COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Estimates

(Public)

TUESDAY, 30 MAY 2017

CANBERRA

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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Tuesday, 30 May 2017

Members in attendance: Senators Abetz, Carol Brown, Di Natale, Duniam, Farrell, Gichuhi, Griff, Kakoschke-Moore, Lines, Ian Macdonald, O'Neill, Polley, Reynolds, Siewert, Singh, Smith, Sterle, Urquhart, Waters, Watt, Xenophon.

HEALTH PORTFOLIO

In Attendance

Senator Nash, Minister for Local Government and Territories, Minister for Regional Communications and Minister for Regional Development

Department of Health

Whole of Portfolio

Mr Martin Bowles PSM, Secretary

Professor Brendan Murphy, Chief Medical Officer

Dr Tony Hobbs, Deputy Chief Medical Officer

Ms Alison Larkins, Deputy Secretary, Chief Operating Officer Group

Mr Mark Cormack, Deputy Secretary, Strategic Policy and Innovation Group

Mr Shane Porter, Assistant Secretary, Strategic Policy, Department of Health

Mr Andrew Stuart, Deputy Secretary, Health Benefits Group

Dr Lisa Studdert, Acting Deputy Secretary, National Program Delivery Group

Mr Paul Madden, Special Adviser, Strategic Health Systems and Information Management

Adjunct Professor John Skerritt, Deputy Secretary, Health Products Regulation Group

Dr Margot McCarthy, Deputy Secretary, Ageing and Aged Care

Mr Matt Yannopoulos, First Assistant Secretary, Portfolio Investment Division

Mr Craig Boyd, Chief Financial Officer, Portfolio Investment Division

Mr Charles Wann, Chief Budget Officer, Portfolio Investment Division

Ms Rachel Balmanno, First Assistant Secretary, People, Capability and Communication Division

Mr Robert Wright, Assistant Secretary, Ministerial, Parliamentary, Executive Support and Governance Branch, People, Capability and Communication Division

Ms Jodie Grieve, Assistant Secretary, Communication and Change Branch, People, Capability and Communication Division

Ms Donna Moody, First Assistant Secretary, Health State Network

Mr Paul McCormack, Assistant Secretary, Frameworks Branch, Health State Network

Ms Marianne Cullen, First Assistant Secretary, Medicare and Aged Care Payments Division

Ms Kerrie-Anne Luscombe, First Assistant Secretary, Legal Division

Mr Daniel McCabe, First Assistant Secretary, Information Technology Division

Ms Janet Quigley, Acting First Assistant Secretary, Health Systems Policy Division

Outcome 1

Ms Bettina Konti, First Assistant Secretary, Digital Health Division

Mr Graeme Barden, Acting First Assistant Secretary, Research Data and Evaluation Division

Ms Erica Kneipp, Assistant Secretary, Health and Medical Research Branch, Research Data and Evaluation Division

Ms Natasha Cole, First Assistant Secretary, Health Services Division

Dr Andrew Singer, Principal Medical Adviser

Professor Anne Kelso, Chief Executive Officer, National Health and Medical Research Council

Mr Tony Krizan, Executive Director and Chief Financial Officer, Corporate Operations and Information, National Health and Medical Research Council

Mr Tim Kelsey, Chief Executive Officer, Australian Digital Health Agency

Mr Ronan O'Connor, Executive General Manager, Core Services Systems Operations Division, Australian Digital Health Agency

Mr Terence Seymour, Executive General Manager, Organisational Capability and Change Management Division, Australian Digital Health Agency

Ms Bettina McMahon, Executive General Manager, Government and Industry Collaboration and Adoption Division, Australian Digital Health Agency

Mr Tony Kitzelmann, General Manager, Cyber Security, Australian Digital Health Agency

Outcome 2

Mr Jaye Smith, Acting First Assistant Secretary, Population Health and Sport Division

Dr Bernie Towler, Principal Medical Officer, Population Health and Sport Division

Ms Elizabeth Flynn, Assistant Secretary, Preventive Health Policy Branch, Population Health and Sport Division

Ms Alice Creelman, Assistant Secretary, Cancer and Palliative Care Branch, Population Health and Sport Division

Mr David Laffan, Assistant Secretary, Drug Strategy Branch, Population Health and Sport Division

Mr George Masri, Assistant Secretary, Tobacco Control Branch, Population Health and Sport Division

Ms Bobbi Campbell, First Assistant Secretary, Indigenous Health Division

Mr David Hallinan, First Assistant Secretary, Health Workforce Division

Ms Lisa La Rance, Assistant Secretary, Rural Access Branch, Health Workforce Division

Ms Fay Holden, Assistant Secretary, Health Training Branch, Health Workforce Division

Ms Lynne Gillam, Assistant Secretary, Health Workforce Reform Branch, Health Workforce Division

Ms Janet Quigley, Acting First Assistant Secretary, Health Systems Policy Division

Mr Graeme Barden, Acting First Assistant Secretary, Research Data and Evaluation Division

Mr Shannon White, Assistant Secretary, Health System Financing Branch, Research Data and Evaluation Division

Ms Natasha Cole, First Assistant Secretary, Health Services Division

Dr Andrew Singer, Principal Medical Adviser

Ms Bettina Konti, First Assistant Secretary, Digital Health Division

Dr Peggy Brown, Chief Executive Officer, National Mental Health Commission

Mr James Downie, Chief Executive Officer, Independent Hospital Pricing Authority

Outcome 3

Mr Jaye Smith, Acting First Assistant Secretary, Population Health and Sport Division

Dr Bernie Towler, Principal Medical Officer, Population Health and Sport Division

Mr Andrew Godkin, Sports Integrity Adviser, National Integrity of Sport Unit, Population Health and Sport Division

Ms Narelle Smith, Assistant Secretary, Office for Sport, Population Health and Sport Division

Ms Judith Lind, Acting Chief Executive Officer, Australian Sports Anti-Doping Authority

Ms Elen Perdikogiannis, National Manager, Legal and Support Services, Australian Sports Anti-Doping Authority

Ms Kate Palmer, Chief Executive Officer, Australian Sports Commission

Mr Matt Favier, Director, Australian Institute of Sport

Mr Geoff Howes, Acting General Manager, Participation and Sustainable Sports, Australian Sports Commission

Ms Carolyn Brassil, General Manager, Corporate Operations, Australian Sports Commission

Ms Fiona Johnston, Chief Financial Officer, Corporate Operations Division, Australian Sports Commission

Outcome 4

Ms Maria Jolly, First Assistant Secretary, Medical Benefits Division

Mr Andrew Simpson, Assistant Secretary, Medicare Reviews Unit, Medical Benefits Division

Ms Tracey Duffy, Assistant Secretary, Private Health Insurance Branch, Medical Benefits Division

Ms Trisha Garrett, Assistant Secretary, Office of Hearing Services, Medical Benefits Division

Ms Natasha Ryan, Assistant Secretary, Medical Specialist Services Branch, Medical Benefits Division

Ms Teresa Gorondi, Acting Assistant Secretary, Medical Specialist Services Branch, Medical Benefits Division

Mr Jack Quinane, Acting Assistant Secretary, Primary Care and Diagnostics Branch, Medical Benefits Division

Ms Penny Shakespeare, First Assistant Secretary, Pharmaceutical Benefits Division

Mr Nick Henderson, Assistant Secretary, Pharmaceutical Policy Branch, Pharmaceutical Benefits Division

Ms Julianne Quainne, Assistant Secretary, Pharmaceutical Access Branch, Pharmaceutical Benefits Division

Ms Louise Clarke, Assistant Secretary, Pharmaceutical Evaluation Branch, Pharmaceutical Benefits Division

Mr Simon Cotterell, First Assistant Secretary, Provider Benefits Integrity Division

Ms Janet Power, Assistant Secretary, Office of Chemical Safety

Ms Janet Quigley, Acting First Assistant Secretary, Health Systems Policy Division

Ms Susan Azmi, Acting Assistant Secretary, Private Health Insurance Taskforce, Health Systems Policy Division

Dr Andrew Singer, Principal Medical Adviser

Outcome 5

Ms Sharon Appleyard, First Assistant Secretary, Office of Health Protection

Dr Gary Lum, Principal Medical Adviser, Office of Health Protection

Associate Professor Tim Greenaway, Principal Medical Adviser, Health Products Regulation Group

Ms Jenny Francis, Principal Legal and Policy Adviser, Health Products Regulation Group

Dr Larry Kelly, First Assistant Secretary, Medicines Regulation Division, Health Products Regulation Group

Ms Jane Cook, First Assistant Secretary, Medical Devices and Product Quality Division, Health Products Regulation Group

Mr David Weiss, First Assistant Secretary, Regulatory Practice and Support Division, Health Products Regulation Group

Mr Bill Turner, Assistant Secretary, Office of Drug Control, Health Products Regulation Group

Ms Janet Quigley, Acting First Assistant Secretary, Health Systems Policy Division

Ms Gill Shaw, Assistant Secretary, Best Practice Regulation Branch, Health Systems Policy Division

Ms Janet Power, Assistant Secretary, Office of Chemical Safety

Dr Andrew Singer, Principal Medical Adviser

Outcome 6

Ms Catherine Rule, First Assistant Secretary, Ageing and Aged Care Services Division

Dr Nick Hartland, First Assistant Secretary, Aged Care Policy and Regulation Division

Ms Fiona Buffinton, First Assistant Secretary, Aged Care Access and Quality Division

Mr Nigel Murray, Assistant Secretary, Funding Policy Branch, Aged Care Policy and Regulation Division

Mr Patrick Newton, Acting Assistant Secretary, Prudential and Approved Provider Regulation Branch, Aged Care Policy and Regulation Division

Ms Shona McQueen, Assistant Secretary, Home Care Reform Branch, Aged Care Access and Quality Division

Ms Rachel Goddard, Assistant Secretary, My Aged Care Operations Branch, Aged Care Access and Quality Division

Ms Amy Laffan, Assistant Secretary, Quailty Reform Branch, Aged Care Access and Quality Division

Mr Nick Ryan, Chief Executive Officer, Australian Aged Care Quality Agency

Ms Ann Wunsch, Executive Director, Operations, Australian Aged Care Quality Agency

Ms Rae Lamb, Australian Aged Care Complaints Commissioner

Committee met at 09:04

CHAIR (Senator Duniam): I declare open this hearing of the Senate Community Affairs Legislation Committee. I welcome back the minister, Senator Fiona Nash, and the secretary of, and officials from, the Department of Health. We are in continuation from yesterday and we will start with outcome 2, program 2.1, Mental health.

Senator O'NEILL: My first questions are in regard to the NDIS.

Mr Bowles: It will just depend on which parts of it, Senator.

Senator O'NEILL: Yes, that is what the community is saying too. My questions go to the psychosocial support services. There was $80 million included in the budget. Can the department provide annual funding amounts for the programs that it is responsible for in regard to that money? Partners in Recovery and Day to Day Living—how much for those two programs?

Mr Bowles: In the context of the current budget, or in relation to the $80 million?

Senator O'NEILL: How about we do both?

Mr Bowles: They are two separate issues, so yes.

Ms Cole: The figure for 2016-17 for Partners in Recovery is $143.9 million, and for Day to Day Living it is $15 million. For 2017-18, Partners in Recovery is $145.9 million and Day to Day Living is $15.5 million. Then, for 2018-19, Partners in Recovery is $148 million and Day to Day Living is $15.7 million.

Senator O'NEILL: Would you be able to give me the number of people that these programs support every year?

Mr Cormack: We do not have a precise number available, due to the distributive nature of the service providers. So we do not have an exact figure for you. Indeed, some clients are receiving the service on an ongoing basis, and they may meet the criteria for transition to the NDIS. Then there are others that do not necessarily meet the criteria and may have a relatively short-term need for some support. But we do not have precise numbers on that.

Senator O'NEILL: I can understand that you might not have precise numbers, but you are able to make a distinction between those who potentially might be ongoing and those who might not. Can you give me estimate figures for Partners in Recovery?

Mr Cormack: We can give you some figures; I will refer to the department's submission to the Productivity Commission.

Senator O'NEILL: Thank you.

Mr Cormack: But, when I say these figures, it does not necessarily mean that Commonwealth funds alone are supporting their psychosocial needs. It is important to note that the Commonwealth is very much a minority funder of psychosocial services; it is predominantly a state and territory government responsibility. We would be funding probably less than a quarter of the overall funds that go into that. I am referring to some figures that are in a submission we gave to the Productivity Commission. We estimate, from the National Mental Health Service Planning Framework—that is a tool that has been developed over a number of years with the Commonwealth and state governments; it is a demographically and epidemiologically based service planning tool—that 281,480 people aged between nought and 64 years would have a mental health disorder requiring psychosocial supports. We hasten to add that not all of those individuals would necessarily meet the NDIS eligibility requirements. It is only an estimate because, as I think we have mentioned on a number of occasions, we do not have policy responsibility for the NDIS, but we estimate that 91,916 people aged 18 to 64 with severe and complex disorders would probably align with the NDIS eligibility population. So the balance, which is about 190,000, would require lower levels of assistance. Of that 190,000 approximately, some of those people would be accessing psychosocial support services through the two programs that Ms Cole has described—Partners in Recovery and Day to Day Living—and also the DSS funded program, which is PHaMS.

Senator O'NEILL: Where does that fit in?

Mr Cormack: We do not have responsibility for that; you would need to talk to DSS. We have no funding or policy responsibility for that.

Senator O'NEILL: And the Mental Health Respite: Carer Support?

Mr Cormack: That is DSS as well, so you can talk to them about that. The funding pool that the Commonwealth funds through locally distributed service providers looks after a small portion of that estimated 190,000. A much bigger proportion of that group that are receiving or accessing services will be funded through the state governments—

Senator O'NEILL: To the tune of about 75 per cent, based on your earlier evidence.

Mr Cormack: Yes. This is all estimates stuff, because there is not really—

Senator O'NEILL: It is a perfect place to be giving me estimates.

Mr Cormack: Yes, of course. It is something of that order.

Senator O'NEILL: Where did the $80 million that was featured recently in the budget emerge from? Did you come up with that figure, or was it a figure that you were allocated to work within?

Mr Cormack: It was within the context of a very large, complex budget. The minister was particularly focused on the potential for some of these clients that I have just talked about, who would not transfer into the NDIS, not necessarily being supported as well as they might be during the transition. The minister advocated very strongly for this measure and, within the context of the budget, was able to secure $80 million over four years. The important point here—this reflects what I said earlier—is that that is required to be matched or co-contributed to by state and territory governments. The minister, through the department, has written to his state and territory counterparts and the department is currently in the process of working through the shaping of a potential agreement with the state and territory governments to contribute on top of that $80 million.

Senator O'NEILL: To be clear, the $80 million was not a number that you came up with through calculations and assessments; it was a number that was provided to you by the minister?

Mr Cormack: The $80 million was part of a very complex budget process.

Senator O'NEILL: But did you give the minister that number based on—

Mr Cormack: We provided the minister with a range of advice on this and other measures in the budget. As you can probably appreciate, budgets are a contested activity; there are competing priorities. The minister, consistent with his stated priority on mental health and preventive health as one of his four pillars, has clearly indicated that he has identified a need and secured some funding through the budget process and will use that to engage the states to seek their commitment to address this potential gap.

Senator O'NEILL: I understand that. You have just gone over some ground and I have lots and lots of questions.

Mr Cormack: Fantastic.

Senator O'NEILL: Thank you for the frankness of your answers so far, but perhaps I could ask you to give me the information a little more quickly. I have many more questions to go. My question really is: did you provide the number $80 million to the minister and on what basis was the minister provided with—

Mr Bowles: We cannot make it any clearer. It was part of the budget process and $80 million was the figure.

Senator O'NEILL: Was any analysis undertaken that would back up—

Mr Bowles: We provided advice to the minister, as Mr Cormack said.

Senator O'NEILL: And the minister did what he could do to get as much as he could get?

Mr Bowles: We provided advice around the nature of the program and the figure, through the budget process, was $80 million, to be matched by the states and territories.

Senator O'NEILL: Can you explain why you have allocated the specific amounts set out across the budget forward estimates of 7.8, 23.7, 24.1 and 24.4?

Mr Cormack: Yes. Broadly speaking, the impact that this measure is intended to address is not with us now; it will build as the transition of this component of the NDIS progresses. The department continues to hold the funding for Partners in Recovery and Day to Day Living for the next two financial years. At this point we provide it in kind; after that point it transfers. The first year is to start to build up the capability at the regional level that would be needed to do that, working with PHNs and state- and territory-funded providers, and it will build up to a steady state that is outlined there in the final year of that measure.

Senator O'NEILL: Just in terms of the number of people with mental illness who are not eligible for the NDIS, how much will this amount here, the 23.7, support per annum?

Mr Cormack: It is hard to say and the reason why it is hard to say is that every person is an individual. This is not a homogenous group of people. Many of these people will have episodic requirements for psychosocial supports. Those who have a lifelong requirement for them effectively would be part of the NDIS cohort. So it is very difficult to specifically quantify exactly how many would be serviced by that.

Senator O'NEILL: You have said that the problem is not with us now, which is why you have only indicated 7.8 million initially, to increase to 23.7, but I would put to you that the community has a very different view about the nature of the problem of access to funding for mental health services, including Partners in Recovery, right now; there is a very big hole already.

Mr Cormack: I certainly would not deny that there are gaps in service coverage for this group of clients. I would also point out to you that the state and territory governments have primary responsibility for this area of

activity. The Commonwealth, through the minister's measure, has sought to use this to make sure that the states continue to live up to their responsibilities to fund this group of clients.

Senator O'NEILL: Mr Cormack, you can understand that families of people who are accessing these services currently or have accessed them in the past, particularly in areas prior to the rollout of the NDIS, are already experiencing significant service gaps and, even if you add in the state and territory contributions and even if you look at the amounts that have been allocated over previous years there seems to be a funding shortfall and a big hole in this space.

Mr Cormack: I do not think that has been established. I think what we have identified—and you can see in the submission that I put up that we recognise that there is a potential gap that has emerged—is that those that meet the NDIS criteria will transfer into that scheme with significant funding and I think their needs will be well catered for. But we do recognise that there is a significant number of people who will not transfer across. We cannot quantify that number exactly. We also cannot quantify how many people would be impacted at any one time, because people come in and out of the system. This represents a recognition of a problem. It also proposes an approach with the state and territory governments as the primary funders of this and I am sure that the minister and the government will have another look at this in the context of future budgets. If there is a need for any further activity, that is a matter for future—

Senator O'NEILL: For additional funding because, if you actually do not know the quantum of the gap, which is what you have said to me, and you do not actually know the number of people, for a range of reasons, including the fact, happily, that it is episodic—people experience significant periods of wellness—if you do not know those two elements, it is very difficult to say that $80 million is going to be adequate.

Mr Cormack: Or inadequate.

Senator O'NEILL: Given the quantum that already existed and this is a reduction.

Mr Cormack: It is not a reduction; it is an addition.

Senator O'NEILL: After you have removed a whole—

Mr Cormack: It has not been removed; it has moved into the NDIS and that will support a very significant number of people under that scheme with additional Commonwealth funding through the NDIS, and you can talk to DSS about that. This cannot in any way be portrayed as a reduction in funding. This is an increase in funding. This is a point to leverage the state and territory governments to increase their funding. It is not a cut; it is an enhancement. If the government needs to look at the needs further down the track, I am sure it will do so in the context of the budget.

Senator O'NEILL: It is funding into an unknown quantum gap. Was there any consultation undertaken by the Department of Health, the minister or his office with state and territory governments prior to the budget about the funding being contingent on matched funding?

Mr Cormack: I cannot recall any conversation with the states and territories on that. But let us face it: it is a budget measure.

Senator O'NEILL: Before you go to an explanation—

Mr Cormack: Budgets are developed in context and in confidence. You do not—

Senator O'NEILL: And often in consultation with key players.

Mr Cormack: And often in the normal process of a budget, which is conducted in a confidential cabinet context. So it is not at all unusual that we would develop a measure—

Senator O'NEILL: Mr Cormack, you have been at pains to explain to me this morning that this budget measure is only going to work if it is contingent upon the states coming to the party. You made the announcement and you just said that there was no consultation with the state or territory governments prior to the announcement. Is that correct?

Mr Cormack: I am not aware of any consultation undertaken by the department in relation to this measure and I am saying that is not unusual. But I am also saying that there has been extensive consultation with the state and territory governments in the context of the development of the Fifth National Mental Health Plan, of which this issue and psychosocial supports are a major component. So we have had significant consultation with—

Senator O'NEILL: Have discussions gone to the quantum of funding required for the—

Mr Cormack: No, discussion has not gone to the quantum of funding required. To be frank—and you can see that from the department's submission to the Productivity Commission—it is difficult to quantify that. But we have put it to the Productivity Commission, who are looking at the impacts of the implementation of the NDIS—

we are giving them all the information that we have available—to enable them to undertake their deliberations and to inform government about what, if any, response it needs to make as the implementation of the NDIS progresses.

Senator O'NEILL: Have there been any further discussions, since the budget, with the state and territory governments?

Mr Cormack: Yes. The minister has sent letters out. We have also separately written to the states seeking information about their intent and what they are planning to do on full transition into the scheme. We have an AHMAC meeting coming up in about a week and the secretary will go through the budget impacts for the state and territory governments. This matter will be considered, as will a range of other matters where there is a budget impact or interrelationship with the state and territory governments.

Senator O'NEILL: Do you know if this matched funding will be based only on new moneys from the state and territories or whether it could potentially be existing funding—for example, in New South Wales, where they have increased funding to community mental health services?

Mr Cormack: We will need to assess each state's unique circumstances. Not all of the states have approached the NDIS transition and, indeed, the provisioning for psychosocial services in the same way. So we will be having dialogue with them. But I think the minister is very, very clear that this money is not going to simply be a substitution of existing effort by the states.

Senator O'NEILL: Existing funding, as it stood on the night of the budget, does not count; it will be new funding that is required from the states and territories?

Mr Cormack: These are matters for negotiation and discussion with state and territory governments. We do a fair bit of this stuff. The intent of this is to put additional money into the system to ensure that there is no adverse impact for this group of clients as a result of the transition into the NDIS. We will look at all of those factors and take those into account.

Senator O'NEILL: I have a couple more questions on this one. Could a state like Victoria, where they have community-based mental health funding—it has all moved into the NDIS—argue that funding included in their recent budget for family violence protection, which includes community-related mental health services, is for community mental health services even though it is not specifically listed for—

Mr Cormack: I think that is hypothetical. I am not overly familiar with that state government measure. But once we get down to negotiating and discussing in detail, as the minister has foreshadowed, we will get to the heart of those details to ensure that this additional investment into psychosocial services is directed towards addressing the problem that it is intended to and not merely to substitution of existing effort. That would be our intent.

Senator O'NEILL: Given that you have not had any conversations with the states or territories, if a state or territory is unable to match the funding, does it mean that people with mental illness living in that state or jurisdiction would be completely missing out on these essential services?

Mr Cormack: I think that will be a matter for discussion with the state and territory governments. But I think the minister's public statements on this are pretty clear. He would be wanting to make sure that this $80 million and its associated state and territory government additional contributions address a potentially emerging problem and, of course, we would seek to do that on a nationally consistent and equitable basis. But I would also repeat my earlier comments: the Commonwealth is the minor funder in this space and it is the Commonwealth that is actually taking the lead to ensure that the state and territory governments continue to provide the necessary supports in this game, recognising that they are funding over 70 per cent of this activity at the present time.

Senator O'NEILL: Has there actually been a proper piece of work examining the exact levels of ineligibility and what percentage of the number of people the $80 million and hopefully then the $160 million will actually assist and would there still be a gap?

Mr Cormack: I think that there is some work to be done. The main thing that we do not know but we will know soon is, of that 281,000-model figure, how many of those will transition into the NDIS and then how many are left. Then we will need to look at those on a population cohort-by-cohort basis. It is not easy to simply apply a formula for this group of clientele who enter and exit the system according to their stage of health or recovery. That is why we will need to work this through at a regional level and at a state level with state and territory governments.

Senator Nash: It might be worth adding here as well: there has been a lot of discussion around the funding but it is not just about the money. I think there has been very clear intent from the minister to show that it is a

measure of good faith and leadership in encouraging the states and territories to do their bit. I think there has been some discussion this morning around it being primarily a states' and territories' responsibility to do this. Obviously we have put on the table the additional $80 million and the minister is showing leadership in this. But I think it is really important to recognise that it is not just about the money; we need a collaborative approach to this to get the best outcomes.

Senator SIEWERT: Minister, I will go from where you have just left off. While I appreciate the fact that $80 million has been kicked in, there was a massive hole there, which we discussed at the last couple of estimates. When was the decision taken or the acknowledgement made that there was a looming gap and some additional money needed to be put on the table from the Commonwealth as well as from the states? I have taken on board everything that you have said about the states.

Mr Cormack: I think I have reported on a number of occasions here that we have been working very closely with DSS in the lead-up to the transition. We have worked closely with DSS and also now, using the national mental health services planning framework, have undertaken some modelling activity that we had not previously undertaken.

Senator SIEWERT: Are we able to get hold of that model; are you able to table that?

Mr Cormack: If you read the submission to the Productivity Commission, those figures are directly derived from that modelling work.

Senator SIEWERT: Can you give us the framework for the modelling?

Mr Cormack: The national mental health services planning framework is a Commonwealth and state planning tool; it is largely finalised as a planning tool. We do not own that model. I would have to take that on notice and consult with the states and territories.

Senator SIEWERT: Okay.

Mr Cormack: Going to the heart of your question, there has always been a concern about a potential gap and, in the context of the budget, it was really when the minister in particular focused on and took the opportunity in this budget process to begin to make some financial commitments and apply some leverage to address this potential problem. So it was really throughout the context of the budget process. I cannot give you a specific date when a measure popped onto the list, but it was certainly within the context of this budget.

Senator SIEWERT: The money is for the next four years for transition. What is going to happen after that? I realise that is beyond the forward estimates, but surely there is an acknowledgement from government that that group of people that this money is intended to support are not ever going to transition to the NDIS, so there will always be a need for this sort of funding. Is that acknowledged?

Mr Cormack: As Minister Nash just indicated, the government has acknowledged a need. The minister has taken a national leadership role and has applied some funding. The funding flows out through the forward estimates and, as the scheme unfolds and the extent to which the gap that we are concerned about is able to be better quantified, there will be more information available to Commonwealth and state and territory governments to inform future decisions about this group of clients and their needs. I think, Senator, that we can take this as a very tangible recognition of a problem—I know that you have been consistently focused on that and questioned us extensively about that—and I think the government has certainly taken on board the information that it has available and has made a commitment. No doubt, if it needs to be modified in the future, that can be considered by government in the context of future budgets.

Senator Nash: Very much so, Senator. You are probably well aware that Mental Health Australia and Community Mental Health Australia have been very supportive of this and have welcomed the budget measure.

Senator SIEWERT: If you recall, as I started asking questions, I am sure that I said outright that, yes, it is good having the money in there, but it is for four years. We have sat here before talking about the gap and we did not get to the point where there was acknowledgement. In fact, I was told to go and ask DSS and, by the way, DSS told me to come and talk to you—which was not very helpful, I have to say. So, yes, of course I am pleased that money is on the table and that there is acknowledgement of a gap. What I am also seeking assurance about is that the government realises that the gap will not be fixed when transition is over because there will always be a cohort of people who need support outside the NDIS.

Senator Nash: Yes.

Senator SIEWERT: I realise that I have to ask the NDIS and the DSS a whole lot of questions about this as well. I heard what you said to Senator O'Neill. In terms of the quantum—I am trying to phrase this in a way so

that you are not going to give me the same answer that you gave Senator O'Neill—the $80 million, obviously it is not a stab in the dark; you do not put something up on the wall and throw darts at it.

Senator O'NEILL: Maybe they do.

Senator SIEWERT: I am giving you the benefit of the doubt on that one. How do you look at and work out the quantum that you think will address the gap without just saying, 'Well, we think we can afford $80 million, so there you go'?

Mr Cormack: I will try not to give the answer that I gave before, but any budget requires decisions to be made on the basis of relative priorities regarding different policy options. This is an important policy matter for the government. The minister has been very clear about it. Mental health and preventive care are one of his clearly stated four pillars in his long-term health plan. I can honestly say that there is not a precise formula that is available to be applied, based on the information that we have from our modelling, that would land a figure that we think is going to be exactly right, not enough or too much. What it does is to put a significant amount of additional money in the system, recognising that this is a fluid space and recognising, as both you and Senator O'Neill have mentioned, that historically this has been an area with some gaps in services—again, predominantly a state and territory responsibility, but the Commonwealth has also invested in this area. It is a significant amount of money that should be able to start to address problems as and if they emerge. The option is always open to government—Commonwealth, state and territory—to revisit on the basis of the outcome of the transition to the NDIS. This is a big system change, and what the government have done is put a stake in the ground and make an investment. I do not think they have closed off their options to look at future consideration of the quantum and type of investment that they would make in this space.

Senator SIEWERT: Can I move on to what the mechanics are of how the money will be rolled out? Maybe I am looking in the wrong place, but we have not been able to find a lot of detail about how the money will be spent.

Mr Cormack: This is the $80 million that you are talking about?

Senator SIEWERT: Yes. How is it going to roll out? PIR and Day to Day Living are winding up, as you said, in two years.

Mr Cormack: Yes.

Senator SIEWERT: But already some services are starting to wind up, so it is pretty urgent.

Mr Cormack: What we are trying to do—we will be working closely with NDIA on this—is to have a look at the Commonwealth funded activities that are already on the ground because they have grown up in a slightly or not totally planned fashion—

Senator SIEWERT: There is an organic approach.

Mr Cormack: I think that is a good way to describe it. We need to recognise that this money rolled out in a progressive, organic fashion over a number of years, so we will need to have a look at what the baseline of activity is and we will need to use the mental health services planning framework to give us some idea of model or likely need. We would then need—we have already started this work with the state and territory governments—to overlay their investments in this sort of activity, noting that they too are going through the same transition process to the NDIS. So we need to work out what investments of theirs now in this space are going totally or partially to the NDIS and what is left. We will then need to work through, looking at it on a regional basis. The minister has indicated that the PHNs, as they currently do now in many instances, would have a very significant role in assessing regional need and looking at the respective contributions of state and territory governments and Commonwealth contributions. Over time we will develop an equitable funding model, in partnership with the states, to support this group of clients.

Senator SIEWERT: As you know, there is very strong support for PIR.

Mr Cormack: Yes.

Senator SIEWERT: Is it feasible that some of those services will be able to remain in place or will everything be thrown up into the air for a whole new model?

Mr Cormack: What we can say is that those services remain in place and their contributions—

Senator SIEWERT: For the next two years.

Mr Cormack: Yes, pretty much as is—

Senator SIEWERT: Except here, in the ACT. I will come back to that.

Mr Cormack: Organic. These services will remain in place. We will continue to fund them to the tune of about $161 million a year across those two programs. PHaMs is different; it has been cashed out. We will continue to fund those and—

Senator SIEWERT: For the two years.

Mr Cormack: For the next two years, yes: 2017-18 and 2018-19. They will be funded. The money associated with that will roll into the NDIS. Many of the clients that they are seeing will roll into the NDIS.

Senator SIEWERT: At the moment, where we have started to see PIR clients roll in to the NDIS, we have not seen enormous numbers in some regions.

Mr Cormack: It is moving steadily forward. You are right; it still has a way to go, but there are two years to run on this. What I think we would look at, well before the end of that two-year period, in partnership with the states, is: what is the best local model? It could well be a PIR or Day to Day Living type entity or service model that may wish to continue providing this sort of service, albeit for a different client group that is not about the NDIS. But we would be applying a commissioning approach through the PHNs. They would have a look at the market and, if there are good quality providers in that regional area, as there is new Commonwealth funding and there is state and territory government money flowing into that, the PHNs could commission a PIR or Day to Day Living type service from 2019-20 onwards. But we would not want to pre-empt that, because there is a big change in the whole human services market as a result of the NDIS overall.

Senator Nash: It might be useful to add at this point that the minister has been clear that this is the start of an ongoing process; I think it is important to note that. There is recognition of this as an issue. Obviously, there is the commitment to work with the states, ongoing, to maintain those psychosocial supports outside the NDIS. It is a very genuine commitment to recognise this and find some solutions with the states and territories.

Senator SIEWERT: There is a lot of concern about PIR winding up. Was consideration given to funding PIR to continue, on the basis that there is only going to be about a quarter of the clients transitioning into the NDIS?

Mr Cormack: We have not got to that point at this stage. The PIR providers, we anticipate, will continue operations for the next two financial years. We need to note that, in the full rollout of the NDIS, there is also a different services market that will arise from the full scheme. Indeed organisations that currently provide Partners in Recovery may well have multiple roles. They may well have a role as a provider in the NDIS and they may well have a similar role as a psychosocial services provider with funding from this measure and whatever we can bring to the table from the state and territory governments. I would not want to give any guarantees, but it would seem to be a logical thing to do. If you have a viable service provider in a region with the skills and experience, that has the interest, and is going to continue in some form with the NDIS and with additional funding from the Commonwealth and the states continuing in this space, I would have thought they would be part of a commissioning market.

Senator SIEWERT: I am getting the evil eye. Can I ask two more questions?

CHAIR: Yes.

Senator SIEWERT: I just want to check this. We have had discussions around the gap, if you remember, with existing clients who are not going to move into NDIS and who are already on the books. This new money also includes, I presume, new people coming in?

Mr Cormack: Yes. I know specifically where you are going there. This program obviously focuses on growth.

Senator SIEWERT: Thank you for clarifying that. Here in the ACT, my understanding is that it is a bit of a different circumstance from some of the other states and territories because of the earlier rollout. Will the issues that are specifically here in the ACT, will there be some additional resources to deal with them or their more immediate transition process?

Ms Cole: What precisely are you asking about?

Senator SIEWERT: With the rollout of the $80 million, there is some for the next financial year.

Ms Cole: Yes.

Senator SIEWERT: Here in the ACT, I understand there are issues around some of the services finishing. Will those specific issues be dealt with here in Canberra with this money most immediately?

Ms Cole: Most of the clients in the ACT have actually transitioned to the NDIS. From my understanding, there are about 40 individuals who are left and some of those have chosen not to even apply. They would be clients who could fit under this category.

Senator SIEWERT: That is what I am asking about.

Ms Cole: The other thing to take into account is that I understand the ACT government, as the 'major responsibility' government for this area, is actually providing services or funding for services for those 40-odd individuals at the moment. But I can confirm all of that and come back to you.

Senator SIEWERT: So there are the 40 individuals that are outside of the NDIS, because not everybody is rolled in or can be rolled in.

Ms Cole: Yes.

Senator SIEWERT: But there is also that new cohort coming through as well, which we have just discussed.

Ms Cole: Yes. So obviously the ACT would like to, I expect, open negotiations very quickly on this issue.

Senator SIEWERT: Have you been talking to them already? You have already said that you are talking about—

Mr Cormack: We have written to them and, as I have mentioned, the secretary and I will be at AHMAC next week; this is clearly a matter that will be a topic of conversation. I know that the minister is very keen to sign up willing jurisdictions. Clearly, he wants this investment to be made quickly and appropriately. If there is an early adopting jurisdiction then ready to put some of its own resources on to the table to go with it, then we would love to kind of get cracking on it.

Senator SIEWERT: Thank you. I will have some more questions later.

Senator KAKOSCHKE-MOORE: I would like to stay on this topic as well. In particular, I have some questions around the mechanics of the rolling out of this money and as it relates to South Australia. I just want to clarify. I have been listening to the responses to questions, but it is still a little unclear to me exactly how the $80 million will be divvied up between the states. Could you talk me through that, please.

Mr Cormack: That is something that we will need to work through. The way the Commonwealth approaches new funding and new programs would broadly follow a needs based or population distribution model, so I think that will be a key component. But the other component will also be to have a look at the existing pattern of Commonwealth investment because, I think as Senator Siewert mentioned, it has been somewhat organic in its development and deployment. So we will need to take that into account because we want to make sure that, with the money that is available, we do not deploy it into areas that are relatively better serviced than others, but we also need to balance the intent and willingness of the states. I think this is the area that is probably the one that we know the least about and need to work the hardest on because they all seem to be doing it a bit differently and we do not have full visibility of the nature of their current investments, the extent to which they migrate partially or totally into the NDIS and what they intend to invest post the migration of some clients and program funds into the NDIS. That is a matter that we will need to work through with each state and territory. The other principle, as I mentioned earlier—and the minister has made it very clear—is that this money is a new investment into an area that needs investment and anything that looks like new for old or substitution would certainly be a factor that we would take into account; it is not just going to allow state and territory governments to disinvest off the back of new Commonwealth funding.

Senator KAKOSCHKE-MOORE: On that point, can you confirm whether or not the South Australian government will need to provide additional funding in order to access—

Mr Cormack: We cannot confirm that at this stage. We have asked that question. Only last week the minister wrote out to his state and territory colleagues and, prior to that, we had written to officials on a slightly different matter; it was not in the context of the $80 million measure but really just to get some clarity about what they intended to do post full scheme implementation.

Senator KAKOSCHKE-MOORE: Staying in South Australia for a moment, how far progressed are your discussions and do you have a time frame for when you would like to see these discussions concluded?

Mr Cormack: There are in relatively early stages. As you can see from the build-up of the measure, year 1 would largely be around getting the planning and supporting infrastructure in place; with year 2, you would start to see more of the investment going into expanding services; and then, with year 3 and year 4, it would get up to the maximum Commonwealth investment that is available under this measure. We will sort of be aiming to have this hit fill deployment around the time of full scheme transition into the NDIS so that we can minimise the gaps as they emerge.

Senator KAKOSCHKE-MOORE: Given that mental health is transitioning into the NDIS in South Australia later than it is in other states, when in the four-year funding cycle for this $80 million in funding will the South Australian government need to match that funding?

Mr Cormack: We recognise that states are at different starting points. The minister has been very clear that this program requires a matching of funding by the state and territory governments. The timing of that may vary from state to state, but the minister is very clear that that is what he expects out of this. He has written that into the letter that has gone to the states.

Senator KAKOSCHKE-MOORE: If a state such as South Australia is later in the funning cycle due to the fact that its mental health services have been transitioned to the NDIS later, will it still receive an allocation for the four-year period or would it be less?

Mr Cormack: I think that is a degree of detail that we will need to work through. But I think what we are focused on is, I guess, the end point here. The transition is important, but the end point is probably more important. The extent to which gaps emerge, when they emerge and how big they are over the long term: we want that money to be solidly in place. We are certainly not aiming to advantage or disadvantage any state but just recognising that they are all at different starting points and we will need to take that into account as we roll this measure out.

Senator KAKOSCHKE-MOORE: Will the $80 million that has been allocated ensure that psychosocial support services are maintained at current levels across the states?

Mr Cormack: The Commonwealth and the states have a continuity of support requirement and so it is part of the NDIS deal that, post transition into the scheme, there is a commitment that existing clients in the scheme get continuity of service. That is already established as part of the IGA that underpins this. This additional money recognises that, but it also recognises that it is not just about existing clients, because there are new clients coming in all the time. Some people will move on; others will enter the scheme. It is a dynamic growing and changing cohort, and it recognises that.

Senator KAKOSCHKE-MOORE: My next questions are directed mainly to the NDIA, but I will give it a go in case I get told by them that I should have asked them here. I understand that the NDIA are promoting a view that approximately 80 per cent of South Australians who apply for psychosocial support through the NDIS will be successful and that this is based on findings from the eastern states, which are in line with the NDIA's quarterly reporting. Are you familiar, off the top of your head, with what estimates those reports are based on? Are they trial sites or transition sites, or is it by other methods?

Mr Cormack: It is trial sites. Also the NDIA has an ongoing program of assessments and establishment of plans. They have targets each month. They are progressing—again you can talk to DSS about this—towards those targets and, the more assessments that are undertaken and the more plans that are developed and agreed, the clearer they are about percentages of populations that are likely to be eligible or ineligible; I think the evidence of that is building month by month. That is why, even a few months ago, certainly we would not have had that much clarity. But, as the NDIA progresses with the signing up of clients to plans, these things start to emerge and become clearer and then we can respond to the areas that we remain responsible for.

Senator KAKOSCHKE-MOORE: Just to clarify: when you say 'assessments', are you talking about assessments of clients?

Mr Cormack: Clients, yes.

Senator KAKOSCHKE-MOORE: Is there a snapshot for each trial site somewhere so that we can get a bit of an idea about what—

Mr Cormack: It is probably better to ask that of NDIA or DSS; they can give you a better sense of that.

Senator KAKOSCHKE-MOORE: I can do that, for sure. Going back to the $80 million in funding and some of the mechanics around how it will be distributed, will the funds be directed towards primary health networks, for example, and then—

Mr Cormack: That is the intent and the minister has certainly made that clear. But, as I mentioned earlier in response to questions from Senators O'Neill and Siewert, there is a much more significant state and territory government historical investment and hopefully future investment as well. While it is our intent to channel the Commonwealth's additional funding through the PHNs, because they know what is happening at a regional level, the extent to which the state and territory governments align with that model will be a matter of significant negotiation with them. But that is our intent. I have to say that, in other areas of service planning that we have done with the states, they do like the PHN model because they have their own regional footprint and they like the ability to be able to jointly plan and jointly commission services. So that is our hope and anticipation, but we cannot guarantee that it will be smooth from day 1. We will just have to see how that pans out.

Senator KAKOSCHKE-MOORE: Have these PHNs already been identified?

Mr Cormack: There are 31 PHNs. We could take on notice or perhaps even find out today for you the extent to which we currently have Partners in Recovery and Day to Day Living funding channelling through those. Most of the PHNs, if not all, have some funding relationship or experience of these players within their region, so this is not unfamiliar turf to the PHNs.

Senator KAKOSCHKE-MOORE: This is my final question. You said just then that you cannot guarantee that things will go smoothly. Can you just unpack that a bit for me.

Mr Cormack: I guess that, with anything to do with the Commonwealth negotiating new agreements with the state and territory governments, there is always a period of initial discussion, posturing and all that sort of stuff. Generally speaking, we land agreements pretty well but there are always different perspectives about who does what and whether the contribution from the respective parties is fair, equitable. With a new program like this, we anticipate that they are not just going to walk in the door and sign on the dotted line straight away; we will need to negotiate these things through and work that through with them. But we generally work pretty well with the state and territory governments on most matters of cooperative health endeavour and we anticipate that we will get there with the states.

Senator KAKOSCHKE-MOORE: Is there a particular sticking point that you are worried about with the states?

Mr Cormack: I think the only issue that we are concerned about at the moment, which is why the department has written to the states followed by the minister writing more specifically to the states, is that we are not entirely clear on a state-by-state basis what their continuing investment plans are, their continuing funding plans, for this cohort of approximately 190,000 people who, our model suggests, would require ongoing psychosocial supports but would not come under the main elements of the NDIS. We do not have clear visibility of that. We are trying to get clear visibility of that. Once we have that, I think we can be much more focused on how we roll this program out and also what additional information we may need to bring back to the minister and to the Commonwealth government to consider the future shape, size and distribution of its ongoing investment in psychosocial supports.

Senator O'NEILL: I have a couple of quick questions following on the excellent questions from my fellow senators. You indicated that you have corresponded with the states and territories around this matter. Would you be able to provide us with copies of that correspondence?

Mr Cormack: We will certainly take that request on notice.

Senator O'NEILL: Thank you very much. Would I be right in assuming that that letter might be some sort of audit of the current practices with regard to funding of mental health by the states?

Mr Cormack: I would not have thought that its prescriptive is an audit but we have asked them pretty specifically what they are currently doing and what they intend to do. I am not quite sure that we have been overwhelmed with responses just yet. I have just been corrected; that was a letter from the minister.

Senator O'NEILL: It was a letter from the minister and not a separate one from you?

Ms Cole: That is correct. There were two letters from the minister. One was prior to the budget where he asked his colleagues to indicate, in general terms, what they are planning to do in terms of psychosocial and their transition to the NDIS. Then there was a second letter post the budget which indicated that he wished to open discussions around the $80 million.

Mr Cormack: Chair, I want to correct my earlier advice, which was that I thought the first letter was from the department. It is the same letter but it was actually from the minister. The second letter is post budget and the $80 million measure. Thank you.

Ms Cole: In addition, we have had informal discussions at an official level in the last two months or so around what the states and territories may be thinking in terms of what they are going to do post transition.

Senator O'NEILL: Could you provide us with a copy of that correspondence?

Mr Cormack: We will certainly consult the minister on that and see if that can be made available.

Senator O'NEILL: Thank you very much. What is the proposal if one of the states or territories decides that they do not want to join up?

Mr Cormack: The minister is very clear that he wants this $80 million measure fully rolled out; so there will not be a reserve that would be withheld and not spent if a state chooses not to go ahead with this. Our instructions from the minister are: he wants this to be a national program and he wants all states participating but, if a state does not wish to participate or if a state does not wish to meet the matching requirements, then that money would be available for investment elsewhere in another state or states or territories.

Senator O'NEILL: I have a couple of questions with regard to the PHNs. Would the types of services be determined by a needs analysis conducted by the PHNs and would services then need to tender for these services which could be commissioned by the PHNs?

Mr Cormack: That is generally the approach that we adopt for all services that are funded through the PHNs. They are no longer involved in direct service provision; they do approaches to the market and commission according to service needs. The department will provide guidance. This is a new program or a modification to an existing program with additional money. We provide guidance material to the PHNs that ensures that, when they go out to commission this, the money is spent for the policy purposes for which it was appropriated. They will then commission that according to their local needs. So there will be some variation in approaches and that is because there is variation in the geographical populations served by each PHN.

Senator O'NEILL: Would a PHN that was a PIR provider potentially be able to continue this service if they received a portion of the $80 million in funding?

Mr Cormack: I do not think that we have PHNs that are PIR providers—

Ms Cole: No; they are lead agencies.

Mr Cormack: Yes.

Senator O'NEILL: They are lead agencies?

Ms Cole: Yes. In most cases, PIR is actually provided by a consortium within a region and the PIR might be the lead agency. This is a residual measure, I guess, from the ML days in a sense—from the Medicare Local days. Essentially, they do the central administration for that consortium of service providers within a community. Theoretically, you could have a situation where they were able to use that model again, using the appropriate proportion of the $80 million for that region.

Senator O'NEILL: I would like to move on to some questions on headspace.

Senator REYNOLDS: I have a few more on this matter.

CHAIR: Let us finish this component. Senator Siewert.

Senator SIEWERT: You have said that there were two letters that were sent. Have you received anything back from any of the states on that first letter? That was the one asking how they are currently funding psychosocial services.

Ms Cole: I have not seen anything back from the states and territories yet but it is possible that something may have been received in the last day or so in the minister's office.

Senator SIEWERT: Just to clarify, you have not received anything back from the first one; the second one has only just gone out, so presumably you have not heard back from that?

Ms Cole: That is correct.

Mr Cormack: No. It was only a week or so ago, I think.

Senator SIEWERT: In terms of the understanding—not using the word 'audit'—of the states, do you have an understanding of any of the states or do you not have a picture across Australia of what additional resources they are putting in?

Mr Cormack: We have got some understanding of the current service provision from some states. As Ms Cole said, I do not think we have seen a formal response to either letter. Ms Cole and her team regularly engage with the state and territory officials; so we would have some indication. But, to be frank, I do not think we have a sufficient, granular picture of what is happening out there. Also, we would need to work closely with NDIA, who are also gathering a lot of data and information now about the clients. We will draw upon that information. We have some; it is incomplete. But I have to say that the first letter was kind of hypothetical in a sense. It was really just asking for information; it did not foreshadow a budget measure. Now that there is a budget measure, I think the state and territory governments will probably turn their mind to it, one would hope.

Senator SIEWERT: Playing devil's advocate for a bit, I am a state and I have some money that I have been putting in but now I know that you are going to put money on the table. All of a sudden, it is new money and not money I was going to put on the table anyway. How do we know that that is—

Mr Cormack: I think that just shows the importance of getting as much information as we can about what is going on at the moment. Having been a state bureaucrat, I understand that situation very well. We kind of know what they are up to and—

Senator SIEWERT: Are you getting ground truth from some of the service providers and NGOs who will know what is going on on the ground?

Mr Cormack: Yes. We try to get as much intelligence as we can. As to Mental Health Australia and their affiliated organisations, we work very closely with Frank and his people; they have a great source of information, intelligence and advice that we can reality-test. We do not formally go in with an audit; I guess sometimes we might like to but typically we do not. We work with the states. We ask them for information and they provide it to us. We accept it at face value, we test it as appropriate and then we strike up an agreement with them, which has provisions in it that require maintenance of effort and those sorts of things. We cannot rule out the possibility that some will try something on but hopefully not; we think they are committed to the cause.

Senator SIEWERT: In terms of what you will accept as half of the dollar for dollar, say one of the states is actually right on the ball and has additional services, do they have to put in more new money? Where will the line be?

Mr Cormack: It will vary from state to state because, unlike the Commonwealth, some states might have a baseline level of activity and they might have significant service investment and plan for the out years for this purpose but it is not already on the ground at the moment. That should be relatively transparent from their budget papers. We would need to take that into account. We will need to deal with it on a case-by-case basis and recognise that at the end of the day, if this money can be mixed with additional state and territory government funding to address a gap that we think is going to emerge but cannot fully quantify, then that is a good outcome. I think the minister is very keen to take the lead to ensure that he gets the best possible bang for the buck and the Commonwealth and the state money grows to meet any emerging service gap.

CHAIR: I will ask a quick question. In regard to the second letter that has gone out—and, agreed, it is only early days—if states do not respond and participate, do not take up the offer from the Commonwealth, what happens with that overall pool of money? Is it reallocated amongst those states that do?

Mr Cormack: Yes. We really do not want that to happen and—

CHAIR: I know that we are talking hypotheticals here.

Mr Cormack: It is not out of the realms of possibility that a state may decide not to do anything. But the minister has been very clear that, if an agreement cannot be struck with a state, that $80 million or, if you like, the portion that would have gone to a state that is not willing to co-invest can be reinvested across the pool—either through the other seven states and territories or through some other arrangement that ensures that the $80 million in its matching components is delivered. But we would like to see it on a nationally consistent basis. That is ideally what we want, but we cannot guarantee that.

Senator KAKOSCHKE-MOORE: I want to follow up on the answer that you gave in relation to how the funding will be allocated between the states. As a starting point you might look to the needs base and population distribution amongst the states. Where will you draw that data from?

Mr Cormack: There are a couple of ways that we can approach that. Firstly, there are annual statistics published on mental health expenditure. They are compiled by the Australian Institute of Health and Welfare; that is a good, objective time series report that helps us to look at the patterns of investment. Secondly, we can do a more detailed analysis at a regional level through our PHNs, who have very good intelligence on the ground. We can use the NGO sector and the peaks to advise us of service gaps. Also we have, as I mentioned earlier, the mental health services planning framework, which is a good, useful tool that has been under development for several years. We have obviously used that to provide a submission to the Productivity Commission, so that is also a useful tool. It will not be any one measure, but we will triangulate a number of different data sources to ensure that we distribute it on a fair and equitable basis, and one that maximises the investment of Commonwealth and state governments.

Senator KAKOSCHKE-MOORE: It is a relief to hear that it will not be 2011 census data or something that old, compared to some of the other funding.

Mr Cormack: We will get the latest that we can.

Senator KAKOSCHKE-MOORE: Thank you.

Senator O'NEILL: I am seeking information about the 10 headspace centres. Three of the 10 centres have now been announced?

Mr Cormack: That is right.

Senator O'NEILL: Grafton, Whyalla and Mandurah. I hope I have pronounced that correctly; I do not want to offend the Western Australians. Have locations been determined for the remaining seven headspaces?

Mr Cormack: The remaining headspace services will be announced shortly.

Senator O'NEILL: So, yes?

Mr Cormack: Yes, we have worked through those with the minister. As you quite correctly point out, he has announced three and he will announce the other seven in due course. We are not at liberty to disclose those, in case that was your next question.

Senator O'NEILL: In due course?

Mr Cormack: I think the minister is very keen to do it, but that is a matter for the minister. He has been pretty busy since the budget. I am sure that he will be very keen to announce these as soon as he can.

Senator O'NEILL: Could you explain why the Grafton site was chosen as one of the new headspace centres?

Ms Cole: Essentially, there was a process whereby we modelled youth populations and service availability within Australia. We did a big mapping process and we came out with a number of locations where essentially there were low services available and an appropriate youth population.

Senator O'NEILL: I am sorry; you modelled and mapped and you came out with—

Ms Cole: With a number of locations where they had a low service availability, plus they had an appropriate youth population.

Senator O'NEILL: An 'appropriate' youth population?

Ms Cole: Yes. You need a certain cohort of young people within a reasonable travelling distance to make a headspace centre viable.

Senator O'NEILL: What number of locations did you come up with?

Ms Cole: It was around 25. We then went through a separate process of bidding with the PHNs. We asked the PHNs what their views were about where a headspace centre would be an appropriate place because we wanted to compare the local, on-the-ground intelligence, in a sense, with what was happening at a national level in terms of our statistical analysis. We combined those two together and we came up with a list of possibilities.

Senator O'NEILL: How many were on that list of possibilities?

Ms Cole: That list went down to about 20 or so in the end.

Senator O'NEILL: Of those 20 possibilities, you put 20 to the minister and it was at his personal discretion, or on what basis was it done? Was there a priority listing?

Mr Cormack: At the end of the day—I think Ms Cole has outlined the process that we went through—the final decision on the location of the headspace centres was based on comprehensive advice that the department provided to the minister, and it is a decision for the minister.

Senator O'NEILL: Could you advise, Ms Cole, if they were ranked or tiered in some way, indicating where they would have the most efficacy, or was it just 20 picked—take your pick?

Ms Cole: No, the department ended up with 20.

Senator O'NEILL: Were they ranked or tiered in the advice to the minister, or did you just give him 20 and he could pick any 20; they were all of equal value?

Ms Cole: We did have a ranking from that process.

Senator O'NEILL: The ranking was based on those two critical factors that you identified?

Ms Cole: Plus the input from the PHNs.

Senator O'NEILL: So there were two elements to it. Were they ranked one through 20 or were they ranked in groups of five at a time?

Ms Cole: We did group them a bit in terms of those that would suit the traditional model and those that needed a modified model, because we were starting to get down into communities that were getting a bit small for a traditional headspace, when you looked at all the other headspaces across Australia, and noting that the emphasis on this round was to be regional and rural.

Mr Cormack: The other point, too, is that it is not like you just got one to 20. We provided advice on the pros and cons of one over another, and you need to take into account factors such as the information that has been collected through the PHNs as well as the time taken to be able to commission a service. That is important. So there are a range of other factors that we bring to the minister's attention and the minister makes his decision based on that. These are decisions of government.

Senator O'NEILL: How do you identify the time to commission? Do the PHNs actually put forward a bid or not?

Ms Cole: When we ask them to put forward a bid, we ask them around the availability of logical lead agencies within the region: is this a community which has an appropriate service provider already located or located nearby? It is that sort of assessment, in a sense, of the ability of that community to be able to pick up a headspace centre quickly. They still have to go through a commissioning process. They still have to open it up to market, in a sense, in their commissioning process. But they have a sense of whether or not there are already service providers within a community who would be able to pick up that role relatively quickly and appropriately with the right staff.

Senator Nash: Senator, the officials have outlined the process, but, in relation to Grafton, I have been contacted by people up there over a period of time who are quite distraught about the significant level of mental health in the area and suicide rates. While the officials have outlined the formal process, it certainly seemed to me, travelling around a lot of regional areas as I do, that that seemed to be a particular hot spot; they were really concerned about it up there.

Senator O'NEILL: Would you say the same for Whyalla and Mandurah?

Senator Nash: I have not spent as much time there. I was just giving you my local knowledge in New South Wales, as you know.

Mr Cormack: The other point is that there are 99 open at the moment, with the 100th about to open. From previous commissioning of headspace centres, there will be 110. When you think of the nature of the service model, that is a pretty significant national network of service delivery, particularly coupled with some of the other services that are funded. So we are certainly very confident that the distribution, the viability and the implementability of these new headspace centres are really consistent with the government's priority to have good quality, locally available, accessible headspace centres for youth and young people. We think that, when the minister makes the announcement, we will see a very comprehensive, fairly distributed national network of headspace centres.

Senator O'NEILL: You have indicated that it is a priority, and you have indicated the announcement. Will the next seven be announced all in one go?

Mr Cormack: It is up to the minister as to how he announces those things.

Senator O'NEILL: You have identified a clear process. What about lobbying from a member of parliament or a community petition? Do they hold any weight or count in terms of why a headspace centre should be located in a specific area?

Mr Cormack: It is very important that the department, in providing advice to the minister, gauges local opinion; in fact, we go out and seek that. That is why we talk to the PHNs. So we take into account input from a whole range of sources. Indeed the minister's office manages their constituents and their relationships as they see fit. We are not part of that process. At the end of the day we provide the information and the minister makes the decision.

Senator O'NEILL: I understand that the member for Canning was pushing for a headspace to be located in the Peel area of Western Australia. Of course, last week Minister Hunt sent out a media release announcing a new headspace centre for the very area that the member was increasingly hopeful of securing. I was wondering why he would say this, given that the process is essentially supposed to be driven by mental health—

Mr Cormack: I think that is a question you would have to ask of the minister.

Senator O'NEILL: Senator Nash, would you be able to answer the question on behalf of the minister?

Senator Nash: I could take it on notice for you. I am not aware of those circumstances, but I am happy to ask him and come back to you.

Senator O'NEILL: It would be concerning if there were not an evidence base for the announcements of these vital—

Mr Cormack: I think I have outlined a very extensive—

Senator Nash: I do not think anyone has said that. I am certainly happy to take that on notice for you. There has been a process in place here. Clearly, I am not aware of that particular circumstance. We will come back to you on that.

Senator O'NEILL: Can you take this on notice: has the minister ticked off on another headspace for the member for Canning, bypassing an evaluation process? Can the minister confirm that Canning was one of the 20 that was on the final list? It seems that the member for Canning might have already known something or an impending announcement. Has he been part of the process?

Senator Nash: I do not think it is fair to categorise it that way. Members in electorates right across the country are continually raising issues of importance in their electorates with ministers in the area of health, education and across a whole range of issues. It would not be unusual for a member to raise something that they thought was important in their electorate.

Senator O'NEILL: But it would be unfortunate if it were—

Senator Nash: Well—

Senator O'NEILL: The headline was 'Mandurah wins headspace', as if it was a competition between colleagues who are pushing for their favourite area over a proper response to needs on the ground.

Senator Nash: I would certainly hope that you would not want to make something as important as new headspace sites a political issue.

Senator O'NEILL: I fear it may well have become one already, Senator Nash.

Senator Nash: It is incredibly important that we get these sites out across the country, adding to what we have already done. As you know, they are really well received, and the last thing people want to see is people using headspace sites as a political football.

Senator O'NEILL: It would be really frightening to think that the precious money that needs to go to these services across a state as big as Western Australia ends up in the wrong place because of lobbying rather than through analysis.

Senator Nash: I would not be frightened pre-emptively at all. There has been a very rigorous process around this. I have undertaken, on that particular circumstance, to come back to you with the information.

Senator O'NEILL: Thank you.

CHAIR: Senator, every decision made is made as a result of the process. That was what I heard.

Senator O'NEILL: At the discretion of the minister.

Mr Bowles: The minister makes the final decision.

CHAIR: That is through a process.

Mr Bowles: We provide comprehensive advice to the minister and the minister makes appropriate decisions based on the advice and other issues—whatever the minister has at hand. What I will say, without going to the specifics of this particular issue, is that the department provides that advice and we are very comfortable with the decisions that are made in this case.

Senator O'NEILL: I have a question of fact: did you provide, Ms Cole, advice to Minister Hunt on determining why Mandurah should be one of the 10 new headspaces?

Mr Bowles: We cannot go to the advice that we give about specific issues. I have said that we provided advice, and I am comfortable with the decisions made to date.

Senator O'NEILL: Am I right in saying that there are now 11 headspaces in Western Australia, but not north of Geraldton? Surely, there is a mental health need north of Geraldton. There is a big gap between the 11 in the south.

Ms Cole: Part of the problem is population size. If you do not have a community of more than a certain size, the headspace model, as it currently exists, with an actual, separate centre—a certain minimum number of staff and so on—is not viable. One of the things that we are looking at is alternative models, in conjunction with headspace national office, around some of these things. However, your statement was not actually correct, because we do have a headspace centre in Broome.

Senator O'NEILL: It is a long way, with respect to the gap between the most northern one and those located down in the south. It is a very long way.

Ms Cole: It is an issue around viability in terms of particular locations. To some extent I alluded to that when I started talking about traditional headspaces versus—

Senator O'NEILL: Modified models?

Ms Cole: Yes, outreach services, satellite services and those sorts of things, which may be the only way we could provide a headspace type service to some of these smaller communities.

Senator O'NEILL: I might have a couple of questions on notice around that, in particular with regard to this new modified model—what are the elements of it, how is that determined.

Ms Cole: Yes.

Senator O'NEILL: And if you could take on notice what role, if any, that local petitions play in your recommendations to the minister.

Mr Bowles: We can take that on notice, Senator.

Senator O'NEILL: Thank you.

Mr Bowles: We may have very little information on that. We provide apolitical advice on these issues.

Senator O'NEILL: Yes. That is why it was concerning to have that 'Mandurah wins' headline, and the local member crowing about it as a victory for him.

Mr Bowles: We cannot control headlines. And have never tried.

Senator Nash: We certainly cannot control the media.

Senator O'NEILL: Can you explain to me how the funding works for each of these 10 headspace centres? The funding is $20 million: is that correct?

Ms Cole: Essentially there is a broad average which we work off, which is around $840,000 per headspace centre per year, with an initial setup of around $450,000 per headspace centre per year.

Senator O'NEILL: That is the initial setup, but it is not per year, is it?

Ms Cole: No. The first year is a setup year, usually.

Senator O'NEILL: That is the $450,000?

Ms Cole: Yes, that is the $450,000, and that covers things like securing the lease, the initial costs of staff, and the fit-out—because there are quite specific fit-out requirements for headspace—and so on and so forth.

Senator O'NEILL: I have to say, having visited many of the headspaces now up and down the eastern seaboard, that the specification you have been overseeing there has been very effective in making it a very welcoming place for young people. I think that is undoubtedly a success and it is very much appreciated by the clients with whom I have been able to converse.

Ms Cole: Most of the credit belongs to headspace national office in this space.

Senator O'NEILL: It is quite remarkable, and it makes such a difference to the interactivity. But, if you could continue, apart from that $450,000 setup, then where do we go to?

Ms Cole: We work on an average of 850, but it varies depending on the circumstances of each individual headspace. It varies on two main variables. One is the actual leasing cost for a particular location, because they can be significantly different. The other variable is the service levels expected in that particular headspace.

Senator O'NEILL: I will come back to that; that is a question from my experience of conversing with them. How is the service delivery decision-making determined and how frequently is it reviewed? I guess it does go to some of the questions that have been raised about how people have got on a funding level and that is it—they have just stayed there, regardless of significantly varying need. I want to speak about that a bit more, too.

Mr Cormack: There is a transition process that we are going through now. Historically, prior to the announcement of the government's response to the National Mental Health Commission in November 2015, we had effectively a large-scale funding agreement with headspace national. They managed the contracting arrangement with the individual headspace centres, and in a couple of cases they ran them more or less directly themselves. That process has changed and the contracting arrangement resides with the PHNs. That kind of brand and model fidelity, that consistency of service and the look and feel that you describe, Senator, are very much the role of headspace national. They maintain and update the service model. So they are less involved now in the contracting—in fact, they are not directly involved in the contracting. Through this transition, it went from one head contractor down to 31—

Senator O'NEILL: Through the PHNs?

Mr Cormack: Yes. We have been able to identify quite significant anomalies, not in a bad sense, but just historical funding levels that did not seem to necessarily make sense when you looked at it with a clean set of eyes. So through the new arrangements that we have put in place we have been able to, in some cases, adjust some of those funding levels to recognise valid increases in cost and demand. We will continue to work with the PHNs to ensure that, while there is a consistent funding model, we also need to recognise that with 110 locations—which is where we will get to shortly—there will be 110 different sorts of circumstances, different rental markets, different labour markets, and different arrangements that can vary the cost. So it is not going to be one-size-fits-all, and with the PHNs now having flexibility, they can adjust those funding levels up according to those changing needs.

Senator O'NEILL: The PHNs will have the discretion to determine how much of the money that you allocate goes to—

Mr Cormack: The government has been very, very clear that there is a transition process that we are nearly through, and each PHN is to maintain the headspace model. This was certainly made very, very clear, particularly during the election campaign. Indeed, it was made very clear prior to that: that the headspace network is very much the government's preferred model for the delivery of accessible mental health and related services for young people and young adults. That continues, and the expectations are made very clear to the PHNs that this is a government program, and they are responsible for commissioning and contracting it. They understand that very well.

Senator O'NEILL: That it needs to stay; they cannot kill it off by degrees?

Mr Cormack: They know that.

Senator O'NEILL: You mentioned $850,000, Ms Cole, as the average quantum of funding per annum?

Ms Cole: Yes.

Senator O'NEILL: Is that what has been allocated to each of the three that have been announced, or have they just got their 450 start-up money?

Ms Cole: The 840 is what we use as a costing mechanism. So when we do the costs for 10 new headspaces, we use an average of 840. That does not mean that that is the final figure those three will get, but it is in the region. Averaged out over the 10, we are expecting it will be about 840 per year per headspace centre.

Senator O'NEILL: Would you be able to provide me on notice with a list of the 110, maybe with seven little holes that I can fill in?

Mr Cormack: Sure.

Ms Cole: Sure.

Senator O'NEILL: With the list of how much funding they have actually received over the last couple of years and into the forwards as well, where you see that money going?

Mr Cormack: It will be for the contract period.

Senator O'NEILL: Which varies from place to place?

Mr Cormack: Yes, and it does not run to the end of the forwards, because the contract period is the contract that is held between the PHN and the entity.

Senator O'NEILL: With that variation.

Mr Cormack: Yes.

Senator O'NEILL: Just so I can get clarity about what is going where; that would be very helpful. Do you have any oversight monitoring of waiting lists and waiting times for all of the headspace centres? It is becoming apparent that the cuts to federal hospital funding—

Mr Cormack: There have not been any cuts to federal hospital funding, Senator.

Senator O'NEILL: The funding pool that the state government has as a result of the tearing up of the national health partnership agreements seems to have a flow-on effect in terms of the service provision of mental health across the country. Certainly headspaces are reporting that, instead of being an early intervention and prevention service, the clientele they are now having to interact with, deal with and manage are having some difficulty transitioning to state services that are becoming more complex. Have you got sight of that, and is that a factor in your funding and response to headspace?

Mr Cormack: Let us deal with the headspace policy issue here. The headspace policy issue is that we have a very clear, mature and expanding headspace program running out across the country. Ms Cole has outlined how we have been able to review the levels of funding in response to need. The individual headspace centres are able to raise any concerns or issues about their waiting times and changing service profiles with their funding body, and the funding body with us. We are very happy to focus on addressing and responding to those. However, it is an exceptionally long bow to draw a link between changes that may or may not be occurring at an individual headspace centre with a Commonwealth hospital funding agreement that does not fund the same sorts of services and has not been cut over the forward years. So I take your point, but we do not see any logical linkage between one and the other.

Senator O'NEILL: It might be a long bow here in Canberra, Mr Cormack, but on the ground it is an even longer distance between access to service for some people. Certainly it has been widely reported that there are major concerns in terms of access for young people to critical services and the pressure on headspace is growing.

Mr Cormack: And the government has responded with a 10 per cent increase in the footprint, and the minister will be announcing the remaining seven of those shortly. But we need to understand that the Commonwealth is not responsible for the management of acute mental health conditions for adults and children. There is a clear responsibility for the states in this space in the same way. Apropos our earlier conversation about psychosocial services, the state and territory governments have very clear responsibilities in this space. The Commonwealth government's investment in mental health continues to grow and its commitment to youth and to the mental health of young persons is clear. I think the issues about what is happening in the acute side of the mental health system are best directed to the state and territory governments.

Senator O'NEILL: Just on the same area but slightly different, could you provide on notice the dates on which the PHNs were provided with the capacity to offer contracts to the service providers in the headspace? The delay was significant. People were working with only two months' notice, feeling very uncertain about their future. The impact on continuity of care for young people and service provision was felt. There were staff who left just because they had no certainty. So the dates at which those offers were made are very important, and perhaps a commitment to try to do it a whole lot more quickly for those who are running out in future, because there is a practical impact in the sector.

Ms Cole: Senator, are you asking about the changeover at the beginning of last calendar year? What happened was that the allocation to PHNs was given to them at the end of April, which was the specific allocation for each headspace centre. Then those PHNs worked as fast as they could with the lead agencies for each of the headspaces that they had responsibility for. Then the funding commenced from 1 July. Is that the transition period you are asking about?

Senator O'NEILL: Yes, Ms Cole, because if you only knew that you had eight weeks pay coming, you might be thinking, 'I'd better get a more secure job.' That is the reality.

Ms Cole: I guess the thing that we did was we gave that funding certainty to the PHNs.

Senator O'NEILL: In April?

Ms Cole: In April, with clear directions that this funding was specifically for the specified PHNs. We were not able to do it much faster than that because we had to sort out which headspace belonged to which PHN, which sounds crazy, but in a city situation it is harder than it looks. So there was a little bit of mucking around then, but the PHNs actually had the contracts from the Commonwealth in April and were able to provide that certainty to the headspace centres from that point.

Senator O'NEILL: But eight weeks is not very much certainty, Ms Cole. It just is not.

CHAIR: Senator Siewert.

Senator SIEWERT: Thank you. I want to go back to a couple of NDIS and transition questions, if that is okay. First off, though, have you recently had discussions with the NDIA about issues around mental health and eligibility for the NDIA?

Mr Cormack: Senator, our primary contact in relation to these sorts of issues is with the responsible policy department, which is DSS, and yes, we have had extensive discussions with DSS—for several months actually. But certainly over the last three to four months we have been very, very focused on that.

Senator SIEWERT: Could we explore that a little. I appreciate what you said. You go to DSS. DSS deals with NDIA.

Mr Cormack: Yes. But we do deal with the NDIA. For example, they have made data requests of us because we fund Partners in Recovery and Day to Day Living, and they have already commenced the process of getting a better understanding of the clientele because these people are going to be transitioning in. We do liaise with the NDIA in their role as the funder and service provider for the NDIS, but more with DSS.

Senator SIEWERT: I want to go to a place where you just took my brain with the discussion around the data issue. If I understand correctly, you have been liaising with NDIA about the client numbers?

Mr Cormack: They have approached us for information about client numbers and types that we fund through the PHNs to Partners in Recovery, yes.

Senator SIEWERT: I understood from our discussion earlier today that you did not have a good idea on some of those numbers.

Mr Cormack: And we do not.

Ms Cole: That is correct. What they asked us to do was facilitate with our PIR lead agencies, then provide details around client numbers that they held at that time to the NDIS.

Senator SIEWERT: So the providers of PIR provide those numbers straight to—

Ms Cole: Yes, that is correct.

Senator SIEWERT: Why can they not provide them straight to you as well?

Ms Cole: They could if we asked them, but we do not habitually collect specifically client numbers from PIR.

Senator SIEWERT: But if NDIA was after them, I would presume to do some planning around numbers, why could you not ask the same thing so that you have a better idea of the numbers that you may be dealing with in regard to all the other discussion that we had this morning?

Mr Cormack: I think they are different. In regard to the sort of information that we can get from Partners in Recovery and Day to Day Living, (a) they are datasets and not particularly good; (b) they are useful for some assessment of local preparedness and local need but, because of the organic nature of the way these have been funded over the years through the Commonwealth, they do not make up a logical kind of population base that would inform and enable modelling.

What we used instead was the National Mental Health Service's planning framework, which has only really come to the point of finalisation and release for use by state and territory governments. Indeed, we are starting to make it available to PHNs. That is the modelling tool that we have now been able to use for the purposes, as I outlined before, of providing a pretty recent submission to the Productivity Commission that is looking at the figures and the numbers that underpin the NDIS.

Senator SIEWERT: I will chase that further, obviously, with the NDIA when we see them tomorrow. In terms of the eligibility issue, I am sure you are fully aware of the debate that has been going on since NDIS started but most recently now that we are starting to see the rollout of NDIS.

Mr Cormack: Yes.

Senator SIEWERT: In terms of the nature of the discussions you have been having with DSS, have you been providing any advice to them in terms of any possible changes to the definition?

Mr Cormack: No, we have not. We have been having quite an intense dialogue with the DSS—and this goes back some months now—and it is really in the context of the progressive implementation of the scheme and the emergence now of a reasonable sample size of people that have gone into the scheme. I think we have just under 2,000 now that have migrated from the existing arrangements into the NDIS.

We have provided them with information using the National Mental Health Service's planning tool, which is, from our perspective, a relatively recent tool that has been available to us. Clearly, they have overall policy responsibility for the NDIS and they continue to advise their minister, Minister Porter, as needs be on the impact of the rollout of the scheme, and they have provided a submission to the Productivity Commission as well.

Senator SIEWERT: So your advice has been more around the numbers?

Mr Cormack: Yes.

Senator SIEWERT: Rather than looking at eligibility changes?

Mr Cormack: That is right. That is a policy matter, really, for DSS.

Senator SIEWERT: I understand that but, given that you are the Department of Health, I would think that there was quite a lot of crossover there in terms of your area of expertise.

Mr Cormack: Yes.

Senator SIEWERT: But you have not had those discussions?

Mr Cormack: What we have talked about is the numbers. What we have talked about is the emerging real experience of people transitioning into the scheme, and we are trying to make some sense of what those numbers might mean into the future. But those discussions are on the basis that the government and, indeed, the previous government, had made policy decisions about who was and who was not in the scheme, and we accept that as a given. The extent to which there may be any consideration of eligibility changes, Health is unaware of those, and that is the sort of thing you should talk to DSS about.

Senator SIEWERT: The discussion is more live in the community?

Mr Cormack: Indeed, the community have been very active.

Senator SIEWERT: Has it come across? Has it turned up in the work that you are doing in terms of the issue around permanent disability versus recovery?

Mr Cormack: Yes.

Senator SIEWERT: The fact is that it is still a live discussion in the community.

Mr Cormack: Absolutely. It is a live discussion. We are open to that discussion. The minister has responded and the government has responded with an $80 million measure. Now that the numbers are starting to come into the scheme, we are advising government on how to respond to that, which was hypothetical a couple of years ago. It is now real and it will become more real in the next two years. But we are extremely conscious of the views of a number in the sector that do not like the definition. But we are public servants; we are implementing government policy. Government has made a decision, and the definition is set and is not one that certainly Health has any say over the modification thereof.

Senator SIEWERT: Thank you. I will be pursuing that matter with DSS and NDIA. Still on the NDIS and this issue of the guarantee of continuity of support, do you have a definition, an operational definition, of 'continuity of support'?

Mr Cormack: I could search for a written down definition of that but I guess, from our perspective, as the new scheme comes in and migrates across existing clients in the scheme, it is recognised that some clients will not be migrating across. That is the figures we talked about before. At the point in time of transition, there is a continuity of service obligation on the Commonwealth and on the states for those people receiving services who will not be migrating into the NDIS. There is a commitment by the Commonwealth, by the state and territory governments, to maintain continuity of support for that group, and that is a commitment that government has given.

However, there is another group—and I think that is probably what you are focusing on—who were not receiving services and, in fact, may not have been unwell at the time of transition.

Senator SIEWERT: Exactly, yes.

Mr Cormack: And they will come into a service system that has changed completely by virtue of NDIS, and that requires a new investment or a continued investment in psychosocial services for that group. It is not just about the continuity of support group; it is that group. Indeed, the measure that the government has announced addresses that, noting, of course, all the caveats we had this morning about us not knowing what the size of that will be. Government is, of course, able to revisit that as it needs to at a point in time in the future.

Senator SIEWERT: In terms of ILC, can I just tease out that there are a few programs running under ILC already?

Mr Cormack: Yes.

Senator SIEWERT: If I have got some funding under ILC, how does that relate to continuity of service? At the moment we have been largely talking about if I am a full participant.

Mr Cormack: I would really appreciate it if you ask that of DSS, because what we are focused on, to be honest, is those going into what we would call the kind of tier 3 or the full scheme.

Senator SIEWERT: Full scheme, yes.

Mr Cormack: Yes. Money is going with them. And those that are left require ongoing services. That will be addressed through continuity of service obligations and new money that addresses those that are not already in the scheme. On the issue of information linkages and capacity building—which is, I think, what ILC is about—I would suggest you ask that of DSS because we probably do not have the clarity on that aspect of it. We are focused on continuity of service and potential resulting service gap for those that do not go into the scheme.

Senator SIEWERT: I understand where you are coming from. I am certainly not clear about how that relates to continuity of service. I am not trying to be a smart arse here; I am trying to actually understand: has that issue been considered in terms of the issues that we are talking about in terms of continuity of service? I understand exactly what you have just said. But it sounds like that issue has not been sorted yet.

Mr Cormack: That issue is largely an artefact of the NDIS. The NDIS is the policy responsibility of DSS. Our focus has been on continuity of service, addressing potential gaps in partnership with state and territory governments and an $80 million measure that enables commencement of some additional resources to address those.

Senator SIEWERT: I will go to DSS but I suspect I will be back here in October.

Mr Cormack: That is fine.

Senator SIEWERT: Asking that question again.

Mr Cormack: I will be here waiting for it.

Senator SIEWERT: It may be a question on notice after tomorrow. I am presuming for what you have just said: that continuity of service is taken for granted, that it just continues?

Mr Cormack: It has to happen.

Senator SIEWERT: It has to happen, and it continues with the person as long as they need it?

Mr Cormack: Yes. There is possibly a more elegant definition than that, but that is how we are interpreting it. We have a continuity of service obligation to those people.

Senator SIEWERT: I am specifically interested in, then, obviously, as Senator O'Neill articulated before: is this is an episodic illness for many people?

Mr Cormack: Yes.

Senator SIEWERT: So it is over their lifetime?

Mr Cormack: Correct. That is how we would interpret it.

Senator SIEWERT: I have some more questions, but I think they are my NDIS ones.

CHAIR: Thank you very much. We will break for 15 minutes, returning at 11.14. Senator Sterle will ask a short bracket of questions relating to Indigenous suicide in the Kimberley and then we will return to this matter.

Proceedings suspended from 10:59 to 11:14

CHAIR: Senator Sterle, would you like to kick off questions for us?

Senator STERLE: I would. Thanks, Chair. Minister, I want to ask questions in relation to the roundtable communique that was held in Western Australia in the Kimberley region regarding Aboriginal suicides. Is this the right area to ask?

Senator Nash: Roundtable on suicides? Yes.

Senator STERLE: If it is not, I am happy to come back at another time. Bear with me; just a little preamble, Minister. This initiative was under Minister Ley; I have no doubt you would be all over it. It is in relation to the outcomes from the roundtable. I am asking this question because I do work extensively in the Kimberley.

Mr Cormack: I know you do.

Senator STERLE: This is a shockingly important issue that we are confronted up there: youth suicide—not only youth, but Aboriginal suicides. One of the two key outcomes from the budget roundtable included in the announcement was, firstly, an agreement for shared commitment between the Australian government and the community and service providers to reduce the high rates of suicide in the Aboriginal and Torres Strait Islander communities in the Kimberley region. One of the other dot points—there were about eight of them—was that government funding and investing needs to be better targeted, with more local involvement and streamlining between state and federal funding agreements. My question to you, Minister, or to the officers of the department is: is there any new funding in the budget for ATSI suicide prevention, or mental health programs to combat Indigenous suicide?

Ms Cole: There was not additional specific funding for Indigenous mental health or suicide prevention in this budget, but in the previous budget, in MYEFO, following the election commitments, there was specific funding given for the two Indigenous suicide prevention trials.

Senator STERLE: Ms Cole, how much was it before—in the previous budget?

Ms Cole: There has been specific funding in existence already for Indigenous suicide prevention, and an additional $80 million or $84 million was given for Indigenous mental health when the PHNs were established in the government's response to the National Mental Health Commission's report. Those two elements of funding have now gone into the PHN flexible pools and are being commissioned out for specific services in various regions.

Senator STERLE: Ms Cole, so one was $80 million and one was $84 million?

Ms Cole: About an additional $5.6 million ongoing was given to the PHNs specifically for Indigenous suicide prevention.

Senator STERLE: Yes.

Ms Cole: In addition to that, there was $84 million over three years for Indigenous mental health services.

Senator STERLE: Yes.

Ms Cole: So certainly the first one is ongoing. In addition, in MYEFO there was some $46 million-odd given for suicide prevention, which included some funding of $3 million over three years for each of two trials, one which was subsequently placed in the Kimberley and one which was placed in Darwin.

Senator STERLE: So that was in the previous budget, not this budget?

Ms Cole: In MYEFO, yes.

Mr Cormack: Senator, there are some items in this budget that I think are relevant to access to mental health services and suicide prevention. There is the $9.1 million telehealth initiative. That enables Australians who live in rural and regional Australia to access psychological services via more contemporary technology. The current arrangements are that the 10 sessions under that program required face-to-face. This now changes that so that seven out of the 10 can be through a videoconferencing facility. There is also some additional funding for suicide prevention and support activities. There has been funding for suicide hotspots.

Senator STERLE: How much is this?

Mr Cormack: The total amount for suicide hotspots is $11 million. That will form the basis of a national partnership agreement with the states and territories, recognising that it is a primary area of responsibility, plus some additional funding to Lifeline to support that with a capacity to promote help-seeking messages at hotspot locations. The other important pieces of investment in this budget—we can certainly go through the total suicide prevention investment in a minute—are three targeted research programs in mental health. Orygen, the National Centre of Excellence in Youth Mental Health, got $5 million to upgrade their research and translation facility in Melbourne. The sum of $5 million went to the Sunshine Coast Mind and Neuroscience - Thompson Institute, which is for research involving young people with major mood or psychiatric disorders and suicide prevention, and $5 million went to the Black Dog Institute in conjunction with the Hunter Institute to translate research findings into improved and innovative service delivery for people with anxiety and depression. The budget continues a series of significant service and system reforms that the government has made in mental health. Some very significant election commitments—$194.5 million—were confirmed at MYEFO, and the measures that we have just outlined for you.

Senator STERLE: Thank you for all that, but I want you to point me to where, as one of the key outcomes at the roundtable, it clearly stated 'the agreement for a shared commitment between the Australian government and the Kimberley region'. So help me out. I understand there was $84 million in the last budget for mental health, and then with MYEFO there was $5.6 million for ongoing suicide prevention. Just focus on the Kimberley for me after the roundtable and all the meetings that were going on and getting everyone engaged.

Ms Cole: Essentially there have been two meetings of the working group which has the state and territory people on it: from education, the police, the PM&C, who have an important role in terms of the social wellbeing component of this, ourselves and representatives of local service providers and the local communities. Part of that process has been mapping out the existing services. They are in the process of doing that now with a view to being able to adjust any overlaps or whatever and refocus efforts around where it will make the most difference in suicide prevention. At the same time, the PHN has a component of money under their mental health money, their drug and alcohol money and their suicide prevention money specifically set aside for the Kimberley region.

Senator STERLE: So how much is that, Ms Cole? How much money has been directed—after the roundtable, with all the light and mirrors and the big hoo-ha in the announcement—to the Kimberley?

Ms Cole: There is $3 million specifically for the trial, and then there is ongoing funding, which the PHN is going to focus following the consultations with the community around the issue of suicide prevention.

Senator STERLE: Ms Cole, how much is that ongoing funding?

Ms Cole: I will have to take that on notice for you, Senator.

Senator STERLE: So after all that, we have established that there was $3 million for the trial. When does the trial complete?

Ms Cole: The trial is running for three years, from 2016-17.

Senator STERLE: Three years of trialling. So there is no new money there.

Mr Cormack: That is new money. A million dollars a year is allocated to that work. There are 12 trial sites. You are clearly interested in the Kimberley.

Senator STERLE: Yes, I am.

Mr Cormack: That new money will enable local solutions to be identified and funded over that three-year period.

Senator STERLE: So that $3 million is specifically the trial just for the Kimberley?

Ms Cole: That is correct.

Mr Cormack: That is right.

Ms Cole: In addition to that, new funding was provided for Indigenous mental health and suicide prevention in the government's response—

Senator STERLE: How much is that?

Ms Cole: That is the $80 million across Australia over the three years, and the $5.6 million annually ongoing that I mentioned earlier.

Senator STERLE: This may sound like a dumb question, but how do you divvy that up?

Ms Cole: The Indigenous-specific component was essentially divvied up on a population basis for Indigenous Australians.

Senator STERLE: How much is that money? How much will the Kimberley get out of that $84 million?

Ms Cole: That breakdown, because it is for country Western Australia, I have to get for you on notice because it is a subset of the overall funding—

Senator STERLE: Okay. Are you in a position to tell me how much country Western Australia will get as a total?

Ms Cole: For those two components?

Senator STERLE: Yes.

Ms Cole: I will have to have a look. I may be able to get it for you later, Senator, rather than—

Senator STERLE: I am of the opinion, Ms Cole, that it is always easier if you can do it now, to save you going back and having to beaver away—you know how it all works. But if you cannot, I accept that.

Ms Cole: I understand that, Senator, but I may not have that level of detail.

Senator STERLE: I have been around estimates for a couple of weeks now, so I do understand how hard it can be for you people to provide all the info, for a myriad of reasons. So I am saying that, if you have to take it on notice, I understand. But if you have got it there, that would be great.

Ms Cole: The country WA PHN, which is the relevant PHN, is receiving in 2017-18, $18.7 million for mental health, which includes $0.5 million for community suicide prevention and $0.62 million for Indigenous suicide prevention. So that is the overall bucket that they have. Then they are using a formula of around 20 per cent for the Kimberley region of their total amounts of funding.

Senator STERLE: So about $200,000-odd?

Ms Cole: Ongoing, yes.

Senator STERLE: Yes, per year.

Ms Cole: So that is only their specific suicide prevention money. They also have their mental health money—so 20 per cent of their mental health money—and their community suicide money as well.

Senator STERLE: So, to save me adding up, how much is the whole package going to the Kimberley following on from the two roundtables?

Ms Cole: That is where I will have to go back and do the sums for you.

Senator STERLE: If you can find that out for me. Just bear with me, because you have answered a lot of the questions that I have had written out. So there is a working group now, is there not?

Ms Cole: Yes.

Senator STERLE: Still a working group?

Ms Cole: Yes.

Senator STERLE: Can you tell me who is on the working group, please?

Ms Cole: Yes. We have already provided that information in a question on notice.

Senator STERLE: You have done that this morning?

Ms Cole: From the last additional estimates.

Senator STERLE: Do you want to table it? Is that easier?

Ms Cole: Yes. So we can table that again, if you would like.

Senator STERLE: If you can table that for me. If you can tell me how often it meets, too, please?

Ms Cole: It meets every three months, approximately.

Senator STERLE: Okay. Has someone got it there behind you?

Ms Cole: Yes.

Senator STERLE: That is great—tremendous. It will save you running back to the office.

Ms Cole: We will sort that for you.

Senator STERLE: Thank you. While that is being dug up, can you tell the committee what has been the advice to government to date coming out of the workings of the committee?

Ms Cole: Senator, this working group is unusual because it is chaired by Minister Wyatt. So Minister Wyatt is involved fairly intrinsically in this process. For that reason, although we provide him with briefings and so forth as the chair, we do not need to brief him in the sense of a normal kind of information brief. He knows what is going on in the Kimberley region because he is chairing the committee.

Senator STERLE: So you brief the minister?

Ms Cole: Yes.

Senator STERLE: Can you share that with the committee?

Ms Cole: No. We do that as chair's notes, is what I am saying. Because he is chairing the working group, he is intimately involved in the development of the work of that group within the Kimberley region. So we provide him with chairing notes and so forth. We do not provide him with separate briefing on the progress of the working group, let us say.

Senator STERLE: No, but surely someone must be in the position to tell us how those meetings are progressing and what issues have come up. That is what I would like to know.

Ms Cole: I can tell you that, Senator, because I attend as well.

Senator STERLE: Where are we heading? What are we going to do to seriously tackle this head on, which everyone wants to do?

Ms Cole: Yes.

Senator STERLE: That is the information I am requesting.

Ms Cole: The group is essentially mapping current services, looking at gaps, getting input from local communities, particularly the community reps. There are a number of themes that are coming out. The themes are around wanting some greater education of parents and caregivers of young, quite young, Indigenous Australians who may be on the pathway towards suicide prevention, understanding those warning signs, the kind of mental health first aid they are seeking. They are also very interested in the provision of after-hours services in a crisis situation, particularly in some of those small communities in the region like Derby, for example, and they are very interested in the interaction, in particular, between the drug and alcohol services and mental health services and adequate provision of follow-up services following a residential period for a drug and alcohol issue, whether that is in Port Hedland or in Broome or in Perth, depending on the type of service needed, and then appropriate follow-up for that individual when they return back to community. Those are among the major themes that have come out.

There is also a fair bit of discussion with principals and the education authorities within the region about how schools can be hooked into some of these services. It is not by any means conclusive at this stage. There has also been a youth forum, which was just held in the last couple of weeks in the Kimberley region.

Senator STERLE: Where was that held?

Ms Cole: In Broome, is my understanding. There are some suggestions which have come from the youth of the region which we are expecting to be imported, including by a couple of members, into the working group to give that perspective of the young people on the ground.

Senator STERLE: Have you got a list of the working group? Can that be tabled for me please? Is that all Kimberley people on that?

Ms Cole: Yes, except for a few people such as Pat Turner, the CEO of NACCHO, the minister himself, a couple of departmental reps and a couple of reps from the WA Mental Health Commission.

Senator STERLE: That is covering all the Kimberley, east and west as well?

Ms Cole: Yes.

Senator STERLE: Is it possible to see it? You are just getting it copied? How is that committee funded?

Ms Cole: That committee is largely volunteers, all paid for out of people's salaries. And then for the community members, the PHN has some funding available to help with the travel costs associated with attending the meetings, particularly those who are travelling from some of our remote communities.

Senator STERLE: And we know how expensive travel is in the Kimberley. Does part of that funding from PHN come out of—

Ms Cole: The $3 million, yes.

Senator STERLE: The suicide funding as well. It is a basket that has to do everything at this stage. We think the trial will go for another—how long? You said three years?

Ms Cole: Three years from 2016-17.

Senator STERLE: Can it finish earlier?

Ms Cole: It could. I think it is unlikely that that would happen. Or it can be extended out, if needs be. In terms of the time frame, the funding is for three years.

Senator STERLE: The reason why I ask is that I was in the east Kimberley not long ago and they had not even had any involvement, unfortunately. That is why I am so glad that they are now involved.

Ms Cole: There is actually a community representative from Kununurra. Is that where you are thinking of?

Senator STERLE: Yes. There was not on the first one. Thanks very much.

Ms Cole: And unfortunately that community rep was not able to attend the last meeting. I think there was a family issue. No, actually the roads were closed.

Senator STERLE: It happens. They could not fly down?

Ms Cole: I assume they chose to drive. You would expect that they would fly normally.

Senator STERLE: I have got one more, if I may, chair.

CHAIR: Yes.

Senator STERLE: Suicide prevention researcher Gerry Georgatos, who is published widely and who was a member of ATSISPEP, if I can use that term, and is a member of the National Indigenous Critical Response Service, insists that the suicide crisis will get worse—these are his words—and that governments are not hitting in targeted ways the vulnerable and critically vulnerable when it comes to Indigenous suicide. Can you tell me what is the department's response to that?

Ms Cole: That one is a bit tricky, because it is an opinion.

Senator STERLE: I think he would be pretty close to being on the money. I do not think he is just guessing because he has got nothing better to do. I am certainly not going to politicise this because this should have been done years ago and we have lost, I think, about 100-odd Aboriginal people in the last five years. We are all very concerned. Three years of trials, there is not a lot of money. When experts say, 'It's not targeting,' I think you cannot just dismiss them.

Ms Cole: I do not think that is perhaps an accurate reflection, because in the $3 million campaign for additional services or the setting up of additional services, for example, if we wanted to follow up on the suggestion that there is a significant education campaign of parents and carers so that they understand the warning signs of suicide, obviously that is something that could be funded out of that $3 million.

Senator STERLE: Out of your $1 million per year for three years?

Ms Cole: That is correct. The other thing to note is that the theoretical basis of the trial is essentially using the work out of the University of Western Australia in terms of the report there about what works and what our people are telling us. The name of the report is the ATSISPEP report. I guess in a sense it is difficult to see exactly what the commentator is basing their opinion on, given that the work of the trial is using that theoretical basis provided by the University of WA and the expertise of both Professor Dudgeon and Adele Cox in developing solutions.

Senator STERLE: I am well aware of the fine work that has been conducted by KALACC for years and years and no-one would listen to them. I know how frustrated they have been over the years. The work of Wes Morris has been second to none. The $3 million over three years that is targeted for suicide prevention in the Kimberley with our Aboriginal people up there is the only funding stream?

Ms Cole: No, it is not the only funding stream; it is the additional funding.

Senator STERLE: Sorry, the additional funding stream for the trial.

Ms Cole: Yes.

Senator STERLE: For the purposes of the trial, and that takes in a lot of things. And part of the money out of PHN will come in to try and run the trial and do whatever?

Ms Cole: Yes.

Senator STERLE: Does this $3 million over three years end in three years and that is it?

Ms Cole: At that stage, yes.

Senator STERLE: It is a decision for government?

Ms Cole: There are 12 trials going across Australia, and I expect that they are having a formal evaluation and they will recommend the lessons learned from the trial and how that can shape future policy and funding arrangements going forward.

Senator STERLE: Ms Cole, I am going to leave it at that. That has given me some food for thought. I am happy to have who is on the list, because I will be up there in two weeks time or three weeks time. I can follow up, and I will check out how it is going in the east Kimberley. I see there is Broome, Derby, Fitzroy Crossing, Halls Creek, Kununurra and Wyndham, but it does not say who they are. Do we have a list of who they are?

Ms Cole: We do but—

Senator STERLE: Only because I will check with them when I go up there.

Ms Cole: I guess we are just a little reluctant to give individual community members' names out in public.

Senator STERLE: What about if you just give it to me in private and then I can visit them?

Ms Cole: Can I just check with those individuals and then I will—

Senator STERLE: I beg your pardon?

Ms Cole: I will check with those individuals and then get back to you.

Senator STERLE: All right.

CHAIR: Senator Siewert.

Senator SIEWERT: Can I go to the Fifth National Health Plan and ask where things are up to, firstly?

Mr Cormack: Certainly. And I might ask another colleague to join me at the table. The Fifth National Mental Health Plan is progressing well. There is a pretty well-developed draft that has been through an extensive process of national consultation and engagement. It will be considered at the Australian Health Ministers' Advisory Committee meeting this week, Friday. And it is down for consideration by the COAG Health Council in August.

Senator SIEWERT: Sorry, who is looking at it this Friday?

Mr Cormack: AHMAC, which is the officials group, and effectively it will progress through that process and then go to ministers in August.

Senator SIEWERT: All the comment on the draft has been incorporated into a revised plan?

Mr Cormack: That is right. There has been extensive consultation. There is now a pretty much final draft. There are a number of points that will be discussed and debated this week and then from that there will be a draft that will go to COAG Health Council in August.

Senator SIEWERT: That pretty much final draft is the one AHMAC will consider?

Mr Cormack: Yes. They are considering effectively a final draft this week and then it will go forward, as most papers going to health ministers do. They go through a process with officials first, and they will go through to COAG Health Council in August.

Senator SIEWERT: Has the pretty much final draft gone out to any stakeholders or has there been any further discussion with any of the major stakeholders?

Mr Cormack: There has been extensive involvement and engagement with stakeholders to lead up to the development of a final draft. I cannot confirm whether they have seen the final draft, but that is not unusual with a national consultation process. But I can certainly clarify with officials the extent to which the draft that is going to AHMAC on Friday has been seen. But certainly the drafting group and the consultation process has gone through this exhaustively, and what is being presented we think reflects the outcome of that consultation.

Senator SIEWERT: I just want to be clear about the process from when the submissions on the draft came in and then the subsequent work done on the draft. Were any of those then subject to further consultation with stakeholders, formally or informally?

Mr Cormack: The consultation draft was publicly released on 21 October last year. The national consultation process was conducted throughout November and December. Eight hundred people attended the consultation workshops that were held in every state and territory, 140 written submissions and over 140 online surveys were completed. There is a drafting group that works to MHDAPC, which is the Mental Health and Drug and Alcohol Principal Committee, which is a subcommittee of AHMAC. They have now worked through all of the outcomes of consultation. The MHDAPC has considered that draft. It is going through to AHMAC and will go through for consideration by health ministers.

Senator SIEWERT: Thank you for the outline. It was useful but it did not actually answer my question: has it gone beyond the drafting group to other stakeholders in terms of issues that were raised to see if people are happy with the near to final draft—I will not say 'final draft' as I understand that it is not often that you take those final drafts out—or the next version of the plan?

Mr Cormack: I will need to take on the specifics. As soon as we find the official, we will give you the status of which draft has been seen by which stakeholder group. You can appreciate—

Senator SIEWERT: That would be appreciated.

Mr Porter: As Mr Cormack has said, the first consultation process was October-November last year. We then went back in-house with the drafting group and redrafted. We then did what we call second round consultation in February, March and April, which took a range of different forms. It included a whole range of bilateral meetings, as you would appreciate, with particular stakeholder groups. It also included a number of consultation workshops, again, to run through particularly the difficult issues that had arisen from consultation and how the drafting group had dealt with them. The draft following that, including as recently as about 10 April, was then redrafted again, and that is the final draft version that has not been shopped with stakeholders as yet but is the version that is going to AHMAC this week.

Senator SIEWERT: Thank you. That is appreciated. There have been a number of rounds of further consultation with specific stakeholders?

Mr Porter: Yes, there have been. We have been very focused on making sure that we touch as many stakeholder groups as we possibly can, because we recognise the import of the plan and what it is aiming to do. So we really are looking to engage with as many stakeholders as we can. We have been very fortunate that we formally partnered with Mental Health Australia, the peak organisation, to undertake the consultations in a truly collaborative and co-design sense. We jointly hosted, between the Department of Health and Mental Health Australia, the consultation process. They have been fantastic facilitators as well.

Senator SIEWERT: In that process from the draft, what about the second round of consultation?

Mr Porter: The first round of consultation was when we did the formal partnering.

Senator SIEWERT: What about in the second round?

Mr Porter: In the second round we have used Mental Health Australia in essence as the facilitators for us to continue to access the stakeholders that we need to.

Senator SIEWERT: In a similar way?

Mr Porter: In a similar way, but not a formal thing. We had originally contracted them late last year to help us organise the consultation processes and run sessions and those sorts of things. The second round of consultation was more informal, simply because of time frames and the dynamic nature of the redrafting.

Senator SIEWERT: Did that occur across Australia? Not the first round, the second, more informal consultation?

Mr Porter: I do not think we went to each state and territory, but we certainly had representatives attend sessions from each state and territory.

Senator SIEWERT: I just wanted to make sure that we have covered the ground around Australia.

Mr Porter: Yes, we have.

Senator SIEWERT: The COAG meeting is in August?

Mr Porter: Yes.

Senator SIEWERT: And the plan is then hopefully to announce it after that—the final release?

Mr Porter: The intent would be for ministers to consider and approve the plan and the precise format of when and how it is released. That is the aim. Certainly, all the jurisdictions are working towards agreement on that plan and having it announced and released at that time. Governments will then, of course, need to turn their mind to implementation, which will clearly be pointed to within the Fifth National Mental Health Plan. Each government

will need to look closely at its actions in response to an agreed plan. Collectively AHMAC and the COAG Health Council will almost certainly agree on an ongoing monitoring process. The mechanism for doing that will be a matter for consideration at the AHMAC and COAG Health Council meetings.

Senator SIEWERT: In terms of a more formalised implementation approach?

Mr Porter: Yes, and monitoring.

Senator SIEWERT: I have more questions, but I will come back.

CHAIR: Thank you. Senator O'Neill.

Senator O'NEILL: Thank you very much, Chair. I have several questions that I will put on notice regarding the ATSI mental health issues. Senator Sterle has raised a number of them. In regard to the 2017-18 budget, how much of the $115 million allocated was specifically for Aboriginal and Torres Strait Islander mental health and suicide prevention programs or services?

Mr Cormack: I will ask some of my other colleagues to assist with that question, Senator. I will ask you to repeat that question, if you do not mind.

Senator O'NEILL: With regard to the budget, how much of the $115 million allocated was specifically for Aboriginal and Torres Strait Islander mental health and suicide prevention programs or services?

Ms Cole: We did just go through this with Senator Sterle.

Senator O'NEILL: I heard some of that. I do not want to go into too much detail. It sounded like there were bits coming from everywhere.

Ms Cole: There are four major measures in the health budget which improve or enhance services available. There is a telehealth measure, a mental health measure, the community mental health measure, which we talked about in some detail this morning, and there is also a hot-spot suicide prevention measure. All of those measures will be beneficial for all Australians—Indigenous and non-Indigenous.

Senator O'NEILL: Yes, I heard that part of the answer.

Ms Cole: There is not specific funding dedicated in this budget solely for Indigenous Australians for mental health and suicide—

Senator O'NEILL: So there is no specific money for Aboriginal and Torres Strait Islander mental health services?

Ms Cole: In this budget, noting that in previous announcements by the government there have been some specific measures.

Senator O'NEILL: Thank you. Could I go to the government's mental health and suicide prevention announcement of $115 million? I would like to get to veterans as well. We have talked about the NDIS; I will not go over that. For telehealth or psychosocial services, I am curious about how this works. Can you explain what is meant by 'improving access to psychosocial services'?

Mr Cormack: Yes. This measure—

Senator O'NEILL: I have lots of questions, Mr Cormack.

Mr Cormack: I will be brief. This measure effectively enables a portion of the 10 sessions under the Better Access program for psychological services, for seven out of those 10, to be delivered via videoconferencing. That is in essence what the measure is. It is in modified Monash model geographical areas 4 to 7. So it is targeted—

Senator O'NEILL: So an eligible area is the modified Monash—

Mr Cormack: That is right; classifications 4 to 7.

Senator O'NEILL: Funding is set at $9.1 million across the forward estimates.

Mr Cormack: Yes.

Senator O'NEILL: How many people living in regional, remote and rural areas will this assist?

Ms Cole: That calculation is based on an eight per cent growth figure anticipated in terms of the number of Australians accessing those services. It is not an individualised figure; it is a figure around growth in the Medicare benefit.

Senator O'NEILL: How many people do you believe it will assist?

Ms Cole: I will have to take that on notice because it depends a lot on how many services each individual chooses. It is an eight per cent growth in the service rate, noting that it can be up to a certain limit. But most people do not actually take the full amount.

Senator O'NEILL: Do you have the raw number of individuals who have accessed the service?

Ms Cole: No, because it is not currently in place.

Senator O'NEILL: Who do you anticipate will access the service?

Ms Cole: I can give you an averaged figure. Assuming that each person in rural Australia takes the average number of sessions, we can work it backwards from that. But it is a very tenuous figure. It is not how we normally calculate Medicare items.

Senator Nash: It might help to clarify as well that it is actually for the Medicare rebate. So for the first time this will actually be a rebatable item.

Senator O'NEILL: Is this initiative contingent on people living in these areas having access to a computer or reliable internet services, like the NBN?

Ms Cole: It is reliant on them having access to some kind of computer service. It does not have to be in their personal situation. Some PHNs are already working with, for example, headspace services and remote GP practices to allow young people in really remote locations to be able to access a psychologist through headspace. So there are some ways and means around some of those access issues that you might be thinking about.

Senator O'NEILL: People might still need to travel to access this service in a place other than their home?

Ms Cole: If they do not have their own arrangements.

Senator O'NEILL: What arrangements have been made for people who might have a lack of digital literacy to engage with this technology?

Mr Cormack: Ms Cole has just indicated that we have a network of PHNs. They will do what they can to facilitate access to videoconferencing. It can be as simple as a connection via Skype. I know that in some parts of Australia that might not be possible, but pretty much in most parts of Australia it is.

Senator O'NEILL: Have you been following the NBN inquiry, Mr Cormack?

Mr Cormack: The point is—

Senator O'NEILL: Sky Muster is not going so well.

Mr Cormack: I think—

Senator Nash: It is actually going very well, Senator, in many places, but I suspect you are in the wrong committee to have that discussion.

CHAIR: You know better than that.

Senator Nash: I am very happy to have that conversation with you, Senator, at any time.

Mr Cormack: The real issue here is that under the rules prior to this measure the only way that people could receive their sessions and get an MBS benefit for it was face to face. The government have recognised that, due to a whole range of factors—distance being the main one, and local workforce supply—we can use contemporary technology to deliver the same sort of service offering using the internet. For those people living in the more disadvantaged areas, 4 to 7, it immediately opens up access to a service that perhaps they would have had difficulty in easily accessing.

Senator O'NEILL: Who determines access to video consultants? Is that the GP or the psychologist? How is that determined?

Ms Cole: It is essentially a modification to the current Better Access arrangements. To access Better Access at the moment, you must have a GP mental health plan in place. So, yes, it does require going through a GP service.

Senator O'NEILL: Will there be continuity of care?

Mr Cormack: We would anticipate that the continuity of care arrangement under this would be the same as under the current arrangements, albeit that seven out of the 10 sessions can be delivered remotely through videoconferencing. In fact this could probably enhance overall continuity of service because the service is going to be more accessible to people over time.

Senator O'NEILL: Will people who already have their psychologist be able to stick with the same psychologist, or will they have to choose from—

Ms Cole: If their psychologist chooses to make this service available to them.

Senator O'NEILL: If not, they would be able to continue under the current arrangement?

Ms Cole: Yes.

Mr Cormack: That is right. It does not disrupt the current arrangement at all.

Senator O'NEILL: In the explanatory notes it says clearly that this will mean people living in regional, rural or remote Australia will get the same access to psychologists as those living in major cities. Are you measuring that statement? Can you guarantee that outcome?

Mr Cormack: It is not really our job to guarantee these things. Certainly, as with all new programs, we will undertake the necessary evaluation to confirm its effectiveness or otherwise.

Senator O'NEILL: So it is an aspiration rather than a guarantee?

Mr Cormack: It is a policy commitment by government, Senator. We will be implementing it according to the government's instructions. As with all new budget measures, there will be a requirement for us to evaluate that and be accountable for its delivery.

Senator O'NEILL: You just mentioned that one vital part of the puzzle is access to a mental health plan. In relation to that, I would like to ask a couple of additional questions with regard to the Medicare rebate freeze, specifically with reference to mental health services delivered by psychologists under the Better Access—

Senator Nash: That is the freeze that Labor started that the coalition is ending.

Senator O'NEILL: The GP rebate for the mental health plan—

Senator Nash: Is that the one, just to clarify?

Senator O'NEILL: For each of these, can you confirm that they are both part of the government's rebate freeze? Were you able to hear my question?

Mr Bowles: We can take it on notice, because we do not have that here.

Senator O'NEILL: It has been in the media that mental health services, in terms of access to GP rebate for the mental health plan and access to psychologists, are subject to a freeze until 2020.

Mr Bowles: You are conflating a range of issues now, Senator, and—

Senator O'NEILL: Why don't you clean it up for me and tell me the facts?

Mr Bowles: Excuse me, Senator; I was speaking.

Senator STERLE: How dare you—

CHAIR: Order!

Senator O'NEILL: I was listening for an answer and I was not getting one, Mr Bowles.

CHAIR: Furthermore, the secretary said that he would take it on notice, from memory.

Mr Bowles: I did, Chair. I will take it on notice. It was in an outcome raised yesterday. We did go through this in some detail yesterday.

Senator O'NEILL: Chair, I want to ask this question again. Mr Bowles has just indicated he went through it in some detail yesterday, so I cannot understand why he would not have the detail today. Also, this is a matter of a document in the public place.

CHAIR: Just so that we are clear, Senator O'Neill, I understand that the secretary took on notice your first question and pointed out also that you were conflating some issues and was going through the detail on that.

Senator O'NEILL: I have invited him to give me the facts, so I will ask my question again: in relation to the Medicare rebate freeze, specifically with regard to mental health services delivered by psychologists under Better Access, and the GP rebate for mental health plan, for each of those, can you confirm that they are both a part of the government's rebate freeze?

Mr Bowles: As I said before, I will take that on notice. We went through that outcome yesterday in some detail—not all with me, but with the relevant people in that particular outcome. I can take your question on notice.

Senator O'NEILL: Mr Bowles, I was not here yesterday, and this is an important question for people to access. We are talking about mental health today.

Senator Nash: And, Senator, the secretary has said on a couple of occasions that he will take your question on notice.

Senator O'NEILL: Yes, Senator Nash.

Senator Nash: I am about to add some information for you, Senator, which might assist. Whether or not the indexation freeze applies to this Medicare rebate, as the secretary has indicated, he will take that on notice. I find it extraordinary that you are asking questions of this nature, given the fact that for the first time under the coalition government we are going to see a Medicare rebate for this particular access to psychological services, which you could well have done when you were in government, Senator, and you never chose to do. For the

Labor government to sit here and ask these types of questions about a program that is going to be so beneficial for rural and regional people—which you never did when you were in government—is extraordinary. But, as the secretary said, he will take your specific question on notice.

Senator O'NEILL: I thank you for that dressing down—

Senator Nash: It is not a dressing down at all—

Senator O'NEILL: I am here to get the facts on the record—

Senator Nash: I am stating some facts.

Senator O'NEILL: We have a right to have some transparency in answer to these questions. I will ask again. Mr Bowles was able to provide the information yesterday. I am sure that there must be enough people here to provide the answer to me today.

Senator Nash: We have the appropriate officials in place on each given day for any part of the program.

Senator O'NEILL: This is mental health. I am asking questions about mental health and you should be able to answer these questions. This is topical and of the moment. Can you confirm that Better Access and the GP rebate for a mental health plan are both part of the government's rebate freeze?

Mr Bowles: I will take that on notice, Senator.

Senator O'NEILL: That is not an adequate response, Mr Bowles.

CHAIR: The secretary has answered—

Senator Nash: Oh, for goodness sake! Of course it is an adequate response. Officials are perfectly entitled to take on notice questions when they are not able to provide a full answer. You know that, Senator.

Senator O'NEILL: Not being able to provide a full answer—

Senator Nash: And it is entirely an appropriate response.

Senator O'NEILL: and actually refusing to answer are two different things.

Senator Nash: Not at all, Senator.

Senator O'NEILL: If this information was provided—

Senator Nash: No, no, no. I will not have you speak to the officials like that. We did the Medicare indexation freeze in detail yesterday at the appropriate part of the program. If you had questions around the Medicare indexation freeze, I would suggest that you should have been here yesterday, Senator. We are now dealing with mental health, and the secretary has indicated he will take the specifics of that on notice, which is quite appropriate for him to do.

CHAIR: Senator O'Neill, have you a question?

Senator O'NEILL: In terms of access to the mental health plan, clearly this is a very significant issue. I am particularly thinking of young people. We have had a discussion about headspace; great initiatives are being operated throughout the country by the people in those centres. It will not help young people if there is a freeze on access to a mental health plan, if that is part of what they need in terms of getting treatment. I am surprised that you are unable to answer that question about mental health treatment plans in the section on mental health.

Mr Bowles: Again, Senator, I said we went through this in some detail yesterday with the relevant officials at the table. It will be in *Hansard*, those sorts of issues. I can take your question on notice and I can deal with the specifics of those.

Senator O'NEILL: How many people a year access services under these Medicare services: Better Access—

Mr Bowles: Again, that relates to a different outcome. I can take it on notice.

Mr Cormack: We will take it on notice. I am sorry we do not have that.

Senator O'NEILL: For mental health, you do not have those numbers here?

Ms Cole: Senator, you asked a question about the number of people who access Better Access. I do not have the figures for the number of individuals accessing Better Access. At the moment—because I did not anticipate your question—I do not have the latest service item numbers, either. However, I can take both of those and come back to you later during the day.

Senator O'NEILL: If you can, I would appreciate that. That would also be helpful with regard to the other question that has caused so much consternation here. Could you provide details in relation to the $15 million that was included in the budget for research?

Mr Cormack: Yes.

Senator O'NEILL: So, as outlined in the budget papers, it is going to three research institutes—the Black Dog Institute, Orygen and the Thompson Institute; is that correct?

Mr Cormack: That is correct, yes.

Senator O'NEILL: Is anybody else getting funding?

Mr Cormack: Under this measure, there are three organisations. You have correctly identified them. They have been allocated $5 million each over two years to support mental health research.

Senator O'NEILL: Did you say $500,000?

Mr Cormack: No, it is $5 million each over three years. That is $15 million in total.

Senator O'NEILL: Was that an open tender process or were these organisations handpicked?

Mr Cormack: It was not an open tender process.

Senator O'NEILL: So they were handpicked?

Mr Cormack: These are reputable research organisations.

Senator O'NEILL: Undoubtedly.

Mr Cormack: This is a budget measure, part of an overall package, in accordance with the four pillars that the minister has outlined. This is under the mental health and preventative health care pillar and cuts across into another one of the pillars, the long-term health plan, which is health and medical research.

Senator O'NEILL: I will have more questions on that as well.

Mr Cormack: Okay.

Senator O'NEILL: I am just trying to understand, Mr Cormack, why these three organisations received funding and other research organisations did not receive any funding.

Mr Cormack: These organisations are very active, top-shelf research outfits.

Senator O'NEILL: I agree wholeheartedly, Mr Cormack. But why were other organisations not able to—

Mr Cormack: It is a budget decision in the budget context. That is pretty much all I can say about that.

Senator O'NEILL: Was any analysis undertaken to determine how the funding was to be allocated in the forward estimates?

Mr Cormack: The forward estimates outline a profile of $7.5 million per year over two years. We provided some advice to the minister. Now that these have been announced, we will work more closely with the three organisations to convert the measure into contracts. Once that is completed, no doubt you will have some further questions to ask us about that, and we will make that available.

Senator O'NEILL: Is this funding tied to specific research, or is it up to each of the three organisations to decide how best to spend that money?

Mr Cormack: Let me just run through the three elements. Orygen is a major national youth and young persons' research and translational facility.

Senator O'NEILL: Yes, I have had the benefit of visiting, Mr Cormack.

Mr Cormack: The government already has a range of funding arrangements with Orygen, and this one is targeted to the contribution to the construction of an integrated health and translational research facility.

Senator O'NEILL: So this is research money that is going to infrastructure; is that correct?

Mr Cormack: It is going to support a facility to undertake healthcare and translational research.

Senator O'NEILL: So it is research money that is going to support infrastructure. Do you know the quantum of that $5 million; how much is going to infrastructure?

Mr Cormack: We will need to work that through, but the measure identifies $5 million to contribute to the construction of an integrated healthcare and translational research facility, and we will work through the detail of that with Orygen in the coming weeks and months. The second one is to the Thompson Institute for research in young people with major mood or psychiatric disorders and in suicide prevention.

Senator O'NEILL: Is that a research project?

Mr Cormack: It is for research in those areas, which are the specialty of the Thompson Institute. We will work through the details of that with the Thompson Institute. The final one is to the Black Dog Institute to support, in collaboration with the Hunter Institute, the translation of research findings into improved and innovative service delivery for people with anxiety and depression. They are three projects, three different kinds

of areas of activity. They were developed in the context of this budget, and, now that it has been announced, we will work with those organisations to convert and translate those into detailed funding agreements.

Senator O'NEILL: Have the research outcomes been discussed or discerned yet to provide any measure? How do you get research outcomes out of a building?

Mr Cormack: Well, you cannot do research without infrastructure, Senator. Most research requires some infrastructure. You can look across the Australian landscape, particularly the public health landscape, and see that if you are undertaking research into any area of health or medical care you need equipment, you need space to put people and you need infrastructure to enable the best quality researchers to undertake their work. Infrastructure is a core, but not the only, component of research. Other research grants can be specific to identified projects and priority areas. As we discussed last night in the context of the Medical Research Future Fund, money can be directed to health and research, advanced health and research translation centres. So the investment in research can touch on a number of different ways of supporting research, and infrastructure is one of those components.

Senator O'NEILL: So it could go to staffing, administration, infrastructure?

Mr Cormack: Indeed.

Senator O'NEILL: It is quite discretionary?

Mr Cormack: No, a funding agreement will be developed that will specify the deliverables, the outputs and outcomes from this investment. That is the level of detail that we will be able to progress with these three organisations.

Senator O'NEILL: With regard to the suicide prevention funding, could you provide a breakdown on that funding by organisation, by amount? I might put that one on notice. I will certainly have some more questions around funding for suicide prevention for programs, et cetera. Also, there was a written question on notice from me which asked for quite a degree of detail. Thank you for the response that you gave, but it was not entirely everything that we needed, so I will have more questions with regard to that.

Mr Cormack: Okay.

Senator O'NEILL: There were two, in particular, that go to some of the questions I was just asking you about outcomes. How is the department measuring outcomes; how are you identifying them? Have you given any advice to the minister? Those two parts of my question were not answered.

Mr Cormack: We will be specifying those in terms of advice to the minister as we develop and finalise the funding agreements for those organisations.

Senator SIEWERT: I have some questions that go between the department and the commission. So can I ask the commission to come up, please. Can I come back to the mental health plan? I want to ask about the more formal involvement of consumers and carers in the implementation of the plan. I am aware that the commission has a project on consumers and carers, and I would like to ask about that, too. I have other questions for you about another area. In terms of consumers and carers, I understand that in the past members of the mental health standing committee oversaw implementation of the plan, or measures of it? Is that correct? Mr Cormack, I will ask you first.

Mr Cormack: We will bat between each other. So you are asking specifically about the governance arrangements for the development of the Fifth National Mental Health Plan; is that right?

Senator SIEWERT: It is the implementation, and overseeing the implementation, of the plan and what formal arrangements will be in place for consumers and carers to be involved in that more oversight role of the implementation.

Mr Cormack: I might answer the AHMAC, COAG Health Council side of things and Dr Brown can perhaps talk about the potential role of the commission in that space.

Senator SIEWERT: Yes.

Mr Cormack: As I outlined before, the plan goes to AHMAC at the end of this week, and the COAG Health Council in August, and part of that will be discussion around the governance arrangement for implementing and monitoring the implementation from the AHMAC and COAG Health Council perspective. That matter is not settled, but it has certainly been raised right throughout the consultation process, and we envisage that following consideration by AHMAC we will have a pretty good idea of what that would be. But there is clearly agreement that we need to have an inclusive process in place that is not just about officials, to ensure that the Fifth National Mental Health Plan implementation has an appropriate monitoring arrangement. That is probably the best that I can say about that. Perhaps Dr Brown can say more.

Senator SIEWERT: Dr Brown, before I come to you, I want to ask a follow-up question. In terms of the mental health standing committee, am I correct in my understanding that consumers and carers are not on that anymore?

Mr Cormack: That is correct. MHDAPC is the Mental Health, Drug and Alcohol Principal Committee of AHMAC. As with pretty much all of the COAG Health Council committee structures, they are made up almost exclusively of officials. That is just the way it works. But there is active discussion and consideration of a modification to that arrangement to be more inclusive of the sector and more inclusive of consumers and carers. That was the very strong feedback that we got, and that matter will be considered by AHMAC on Friday and by COAG Health Council in August.

Senator SIEWERT: Is it your expectation that, along with, hopefully, the signing off of the plan, there will be signing off on the inclusion of consumers and carers in that oversight role?

Mr Cormack: I would expect that there will be very clear guidance or a decision about how the sector, the non-government sector, and consumers and carers are engaged and involved in the governance of the implementation of the Fifth National Mental Health Plan. Almost certainly that will be a matter of significant discussion in December.

Senator SIEWERT: Thank you. Dr Brown.

Dr Brown: From the commission's point of view, we were set up, I guess, to have a role to hold governments and the mental health system accountable for services. We see that we have a very clear and important role in this space. It is not just around the fifth plan, however. That is part of what we need to be monitoring and reporting on. But the fifth plan has a specific number of priorities. I think there are eight currently. It is not everything that needs to happen in the mental health system and related systems. Our role is to monitor and report on the broader issues as well as those that are contained within the fifth plan.

I think the distinction I would like to draw from the previous conversation is that we do not have a governance role; we have a monitoring and reporting role. We have a role, where it is appropriate, to facilitate change, to be something of a catalyst for change. But we are not a governing body.

Senator SIEWERT: In terms of the fifth plan, you are making the distinction that, if carers and consumers are actually included in that implementation process, you are standing outside that process to do the more detailed monitoring of its implementation? Is that correct?

Dr Brown: What I am drawing is the distinction between the role of the National Mental Health Commission and whatever committee is established under the AHMAC process that actually oversees the implementation per se.

Senator SIEWERT: Can I go to something slightly different, the project that you have underway in terms of consumers and carers, and ask you to expand on that a little. I am very aware of the work that was launched not that long ago in terms of the role of mental health carers and the value of mental health carers and some of the issues that are also starting to appear in terms of the NDIS and where carers are funded and supported in that process. Is that included?

Dr Brown: Yes. Firstly I would say the National Mental Health Commission from its inception has stressed the importance of engaging with consumers and carers as an integral part of everything that occurs within mental health service systems, whether it is in policy or service design or in evaluation or in education of the workforce.

The work that we are doing at the moment arose from a specific request from the former Minister for Health for us to look at the development of a framework for consumer and carer engagement and participation. In commencing this project we have set up a steering committee made up of people with lived experience—consumers and carers—and we also have engaged with Mental Health Australia, given their key role in this space as well, and they sit as an observer in that committee process.

We are approaching this project in stages. We are acutely aware that there are many existing consumer and carer frameworks. There was one that was developed by the National Mental Health Consumer and Carer Forum, albeit that it is now probably more than a decade ago. We did not want to develop yet another consumer and carer participation framework that might sit on a shelf. Most health services have a consumer and carer participation policy or framework. PHNs have developed them, research bodies have them. We felt we needed to actually understand what is out there, look at what are the essential elements, so that we are actually undertaking a project initially to scope out what is there and understand better what might be the essential components of a framework.

We will then see what comes back from that process to determine what the next step is. We may or may not need to go on to actually develop a specific new framework or we may be able to endorse the current framework, an existing framework.

What we also want to understand, however, is how such frameworks are actually utilised and are they actually implemented. What are the things that assist in succeeding with implementation? What are the barriers to effectively engaging consumers and carers in all aspects? We are in a process and not entirely sure what the end product will be, depending on that outcome.

Senator SIEWERT: What is your time frame for that section of your work?

Dr Brown: We have just completed a tender process to engage a consultant to do this piece of work. That will be in the second half of this year, and then we will make a decision before the end of the year, I think, as to what the next step will be.

Senator SIEWERT: Are you able to tell us who the consultant is?

Dr Brown: I would—

Senator SIEWERT: Maybe take it on notice.

Dr Brown: I will take it on notice. I do not know that they have actually been informed yet.

Senator SIEWERT: If you could take that on notice in a timely manner so that we are fitting in with your time frame?

Dr Brown: Yes.

Senator SIEWERT: I have another section of questions for the commission. I do not know if you want me to hold on or go ahead with them.

Senator O'NEILL: I have got questions.

CHAIR: Senator O'Neill, are they the last bracket you have?

Senator O'NEILL: No. I have got a couple more that I want to ask some short questions on.

CHAIR: If we do those questions now, noting I would be very keen to try and work through as much of the remainder of outcome 2 as possible before the lunch break and then conclude it as planned by 3 pm so that we can move on to aged care, if that is okay. If we can sort of agree to that, why do we not continue on with your questions and then we will do other questions.

Senator SIEWERT: I have just got to pull something up, because I do not want to misquote the commission, Dr Brown. I want to ask about seclusion and restraint and your position, and the comments that you made a couple of weeks ago. I particularly want to look at the comments that you made about the national approach to the regulation of seclusion and restraint. That includes standards and guidelines to support national consistency. You know what you said. But that is the frame that I would like to ask you about and ask you about an issue that I have long taken an interest in. Can I ask where you are going with this issue now? What next?

Dr Brown: There are a couple of things I would say in response to that. In 2005 all Australian governments signed up to the national safety priorities document, and reducing where possible or eliminating seclusion and restraint was one of four top priorities identified by the mental health sector. Work commenced shortly after that to actually look at how we could achieve such a change in service delivery. It has been ongoing for over a decade now. In fact, I was privileged to be a part of that work back in 2007.

I think it is fair to say that some improvements have been made, and they are particularly around the use of seclusion, albeit that we have still got quite a long way to go. I guess where we are heading now in terms of our current call is to say that 10 years on we still see seclusion being used at a rate higher than we think it should be. We also see in recent media reports, recent reports from other services, instances where there is poor practice in evidence. I guess after a decade of effort we feel that we need to see increased efforts to reduce the use of seclusion and restraint.

Restraint had less focus over the past decade than seclusion. I think that was a pragmatic choice in the first instance. It was a difficult issue, so tackle one at a time, and seclusion was the topic that was selected first. Restraint has come into the focus more recently, and it is a focus. But we saw just recently the first ever public release of data on the use of restraint in Australia.

We feel that there needs to be a stronger commitment from services towards reducing the use of seclusion and restraint, with the ultimate goal, if possible, of eliminating it altogether. We would certainly like to see a continuing focus on data collection and reporting. Part of what became evident in the recent AIHW report was that we do not have consistent definitions, for example, around physical and mechanical restraint, and, therefore,

some jurisdictions were not able to report. Some do not have systems that accurately collect the data. So we need to ensure that we have consistent definitions, that we have data collection systems that ensure we can compare like with like and that there is public reporting of this data on an ongoing basis, with the capacity, I guess, for services to use that for quality improvement at the local level as well.

Certainly we think there should be some statements on national standards, for example, as issued by the Australian Commission on Safety and Quality in Health Care in relation to restrictive practices in health services.

Senator SIEWERT: Thank you for that. In terms of the nationally consistent standards, who are you working with, and which is the body that you think now, given the history you have just been through, should be responsible for that? I should not ask 'do you think', because that is asking for an opinion. Who are you talking to about it?

Dr Brown: The commission has been part of the Safety and Quality Partnership Standing Committee of AHMAC for many years. That is the subcommittee or standing committee of MHDAPC that has had carriage of the seclusion and restraint work since the publication in 2005 of the national safety priorities document. They certainly have been focusing on seclusion and restraint.

In addition, MHISSC, the Mental Health Information Strategy Standing Committee which, again, are a standing committee of MHDAPC, are the data experts. They have the technical expertise around data definitions et cetera. AIHW is a member of both those groups. We work with SQPSC, we work with MHISSC and we are working with AIHW.

Mr Cormack: Just a quick point about the architecture of the standards and I think you are wanting to know who really should be responsible for all of these things.

Senator SIEWERT: Yes.

Mr Cormack: In essence, the Australian commission for safety and quality is responsible for developing the national health standards. That applies across the health system. The endorsing body for those standards is the COAG Health Council. The next version of the standards is currently with health ministers for approval. They strengthen a number of the measures around the use of seclusion so that the standards will go up to support the effort that Dr Brown has articulated. The governance for that is the COAG Health Council. Those standards are used for the regulatory compliance activities undertaken at the state and territory government level.

Senator SIEWERT: I understand. Thank you for that; that is useful. I understand the issue you have just pointed to about the next iteration of standards—that we have had a significant period of time when we still have not seen the elimination of seclusion and restraints. I am not just thinking about issues around mental health; I am also thinking of disabilities, because you would be aware of the Senate inquiry where we have recommended that we need to be doing more work. In fact I think we almost mirrored, if I recollect correctly, similar recommendations for our inquiry into indefinite detention and cognitive and psychiatric impairment. The question is: have you considered a stronger approach or regulatory approach at a national level to ensure that there are significant steps being taken regarding what everybody agrees should be happening?

Mr Cormack: Yes. We can talk about the health standards, and the national safety and quality health standards are the tool that is used for regulatory activity and regulatory compliance. The new version, which is with ministers now to be approved and endorsed, significantly ups the standard of practice required and makes, as part of the regulatory settings, the progressive elimination of this activity. In that sense, it is not going to guarantee that there will be elimination, but it does show, as Dr Brown has said, there has been some improvement—not enough, and the standards are being arced up and strengthened so that compliance activity can be undertaken against that standard to a higher level than certainly applied in the instance of the Lismore Base Hospital one that has obviously been in the media.

Senator SIEWERT: The latest.

Mr Cormack: That is right.

Dr Brown: It is a complex area. You will find that, if you go to each of the jurisdictions, seclusion and/or restraint are variably provided for under the jurisdictional mental health legislation as well. So it does not rest solely under the regulatory framework of the standards. Addressing this, I need to make the point that, whilst I have been a strong advocate for a long time for the need to reduce and, where possible, eliminate, it is not as easy as just saying, 'Let's ban it.' I am not suggesting that that is what you are suggesting, but I think there is a temptation to look at it in a simplistic fashion.

Seclusion and restraint are very restrictive practices. Most staff in mental health services do not particularly like to utilise them. They utilise them when they personally feel that there is no other appropriate intervention. We

know from the literature and we know from the experience of services where there has been a focus on reducing the use of these practices that you can effectively reduce them substantially, if not eliminate them. But it needs a lot of things to be in place. It needs education and training of staff, they need strong clinical leadership and that needs to be sustained. And you need to have options there for alternatives to the use of seclusion when someone is agitated and escalated. You need to look at the design of your facilities. You need to look at your staffing levels and your skill mix. It takes a lot to do this, and it can be done, but it is not something that can be done quickly.

Senator SIEWERT: Dr Brown, thank you. That is where I am going with: what else do we need to be doing to ensure that happens? As you clearly articulated, we are 12 years down the track from 2005. Where are the key investments to improve the standards? I appreciate what you just said, Mr Cormack, in terms of where the standards are going. But then it needs that implementation approach, and funding for it.

Dr Brown: In my view, where we need to be going is to enhance our clinical leadership. I think our professional colleges need to increase their role. The college of psychiatrists and the College of Mental Health Nurses, for example, have put out position statements. I think there is more they can do in terms of continuing to reinforce that, looking at training of up-and-coming staff. We need to look at the investment in training, we need to look at how our data is used and make sure that there is a sustained focus on this.

Most of all, it is about the engagement and involvement of consumers and carers in this work. I was in the ACT when we commenced that work in 2007, and we got our seclusion rate in our acute unit down to less than one. It was a dramatic difference. I would say—'I have said many times publicly—that it was the engagement with consumers and carers that really drove that change with the staff.

CHAIR: Senator O'Neill.

Senator O'NEILL: Chair, I am very mindful of the time. I would love a much more substantive discussion with you, Dr Brown, but that is not going to be allowable today. I have a few pretty short, sharp questions. With regard to your 2016 report card, you expressed concerns about psychosocial investment. I am sure you are welcoming the $80 million, but is it going to be inadequate in terms of supporting people with mental illness who are not going to be eligible for the NDIS?

Dr Brown: The commission stated publicly that it welcomed the investment of the $80 million. It would not come as a surprise that the commission's view is that we need to continue to invest in the mental health service system, not just in psychosocial supports but more broadly, to achieve the reform that will get the best outcomes for consumers and carers.

There is no doubt that psychosocial support plays a really important role in the overall system, because with psychosocial support in place you can reduce the reliance on clinical supports in some instances, you can certainly reduce the need for acute care, and you can probably also reduce the severity of the disability and the impact an illness might have on an individual, particularly if it is available at the early stage of an illness coming on. So psychosocial supports are really important.

Senator O'NEILL: Is it enough, though, Dr Brown? That is my question.

Dr Brown: We think it is a starting point.

Senator O'NEILL: It is a starting point.

Dr Brown: We certainly need to see how the NDIS unfolds. There is a lot of discussion at the moment about what is required, and people's calculations. We certainly need to see how it unfolds over time. $80 million is not a lot; it is not going to buy all of the psychosocial support that is required. We are not entirely sure yet how much the NDIS will deliver. But I think government have recognised that there is a need. They are working with states to look at how that can best be addressed. It should be remembered, as Mr Cormack has pointed out, that states and territories historically have responsibilities in this space as well. So let us see how it unfolds.

Senator O'NEILL: But it is a start?

Dr Brown: Yes.

Senator O'NEILL: With regard to the recommendations that you made in your review, regarding a 50 per cent reduction in suicides over 10 years, do you still hold to that view? Have you provided any advice to the former minister or the current minister in regard to implementing a recommendation around a suicide reduction target?

Dr Brown: The commission finalised that report in 2014, and the view expressed in that report was a reduction and a target of 50 per cent. Commissioners took the opportunity late last year to relook at some of the recommendations and discuss that particular recommendation specifically. I think their view has shifted somewhat. They certainly expressed a view that we should be working very seriously to look at suicide

reduction—a bit like with seclusion and restraint, with the ultimate goal of aiming for zero. So towards zero was the statement that commissioners made when we discussed it last year.

Senator O'NEILL: So it is setting a higher target, if anything?

Dr Brown: In some ways, yes. One of our commissioners said quite pointedly, 'Well, which 50 per cent of us are you happy to allow to die by suicide, if you are setting a target of 50 per cent?' That is a very strong and emotive statement. I think the 50 per cent target initially was established because it was seen to be aspirational, but it is seen that a target is better than something that is—

Senator O'NEILL: Untargeted.

Dr Brown: Untargeted. However, we do know from the literature that achieving a 50 per cent reduction is a very significant stretch on our current efforts. We think there is value in having a focus of attention. We recognise that setting a target is a challenge. Our advice to government is that we need to focus very strongly on suicide prevention, but we need to work collaboratively with all of the players in the sector. There is a lot of investment in suicide prevention. What we know, however, is that there is a lack of coordination in some of the efforts, and there are probably duplications and gaps in suicide prevention. So we strongly support the efforts outlined in the fifth national mental health and suicide prevention plan that are looking to address the coordination of efforts.

Senator O'NEILL: The fifth mental health and suicide prevention plan has 23 indicators. Will the commission have any role in relation to these indicators?

Dr Brown: That will ultimately be decided by the COAG Health Council when they consider this matter in August. We are anticipating that, yes, the commission will have a role in monitoring the progress of implementation of the fifth plan and some of the broader indicators around outcomes for consumers and carers.

Senator O'NEILL: I might put some more detailed questions on notice with regard to that. Dr Brown, you are going to be one of the co-chairs, alongside Mr Quinlan from Mental Health Australia, of the new primary health network advisory panel; is that correct?

Dr Brown: Yes.

Senator O'NEILL: Why did you agree to co-chair this advisory panel, and do you think there are issues across the primary health networks where local need is not being addressed or standards are not adequate?

Dr Brown: I certainly agreed to participate as a co-chair in this because I think this is an important reform platform for the mental health sector in Australia. The change to the architecture towards a more regional approach and the ability to look at local needs and local solutions is really important.

Senator O'NEILL: But isn't there a concern about differentiation—that there is a decline in the application of standards and about from whom the advice locally is being sought? Is that one of the concerns in the sector?

Dr Brown: I have heard many concerns across the sector, and they are certainly not consistent when you go to different regions and different parts of the country. I think it is early in this whole reform process, in terms of the work the PHNs are undertaking. There is perhaps still quite a deal of scope for all of the stakeholders to fully understand what each other is doing. I think this process will afford us the opportunity for a better understanding across all of the stakeholders, not just of what the PHNs are doing but of the other stakeholders, what their interests are, how they can engage, and, particularly going forward, how we can all best work together to support this really important platform for reform.

Senator O'NEILL: Are you clear about what you want to achieve? Have you been given a brief and a set of outcomes?

Dr Brown: I am relatively clear on what we want to achieve, yes.

Senator O'NEILL: I might ask you to provide that on notice, if you can. That would be wonderful.

Dr Brown: Yes.

Senator O'NEILL: I will just direct to you a few questions around the PHN Mental Health Advisory Board, which was announced on 23 March. Have the terms of reference, membership and exact tasks of the panel yet been made public?

Mr Cormack: The terms of reference have been finalised.

Senator O'NEILL: So not yet public or with the minister? Where are they in the process, Mr Cormack?

Mr Cormack: I will need to consult with the minister, but from our perspective they are finalised but not released yet.

Senator O'NEILL: And the membership?

Mr Cormack: It is finalised but not released.

Senator O'NEILL: And the exact tasks that it is going to undertake?

Mr Cormack: It is contained within the terms of reference that the minister will no doubt release when he makes the appointments.

Senator O'NEILL: Will it be tasked with reviewing or providing advice on all the plans or needs assessments of each of the 31 PHNs?

Mr Cormack: I am not going to pre-empt the minister. The minister, as we understand, has settled on the terms of reference and the membership of the committee, and he will make the necessary announcements. The detail will be contained within that.

Senator O'NEILL: Has any funding been allocated to the advisory panel?

Mr Cormack: The department has been given the task of supporting the secretariat arrangements for the task force, and certainly sufficient resources will be made available through the department's normal allocations to undertake this work to support the task force.

Senator O'NEILL: So no additional funding? You are absorbing it within your workload?

Mr Cormack: From time to time, the department has to set up and stand down a range of advisory mechanisms.

Senator O'NEILL: And this is one of them?

Mr Cormack: This is one of them; that is right.

Senator O'NEILL: Will the advisory panel report directly to the Minister for Health?

Mr Cormack: That is my understanding, but I think we would best wait to see the terms of reference when the minister releases them.

Senator O'NEILL: Have any time lines been any provided to the advisory panel?

Mr Cormack: The advisory panel has to be formally appointed and the terms of reference have to be released. The work plan that is associated with that will also be confirmed and made public. But at this stage the panel is not operational, though all of the details associated with its architecture are effectively settled. The minister will make that announcement when it suits him.

Senator O'NEILL: How has the membership of the panel been determined?

Mr Cormack: The minister consulted widely with the sector. The minister also sought advice from the department. We have provided advice to the minister—

Senator O'NEILL: And from the PHNs, to ensure that regional perspective?

Mr Cormack: Yes, indeed. It is right across the sector—from the PHNs, the other players involved in delivery of services, the peak bodies. It will be quite an inclusive panel.

Senator O'NEILL: I have a number of questions to put on notice, and a couple of quick questions now. Can the department clarify the funding of $58.6 million for veterans' mental health? Is that the correct number, for starters?

Mr Cormack: Sorry?

Senator O'NEILL: The budget had a number of mental health services, including $58.6 million for veterans' mental health. Is that the full amount?

Mr Bowles: I cannot recall. It is something like that, but it is probably best asking Veterans' Affairs. I think they are on tonight, in another area.

Senator O'NEILL: Can you clarify that this funding is from the Health budget, or is it from the Department of Veterans' Affairs budget?

Mr Bowles: It's a Veterans' Affairs issue, yes.

Senator O'NEILL: So there is no money in Health for this initiative.

Mr Bowles: No, it is a mental health component of the Veterans' Affairs budget. It is part of mental health more broadly, but Veterans' Affairs is the best place to talk about that.

Mr Cormack: Okay, because Minister Hunt has been talking about it—

Mr Bowles: It is part and parcel of health—mental health—but it is the responsibility of Veterans' Affairs.

Senator O'NEILL: Just to be clear, who is responsible for this part of the budget—Minister Hunt or Minister Tehan?

Mr Bowles: Minister Tehan will be, in the context of Veterans' Affairs, but clearly, because it is mental health, Minister Tehan and Minister Hunt will talk together on a whole range of mental health issues.

Senator O'NEILL: Can the department provide a breakdown of total funding allocated for services and programs that relate to veterans' mental health and suicide prevention?

Mr Bowles: You would be best to ask that of Veterans' Affairs.

Mr Cormack: Yes.

Senator O'NEILL: You cannot tell me about the money Veterans' Affairs have to do that?

Mr Cormack: No.

Mr Bowles: That is correct.

Mr Cormack: All we can say is that, as you have said, $58.6 million, via the Department of Veterans' Affairs, was allocated for the expansion of services for current and former members of the ADF, suicide prevention and family counselling. The rest is as per Mr Bowles's response.

Senator O'NEILL: It is a bit hard to tease out who is responsible for what and where the integration points are.

Mr Bowles: Veterans' Affairs is responsible for the health of veterans more broadly. If you look at health spending, you will notice in a lot of the work that we do we talk about whole-of-government spending on health. That then comes in to us. It does not give us responsibility for delivering the services in Veterans' Affairs. That is why Minister Hunt deals with it in the broad context, but then Minister Tehan in the context of Veterans' Affairs will deal with the specific components that relate to veterans.

Senator O'NEILL: There are a number of other questions that I have, but I think that, in the interests of time, I might have to put them on notice. There was one particularly important question that I was seeking an answer to. You indicated you were going to be able to take that on notice—with regard to the Medicare freeze for mental health care plans and Better Access. Would you be able to provide that by the close of the hearing today, Mr Bowles?

Mr Bowles: I will see what I can do.

Senator O'NEILL: Thank you.

[12:51]

CHAIR: Excellent. Thank you, Senator O'Neill. We will move to program 2.3, Health workforce.

Senator KAKOSCHKE-MOORE: I would like to go to the issue of the health workforce in the context of gaps and overlaps in our health workforce framework, using remote area nurses as an example to flesh out this issue. In March last year in South Australia remote area nurse Gayle Woodford was murdered while on a callout. Following her death, the Department of Health commissioned a report by CRANAplus. This report was completed and handed to the department in January. When I questioned the department about any consideration having been given to the report at that stage in February, during Senate estimates, I was told that consideration had been delayed pending the establishment of the national rural health commissioner, and a roundtable that was going to be held by the commissioner, which was supposed to be in May. We know that that has not happened because the national rural health commissioner has not been established; the legislation is still waiting to pass the Senate. Minister, do you know when this legislation is due to be brought on in the Senate? It has been four sitting weeks since the announcement was made that the government intended to establish this position.

Senator Nash: I do not, not being the minister responsible, but the officials might.

Dr Studdert: The legislation passed the lower house in March, and it is now introduced into the Senate, but until the next sitting period it will not move along. However, Minister Gillespie, recognising the delays with progressing the legislation and the subsequent appointment of a rural health commissioner, has decided to convene another meeting of the rural health roundtable. I believe that is planned for 30 June, and that the CRANAplus materials and report will be considered at that time.

Senator KAKOSCHKE-MOORE: Going back to the delay in this report being considered at all, and prior to the announcement of the establishment of a rural health commissioner, it is my understanding that people or bodies that could be generally seen to be having an interest in this and an interest in achieving some action in this would include the Minister for Health, the Assistant Minister for Health, the Department of Health, the Australian Health Ministers' Advisory Council Rural Health Standing Committee, and the Australian Institute of Health and

Welfare. Yet it seems none of those bodies or organisations I have just listed had the capacity or the preparedness to consider this report once it was given to the government in January.

Mr Hallinan: It might help if I clarify the nature of the report and the activities that we funded CRANAplus to undertake.

Senator KAKOSCHKE-MOORE: I have read the report. I understand what is in it, what the government asked for and the recommendations that have flowed from the report. What I am concerned about is the lack of action in terms of implementing any of the recommendations of the report.

Mr Hallinan: I think it would help if I clarify a couple of points. Following the tragic circumstances around Gayle Woodford's death last year, we did establish a project with CRANAplus to undertake a review into remote area safety and produce a few outputs. The report that you have identified is the first of those outputs, and there are a few others. I will just run through what those are, if that helps, and then perhaps talk through the approaches that we have been taking for promotion of those actions beyond the department and beyond CRANAplus. You are correct—in January, CRANAplus did deliver a report, the *Remote health workforce safety and security report: literature review, consultation and survey results*. That has been distributed by the department to states and territories through the Health Workforce Principal Committee, which is a subcommittee of AHMAC, which is one of the committees that you noted earlier.

Senator KAKOSCHKE-MOORE: Yes.

Mr Hallinan: It is also a report that has been provided by CRANAplus more broadly through the sector, and parts of it at least have been promoted through the sector by other organisations, such as NACCHO. The second deliverable we have is the national safety and security guidelines for remote and isolated health practice. These are guidelines that can be provided to employers, people employing remote workers, on the sorts of things that they can undertake to ensure the safety of those workers.

Senator KAKOSCHKE-MOORE: But the Commonwealth is not requiring health workforce organisations to comply with these guidelines? They are voluntary, are they not?

Dr Studdert: I do not think we have the levers to require that, but I think they have been embraced and looked at very closely by employers because it is something that they actively seek guidance on.

Senator KAKOSCHKE-MOORE: Something that has occurred to me is the fact that in South Australia, at least, the vast majority of outback health workforce organisations are funded by the federal government. That is where the bulk of their funding comes from. It appears to me that some guidelines might be a very neat and precise way of tying funding to the attainment of safety measures, particularly for remote area nurses, given we know some of the dangerous conditions that they are operating in. I can leave that there as a suggestion.

Dr Studdert: We provide the funding to the communities to run the community-controlled health services. Obviously we would look to promote the use and adoption of those guidelines by them as employers of remote workers.

Senator Nash: Having been involved in this at the beginning, with some responsibility at the time, there was quite a considerable discussion around the community-controlled health organisations which, as you would know, make up a large bulk of the funding. There was a lot of discussion around their autonomy, and the Commonwealth government not wanting to come in and impose on them what we thought might be right. So the process probably has taken a little longer than we would have liked for a couple of reasons, but I think it was really important for that CRANAplus report to come to its end, to be considered properly and very much work with people on the ground who know best the circumstances in their local areas. Sometimes it is not a one-size-fits-all, and what is going to work in one place is not necessarily going to work in another.

Senator KAKOSCHKE-MOORE: Just going back to the establishment of the commissioner and the intention, at least in January, to wait until the commissioner had been set up before consideration of this report was going to be progressed, is the commissioner going to have more powers than, say, the Assistant Minister for Health, Dr Gillespie?

Senator Nash: I do not think Dr Gillespie would like to think that.

Senator KAKOSCHKE-MOORE: So if the commissioner is not going to have more or better powers, why wait? Why not leave it to the person who has the powers now to do something?

Dr Studdert: To wait for?

Senator KAKOSCHKE-MOORE: The commission to consider the report at a roundtable.

Dr Studdert: I think it is the process of working with the stakeholders, with the guidance and leadership of the commissioner to look to, as the minister just said, how you promote and support the adoption of those,

recognising the autonomy of the community-controlled services and the need for there to be tailoring and adaption of those guidelines into what is a best fit for each of those services, given the unique circumstances of them. So it is an iterative process. The guidelines are out there for people to consider now. With the support of the rural health commissioner in that leadership role, amongst other tasks that the commissioner will have in terms of supporting the minister and guiding our work, that will be what they look to take on.

Senator KAKOSCHKE-MOORE: Just going back to the commissioner, the office has been established—I have had a look on the website and Dr Gillespie has announced the commissioner—and essentially they have been given a priority, which is to improve access to training for doctors in regional, rural and remote Australia. Nurse safety is not the first priority of the commissioner. Who decided what that priority would be? Was that Dr Gillespie, was that the incoming commissioner or was that the health minister? Who made that decision?

Senator Nash: It was a discussion at the time, from recollection, around the National Rural Generalist Pathway that we had been discussing. It was around the workforce issues. That was one of the things that we indicated would be one of the first priorities. It is now in the purview of Minister Gillespie and I certainly do not want to cut across what he is doing. But I do not think that was exclusive; other things were happening at the time. We indicated that was one of the key priorities, but I am very happy to take that on notice for you, if you would like.

Senator KAKOSCHKE-MOORE: Thank you. If they are listing, as a first priority, training for doctors, where in the chronological order is nurse safety? I would like to know if they are going to list them as—

Dr Studdert: I would think the safety of all workers in remote areas would be critical because, if we are looking at the problems of distribution and attracting and retaining workforce in rural and remote areas, ensuring their safety is critical to that.

Senator KAKOSCHKE-MOORE: I agree with you on that. Something struck me as I have been trying to figure out who really has responsibility for addressing this issue. The fact is that we have a minister and an assistant minister and now a commissioner. How do the assistant minister's and the minister's duties and powers differ? Who has the power to actually do something here?

Dr Studdert: Our ministers have fairly well defined and delineated areas of responsibility and, as the minister was just saying, the Rural Health Commissioner is a person who will advise and support the minister in enacting their legislative policy and budgetary powers and responsibilities.

Senator KAKOSCHKE-MOORE: If the assistant minister advises and supports the minister, my concern is that, at least from the interactions I have had, the advice that is being fed to the minister is such that there is nothing really for us to do here; we are powerless.

Dr Studdert: What advice are you referring to?

Senator KAKOSCHKE-MOORE: Of the assistant minister. Just from the interactions I have had, the advice that I have been given is that essentially all the assistant minister can do is ask the health minister to take this matter to COAG and that is it.

Dr Studdert: No. I think the assistant minister has a whole range of programs and budget areas that he has responsibility for and has options for shaping and crafting those with support and advice from the department.

Senator KAKOSCHKE-MOORE: What are some of those options for doing something?

Mr Hallinan: I will continue where I was earlier, the remote area safety project that we have undertaken with CRANAplus. Beyond those two deliverables which I outlined, we are also anticipating another four deliverables in the next couple of months. One is an industry handbook called *Working safe in rural and remote health*, which will be freely distributed by CRANAplus throughout the network. The complexity here is that employers in remote areas can be Commonwealth funded, they can be state funded or they can be private; they can be anyone. So the governance structure around directing people to undertake these things is complex, which is why we are working with states and territories as well as promoting these through existing employer arrangements. Another will be a self-assessment tool on safety and security for workers who are employed in remote work.

Senator KAKOSCHKE-MOORE: And will any funding be made available to workers to undertake this self-assessment or will there be a cost involved for the worker to do that?

Mr Hallinan: Only their time. There would be something that provides an agency for that individual to undertake an assessment of their own work practices and how those practices could affect their safety and how the practices of their employers could affect their safety, something to empower the worker, and also an area remote learning module, online learning for people in this area, and a mobile phone app called 'Being safe in remote

health', which provides information easily at hand for people to carry around in their pocket if they have got the phone app. We have tried to tailor that response to both employers and individuals employed in those locations.

Senator KAKOSCHKE-MOORE: I might come back, time permitting, later to some of those issues, but I just have two more questions now to wrap up this first line of questioning. I was told that Dr Gillespie would be asking Minister Hunt to take the issue of remote health workforce safety, in particular remote nurse safety, to COAG. Minister Nash, have you already taken this issue to COAG?

Senator Nash: It is not within my purview, sorry.

Senator KAKOSCHKE-MOORE: Did you in the past when you were first involved in this?

Senator Nash: No. I was the Minister for Rural Health but Minister Ley was the senior minister; so she did the COAG arrangements.

Senator KAKOSCHKE-MOORE: Did she take the issue of remote area safety to COAG?

Senator Nash: I would need to check. From recollection, I think she did after the initial roundtable we had but I would need to check with officials.

Mr Bowles: I would have to probably take on notice the details but my recollection is that it has definitely been discussed at a COAG Health Council meeting. I cannot recall all the details but it was clearly an issue that many of the ministers were particularly interested in at the time. But I can take on notice when that might have been discussed.

Senator KAKOSCHKE-MOORE: If you could. I am concerned. If the advice is that all the assistant minister can now do is take the decision to COAG and it has already been taken to COAG, it just seems as though we are repeating history really and nothing new is coming from—

Mr Bowles: There is always a benefit in re-engaging with COAG colleagues because predominantly these issues of safety in workforce scenarios are the responsibility of states and territories. The Commonwealth has obviously responsibilities around some of the workforce issues that you mentioned earlier that we might fund, but predominantly the overarching workforce issues are the responsibility of states and territories. It will never hurt to continue to have those conversations. Particularly as the deliverables roll out, it will be good to keep this on the agenda. In both AHMAC and COAG, workforce is separate committees. Particularly in the COAG context, there is a workforce committee and a COAG committee; they are both COAG committees. They actually work together but they are quite significantly separate for this very reason that workforce is so important.

Senator KAKOSCHKE-MOORE: I suppose that conversations are good but action is better.

Mr Bowles: Yes, and there is a lot of action that comes out of the COAG arrangements because, again, the implementation has to happen at a state and territory level. So we have to make sure that we have those conversations, and there are some significant decisions that are made through that process.

CHAIR: Senator Watt.

Senator WATT: My questions are in 2.4. We are moving to that?

[13:08]

CHAIR: Yes, we will move to program 2.4, Preventive health and chronic disease support.

Senator WATT: I have some questions about the department's approach to drug and alcohol services. Can you please provide the average waiting time for someone to access residential rehab services in each state and territory?

Dr Studdert: I do not have my key advisers here. I am fairly certainly that we would have to take that on notice. That is a matter for the states and territories and—

Mr Bowles: It would be a state and territory issue.

Dr Studdert: We would have to see whether they have that data.

Senator WATT: If you could, please take on notice figures broken down state by state or territory.

Dr Studdert: Pending the availability of it from our jurisdictional base.

Senator WATT: Yes. What can you tell us about average waiting times for accessing residential rehab services around the country?

Dr Studdert: It is not something that we hold data on in a detailed or quotable form.

Senator WATT: No doubt the waiting times are different. In some states it would be shorter than in others, and in some states it would be longer than in others.

Dr Studdert: And it depends on the nature of the service that is being sought and it would vary across regions and no doubt across periods of time and across a year.

Senator WATT: I accept that many of these services are state funded or provided but the Commonwealth must have some understanding of whether waiting times are growing or shortening, in a general sense.

Mr Laffan: Waiting times are not actually captured in the alcohol and drug national dataset at this particular point in time but that is certainly an item that we are developing currently.

Senator WATT: The Commonwealth does not currently capture waiting times for accessing residential rehab services?

Mr Laffan: That is right. It is not in the dataset.

Senator WATT: Leaving aside the fact that it is not in the dataset, have there been any discussions with the states and territories about waiting times or anything on which to base some assessment of how it is going?

Mr Laffan: Not recently, to my knowledge.

Senator WATT: The Commonwealth is administering funding to the states and territories through the National Ice Taskforce though, is it not?

Dr Studdert: Funding to the PHNs in the respective jurisdictions.

Senator WATT: So the Commonwealth does have some role to play in the provision of rehab, and one of the Ice Taskforce's objectives is rehab services?

Mr Laffan: That is within the scope of the PHNs, yes.

Senator WATT: So the Commonwealth does have some role then in funding rehab services and must therefore have some idea about what is going on in that space?

Dr Studdert: I am sure that our respective PHNs, 31 of them, in the process that they have gone through in the last 12 months with doing needs assessments, consulting with the states and territories, which of course provide the majority of services in each jurisdiction, would have had conversations along those lines and gathered data along those lines. It is not something that is provided directly to the Commonwealth other than—

Senator WATT: In the consultations that have occurred with the states and territories and PHNs to date or through the Ice Taskforce review, what information do we have now in a general sense about the availability of residential rehab services around the country?

Mr Laffan: Primarily in relation to the PHNs, they went through an extensive needs assessment and market analysis within their individual areas where they came back and commissioned services to meet the needs within that local region. I do understand that, in relation to PHNs themselves, six of the 31 PHNs have chosen to have residential rehabilitation or residential withdrawal as part of the services that they have commissioned locally.

Senator WATT: So that means that 25 have not?

Mr Laffan: That is right.

Senator WATT: Just so I understand that, of the 31 PHNs around the country, six of them have commissioned residential rehab or withdrawal services—

Mr Laffan: That is correct.

Senator WATT: Is that specifically around ice or drugs and alcohol generally?

Mr Laffan: That would be drugs and alcohol generally. In addition to those services that have been commissioned by PHNs, the Commonwealth, through the drug and alcohol program, also provides just over $26 million for residential rehab each year in addition to that money that has gone to the PHNs.

Dr Studdert: Noting of course that residential rehab is just one of the array of offerings that are sought and needed in drug and alcohol treatment.

Senator WATT: Not to harp on this, but surely if you are providing funding for these sorts of rehab services you must have some sense of what the waiting times are and you must be looking for improvements in that as a condition of funding?

Dr Studdert: I certainly think that we are looking for improvements because it is a significant investment of new funding for services. But again I think we would have to say that it varies across regions and times. To give you a general answer would not be an accurate reflection of this.

Senator WATT: That federal funding that is being provided presumably acknowledges that the availability of rehab services is an issue and needs to be improved?

Dr Studdert: On the availability and the range of offerings, I think there is always room for improvement there. As needs change, as has happened with the emergence of ice and other drugs and substances in local areas that are seeing 'abuse change', I think we want to give those local areas the ability and flexibility to respond to those needs.

Senator WATT: How would you describe the problem that exists currently around accessibility of residential rehab services? You acknowledge that it is a problem?

Dr Studdert: I acknowledge that there are needs that the PHNs are working to fill, yes.

Senator WATT: So there is unmet need in the community for—

Dr Studdert: I am not going to give you a general answer for the situation across the—

Senator WATT: You are handing over taxpayers' funds to improve—

CHAIR: We will suspend for lunch and return at 2.15.

Proceedings suspended from 13:15 to 14:15

Mr Cormack: I have a quick point about the architecture of the standards. I think you were wanting to know who really should be responsible for all of these things. In essence, the Australian Commission on Safety and Quality in Health Care is responsible for developing the National Safety and Quality Health Service Standards, and that applies across the health system. The endorsing body for those standards is the COAG Health Council. The next version of the standards is currently with health ministers for approval. They strengthen a number of the measures around the use of seclusion, so the standards will go up to support the effort that Dr Brown has articulated. The governance for that is the COAG Health Council, and those standards are used for the regulatory compliance activities undertaken at the state and territory government level.

Senator SIEWERT: I understand. Thank you for that. That is useful. I suppose where I am going, and I understand the issue you just pointed out about the next iteration of standards, is: we have had a significant period of time now where we still have not seen the elimination of seclusion and restraints. I am not just thinking about issues around mental health. I am also thinking about disabilities because, as you would be aware, there was a Senate inquiry where we recommended again that we need to be doing more work in that area. In fact, I think we almost mirrored, if I recollect correctly, the recommendations for our inquiry into indefinite detention and cognitive and psychiatric impairment. The question then is: have you considered a stronger approach or regulatory approach at a national level to ensure that there are significant steps being taken to ensure that everybody agrees on what should be happening?

Mr Cormack: Yes. We can talk about the health standards. The National Safety and Quality Health Service Standards is the tool that is used for regulatory activity and regulatory compliance. The new version, which is with ministers now to be improved and endorsed, significantly ups the standard of practice required and introduces, as part of the regulatory settings, the progressive elimination of seclusion and restraint. In that sense, it is not going to guarantee that there is going to be elimination, but it does show, as Dr Brown said, that there has been some improvement. However, there has not been enough, and the standards are being arced up and strengthened so that compliance activity can be undertaken against that standard to a higher level than that which was certainly applied in the instance of the Lismore Base Hospital. That is one that has obviously been in the media.

Senator SIEWERT: The latest one?

Mr Cormack: That is right.

Dr Brown: I might just add to that. It is a complex area because you will find that, if you go to each of the jurisdictions, seclusion and/or restraint are variably provided for under the jurisdictional mental health legislation as well, so it does not rest solely under the regulatory framework of the standards. In addressing this, I need to make the point that, whilst I have been a strong advocate for a long time for the need to reduce and, where possible, eliminate seclusion and restraint, it is not as easy as just saying, 'Let's ban it.' I am not suggesting that that is what you are suggesting, but I think there is a temptation to look at it in a simplistic fashion. Seclusion and restraint are very restrictive practices. Most staff in mental health services do not particularly like to utilise them. They utilise them when they personally feel that there is no other appropriate intervention. We know from the literature and we know from the experience of services where there has been a focus on reducing the use of these practices that you can effectively and substantially reduce, if not eliminate, them. But it needs a lot of things to be in place: it needs education and training of staff, and there needs to be strong clinical leadership, and that needs to be sustained, and you need to have options there for alternatives to the use of seclusion when someone is agitated

and escalated. You need to look at the design of your facilities, you need to look at your staffing levels and your skill mix. It takes a lot to actually do this. It can be done, but it is not something that can be done quickly.

Senator SIEWERT: Thank you. What else do we need to be doing to ensure that happens? Because, as you clearly articulated, when we are 12 years down the track from 2005, where are the key investments improving the standards? I appreciate what you have just said, Mr Cormack, in terms of where the standards are going, but then it needs that implementation approach and funding for it.

Dr Brown: In my view, where we need to be going, I think, is to enhance our clinical leadership. I think our professional colleges need to increase their role there. The College of Psychiatrists, the College of Mental Health Nurses, for example, have put out position statements. I think there is more that they can do in terms of continuing to reinforce that, looking at training of up-and-coming staff. We need to look at the investment of training and we need to look at how our data is used and make sure that there is a sustained focus on this—and, I think, most of all, the engagement and involvement of consumers and carers in this work. I was in the ACT when we commenced that work in 2007, and we got our seclusion rate in our acute unit down to less than one. It was a dramatic difference. And I would say, and I have said many times publicly, it was the engagement with consumers and carers that really drove that change with the staff.

Senator SIEWERT: Thank you.

Senator O'NEILL: I would love a much more substantive discussion with you, Dr Brown, but that is not going to be allowable today, I think. So just a few, pretty short, sharp, questions: with regard to your 2016 report card, you expressed concerns about psychosocial investment, and I am sure you are welcoming the $80 million. But is it going to be inadequate in terms of supporting people with mental illness who are not going to be eligible for the NDIS?

Dr Brown: I think the commission stated publicly that it welcomed the investment of the $80 million. As would not come as a surprise, the commission's view is that we need to continue to invest in the mental health service system, not just in psychosocial supports but more broadly to achieve the reform that will get the best outcomes for consumers and carers. There is no doubt that psychosocial support plays a really important role in the overall system, because with psychosocial support in place you can actually reduce the reliance on clinical supports in some instances; you can certainly reduce the need for acute care, and you can probably also reduce the severity of the disability and the impact an illness might have on an individual, particularly if it is available at the early stage of an illness coming on. So psychosocial supports are really important.

Senator O'NEILL: Is it enough, though, Dr Brown? That is my critical question.

Dr Brown: We think it is a starting point; we certainly need to see how the NDIS unfolds. There is a lot of discussion at the moment about what is required and people's calculations. I think we certainly need to see how it unfolds over time. $80 million is not a lot; it is not going to buy all of the psychosocial disability support that is required. We are not entirely sure yet how much the NDIS will deliver, but I think government has recognised that there is a need; they are working with states to look at how that can best be addressed, remembering, as Mr Cormack has pointed out, that states and territories historically have responsibilities in this space as well. So I think, let's see how it unfolds.

Senator O'NEILL: But it is a start.

Dr Brown: Yes.

Senator O'NEILL: Could I ask you, with regard to the recommendations that you made in your review, with a 50 per cent reduction in suicides over 10 years, do you still hold to that view? Have you provided any advice to the former minister or current minister in regard to implementing a recommendation around a suicide reduction target?

Dr Brown: The commission finalised that report in 2014, and that was the view expressed in that report of a reduction of a target of 50 per cent. Commissioners took the opportunity late last year to relook at some of the recommendations and discuss that particular recommendation specifically. I think their view has shifted somewhat. They certainly expressed a view that we should be working very seriously to look at suicide reduction, a bit like seclusion and restraint, with the ultimate goal of aiming for zero. So towards zero was the statement that commissioners made when we discussed it last year.

Senator O'NEILL: So it is setting a higher target, if anything.

Dr Brown: In some ways, yes. One of our commissioners did make the point, quite pointedly I think, in saying 'Which 50 per cent of us are you happy to allow to die by suicide if you are setting a target of 50 per cent?'

Now that is a very strong and emotive statement. I think the 50 per cent target initially was established because it was seen to be aspirational but it seemed that a target is better than something that is—

Senator O'NEILL: Untargeted.

Dr Brown: Untargeted. However, we do know from the literature that achieving a 50 per cent reduction is a very significant stretch on our current efforts. We do think there is value in having a focus of attention. We recognise that setting a target is a challenge. Our advice to government is that we need to focus very strongly on suicide prevention but we need to work collaboratively with all of the players in the sector. There is a lot of investment in suicide prevention. What we know, however, is that there is a lack of coordination in some of the efforts, that there are probably duplications and gaps in suicide prevention, and so we strongly support the efforts outlined in the Fifth National Mental Health and Suicide Prevention Plan that are looking to address the coordination of efforts.

Senator O'NEILL: Yes. The Fifth Mental Health and Suicide Prevention Plan has 23 indicators. Will the commission have any role in relation to these indicators?

Dr Brown: That will ultimately be decided by COAG Health Council when they consider this matter in August, but we are anticipating that yes, the commission will have a role in monitoring the progress of implementation of the fifth plan and some of the broader indicators around outcomes for consumers and carers.

Senator O'NEILL: I might put some more detailed questions on notice with regard to that.

Dr Brown: Sure.

Senator O'NEILL: Dr Brown, you are going to be one of the co-chairs alongside Mr Quinlan from Mental Health Australia for the new Primary Health Network Advisory Panel. Is that correct?

Dr Brown: Yes.

Senator O'NEILL: Why did you agree to co-chair this advisory panel, and do you think there are issues across primary health networks where local need is not being addressed or standards are not adequate?

Dr Brown: I certainly agreed to participate as a co-chair in this because I think this is an important reform platform for the mental health sector in Australia. I think the change to the architecture towards a more regional approach and the ability to actually look at local needs and local solutions is really important.

Senator O'NEILL: But isn't there concern, in differentiation, that there is a decline in the application standards and about from whom the advice locally is being sought? Is that one of the concerns in the sector?

Dr Brown: I have heard many concerns across the sector, and they are certainly not consistent when you go to different regions, different parts of the country. It is early in this whole reform process, in terms of the work the PHNs are undertaking. I think there is perhaps still quite a deal of scope for all of the stakeholders to fully understand what each other is actually doing. I think this process is going to afford us the opportunity for a better understanding across all of the stakeholders, not just what the PHNs are doing, but where the other stakeholders—what their interests are, how they can engage and particularly going forward how we can all best work together to support this really important platform for reform.

Senator O'NEILL: Are you clear about what you want to achieve? Have you been given a brief and a set of outcomes?

Dr Brown: I am relatively clear of what we want to achieve, yes.

Senator O'NEILL: I might ask you to provide that on notice, if you can. That would be wonderful.

Dr Brown: Yes.

Senator O'NEILL: Just directly to a few questions around the PHN mental health advisory board. I know it was announced on 23 March. Are the terms of reference, membership and the exact task for the panel yet made public?

Mr Cormack: The terms of reference have been finalised.

Senator O'NEILL: Are they not yet public or are they with the minister? Where are they in the process?

Mr Cormack: I will just need to consult with the minister, but, from our perspective, they are finalised but not released yet.

Senator O'NEILL: And the membership?

Mr Cormack: It is finalised, but not released.

Senator O'NEILL: And the exact task that it is going to undertake?

Mr Cormack: It is contained within the terms of reference that the minister will no doubt release when he makes the appointments.

Senator O'NEILL: Will it be tasked with reviewing or providing advice on all the plans, needs or assessments of each of the 31 PHNs?

Mr Cormack: I am not going to pre-empt the minister. As we understand, the minister has settled on the terms of reference and the membership of the committee, and he will make the necessary announcements. The detail will be contained within that.

Senator O'NEILL: Has any funding been allocated to the advisory council?

Mr Cormack: The department has been given the task of supporting the secretariat arrangements for the task force. There will certainly be sufficient resources made available through the department's normal allocations to undertake this work to support the task force.

Senator O'NEILL: So there is no additional funding. You are absorbing it within your workload.

Mr Cormack: From time to time the department has to set up and stand down a range of advisory mechanisms.

Senator O'NEILL: And this is one of them.

Mr Cormack: This is one of them, that's right.

Senator O'NEILL: Will the advisory panel report directly to the Minister for Health?

Mr Cormack: That is my understanding, but I think the best way to see it is when the minister releases the terms of reference.

Senator O'NEILL: In terms of time lines, have any been provided to the advisory panel?

Mr Cormack: The advisory panel has got to be formally appointed. The terms of reference have to be released, and the work plan that is associated with that will also be confirmed and made public. At this stage, the panel is not operational, though all of the details associated with it—its architecture—are effectively settled. The minister will make that announcement when it suits him.

Senator O'NEILL: In terms of the membership of the panel, how has that be determined?

Mr Cormack: The minister consulted widely with the sector. The minister also sought advice from the department. We have provided advice to the minister.

Senator O'NEILL: And to the PHNs to make sure it gets that regional perspective?

Mr Cormack: Yes, indeed. It is right across the sector from the PHNs, the players involved in the delivery of services and the peak bodies—it will be quite an inclusive panel.

Senator O'NEILL: I have quite a number of questions to put on notice there, if I can. I have just a couple of quick ones with regard to Defence. Can the department clarify the funding of 58.6 million for veterans' mental health. Is that the correct numbers, for starters?

Mr Cormack: Veterans' Affairs?

Senator O'NEILL: The budget had a number of mental health services, including 58.6 million for veterans' mental health. Is at the full amount?

Mr Bowles: I cannot recall. It is something like that, but it is probably best to ask the Veterans' Affairs. I think they are on tonight in another area.

Senator O'NEILL: Can you clarify: is this funding from the Health budget or is it from the Department of Veterans' Affairs budget?

Mr Bowles: It is a Veterans' Affairs issue, yes.

Senator O'NEILL: So there is no money in Health for this initiative?

Mr Bowles: It is a mental health component of the Veterans' Affairs budget.

Senator O'NEILL: Through their budget?

Mr Bowles: It is through part of mental health more broadly, but Veterans' Affairs is the best place to talk about that.

Senator O'NEILL: Okay. Minister Hunt has been talking about it, and I thought it was—

Mr Bowles: It is part and parcel of mental health, but it is the responsibility of Veterans' Affairs.

Senator O'NEILL: To be clear, who is responsible for this part of the budget? Is it Minister Hunt or Minister Tehan?

Mr Bowles: Minister Tehan will be in the context of Veterans' Affairs, but clearly, because it is mental health, Minister Tehan and Minister Hunt will talk together on a whole range of mental health issues.

Senator O'NEILL: Can the department provide a breakdown of total funding allocated for services and programs that relate to veterans mental health and suicide prevention?

Mr Bowles: You would be best to ask that of Veterans' Affairs.

Senator O'NEILL: You cannot tell me about the money that Veterans Affairs' have to do that?

Mr Bowles: That is correct.

Mr Cormack: All we can say is that, as you have said, $58.6 million, via the Department of Veterans' Affairs, was allocated for the expansion of services for current and former members of the ADF, suicide prevention pilots and family counselling, and the rest is as per Mr Bowles's response.

Senator O'NEILL: It is a bit hard to tease out who is responsible for what and where the integration points are.

Mr Bowles: Well, Veterans' Affairs is responsible for the health of veterans more broadly. If you look at health spending, you will notice that in a lot of the work we do we talk about whole-of-government spending on health and that comes into us. It does not give us responsibility for delivering the services in Veterans Affairs'. That is why Minister Hunt deals with it in the broad context but Minister Tehan, in the context of Veterans' Affairs, will deal with the specific components that relate to veterans.

Senator O'NEILL: There are a number of other questions that I have, but I think in the interests of time I might have to put them on notice. Can I just clarify, if possible: there was one particularly important question that I was seeking an answer to, and you indicated that you are going to be able to take it on notice. It was with regard to the Medicare freeze for mental health care plans and Better Access. Would you be able to provide that by the close of the hearing today, Mr Bowles?

Mr Bowles: I will see what I can do.

Senator O'NEILL: Thank you.

[12:51]

CHAIR: We will move to program 2.3, Health workforce.

Senator KAKOSCHKE-MOORE: I would like to go to the issue of the health workforce in the context of gaps and overlaps in the health workforce framework. I will use remote area nurses as an example to flesh this issue out. We know that in March last year in South Australia remote area nurse Gayle Woodford was murdered while on a call-out. Following her death, the Department of Health commissioned a report by CRANAplus. This report was completed and handed to the department in January. When I questioned the department about any consideration that had been given to the report at that stage in February, during Senate estimates, I was told that consideration had been delayed pending the establishment of the National Rural Health Commissioner and a roundtable that was going to be held by the commissioner, which was supposed to be in May. We know that that has not happened, because the National Rural Health Commissioner has not been established. The legislation is still waiting to pass the Senate. Minister, do you know when this legislation is due to be brought on in the Senate? It has been four sitting weeks since the announcement was made that the government intended to establish this position.

Senator Nash: I do not, not being the minister responsible, but the officials might.

Dr Studdert: The legislation passed the lower house in March and has now been introduced into the Senate, but until the next sitting period it will not move along. However, Minister Gillespie, recognising the delays with progressing the legislation and the subsequent appointment of a rural health commissioner, has decided to convene another meeting of the Rural Health Stakeholder Roundtable. I believe that is planned for 30 June and that the CRANAplus materials and report will be considered at that time.

Senator KAKOSCHKE-MOORE: I want to go back to the delay in this report being considered at all and prior to the announcement of the establishment of a Rural Health Commissioner. It is my understanding that people or bodies that could be generally seen to be having an interest in this and an interest in achieving some action in this would include the Minister for Health, the Assistant Minister for Health, the Department for Health, the Australian Health Ministers' Advisory Council's Rural Health Standing Committee, the Australian Institute of

Health and Welfare. Yet, it seemed that none of those bodies or organisations that I just listed had the capacity or the preparedness to consider this report once it was given to the government in January.

Mr Hallinan: It might just help if I clarify the nature of the report and the activities that we funded CRANAplus to undertake.

Senator KAKOSCHKE-MOORE: I have read the report. I understand what is in it, what the government asked for and the recommendations that have flowed from the report. What I am concerned about is the lack of action in terms of implementing any of the recommendations of the report.

Mr Hallinan: I think it would help if I just clarified a couple of points. Following the tragic circumstances around Gayle Woodford's death last year, we did establish a project with CRANAplus to undertake a review into remote area safety and produce a few outputs. The report that you have identified is the first of those outputs, and there are a few others. I will just run through what those are, if that helps, and then, perhaps, talk through the approaches that we have been taking for promotion of those actions beyond the department and beyond CRANAplus. You are correct: in January, CRANAplus did deliver a report—the *Remote health workforce safety and security report: a literature report, consultation & survey results*. That has been distributed by the department to states and territories through the Health Workforce Principal Committee, which is a subcommittee of AHMAC, which is one of the committees that you noted earlier. It is also a report has been provided by CRANAplus more broadly through the sector. Parts of it, at least, have been promoted through the sector by other organisations, such as NACCHO.

The second deliverable was the National Safety and Security Guidelines for Remote Health Practice. These are guidelines that can be provided to employers—people employing remote workers—on the sorts of things that they can undertake to ensure the safety of those workers.

Senator KAKOSCHKE-MOORE: But these guidelines—the Commonwealth is not requiring health workforce organisations to comply with them. They are voluntary.

Dr Studdert: I do not think we actually have the levers to require that, but I think they have been embraced and looked at very closely by employers, because it is something that they actively seek guidance on.

Senator KAKOSCHKE-MOORE: Something that has occurred to me is the fact that in South Australia at least the vast majority of our outback health workforce organisations are funded by the federal government. That is where the bulk of their funding comes from. It appears to me that some guidelines might be a very neat and precise way of tying funding to the attainment of safety measures, particularly for remote area nurses, given that we know some of the dangerous conditions they are operating in.

Dr Studdert: Yes. I think so.

Senator KAKOSCHKE-MOORE: I can leave that there as a suggestion.

Dr Studdert: We provide the funding to the communities to run the community-controlled health services. I think we can act, obviously, and look to promote the use and adoption of those as employers of remote workers.

Senator Nash: Having been involved in this at the beginning with some responsibility at the time, there was quite a considerable discussion around the community controlled health organisations which, as you would know, make up a large bulk of the funding. There was a lot of discussion around their autonomy and the Commonwealth government not wanting to come in and impose on them what we thought might be right. So the process has probably taken a little longer than we would have liked for a couple of reasons. But I think it was really important for that CRANAplus report to come to its end, to be considered properly and very much work with people on the ground. They know best locally in their areas—the circumstances. Sometimes, it is not a one size fits all. What is going to work in one place is not necessarily going to work in another.

Senator KAKOSCHKE-MOORE: Just going back to the establishment of the commissioner and the intention at least in January to wait until the commissioner had been set up before consideration of this report was going to be progressed, is the commissioner going to have more powers than the Assistant Minister for Health, Dr Gillespie?

Senator Nash: I do not think Dr Gillespie would like to think that!

Senator KAKOSCHKE-MOORE: If the commissioner is not going to have more or better powers, why wait? Why not leave it to the person who has the power now to do something?

Dr Studdert: To wait for?

Senator KAKOSCHKE-MOORE: The commissioner to consider the report at a roundtable.

Dr Studdert: As the minister just said, it is with the guidance and leadership of the commissioner that the process of working with the stakeholders will look to how to promote and support the adoption of those, recognising the autonomy of the community-controlled services. There needs to be tailoring and adaption of those guidelines into what is best fit for each of those services, given the unique circumstances of them; it is an iterative process. The guidelines are out there for people to consider now. As well as that leadership role, the Rural Health Commissioner will, amongst other things, support the minister and guide our work.

Senator KAKOSCHKE-MOORE: I have looked at the website at Dr Gillespie's announcement of the commissioner. Essentially they have been given a priority which is 'improve access to training for doctors in regional rural and remote Australia'. Nurse safety is not the first priority of the commissioner. Who decided what that first priority would be? Was that Dr Gillespie or the incoming commissioner or the health minister? Who made that decision?

Senator Nash: There was a discussion at the time—from recollection—around the National Rural Generalist Pathway that we had been discussing. It was around workforce issues, and that was one of the things that we indicated would be one of the first priorities. It is now within the purview of Minister Gillespie, and I certainly do not want to cut across what he is doing, but I do not think that was exclusive of other things happening at the time. We indicated that was one of the key priorities, but I am very happy to take that on notice.

Senator KAKOSCHKE-MOORE: If they are listing training for doctors as a first priority, where in the chronological order is nurse safety? I would like to know whether they will be listed as first or second.

Dr Studdert: I would think the safety of all workers in remote areas would be critical, because if we are looking at the problems of distribution, attracting and retaining workforce in rural and remote areas, ensuring their safety is critical to that.

Senator KAKOSCHKE-MOORE: I agree with you on that. It was something that struck me when I was trying to figure out who really has responsibility for addressing this issue and the fact that we have a minister and an assistant minister and now the commissioner. How do the duties and powers of the assistant minister and the minister differ? Who has the power to actually do something here?

Dr Studdert: Our ministers have fairly well-defined and delineated areas of responsibility. As the Minister was just saying, the Rural Health Commissioner will advise and support the minister in enacting their legislative policy and budgetary powers and responsibilities.

Senator KAKOSCHKE-MOORE: If the assistant minister advises and supports the minister, my concern—at least from the interactions I have had—is that the advice that is being fed to the minister is 'There is nothing really for us to do here—we are powerless.' It is—

Dr Studdert: What advice are you referring to?

Senator KAKOSCHKE-MOORE: Of the assistant minister. From the interactions I have had, the advice I have been given is that essentially all the assistant minister can do is ask the health minister to take this matter to COAG. And that is it.

Dr Studdert: I think the assistant minister has a whole range of programs and budget areas that he has responsibility for. He has options for shaping and crafting those with the advice and support of the department.

Senator KAKOSCHKE-MOORE: What are some of those options?

Mr Hallinan: I will continue with where I was earlier on the remote area safety project that we have undertaken with CRANAplus. Beyond those two deliverables which I outlined, we are also anticipating another four deliverables in the next couple of months. One is an industry handbook, called 'Working safe in remote health', which will be distributed by CRANAplus throughout the network. The complexity here is that employers in remote areas can be Commonwealth funded or state funded or private—they can be anyone. The governance structure around directing people to undertake these things is complex, which is why we are working with states and territories as well as promoting these through existing employer arrangements.

Another will be a self-assessment tool on safety and security for workers who are employed in remote work—

Senator KAKOSCHKE-MOORE: Will any funding be made available to workers to undertake this self-assessment? Would there be a cost involved for the workers to do that?

Mr Hallinan: Only their time. Something that provides agency for an individual to undertake an assessment of their own work practices—how those practices could affect their safety and how the practices of their employers could affect their safety. It is something to empower the worker. There is also a e-remote learning module—online learning for people in this area—and a mobile phone app, called 'Being safe in remote', which

provides ready information for people to carry around in their pocket, if they have their phone with them. We have tried to tailor that response to both employers and individuals employed in those locations.

Senator KAKOSCHKE-MOORE: I might come back, time permitting, to those issues but I have two other questions now. I was told that Dr Gillespie would be asking Minister Hunt to take the issue of remote health workforce safety, and in particular remote nurse safety, to COAG. Minister Nash, have you already taken this issue to COAG?

Senator Nash: It is not my purview.

Senator KAKOSCHKE-MOORE: Did you in the past, when you were first involved with this?

Senator Nash: No, I was the Minister for Rural Health, but Minister Ley was the senior minister and so she did the COAG arrangements.

Senator KAKOSCHKE-MOORE: Did she take the issue of remote area nurse safety to COAG?

Senator Nash: I would need to check, but from recollection I think she did after the initial round table that we had.

Mr Bowles: I would have to take on notice the detail, but my recollection is that it has definitely been discussed at a COAG Health Council meeting. I cannot recall all the details, but it was clearly an issue that many of the ministers were particularly interested in at the time. I can take on notice when that might have been discussed.

Senator KAKOSCHKE-MOORE: If you could. I am concerned that if the advice is that all that the assistant minister can now do is take the issue to COAG, but if it has already been taken to COAG, it seems as though we are repeating history and that nothing new is coming from—

Mr Bowles: There is always a benefit in re-engaging with COAG colleagues because, predominantly, these issues of safety in workforce scenarios are the responsibility of states and territories. The Commonwealth obviously has responsibilities around some of the workforce issues which you mentioned earlier and which we might fund, but predominantly the overarching workforce issues are a responsibility of states and territories. It will never hurt to continue to have those conversations and particularly as the deliverables roll out it will be good to keep this on the agenda. In both AHMAC and COAG, workforce is considered by separate committees. Particularly in the COAG context there is a workforce committee and a COAG committee—they are both COAG committees and they work together but they are quite significantly separate—for this very important regional workforce issue.

Senator KAKOSCHKE-MOORE: I suppose conversations are good, but action is better.

Mr Bowles: Yes, and there is a lot of action that comes out of the COAG arrangements, because, again, the implementation has to happen at a state and territory level. So we have to make sure that we have those conversations and there are some significant decisions that are made through that process.

[13:08]

CHAIR: We will move on to 2.4 Preventative Health and Chronic Disease Support.

Senator WATT: I have some questions about the department's approach to drug and alcohol services. Can you please provide the average waiting time for someone to access residential rehab services in each state and territory?

Dr Studdert: I do not have my key advisers here, but I am fairly certain we would have to take that on notice. It is a matter for the states and territories—

Mr Bowles: It would be a state and territory issue, Senator.

Senator WATT: If you could take on notice a state-by-state breakdown—

Dr Studdert: Depending on the availability from our jurisdictional colleagues.

Senator WATT: What can you tell us about average waiting times for accessing residential rehab services around the country?

Dr Studdert: It is not something that we hold data on in a detailed or quotable form.

Senator WATT: No doubt the waiting times are different. For some states they would be shorter than for others and some states longer than others.

Dr Studdert: And it depends on the nature of the service that is being sought and it would vary across regions and, no doubt, across periods of time and across a year.

Senator WATT: I accept that many of these services are state funded or provided, but the Commonwealth must have some understanding of whether waiting times are growing or shortening in a general sense?

Mr Laffan: Waiting times are not actually captured in the alcohol and drug national minimum dataset at this particular point in time, but that is certainly an item that we are developing currently.

Senator WATT: So the Commonwealth does not currently capture waiting times for accessing residential rehab services?

Mr Laffan: That is right; it is not in the dataset.

Senator WATT: Leaving aside the fact that it is not in the dataset, have there been any discussions with the states and territories about waiting times or anything on which to base some assessment of how it is going?

Mr Laffan: Not recently, to my knowledge.

Senator WATT: The Commonwealth is administering funding to the states and territories through the Ice Taskforce though, isn't it?

Dr Studdert: It is funding to the PHNs in the state jurisdictions.

Senator WATT: So the Commonwealth does have some role to play in the provision of rehab. In the Ice Taskforce, one of the objectives is about provision rehab services.

Mr Laffan: That is within scope for the PHNs, yes.

Senator WATT: So the Commonwealth does have some role, then, in funding rehab services and must, therefore, have some idea about what is going on in that space?

Dr Studdert: I am sure our respective PHNs—31 of them—in the processes that they have gone through in the last 12 months, doing needs assessments and consulting with the states and territories, which, of course, provide the majority of services in each jurisdiction, would have had conversations and gathered data along those lines. It is not something that is provided directly to the Commonwealth, other than—

Senator WATT: In the consultations that have occurred with the states and territories and PHNs to date, or through the Ice Taskforce review, what information do we have now, in a general sense, about the availability of residential rehab services around the country?

Mr Laffan: Primarily, in relation to the PHNs, they went through an extensive needs assessment and market analysis within their individual areas, where they came back and commissioned services to meet the needs within the local regions. I do understand that, in relation to PHNs themselves, six of the 31 PHNs have chosen to have residential rehabilitation or residential withdrawal as part of the services that they have commissioned locally.

Senator WATT: So that means 25 have not?

Mr Laffan: That is right.

Senator WATT: Just so that I understand that: of the 31 PHNs around the country, six of them have commissioned residential rehab or withdrawal services for—

Mr Laffan: That is correct.

Senator WATT: Is it specifically around ice, or drugs and alcohol generally?

Mr Laffan: They would be drugs and alcohol generally; in addition to those services that have been commissioned by PHNs, the Commonwealth, through the drug and alcohol program, also provides just over $26 million for residential rehab each year in addition to that money that has gone to the PHNs.

Dr Studdert: Noting, of course, that residential rehab is just one of an array of offerings that are sought and needed in drug and alcohol treatment.

Senator WATT: Not to harp on about this, but, surely, if you are providing funding for these sorts of rehab services, you must have some sense of what the waiting times are and you must be looking for improvements in that as a condition of funding, or—

Dr Studdert: I certainly think that we are looking for improvements because it is a significant investment of new funding for services. But again, I think we would have to say that it varies across regions and times. To give you a general answer would not be an accurate reflection of—

Senator WATT: That federal funding that is being provided, presumably, acknowledges that the availability of rehab services is an issue and needs to be improved.

Dr Studdert: The availability and the range of offerings—I think that there is always room for improvement there. As needs change, as has happened with the emergence of ice and other drugs and substances in local areas

that have seen abuse change, I think that we want to give those local areas the ability and flexibility to respond to those needs.

Senator WATT: How would you describe the problem that exists currently around accessibility of residential rehab services? You acknowledge that it is a problem?

Dr Studdert: I acknowledge that there are needs that the PHNs are working to fill, yes.

Senator WATT: So there is unmet need in the community for—

Dr Studdert: I think I know what you are trying to—I am not going to give you a general answer for the situation across the country.

Senator WATT: You are handing over taxpayers' funds to improve—

CHAIR: On that, we will suspend for lunch and return at 2.15.

Proceedings suspended from 13:15 to 14:15

CHAIR: We will continue on program 2.4.

Senator ABETZ: I have a very brief bracket of questions relating to some questions that have been asked of the Joint Committee on Law Enforcement in relation to illegal tobacco, plain packaging of tobacco. I am assuming or I am hoping somebody has answers on notice from the Joint Committee on Law Enforcement?

Mr Bowles: I do not think I do.

Senator ABETZ: If somebody does, that would be extremely helpful. Question No. 9 is the one I want a bit of clarification on. In the second paragraph of the answer, we are told:

Complaints which are received late in the financial year may not be investigated in that financial year. When this occurs the complaint will be reported as being investigated in the following financial year.

Has that always been the case with the reporting methodology under section 108 of the plain packaging legislation?

Dr Studdert: I think that actually refers to some particular instances. I think it was the 2015-16 financial year, where, on 30 June, the department received a large bundle of complaints, several hundred.

Senator ABETZ: But I just mean the methodology. What I am trying to ascertain is whether this is the first time that has occurred.

Dr Studdert: I believe it is but I will let my colleague answer that.

Senator ABETZ: First of all, is that the first time that has occurred?

Mr Masri: In previous years, we were assessing the number of complaints received and then also assessing complaints that we have commenced investigations into and then there is a separation.

Senator ABETZ: Is 'complaints received' identical to 'alleged contraventions' in the formatting of your material?

Mr Masri: We might have received a number of complaints on 30 June, for example.

Senator ABETZ: But is the terminology 'alleged contraventions' the same as 'complaints'? This is not a trick question; I just want to make sure we are not talking at cross purposes.

Dr Studdert: The reference to the terminology 'alleged contraventions', was that in that answer? I am not sure where that terminology is used.

Senator ABETZ: No, it was not. It is a table that I have got. Let's stay with your terminology.

Dr Studdert: In the hierarchy, there is the total number of complaints received then there is the number of cases, which is a subset of the number of complaints because, on occasion, there is more than one complaint received for a particular case.

Senator ABETZ: I understand.

Dr Studdert: We can give you data on the number of investigations ongoing, the number of cases closed and various other steps in the process.

Senator ABETZ: We were told, I think, over the page in answer to (a)iii that the department reported that, pursuant to section 108 of the TPP act, 210 potential contraventions of the act were investigated in 2015-16. The majority of these matters were continuing investigations from the previous year, right?

Dr Studdert: Yes. To distinguish between the number of complaints received in any one year and the number of cases being investigated: they will not be exactly aligned. Some roll over from year to year.

Senator ABETZ: In previous years has it also been the case that they have rolled over and you have had continuing investigations? The figure I have is 59 in 2012-13 rolled over to be 59 in 2013-14 and then 226 in 2014-15. In that figure of 226, could we assume that some of the 59 from the previous year are added in?

Dr Studdert: I think that would be correct.

Senator ABETZ: That is what I wanted to check. In the event that that is not correct, could you get back to us on notice please. I would be much obliged.

Dr Studdert: Absolutely.

Senator ABETZ: Would you be able to provide us in future reporting of how many new complaints have been received each year as opposed to the continuing investigations might be helpful. In the fourth paragraph of 1(d) of the answer—the middle sentence—we are told, 'An authorised officer must seek consent from the controller-occupier to perform their powers under the TPP Act.' Do you have that section?

Dr Studdert: Yes, I have got that.

Senator ABETZ: When we talk about controller-occupier, that is the controller-occupier of the particular premises?

Mr Masri: That is correct.

Senator ABETZ: What happens if the consent is denied—if somebody is red-hot guilty and just denies consent?

Mr Masri: These are matters that we consider through the enforcement committee, which is made up of people from the department, including me, and an officer from the National Measurement Institute. We consider the matters, and then there is the issue of whether we go to the Administrative Appeals Tribunal and seek a warrant to enter the premises.

Senator ABETZ: How quickly can that happen?

Mr Masri: It can be a matter of days in the sense of looking at the material, judging the issues, what attempts were made to enter and look at the product and the availability of the tribunal member. Putting a submission to the tribunal takes some preparation as well.

Senator ABETZ: I am still wondering how many other law enforcement agencies—and I am asking this out loud and not necessarily expecting you to be able to answer. Having such a restriction on you must be quite an impediment to be able to pursue these.

Dr Studdert: I think that might be in part the distinction between law enforcement and compliance, which is what these powers are about.

Senator ABETZ: Yes.

Mr Masri: And these are certainly in the context of plain-packaging legislation. There may be information that we pass on to other agencies including law enforcement agencies. That may be useful in relation to other aspects.

Senator ABETZ: One assumes that, during that period of time, if one is so engaged, one might ensure that certain evidence is no longer available.

Mr Masri: It has not stopped us seeing some of the material when we have gone into premises with a warrant. It has not been a barrier.

Senator ABETZ: All right. You surprised me. I thought you or the NMI might want more or greater powers. Thank you for that.

Senator Nash: I want to put on record my appreciation for the committee for moving around the time table today to accommodate my commitment at lunch time. Thank you very much.

CHAIR: Our pleasure. Senator Watt.

Senator WATT: I go back to where we were before the lunch break. I think we were told that six of the 31 PHNs had commissioned new rehab services.

Dr Studdert: 'Residential rehab' was the distinction.

Senator WATT: Which PHNs are they?

Dr Studdert: We would have to take that on notice. I do not think we have that level of detail here today.

Senator SIEWERT: Here today or right now? Surely some of your staff here will have those things.

Dr Studdert: I can undertake to try to get it to you.

Senator WATT: Thank you. Do you have any data about the number of people actually turned away from services in each state and territory?

Dr Studdert: We do not have that data. It goes to the similar sorts of datasets we were talking about before the break. We can certainly look at whether there are publicly available datasets that would have that.

Mr Laffan: I think it is important to make a distinction here as well that the people who do present to the wide variety of alcohol and drug services that are available are assessed and treated on the basis of clinical need, so that those people who need those services the most are able to access them.

Senator WATT: Could you take that on notice? I understand it might involve some collection of data if it is not something that you have readily to hand.

Dr Studdert: I would see if there are some other datasets that are not Commonwealth that we could point you to.

Senator WATT: Okay. Maybe you could do that.

Dr Studdert: Yes.

Senator WATT: Do you have any figures on the number of residential rehab beds available in each state and territory?

Dr Studdert: Again, we would have to look for other data sources for that.

Senator WATT: I am sure you kind of know where I am leading with this. In the budget the government announced a trial of drug testing for 5,000 jobseekers receiving Newstart allowance or youth allowance in three locations. Was the department consulted on this measure prior to its announcement?

Dr Studdert: The advice I have—and I was not present at the time—is that we have been consulted and talked to DSS. I do not know if that was prior to or since.

Senator WATT: I think that is important to know. Is there anyone present who was involved in those discussions?

Mr Smith: Yes, the department was consulted.

Senator WATT: Prior to the announcement of this measure?

Mr Smith: Yes.

Senator WATT: When did that occur? How far before the budget?

Mr Smith: I would want to take that on notice. In the weeks and months leading up to, but I would be very careful about giving you a date without checking that.

Senator WATT: If you could please. What was the department's involvement in the preparation of this measure?

Mr Smith: As an agency with policy responsibility for elements of that measure we were consulted in the budget context.

Senator WATT: Did you do some policy work around it? It was something worked up by DSS, and we will no doubt talk to them about that tomorrow. It was a proposal worked up by DSS—

Mr Smith: Yes.

Senator WATT: that they came and talked to you about?

Mr Smith: I would need to refer you to DSS for the details of the working up of this measure. We were consulted in the budget context.

Senator WATT: So Health did not provide any policy advice to the proposal?

Mr Bowles: It would not be a policy issue for the department. They would be talking to us in regard to potential implications that may come towards Health, which will not necessarily be policy related.

Senator WATT: What policy implications did you consider might arise for Health?

Mr Bowles: I do not know personally. Did we think of any?

Mr Smith: With my division having responsibility for drug and alcohol treatment policy we were consulted in the working up of this measure, which relates to drug and alcohol treatment services.

Mr Bowles: But not from a policy perspective, because the policy is a DSS policy.

Senator WATT: So did DSS consult you about the ability of rehab services to deal with any additional needs?

Dr Studdert: Given we do not have that data at a local or regional level, I think that is something we could not have given them specific details on. We could provide them with information about the process we are going through working with the PHNs to enhance services, but I do not think we could have been in a position to give numbers.

Senator WATT: Given that it is state based data and services, I take it from that that DSS did not seek the opinion of Health as to whether rehab services were adequate to deal with anyone who was picked up using drugs through this process?

Dr Studdert: I think we could give them the information that we have, in terms of where our funding is going with the PHNs, the process that the PHNs are going through and the variability of services. But beyond that, because there are no specific details of where and how the DSS trials will be applied, that level of detail would not have been.

Senator WATT: It feels like you are not quite answering my question.

Mr Bowles: I will cut through: I think it is an issue for DSS, because they have not announced the sites. So I think it would be a question best asked of them.

Senator WATT: I will have plenty of questions for them tomorrow.

Mr Bowles: Then I am happy for you to put them on notice.

Senator WATT: I am genuinely interested in Health's involvement, because this is a proposal that obviously has some implications from a health perspective.

Mr Bowles: Yes, and I would be happy to take them on notice after you have talked to DSS—where you think the implications for us are.

Senator WATT: Sure. But what I am hearing is that you have provided a range of information to them, but that does not include providing any advice on the ability of rehab services to respond to needs that come out of this testing proposal.

Mr Bowles: Well, we will not be the only ones who will provide that, given that a lot of these things are state and territory responsibilities. We would have provided them advice about our view, from a service delivery or a funding perspective, of what we do. But at the end of the day it is a DSS policy, and they need to determine where it all happens, and then you can relate it back to the services on the ground.

Senator WATT: Has your department consulted with rehab service providers about the trial?

Mr Laffan: At this point, no, we have not, but I do understand that Social Services are, with the peak bodies who represent those organisations.

Senator WATT: Have you had any feedback from health stakeholders in this drug and alcohol treatment space since the trial was announced?

Dr Studdert: I am advised that the Australian National Advisory Council on Alcohol and Drugs had a discussion about the matter. That is a body that does provide advice to government, but we are not privy to that advice.

Senator WATT: So that was a discussion they had with DSS?

Dr Studdert: Not with DSS. At their—

Mr Laffan: The Department of Social Services attended the meeting at the request of ANACAD and provided some information in relation to the measure itself so that ANACAD may be in a position to respond and provide them with some advice in future.

Dr Studdert: Or indeed DSS, to talk about that consultation.

Senator WATT: But ANACAD has not raised any issues with the health department?

Mr Smith: ANACAD discussed it at their meeting. I would need to take on notice whether there has been any formal correspondence in relation to the outcomes of that discussion.

Senator WATT: Did anyone from Health attend that meeting?

Mr Smith: Yes.

Senator WATT: What was the view put by ANACAD at that meeting about this proposal?

Mr Laffan: The considerations of ANACAD are confidential and provided directly to the minister.

Senator DI NATALE: Did they support the proposal?

Mr Laffan: I cannot comment on that.

Senator Nash: I think he just said it was confidential, but nice try. I think it is useful to have some context here as well. It is a trial. There will be three to four locations. As I understand it, they have not been determined yet, so it would be difficult for officials to discuss people in locations that have not been decided yet. I think it is worth noting that the $300 million that went to the Ice Action Strategy was unprecedented; we had not seen anything before like that from previous Labor governments—$684 million in total for drug funding over the next four years. It is primarily a matter for DSS. Recognising that, I think we also need to keep it in context of a trial, and the locations have not been determined yet, so it is very difficult for officials to even look to give specific examples when we have not identified those sites.

Senator WATT: Are you aware of whether ANACAD were consulted before the proposal was announced? I am not asking what they said, just whether they were consulted.

Mr Laffan: I am not aware if they were.

Senator WATT: From a health department's perspective, are you aware of any evidence base which suggests that this trial will assist people with their drug addictions? I have a range of questions for DSS, but I am asking, from a health perspective, are you aware of any evidence base?

Mr Bowles: We would have to turn our minds to that. I have not seen anything.

Senator WATT: Okay—there is no evidence base, from Health's perspective.

Dr Studdert: No, I do not think—

Mr Bowles: That is not what we said. We said we are not aware of it.

Senator WATT: You are not aware of any evidence base. That will have to do for me.

Senator DI NATALE: Can I go back to this issue of consulting with the Advisory Council on Alcohol and Drugs. To be clear, were they consulted prior to the proposal being announced?

Mr Bowles: We said that we did not know.

Senator DI NATALE: This is the Advisory Council on Alcohol and Drugs, set up specifically to provide advice on alcohol and drugs to the department. Were they consulted prior to this announcement?

Mr Smith: It was not discussed in formal meetings that were arranged through the department. Whether they were consulted in some other way—through correspondence directly with DSS—we cannot answer that.

Senator DI NATALE: But they report to you, do they not? The Advisory Council on Alcohol and Drugs report to the Department of Health.

Dr Studdert: They report to the minister.

Senator DI NATALE: Sorry?

Mr Laffan: It reports to the minister.

Senator DI NATALE: So you are saying to us that you are not aware of whether they were consulted beforehand. As far as you are concerned—

Dr Studdert: I have to say it is unlikely, given it was a budget measure, that they would have been consulted in any specific way around the proposal. As my officials have said, it was not on any formal agenda in the meetings prior to the announcement.

Senator DI NATALE: It was not on any formal agenda prior to the announcement of this policy—we are not talking about after the announcement—of any meetings that you were involved in with the Advisory Council on Alcohol and Drugs. Would you expect to be involved in any meetings with the Advisory Council on Alcohol and Drugs if there were a meeting between the minister and the advisory council?

Mr Laffan: No, the advisory council operates independently of the department.

Senator DI NATALE: Is there a department representative or is there any involvement with the department?

Dr Studdert: The formal meetings are organised by the department, and the secretariat support is provided by the department, but the members are available to consult with—

Senator DI NATALE: Did you provide any—

Senator Nash: Let the official finish, please.

Dr Studdert: The members are available to consult and support the minister as needed, and be called on.

Senator DI NATALE: Did you provide any secretariat support to organise a meeting between the advisory council and the minister?

Dr Studdert: Prior to the budget announcement? I think the official has been clear that was not the case.

Senator DI NATALE: Just to confirm: you think it is unlikely that any official meeting took place, given that it was a budget measure?

Mr Bowles: You would have to ask DSS whether they did that or not. We would not know, necessarily.

Senator DI NATALE: I am asking because—

Mr Bowles: Well, I am answering.

Senator DI NATALE: Dr Studdert said a moment ago that she thought it would be unlikely that there would be a meeting between the advisory council—

Mr Bowles: Yes, from our perspective it would be unlikely. However, I think the caveat would be you would need to talk to social services, because we would not necessarily have visibility of what they have done in that phase.

Senator DI NATALE: Okay, we will certainly ask social services. But you are saying that, theoretically, a meeting could happen between the minister and the advisory council, and you would have no knowledge of it?

Dr Studdert: I think that the members are experts in the field, and that the minister could talk to them. But it is entirely theoretical. I do not think that—

Senator DI NATALE: Independently of ANACAD's involvement, was the department consulted prior to the announcement?

Mr Bowles: Yes.

Senator DI NATALE: I thought that was the answer you gave. On how many occasions?

Mr Smith: I would have to take that on notice.

Senator DI NATALE: You were consulted about the nature of the proposal. Why would you not discuss that with the group specifically set up to deal with alcohol and other drugs—that is, the advisory council? Given that they are asking your advice on an issue that the advisory council exists specifically to provide advice on, why would you not involve them in that process? Can you help me understand that?

Dr Studdert: As my colleague said, the consultation with DSS was around the technical nature of services and what we understand of the way services deliver. I do not think it was specific to any details of the budget measure, because, as the minister said, the sites and the specifics of the role have not been determined, and it would not have been appropriate or possible for us to consult with the advisory council because it is a budget-in-confidence process.

Senator DI NATALE: Again, I am just seeking to understand. The advisory council would not normally be involved in the discussion of a specific policy measure in the budget that they are directly set up to provide advice on.

Dr Studdert: Not at the initiation of the department, no.

Senator DI NATALE: What is the point of having the advisory council? I am not sure I understand what their role is. Can you explain their role? If the government is going to establish a process that, specifically on alcohol and other drugs—

Dr Studdert: I was distinguishing a budget-in-confidence process from a whole range of other advice that they have been asked to provide to the minister, in particular around the rollout of the National Ice Action Strategy.

Senator DI NATALE: So we have an expert body that is supposed to be dealing with alcohol and other drugs that was not consulted, as far as you are aware, prior to the announcement of this budget measure.

Dr Studdert: That is what I said.

Senator DI NATALE: What form did the advice that the department provided to the minister take?

Dr Studdert: Just to be clear, Senator, the department did not provide advice to the minister. The department was consulted by DSS in the development of their budget measure.

Senator DI NATALE: What form did the advice to DSS take?

Mr Smith: There would have been discussions. There would have been advice or information put in writing, which Dr Studdert referred to—the nature of the types of services and how funding rolls out through PHNs. I cannot tell you specifically how every piece of advice was provided, but it would have been through a range of mechanisms.

Senator DI NATALE: How much funding has been allocated to provide for the trial?

Dr Studdert: You would have to ask DSS that.

Senator DI NATALE: Surely, I can ask you some specific details about the tests.

Dr Studdert: No, Senator, because we do not have that detail. That would be DSS.

Senator DI NATALE: Drug testing is surely something that sits within the Department of Health.

Dr Studdert: That is a clinical service that is provided through health services at a jurisdictional level or through primary care. I am not familiar—I do not think any of us have that level of detail.

Senator DI NATALE: So you do not know how that testing is going to be done?

Dr Studdert: No, Senator.

Senator DI NATALE: You do not know whether it is going to be saliva testing, hair follicle testing. You do not know what the nature of the tests are—gas chromatography, immunoassays. You have none of that information.

Dr Studdert: No, Senator.

Senator DI NATALE: What advice were you providing to the department? This is all the nuts and bolts of the scheme. What were you consulted on?

Dr Studdert: I think Minister Smith just explained that. It might have been on some of the—actually, I am speculating, because Mr Smith really should respond to this.

Mr Laffan: Advice that was provided to social services went to the nature and location of alcohol and drug services that are provided potentially through the PHNs or other things that the department provides in contract directly for—

Senator DI NATALE: So, basically, you provided them with advice about where waiting lists might be low for alcohol and drug treatment services.

Mr Laffan: We do not have specific data in relation to waiting lists, but we did provide an indication of what types of services were available in specific areas.

Senator DI NATALE: Was that the limit of the advice on which you were consulted?

Mr Laffan: I think that was the majority of it. I cannot think of anything else, off the top of my head, Senator, that we specifically provided to DSS.

Senator DI NATALE: So there was no information about drug testing or the nature of the testing involved. There was none of that.

Senator Nash: Senator, I think we have just covered all that. You have just asked all of those exact same questions.

Senator DI NATALE: I am just double-checking. That is all I am doing. Forgive me, but sometimes we get different answers—

Senator Nash: I am sure we can take it that, when the officials give an answer, we do not need to go and ask them the same questions all over again.

Senator DI NATALE: Well, do you know what, occasionally you get different answers from different officials. It has happened before.

Senator Nash: You do not need to double-check.

CHAIR: Order!

Senator Nash: Senator, they have also been very clear that it is primarily a matter of the DSS and that your questions would be better directed there.

CHAIR: That being noted—

Senator DI NATALE: I have not finished.

CHAIR: Thank you. I will give you the call then.

Senator DI NATALE: I will go to questions around treatment. Mr Laffan, you have just said you do not have information on waiting lists.

Mr Laffan: That is correct. It is not part of the Alcohol and Other Drug Treatment Services National Minimum Data Set.

Senator DI NATALE: Can I ask about providing advice. You provided advice to DSS about where services are located. How are we to know whether there are six-month waiting lists or one-year waiting lists in those locations?

Mr Laffan: That information is not available. Because it is not part of the dataset, it is not information that the department collects.

Senator DI NATALE: Isn't it a bit redundant to be providing advice on services if people have got no way of accessing those services?

Mr Laffan: I think in relation to the services that are available in any area across the country, people who seek to access them are treated on the basis of clinical need and in that order of priority.

Senator DI NATALE: That is right. Many people who need access to a service cannot get access to it. We know that; that is the reality of drug treatment services. So what utility is information about the availability of services to DSS if they have got no information about whether someone can access those services?

Mr Bowles: You do not know whether they have got any information. You would need to ask them.

Senator DI NATALE: We have just heard that none of that information was provided.

Mr Bowles: You have asked us certain questions. You need to talk to Social Services about what else they have done because we are not the sole repository of this thing. The states and territories are involved.

Senator DI NATALE: Did the department undertake any modelling to determine whether any additional investment in drug treatment services would be required as a result of this testing?

Mr Laffan: That is a matter for Social Services.

Senator DI NATALE: Were you asked to provide that information?

Mr Laffan: No.

Senator DI NATALE: Do you have any view on whether that modelling is available or has been done?

Senator Nash: You cannot ask questions about their opinion.

Senator DI NATALE: Do you have any concerns that this trial may in fact lead to people substituting other drugs—

Senator Nash: You are asking for opinions again.

Mr Bowles: We are not going to give an opinion on that.

Senator DI NATALE: It is not—

Mr Bowles: It is an opinion on a policy of government.

Senator DI NATALE: No, it is not an opinion on a policy.

Mr Bowles: I disagree.

Senator DI NATALE: It is a view about drug testing generally.

Senator Nash: A view and an opinion are the same thing, Senator.

Senator DI NATALE: Do you have any information on what the impact will be if a jobseeker tests positive on more than one occasion? Is that something that you are able to deal with?

Mr Laffan: No. That is a matter for Social Services.

Senator DI NATALE: So the department was consulted. It provided advice primarily on the location of drug treatment services. That was effectively the extent of the advice provided to the Department of Social Services. As far as you are aware, the advisory council on alcohol and other drugs was not consulted—we will test that tomorrow—and the extent of your involvement in this process has been to provide information as to where drug and alcohol treatment services are located. Is that an accurate summary?

Dr Studdert: Senator, because I was not a party to those conversations, can I take on notice to give you a more specific answer around the nature of the advice that was provided? I think it was probably broader than just the location of services. I think the nature of services, the work that we are doing through the ice action strategy and the consultations that were done as part of the ice action strategy were likely part of those conversations. We are very happy to give you a little bit more information so as not to oversimplify in characterising that advice.

Senator DI NATALE: I just got the tail end of the conversation on PHNs. I think I heard you say there are a number of PHNs now that are offering non-residential treatment. Is that correct?

Dr Studdert: The commissioning that the PHNs have done of drug and alcohol treatment services is the full range of services, and the majority of that is non-residential, based on the identified needs of the areas that they have done through their gap analysis.

Senator DI NATALE: My understanding is that residential treatment has not really been commissioned through the PHNs. There might be some isolated examples of where that has occurred.

Dr Studdert: I think there are a small number that have, and we have undertaken on notice to get the specific details of those services and which ones they are.

Senator SIEWERT: Preferably today.

Dr Studdert: Yes, right. I expect it is on its way now.

Senator DI NATALE: I think most of my questions need to be directed to the Department of Social Services tomorrow. If I have got any more, I will come back.

Senator KAKOSCHKE-MOORE: There are two issues I would like to traverse. The first is the Life Education program, if you are familiar with that—most people might know it by the van with the giraffe! It previously received some federal funding, but I understand there have been some changes. I want to go through that issue first and then return to the National Ice Action Strategy funding with some more questions around that.

On Life Education, I have been advised that it has been receiving funding to provide classes about the dangers of illicit substances, including crystal methamphetamine. Is that correct?

Mr Laffan: They have certainly received some funding in the past from, I understand, both the Department of Health and the Department of Education and Training.

Senator KAKOSCHKE-MOORE: But was the funding that was provided by the Department of Health allocated towards these programs directed to children, warning them of the dangers of drugs?

Mr Laffan: I do believe it was from the money provided from the prevention side of things, yes.

Senator KAKOSCHKE-MOORE: Can you confirm whether or not funding will no longer be provided by the Department of Health for Life Education?

Mr Laffan: My understanding at this time is that no money has been provided at this point. No further funding has been provided at this point.

Senator KAKOSCHKE-MOORE: Do you know if the Life Education program will be replaced by a different program achieving similar ends?

Mr Laffan: I am not aware, although I do know that there are many prevention programs that are out there and available for people in schools, for teachers, to take advantage of.

Dr Studdert: I might just add to that answer. Under the National Ice Action Strategy, funding was put to the Positive Choices web portal, which is a resource for teachers, students and parents around drugs and alcohol. So yes, there is a—

Senator KAKOSCHKE-MOORE: There is some, but not the same sort of face-to-face delivery that Life Education offers?

Dr Studdert: I think there are resources on that site for teachers to use in classrooms and parents to use in the home for education around those issues.

Senator KAKOSCHKE-MOORE: Was the funding that had been provided previously to Life Education from Nation Ice Action Strategy funding?

Dr Studdert: It was not Ice Action Strategy funding, no. I think we will take that on notice to identify the specific source and let you know.

Senator KAKOSCHKE-MOORE: That would be good, thank you. Can you tell me why the decision was made to discontinue the funding to Life Education?

Mr Laffan: We would need to take that on notice. But you will appreciate there are lots of competing priorities in the drug and alcohol space.

Senator KAKOSCHKE-MOORE: I understand. I think they were filling quite a unique need, so I will just be interested to hear some of the thoughts around the department in the decision-making process when the decision was made to no longer fund Life Education for these early-years-intervention training modules, particularly for young children.

I will return now to the issue of National Ice Action Strategy funding. I know from questions on notice answered in the context of the joint select committee inquiry into crystal methamphetamine that, of the $241

million in the National Ice Action Strategy, there is still around $64.4 million that has not been allocated to primary health networks or other organisations. Is that figure, the $64.4 million, still correct?

Mr Laffan: I am not sure specifically about the $64 million that you refer to. The National Ice Action Strategy was for $298 million. Two hundred and forty-four million dollars was specifically for treatment services, and at the moment, of that $244 million, $177 million has been contracted with PHNs for service delivery. That is for the first three years of the four years. The final year is not yet in contract with the PHNs.

Dr Studdert: But then, just again to add to that, there are other things that the Ice Action Strategy is funding: a national centre of excellence, the Positive Choices website that I just mentioned, the wastewater testing—

Senator KAKOSCHKE-MOORE: And that is all coming from the $298 million?

Dr Studdert: Yes, exactly. The money is all allocated for specific actions in response to that strategy.

Senator KAKOSCHKE-MOORE: Perhaps on notice, could you provide me with a breakdown of how much has been allocated to the establishment of the national centre for excellence and the—

Dr Studdert: I am pretty sure we can give you that figure now.

Mr Laffan: For the national centre for excellence, it is $8.8 million.

Senator KAKOSCHKE-MOORE: And for—you mentioned the name of it before—the positive changes web portal?

Mr Laffan: Positive Choices was $1.1 million.

Senator KAKOSCHKE-MOORE: Was there anything else outside of the funding that has been set aside for treatments?

Mr Laffan: Not for treatments specifically, but there are additional funds set aside for prevention activities. So for the creation of the local drug action teams there was $19.2 million.

Senator KAKOSCHKE-MOORE: Is that total for local drug action teams?

Mr Laffan: Over the four years, yes. That is the same for the Good Sports Program. The new Tackling Illegal Drugs module associated with the Good Sports Program will have $4.6 million over the course of the four years to reach about 1,200 community sporting clubs.

Senator KAKOSCHKE-MOORE: And that is focused toward crystal methamphetamine use in sports?

Mr Laffan: That particular module is focused on illicit drugs, so it is broader than crystal meth.

Senator KAKOSCHKE-MOORE: But it has come out of the National Ice Action Strategy funding pool?

Mr Laffan: That is correct.

Senator KAKOSCHKE-MOORE: I might return to that in a moment and stay on the money that has been set aside in the National Ice Action Strategy for treatment. On notice, I was advised that the way the funding was allocated between the states was based on 2011 census data.

Mr Laffan: For population, yes.

Senator KAKOSCHKE-MOORE: For population, degree of rurality, Indigenous population—

Dr Studdert: It was allocated amongst the PHNs, not the states.

Senator KAKOSCHKE-MOORE: Yes, amongst the PHNs. You used 2011 census data to determine the level of need of these PHNs for ice treatment facilities.

Mr Laffan: As one of the criteria, yes.

Dr Studdert: It was one of the elements that was used in modelling that was done for the funding. That would have been the current census data at the time.

Senator KAKOSCHKE-MOORE: Was any updated data used at all? I asked on notice for the actual formula that was used to allocate the funding between PHNs, and all I was told was that it was 2011 census data, essentially.

Mr Laffan: There was 2011 census population data, but also other factors for rurality, socioeconomic disadvantage and Indigenous population. I think those were the other things.

Senator KAKOSCHKE-MOORE: So were those factors somehow derived from the 2011 census data?

Mr Laffan: I believe they would have been based on that data, yes, because that was the most current that was available.

Senator KAKOSCHKE-MOORE: Is it possible for me to see the actual formula? It is what I asked for the first time. I understand that you have some weightings there, but it is not clear to me if one factor was weighted more heavily than the other.

Mr Laffan: In terms of the weightings that were applied, I can tell you that non-Aboriginal or Torres Strait Islanders had a weighting of one. For Aboriginal and Torres Strait Islanders there was a weighting of three. For the different socioeconomic quintiles: for the most disadvantaged there was a weighting of two, for the second quintile there was a weighting of 1.5 and the remaining quintiles had a weighting of one. It also took into account the ASGC remoteness areas. Major cities received a weighting of one, then there was a stepped scale to very remote areas, which had a weighting of 2.5.

Senator KAKOSCHKE-MOORE: Can we see how that formula was then put together for each of the Primary Health Networks? I appreciate the level of detail you have given me now, which I did not have before, but just in terms of being able to get my head around it—

Dr Studdert: Certainly, Senator. We can take it on notice and do that in detail.

Senator KAKOSCHKE-MOORE: You said for ASGC remoteness, major cities were given a weighting of one, but very remote areas were given a weighting of 2.5.

Mr Laffan: That is right. Over the five levels they step up from one to 1.2, 1.5, two and then 2.5 for the very remote areas.

Senator KAKOSCHKE-MOORE: Just bearing in mind the fact that relatively old information was used to determine this initial allocation and we now have much more updated and specific information about actual drug use in major cities and communities thanks to the wastewater analysis, of the remaining $64.4 million that is still to be allocated for treatment services, will more updated information be used?

Mr Laffan: You are talking about the final year of the money?

Senator KAKOSCHKE-MOORE: Yes.

Mr Laffan: I would have to take that on notice. I am not sure if the data will be updated prior to the specific allocation of that money.

Senator KAKOSCHKE-MOORE: It just strikes me as odd that we are going through this process of getting very specific localised information about actual drug usage in our communities but we are relying on outdated information to determine which communities get what for ice treatment funding.

Dr Studdert: I think it is—I do not want to say standard formula—but I think it is a formula we have consulted with experts on, that they thought was a reasonable basis for allocating quite a large amount of money across 31 PHNs. I would think that the services themselves might then use some of that more granular data around the patterns of drug use in their communities, the drugs of concern and the subregions within a PHN—and that would be the level of data. I don't think we have put any money into an area where there is not some need for enhanced services. So I don't think there is a gross misallocation.

Senator KAKOSCHKE-MOORE: I would like to know whether or not any further funding allocation decisions will be informed by more updated information gathered about drug use in specific areas.

Dr Studdert: We will be looking at the progress of delivering under the current—it is a major task to have gotten to where we have. There will be progress reports, evaluation of data, consultations with the PHNs and new and updated data that we can draw on as we move towards the—

Senator KAKOSCHKE-MOORE: Your future funding decisions will be based on updated information—

Dr Studdert: I am not committing to that. I am just saying that we will look at a range of data sources and also look at the experience we have had with the rollout and each of the PHNs as we move forward. But you can understand that there is also a process where we are committed to enhancing services, investing in the workforce and investing capacity in the areas where we will not necessarily want to make sudden and dramatic changes in allocations, unless of course we find pockets of areas where maybe resources are not needed.

Senator KAKOSCHKE-MOORE: Has the remaining funding already been committed and just not been handed over yet?

Mr Laffan: That is correct. That money would be provided for the treatment services. It just has not been committed to specific PHNs at this time.

Senator KAKOSCHKE-MOORE: Based on 2011 census data!

Dr Studdert: I do not think there is a suggestion that it has not been going to areas of need.

Senator KAKOSCHKE-MOORE: No, I just think that there is a much more precise way in which you could have looked at allocating this funding. But I will leave it there.

Senator SIEWERT: Going back to the drug testing, you said you provided to DSS a list of the specific services, presumably in the PHNs—

Dr Studdert: We would have shared the information we have on the services we are funding, but of course that is only a subset of the broader range of services—

Senator SIEWERT: Are we able to have that list?

Dr Studdert: The list of services we are funding?

Senator SIEWERT: Yes.

Dr Studdert: Yes, certainly.

Senator SIEWERT: That would be appreciated. You were speaking earlier about the specific testing that is contained in the budget. Have you provided advice about drug testing in general to the Department of Social Services—not the specific budget measure, but about drug testing in general.

Mr Smith: I would have to take that on notice.

Senator SIEWERT: That would be appreciated. In the discussions you were having DSS, was there any discussion of your knowledge of drug testing internationally?

Mr Smith: We will take that on notice. Dr Studdert indicated that we would go away and have a look at the broader nature of the advice that had been provided and what was included in that—

Senator SIEWERT: I understand that, but we are asking DSS questions tomorrow, so I would appreciate as much information as possible now. That is why I am asking. If you are aware of it now I would appreciate knowing now.

Mr Smith: I am not aware of any advice on that nature. That does not mean we did not provide it. I would have to take that on notice.

Senator SIEWERT: Have you looked at the international data on drug testing? I am not asking about the advice you have provided. I am asking if you have ever looked at it.

Dr Studdert: Given that it is not a service that the Commonwealth delivers we would be looking at secondary sources of information or referring to experts ourselves. I expect DSS has done some of that themselves, but you would have to ask them. We are not a service provider in actual drug testing, so we rely on the services we fund to be up to date on the technology and practices, internationally and domestically.

Senator SIEWERT: Are you aware if the council has ever discussed drug testing, in the context in which it is being applied? I am not asking for the advice. I am asking—

Dr Studdert: To give you an exact answer, given that the life of ANACAD precedes all of us, we could review the agenda and certainly give you a yes or no answer on that question.

Senator SIEWERT: It would be appreciated. In regard to the data that PHNs hold, and the work they have been doing around task force measures you have just been discussing, do they hold data on individuals in terms of any work they are doing on the ice task force?

Dr Studdert: No, they would not hold data on individuals. They are commissioners.

Senator SIEWERT: So they would not be holding any data at all?

Mr Bowles: No.

Dr Studdert: I could not say definitively, but I think it would be highly unlikely. They commission services. I do not see why they would be in any position to want to, much less be able to.

Senator SIEWERT: I presume the services they commission hold data on individuals? Who would I ask?

Dr Studdert: Yes, I would assume they would. As clinical service providers, you would hope that they would hold data on their clients—I presume that to be the case—and to do so in a professional way, as services would.

Senator SIEWERT: Would the privacy provisions cover them and PHNs?

Dr Studdert: PHNs would not hold that data.

Mr Bowles: You are asking for personal data from individuals who have drug records. We would not hold that. PHNs would not hold that. Their doctors or other providers would hold that, but that would be personal to the patient and the doctor or other provider.

Senator SIEWERT: Some programs require data collection on individuals they provide services to. Go and ask DSS. I can take you three years of questions I have asked about that. Do you require any data collection on the clients?

Mr Smith: PHNs will be required to report on their activities, including in relation to the ice money—I will stress that I am not broadly responsible for PHNs so I will speak in general terms—and that will include the analysis of data. That data would be in de-identified form. It would be in aggregate.

Senator SIEWERT: So the department would have de-identified aggregate data is supplied to the department from the PHNs?

Dr Studdert: In their progress reporting, yes, but it would be the number of clients served and probably not a whole lot more granularity than that.

Senator SIEWERT: Who do you provide that data to?

Dr Studdert: In terms of accountability for the resources provided, it would be held by the department.

Senator SIEWERT: Is that data being provided to DSS?

Dr Studdert: Certainly not. To date we are only in the early stages and I do not see why that would be necessarily the case.

Senator SIEWERT: Has DSS asked you for it?

Dr Studdert: No.

Senator SIEWERT: Would you provide it if they asked you for it?

Mr Bowles: That is hypothetical—

Senator SIEWERT: It is hypothetical, but the reason I am asking—

Mr Bowles: We would make a decision if we were asked.

Senator SIEWERT: The reason I am asking is that the government said that you are using data profiling to work out where they are going to be applying the trials. Have you been asked yet?

Mr Bowles: We have said no.

Senator SIEWERT: What are the protocols if they do ask for that data?

Mr Bowles: It would go through our data governance arrangements in the department and we would make a decision from there. I could not pre-empt what that might be.

Senator SIEWERT: Could you provide the data governance—

Mr Bowles: We have a data governance analytics committee. It is a high-level committee that looks at our data usage.

Senator SIEWERT: I presume you have protocols that govern that.

Mr Bowles: We will have a terms of reference. We can provide that on notice.

Senator SIEWERT: Thank you. I want to know what access to that sort of data the department can make, given that they have said that they are going to data profiling to decide who, and where they are going to do the trials.

Mr Bowles: I think you should ask that of DSS.

Senator SIEWERT: I am going to ask them, but I want—

Mr Bowles: We are not going to be able to help you on that. We do not get individual data that does that, so we cannot provide that to you.

Senator SIEWERT: But you can—

Mr Bowles: I can tell you about a whole range of things, and so can groups like the Australian Institute of Health and Welfare, but it is not at that patient level. We are not interested in profiling.

Senator SIEWERT: Okay. What I have understand is that they are doing it for risk assessment on individuals. But also, obviously, they are going to be picking the trial areas—

Mr Bowles: Yes, and we—

Senator SIEWERT: So the higher level data would be of use, potentially, for that?

Mr Bowles: Maybe. Again, I think you need to ask them. We have given our answer.

Senator SIEWERT: I am going to, but I do not want to be told tomorrow to come back and that I should have asked the Department of Health—which happens frequently! That is why I am asking now.

Dr Studdert: I think that we should also note in this space that the Commonwealth funds less than the majority of drug treatment services—30 per cent or so. Any data that we had, much less provided, would only be a slice of the sort of data that you would expect DSS might have been looking at.

Senator SIEWERT: I understand that.

Dr Studdert: I cannot think that that would be particularly useful.

Mr Laffan: Just in relation to the information that is collected as part of the alcohol and drug national minimum data set: that information also goes directly from service providers to the AIHW. It does not come through the department.

Senator SIEWERT: But you do get it from the PHNs?

Mr Laffan: Yes. We have activity information from the PHNs, but data that contributes to that data set goes to the AIHW.

Senator SIEWERT: Okay.

Senator KAKOSCHKE-MOORE: I have a couple of questions around the LDATs—the Local Drug Action Teams. There has been $19.2 billion set aside over four years for the establishment of the LDATs—is that the shorthand you are using?

Mr Laffan: LDATs, yes.

Senator KAKOSCHKE-MOORE: I am just trying to get my head around exactly what the services are that the LDATs are providing. I have jumped on the website and I can see that they are aiming to perform 'evidence-informed social change activities'. Can you just give me some examples of what evidence-informed social change activities are?

Mr Laffan: The LDATs will work primarily in that prevention space. A local organisation will form the LDAT in conjunction with the organisations that it has partnered with. So, for example, a local organisation might provide people for mentoring and coaching of high-risk students in a school environment or something of that nature.

Senator KAKOSCHKE-MOORE: Yes.

Dr Studdert: Can I just add that the point of the LDATs is that they are very much tailored and driven by local communities and what their priorities are. So it will vary enormously for LDATs across the country.

Senator KAKOSCHKE-MOORE: It is my understanding that some of this $19.2 million has already been handed over because there have already been applications made by states. I think we have two in South Australia that have been approved?

Dr Studdert: We have had a first round open to applications and 40 LDATs were funded. They are spread across the jurisdictions. I think you are correct—there are two funded in South Australia. And then—

Senator KAKOSCHKE-MOORE: Exactly how much funding did those two get?

Mr Laffan: The two South Australian LDATs got $40,000 each, so a total of $80,000.

Senator KAKOSCHKE-MOORE: Very good.

Senator Nash: It might also be helpful to know that the LDATs came about when we were doing all the work around the National Ice Action Strategy—holding all the community meetings and roundtables. There was a really strong sense in virtually every community that I was in, and which others involved in the process were in, that local people wanted to be part of trying to find a solution. That led to the provision of funding for the Local Drug Action Teams so that people locally could be very involved in developing models that would help in their local area.

Senator KAKOSCHKE-MOORE: Okay, thank you. I have a clarifying question about some information we discussed during my last questions. Of the $64.4 million that is remaining from the $244 million that has been set aside for treatments under the National Ice Action Strategy, how much will PHNs in South Australia get from that?

I know we have about $11.6 million from the $177 million that has been allocated so far.

Mr Laffan: For South Australia, for the four years, the treatment money for the ice strategy is $15.54 million.

Senator KAKOSCHKE-MOORE: Could you provide on notice a breakdown of the total funding that each state will receive from this. I have it for the funding that has been handed over so far, so to speak, but I do not have it for the remainder.

Dr Studdert: We can provide that on notice for the four-year figure.

Senator KAKOSCHKE-MOORE: That will be great, thank you.

Dr Studdert: We undertook to get the names of the three PHNs that have commissioned residential rehab services. I believe we have those details now for you.

Mr Laffan: There are six PHNs who are providing residential rehab and withdrawal services: Central Queensland; Darling Downs; Hunter New England; Murray, North Coast; and Country WA.

Senator SIEWERT: Do you know where the country one in WA is?

Mr Laffan: I would hesitate to answer that; I am not entirely sure.

Senator SIEWERT: Country WA is a humongous area.

Mr Laffan: It is very large, yes.

Senator SIEWERT: I am sorry to be difficult. If you could actually tell us the locations—

Dr Studdert: We will try and get the locations.

Senator SIEWERT: that would be great. Thank you.

Senator WATT: Chair, can I get some guidance about how we are going to manage the program from here so I can work out what I ask and how much?

CHAIR: It was my hope that we would move off outcome 2 at 3.30, but that hope is fast fading. We still have program 2.5, with a number of senators asking questions; and 2.6 and 2.7 with a couple of senators asking questions that would see us out. Less would be more, Senator Watt.

Senator WATT: Yes. I have already culled quite a lot of topics. If everyone can do what they can to cull so that we minimise the amount of time that we lose out of the ageing section, it would be much appreciated. I am sure Senator Polley would agree with that.

Senator POLLEY: Absolutely.

Senator WATT: I have some questions about the Cancer Screening Register—again, I will cut back on the number of questions I was planning to ask. This is obviously something we have talked about on a couple of occasions at an inquiry—I think it came up at the last estimates. I am keen to get an update. Originally, this screening program, which was to screen for bowel cancer and cervical cancer, was going to be rolled out on 20 March this year for the bowel cancer program and 1 May for the cervical cancer program. Around the time of the last estimates, you announced that the cervical screening program would now move back from 1 May to 1 December. I do not know if a date has ever been given for the bowel cancer start date.

Mr Bowles: No. We said we would continue with the current bowel screening program, and that will probably go into the new year.

Senator WATT: Do we have anything closer to—

Mr Madden: We will be, into the first part of next calendar year. We are focusing completely on supporting the cervical renewal from 1 December with the register to support it first. Once we have that secured in a planning sense, we will come out and announce a bowel screening date.

Senator WATT: That is nearly 12 months away for the bowel cancer register, given it was going to be 20 March. Time does not allow me to repeat back to you the various comments that the department made at the inquiry into this, which warned senators about the risks to human health if the legislation was delayed and if the registers were delayed. I will just note that. Maybe I can provide them to you on notice! It is a serious matter. This is going to be a lengthy delay, which is going to be putting people's health at risk. Are we still confident that the cervical register will be up and running by 1 December?

Mr Madden: We have a revised plan that Telstra Health and the Department of Health are watching on a weekly basis at a high level of governance to make sure that we are tracking to that. At this stage, we are tracking towards the December date for cervical renewal and for the new register to support that as well.

Senator WATT: In short, what is the key reason for the delay in the rollout of these two important registers?

Mr Bowles: We have been through that before. Do you want to go over all of it again?

Senator WATT: Just briefly, what do you say is the reason for the delay? This is the first time we have heard that the bowel register might be next year rather than—it has never been pinned down on a date. So what is the reason for that?

Mr Madden: The main cause, which I think was provided at the last estimates committee meeting, was around the complexities for the migration of the data from what I will call nine registers to one—that is, eight state and territory registers combined with the Medicare register to come up with one central register—and the

data quality issues and the mapping issues that come with that. We have come into this program with the replanning. I am new at the overall accountability level. We have looked at the overall plans, the schedules, governance arrangements, communications and accountabilities. We have worked through the plans for the migration of data, and those complexities are real. We have worked through that and we have actually figured out the means to get that through. We have done some work in the first runs of testing the integration of that data, and things are looking good, so they are promising. That was the most complex, time-consuming part, and I think we have that under control now.

Senator WATT: I noticed in that answer you referred to data a number of times—issues about the transfer of data. So that is the key issue where there have been problems?

Mr Bowles: It has always been the complexity of pulling together eight separate registers with the Medicare system.

Senator WATT: You might remember, when we did the inquiry into this, that we asked for the contract between Telstra and the department to be tabled. I think a redacted version of that contract was tabled. It is not my intention to revert anything that was redacted and, if you feel I am doing so, let me know. I had a look at the deliverables in that contract just to try to get a bit of a sense of what the time line was originally intended to be and work out where the hold-ups might have been. From the Commonwealth's point of view, has Telstra complied with the time lines that were set for it to deliver its milestones along the way?

Mr Madden: I think, given we did not achieve the March and May rollout, some of those deliverables were not delivered in accordance with the contract.

Senator WATT: Were not delivered?

Mr Madden: Were not. So we have replanned each of the key deliverables to map the safe delivery of this program to 1 December 2017, so that means rephasing some of those activities. We have had a particular focus on deliverables, which I will call outcomes—system available, system tested, system ticked off by users, migration complete, system operational. They are the ones we are focused on now to get us through to 1 December. Just to add to that: 1 December is not when the system needs to be there. The first state and territory to transition to this will be in the middle of October. To do that transition in a stepped manner means a system will be signed off by the middle of September.

Senator WATT: I see, for instance, in these deliverables that Telstra was required by November 2016 to set up a contact centre and mail house. Has that been done?

Mr Madden: The contact centre and mail house has been established.

Senator WATT: Was it late?

Mr Madden: I think it was behind that time. There is a question of having premises and facilities to enable a contact centre and mail house and, not having any business to put there, we do not expect that to be alive until around now. But the contact centre and mail house physically exists.

Senator WATT: Obviously, originally, the go-live date for the bowel cancer register is in this contract as being March. That has obviously been delayed, and that included user acceptance testing, report completed and accepted by Health. Is that a reference to a trial or a pilot of this?

Mr Madden: User acceptance would be a key component of the system, as seen by users, which would be a view from states and territories. They would be seeing the access to reports and information about their patients in the system. People in the register, or the mail centre and the operations centre, would see the register operate on behalf of the people, and the portals for providers and participants would be the systems that the users would see and test to make sure that they are meeting their useability requirements and functionally working okay.

Senator WATT: I understand that the go-live date has been delayed, but has that milestone now been met? Has user acceptance testing been completed?

Mr Madden: If we go back to the rebaselining and the rephasing of the entire project to deliver for 1 December, based on some of the things we had with the data, the user acceptance is ahead of us.

Senator WATT: So it has not been completed yet?

Mr Madden: It has not been there yet, because we have actually had to stop the build and the deployment of the system, because in the phasing we had we would be testing the bowel components before cervical. Now that we have cervical as a key priority, we have changed the ordering of that so all of the cervical parts of the system are first. So we have rebased all of that, and the user acceptance testing is due.

Ms Konti: The functional user acceptance testing will be conducted between mid-July and the end of August according to our current plan.

Senator WATT: For the bowel register?

Ms Konti: No, for the cervical screening.

Senator WATT: And then the bowel will be later?

Ms Konti: Yes.

Senator WATT: That answers my next question. I was going to ask you whether the user acceptance testing has been completed for cervical cancer. They were requirements of Telstra under the contract to do that, but are you saying that, because of the various problems that have existed, the department has relaxed the requirement on Telstra to deliver by those time frames?

Ms Konti: No. Because we have rephased and done the replan and cervical screening is now coming first, we needed to replan the entire schedule to make sure that we could meet that.

Senator WATT: Okay. I notice that below this table about the milestones it talks about dependencies, which I presume are sort of like provisos for Telstra to meet those milestones. All of these things seem to be things that were within the Commonwealth's control. The first one was that the new law would be enacted to support Telstra's ability to deliver the register, so that was done.

Mr Madden: Yes.

Senator WATT: When did the legislation actually end up getting passed? Was it October?

Mr Madden: Yes, October, before the 31st.

Senator WATT: Before 31 October? So that is ticked; that one is done. The second one is that any go-live data is dependent on an elapsed time of four months for the bowel register and six for the cervical register. Obviously that is well and—

Mr Madden: We will change that.

Senator WATT: Yes, it will be changed around. But, by the time they are up and running, a lot more time will have passed than just that. Then the next one is de-identified data to be made available four weeks prior to the commencement of user acceptance testing. I am interested in that, because it sounded like the data issues seemed to be a key part of the reasons for the delays.

Mr Madden: Yes.

Senator WATT: Has this de-identified data been made available to Telstra?

Mr Madden: All of the data from the Medicare register side and each of the eight states and territories have been supplied in total, so they have the complete sets. They are working through the matching and the quality processes now. There will be a further instalment just before go-live, which will be on 20 September. So those things are well on track according to the new plan.

Senator WATT: There will be a further instalment of data provided?

Mr Madden: We took the cut of those registers on 13 May, and there are a whole range of things that will happen. There are cervical registers at the state level which need to be updated just before we go live. There will be things in the Medicare register—changes of addresses, deceased indicators, family changes and the whole bit. All of those changes in those registers need to be picked up in September, just before we go live.

Senator WATT: You said data was provided on 13 May—was it?

Mr Madden: Yes. The data was taken at a point in time, which is 13 May, and provided on 15 May.

Senator WATT: Was all the data that has been provided to date provided in one hit on that date?

Mr Madden: Yes.

Ms Konti: The Medicare data was provided on those dates. The data from the eight states and territories was provided in bits and pieces in the month before that.

Senator WATT: Okay. You might remember, Secretary, that I have previously raised concerns about data security. That was really the biggest concern I think Labor had in considering the legislation, and we were seeking assurances around patient data security. We expressed concern about the provision of that private data to a private corporation. That is a whole other issue. So that data has been provided. How does that actually occur?

Mr Madden: The passage of the data for Human Services is through secure lines between Human Services and the Telstra data centre in an encrypted form, and it is similar for the data from the states and territories going

to the Telstra data centre. The facility that supports the register needs to meet all of the Commonwealth's information security requirements—the cyberprotocols and the standards for cybersecurity interventions—and Telstra need to have made that as if they are treating the data is if they are doing it for the Commonwealth, because that is exactly what they are doing. So they meet those requirements to get that data safe, and the transmission of data between one point and another needs to meet those requirements as well.

Senator WATT: So the data was provided by DHS rather than Health?

Mr Madden: Yes.

Senator WATT: Because they hold all the data?

Mr Madden: We do not have the identity data for any patients.

Senator WATT: So the DHS provided this patient data to Telstra via secure lines?

Mr Madden: Yes.

Senator WATT: In one hit on or around 13 or 15 May?

Mr Madden: The 15th of May.

Senator WATT: What about the state and territory data? How is that being transmitted?

Ms Konti: Similarly, in its encrypted form in whatever secure mechanism the states and territories are able to provide. The time frame for the states and territories was just prior to 13 May for the Medicare data.

Senator WATT: So that was similar—the states and territories transmitted that through secure lines or secure exchange lines or whatever they are called?

Ms Konti: Yes.

Senator WATT: I would love to keep going, but time is out. Are we going to move straight to 2.5?

CHAIR: No.

Senator Nash: Just before we do, I think it is useful to get on the record that the College of General Practitioners and the other professional groups actually supported that delay. They wanted to make sure that we had this right, obviously, and that we rolled it out all appropriately. I think it would be useful to have that on the record as well.

CHAIR: Thank you, Minister. Senator Di Natale to round out 2.4.

Senator DI NATALE: I have some questions on the issue of prevention. The Prime Minister said:

In 2017, a new focus on preventive health will give people the right tools and information to live active and healthy lives.

Then the minister for health, Minister Hunt, expressed a similar sentiment:

… a new focus on preventive health that will give people the right tools and information to live active and healthy lives.

Given the Prime Minister's announcement of a new focus on preventive health and these new tools, can you highlight what measures in the budget point to these new tools?

Dr Studdert: I can certainly point to a few. There is the Healthy Heart Initiative, which was $15 million over the forward estimates for supporting physical activity programs, with the national Heart Foundation, and there is work with GPs through the College of General Practitioners, to enhance resources for GPs to work with patients on healthy weight programs. There is funding for the continuation of BreastScreen Australia's programs to invite older women to participate in biannual screening from the ages of 70 to 74 years old. There is the ongoing investment, as was just discussed, in the Cancer Screening Register and—

Senator DI NATALE: I do not want to be rude and interrupt, but, in the interests of time: he talked about new tools; that is ongoing investment. You have highlighted the Walk for Life Challenge and the $5 million for GPs as new initiatives. Those other initiatives are not new initiatives.

Dr Studdert: I think there is a renewed commitment and ongoing support for those.

Senator DI NATALE: Yes. They are not new tools. They are existing tools.

Dr Studdert: They need to be continued, though.

Senator DI NATALE: If we are talking about new tools, can you talk to me about the two things that are new—

Dr Studdert: I should just mention there is also an element of Medical Research Future Fund investment, $10 million, for the Australian Prevention Partnership Centre to invest in translational research around prevention.

Senator DI NATALE: Okay. That is research. In terms of active prevention, given that this was going to be a big focus for the Prime Minister, let us just talk about the $10 million Walk for Life Challenge. How often is that going to occur? Is that like an annual event?

Dr Studdert: Not at all. My understanding, from conversations with the Heart Foundation, is that they are aiming to—and we would certainly be expecting them to—support regular physical activity year round and to support walking groups, workplace based activities and school based activities that support regular and ongoing physical activity.

Senator DI NATALE: So it is not just one discrete event.

Dr Studdert: No.

Senator DI NATALE: It is a series of ongoing measures. I think the minister for health indicated that there was a strong commitment to tackling obesity. Apart from that money for the Walk for Life Challenge, is there any other additional funding for tackling obesity? Additional new funding—new money—not a renewed commitment to existing programs.

Dr Studdert: The Walk for Life Challenge and the funding for the College Of General Practitioners to support GPs in weight management and healthy living. There are the ongoing programs around the Healthy Food Partnership—

Senator DI NATALE: Not ongoing. We talked about new tools. I just want new. Given that the government has cut a lot of money from prevention, I am not interested in what it is continuing to spend money on. I am just interested in new initiatives in the budget. We have got the $10 million for the Walk for Life Challenge and $5 million for the GPs Healthy Heart Partnership. Are there any new initiatives in the budget that you can point to?

Dr Studdert: The $10 million for the research prevention—

Senator DI NATALE: Again, that is research. We have got $15 million.

Dr Studdert: That adds to $25 million.

Senator DI NATALE: Given the scale of the issue and given how serious the obesity problem is in Australia, do you think that that is a significant enough investment in tackling obesity—to actually address the issue in any significant way?

Dr Studdert: I think you are asking for an opinion there.

Senator DI NATALE: Let me ask you then about the comments of the chair of the Council of Presidents of Medical Colleges, Professor Nick Talley. His view was that the lack of a coordinated national policy on obesity is unacceptable. He said: 'It's been bits and pieces. We need a plan, we need a strategy.' Has the government got a national obesity strategy?

Dr Studdert: Not explicitly. We have just, in the last two weeks, released the National Strategic Framework for Chronic Conditions, which is intended to be—and has been worked up, over a long period of time, in great detail with the states, territories and a vast range of stakeholders—a comprehensive approach to chronic conditions and all the risk factors, including obesity, that contribute to—

Senator Nash: Senator, it is not just all about a bucket of money. I think you are looking for something that has got obesity in the headline. I think we are doing a significant number of things—obviously, touching on the new things in the budget. But when we talk about, 'Have we got a strategy?' Yes, we do. It goes to things like the Health Star Rating system that is rolling out and being really successful; the Healthy Food Partnership, which I instigated, that is also being very successful; the Healthy Weight Guide around advertising; and the Girls Make Your Move campaign, which has been absolutely fantastic. I do not know if you have seen that, Senator, but I think it is tremendous. The $100 million for the Sporting Schools initiative. Couple all that with what we have got in the budget as well, and I think it is fair to say that we do have a really good obesity strategy, and it is coupled with—

Senator DI NATALE: Where is the strategy?

Senator Nash: If you are looking for a square box with three lines that say 'this is the obesity strategy' under a special name—

Senator DI NATALE: Yes, that is exactly what I am looking for.

Senator Nash: We could box it all up under a nice name and we would put all of these things underneath it. You need to have a holistic approach to this type of thing. We need to make sure that we are targeted on obesity. The government has got an absolute commitment to this. Indeed, Minister Hunt put prevention in as one of his four pillars. I think it is very much there and, packaged up right there, you have got a very good obesity strategy.

Senator DI NATALE: I go to the issue of whether the government has done any work looking at the impact of a levy on sugar-sweetened drinks. The department has not done any work in that area?

Dr Studdert: No.

Senator DI NATALE: Has the government done any work on the issue of junk food advertising to children, and modelling what the impacts of that are and whether any restrictions in that area might be forthcoming?

Dr Studdert: No.

Ms Flynn: We have not done modelling, but—

Senator DI NATALE: Sorry—any work—I know modelling has a very technical definition.

Ms Flynn: Under the COAG Health Council there is a body of work being undertaken at the moment on the advertising of junk food to children, the sort of food that is associated with sport and recreation, menu labelling and that kind of thing.

Dr Studdert: That is being led by Queensland.

Mr Bowles: There is a broader conversation in that COAG Health Council and AHMAC arena on obesity. From that perspective, we are looking at that at a national level through AHMAC and the COAG Health Council.

Senator DI NATALE: That is being led by the Queensland government—is that right?

Ms Flynn: Yes.

Senator DI NATALE: What specific issues are they looking at? Obviously that involves the Commonwealth through the COAG process.

Ms Flynn: They are looking specifically at things like menu labelling, whether there are different systems that apply in different state and territory jurisdictions. You would appreciate that food and marketing are not only the responsibility of the Commonwealth, so it is looking at how we can work together with the jurisdictions at the way food is marketed at children.

Senator DI NATALE: Menu labelling—what else?

Ms Flynn: Junk food advertising.

Senator DI NATALE: What specifically?

Ms Flynn: Well, junk food advertising—whether there needs to be some kind of initiative jointly with the jurisdictions on restricting advertising of junk food to children.

Senator DI NATALE: Would that include restrictions on TV advertising?

Ms Flynn: The work is underway at the moment. I cannot tell you the specific scope of it because it is being planned at the moment.

Senator DI NATALE: Is that the scope of the discussion? We can restrict very small parts of some of the promotion of junk food to young kids, but are we talking the potential for restrictions around advertising targeting kids through broadcast media—sport, for example?

Mr Bowles: I do not think we can go to that yet. The conversation is still underway.

Senator DI NATALE: Any discussions about restrictions on alcohol advertising during sports programs?

Dr Studdert: No work in this part.

Senator DI NATALE: They might be good thing to include as part of the strategy. I am done now, Chair.

CHAIR: Thank you. That concludes program 2.4.

[15:41]

CHAIR: We now move to program 2.5, Primary healthcare quality and coordination. The coalition senators have put their questions on notice.

Senator WATT: How decent of them. We will do that for some of ours as well. My first question is about Health Care Homes. In regard to Health Care Homes, which the government has described as its signature health reform, I see that the budget confirms that that trial will be delayed. I understand that the plan is for 20 practices to become Health Care Homes on 1 October this year and 180 on 1 December this year.

Mr Bowles: That is correct.

Senator WATT: Can you guarantee that there will not be a further delay?

Mr Bowles: Again, I am not going to get into the semantics of guaranteeing. It is the current policy. We are working to the 20 on 1 October and 180 on 1 December.

Senator WATT: You are confident you are going to meet those time frames?

Mr Bowles: Yes.

Senator WATT: According to the budget measure, 20 practices will become Health Care Homes on 1 October. I understand there are 200 practices that have been shortlisted. Has a decision been made about which 20 will be ready on 1 October?

Mr Bowles: Not at this stage.

Senator WATT: So there are shortlisting and selection processes still going on?

Mr Bowles: Yes.

Senator WATT: Are you still expecting 65,000 patients to participate in the trial?

Mr Bowles: Yes.

Senator WATT: Okay. The only other matter for us under 2.5 is about the establishment of the PHNs. The decision to establish these PHNs was announced in the 2014-15 budget?

Mr Bowles: Ah, yes—sometime like that.

Senator WATT: In a press release issued on 12 April 2015, then Minister Sussan Ley said the Murrumbidgee PHN had been established as a result of feedback received during the tender process. What was the nature of that feedback?

Mr Cormack: We went out for 30 PHNs. We had good responses for virtually all of the PHNs that were put out in the approach to market. For one of the PHNs, which was a large western New South Wales PHN, we did not get what we believed were suitable or appropriate applications for that large PHN. The department had a look at the situation, and we provided advice to Minister Ley that effectively dividing that up into two would enable a more effective PHN national network and one that could be addressed through the applicants through the ATM process. So it was an approach to the market which was, by and large, successful, but with one particular problem area that we recommended lead to the creation of 31, and there were no additional resources required to establish that 31st PHN as opposed to the original 30.

Senator WATT: I will come to that in a tick. When the minister said that, as a result of feedback received during the tender process, this decision to create a new 31st PHN was made, was that feedback received from the department?

Mr Cormack: I am referring to the feedback that we gave to the minister. The department managed the procurement process. The minister was not involved in the procurement process—up until, obviously, the final decision point. But our advice was that, to avoid having to go back out to the market and possibly achieve the same result, given the vast size of that particular proposed PHN, we recommended two.

Senator WATT: So the department did receive feedback from outside sources in that tendering process?

Mr Cormack: It actually came up during the procurement process. We went out to the market seeking 30 operators and consortia to operate 30 PHNs. We got a good response to 29 of them and an unsatisfactory response to the western New South Wales PHN, and we worked that through and provided some advice to the minister as to how to get around that problem, and the minister accepted that advice and we now have two PHNs covering that original western New South Wales PHN boundary.

Senator WATT: So that decision to create an additional 31st PHN was ultimately a decision made by the minister?

Mr Cormack: Yes, on advice from the department. And, as required under the Commonwealth Grants Rules and Guidelines, the former minister immediately wrote to the Minister for Finance to notify the boundary change and the approval of the grant, as it fell, as you would be aware, within Minister Ley's electorate.

Senator WATT: Did she write to the Minister for Finance?

Mr Cormack: She wrote to the Minister for Finance.

Senator WATT: Was that almost like a conflict-of-interest type arrangement?

Mr Cormack: Yes. It is a standard provision—that is right. The minister was involved in the decision-making process, and, as the decision that she made affected her electorate, she was required to notify the Minister for Finance, and she did that.

Senator WATT: Did the department provide any advice to Minister Ley that she should not be the decision-maker because it was going to directly affect, or benefit or however you want to put it, her electorate?

Mr Cormack: I do not recall. To be fair, I was not with the department at the initial time of the setting up of the approach to market—I joined while it was out to market—and I cannot recall what advice was given in relation to the establishment of the procurement exercise, but it is not unusual for a procurement of that size to be either delegated to the department or not delegated to the department. In this case, the decision-maker was Minister Ley, but I think just the timing would suggest that Minister Ley was probably not the minister when the approach to market went out. That, I think, probably would have been undertaken when Minister Dutton was the minister, but we will take that on notice and double-check.

Senator WATT: Mr Bowles, you were not the secretary of the health department at that point, either, were you?

Mr Bowles: I cannot remember exactly when that went out. I have been the secretary since October 2014.

Senator WATT: It was April 2015.

Mr Bowles: I was there.

Senator WATT: You do not recall the department providing any advice to the minister that she should not be the decision-maker?

Mr Bowles: No. It is not unusual. When we talk about national programs and national rollouts, ministers' electorates are always there. You cannot do much about that. You just have to put in place the appropriate mechanisms to deal with it, which in this case was done.

Senator WATT: Mr Cormack, you mentioned that there were no additional resources required to create this 31st PHN?

Mr Cormack: We were able to accommodate it within the funding allocation.

Senator WATT: Inevitably that means that the remaining 30 had to take a little bit less, to free up some resources for the 31st?

Mr Cormack: If it was in the existing envelope, which it was, then they would have got a bit less than what was originally intended.

Senator WATT: Did Minister Ley or her office make any representations when she first came into the portfolio, expressing concern about the number of PHNs?

Mr Bowles: Definitely nothing to me.

Senator WATT: So the first contact between the department and Minister Ley or her office about the creation of this 31st PHN that covered her electorate was in the form of the department taking this to the minister, not the other way round?

Mr Bowles: Yes. Like a whole lot of procurements that ministers are responsible for, they are never involved until that last, final point when we provide advice ministers about how to proceed.

Senator WATT: Did the department meet with any external stakeholders regarding the decision to establish the Murrumbidgee PHN?

Mr Cormack: I do not believe so but I will take it on notice and check. I was one step removed from that process, although I had some visibility of it. I will take that on notice to confirm.

Senator WATT: Okay. I might need to leave it at that, I think.

CHAIR: Senator Waters, who has questions on 2.5, has been taken away by business briefly. In the interests of time, would we be able to go to Senator Griff's questions on 2.6?

Mr Bowles: Yes. That is fine.

Senator GRIFF: We are still on 2.5, the PHNs. The key objectives of PHNs are to increase efficiency and improve coordination of care. Can you tell me what nationally consistent indicators collected directly from general practice software systems are currently being used to measure the efficiency and effectiveness of PHNs?

Mr Cormack: What I can do is just go through the headline indicators for PHNs.

Senator GRIFF: Do you actually collect directly from GP software systems?

Mr Cormack: No, we do not.

Senator GRIFF: Why don't you do that?

Mr Cormack: Our contractual arrangement for the performance indicators that are attributed to the PHNs is with the contracted party, and that is the PHN. The PHNs have very good relationships with GPs within their areas. A number of them have got arrangements to access data directly from the software providers, the software

vendors, that service the practices within their network. However, we do not mandate that. But we have a set of indicators that we ask them to collect. In the fullness of time, we will certainly revisit those indicators. We are always looking for opportunities to improve the collection of data in the primary health care space. We are doing work in that space, but not part of the PHN program.

Senator GRIFF: Did you help fund some of these systems to implement—I know you certainly did with nKPIs. So ultimately you see yourself being able to pull that data out and use it?

Mr Cormack: What we are seeking is for the PHNs to be able to collect data as specified in the contracts, the organisational performance indicators, and then over time we would work with the PHNs and with the sector to improve the data collections available in the primary health care space. We envisage that will involve the software companies, because there is a relatively small number of companies that cover the majority of practices. We think that is a good efficient way to do that.

Senator GRIFF: What do you think is the fullness of time—is that a year?

Mr Cormack: It would be over the coming year or two. We have commenced work in our Research, Data and Evaluation Division to work with the National Prescribing Service, which collects data from GP software providers. We believe that data, in time, will be very useful in pooling together a good quality minimum dataset for general practice.

Senator GRIFF: Looking at the key indicators that can be sourced from general practice software systems, there is also a wealth of information that you have not included in your headline performance indicators, which are health checks for Aboriginal and Torres Strait Islanders, cardiovascular disease assessment and diabetes. Is there any particular reason why you have not included those in your headline performance indicators?

Mr Cormack: The reason why we have not included them is that for this sort of establishment phase—which we are really still in with the PHNs—we needed to be able to commence with a manageable set of performance indicators that look at the governance of the organisation.

Senator GRIFF: What are the ones you have now?

Mr Cormack: I will quickly run through them—I will not go through them in minute detail. We have governance indicators, which are around the performance of the board risk management arrangements; financial management, which is an important function; and stakeholder engagement. Then, in the service delivery areas, we look at, for example, access to low-intensity psychological interventions, psychological therapies delivered by mental health professionals and clinical care coordination for people with severe and complex mental illness. We look at a range of mandatory performance indicators to do with immunisation and time to certain types of services. There are a range of indicators which **I** will provide to you on notice, if you wish, rather than work my way through them one by one.

Senator GRIFF: Okay. What are you putting in place to see how we progress, effectively, with—I suppose you could say—the great health challenges of our time, which are obesity, type 2 diabetes, cardiovascular risk and Indigenous health?

Mr Cormack: That is a very broad question.

Senator GRIFF: It is but, in relation to these groups, is there any focus?

Mr Cormack: Yes. There certainly is. I think it starts with providing the PHNs with ready access to good quality datasets. The department has established a PHN portal, and that is a service available to PHNs. It includes demographic and epidemiological datasets, stats around services available in your area, service utilisation—those sorts of things.

Senator GRIFF: I have seen this information, and that is Medicare and a whole lot of other sources that you have. But, as you said, it will take at least a year or two before you are drawing information out of their own self-run systems—

Mr Cormack: That is right.

Senator GRIFF: which I think, at that point, will make it very valuable.

Mr Cormack: Yes. I think it will, but I think the main challenge for the PHNs is to understand the needs of their community. There is very good data available on that. We have made that available. The second phase, which they are in at the moment, is the commissioning of services against those needs. And then, in the fullness of time, when they commission those services, we will start to look at the outcomes of their commissioning efforts in terms of the access indicators that I described before. In the longer term, we will start to look at some of the broader population health indicators around immunisation rates, potentially preventable hospital admissions

and all of those sorts of things that will take time to attribute back to the PHNs' planning, commissioning and funding efforts.

Senator GRIFF: The Health Care Homes full rollout is close to seven months away, I believe?

Mr Cormack: Yes, but not quite that far. The beginning phase is October.

Senator GRIFF: That is the initial 20,000, I think, wasn't it?

Mr Cormack: Yes.

Senator GRIFF: We have a set of indicators, like KPIs, that are already in use and widely accepted by clinicians as useful measures of quality outcomes. Are you planning on using those or are you starting from scratch?

Mr Cormack: I will ask Ms Quigley, who has carriage of this, to outline the sorts of data and KPI requirements that we will be seeking from our Health Care Homes.

Ms Quigley: The focus of the first stage is very much linked to the evaluation framework. We are expected to report back after the first 12 months of activity. That will have a strong focus on the implementation aspects which relate to patient outcomes, patient experience, uptake by the sector and validating the funding model and the tiers of funding. So that will be our first focus, and then we will be looking at developing baseline data. At the moment, we are also looking at how we link data from the GP software and GP data aspect right through to the hospital data so that we can track a patient—

Senator GRIFF: So that will be within the next 12 months or so?

Ms Quigley: Yes, that is work that will continue through this first phase.

CHAIR: Just for the information of officers at the table, what I propose we do is push on to finish this outcome and then have the break. There should hopefully only be another 10 or so minutes amongst the three senators who have questions remaining. So we will do program 2.6 now, go back to Senator Waters and then finish off with Senator Watt. Then we will break and go to aged care.

Senator GRIFF: What is the amount that the department has paid for the Practice Incentives Program After Hours Incentive since launch?

Mr Cormack: Is this the PHN after-hours funding you are talking about?

Senator GRIFF: Yes.

Mr Cormack: For 2016-17, the expenditure, as of 30 April 2017, is $64.9 million, which leaves an available balance of about $6.5 million for the rest of the year, which would take us to just over $70 million. For 2017-18, it will be $72.2 million. For 2018-19, it will be $73.2 million.

Senator GRIFF: How many have you got enrolled at this point?

Mr Cormack: As of February 2017, there were 5,015 general practices enrolled.

Senator GRIFF: That is very much on your target.

Mr Cormack: I think it is good. There are 5,115 general practices registered for the PIP After Hours Incentive, which is 88 per cent of all PIP registered practices.

Senator GRIFF: How are you actually tracking the effectiveness of the program at a practice level, particularly against your stated activities on the website of continual improvement, quality care, enhanced capacity, improved access and improved health outcomes?

Mr Cormack: Are you just talking about the PIP After Hours Incentive or are you talking about the overall PIP program?

Senator GRIFF: It could be either one, but are you actually tracking those stated activities? Are you actually physically tracking the performance?

Ms Cole: We have a PIP advisory group which has all the major stakeholders and the department on it. Essentially, we use that as a referral mechanism for examining whether or not PIP is working from the practice's point of view. Because they have a specific activity they have to meet in order to be eligible for the after-hours PIP, whether it is a provision of a specific after-hours service or appropriate for all mechanisms, is a bit hard to judge, necessarily, the effectiveness of that for every single patient who may be affected or receives a benefit from those services.

On the whole, we are receiving feedback from the stakeholders that the reinstated service is going reasonably well. There are a few tiny hiccups in some of the country regions about how the new PIP system works and whether or not it is appropriately reimbursing or accessible by a few country practices. I guess, in a sense, to some

extent we make an assumption that practices, through using this expenditure, are providing those services as they state that they do. But we will evaluate it in due course in more detail.

Senator GRIFF: So you are really tracking how happy they are, but you do not have any hard statistics in relation to whether there is any form of improvement?

Mr Cormack: To put the current work in context, the various PIPs have built up over time in response to emerging issues. The most recent is the ePIP which is a payment that is made to facilitate general practice participating in the My Health Record system. That is the way the PIPs have built up. The government decided a couple of budgets ago to start to look at coalescing a number of those PIP payments into a consolidated quality improvement payment. That necessarily goes to the heart of the question you asked which is that the data we have been able to collect from individual PIPs is of some limited value. But we are trying to work with the sector to come up with a more flexible PIP payment that gives us much better data about the quality of practice that is being delivered and the outcomes that it is delivering for the patients of a practice. That work has been going on now for a bit under two years and because of the complexity of that and because it involves the potential collection of new data sets in a nationally consistent way, we are taking our time to get it right. We will be coming back to government later in the year with a proposal, based on the consultation we have undertaken with the sector, to simplify that down. We believe we will get a much better data collection that will go to the heart of your opening question which is really, 'How do you know you are improving the overall health of the community?' That is what we want to get to with the PIP redesign.

Senator WATERS: I have some questions about the National Framework for Maternity Services and its predecessor the National Maternity Services Plan. Do we have the right folk here for those questions?

Mr Cormack: We do.

Senator WATERS: I want to ask about the plan first. Was there ever an evaluation or a review done of that plan?

Mr Cormack: I will start and then I might ask Ms Cole to help me with this. As you are probably aware, the National Maternity Services Plan concluded on 30 June 2016. There was a working group that was collecting information and analysis of how each of the jurisdictions were going against the various goals and targets that had been set under that framework. In April last year, the Australian health ministers, who oversee this framework, agreed to continue to work together to further improve maternity services through the development of an enduring National Framework for Maternity Services rather than a plan that had a beginning and an ending. That framework will consider the potential inclusion of neonatal, child-health services, antenatal health-risk factors and screening for family violence. That is the unfolding scope for that. The development of the framework is being led by Queensland. The Commonwealth is involved in that, as one of nine jurisdictions. A draft of the framework was available for public consultation between 21 March and 18 April this year, and, as I understand it, that working group is progressing through analysis of those submissions. That will be considered through the AHMAC and COAG Health Council process by the end of this year.

Senator WATERS: Thanks for that background. I do want to come back to a few more detailed questions about the framework, but can I just start off with the plan first, which as you pointed out has now expired. There was a commitment under that plan that a formal evaluation would take place during year 5 which would make recommendations for future actions. Was that done?

Mr Cormack: I might just ask Ms Cole.

Ms Cole: There was a final report which was done and which is available on our website, and also the AHMAC website.

Senator WATERS: Sorry, could you say that again?

Ms Cole: There is a final report on the plan. There were pretty much yearly reports, annual reports, which described the actions taken by jurisdictions in response to the plan, and then there was a final report which was done at the end, obviously, of the five years, and that is currently available on our website and also the AHMAC website.

Senator WATERS: Was that an evaluation as such?

Ms Cole: I will just check with my colleagues—not a formal evaluation.

Senator WATERS: So what was it then?

Ms Cole: Sort of a summation of all the activities.

Mr Cormack: There were an agreed set of actions over the life of that plan, and there was a small secretariat that asked each jurisdiction to provide regular update reports, so in a sense it was an evaluation of what they said

they were going to implement. I do not think it would meet the criteria of an impact evaluation, but it certainly was more process orientated.

Senator WATERS: I understand, thank you. So, given the original commitment in the plan itself that there would be an evaluation which would include the review of achievements and outcomes, and recommendations for future actions, who took the decision not to do that more fulsome evaluation, and when was that taken?

Mr Cormack: I am not quite sure that a conscious decision has been taken not to do that. I think it is possibly an interpretation of what is meant by an evaluation; that can mean many things to many people. But this is not something the Commonwealth is leading. We are certainly participating in it. I think the best thing we can do is check with the Queensland lead on this, and the AHMAC secretariat, to clarify the specific question that you ask. I do not recall a conscious decision to not evaluate; I suspect it is the way it has been done.

Senator WATERS: It just did not happen. Okay. Thank you for taking that on notice and following up with those other folk. I will look forward to that response. Moving now to the development of the National Maternity Services Framework, which you started to take me through earlier, who is leading the development of that? You said Queensland was?

Mr Cormack: Queensland, yes.

Senator WATERS: Are there any private consulting firms being engaged as well?

Mr Cormack: Yes. Deloitte Touche Tohmatsu, or Deloitte, have been engaged to develop the framework.

Senator WATERS: Can I ask why that is? Why has that been outsourced?

Mr Cormack: It is not uncommon, when you have got a large-scale piece of policy work involving multiple jurisdictions, to contract specific expertise for parts or all of the work. That is a very common approach we use for a lot of national policy development.

Senator WATERS: Is there not the expertise within the department to do the work?

Mr Cormack: Just to make it clear, this is not the department's framework. It is a framework that is being developed under the auspices of COAG Health Council. We have some expertise to contribute to this, but, as with any policy development work, we engage specialised stakeholders from the different stakeholder groups. It could be universities, colleges et cetera, and we would also engage advisory groups such as Deloitte to assist us with the rapid conduct of that piece of work. So it is just the way that business is done.

Senator WATERS: You mentioned key stakeholders there. Can I ask what consultation has been undertaken, and with which key stakeholders, in the development of that framework?

Mr Cormack: A number of stakeholder groups have been consulted, but I think you are getting to the question of the AMA and whether they were happy with the process or not—is that right?

Senator WATERS: I am just interested in the breadth of who has been consulted, not necessarily AMA, but that is good to know.

Mr Cormack: My understanding, and I do not actually have the full details in front of me, is that there was a consultative process set up that involved public and private healthcare providers and a number of professional groups. We are aware that the AMA and the National Association of Specialist Obstetricians and Gynaecologists had expressed some concerns about the level of representation in the working group. Queensland has taken that on board. They have admitted that at least one group, the AMA, was omitted from the initial consultation, and I understand they have taken steps to rectify that. I am certainly aware that there was some concern, and I think Maternity Choices Australia has also written to the Queensland health minister seeking some further advice about the way this has been undertaken. I understand that Queensland Health, as the lead institution, is following up on those concerns have been raised. I am not specifically aware of the nature and detail of the concerns they have raised, other than concerns have been raised about whether the consultation process is as inclusive as it should be, and I think Queensland Health is responding to that.

Senator WATERS: Could you take on notice to check on the list of folk who were consulted?

Mr Cormack: I certainly will.

Senator WATERS: An associated question is whether or not consumers of maternity services have been consulted.

Mr Cormack: I will take that on board.

Senator WATERS: Just wrapping up, because I know we are very tight on time, will the new framework include the provision for public reporting of data, either from the hospital themselves as well as progress under the plan's various objectives?

Mr Cormack: I cannot answer that question, because the framework has not been settled. It will be considered through the AHMAC and COAG Health Council process towards the end of year, but we are happy to take that on notice. And we will provide you with advice as to whether that is part of the process.

Senator WATERS: I have a couple more questions and I will put them on notice in the interests of time.

Senator IAN MACDONALD: On the Primary Health Networks, how are they established? How are the boards appointed?

Mr Cormack: It varies a bit across the 31. Essentially, we went out and approached the market. There was an approach to market, which resulted in the selection of 31 organisations, most of whom had consortium arrangements. They are then required to establish appropriate company structure and with contemporary corporate governance arrangements. We do not specify the nature and type of people that should be on their boards; however, our guidance to them is contemporary skills-based boards as opposed to representation. And we have a range of different company membership structures and board structures that vary across the countryside. We have recently undertaken a provisional review of those governance arrangements to ensure they comply with contemporary corporate governance and also that they specifically include representation from Aboriginal and Torres Strait Islander people, community members and relevant general practice and other health providers.

Senator IAN MACDONALD: Are they formally appointed by the minister?

Mr Cormack: No. They are private companies.

Senator IAN MACDONALD: Are they fully funded by the Commonwealth government?

Mr Cormack: That is correct.

Senator IAN MACDONALD: What control do we, as the Commonwealth government, who are providing the money, have over them?

Mr Cormack: We have a contractual arrangement with them. A standard Commonwealth contract has very significant provisions for the Commonwealth to take action to ensure that the performance of the organisation is consistent with the contract requirements.

Senator IAN MACDONALD: Let me give you a ridiculous example, but if I can find 10 friends—if I cannot find friends I will find 10 relatives—and get them appointed to my PHN board and then I have millions of Commonwealth dollars that I and my friends can decide how to spend in the health area—is that possible?

Mr Cormack: I do not think it is possible in the way that you have described it.

Senator IAN MACDONALD: When you say you go to the market, what does that mean in ordinary language?

Mr Cormack: We ran a tender. We specified the types of entities and organisations that we were looking for to run the new PHNs. That was an open tender.

Senator IAN MACDONALD: So if you had seen me as a tender applicant and my board consisted of my 12 relatives, what you are saying is that you would not have given me the tender?

Mr Cormack: We would check the application's company structure against the specifications of the approach to market. There are very specific provisions in relation to the management of conflicts of interests and disclosure of interests in relation to that.

Senator Ian Macdonald: So if five or six state hospital boards whose members are appointed by the state government had got together—

Mr Cormack: Senator, I know where you are going with this so can I just cut to the chase?

Senator Ian Macdonald: Sure. If you know where I am going you are one step in front of me!

Mr Cormack: When we went out with the approach to market we specified the types of organisations that would be considered to be suitable organisations to run, operate and in partnership with others form a consortium. That included state health facilities. In the case of Queensland, we ended up with three PHNs that were put forward by state health entities—the LHNs. That complied with the approach to market. Since that time we have observed the way the organisations have set up their company and governance structures, we have taken a close look at those, we have reminded the organisations of the need to comply with our expectation with the Commonwealth's expectations, and in the case of the three Queensland PHNs we have formally asked them, to the extent to which their company membership structures and their board compositions could be seen to be a conflict of interest, to address that. Two of those have taken steps to do that; the third one, we are taking further steps to encourage them to comply with the expectations of the Commonwealth.

Senator Ian Macdonald: I will not ask for names, or which is which, but you have encouraged them—if your encouragement falls on deaf ears, what is the next step?

Mr Cormack: We have very significant powers under the contract arrangements that we can draw upon. It is not appropriate here, as we are in the middle of a dialogue with three of them, to specifically outline what those could be, but the Commonwealth has in its standard contracts very significant ability to do whatever it takes to ensure that an organisation complies with its contract.

Senator IAN MACDONALD: That is somewhat reassuring. My concern—this is perhaps hypothetical—is that if you have a PHN, or particularly three in one state, that are in effect controlled by the Queensland health department, you then abrogate the Commonwealth's responsibility for all the good things we want to do and you become a slave to whatever any particular state government's approach might be, which may not be the Commonwealth's approach.

Mr Cormack: Absolutely. That is why we have taken and continue to take proportionate measures to remove that risk. We are well advanced in that.

Senator WATT: My questions are in 2.7—hospital services. They are a few questions that follow on from the lengthy discussion we had yesterday about the work being done in the GAP task force about hospital funding. I probably have a couple of questions for the Independent Hospital Pricing Authority as well, if they are here, as part of this area. Mr Bowles, I have gone back and had a look at what you said yesterday. You are obviously just piecing together your recollection, but I think where you got to was that you attended the December meeting—before I ask these questions, how did you go with tracking down the minutes of those meetings?

Mr Bowles: They are not our minutes. We are asking the GAP if they will release them. I have not got an answer yet.

Senator WATT: I think we are allowed to ask for any document in your possession, aren't we?

Mr Bowles: They are confidential document of completely separate organisation. I have taken it on notice.

Senator WATT: And you are funding it.

Mr Bowles: I am funding part of it. We are only part funding this. It is not totally funded by the Commonwealth.

Senator WATT: Who else is funding it?

Mr Bowles: The GAP.

Senator WATT: Private health insurers?

Mr Bowles: I have no idea. It is an independent group. I have said that a number of times.

Senator WATT: So you do not know who else is funding it?

Mr Bowles: No.

Senator WATT: Does Mr Cormack know if there are any other bodies funding the work that GAP is going?

Mr Cormack: No. I am not aware of any other bodies apart from GAP that are contributing to this exercise.

Senator WATT: If they are only making $55,000 out of it and they are funding some of that, they are not making a lot of money out of it.

Mr Bowles: They are not making money. This is not about making money.

Mr Cormack: It is a not-for-profit organisation.

Senator WATT: Mr Bowles, you attended of the December meeting of the GAP task force.

Mr Bowles: That is correct.

Senator WATT: I think what you told us yesterday was that it was at that meeting that you said that this Commonwealth health benefit was not government policy.

Mr Bowles: That is correct. I think I said not government policy and not under active consideration.

Senator WATT: And you did not attend the March meeting?

Mr Bowles: No, I did not.

Senator WATT: But Mr Cormack did.

Mr Cormack: Yes.

Senator WATT: Mr Cormack, you know that presentation I tabled yesterday that you gave, which meeting was that? Was that at the December meeting?

Mr Cormack: Yes. That presentation was provided at the December meeting and the same presentation was effectively made available. I did not give the presentation. The same presentation was provided at the March meeting.

Senator WATT: Prior to the December meeting, had then Minister Ley ruled out this as government policy or told you to take it off the table or anything like that?

Mr Bowles: I do not believe so.

Senator WATT: Obviously Minister Hunt came out yesterday and said that he had ruled out. So Minister Ley had not ever told you, 'I'm ruling this out—it is not going ahead.'

Mr Bowles: I am going back over time and giving you my recollections. It starts with the federation white paper. We go through an exercise. We move on. No, I cannot recall anything of the sort.

Senator WATT: Why did Mr Cormack give a presentation on this matter when it was not government policy?

Mr Bowles: We were asked, as part of an independent group, to talk about a model that everyone was interested in. Therefore we gave a presentation.

Senator WATT: The minutes of that December meeting, which I tabled yesterday—I do not know if you still have them handy, but when you see them you will see that on page 2 it talks about COAG and says that 'COAG met in early December 2016 and approved public hospital arrangements up to 2020. These will be revisited in 2018 to plan future changes'—

Mr Bowles: That is correct.

Senator WATT: And this is the important part: 'and if the Commonwealth health benefit was to gain traction, then it could be incorporated in future reforms.'

Mr Bowles: As concept, yes.

Senator WATT: If you ruled out this policy going forward at some point in that meeting, why do the minutes say that the Commonwealth health benefit could become Commonwealth policy?

Mr Bowles: There is a lot of difference between could, would, if and may and all those sorts of words.

Senator Nash: The minister said 'won't'.

Mr Bowles: It is not. I opened the meeting with not government policy, not being actively considered. We have a group who are an independent think-tank-type group on public policy who are talking about a range of issues. It is done in that context. Mr Cormack presented at that particular meeting at the request of the group, to talk about that process.

Senator WATT: One of the other things you took on notice yesterday was whether there was any reference to this in Minister's Hunt's incoming minister briefs. Have you had an opportunity to confirm that?

Mr Bowles: There is no reference to GAP. Going from recollection again, I am pretty sure it was a reference to the hospital benefit model as a throwaway line in a broad context. It was not really raised then until that February time frame when we had the prebrief for the COAG Health Council, as I said yesterday.

Senator WATT: So the reference to this work in Minister Hunt's incoming minister briefs was in the context of a discussion about hospital funding policy going forward?

Mr Bowles: All the things we were talking about in the context of COAG, AHMAC—all those sorts of things. It would have been a very short reference in the context of that.

Senator WATT: Mr Downie, your agency is a participant in this process. Is that you personally?

Mr Downie: We were invited to participate. I could not attend the first meeting, so one of my staff went.

Senator WATT: When was that first meeting?

Mr Downie: I think it was 9 June.

Senator WATT: We had a bit of trouble yesterday working out when these meetings occurred.

Mr Downie: I did not attend that first meeting. I had something else.

Senator WATT: We dealt with this yesterday as well. Are you sure that that meeting actually happened on 9 June?

Mr Downie: I am not positive.

Senator WATT: We worked out that that might mean caretaker period and we were not sure whether it got rescheduled.

Mr Bowles: We believe it went ahead.

Senator WATT: During caretaker?

Mr Bowles: Yes.

Mr Cormack: The standard disclaimer was made at the meeting. Just be clear, you are making quite a big deal about what was said at one meeting. From the beginning of this process to its conclusion, we have always been clear with the GAP that this is not government policy. I know you are making a big deal of it, but we want to make really clear—

Senator WATT: If you want to see me make a big deal, I can do a big deal. This is a small deal.

CHAIR: We are happy to have no deal. Move on, Senator.

Senator WATT: Mr Downie, you were not able to attend that first meeting on 9 June.

Mr Downie: One of my staff attended.

Senator WATT: Have you attended any subsequent meetings?

Mr Downie: I attended the last two.

Senator WATT: One of them was in December last year, then there was another one in March this year.

Mr Downie: Yes.

Senator WATT: Have you been part of any subsequent discussions about this with the department—

Mr Downie: No.

Senator WATT: —or with GAP since that meeting in March?

Mr Downie: No. that is the last time I heard about GAP.

Senator WATT: In your recollection, at those meetings what has been said about the position of the government on this proposal around health funding?

Mr Downie: I have a very clear recollection of both the secretary and Mr Cormack making it very clear that it was not government policy.

Senator WATT: Had it gone any further in the sense of government having ruled it out?

Mr Downie: I do not recall that, but I certainly recall it being very clear that it was not government policy.

Mr Bowles: Let me put on record again: I said at the December meeting that it is not government policy and it is not being actively considered by government.

Senator WATT: And that is what Mr Downie remembers you saying.

Mr Bowles: If you want third-party agreement with what I said or you are doubting my word.

Senator WATT: I am just trying to reconcile things, because we do not have minutes of all these meetings. Did you have any involvement in doing any of the preparatory work for this model?

Mr Downie: No.

Senator WATT: Your agency has not done any modelling around what the effects would be?

Mr Downie: No. We would do not do that sort of modelling.

Senator WATT: You would not get involved in modelling around the pricing of hospital services?

Mr Downie: We determine the National Efficient Price each year for public hospital services. That is our core business. Any health minister can request we undertake other work to produce a report, but we have not had any requests along those lines around a Commonwealth benefit.

Senator WATT: Yesterday we dealt with an example that was provided within this presentation which talked about an assumption of moving to a National Efficient Price of 35 per cent in the private sector, which would be an increase from the current amount. Do you have any recollection of that work? We were trying to figure out how that figure had been come up with.

Mr Bowles: As I said yesterday, it was an example worked up to show how it might work. I did say—and you can ask Mr Downie to verify whether this is true or not—we have done no modelling and we have asked nobody to do any modelling or any activity in calculating prices or any other activity in relation to this concept that we were discussing at that meeting and at subsequent meetings of that group.

Senator Nash: I am very mindful that many of the senators have put a lot of their questions on notice. They have been very considerate of time.

Senator WATT: I have barely asked anything today.

Senator Nash: I know, but unfortunately the things you are asking are exactly the things you asked yesterday. There is nothing to see here, move on.

Senator WATT: We have a new witness here. Why is this the only topic you do not want to talk about?

Senator Nash: I can talk about it until the day is old, and we did yesterday.

Mr Bowles: We did more hours yesterday.

Senator Nash: I can say, 'Minister Hunt has ruled this out,' as many times as I like. I can say, 'Even if it comes up again, he's not going to do this.' I can say that again.

Senator WATT: I know you are very defensive about this.

Senator Nash: I am not defensive at all.

Senator WATT: All day people have asked questions at length and you have not said anything, and this is the only thing you want to shut down. That is okay.

Senator Nash: I am not shutting it down. My point is being considerate of other senate colleagues who have put questions on notice—

Senator WATT: Sure, and I have been—

Senator Nash: Let me finish. You are asking exactly the same questions that you asked yesterday. I am just asking you to be considerate of the other senators. If there is anything new, perhaps keep asking.

Senator WATT: I can assure you, if you talk to my Senate colleagues, they will tell you how considerate I have been today. I think they will reflect that I have barely asked anything.

Senator IAN MACDONALD: Do not ask me.

Senator WATT: I felt the tone lower when you walked in, Senator Macdonald. I have one last question of Mr Downie.

Senator Nash: Last question? Excellent, that is all I was trying to get to.

Senator WATT: Mr Downie, when Minister Hunt ruled this out yesterday, that was the first time you had heard that a minister had ruled this out.

Mr Downie: Yes.

Proceedings suspended from 16:37 to 16:49

CHAIR: We will recommence with outcome 6.

Senator POLLEY: How many comprehensive assessment referrals have been received for the first three months of 2017 compared to 2016 and 2015, please?

Dr McCarthy: You are referring to assessments—

Senator POLLEY: ACAT and RAS assessments.

Dr McCarthy: Thank you. Ms Buffinton has data on that.

Senator POLLEY: Bearing in mind we are short on time, as usual.

Dr McCarthy: Could we check: it was comprehensive assessments in the first three months of this year—

Senator POLLEY: This year, 2017.

Dr McCarthy: Compared to—

Senator POLLEY: Compared to 2015 and 2016.

Dr McCarthy: We may not have it in that—

Senator POLLEY: I think you do.

Dr McCarthy: form.

Ms Buffinton: I can give you the number of assessments that have been completed for the last financial year and I can give you the figures for the first quarter of 2016-17 and second quarter 2016-17 if that is helpful.

Senator POLLEY: You cannot give us any figures for the first three months of this year?

Dr McCarthy: I am sure we can—we just may not have them at this table now. We have the data I think in its raw form.

Ms Buffinton: For comprehensive assessment referrals issued by My Aged Care for the first quarter of this year—the third quarter of the financial year—there were 62,000.

Senator POLLEY: How do they compare?

Ms Buffinton: Each quarter has been around 60,000.

Senator POLLEY: Overall, how many have been completed? What is the figure for those years? Is it true to say that there has been a drop in the number of completed assessments?

Ms Buffinton: As we discussed in one of the questions on notice, there has been a drop. As we discussed at the last estimates, the nature of ACATs has changed. As we explained in the question on notice, there has been a reduction. That is because now we do ACATs, we also now have what is called a support plan review and we also now have the regional assessment services. At our last estimates, when you were quoting back into 2013-14, what have we changed? We have changed the fact that we used to have high care and low care. We have changed that differential. The next thing is that we have brought in RASs, which have taken up a certain number of assessments that would have gone to ACATs in the past.

Senator POLLEY: We did go over that at last estimates.

Ms Buffinton: Yes. And we now have a support plan review rather than a full new assessment.

Senator POLLEY: During the last estimates you said that there would be some discussions with the ACA teams in April. Can you inform us as to what happened. What did you find out—hopefully you did find out why this is happening—and what action have you taken to address it?

Ms Buffinton: Certainly. As we described last time, we had data for the first time using My Aged Care. We used to use another computer system. With My Aged Care, the states did not get to see their data until early this year. At the time, and as we said in our question on notice answer, we were giving them the opportunity of commenting on their data. What we can see is that it is not so much how many assessments; it is the timeliness of the assessments that is the issue that we were discussing. As you know, we have agreements with each of the states. We have a timeliness requirement and a quality requirement. We are concerned also about some aspects of the timeliness.

Senator POLLEY: I think we agreed to this, but I have got limited time. What I need to know is: what are the government and the department doing to address the drop, the time lapse, that is taken for people to be properly assessed?

Ms Buffinton: I have gone around and spoken personally to each state and territory government department that has a contract with us. We have also brought them in for a couple of days of discussions, where they had to do a plan of how they are improving their timeliness and quality. They have supplied that, and we are holding them to account. We have identified areas of concern. Some states are more timely than others, and so there are some states where we have taken a much stronger action with them.

Senator POLLEY: What is the penalty for those who are still lagging behind? Can you go through the order of those that are of most concern? Who gives you the most concern in terms of their tardiness of timely assessments?

Ms Buffinton: We acknowledge that there are some assessments that are not actually delayed, but in our system are just showing as having not been completed even though they are. So the numbers I have been looking at, in terms of completed assessments, are how long it takes to complete 80 per cent of assessments. I can see that I have got some states where they get 80 per cent of assessments done in under 20 days. In some other states, I have them taking anything up to 86 days to complete 80 per cent of assessments.

Senator POLLEY: Do you realise that when we are talking about assessments we are talking about assessments of older people who need help?

Ms Buffinton: I am very aware. That is why I have taken it as seriously as you have, Senator Polley.

Senator POLLEY: What resources have been allocated to ensure that there is a reduction in this tardiness?

Ms Buffinton: It is not so much the resources. I think we are actually resourcing the states sufficiently. On reflection, the states themselves realise that they in turn contract out or pass this over to their regional health networks or whatever their terminology is for their regions. Some states work very tightly as an ACAT right across their states. Other states are quite individual in their ACATs spread across their states. What we are asking the states to do is to: treat it as a complete state team, actually work in terms of education, monitor timeliness, make sure they educate, make sure they have got the right number in their workforce to undertake these assessments, and have the right level of technology.

Senator POLLEY: Is it a common issue that there are not enough human resources to carry out these assessments?

Ms Buffinton: States are passing the funding onto regions, and the regions are making a decision on how many resources they are putting into assessments; however, we now have an arrangement with the states where

we are now taking an interest in resourcing and what technology—because it is highly variable, the technology—the ACATs are using. Some regions are using very modern technology—iPads and an application that can reduce the time for each assessment by 30 minutes—and some regions are using very old technology. We want to run a nationally consistent assessment service, and that is the work we are doing with the states.

Senator POLLEY: So the government is not going to commit any additional funding to resolve these failures; it is just going to be the same as it has been up to now? So there is no extra resourcing from the federal government—

Dr McCarthy: I think what Ms Buffinton is explaining is that she is working very closely, and has worked personally, with each state and territory to ensure that we are holding each state and territory to account. There is an agreement between the Commonwealth and each state and territory—

Senator POLLEY: Which they are failing to deliver on.

Dr McCarthy: and there is an amount of money under those agreements. Under those agreements, the states and territories are required to deliver against certain key performance indicators. Ms Buffinton is managing that very closely. She is finding that there is variability across Australia in terms of how each state and territory is doing that.

Senator POLLEY: Yes, I do understand that. We can talk and try to explain it away, but, at the end of the day, the states are not meeting the commitments that they have made with the federal government, and it is real people who are carrying that burden. That is the reality of it. If I could move on, maybe this will help clarify the situation. Can you confirm that the average number of days between the issue of assessment referrals and the completion of an ACAT assessment for high priority clients in South Australia is currently around 14 days, which is, I think, about seven times the KPI?

Ms Buffinton: What I can see—

Senator POLLEY: It is around 14 days as I understand that.

Ms Buffinton: My figures are showing me that for quarter 3 of 2016-17—I actually do not have the number of days. What I can see is that for South Australia, for high priority, which is assessments issued to first intervention, which is the 48-hour mark, they were meeting their KPI at 92.3 per cent of ACATs in the South Australia.

Senator POLLEY: I will just interrupt you. I have some figures in front of me—

Dr McCarthy: Senator, it might be helpful if we know what the source of your information is. Was it perhaps a question on notice that we answered?

Senator POLLEY: The source of information that I have suggests that for South Australia high priority is seven days, medium to low priority is 11 days, and low priority is 14 days. That is between 1 July and 31 December 2016.

CHAIR: Senator Polley, would you like to table that to assist the—

Senator POLLEY: No, I would not.

Ms Buffinton: Senator, without knowing the source—

Senator POLLEY: You give me your figures and then we will compare them to what I have when I am led to believe—

Dr McCarthy: We are endeavouring to give you our figures. We just may not have them in exactly the form that you have those figures.

Senator REYNOLDS: A point of order, Chair: rather than playing 20 questions, guessing if this is the right one or not, it might be easier if we do have something that the department can actually have a look at and check against?

Senator POLLEY: I have put the question to the officers. I am waiting for their response. That is the normal practice.

CHAIR: Okay, but for clarification, to save time—

Ms Buffinton: In answer to your response, I do not have it in that—

CHAIR: Sorry, Ms Buffinton; Senator Polley, is there a series of questions with those sorts of numbers?

Senator POLLEY: I have a series of questions in relation to the time that it is taking to have the full assessments.

CHAIR: Okay, so you are not going to have a series of numbers.

Senator POLLEY: No, I am not going to have a series of numbers.

CHAIR: Continue on, Ms Buffinton.

Ms Buffinton: What I can see for South Australia, for the first quarter of this year, is that South Australia was at 92.3 per cent of—

Senator POLLEY: How many days is it that they are waiting?

Ms Buffinton: That is 48 hours from when they have got to make first contact.

Senator POLLEY: For the final assessment?

Ms Buffinton: For the whole of the first assessment for South Australia. I do not have the figures with me for—I have got the average, and the median for South Australia, for all assessment types, is six days. They are one of the strongest performing states.

Senator POLLEY: So you are saying the median length of time for South Australia for high priority is six days—

Ms Buffinton: No, that is for all assessments.

Senator POLLEY: And you cannot give me the figures broken down for the priority of high, medium and low care? Can you take that on notice, then?

Ms Buffinton: I can take that on notice, but I can see that they are surpassing their KPI for high care.

Senator POLLEY: Regarding the support that is provided for these high-needs people, often vulnerable and frail older people, my understanding from the information that we have—this information comes from the sector and people who are using the services—is that they are waiting 14 days on average and often significantly longer. You are disputing that, are you?

Ms Buffinton: Are you referring to South Australia?

Senator POLLEY: South Australia, for the completed assessments.

Ms Buffinton: I am. In the last quarter, as I said, for high priority they are meeting their KPI, which is a KPI of at least 90 per cent and they have 92.3. I can see that for South Australia, for all assessments, the median is six days for all priorities. They are one of the strongest performers.

Senator POLLEY: And you will check those figures and, if they need to be changed, you will advise us of that, no doubt. Can we move onto Tasmania, please. How long does it take to have a complete assessment in Tasmania for low priority? How many days? I thought that is what the KPI is related to.

Ms Buffinton: Again, my figures are in a slightly different format, but as to whether Tasmania are meeting their KPI for low priority, which is within 36 days, they are not meeting their priority. I can see that, for Tasmania, their median for all assessments is 16 days, whereas South Australia was six days.

Senator POLLEY: What are you doing with the Tasmanian government to address this? It is pretty significant—it is a long wait.

Ms Buffinton: It is, and that is why I have been personally down to Hobart to talk with the Tasmanian government, and the Tasmanian government have come to speak to us. They have put in a plan of improvement with us and they are aware of the fact that they are wide of their KPI mark.

Senator POLLEY: Has the overall number of ACAT assessments in, for instance, Tasmania, been reduced for the last financial year?

Ms Buffinton: ACAT numbers have been reducing because of the factors that I explained, and I would suggest that Tasmania would follow that same trend. I think that is a separate issue—the reduction in ACATs versus the timeliness.

Senator POLLEY: Could you put on record the details of the characteristics that a client satisfies to have a high-priority assessment referral. What would somebody have to display to have a high-priority assessment done?

Ms Buffinton: We will take it on notice to give you the exact criteria that we use for high-priority assessment.

Senator POLLEY: You cannot tell me, as the government and the department, the criteria that are measured against somebody when they are being assessed as to whether or not they are going to be classified as high priority?

Ms Buffinton: Just so we are aware of the methodology, there are a couple of methodologies. One is if somebody is going through our contact centre. We have a screening tool asking a range of questions and characteristics of what the issues are, and behind that assessment sits an algorithm that indicates whether somebody is a high, medium or low. We also have the opportunity of taking web forms directly from, for

example, GPs or discharge professionals in hospitals. They can also give us an indication in their professional opinion of whether it is a high, medium or low priority.

Senator POLLEY: Okay. So you will take the rest of it on notice so we have a very clear—

Ms Buffinton: Yes. Very happy to.

Senator POLLEY: Overall, did you put any time frame on the resolution to be able to have the states meet their agreement in terms of the KPIs? Have you set a time for which the government or the department will reassess the situation?

Ms Buffinton: The first thing was that the states had to have their plan for improvement in to the department by last week—just reminding that this was new data that we exposed them to.

Senator POLLEY: Have they met that deadline?

Ms Buffinton: Three states have met that deadline.

Senator POLLEY: Who has not?

Ms Buffinton: Three states have met that. The two states that we have particular concern about are Queensland and Tasmania, and we also have—

Ms Goddard: South Australia.

Ms Buffinton: South Australia.

Senator POLLEY: Can I move on to some questions around My Aged Care?

CHAIR: For a few minutes and then we will move to Senator Siewert.

Senator POLLEY: What is the average mean wait time on the My Aged Care hotline for the two months after 27 February compared to the two months prior?

Ms Buffinton: While my colleague is looking for the number, in order to maintain as close as we could our quality, we made sure—as we have learnt from our experience in 2015—that we had additional staff on the contact centre, because we knew that bringing in increasing choice and the letters we were sending out would bring on additional work. Our average speed to answer for January 2017 was six seconds. Our average speed to answer in February 2017 was 24 seconds. Our average speed to answer in March was 45 seconds. And the average came back in April to 14 seconds.

Senator POLLEY: How many home support assessment referrals were made during that same period?

Dr McCarthy: We may not have that information with us. If we do not, we will take it on notice.

Ms Buffinton: When you say 'home support referrals', just so we are clear—up to 27 February, we used to do home support referrals, reminding ourselves that what the change was about was that up to 27 February we would assess and then we would refer to service; the big change from 27 February was that, instead of referring to service, we now support consumers to make choice of service. There is actually almost like a time break in that series.

Senator POLLEY: I realise that. Have complaints actually increased with regard to My Aged Care since 27 February?

Ms Buffinton: While I am happy for my colleague to be looking at complaints, what happened on the weekend leading up to 27 February was that we had a major IT release. It was highly complex, obviously, bringing in the increasing choice IT. It was complex, in terms of talking with the DHS computers, Health Direct, My Aged Care, so we had a certain number of IT issues. We have been very open, as we have been all the way through with My Aged Care, on those issues. When we identified that we had some issues that needed some manual intervention, we put staff on for the manual intervention. I would suggest that the sector understood the complexity, because it was not just a case of IT issues; it was also providers getting used to the new system and how to use the new system. So have we been plagued by a lot of complaints? I do not believe that we have.

Senator POLLEY: Well, it has been brought to my attention from across the sector and from consumers that the wait times that they have been left hanging on the end of a phone have blown out. I am concerned as to whether or not you are aware of the sorts of issues that are coming to my office and my colleagues' offices in terms of the frustration of elderly people being left on the phone for up to half an hour.

Ms Buffinton: My colleague can probably find for you the longest time people have waited as an individual number; otherwise we will take that on notice. But could I go back to the times I was just describing to you. If I go back to July 2015, average wait times were 10 and 12 minutes, and I was describing to you in seconds what the

average was. We acknowledge that round about 11 am and 2 pm is a peak in terms of both the provider helpline and the consumer inquiry line. That goes beyond the averages, and it rose for about four to six weeks.

Senator POLLEY: Would you be surprised if there were elderly people ringing through and being left on the phone only to be told no information in relation to when a package would be available to them or when they were going to have an assessment? Would that surprise you?

Ms Buffinton: In terms of when they were going to get a package, that is not what, from 27 February—

Senator POLLEY: No; in terms of their assessment. We will not talk about packages; that is another issue. We will talk about waiting to find out when they are going to be assessed and then, having been on the phone for half an hour or sometimes longer, not being informed about when an assessment might happen. You are not aware of any instances like that?

Ms Goddard: Looking at the performance of the contact centre, an example that I would like to give you is for March and April this year—obviously after the reform changes have come through. On average, calls in March were answered in less than a minute—

Senator POLLEY: Yes, we know that they are being answered more quickly.

CHAIR: Please allow the official to answer.

Ms Goddard: I understand that.

Senator POLLEY: That is not my question.

Ms Goddard: No. But in terms of the longest wait time during that period, it was just over half an hour. I think the importance of those two figures together is that the majority of calls are answered very quickly, but there are peak times within the contact centre when people do wait on the phone because of that peak load at that point in time. In terms of how long people are waiting, generally it is less than a minute to be answered and spoken to.

Senator POLLEY: To be spoken to, but what I am saying is—

CHAIR: We will go to Senator Siewert.

Senator POLLEY: Could I just finish, Chair?

Ms Buffinton: Your question was with regard to the ACAT. Once the contact centre has screened a client and referred out to the ACAT, it is the ACAT that is prioritising—

Senator POLLEY: But they are not getting referred out to the ACAT team.

Ms Buffinton: They are getting referred out to the ACAT team in a timely manner. This is back to the original question, which is how the ACATs are prioritising who and how they undertake the assessment.

Dr McCarthy: I think what Ms Buffinton is explaining is that it is up to the ACAT teams. As you have heard today, the capacity and the performance are variable. It is up to the ACAT teams how quickly they do the assessments. The role of the contact centre is to refer for assessment.

Senator POLLEY: I realise that, but they are waiting on the phone and not getting referred.

Dr McCarthy: I think all the evidence we have given you today is that, while there may be some outliers, it is not the case that, as I think you have described, large numbers of consumers are waiting unreasonable amounts of time. I do not think any of the evidence we have here today would support that. Of course there will always be individual clients who wait longer than they would wish or is reasonable, but I do not think, across the board, that that is the case.

Senator SIEWERT: Is this the appropriate place to be asking about the home care packages and number of applications?

Dr McCarthy: Yes, it is perfectly fine to ask us about home care packages.

Senator SIEWERT: Have you got the figures for the number of packages that have been applied for since February?

Ms Buffinton: As at 26 May, the total number of packages that have been released is 30,057.

Senator SIEWERT: Do you have a comparison for the same period last year?

Dr McCarthy: I think the issue there is that we will be talking apples and oranges, because we have had a very big system change. It used to be that the home care packages were released in one go under the aged-care approvals round. We are now releasing them almost constantly. So it would be very difficult to do a comparison.

Senator SIEWERT: Yes, I take your point. We will not know the figure for the three months prior to that, will we?

Ms Buffinton: One way that I try to explain it to people is that once a year we used to have an ACAR, and I will double-check the figure in a moment, but I think there were about 6,000 additional packages in the previous year, released in the March 2016 ACAR. Since 27 February, rather than waiting a year—

Senator SIEWERT: Yes, I do understand what you are saying.

Ms Buffinton: What we are releasing—and it has been settling, but now it looks like it will be about weekly— over time will be a certain portion of brand-new packages. If you like, it will be that week's worth of what would have been that element of the ACAR. So over time in the course of this year we will be releasing a certain number of new packages, like the old ACAR. But really what is important about the new environment is—as soon as a package becomes vacant, is not taken up, or we can tell even with trends—rather than waiting for a package to become vacant, we are trying to maximise the number of packages being utilised. We are releasing probably about 2,000 packages a week. Some of those are brand-new and some are where people have not taken them up or have passed away or have moved on to residential care.

Senator SIEWERT: Of that 2,000 a week, what proportion—

Ms Buffinton: When I said 30,057, as of 26 May, there were 7,635 brand-new packages. Remembering that leading up to 27 February—traditionally, if I go back to mid last year, although we had just under 79,000 operational places, that was one of the problems with the old system. In fact, mid last year only 81 per cent of those packages had people in them. So we had just over 64,000 people. In this new environment, we have got the new ones, but we have very rapidly been able to release to make sure those packages are being utilised, if you like. I am trying to compare the old system in old system terms to new system terms.

Senator SIEWERT: I was just thinking that you cannot compare apples and oranges; I appreciate that. In terms of people being flagged as priority, can you take us through how that process has been working with the urgent and priority cases?

Ms Buffinton: Under the new home care, we have different ACAT priorities. For home care we have high-priority packages and we have medium-priority packages. First of all, with anybody who transferred on 27 February, we first of all considered them to be medium but asked the ACATs to go back and look. So, for people sitting with their ACAT assessment but who have not yet come into home care, we have asked the state ACATs to have a look and prioritise those that were pre-27 February. Obviously, as part of the new system anybody who has had an ACAT since 27 February is assessed whether they are medium to high, remembering that if somebody is already on a level 4, we would see them as being a higher priority. I will give you the numbers, just to give you a feel for it. Of those 30,057 packages that we have released, obviously they have been released across levels 1, 2 3 and 4. Then, in terms of high priority, 4,790 or 16 per cent of them have been high-priority packages, and 25,267 or 84 per cent of them are considered to be medium-priority packages. That is really how we have modelled it. If you are in home care you have a higher need than if you are in Commonwealth home support. To be a high priority, you really need to be very high priority and needing to be connected to service.

Senator SIEWERT: Can we quickly touch on the national queue process and how that is working and then how the high priority are being dealt with through that process.

Ms Buffinton: At the moment where our numbers are settling—and I will explain why—even when we looked at, as a ballpark figure, the fact that by May I knew that on 27 February that there were just over 72,000 people who were on the eve of going into the new system and were in operational places, operational packages; but on that weekend, all I could see was that there were about 65,000 or 66,000 people assigned to packages. It tells me that it takes about three months for providers—that is why we are always out by about three months, because providers do not real-time put people down into their packages. They had assigned the package, but they had not put them into our IT system. So there is a lag effect. It takes them up to three months to fill in the system, if you like. So they are on the books. They had already made a decision. We had all these vacant packages through the ACAR. A number of providers had packages. They had not put people in them. I described that mid last year. Despite the fact that we had just under 79,000 packages, we only had about 64,000 people in those packages. Not surprisingly, because we were coming up to a change in system, providers did get quite busy and put people in those packages leading up to the 27th, before we moved to the new month.

Senator SIEWERT: So it topped it up to more than 100 per cent.

Ms Buffinton: We know that, say, for level 4 packages, 99 per cent of them were utilised on the eve of going—

Senator SIEWERT: Okay.

Ms Buffinton: But it takes about three months, surprisingly in some respects. We might think that some providers would immediately go into their IT system—and many do, but many do not. That is why we are trying

to encourage them. It is really important that providers put this information in quickly so that we know exactly what is happening in the system. We are flowing through the old system. That is why we have been quite clear that we were not going to be starting to talk about figures and waitlists. So we are going to be issuing that information quarterly. The first quarter will run for four months. It will be 27 February to 30 June, and we will be publishing that by the end of July. Thereafter each quarter we will be publishing that information.

Senator SIEWERT: The upshot is that you cannot tell me at the moment—

Ms Buffinton: No, because at the moment, genuinely, people are still putting things into the system. I think it is fair to say that we have been going to a lot of trouble to inform providers of how the new IT systems are developing. They have also been learning and getting to their front line how to use the new system. Understanding consumer behaviour has also been something that we have been learning about, and I am happy to discuss a little of the work that we have been doing on that. But it is as you would expect with something that is a big, dramatic change. As of today, it is three months that we have been operating. It is operating well. We have people who are in home care. We are also learning a lot about what we thought behaviours would be and we are discovering that some of those things are confirmed and some are different to what we thought.

Senator SIEWERT: You will have that first lot of figures available before next estimates. So could you take on notice to provide those figures once they become available.

Ms Buffinton: Yes.

Senator POLLEY: If you are releasing 2,000 a week, why is that people are not given any indication of how long they have to wait?

Ms Buffinton: After we release a package to an individual and we write to the individual, they have 56 days to make that initial decision. If they find they need longer, they can ask for an additional 28 days.

Dr McCarthy: Were you asking why we cannot tell people how long it will be before they are allocated a package?

Senator POLLEY: Yes.

Dr McCarthy: As I think Ms Buffinton just explained to Senator Siewert, we will not have data available on the state of the national queue until the end of that four-month period.

Ms Buffinton: Based on figures, that will take until 30 June and our aim is to get that information out by the end of July.

Dr McCarthy: So we do not have the data yet because we have not had the necessary wash through the system.

Senator SIEWERT: I will come back to it when I get the information. In terms of the three months process to add to enter the data—

Ms Buffinton: Up to.

Senator SIEWERT: Is that the old system or is it still happening?

Ms Buffinton: Up to 27 February, notionally, the provider owned the package. The fundamental change is now the consumer owns the package. What the system has changed is the consumer has up to 56 days to select a provider. If they need to, they can ask for an additional 28 days. Then they are linked in and then the provider can go into the IT system and confirm that they are now in that.

Dr McCarthy: The provider will still need to provide that information.

Senator SIEWERT: I understand that.

Ms Buffinton: Otherwise, the provide will not be paid.

Senator SIEWERT: That is what I was going to ask. Can you solve that now? Unless you actually enter the data straightaway, you do not get paid until you actually put it in.

Ms Buffinton: Yes.

Dr McCarthy: It may also be the consumers taking the full amount of time that they have under the legislation to take up their package.

Senator SIEWERT: I understand.

Senator POLLEY: Or they may not have any options.

Senator SIEWERT: You can come to that when it is your turn again—sorry. In terms of a couple of those behaviours, you said you have confirmed some behaviours and there are some that you did not expect. Can we go through that first?

Ms Buffinton: Sure. Remember that about a third of the packages I have described are what I would call upgraded packages—so somebody already in care; maybe they have been in care in the past at level 2 and now they are getting a package of level 4. A third of those 30,000 have been automatic upgrades, so a consumer does not have to do anything. We write to them and say, 'Now you have been upgraded.' They were assessed at needing a four; they were an interim package and now they have got—

Senator SIEWERT: Yes, because there are not enough level 4 packages.

Ms Buffinton: So we write to the consumer and we write to the provider, and the provider needs to then upgrade the package and offer a higher range of services.

Of the remaining two-thirds that we are writing to, we have been trying to analyse—there is a whole range of consumers that have made choice, so we took a look at those at 30 days. That is significant because, in that 56 days, at 35 days we send out a reminder note and we also send out a little pamphlet; they have already been given pamphlets by the ACAT assessor on home care and the changes we have made. Some of these have had their ACAT done prior to 27 February, so we are giving them additional information to help them make a choice. We decided to contact—not the ones that got the upgrade, not the ones that had already, in 30 days, activated and gone and made a choice—but we contacted just over 500 consumers. We were also learning about consumer behaviour and we had done some modelling. Of the just over 500 consumers that we contacted by phone, we know that 48 per cent, so less than 50 per cent of the total—they are the ones who have not got an automatic upgrade and the ones that have not made a decision. Forty-eight per cent of these consumers requested more time and stated that they did not think they could make the decision in 56 days so they asked to be extended for the 28 days.

Senator SIEWERT: They all did that?

Ms Buffinton: Forty-eight per cent.

Senator SIEWERT: Forty-eight per cent said that they wanted to extend.

Ms McQueen: They asked for the extension.

Ms Buffinton: Of those 500 consumers that have not got the upgrade, 55 per cent told us that they understood what they needed to do next, after reading the letter. Then of course my interest, and yours, is what happens to the 45 per cent who did not claim that they understood what they needed to do next: five per cent told us that they had not read the letter; 20 per cent claimed that they did not receive the letter, and we are now following that up; 20 per cent said they did not understand the letter, which is causing us to now review whether we have made our communication clear enough. Of that 500, many were still considering whether they wanted to use a home care package. They had been sitting, theoretically for some time, and now we have written to them and said, 'you have got a home care package' and some are considering whether they want to take up a home care package at this time. Many of them were happy with their current arrangements and were coping okay at the moment and some, of course, when we contacted them had gone into residential care or their circumstances had changed and they no longer needed home care. I am being quite open with what we are learning, and I have been quite open at the National Aged Care Alliance. When we were looking at consumer behaviour through NACA, we did have a home care advisory group, including consumer peak bodies and a small group of consumers who were giving us advice. We did the best we could with what the letters said and so forth, but we acknowledge that this is us learning and adapting. Just as we are asking providers and consumers to adapt, we as a department are adapting to what we are discovering. Of this, we know that the majority of people who were either in upgrade or have made choices—of that subset that we contacted, 55 per cent understood what they needed to do next, and that is good. 45 per cent had a range of issues, and all of those we are now looking into.

Senator GRIFF: My questions relate to the Aged Care Quality Agency.

CHAIR: Do you have any on access and information? The secretary is not here. Do you want to wait?

Senator GRIFF: I can wait, that is fine.

CHAIR: Well, we will deal with these earlier outputs.

Senator XENOPHON: I have also got some questions of the department in relation to the issue of aged care accreditation standards, and the communication between the agency and the department.

Senator POLLEY: That is later in the program.

CHAIR: Just to be clear, Senator Xenophon was talking about the communications between the department and—

Dr McCarthy: Yes, certainly.

CHAIR: Is that later or now?

Dr McCarthy: It would probably be under 6.4, Aged Care Quality.

CHAIR: All right. We will deal with you at that point in time.

Senator XENOPHON: You will deal with us then.

CHAIR: Well, you can deal with them at that point in time. Okay. Well, Senator Macdonald, do yours relate to access and information? We should just test with the department.

Senator IAN MACDONALD: Thank you. My questions relate to the capital grants round. Is that now?

Dr McCarthy: I think that is 6.3; that would be Residential and Flexible Care.

Senator IAN MACDONALD: And that is now?

CHAIR: No.

Senator IAN MACDONALD: We are not doing all of 6 together?

CHAIR: No, we are working, as best we can, sequentially through the program.

Senator IAN MACDONALD: So everyone gets twenty minutes on 6.1 and then 6.2 and 6.3? If that is the case, I will go away and come back.

CHAIR: Would you like us to alert you when we reach 6.3?

Senator IAN MACDONALD: Yes—if you ever do reach 6.3!

CHAIR: We will get there, I can assure you.

Senator SIEWERT: We work in cooperation here!

CHAIR: We will get there. So we will go back to Senator Polley.

Senator POLLEY: I just want to go back. I am happy to table, now—I have redacted any incriminating evidence about myself and my drawings!—in relation to those figures that I was quoting, in relation to the time for assessment referral issues to assessments that are being completed for RAS and ACAT. So perhaps you can have a look at these figures and let me know whether or not they are accurate.

Dr McCarthy: Whether we can confirm that right now will depend on whether we have information in the same form, but we will do our best.

Senator POLLEY: I think that information was provided in that form from the department, so you should have it.

Dr McCarthy: I did ask earlier if you were referring to an answer to a question on notice. We have—

Senator POLLEY: No, it is not. That was the copy that he copied, so I am sorry, but that could have gone straight to you.

Dr McCarthy: That is all right.

Senator POLLEY: Going back to My Aged Care, while we are waiting for them to come back: there was an allocation in the budget of $3.1 million for the aged care platform. That is additional money from last year; there was money given. Can you tell me what that money is going to be used for, because it seems to me that My Aged Care, with the millions of dollars that are going into it, is a bit like a black hole or a racing horse or a fishing boat. It is just never-ending.

Dr McCarthy: There was, as you have indicated, a significant allocation in the 2016-17 budget to manage what was a higher than expected volume of calls. Ms Buffinton has spoken at length in previous estimates about our experience of July 2015, and learning from that, and finding that we had, for example, more callers than expected and more correspondence than expected. In the most recent budget, there is a smaller allocation for the ongoing operations of My Aged Care.

Senator POLLEY: Is this $3.1 million now going to fix the problems that not only the providers but also consumers have been talking about? Can we say that this 3.1 is going to fix the system, so that now it will be user-friendly and it will be up to date?

Ms Buffinton: Let's remind ourselves as to what My Aged Care is, in terms of 'user-friendly'. It is the website, it is the contact centre—

Senator POLLEY: I think we can, but we have got limited time, so we do not need to do that. I just need to know—I am sorry, but we have got limited time, and we can talk and talk and talk, but I actually need some answers about what that money is going to be spent on and the outcomes we can expect.

Dr McCarthy: The $3.1 million is to provide additional funding for ongoing support for the platform. You have referred to problems in general. If you could you be more specific then we could give you some information about the different parts of the system and what we are doing about the issues that you are referring to.

Senator POLLEY: The $3.1 million, which you obviously requested from the government—you must have had in mind what you were going to spend that money on. Is it ICT? What in ICT does that relate to? I just want to know when we can expect My Aged Care to actually meet the expectations of not only consumers, who are the most important, I think, but also the providers, who are all complaining that it is not working properly.

Ms Buffinton: I might take that in a couple of tranches. We should remind ourselves that we receive more than a million phone calls each year to the contact centre. When we were originally given our budget in 2012 it was just an information-only platform, so the funding last year was for the contact centre, where a much larger volume—as you are aware, and as we have discussed before, our call-to-answer times and so forth were not appropriate, and now we have come to a much more appropriate standard of service.

Senator POLLEY: So, this year?

Ms Buffinton: That money last year was across four years. In terms of My Aged Care, you are saying it is not meeting expectations. We will be releasing in July our second wave of research. We do independent research—AMR do independent research—and the one thing that I can assure you on My Aged Care is that pretty well all perspectives, except for assessors', are much more positive about My Aged Care. If you talk to any member of NACA, they would all acknowledge it. It is not cheap talk. It is actually fact and experience—

Senator POLLEY: That is not what providers are telling me firsthand when I go and visit them. So we will agree to disagree.

Ms Buffinton: Okay. The AMR research and NACA acknowledge the fact that My Aged Care has improved markedly. In terms of that $3.1 million—in order to run My Aged Care annually the costs have traditionally been about $15 million. As we make a more complex system, that $3.1 million for this year is for making sure that the IT system continues to work. It is not for enhancements. It is just to make sure that the IT system works. We do releases about every quarter, and it is to make sure that the system is working as optimally as we can make it. It is not an additional enhancement of function.

Senator POLLEY: Perhaps you could just take it on notice and let us know what it is you are actually doing. But I have to move on because we are short of time. I will move on to the assessment framework. The budget stated that the regional assessment services will be extended in line with the delay in the integration of the Home Care Packages Program and the Commonwealth Home Support Program until July 2020. Is the government committed to moving to a single assessment process on 1 July 2020—or before then?

Dr McCarthy: The announcement that was made in the 2015-16 budget was that the government intended to integrate two different types of programs. There was not a commitment at that stage to a single assessment process. As we have been working with stakeholders to look at how we might better integrate our in-home support programs, that has been an issue that has come up and that we are discussing. But there was not a commitment to a single assessment process. It was certainly part of the conversation, but there was not a commitment.

Senator POLLEY: The Council on the Ageing criticised this delay, because nothing has happened, suggesting that an 'integrated Aged Care Assessment Service is an essential building block in the aged care reform process and its development should proceed without delay.' What is your response to that statement?

Dr Hartland: I do not have the statement from the Council on the Ageing in front of me, but I think they would have been referring to some discussion that was in the Aged Care Roadmap about the long-term desirability of having a single assessment system. In this area, there are a number of overlapping policy development processes. Dr McCarthy was talking about a policy development process that we are engaged in around how the Commonwealth Home Support Program and the home packages program should work better together. One objective that some have articulated is that there be a single program. The road map also talks about a single assessment system, but they are separate discussions, so I think the Council on the Ageing were making the point to us that they value the idea of a single assessment system and they want to see work proceed on it.

Senator POLLEY: So is there going to be a single assessment? Is there a process to bring that online or is the department not pursuing it?

Dr McCarthy: That is a matter for government. We are engaged in—

Senator POLLEY: Minister?

Dr McCarthy: discussions with the sector about how to best to manage, on the one hand, integration of those two programs, and, as I said, there has been no commitment to a single assessment program. We are aware of views in the sector, and we continue to discuss it with them.

Senator POLLEY: So you have not done any modelling or any work on it?

Dr McCarthy: I do not think we have done any modelling—

Dr Hartland: We are preparing a discussion paper on the next wave of reforms. I think it is fair to say that that has not reached the stage of modelling, but this is an idea that has been discussed. It was certainly discussed in the road map, and we helped draft that document in support of the Aged Care Sector Committee, so it is not true to say that it has never occurred to us.

Senator POLLEY: No, because I know how much forward thinking the health department does. When is the discussion paper going to be released? We heard all about it yesterday, continuously.

Dr McCarthy: The discussion paper that Dr Hartland is referring to is, as he indicated, about how to better integrate in-home support, currently Home Care Packages and Commonwealth Home Support. We do not have an exact date, but we would expect within the next month or so to release a discussion paper.

Senator POLLEY: Has any work been done on the development of a single government operated assessment process, including funding, such as the ACFI assessment?

Dr Hartland: The issue about ACFI assessment is being actively considered and, as we have talked about before, we have commissioned the University of Wollongong to look at options for different forms of assessment.

Senator POLLEY: I am sorry, I am having trouble hearing you.

Dr Hartland: We have talked before, at estimates, about commissioning the University of Wollongong to do some work on options for assessment. That has raised different approaches to this. We are actively talking to the sector now about the future of needs assessment in residential aged care. One of those options would be integrating needs assessment with eligibility assessment. Having said that, these discussions are still at quite a preliminary stage, and we expect over the coming months that we will be holding engagement with the sector and trying to test their understanding of the options and their views on it.

Senator POLLEY: You will be aware that COTA, for instance, has some concerns about moving forward and the need to do it in a more timely way.

Dr McCarthy: We engage very closely with COTA and are aware of their views on a whole range of matters.

Senator POLLEY: We will put some other questions on notice to save some time. Moving to another area, the 2017 budget included $1.9 million over two years from 1 July 2017 to establish and support an industry led aged-care workforce task force. Can you provide me with some detail about this task force. Who is going to be on the task force, how were these people selected and when will they meet? Or has it already been established?

Ms Rule: The task force has not yet been established. The budget announcement was an industry-led task force. We are currently working with stakeholders within the sector to identify the make-up of that task force, but nobody has been appointed yet and the task force is yet to meet.

Senator POLLEY: I think that if we went back to the last estimates in February—and Senator Nash said that the industry should lead this workforce strategy; it should be driven by the sector. Is the task force contributing to the development of an aged care workforce strategy, or just leading it?

Ms Rule: The output that we will expect from the task force will be a strategy, but our policy view continues to be that workforce is a matter for the sector and for the providers and, therefore, it is not up to the department or the government to tell providers what their workforce should look like. What this budget measure allows us to do is provide some money to the sector to support them to develop the workforce strategy.

Senator POLLEY: Who will form the membership, as I said, of the task force? How will those people be selected? Is it true that unions and other employee representative and consumer groups have been excluded from this task force?

Ms Rule: The task force has not yet been established, so nobody has been included or excluded at this point.

Senator POLLEY: So what were the guidelines? What parameters have been set down for the construction—that is probably not the right word—of this task force? For the selection of this task force, surely the government would have given some outline of what they expect as to who is going to be on that when they are spending $1.9 million.

Ms Rule: No task force—

Senator POLLEY: They have not?

Ms Rule: There has been no—

Senator POLLEY: So, 'Here you are,' to the sector. 'Here is $1.9 million. Set up a task force and go for your life.'

Dr McCarthy: No, the task force will be expected to consult widely within the sector.

Senator POLLEY: Within the sector, but what about the consumers, workers representative groups and unions? It was not part of the government's directive that they should be involved in this task force?

Dr McCarthy: As Ms Rule said, the make-up of the task force is yet to be established. When the task force is established, as is usual in these cases, there will be guidelines. But we would expect, in line with a very strong commitment by the government and within the sector to consultation, the task force to consult widely across the sector.

Senator POLLEY: Will there be anyone from the department, or the minister or his representative on the task force?

Ms Rule: No, we envisage that the role of the department will be to provide support to the task force. For example, one of the roles that we envisage is being able to connect with other parts of government, like the Department of Employment, the department of education and others who might be of assistance to this sector in developing this task force, but we do not envisage that we will be members of the task force.

Senator POLLEY: Will the government adopt the aged care workforce strategy that is supposed to be produced by the task force as government policy?

Ms Rule: That will be a matter for the government.

Senator POLLEY: Minister, you might be able to shed some light on it.

Senator Nash: No; unfortunately, I am not the minister responsible, but—

Senator POLLEY: Can you take that on notice?

Senator Nash: I can take that on notice for you.

CHAIR: Can I just clarify what your question was? Did you ask would the—

Senator POLLEY: Whether the government would take up the policy of this task force recommendation as their strategy.

CHAIR: That is yet to be formulated; so the group has not been established, the document has not been written—will it be adopted?

Senator POLLEY: They have not even written any guidelines for it yet, but they have given it $1.9 million.

CHAIR: Okay, I just thought that it makes it—

Ms Rule: The output that we are expecting from this task force is a workforce strategy that will be a product that belongs to the sector that will help them to inform decisions about how they manage their workforce. The output from the task force is not expected to be advice to government.

Senator POLLEY: Is there anything that you can inform the committee about any interactions you expect the task force to have with the $33 million Boosting the Local Care Workforce program listed in the Department of Social Services budget papers?

Ms Rule: The measures are related indirectly. The Department of Health has made a $3 million contribution to that measure that belongs to the Department of Social Services. That social services measure is about building a local workforce for the National Disability Insurance Scheme, but also for aged care. It is important to note that the workforce development issues are different for those two sectors. Aged care is a much more established industry in its current form than what will be required to support the NDIS; hence the fact that we are making a smaller contribution to that overall measure, but we do it expect to work closely with the Department of Social Services. We have already flagged with them that, once this task force is established, we would like them to come and talk to the task force about that measure.

CHAIR: It being 6 pm, we will suspend for dinner and return at seven.

Proceedings suspended from 18:00 to 18:59

CHAIR: We will continue our consideration of outcome 6. Senator Polley, you have a few minutes of your round of questions remaining.

Senator POLLEY: Yes. I just want to quickly go back to the document that was tabled and ask if there is anything you want to add to whether or not you recognise those figures or you are disputing those figures, bearing in mind that we do not have a lot of time.

Dr McCarthy: That is not a document that we have with us, and it does not have any kinds of identifying markers on it that would enable us to determine whether or not it is a departmental document.

CHAIR: Do we have a source for this—as in a booklet?

Senator POLLEY: A very reliable source.

CHAIR: Okay, one of those.

Senator POLLEY: Yes.

Mr Bowles: It will be a bit hard if we cannot identify where this comes from. We can take it on notice.

Senator POLLEY: You can take it on notice. I do not know where it came from either. It just appeared. We do not want to waste any more time.

Mr Bowles: Oh, it just appeared!

Senator POLLEY: We can move on, then, because there is a lot to cover. The New South Wales government recently voted against restoring the state based legislation that requires one registered nurse on duty at all times in high-care nursing homes but would refer the matter to COAG. What discussions has the department had with the New South Wales government about this?

Dr McCarthy: I am not aware of any specific discussions with the New South Wales government on that issue. I know it has been referred to COAG.

Senator POLLEY: So you will take it on notice?

Dr McCarthy: We can take that on notice.

Mr Bowles: I know it has been discussed at COAG or released at AHMAC. I do not think it has actually yet gone to the COAG Health Council. I could be wrong. But we will take that on notice.

Senator POLLEY: Thank you. Then—

Dr McCarthy: Senator, I have just been reminded. There was a broader discussion with the New South Wales government on the draft single quality framework, and the issue, I am advised, did arise in that context.

Senator POLLEY: Have you done any work for the government in relation to registered nurses being on call 24/7 or a minimum of nurse patient-care hours?

Dr McCarthy: We are aware of the issue, but the Aged Care Act, as I think we have discussed before, does not have any requirements of that nature. There are some requirements in relation to only registered or enrolled nurses being able to do certain things, but, no, we have not.

Senator POLLEY: So you have not undertaken any work or analysis, or you are not aware of any such analysis being undertaken, for the government that would improve the care of those in residential care?

Dr McCarthy: We do a lot of work for government on the issue of quality of care in residential care. We have not specifically done work that I am aware of on that issue. It is an issue, though, of which we are aware.

Senator POLLEY: Has the government undertaken any work on improving the training of careworkers to deliver a higher standard of care for those in residential care?

Dr McCarthy: The training of the workforce, the training of careworkers, is the responsibility of the approved provider.

Senator POLLEY: Yes, but, as you know, there have been some training providers who have not been meeting the critical standard. I just wonder if the government has asked you to do any work in relation to a standard of training, perhaps across the country, that was uniform.

Dr McCarthy: Yes, I am aware that there are some concerns on the part of aged-care providers about some training providers. I do know that, as part of the workforce strategy, vocational education and training will be one of the issues that the taskforce will be expected to look at.

Senator POLLEY: Can you inform us as to whether or not there has been any identification of areas within the aged-care sector and around nurse or careworker shortages in the country? In other words, are you aware of any shortages that the department or the government are aware of, whether it is carers in aged care or it is registered nurses?

Ms Rule: There are not particular shortages in particular places, that we are aware of. We understand from the sector that attracting and retaining a suitable workforce is a challenge for some of them, and that is part of the budget measure to develop the workforce strategy. The budget announcements around that talked about ways to improve, boost and maintain supply in the workforce. So we are aware that there is some pressure on the sector in that regard, and that is part of what the workforce strategy will be aiming to address.

Senator POLLEY: Can you provide the total number of aged-care nurses that are in the country on 457 visas.

Ms Rule: I would have to take that on notice. I am not aware that we have that data but I can have a look.

Dr McCarthy: I think we might have been asked a similar question before and I am not sure we were able to obtain that, but we will take it on notice.

Senator POLLEY: And if you can take that on notice, it would be helpful to have that broken down into the aged-care planning regions. Obviously, there are some areas in the country, such as remote and regional areas, where they would struggle to get registered nurses, more so than somewhere in the capital cities.

Dr McCarthy: We can take that on notice.

Senator GICHUHI: My question relates to the same area of aged care. I am aware that in most hospitals, child care and schools—mainly child care—there is a client-staff ratio. Do we have such a ratio for aged care, especially residential aged-care facilities?

Dr McCarthy: No. In the Aged Care Act, which governs residential care, there are no staff ratio requirements. There is a requirement for approved providers to have an adequate number of people with the right skills for the particular aged-care service in question.

Senator GICHUHI: With that in mind, I come from South Australia and we are having the South Australian Oakden facility issue. Earlier on there was a situation in the media where one of the residents was caught on camera. The family of this particular patient had to put a camera in the room because they had questions surrounding how the patient was being treated. My question is: what is the department doing about some of these issues, like the client-staff ratio and the issue of having surveillance cameras installed in the facilities of the most vulnerable patients? Is the department in a position to kick-start a system, or a process, where the registration could be reviewed to take into account the needs of these most vulnerable Australians?

Dr McCarthy: On the matter of cameras in residents' rooms, that is something that is governed by state and territory legislation. More broadly in relation to the safety and the care of residents, there is a regulatory framework and there are a range of standards that that regulatory framework is designed to help ensure are met. There are various different parts of the portfolio that work together—the quality agency, the department, the aged-care complaints scheme—to monitor and to help provide assurance around issues of quality.

Senator GICHUHI: What relationship exists between the Australian Aged Care Complaints Commissioner and the Australian Aged Care Quality Agency?

Dr McCarthy: As I just mentioned, as part of the regulatory framework covering aged care, the Department of Health works with the Aged Care Quality Agency and the Aged Care Complaints Commissioner. The Department of Health is responsible for setting the policies around the regulatory framework. We also conduct some regulatory action in terms of issuing notices of non-compliance and, if necessary, sanctions against providers. That regulatory action can be instituted on the basis of advice from the Aged Care Quality Agency about any unmet standards that they might find. Indeed, the complaints commissioner is also able to refer information that comes to her knowledge to the quality agency and to the department. So information flows between those three entities within the portfolio to help make sure that regulatory framework operates effectively.

Senator GICHUHI: In that regard, the same facility, Oakton in South Australia, and other facilities around the country, are close to the standards required on the current 44 expected outcomes. Is that sufficient accreditation?

Dr Hartland: Our assessment is that the Oakton facility does not meet all of those 44 standards. They are actually in a compliance process now, which is designed to bring them back into compliance with standards.

CHAIR: Senator Gichuhi, we will be coming back a little later on, in program 6.4, to the specific issues around the Oakton, accreditation et cetera. Do you have anything relating to the more broad—

Senator GICHUHI: Yes, along the same lines. How many complaints were reported through to the commissioner in 2015-16?

CHAIR: Again, all the complaints, accreditation and things will be later on. So we might return to that a little later on if that is all right, Senator. We will be in touch with your office about when that comes up on the program.

Senator GICHUHI: Thank you very much.

CHAIR: Senator Macdonald.

Senator IAN MACDONALD: I am conscious that there was a Senate committee inquiry into staffing in aged-care facilities, so I do not want to waste too much time on that because we have a lot to get through. But are you conscious of difficulty in attracting staff to some rural and remote areas?

Dr McCarthy: Yes, we are aware of that. I am not sure whether you were here when Ms Rule mentioned that we know that some providers in some areas do have difficulty attracting staff.

Senator IAN MACDONALD: Is that something the government can do anything about?

Dr McCarthy: In rural and remote areas, depending on the location, there is a viability supplement for residential aged care. That is an additional amount of funding that is made available to qualifying services.

Senator IAN MACDONALD: An additional payment?

Dr McCarthy: That is an additional payment for qualifying services. There is something called the modified Monash model which, depending on location, it is determined whether a service qualifies. That is an additional amount of funding that can assist providers. We know that, particularly in remote areas and in some rural areas, there are a range of additional challenges that providers face.

Senator IAN MACDONALD: Do you have any data on what parts of Australia experience more difficulty than others? Do you keep that sort of data?

Ms Rule: We would have to take it on notice.

Senator IAN MACDONALD: I am not really asking for the details. I am simply asking whether you have that data. Is that available?

Ms Rule: We do conduct a workforce survey. We are just trying to determine whether that has a regional breakdown. We will see what we can find out for you, but we will have to take it on notice to find out whether the workforce survey goes down to a regional level.

Senator IAN MACDONALD: Does ESS have anything to do with staffing levels?

Dr McCarthy: Extra Service Status?

Senator IAN MACDONALD: Yes.

Dr McCarthy: No, there is not a relationship between staffing levels and—

Senator IAN MACDONALD: So what does that relate to?

Dr McCarthy: A provider can apply for what are called Extra Service Status places. So a provider can choose to apply in the Aged Care Approvals Round for particular Extra Service Status places. There are particular extra conditions around them and, I guess, conditions that providers have to meet in order to be able to have those Extra Service Status places.

Dr Hartland: Those are where the provider provides a higher standard of hotel and accommodation services to the recipient.

Senator IAN MACDONALD: A higher standard—

Dr Hartland: More expensive.

Senator IAN MACDONALD: A higher standard the normal, than what the average might be?

Dr McCarthy: That's right.

Ms Rule: But it has been some time since we have offered Extra Service Status places under the Aged Care Approvals Round. It has been a number of years; I cannot tell you exactly how many; I would have to take that on notice. But they are no longer something that is commonly offered through the Aged Care Approvals Round.

Senator IAN MACDONALD: Are there many homes still have that status?

Ms Rule: I would have to take that on notice.

Dr McCarthy: They are a declining proportion. They date from a time before some reforms were made to legislation around aged-care funding. So they are not as much in use anymore.

Senator IAN MACDONALD: As I understand it, if you have that status you are not eligible for any capital grants.

Dr McCarthy: I think you are not eligible to apply, that's right.

Senator IAN MACDONALD: And can you 'de-apply'? What is the impact of that status on applications for capital grants? And if it prevents you from it, what are the consequences if you 'de-apply'?

Ms Rule: A service could give up their Extra Service Status places. They would effectively surrender those. But to replace those places they would then have to apply in an Aged Care Approvals Round to get mainstream

aged-care places. A provider can surrender any type of place at any time, including Extra Service Status places. But they then effectively forfeit those places and would have to reply through the Aged Care Approvals Round.

Senator IAN MACDONALD: So what happens to those places?

Ms Rule: We would take them out of the mix. Because they are Extra Service Status places, which is something we no longer tend to offer, those places would no longer exist and we would look to redirect that funding into mainstream aged-care places.

Senator IAN MACDONALD: I assume you get a greater payment.

Ms Rule: Yes, that's right.

Senator IAN MACDONALD: Could a home say, 'We don't want the greater payment, we'll just keep this as a normal—

Dr Hartland: The Extra Service Status Places do not attract more government funding. I would have to take on notice the precise details of the arrangements, but they effectively allow consumers to pay for a higher standard of funding. They do not attract a greater level of government funding.

Senator IAN MACDONALD: So it allows the home to charge a higher fee, but somehow the rules say that means the home cannot then apply for any capital grants?

Dr Hartland: The policy rationale behind extra service places was to allow some flexibility in the system towards aged care accommodation options that consumers were paying a higher amount for. The capital funding is to support services that are serving local communities that would not be able to generate their own funding through consumer contributions—the rationale follows.

Senator IAN MACDONALD: If homes apply for capital grants and they have that ESS, for starters, do you immediately say to them, 'Do not bother applying because you are not eligible'?

Ms Rule: There are two ways that we advise eligibility. When we open an aged care approvals round we publish a whole range of guidance for providers on what they can apply for and what the rules are. In that guidance it is clear that services who hold those extra service status places are not eligible to apply for capital grants. There is general guidance in terms of how the application process—

Senator IAN MACDONALD: So if they apply to you, do you send it back and say, 'Sorry, here is your application back we do not'—

Ms Rule: That would be our standard practice.

Senator IAN MACDONALD: Of course, you know in the case of Bowen you did not do that for a couple of years in a row. You are conscious of that, I think.

Ms Rule: I think you are aware that information about individual services and their applications under the Aged Care Approvals Round is protected information under the Aged Care Act. I am not in a position—

Senator IAN MACDONALD: Protected information? I am not asking about individual people or names, but about particular homes.

Ms Rule: The Aged Care Act has protection for providers. We are not allowed to disclose information about individual providers in most circumstances. We are not at liberty to talk about individual providers in this forum. I am aware of the case that you are talking about, though.

Senator IAN MACDONALD: What about if the particular provider says to me, 'You have got permission to raise this as loudly as you like'?

Ms Rule: If we had permission from a particular provided to waive those protections then, yes, we can do that.

Senator IAN MACDONALD: So next estimates I should come with a letter from them saying you can tell—

Senator POLLEY: We will have a stack of letters then!

Ms Rule: As I said, if we have permission from a provider we can talk about those issues.

Senator IAN MACDONALD: Are you aware that some homes are paying tens and tens of thousands of dollars to complete the application form for funding under the government's programs?

Dr McCarthy: We have heard that said.

Senator IAN MACDONALD: Do you not know that it is true?

Dr McCarthy: I am not disputing whether it is true or not. I know that that is a practice, yes.

Senator IAN MACDONALD: Are you not aware of certain consultants who make a very good living out of charging tens and tens of thousands of dollars for people to complete the forms for assistance under your—

Dr McCarthy: We are aware that there are a range of consultants in the aged care industry.

Senator IAN MACDONALD: Does that suggest to you that your forms are so complicated that aged persons homes' normal clerical staff are simply incapable of completing the application?

Dr McCarthy: That is a conclusion that clearly you have drawn. I do not think our view would be that you cannot complete the form without the assistance of a consultant and certainly I would guess that the vast majority of providers do not use that sort of assistance.

Senator IAN MACDONALD: Do you know that there are consultants who go around saying, 'If you want to get a grant come to us, pay us our fee and we can almost guarantee that you will be successful'? Are you aware of that?

Dr McCarthy: I have not heard that.

Senator IAN MACDONALD: Do you know of these firms of consultants who deal specifically in completing aged persons home applications?

Dr McCarthy: I have heard that there are such consultants. I could not tell you who they are.

Senator IAN MACDONALD: Once you get a place, having got it from the Commonwealth for nothing after making an application for three or four beds in a particular place, can you then trade that? Are you aware that there is now a market on selling those places for quite considerable sums of money?

Dr McCarthy: I am aware that places do change hands. I think they are classed as intangible assets. I am just checking.

Dr Hartland: Some providers will put the bed licence as an intangible asset on their balance sheet. There are rules around that. They would have to apply to us. We are aware that places change hands. It is part of a commercial transaction, so we could not confirm the amount of money involved.

Senator IAN MACDONALD: But you have to approve it, do you?

Dr McCarthy: There is a process.

Dr Hartland: We do have to approve it.

Senator IAN MACDONALD: I may bring you evidence there is a market for tens of thousands of dollars to acquire a place, which is granted by the Commonwealth taxpayers to these homes. I understand that is approved by the department. Are you conscious of that?

Dr McCarthy: As I said, we are aware that places do change hands. We administer a process where we have to approve the change of place.

Dr Hartland: In a scenario where someone just got a place and sold it on, I can see the point you are making, but, the provisions for moving places are also to allow, say, a small provider that cannot function any more or its owners who wish to retire out of the business to sell the business. There are a whole range of different ways and reasons that places might move in the system.

Senator IAN MACDONALD: But this is not selling a home or a bed in a particular town. It is saying to the market at large, 'Do you want an extra bed? Give us 30 thousand, or 40 thousand, or 50 thousand, and here is one.' I understand it has to be approved by the department. That cannot be right, can it?

Ms Rule: It is right that we approved the movement of places. There are strict requirements around the management of aged-care places and aged-care approvals.

Senator IAN MACDONALD: So you would know if someone was charging tens of thousands of dollars?

Ms Rule: Not necessarily. We would know that a provider is seeking to transfer a place to another provider.

Senator IAN MACDONALD: And you would not ask or make inquiries on whether there was a cash transaction involved?

Dr Hartland: The criteria we would have would be that we would protect rural and remote communities, where possible, and that the providers were accredited properly under the Aged Care Act.

Senator IAN MACDONALD: What would you do if I provided you with evidence of people offering these places for sale for a cash sum? Would that be in breach of the act?

Ms Rule: We would have to have a look at the individual case.

Dr McCarthy: But the place could not change hands without the approvals process been gone through.

Ms Rule: We are happy to look at individual cases. We would have to look at in what circumstances the place was changing hands.

Senator IAN MACDONALD: If I ran an aged-care home, as well is applying to you for a new place, I can go out into the market and try and get a place from someone else who has surplus to their needs. That means the Commonwealth has given the seller that benefit, which is converted into a cash term, and that person can then sell it at a profit, thanks to the Commonwealth taxpayer.

Ms Rule: The Commonwealth's interest is in making sure that people are getting access to the aged-care services that they require. If the movement of that place is going to mean that a service is available to someone, and it meets the conditions of the act, then it may be approved by the Commonwealth.

Senator IAN MACDONALD: Even if it comes with a profit cash component?

Ms Rule: I do not believe that there is anything under the legislation that prevents that from happening.

Senator IAN MACDONALD: Perhaps that is something the legislation or the parliament or the department, first of all, needs to look at. Perhaps I will provide you with some evidence, through the minister's office, of this sort of activity going on.

Dr Hartland: Of course, Senator. We would be happy to look at the case and consider the issues.

Senator IAN MACDONALD: Okay. I will do that between now and the next estimates, and perhaps come back next estimates and ask. I will also come with the letter from the Bowen home for the aged so that we can talk about their situation, where they are not eligible. Apparently, after three years of applying, I think, they have now worked out that they are not eligible. I would be interested if you could tell me on notice why a particular home would keep applying if you had advised them the year before that, because of their ESS status, they should not waste their time applying.

Ms Rule: We can take that on notice.

Senator IAN MACDONALD: All right. Thanks, Chair.

CHAIR: Senator Siewert.

Senator SIEWERT: I want to follow up on some of the questions I asked about better access to mental health services. We had a discussion at the last estimates which involved the MBS review, but if you recall we also had further discussion about the fact that some interim arrangements could potentially be made around better access in terms of a change to older people being classed as patients. I have subsequently written to the minister. I am wondering if there has been any movement on that particular issue.

Dr McCarthy: That is an issue that we are continuing to investigate, and, to that end, Minister Wyatt convened a think tank—what he refers to as a think tank—of a range of stakeholders with expertise in the areas of mental health and aged care. It was a meeting that went for several hours, and that was an opportunity to discuss mental health generally in relation to older people, and of course we also covered the better access issue and there were a range of conversations about options for how that might be addressed. We are still working on that issue, so we do not have a solution that we can give you this evening, but I can assure you it is under active consideration, and Minister Wyatt was very keen to hear from stakeholders about the issue and the mental health of older people more broadly.

Senator SIEWERT: Thank you. Did you say it was called 'a think tank'?

Dr McCarthy: A think tank, yes.

Senator SIEWERT: I want to come back to Better Access in terms of mental health services for older people. What is the aim now, or where you are going to now that you have had a think tank and you said you talked about a range of issues? What is the process?

Dr McCarthy: The aim now is to prepare advice to government on how we might address the issue that has risen around the Better Access program and it not being available to older people in residential care. So the aim is to provide some advice on that.

Senator SIEWERT: So you are trying to ensure that older people can benefit from better access to—I am trying to say—

Dr Hartland: Better access to Better Access?

Dr McCarthy: Yes.

Senator SIEWERT: I did not want to say 'better access to Better Access'!

Dr McCarthy: I think we would want to give government a range of options. Clearly, opening up Better Access is one option, but there may be other ways of providing mental health services of the kind that the rest of the community is able to enjoy through Better Access in residential care.

Senator SIEWERT: That is what I had taken from the comments. I just wanted to clarify those. Can we go back to the time line. This issue has been going on now for some period of time. Has the minister set a time line or a deadline on this process?

Dr McCarthy: No, I cannot give you a date by which a decision will be made.

Senator SIEWERT: Without an end date it is ipso facto endless. Have you given consideration to that temporary fix that we discussed last time to enable at least some sort of better support while you are coming up with a longer term solution?

Dr McCarthy: No decision has been made yet about either a longer term solution or an interim solution.

Senator SIEWERT: So we are still in the position we were in previously where older people cannot access it because they are no longer classified as patients?

Dr McCarthy: It remains the case that the program is not available to people in residential care.

Senator SIEWERT: I have been reading through this. Could that be fixed by regulation?

Dr Hartland: We would have to look at the MBS legislation. I do not think either Dr McCarthy or I—

Dr McCarthy: We would need to take that on notice.

Senator SIEWERT: If you could take it on notice, because this issue has been around for a significant period of time. We are now a significant way down the track—three months from February, when we were discussing it previously. In the meantime people are not getting access to mental health services. Are you able to find that out tonight or would it take longer than that?

Dr McCarthy: Is that the specific question about whether it could be changed by regulation?

Senator SIEWERT: Yes, or is there another simple way of fixing this classification issue that could be done. I appreciate what you are saying in terms of the bigger picture. I think that is a good approach. At the moment I am focused on how we ensure older people are getting Better Access.

Dr Hartland: Irrespective of whether the fix is a simple regulation change, a small change to the act or some other form, for agreement to be reached on any policy change there would need to be a costing taken to government and a process around government to deal with that.

Senator SIEWERT: Have you done any costing on enabling people to use Better Access? Has there been any costing done on that? Was there any discussion of that in the think tank?

Dr Hartland: I am not sure. I could not say whether we have done a formal costing of the issue, but we are aware of the dimensions. We know how many people are in residential aged care and how many people have a mental health issue. We kind of know the dimensions of the problem. The next question I anticipate is: what is the order of those dimensions? I am sorry I do not have that in my head well enough to give you a proper answer.

Senator SIEWERT: We know how many people are in aged care and we know the percentage of people in aged care who are likely to have a mental illness.

Dr McCarthy: As my colleagues may have mentioned previously, while I know it is not a substitute, there is the chronic disease management item under which a residential GP can contribute to a care plan prepared by the facility and the resident may then be eligible for referral. I know it is not the same as Better Access, but there is an avenue.

Senator SIEWERT: Yes. How many people?

Dr McCarthy: I do not have that data.

Senator SIEWERT: You do not have it, but can you take it on notice?

Dr McCarthy: I could take that on notice, yes.

Senator SIEWERT: Could you take on notice how many people in residential aged care have accessed or have had a chronic disease care plan done?

Dr McCarthy: I can take that on notice.

Senator SIEWERT: That of course will not tell us how that relates to mental illness per se.

Dr McCarthy: No, and we may not know which allied health services they have been referred to.

Senator SIEWERT: Having that quantum would be useful, but then if you are able to tell us—and I understand that with restrictions around privacy you may not know—whether there was access to mental health services—

Dr McCarthy: We will see what we can do.

Senator SIEWERT: In terms of the costing, could you take on notice whether you have done any, Dr Hartland. I interpreted what you said as that you weren't sure—that there hadn't been any costings done?

Dr Hartland: I was not sure whether a formal costing had been done, no.

Senator SIEWERT: Could you take that on notice to see if there has been; and, if there has, what it is?

Dr Hartland: I think I have seen answers in the past about whether advice has been provided but, rarely, if the government has not published what the nature of that advice is.

Senator SIEWERT: I missed what you said?

Dr Hartland: We will take it on notice.

Senator SIEWERT: It would be useful to know if you have.

Dr Hartland: I suspect the answer will be that we would not be able to tell you what the actual outcome of the costing would be.

Senator SIEWERT: Okay, but you can tell me whether you have done one—

Dr McCarthy: We can.

Senator SIEWERT: and then tell me: not available or whatever. I want to go back to this issue of the time line: you said you have not fixed one—is this a matter of urgency for the minister?

Dr McCarthy: The minister certainly sees it as a very important issue that he wants to progress.

Senator SIEWERT: I realise it is not up to you—you can't tell me what you do not know. In terms of the deadline, it is up to me then to pursue the government or the minister about it again? Thank you. That is all I have on that one.

CHAIR: So is that 6.1, from your point of view, done?

Senator SIEWERT: I have got some data questions.

Senator POLLEY: Can I seek some clarification: if we are going to continue giving everyone 20 minutes on at least all these programs, we are not going to get through the rest of them.

CHAIR: It is up to members to be judicious with their questions, noting the time limits we have.

Senator POLLEY: If I make a judgement that I will go 10 minutes on 6.2 and 10 minutes on 6.3, are you going to allow that to happen? Otherwise, we are going to run out of time.

CHAIR: Sure, I am happy to go that way. Senator Siewert?

Senator SIEWERT: If you had just let me finish, I was about to say: I have got some data questions, and I am just checking to see if there are any that I should ask now and the rest I will put on notice. I do have one other area that I was going to come back to later.

CHAIR: Fine.

Senator SIEWERT: I think I can put the rest of my data questions on notice.

CHAIR: Okay

Senator SIEWERT: Yes, I can put those on notice.

[19:42]

CHAIR: We can move to program 6.2, and Senator Polley you indicated that you were prepared to go from there?

Senator POLLEY: Yes I can, but I was not asserting anything about Senator Siewert; I just meant that we have only just finished 6.1. We are finishing at 9.30, and we have got a number of, I would think, contentious areas to cover yet. I just want some guidance.

CHAIR: As I say, I am in your hands as to how you want to spend your time. The committee has operated on good will and, if senators want to take a certain course of action, feel free to suggest.

Senator POLLEY: I will go straight into 6.2. Do we have any information available now as to the average consumer's contribution to the HCP program services as a percentage—home and community care program?

Ms Rule: The Home Care Packages Program? We do have some data on consumer contributions—we will just check to see, if we have what you need.

Dr Hartland: So the last Aged Care Financing Authority report said that, on average, their estimate was that fees made up around 10 per cent of the value of services. That is for CHSP?

Dr McCarthy: Sorry, we are just clarifying—

Dr Hartland: You were after CHSP?

Senator POLLEY: Yes.

Dr McCarthy: Commonwealth Home Support Program, not home care packages?

Senator POLLEY: No, the home care package.

Dr Hartland: The home care package—I was answering about CHSP. In home care, consumer fees are around about 10 per cent, as it turns out. Eighty-five per cent of that is estimated to be the basic daily fee and around 10 per cent are the income-tested fees.

Senator POLLEY: Meals on Wheels have raised concerns that the level of funding provided to provide meals is significantly lower than for other services. They have suggested that Meals on Wheels services bore 50 to 80 per cent of the cost of the service, depending on where clients live, while most users of Home Care Packages and the CHSP contribute only 10 per cent of the cost of the services. Can you verify their assessment for us please?

Ms Rule: Funding to Meals on Wheels is provided under the Commonwealth Home Support Program, not under the Home Care Packages Program. The arrangements for funding under the Commonwealth Home Support Program are what we describe as 'block' funding. We do not pay Meals on Wheels providers on a per meal basis. They get funded a block amount under a grants program and then they determine how they spend that money.

Senator POLLEY: What they are saying is that they are being treated differently—that in providing this service—

Ms Rule: Individual providers have been treated differently?

Senator POLLEY: No—those people delivering the Meals on Wheels. That organisation believes that they are being dealt with differently in the method by which you make their payments.

Ms Rule: Differently to whom?

Senator POLLEY: To other service providers.

Ms Rule: I am not aware of that being the case.

Dr McCarthy: Common process would include the grants; I would be very surprised if Meals on Wheels grants were administered differently to others.

Senator POLLEY: They are suggesting that they have been. Maybe you can take that on notice?

Will any of the $240.4 million growth funding, including in this 2017-18 budget, be allocated to address the concerns? You are not acknowledging that there are any concerns about their funding? They are looking at an additional $5 million. But you say that they are funded appropriately?

Ms Rule: We are saying that we provide them with grant funding in a block and through a competitive grants process which applies to all of the Commonwealth Home Support Program. Meals on Wheels providers in certain locations received an increased funding allocation in the recent Commonwealth Home Support Program growth round. There was $1.3 million in additional funding provided in certain locations, based on applications from providers in those locations.

Senator POLLEY: Okay. So Meals on Wheels and other organisations have raised concerns about the lack of engagement from government on the planned integration of the Home Care Packages Program and the Commonwealth Home Support Program. Now that this has been delayed, will the government commit any funding to provide sector support to assist organisations to prepare for this transition?

Ms Rule: The government announced in the budget a continuation of Commonwealth Home Support Program funding for two years.

Senator POLLEY: Yes.

Ms Rule: That provides funding certainty. No decisions have been made yet about what the nature of the program integration will look like, and therefore no decisions have been made about funding that integration.

Senator POLLEY: So no work has been done on that?

Ms Rule: I did not say that. I said that no decisions have been made yet, and therefore no funding has been allocated yet.

Senator POLLEY: But you have been doing work on it?

Dr Hartland: That is right. We have been consulting with the sector and, as we talked about prior to the break, we are in the process of preparing a discussion paper for release for a broader consultation. So we have been working on this issue.

Senator POLLEY: Right. Clients have reported being unable to engage Commonwealth Home Support Program services that they have been approved for; periods of over six months are the usual wait times for Commonwealth Home Support Program services. Were you aware of that—people waiting for up to six months for services?

Ms Rule: Not specifically that figure of six months. We have heard reports from certain providers in certain locations that there are some wait times, but I cannot verify that six-month wait time.

Senator POLLEY: Do you have any data at all that actually outlines the waiting periods?

Ms Rule: We do not.

Senator POLLEY: Are you doing anything to address those waiting periods?

Ms Rule: Because the Commonwealth Home Support Program has a different funding model from Home Care Packages, it is not the same system where there is a national queue—new or otherwise. It is grant funding. We do not fund providers on outputs—we give them a block of funding. How many services they provide for that funding is a matter for them. Having said that, we are working with providers to improve data collection to help us have more visibility of that, but it is not in place yet.

Dr McCarthy: As part of the extension of Commonwealth home support funding, we will be working with providers to ensure that there are some new conditions around the funding that relate to not only increasing the focus on wellness and reablement but also giving consumers more choice.

Senator POLLEY: Are you aware that there are clients who have reported that information on the My Aged Care service finder is regularly wrong? I know you have said before that it is up to service providers to keep that information updated, but is there not a responsibility on government when consumers are out there waiting for services and they are told that there are services provided on My Aged Care, but when they make contact and want to take up those services they are not actually there? What is the government doing about that?

Dr McCarthy: That is a concern and in fact as recently as last week at a meeting of the National Aged Care Alliance Ms Buffinton made very clear to providers just how important it is to ensure that the system can be as efficient as possible and most importantly that consumers are given the right information. She made it very clear at the National Aged Care Alliance, which as you know is a large coalition of organisations in the sector including provider organisations, how important it is that that information be accurate. So we are getting that message out there, and have been doing so regularly.

Senator POLLEY: So next estimates you will have a big tick that you have resolved the issue?

Dr McCarthy: It is our hope that providers are doing what we have asked them to do.

Senator POLLEY: Do you have an estimated average wait time for each level of home care package, or is it like what I asked about earlier in the day?

Dr McCarthy: It is the same issue and we will not have that information until the end of that first four-month period that Ms Buffinton referred to.

Senator POLLEY: We do not know at this stage how long people are waiting, so for those people who are waiting for a long period there is no relief for them between times?

Dr McCarthy: As I said, we do not have access yet to data we can give you on waiting times. We do know that older people who are waiting either for a home care package or for an upgraded package may indeed already be accessing Commonwealth Home Support Program services, which are entry-level services, or indeed may be able to access those while they wait for care.

Senator POLLEY: Of the 25,000 new packages that have been released—

Ms Buffinton: It is 30,000.

Senator POLLEY: Can you tell me how many new, not vacant, packages have been allocated since 27 February this year?

Ms Buffinton: I think we might have covered this earlier, but of the 30,057 there are 7,635 new packages.

Senator POLLEY: That is right, you did say that. I will skip over that, then. The department has stated that a client's position in the national prioritisation will be determined by their time waiting in their priority for home care services as determined through the comprehensive assessment undertaken by ACAT. We did ask about this during the last hearing, but it was unclear: does a client's time waiting commence the day the client is referred for an assessment on My Aged Care or is it the date that the comprehensive intensive assessment is undertaken, or is it the date the client is assessed as eligible to receive a package?

Ms Buffinton: It is the date that the delegate approves the completion of the ACAT, and that is the date from which the package is then assigned. So, it is from that date.

Senator POLLEY: Are there processes in place to allow clients who are in need of emergency or urgent care to receive a package immediately? Can they jump the national queue?

Ms Buffinton: As we have discussed, people are, on average people, in the medium priority. And we talked about how the packages are released for high priority. For both residential and home care, we have an emergency approval applications process.

Senator POLLEY: What is that?

Ms Buffinton: That is if there is an acute need for going into residential—say, for release from hospital or release into home care—that is considered to be acute. It is very rare, considering the 160,000 or 170,000 ACAT assessments we do in a year. For the year to date there have been 644 emergency approval applications.

Senator POLLEY: Over what time period?

Ms Buffinton: That is from 1 July to date—late May.

Senator POLLEY: I just want to be able to understand that: consumers who are frustrated and stressed, who do not know anything about where they are in the queue or when they are going to get their package—we have to wait until the end of June to find out?

Ms Buffinton: At the end of June we will have the data that we will release at the end of July. Remember, under the last scheme, when we assigned those packages to providers, the queue sat in front of providers. Nobody knew how long the queue was. Where we are heading is that we will have a national queue. It will be transparent. We are in the transition phase, and it is going to be far more transparent than the previous method.

Senator POLLEY: You would be aware that there are families who are desperate to get help for their loved ones. They are calling My Aged Care on a daily basis, to be told that there is no information available. I have people ringing my office, people now being admitted to hospital because there are no packages available to them. You are telling me that those people are better off now than they were in the past. Well, I do not think, when people are actually having to move in to care for their own elderly relatives, that they accept that. They do not accept that when I try to talk them through the process. And there are people who are waiting very long periods of time to get a package. Is the department aware of that?

And I want to table a document that was provided to me from a provider. They are concerned as well that people are actually dying. So, I will table this, for you to tell me whether or not the department is aware, and whether you can confirm that these are your figures, because people in Tasmania and people in South Australia and right around this country are waiting for up to 12 months for a package. That is why family members are moving in to care for them. That is why they are ending up in accident and emergency. What is the department's solution to this? We should wait and see what happens by the end of June?

Dr McCarthy: You have raised two separate issues. I think the first issue—

Senator POLLEY: I have very little time, so I have to.

Dr McCarthy: It is just that I think we need to distinguish between the fact that we do no know at the moment but we will know soon what those waiting times look like at a national level, and that is information that will not have been available before. That is absolutely an improvement in transparency. We also know that in any one year only a certain number of homecare packages are available and that some people, before the 27 February changes, will have had to wait longer than is ideal for their package to be assigned. It will still be the case, for example, that people will not get packages immediately on being found eligible. So, I am just distinguishing between the issue of the queue and the fact that we know that there is a very high demand for homecare packages. We have released, as Ms Buffinton indicated, an additional 7,635 new packages as at 26 May. And the total number of packages released since the 27 February changes is, as Ms Buffinton said, around 30,000. And new packages are being released all the time.

Senator POLLEY: Is this document I have here accurate? This is off My Aged Care. That is really very depressing for those who are waiting for packages.

Dr McCarthy: We do know about this particular document.

Senator POLLEY: So, it is not accurate?

Dr McCarthy: That is not accurate, and Ms Buffinton will explain why.

Senator POLLEY: So, for people who are ringing my office, it is not accurate that they are waiting for nine months, that a 92-year-old man in Tasmania was told that he would have to wait 18 months? And unfortunately he probably will not be here by then.

Ms Buffinton: There is no information out there. If somebody has been told 18 months, that is incorrect. There was—

Senator POLLEY: Are you calling the families liars?

Ms Buffinton: No.

Dr McCarthy: I think Ms Buffinton is pointing out that if the family was told that, there is no basis on which they should have been provided with that information, and Ms Buffinton can explain this particular document, which was test data that should not have gone up and which is not accurate, because it was test data.

Senator POLLEY: So, how are people informed ,when they are on the queue, as to how they are progressing?

Ms Buffinton: We have not released any information about waiting times. You are describing how many months they have been told they are waiting. What that wait time is has not been sourced from us. What you are referring to was a screen shot on the aged care provider and assessment portal. On Friday 5 May information on wait times for homecare packages was displayed. It is not correct data. The wait time information displayed was test data. This is preparing for the eventual release of data. So, this has no background. Immediately when the Department of Social Services, which runs the IT system, made us aware that this test data had been displayed, we immediately let the sector know that that was the case and that this information is incorrect.

CHAIR: Excellent. Thank you for that, Ms Buffinton. That clears it up.

Senator POLLEY: Well no, it does not, really.

CHAIR: We will now suspend for a brief private meeting to sort out timing for remaining programs in aged care.

Proceedings suspended from 20:05 to 20:10

CHAIR: We are back. The proposal we have agreed to is that for the remaining programs—the balance of 6.2 and program 6.3—we will work through those up until quarter to nine. If we can, with your indulgence, Secretary and officers, we will treat 6.4, the Australian Aged Care Quality Agency and the Australian Aged Care Complaints Commissioner as a group because the questions I alluded to before will cover the lot. So from 8.45 through to 9.30 we will deal with those matters. Then we will break at 9.30 and resume at 9.45 for sport and recreation. Senator Polley, would you like to continue?

Senator POLLEY: A range of clients were sent paperwork that included a unique referral code after 27 February suggesting they had been allocated a package when in fact they had only been added to the national queue. Can you confirm that this occurred?

Dr McCarthy: To clarify, you are asking whether someone had been informed that they had been allocated a package but had not?

Senator POLLEY: Yes. They had only been added to the queue. There was a unique referral code suggesting that they had been allocated a package when in fact they had not; they had just been put on the queue. Did this happen?

Ms Buffinton: I am aware that there has been a small number—well less than one per cent of letters—

Senator POLLEY: You are saying less than one per cent?

Ms Buffinton: Yes.

Senator POLLEY: What is that figure? Do you have the actual figure?

CHAIR: The raw number.

Ms Buffinton: I will have to take that on notice. A very small percentage of clients received home care letters with some incorrect information.

Senator POLLEY: How did this happen? What process was gone through to give people hope that they were going to get a package when they were not?

Ms Buffinton: Clearly, the fact that we made an error is not acceptable. We are dealing with a brand new system that was released for the first time and the high volume of letters we have been dealing with for people who have current ACATs and so forth. Through the home care process we have probably sent in excess of 300,000 letters.

Dr McCarthy: I think it is a transitional issue that we have addressed.

Senator POLLEY: When you send out such letters—you referred to some letters earlier today that people failed to read or did not understand—do you actually send out letters that have the information in other languages? I recall being at a centre recently where a couple in Melbourne had received four letters in three days, but they did not understand them because they only speak Greek, for instance.

Ms Buffinton: We have translated all our home care package information, as opposed to the letters. All the information is available in 18 different languages. We have been working with FECCA to make sure that advocacy groups that are working with people from different communities are aware of the fact that this information is available. As I mentioned earlier, in getting ready for home care and having worked through the letters with a number of consumer groups already as part of that, we sought to not write in complex language but we are open to the possibility that we can improve those letters, and that is what we are currently looking at.

Senator POLLEY: I want to refer to a recent NATSEM report on the economic cost of dementia in Australia, commissioned by Alzheimer's Australia. It suggests that a national dementia strategy could lead to savings of $5.7 billion from 2016 to 2025. Why will the government not commit to what the report is calling for?

Dr McCarthy: I think we have discussed this before and I have indicated that we are aware of Alzheimer's Australia's call for a strategy. We have referred to the national dementia framework, the work done by COAG. Strategies are a matter for government.

Senator POLLEY: Are you aware of the World Health Organization's new report, released today, about the global plan of action on dementia, which calls on all countries to have a dementia strategy? Are you aware of that report?

Ms Rule: I am aware of that report.

Senator POLLEY: What is the government's response to this international call for action on dementia? The draft principles have been in the public domain since late last year. Have you done any work for the government in preparation for developing a strategy on dementia?

Dr McCarthy: There is not a national strategy of the kind referred to by Alzheimer's Australia, but there is a range of government programs, both in the aged-care program and in other parts of Health, that are designed to provide support for people living with dementia. There is also significant research funding available.

Senator POLLEY: Yes, we are very aware of the research funding, which is great. We accept that and commend the government for taking that action. But there is no dementia strategy itself, and there is no framework. We know that the figures that we are going to be confronted with in this country are enormous, but you have done no modelling, no papers, no discussion around dementia, and yet there are so many other issues that the health department talk about, do research into and present government with option papers on. You are saying there has been nothing on a national strategy?

Dr McCarthy: I do not think that is an accurate picture of the work being done. I mentioned a National Framework for Action on Dementia, and funding is currently allocated to initiatives under all seven priority areas of that framework. Ms Rule can go into more detail about some of that funding and some of that work.

Senator POLLEY: Am I right in my assessment that the second leading cause of death in this country is dementia, and there were no funds allocated out of the 2017-18 budget?

Dr McCarthy: In the area of aged care, there was an extension of the Commonwealth Home Support Program funding, which supports a range of people, including people with dementia. There was no specific measure relating to dementia in the aged-care program.

Senator POLLEY: But there are people who live with early-onset dementia and people who live with dementia already at home, so there are a significant number of people that are living with dementia themselves, let alone their carers.

Dr McCarthy: You are right, of course; that is true, and there is government funding under a range of programs available to provide assistance to people living with dementia. If it would be helpful, we can talk about the funding that is available under a range of programs.

Senator POLLEY: We already know what is there. I guess I was saying—and I think you have actually answered this—that there is no national strategy for dementia that is being funded out of this budget at this time. I will move on, because we have limited time.

Mr Bowles: Just because there is no additional money in this budget does not mean there is nothing happening in this space. That seems to be the inference you are making. That is not true.

Senator POLLEY: There is no additional money for the second leading cause of death—

Mr Bowles: There is no additional money in about 150 of our programs.

Senator POLLEY: But there has been no additional money for the second leading cause of death in this country. That is astonishing when it comes—

CHAIR: That is a statement.

Mr Bowles: It is a statement.

Senator POLLEY: It is.

CHAIR: We should get to questions—

Senator POLLEY: Okay. But if you would let me continue with my questions—

CHAIR: given our limited time.

Senator POLLEY: Yes, that is what I was trying to do. Can you provide an update on the services that have been provided by the Severe Behaviour Response Teams and the Dementia Behaviour Management Advisory Service? I am hearing that there is some disquiet within the sector both from providers and from the workforce in how that is assisting people living with dementia in residential homes.

Ms Rule: From 1 October 2016 to 31 December 2016, the Dementia Behaviour Management Advisory Service received referrals for 2,520 cases. That comprised 948 requests for one-off support, information or advice and 1,572 short-term cases. For the Severe Behaviour Response Teams, from its commencement on 2 November 2015 until 31 December 2016 there were 497 cases. Those programs are demand-driven, so those are services that are provided to the sector. If services choose to contact those services, then the response will be provided. I have not heard disquiet from the sector on these programs, but I am happy to look at any particular cases you might have.

Dr McCarthy: Perhaps you could tell us the nature of the disquiet, Senator.

Senator POLLEY: In relation to whether or not these flying squads are actually working, what process has been put in place by the department to make a genuine assessment about whether or not they are effective?

Ms Rule: I can tell you that, for the Severe Behaviour Response Teams, from March 2016 to December 2016, 97 per cent of referrals have received a face-to-face assessment within 48 hours, where that has been requested by the service provider, and the remaining three per cent received an assessment within 90 hours, and 92 per cent of clients were satisfied with the Severe Behaviour Response Teams' service.

Senator POLLEY: Is any of this information that you are gathering going to go towards developing a framework to establish an overall dementia strategy?

Dr McCarthy: As I have said before, there is a National Framework for Action on Dementia and there is funding allocated against all seven areas. All of the information that we gain and everything that we learn from these programs helps increase our store of knowledge about dementia and helps providers and advocacy organisations and the government in the development of policy and program design.

Senator POLLEY: Have you prepared any work—

Senator Nash: Given your comments about the budget before as well, I think it is useful to note that, when it comes to dementia, we announced a $5½ billion extension of the funding arrangement for the Commonwealth Home Support Program over two years from 1 July 2018, which—

Senator POLLEY: Yes, we have got all that.

Senator Nash: I know, but it is important, Senator, because you are saying that we did not have funding in the budget. This covers people with dementia. I think it is really important not to discount the funding that is there in programs that also covers and helps people with dementia. Rather than trying to dismiss, as you are, that there was not any funding in the budget, I am saying that, of course, there was.

Senator POLLEY: Well, there was not any that—anyway, I am not going to argue with you. If we can move on. Can you—

Senator Nash: And nearly 10,000 new places under the latest ACAR round. Many of those cater specifically to dementia clients. I do not accept that nothing is being done, Senator, and you are incorrect in saying so.

Senator POLLEY: Can we move on now to—

CHAIR: To 6.3? Let's go for gold.

Dr McCarthy: Chair, Ms Rule does want to correct the record on one matter.

Ms Rule: Previously, I told Senator Macdonald that extra service status places would need to be relinquished and providers would need to reapply for new places. I have since received some additional advice to correct that. Services who have extra service status can relinquish that status through an administrative process, but they maintain those places. Apologies for that confusion.

Senator SIEWERT: That did not make sense.

Ms Rule: There is a thing under the Aged Care Act called extra service status, which can be attached to an aged-care place. Previously, I said that, to get rid of that extra service status, providers would have to relinquish that place and reapply for new places. That was incorrect. They can relinquish the extra service status but maintain that place.

Dr McCarthy: It just becomes a normal place.

Senator SIEWERT: Right. That is the qualifying bit I needed.

CHAIR: We shall now move to program 6.3.

[20:26]

Senator POLLEY: The 2016-17 ACAR results were announced last week. How were the places prioritised and how were the areas of unmet need determined? Was this allocated from 1 July 2016? Has the delay simply been a cost saving measure?

Ms Rule: No. When the places are allocated, there is usually a time lag for those places to become active places. For example, people who receive places in this last ACAR—they might actually be for services that do not even exist yet. Those services have to be built and beds made available. That can take a number of years. The funding only flows when a provider brings that place online—when there is actually a person in that bed.

Senator POLLEY: How do you prioritise the areas?

Ms Rule: There is a range of modelling that goes into how we determine places. We use statistical analysis at a regional level, called statistical area level 3. That is the level at which the Australian Bureau of Statistics reports census data. It allows us to break the country up into regions. We look at the regions in those statistical areas and we look at the number of places that are available versus their population profile of a certain age and what that is going to look like over the next few years. We have the aged-care planning ratio that dictates how many places should be available per person in a particular region. We use all of that data to come up with models about where our highest areas of need are.

Senator POLLEY: Are any of the 475 new short-term restorative care places announced in February operational yet?

Ms Rule: Yes, they are.

Senator POLLEY: Do you want to table those?

Ms Rule: I do not have them in a form that is suitable to table, but I can tell you that around 39 services have advised us that they now have those places operational.

Senator POLLEY: Where are they?

Ms Rule: I would have to take that on notice. I do not have a list of the 39.

Senator POLLEY: You would not be able to tell us now what states and whereabouts? You can take that on notice.

Ms Rule: I can take that on notice.

Senator POLLEY: How many of the residential aged care places allocated in the previous ACAR rounds remain nonoperational?

Ms Rule: I would have to take that on notice. I do not have it, as it relates to the last aged-care approvals round.

Senator POLLEY: Am I correct that a number of residential places were committed as part of the 2016-17 ACAR for specialist dementia care units?

Ms Rule: No, that is not quite right. The specialist dementia care units, as you know, were announced in 2016. Those specialist dementia care units are not operational yet. We are currently working through with a range of stakeholders, including clinical experts, service providers and Alzheimer's Australia—a range of stakeholders—to develop the model for specialist dementia care units to make sure that we have all of the policy settings right. Once we have that, then we will move to use places out of a future Aged Care Approvals Round to establish those specialist dementia care units.

Senator POLLEY: From where are you resourcing your research as to the best models?

Ms Rule: Do you mean how are we paying for it?

Senator POLLEY: No. What are you basing the best models on? Are you looking overseas as well as at providers here?

Ms Rule: Yes, absolutely. One of the key people we are working with is Henry Brodaty, who has done a lot of work about the different levels of dementia and severity of dementia and what the right clinical models are to provide care to the people who are in the most severe categories of dementia.

Senator POLLEY: Can you remind me, on what basis are those units going to be allocated? Are they going to be trialled in certain electorates or in certain states?

Ms Rule: The government announcement was that there would be one in each of the Primary Health Network regions.

Senator POLLEY: How many of the 31 Primary Health Networks have received places, and, on average, how many were approved in each PHN?

Ms Rule: As I said earlier, the specialist dementia care units are not yet operational.

Senator POLLEY: There has been no work done?

Dr McCarthy: We are working to get the model right first.

Senator POLLEY: Is any additional funding provided to providers who receive specialist dementia care places?

Ms Rule: Those places are not yet operational, so there is no funding provided to people to deliver those services yet.

Senator POLLEY: Do you envisage that there is going to be additional funding needed?

Ms Rule: Yes.

Senator POLLEY: Have you done some modelling around that, because that is still—

Ms Rule: We need to determine what the model is, and then we can cost that.

Senator POLLEY: Where do you perceive the additional funding will come from?

Ms Rule: The money will be redirected from the Aged Care Approvals Round. They will be mainstream places, if you like, that will be converted to cover the costs of the specialist dementia care units.

Senator POLLEY: How do you see these special dementia units being different from normal residential care places?

Ms Rule: The intent is that they are a more intensive level of service for people who are suffering from severe dementia or more severe dementia—at the higher levels of the Brodaty model of dementia. How would that look in a clinical sense? We are not sure yet. As I said, we are working with relevant experts to determine that, and to make sure that we are aligned with, for example, best clinical practice, what happens in the acute care setting and not duplicating work that happens in states and territories. There are a whole range of considerations and, as you would appreciate, it is really important that we get this right before we start doing it.

Senator POLLEY: Am I right that—just to make to make it very clear—none of the $7.5 million has been allocated? None of it has been used as yet.

Ms Rule: Not yet.

Dr McCarthy: That is right.

Senator POLLEY: Can we move on then to ACFI. We have all heard a lot about the Wollongong report. Does the government support the findings of the recommendations of the University of Wollongong report into ACFI?

Dr McCarthy: The government has not made any decisions. We are currently consulting widely within the sector on the report to enable us to prepare advice for government.

Senator POLLEY: Do you support the findings that ACFI is no longer fit for purpose?

Dr Hartland: I think our evidence to you over the last estimates is that the tool, as currently constructed, needs some fairly fundamental reform.

Senator POLLEY: Will the department commit to undertaking a cost of care study as recommended by the report?

Dr Hartland: It depends on what you mean by 'cost of care study'. The university recommended a resource utilisation and classification study, which was to look at the comparative cost of care. You are probably briefed by stakeholders about cost of care studies. They would, I think, have in mind something slightly different, which would be a ground-up study where you would take the cost of providing care to every individual and aggregate it up. The recommended study by the University of Wollongong is comparative costs of different groups. It is not a ground-up study.

Senator POLLEY: Do you have a time frame for when the government will actually respond to the report?

Dr McCarthy: No.

Dr Hartland: There is a considerable amount of work to be done in considering the report. I think the time frame we can give you is really that the first phase of this work is go to the sector and have some fairly detailed conversations with them. We will do that over June and July. The time frame I can give you now is that, by the end of July, we will be able to feed back to the government what the sector's views are on the recommendations of the University of Wollongong report.

Senator POLLEY: Do you agree with the statement by the author of the University of Wollongong report that residents are older and frailer when entering residential aged care and that the average age at entry has also increased since ACFI was developed?

Dr Hartland: Yes, we do.

Senator POLLEY: Do you admit that, in context, aged-care providers will increasingly be assessing residents at the highest level of ACFI funding in the future?

Dr Hartland: As we have said to you before, Senator, it is clear that residents have drifted to the upper levels of ACFI. I remember us having some conversations over a number of estimates about the rate of frailty growth. To save time and anticipate a question that you might have, I do not think saying that there has been a long-term increase in frailty in residential aged care since ACFI has been introduced undermines the department's position which we put to you previously, which was that in 2015 a sudden spike in frailty could not be accounted for as a genuine increase.

Dr McCarthy: As I think we have mentioned before, the forward estimates allow for an increase in frailty each year as, over a period of time, the residents entering aged care enter at an older age.

Senator POLLEY: Do you have any current thinking around Richard Rosewarne of Applied Aged Care Solutions, who is looking at ways to reform the current ACFI model and also looking at external assessments?

Dr McCarthy: We are waiting for the report.

Dr Hartland: Yes. We have commissioned Richard to undertake a study of ACFI. As Dr McCarthy just said, that report is not complete. We are waiting for it to be looked at. I said before—sorry, I did not say this quite as clearly as I should have—that, if the government were going to proceed with the University of Wollongong report, that would be a considerable amount of work and would take some time. We have also said that we think the ACFI as it currently stands needs some work. So, in effect, the aged-care solutions work is to look at shorter- to medium-term fixes to ACFI that would prevent what we saw in 2015 occurring again, because it would be extremely undesirable to have another spike in growth rates.

Senator POLLEY: You said you do not currently have the report that you have commissioned. What is the time line for that report being presented to the government?

Dr Hartland: It is due in late June, to the department.

Senator POLLEY: To the department. Will that document then be released publicly?

Dr Hartland: Possibly. We have not considered in what form we would communicate the results of that finding. It might be the release of a document. It might be some other method.

Senator POLLEY: Do we have a time frame for when the government will respond to his report?

Dr Hartland: The government will consider the report soon after June. We will brief ministers on it soon after June. Whether the government makes a formal response, and what form that response takes, would be a matter for the government at that time.

Senator POLLEY: Thank you. Can you provide an update on the most recent ACFI figures. What is the current rate of normal growth of the ACFI spending?

Dr Hartland: Yes, we can.

Senator POLLEY: Thank you.

Dr Hartland: Mr Murray can give you some more details, but I think the headline is that, overall, aged care expenditure in 2016 is tracking broadly in line with what we estimated in the last MYEFO in that budget.

Mr Murray: The department publishes regular monthly reports on its website of how ACFI is tracking. The last published report was the December report, and the January report would not be too far away. That can be seen on the website, and that shows that growth is tracking pretty much broadly in line with the estimates.

Senator POLLEY: Is the growth of ACFI consistent between metropolitan and regional and remote providers?

Mr Murray: If I can refer you to the information that is available on the department's website in these monthly monitoring reports, there is a table in those reports—table 2—that does break down into major cities, inner regional, outer regional, remote and very remote. The growth rates do change. As you would probably expect, there are less people in the remote areas and, hence, they are little bit more volatile. In terms of the recent period report of up to December, the actual growth rate for remote Australia was higher, at 9.9 per cent. In the other areas, it was between three to four per cent between the major cities and the inner and outer regional areas.

Senator POLLEY: I will put the rest of my questions on this line on notice to save some time.

CHAIR: Excellent; that is a delight to my ears!

Senator POLLEY: Always trying to please!

CHAIR: I know that, Senator Polley, and I am grateful for that.

[20:41]

CHAIR: As discussed before, we will now move to the job lot, program 6.4, with the agency and the commissioner. On the basis of what we discussed at our private meeting, Senator Polley will kick off, and then we will go to Senator Griff.

Dr McCarthy: Apologies, Chair; we were not paying enough attention!

CHAIR: It is late! We are now moving out of 6.3 to that job lot which is program 6.4, and the agency and the commissioner.

Senator POLLEY: I will kick off, and, hopefully, people will be at the table. Minister Wyatt announced on 11 May that Ms Kate Carnell and Professor Ron Paterson would undertake an independent review of the Commonwealth aged care quality regulatory processes. What impact do you expect the review of the national aged care quality regulatory processes will have on the expected 1 July 2018 start of the single set of aged care standards for all aged care services?

Dr McCarthy: As you know, we conducted some public consultation on that single set of standards. We would certainly not be looking to finalise our work on the single quality framework until the review has reported. We would expect the findings of the review to inform the single quality framework.

Senator POLLEY: Given the significant failings of the current accreditation process, do you not think the development of a single set of standards should be halted and a new approach developed in response to the findings of the independent report?

Dr McCarthy: As I have indicated, we would not be looking to finalise that work until the review has reported.

Senator POLLEY: What resources have been provided to the independent review—staff, secretarial support, money?

Dr Hartland: We currently have a small team of three people that provide secretarial and other assistance to the review. They will soon be taking on another person to help them organise the consultations. As we go through the work of the review, if the reviewers want additional resources, other areas of the division that look after compliance are expert on how we conduct compliance, and those resources or work would be done for them.

Senator POLLEY: If we go to the compliance process, how many type 4 referral review audits did the department request in 2016 compared to 2015 and 2014?

Dr Hartland: These are references from us to the agency? Is that what you are looking for?

Senator POLLEY: Yes.

Dr Hartland: We do not request them.

Dr McCarthy: Is it possible you are referring to referrals from the complaints commissioner to the quality agency?

Mr Ryan: I think it is important to note that the Aged Care Complaints Commissioner and I, and the department and I, have MOUs. Under those memoranda we have a frequent exchange of data, and you are quite correct that there is a MOU with the complaints commissioner, and that has been in existence since early last year. We have revised that down to three levels of referral at which the complaints commissioner could refer a matter for the quality agency's attention: level 1, which is for case management information; level 2, for next time we would be on site in that facility; and level 3, which would indicate an urgent need to visit that home. I should also state that, under the Aged Care Act, the Secretary of the Department of Health or his delegate has the power to direct the quality agency to undertake a review audit. A review audit is not a regular reaccreditation audit, but it is a full audit against all four standards and 44 outcomes, and that would be undertaken as a matter of urgency.

Dr Hartland: I do not have in front of me the breakdown of our referrals to the quality agency about those types. Mr Ryan might be able to get that for you. But, in terms of the gross numbers, in 2015-16 we made 737 referrals. As at 31 March, we have made 333 referrals in 2016-17.

Mr Ryan: If I may, in specific answer to your question, in 2013-14 there were four level 4 referrals, which would be the equivalent of a level 3 under the new scheme. In 2014-15, there were three level 4 referrals, and there were none last year. Type 3 referrals, which were close to that, were 53 in 2013-14, 73 in 2014-15, and 27 in 2015-16.

Senator POLLEY: How many facilities are currently not meeting their accreditation standards? Can anyone provide the committee with a list of these?

Dr Hartland: As of 25 May, we had sanctions applied to eight facilities and we had notices of noncompliance in relation to 53. That is the tip of the kind of compliance iceberg for facilities not meeting the standards. There would be facilities that the agency has identified that we have not yet moved to make compliance action in relation to.

Senator POLLEY: Can you identify, with those ones you just referred to, the standards which they are not meeting?

Dr Hartland: Yes, we know that. I am not sure—of course we know that.

Dr McCarthy: When we issue the sanction or when we issue a notice of noncompliance, yes, we know which standard or standards are not being met.

Senator POLLEY: Can we know that? Can we have that tabled, or a copy of that?

Dr McCarthy: We do not have that in tabular form. That information would be information relating to each of the providers. We would probably need to take on notice giving you that information.

Senator POLLEY: That is fine.

Dr Hartland: We will take it on notice. They are a mixture. There are quality standards and there are prudential standards. My anticipation is that our answer will show that there are more quality matters than prudential.

Mr Ryan: I do have specific data to that effect. The most frequent not-met outcome or breach of an outcome in year to date—are you happy with year to date?

Senator POLLEY: Yes.

Mr Ryan: Until April of this year, it was outcome 1.6, human resource management. That is followed by 2.4, clinical care. There were 18 failures against 1.6; there were 15 failures against clinical care, 2.4; and there were 13 failures under medication management. That is out of 2,670 residential aged-care facilities within Australia, just to give you what the proportions are.

Senator POLLEY: Can you detail how many facilities have had sanctions imposed over the past five years, and what sorts of sanctions were imposed?

Dr Hartland: I can give you some totals by year.

Senator POLLEY: Thank you.

Dr Hartland: In 2014-15 there were two sanctions; in 2015-16 there were six; and, as I said, year to date 2016-17, until around the end of May, there were eight.

Dr McCarthy: Senator, you asked about what type of sanctions. It varies, but, in relation to issues around quality of care, it will usually be a requirement, for example, that the provider, at their own expense, employs an external nurse adviser to assist them in bringing the service back into compliance. There may also be requirements around, for example, training, and another type of sanction that could be issued is that, until the service comes back into compliance, they cannot accept any more Commonwealth funded clients.

Mr Ryan: And we frequently monitor compliance in a home under sanctions, and we need to assure ourselves and assure the secretary or his delegate that they return to compliance at the end of that period. Normally, where sanctions are applied, accreditation would be reduced to a significantly shorter period, typically six months. So, as well as serving out the compliance, they do need to assure the quality agency, myself or my delegate that they return to compliance.

Dr Hartland: Senator, the other aspect of your question—we are bubbling over with information on sanctions—is that, apart from two, they were all in the quality area.

Senator POLLEY: What is the time between a provider failing to respond to noncompliance and them being issued with a sanction?

Dr Hartland: It can vary. The act sets out a number of processes by which we might arrive at a sanction. The time can be very short. In relation to some recent failures, we have moved immediately to sanction as soon as the quality agency has done a review audit, and that occurs when we judge that there is immediate and severe risk in the service. That can be overnight. The agency can provide us with information coming out of their audits and, if we think that there is an immediate severe risk to consumers, we will turn that around on the spot. If the type of noncompliance does not meet the criteria of immediate severe risk, then the act requires us to go through a process whereby we issue a notice of noncompliance, we give the provider a chance to make a submission in relation to that, and then, depending on the nature of that submission, we can give them a notice of an intention to impose sanctions and, depending on their response to that, we will impose sanctions. Those administrative paths, by the nature of the act, can take some time. There are also other remedies that do not involve sanctions but which involve a formal compliance action, where we ask them to undertake to us to correct the lack of compliance.

Dr McCarthy: And some of that time taken can be in relation to a timetable that the quality agency may have set for the provider to come back into compliance.

Dr Hartland: That is correct.

Senator POLLEY: Are residents and their families immediately advised that there has been noncompliance or a sanction imposed?

Dr McCarthy: Residents and families are advised very soon after, yes.

Senator POLLEY: Was the agency ever refused permission to conduct an unannounced visit during the period of accreditation of the Oakden facility?

Mr Ryan: By means of background, Oakden is a mental health facility that comprises three wings. The Clements wing is not a residential aged-care facility and we cannot particularly comment on what occurs in that wing. The Makk and McLeay wings are residential aged-care facilities. I would have to take on notice whether there was a specific refusal of access. Normally, providers, where we conduct an unannounced visit, do understand that we have a regulatory basis to be there and they cooperate with the visit. I might take that on notice specifically.

Senator POLLEY: Okay.

Dr Hartland: I would say that we should double-check because Oakden is a matter of public interest, and rightfully so. The documents we have looked at so far—we have provided extensive documents to the Senate so we have looked at the documentation around Oakden—do not show that they have refused entry to the agency. But we will double-check because obviously if that has occurred we would want to be certain in our answer.

Mr Ryan: Likewise, in terms of our full review—you can imagine we have been exhaustive—we are not aware but, if you have additional information, we would be happy to follow up on that.

Senator POLLEY: I am just putting it out there—crossing our t's and dotting our i's.

Dr Hartland: We will check.

Mr Ryan: We will take it on notice.

Dr Hartland: We have not seen that issue yet, but we will double-check.

Senator POLLEY: I understand you have undertaken an internal review of how your agency could have found the accredited services at Oakden compliant. Can you detail, based on your assessment so far, why your regulatory process has failed?

Mr Ryan: Let me say that what occurred at Oakden were a range of failures by a range of different parties. We are very, very disappointed, and we certainly consider that what occurred at Oakden was a terrible outcome for the residents and their families. After visiting the facility on 27 April, I absolutely took it upon myself to seek external advice from an external agency to undertake a review of how in February 2016, and, in fact, for three

previous cycles of accreditation, we could have found the facility compliant. I should add that in February and March of this year, we undertook a review audit. We found 15 out of 44 outcomes not met. We called serious risk at that time, sanctions were applied by the department and their accreditation was reduced to six months, which is normally the shortest period of accreditation. I should add that that was prior to Dr Groves and his colleagues releasing their report. Nevertheless, if there are learnings and lessons to be learnt from Oakden, I am determined to find out what they are and to remedy those at the earliest possible time. I have engaged an external organisation to conduct an external assessment of what occurred. They will report to me by the end of June, and I will make the findings of that public.

Senator GRIFF: Mr Ryan, if we can stay where Senator Polley was, as you said, they had passed fabulously in the previous year when they got a 100 per cent score. How can that happen? Is that a case of the facility saying one thing to assessors and not thoroughly looking at it? Or is it a failure with the accreditation system? There must be something that you can attribute it to. And on that, and before you answer the question, I find it interesting that the 2016 audit was over two days involving 26 interviews and the 2017 was over six days with 43 interviews. Why the difference between the two?

Dr McCarthy: Mr Ryan will answer your question about the audit methodology. Obviously, it is very concerning that the Commonwealth regulatory processes did not, until March this year, adequately identify the extent of the failings.

It is deeply concerning, and that is why the minister has commissioned an independent review to find out why all of the regulatory processes, the accreditation process, the processes that the department undertakes for example, did not adequately identify those failings. Mr Ryan, as he has indicated, has also procured some external expertise to look at his specific organisation.

Mr Ryan: Certainly I do not have a simple or an early answer on that. You have canvassed a range of options. One of the options is that the facility itself were good at perhaps providing information that met certain criteria. Our job is to go beyond looking for that type of information. Fundamentally when we undertake any re-accreditation audit, the first place that we start is that we interview between 10 and 15 per cent of the residents and all their family members. We want to understand what the lived experience of those residents in the home is like. It is that particular information that guides and, if you like, emphasises areas that our assessors, now called 'surveyors,' undertake when they look at the home system, when they interview the staff and so forth. I do note that Dr Groves, on 24 April this year when he was interviewed on Adelaide radio, said that he visited the home in June of last year and found nothing wrong with the home. He was there for two and a half hours. Nevertheless that is a matter for Dr Groves.

Senator GRIFF: Yet there have been issues since 2001 that have been reported.

Mr Ryan: Correct, and you would see because all of the accreditation history has been tabled in the Senate, that there was significant intervention in 2006, 2007, 2008, 2009 and 2010. From that period onwards there were three periods of three years accreditation. There were unannounced visits, which is normal with every residential aged care facility. But, fundamentally, there were things happening in that home that certainly—and I am particularly interested in February 2016, but we have to understand that in terms of its history. I want to understand what it is about that home and what it is about the case management, because every home has a case management model. What didn't we pick up? Was it the surveyors on the site? Was it the decision-making process? Was it the exchange of information amongst the three entities in the regulatory process? I am determined to find out what has happened and to rectify that.

Senator GRIFF: When do you see that you will have that internal review completed?

Mr Ryan: That external advice is due to me by the end of June and I would expect to release it in early July.

Senator GRIFF: Is this a case of positive bias in the accreditation process. A bit like the GFC with banks, that they are too big to fail?

Dr McCarthy: As we know, there is a review that Mr Ryan has commissioned and the minister has commissioned an independent review of the entire regulatory process to determine—

Senator POLLEY: There is a Senate inquiry now too.

Dr McCarthy: I think it is important to await the outcomes of the review. There could be a range of reasons, and both of the reviews are going to be looking very carefully to find out what went wrong.

Senator GRIFF: Going back to the unannounced visits, why are any of the visits announced?

Mr Ryan: That is a good question. The nature of our accreditation process is that we are responsible for assessing and monitoring the quality of aged care in Australia. Our responsibility is to hold providers to account

in their activity against a set of standards. As mentioned, one of the fundamental parts of that is to anchor that in interviewing 10 to 15 per cent of the resident mix. In order to do so we do need to provide advice that we are coming. It is an opportunity for the home to ensure that they can provide the most comprehensive information in order for us to make decisions. That is counterbalanced, as mentioned, with a case management and risk assessment model against every residential aged care facility in Australia.

We do share information with the Australian Aged Care Complaints Commissioner and with the Department of Health. We take on board the accreditation history of every home. Perhaps a home might be part of a group of homes; we take that on board. We also then schedule unannounced visits, not randomly but based on active case intelligence. The unannounced visits are a minimum of one per year, but homes that have had a history of accreditation problems will normally receive many more than one, or certainly more than one.

Senator GRIFF: In that case, what triggers more than one visit?

Mr Ryan: If we were to go in and find a failure against the standards, we would put a home on a timetable for improvement. A timetable for improvement normally means that we first advise the provider that there is failure and we are quite specific about where the failure is. We then actively monitor the home on a very regular and frequent basis and we provide industry education. We have a significant industry education process. In the last 12 months, we have provided 366 education sessions to assist homes to comply with the standards. I will talk you through a bit more of the process. If we think that there is regulatory failure and what we call 'serious risk'—that is, a statutory finding under section 2.62 of our principles—at that point, even before completing our accreditation process, my delegates would advise the secretary and/or his delegates. In those instances, sometimes the department will apply sanctions immediately, before we have completed our accreditation process. Where we find failure that does not place residents in serious risk, they are on a timetable for improvement and there is regular monitoring and compliance and the provision of education. Where sanctions are applied, as Dr Hartland and Dr McCarthy have advised, there is significant activity for the home, but that does not excuse them from what we will do in terms of regular compliance visits and well as providing education.

Dr Hartland: We know that, through these activities, we do find homes that are not meeting the accreditation standards. As we have talked about before when we discussed sanctions and the department's regulatory process, we can also tell you when we kick into gear to require providers, through their levies under the act, to address that failure. But I do not want you to have the impression that the department or the agency have a view that this process ought not to be looked at. It is clear that there was a failure in Oakden and the dimensions of the failure are set out very clearly in the terms of reference that the minister asked the review to look at, which is why we did not spot earlier what appears to be, from the Groves report, systemic lack of quality of care and basic human dignity afforded to the recipients of aged care. We are all determined to work with the review to find out why we did not spot this earlier.

Senator GRIFF: Are there any resourcing or staffing issues in your department? Do you need more resources or more staff for the auditing process?

Mr Ryan: I can speak for the quality agency. I have the resources that I need to undertake my functions under our model at present. We conducted 4,251 visits last year, and that included 2,866 unannounced visits. I believe that we have the resources, and there will be multiple ways to look at this—we just need to ensure that we are focusing on a particular risk area. Oakden is an unusual facility; it is not a mainstream residential aged-care facility, but clearly we did not find what we ought to have found there and we are determined to uncover that and to implement changes as required.

Senator GRIFF: I imagine you would have seen this report published in the Medical Journal of Australia yesterday highlighting how nursing home deaths due to falls and other injuries have increased fourfold over a decade. Have you observed a rise in falls, choking and other instances in the data that you collect?

Dr Hartland: We are obviously aware of the Professor Ibrahim study. I think it is great that there is such a thorough study being done of this. We will want to use the study to look at whether, as the professor suggests, there are things that we can do to reduce harm. I think the only thing that we would say about the study to put it in context—and if you look closely at the study you will see this—is that the external cause of death falls, about 3,000 over the entire period, are a sizeable percentage of the cases that go to the coroner, but of course, not all deaths in aged care get referred to the coroner. Over the same period, if you look at box 1, it reports that there are around 600,000 deaths in aged care. So this is a concerning study that there appears to be—sorry, I should not say appears to be, because I did not want to by description diminish the report—there has been an increase in the rate of external-cause deaths, but they are a very small proportion of all the deaths in aged care, and whether or not this increase in the rate means that standards of care are dropping is also something that is not clear to us at this point.

Senator GRIFF: Do you formally collect this type of data in your audits?

Dr Hartland: No, we do not.

Mr Ryan: We do not collect causes of death; there is a requirement under the Aged Care Act—

Senator GRIFF: Falls, though, for instance, falls leading to deaths. Do you actually collect that information?

Mr Ryan: We do not collect that information specifically, but of the 44 outcomes, expected outcome 2.14 regards mobility, dexterity and rehabilitation, and one of the questions that our surveyors going into a home look at is if there are fall risk assessments. Can the home show that they actively undertake assessment, planning, review, and any lessons learnt from patterns of falls? We are particularly interested where a resident might be medicated, or there might be confusion, delirium, anxiety and so forth.

Senator GRIFF: How do you verify that?

Mr Ryan: The accreditation scheme says to a home, 'Show me evidence that you plan for this particular part of care; show me the case evidence, show me your case plans and your case records of where there are falls; show me how you check that there is not delirium, medication, ataxia, or other medical conditions that contribute to that; show me how you review where they occur that you might change the physical environment of a home, call in an occupational therapist and so forth.' So as well as us checking, it is beholden upon the provider to show evidence of functioning systems around this home—not just hopes and wishes, but functioning systems. If I could also add that Professor Ibrahim is also well known for what he calls the dignity of risk, and the dignity of choice. So one of the things that Professor Ibrahim has shared with the aged care community is that, as people grow older, they should be afforded active choices. There is a balance between the care responsibilities of a home and the rights of every older Australian to make decisions, whether they live at home or in a residential aged care facility, around how they want to live.

Senator GRIFF: That is fine, Mr Ryan, but we have heard evidence from—in fact, even just today, with family members that had other family members in Oakden, where falls were rarely recorded at all. And a lot of other issues were never recorded either. So I am just wondering how you actually verify the information is correct, because—

Ms Lamb: One of the things we collect is issues that arise in complaints. So we do get some data in terms of what we see, in terms of the number of times that people come to us with complaints about falls, about why they have occurred, how they have been managed afterwards. We do not look at cause of death. Of course, that is a matter for the coroner and the police, and for doctors. But we do look at instances of falls where people bring their concerns to us.

Senator GRIFF: It almost appears that you have your standards, the accreditation standards, and manuals, plans, and it is that kind of thing you seem to be interested in seeing, more than actually hard, cold numbers. And in that particular instance, you are not really seeing if there is a true problem happening in this particular facility. You seem to be interested in seeing if they have the right kind of manuals and the right sort of processes but you are not getting the hard stats. How do you really know if there is a problem?

Mr Ryan: There will be between 55,000 and 60,000 interviews in the coming financial year. That is where those interviews enable us to start with the lived experience of residents in the home and their family representatives.

Dr Hartland: Locating this issue of falls in Oakden obviously brings home again that, whatever it is that happened in Oakden, we were not across it enough, and we need to look at our processes to see: is there something that we can reasonably do that means that we will identify these cases where a provider is systemically unable to provide decent quality care to consumers? We would not want to get too far into speculating about precisely what the solution is or what we failed to miss, in advance of the review looking at this properly, because I do not want to constrain the reviewers or be too optimistic that there is a simple solution here.

Dr McCarthy: And I think that, in Professor Ibrahim's article—which is a very important article and, indeed, was, in part, funded by a grant from the aged care program—he draws attention to, as you have indicated, a rise in premature deaths, and one premature death is one too many. He also draws attention to the importance of seeking to manage effectively high-prevalence risks, and you have noted the one that is probably of most concern, which is falls. I know the external review being conducted by Ms Carnell and Professor Paterson will be very interested in Professor Ibrahim's article, and indeed the sector more generally, as to how to better manage these risks while still enabling consumers to exercise choice and control.

Senator GRIFF: Are the results of this review going to be published?

Dr McCarthy: The review will be made to the minister and that will be a matter for the minister.

Senator GRIFF: And that will be by the end of June?

Mr Ryan: Sorry, a correction: the independent advice that I have commissioned will be available by the end of June; I believe that Ms Carnell and Professor Paterson's independent review is due to report by the end of August.

Senator GRIFF: Will your advice be tabled?

Mr Ryan: I have answered that; yes.

Senator GRIFF: How long, on average, does it actually take to assess a facility for its reaccreditation?

Mr Ryan: Typically, it would take two to three days. That would depend on the layout of the facility and the number of residents.

Senator GRIFF: Why do we have that variance that I mentioned earlier on, in relation to 2016 being two days and 26 interviews and 2017 being six days and 43?

Mr Ryan: We found 15 out of 44 outcomes not met. Where we have a review audit, this is an audit that we will undertake because we have found areas of significant concern. Where we have found areas of significant concern, we will look at each and all of those at great length, and that is why it normally takes longer. To find 15 out of 44 outcomes not met—it is not surprising that that would take five to six days.

Dr McCarthy: In summary, there are different kinds of reviews and audits that the quality agency undertakes.

Senator GRIFF: What happens in circumstances where a state government might launch an inquiry or take some other form of action? Do you cooperate with each other?

Mr Ryan: There are clear protocols around the exchange of information around, for example, gastroenteritis and similar outbreaks. The quality agency was not advised by the South Australian government or the North Adelaide health network of what became known as the Groves or Oakden report. We were aware that there was a review going on. We did not participate in that review. It is not unusual for a home to say, 'We're currently reviewing this approach or that approach.' We certainly had no idea of the extent of the review or the degree of—there were things uncovered by Dr Groves and his colleagues that we did not find in six days. As Dr Groves has said, two psychiatrists, a senior researcher and a senior psychiatric nurse were in there every week for 12 weeks to uncover what they uncovered. Their report fully corroborates what we had found the previous month but finds even more things than we found.

Dr McCarthy: The involvement of the state government would depend in part on whether the approved provider is a government provider and, in this case, the approved provider, the operator, of this facility is a South Australian government provider, but most of the residential aged-care facilities in Australia are not owned by a state government. But in this case of course, with the Makk and McLeay wards at Oakden, it is a relevant consideration.

Senator GRIFF: Mr Ryan, would you agree with the Groves finding 2, which says:

The Review finds that the Oakden facility is more like a mental institution from the middle of the last century than a modern Older Person's Mental Health Facility.

Dr Hartland: We are aware of the Groves report. One of the things that is unique about the Oakden report is that it is a mental health institution as much as an aged-care facility. I do not want to be in a position of trying to explain away the problems at Oakden to you, Senator. It is clearly a context that makes Oakden different to many other aged-care facilities and it does not make it easier for regulators to go into a facility with such a different profile of needs, but, nonetheless, we would say the types of failures identified in the Groves report are the types of things we should have been alert to and, indeed, when we went in, in the same context, we found similar problems. We have a similar compliance action.

Senator GRIFF: I appreciate that. We all have to move forward on this. In 2016, you collected care, recipient and staff surveys, I understand. Who conducted these surveys?

Mr Ryan: I do not know specifically. Are you reading from one of our reports? When you say 'surveys', do you mean interviews?

Senator GRIFF: It is stated as 'care, recipient and staff surveys'.

Dr McCarthy: If that is one of the documents from the return to order, we have the return to order documents in another room and indexed. Would you find it helpful if we had those in front of us and I could speak from the documents?

Senator GRIFF: No. On notice, what I would like to do is be able to receive copies of those, if I could.

Mr Ryan: We believe that, other than the interviews that we have undertaken, the provider undertook its own surveys. We may well have cited them. We will take it on notice and we will provide whatever information. We have already tabled that information in the Senate according to the order, but I am happy to check and validate that.

Senator GRIFF: That would be great. How do you actually assess the suitability of aged-care home staffing? Do you look at qualification levels and numbers? Do you look at things like criminal convictions or any other issues? How do you evaluate that?

Mr Ryan: One of the outcomes under the accreditation standards is outcome 1.6, which is to do with human resource management. Certainly, the law is very clear that every worker in a residential aged-care facility needs a police suitability checks. We do two things: we ensure that their policy is appropriate and correct; we ensure that they are able to demonstrate that policy generally and then we will check it staff member by staff member. Sometimes we will check it against each and every staff member and sometimes we will sample that. Then what we need to do is understand how they account for and plan for the particular needs of their resident mix. If their residents include a high number of residents with, say, dementia, we will look for specific staffing strategies that meet that need. We do not have a one-size-fits-all approach; we need to see active case management and active case planning relative to the care needs of the residents, and we need to ensure their recruitment through a police check. We need to understand how they supervise, how they assess, how they train, how they continuously improve and provide feedback. Crucially, where there are negative events in the home, were they are able to identify them and take appropriate corrective action? Those are some of the things we would look for. We also asked the question doing the 55,000-plus interviews: do you receive care when you need it? Do you receive the appropriate care when you need it?

Senator GRIFF: And that is going to families as well?

Mr Ryan: Correct. In fact I am pleased to advise that we have now standardised, using research from La Trobe University, a set of 10 questions we will conduct in all of those interviews, as well as two open ended questions. We will publish in each and every assessment contact, reaccreditation report and review audit what the 10 to 15 per cent of the residents and their families have to say about the quality of care and services. That will become public information about what residents and their families have to say.

Senator GRIFF: When is that going to be?

Mr Ryan: We commenced collecting that information this month and will start publishing that early in the new financial year.

Senator GRIFF: That is going to appear on your website.

Mr Ryan: It will. Just to correct, it is only reaccreditation audits and review audits that will publish that information at present, but we will look for options going forward.

Senator GRIFF: Can you provide, again on notice, in more detail the facilities nationally that are being reaccredited for a full term and have subsequently been sanctioned over the past 10 years?

Mr Ryan: We would take that on notice, if it is 10 years.

Dr Hartland: I think almost by definition every service that we have sanctioned would have been reaccredited some time over the last 10 years, because otherwise they would not be in the system. I am not sure what this is going to actually show you, but we will take it on notice and see.

Senator GRIFF: Is a national reporting system in place where anyone can go to report a problem at a facility?

Mr Ryan: Yes.

Dr McCarthy: Ms Lamb runs an independent complaints scheme, and anyone can make a complaint.

Senator GRIFF: Few people would know about that.

Dr McCarthy: Ms Lamb has been doing a lot of work to publicise the service.

Ms Lamb: We have been in existence—I have been in charge of it since 1 January last year. We have seen a 20 per cent increase in complaints in our first year. The complaints are going up by about 2.5 per cent a quarter. One of the great things about being an independent commissioner is I have a lot more freedom than the department did to try to raise my profile. You hopefully have been seeing a lot more media, a lot more mainstream stuff. I have a proactive education function. We are working really hard to make sure that people know not only that we exist but that they can come to us on a confidential or anonymous basis too if they are a bit worried about it, also with the support of advocacy services and others.

Senator POLLEY: I understand all the evidence that has been given today. I understand Minister Wyatt has today agreed to have a Senate inquiry into Oakden, but I—and every family out there in the community, I am sure—want to be assured that this is not just the tip of the iceberg. If you look at what was written in *The Australian* on the weekend, some serious issues are being brought out into the public. From the evidence given tonight I am not sure we can reassure the community that, when there are sanctions and when there has been breaches and residential homes have been accredited, they can be confident that their loved ones are going to be safe.

Dr McCarthy: The independent inquiry was commissioned precisely because of concerns people may have that the regulatory processes which were in train in relation to Oakden are the same regulatory process which were in train in relation to a whole range of other residential aged care facilities. We are very conscious of the importance of that regulatory process working as well as it possibly can. What happened at Oakden clearly was unacceptable, and we need to understand why those processes, until March this year, did not adequately identify the extent of those failures. We are deeply sorry that that did not happen. We have no reason to believe, though, that the vast majority of providers in the aged care sector as a whole—and we are talking about a very large sector of, as I think Mr Ryan mentioned, over 2,600 services, 949 approved providers and around 260,000 people receiving care—are doing anything other than striving to deliver good quality care. As I think Dr Hartland pointed out, our systems, both before and after the events in March this year, issued notices of noncompliance and sanctions. The stakeholders and, most importantly of all, the consumer advocates with whom we regularly engage would not hold the view that failures of care to this extent are widespread. That does not mean that they do not share our concerns about individual failures of care. Any individual failure of care is unacceptable.

Senator POLLEY: I accept all that.

Proceedings suspended from 09:31 to 09:42

CHAIR: We are now dealing with outcome 3, sport and recreation, and we will begin with program 3.1, sport and recreation and associated agencies.

Senator FARRELL: I was going to commence with the funding trends and the National Sports Plan. It may be helpful if the Sports Commission could come forward.

Mr Bowles: You may start with the department. Let's fire away and see where we go.

Senator FARRELL: I am happy if you can answer some of the questions too, Mr Bowles. On budget day, Minister Hunt was quoted in *The Australian* saying a national sports lottery would be:

…a significant, additional income stream which will help the states and the sports manage sports funding in perpetuity.

Do you recall that comment, Ms Palmer?

Ms Palmer: Yes, I do.

Senator FARRELL: On 22 May, at the launch of the National Sports Plan, Minister Hunt stressed that the government would not be reducing funding. He was asked by a journalist:

Would you envisage that the Federal Government would still maintain its level of funding in sport, even with the lottery?

Mr Hunt replied, 'Yes.' Did you see that comment by the minister?

Ms Palmer: Yes, I did.

Senator FARRELL: Is it the Sports Commission's understanding that government funding would be maintained and that any potential lottery revenue would not be used as an excuse to reduce funding?

Ms Palmer: That is my understanding.

Senator FARRELL: I wonder if we can refer to the ASC's budget statements. Have you got them in front of you?

Ms Palmer: Yes, I do.

Senator FARRELL: I refer you, in particular, to page 277. Do you have that available to you?

Ms Palmer: It is probably different numbering.

Senator FARRELL: Is it? It is entitled 3.2 Budgeted Financial Statements. Can you see the line that reads 'revenue from government'?

Ms Palmer: Yes.

Senator FARRELL: If we look at the 2016-17 year, we see that the revenue is approximately $250 million. In the 2017-18 year it jumps to approximately $264 million, but then in 2018-19 it drops to $227 million. In 2019-20 it drops to $207 million and then jumps up in 2020-21, presumably because it is the Tokyo games, to $209 million. That would suggest that, rather than maintaining funding, in fact funding is dropping.

Ms Palmer: I think there are a range of factors that contribute to that. The first is that there was a one-off grant of $15.5 million from the government to top up funding in preparation for the Commonwealth Games.

Senator FARRELL: Is that the jump that we see there in 2017-18?

Ms Palmer: Yes. We also will receive $424,000 from the modernisation fund around a digital platform. There is the impact of the efficiency dividend, which is a reduction of 2.5 per cent across all revenue. So a range of factors contribute to that. The funding for Sporting Schools ends at the end of 2018, so that has an impact as well.

Senator FARRELL: Let's go back to what the minister said. He was asked:

… would you envisage that the Federal Government would still maintain its level of funding in sport, even with the lottery?

The minister says yes, but these figures suggest something quite different, don't they?

Ms Palmer: No, because the funding is maintained at the same level but is impacted by a range of factors, including one-off funding, efficiency dividend and CPI increases. I anticipate that through the National Sports Plan we will have an opportunity to submit other policy proposals which will increase. Certainly Sporting Schools is a program that we are very keen to retain.

Senator FARRELL: Yes, but the funding dries up in, what, 18 months?

Ms Palmer: Yes, that is right—well, the funding does not dry up; the program is ceased, at this point, on 31 December 2018.

Senator FARRELL: In the absence of an increase in funding, it simply is not true that the government is maintaining funding into the future, is it? Either these figures in the budget or wrong—and I am assuming they are not wrong and they are the correct figures. If we have got in the current financial year $250 million being spent on sport and in the 2021 year $209 million, that looks to me like a drop of $41 million.

Ms Palmer: Across those years, though, we would be impacted by a range of factors, as I outlined to you previously.

Senator FARRELL: I understand that.

Dr Studdert: I think what you see there is a trend that has been in the forward estimates for some few years now. When the minister talked about the additional funding that could be anticipated from the lottery, it was, I expect in reflection, not necessarily correcting that but suggesting that that funding would not in any way accelerate or change that.

Of course, there is also the process of developing the National Sports Plan. Government will make decisions at the end of that process, as I think the minister has indicated. On the Sporting Schools I think the minister has also indicated that there is funding for the next 18 months and that there will be a review by government in the next budget process as to the future of that program.

Senator FARRELL: So we cannot rely on these figures in the budget as an accurate reflection?

Dr Studdert: I think it is accurate at the time of the budget. The minister has flagged a couple of processes that are in place that will—

Senator FARRELL: This is my point. When the minister was asked by journalists on 22 May, 'Would you envisage that the federal government would still maintain its level of funding in sport even with the lottery?' he said yes, but in fact the government, according to these figures, is not maintaining—

Mr Bowles: The two are not inconsistent.

Senator FARRELL: How is that?

Mr Bowles: Because these are historical numbers. The further you go out in forward estimates, as you would know, they are more historical than anything. The changes in the 2017-18 year reflect, as Ms Palmer said, the Commonwealth Games and an additional $15.5 million to the Sports Commission, which gets you to the 265.

Senator FARRELL: I have taken into account what Ms Palmer said and I have left that figure out of the calculations. D**o you still have those figures in front of you?**

Mr Bowles: Yes—the 227, the 207 and the 209.

Senator FARRELL: If we take out the $15 million for the Commonwealth Games, we look at the $250 million in the current financial year and it drops to $209 million by 2021. That is a $41 million reduction.

Mr Bowles: That is right. What I am saying is, they have been historical figures in the budget for a long period of time. The minister has addressed the 2017-18 year on the basis that he is going to come back to cabinet with a national sporting plan. He has also flagged the issue around Sporting Schools. You might recall that Sporting Schools was a terminating program about 12 months ago that was refunded for an extra period which

now finishes in December 2018. The minister dealt with the issue of the budget for 2017-18 with a view to the National Sporting Plan looking at sport more broadly for the longer term. But the figures here are still the historical figures that have always been the case, which have been impacted by the factors that Ms Palmer talked about before.

Senator FARRELL: The minister said that he is going to maintain funding for sport. But the figures drop over that period of time, that four-year period.

Mr Bowles: He said he would maintain them as they have been and he will develop a national sporting plan. These are as the figures have been.

Senator FARRELL: So the minister meant, when he said he was going to maintain the level of funding in sport, that he was going to reduce them by $41 million.

Mr Bowles: No,. That is not what I said and that is not what he said. These are historical figures. He has dealt with the issues in the 2017-18 year. He has also said on a number of occasions now that he will come back with a national sporting plan that will deal with the long-term issues for sport in this country.

Senator FARRELL: Yes, but for the time being, as far as these figures are concerned, funding for sport in this country, if you take out that $15 million bump, is in fact going down, is it not?

Mr Bowles: If you look at the out-years, they are going down. But—

Senator FARRELL: What else can we can look at, Mr Bowles?

Mr Bowles: The issue here is that we spend only one year at a time. We have dealt with the issues in 2017-18 and the minister will come back with a national sporting plan which will deal with these issues in the longer term.

Senator FARRELL: So we cannot rely on these figures as being an accurate—

Mr Bowles: They are an accurate reflection of the budget as it stands.

Senator FARRELL: If they are an accurate reflection then the spending of the government on sport in this country is going to be reduced by $41 million between the current financial year and the 2021 year.

Mr Bowles: In the context that the government is—

Senator FARRELL: Am I right? Have I misread these figure, Mr Bowles?

Mr Bowles: You have not misread the figures but you are not listening to what I am saying about the National Sporting Plan and the minister coming back—

Senator FARRELL: We will come to the National Sports Plan in a minute. But, as far as these figures are concerned, over the next four years the government intends to reduce its spending on sport. That is what these figures show, don't they?

Dr Studdert: That was the situation as we went to budget, and as the Treasurer said—

Senator FARRELL: That is all I want to know. So the funding figure for sport is dropping over the next four years.

Mr Bowles: Based on a range of factors that Ms Palmer went through before, without the benefit of everything else that has been—

Senator FARRELL: I am going to come to the National Sports Plan; don't worry about that. All I am saying is that, according to these figures here, funding for sport in this country is going to drop by $41 million over the next four years. Is that correct?

Mr Bowles: Only with the caveat that I have already put on it.

Senator FARRELL: So, when the minister said that he is going to maintain the level of funding in sport, that, in fact, is not correct. The level of funding in sport is going to be reduced by $41 million.

Mr Bowles: Again, Senator, I do not see it in that context. We are dealing with the 2017-18 year. If the minister comes back with a plan for sport that deals with the long-term issues in sport, that addresses those issues.

Senator FARRELL: If he does. Just on a related matter, when is the Sports Commission going to release its 2017-18 investment allocation?

Ms Palmer: We are just finalising that at the moment. In actual fact, I saw the last draft today. Once it goes to the minister for approval, sports will be notified at that time.

Senator FARRELL: When do we think that it might go to the minister?

Ms Palmer: It has to be approved by the chair. Once that has been done, he will receive those in the morning. We anticipate that they will go to the minister this week.

Senator FARRELL: Did you say 'this week'?

Ms Palmer: Yes—to the minister this week.

Senator FARRELL: You are very keen to talk about the National Sports Plan. Has the minister promised the Sports Commission that the lottery will be additional and that it will not simply replace government funding now or into the future?

Ms Palmer: I have confirmed the announcement that the minister made just recently, and that is at this stage the fact.

Senator FARRELL: Why do you use the words 'at this stage'?

Ms Palmer: In terms of my not hearing any further information to this point.

Senator FARRELL: So you have—

Senator Nash: I think the minister has been clear in that he has said it would be in addition.

Senator FARRELL: So he is dropping $41 million from sports funding over the next four years and he is going to introduce a lottery. Is that how we understand it?

Ms Palmer: No, the minister is not reducing funding. We have reasons why the funding in the budget is indicated as being reduced. We anticipate that, as part of the National Sports Plan, we will be considering the future of the Sporting Schools program, which in any one year alone is a $40 million investment.

Senator FARRELL: But he has not committed to keeping that scheme, has he?

Ms Palmer: We need to go through a process to ensure that that program is fit for purpose and delivering the desired outcomes for the government.

Senator FARRELL: But the minister has not indicated he is going to continue the program, has he?

Senator Nash: But my understanding, Senator, would be that that would be considered in the 2018-19 budget context. That would be appropriate.

Senator FARRELL: That may be so, Minister. All I am asking is: has the minister committed to continuing the program?

Mr Bowles: This is not the time to recommit, because the funding is there for 2017-18 and half of 2018-19, and it does not have to be recommitted until the 2018-19 budget, which is when he would look at that again.

Senator FARRELL: That may be true, but the question I am asking is: has the minister committed to continuing with the funding after that due expiry?

Mr Bowles: I have just explained that. The minister does not have to formalise any commitment at this stage.

Senator FARRELL: So the answer is no?

Mr Bowles: That is not my answer. The minister is very keen on sport, physical activity and a range of issues, and he will look at these in the context of the 2018-19 budget, as is the normal case for all programs.

Senator FARRELL: That may be so, but I have asked a very simple question: has he committed to continuing the scheme after it is due to expire in 18 months?

Mr Bowles: And I have given you the answer.

Senator FARRELL: It seems to me that the answer is no. If it is something other than no, please tell me.

Mr Bowles: I have just told you what the answer is. It is: he does not have to be committed in a budget context until the 2018-19 budget. That is when the minister will turn his mind to that, after looking at a valuation of the program. It has already been extended once as a program that was terminating, and that happened about 12 months ago, from memory.

Senator FARRELL: So the minister could have, in this last budget—

Mr Bowles: No because, in the budget context of when it was terminating, it was determined to be continued. It will happen again in the same context, as is the normal process.

Senator FARRELL: Surely the minister, in the last budget round, could have said, 'We're extending this for another 12 months.' Surely he could have done that.

Mr Bowles: There was no need to do that because there is funding—

Senator FARRELL: Surely he could have done that. We have funding out here to 2021. Surely the minister could have said: 'Yes, this is such a terrific program. We want to keep it, and we're going to fund it to 2021.' He could have done that, surely.

Ms Palmer: It was really important that that program was considered in the context of the National Sports Plan. Consultation with all of the stakeholders, the community and schools was really important before there were any decisions made.

Senator FARRELL: So the minister decided not to extend the Sporting Schools program because he was considering this National Sports Plan?

Ms Palmer: No. It is important that we can—

Mr Bowles: That is a very creative interpretation.

Senator FARRELL: I think it was a pretty straightforward interpretation, if I—

Mr Bowles: I have said it a couple of times already. First of all, the department, with the Sports Commission, will look at the Sporting Schools program in the context of the 2018-19 budget, when the minister will make his decision around that. It cannot and should not be brought forward to have that conversation until the National Sports Plan has been developed and we can—

Senator FARRELL: Why on earth not? If it is such a good program—

Mr Bowles: It is because it is a normal process that you go through an evaluation of programs before you recommit to them.

Senator FARRELL: If it is such a good program and the minister is so keen on it, why can't he extend it? He has obviously extended $209 million worth of programs.

Mr Bowles: They are ongoing funding programs. The Sporting Schools program is a terminating program. It is the way the budget works. I have answered that question.

Senator Nash: Even though it is such a good program, Senator, I understand that Labor did not commit to funding it at the election.

Senator FARRELL: No, but we had a number of other programs.

Senator Nash: I see. That gives us a bit of clarity! Sorry, go on.

Senator FARRELL: You said that the minister has said that the additional funding through the lottery will not replace government funding either now or in the future. Have you received that undertaking in writing?

Ms Palmer: No. I did not think that that was necessary.

Mr Bowles: The minister has made public statements on that.

Senator FARRELL: It was just a simple question.

Mr Bowles: And I have just given you a simple answer.

Senator FARRELL: It was a very simple question. Was it in writing or not? I did not need an aggressive answer like that, if I can be perfectly honest.

Mr Bowles: I do not believe it was aggressive. Chair, was I aggressive? I do not believe I was.

CHAIR: No, I did not feel threatened by you at all.

Mr Bowles: Thank you.

CHAIR: And I do not think anyone else did. Ms Palmer did answer that.

Senator FARRELL: I would not go on your assessment of that, Chair.

CHAIR: You do not have to. That is fine.

Senator FARRELL: I am not going to.

CHAIR: Okay.

Senator FARRELL: With the lottery, there obviously has to be discussions with the states and the territories. Do you know whether or not the government will seek a guarantee that any money from the lottery will not be used as replacement funds for existing expenditure by the states or territories?

Ms Palmer: The Australian Sports Commission involvement to date has been around doing the preliminary work on the lottery, and now this is moving into a new phase where the lottery will be fully explored. So I have no further information than that on the lottery.

Senator FARRELL: Minister, can you tell us whether or not the government has had any discussions with the states or territories to ensure that they will not be cutting back any sports funding as a result of any income they receive from the lottery?

Senator Nash: I am not aware of specific discussions, Minister. I am happy to take that on—

Senator FARRELL: No, you are the minister!

Senator Nash: True! But I hark back to days gone by occasionally, and you were such a good minister before they got rid of you. And then you came back, Senator Farrell. We were very happy to see that.

Senator FARRELL: No need to be abusive. I have not been abusive to you.

Senator Nash: I was actually meaning to be kind, Senator. I am sorry; I was quite genuinely meaning that we were happy to have you back in the Senate—quite genuinely. But, back to your question, I am not aware of any specific conversation with the states and territories. I am happy to take that on notice for you. As I indicated earlier, though, I am aware that the minister has indicated that this will be additional funding, so I would expect that that would apply across the board.

Senator FARRELL: So you are saying that, when the minister says it is additional funding, that is also—

Senator Nash: No, I am saying that my expectation would be that it was. But I am clearly not the minister, so I have undertaken to take that on notice for you. I have simply made the comment that he has stated that it is additional funding.

Senator FARRELL: My question, obviously, is in relation to whether the states and territories think similarly.

Senator Nash: And clearly I cannot comment on that, Senator.

Senator FARRELL: No, but you are going to check it out.

Senator Nash: I will most certainly take it on notice for you.

Senator FARRELL: Thank you, Minister.

Senator Nash: Happy to assist.

Senator FARRELL: Good. Now, the Sports Commission presumably has been aware of previous plans and ideas regarding a sports lottery?

Ms Palmer: Being new to this role I am unaware—

Senator FARRELL: [inaudible] last estimates.

Ms Palmer: I can take that on notice.

Senator FARRELL: So you have never heard of the idea of a lottery having being raised?

Ms Palmer: I have heard of a lottery being raised previously, yes.

Senator FARRELL: Yes. Obviously, it comes from the idea in England. Is that fair to say?

Ms Palmer: Yes, that is right.

Senator FARRELL: Where it is both a sports lottery and a heritage lottery, I think.

Ms Palmer: Yes, the good causes lottery.

Senator FARRELL: And arts? Is arts thrown in as well?

Ms Palmer: I believe so.

Senator FARRELL: Has there been any question regarding the legality of a lottery—in particular, the Commonwealth powers in respect of conducting a lottery?

Ms Palmer: I will hand that back to Dr Studdert.

Dr Studdert: I can say that is something that the department is now currently consulting with Attorney-General's and getting further advice on.

Senator FARRELL: Have you received any advice?

Dr Studdert: No, that is still in process.

Senator FARRELL: So, whenever this issue has arisen before, you have never received advice about your constitutional powers?

Dr Studdert: Well, there has been some preliminary advice provided in the past, but now that we are moving and looking at some specific models we will be getting detailed advice.

Senator FARRELL: Okay. You heard the question I asked Ms Palmer about whether she had heard of any ideas in the past about a lottery. That suggests to me that you have heard of some of these ideas before.

Dr Studdert: Sorry. I thought, in relation to your question to Ms Palmer, you were talking about the overseas experience. And yes, certainly, all of us that have been thinking about this issue most recently and in the past—

Senator FARRELL: Yes, I did talk about the overseas experience, but I did predicate that question based on whether or not there had been any suggestions about lotteries in Australia before that. Now, have you heard of any of those?

Dr Studdert: Well, yes, I have.

Senator FARRELL: And in the past, when that issue has been raised, was there any advice about the Commonwealth's constitutional powers in respect of a lottery?

Dr Studdert: As I said, Senator, there have been some preliminary conversations and advice, but now that we are moving, as the minister has announced, into a specific process of getting advice and providing detailed advice to government, that will be what we are now working on with our colleagues across government

Senator FARRELL: The preliminary advice—what did that suggest as to the constitutional validity of a lottery?

Senator FARRELL: What did the preliminary advice suggest as to the constitutional validity of a lottery?

Dr Studdert: I am a bit hesitant to quote that without it in front of me, but there are mechanisms for the—

Senator FARRELL: There is some written advice on this?

Dr Studdert: I would have to take that on notice.

Senator FARRELL: You do not know whether or not there is written advice?

Dr Studdert: I actually do not know whether there is written advice.

Senator FARRELL: So what were you referring to when you said there was some advice?

Dr Studdert: Well, as I said, there have been early conversations—

Senator FARRELL: Was that oral advice?

Dr Studdert: I would have to take that on notice whether it was actually in writing, but there have been early conversations and there are mechanisms for the Commonwealth—

Senator FARRELL: There is some advice. We can put aside for a minute whether it was written or oral. Did that advice suggest that there are some constitutional difficulties with a national sports lottery?

Dr Studdert: It suggested there are constitutional considerations that have to be made, but there are mechanisms and ways of considering those, and that is why we are progressing the conversation.

Senator FARRELL: So as far as you know, there is no advice which suggests that there is a constitutional impediment to a lottery?

Dr Studdert: I do not know how you would characterise it. There are constitutional considerations is the way I would prefer to reflect on it.

Senator FARRELL: Can I interpret that word as difficulties—constitutional difficulties?

Dr Studdert: No, I would not interpret it that way.

Senator FARRELL: Would they be constitutional concerns?

Dr Studdert: They would be considerations.

Mr Bowles: Considerations.

Senator FARRELL: So, you are considering whether there are some constitutional issues?

Mr Bowles: No, there considerations that we need to understand in the way you conduct a lottery. That is what we are exploring and we will get further advice on that.

Senator FARRELL: So you are looking for a way to conduct the lottery that does not run into constitutional problems? Is that a fair way to put it?

Mr Bowles: That would be a good start.

Senator FARRELL: Okay.

Senator Nash: Was that a question you asked the minister? I understand he did give you a personal briefing around the lottery.

Senator FARRELL: He did. I am pleased to see he is paying some attention to the—

Senator Nash: We are all paying a lot of attention to you. We always do.

Senator FARRELL: Does he have anything else he wants to say to me?

Senator Nash: Do not presume I just do not know an awful lot of things.

Senator FARRELL: Good. There are some constitutional considerations.

Senator Nash: That is correct.

Senator FARRELL: What do we think the timeframe for resolving those constitutional considerations will be?

Dr Studdert: I am not sure 'resolving' is the right word, but getting further advice on how to take those considerations into account as we have progressed the minister's request for a way forward on this. We will be getting advice on that in the coming weeks.

Senator FARRELL: Where do you expect to get that advice from?

Dr Studdert: From the Australian Government Solicitor.

Senator FARRELL: What has been sent to the solicitor? Is it a set of questions?

Dr Studdert: At this stage, I could say my team has had a preliminary face-to-fact meeting and there have been no written instructions.

Senator FARRELL: Who has had that preliminary—

Dr Studdert: The staff from my team. There have been no written instructions issued at this stage.

Senator FARRELL: So you have had a meeting with the solicitor?

Dr Studdert: With the solicitor's office, yes.

Senator FARRELL: And you have said you would like some response to—

Dr Studdert: We would like advice on the range of considerations that needed to be taken into account in progressing a model and mechanism for a national sports lottery.

Senator FARRELL: When do you expect to get some advice?

Dr Studdert: We expect to get advice in the coming weeks.

Senator FARRELL: Will the issue be progressed until you have received that advice?

Dr Studdert: Yes. That is obviously a very critical part of that, but we are working with the Sports Commission on the process of consulting around the National Sports Plan, which includes inputs, undoubtedly, on the proposal of a lottery. We expect to be doing consultations with a range of stakeholders.

Senator FARRELL: So you will run those two things simultaneously, will you?

Dr Studdert: Yes.

Senator FARRELL: So you will be getting some advice on the constitutional—

Dr Studdert: At the same time as the consultations are underway around the National Sports Plan.

Senator FARRELL: Has the government or the ASC commissioned any modelling on the revenue potential of a lottery structured in the way that the minister has suggested?

Ms Palmer: Yes. The Australian Sports Commission had some preliminary work done which indicated that it could be progressed, and that preliminary work now will be moved into the full project.

Senator FARRELL: When was that done?

Ms Palmer: Over the last month.

Senator FARRELL: Over the last month or so? That was in response to some indication from the minister that he was considering going down this path?

Ms Palmer: It was in response to the Australian Sports Commission's conversations around opportunities to generate revenue in alternative ways.

Senator FARRELL: Did you consider anything else other than a lottery?

Ms Palmer: We consider a range of things annually when we undertake our planning.

Senator FARRELL: But obviously this one you took more seriously than the others.

Ms Palmer: Because of its potential to generate significant levels of revenue.

Senator FARRELL: How did you make an assessment as to how much revenue it might raise?

Ms Palmer: I am not close to the project, but we used a consultant who did the work on that—the projections. I believe it was a reasonably scientific approach based on the current market.

Senator FARRELL: Who conducted this survey?

Ms Palmer: Joe Coghlan. I am not sure what the name of his business is—Coghlan Bower.

Senator FARRELL: What are they?

Ms Palmer: A consulting firm.

Senator FARRELL: What are their qualifications to give advice on this type of thing?

Ms Palmer: Joe Coghlan in particular is very experienced and has completed a range of work for most of the large sporting organisations in this country, around a range of elements of their business.

Senator FARRELL: So they are experts in these sorts of things?

Ms Palmer: They are experts in working on projects that need input from a broad range of people. They are a consulting firm who run major projects for major sporting entities.

Senator FARRELL: What was their brief?

Ms Palmer: Their brief was to explore the opportunity, using the example of the UK lottery and other good-cause lotteries internationally, to consider the feasibility of taking next steps. So it was a very preliminary overview of the value of progressing.

Senator FARRELL: What other examples are there, apart from the English example?

Ms Palmer: I will have to ask my colleague Geoff Howes, who is more familiar with it.

Senator FARRELL: He can come up to the table and give us the benefit of his knowledge.

Mr Howes: I think, when we looked at it, there were probably about another six or seven countries that ran similar sorts of lottery approaches.

Senator FARRELL: Can you tell us which ones?

Mr Howes: I cannot remember the countries' names.

Senator FARRELL: Okay. We know the English example, because it seemed to be a great success. In the case of the other six or seven countries, did they also benefit in the same way that the United Kingdom has?

Mr Howes: From what I can recall, there are no countries that run lotteries that are specifically focused on sports. So, generally they are a good cause focus, and they have all derived similar benefits from the arrangements, yes.

Senator FARRELL: What would you say is a similar benefit?

Mr Howes: Well, level of funding that gets allocated to a number of different areas, including sport.

Senator FARRELL: So the English model raises—what, is it $100 million a year?

Mr Howes: I think in our numbers it is about $125 million.

Senator FARRELL: Do any of these other examples raise as much as that?

Mr Howes: I do not think they do raise as much as that, no.

Senator FARRELL: When Mr Coghlan did this, what figure did he come up with as what he thought we might be able to get out of this scheme?

Mr Howes: In any sort of assessment, there is a range of options— a good case, a worst case and a best case. We are looking at somewhere between $30 million and $70 million, depending on how it is actually delivered.

Senator FARRELL: And in a worst case situation?

Mr Howes: About $30 million, yes.

Senator FARRELL: Is that based on the reach of the lottery, or the success of the lottery or—

Mr Howes: It all depends on the market size, and the assessment of the market size, and propensity to pay. So there are a range of different factors that would impact on that.

Senator FARRELL: Australians are notorious gamblers.

Mr Howes: Well this is why we want to go into a detailed project phase.

Senator FARRELL: Right. Okay.

Senator Nash: And they have been very successful before. I understand the Sydney Opera House was, indeed, funded by a lottery.

Senator FARRELL: It was. Can you give us some other examples, Minister?

Senator Nash: No. That is the only one I have at the moment. You are very well versed in it. I did not actually know that, Senator. I am very impressed that you knew that.

Senator FARRELL: The Sydney Opera House?

Senator Nash: Yes. Very impressed.

Senator FARRELL: Are you trying to flatter me, Minister? I mean, first of all you are having a go at me, and now—

Senator Nash: You are not even an eastern seaboarder! I was not having a go at you. I made that very clear, Senator. I meant that very genuinely. You got a rousing round of applause when you came back to the Senate—most unusual.

Senator FARRELL: Is it? Okay. So, the projections are somewhere between $30 million and $70 million?

Mr Howes: Yes that is the preliminary assessment. We obviously want to get a more detailed assessment.

Senator FARRELL: The next stage in the assessment, to try and nail down a closer figure: how will that be done?

Mr Howes: There is a number of things you have to look at. Obviously, there is the advice that we need to receive. But there is also—

Senator FARRELL: The advice about the constitutional issues?

Mr Howes: Well the considerations, yes. You need to look at what particular model you might adopt. There are online or over-the-counter type of models. You need to look at a range of different things.

Senator FARRELL: Do we assume, then, that we cannot make a final modelling projection without first answering those constitutional considerations?

Mr Howes: I think you can look at a number of things in parallel.

Senator FARRELL: You can make some assumptions. If one particular model met the constitutional requirements and another one did not, you could get some advice—

Mr Howes: Correct. There are also costs around the particular design, to how it is set up, how it is operated. So there are a range of things that need to be considered.

Senator FARRELL: Yes. The model that gets the $70 million: what particular feature does it have that makes it so much better than the worst-case model?

Mr Howes: It is much more about market size and propensity to pay than anything else.

Senator Nash: Size does matter!

Senator FARRELL: How do you make some judgement values about those. How do they, these experts—

Mr Howes: The methodology usually involves doing some kind of market analysis.

Senator FARRELL: Did they do that this time or will that be the next step?

Mr Howes: There was some preliminary work done, but we need to get some more of what we would call robust advice.

Senator FARRELL: Are you able to provide us with the information that has been gathered so far?

Mr Howes: I will take that on notice.

Senator FARRELL: Thank you. The minister has indicated that he has discussed the lottery plans with four state premiers—two Labor Party premiers and two Liberal premiers. Was it premiers or was it sports ministers? Do we know?

Dr Studdert: You seemed to be reading from a quote on his comments on that.

Senator FARRELL: Yes. I have written down 'four state premiers', but I have a feeling it was four sports ministers. Does anyone happen to know who the minister has consulted with from the states about the lottery?

Dr Studdert: No, I do not know which states or territories he has consulted with.

Senator FARRELL: Minister, do you happen to know?

Senator Nash: I think you asked me that before, didn't you?

Senator FARRELL: It is the first time I have asked you that question.

Senator Nash: No, I do not know, but—

Senator FARRELL: I would remember if I had asked you.

Senator Nash: I am happy to take that on notice.

Senator FARRELL: Can you?

Senator Nash: Yes. I must have been thinking of something in relation to another question you asked me before.

Senator FARRELL: Has the Office of Sport provided any briefs to the minister's office for any meetings with state ministers about the national sports plan?

Dr Studdert: Generally our briefs to the minister for meetings with a sports minister or a premier would cover a range of issues. I am being advised that there is no specific brief on a specific meeting about the lottery. I think in some cases those conversations were probably opportunistic when involved in other meetings and interactions, but we can certainly take that on notice and give you—

Senator FARRELL: So, to the best of your knowledge, you have not been asked to provide any advice in advance of the minister speaking with a state or territory—

Dr Studdert: Not in relation to a specific meeting about the lottery, no.

Senator FARRELL: What about the National Sports Plan?

Dr Studdert: I do not believe so, but I would be happy to take that on notice.

Senator FARRELL: Would you normally provide a minister with advice about these sorts of things?

Dr Studdert: We frequently provide briefs to the minister for meetings. We often are anticipating and speculating as to the topics of those meetings and provide advice on a range of topics that may come up. Given the sports plan was only formally launched just over a week ago and the minister has been here most of that time, I do not think there have been any meetings where we have provided briefings on that issue. But, as I think you know, he has said publicly that he has had a number of meetings with—

Senator FARRELL: Or he has had discussions. I am not sure you would call them meetings.

Dr Studdert: 'Discussions' in fact is probably a more accurate—

Senator FARRELL: I rather got the impression that they might have been telephone discussions rather than face to face. When was the last meeting of sports and recreation ministers?

Dr Studdert: December 2016.

Senator FARRELL: And that would have been Minister Ley?

Dr Studdert: Yes, Minister Ley.

Senator FARRELL: Is it true that there was a meeting scheduled for earlier this month and it was cancelled?

Mr Smith: Yes.

Senator FARRELL: Why was it cancelled?

Dr Studdert: There was a scheduling conflict in getting the ministers together in one place.

Senator FARRELL: Was it our minister who had a problem?

Mr Smith: [inaudible]

Dr Studdert: I could not say. I think there are always a range of challenges.

Senator FARRELL: What was that answer, Mr Smith?

Dr Studdert: It was state ministers that—

Senator FARRELL: State ministers could not attend.

Dr Studdert: Of course, that is a dance around finding a date that works for everyone, and my understanding is that that was not possible.

Mr Smith: A meeting is scheduled, or is being planned, for August.

Senator FARRELL: August? Okay.

Mr Smith: I would have to take the exact date on notice.

Senator FARRELL: Yes. Typically, how often do the sports ministers get together?

Dr Studdert: I think it has been intermittent in recent years, to my recollection. I do not think there is a formal schedule. I think it is as needed and as possible.

Senator FARRELL: Given that this is a pretty big announcement about a new project and there is lots of work being done on it, wouldn't you expect that the meeting would be sooner rather than later?

Dr Studdert: That was the plan until quite recently. I expect we will be working with the minister and his office to ensure there are consultations with his colleagues sooner rather than later.

Senator Nash: I understand the minister wrote to all the sports ministers before the launch to let them know. I can clarify more information on that for you.

Senator FARRELL: I missed that, Minister.

Senator Nash: The minister wrote to the sports ministers before the launch.

Senator FARRELL: To let them know it was coming?

Senator Nash: Yes, to let them know.

Senator FARRELL: All right. When did he write that letter, do you know?

Senator Nash: That, I do not know, but I will take it on notice for you.

Senator FARRELL: Could you?

Senator Nash: Yes, of course.

Dr Studdert: I was just advised it was the Friday before, so it would have been the 19th that the letters were sent.

Senator FARRELL: So that was Friday a week ago?

Dr Studdert: It was 19 May.

Senator FARRELL: Yes. Can you tell us who will be involved in the consultation process for the National Sports Plan?

Dr Studdert: The minister has indicated that it will be a very broad consultation. There is a website where people can provide input and submissions. But we will be proactively reaching out to national sporting organisations, community groups, groups that are interested in the health benefits of physical activity and sports participation—there are quite a long list of stakeholders that we anticipate will be submitting to this process.

Senator FARRELL: How will you contact them? At the moment you can register that you are interested in making a submission; is that right?

Dr Studdert: You can provide input on the site at this stage, and we will be providing further guidance—

Senator FARRELL: I thought at the moment you could only register that you were—

Dr Studdert: All right. I may stand to be corrected on that. I know we have a site up, ready for consultation.

Senator FARRELL: Sorry?

Dr Studdert: I know we have a site up that is available for input.

Senator FARRELL: Yes.

Dr Studdert: I stand corrected. We are finalising some guidance for consultation that will go up in the next week or so. We have mailing lists, and the Sports Commission, I am sure, has contact lists for a whole range of stakeholders in these spaces, and we will be working together to ensure that as many and all identified stakeholders are aware of this process.

Senator FARRELL: So you will be getting a list from the Sports Commission?

Dr Studdert: I do not think we have quite worked out who will send out respective invitations, but I think between us we will be very efficient, and we have already had quite a lot of discussion between us about how this will be managed efficiently, and we will be ensuring that all those stakeholders are reached.

Senator FARRELL: And who is going to be doing the consultation?

Dr Studdert: The Office for Sport and the Sports Commission are working together on this.

Senator FARRELL: And so one group will do some and—

Dr Studdert: I guess that is how we will work it out, yes.

Senator FARRELL: All right. What is your expectation as to the sort of feedback that these organisations will be able to give you? What are you looking for and what do you think that they might provide you with?

Dr Studdert: The minister has outlined the four themes, or expectations, around shared goals for high-performance sports, sporting participation, cultural and public health outcomes, and willingness to pay for these services. There are also the four interrelated pillars: participation, performance, prevention through physical activity, and integrity. So I think there are going to be a very broad range of inputs and contributions that we will get across all those elements.

Senator FARRELL: Right. And how much do you think that will cost?

Dr Studdert: What, the—

Senator FARRELL: The consultation.

Dr Studdert: It is a process we are running internally. I do not think it is going to cost a lot of my staff's time and energy but I think that is something we are all very committed to doing and, as requested by the minister, will be doing.

Senator FARRELL: So are you not expecting any additional costs other than the cost of the labour of the people at the two organisations?

Dr Studdert: Not at this time, but we do have to sit down and look at the resource implications and plan for that over the coming months.

Senator FARRELL: Will the plan look at the structure of the ASC and at the operations of the AIS?

Dr Studdert: I do not think that is anticipated at this stage, but obviously we are going to be responding to the input and contributions we get.

Senator FARRELL: I am not asking you to do this now but could you provide us with a breakdown of the staff at the ASC, including the basic details of what they do and what payment and they sit under.

Ms Palmer: Yes.

Senator FARRELL: And could you also specify which staff are employed specifically to run the day-to-day operations at the AIS.

Ms Palmer: Yes.

Senator FARRELL: There has been a lot of discussion about plans to centralise control of sports institutes. We have had some queries from state ministers about those plans. Are there any plans to intervene in the operation of the state sports institutes?

Ms Palmer: Presently there is a National Institute Network review. The purpose of that review is to consider the operating model of the National Institute Network to ensure that it is delivering the outcomes needed for our high-performance system. At this present time, the state institutes of sport and academies work very collaboratively with the Australian Sports Commission, and our aim would be for that to be enhanced.

Senator FARRELL: There is some talk of a hub-and-spoke model. Have you heard that term?

Ms Palmer: I have heard that term.

Senator FARRELL: Would you like to expand on what you understand that to mean.

Ms Palmer: At the present time, the Australian Sports Commission provides approximately 45 service personnel into the daily training environment in each of the states where the athletes are residing. The opportunity to actually ensure that the athletes have what they need when they need it is really important, and now we have program coordinators who make sure that those staff are in the right place at the right time. So it is hub-and-spoke in that they may be based at the Australian Sports Commission in Canberra or at the AIS in Canberra.

Senator FARRELL: Who are we talking about would be based there?

Ms Palmer: It would be service personnel. Some sports only require a percentage of a person to deliver the services so it is important that that is well coordinated. That is the conversation but it has not been decided. It is part of the review about what is the best operating model going forward.

Senator FARRELL: So it may be that the review itself is creating some unease in certain states; would that be the case?

Ms Palmer: No. In actual fact, my experience is it has been a very productive process. In actual fact, it has representatives from almost all jurisdictions and from different levels. At the moment it is the exploratory process, where we are compiling a significant amount of information about the current operations of all of the institutes and of the Australian Institute of Sport. I have to say it has been very productive and positive process.

Senator FARRELL: Has this been something that started since you took over or did it predate your—

Ms Palmer: In actual fact, there was a review in 2014 that started to consider how the organisations could work more effectively together. Since that time—I cannot recall the number—a significant number of recommendations were made and most of those have been completed. Now this next stage is around how we can work more cooperatively to deliver. We are blessed with a significant number of high-performance personnel who have expertise. We want to make sure that we can maximise their contribution to the system.

Senator FARRELL: Thank you, Ms Palmer. I now want to ask some questions about the Commonwealth Games. There is $11.7 million in the budget for other related services associated with the staging of the games. Can you please detail what those other related services are.

Mr Smith: That funding relates to work that agencies are undertaking that are providing operational support to the Commonwealth Games. It would include resources that have been put forward through the Department of Health; through the Office for Sport and the team that supports that; through the Department of Immigration and Border Protection; and through the Attorney-General's Department and other security agencies.

Senator FARRELL: Defence?

Mr Smith: There is a specific measure for Defence that is separate to that $11.7 million.

Senator FARRELL: It is a separate figure?

Mr Smith: Yes.

Senator FARRELL: As I recollect, that is 34—

Dr Studdert: 34.2.

Senator FARRELL: 34.2, yes. The budget papers say that those services will be funded from within existing resources of affected agencies. Does that mean that those agencies will have to find their share of the $11.7 million from their pre-existing budgets?

Mr Smith: It is an estimation of what effort agencies are putting forward to support those events and that they are already putting forward from existing resources.

Senator FARRELL: So that $11.7 million is not actually new money?

Mr Smith: No.

Senator FARRELL: Would that have an impact then? If it is not new money and it is coming out of their existing resources, would that affect their other regular activities?

Mr Smith: It is activity that, by virtue of this event being held in Australia, agencies must be engaged in and that agencies have made resources available for, and this is an effort to quantify that, to give a full picture of Australian government support towards the Commonwealth Games.

Senator FARRELL: There are six revenue measures related to the Commonwealth Games listed in Budget Paper No. 2. Does that mean that the agencies listed there are providing services which Queensland and/or the Gold Coast 2018 Commonwealth Games Corporation will have to pay for?

Mr Smith: Sorry, Senator, did you say six revenue measures?

Senator FARRELL: Yes. There are six revenue measures related to the Commonwealth Games listed in Budget Paper No. 2—

Mr Smith: Do you have a page reference there, sorry?

Senator FARRELL: Pages 1 and 2. I have got them listed as pages 1 and 2.

Mr Bowles: BP2, Budget Paper No. 2? Is that what you are talking about?

Senator FARRELL: Yes, I think so: part 2, budget measures 2017-18 expense measures.

Mr Bowles: 106, yes. I am sorry.

Mr Smith: It is 106 in ours.

Dr Studdert: There are agencies that are in the process of negotiating and working with the Queensland government and the GOLDOC, the Gold Coast organising committee, for services that will be cost recovered, and those processes are ongoing. That is why they are listed there, but the final details of those numbers are yet to be determined.

Senator FARRELL: And that will be after the event?

Dr Studdert: I expect it will be in the coming months.

Mr Bowles: It will be in the build-up to the games. Some of them could be late—for instance, testing services and the like. They could be right up until the games, so you are not quite sure until you get to the end point.

Senator FARRELL: Yes. There is some new money for the Australian Defence Force security, but are the other services going to be paid for by Queensland or the—

Dr Studdert: I think there are two elements, as we have just discussed, as Mr Smith has said. There are those that are being absorbed by the agencies, and that is outlined in the budget paper, and then there are those where there is an element of cost recovery, and those are in the process of being negotiated.

Senator FARRELL: I do not expect you have got a copy of this, but in the 2006 budget papers—

Dr Studdert: No.

Senator FARRELL: That is right—there did not appear to be any revenue measures relating to the Melbourne Commonwealth Games, so we assume that they were not charged for, but they are going to be charged for this time?

Mr Bowles: I cannot comment on 2006, but it is not unusual practice to do revenue collections based on cost recovery arrangements for a range of those services.

Senator FARRELL: So you think that they may in fact have been done in 2006?

Mr Bowles: I do not know, but it is not unusual to do cost recovery for large-scale exercises. It happened, I am pretty sure, in a number of the other major sporting events that we have dealt with in the past, from memory.

Mr Smith: We would want to take specifics of that on notice in relation to previous sporting events.

Senator FARRELL: Will you?

Mr Bowles: Yes.

Senator FARRELL: Could you give us a bit of a comparison between this and the last one?

Mr Smith: Yes, we can have a look at that.

Senator FARRELL: Thank you very much. You are very helpful, Mr Smith.

Mr Bowles: That's not a compliment!

Senator FARRELL: Was that an offensive remark?

Mr Bowles: I was joking, Senator.

Dr Studdert: It's been a long day, Senator!

Mr Bowles: I've been here for two days.

Senator FARRELL: I've been here longer than that—not at this particular one; that's all. Obviously security is a significant issue in the lead-up to the games. Will both the Queensland police and ADF personnel be travelling with the relay?

Mr Bowles: I do not know. You would have to ask Defence about what they are doing and Queensland police about them. But I imagine they will not be commenting too much on security implications.

Senator FARRELL: I previously asked some questions on notice—and I am mindful ASADA is here, and this will be the last question about this before ASADA; I do not want them to think that we are not interested in asking them some questions. In the answer to question on notice 97, from the last round, we were informed that Minister Ley, despite some pretty frequent trips to the Gold Coast, only ever attended three events or meetings in relation to the Commonwealth Games. Can you tell us how many visits Minister Hunt has made to Queensland?

Mr Bowles: No. We do not look after his diary, so it would be a matter best asked of the minister.

Senator FARRELL: Minister, do you happen to know how many visits Minister Hunt—

Senator Nash: I do not have access to his diary either, but I can take that on notice for you.

Senator FARRELL: Could you, and find out how many times he has been up there to visit them? I have a few other questions but I will put them on notice, if you do not mind, and maybe in the remaining few minutes that we have got we will have a chat. Thank you for answering those questions for me.

Senator O'NEILL: I am just following up on questions on notice from this morning.

Mr Bowles: This is the list here. I am just trying to read it. I have not had much of a chance to do anything, to be honest. There is a list on our website—I do not know if you have seen that—of, year by year, when different codes come on and off. It is all on the website and has been there since budget day. I just literally have not had a chance to do anything with this, and there is no-one here now who was around at the time. If I go back, it progressively comes in from 1 July 2017 with the bulk-billing services; 2018 with standard GP consultations and specialist attendances—and there will be some mental health issues in the GP attendances; July 2019 with specialist procedures, which will bring in psychiatry, for instance; also in July 2019 allied health services will come back, which will include some of the psychology; and the rest will come back on 1 July 2020, along with, for the first time since 2004, a number of diagnostic imaging services around CT mammography, fluoroscopy and interventional radiology. They will all come in as well in 2020.

Senator O'NEILL: The two ones that I specifically—

Mr Bowles: I cannot recall off the top of my head—

Senator O'NEILL: Better access—

Mr Bowles: but if you have a look at the website they will be listed on there when everything comes back in. Year by year is how we did that, and they will fit into one of those categories.

Senator O'NEILL: I believe they fit in the 2020-21—

Mr Bowles: That may be true, and you can confirm that by looking at the website. As for the number of people, when we had this conversation yesterday my colleagues talked about it from a GP perspective. Once we get to 1 July 2018 when the standard GP consultations happen, I think they said yesterday it relates to 90 per cent of GP services. Both vocationally registered and non-vocationally registered doctors would be covered in services that come back online on 1 July 2018. That is just from memory, from yesterday's conversation.

Senator O'NEILL: That was a more general question. With this one, I am happy for you to take it on notice.

Mr Bowles: This is the specifics—I understand that. One of your things here was about the number of people. I do not know, other than 90 per cent do come in on 1 July 2018, for vocationally registered and non-vocationally registered.

Senator O'NEILL: To be clear, both the Better Access program and the rebate for mental health plans are both part of the government's rebate freeze?

Mr Bowles: Well, everything was under a freeze until they have been lifted progressively. I have said I literally cannot recall everything that is in these things, but if you go to our website it will have what happens from 1 July 2017, what happens from 1 July 2018—and I think it actually lists the numbers beside them, from memory. Regarding Better Access, I just do not know all the numbers. I do not have the relevant people here and I have not had a chance to get away from the table for a little while.

Senator O'NEILL: I thought your staff might provide that for you, Mr Bowles.

Mr Bowles: We are getting it, but—

Senator FARRELL: How much of the almost $1.5 billion announced in the last budget for anti-doping measures in the lead up to the Gold Coast Commonwealth Games has been spent?

Ms Lind: For last year's financial year it was $0.365 million and about $1.1 million is allocated for this current financial year to conduct that pregames testing. So the vast majority of that money—given that we are nearly towards the end of this financial year—has been spent on the program.

Senator FARRELL: So nearly all the money has been spent?

Ms Lind: That is correct.

Senator FARRELL: Was that what you were expecting? Was that how you would have planned it?

Ms Lind: Yes, that money was buying approximately 375 additional tests, both for testing of domestic athletes likely to compete and 375 additional tests on international athletes. We are rolling that program out as we speak.

Senator FARRELL: Do you have enough funding to do the testing that you would like to do in the lead up to the games?

Ms Lind: That $1.5 million is top-up funding, so, in relation to our domestic testing program in the lead up to any major sporting event, we would be skewing our testing program towards that anyway. For this financial year we are tracking towards about 2½ thousand tests for our domestic athletes, covering the Commonwealth Games. The 375 international tests is a new addition to our—

Senator FARRELL: What was that figure?

Ms Lind: 375 additional tests.

Senator FARRELL: And that is for foreign—

Ms Lind: Correct. We are working with our partners overseas to roll those tests out on our behalf.

Senator FARRELL: Do they make any contribution to that funding?

Ms Lind: It depends on the partner that we are working with. They will charge us for the cost of conducting those tests for some of our partners. For others we are doing it on a quid pro quo basis.

Senator FARRELL: What is the quid pro from our point of view?

Ms Lind: That they will do some testing free of charge on our behalf.

Senator FARRELL: There appears to be no new additional funding for ASADA in the 2017-18 budget, but there are both revenue and expense measures listed as 'not for publication'. Does that mean that any remaining antidoping measures for the Gold Coast games will be on a cost recovery basis?

Ms Lind: That is right.

Senator FARRELL: Does that mean that once the funding from the last budget has run out, ASADA will only conduct antidoping activities for the games to the extent that Queensland can afford them?

Ms Lind: The not-for-publication figure relates to the cost of ASADA had to bring the in-games antidoping component. That is currently not for publication because we are in the process of negotiating the cost of that program with GOLDOC. That is on a full cost recovery funding basis.

Senator FARRELL: When that negotiation is completed, will those figures then be published?

Ms Lind: That will result in a service provider contract with GOLDOC. That would be in the public domain.

Senator FARRELL: Are you satisfied that that process will not present any risk to the integrity of the games?

Ms Lind: We have had a lot of discussions in the last six months with both GOLDOC and the Commonwealth Games Federation about the design of the program. We have had a lot of discussion about the elements that we want to roll out, and we are currently moving into the stage of costing those and negotiating those costs under that cost recovery contract with GOLDOC.

Senator FARRELL: You will recall that at the last estimates Mr McDevitt gave us his swan song, I think it would be fair to say. When did he finish up?

Ms Lind: He finished up on 8 May this year.

Senator FARRELL: So that is about three weeks ago. You are obviously acting in that role. Did you take over directly when he finished?

Ms Lind: Yes.

Senator FARRELL: What is the process of appointing a new CEO?

Ms Lind: That is a question for the department.

Mr Bowles: It is a merit-based process. We have done a recruitment exercise. We will go through that process, provide advice to the minister and go from there.

Senator FARRELL: How many candidates are you currently looking at?

Mr Bowles: We looked at a number of candidates and ultimately we have interviewed four.

Senator FARRELL: Are you one of those, Ms Lind?

Ms Lind: Yes.

Senator FARRELL: Good luck!

Ms Lind: Thank you.

Senator FARRELL: When do you expect to make a decision?

Mr Bowles: It will go through the normal process. It may be few weeks yet.

CHAIR: That concludes our examination of the Health portfolio. Thank you for your attendance. Answers to written questions on notice should be provided to the secretariat by the close of business on Friday, 9 June.

Committee adjourned at 22:29