 months or so ago. Part of that evidence included the fact that it was extremely difficult to sustain clinics in PNG as well and often difficult even to land in some of the communities that would require those health clinics. I am just concerned that these clinics are to close.

Ms J Bryant: In our discussions with Queensland Health, as I mentioned before, there are about 60 patients who are currently receiving treatment. Arrangements will be made for those patients to continue to be treated, so Queensland Health is liaising with medical counterparts in PNG and they are doing a proper medical handover of the individual patients. Queensland is also supplying the medications to enable their continuous treatment, so those medications will continue to be supplied by Queensland. A number of them—

Senator BOYCE: Are they funded by Queensland?

Ms J Bryant: That is my understanding, noting of course that the Commonwealth makes a contribution to costs Queensland incurs in delivering services but, yes, my advice yesterday was that they would be continuing to provide that medication. Not all of it is available in normal circumstances in New Guinea because it is not treatment that necessarily follows the WHO protocols, so in order to ensure continuous treatment and no disruption to the drug protocols that these individuals are on, the medications will continue to be supplied.

Senator BOYCE: My concern here is that this is a serious public health issue for Australia, potentially, so when might we expect some resolution?

Ms J Bryant: Professor Baggoley may wish to comment.

Prof. Baggoley: I think the important issue relates to the level of tuberculosis in Papua New Guinea, which is thought to be around—and they do not have good data—at least 330 or more prevalence of patients infected with this per 100,000 population. So, one would expect there would be at any one time people who are coming from Papua New Guinea and transiting into the Torres Strait not only those relatively small numbers who are seeking treatment in the Torres Strait islands but also those who have an infection and are crossing into Torres Strait. The risk for Australia, if you would like, is a concern that multidrug-resistant tuberculosis, which is running at about 2 per cent of TB cases of those they have been able to ascertain, in Papua New Guinea might spread into Australia, which as you are aware has a very low rate of tuberculosis. So, for non-Indigenous, Australian-born residents it is less than 0.1 of a case per 100,000 per annum.

Senator BOYCE: But even for tuberculosis that responds to treatment, that is still a big issue for Australia.

Prof. Baggoley: It is an issue, but the target must be the management of tuberculosis within Papua New Guinea, and all involved with the discussions here agree that that must be the approach, hence the work with AusAID, which is looking to put more facilities and more assistance into Daru General Hospital and into the clinics in the South Fly district. The aim there is, of course, to make sure that the treatment that occurs is correct and supervised, because managing it on the Australian side of the border just ignores the major problem that there is from within Papua New Guinea, and the increased risk of developing resistance is when therapy is discontinued or interrupted. So, the strategy is right; it must be tackled in Papua New Guinea. The resources are going into that and again, as I say, all involved would agree that that is the right strategy.

Senator BOYCE: What levels of resources are going into that at federal level?

Prof. Baggoley: I do not have that number.

Ms J Bryant: Into?

Senator BOYCE: Into the TB clinic development in Daru; you would not know?

Ms Halton: No, we do not. That is an AusAID question.

Senator BOYCE: But again, how can you be confident that we are monitoring this public health problem if you do not know how much we are spending on it?

Ms J Bryant: I am sure we could make inquiries with our colleagues in AusAID.

Senator BOYCE: I am happy to ask that of AusAID, but I still ask that question: how can you know that we are protecting public health if you do not know whether we are spending $20 or $20 million?

Ms J Bryant: I do understand that the services are not just at Daru hospital, so they are certainly improving facilities at Daru hospital but they are also improving outreach services to the treaty villages along that southern coast, so it is not just centred around Daru, it involves additional clinic outreaches.

Senator BOYCE: Of course, you realise there are some issues about some of the villages that are not treaty villages that, indeed, have issues as well?

Ms J Bryant: Yes.

Senator BOYCE: I will stop there.

[14:04]

CHAIR: We will go to Outcome 1.2.

Senator BOYCE: First, I just wanted to ask about an increase in gonorrhoea notifications in the ACT. I currently have only the April figures for the national notifiable diseases survey system. Perhaps Professor Baggoley, could you tell me about the incidence of gonorrhoea notifications, which seems to be increasing?

Ms J Bryant: We do not have data on the situation in the ACT with us, unless Ms Goodspeed has some additional data.

Senator BOYCE: I am reading from an ACT Health 'Gonorrhoea update', April 2011.

Ms J Bryant: I am not aware of that particular document.

Senator BOYCE: It is saying that there have been 45 cases between January and March this year in the ACT, whereas there are only 13 cases for the whole period in 2010.

Ms Goodspeed: I do not have the exact figures in front of me, but I do know that the increase in gonorrhoea notifications was noted at a meeting last week of the blood-borne viruses and STI subcommittee of the APHDPC, which is a long winded way of saying a cross-jurisdictional committee that looks at blood-borne virus matters.

Senator BOYCE: It is an interdepartmental committee on Australian population health; is that right?

Ms Goodspeed: Yes. So, it involves states and territories as well as a number of community based organisations. These numbers were observed at that meeting as well as some increases in some other jurisdictions and it was agreed that—

Senator BOYCE: Jurisdictions being diseases?

Ms Goodspeed: States.

Senator BOYCE: Yes. I was going to, for instance, look at Queensland's figure, which seems extraordinary. It is 228 for the month of—

Ms Goodspeed: I believe Victoria as well has a high figure. This was observed and the committee agreed that it is something that needs to be further explored and that they would refer it to the Communicable Diseases Network of Australia to do that.

Senator BOYCE: Was there any discussion as to why this has happened?

Ms Goodspeed: No. Normally in these areas of public health people get together and they explore the data that is available to get a better understanding.

Senator BOYCE: So, you have referred it. What will happen now?

Ms Goodspeed: The Communicable Diseases Network of Australia will gather up the information and they will share the knowledge of the public health clinicians and their engagement with the clients, and understand whether it is particularly an issue that is occurring amongst gay men or amongst heterosexual people They will look at whether there

is any public health messaging that needs to be done, or other interventions that need to take place, to try to understand why it is happening and to address it. Public health interventions are generally managed at the state and territory level, which is why it is important that these committees share information together.

Senator BOYCE: But it does look as though we are looking at something that is at least more than a single state issue?

Ms Goodspeed: Yes, the national numbers look like they are about 1.4 times the five-year rolling average.

Senator BOYCE: Because we have got 884 nationally for the month and 3,812 for the year, so a quarter of all the notifications happened in April pretty much, which seems—

Ms Goodspeed: It needs to be understood whether it is particular practices that are leading to it and what kind of populations it is occurring in, and then the messaging can be provided in appropriate ways.

Ms J Bryant: It does follow a period of stability. The population rate was steady between about 2005 and 2009 at about 36 per 100,000 population, so this does appear to be a relatively more recent thing that is emerging and does require that examination.

Prof. Baggoley: Again, the basic reason for an increase in this has to be increasing rates of unprotected sex. The key question is to find out why and in what groups is this occurring so messages can be targeted. These messages have been conveyed for well over 20 years—up to 30 years in relation to HIV prevention—but when the numbers go up it certainly does cause reason for thinking and to develop strategies which Ms Goodspeed has pointed to.

Senator BOYCE: My other little section of questions in this area, Chair, relates to malaria and the other viruses like that, and particularly to the Queensland figures, which have seen something of a jump in areas of dengue virus, malaria and Ross River fever, where Queensland easily outclassed every other state for the number of the incidents of Ross River virus in April. Do any of these cases relate to the floods and the cyclone? Would you see this as a causative effect?

Prof. Baggoley: The incidence of particularly mosquito borne diseases, such as dengue, Ross River virus and also Murray Valley encephalitis, certainly relate to wet conditions, and Australia has seen that not just in Queensland but of course the higher rainfall in the southern parts of Australia has also shown an increase in these viral conditions. Apart from public health notices that have been occurring particularly in the northern parts of Australia about protecting the public from mosquito bites, also working with councils to try and eliminate mosquito likely breeding grounds—

Senator BOYCE: I discussed this with your predecessor last time, Professor Baggoley, in terms of the fact that the health department had hired extra people to wander around backyards emptying out containers of water when they came across them.

Prof. Baggoley: I think such is the nature of these diseases—Ross River virus, dengue and Murray Valley encephalitis—that—

Senator BOYCE: I probably should add Barmah Forest to that one.

Prof. Baggoley: Yes. Not everyone becomes clinical with them, but they can be chronic, debilitating diseases that take a long time to recover from and occasionally people can die from them, so it needs to be taken seriously, and it is.

Senator BOYCE: But we do seem to have an increasing incidence and we risk the fact of—I suppose they are already endemic—an increased level of being endemic.

Prof. Baggoley: They are certainly endemic in the northern parts of Australia, in northern Queensland, the Northern Territory and the upper part of Western Australia. What we have seen this year, for example with Murray Valley encephalitis, is an outbreak across the country the like of which has not been seen since 1974. We have had up to about four deaths in relation to Murray Valley encephalitis. That, of course, is a disease that is harboured within water birds. Water birds can certainly spread where there is water in areas where it is normally not present. I think the Rufous Night Heron is one that is particularly implicated in this, and the mosquitoes carry that and, of course, the mosquito can transfer it to humans.

The other part of this relates to the fact that it can be more than one season that the mosquitoes can carry the virus with them, so if it is a dry year this year we still could have an outbreak of Murray Valley encephalitis. So, because there is no treatment, any strategy that can be undertaken to minimise or prevent this is important, but the climate that has occurred and the rainfall that has occurred this year across most of Australia has just made the situation ripe for the breeding of the mosquito and the migration of the birds.

Senator BOYCE: Australia was declared malaria free by the WHO in 1981. Is that still our status? Can you have a certain incidence before you fall off the malaria free list?

Prof. Baggoley: I am not aware of the current status or the threshold. Maybe my colleagues can help.

Ms Goodspeed: I could not confirm 100 per cent that we are malaria free—I have not heard that spoken—but I do think that the cases we are seeing are actually imported on the whole, coming in from other countries.

Senator BOYCE: Which brings me to my last question in this area. There are three reported cases of cholera in Queensland in the month of April. Are they the ones you were talking about earlier, Professor Baggoley?

Prof. Baggoley: No, I was talking about Murray Valley encephalitis. The cholera, Ms Bryant—

Senator BOYCE: I am sorry. I thought we were discussing that earlier when we were talking about Papua New Guinea. Can you tell me about those three cases of cholera?

Ms Goodspeed: I understand that they all occurred in travellers who were diagnosed in the Torres Strait islands and subsequently treated and returned to Papua New Guinea.

Senator BOYCE: Thank you.

CHAIR: Does anyone else have anything under Outcome 1.3?

Senator SIEWERT: That is the drug strategy. Is that where we ask about alcohol?

Ms Halton: And FOIs.

Senator SIEWERT: Let us start with the FOIs that I asked about yesterday. I was going to ask that at the break, actually, to see if there is any more information.

Ms Halton: I gather there has been some press release, Senator Fierravanti-Wells, which at some point you would like to hear about. I have not seen the press release; I would quite like to know what it says.

I know that Senator Siewert has a particular interest in FOIs and I would be delighted to give her some information. If I could just recap, since the tobacco plain packaging measures were announced in April 2010, the department has been asked to handle some 46 FOI matters, almost all of which have been generated by two of the global tobacco giants and most of which are very broad requests requiring extensive file searches and the examination of a large number of documents.

I have got a document—which I will ask the team to table, thank you—which shows the status of those matters which will be circulated to the senators. I should just say that we do take our obligations under FOI seriously and we are committed to the FOI reforms and the pro-disclosure culture about openness, however I would want to make a couple of observations about this particular round of FOIs. To start with, the department and the government have been very open about the rationale for, and the implementation and approach to, plain packaging. As you know, we have had a consultation paper, exposure draft, rationale and approach have all been outlined.

I would say that in my observation there is a pattern to the FOI requests from industry and the pattern certainly appears to be disruptive of the department's business. So, what we do is we get very broad ranging requests—very broad ranging requests—which are then slowly negotiated to a narrower scope and lowering costs, which are then duly processed and decisions are made about the documents to be released. Almost every decision is then appealed at internal review. Following internal review, decisions are also then appealed to the AAT. Two have been appealed at this point and now one of the AAT decisions has been appealed to the Federal Court. This relates to the tobacco industry seeking government's legal advice, and I think we have talked in the past here—in fact, we have had the conversation—about legal-professional privilege and what is understood by that in the FOI Act.

Again, just to remind people, in one current case the department has spent eight months in negotiation with a tobacco industry applicant on narrowing the scope of a large number of detailed requests from 10,000 files down to 242 files containing over 92,000 documents. In that case, the initial charge estimate to process the documents requested was $1,471,372.52, and negotiations on the scope brought that down to $800,409.58. We ended up with an actual cost of $367,106.33. In relation to the first case, the department is continuing to process the documents in tranches as agreed with the applicant and this is very resource intensive—I do not have extra funding for this—and the department has had to indicate its intention to refuse to process additional broad ranging requests made by that applicant due to the significant diversion of resources they represent.

I would make the point that, whilst there is a schedule in the FOI arrangements in relation to charging, that charging arrangement basically has not been adjusted—and I could be corrected—since about 1986; it is a very long time. The dollars that we are permitted to charge are not in relation to the first five hours and not in relation to any of the review processes at all. We are permitted to charge $15 for search and retrieval and $20 per hour for decision making time. To give the senators a sense of how this compares to what it actually costs to do things in the department—what I get funded from finance for new policy on

average—the total cost for an APS6 ranges somewhere between $44.80 and $50.54 an hour. As you would understand, it would be very few of these FOI requests that can be dealt with by an APS6.

You indicated that you were interested in who else has been in receipt of these requests. To start with there has been a complaint about all of this to the Ombudsman about the size of the charge and department resources in respect of this.

Senator SIEWERT: Is this from the tobacco companies?

Ms Halton: Yes, they have complained.

Senator SIEWERT: They have complained that you are charging too much?

Ms Halton: Correct. And I should say that there is an algorithm that we are required to use to estimate the costs, but as I have already pointed out the hourly rate that we are permitted to charge is under half the actual cost of an APS6, and I do not have any extra money to do this.

The other agencies who have received tobacco related FOIs include the Attorney-General's Department, the Australian Competition and Consumer Commission, Australian Customs and Border Protection Service, the Australian Government Solicitor, the Department of Finance and Deregulation, the Department of Foreign Affairs and Trade, the Department of Innovation, Industry, Science and Research, the Department of the Prime Minister and Cabinet, IP Australia, the office of the Minister for Competition Policy and Consumer Affairs, the office of the Minister for Health of Ageing, the office of the Minister for Trade, the office of the Prime Minister, the Treasury, the New South Wales Department of Health and the Northern Territory Department of Health. Those are the ones that we are aware of.

Again, I think I have already indicated that we have had to, at any one point in time, employ up to six additional staff to deal with this and sometimes up to nine working simultaneously on these various things, and these imposts remain.

Senator SIEWERT: At the last estimates we were up to 20, were we not?

Ms Halton: I think that might be right.

Senator SIEWERT: It is now 46, so we have had 26 since February; is that a correct interpretation? I have not had a chance to read this much because I have been writing and listening rather than reading.

Ms Halton: To be honest, we would have to go back and have a look. I think what we have actually included in here is everything, including the transfers from other agencies, so I think what you will find here are the transfers together with the new ones.

Senator SIEWERT: So, this includes the new ones plus transfers?

Ms Halton: Correct.

Senator SIEWERT: Obviously, just at a quick look, all the new ones are not explained just by the transfers from other agencies?

Ms Halton: No. In fact, this is why we have given you the dates. I think if you look at probably page 12 on, they will be the ones that have come in since. They are numbered 29 through to 46.

Senator SIEWERT: Some of them you are currently in negotiation on and some of them you have refused.

Ms Halton: Yes.

Senator SIEWERT: So, these are all still ongoing?

Ms Halton: Mostly. There are one or two that have been—

Senator SIEWERT: How many have you completed since last estimates?

Ms Halton: We will have to take that one on notice.

Senator SIEWERT: Sorry, I did not bring the other ones up here, so I cannot compare the two.

Ms Halton: We will have to take that on notice. We will come back to you with that.

Senator SIEWERT: Thank you.

Senator BOYCE: What does 'deemed refusal due to admin oversight' mean?

Mr Cotterell: One of the requests was transferred to the department and it was misplaced in the transfer. As a result a decision was not made within the statutory 30-day time frame, so we have written to the applicant to ask if they would like us to process that request.

Senator SIEWERT: Is it likely that the agencies that you are aware of that have also had FOIs have had multiple FOIs like you have?

Mr Cotterell: Some of them have, because they do consult us on some of the documents before release if we have been involved in the preparation of those documents.

Senator SIEWERT: It is fair to assume that each of those will then be comparing your costs that you are dealing with for the FOIs that you have got and any that have been transferred, so it is likely that these agencies will have had substantial costs as well?

Ms Halton: Yes.

Senator SIEWERT: In terms of the appeals, you said at the beginning that they are broad requests and we have had a discussion before about the catch-all approach they have taken, and they are also going quite a long way back. You have said that you think that there is a pattern that disrupts the work of the agency.

Ms Halton: Absolutely.

Senator SIEWERT: How many have you had so far? I think you said there is one in an appeal at the Federal Court; is that correct?

Ms Halton: Yes.

Senator SIEWERT: How many others have then subsequently gone to appeal?

Mr Cotterell: One matter is currently being appealed in the AAT. The matter that is in the Federal Court has already had an AAT decision made on it. So, that is the two at the AAT. Where documents were not released or where exemptions were claimed over the documents, all but one of those cases have been appealed at an internal review.

Senator SIEWERT: So, all these where it says 'completed' have been appealed, except one; is that correct?

Mr Cotterell: That is right.

Senator SIEWERT: So, it is fair to say, in fact, all these FOIs other than one are still in some way live; is that a fair representation of things?

Ms Halton: That is a fair representation.

Senator SIEWERT: Can I go on to ask other questions about smoking?

CHAIR: We are going to have to extend this session. I know Senator Fierravanti-Wells has questions under Outcome 1.5, but we cannot go beyond a quarter to three in Population Health in this area. That is already extending it, so that is how much time we have got left for all questions up to FSANZ.

Senator SIEWERT: I will ask one about smoking and I will put my alcohol ones under the agency, so I will not deal with them now; is that okay?

CHAIR: Yes.

Senator SIEWERT: In terms of smoking, in the media there has been speculation around chop-chop and discounting. Could we just quickly ask about chop-chop? I know there have been questions asked in other committees, but my calculation was, according to industry if you looked at their figures, there would be one in six people smoking illegal cigarettes.

Ms Halton: They say 15.9 per cent of the market.

Senator SIEWERT: I saw 16 per cent; they must have rounded up. Have you had any figures that would suggest that in fact there is any substantiation for that figure?

Ms Halton: No; on the contrary.

Senator SIEWERT: What figures have you got?

Ms Halton: You can do it.

Mr Cotterell: I enjoy doing it. The last population level survey that we had on this was the 2007 National Drug Strategy Household Survey and it showed that only 0.2 per cent of Australians aged 14 years or older smoked unbranded tobacco half the time or more. That is equivalent to about 1.2 per cent of people who smoke daily.

Senator SIEWERT: I am aware of time, so I might put others on notice. Have you looked at any provisions that could actually deal with the issue of discounting?

Mr Cotterell: Certainly, the claims that have been made about by how much cigarettes could be discounted we do not accept. Already, taxes account for two-thirds of the price of a packet of cigarettes. So, excise alone, which is without GST being applied to a pack of 25 cigarettes, amounts to about $8.40, and to a pack of 30 cigarettes about $10.09. Any claims that cigarette prices could be halved are not realistic.

Ms Halton: Again, we do not think this is a credible claim.

Senator BOYCE: Mr Cotterell, are you aware of a survey over the past few years done on an electorate-by-electorate basis looking at changes in use of illicit tobacco?

Mr Cotterell: You may be referring to a report prepared by Deloitte in which they produced a map of how illicit trade might be impacted by changes in tobacco control policy.

Senator BOYCE: That is right.

Mr Cotterell: Again, we do not accept the validity of the methodology used. For a start, it assumes the 15.9 per cent figure and then it applies it in a pretty standard way.

Senator BOYCE: I thought it was talking about current usage and not forecast usage.

Mr Cotterell: I would have to have a look at it, but we do not accept that it is valid.

Senator BOYCE: My question goes to the recent case of diphtheria in Queensland. Professor Baggoley, I am aware of the case, but could you describe what has happened at a federal level in response to that?

Prof. Baggoley: My understanding in relation to the case was firstly derived from a discussion with the Chief Health Officer in Queensland. It was again a very tragic circumstance where a young lady in her early twenties, as I recall it, developed diphtheria, which is a vaccine preventable condition, and thought to have been conveyed to her by her boyfriend who had returned from Papua New Guinea. He had developed a throat infection over there, but was not seriously affected. He had been immunised against diphtheria. Then the young lady developed the disease and, sadly, succumbed to it. The Queensland Department of Health followed up any further contacts. It highlights the ongoing need for immunisation against vaccine preventable diseases and the importance thereof.

Senator BOYCE: It mentions that there were three Queensland cases of diphtheria in April. Can you tell me about those?

Ms Bryant: According to my information, there have been four notifications of diphtheria as at 20 May. There was one cutaneous case imported from Indonesia and a cluster of three cases, which are probably the three that you are talking about.

Senator BOYCE: They were on the surveillance system for the month of April.

Ms Bryant: I believe they were mostly reported in April. What would you like to know?

Senator BOYCE: Was the cluster of three the woman who died and her family members?

Ms Bryant: Her partner and so on, yes.

Ms Goodspeed: I can add to that. There were three cases that included the boyfriend, the girl who died and another asymptomatic case that was identified as a patient in the same hospital, but they did not have any symptoms.

Senator BOYCE: As we all know, you should have a diphtheria vaccination after 50, which is mentioned on the Queensland Health fact sheet on diphtheria but not mentioned on the Immunisation Australia fact sheet on diphtheria. Can you explain why that is the case?

Ms Bryant: I would have to check on that. I am not familiar with the particular specifics of the fact sheet that you are referring to. It may be that the fact sheet on the Immunisation Australia website is information targeted to the free vaccine that we provide under the program, and because we are not providing free adult diphtheria vaccination it may not be part of our fact sheet. Again, I would have to check.

Senator BOYCE: We are down to something like 50 per cent coverage rate for vaccines such as diphtheria by the time we get to the over 50s, are we not?

Ms Bryant: I do not have any data on coverage of diphtheria vaccination in adults. There is an AHW vaccination survey.

Senator BOYCE: Is that the one in 2003?

Ms Bryant: Yes. It predominantly reports on the uptake of flu vaccine and the meningococcal vaccine. I am not certain how much information, if any, it contains on diphtheria.

Senator BOYCE: It also covers diphtheria, but we are talking about 2003 data. I would appreciate anything you can tell me on notice.

Ms Bryant: Yes.

Prof. Baggoley: Perhaps I can advise that in the *Australian Immunisation Handbook* 9th edition 2008, when talking about diphtheria and vaccination of adults it indicates that all adults who have reached the age of 50 years without having received a booster dose of diphtheria and tetanus—and of course it is a combination of the previous 10 years—should receive a further booster dose of diphtheria and tetanus or preferably diphtheria, tetanus and pertussis, if this has not been given previously, to also provide protection against pertussis. That is the sort of thing that people and their GPs should be aware of. It is just like we all have a responsibility and are advised to keep our tetanus immunity up to date. You have certainly reflected good clinical practice.

Senator FIERRAVANTI-WELLS: I would like to refer to a couple of articles that have appeared recently in the *Age* and the *West Australian* about the report. One is titled 'Report raises issues about vaccine safety' and called for a body to monitor vaccines. I will hand those up. This is the report that Professor Horvath has undertaken. One of the articles states:

Australia's response to an outbreak of convulsions among children who received the flu vaccine last year was plagued by delayed reporting, communication breakdown, insufficient data on immunisation rates, an independent review has found.

The other article refers to the need for an improved system of governance for vaccine safety monitoring and provides options for consideration, including the establishment of a vaccine safety committee. What changes will be implemented or are contemplated, if any, in response to Professor Horvath's report?

Ms Bryant: The government has accepted all of the recommendations in Professor Horvath's report. The Parliamentary Secretary, Ms King, issued a media release on 25 May stating the government's acceptance of the recommendations. We have been asked to establish a working party that will progress the implementation. We have had some preliminary discussion with the states and territories, the TGA and so on to progress that working party, and it will be seeking to implement the recommendations over the next two years.

Senator FIERRAVANTI-WELLS: I will not traverse the evidence that was given in this committee in relation to the vaccine saga, but I would have thought that perhaps a revision of some of the evidence would be appropriate in light of what this report has found. Throughout the whole process, constantly in my questioning there seemed to be a lot of push back, that everything was done properly and right up front, but this report would seem to be quite scathing in part. I invite you, Ms Bryant and other officers, to go back over some of that evidence and perhaps some of it may need to be reviewed or revised.

Ms Bryant: I am happy to review the transcript, but absent the transcript on this occasion, Professor Horvath's review found that the TGA regulatory actions following the first batch of adverse case reports were appropriate and timely. Professor Horvath's report also concluded

that the decision by the Chief Medical Officer at the time, Professor Bishop, and his decision to suspend the use of seasonal influenza vaccines for children was appropriate and proportionate to the risk. Those are the two key conclusions that Professor Horvath reached, which seem to go to the issue that you are raising.

Senator FIERRAVANTI-WELLS: As you would know, my comments were in relation to the amount of vaccine ordered and the process that we went through, and the fact that ultimately, when all was said and done, about half of the vaccine was not used or in some cases destroyed or disposed of.

Ms Halton: Let us be very clear about this. That is a separate issue. This is an issue in respect to the regulatory approach to Fluvax, the problem in its manufacture and when that was spotted. The issue of what was purchased by government, which is that other issue, is a completely separate issue. It is not related in any way, shape or form.

Ms Bryant: Professor Horvath's review related to a product called Fluvax. The issue of government order related to a separate monovalent vaccine called Panvax, which are separate vaccines and separate issues.

Senator FIERRAVANTI-WELLS: I am going to put further questions on notice in relation to it, because I am conscious of the time. In relation to this year's seasonal flu vaccine, will that include all population groups that are eligible under the national immunisation program?

Ms Bryant: The groups eligible under the national immunisation program will be able to access free seasonal influenza vaccine. The 2011 seasonal influenza program commenced on 15 March. It is well underway. As at 30 April approximately 72 per cent of the anticipated vaccine purchases for this season had already been made and a significant proportion of those had obviously been administered.

Senator FIERRAVANTI-WELLS: Firstly, what changes have been made to the process of informing the public, practitioners and states and territories of adverse reactions with a vaccine? Secondly, can you explain the program expense drop at page 100 of the Portfolio Budget Statements from $74 million to $46 million and continuing at $46 million in the forward estimates?

Ms Quaine: In relation to advice we have given to the public and providers on seasonal influenza this year, prior to the commencement of the program on 15 March the previous Chief Medical Officer wrote to all immunisation providers advising of the start date for the program, and the fact that the vaccine would be the same vaccine that had been used previously. He urged all providers to be aware of adverse events and to report adverse events to the appropriate jurisdictional health department or directly to the TGA. He also asked providers to report vaccines given to children under seven to the Australian Childhood Immunisation Register.

Senator FIERRAVANTI-WELLS: Was that additional reporting to the previous year?

Ms Quaine: No, not additional reporting, but reminding providers of their need to report vaccines given for influenza to the Australian Childhood Immunisation Register, which would allow us to know exactly how many children were vaccinated. The other one was to remind providers of the importance of reporting adverse events.

Senator FIERRAVANTI-WELLS: So, there has been no change to what we have done in the past with the process of informing the public?

Ms Quaine: No. We have been encouraging providers to report adverse events using the existing passive surveillance system, which Professor Horvath's review—

Senator FIERRAVANTI-WELLS: My question was: have you done anything different this year? It was specific as to what changes have been made to the process of informing the public and so on. So, the answer is that there have been no changes?

Ms Bryant: In early March, at the commencement of the season, Professor Bishop wrote to all general practitioners.

Senator FIERRAVANTI-WELLS: I am just asking whether there has been any change. My question went to whether there was a change. The answer is either yes or no.

Ms Bryant: There was an enhanced communication strategy in terms of asking general practitioners to be alert to and ensure that they provided timely reports of any adverse events that were observed.

Senator FIERRAVANTI-WELLS: Which is not what happened last year.

Ms Bryant: It is a standing advice, but this year there was a targeted piece of communication to remind people and emphasise the importance of that.

CHAIR: Your time has run out. Any other questions for Outcome 1, Population Health generally, will have to go on notice. We will now move on to FSANZ. I thank the officers.

[14:46]

Food Standards Australia New Zealand

CHAIR: I call the officers from FSANZ. Senator Xenophon has questions.

Ms Halton: Whilst the officers are coming to the table—Senator Xenophon was asking questions earlier of the Therapeutic Goods Administration in relation to the DePuy orthotic devices, the hips. You asked whether there had been any unusual or different conditions placed on the registration of that device in the first instance. We have had the document inspected and it was the standard conditions that apply to the registration of the device that were applied to this device. I have actually had a look at it.

Senator XENOPHON: So, it was a standard approval process?

Ms Halton: Yes, but all the conditions that apply to devices of this kind—which are quite lengthy, and we are happy to give you separately—applied to this device. I think there were two parts to the question.

Senator FIERRAVANTI-WELLS: So, there were no specific conditions attached to the approval of this device, in terms of usage by any other specific category, for example, pregnant women or anything like that?

Ms Halton: No. The conditions are the conditions that apply to prostheses internal joint, hip.

Senator XENOPHON: Are you able to table that for us?

Ms Halton: I will have the relevant bit extracted and table it for you.

Senator XENOPHON: That will be fine.

CHAIR: Senator Xenophon, you also have another question you would like to ask to see whether you can get a response—on nanotechnology?

Senator XENOPHON: Yes. I have some tiny questions on nanotechnology.

CHAIR: We will put on record; he has a question.

Senator XENOPHON: Perhaps I could start with the department before I ask FSANZ some specific questions. Is the department aware of research which shows that nanoparticles could damage DNA, for example, nanoparticles of titanium dioxide have been linked to possible DNA damage, brain degenerative diseases, skin cell toxicity, and nanoparticles of iron and aluminium have been linked by studies to potential nerve and neural damage? That is an issue relating to sunscreens, and there has been some recent media about that. Is that something that the department has looked at in terms of advising the labelling of those products?

Ms Halton: The specific research that I am aware of was research, as I understand it, done by the CSIRO and, indeed, that research was very carefully looked at by us. The scientific conclusion was that it did not demonstrate an effect.

Senator XENOPHON: Are you aware of some more recent studies in relation to that?

Ms Halton: Personally, no. If there is anything else I cannot comment on it, but I am aware of that particular CSIRO research.

Senator XENOPHON: Is there any ongoing monitoring of that?

Ms Halton: We take an interest in that issues, yes, very definitely, but if there is a particularly more recent research that has not been brought to my attention?

Senator XENOPHON: I might ask questions and text at the same time so I can hopefully get that. I have some questions for Mr McCutcheon. What are the current rules around the labelling of products that include nanotechnology particles? FSANZ has a standard specifically for novel foods described as non-traditional foods with no history of safe use. The characteristics of food that make it novel means that scientists cannot be certain that they are safe to eat. Are foods that contain nanoparticles considered novel?

Mr McCutcheon: I will answer the last part of your question first. Any consideration of foods with manufactured nanoparticles would be considered, amongst other things, under our novel foods provisions. As yet, though, we have not received any applications for manufactured nanoparticle derived food. The second question was around labelling. There are no labelling requirements around nanotechnology.

Senator XENOPHON: Is that not inconsistent? So, any nanotechnology used in foods will be taken to be a novel food; is that right?

Mr McCutcheon: It would depend on the application. As I said, there are a number of provisions under our legislation where we would consider an application for a food containing manufactured nanoparticles. It could be under the novel foods provisions, the food additive provisions and so on. It would depend on the nature of the application.

Senator XENOPHON: You are saying that there are no foods with nanoparticles in them at the moment in the Australian market?

Mr McCutcheon: We have not received any applications for foods containing manufactured nanoparticles. That was an explicit requirement in 2008 when we amended our application handbook.

Senator XENOPHON: So, if something has nanoparticles it needs to go through an approvals process?

Mr McCutcheon: That is correct.

Senator XENOPHON: Once it goes through the approvals process, and if it is approved does that mean it would need to be labelled as having nanoparticles?

Mr McCutcheon: No.

Senator XENOPHON: It is not your role to comment on policy, but do you see a disconnect between the requirement to go through presumably a rigorous approval process for nanoparticles in food and, once it is approved, for there not to be any requirement to have it labelled?

Mr McCutcheon: The process that we would go through for a permission for a food containing manufactured nanoparticle to be put on the Australian market would be around the safety assessment. Providing that food passed the safety assessment, it would be approved for sale. In that sense, and because there are no requirements around labelling, we would not require or impose any labelling provisions.

Senator XENOPHON: It is my understanding that Europe, Canada and the United States have introduced at varying levels regulations for labelling and mandatory safety testing of nano ingredients in products. Are you familiar with the approach in those jurisdictions?

Mr McCutcheon: Not specifically. We see lots of reports from time to time, but when we investigate them the actual substance of what the report says is not matched by what is actually in place under the regulatory regimes in those countries. As far as we understand it, the arrangements that we have in place currently in Australia, where we assess nano materials under existing provisions, are pretty much the same approaches adopted in other jurisdictions around the world.

Senator XENOPHON: In terms of the way FSANZ works, does that mean when it comes to additives and ingredients in food that you regularly see what other jurisdictions are doing? What is the interplay and level of communication between, say, Australia and Europe, the EU, UK, United States and Canada?

Mr McCutcheon: We keep a very close watch on the regulation of food in many countries around the world, particularly Europe and North America. As I said, if there were changes in their regulatory regimes or they discovered something that was of concern to us, that would certainly be a trigger for action by us.

Senator XENOPHON: I would like to go to Ms Halton. The European parliament has recently moved to recognise the novelty of certain nano materials under the cosmetics directive. They actually have a directive for cosmetics in the European Union.

Ms Halton: I am not going to comment on that.

Senator XENOPHON: It may say something about the bureaucracy in the EU. There is a cosmetics directive 76/768/EEC legislation that defines what a nano material is. As I understand it, there is some labelling. In this proposed amendment there is the statement:

... all the ingredients present in the form of nano materials shall be clearly indicated in their list of ingredients. The names of such ingredients shall be followed by the word (nano).

Are we looking at that here, similar to the European directive?

Ms Halton: I would say not explicitly and separately to the other broader work that has been done on labelling. You will be aware of the labelling review undertaken under the leadership of former Health Minister Neal Blewett. You would be aware that it makes a number of recommendations, including some of the issues in respect of technology and what he has proposed in relation to labelling that should apply to novel technologies for a particular period. That review has not yet been considered fully by food ministers who have responsibility for this and then, obviously, there would have to be a process of consideration by governments more broadly. We are not considering that separately, but what I can tell you is that everything to do with labelling is currently on the table, and that includes new technologies.

Senator XENOPHON: Is that response still three, four or five months away?

Ms Halton: It will go to the next food ministers meeting for a preliminary discussion, and they have indicated their strong desire to take action in respect of labelling this year, but obviously that is not in my gift.

Senator XENOPHON: Mr McCutcheon, I would like to understand the sequence of things. So, anything with nanoparticles in terms of foodstuffs must go through an approval process?

Mr McCutcheon: For manufactured nanoparticles, yes. There are provisions in our handbook that when applications are made for foods to be permitted entry to the Australian market they must include information around the size and so on.

Senator XENOPHON: If there is an imported product that has nanoparticles would that be subject to a separate approval from FSANZ?

Mr McCutcheon: Absolutely, because any food, whether it is produced here or imported, needs to meet the requirements of the code. If there is no permission in the food standards code itself, then that food would not be permitted entry.

Ms Halton: Or sale if it is manufactured here.

Senator XENOPHON: That is right. But are you confident that in terms of the current testing regime and the current regime that we have in place that we do not have products with nanoparticles in the country?

Mr McCutcheon: I think we can be confident not because of any information we have from enforcement agencies, which is outside of our realm of responsibility, but just our observations of international developments in nanotechnology in food; there has not been a great deal of interest, of which we are aware, and from memory there were only two applications related to nanotechnology that had been submitted in North America in the last couple of years, and they were around packaging materials and not food itself. There has not been the huge interest in nanotechnology in food that one might have expected some years ago.

Senator XENOPHON: So, any nanoparticles approval process is thoroughly assessed, but then if it is approved, consumers do not find out whether you have nanoparticles in the food?

Mr McCutcheon: Again, we are talking about manufactured nanoparticles. There are naturally occurring ones that are in food, anyhow. Again, we are confident there are no foods being sold in Australia, whether produced here or sourced from overseas, that would contain manufactured nano-scale material.

Senator XENOPHON: Ms Halton, with respect to the issue of labelling in terms of sunscreen, more recently the Australian Education Union expressed some concerns. The slip, slop, slap campaigns are obviously worthy and necessary campaigns, but the Victorian branch of the AEU voted to urge schools to use nano-free sunscreens as part of the sun smart programs until research conclusively proves nano products are not toxic. That is relatively recent—only a couple of weeks ago in terms of media reports. Have you looked at any updated assessment of the evidence, including overseas studies, where there has been a rethink on the need to label that so that consumers can at least make a choice with sunscreens as to whether it has nanoparticles or not?

Ms Halton: I would have to go to the content people on this. I am not aware that there has been. As I said, I was aware of the work that was done following that CSIRO study and that was fairly comprehensive. You suggested there are a number of new pieces of information and I will have to ask the chemicals people.

Senator XENOPHON: It refers to research by Macquarie University Professor Brian Gulson and others indicating that the zinc from sunscreens can penetrate healthy adult skin.

Ms Halton: That actually sounds like the original CSIRO study. If it is that particular study, I think we have some issues with its validity. But I think we should probably come back on notice.

Senator XENOPHON: Is this the most recent study or is that the initial study?

Ms Halton: That sounds like the initial study, but again I think we should perhaps get from you the particular references and then we can give you a considered answer.

CHAIR: I thank the officers from FSANZ. There could well be questions on notice, but they are the only questions I have been made aware of.

Australian Radiation Protection and Nuclear Safety Agency

[15:00]

Senator LUDLAM: Do we have Dr Larsson with us this afternoon?

Ms Halton: No, I regret to say that Dr Larsson is in Europe. He is actually attending one of the peak bodies in this area. Given the recent events and given his global role, it was important that he attend that meeting. However, we are ably assisted here by the officers you have in front of you and we will certainly make sure that any questions you have that we cannot answer—but I am sure we can—we will answer for you. Dr Larsson and I did discuss in great detail the fact that he would be absent, and on balance it was my view that he needed to go and attend that global meeting.

Senator LUDLAM: I am going to pick up on some of the threads that I asked him about last time, which is around the National Radiation Dose Register, which I know is a project

that has a couple of years behind it now. I understand that you have started accepting workers radiation dose records from 1 July 2010. I am interested to know how many workers have provided their information so far.

Prof. Johnston: Workers themselves do not provide their dose information. The dose information is provided by the operators of the uranium mines involved. As at 13 October 2010 we had data covering 16,499 workers, and that covered a period of five years.

Senator LUDLAM: That probably outnumbers by a factor of five the number of workers on Australia's uranium mines, I would have thought, in any given year. Does that include past cohorts or where does that number come from?

Prof. Johnston: That comes from five years of data for Olympic Dam and Beverley uranium mines.

Senator LUDLAM: And Ranger?

Prof. Johnston: We do not have any data in the register this time from the Ranger uranium mine.

Senator LUDLAM: Why is that?

Prof. Johnston: It is primarily because of privacy issues under the Commonwealth privacy legislation.

Senator LUDLAM: How come BHP and General Atomics have been okay to hand their workers records over but ERA have not?

Prof. Johnston: Under the South Australian radiation protection legislation the South Australian Environmental Protection Authority can impose licence conditions requiring the mines to provide their data to ARPANSA to be included in the dose register. Unfortunately the Northern Territory radiation protection legislation does not provide for equivalent licence conditions to be applied. As a consequence for Ranger uranium mine to provide their data to us would be in breach of Commonwealth privacy legislation.

Senator LUDLAM: But it is a Commonwealth agency requesting the data.

Prof. Johnston: No, we are not requesting the data. We would like to get the data, but the mines in South Australia are providing the data to us as a licence condition under the radiation licence.

Senator LUDLAM: How do you plan on resolving that?

Prof. Johnston: There have been discussions primarily between the Department of Resources, Energy and Tourism and the Northern Territory government to amend their legislation to enable the Northern Territory radiation regulator to impose that licence condition.

Senator LUDLAM: I will not ask you to speak for the company, but are they participating and willing to do that?

Prof. Johnston: We have no indication that they are unwilling.

Senator LUDLAM: How long do you estimate it will be before that is squared away?

Prof. Johnston: I could not possibly guess how long it would take the Northern Territory government to change its legislation.

Senator LUDLAM: That is probably a fair response. Does the 16,000 really only cover workers at Roxby and Beverley for the last 5,000 years? I am sorry, when you start talking about uranium that is where my head goes. For the last five years, just those two facilities?

Prof. Johnston: Yes.

Senator LUDLAM: Do you have radiation workers or people taking occupational radiation doses at hospitals or at any of ANSTO's facilities, for example?

Prof. Johnston: There are of course occupationally exposed people at those facilities, but at this stage the dose register is only funded for the incorporation of data from the uranium mining industry.

Senator LUDLAM: How far back are you hoping to go? I do not have the transcript on me, but I understand Dr Larsson indicated last time we spoke that he is very interested in going back and incorporating records as far back as you can go.

Prof. Johnston: Indeed , that is the case. I do not have that information with me. As I said, in the first instance we got five years of data. We do know that the mines hold much more data than that, and they have indicated a willingness to provide that data. We simply have not got to that point yet.

Senator LUDLAM: But that is part of your work plan?

Prof. Johnston: If you would like me to take the question on notice I can provide you with an answer on what we have been told they hold in terms of back data.

Senator LUDLAM: Yes, I am interested to know that. This is really valuable work. It probably should have been set up decades ago, but it is great that you are doing it. I am just interested to know how far back you are intending to go and how far back the datasets go that you are going to be able to incorporate. Is there anything that the Commonwealth can or should do simply to compel the Northern Territory to have that as a licence condition?

Prof. Johnston: I think the approach at the present time is to work constructively with the Northern Territory to change its law.

Senator LUDLAM: We can compel in constructive ways, can we not? Let us move on. The main benefit for establishing whether the workforce had been harmed in the course of occupational exposure would be comparing the various cohorts that you have in your dataset with control groups or equivalent perhaps workforces in other sectors of the mining industry to tell us whether there are any differences. Is there any intention to do that? What will you actually be doing with this dataset once you have established it?

Prof. Johnston: We will be doing a number of things. The first thing we will be doing is providing access to miners to their radiation dose histories—

Senator LUDLAM: That is great.

Prof. Johnston: which they may find useful if they wish to make some claim in the future about occupational exposure. The second thing that we believe that the dose register is very useful for is as a tool for what is called optimisation. In other words, the fact that one actually records doses on a continuous basis provides a tool for driving down the radiation exposures. They are the two major benefits of the dose register at this time.

Senator LUDLAM: But if you were an epidemiologist and you were trying to establish whether, for example, uranium mine workers have higher rates of lung cancer, as has

certainly been the historical experience, but as to whether the modern experience bears that out you will want to take the dataset that you are collecting and compare it with those for mine workers who have not had occupational exposure to radiation?

Prof. Johnston: That might appear superficially attractive, but in fact the radiation doses that uranium mine workers get in Australia are much lower than would be suitable to use for epidemiology. At the types of doses that we are seeing in the mines in Australia you will probably a need a cohort in the millions to be able to see such an effect.

Senator LUDLAM: That is interesting. If you able to take on notice for us the information that you have just undertaken to, that would be appreciated. Do you do worker awareness programs? Do you actually visit mine sites or conduct workshops or anything like that?

Prof. Johnston: As you are probably aware, this measure was only funded as an ongoing measure on budget night this year. Part of our discussions with the Department of Resources, Energy and Tourism is to do exactly that. We do plan a road show to talk with miners about the dose register, its importance and to educate them somewhat more about the radiation doses to which they are exposed.

Senator LUDLAM: You are planning that. Will you take that to the Northern Territory, because there has been—

Prof. Johnston: We certainly will, yes.

Senator LUDLAM: Is it going to be a little bit awkward explaining to mine workers in the NT why they are not part of your system?

Prof. Johnston: We hope that it will not take terribly long for the Northern Territory government to act, but that is beyond our control.

Senator LUDLAM: Could you please update the committee on ARPANSA's assessment of a licensing process for advancing the national radioactive waste dump?

Prof. Johnston: As you would be aware, there is no licence application for a radioactive waste management facility under Commonwealth legislation at the current time. When we get an application, we expect it will be a staged application. There will be three stages. There will be a siting application, a construction application and an operating application. The siting application will, to a very large degree, overlap with requirements under the EPBC Act. We have had some preliminary discussions with the Department of Sustainability, Environment, Water, Population and Communities—

Senator LUDLAM: The department of everything.

Prof. Johnston: yes, them, about coordinating those two processes.

Senator LUDLAM: The last time I approached Dr Larsson on this issue he said that process was already well underway. I do not want to put words in his mouth, but that ARPANSA was in the process of designing, if you will, the mechanisms, seeing as how we have never licensed it, a long-lived intermediate level waste dump, in Australia before.

Prof. Johnston: We have certainly licensed an intermediate level waste store at Lucas Heights. There is one now.

Senator LUDLAM: That is fair enough.

Prof. Johnston: We have also licensed disposal facilities at Maralinga associated with the cleanup of former uranium mines in the South Alligator Valley. We have extensive experience in the licensing of waste facilities in Commonwealth entities. With respect to the national radioactive waste management facility, we are preparing a regulatory guidance document which is an update of a document that was prepared in 2006. We are undertaking a revision of the code of practice for the near surface disposal of radioactive waste.

Senator LUDLAM: Near surface disposal—is that the material that is not actually destined for this particular dump? This is the very long-lived material that is being held there in the interim?

Prof. Johnston: We have no licence application so I cannot predict what in fact will be applied for.

Senator LUDLAM: But you know what Australia's radioactive waste inventory looks like? You have a pretty good idea.

Prof. Johnston: The vast majority of Australia's radioactive waste inventory is in fact low-level waste that would be suitable for a near surface disposal facility.

Senator LUDLAM: What does 'near surface' mean in the context of your regs?

Prof. Johnston: A near surface disposal facility would be a disposal facility in trenches or some other entry into the ground that would be of the order of 20 metres deep.

Senator LUDLAM: The former Lucas Heights reactor core and the spent fuel that is to be returned from Europe?

Prof. Johnston: A near surface disposal facility is only suitable for low-level waste. Low-level waste by its nature precludes generally long-lived radioactive waste.

Senator LUDLAM: Why are we proposing to cart that long-lived material to an unsuitable facility?

Prof. Johnston: As I said, we do not have an application for a facility this time, but in general terms one could imagine two components to a facility. One would be a low-level waste disposal facility and another component might be a storage facility for intermediate-level waste.

Senator LUDLAM: So, a hole in the ground and a shed as two co-located components?

Prof. Johnston: Without an application, I cannot tell you what will be applied for.

Senator LUDLAM: Co-location is government policy. I am not trying to lead you off down some hypothetical. This stuff has been kicking around for 50 years. What is your process, then, when there is an application? Firstly, Minister Ferguson will need to say it is going to be there. He is going to pick a location. At that point what will your process be?

Prof. Johnston: He will have to make an application.

Senator LUDLAM: A determination of a plan—

Prof. Johnston: The first application will be a siting application. In fact, for something like this I would imagine, generally, he will probably have to make two applications, one for a near surface disposal facility if he chooses to apply for such a thing, and a second application for an intermediate level store.

Senator LUDLAM: That is helpful. The DRET folk are not necessarily quite so clear, so it will be interesting to see what actually does come forward. I understand a revised inventory of radioactive waste will be assembled for the next UN Joint Convention on the Safety of Spent Fuel Management and the Safety of Radioactive Waste Management—whatever that acronym is—in May 2012 and international best practice for near surface waste disposal will have to be incorporated into ARPANSA's updated radiation health series No. 35 code of practice, 1992, and possibly an associated safety guide. Is that what you were referring to before about updating your guide?

Prof. Johnston: RHS No. 35 is the code of practice for near surface disposal.

Senator LUDLAM: That is the one, okay. When do you expect to have that completed and published?

Prof. Johnston: There are actually three key documents. One is the report to the joint convention, and there is no acronym, unfortunately. It is just a very long, wordy title. The joint convention report has to be completed by October of this year. The near surface disposal code is actually with the radiation health committee. The radiation health committee processes—and being a Commonwealth-state processor—not necessarily being fast, one would hope that would be concluded by late next year.

Senator LUDLAM: Late 2012?

Prof. Johnston: We are aiming to complete the regulatory guidance document within the next couple of months.

Senator LUDLAM: Before the end of this year?

Prof. Johnston: Certainly.

Senator LUDLAM: What advice has ARPANSA provided to agencies or the Australian government in relation to the continuing nuclear emergency at Fukushima in Japan?

Prof. Johnston: I have actually prepared an extensive presentation on Fukushima if it is of interest to the committee, but you may not have time.

Senator LUDLAM: I understand Senator Boyce might have been about to ask you about this as well. I have changed the subject to Japan, so if you want to lead off.

Ms Halton: Professor Johnston has actually brought a copy of his presentation. I will get somebody to copy it for us and we can table it as well. Before he launches forth, it might be sensible to give him an indication of how much time he has so he can tailor the actual spoken word part of this.

CHAIR: You have five minutes, Professor. I am sorry to do that to you. It might be useful, Senator Ludlam, if we did ask the minister to have a briefing on this. I think it would be useful to have an extensive briefing. Ms Halton, we will put that to the minister, that we get Professor Johnston at a future time to come with his paper and do a briefing for interested senators.

Ms Halton: It is a really good idea. I think the other part of that might be to have the Chief Medical Officer—

CHAIR: I think it would be very useful.

Ms Halton: Not this Chief Medical Officer but certainly in the briefings that were done of government the department, including the Chief Medical Officer and ARPANSA worked very closely on these advices to government.

CHAIR: I hope that appeases my cruelty in only giving you five minutes.

Ms Halton: So the edited highlights.

Prof. Johnston: So, the focus should be on ARPANSA's role with respect to advice to government? Unfortunately the emergency is not over. We have a continuing emergency in Japan. The reason I say that is that the reactor systems are still not in a state where they are undergoing active cooling. The consequence of that is that they are still emitting small amounts of steam with radionuclides in them. They are not a sealed system. Until active cooling is resumed they cannot be sealed up and the emergency cannot be ended. As a consequence of that there is an area around the reactors where people are not allowed to return to their homes.

ARPANSA was involved in an interdepartmental emergency task force that was set up by DFAT as a result of the emergency in Japan. This is a whole-of-government response to the earthquake, tsunami and subsequent nuclear crisis. We worked from Australian guidance for emergency in the event of a release from a reactor, which we have for our own use. We provided advice for a large range of different eventualities, including advice for Australians remaining in Japan, advice in terms of being required to shelter in place in Japan, the use of potassium iodide tablets, which was joint advice between ARPANSA and the Chief Medical Officer, advice for Australians returning home, advice to medical practitioners, including frequently asked questions. We had routine discussions with FSANZ, AQIS, Customs and anybody who has worried about goods or food entering Australia. We were involved in regular communication with the Department of Foreign Affairs and Trade with regard to travel advice for Japan. We were involved with Customs in generating Australian Customs notices about goods entering Australia from Japan.

In addition to working with FSANZ and ultimately halting orders on food entering Australia from Japan from various prefectures, ARPANSA has also been the designated laboratory for measuring food. Of the samples we have measured of food coming from Japan I think only two samples have been above the minimum detectable level, and those samples have been of the order of a factor of 100 below the Codex Alimentarius values for radioactive contamination in food. We are fairly comfortable that contaminated food has not entered Australia.

CHAIR: Senator Boyce might have some questions and we have only got five minutes.

Senator BOYCE: On this particular issue, I have been watching your updated website. What resources has ARPANSA devoted to the Japanese emergency, so to speak?

Prof. Johnston: We stood up our emergency operations activity on the night of the disaster. It ran 24/7 for about three weeks, I guess, before we were able to give people time off. We had around 20 people on shift and we were operating 12-hour shifts seven days a week for that time.

Senator BOYCE: There were 20 people all up working; is that what you mean?

Prof. Johnston: Per shift.

Senator BOYCE: Okay.

Prof. Johnston: We mounted teams looking at monitoring data. We were modelling the plumes and providing advice to, for example, the urban search and rescue teams, the consular teams and so on who were operating in Japan. Government liaison was a huge activity. We handed over essentially all of the media responsibility to the department of health. Simply because of the volume we could not maintain that activity. We have since been able to deal with most of the phone calls by deflecting them to our website. We have answered large numbers of emails and we are still answering emails on a regular basis. It has been a huge activity for the agency and exhaustion was setting in around Easter.

Senator BOYCE: Going by your smile, I judged there had been a lot of resources. Where has the funding for those resources come from?

Prof. Johnston: We have had no additional appropriation at this stage. We are hoping we will be able to manage it within our existing appropriation, but our CFO might be able to help.

Mr Savvides: There was in the order of $220,000 in terms of overtime and shift penalties, but we have been able to fund that from within our existing budget, because we have income sources other than appropriations that we can draw on.

Senator BOYCE: My further questions go really to this topic of resources. We have had the launch of the online solarium operators course, but I presume that is not providing mega-dollars to ARPANSA. You have also launched your Australian Clinical Dosimetry Service. Is that actually functioning or is it still in the stage of being set up?

Prof. Johnston: I had better look at the brief; otherwise I will get this wrong. In most respects I would have to say it is still in the process of being put together, although the very first audits have actually happened.

Senator BOYCE: How many audits have happened and what are you charging for an audit?

Prof. Johnston: I think at this stage we are not charging at all. It is very early days. There are three levels of audit and the most basic level is Level 1. One Level 1 audit has been successfully passed. Two Level 1 audits are underway and the equipment is being returned from the auditee. We have performed one onsite pre-clinical dosimetry check for a new centre and so on.

Senator BOYCE: Has anyone failed their audit, I suppose, is the question?

Prof. Johnston: No, no-one has failed an audit.

Senator BOYCE: How will you be reporting on those audits?

Prof. Johnston: That is a very good question. I think I will have to take that on notice.

Senator BOYCE: If you could advise me of the regularity and the level of public availability of your audit reports, please, and perhaps if possible the costings that will be associated with the audits once you are charging for them. I notice also from the minutes of the last Radiation Health and Safety Advisory Council meeting that you are going to improve public and political debate around risk perception of radiation to ensure a better understanding of radiation risk. Can you tell me a bit about that program? Is it underway yet?

Prof. Johnston: Not really. But we have had some discussions with Beverley Raphael.

Ms Halton: Professor Beverley Raphael.

Prof. Johnston: In general terms people often discount very major risks in their lives and often overestimate very minor risks in their lives.

Senator BOYCE: It tends to be associated with whether it is a risk I chose to take or a risk that was forced upon me by others.

Prof. Johnston: That is a factor. Nevertheless, the comments are still true. We underestimate, for example, the risk of smoking and we overestimate the risk of—

Ms Halton: Vaccination.

Senator BOYCE: I do have some experience of working for chemical plants way back and certainly people were far more worried about chemical plants than they were about things with about a thousand times greater risk of happening to them.

Prof. Johnston: We think that part of our role should be to try to help educate the public about the magnitude of risks. We think it will help public discourse.

Senator BOYCE: Lastly, your budget appears not to be going to increase at all, or in a very minor way, over the forward estimates. You are looking at the getting three extra new staff. You are undertaking several—that we have talked about and you have others—new projects in addition to what you are already doing. How are you going to manage this?

Mr Savvides: Are you referring to the additional measure around the dose register? That has funded the three additional roles that you are referring to.

Senator BOYCE: But are you intending to undertake a major promotion, a public awareness campaign or public education campaign on the topic of radiation risk?

Prof. Johnston: We have started having a discussion with the professionals in that area, and we have not fleshed out the extent of what that is going to be at this stage.

Senator BOYCE: Are you confident you have sufficient resources, both human and monetary, for the coming 12 months?

Mr Savvides: Only about half our income is from appropriation. We have income from other endeavours that we should be able to cover in a couple of extra roles.

Prof. Johnston: I think it is fair to say that we do not yet know what the ongoing cost of dealing with things like Fukushima is. We really will need to make some assessment of how we can cover that in the future to decide whether or not we have sufficient resources to do what we have to do.

CHAIR: I thank the officers from ARPANSA. There will be questions on notice. I know I had to cut off Senator Ludlam, and we will be following up with the minister for a briefing. Thank you very much.

Ms Halton: The document I referred to, the conditions of listing of the device that we were discussing earlier, we have now topped and tailed that to the particular conditions and we will table that document.

Proceedings suspended from 15:31 to 15:42

Australian National Preventive Health Agency

CHAIR: We welcome officers from the Australian National Preventive Health Agency. I think this is your first estimates, so it is good to have you with us. We have allocated half an

hour. I am not quite sure what the senators' questions are, but I know that Senator Adams and Senator Boyce have questions for the agency.

Senator BOYCE: And Senator Fierravanti-Wells.

CHAIR: Yes.

Senator ADAMS: The Australian National Preventive Health Agency was established in January to further the preventive health agenda in the areas of tobacco, obesity and alcohol. Is it correct that the agency handed its first strategic plan to the health minister in April?

Dr Galbally: Yes.

Senator ADAMS: Can you tell me whether the government will make the strategic plan public?

Dr Galbally: Under the legislation we were required to hand the reports, the strategic plan, the first-year work plan—the operational plan—to the minister, which we did by the 30th. She has signed off. There are some formalities to go through with the advisory council yet to be appointed and then to the conference of ministers, where they will all have a chance. We discussed it widely with all the states and territories.

Senator BOYCE: Is there a strategic plan or strategic plans?

Dr Galbally: There is a strategic plan that is five years, and then there is a one-year operational plan.

Senator ADAMS: By the sound of that, it may be quite a long time before the strategic plan becomes public?

Ms Halton: I would not think so, no.

Senator ADAMS: Do you think it will come out a lot quicker?

Ms Halton: That would be a question for the minister.

Senator ADAMS: This one is probably for the minister as well.

CHAIR: Senator McLucas, do you have any comment?

Senator McLucas: If the minister has some further advice about when that will be available, I will bring that to the committee.

Senator ADAMS: You might be able to answer this question too. Will the government be setting budgets for each of the priorities of tobacco, obesity and alcohol?

Senator McLucas: I do not know, but I will follow that up as well.

Senator ADAMS: Thank you.

CHAIR: Senator Boyce.

Senator BOYCE: I wanted to check on how the Preventive Health Agency's strategic plan will sit with the COAG national partnership agreement on preventive health?

Dr Galbally: We have been given responsibility for undertaking the evaluation of the national partnership agreement. That is how they sit together. That is one of our priorities. It is in our 12-month work plan. We have started doing that work. We have guidelines and drafted the brief ready for tendering. That will be tendered in the second part of the year. There have been extensive discussions with state and territories.

Senator BOYCE: So, you will assess the COAG strategic plan; is that what you are saying?

Dr Galbally: We will be doing a meta evaluation of all of the work that the states and territories are doing.

Senator BOYCE: Have done or are doing?

Dr Galbally: Are doing.

Senator BOYCE: Can you talk us through how that will report, who you will consult and so on?

Dr Galbally: That is a two-year evaluation. It will be reporting regularly and publicly.

Senator BOYCE: Who would you consult during your evaluation?

Dr Galbally: States, territories, stakeholders, NGOs, industry and everyone involved in the obesity issue, because that is the states' focus is on obesity.

Senator BOYCE: I am not talking about obesity. I am talking across-the-board.

Dr Galbally: I thought you were talking about the national partnership. The national partnership from the states' input is mainly about obesity.

Senator BOYCE: I thought it was on preventive health.

Dr Galbally: It is called preventive health, but the focus is obesity.

Senator BOYCE: Is it correct that there are reward payments that are going to go to the states under the COAG agreement?

Dr Galbally: Yes. The reward payments are a matter for COAG.

Senator BOYCE: Will you have any input into how that happens?

Dr Galbally: No.

CHAIR: Senator Boyce, I would like to cut in, because Senator Siewert has to go to another set of estimates. Can she come in and then you could follow up later?

Senator BOYCE: Yes, that is fine.

CHAIR: I just thought that you had reached a stage where there was not a follow-up question.

Senator BOYCE: There is, but I am just trying to get my head around them.

CHAIR: While that is happening Senator Siewert can jump in.

Senator SIEWERT: Thank you. I would like to ask about alcohol and the community sponsorship fund and where that process is up to.

Dr Studdert: The agency has been consulting closely with the department about the transition of the binge drinking initiatives to the agency, but at this stage we are not involved directly in running any of the particular initiatives. For details on those I will refer to one of our colleagues from the department.

Ms Halton: Here is one I prepared earlier.

Ms Harman: Obviously this is about managing an orderly transition from the work that we have started and continue to do with the agency. As my colleague pointed out, we are continuing to work very closely with the agency. We are continuing implementation and in

everything we are doing and planning and rolling out we are consulting and getting the tick-off from the agency before we progress it.

We provided you with quite a detailed response to a written question on notice from the last hearings. Since the progress that we reported in that response, in terms of the $5 million enhanced telephone alcohol counselling and referral service, we have released a tender for the development of a national minimum standards for service delivery for that single hotline and also for the 1800 number. That was a tender that was let on 2 May this year and will close on 17 June this year.

Senator SIEWERT: Is that to develop standards?

Ms Harman: That is to develop the standards, but also the 1800 number and the infrastructure around that. My colleague Mr Kennedy might have a bit more detail if that is useful for you.

Senator SIEWERT: Yes. Is it possible to get a copy of the tender document?

Mr Kennedy: Yes. I can provide a copy of the documents for you.

Senator SIEWERT: I am a bit confused. Is it correct that it is also calling for people to tender to provide the service? Ms Harman, did I misunderstand?

Ms Harman: I think I probably confused you.

Senator SIEWERT: Yes, you have. I am easily confused at this time in estimates fortnight.

Ms Harman: The main purpose of the tender is to develop the national minimum standards for the service.

Senator SIEWERT: Yes, that is what I understood it would be.

Ms Harman: The service will bring together a multitude of 1800 numbers. All states and territories are fully on board in terms of rolling those up into a single 1800 number. This will develop the service standards and then we will be able to roll out the service. We will be providing funding to the states and territories from next financial year onwards—from 2011-12—for the next two years.

Mr Kennedy: The tender will provide the benchmark for states and territories to assist them in providing consistent service across all states and territories. It will set the minimum level of standard and service applicable, and then provide the benchmark so states and territories can operate on that basis.

Senator SIEWERT: Can you provide that tender document?

Mr Kennedy: Yes.

Senator SIEWERT: That is the hotline.

Ms Harman: Yes.

Senator SIEWERT: What about progress on the other initiatives, say, in terms of the community sponsorship fund? Last time we had feedback around the development of the consultation process that you had 41 submissions and you were going to finalise the steps for 'where to from here'. What steps have been finalised?

Ms Harman: As I opened my response, this is obviously an orderly transition process and we need to make sure that the work we have done transitions seamlessly to the agency. We

are working very closely on finalising that and I believe we are very close. There will be a number of arrangements that still do need to be worked through in terms of the finer detail around systems, resourcing and that kind of thing, but our ultimate aim is to hand this over as quickly as possible. I know the agency is very keen to receive the funding and to continue the work that we are doing. I am hopeful that will be happening relatively soon. That is a similar situation with the community level initiative grants part of the measure as well. We have developed the guidelines and it is ready to go in terms of the third grants round being advertised.

Senator SIEWERT: Is that for the community grants?

Ms Harman: That is exactly right, yes. There is the community sponsorship fund and the community level initiative grants program.

Senator SIEWERT: Let us go to the sponsorship fund first. There was a budget allocation for 2010-11, but you are clearly not going to make that. Correct me if I am wrong, but you will not be releasing the application process and have completed that by the end of June being next month; is that correct?

Ms Harman: I would imagine that releasing the application process, processing them and closing them by 30 June would probably not occur.

Senator SIEWERT: So, what happens to that money?

Ms Harman: Those are the sorts of details that we are working very closely on finalising in terms of arrangements.

Senator SIEWERT: Can you and the minister guarantee that those funds will be available for another round of the fund?

Senator McLucas: I understand we are going to transition those funds to the agency before 30 June.

Senator SIEWERT: Thank you. So, they will be available and we are not going to lose funds?

Senator McLucas: This government's commitment to preventive health is pretty clear. We were not going to be letting any money go back to the consolidated revenue.

Senator SIEWERT: That is excellent. Has the application process been finalised?

Ms Harman: The materials for the application guidelines have been finalised and signed off.

Senator SIEWERT: Are they publicly available yet?

Ms Harman: No, they are not publicly available.

Senator SIEWERT: Does that mean they will not be available until the grant is actually called?

Ms Harman: That is the usual process. Those will ultimately be matters for the agency to discuss with the minister, but that would be the usual process.

Senator SIEWERT: In terms of the community grants, the third round of those will be released shortly as well. Did I interpret what you said earlier correctly?

Ms Harman: Our plan is to finalise these things as quickly as possible, hand the money to the agency and then hand the work that we have done in terms of progressing the measures

over to the agency for the agency to release the various parts of the measure as quickly as they possibly can. I cannot give you a definitive timeframe. I do not think it would be proper for me to do that at this stage.

Senator SIEWERT: I understand that all the other elements of the binge drinking strategy are being transitioned over as well?

Ms Harman: No. Early intervention measures such as the Club Champions program are measures that are remaining with the department and are continuing.

Senator SIEWERT: Rather than going through it now, so I can get it clear would you be able to give us a list of what has been transitioned and what has not in terms of the program?

Ms Harman: Of course. We will take that on notice.

Senator BOYCE: And why you have transitioned what you have transitioned and not transitioned the other parts?

Ms Harman: The decision about what the agency would take the lead on in terms of rollout and implementation was a decision taken by the government and that is a public decision. That is the $50 million expansion measures that were announced in the budget process.

Senator SIEWERT: I am not sure whether it is appropriate to ask this question of the agency or of the department. I am interested in the price control measures that may have been considered, particularly in light of the discussions in the Northern Territory and how much engagement there was between the Commonwealth and the Northern Territory over their recent introduction of new restrictions and any further discussions there might be around the use of a price as a mechanism?

Dr Galbally: The government's response to the report of the Preventive Health Taskforce stated that the Commonwealth would ask ANPHA to develop the concept for a minimum floor price of alcohol for further consideration of government. That is in the proposed operational plan for 2011-12.

Senator SIEWERT: I will come back to the department in a moment, because I still want to talk about the current issues. Perhaps I could talk about the operational plan. I realise this is still with government, but does that mean that over the next 12 months you will be working on that initiative?

Dr Galbally: Yes.

Senator SIEWERT: When you talk about floor price, do you mean the various concepts? There is a minimum price per unit of alcohol and there is the floor price. Is the proposal to work on both of those concepts?

Dr Galbally: We are still scoping that.

Senator SIEWERT: Will you pick one or the other or look at the broader range of initiatives?

Dr Galbally: It will be the broad range.

Ms Halton: In terms of the current activity in the Northern Territory, there is the hearing on Friday in relation to Indigenous specific issues.

Senator SIEWERT: Can I ask there?

Ms Halton: I think so. As we know, this is an issue that has oft been debated, and I am aware there have historically been some discussions. My understanding is that some of those officers have been party to some of those discussions. They are not necessarily in a determinative way, but it won't surprise you to know that we have opinions about this.

Senator SIEWERT: Yes. I am happy to put off the discussion til Friday.

Ms Halton: I can make one comment in relation to the National Partnership Agreement on preventive health. It is broader than obesity. I think you know there is $872 million. It covers healthy children, healthy workers and healthy communities. There is the industry partnership. There is a whole series of things under it.

Senator BOYCE: As I understand it, there are six initiatives in it?

Ms Halton: Yes, we could be getting up to six.

Senator SIEWERT: I have questions around some of the other areas that you are working on, but I am conscious of time so I will put them on notice.

Senator BOYCE: As I said, we have obesity and the other initiatives that Ms Halton started enumerating. Why was the one initiative transferred to the National Preventive Authority and not others? When are they going to transit and what is the plan?

Ms Halton: As Ms Harman has already said, the government took a decision about what would be where. In terms of the transition, I think we should take it on notice as to the likely timetable around the various bits. As we have already indicated, we might give you all of that in a comprehensive answer.

Senator BOYCE: If you are going to have some preventive health stuff happening here and there, how are you going to organise cooperation between the jurisdictions on this?

Ms Halton: That is one of the reasons the agency will have a strategic plan, so we can all see who is doing what. The truth is that preventive work spans not just the detailed work of the agency; it spans most of what we do in the department and, indeed, for most of the jurisdictions a lot of what they do should have a prevention focus. We have to get this plan out, which means we can then have the dialogue. I know the minister will be talking to her state colleagues about those issues.

Senator BOYCE: How will data be shared between the federal department, the agency, the states and territories and so on?

Ms Halton: I do not think we should answer that question hypothetically, because it is early days, other than to say that the agency will have to have access to relevant information and there will have to be a free flow. I do not think we should get into hypotheticals, because we have not got to that level of specific discussion yet.

Senator BOYCE: It concerns me whether it is a hypothetical or whether it is going to be another system where we have four or five different gateways that may or may not be doing the same thing.

Ms Halton: That is a reasonable concern. One of the things that we are trying to do in the department with the strategic review and the alignment work, which I think you already know, is to cut down the duplication and the number of times we hold information to make it much more seamless. Obviously our objective would be to make sure, for example, that we

have one set of data which is collected that all the relevant parties can use. That is absolutely our objective.

Senator BOYCE: Perhaps on notice you can give me the outcomes that are expected from the COAG partnership agreement and from the Preventive Health Agency's strategic plan so that I can try to understand this.

Ms Halton: I am happy to do that.

Senator BOYCE: And how anyone will work out what fits in each box, which is very tricky.

Ms Halton: I am very happy to do that on notice.

Senator FIERRAVANTI-WELLS: I would like to ask some questions about your establishment. How many staff do you have?

Mr Kalokerinos: We have 21 staff to date.

Senator FIERRAVANTI-WELLS: How many do you envisage that you will eventually have? What is your full allocation?

Mr Kalokerinos: Somewhere between 30 and 35.

Senator FIERRAVANTI-WELLS: Is that across a range of different levels?

Mr Kalokerinos: Yes.

Senator FIERRAVANTI-WELLS: Where will you work from?

Mr Kalokerinos: The agency is currently headquartered in Canberra in Civic at 40 Marcus Clarke Street.

Senator FIERRAVANTI-WELLS: Who are you co-located with?

Mr Kalokerinos: We are the only agency on the floor. It is a health tenancy.

Senator FIERRAVANTI-WELLS: Tell me about the CEO position. Dr Galbally, you are acting in the position. What is the situation? Is your position going to be advertised and filled on a permanent basis?

Ms Halton: That is probably not a question for Dr Galbally. That is probably a question for me.

Senator FIERRAVANTI-WELLS: Certainly.

Ms Halton: Yes, it has been advertised, there has been a recruitment process and we would anticipate that there will be an outcome of that soon.

Senator FIERRAVANTI-WELLS: In looking at governance arrangements, you will have direct responsibility to the minister and there will also be a National Preventive Health Agency advisory council that will be appointed by the minister. Has that been appointed yet?

Dr Galbally: No. It has not been appointed yet, but it has been advertised. I imagine it will be appointed soon.

Senator FIERRAVANTI-WELLS: I notice that the membership is defined as one member representing governments, states and territories—so at least five, but not more than eight other members with expertise relating to preventive health. Has an advertisement been put out calling for people who are interested to serve on the council and who have preventive health expertise?

Dr Galbally: Yes.

Senator FIERRAVANTI-WELLS: I assume a decision on that will be made at some stage.

Ms Halton: By the minister.

Senator FIERRAVANTI-WELLS: The budget is $872 million over six years for the COAG National Partnership agreement. In terms of your operations, what is your budget? I noticed at page 474 of the Portfolio Budget Statements it states, 'The budget measures relating to the agency are detailed in Budget Paper No. 2', but I had difficulty finding it in Budget Paper No. 2. I thought I had traversed it sufficiently, but I cannot find it so can you assist me?

Mr Kalokerinos: I can potentially assist. The agency's departmental appropriation for the current year is only $1.826 million, which covers the costs of agency operations such as staff and supply costs. Our administered appropriation, which is the larger sum, for 2010-11 is $33.803 million.

Senator FIERRAVANTI-WELLS: Where is that? Can you point me to a page?

Ms Halton: Where are you looking?

Senator FIERRAVANTI-WELLS: On page 473.

Ms Halton: Of the PBS?

Senator FIERRAVANTI-WELLS: Yes.

Ms Halton: As just outlined, all of those monies are indicated there.

Senator FIERRAVANTI-WELLS: Whereabouts is it in the blue book?

Mr Kalokerinos: I am not familiar with that.

Senator FIERRAVANTI-WELLS: Page 474 of the yellow book, at the top of the page.

Ms Halton: In terms of BP2, the only part where the agency is separately identified is at page 125, the efficiency dividend, which is the temporary increase and a whole-of-government measure. You will not find it separately identified in here.

Senator FIERRAVANTI-WELLS: The Portfolio Budget Statement states at the top of the page, 'The budget measures relating to the agency are detailed in Budget Paper No. 2.'

Ms Halton: That would be the efficiency dividend.

Senator FIERRAVANTI-WELLS: Is that the efficiency dividend?

Ms Halton: Yes.

Senator FIERRAVANTI-WELLS: Thank you.

[16.08]

CHAIR: We have run out of time for questions for the agency. There could be questions on notice. We will now move to Outcome 6, Rural Health.

Senator NASH: I would like to start with the budget paper and the dedicated regional health unit that has been announced. How exactly is this unit going to work?

Ms Morris: The agency will bring together all information based on anything regional or rural that we have in the department. It will provide a 1800 number, a free call number, for people who want to ring up and find out about things. It will also use a website to give people

information. Trying to explain it simply, the difference will be that, apart from the fact that all the information will be available in the one place rather than someone trying to track—

Senator NASH: So, any information that is regionally related?

Ms Morris: Yes, health information regarding programs that apply to people in regional and rural Australia. It will be relevant to an area. Currently information around programs tends to be set up for the people are applying under it. You could be a doctor who is interested in working in a regional area or a more remote area. This will be more publicly available and relevant information, available to anyone who wants to find out, plus the unit will have a strong advocacy role within the federal government, on behalf of rural and regional health issues. I will check whether my colleagues who are doing the work on it having anything to add.

Mr Booth: That is correct. The agency is going to build on the existing capacity of the Office of Rural Health within the department and is going to provide those kinds of services in terms of information for people who want to gain information on rural services.

Senator NASH: I understand that you are painting a broad picture, but could you take on notice for me the actual detail of the types of things that currently exist within the department that will be brought into the one area? I know that the budget papers say that it is going to be met within existing resources within the department. What is the estimated cost of that, where is that funding coming from and are there going to be commensurate cuts elsewhere within the department to fund it?

Ms Halton: We have talked at some length in these estimates about the strategic review of the department and the position that the department will be in. One of the things that we did in terms of finding some money as an offset was to take some of the efficiencies that were generating through. We have talked about the streamline funds and the way that we reduce our administrative overhead from putting those in place. Some of the money that we will free up from adopting these administrative efficiencies is being directed to this particular need. It is not being done at no cost. It is being funded through the efficiencies that we are finding elsewhere in the department.

Senator NASH: As an offset; that makes sense. What is the cost?

Mr Andreatta: The estimate is $5.4 million.

Senator NASH: Over what period?

Mr Andreatta: That is over four years. The majority of that $5.4 million will be spent in the first year as set-up—the development of the website and the call centre function. In the out years the amount is simply resourcing a small cell within the department.

Senator NASH: How many staff do you see allocated to the unit from within the department?

Mr Andreatta: The final number has not been determined at this stage. We have a project team set up to deliver the functions that have been mentioned, but the final establishment number is yet to be determined.

Ms Halton: Let us take it on notice. There was a number projected in the costing. It is true that when you get inside some of these projects that you want to play around a bit with the numbers, but we will tell you what we think in rough order of magnitude.

Senator NASH: That would be useful. I imagine you would have some idea given that you have identified some offsets.

Ms Halton: That is exactly right.

Senator NASH: I imagine that you would not be setting it up without some sort of dollar figure attached to it.

Ms Halton: That is correct.

Senator NASH: Am I right in understanding that it is not a service provider but more of a one-stop shop to collect all of the regionality within the department to provide it as a go-to place? Am I reading it right?

Ms Morris: The best way to describe it is that it is information and advocacy within government.

Senator NASH: How does the advocacy that will come from the unit itself differ through the department advocacy from existing regional resources and will it be in association with organisations such as the Rural Doctors Association?

Ms Halton: I would be a bit careful about the use of the word 'advocacy'. I think 'advocacy' is a term that has meanings that range depending upon the image you have in your head.

Senator NASH: That is precisely why I asked the question.

Ms Halton: There is the placard-waving advocacy through to email driven. You know what I mean. Its role is to be a source of information. It is to ensure that, when it comes to decision making, people are properly equipped in respect of the numbers and the issues that are relevant inside government. It is not the same as the Rural Doctors. The Rural Doctors have a very particular set of interests, which they represent very well. This is a policy and program administration. It is to describe, understand, provide information externally and then inform internal processes of policy development so that program administration is appropriately informed and cognisant of what the issues are for people in regional and remote areas.

Senator NASH: Within the staffing for this unit will you designate people who have some sort of rural and regional background or not necessarily?

Ms Halton: No. It is not our habit to have designated positions in the department. I do not have designated positions for people with disabilities or Indigenous people. That said, we have a lot of people with disabilities in the department and a lot of people from an Indigenous background. Undoubtedly we will have people who have experience of and expertise in these issues, but we will also have your standard common or garden public servant, if you know what I mean.

Senator NASH: I am not sure they would like to be called the common garden variety.

Senator FIERRAVANTI-WELLS: Some of us were common garden variety public servants at one time.

Senator NASH: I know. I am sure the common garden variety in your department are in full bloom.

Ms Halton: I will have to go to Monday morning's executive meeting and inquire as to who is in full bloom and who has lost a few petals.

Senator NASH: And who has thorns.

Ms Halton: Absolutely right.

Senator NASH: Obviously they will have, by way of background, some sort of regional expertise. When you talk about them being informed, who do you see them being informed by? What is the understanding of how that sort of process will work?

Ms Morris: What I articulated as the two roles were, firstly, providing information, and for that to happen this agency needs to be able to garner all relevant information from within the department. That is why Mr Andreatta referred to the initial start-up costs and IT costs. It is about being able to extract information and make sure that it is relevant, up to date and useful to people. That is how we organise information flows within the department and that sort of core business for government in terms of how we arrange ourselves and send information around. The other function, as Ms Halton articulated, is within the government itself.

Senator NASH: That is the advisory-type role?

Ms Morris: Yes. It is having a go-to place for issues to do with rural and regional health. Not all the expertise needs to be there, but there needs to be a defined point to which questions are addressed and from which we provide views and input on things. We will work very closely with the rest of the department in getting that. Not all of the expertise to do with anything rural or regional is going to be in this agency and we are not trying to segregate/dismantle programs that have a large rural and regional component. There will still be big programs located in program areas, but with information and issues relevant to rural and regional people there will be a transfer of knowledge to this agency.

Senator NASH: That makes sense. One of the issues that I know has created a considerable deal of angst is using the ASGC-RA map for the incentive payments for rural doctors, which was about the middle of last year; is that right?

Ms Morris: Yes, it was about July last year.

Senator NASH: Again, it is the Rural Doctors Association and others, and I have been contacted by many regional doctors that had issues with this when the change came in. Is having a review of how the ASGC-RA map is working in relation to these incentive payments something that the new regional unit is likely to do? As somebody who has been very involved with this map from the education side of things, I can completely understand how there have been anomalies for doctors in smaller towns being lumped in to, say, the inner regional zone where they may well be in a very small country town. Is this something that will be part of your undertaking as the new unit?

Mr Booth: Certainly. One point that I would make is that the ASGC-RA system was only introduced for the incentive payments from 1 July last year. We are still keeping an eye on what is happening. It has been in operation for around nine months, and we are really seeing what the effects are and what is happening. We are looking at what the impacts and effects are. Mr Andreatta may have some additional detail on that.

Mr Andreatta: You referred to it as a review. We are actually looking at some specific cases that the rural health stakeholders have identified.

Senator NASH: There will be plenty of them.

Mr Andreatta: There were around 23-odd areas that they had concerns with. We are currently looking at those. As Mr Booth said, it is very early days for an implementation of this classification to see the trend and the impacts that may have in the long term, but we have an expert organisation, GISCA, from the University of Adelaide, looking into those particular areas of concern. We are analysing feedback that we have received from that organisation at the moment.

Senator NASH: What does that mean?

Mr Andreatta: That means they have looked at those particular areas that were identified by the rural stakeholders. They have made some analysis of the particular areas that were identified and have come back to us with their thoughts on what the potential impacts might be. Again, there is no solid data yet to prove that there are any negative implications around the new classification.

Senator NASH: Have they made recommendations to you in any way or have they just come back with some general assessment? What have they actually done?

Mr Andreatta: They have made some comments around those areas and comments around the way particular boundaries have been drawn under that classification.

Senator NASH: Is that something that you can provide to the committee?

Mr Andreatta: At the moment that is an internal report that the department is considering.

Senator NASH: It seems that you were waiting for the negative effect to be clearly seen before you would act on any indication of anomaly. When you say it is early days yet, it is not hard to figure out that when you have a tiny little town in inner regional and you have a town like Wagga, which is also classified as inner regional, that the need is entirely different in those two areas. What are you waiting for when you say that it is early days?

Mr Andreatta: Firstly, the data is not showing that negative impact to date. The classification has only been in place for 11 months. We also know that our incentives alone are not the only factors that doctors take into account when deciding to move from one location to another. There are non-financial issues that they take into consideration as well.

Senator NASH: I understand that. How do you identify the negative impact of a doctor choosing not to move to a more remote area because of the current definition under the ASGC-RA map? How do you measure somebody choosing not to do something, which of course would be a huge negative impact?

Mr Andreatta: At the moment we are getting anecdotal information from our rural health stakeholders. There is no evidence at the moment. They are simply saying that these two locations may be competing for the same doctors in the same classification area.

Ms Halton: Perhaps I can put it another way. Essentially in any system there are views, comments and suggestions made by all sorts of people about what is good and bad about the system. The last system had manifest deficiencies. They were very visible. We know that they did not help us to get the right number of people out of the leafy metropolitan suburbs and

into the bush. This system has been put in place and its overarching objective is to get more doctors out there and to keep them out there. That is its objective. The government thought about this very long and hard, because any kind of change is very difficult and, in fact, it required a significant additional investment of funds. You say, 'How will you measure the effect?' Fundamentally, will we have more doctors out there than we did. And do we have them in the right places? We have to wait a period, taking account of the feedback and taking account of what the numbers are at a point in time and then over a period to make that assessment.

Senator NASH: I take your point that it is not just the particular dollar figures that contribute to a medical provider's decision to change location. I would imagine that even in the interim there are going to be some glaringly obvious anomalies. For instance, you can take somewhere like Werris Creek in the north of New South Wales, which has a population of something like 1,500 people, compared with Tamworth or Armidale, which has some 25,000 people, yet they are both classed as inner regional. Surely you do not need to wait for evidence to come back to show that, if the incentive is the same for a doctor to move from Sydney to Tamworth or from Sydney to Werris Creek, there is no incentive provided for them to go to that less populated area of Werris Creek. I am trying to get a sense of what you are waiting for when there are some very simple examples that show that if a medico is going to get the same amount of money to go to Werris Creek or to Tamworth they are going to go to Tamworth, with all the other things that they have on offer. Has that type of thing been considered?

Ms Halton: Let us be clear. If you have a group of doctors who might move from Mossman to somewhere in northern New South Wales, you would probably want slightly more of them to go to Tamworth, because there are more people living there, but we do not actually have a suggestion that we will not get a doctor in Werris Creek. This is where there is a lot of speculation about what is happening, but the actual behaviours, given the difficulty of changing these systems, we will have to have some on-the-ground practical evidence before there will be significant changes to the arrangements. As the officer said, they have been in place 11 months. We are monitoring this to see whether some of the things that people are concerned about are realised to be fact or not.

Senator NASH: As you work through that detail, perhaps you could provide the committee with some more detail. If that comes through before the next lot of estimates, that would be quite useful. I have to say that I disagree with you, Ms Halton, that you would want the doctors to go to Tamworth because there are more people. I think it is actually a needs basis. If a small town has none or one doctor compared with a larger population, I would say the need is much greater in the smaller town.

Ms Halton: I agree with that. I do not want to trivialise this, because that is not a reasonable thing to do. My point is simply that, if you had no doctors in both of those places, you would need a couple more in Tamworth versus Werris Creek. Your point about the relative need is absolutely correct and we do not argue about that at all.

Senator NASH: As you said, you want to give this some more time to be able to measure the impact. Do you have a date in mind at which point you will be able to say, 'Yes, we have gathered enough information. We now have enough evidence to say whether this needs to be reviewed or not'? Do you have a time frame in mind of how you are going to assess this?

Ms Halton: My expectation is that after a program has been in operation for a year and a half to two years, you might actually be starting to have some indication, but that would be—

Senator NASH: We are looking towards the middle of next year or the beginning of next year—somewhere there?

Ms Halton: I think to form any kind of preliminary conclusions you do actually have to see things in operation for a couple of years, because otherwise you are seeing historical decision-making patterns. It takes people quite some time really by the time they reorganise their lives and they think about where they want to be et cetera.

Senator NASH: On the unit again, the issue of attracting, recruiting and retaining doctors is the perennial one. What work will you be doing? Is this part of your bailiwick? Will you be doing work in that area? Will you be liaising with organisations like the Rural Doctors Association to see what can be done in that area?

Ms Halton: We need to be really clear. This unit will not take on all the policy responsibilities from other parts of the department. There is a whole workforce division. They will not kind of acquire all of those workforce roles and responsibilities. They will be looking at the information and they will be interacting with the workforce people. But workforce has to continue to run its programs and be responsible for those activities. We have had the debate about advocacy as a word; they will have a representational role and undoubtedly they will be party to those policy discussions, but they will not be personally responsible for those policies.

Senator NASH: Will it be more of an ability to provide input to the process that workforce—

Ms Halton: Yes, absolutely, and to make sure that those issues are not forgotten, that they are right up there front and centre in policy discussions, evaluations and debates.

Senator NASH: I just want to ask some questions around the mental health service provision. I understand this was covered yesterday, but I have specific rural health perspectives on this. As to the Better Access initiative, as it was, does the department have a breakdown of funding by regions? Does the department have any sense by region how, under Better Access, that funding has been expended?

Ms Halton: These officers cannot answer any of those questions. This is a mental health program question. But what I can tell you is, yes, we do know where Better Access funds are expended.

Senator NASH: Can you take on notice for me to provide that by region? How do you break it up, by region, or is it by ASGC map?

Ms Halton: You name it. We can probably break it up that way. Regionally is probably easiest for us.

Senator NASH: Regionally would be very useful.

Ms Halton: We will do that.

Senator NASH: I understand these are mental health questions, but mental health is probably one of the biggest issues in rural Australia. I would hope that the rural health officials might be able to shed some light on some of this.

CHAIR: You can be assured that in the mental health component significant questions were asked about this.

Senator NASH: I am sure everything has already been traversed, so stop me if it has. You may not be able to answer this, but as to the allied health treatment services what percentage of those were from remote, rural and regional areas?

Ms Halton: Again, these officers—

Senator NASH: I understand that these officers cannot answer these questions. I will put these on notice.

CHAIR: It might be useful, because of the fact that there are a few questions here, if we could clarify the way that the rural health area interacts with the other parts of the department. The other agencies take leadership in their own areas, but there would be an interaction?

Ms Halton: Absolutely.

CHAIR: It would just be nice to have that on record.

Ms Halton: It is a good point to clarify. For the record, this group will have the information about what is where, how it is delivered, but they will not have the policy responsibility for the particular program. They will have the—not 'advocacy' word—responsibility for providing input on these issues into the respective program and policy areas, and they will be available to provide information about what is where to external parties as well as providing an internal-servicing function. Obviously we would have to think about the technology side, the websites and things of that ilk. I cannot do the acronym for the new regional services department. We know what the acronym is. I am never sure what Hansard does when we use acronyms, but we do refer to them in the Public Service as DORA, which sounds—I should not go on with that line of thought. I will stop now. But essentially the Department of Regional Affairs is undertaking the development of a website. So, the question for us is: to what extent we do our own work in this domain or do we have a section where we make some of this information available via that website through links. We have not actually got there yet in terms of what is easiest for people. I am mindful of the fact that people find it quite hard to navigate through 25,000 websites, so sometimes being able to go to one place and then follow the link is easier. We cannot answer that question yet, but making information available electronically to people externally and obviously through other means would be a key role.

Senator NASH: The Specialist Obstetrician Locum Scheme.

Ms Halton: That is correct.

Senator NASH: I do have a range of other questions and I will put them on notice. I do appreciate your officials cannot answer those. I believe $2 million is going to be provided in continued funding for the Specialist Obstetrician Locum Scheme. How many locums has the program actually brought to rural and regional areas since, I think, 2006?

Mr Andreatta: I do not have the figures back to 2006. I can tell you the targets for 2010-11 and what we have achieved to date.

Senator NASH: Yes, we can start there. Could you take on notice back to 2006?

Mr Andreatta: For specialist obstetricians, the target for 2010-11 was 90; for the year to date, 31 March, we have achieved 62.

Senator NASH: When you say 90, are they 90 separate—

Mr Andreatta: Ninety placements.

Senator NASH: Over what period is that placement?

Mr Andreatta: How many days? We do have targets for days as well. I can give you the number of days we targeted and the number of days we have achieved with those 90 and 62. I will read through the full facts. For the 90 placement targets in 2010-11 the target dates were 717. We achieved 62 placements in the year to date and have achieved 415 placement days year to date.

Senator NASH: So, 62 specialists and across the 62 specialists between them they have done 415 days of service?

Mr Andreatta: That is correct.

Ms Morris: That is until the end of March, not today.

Mr Andreatta: For GP obstetricians we have a placement target of 25 over 2010-11. We have achieved 23 year to date. In relation to target days, 350 was our target and we have achieved 155 year to date.

Senator NASH: Can you break those down—obviously you cannot do it now—into locations? Of the 62 so far for the specialist obstet, where they have actually gone to and the same with the GP obstets.

Mr Andreatta: When you say 'location', is that—

Senator NASH: Where did they go and spend their days?

Mr Andreatta: community or RA location?

Senator NASH: Which town did they go to? Where did they actually spend those days? Of the 62 could you break them down to how many days are actually allocated to each of those specialists and which towns they have gone to?

Mr Andreatta: Yes.

Senator NASH: Do you want to add something?

Ms Morris: Given that we are talking about very small communities, those communities will know the individual they are talking about. Can we just check that?

Senator McLucas: We will if we can. We do not want to compromise anyone's—

Ms Morris: We will give you a level of information.

Senator NASH: Is that on the basis that the specialists may not want to have known publicly that he or she is supported by this program?

Senator McLucas: Possibly. I do not know.

Ms Morris: We will just check and we will give you what we can.

Senator McLucas: I am always nervous when we start talking about—

Senator NASH: That is fair enough. If you would not mind trying, and then if it is not possible if perhaps we could do it by some sort of region to remove any identifiers?

Ms Morris: I appreciate your interest and what you are trying to get to and we will look at what information we can provide you with, taking into account whatever restrictions we have.

Senator NASH: I appreciate that very much. Could you also provide for me the travel mode for those trips? Did they fly? Did they drive? And the distance from designation to arrival?

Mr Booth: I do not know that we go into that depth of information, because these programs are run on behalf of the department.

Senator NASH: Is that not a cost that is factored in?

Ms Halton: We do not administer these. To go out and ask for that level of detail from other parties I would query—

Senator NASH: So, is the travel not an associated cost?

Mr Andreatta: It is. We provide a subsidy for both the locum service for the time in the particular location, travel time and travel costs. There are amounts that—

Senator NASH: So there is a bucket of money that they can use however they need to travel from X to Z?

Mr Andreatta: There are different amounts, whether it is a specialist or a GP obstetrician.

Senator NASH: What about the distance involved in having to travel?

Mr Andreatta: There is travel time.

Senator NASH: It would be a bit different in a car to a plane, I would imagine.

Mr Andreatta: I could take that on notice.

Senator NASH: I am very happy for you to take it on notice, but I would be very interested in the detail of how the cost factor is applied to the travel required for the medicos to get from point A to point B. Also—and this would have to be a consideration for government—what level of that service provision is through regional airlines and whether or not those regional airlines are providing that transport service?

Ms Morris: I do not know that we can answer—

Senator McLucas: We might be able to tell you what proportion of the total expenditure is expended on travel. That is a reasonable question for you to ask, but then to drill down to how did that person travel there; that is something that I do not know.

Senator NASH: I imagine, though, that it would be quite a significant question for government, because for them to be able to provide this service there has to be a mode of transport to get the medico from point A to point B. So surely that would be information that government would be keen to hold—that is, how these medicos are actually getting from point A to point B. The point is if a regional airline or a route falls over then government cannot actually provide this service. I would have thought that somebody somewhere might know. Perhaps you could take it on notice for me as to where within government somebody might hold that information, because I imagine that would be crucial to the whole program.

Ms Halton: That is actually beyond us.

Ms Morris: It is not a health policy question.

Senator NASH: But isn't the provision of the medicos?

Ms Halton: This is getting right out to the periphery. Yes, the department of transport is concerned about regional transport infrastructure and that is an issue that it worries about. But

for us, our focus is on the service that we are delivering. Frankly, we are not resourced and do not have time to get into a more arcane debate—for us, that is, not for transport—about regional airlines. We do not keep that information. It is not relevant to what we do.

Senator NASH: Could you take on notice to give me some direction as to who holds that, because actually being able to provide transport for these medicos comes back to the whole policy decision of what you are doing. There is no point in providing this money if you cannot get the medico from point A to point B. I appreciate that you do not hold the information, but if you could give me some guidance as to who does.

Ms Morris: I think we would be aware if in running the program—because it is contracted out for running—we were told we cannot actually get doctors to patients, but I am not aware that we are getting that feedback, are we?

Ms Halton: There is nothing further that we can say on notice on this other than to say to you that the department of transport is the answer.

Senator NASH: So you do not take into consideration how these doctors can get from point A to point B?

Ms Halton: We contract the management of this program out and that is something that they work with the individuals on.

Senator NASH: Who do you contract it out to?

Mr Andreatta: The Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

Senator ADAMS: As to the development with the National Strategic Framework for Rural and Remote Health services, at our last little encounter in February you were saying it was nearly there and it was just about to go out to the jurisdictions for comment. I am just wondering where it is now.

Mr Cameron: Yes, we did talk about that at last estimates, and I am happy to provide an update. I can let you know that the most recent draft of the framework is currently with our state colleagues and we are hopeful that it will be tabled for endorsement at the next meeting, or the one after, of the Rural Health Standing Committee of AHMAC. The next meeting of that subcommittee of AHMAC is on Thursday next week. It is most likely—and I do not want to fall into the trap of being as overly optimistic as I might have been last estimates, to tell you that it is going to be signed off then. It is most likely that it will go to the RHSC meeting following that—so three months hence. Or depending on the degree of enthusiasm from the members of that national body, we could try to get it endorsed out of session. I must add that it then needs to move through the principal committee of AHMAC and then to AHMAC, where it gets its tick, as it were.

Senator ADAMS: So by next estimates in October we might have it, by the sound of that time frame?

Mr Cameron: I nearly said what I said last time. Yes, we might.

Senator ADAMS: As to the progress with that framework, has the new national rural health agency been involved with it, or what is the story there? What sort of input have you had from other areas to—

Mr Cameron: I am sorry, would you mind clarifying—the rural health agency?

Senator ADAMS: I was trying to work out—

Mr Cameron: Our agency. I am sorry, I misunderstood the question. In a very real sense in terms of the development of the framework the people that have been working on it are the agency. In our department that rural health policy function will articulate into the agency as part of that policy development program role that Ms Morris was describing earlier.

Ms Morris: It is the Office of Rural Health that both Mr Cameron and Mr Andreatta are the senior officers from. They have done the work on this as the Office of Rural Health. The policy function done by the Office of Rural Health, as Mr Cameron said, will transform into the rural agency when it is established from 1 July. I think this is the update for the agency.

Mr Cameron: Correct.

Senator ADAMS: That was one—

Ms Morris: The answer is, yes, but with the nomenclature you were getting ahead of yourself.

Senator ADAMS: At its conference the National Rural Health Alliance was saying that they wished to develop a national rural health plan that would complement the strategy. Have they have been involved with it at all in giving any advice?

Mr Cameron: We have heard from the alliance and we heard what was discussed at the conference in Perth. I was not there. Mr Andreatta was. We understand very clearly that the alliance wishes to see a national rural health plan. We are working firstly to finalise the framework as I described earlier. Whether we end up with a national plan I think is still moot. We would need to get the full subscription of our state and territory colleagues for such a document before we commenced. It is not a Commonwealth document. It would be a national thing of all the jurisdictions and so that is not just us.

Senator ADAMS: I asked this question of another area that had produced a report very recently, and my question to you is: as far as the Medicare Locals and the local network boards are concerned, have they been included in the strategy or is that going to come later? How is this going to work for rural and remote?

Ms Morris: The Medicare Locals are not yet established.

Senator ADAMS: I know that. You have told me that about four times, but I am still asking.

Ms Morris: Local Hospitals Networks—I am trying to remember the answer from yesterday—opened for operation in some states, but it is very similar to the question you asked about the maternity services plans. Is that what you are referring to?

Senator ADAMS: That is what I am referring to.

Ms Morris: I will go back to my analogy of principal legislation and subordinate legislation. Whatever is agreed or promulgated as a strategy or as a plan in the health area now will be functioning within the new governance arrangements. The issue for Medicare Locals and Local Hospitals Networks would be the operationalisation of any plan at a local level and what it means for resources and how it translates through into health outcomes for people.

Senator ADAMS: The reason I asked is that I would hate to see a delay in this strategy coming to light, because of the changes in governance, and this is why I keep asking these questions.

Ms Morris: I appreciate your concern with these questions. It is worth while raising and reminding us that we need to take it into account, so thank you.

Senator ADAMS: We will now change to another subject, which Mr Cameron and I did discuss last time too. As to the PATS national guidelines, what progress have we made?

Mr Cameron: I mentioned the Rural Health Standing Committee meeting next week. The national principles for harmonised PAT schemes and the modelling that I referred to at last estimates, which you asked about, will be presented at that Rural Health Standing Committee meeting next week for endorsement on its way up that committee chain that I described a minute ago. That is in fact the main agenda item for the meeting next week.

Senator ADAMS: That is good. As to the Western Australian Southern Inland Health Initiative, you may remember last time I was talking about the lack of GPs in the wheat belt area. Because Western Australia has been so proactive in putting forward $565 million towards improving health services in that particular area, are we going to be penalised—I suppose the minister might have to answer this—for our initiative, because this is a wonderful thing to be able to attract medical practitioners? The shires have had a terrible time—it has been in a drought area—trying to fund medical practitioners with incentives to go out into the wheat belt area. I am just a little worried that because our government has been so generous the federal government might see that they do not need to help us anymore in that respect.

Senator McLucas: We are all in the business of trying to provide better health services to people in underserviced areas.

Senator ADAMS: This is a huge boost, of course, for that area, which is wonderful.

Ms Morris: Our incentive and retention programs were all provided on a national basis based on programs and guidelines.

Mr Booth: That is correct.

Mr Andreatta: I might add that, since we last spoke about that particular issue around the wheat belt, I did check with the rural workforce agency in WA, Rural Health West, and got from them the sorts of activities that they are undertaking at the moment to try to look at new models both in the eastern wheat belt area, where they are looking at shared fly in, fly out GP services; in the lower mid-west they are looking again at a GP drive in, drive out service. This is something they are trialling to get over the problem with securing more permanent GP services. They have also taken on the role of trying to recruit more OTDs to the areas. As I have noticed, there are 40 communities in the wheat belt area and I think 34 of them are districts of workforce shortage. They are certainly eligible for the overseas trained doctor placements. The agency is putting a lot of effort into that recruitment process.

Senator ADAMS: With the extra financial incentives hopefully we will get many doctors out there. There was one area this morning concerning Regional Cancer Centres, but I think that this is probably not the right area. Unfortunately, I did not realise that there is one in Tasmania. The Health and Hospital Fund Regional Priority Round was yesterday as well, so I think those questions will have to go on notice. With respect to funding under the National

Healthcare Agreement for subacute hospital beds, elective surgery and emergency departments—

Ms Morris: That will be acute care. I think that is on later this evening. It is outcome 13 this evening.

Senator ADAMS: In relation to medical specialists outside the major cities, are you right with the Medical Specialists Outreach Assistance Program?

Mr Cameron: Yes.

Mr Booth: Yes.

Senator ADAMS: You may need to take this on notice, but can you tell me what the distribution is of medical specialists outside main cities by specialty and what is the distribution of expenditure under the Medical Specialist Outreach Assistance Program by specialty and by rurality? Once again, this is very like Senator Nash's question.

Mr Cameron: We have that information, but we would need to take that on notice.

Ms Morris: I would add that, similar to the comments we made around Senator Nash's question, we will give you what we can, taking into account any privacy or other issues we may need to consider. I understand what you are trying to get information on and we will give you what we can.

Senator ADAMS: It is quite difficult. One of the things tied up with PATS is the fact that the visiting specialist has a three-month waiting list. Then the person still has to travel—to Perth, for us, because that is where the majority of our specialists are. I was wondering whether we could look at WA specifically as to where the specialists are and where patients go, because that would help with the other issues that I will raise later on. Because I have been following rural issues so hard throughout this lot of estimates, I have actually run out of questions.

CHAIR: I am very pleased with that. Are there any other questions in the area of rural health? There probably will be some on notice for the officers, so thank you very much for your assistance with outcome 6. We now move to outcome 9, private health.

Senator FIERRAVANTI-WELLS: Obviously, you are aware of the Deloitte report that has been out in the public arena. It is too long; I have the executive summary but I am sure, Mr Bartlett, that you are aware of it. You have a colour version; you are lucky. I do not have a colour printer. I am going to work off page 265 of the yellow book. Can you tell me what the precise levels of expected savings are under the revised income tiers? First of all, in relation to the budget paper, are we going on the previous tiers in relation to the previous legislation?

Mr Bartlett: What is in the budget papers reflects the policy as it was. It is being updated at the moment as the legislation is being finalised, but I should also say that what is in the budget papers does not reflect the full estimate for private health insurance. It never does, in part because that is considered market sensitive in terms of things like premium rounds.

Senator FIERRAVANTI-WELLS: You are revising the tiers, in the third time—hopefully lucky for you—shot at the legislation. A third version of it, if I can put it that way, is going to have different tiers to the previous legislation; is that what you are saying?

Mr Bartlett: There was an indexation methodology that was announced as part of the original proposals. That indexation methodology is being applied, so the tiers will differ.

Senator FIERRAVANTI-WELLS: We are talking about minimal, so 75 and at that tier 1, 75 and 150, will be slightly higher.

Mr Bartlett: Something like 80 and 160.

Senator FIERRAVANTI-WELLS: What is the most up-to-date costing for the measure, given the number of people with private health insurance has changed and premiums have changed since it was last introduced?

Mr Woodley: The most recent numbers are from the 2010-11 MYEFO, and the estimate at that stage was $2 billion over four years.

Senator FIERRAVANTI-WELLS: If I look at page 265 of the yellow book, I am trying to work through those figures in terms of what contributes to the reduction. As I calculate it, page 265 shows a reduction in program expenses of about $3.5 billion over the forward estimates compared to the 2010-11 figures. Am I correct in that calculation?

Mr Bartlett: Those are the figures that are there.

Senator FIERRAVANTI-WELLS: What contributes to this reduction other than the rebate changes?

Mr Bartlett: As I said a little while ago, the figures in there do not reflect the full amount because one of the key drivers for private health insurance growth is the outcome of the premium round. We have not, for that reason, published a full estimate for a period of time. It has a nominal indexation rate in there in terms of growth in outlays, which does not reflect premium round outcomes.

Senator FIERRAVANTI-WELLS: I guess there is a big difference between $3.5 billion and $2 billion.

Mr Bartlett: But if you look at what is happening in terms of the out years, the rate at which you index the increase has a significant impact on the saving, so if you are talking about a flat increase or a three per cent increase or an eight per cent increase, you are going to get a very different figure.

Senator FIERRAVANTI-WELLS: Have you undertaken research or modelling of the impact of the private health insurance rebate changes separate to what has previously been conducted by Treasury?

Mr Bartlett: The modelling is done by Treasury; as I understand it, Treasury are currently revising their modelling.

Senator FIERRAVANTI-WELLS: Given that Medibank Private, the Commonwealth's own insurer, has provided evidence that it alone will have more people drop private health insurance than estimated by Treasury for the entire sector, have you considered the impact of the changes on premiums or extra episodes of care in public hospitals?

Mr Bartlett: As I understand it, Medibank Private's comments were an educated guess and they covered both hospital and general treatment policies. It is higher than Treasury's estimates, but at this stage there is nothing there that would make us think the Treasury's estimates are therefore wrong.

Senator FIERRAVANTI-WELLS: So, you are querying the admission at finance and public admin the other evening that Medibank estimates that 37,000 of their members would drop their cover and over 90,000 would downgrade? You are questioning that?

Mr Bartlett: We asked Medibank the basis of that because we heard the term that was quoted in the media of internal modelling and we were told that it was an educated guess.

Senator FIERRAVANTI-WELLS: That is what they have said to you, but they certainly gave us that, on oath, at estimates. I was not present but I understand that it was given under questioning. Are you saying that what Medibank has said in an estimates hearing is incorrect, as opposed to what they have told you privately? Is that what you have said?

Mr Bartlett: No, I am not saying that at all. What I am saying is that we asked for clarification on the raw numbers that were given and that is the clarification we were given. I cannot comment on what they said in estimates—I was not there either—but the thing I would say is that in a sense what they said is immaterial. The Treasury modelling is what it is. There has certainly been no concrete reason given why we would necessarily accept that the Treasury modelling is wrong.

Senator FIERRAVANTI-WELLS: Has the department undertaken any assessment of the number of people who would downgrade their cover across the whole system and, of course, the impact that that will have on premiums and extra episodes of care in the public system?

Mr Bartlett: I struggle to understand why downgrading is considered such an issue. Health insurers offer a range of policies; people move between policies. The evidence that we have is that private health insurance participation rates continue to grow. We are not seeing, in terms of people's movement between different policy types, the sort of issues that you are describing and, to be honest, it is an issue of what value people perceive in the different policy types they hold. Again, people will downgrade for a range of reasons; why that is going to have an effect on private health insurance affordability, I am not sure, because if they have priced their policies correctly, it remains as affordable and therefore it is as profitable for them as it is now. In terms of treatment choices, they retain treatment choices, so the downgrading seems to me to be something different. It is hard enough to model who is going to drop out; downgrades really are something that is a different order of magnitude to try and come to terms with and it is harder to actually work through a logical impact on what it is going to do.

Senator FIERRAVANTI-WELLS: I asked you the question in the context of the impact it would have, certainly on the premiums, but the extra episodes of care in the public system. If people cannot go and get care and then claim it through private health insurance, they will go to the public system. That is the question I am asking you. Have you—

Mr Bartlett: There is a significant number of people—sorry.

Senator FIERRAVANTI-WELLS: At least let me finish asking my question. The question is yes or no. You cavil with the use of the word 'downgrade', but have you undertaken any assessment of the number of people who would change their cover and the impact that this would have across the system, and in particular any increases that that would have on the public hospital system?

Mr Bartlett: No.

Senator FIERRAVANTI-WELLS: You have not done it?

Mr Bartlett: No.

Senator FIERRAVANTI-WELLS: You do not think it is worthwhile doing it? I mean, ultimately, there will be a cost to the Commonwealth; you are saying there is no cost.

Senator McLucas: That is an assertion.

Mr Bartlett: Would you like me to answer your question? What I am trying to say is that there is a range of reasons why people change policies. It is exceptionally difficult to model this, but I would also say that Treasury has done the modelling, in terms of the impact of the tiers and we are not modelling the effects of downgrades, as we are not modelling the effects of withdrawal rates.

Senator FIERRAVANTI-WELLS: Is there any provision to review the current healthcare agreement in a situation where there would be or could be unintended consequences such as cost shifting or perverse incentives that may create a greater burden on the public system?

Mr Bartlett: I could not answer that question.

Senator FIERRAVANTI-WELLS: You have got that copy, so you are obviously aware of the Deloitte report. So, in summary, what is your opinion of the Deloitte report?

Senator McLucas: You know you cannot ask an opinion of the officer.

Senator FIERRAVANTI-WELLS: In other words, what you are saying, do I take it, is that you do not agree with the finding in the Deloitte report that 175,000 will drop their cover in the first year alone?

Mr Bartlett: The report makes a few assumptions. It assumes in the first year that there will be 175,000 people who are affected by the loss of the rebate who will drop out. That is significantly at odds with Treasury's assessment, so clearly I have no reason to dispute Treasury's modelling. From the second year onwards, it assumes that there is a significant number of the people who drop out who are not affected by the rebate tier changes who are dropping out because of a notional increase in private health insurance premiums that Deloitte has assessed is on average about 2.5 per cent per year over and above what they would have been. If you look on page 30 of the report, you will see that from year 2 onwards the overwhelming proportion of those who drop out are not affected by the tier changes.

If you look at what has happened in terms of private health insurance premium changes over the last five or six years, the different insurers, based on variations in premium increases, you do not see the sort of variations that that sort of graph would give you to expect would occur in terms of membership numbers. For example, if we have a look at HBF, in 2009 it had a 7.95 per cent premium increase; that was well above the industry average. Despite that premium increase, its membership in that period continued to grow, whereas if you accepted this sort of graph, you would expect to see a significant loss in membership. I can quote you similar examples from other health insurers. You do not see that dropout in membership; there is not the sensitivity that this would lead you to expect even if you accept the 2.5 per cent argument, which I think is, again, premised on the basis that somehow there is a cycle happening here that certainly the evidence we have suggests would not occur.

Senator FIERRAVANTI-WELLS: Just one last question and I assume I will have to go to Treasury. In relation to the assumptions relating to the modelling that Treasury is doing, I will have to ask Treasury. Thank you.

CHAIR: Thank you. Any other questions in outcome 9.1, private health insurance?

Senator McEWEN: Mr Bartlett has said, in regard to one of Senator Fierravanti-Wells's questions, that participation rates in private health insurance continue to grow—is that right?

Mr Bartlett: Yes, it is.

Senator McEWEN: What is the actual trend in data in participation rates in recent years?

Mr Bartlett: In terms of numbers of insured persons with hospital treatment: in September 2009, the number was 9.820 million; December 2009, 9.866 million; March 2010, 9.912 million; June 2010, 9.973 million; September 2010, 10.064 million; and December 2010, 10.117 million. In terms of general policies: September 2009, 11.304 million; December 2009, 11.362 million; March 2010, 11.449 million; June 2010, 11.541 million; September 2010, 11.647 million; and December 2010, 11.714 million.

Senator McEWEN: So, participation rates are trending up. Over that same period of time, private health insurance premiums have gone up as well?

Mr Bartlett: That is correct.

Senator McEWEN: So, we have both going up—the insurance rates and the participation rates—which gives lie to the claim that because the cost of the insurance premium goes up, people naturally drop out. There is no evidence for that.

Mr Bartlett: There is clearly a much more complicated decision that people are making when they decide what they are going to do with private health insurance. The ultimate example that I have seen is when we met with a private health insurer to talk to them about how things have gone, they put their premiums up by 16 per cent in one year; they lost 34 members and they gained 150. They are a small fund, but again it shows that people are making decisions about a range of things, including their comparability with others, the value people feel they are getting from their premium and a series of things like that. It is more than just the straight premium or the increase.

Senator McEWEN: So, for example, somebody of my age whose children have taken out their own private health insurance would readjust from a family cover to a couple cover. Those sorts of things are happening all the time, I presume.

Mr Bartlett: People make changes in their cover regularly.

Senator McEWEN: What has the trend been in the increase in the private health insurance premiums in recent years? Has the increase got bigger from year to year or smaller from year to year?

Mr Bartlett: The last couple of years, premium increases have shrunk. In 2005, the premium increase was 7.96 per cent; 2006, the premium increase was 5.68 per cent; 2007, 4.52 per cent; 2008, 4.94 per cent; 2009, 6.02 per cent; 2010, 5.78 per cent; 2011, 5.56 per cent.

Senator McEWEN: So, the highest rate in that period of time was in 2005?

Mr Bartlett: That is correct.

Senator McEWEN: I wonder who was in government then? Alright, thank you very much for those answers.

CHAIR: Any other questions on Private Health? Senator Boyce.

Senator BOYCE: I am sorry I am late, so I may well ask some questions that you have already been asked, but let us see how we go. I think Senator Fierravanti-Wells has discussed the Medibank Private evidence given earlier this week. Catholic Health Australia has said that it thinks it will lengthen public hospital queues. They look after 10 per cent of the nation's hospital admissions and they think that it will lengthen public hospital queues. What is the assessment the department has made in that regard?

Mr Bartlett: As I said to Senator Fierravanti-Wells, Treasury has done modelling in terms of anticipated outcomes of the rebate tier changes.

Senator BOYCE: This is the modelling they did some years ago now.

Mr Bartlett: That is the modelling that they have done some years ago which they are updating at the moment. There is nothing that Catholic Health has said that would necessarily suggest that that modelling is flawed. They have given a view.

Senator BOYCE: So you continue to disagree with that view?

Mr Bartlett: I do not understand the basis of the view, so it is very difficult to comment on whether it is valid or not.

Senator BOYCE: They have also pointed out that in the time since first suggestion and now, waiting times at hospitals has gone up from 34 days to 36 days. Why can we not expect that this will continue, that this will worsen?

Mr Bartlett: As we talked about a couple of minutes ago, you anticipated it having a material effect on public hospital waiting lists if there are significant withdrawals from private health insurance. The Deloitte report, which seems to be an argument that is made or some attempt to create a valid framework for the argument, essentially is based on the assumption that significant numbers of people will leave their private health insurance on the basis of very small variations in premium.

Senator BOYCE: I have heard all the sticky arguments about private health insurance, but surely when Medibank Private and Catholic Health Australia say that they do not support those arguments, is there not time for a reassessment?

Ms Halton: Only if we agree with them, and we do not.

Senator BOYCE: Again, tell me if this territory has been traversed. I am talking here about Budget Paper No. 1, which I do not have with me. You are expecting to save a billion dollars with the means testing in financial year 2011-12; is that correct?

Mr Bartlett: We worked through the basis of the what is there, as I have said.

Senator BOYCE: The fact that the rebate will come off; what will happen? People will simply pay a higher fee or their rebate will be returned to them? How will this work? Some people are going to continue to receive a rebate; some people will not. My health insurance company, were they to bill me, will not know what to bill me unless I tell them my income. So, how is this going to work in practical terms?

Mr Woodley: The majority of people, we expect, will need to identify to their insurer the level of the rebate which they estimate they will be entitled to. If, at the end of a financial year their income has changed such that the rebate did not apply then that would be corrected through the taxation system.

Senator BOYCE: But that still means that I have basically got to tell my health insurance company what my level of income is, does it not?

Mr Woodley: No, the level of rebate to which you estimate you would be entitled to.

Senator BOYCE: But it is did I earn more than $160,000 or did I earn less than $160,000, is it not?

Mr Woodley: It would be in a series of bands, yes.

Senator BOYCE: So, I have to tell them. How wide will the bands be?

Mr Woodley: There are effectively four tiers. We discussed earlier the fact that these parameters have been adjusted since the original announcement through the application of an indexation factor. There is a band for singles of $80,000 or less; the next band would be $93,000 or less and more than $80,000; the next band is $93,001 up to $124,000; and the final band is $124,001 or more.

Mr Bartlett: Families are double that.

Senator BOYCE: I am telling my private health insurance company roughly what my income is, am I not?

Mr Bartlett: You are nominating the level of rebate that you are entitled to.

Senator BOYCE: By telling them what my income is.

Mr Bartlett: You can tell them your income or you can tell them the rebate to which you are entitled.

Senator BOYCE: At which stage they would know what I presumed my income would be.

Mr Bartlett: They can certainly make an estimate of the range that your income is within.

Senator BOYCE: Yes. We surely cannot argue about whether this means that an insurance company will know roughly my level of income or not?

Mr Bartlett: Roughly.

Senator BOYCE: They will.

Mr Bartlett: An individual could choose not to reveal that information.

Senator BOYCE: And receive no rebate.

Mr Bartlett: It would be adjusted, again, through the taxation system at the end of the financial year.

Senator BOYCE: So you would get it back from the tax office once a year?

Mr Bartlett: That is correct.

Senator BOYCE: Or not, as the case may be, but you would get a deduction at least off your tax for it.

Mr Bartlett: As a number of people do now.

Senator BOYCE: How many people do that now?

Mr Bartlett: Quite a small number, but there are a number who do.

Senator BOYCE: Yes, but it would be—

Mr Bartlett: It is in the thousands, but it is in the small thousands.

Senator BOYCE: It would be in the four figures, not the seven or eight figures, I would have thought. That is presumably because people prefer to pay less on an ongoing basis than to receive a lump sum at the end of the year. We did talk a little bit about what happens if you misjudge, but what happens with the self-employed person who may not know what their salary is or somebody goes from being a single to a couple or whatever half way through the year; what do they do?

Mr Bartlett: The same approach will apply. In effect, they can tell their health insurer what they think their income will be; if they get it wrong it is adjusted through the tax system.

Senator BOYCE: Have you estimated the cost to the health insurance companies of the tiering of the rebate system over and above what the current system costs?

Mr Bartlett: As far as I know, we have not. I am not sure of any reason why the cost should be significant. There is a range of dealings that they have with their policy holders now; it is one more element, but it does not appear to me to be particularly stringent.

Senator BOYCE: It is one more element with five steps in it instead of one, is it not?

Mr Bartlett: At the moment, you have got health insurers who are interacting with policy holders about a significant range of policies. They have got many different policies to manage. Adding information about the tier level of a particular individual to that I would not have thought is a particularly arduous part of that management process.

Senator BOYCE: An ANOP survey that was done recently said that 23 per cent of Australians with private health insurance were aware of the intention to means test the rebate. Are you aware of this study?

Mr Bartlett: I am aware of the survey.

Senator BOYCE: Could you comment on the survey? Do you think it is accurate?

CHAIR: That, again, is asking for an opinion.

Mr Bartlett: I can respond to the extent of saying there have been a number of surveys done about people's awareness and motivations and things like that in terms of decisions about private health insurance. This survey is significantly at odds with the findings of others.

Senator BOYCE: Could you explain what sort of communications program you intend undertaking if the legislation is passed and becomes law from 1 July?

Mr Bartlett: That is in planning at the moment so I cannot give you the details as it stands.

Senator BOYCE: In what way is it in planning?

Mr Bartlett: It is an integral part of the planning for the legislation that is to be reintroduced to parliament.

Senator BOYCE: What is the budget for it?

Mr Bartlett: At this stage I cannot tell you that at this stage, because it is under development.

Senator BOYCE: So, you do not have a budget for it yet or you have not worked out how much it is going to cost?

Mr Bartlett: I do not have a figure at the moment.

Senator BOYCE: Will it be something that would go out for tender for a public communications organisation to undertake?

Mr Bartlett: There is a range of rules that have to be followed with government advertising and we will follow the rules that are in place.

Senator BOYCE: So, you are seeing it as an advertising campaign?

Mr Bartlett: I am not saying that I am seeing it as anything at this stage. I am saying that a decision will be made about the process to inform the public about the initiative, given that it gets through parliament, and the rules that are in place about campaigns and a range of other things will be followed to the extent they are appropriate.

Senator BOYCE: So, this is supposed to start in a month and you are not sure what this communications program is?

Mr Bartlett: The legislation has not been introduced to parliament yet.

Senator BOYCE: But it is still supposed to start in a month?

Mr Bartlett: The legislation has not been introduced to parliament yet.

Senator BOYCE: I have more questions, but I am happy to put them on notice.

CHAIR: There are no other questions apart from you. This was scheduled to go to 5.45 pm, so if you wish to continue asking your questions you can do so or you can put it on notice and move into the next outcome.

Senator BOYCE: I am happy to put my further questions on notice.

[17:32]

CHAIR: I thank the officers from outcome 9. We will now move to outcome 2, Access to Pharmaceutical Services.

CHAIR: I am aware we have questions from Senator Fierravanti-Wells, Senator Siewert and Senator Boyce. Is there anyone else who has questions in this area?

Senator COONAN: I do.

CHAIR: That is just so I do not miss you and we can get a sense of sharing the time. Senator Siewert, you can start on this one as you only have a couple of questions.

Senator SIEWERT: I would like to go to the fifth pharmacy agreement.

CHAIR: That is 2.1.

Senator SIEWERT: Is that where it fits?

CHAIR: Senator Siewert, 2.1.

Senator SIEWERT: I am interested in the elements of the fifth pharmacy agreement and the patient service charter, which is supposed to be in place by 1 July 2011. Is this on track and when will it be released?

Ms Janz: Yes. What is now called the Community Pharmacy Service Charter is on track and will be in place by 1 July. It was a consultation process that had been undertaken from December last year through to about March this year. It has now been finalised. The minister has agreed to the text of it and it is on its way to production.

Senator SIEWERT: So, the public consultation process happened between December and March?

Ms Janz: That is correct.

Senator SIEWERT: Was that an open call for submissions?

Ms Janz: No, it was not. It was targeted at key stakeholder groups. Twenty-nine individuals were invited to a consultation workshop in December last year and of those 18 participated. They covered groups such as Carers Australia; Consumer Health Forum; the program reference group of the Community Pharmacy Agreement, which has 12 members outside of the department across a whole range of backgrounds with specific expertise in different areas, the Pharmaceutical Society of Australia, the Pharmacy Board of Australia, the Australian Commission on Safety and Quality in Health Care, and the Pharmacy Guild.

Senator SIEWERT: When you say that it went from December to March, you would have held a workshop. Did you invite written submissions from targeted stakeholders?

Ms Janz: No, we did not seek written submissions. Following the workshop, we provided the outcomes of the workshop for those participants to agree with or comment on, and from there we developed some text of the charter itself, put that out for further comment and came back with a final product.

Senator SIEWERT: We are following up quite strongly through the fourth pharmacy process some of the evaluation of the various components, so I am starting early on this one. What is the evaluation process for this particular element?

Ms Janz: There is an evaluation framework, which we now have in hand for the whole of the agreement that covers all the different elements. With this one we will be looking to engage quite strongly and particularly with the Consumer Health Forum to gain feedback on how effective it is in terms of meeting its objectives, which are really around making consumers much more aware of the level of service they can expect when they visit a community pharmacy.

Senator SIEWERT: Do you have an implementation plan in place or are you developing that?

Ms Janz: The strategy for the whole agreement has now been agreed. The individual elements of that are what we are working on at the moment, so I cannot give you the detail of it. It certainly has been agreed that it will be evaluated and we will need to start doing that from when it rolls out.

Senator SIEWERT: That is what I wanted to do. I also wanted to know whether, when it starts and as it rolls out, there will be progressive monitoring of the process?

Ms Janz: Very much so, yes.

Senator SIEWERT: Thank you. I am finished with that section.

CHAIR: Are there any other questions on 2.1?

Senator BOYCE: I am intrigued as to how diabetes comes in here, but I do have a question to ask.

CHAIR: That is 2.3.

Senator BOYCE: So, it is targeted assistance?

CHAIR: Do we have anything else on 2.1?

Senator BOYCE: I do not have the outcomes here.

CHAIR: We can go to 2.2.

Senator BOYCE: I have questions regarding PBAC.

Senator SIEWERT: That is in 2.2.

CHAIR: Senators Boyce, Siewert and Coonan have questions on PBAC. We will start with Senator Boyce.

Senator BOYCE: We have the situation of the cabinet deferring recognition of seven medications recently that had been recommended by PBAC. Can we have confirmation of that?

Ms Halton: That is correct.

Senator BOYCE: Can you tell me how those applications were lodged in the first place?

Ms Halton: You will have to be a bit more specific than when they were lodged.

Senator BOYCE: Why did those drug companies decide to apply?

Ms Halton: We cannot answer for them. We can simply say what they applied for. We cannot speculate, other than to say that they wanted to list those products on the PBS. In terms of why they applied, I cannot answer that question. My officers can only tell you what they applied for.

Senator BOYCE: Perhaps we could look at one of these drugs which applied for listing at the request of PBAC. Are you aware of that?

Ms Halton: Which drug would that be?

Senator BOYCE: It is a Pfizer drug called Synarel. PBAC wrote to the company asking them to apply for PBS listing for the drug; is that correct?

Ms McNeill: Yes, it is.

Senator BOYCE: So, you wrote to Pfizer asking them to apply to have it listed; is that correct?

Ms McNeill: PBAC wrote to the company and all companies with respect to medicines that might be suitable for the Section 100 IVF/GIFT program advising that they would be willing to consider applications for the scheme.

Senator BOYCE: How many other companies were written to in the same way as Pfizer?

Ms Platona: One more.

Senator BOYCE: Which company was that?

Ms Platona: The letter to Pfizer was sent on 23 December 2009 and was in response to a previous consideration by the PBAC of a product called Ganirelix. That product was considered by the PBAC and as part of the PBAC consideration it instructed the secretariat to approach other companies making similar products. One of them was Pfizer, which makes the drug Synarel. There was another product called Cetrorelix. There is a group of three products that are very similar to each other.

Senator BOYCE: How many manufacturers did you write to?

Ms McNeill: Two.

Senator BOYCE: Which company had the two drugs? Can you give me the name of the other company?

Ms McNeill: A drug had already been listed on the IVF program. That was the Ganirelix. And following PBAC's recommendation for that listing they wrote to the other two companies that also had similar drugs for this treatment.

Senator BOYCE: PBAC recommended listing of Synarel, but the cabinet said, no; is that correct?

Ms McNeill: It has been—

Senator BOYCE: What happened with the other drug?

Ms McNeill: Centrorelix has been listed.

Senator BOYCE: It has been listed?

Ms McNeill: Yes.

Senator BOYCE: Why did the PBAC ask these companies to apply?

Ms Platona: The PBAC in its letter says that the PBAC considers that there is a clinical need for these products on the program. If one was listed there is always the intention to write to other suppliers to also get some benefit from competition from other suppliers.

Senator BOYCE: So, are you hoping to decrease the cost to the PBS by setting up competition?

Ms Platona: That is one of the motivations; plus, there is a clinical need.

Senator BOYCE: So, it has a clinical need and you hope that the costs to the PBS system will drop? Did both of these companies write back to you asking about whether they would have to pay the application fee?

Ms McNeill: I would have to take that on notice.

Senator BOYCE: Did both of them pay the application fee?

Ms McNeill: Again, I would have to take that on notice.

Senator BOYCE: Perhaps I can help you in regard to Synarel. Given that PBAC asked them to apply to list the drug, they asked if the application fee might be waived, which is a perfectly reasonable commercial thing to do, but they were told, no. I am told that they paid their $12,500 to apply to have this drug listed. The PBAC agreed that it met a clinical need and had the potential to reduce the costs to the PBS; is that correct?

Ms Platona: The $12,500 is the cost recovery fee for a minor submission to the PBAC. That part of the assessment has been completed for this product. The application has been received and the PBAC has considered it. Therefore, there is a fee for that part of the assessment. There is no fee beyond the initial PBAC consideration.

Senator BOYCE: On notice, can you tell me the whole background of the fees, whether they asked for a waiver and what they ended paying for? It seems to me that we have the PBAC saying, 'There is a clinical need for these drugs. There is a potential to save money by listing them, because of the increased competition.' On that basis, in good faith, the companies apply for these drugs to be listed. The PBAC duly agrees that they should be listed, and then cabinet defers approval for an indefinite period. Is that not rather embarrassing?

Ms Halton: I think the minister is on record in relation to the financial position that the government finds itself in. The minister is on the record as saying that these drugs have been

deferred in view of those circumstances. At the end of the day those are the bald facts and that is why this has occurred. It may have been the case in 2009 when we would all agree that circumstances were quite different that certain things happened, but at the end of the day, in terms of preserving our budgetary position and the government's stated aim in respect of returning to surplus, these drugs were deferred.

Senator BOYCE: You point out that the situation has changed since 2009. One of the reasons the situation would change is the length of time it takes for a drug to get through the PBAC system. Do you agree, Ms Halton?

Ms Halton: I am missing the point.

Senator BOYCE: You seem to be claiming that financially things were different in 2009.

Ms Halton: Indeed. The bottom line is that it is acknowledged that the decision to defer some products is a decision taken by the government in the context of the financial circumstances in which it finds itself. It did not find itself in those circumstances previously, but it does now. There is a stated commitment to return to surplus in a defined period, and at the end of the day the government therefore took a decision to defer these particular drugs. My point is that they have been quite clear about that.

Senator BOYCE: Who made the decision that the listing of a hormone agonist should be deferred? Was that a cabinet decision?

Ms Halton: The minister is responsible for listing or otherwise. At the end of the day it is known that there is advice and guidance sought and delivered in relation to that, because of the financial consequences of decisions.

Senator BOYCE: How many drugs were assessed as being potentially likely to be deferred? There were seven deferred, but how many were on the maybe list?

Ms Halton: I cannot answer that question.

Senator BOYCE: So, you do not know?

Ms Halton: No. That is not the way the process works. It is not potentially deferring, thinking about deferring and then finally deferring. It was, 'Here is the list and here is a decision that we have deferred the following.'

Senator BOYCE: So, are you saying the list was generated out of cabinet?

Ms Halton: I would have to take advice on what I can say in respect of those matters.

Senator BOYCE: I am trying to understand who had the expertise to decide on the list and where that expertise came from.

Ms Halton: I certainly think the minister has been on the record in respect of high priority listings. Again, I can take some of that on notice.

Senator BOYCE: You are aware of the uses of some of the drugs that have been deferred and the fact that there is a lot of disquiet in certain parts of the community because of it?

Ms Halton: Yes. Of course I am aware of that, but I am also aware of the fact that the drugs that were listed in this particular round were drugs where there was potentially no alternative for people and with the ones that were deferred, in a number of instances, there were alternatives. Ms Platona, in answering your earlier question, indicated that there is an alternative. The point is that the ones that were listed were the ones that were high priority.

The others, whilst it is acknowledged they passed the PBAC process, were certainly alternative options.

Senator BOYCE: That takes me back to my question about where the expert advice came from on what to list and what not to list.

Ms Halton: I will come back to you so I can be completely accurate about how I answer that question.

Senator BOYCE: There has been a lot of debate about this over the years and up until now it has been fairly settled that the PBAC functions in a very independent way from government.

Ms Halton: That is correct.

Senator BOYCE: How can industry or the public have any confidence whatsoever in this process when we have examples of two companies that were asked to apply, did so and then had their applications deferred because of a cabinet decision and not because of a PBAC decision?

Ms Halton: At the end of the day, companies understand that the PBAC process is a very rigorous one. We all know that it is a hard process. Companies also understand that in the current financial climate decisions about deferral have had to be made. I think they understand that. The conversations I have had with a number of people suggest to me they understand that full well. I do not know whether I can say much more than that.

Senator BOYCE: Thank you. I have questions in another area, if we have time.

CHAIR: Senator Coonan.

Senator COONAN: I have a few questions following on from that. The deferral was said to be temporary. How long is 'temporary' and is there a timeframe in the process for reconsideration of the seven drugs and the vaccine?

Ms Halton: Welcome to the committee. We have not seen you here for quite a long time. My understanding is that the minister indicated that it would depend on when the budget was in a position to be able to accept those listings. I am not aware of a timetable being put on it, but I will ask for correction if I am wrong. No, I am correct.

Senator COONAN: In a speech on 29 April the minister said that she would be looking at a time frame and consulting in relation to particular reconsiderations. Has anything been done in relation to that?

Ms Halton: My understanding is that it is determined by the financial position of the budget. So, no, I am not aware of anything. If I am proven to be incorrect, I will provide you with the information.

Senator COONAN: Does that mean returning the budget to surplus?

Ms Halton: That is my understanding of it.

Senator FIERRAVANTI-WELLS: What was your answer to that?

Ms Halton: The rationale is, as I have outlined, in respect to the budgetary position, and I think the suggestion is that this would be able to be reconsidered potentially when the government comes back to a budget surplus.

Senator FIERRAVANTI-WELLS: Your answer was, yes?

Ms Halton: Yes. That is my understanding, but at the end of the day, it might be that there are other comments on the record on this and I am looking to my colleagues in case there are things that I am not aware of.

Senator COONAN: What was the criteria for the section of each of the drugs deferred?

Ms Halton: As I have already indicated to Senator Boyce, it is in terms of the alternatives that might be available to people versus those where there are no alternatives and based on priority. We have indicated that we will come back with some further information on notice about that.

Senator COONAN: I was particularly interested in Symbicort. What is the existing treatment available that is as efficient and well tolerated as Symbicort? It is an asthma preventive.

Ms McNeill: We have Fluticasone on the PBS for the same treatment.

Senator COONAN: Why is that more efficient than Symbicort or why was that picked over Symbicort?

Ms McNeill: It is already on the PBS.

Senator COONAN: Symbicort has been on the PBS for quite a while.

Ms McNeill: Yes, it has, but this is for this particular indication. For this indication the other drug is already on the PBS.

Senator COONAN: I am sorry, I do not understand that. Symbicort has been on the PBS for some time.

Ms McNeill: Yes. When a drug is listed on the PBS it is done so for a particular indication for a particular circumstance and for a particular treatment. The manufacturers of Symbicort were seeking an extension to their existing listing to cover another type of indication. There is already another drug on the PBS that covers that indication as a treatment option.

Senator COONAN: Has that co-existed with Symbicort for a number of years?

Ms McNeill: Yes.

Senator COONAN: For how many years?

Ms McNeill: We would have to take that on notice.

Senator COONAN: Thank you. There is another one that I was particularly interested in. What about for treatment of severe primary axillary hyperhidrosis? Is there any alternative medication for that?

Ms McNeill: No. There are listings on the PBS to treat the side effects of the condition, but not the primary cause.

Senator COONAN: What is the level of savings that this policy change will deliver for the deferrals announced to date over the forward estimates?

Ms Halton: It is not a saving.

Senator COONAN: Where does it appear in the budget?

Ms Halton: It does not.

Senator COONAN: I did not think so. How do we estimate it? There must be some benefit if we are trying to get the budget back into surplus, and this is a key factor, so we are told. It must have some figure attached to it?

Ms Halton: In terms of expenditure forgone; we will take that on notice.

Senator COONAN: Is it $100 million? That is what it should be.

Ms Halton: We will take it on notice.

Senator COONAN: It is $25 million over four years, if that is right.

Ms Halton: We will come back to you on notice.

Senator COONAN: Thank you. I realise that you do this differently with Medicare's date of supply, but I am interested in looking at the table on page 13 for Access to Pharmaceutical Services and the PBS forward estimates. On my reading, it shows that spending on the scheme is expected to continue growing from $9 billion this financial year to $9.6 billion in 2011-12, our current budget year; on to $10.1 billion in 2012-13; $10.9 billion in 2013-14, and $11.7 billion in 2014-15. The amounts of increase are $800 million for 2011-12; $500 million in 2012-13 and $800 million in each of the outlying years. In percentage terms, these equate to 6.5 per cent; 4.8 per cent; 7.8 per cent and 7.3 per cent. The biggest percentage growth is expected to occur in 2013-14, and by that year the government expects the PBS growth to have returned to current levels. Am I reading that correctly?

Ms McNeill: Yes, you are.

Senator COONAN: Why is it that the government expects growth surge in the last two years of the estimates?

Ms McNeill: If we talk about the fact that the year prior you have a 4.8 per cent growth and then you move on to the 7.8 per cent growth, under the expanded and accelerated price disclosure program that was announced by the government in last year's budget, the impact of the price changes will come into effect in that year, which is why we see a significant moderation in growth for that financial year as the prices adjust. However, when we move back into the outyears, script volume continues to grow and prescribing patterns of prescribing more expensive drugs continues to grow and so that is why you are going to see a return to the growth numbers.

Senator COONAN: We know that prices are going down, because the cost of new medicines added to the PBS—that is not happening with these deferrals; is that right? Right now and for the future costly new medicines are not being listed.

Ms McNeill: I will correct you on that. Since January this year we have listed $465 million worth of major listings on the PBS.

Senator COONAN: As I understand the minister's statements, the government is concerned about possibly unsustainable growth. What is the impact of the number of prescriptions dispensed? It is growing, too, but not at a great right. Is it about three per cent?

Ms McNeill: It continues to grow, yes.

Senator COONAN: But it is not very much. Is it three per cent?

Ms McNeill: It is around about three per cent, yes.

Senator COONAN: What is the downward pressure on prices through the MOU? Do you have a figure on it or can you give the committee any information?

Ms McNeill: As announced in the budget last year, it is anticipated that it will deliver $1.9 billion worth of savings over five years.

Senator COONAN: So we already have those savings. We have an expectation that in the out years there will be a return to supposedly currently unsustainable levels. How does that work?

Ms McNeill: As we have already discussed, the level of script volume does continue to grow and the trend towards the prescription of new and more expensive medicines also continues.

Senator COONAN: Has the government given any consideration to the longer term impact of this deferrals policy on the integrity of the scheme? In other words, what I am getting at is: has the government given any consideration to the impact of any private track listings, so companies not worrying about the PBS and just having private listings?

Ms Halton: Not that I am aware of.

Senator COONAN: Is the government aware that a number of companies have already launched new medications deferred by cabinet into the private market in Australia?

Ms Halton: I do not know whether or not the government is aware of that.

Senator COONAN: Is the government aware, Minister?

Senator McLucas: I will seek some advice.

Senator COONAN: On my information one of these companies, Novo Nordisk Australia, which is the largest insulin supplier and a world leader in diabetes care, has stated, 'If we examine the possibility of not engaging further with the PBAC process and not launching a pipeline of new drugs in Australia to the disadvantage of a growing number of diabetes sufferers in this country unless the government reconsiders this approach.' Are you aware of that, Minister?

Senator McLucas: I was not but the minister may be able to give some advice.

Senator COONAN: If these suggestions are true and come to pass it really will lay the foundations for a system which will deny the majority of Australians who cannot afford access to private drugs access to new cost-efficient medications. Is that not the obvious outcome of this policy decision? It is a serious risk.

Senator McLucas: It is a fairly big threat from one company that is currently having a discussion about the listing of a drug. These are commercial discussions—

Senator BOYCE: I am sorry to interrupt the minister but I am having all sorts of problems hearing.

Senator McLucas: I am saying that there is a current discussion between a particular manufacturer of a medication who has a different point of view to the government at the moment. The decision to defer I imagine impacts on that particular pharmaceutical company, but to say that you are not going to play in the Australian market is I think probably a threat that they are making in the current context.

Senator BOYCE: But isn't certainty an important component of undertaking any business development, surely?

Senator McLucas: They are the same rules that applied when your party was in government.

Senator BOYCE: I am sorry, I missed that again.

Senator McLucas: These are the same rules that have applied when your party was in government, and the pharmaceutical industry is extremely well aware of it.

Senator BOYCE: I do not think that is quite true.

Senator COONAN: I will not take up the committee's time for too much longer but what is really concerning about these kind of knee-jerk reactions that appear to be the basis for this decision without really much foundation that there is some mythical return to budget surplus is that the real risk to the integrity of a system that served this country very well, that is internationally renowned, when there seems to me to be a serious risk—and I have just picked out one example; there are others—of a company developing drugs of enormous assistance to diabetes sufferers taking their inventions and innovations outside the system. I was interested to know what assessment the government had made of that risk?

Senator McLucas: I do not know if I can add anything further to your question about an assessment of risk to the potential supplier of pharmaceuticals in the country. But I can add this for the benefit of the committee, I remember sitting over there and asking very similar questions of your government when they were sitting here, when cabinet under the Howard government deferred a number of pharmaceuticals. These things are not new.

Senator COONAN: Would you like to give me a list of the deferrals apart from Viagra from the Howard government.

Senator McLucas: I do not have them in my head but we will see what we can do to assist you.

Senator FIERRAVANTI-WELLS: You have obviously made an assertion, Minister, back it up.

CHAIR: As to the process the minister said she was going to come forward with that information. I would have thought that was an entirely appropriate response.

Senator FIERRAVANTI-WELLS: Can I just take the discussion from a different tack? The announcement of the deferral was made by the minister for health in a press release I think on 25 February 2011. Can you confirm that this is the case and this was the first time that the decision was made public?

Ms McNeill: Yes.

Senator FIERRAVANTI-WELLS: Did any of the affected companies receive any advance notice of this announcement?

Ms McNeill: The companies were advised by the department, yes.

Senator FIERRAVANTI-WELLS: My question was: did they receive any advanced notice, that is before 25 February? When were they called? In the morning, before the press release went out or when?

Ms McNeill: Can I take that on notice and get back to you later this evening?

Senator FIERRAVANTI-WELLS: You have said that they were advised. Do you have just have to check with somebody to get the fact, do you?

Ms McNeill: To check the correct date, yes.

Senator FIERRAVANTI-WELLS: Can you tell me who made the call, please? Was it a call, was it in writing or by email in relation to each of those deferrals? And, as Senator Coonan reminds me, was there any consultation with any of those affected companies? Prior to this announcement would any of those companies have had any reason to expect that the $10 million threshold for cabinet consideration was no longer going to remain intact? Was the threshold of $20 million discussed with anyone?

Ms McNeill: The threshold of $20 million?

Senator FIERRAVANTI-WELLS: Isn't there a threshold that drugs below a certain value have to go to cabinet? What is the threshold?

Ms McNeill: The current threshold is that all drugs with a financial implication go to cabinet.

Senator FIERRAVANTI-WELLS: Isn't it the case that up to $10 million they did not have to? Yes. So now all drugs are going to cabinet?

Ms McNeill: Yes.

Senator FIERRAVANTI-WELLS: Did the department make the companies aware at the time it submitted to the PBS or any time thereafter their submission would be or could be subject to cabinet consideration?

Ms McNeill: When they actually submitted to the PBS?

Senator FIERRAVANTI-WELLS: Yes.

Ms McNeill: These submissions to the PBS date back to consideration in July last year or even pre that time period—

Senator FIERRAVANTI-WELLS: So the threshold—

Ms McNeill: At that time the threshold was $10 million.

Senator FIERRAVANTI-WELLS: at that time was $10 million?

Ms McNeill: Yes.

Senator FIERRAVANTI-WELLS: They went in with a threshold of $10 million and now they have found that the circumstances have changed, so let us look at it from the company's perspective. They obviously have to guarantee supply before the product got listed on the PBS, so they have got to have stock available.

Ms McNeill: I will just clarify that. It is not guarantee of supply. It is assurance of supply.

Senator FIERRAVANTI-WELLS: Okay.

Ms McNeill: Guarantee of supply relates to generics when brand competition comes into it. This is about assurance of supply. I am sorry, it is just that they are two different issues.

Senator FIERRAVANTI-WELLS: Obviously a company would normally be expected to have a holding. Do you have a rough estimate as to what that could be, as to how much that would be worth?

Ms McNeill: No, a company has to assure the department that they can meet supply when they are listed on the PBS. As to what they determine that needs to be, how much that needs to be and how they do it is entirely a matter for the company.

Senator FIERRAVANTI-WELLS: But that could run into billions of dollars.

Ms McNeill: That is a decision for the company. What we ask a company to do is to tell us that when the time comes for them to be listed, when that date goes ahead they have the capacity to supply the market as envisaged.

Senator FIERRAVANTI-WELLS: In the case of a listing that was not expected to go to cabinet, the company would then have ensured its product would be available and, noting that all medicines have a shelf life after which they cannot be used, if they are not listed in the immediate future the consequences of that would be destruction of the drug at further cost to the companies.

Ms McNeill: That depends. There is also the private market and the hospital markets where these drugs can also be sold and dispensed.

Senator FIERRAVANTI-WELLS: In relation to consultation with the companies because the circumstances had changed, did you not think it appropriate to at least advise the companies so that they could take alternative precautions in relation to disposing of any product that they may have had or is it just—

Ms McNeill: I am sorry, I do not understand what you mean by an alternative precaution.

Senator FIERRAVANTI-WELLS: Let me rephrase that. Obviously you would assume that companies would have a stock. If you are going to change the circumstances and parameters under which they are going to be able to operate because you are going to defer, did anyone at any stage think, 'Well, why don't we just tell the companies?', so that they could minimise any loss that that company could suffer so that they could dispose of any stock they may have in an alternative manner?

Ms McNeill: Nobody had told those companies that they were going to list.

Senator FIERRAVANTI-WELLS: I am sorry?

Ms McNeill: Nobody had told the companies—

Senator FIERRAVANTI-WELLS: That is right.

Ms McNeill: that they were going to list or that there was going to be a date for list. That is quite a common process when it comes to listing on the PBS. Once a decision is made to list the drug advice is given to the company and when that advice is given and a date is given to the company, it is then up to the company to determine whether they have the capacity to supply from that start date. At any time a company can choose to start at a later date if they are not ready to assure supply.

Senator BOYCE: Surely the two backers would say, 'Could you please apply because there is a clinical need for your medications?' I mean, yes, you did not give them a gold-plated guarantee but surely they could anticipate that these products would be listed in that circumstance?

Ms McNeill: The department makes no commitment as to when a drug will be listed on the PBS.

Senator FIERRAVANTI-WELLS: I will not traverse the cost issues but I am not sure in terms of the material or the question that you are going to take on notice what is the cost of these seven medicines to the government over the forward estimates and how much is being saved. That encompasses what I think Ms Halton was going to provide. From where did the recommendation originate to defer these medicines?

Ms Halton: That was not a recommendation. It was a decision of government and the minister as the responsible person under the legislation.

Senator FIERRAVANTI-WELLS: The point that I am asking is did Minister Roxon make a recommendation to cabinet?

Ms Halton: I cannot comment about that.

Senator FIERRAVANTI-WELLS: In relation to the legal consequences of this decision to defer, have you taken any legal advice in relation to any potential legal liability as a consequence of cabinet's decision to defer these drugs?

Ms Halton: I do not know whether we have but I do not believe there is any. We have not, I am told, but I would be surprised if there were any.

Senator FIERRAVANTI-WELLS: Is that a categorical statement? You have not taken advice?

Ms Halton: We have not taken advice but, knowing the legislation relatively well, I think it is fair to say that I would be very surprised if there is any such issue.

Senator FIERRAVANTI-WELLS: In relation to the list of medicines that are being deferred, is the list purely what is in Minister Roxon's press release of 25 February? Is that the list? Just those seven?

Ms Halton: Yes.

Senator FIERRAVANTI-WELLS: Can the department advise how many patients you estimated each medicine would have treated?

Ms McNeill: Can I take that on notice, please?

Senator FIERRAVANTI-WELLS: I would have thought you would have worked that out if you have worked out how much you are going to save over the forward estimates.

Ms Halton: But it is not something we can just read in here.

Senator FIERRAVANTI-WELLS: So, you have the figure, but you just do not have it here?

Ms Halton: Yes.

Senator FIERRAVANTI-WELLS: So, when will the medicines that you have deferred in February be reconsidered by cabinet?

Ms Halton: As I said, I cannot answer that question.

Senator FIERRAVANTI-WELLS: Just out of curiosity, before this sort of mass deferral, we have asked before here the average time that it takes for cabinet consideration of drugs. I think we went from six months to nine months. What was the average before this decision?

Ms McNeill: For high-cost listings—

Senator FIERRAVANTI-WELLS: It has been asked in the past. The last time I asked, it was nine months.

Ms McNeill: Under the new arrangements, under the memorandum of understanding with Medicines Australia, the commitment to best endeavours of six months from the date of pricing be agreed between the company and the department, to consideration by government, and we are currently trending at 3.5 months for those medicines that are covered by the MOU.

Senator FIERRAVANTI-WELLS: And for medicines not covered by the MOU?

Ms McNeill: It is about nine and a half months.

Senator FIERRAVANTI-WELLS: That is higher than the last time we looked at it. In relation to this decision, was the Department of Health and Ageing asked for advice about which of the PBAC recommended medicines should be funded or deferred for funding by the government?

Ms Halton: I would have to look at what exactly the advice was. I think I have already indicated I will look at this, but I do not want to answer that question without consulting with the paperwork concerned.

Senator FIERRAVANTI-WELLS: How many medicines costing less than $10 million have been listed on the PBS in the last five years? Will you take that on notice?

Ms Halton: I am sure we will have to take that on notice.

Senator FIERRAVANTI-WELLS: What is the current length of time taken for a medicine to go from being recommended by PBAC to being listed on the PBAC and how does this compare over the past five years? You will have to take that on notice?

Ms McNeill: I will take that on notice again for you.

Senator FIERRAVANTI-WELLS: Can you provide a detailed overview of the specific criteria by which medicines are assessed for listing on the PBAC and are these the criteria, or are there any other criteria, that cabinet is using in determining whether or not to defer PBS listing of medicines?

Ms McNeill: The criteria for the consideration of listings by PBAC are in the legislation.

Senator FIERRAVANTI-WELLS: But my question goes more to the criteria or any other criteria that are now being used by cabinet in determining—

Ms Halton: I do not think we can provide any such thing, because I do not believe it exists. We can answer the questions in respect of the seven—

Senator FIERRAVANTI-WELLS: Let me rephrase the question. Are these the criteria or are there any other criteria used by cabinet?

Ms Halton: The answer to that is, are there formal criteria, no; is there an explanation for the ones that were chosen, yes, but in terms of a formal criteria, no.

Senator COONAN: I would just be interested to know that if you accept the proposition that this is really about opening up new pathways to enable further savings off the PBS in the future, does the government expect to defer listing some additional drugs every four months when PBAC presents its latest recommendations or is this a one-off?

Ms Halton: A couple of things. Firstly, that is a contention which I have never heard put before and I am not going to make a comment on it. I cannot speculate and I cannot offer

opinion. All I can simply say is, this is the decision as it applies in these circumstances, and beyond that I cannot make any comment.

Senator COONAN: Thank you. Minister, can you rule out the prospect that, every four months when the PBAC comes up, there will not be further deferrals?

Senator McLucas: I think that is a hypothetical question that cannot be responded to.

Senator COONAN: So, you are not ruling it out? There could be more?

Senator McLucas: It is a hypothetical question.

Senator COONAN: You are not ruling it out?

Senator McLucas: There is no way that we can respond to that in a way that this committee operates.

Senator BOYCE: The Department of Health and Ageing sought a report by McGrathNicol into the investment practices of Diabetes Australia; is that correct?

Ms McNeill: Yes.

Ms Halton: We have not quite framed that yet.

Mr Learmonth: We sought a report from McGrathNicol into the finances and accounts of Diabetes Australia Limited, not their investment practices.

Senator BOYCE: As I understand it, this report was not made public until there was a freedom of information request from Fairfax Media; is that correct?

Mr Learmonth: Correct.

Senator BOYCE: Why was this report not made public when it was received?

Mr Learmonth: It was essentially a commercial matter between us and an entity that we contracted with.

Senator BOYCE: But Diabetes Australia is a large not-for-profit. According to the report here their investment practices, which were not within their constitution, led to a $2 million loss and a deficit of more than $3 million in 2009; is that correct?

Mr Learmonth: The loss is about right. I cannot recall in relation to the deficit, but certainly the net loss was of that order.

Senator FIERRAVANTI-WELLS: When did you first become aware that they had made unauthorised investments?

Mr Learmonth: I will have to take that on notice. It was some time ago now.

Senator FIERRAVANTI-WELLS: Surely the points are: this organisation is a not-for-profit, it relies on taxpayer money and it relies on donations, and you had a report which suggests that these funds were not being used at all well and did not make it public.

Mr Learmonth: The report was in relation to money paid under contract by the department, not its broader sources of income, and we engaged in a process of understanding what happened to the funds paid under contract, understanding whether or not those funds had been applied to the purposes of the contract and came to an appropriate arrangement, ultimately, with the entity for repayment of those funds. It was a matter of managing the obligations of an entity under the contract for the funds provided under the contract, not their broader income.

Senator FIERRAVANTI-WELLS: What was the contract for?

Mr Learmonth: The contract was for provision of services under the National Diabetes Services Scheme.

Senator FIERRAVANTI-WELLS: What was the total value of the contract?

Mr Learmonth: I will take it on notice. It was in the order of $120 million for the year.

Senator FIERRAVANTI-WELLS: Do we know the total value of the Commonwealth funds that were invested?

Mr Learmonth: The total contract we will have to take on notice, but it was in the order of $120 million a year.

Senator BOYCE: Over 12 months?

Mr Learmonth: Per year. It obviously escalated in terms of costs and number of clients, so it was not a fixed number.

Senator BOYCE: And now you found that there was a deficit of $3 million—on the contract or on the organisation?

Mr Learmonth: No, it was not an issue about the organisation running a deficit in terms of its whole operation. What the audit uncovered was there had been a net loss of funds provided under the contract, those funds had not been applied to the purposes provided under the contract, and there was a process of repayment by the organisation of those contracted funds.

Senator BOYCE: How much was repaid?

Mr Learmonth: There was a settlement and all of the outstanding money was repaid.

Senator BOYCE: Which is how much?

Mr Learmonth: It was the net loss of the order of $2 million. I cannot recall the precise figure.

Senator FIERRAVANTI-WELLS: So, they paid immediately?

Senator BOYCE: On notice you can tell us exactly how much.

Mr Learmonth: They paid. It was paid back.

Senator FIERRAVANTI-WELLS: It was paid back. So, you sent a letter and they made—

Mr Learmonth: There was a settlement that encompassed a range of things, including repayment and some changes to the contract to improve visibility and accountability of finance.

Senator FIERRAVANTI-WELLS: So, it was paid as a lump sum or in an arrangement?

Mr Learmonth: I cannot recall, I am sorry, whether it was a lump sum or not.

Senator FIERRAVANTI-WELLS: What action have you now taken to ensure that there has been no other unauthorised use of taxpayers' funds?

Mr Learmonth: Two things. For the duration of the contract, which is up I believe at 30 June this year, there was a range of amendments that contract agreed to as part of the settlement. It was not merely repayment of the funds, it was some additional measures around transparency and accountability in that contract to mitigate further risk. Certainly, the board

are very aware of that and we are now in the process of negotiating a new contract with Diabetes Australia and there will be appropriate, again, measures for accountability and transparency.

Senator FIERRAVANTI-WELLS: There are two questions are rising out of that. One is what is the current financial situation of Diabetes Australia and its capacity to deliver under the scheme? That is the first thing. Secondly, given what has happened, how confident are you with an organisation that is engaged in this sort of conduct? Ought you not to be giving consideration, perhaps, to some other alternative?

Mr Learmonth: It is a significant and well-regarded organisation. The services that it delivers are effective and well-regarded. It made a particular misjudgment in relation to investment of some income it had—some, essentially, working capital that it had. It made that mistake; it rectified that mistake. There have been risk mitigations put in place in terms of both the existing contract and the ongoing contract, but we have every confidence in the ability of the organisation to continue to deliver good service.

Senator FIERRAVANTI-WELLS: Are there any other organisations that would be in a position to deliver under the scheme? Are there alternative organisations that could do this?

Mr Learmonth: None immediately spring to mind. There is a range of services that are provided, from the provision of consumables to advocacy, client support and advice. There is a national federal network underneath this, so there is not immediately anyone obvious that could step into that. It has been around for a while and is very capable.

Senator BOYCE: What prompted the department of health to commission this report into Diabetes Australia?

Mr Learmonth: I will have to take that on notice, I am sorry.

Senator BOYCE: I mean was it information?

Ms Halton: I think it was an audit.

Mr Learmonth: We received information.

Ms Halton: We received information.

Senator FIERRAVANTI-WELLS: It fell off the back of a truck.

Senator BOYCE: Are there other not-for-profits that you are currently having investigated?

Ms Halton: We receive information a lot of the time about organisations that we fund.

Senator BOYCE: Absolutely, and some of it would be malicious.

Ms Halton: And some of it would be worse than malicious.

Senator FIERRAVANTI-WELLS: But some of it is very profitable and could very well may be true.

Mr Learmonth: And all of it we track down.

Senator BOYCE: You would not involve an outside corporate organisation to investigate every one of these, would you?

Ms Halton: No. What we do in these circumstances—and we do take these things incredibly seriously.

Senator BOYCE: So, you would escalate the inquiry depending on what the responses were.

Ms Halton: Exactly, and we do due diligence on allegations. Some of them are manifestly and clearly able to be dealt with with a quick read and a couple of phone calls. Some of them suggest things which are of significance, and some of them require full-blown, external contracted investigation, as this did, and some quite serious work, which I pay a compliment to the officers for the work that they did. But we do treat basically our obligation to ensure that we get value for taxpayer money very seriously, and this is one example.

Senator FIERRAVANTI-WELLS: It is Diabetes Australia, but without casting aspersions anywhere it potentially could be any organisation. In terms of other organisations, has this triggered perhaps in your mind whether we should be looking at other organisations that may be in a similar circumstance in terms of receiving Commonwealth funds that may perhaps need a revisit?

Senator BOYCE: This might be a genuine result of the GFC.

Ms Halton: Perhaps not. We continue to learn from all of these experiences about how we balance up the need to enable, particularly the community sector, to get on with the job which we asked them to do without having an excessive burden, with the need to be accountable for public moneys. In the way that we contract, the way that we monitor and the way that we sometimes facilitate, coach and do other things in assisting organisations, we try and strike that balance, but it is absolutely the case that every time we have one of these, it causes a period of reflection and then sometimes, to use a non-technical term, tweaking to that accountability framework, so we are very mindful of these things.

CHAIR: Senator McLucas has some answers to some questions she wishes to table before we break for dinner and then we will break until 7.34 pm.

Senator McLucas: Very quickly, thank you, Chair. Not table; just reading. When we were discussing the preventive health agency, there was a question, I think, from Senator Boyce, about whether the strategic plan will become public; or maybe it was yourself, Senator Siewert.

Senator BOYCE: I think it was between us. I also asked about the outcomes for both the National Partnership agreement and the preventive health agency, but sorry.

Senator McLucas: I am happy to advise that it is a matter for the government, but we need to consider that it has to be considered by the Australian Health Ministers Conference prior to Minister Roxon approving it So, it has got to go through the health ministers before it can then be made public. Then there was another question about whether there will be a specific allocation of funds for alcohol, tobacco and obesity. The money has been allocated to the agency as per the COAG agreement.

Senator ADAMS: They were my questions.

Senator McLucas: Senator Adams; I am sorry about that. I am advised that the ministerial advisory council membership decision will be very soon.

Proceedings suspended from 18:32 to 19:34

CHAIR: We will reconvene. We are still in outcome 2, access to pharmaceutical services.

Senator FIERRAVANTI-WELLS: I had questions on diabetes, which I shared with Senator Boyce. In relation to the seven drugs that were referred, one of those drugs was a drug called TARGIN. What is the cost to government for TARGIN over five years? Is that a figure that you had a net cost to government when you take into account the PBS outlay as opposed to NBS cost savings?

Is that a figure that you can assist me with?

Ms McNeill: I think that as the secretary advised earlier, we need to take that on notice to provide that information.

Senator FIERRAVANTI-WELLS: So you obviously know the total number of patients that are treated every year with TARGIN.

Ms McNeill: TARGIN is not listed on the PBS, Senator.

Mr Learmonth: It is a private market so we would not have data on that.

Senator FIERRAVANTI-WELLS: Is this not something that you work out with—

Mr Learmonth: We have an estimate for a potential—

Senator FIERRAVANTI-WELLS: So what do you estimate would be the total number of patients that would be treated with TARGIN per annum?

Mr Learmonth: I do not think we have that with us. We will provide that on notice.

Senator FIERRAVANTI-WELLS: And I assume that you also have information in relation to the sorts of costs that you anticipate would be reduced in terms of illicit use and abuse—

Mr Learmonth: I do not think we would, Senator.

Senator FIERRAVANTI-WELLS: What about the total savings that you would have in relation to the abuse and diversion of OxyContin?

Mr Learmonth: TARGIN is OxyContin, Senator, with an additional element to it.

Senator FIERRAVANTI-WELLS: Yes.

Mr Learmonth: I am not sure that we would have any figures on that which you ask. It is OxyContin plus another pharmaceutical ingredient; it is a combination.

Senator FIERRAVANTI-WELLS: Okay. Obviously, patients take this drug, as I understand it, for the treatment of chronic severe and disabling pain, but there are common side-effects. There is an issue in relation to constipation and then you have to take laxatives—

Mr Learmonth: TARGIN is Oxycodone, which is regularly prescribed for that indication, with Naloxone which has a laxative effect. It is equivalent to taking Oxycodone in its usual form and a laxative.

Senator FIERRAVANTI-WELLS: You claimed that the medicines were deferred due to fiscal reasons. One of the other reasons I think, as was said earlier, was that there were alternative treatments existing in the marketplace. Is that correct?

Ms McNeill: For the most part, yes, Senator.

Senator FIERRAVANTI-WELLS: Let me just take you back, if I can. There would be Medicare savings, wouldn't there be, due to a reduction in opiate-induced constipation, which

would result in fewer GP and specialist consultations as well as fewer hospital procedures for the most severely constipated?

Mr Learmonth: We will take that on notice, but it is not clear to me that there would be. Most people who are prescribed Oxycodone or similar drugs also have a laxative administered as well, if that is appropriate.

Senator FIERRAVANTI-WELLS: So you are saying that it is not an issue.

Mr Learmonth: I am not sure, but we will take it on notice. I am not sure that there would be any savings attributed given that the clinical effect is equivalent to probably usual practice.

Senator FIERRAVANTI-WELLS: So your view is that there would not be anything.

Mr Learmonth: We will come back to you on notice if it is different.

Senator FIERRAVANTI-WELLS: What is your clinical basis? You have clinical evidence obviously. Was that part of the decision—

Mr Learmonth: It is all part of the findings of the PBAC in their considerations of the drug.

Senator FIERRAVANTI-WELLS: Would you take on notice what clinical evidence was used in relation to making this decision?

Mr Learmonth: Certainly, Senator.

Senator FIERRAVANTI-WELLS: I might just leave it at that for the moment. I have got other questions and I think that Senator Boyce—

Senator BOYCE: Mr Learmonth, are any other—to use Ms Halton's terminology—full-blown external investigations of not-for-profits being conducted by the Department of Health and Ageing. Or have you hired anyone to do the same?

Ms Halton: We will have to take that on notice. That question is a whole-of-portfolio question. I am aware that we have a number of processes with a couple of organisations we fund. Whether it is of the same scale as Diabetes Australia I cannot tell you, but we will take it on notice.

Senator BOYCE: Has Diabetes Australia been restructured since this incident? I do not mean it would be necessarily because of this incident, but I understand that some of the states have—

Mr Learmonth: There has been a reconstitution of the board.

Senator BOYCE: In what way?

Mr Learmonth: There are different members and directors.

Senator BOYCE: But is there still the same structure?

Mr Learmonth: Someone will correct me if I am wrong,, but my recollection is that in the previous arrangements, at the time in question when this issue was going on, each of the states and territories—it is a federation—contributed a director to the board. There was Diabetes Australia Ltd along with a range of other directors from different organisations. It was in some ways a representative board. My recollection is that not all of the states and territories are currently represented.

Senator BOYCE: What has the Department of Health and Ageing done to satisfy themselves that the governance of Diabetes Australia is good?

Mr Learmonth: From our perspective there are no concerns with the governance of Diabetes Australia. It is functioning and it is delivering services. We are in constant discussion with them. Whether or not one state or another is a member is neither here nor there insofar as individual state entities are entities in their own right and are subcontractors under the National Diabetes Services Scheme. From our perspective, we are quite comfortable with how things are.

Senator BOYCE: I want to refer to some answers I received to some questions on notice from the last round of estimates. I am particularly looking at E11-060, in which I asked whether the department thought the 1.7 per cent growth rate to wholesalers was sufficient compensation for enhanced PBS reforms and the inflationary costs of doing business. I got a long reply, but I do not think it answered the question of whether you think a 1.7 per cent growth rate compensates wholesalers for the enhanced PBS reform and the inflationary costs currently associated with doing business.

Ms Halton: We should be clear about this, Senator. In fact, I was discussing the CSO with one of the luminaries of community pharmacy only the other evening on the telephone. This is an amount that was struck as part of a negotiation. It acknowledges that there is an issue, but at the end of the day it was never struck based on a line-by-line cost accounting.

Senator BOYCE: I am sorry?

Ms Halton: This is an amount that was never struck on the basis of line-by-line cost accounting. It was struck as part of a negotiation, as an acknowledgement of the costs in this domain. So to say that—

Senator BOYCE: Was it meant to cover the costs?

Ms Halton: It is meant to be a contribution in respect of this activity. It is a macro amount that was negotiated.

Senator BOYCE: Is the contribution seen as a percentage contribution or as a global contribution?

Ms Halton: No, it is seen as an amount. It is seen as a global contribution.

Senator BOYCE: So whether it compensates adequately was not the purpose of it—is that what you are saying?

Ms Halton: Whether it fully met a line-by-line, accounting-derived cost of the function? No, it was never that. It was the amount that was negotiated as a recognition of this particular component of costs.

Senator BOYCE: What is the implication if it is not adequate to cover the costs?

Ms Halton: The implication is that there is an amount of money, now indexed in the way that has been described, which actually comprises this pool. The bottom line is: if, at some point, we have a problem with the fundamentals here—distribution—someone will point this out to us. But it was a macro amount negotiated; it was not a derived total costing.

Senator BOYCE: One of the comments you have made in there is that the wholesale remuneration for PBS medicines that are over $930.06 is a fixed payment of $69.94 and is not

impacted by the price reductions. What percentage of medicines actually cost more than $930.06?

Ms McNeill: I will have to take that on notice.

Senator BOYCE: Would it be a large proportion?

Ms McNeill: I would have to take that on notice. There are some very expensive drugs on the PBS, yes, but as to the percentage of them that are over that figure, I would have to take that on notice.

Senator BOYCE: But would it be well under a quarter—can we say something like that?

Mr Learmonth: I do not know. By price or by volume?

Senator BOYCE: Perhaps we could do both. Well, by price, and let us look at volume. I also want to have a look at the answer to question on notice E11059. That talks about the Fifth Community Pharmacy Agreement and, again, I felt did not entirely address the question, which was that the industry, over five years, is going to get $950 million to distribute under the community service obligations, but that is $225 million less than the government was taking out of the current PBS reforms. Could you advise if that is correct or not?

Ms Halton: This particular question I scratched my head about. The PBS reforms were negotiated. They were negotiated as a reflection of a series of changes that people consensually agreed to.

Senator BOYCE: But they were not the only reforms. There had been other reforms, had there not?

Ms Halton: But this is not an industry that is not mature. It is extraordinarily mature. And the people involved in it actually understand completely well what they are doing. This is my point. They negotiated—

Senator BOYCE: All the stakeholders?

Ms Halton: In the industry—yes, absolutely. So this is a nonsense equation, in my humble opinion. I looked at this question and thought, 'Exactly what is the point of this question? I do not understand it.' There is an amount to distribute—

Senator BOYCE: I would have been happy to have someone come back to me.

Ms Halton: I think people are too polite sometimes.

Senator BOYCE: I would think that the question is not at all hard to understand.

Ms Halton: No, it is not whether it is hard to understand; my point is that it is about comparing apples—

Senator BOYCE: Not liking the question is not the point, Ms Halton.

Ms Halton: No, it is about—

CHAIR: Senator, it would be useful if you were to wait for one person to finish talking before you come through with your comment. Ms Halton was in midsentence when you came through.

Ms Halton: And the reality is, as I have already said, the CSO was a negotiated amount. It was an amount that people were prepared to accept as part of a negotiation about what should be provided as an acknowledgement, not as an accounting-derived, line-by-line cost. Put that

to one side. Then there is a separate negotiation as part of PBS reform as to what is to be provided—an amount. At the end of the day, they are two negotiations. The people who were participants in these negotiations all understood what they were negotiating. So to conjunct the two in a question I do not think is particularly meaningful.

Senator BOYCE: The wholesalers were not compensated, though, were they?

Ms Halton: The wholesalers, at the end of the day, are part of the chain in respect of PBS.

Senator BOYCE: Were they part of the group that agreed?

Ms Halton: We had multiple conversations with the wholesalers in a number of these discussions.

Senator BOYCE: But it was not in terms of the original PBS reform, was it?

Ms Halton: Yes, actually. We did have a conversation with the wholesalers on PBS reform—in fact, the original PBS reform. The reason we have the CSO and the amounts we have is that the wholesalers were party to that discussion.

Senator BOYCE: Could I have, on notice, the dates of those meetings.

Ms Halton: Whether or not we still have records of those, as they were now some years ago, under the last government—

Senator BOYCE: We are looking not just at past reforms; we are looking at the ongoing pattern, which is of course what the industry is talking about. It is not just about reforms that happened then and reforms that happen now. It is the cumulative effect, which is what the industry is concerned about.

Ms Halton: That is as may be. I can tell you for a fact that Mr Learmonth had a number for conversations with wholesalers.

Mr Learmonth: I had quite a number with the National Pharmaceutical Services Association, the individual suppliers and so on as part of it.

Senator BOYCE: As part of?

Mr Learmonth: As part of the general discussions that were happening while the MOU negotiation was in progress.

Senator BOYCE: With Medicines Australia?

Mr Learmonth: Yes.

Ms Halton: Yes.

Senator BOYCE: Perhaps you might be able to tell me about the dates of those meetings and if they were formal meetings.

Mr Learmonth: Possibly. Possibly not all of them. I can assure you that there were that many of them.

Senator McEWEN: What drugs have been listed on the PBS recently? I assume we are still listing drugs on the PBS.

Senator BOYCE: I would not be so sure of that!

Senator McEWEN: That is what I would like to find out, because I want to make sure that people understand that we are still listing drugs.

Mr Learmonth: There are a range coming out. Seven were listed at the last PBAC meeting. There were Romiplostim, for a bleeding disorder; Omalizumab, for severe asthma; Duodopa, for Parkinson's disease; Vildagliptin, for type 2 diabetes; Adapalene, for severe acne; Prevnar 13, a vaccine for pneumococccal; and Menitorix, a meningococcal C vaccine.

Senator McEWEN: In what period of time was that?

Mr Learmonth: That was out of the second last PBAC meeting. They were announced in February.

Senator McEWEN: In February this year we announced drugs that assist people who have asthma, Parkinson's disease, diabetes, acne, pneumococcal and meningococcal disease. They are fairly significant illnesses, I suspect.

Mr Learmonth: Yes, they are.

Senator McEWEN: So the government is ensuring that the TGA is putting drugs on the PBS list that people can then afford.

Mr Learmonth: Yes.

Senator FIERRAVANTI-WELLS: I will ask some questions, in relation to table 2.8, 'Quantitative key performance indicators for program 2.2' on page 126 of the Health and Ageing portfolio budget statements. I notice that there is a footnote saying that the figures were taken out of a report by PricewaterhouseCoopers, entitled *The impacts of Pharmaceutical Benefits Scheme reform*. Is that the situation?

Ms McNeill: That is correct.

Senator FIERRAVANTI-WELLS: In this case, were these checked by Treasury, or did you just use PricewaterhouseCoopers figures?

Ms McNeill: These are a key performance indicator. It is not about incorporation into the forward estimates.

Senator FIERRAVANTI-WELLS: So they are numbers from the Pricewaterhouse Coopers report. You are confident that those figures are accurate?

Ms McNeill: Yes.

Senator FIERRAVANTI-WELLS: Is it normal to just use figures like this? I have not come across you using these sorts of figures in tables such as this in the past. Perhaps I have not read too many yellow books. Is it common?

Ms Halton: This is the modern Public Service, Senator.

Senator FIERRAVANTI-WELLS: I was there for 20 years, Ms Halton. I will not ask you how long you have been!

Ms Halton: No, that would be a personal question!

Senator BOYCE: Ask anyway!

Ms Halton: Nearly 30 years. That is a very scary number, isn't it! We sometimes, as you know, outsource data modelling, collection et cetera. In this case we went to the market for this particular function because it required a level of technical skill that we do not necessarily have available for this in house. We do have these skills but not always available for this particular function. This piece of work was not only done externally but—I think it is fair to say, Ms McNeill—scrutinised up hill and down dale by others in government.

Ms McNeill: They dug deep.

Ms Halton: They did dig very deep.

Senator FIERRAVANTI-WELLS: Based on assumptions that you obviously give them?

Ms Halton: I think it is fair to say that everything about this was debated, negotiated and contested, including the assumptions.

Senator FIERRAVANTI-WELLS: I will put some further, more technical, questions on notice in relation to that. Thank you.

Senator BOYCE: You would be very aware that the generic medicines people were most upset when an MOU was agreed between Medicines Australia and the Department of Health and Ageing. Can you tell me where negotiations are currently at with generic medicines?

Mr Learmonth: There are a couple of things. I am not sure that it would be fair to characterise them as negotiations per se, but there is ongoing and substantial engagement with GMiA in at least a couple of respects—

Senator BOYCE: For what purpose, Mr Learmonth?

Mr Learmonth: In at least a couple of respects, one of which is the consultation in respect of the implementation of the MOU measures. Ms McNeill might wish to add to that. They are a significant player in that. Separately, they have—

Senator BOYCE: A significant player in?

Mr Learmonth: They participate in, contribute to and attend consultation in relation to implementation.

Senator BOYCE: And a significant industry player as well?

Mr Learmonth: I do not know what you mean, Senator. They attend. They contribute. They are part of the consultations for implementation. Separately to that they have a range of other policy interests that we have a regular and structured dialogue with them about.

Senator BOYCE: Could you explain what you mean by 'regular and structured'.

Mr Learmonth: We have an informal gathering of department and GMiA that GMiA's president, Dr Martin Cross, and I essentially jointly chair or manage. We have an agenda. We have a range of policy interests or policy issues that they are interested in, and we work cooperatively to try and understand them and progress them.

Senator BOYCE: And what does 'regular' mean?

Mr Learmonth: We have kicked it off in a structured fashion this year. We have had one face to face. We have another one in the diary; I cannot recall when. Dr Cross and I have had at least one teleconference to monitor progress on their agenda items and to discuss some of the issues in the interim.

Senator BOYCE: Now could you tell me about their input to the implementation of the MOU?

Ms McNeill: They are involved in the price disclosure working group which is representative of companies and industry associations for the implementation of the accelerated and expanded price disclosure, as was announced in last year's budget. They are also on the working group for the generic medicines campaign which is run by the National Prescribing Service. In addition to Mr Learmonth's discussions about the regular meetings

that he and Dr Cross have, we also have a subgroup that then takes the items that were discussed in those meetings and progresses them at a departmental officer level.

Senator BOYCE: So departmental officers meet with other people—

Mr Learmonth: We have a similar informal structure to the Access to Medicines Working Group. There is a group of principals: I and Dr Cross and some others.

Senator BOYCE: Who do the high order stuff?

Ms Halton: I have met with Dr Cross on a number of occasions as well.

Mr Learmonth: That principal group has essentially set a forward agenda and work plan of issues of mutual interest to discuss, and then we will, for some of those items, task a subcommittee or a working group of departmental officers and GMiA people to work up, develop and research some of those particular policy aspects to bring them back to the principals.

Senator BOYCE: How long have those regular and formal meetings been happening, Mr Learmonth?

Mr Learmonth: As I said earlier, we have had one this year. We have another one on the books; I cannot recall the date. We have had, as part of the process we agreed to, teleconferences between Dr Cross and I, between formal meetings, to monitor progress and deal with any particular issues. In some ways, this merely gives some structure to what was there before, which was a very regular engagement on matters of concern between us, and GMiA, including the secretary, are involved in those meetings from time to time. The engagement is not new; that we have put something of a structure and a work plan around it to give it some planning and discipline is more the new aspect of it.

Senator BOYCE: So would you characterise that by saying that they are being given a higher priority within the negotiation of pharmaceutical benefits than in the past?

Mr Learmonth: It is not an issue of priority. They have always been a key stakeholder. They have always been a group that we have engaged with regularly. It has evolved. There is perhaps a more structured approach from them, in terms of a series of policy issues that they wish to have progressed, and, in discussions between us, Dr Cross and I have agreed to perhaps give our engagement a little more structure than it has had in the past, by establishing a work plan and an agenda in an attempt to get through these things with a little more discipline.

Senator BOYCE: Thank you. That sounds like an advance.

Mr Learmonth: We think so.

Senator BOYCE: That was not an opinion, was it, Mr Learmonth?

Mr Learmonth: It was an observation, Senator.

Ms Halton: It was an observation, and if it were an opinion he would be spoken to later!

Senator BOYCE: As to the Pharmaceutical Benefits Pricing Authority: how many price increases have they recommended that have not been implemented?

Ms McNeill: Eight.

Senator BOYCE: And could you give me—either here or on notice, depending on how complicated it is—what those eight are?

Ms McNeill: I will give them to you on notice.

Senator BOYCE: Would you be able to tell me, one by one—and, again, perhaps on notice—what their value in the PBS system is? And could you tell me how long those price increases have not been implemented? Again, you are going to have to take that on notice.

Mr Learmonth: What do you mean by how many have not been implemented?

Senator BOYCE: PBPA has recommended price increases and they have not been implemented. So how long is it that those recommendations have been sitting there unimplemented? Does that make sense?

Mr Learmonth: I am just trying to imagine what the start date of it is, but yes.

Ms McNeill: Do you mean the meeting at which the PBPA recommended the price increase?

Senator BOYCE: Yes.

Mr Learmonth: The start date is a bit arbitrary, Senator. But, if you want to take it as from the meeting of the PBPA at which they were considered, we could take that as the start date.

Senator BOYCE: Look, whatever is reasonable. What I am trying to get to here is: do we have some that have been sitting around for years and years, or are we talking about one or two months?

Mr Learmonth: No. They are considered in a timely fashion.

Senator BOYCE: More information, Mr Learmonth!

Mr Learmonth: We can give you the date of the relevant PBPA meeting and when the price increase was not agreed to by government.

Senator BOYCE: When it was recommended and when it was not agreed to—is that right?

Mr Learmonth: The date of the meeting at which the request was considered by the PBPA.

Senator BOYCE: Okay. Now, for these medicines to stay in the PBS system, the manufacturers need to feel that they are making a profit out of doing so. Could you tell me what you have done to assure manufacturers that that will be the case?

Ms McNeill: Is your question—

Senator BOYCE: Have you had any correspondence with people other than saying, 'The increase on that drug isn't going to happen'?

Ms McNeill: Not at this time, no.

Senator BOYCE: You might be able to just tell me this—off the top of your head, hopefully: how many of those medicines have been waiting more than six months?

Ms McNeill: How many have been waiting more than six months for the price increase?

Senator BOYCE: Yes.

Ms McNeill: I would have to take that on notice, Senator, because it does go back to David Learmonth's point about this, which is that it depends on at which PBPA meeting they were recommended.

Mr Learmonth: It is not likely to be long, Senator. There are a cycle of PBPA meetings that follow the PBAC, so it is not likely to be long.

Senator BOYCE: But the fact that there is concern around this issue suggests that they are not happening as quickly as they were, that they are being deferred for longer.

Mr Learmonth: I suspect the issue is less about how long it is taking and more about whether or not the price increases are improved.

Senator BOYCE: That is, I guess, the point I am making. If it is possible, I would also like to have an assessment of the foregone earnings, so to speak, from those companies—that is, if the price increases had been promptly accepted, how much more money for each drug would those manufacturers be receiving?

Mr Learmonth: We will think about that one, Senator. It is sometimes not easy, particularly if there are competitors or alternative products. There is no guaranteed volume. So we will do what we can to answer your questions.

Senator BOYCE: But, if you know that the cost of the PBS now is $10 million and they were supposed to get a 10 per cent increase, isn't the answer—

Mr Learmonth: It relies on some assumptions about volumes and market share. We will do what we can to answer your question.

Senator BOYCE: Okay. Thank you very much.

CHAIR: That finishes outcome 2, Access to pharmaceutical services. Officers would know that there will be questions put on notice; a number of senators have said that. Thank you very much.

[20:08]

CHAIR: We will now move on to an outcome 14, Biosecurity and emergency response. My understanding is that Senator Boyce has questions here, and maybe Senator Furner or Senator McEwen.

Senator BOYCE: Okay. Do we need to ask these questions in a particular order, Chair?

CHAIR: We only have two subprograms, and I imagine there would not be a lot of interchanging of officers under 14.1 and 14.2, would there, Ms Bryant?

Ms J Bryant: We have people here, depending on what the questions are—

Senator BOYCE: Okay. I will ask my biosecurity questions first. With regard to emergency planning, just so people have an idea of whether they need to hang around for ages, is this the place to ask questions about the Queensland floods and cyclone?

Ms J Bryant: Yes, you can ask questions on that issue.

Senator BOYCE: Okay. I will ask my biosecurity questions first.

Ms J Bryant: Okay.

Senator BOYCE: I am hoping that you might be able to assist me with questions regarding the disposal of containers on farms that include dangerous chemical residues. There have been recommendations from the Australian Pesticides and Veterinary Medicines Authority for some considerable time that there should be controls, that they should go on labels and that these things should not simply be buried all over farms. I understand there has

been a recommendation from AgStewardship Australia. Could someone give me a rundown on the topic and what the involvement of the Department of Health and Ageing has been.

Ms R Bryant: That last one is probably more the Agriculture portfolio. They would be in a better position to respond on that.

Senator BOYCE: We wondered about that. But, given that there is perceived to be a human health risk and it is about setting health standards and that these things are more likely to be a danger to humans as well as animals, I wanted to know what the involvement of the department of health in the issue had been.

Ms Halton: But anything that is an agricultural chemical is under the APVMA.

Ms R Bryant: Yes. We provide human health assessments to the regulator, but the regulator then takes an overall decision, weighing the environmental protection advice, the human health risk and the use conditions and so on, so the Agriculture portfolio is the regulator and it would take that overall decision in the light of all those inputs.

Senator BOYCE: Does that mean no input?

Ms Halton: No. It means that the APVMA, which is an agency within that portfolio, would seek advice from us in respect of anything which potentially has a human health implication, but in terms of the regulation of the evidence, the balancing of the science, in respect of a particular product, it would do that.

Senator BOYCE: But this is not so much about a particular product. This is about the fact that many, many containers containing dangerous chemicals are often simply buried on farm and that there is nothing on the bottle that says you should not do this or how to dispose of them.

Ms Halton: But, again, that is an issue in respect of the regulation of the marketing and the dispensing of those products. That is not a matter for this portfolio. Environment departments have a view about these sorts of things. People who regulate agricultural products have a view about these things. But we, in human health, do not regulate the labelling of those products or indeed the disposal of those products.

Senator BOYCE: I should point out that this was raised with me by someone who said, 'This has been going in and out of government committees for more than two years.'

Ms R Bryant: The regulator is responsible for decisions on labelling, so the APVMA are responsible for decisions on labelling. Their labelling requirements do include a requirement for disposal statements, so they do include advice. But, without knowing a specific circumstance, it is difficult to comment more, and they would be best placed to give you advice.

Senator BOYCE: Okay, thank you. I will try to follow that up with questions on notice. I think there was a report in the *Courier Mail* today, but I do not have it with me, talking about the level of depression amongst people who had been affected by the floods in Brisbane. They were using a young pregnant woman to illustrate this point. Could you please tell me what the department has done to support organisations in Queensland—and I know there was some work in medicines and so forth—in terms of physical and mental health since January?

Ms Halton: This is actually a mental health question.

Senator BOYCE: Well, it is both, because wasn't there a prescription of antibiotics initially?

Ms Halton: That is true. But, in terms of the particular question about what we are doing to support people who might be suffering from mental health issues, the officers who could have answered that question in detail—I can give you the higher level, but they—

Senator BOYCE: But isn't this about emergency planning?

Ms Halton: No. It is true that the immediate response is an emergency planning issue, but what we have actually delivered comes from our mental health programs. So we have rolled out some ATAPS money and a number of other things to assist people. I think you would be aware of some of the public commentary. It is interesting, because people who have been through a number of these events in the past know that it is not immediately—I think the parliamentary secretary and I were discussing this just the other day, weren't we?

Senator McLucas: Yes, we were.

Ms Halton: It is not immediately during or after one of these events that you get the mental health issues; it is three and four months after the event.

Senator BOYCE: That is right.

Ms Halton: Certainly, what we did with the bushfires in Victoria and what we have done on several other occasions was ensure that we can deploy the resources. It is a bit like robbing Peter to pay Paul, but we move the mental health program resources around to make sure that we have greater levels of support in those communities. Now, I am happy to take on notice exactly what we have done. In fact, I know that both Ministers Macklin and Roxon are quite keen on ensuring that, with the new moneys coming in for mental health, we will prioritise those areas for early rollout. But I will take the rest of it on notice.

Senator BOYCE: Yes. I deliberately did not ask these questions under mental health because I thought they fitted in here.

Ms J Bryant: Senator, if I may, perhaps I can explain the role the department plays in an emergency response phase. Given that the floods and the cyclone were Queensland events, Queensland was primarily responsible for the on-the-ground response.

Senator BOYCE: Obviously. But they were beyond the scope of local councils, or state government.

Ms J Bryant: That is right. The Australian government Crisis Coordination Centre then coordinated the overall Australian government input across portfolios. For our portfolio, we activated our national incident room, which essentially acted as a coordination point.

Senator BOYCE: Yes, I think we have been through what actually happened—

Ms Halton: Yes. Jenny, we do not need to go through all that.

Senator BOYCE: at the time.

Ms J Bryant: The longer-term stuff is now being coordinated through disaster recovery arrangements.

Senator BOYCE: Yes, because, as Ms Halton has pointed out, emergency health takes one form when the emergency is occurring, but the need for help to prevent the emergency being ongoing is huge.

Senator McLucas: I think you could also ask these questions tomorrow of FaHCSIA.

Senator BOYCE: Yes, I will be, but I was more interested in looking at the health aspects today, and at the support aspects for organisations and for individuals tomorrow.

Ms Halton: Yes. As I said, I am very happy to give you some details on notice, and I can tell you that we have worked very closely with, for example, FaHCSIA. They have a huge Centrelink response in these sorts of circumstances, but what we can do is deploy our mental health services, ATAPS et cetera, to provide assistance. And we know from the feedback we had, particularly after the Victorian bushfires—where we were really quite creative in making sure we could plug gaps—that that made a very real difference to people. That is what we tried to do here.

Senator BOYCE: Okay. I will be asking these questions tomorrow in terms of disability, but I thought I would ask some tonight—because I thought this was the right place to ask them! In terms of people with disabilities, there were a number of small not-for-profit organisations that actually had better databases than the state department, in that the state department's database only covered the people they provided support to, not everyone with a disability. I want to know what the situation is with regard to people with chronic illness, who might show up as receiving a support pension but not as having a disability support package, or ageing people, who obviously need to be checked on because they do not have the normal ability to get out.

Ms Halton: In terms of the floods?

Senator BOYCE: Yes, or cyclones or whatever the emergency is.

Ms Halton: Again, Senator, because we do not have and we do not ourselves provide, other than benefits in respect of aged care, an individualised service—we fund providers to deliver that—we do not tend to target the individual. I think that is probably a question to ask tomorrow.

Senator BOYCE: I have put the questions on notice to Emergency Management Australia through Attorney-General's. But what concerned me was the question that was raised about not-for-profit groups that had more generalised databases than were available to government—quite reasonably, because that government department only knew about the people that it provided funds to.

Ms Halton: Exactly.

Senator BOYCE: What I want to know here is: in terms of emergency health planning, is there any system by which you know about people?

Ms Halton: No. That is the bottom line. It is an absolutely fair question to ask how, if people chose to register themselves in some way, shape or form—if they were a person with caring responsibilities or what have you—you might provide a whole-of-community view about who might need assistance in the first instance. I think that is a fair question to ask. But the reality from portfolios like this is that we have a segmented view in our portfolio because we deal less directly with individuals other than when we have benefit relationships. We do not have that direct relationship.

Senator BOYCE: But you assume that, if we were to come up with something where we would only ring you if it were really serious, it would have to happen at a national level?

Ms Halton: Yes. I do not disagree with that, but at the end of the day we have strayed into things which are not our responsibility.

Senator McLucas: Senator, I think you did the right thing by going to Emergency Management through the AG's office.

Senator BOYCE: But you have to register there, and we are talking about perhaps groups that would not have the ability to register.

Senator McLucas: My experience in local government is that it is the local government authority that develops the local disaster management plan and that an element of that local disaster management plan is the identification—when I was in local government—of vulnerable people. In many cases—I do not know if all, but in many cases—that work is outsourced, in my experience, to the Red Cross. The Red Cross, in the case of the Cairns City Council, when I sat on the Cairns City Council, ran a register of what they called vulnerable people. That ranged from identifying a residential aged-care facility without naming the residents in that facility, through to homeless people and how they could be contacted in the event of a cyclone, through to people who were receiving HACC programs, by name and address, so that, in the event of a natural disaster, we had a register of people. That was the case in the mid-nineties when I was on the disaster management planning group of the Cairns City Council. That has undoubtedly been updated and improved since those times—

Senator BOYCE: I am not suggesting—

Senator McLucas: but local government I think is where you would go to find the response to that group of people we identify as being vulnerable. Can I say that there has been some commentary in Queensland media about groups of people that were not contacted.

Senator BOYCE: Yes.

Senator McLucas: I tracked that down and tracked it down until I got to the point where the person making the allegation was contacted by the head of the police and by the head of Emergency Services in Queensland. It was not found to be accurate. The request was that the department provide the names and addresses of people with disabilities to that community organisation. That is, of course, highly inappropriate and of course could not be done, but the allegation of people not being supported could not be substantiated.

Senator BOYCE: This is in regard to people with disabilities?

Senator McLucas: It was.

Senator BOYCE: I will certainly check my source and see if we are talking about the same thing. Perhaps we could have a bit of a chat later.

Senator McLucas: Sure. I would be happy to.

CHAIR: Senator Furner, you have 10 minutes.

Senator FURNER: Just concentrating on the Queensland floods and Cyclone Yasi: the government, I understood, commenced or activated the health incident room and pharmacy arrangements. At what stage did they do that? When was the green light thrown to activate that system?

Ms Halton: The green light on the incident room was thrown extraordinarily early—and we would probably have to take on notice precisely when it was—as indeed was the green light in relation to the pharmacy arrangements. One of the habits we have is flicking the

switch on the incident room probably earlier rather than later on the grounds that it is better to be overprepared than under. I do not know whether one of the officers has the actual date.

Ms Bryant: I do not have the date with me, but I believe it was within the first 24 hours for both events.

Senator FURNER: Naturally, that would have been the same throughout the state—because 90 per cent of the state was affected by floodwaters—starting from somewhere prior to Christmas and then going through to January. And then we had the cyclone, of course.

Ms Bryant: Yes. We activated the incident room in respect of the Queensland floods at the time of the flooding in the Lockyer Valley and Brisbane.

Senator FURNER: And that was the most severe part of the flooding, of course. No doubt there would have been people that lost their prescriptions and had no access to pharmacies. They would not have been able to renew their prescriptions. They would have been in all sorts of terrible situations. What were the department's results in terms of resolving some of those major issues?

Ms Bryant: We had a number of issues that we were managing and coordinating a response on. In the case of pharmaceuticals there are provisions that allow pharmacies to provide prescription drugs on a short-term basis—with a script subsequently owing. Where pharmacies were inoperable we gave them permission under the legislation to operate from a different location. The wholesale pharmaceutical supplier in Brisbane was inundated and we coordinated arrangements with other pharmaceutical suppliers to ensure continuity in the pharmaceutical supply chain and so on.

Equally, doctors were affected by the floods. We arranged for doctors to be able to operate from different locations and provide additional assistance on a short-term basis. We allowed doctors who did not normally provide services in these locations to practise there. We have already discussed some of the mental health services that we did. In the case of aged care, where facilities needed to be evacuated we worked with our providers to ensure that we coordinated arrangements for the locations where residents of residential facilities et cetera could be relocated on a temporary basis until their facility was habitable and they were out of danger.

Ms Halton: There was a lot going on.

Senator FURNER: I realise that.

Senator McLucas: There was a lot going on in Queensland too.

Ms Halton: Yes, everywhere.

Senator FURNER: There still is. On that response about the different locations for pharmacies: up in areas like Esk and the Lockyer Valley, people were isolated during that time. Naturally, people could not access their pharmacies because they were inaccessible; some were still flooded or affected. What occurred in that respect?

Ms Bryant: During that time we had consulted with what we call our GP roundtable, which comprises the AMA, the AGPN—the main medical associations—and so on. We also consulted with pharmacists and so on. We were advised in the course of those consultations that emergency services workers in Queensland performed an invaluable service. Where they became available that people needed their prescriptions and so on, arrangements were made

and those workers generally delivered pharmaceuticals to people in their locations, even those who are cut off.

Senator FURNER: There must have been a huge communication avenue between residents that were affected, and these communication workers got their prescription to them.

Ms Bryant: Yes. It was a network, I understand, of emergency services on the ground liaising in some cases with the Queensland state government coordination centre and so on. There was a whole network of communication working, but I understand that in practice they were physically delivered by emergency services workers.

Senator FURNER: Is there any chance of identifying how many engagements occurred in terms of the supply of pharmaceuticals? Has that been documented at this time?

Ms Bryant: Not by us. I am unaware of whether the Queensland government, as the employer of some of the emergency services workers, would have some data on that, but we have no data that we can provide on that issue.

Senator FURNER: Is there any other comment you like to make in terms of the activation of the health incident room and pharmacy supply? Is there anything beyond what you have already explained?

Ms Bryant: No, I do not think so. The detail of the arrangements and exactly how they work is, of course, governed by legislation which is measured by our colleagues in the Pharmaceutical Benefits Division. If you want detail about exactly how the legislative provisions work, they could help you on that. But I think I have highlighted the major things—the wholesale chain pharmacies' delivery of prescription medicines.

Dr Lum: There was the issue of removing the authority prescription requirement for Ciprofloxacin at the time because of the risk of waterborne infections.

Senator BOYCE: That is the one that I was thinking of.

Dr Lum: In that particular part of Queensland there are quite a number of bacterial infections that can be quite nasty during a flood period. Ciprofloxacin is an anti-microbial which is quite effective for some of those infections but not all of them.

Senator FURNER: What other skin infections would have been prevalent?

Dr Lum: The main protection you would worry about—and this is why Ciprofloxacin was taken off the authority—is infections called by *Aeromonas hydrophila* and *Aeromonas sobria*. But there are also infections caused by—

Senator BOYCE: You had better tell us what that means. Is there a common term for that?

Dr Lum: Soft tissue infection of the skin caused by waterborne infection. There is also *Melioidosis*, a disease caused by *Burkholderia pseudomallei*, which can occur in that part of the country. And there is also my favourite bacteria, *Chromobacterium violaceum*, which can cause a really nasty skin infection with abscesses. It is one of the most beautiful bacteria in the world!

Ms Halton: What colour is it? That is categorically showing off, can I just say!

Dr Lum: It ranges from a very light lilac through to almost black. Queensland is well known for its knowledge and research on *Chromobacterium violaceum* infections, particularly

from the Brisbane floods of 1974—when people were carrying things such as old carpet on their shoulders they would get these infections and nobody knew why. So, with the current floods, we were very concerned that we make people aware—particularly general practitioners and emergency departments—that these types of infections could occur.

Senator BOYCE: I am impressed that that corporate knowledge stayed around that long.

Dr Lum: I was a medical student at the time.

Senator BOYCE: Well done! Otherwise it could have taken us two or three months to work that out.

Senator FURNER: Ms Bryant, you indicated that they were quite a lot of cooperation with pharmacy partners. Were you working in cooperation with the Pharmacy Guild?

Ms Bryant: Yes, I believe so. Our colleagues in Pharmaceutical Benefits did the day-to-day liaison with them but, yes, that included the Pharmacy Guild.

CHAIR: Thank you very much to the officers. We got more than we asked for, Dr Lum! We now move to outcome 13, which is acute care. Senator Fierravanti-Wells, would you like to kick off?

Senator FIERRAVANTI-WELLS: I have some questions on blood and organ donation. They are coming after acute care, so I will leave that until the end of proceedings. Yesterday, Ms Flanagan, I was asking a question about the $1.6 billion in last year's budget to fund the capital and recurrent costs of the 1,316 additional acute beds. What has been the outcome thus far?

Ms Flanagan: We can run you through where we are up to on that. The jurisdictions have all put in proposed implementation plans. The large majority of the plans, both subacute and also elective surgery and EDs, have been approved—about $2.2 billion of the $3½ billion has been approved. Ms Smith or Mr Thomann can give you the actual breakdown of what has been approved for the subacute beds and give you an idea of the sorts of implementations that the states proposed around—

Senator FIERRAVANTI-WELLS: So we have got stats as to where the approvals are at on a state-by-state basis, but we are not rolled out yet?

Ms Flanagan: They are starting to roll out. The funding has been flowing for a year and a bit. So we can give you a bit of an idea about, for example, palliative care beds et cetera.

Mr Thomann: We have approved implementation plans across the states and territories to the value of some $2.3 billion out of the $3.4 million. The subacute IP is a substantial part of that.

Ms A Smith: We do not have the table for subacute on its own. We would have to take that specific number on notice.

Senator FIERRAVANTI-WELLS: It is probably best if you could provide to me the total number of beds, what has been rolled out and what is operational—a state-by-state breakdown. I think I heard Ms Smith took about palliative care and some others. You could give us the type if you do not mind. Thank you. Is there a timetable for each state until 2013, or are we talking about only the next year or two?

Mr Thomann: It is over the full life of the NPA.

Ms Flanagan: Just to clarify: some states and territories have only put in a one-year plan—for example, the ACT—but New South Wales has put in a four-year plan. So some of the states and territories have approached this slightly differently. We can give you that sort of detail.

Senator FIERRAVANTI-WELLS: You may have seen an article in the *Daily Telegraph* headed 'Hospital chairs counted as beds'. Perhaps I could get a copy made of that. My question is in relation to that article and an article quoting Minister Roxon, so in fairness I will wait for that copy to be made. Senator Adams may want to fill in the time while I wait for that.

CHAIR: Do you have some questions, Senator Adams?

Senator ADAMS: What guidelines will be followed by the National Health Performance Authority for measuring the performance of smaller hospitals? We will look at rural and regional hospitals. Given the commitment that they will not have Casemix funding, what formula will apply to the funding of the smaller hospitals? The last question is: how will the department ensure that the community service obligations of smaller hospitals are allowed for?

Ms Halton: Senator , we did the reform stuff under whole-of-portfolio.

Senator ADAMS: I know.

Ms Halton: What I can say—I apologise for the level of generality—is that you know that commitments have been given in relation to small hospitals and community service obligations, and once the authority is in place, all of those issues will be clearly part of their remit. But until we get to that level of detail I cannot speculate, other than to tell you as a matter of principle that the issue will be absolutely considered.

Senator ADAMS: That is good. I will ask next time where we go.

Ms Halton: Fair enough.

Senator ADAMS: This is a funding question. What proportion of the funding under the National Healthcare Agreement for subacute hospital beds, elective surgery and emergency departments has gone to regional, rural and remote areas? Are figures on spending on public hospitals available by the ASGC-RA remoteness areas and, if so, what do they show about the relative stresses on emergency departments in regional hospitals as distinct from those in the major cities? We would be looking at regional places like Alice Springs and places like that.

Mr Thomann: Senator , I think rather than the National Healthcare Agreement you are referring to the National Partnership Agreement on Improving Public Hospital Services.

Senator ADAMS: Yes, probably.

Mr Thomann: We are not able to give you a breakdown across the whole NPA, but if we took it on notice I am sure we could give you indications where states have indicated in their implementation plans where specific projects are of a regional nature.

Senator ADAMS: Thank you.

Senator FIERRAVANTI-WELLS: Ms Flanagan, I think you have a copy of two articles. One is a *Daily Telegraph* article dated 16 May and the other is an article in the *Australian* dated 19 November 2010. The article in the *Australian* quotes Minister Roxon saying that New South Wales should provide an extra 450 beds under the COAG arrangement and they

have started and a number of those are now operational. Then on 16 May there is an article in the *Daily Telegraph* which starts off 'Cots, bassinettes and dialysis recliner chairs are being counted as "beds" to fudge the books on the real numbers of hospital beds. There are only 11,800 acute beds available for admission from emergency departments, not 22,000 as claimed.' It then goes on in that report to make other comments. It also says, 'As part COAG agreement with the federal government, New South Wales should have had an additional 439 beds already opened.' I am concerned that Minister Roxon is implying on 19 November that 450 or at least a part thereof were operational, whereas here I think we are still talking around that same figure—439 or around that; we are talking the same beds. This article seems to say that this includes cots, bassinettes and dialysis recliners. Can you compare and contrast those two comments and give me some guidance.

Ms Flanagan: This is sort of like a debating topic more than a—

Senator FIERRAVANTI-WELLS: No. In parlance, I understood 'bed' to be 'bed'. I think that under the COAG agreement—Ms Flanagan, confirm or correct me if I am wrong—we are talking about a normal hospital bed.

Ms Halton: Senator, let us be very careful about this. We have already had the discussion about the AIHW, which is the only place in the country that has an actual definition of bed, because it is actually pinned off the international standard. I think we discussed the fact that each jurisdiction has a different way of defining. The truth of the matter is there are a number of things about a bed as defined by jurisdictions which are in common: (1) mostly, they are admitted; and (2) they take an individual. The truth of the matter is all of that goes to capacity. So what we are actually talking about and what the minister has been talking about here is increased capacity. I think we should be careful that we understand we are on about increased capacity of the acute care system to deliver acute care services. Yes, you are quite right. There is all manner of debate that could be had about cots and bassinettes—though most of the parents I know think cots and bassinettes are actually beds. Certainly in my life and with my children, when they were that age, when they fitted in one, they certainly qualified as beds. There is certainly a debate about chairs—I accept the point. But we are talking about acute capacity. I think we should not get hung up on the fact that one jurisdiction defines one way and one jurisdiction defines another way. We are on about increased acute care capacity and we all acknowledge that each of the states has a different definition. But it is consistent within their jurisdiction.

Senator FIERRAVANTI-WELLS: So for all intents and purposes that 1,316—correct me if I am wrong—could be whatever the variation is of a 'bed' around the countryside. So it could be cots, bassinettes, chairs et cetera.

Ms Flanagan: On the subacute care beds, under the national partnership agreement, one of the things that we asked to have occur was a definition of the baseline of what a subacute care bed was.

Senator FIERRAVANTI-WELLS: A definition?

Ms Flanagan: An actual definition that all of the states and territories agreed on so that we could measure the growth in subacute care beds. But if you look carefully at the national partnership agreement, it talks about beds and bed equivalents, because a lot of subacute care services are actually done in the community and so we are also trying to find a way of

encapsulating the care or the capacity that the subacute care sector is increased by. We are using a proxy of a bed measurement to do that. The states and territories came up with a definition. We had an independent consultant look at that. We found that it needed some further work and I think we currently are about to sign a contract with another consultant that we will employ at the Commonwealth level to come up with an agreed definition of what beds and bed equivalents are in the subacute care sector.

Senator FIERRAVANTI-WELLS: How is this 1,316 going to be divided? Do we have any agreement about that?

Ms Flanagan: Again, there are targets set out in the national partnership agreement, I think by state and by year.

Senator FIERRAVANTI-WELLS: Is that mark 2? I was reading it on a plane the other day. I do not know what the man next to me thought!

Ms Flanagan: It is very interesting reading, Senator.

Mr Thomann: We have a breakdown by state, Senator. I could read that out if you like.

Senator FIERRAVANTI-WELLS: Yes, thank you. If it is somewhere where it was published then I have obviously overlooked it.

Ms Flanagan: But, Senator, note again that these are beds or bed equivalents. We are using it as a proxy to measure increased capacity in the subacute sector.

Mr Thomann: You will find the numbers in schedule E of the NPA. Schedule E refers to subacute beds. But, for the purposes of explaining the 1,316 figure, on page 45 it shows the beds by state and by year. In summary, New South Wales will have 428 beds. Queensland's target is 265. Victoria's is 326.

Senator FIERRAVANTI-WELLS: Which schedule did you say?

Mr Thomann: Schedule E, the schedule which is described as the new subacute beds guarantee funding schedule to the NPA.

Senator FIERRAVANTI-WELLS: Was it part of the agreement?

Mr Thomann: It is the schedule to the agreement.

Senator FIERRAVANTI-WELLS: No, I do not have that.

Ms Flanagan: It makes interesting reading, too, if you are on a plane.

Mr Thomann: It is a fascinating document. We live and breathe by this document.

Senator FIERRAVANTI-WELLS: You can give me a signed copy, Ms Flanagan! Sorry, I am just being facetious.

Ms Halton: There was not a touch of irony in what he just said then—I am impressed!

Mr Thomann: This is a neat little table here which explains it, which we can provide.

Senator FIERRAVANTI-WELLS: Just give me a photocopy, thanks, rather than reading it into the record.

Mr Thomann: Okay.

Senator FIERRAVANTI-WELLS: I have finished my questions on subacute beds.

Senator ADAMS: I have some questions on multipurpose services under the subacute care capacity.

CHAIR: Go ahead, Senator Adams.

Senator ADAMS: With the multipurpose services I note that the government will provide capital funding for states and territories to establish 286 new subacute beds or bed equivalents in the multipurpose services. How does one apply for a bed or is it the state government that actually allocates them to the multipurpose services? What is the process?

Mr Thomann: This program is for 286 additional beds. They are to be the subject of a national partnership agreement. The states will submit implementation plans under that NPA and, through that process, the relevant MPSs which will benefit from these additional beds will be identified and agreed between the Commonwealth and each state and territory and the Northern Territory.

Senator ADAMS: So there is not a funding round or anything like that. It is state health that decides where they go.

Mr Thomann: Yes, it is in relation to the MPSs within their health network, and they will identify where their needs are. We will agree where the beds that are allocated to each state are to be located.

Senator FIERRAVANTI-WELLS: Those subacute beds cannot be used for aged care?

Mr Thomann: No, they are for subacute services.

Senator ADAMS: I was just thinking about the older people coming out of hospital going in to rehabilitate before they go back to where they have come from. My other question is on dental services. How much has been spent on Medicare chronic disease dental scheme annually since its inception?

Ms Flanagan: Senator , I think this is a different program outcome—I think it was 3.

Senator ADAMS: We were told dental was in 13 and I read through it and thought I did not know whether—

Ms Flanagan: Also there are questions that were asked in outcome 12 in the workforce area last night. It might be worth while if perhaps we give you a bit of a map for the next estimates.

Senator ADAMS: I think that would be a wonderful idea.

Ms Halton: So we did actually answer some questions on this last night, Senator Adams.

Mr Thomann: And I think we took that question about the annual expenditure on notice.

Senator ADAMS: I had a few others, but I will put them on notice.

Mr Thomann: I was only able to give an aggregate figure last night.

Senator FIERRAVANTI-WELLS: In Budget paper No. 2 on page 226, under 'National Health Reform Agreement—change in payment arrangements'—for changing from reward payments to facilitation payments—it says:

The Government will bring forward $80.0 million … for elective surgery … changing these from reward payments to facilitation payments.

Can you explain that change? Why have reward payments for meeting emergency department targets been changed to facilitation payments?

Ms Halton: It is quite a simple equation, Senator. As you know, a number of these arrangements were structured with both facilitation and reward and there was a debate, a negotiation, about what the balance between what facilitation and reward was. This one changed.

Senator FIERRAVANTI-WELLS: Is this another one of—

Ms Halton: Simple—it changed.

Senator FIERRAVANTI-WELLS: What is the status of the targets for treatment in emergency departments which were to start phasing in from 1 January?

Ms Flanagan: Again, at the COAG discussion in February it was agreed—and you will see it both in the heads of agreement and also in the national partnership—that an expert panel would be set up to look at the timing and phasing of both the elective surgery targets and the emergency department targets. Professor Baggoley is starting to liven up because he has actually been appointed as the chair of the expert panel. A number of other members have been appointed—I think six members in all from various jurisdictions. There is currently a consultation process underway. Professor Baggoley might like to give you a bit more colour and movement.

Prof. Baggoley: Colour and movement—we will do our best. The expert panel comprises six members—Julie Hartley-Jones from Queensland, who heads the area health service based in Cairns; Associate Professor Brian Owler, a neurosurgeon from Westmead Hospital; Dr Michael Grigg, a vascular surgeon from Melbourne; Ms Heather Wellington, who is a health systems expert, hospital administrator and lawyer; and, Dr Mark Monaghan from Fremantle Hospital in Perth, who is an emergency medicine specialist. He has been leading the four-hour rule implementation there and at the moment is heading up their statewide effort for that. I am the sixth member. We were announced three weeks ago today. The group has met on two occasions and will meet next on 8 June and then 15 June. We have been to four capital cities—Sydney, Darwin, Perth and Adelaide—where we have had I think 11 consultation sessions across those areas. We are starting off again tomorrow, going to Brisbane, then Melbourne on Thursday and Hobart on Friday. We will finish the jurisdictional visits with a meeting in Canberra on Monday. We are meeting with peak groups on Wednesday, 8 June. The organisation and response of the jurisdictions to our visit has really been of a high order and there has been a lot of enthusiasm and willingness to meet with us and also a great willingness by all concerned to improve the quality of health care in emergency elective surgery and emergency department care and an understanding that the task is not trivial, that in fact whole-of-hospital processes will need to be altered. I have been very heartened by the response we have had. We also have the written consultation process which started on 5 May. That will now go through until 10 June. We have to have our report to COAG by 30 June, so effectively we will really have to firm up our recommendations in the week between 8 and 15 June.

Senator FIERRAVANTI-WELLS: There has been a lot of criticism about the four-hour rule. There have been a lot of media reports and comment by various people and various groups. Will you be proceeding with this part of the reform?

Ms Flanagan: That is yet to be decided by COAG, certainly in terms of the timing and phasing of it, but I do not think at this stage, depending on the advice of the expert panel,

there is any desire to move away from that. Professor Baggoley mentioned Dr Mark Monaghan, who is an ED physician from Western Australia. Western Australia has shown in the last two years it can actually do this, and I think it has its clinicians on side. The four-hour target in effect drives whole-of-hospital system change in order to be able to meet that, because you need discharge policies lined up, you need admission policies lined up et cetera. I think the statistics are that they were at 60 or 70 per cent in terms of meeting that four-hour target. Some of the big hospitals are now at 86 or 90 per cent, and also admission to hospital has gone from, again, 50 or 60 per cent down to 11 per cent waiting more than eight hours for admission. There is a state that, even without this NPA, has taken on this change and is actually delivering it.

Senator FIERRAVANTI-WELLS: Is the expert panel, Professor, that you are chairing only in relation to the four-hour target, or also the elective surgery targets?

Prof. Baggoley: It relates to both.

Senator FIERRAVANTI-WELLS: Ms Flanagan, can you repeat the answer to your question before about timing and phasing. You are still committed to the four-hour commitment and the elective surgery targets?

Ms Flanagan: Governments have signed up to those targets again. It is more around how one might arrive at them that they have asked the expert panel to look at.

Senator FIERRAVANTI-WELLS: It has been signed off in the 13 heads of agreement, but there is no actual agreement about them because that component of it has now been given to Professor Baggoley for him to report to COAG, and then there may or may not be an agreement about it.

Ms Flanagan: Certainly the timing and phasing are the terms of reference that have been given to the expert panel, not the targets themselves.

Senator FIERRAVANTI-WELLS: What about the targets themselves for the elective surgery?

Ms Flanagan: They have been signed onto again.

Senator FIERRAVANTI-WELLS: Was the implementation stage for elective surgery to start in July-September last year?

Ms Flanagan: There are periods of assessment that go from December to December.

Senator FIERRAVANTI-WELLS: It did not start then.

Ms Flanagan: What may have happened is that I think in the national partnership we are getting the funding out, so we started providing funding in 2009-10 under the national partnership agreement, but in terms of assessment for reward payments and also collection of information to measure how people are going, there are different time periods specified in the agreement.

Senator FIERRAVANTI-WELLS: Can you explain that for me?

Mr Thomann: Basically, working from the national partnership agreement, with the elective surgery target for the states and territories the states are required to improve elective surgery performance so that 95 per cent of urgency category 1 and 2 patients waiting for surgery are seen within the clinically recommended times by 31 December 2014 and 95 per cent of urgency category 3 patients waiting for surgery are seen within the clinically

recommended times by 31 December 2015. We can give you a table which sets out the percentages—

Senator FIERRAVANTI-WELLS: I am still working on the times here. Am I behind the times with the yellow book?

Mr Thomann: No, not at all. The NPA has what looks like chemistry tables that show percentages for final targets and interim targets that at this stage have been committed to. We would be happy to photocopy them for you.

Senator FIERRAVANTI-WELLS: You can even give me a little booklet—

Mr Thomann: I think I might actually give you my little booklet, but it might have all my cheat notes in there. Maybe we will just photocopy it!

Senator FIERRAVANTI-WELLS: Going back to this four-hour rule, it has been a point of contention. It certainly should have been in the implementation phase by now.

Ms Flanagan: Senator, it is—it is being implemented as we speak. The expert panel is actually looking at the measurement of it, but the fact is, if I can quickly find the figures, a deal of money has already been provided to the states and territories with regard to their implementation plans. They are upgrading ED departments, for example, and/or looking at the way their pathology is processed or whatever. The Commonwealth has provided money under the NPA for them to invest in improving capacity in the system. That is already up and running.

Senator FIERRAVANTI-WELLS: But what about actually making sure that they deliver on the four hours?

Ms Flanagan: The reward funding actually starts to occur in 2011-12. The reward funding does not actually kick in until further on in the agreement because we want the states and territories to invest first so that they have the increased capacity to achieve the targets.

Senator FIERRAVANTI-WELLS: The four hours has been the subject of discussion here—you can turn up at emergency and there maybe an alternative; in other words you might be sent off somewhere else and then the four hours can start again. Is that still on the table, Professor Baggoley, in terms of what the actual four-hour target constitutes?

Prof. Baggoley: The four-hour target constitutes the time between a patient arriving at an emergency department and leaving the emergency department. There would be a very small proportion of patients who would be transferred to another hospital. For some of them, they may not go directly to a ward; they may go to an emergency department. When we are looking at the number of emergency department attendances across the country, that really would be a very small number. We are focusing on the vast majority of patients that arrive and are treated and managed in the one emergency department.

The point of contention of this is whether this is achievable. As Ms Flanagan pointed out, what we have seen in Western Australia is both real and influential. Certainly two years ago those working in the hospitals there and those working in the emergency departments felt it would not be achievable. Our understanding is it has been achieved by really looking at hospital process redesign and by clinicians taking this on as an important quality initiative, and people have worked remarkably well together.

As has also been pointed out, one of the key markers of success and one of the key reasons for doing this is to reduce the harm, and even the death, of people who spend a long time in emergency departments. That is called access block. Certainly for the major hospitals in Perth—Sir Charles Gairdner, Royal Perth and Fremantle—they were running about 50 to 60 per cent of their patients within eight hours in their emergency department. That is now down to 10 per cent, with 90 per cent of the patients, certainly at Royal Perth and Fremantle, getting through their ED experience within four hours. They have quality measures that they are following to make sure there are no unintended consequences for the patients, and they are also paying good attention to their elective surgery and their emergency surgery performance as well. That this is happening in a significant jurisdiction in our country is really influential, as I said.

Senator FIERRAVANTI-WELLS: Ms Flanagan, the funding has been flowing for several years now. What are the results? Are we measuring them?

Ms Flanagan: We have been measuring elective surgery and ED targets for a while now. That is part of the work of the CRC, for example, and also at the Commonwealth level we have been publishing a publication called *State of our public hospitals*, which shows what is actually happening. Under a previous agreement on elective surgery we had a number of different measures—looking at the median wait time, looking at the long waits.

Senator FIERRAVANTI-WELLS: Now you are putting it into that one state of the hospitals report?

Ms Flanagan: That information is also available through AHW, so it is available through a range of forums. It is also the sort of thing being published on the My Hospitals website.

Senator FIERRAVANTI-WELLS: So it is on the My Hospitals website?

Mr Thomann: The AHW produces two publications, one is *Australian hospital statistics*, which has just been released, last month as I recall, and there is a compendium to that, *Hospitals at a glance*, and that information is now summarised on the My Hospitals website. When you go to the website, it is presented in a summary fashion but the links are then made between that summary of national information and each hospital's performance information.

Senator FIERRAVANTI-WELLS: So that website will tell me where the emergency departments are at, what the results are and those sorts of statistics?

Ms Flanagan: Yes

Ms Flanagan: Again, just to be clear on emergency departments, the only thing we are measuring at the moment is the wait time before you are actually seen.

Senator FIERRAVANTI-WELLS: Which was the object originally—from the time arriving in the emergency department to the time seen.

Ms Flanagan: That is right.

Senator FIERRAVANTI-WELLS: And that is what these payments that have been made over the past two years have been for—come in and be dealt with within four hours. That is putting it in a nutshell.

Ms Flanagan: That is what occurred previously. Under this particular agreement the new target is four hours from the time you actually present at the emergency department until the

time you actually leave the emergency department, with treatment included. You are admitted to hospital, discharged or sent somewhere else—hopefully not to the morgue!

Senator FIERRAVANTI-WELLS: Having recently tested the system myself recently, I can assure you that it was a lot longer than four hours.

Ms Flanagan: Indeed, and that is why we have set a target and we are hoping to see improvement.

Senator FIERRAVANTI-WELLS: I sincerely hope I do not have to retest it in circumstances like I experienced recently. Going back to the payments, how many new emergency departments have been revamped? What are the statistics in relation to upgrades? Is that also contained on the website?

Ms Flanagan: That level of detail is not. We can probably give you some detail about what the states and territories have proposed to spend under this particular national partnership and the implementation plans.

Senator FIERRAVANTI-WELLS: So the money has been flowing for a couple of years now—can we show where that money has been spent?

Ms Flanagan: The money really has only been flowing for a year. The NPA was signed in July last year.

Mr Thomann: Senator, we would be able to summarise for you, if we take it on notice, the numbers of emergency projects which have been approved under the implementation plans, under that schedule.

Senator FIERRAVANTI-WELLS: What I am looking for is this. You have handed over x dollars—what have we got in exchange for x dollars? What has improved as a consequence of this money flowing through? The states have been getting funds and we would like to know where the money has gone. This has been a perennial problem in terms of the states, so we need to see the data on what has been bought for the taxpayers of Australia. If that is contained on a website somewhere that is fine; otherwise, can you take it on notice.

Mr Thomann: We will take that on notice.

Senator FIERRAVANTI-WELLS: There is an article in the *Courier-Mail* I will refer to in a minute. Would the status of the limitation of the targets for elective surgery access be contained in the information that we talked about before? In any case, can you provide me with some statistics in relation to elective surgery.

Ms Flanagan: Yes.

Senator FIERRAVANTI-WELLS: There has been criticism about manipulation of the statistics, so how can we at the Commonwealth level guarantee that our funding to the states will achieve the required outcomes?

Ms Flanagan: Again, there are agreed definitions about how we actually count at the moment. There is some state variation, and states admit this. In terms of the issue that has been identified in this article in the *Courier-Mail*, there have been discussions at state and territory level about how we can actually measure something different, which is in effect the time, for example, a GP or somebody at the front end makes the decision that somebody might need surgery through to the time that they actually have their surgery. It is a different measurement period. I think there is a disposition but that is probably a better way to measure

people's experience from the time that it is first diagnosed through to supply. But what that will do, of course, is to completely change the parameter on which you measure. At the moment all we are doing is measuring from the time it is decided to list somebody for surgery. So we agree that this is an issue—there is a disposition to look further at it and there has been some work done—

Senator FIERRAVANTI-WELLS: There are two aspects, really: there is the definitional aspect and then there is the manipulation aspect.

Ms Flanagan: If we were to go to a different definition, the manipulation aspect might be more difficult. But the thing is that at the moment we have an agreed measure. The states and territories have been reporting on that measure for a long time. We do see these reports that there is probably some manipulation around the edges but at the moment it is the measure that we have, it is the measure that the states report on and it is the comparative measure we need to use.

Senator FIERRAVANTI-WELLS: There are 200,000 actually waiting to see specialists before they are placed on a waiting list, and just 32,105 actually listed on the waiting list. It is quite an example of where manipulation can occur.

Ms Flanagan: We are aware that manipulation can occur.

Senator FIERRAVANTI-WELLS: All right. So as part of this process you talked about the agreed definition variation. When is that going to happen? Is that part of this agreement?

Ms Flanagan: It is not part of this agreement. I will need to take that on notice to see where it is up to. I know that a year or two ago we were talking about trying to measure this in a different way. But I just need to take it on notice and we can get back to you with some details.

Senator FIERRAVANTI-WELLS: Thank you. I will put a few more questions about that on notice.

Ms Halton: For the benefit of Hansard, I have just had an email from Dr Lum who I think is feeling that maybe he rushed through some of those technical names. The spelling is m-e-l-i-o-i-d-o-s-i-s. But if you prefer, Hansard, you can refer to it as its common or garden name, which is Nightcliff gardener's disease. He was worried that he had been too exuberant and too quick for Hansard.

CHAIR: Thank you. We will take a break. When we come back we will look at organ and tissue donation, and then we will move to hearing services.

Proceedings suspended from 21:28 to 21:46

CHAIR: The committee will reconvene. We will go to questions in outcome 13 for the agency the Australian Organ and Tissue Donation and Transplantation Authority. I welcome the officers from the agency. Thank you for the information bags. Ms Cass, perhaps you could give us some information about those bags: where you use them, what is the process and how much they cost. Ms Cass, you have a large graph in your hand; are you going to be referring to that?

Dr O'Callaghan: I will be talking about that. I can let you have it. Copies will be distributed.

CHAIR: That would be fabulous. Ms Cass, do you have an opening statement before we go into questions?

Ms Cass: We have just prepared in case there are questions.

Senator FIERRAVANTI-WELLS: Please describe the graph to me. That is my first question.

CHAIR: Yes, what does that show? I am sure from previous estimates there have been standard kinds of questions. So that would be really good.

Ms Cass: I am delighted to explain the graphs to you.

Senator FIERRAVANTI-WELLS: Ms Cass has come to visit us with a different hat.

Ms Cass: I do. It is a different job.

Senator FIERRAVANTI-WELLS: I congratulate you.

Ms Halton: She looks very happy.

CHAIR: Congratulations on your appointment.

Ms Cass: I had an immense experience in PM&C. Now I am happy to be working on the implementation of a reform agenda. We have three graphs here that show outcomes achieved in terms of implementation of the national reform agenda to increase organ and tissue donation for transplantation. The first graph that you have there shows the increase in deceased solid organ donors. Basically the most important thing to note is that between 2009 and 2010 there has been a 25 per cent increase in the number of organ donors in Australia, and the increase over our baseline figure of the average of 2000 to 2008 is 51 per cent. The increase has continued in 2011. So in the year-to-date period to April 2011 there has been a 27 per cent increase in donor numbers over the comparable period in 2010.

Senator BOYCE: Do you have numbers on those?

Dr Cass: There are numbers. You should be getting copies of them.

Senator BOYCE: Okay.

Dr Cass: We can turn to organs transplanted, which is the outcome of the organ donation process, and there are two figures. We will start with the actual number of organs transplanted. In the period from 2009 to 2010 there has been a 16 per cent increase in the number of organs transplanted in Australia and a 37 per cent increase over the baseline. In the year to April 2011 we have seen a continued increase of 30 per cent compared to year to date April 2010.

The third slide shows how that data is then translated into the number of transplant recipients in Australia, where between 2009-10 there has been a 17 per cent increase in people who received transplants and a 32 per cent increase over the baseline. In 2011 there has been continued growth of 30 per cent in the year to date April 2011 compared to the same period to April 2010. The reason we wanted to show you this is to indicate that the national reform agenda is having an impact; it is not to say that we are resting on our laurels. There is much more work to be done to make sure that the increase is sustained.

Ms Halton: And that the increase continues.

Dr Cass: Yes.

Senator FIERRAVANTI-WELLS: I have a couple of articles that I wanted to give you because I just wanted to ask some questions about those. One of those was an *Age* article that talked about donor organs going to waste. You are probably aware of these articles. The other one was from the *West Australian* and talked about how hospitals take organs before brain death. I will start with the latter. I have raised concerns before about if this was happening. Can you just tell me a little bit more about doctors harvesting organs from donor patients before they are declared brain dead? That certainly seems to be what the article is referring to. Can you just talk me through that?

Dr Cass: I am very happy to talk about that. I will get our national medical director, Dr Gerry O'Callaghan, to talk you through donations after cardiac death.

Ms Halton: It is probably important to register a point before he talks. I think you have done a good service in the past in trying to get on the record some of the clarifications about the misinformation around this, but I would have to compliment the authority that we continue, regrettably, to see misinformation peddled about the facts about organ donation. So this is a welcome opportunity to clarify on the record why some of these allegations are false.

Senator FIERRAVANTI-WELLS: It was asked in that context. We were very careful last time to point out that we know that there are ethical issues surrounding this and that it is about encouraging people. But you are not going to encourage more people to donate organs, correct me if I am wrong, if there are ethical concerns about it and if they think they may not be dead when the organs come out of them. I think that scares people.

Dr O'Callaghan: I thank you for the opportunity to clarify this important issue. The confidence of the public in the ongoing successful medical treatment of end-organ failure through the process of transplantation is dependent upon the confidence of the public in the capacity for hospital doctors, as care specialists, to determine death in an appropriately rigorous and ethically sound way and for transplantation decisions about organ donation to occur following an appropriate determination of death, and this would include decisions about the appropriateness of life-supportive treatments and their subsequent withdrawal. So the particular article in the West Australian was ill-informed and that process has not occurred in Western Australia. It is not advocated by any professional college. It is proscribed by the ethical framework provided to us by the National Health and Medical Research Council in their publication and by the Australia and New Zealand Intensive Care Society—ANZIC—Statement on death and organ donation, third edition, which was published in 2008.

The process of donation after cardiac death is one which occurs when a life supportive treatment, such as mechanical ventilation or intravenous inotropic drugs which support blood pressure, are ceased after being deemed to be futile independent of any consideration of organ and tissue donation. That decision is made often by a different team supervised by a hospital process which includes a designated officer—appointed by the hospital and by the health department under the auspices of the minister—who is not involved in either organ donation, patient care or transplantation but who provides a governance or oversight of the process. Subsequent to that, consent is sought from families or surrogate decision makers for permission for organ and tissue donation to proceed, should that be the wish of the deceased. If any evidence can be found, such as a registration under the Australian Organ Donor Register, and should there be no specific objection registered in anyway, under such

circumstances, as permission is granted, organ and tissue donation can proceed following the determination of death and not before.

Senator FIERRAVANTI-WELLS: That will happen after the determination of death. If I am on the register that will not be known until after I pass away.

Dr O'Callaghan: Not necessarily, for example, if you had registered on the Australian Organ Donor Register. In the circumstances of donation after cardiac death, where a catastrophic brain injury which was not compatible with survival had occurred, or if an individual was not declared brain-dead—so they had not reached a state where there was no blood supply to the brain—under such circumstances there may be evidence of residual brain activity but not sufficient to be compatible with independent survival. Under those circumstances a decision would be made by the treating doctors—which would include intensive care specialists such as neurologists, neurosurgeons and allied health professionals—to cease cardiovascular treatments which were prolonging life but which were not in a position to reverse the underlying pathological process which had led to the person's incapacitation in the first instance.

Under such circumstances, permission would be sought by the treating team to cease these treatments. Were such permission granted, subsequent enquiries could be made about the suitability of that individual for organ and tissue donation. This would be prior to that person's death, but independent of it, and it would follow those decisions but not at the same time or proceeding those decisions. Subsequently, the Australian Organ Donor Register might be interrogated with the consent of family and decision makers in order to provide them with more information to make a decision about organ and tissue donation. That could precede death but it could not and should not occur prior to a decision made about the appropriateness of ongoing cardio-respiratory support.

Senator FIERRAVANTI-WELLS: The other article was about donor organs going to waste. This is on the other side of the spectrum. Dr Cass, do you have any comments in relation to that?

Dr Cass: I do. I am familiar with the *Age* articles on 24 and 25 May. The key thing to say is that there is absolutely no evidence that donated organs are going to waste in Australia. We know from the data that we just showed you, for example, that national donation and transplantation rates are increasing in Australia. The national results were that even in the four months to April 2011 we have seen a 27 per cent increase in donation rates and a 30 per cent increase in transplant rates. In Victoria, where this article derived, in the same period there was a 48 per cent increase in donation rates and a 53 per cent increase in transplant rates over the comparable period in 2010. So the data does not indicate that donor organs are being wasted: transplants are increasing at the same, if not higher, rate.

What we are doing is monitoring the impact of increased donation rates on transplant services. The national reform agenda is an agreed agenda between the Commonwealth and state and territory governments. The Commonwealth's investment is focused on ongoing and increasing the donation rates for transplantation. The states and territories are collaborating in the implementation of the national reform agenda. That includes a discussion and a commitment, even at the health ministers meeting in February, to look at proactive planning and resourcing for transplant services to match donation rates. So our indications are that

there is no impact on outcomes at the moment and that the states are on board with continued implementation of this national reform agenda.

Ms Halton: I have to inform you that I have misled the senators. It was not the minister who dropped her awards outside; it was the minister's chief of staff.

Senator McLucas: If the minister's chief of staff had a wheelbarrow because of all of the awards that the minister has been receiving, it would have been better.

Ms Halton: It might have been; I will offer counsel tomorrow.

CHAIR: I thank the officers from outcome 13. I thank the officers from the agency for the demonstration and the beautiful graphs. We will expect them to be updated for the next estimates.

Senator BOYCE: Can I just clarify the question on notice that I mentioned to you before?

CHAIR: Certainly.

Senator BOYCE: Ms Halton, one of the questions that I asked regarded the PBAC medicines and the deferral of the decision by cabinet et cetera. I asked about the costs involved in that, but it has since occurred to me that a better way to ask the question might be to ask, in view of each one of those medicines, what the calculated PBAC cost to the PBS for each of those deferred medicines was.

Ms Halton: Yes, and I think I said it was expenditure foregone. That is what we are going to do.

Senator BOYCE: Thank you.

Senator SIEWERT: On the FOI I was asking for previously, you gave us a list of the other departments and offices that had FOI requests. Are you able to provide the detail of who made those requests, or is that going to be too big a task? Would I need to ask each of the agencies?

Ms Halton: I do not have that.

Senator SIEWERT: Okay, at least I know which ones to go to. [22:04]

CHAIR: I welcome the officers. We are on outcome 7, Hearing services.

Senator SIEWERT: I ran into the minister today and I thanked him for the response. I am very happy that we got it before estimates.

CHAIR: Maybe you should clarify which response?

Senator SIEWERT: To the committee's report, *Hear us: inquiry into hearing health in Australia*. As I said, I did thank the minister and I thank the department for the work they obviously put into developing a response. I would like to go through some of the budget measures that are contained in the report. It might be easier if you just take us through them. As I understand it, there are some budget savings and I want to ask about those. What are the new measures?

Ms Morris: They are essentially changes to the CSO component, such as additional funding and extensions. I will let Mary McDonald cover it.

Ms McDonald: Do you want me to go through the budget changes or the key points in the Senate inquiry and response?

Senator SIEWERT: I think we will focus on the budget changes, if that is okay, because we can deal with some of the other issues later on.

Ms McDonald: There are two key measures in the health portfolio. One is improving access to hearing services, which affects the CSO—community service obligation—part of the program. There are two key features of the changes that were announced. The first one is an extension of the program to cover young people aged 21 to 26—that means to the end of their 25th year—to allow them to continue receiving services under the CSO component of the program. That allows for people who require both hearing aids as well as replacement processors for cochlear implants.

Senator SIEWERT: How much money has been allocated to that? Is that the $47.7 million?

Ms McDonald: There is $47.7 million and it has two components. One bit is to extend the CSO and that is $6.4 million. The other component is a re-basing of the CSO. There was a structural issue in the CSO program where it had a fixed amount of money and yet the population group that required services was growing in number, and also there were increasing numbers coming through from neonatal screening. So to ensure that that quite vulnerable group had access to services in line with growing population numbers, there is an increase in funding each year according to a growth formula for the program to keep pace with that growth.

The other component of the rebasing is a change in the technology costs over time, particularly for children receiving cochlear implants because the uptake of that technology has increased and we now have a lot more children with bilateral implants.

Senator SIEWERT: We have asked about that in the past.

Ms McDonald: So there is an adjustment factor in there as well that takes account of that growth, given that the processes are much more expensive than for hearing aids. Did you want to me to go through the other measure? That was the CSO one.

Senator SIEWERT: Yes.

Ms McDonald: The other one is better targeting services. That largely affects the voucher program. What will happen in that measure is that the existing arrangements allow for a voucher with a two-year validity period and that will be extended to three years. It will be extended for the cohort of people who receive vouchers from 1 January 2012 and they will be issued a voucher with a three-year renewal period. There is a suite of services, including regular servicing that goes with that voucher. If there are people who have a hearing loss at a greater rate and are required to come back earlier, there are exceptions that will allow those people to receive services. The reason for this change is that most people under the hearing program suffer from age related hearing loss, which is generally around one decibel a year. Most hearing aids have a 10-decibel adjustment on them. Within that the bulk of people can easily go through the program in a three-year cycle and, as I said, there are exceptions for people who would need services more frequently, as there are under the current two-year program.

Senator SIEWERT: So those same exception rules would apply?

Ms McDonald: Yes, that is correct. There are some other changes as well. There is going to be a modernisation of the system that Hearing Services operate under, including moving

the current manual processes onto automated systems, which will help both clients and providers, because we will be able to process things a lot faster. There will be a client portal, which will allow people to apply online instead of receiving a paper form, having to fill it out and send it back in. We will have a service provider portal, where we will be able to exchange information with service providers as well, and they will be able to validate client eligibility using that system. So it will take about 18 months to have all those things in place, but it certainly will be a much better system for both clients and for consumers.

Senator SIEWERT: In terms of the voucher system, that incurs a savings in the program, does it not?

Ms McDonald: That is right, because instead of churning that group of people through the program every two years. it will be extending it to a three-year period.

Senator SIEWERT: How much money does that save?

Ms McDonald: In total, a net saving of $122 million over the four years.

Senator SIEWERT: The letter and the minister's responses say that the More Support for Students with Disabilities initiative et cetera. I ask about that in FaHCSIA tomorrow, don't I?

Ms McDonald: Yes, that is FaHCSIA's.

Senator SIEWERT: I did notice it talks about hearing loops in classrooms. As you know there has been a lot of push and support for extending the availability of hearing loops through Australian Hearing Services. I am wondering how far that has been progressed.

Ms McDonald: I will hand over to Ms Ward, who heads up Office of Hearing Services.

Ms Ward: The DEEWR measure More Support for Students with Disabilities I understand includes some provision for hearing loops as well as support for teachers and other supports for students. Australian Hearing does not provide hearing loops. That is something for education departments and DEEWR.

Senator SIEWERT: I know. There has not been any progress there though, has there? That is the only measure that is available?

Ms Ward: Yes.

Senator FIERRAVANTI-WELLS: Senator Siewert has picked up the points I wanted to address. In addition to that, the government's response to recommendation 11 from the report, Ms Macdonald, talks about hearing aid manufacturing, distribution and private providers of hearing health services. I note it says that you will discuss the issues with key stakeholders. Have you given some thought as to how that is going to happen? What is your time frame in relation to actioning that item?

Ms Ward: We will be undertaking a round of consultations during June, July and August. The planned implementation strategy will be discussed and any factors that providers want to take into account while we are looking at possible transitional arrangements will be discussed at that time. General issues about viability and so on will be canvassed at that point.

Senator FIERRAVANTI-WELLS: We might look and see how you progress on that later. The other thing is DoHA will be the lead agency. I notice there are going to be a number of things that are across different portfolios but DoHA will be the lead agency in relation to implementation—

Ms Ward: Each portfolio agency will be responsible for the implementation that they have set forward here in the document.

Senator FIERRAVANTI-WELLS: So that will be coordinated, Ms Halton?

Ms Halton: We have the lead on this, so if anyone asks for an overarching view it will come from us.

Senator FIERRAVANTI-WELLS: Okay. In relation to research, at page 10 of the response it says: 'Through the 2011-12 budget the Australian government has provided additional funds for research into the underuse of hearing aids. The government will consider the proposed areas of research, including work with Menieres Australia.' Could you tell me a bit more about that?

Ms McDonald: There was money provided in the better targeted services component. That was the savings measure to invest in some of that work being done.

Senator FIERRAVANTI-WELLS: So the money is staying in hearing?

Ms McDonald: Yes.

Senator FIERRAVANTI-WELLS: Are all those savings measures going to research?

Ms McDonald: No, sorry, Senator, in terms of that component, the better use of hearing aids, under the savings measure one of the components of extra money that was provided was for that research.

Senator FIERRAVANTI-WELLS: How much is going into research?

Ms McDonald: Into the underutilisation of hearing aids, it is a million dollars.

Senator FIERRAVANTI-WELLS: We have talked about older Australians who get hearing aids and then put them into the top drawer. Some of them are older Italians, not mentioning any names!

Senator SIEWERT: And I knew an older Pom who did the same thing.

Senator BOYCE: And a third generation Australian!

Senator FIERRAVANTI-WELLS: We have been trying on this one for some time. We are obviously going to have to get a bit more innovative. Ms McDonald, are you going to give that some thought?

Ms McDonald: That is why we have the extra money; we are going to have a serious look at the issue.

Ms Halton: And can we all have a pact that when it is us we will not leave it in the top drawer.

Senator FIERRAVANTI-WELLS: The research into those things that young people put in their ears—

Senator BOYCE: That is the technical term!

Senator FIERRAVANTI-WELLS: It is my technical description. You are going to do some research into relation to that as well, Ms McDonald?

Ms McDonald: We have some money under the Hearing Loss Prevention Program and we are certainly encouraging applications from organisations that can do research in that area.

Senator FIERRAVANTI-WELLS: And then obviously you are going to have to be quite innovative in terms of, once you do that research, how you get that message across to another generation.

Ms Halton: That market segment, Senator.

Senator FIERRAVANTI-WELLS: I have one more question. You changed the minimum hearing loss threshold to over 23 decibels. We went through an inquiry and there were some issues there about whether that would disadvantage any people. Have we got any evidence that we have had people disadvantaged because of those changes? I think there was a provision there for special circumstances to look at if somebody fell or it was at the margins or something like that.

Ms Ward: There were a range of exemptions, including for people who currently have hearing aids and can continue to use them. They were an exemption. There were exemptions for people who have a loss at a particular frequency but normal hearing in other frequencies. That was an exemption. Tinnitus was another exemption. People who are blind and very reliant on their hearing was another exemption. We have not had complaints about people being disadvantaged. There have been lower numbers of new clients being fitted who have hearing of 23 decibels and lower, where their hearing is in normal range. But we have not had complaints. It seems to have been taken up well and people have been comfortable with it.

Senator FIERRAVANTI-WELLS: Thank you.

Senator ADAMS: Coming back to our inquiry, I was absolutely delighted that the eligibility age for students has gone up to be inclusive of their 25th year. We had some quite startling evidence with students trying to study and sharing hearing aids, more or less, and things like that. It was not good. What is the means test? It says here: 'Former child clients of Australian Hearing who do not meet the means test may have support on a fee-for-service basis.' What is the actual means is test?

Ms McDonald: The initiative that was announced does not have a means test in it. I know that the committee proposed that a means test be put in place. The reason that it does not is that it is only a very small group of people and no-one else in the CSO is means tested. It would have actually cost more than providing the services to administer a separate means test.

Senator ADAMS: I was not reading it properly. Okay, that is great. How many people do you think you will be dealing with extra?

Ms McDonald: Of the former child clients, 700 lose access to the program every year. It would be that across the four-year period. Then you will have a small increase from other people—new clients that would join.

Senator SIEWERT: That come on in that age group.

Ms McDonald: It is only a small number. It is under a thousand in each group.

Senator ADAMS: Recommendation 6 was on PATS. I note that it is for consideration by state and territory governments. But at least we do have the rural health standing committee working on a nationally consistent scheme. This is another problem for these people—trying

to get some support to travel to the cities from rural and remote areas for their testing. Thank you very much.

Senator SIEWERT: The response to a number of the recommendations was that it is for consideration by the state and territory governments. Where to from here with those? I appreciate why you are saying that. But the problem is that, yes, it is the responsibility of state and territory governments, and things are not happening.

Ms McDonald: For a lot of them we have also noted in the response that we would raise the matter with relevant state and territory government areas, and we will do that through the normal consultation mechanisms. So certainly we will be drawing it to their attention and having discussions about some of those issues.

Senator SIEWERT: I notice on some of the responses it says that and on some of them it does not seem to. Does that mean that will be a standard and it has just been left off or will there be some that are not?

Ms McDonald: Sorry, Senator , do you have a question about a particular recommendation?

Senator SIEWERT: For example, recommendation 8 says, 'While it is the responsibility of state and territory governments, the Australian government is doing this'—which is great, but then the next step could be, 'and we are also going to keep talking to the state governments'.

Ms McDonald: That is correct. That is in relation to the neonatal screening, and we have an ongoing dialogue with the state and territory governments and are working with them on that. So that is correct, we would.

Senator SIEWERT: So that one is already ongoing?

Ms McDonald: Yes.

Senator SIEWERT: Is that how I interpret that?

Ms McDonald: Yes, that is right. I suppose probably the difference you are seeing is that we may not have been as explicit where there is an ongoing dialogue. But in cases where maybe there is not one going on we have made a specific commitment to contact the relevant state and territory areas and raise the matters with them.

Senator SIEWERT: We made a series of recommendations around Indigenous hearing. I appreciate your comment when I asked about the sandfields there. We did make a specific recommendation about changing the act to enable Australian Hearing to provide sound loops. I understand your response and that is that it is the responsibility of state departments. But the federal government provides support for other educational activities that could also, in theory, be classified as state and territory responsibilities. This is a clear area that does make such a difference to hearing for Aboriginal students. We know that they are disproportionately impacted. I am going to keep pushing that one because I think it is an initiative that will make such a difference to Aboriginal students in terms of their overcoming this initial barrier to education. I am wondering what else you are planning in that space. I will jump on my bandwagon in a minute. It is all very well talking about it being a state responsibility. It is not happening adequately enough.

Ms Ward: It was my understanding, Senator, that DEEWR had funded some pilot programs in the Northern Territory and the top of WA with the state governments to put sound loops in and then test what difference it made to the students. I would have to confirm but I had thought that the DEEWR measure had partly come out of that work—so the measure that we mentioned in the inquiry which funds some of that.

Senator SIEWERT: Do I understand therefore that subsequent to that pilot the intention is to look at it again? Or is that my fanciful interpretation of what you have just said?

Ms Ward: I would have to check with DEEWR; I do not know.

Senator SIEWERT: Could you take that on notice?

Ms Ward: Yes.

Senator SIEWERT: I now want to go to recommendation 34, which is the issue around correctional facilities and doing hearing assessments of people in correctional facilities. I had a discussion with Australian Hearing Services last time, if you recall. I undertook to provide some information on the study of the Bandyup Women's Prison. I understood my office did forward that. I am wondering, subsequent to seeing that information, whether you are aware of any other work that is happening in Australia and whether there is anything specifically that the Commonwealth can do to push this particular issue along.

Ms Ward: I am aware that there have been other pilot studies in individual correction centres that have shown higher levels of hearing loss amongst Indigenous people in custodial settings, and that is similar to Indigenous people incarcerated in New Zealand and Canada as well. Children in detention of course are covered by our program because they are eligible. And people whose underlying eligibility under the voucher program is not affected by the term of their incarceration can also access services. Otherwise states are obliged under their own legislation to provide services to those people.

Senator SIEWERT: But they are not, and they are not even testing. I appreciate you have said you will bring it to the attention of state and territory governments. I have done that. I have not got very far.

Ms Ward: I appreciate what you are saying.

Senator SIEWERT: I am wondering what else can be done to actually drive this issue. Again, I think there is leadership required from the Commonwealth on this particular issue.

Ms Ward: It is something we could discuss with our OATSIH colleagues. They may have a network that could be used. We could see what avenues are available. I am not sure at this point what avenues they would be but I can certainly take that further, in discussion with them.

Senator SIEWERT: I am aware that I am crossing into issues that will be dealt with on Friday but it was part of our recommendation. I will probably pursue it a bit more strongly on Friday.

CHAIR: There being no further questions, thank you very much to the officers from outcome 7 and also for the receipt of the response to the report. It is very positive. Ms Halton, as always, thank you to you and your staff members for these two days. Thank you, Parliamentary Secretary, for being with us. Professor, you were not taxed too greatly in these two days, but we look forward to the next session. Thank you also to our secretariat for the

work they have done over this period and also to Hansard. We conclude hearings in the Health and Ageing portfolio. We will reconvene tomorrow at 9 o'clock to start questions on Families, Housing, Community Services and Indigenous Affairs. Thank you.

Committee adjourned at 22:30