
COMMONWEALTH OF AUSTRALIA

# Official Committee Hansard

# SENATE

## COMMUNITY AFFAIRS LEGISLATION COMMITTEE

**Estimates**

WEDNESDAY, 21 OCTOBER 2015

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**SENATE**

**COMMUNITY AFFAIRS LEGISLATION COMMITTEE**

**Wednesday, 21 October 2015**

**Members in attendance:** Senators Carol Brown, Di Natale, Lambie, Leyonhjelm, Lindgren, Ludlam, Ian Macdonald, Madigan, McLucas, Moore, Peris, Polley, Rhiannon, Rice, Seselja, Siewert, Smith, Wang, Waters, Williams.

# HEALTH PORTFOLIO

## In Attendance

Senator Nash, Minister for Rural Health

**Department of Health**

**Whole of Portfolio**

Mr Martin Bowles PSM, Secretary

Professor Chris Baggoley, Chief Medical Officer

Ms Liz Cosson, Deputy Secretary, Chief Operating Officer Group

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

Mr Andrew Stuart, Deputy Secretary, Health Benefits Group

Dr Wendy Southern, Deputy Secretary, National Programme Delivery Group

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

Adjunct Professor John Skerritt, Deputy Secretary, Regulatory Services Group

Ms Margot McCarthy, Deputy Secretary, Ageing and Aged Care Stream

Ms Kate Pope, First Assistant Secretary, Grant Services Division

Mr Paul McCormack, Assistant Secretary, Regional Services Grants Branch, Grant Services Division

Ms Erica Kneipp, Assistant Secretary, National Programme Grants Branch, Grant Services Division

Mr Craig Rayner, Acting Assistant Secretary, Capital Grants Management Branch, Grant Services Division

Mr Adam Davey, First Assistant Secretary, People, Capability and Communication Division

Mr Robert Wright, Assistant Secretary, People Branch, People, Capability and Communication Division

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

Mr Keith Tracey-Patte, Acting First Assistant Secretary, Portfolio Investment Division

Mr Craig Boyd, Chief Financial Officer, Portfolio Investment Division

Ms April Purry, Acting Legal and General Counsel

Mr Ross Hawkins, Assistant Secretary, Ministerial, Parliamentary, Executive Support and Governance Branch

Ms Alanna Foster, First Assistant Secretary, Research, Data and Evaluation Division

Mr Daniel McCabe, First Assistant Secretary, Information Technology Division

Ms Janet Anderson, First Assistant Secretary, Health Services Division

Dr Andrew Singer, Principal Medical Adviser

Mr Mark Booth, First Assistant Secretary, Health Systems Policy Division

Ms Katie Constantinou, Assistant Secretary, Best Practice Regulation, Health Systems Policy Division

Mr Andrew Kettle, Group Head, Business and Governance, Australian Institute of Health and Welfare

Mr Geoff Neideck, Group Head, Housing and Specialised Services, Australian Institute of Health and Welfare

**Outcome 1**

Dr Lisa Studdert, First Assistant Secretary, Population Health and Sport Division

Dr Bernie Towler, Principal Medical Adviser

Ms Felicity McNeill, First Assistant Secretary, Office of Health Protection

Dr Gary Lum, Principal Medical Adviser

Dr Jenny Firman, Principal Medical Adviser

Ms Kirsty Faichney, Assistant Secretary, Immunisation Branch

Mr Graeme Barden, Assistant Secretary, Health Protection Policy Branch

Ms Janet Anderson, 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 Kingdon, General Manager, Research and Operations Group, National Health and Medical Research Council

Ms Samantha Robertson, Executive Director, Research and Operations Group, National Health and Medical Research Council

Mr Steve McCutcheon, Chief Executive Officer, Food Standards Australia New Zealand

Mr Peter May, General Manager, Food Safety and Regulatory Affairs, Food Standards Australia New Zealand

Adjunct Professor Debora Picone AM, Chief Executive Officer, Australian Commission on Safety & Quality in Health Care

**Outcome 2**

Mr Paul Creech, Acting First Assistant Secretary, Pharmaceutical Benefits Division

Ms Andriana Platona, Assistant Secretary, Pharmaceutical Evaluation Branch, Pharmaceutical Benefits Division

Ms Julianne Quaine, Pharmaceutical Access Branch, Pharmaceutical Benefits Division

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

Ms Kerryn Vine-Camp, General Manager, Debt, Appeals and Health Compliance Division, Department of Human Services

Ms Jo-Anne Benson, National Manager, Health Professional Review and Advice Branch, Department of Human Services

Mr Ben Noyen, National Manager, Health Compliance Strategies Branch, Department of Human Services

**Outcome 3**

Ms Maria Jolly, First Assistant Secretary, Medical Benefits Division

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

Ms Tracey Duffy, Assistant Secretary, Office of Hearing Services, Medical Benefits Division

Mr Jaye Smith, Assistant Secretary, Primary Care and Diagnostics Branch, Medical Benefits Division

Dr Megan Keaney, Senior Medical Adviser, Medical Benefits Division

Dr John Primrose, Principal Medical Advisor, Medical Benefits Division

Ms Janet Anderson, First Assistant Secretary, Health Services Division

Dr Andrew Singer, Principal Medical Adviser

Mr Mark Booth, First Assistant Secretary, Health Systems Policy Division

Mr Charles Maskell-Knight Principal Adviser

Ms Kerryn Vine-Camp, General Manager, Debt, Appeals and Health Compliance Division, Department of Human Services

Ms Jo-Anne Benson, National Manager, Health Professional Review and Advice Branch, Department of Human Services

Mr Ben Noyen, National Manager, Health Compliance Strategies Branch, Department of Human Services

**Outcome 4**

Ms Alanna Foster, First Assistant Secretary, Research, Data and Evaluation Division

Ms Janet Anderson, First Assistant Secretary, Health Services Division

Dr Andrew Singer, Principal Medical Adviser

Mr Mark Booth, First Assistant Secretary, Health Systems Policy Division

Dr Diane Watson, Chief Executive Officer, National Health Performance Authority

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

**Outcome 5**

Mr Mark Booth, First Assistant Secretary, Health Systems Policy Division

Ms Janet Anderson, First Assistant Secretary, Health Services Division

Dr Anthony Hobbs, Principal Medical Advisor

Adjunct Professor Debra Thoms, Chief Nursing and Midwifery Officer

Ms Alanna Foster, First Assistant Secretary, Research, Data and Evaluation Division

Ms Bobbi Campbell, Acting First Assistant Secretary, Indigenous Health Division

Mr David Butt, Chief Executive Officer, National Mental Health Commission

**Outcome 6**

Ms Maria Jolly, First Assistant Secretary, Medical Benefits Division

Mr Shane Porter, Assistant Secretary, Private Health Insurance Branch, Medical Benefits Division

Ms Gay Santiago, Assistant Secretary, Medicare Financing and Listing Branch, Medical Benefits Division

Ms Fifine Cahill, Assistant Secretary, Medicare Reviews Unit, Medical Benefits Division

Ms Susan Azmi, Director, MBD PHI Research and Policy Branch, Medical Benefits Division

**Outcome 7**

Ms Bettina Konti, First Assistant Secretary, eHealth Division

Mr David Paull, Assistant Secretary, Design and Operations Branch, eHealth Division

Ms Linda Jackson, Assistant Secretary, Legislation and Policy Branch, eHealth Division

Mr Kim Bessell, Assistant Secretary, Participation and Use Branch, eHealth Division

Mr Mark Booth, First Assistant Secretary, Health Systems Policy Division

Mr Simon Cotterell, Assistant Secretary, International Strategies Branch, Health Systems Policy Division

Ms Katie Constantinou, Assistant Secretary, Best Practice Regulation, Health Systems Policy Division

Ms Felicity McNeill, First Assistant Secretary, Office of Health Protection

Mr Graeme Barden, Assistant Secretary, Health Protection Policy Branch, Office of Health Protection

Ms Janet Anderson, First Assistant Secretary, Health Services Division

Dr Andrew Singer, Principal Medical Adviser

Mr Paul Creech, Acting First Assistant Secretary, Pharmaceutical Benefits Division

Ms Alanna Foster, First Assistant Secretary, Research, Data and Evaluation Division

Adjunct Professor John Skerritt, Deputy Secretary, Regulatory Services Group

Ms Philippa Horner, Principal Legal and Policy Advisor

Dr Tony Gill, Acting Principal Medical Adviser

Ms Mary McDonald, First Assistant Secretary, Medicines Division

Dr Larry Kelly, First Assistant Secretary, Medical Devices and Compliance Division

Ms Samantha Palmer, First Assistant Secretary, Regulatory Practice and Support Division

Dr Robyn Cleland, Acting Gene Technology Regulator, Office of the Gene Technology Regulator

Dr Michael Dornbusch, Assistant Secretary, Evaluation Branch, Office of the Gene Technology Regulator

Dr Peter Thygesen, Acting Assistant Secretary, Regulatory Practice and Compliance Branch Office of the Gene Technology Regulator

Dr Brian Richards, Executive Director, Office of Chemical Safety & Director, National Industrial Chemicals Notification and Assessment Scheme

Ms Yael Cass, Chief Executive Officer, Organ and Tissue Authority

Ms Judy Harrison, Chief Financial Officer, Organ and Tissue Authority

**Outcome 7: Health System Capacity and Quality**
**Program 7.1: e-Health**

**National E-Health Transition Authority**

Mr Peter Fleming, Chief Executive Officer, National E-Health Transition Authority

**Outcome 8**

Ms Penny Shakespeare, First Assistant Secretary, Health Workforce Division

Dr Andrew Singer, Principal Medical Adviser

Adjunct Professor Debra Thoms, Chief Nursing and Midwifery Officer

**Outcome 9**

Ms Felicity McNeill, First Assistant Secretary, Office of Health Protection

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

Dr Jenny Firman, Principal Medical Adviser, Office of Health Protection

Mr Graeme Barden, Assistant Secretary, Health Protection Policy Branch, Office of Health Protection

**Outcome 10**

Mr Andrew Godkin, Sport Integrity Adviser, Population Health and Sport Division

Mr Simon Hollingsworth, Chief Executive Officer, Australian Sports Commission

Mr Matt Favier, Director, Australian Institute of Sport

Ms Fiona Johnstone, Chief Financial Officer, Australian Sports Commission

Mr Michael Thomson, General Manager, Participation and Sustainable Sport, Australian Sports Commission

Mr Ben McDevitt AM APM, Chief Executive Officer, Australian Sports Anti-Doping Authority

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

Mr Steve Fitzgerald, Chief Financial Officer, Australian Sports Anti-Doping Authority

**Outcome 11**

Ms Margot McCarthy, Deputy Secretary, Ageing and Aged Care Stream

Mr Nick Hartland, First Assistant Secretary, Aged Care Policy and Reform Group

Ms Donna Moody, First Assistant Secretary, Ageing and Aged Care Services Group

Ms Rachel Balmanno, First Assistant Secretary, Aged Care Reform Taskforce

Ms Fiona Buffinton, First Assistant Secretary, Access, Quality and Compliance Group

Ms Sharon Rose, Assistant Secretary, Aged Care Policy Branch

Mr Nigel Murray, Assistant Secretary, Funding Policy and Legislation Branch

Ms Karen Pickering, Assistant Secretary, Home Support Branch

Ms Lou O'Neill, Assistant Secretary, Ageing and Sector Support Branch

Ms Kerrie Westcott, Acting Assistant Secretary, Residential and Flexible Care Branch

Ms Shona McQueen, Assistant Secretary, Home Support Reform and Sector Engagement Branch

Ms Rachel Goddard, Acting Assistant Secretary, Access Reform Branch

Mr David Laffan, Acting Assistant Secretary, Prudential and Approved Provider Regulation Branch

Mr Michael Culhane, Assistant Secretary, Quality and Regulatory Policy Branch

Ms Shona Moloney, Assistant Secretary, Aged Care Complaints Branch

**Committee met at 09:01**

**CHAIR (Senator Seselja):** Welcome. I declare open this meeting of the Community Affairs Legislation Committee on 21 October 2015. The Senate has referred to the committee the particulars of proposed expenditure for 2015-16 for the portfolios of Health and Social Services, including Human Services. The committee may also examine the annual reports of the departments and agencies appearing before it. The committee has fixed 11 December 2015 as the date for the return of answers to questions taken on notice. Senators are reminded that any written questions on notice should be provided to the committee secretariat by close of business 30 October 2015. The committee's proceedings today will begin with its examination of the Health portfolio, commencing with whole-of-portfolio and corporate matters and the Australian Institute of Health and Welfare. The committee will then continue with the Department of Health and other portfolio agencies as listed on the program. Tomorrow morning at 9 am, the committee will move forward to examine the Social Services portfolio, followed at 7.30 pm by the Human Services portfolio. Under standing order 26, the committee must take all evidence in public session. This includes answers to questions on notice.

I remind all witnesses that, in giving evidence to the committee, they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee, and such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to a committee. The Senate, by resolution in 1999, endorsed the following test of relevance of questions at estimates hearings. Any questions going to the operations or financial positions of the departments and agencies which are seeking funds in the estimates are relevant questions for the purpose of estimates hearings. I remind officers that the Senate has resolved that there are no areas in connection with the expenditure of public funds where any person has discretion to withhold details or explanations from the parliament or its committees unless the parliament has expressly provided otherwise. The Senate has resolved also that an officer of a department of the Commonwealth shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude questions asking for explanations of policies or factual questions about when and how policies were adopted. I particularly draw the attention

of witnesses to an order of the Senate of 13 May 2009 specifying the process by which a claim of public interest immunity should be raised.

*The extract read as follows—*

**Public interest immunity claims**

That the Senate—

(a) notes that ministers and officers have continued to refuse to provide information to Senate committees without properly raising claims of public interest immunity as required by past resolutions of the Senate;

(b) reaffirms the principles of past resolutions of the Senate by this order, to provide ministers and officers with guidance as to the proper process for raising public interest immunity claims and to consolidate those past resolutions of the Senate;

(c) orders that the following operate as an order of continuing effect:

(1) If:

(a) a Senate committee, or a senator in the course of proceedings of a committee, requests information or a document from a Commonwealth department or agency; and

(b) an officer of the department or agency to whom the request is directed believes that it may not be in the public interest to disclose the information or document to the committee, the officer shall state to the committee the ground on which the officer believes that it may not be in the public interest to disclose the information or document to the committee, and specify the harm to the public interest that could result from the disclosure of the information or document.

(2) If, after receiving the officer's statement under paragraph (1), the committee or the senator requests the officer to refer the question of the disclosure of the information or document to a responsible minister, the officer shall refer that question to the minister.

(3) If a minister, on a reference by an officer under paragraph (2), concludes that it would not be in the public interest to disclose the information or document to the committee, the minister shall provide to the committee a statement of the ground for that conclusion, specifying the harm to the public interest that could result from the disclosure of the information or document.

(4) A minister, in a statement under paragraph (3), shall indicate whether the harm to the public interest that could result from the disclosure of the information or document to the committee could result only from the publication of the information or document by the committee, or could result, equally or in part, from the disclosure of the information or document to the committee as in camera evidence.

(5) If, after considering a statement by a minister provided under paragraph (3), the committee concludes that the statement does not sufficiently justify the withholding of the information or document from the committee, the committee shall report the matter to the Senate.

(6) A decision by a committee not to report a matter to the Senate under paragraph (5) does not prevent a senator from raising the matter in the Senate in accordance with other procedures of the Senate.

(7) A statement that information or a document is not published, or is confidential, or consists of advice to, or internal deliberations of, government, in the absence of specification of the harm to the public interest that could result from the disclosure of the information or document, is not a statement that meets the requirements of paragraph (1) or (4).

(8) If a minister concludes that a statement under paragraph (3) should more appropriately be made by the head of an agency, by reason of the independence of that agency from ministerial direction or control, the minister shall inform the committee of that conclusion and the reason for that conclusion,

and shall refer the matter to the head of the agency, who shall then be required to provide a statement in accordance with paragraph (3).

(d) requires the Procedure Committee to review the operation of this order and report to the Senate by 20 August 2009.

(*13 May 2009 J.1941*)

(Extract, Senate Standing Orders, pp 124-125)

**CHAIR:** Witnesses are specifically reminded that a statement that information or a document is confidential or consists of advice to government is not a statement that meets the requirements of the 2009 order. Instead, witnesses are required to provide some specific indication of the harm to the public interest that could result from the disclosure of the information or the document.

I welcome Senator Nash, representing the Minister for Health, and officers of the Department of Health and the Institute of Health and Welfare.

[09:04]

**Department of Health**

**CHAIR:** Minister or Mr Bowles, would you like to make an opening statement?

**Senator Nash:** Good morning, Chair. No, thank you.

**Mr Bowles:** No, thank you.

**Senator McLUCAS:** Thank you, Mr Bowles and Minister. I want to start with whole-of-portfolio questions, particularly with an update on the status of the proposed Palmerston hospital, please.

**Ms Anderson:** Thank you for the question. The Palmerston hospital is proceeding, as you would be aware. The Commonwealth has paid the commence construction milestone. That payment was made in October—this month—on the basis of the evidence provided to us by the Northern Territory government of the progress that they had made, in particular the engagement of the managing contractor and that managing contractor having now occupied the site.

**Senator McLUCAS:** And that contractor was?

**Ms Anderson:** Lend Lease.

**Senator McLUCAS:** You say 'evidence'; did you just see a contract?

**Ms Anderson:** No, quite the contrary. We have certain expectations of all funding parties around the evidence they need to provide in order that we can be satisfied that milestones have been met and, therefore, that payments can be made. They provided evidence that Lend Lease had been engaged as the managing contractor, which occurred on 22 July. They gave us early design documentation. They provided detail on the project schedule. They provided advice that Lend Lease had obtained access to the site pending approval of the subdivision. We were also advised that Lend Lease had joined the design team from August 2015 at the user group meetings, with the formal novation of the design team to Lend Lease occurring in mid-September. They also provided us with photographic evidence that work had commenced on the site by way of clearing and remediation work.

**Senator PERIS:** I am a bit of a thorn in your side when it comes to the Palmerston hospital. You said that work had commenced. Sorry, I did not hear—did you say you had made a milestone payment?

**Ms Anderson:** That is correct.

**Senator PERIS:** How much was that?

**Ms Anderson:** Thirty five million dollars.

**Senator PERIS:** When I asked you in May about that $35 million, there was a report that had to be given to the department by the Northern Territory government.

**Ms Anderson:** Yes.

**Senator PERIS:** Are you satisfied with that report?

**Ms Anderson:** You will recall the answer I provided in previous estimates that we had received that report and were reviewing it. Some time has passed since May. We have been in discussion with the Territory in relation to the nature of the evidence they could provide about commencing construction. They have subsequently been able to provide that evidence I just cited, which satisfied us that the milestone payment was payable.

**Senator PERIS:** Did that report include detailed engineering plans?

**Ms Anderson:** I could not say. I would have to take that on notice. I am not aware of—

**Senator PERIS:** Was it a subcontractor that got the go-ahead to build the hospital?

**Ms Anderson:** Lend Lease was appointed as the managing contractor.

**Senator PERIS:** Did that design package include a complete fit-out of the hospital? What did the design package look like?

**Ms Anderson:** Again, that is detail I do not have in front of me.

**Senator PERIS:** So you agree that the hospital has commenced construction?

**Ms Anderson:** We have made the milestone payment on commenced construction.

**Senator PERIS:** What sort of construction does that milestone payment include? I think we previously went through what ascertains 'commenced construction'. Does it need fencing or people wearing hard hats? Does it mean a hole being dug?

**Ms Anderson:** As I just outlined to Senator McLucas, there are a number of points of evidence that the Territory provided to us which, in total, satisfied us that they had met the milestone.

**Senator PERIS:** What evidence do you have that suggests that they have commenced construction?

**Ms Anderson:** The evidence has been provided by the Northern Territory in relation to the appointment of the managing contractor, the design documentation, the detail on the project schedule and the fact that Lend Lease has access to the site and is now engaged in detailed design work, and we have photographic evidence of early work on the site.

**Senator PERIS:** What photographic evidence do you have?

**Ms Anderson:** I am advised—I have not seen it myself—that the photos relate to evidence of on-site clearing and remediation work.

**Senator PERIS:** On 16 October, which was just recently—on Friday, in fact—concrete was poured at the hospital site. Do you know what this was for? Was this part of the construction?

**Ms Anderson:** I am assuming it was, yes. Concrete is poured as part of building hospitals.

**Senator PERIS:** So this constitutes construction?

**Ms Anderson:** As part of a process to build a hospital, yes.

**Senator PERIS:** Minister John Elferink and the federal member for Solomon, Natasha Griggs, have claimed that the concrete poured on 16 October is for a stairwell. However, Mr Elferink has admitted that it is not part of the hospital proper. I am not too sure what 'proper' means. Do you know what the stairwell is for?

**Ms Anderson:** No. Those are matters of detail which are well within the scope and responsibility of the managing contractor and the jurisdiction commissioning or overseeing the work. It is not something in which the Commonwealth would get engaged.

**Senator McLUCAS:** But you did say that you have photographic evidence of the work starting, and that was important in terms of the $34 million being transferred.

**Ms Anderson:** $35 million.

**Senator McLUCAS:** $35 million, pardon me.

**Ms Anderson:** It is part of the brief of evidence that we sought and received in order to satisfy ourselves that the milestone payment was due.

**Senator McLUCAS:** But I think this hole in the ground with concrete in it is now contentious, and I am concerned that we have passed over $35 million to the Territory on photographic evidence that now is tested.

**Mr Bowles:** I think the photographic evidence, as Ms Anderson said, is part of the issue.

**Senator McLUCAS:** Yes, I understand, but it is part of it—

**Mr Bowles:** It is part of it, absolutely.

**Senator McLUCAS:** and now there is a dispute about whether or not a hole in the ground is in fact a stairwell or a publicity stunt.

**Mr Bowles:** A dispute in the context of what—that media article?

**Senator PERIS:** I guess what we are trying to draw your attention to is that the clearance amount of the hole that was dug amounted to an area of 10 by 10. There was no other evidence that vegetation had been cleared for further construction. The hole that was dug has now been filled back in with the dirt that was dug out. Are you aware of that?

**Mr Cormack:** Could I just make it clear that the $35 million was a payment due under the agreement we have with the NT government, and the milestone was the engagement of the managing contractor, Lend Lease, and their taking possession of the site. That milestone has been met, and therefore the NT government are entitled to their payment. The Commonwealth does not get involved in the micromanagement of capital works projects. It is not our core business. We have a funding agreement with the NT government. They have met the milestone for the $35 million payment. It is not our job to supervise the construction—the digging of holes and the further investigation of whether the hole should have been dug, its

dimensions or its purpose. These are matters for the managing contractor. They have met their milestone requirements and have been paid accordingly.

**Senator PERIS:** But the milestone payment was for the commencement of construction.

**Mr Cormack:** The milestone payment of $35 million is contingent upon the engagement of the managing contractor, Lend Lease, to take possession of the site and then to commence construction. So they have met their milestone. It does not specify holes to be dug. It does not specify the precise location of every other element of the construction as a requirement for further payments. So we have a contract with them; they have met the milestone; and the Commonwealth has paid what was required.

**Senator PERIS:** Is this not of concern to you? Natasha Griggs stood up in parliament and said that she is clearly delivering for the Northern Territory and Minister Elferink said:

> That's real concrete in the ground, that's a real site office behind us, Lendlease are a real organisation that build real buildings.

The concrete that was poured last Friday has since then been filled back in and they have come out and said that it was for safety reasons. Why are they digging a hole, pouring concrete—

**Mr Cormack:** You would have to ask the construction company.

**Senator PERIS:** Are you happy that the Northern Territory government—

**Mr Cormack:** We are happy that the NT government have met their milestone payment requirement.

**Senator PERIS:** So $35 million of taxpayers' money has been given to the Northern Territory government to contract Lend Lease to dig a hole, get media out there and pour concrete in and, within 24 hours—and the concrete, I assume, is not even dry—they fill the hole back in.

**Mr Cormack:** That is a claim. We have not looked into the specifics of the claim about the nature of any hole dug and filled in. That is a claim that we have not looked into. What we are responsible for is discharging a contractual arrangement with the NT government and a milestone payment for which they met. Engagement of the contractor means that the contractor has done all the necessary planning work and the approval work and they have the subcontract arrangements ready to go. There is a whole range of important works that need to be undertaken in any capital works program.

**Senator PERIS:** So is a hole in the ground filled with concrete a major landmark?

**Mr Cormack:** I do not believe that is actually in the contract, and I do not believe that is a contractor requirement within the NT government.

**Senator PERIS:** So it is a stairway to nowhere, but according to the—

**Mr Cormack:** The NT government have met their milestone payment.

**Senator PERIS:** So are you saying that a hole in the ground—

**Mr Cormack:** No, I am not saying that; you are saying that. I am saying that they have met their milestone payment.

**Senator PERIS:** Natasha Griggs said:

… the first work on the site of the hospital, is a major landmark and all those who have been involved with this campaign over the years deserve to be congratulated.

So they have dug the hole, poured concrete in and they have covered it back up.

**Mr Bowles:** That is an issue for the Northern Territory government. As Mr Cormack and Ms Anderson have said, the Northern Territory government have met their milestone. Construction starts with the appointment of the contractor and the design work and access to the site. They have all of those things. If the Northern Territory government have made claims and have done things, that is an issue for the Northern Territory government, and we should leave it at that.

**Senator McLUCAS:** Mr Bowles, will you conduct an investigation into these matters?

**Mr Bowles:** We monitor all funding that we put out for all purposes and we will continue to monitor all funding for all purposes that we put out, in the normal course of the events that happen. The issue here is that the milestone has been met, because there is a construction company appointed and there is access to the site. The details of the building and all of the things, as has been explained by Mr Cormack and Ms Anderson, are the business of the Northern Territory government. Again, there are milestone payments through the whole process. If they do not meet their next milestone they will not get paid; if they do, they will.

**Senator McLUCAS:** What is the next milestone?

**Ms Anderson:** The next milestone is completion of the base of the building. I understand that there is $20 million attached to that. We are currently in close discussions with the Northern Territory government around the likely timing of that. It may be that there is a negotiation around movement in the timing of that, given where they are now. That is still in play. The Northern Territory government have come back to us and confirmed the intention to complete 2018, which is the date we have always had in mind—they have not shifted from that. The milestones between now and then are the subject of further negotiation, but the next milestone is completion of the base of building.

**Senator McLUCAS:** What does 'the base of building' mean? Sorry; I have only built one house.

**Mr Bowles:** It is probably a technical question that we would have to take on notice.

**Senator McLUCAS:** You have a hole in the ground that is now filled in—

**Mr Bowles:** More than likely, it is the base construction that allows them to go up from there.

**Senator McLUCAS:** So it is the slab?

**Senator PERIS:** So it is the base construction of the entire build?

**Ms Anderson:** I understand it is the skeleton of the building—the overarching structure without much inside.

**Senator PERIS:** So, by May next year, there is a further $20 million and completion of the base hospital.

**Ms Anderson:** The base building, yes.

**Senator PERIS:** Can you confirm exactly how much you have paid the Northern Territory government to date and the dates you made those payments?

**Ms Anderson:** Yes. To date, we have paid $56 million. There was one $1 million paid in 2011, $20 million in 2014-15 and now the most recent payment of $35 million.

**Senator McLUCAS:** Are those milestones and the time line public information?

**Ms Anderson:** As I say, we are currently negotiating with them on an adjustment of the milestones. So that is still a work in progress. The current milestones—which, as I say, are the subject of change—are available on the website.

**Senator McLUCAS:** So that is one and two?

**Ms Anderson:** The milestone payments?

**Senator McLUCAS:** Or the total—

**Ms Anderson:** The milestones, as they were originally configured, are part of a national partnership agreement, which is available publicly. But those milestones will change.

**Senator McLUCAS:** And, as they change, they will be changed on the website?

**Ms Anderson:** Yes.

**Senator PERIS:** Chair, and I able to table this for the department?

**CHAIR:** You can give it to the department for them to have a look at.

**Senator PERIS:** Minister, I am asking for the people of the Northern Territory, who have had their hopes up with this 10-by-10 concrete pour into a hole, which has now been covered up, whether it is something that you would take upon yourself to ensure that the Northern Territory are meeting their milestones. It is approaching November and, I know as a Territorian, wet season is due to kick in and, come May, the base of a hospital is a big construction project.

**Senator Nash:** Of course, I would, and I think the department has been very clear in answering exactly what the process is from the department's perspective. I would have thought that the people of the Territory would be very happy that the payment had been made to the Northern Territory government to progress this. My understanding, having been up in the Northern Territory quite a few times, is that the Palmerston hospital is something that people are very much looking forward to. So I would think that they would be thinking that it is very good progress to see those payments being made to the government.

**Senator PERIS:** I guess it is our perspective that you are making payments for a government to achieve milestones, and what has been put out there by the Northern Territory government is not exactly what the expectations are of the citizens of the Northern Territory. They are expecting a hospital to be built by 2018.

**Senator Nash:** My understanding is that it is absolutely on track to be built by 2018. Obviously, neither I nor the department has a responsibility for digging holes, filling them in, emptying them out or putting things into those. As has been very clearly stated, those types of procedural issues are not for the department, but the department has been very, very clear that the milestone was met, the payment was made and the hospital is on track for completion by the due date. I do not know what else we can say that would assist you, Senator.

**Senator PERIS:** From the federal government's perspective, you are putting $150 million into this project and you have just paid $35 million—

**Mr Bowles:** It is $110 million.

**Senator PERIS:** Sorry, $110 million and $40 million from the Northern Territory government. Are you happy with the way things are: with a hole being dug and filled back in with sand? Has this ever happened before?

**Mr Bowles:** It is not our job to be happy; our job is to monitor the milestones, and that is what we are doing. We have made the milestone payments according to the contractual arrangements that we have with the Northern Territory. If the Northern Territory are doing things that Northern Territorians are not happy with, that is a matter for the Northern Territory government. We will monitor our milestone payments according to the normal way we do that. As Ms Anderson has said, we are already negotiating on the next milestone based on a whole range of factors in that construction. But there has been no indication to us that we are not going to meet a 2018 deadline at this point.

**Senator PERIS:** Based on the evidence that you have received from the Northern Territory government and your contract that you have with the Northern Territory government, that construction was due to commence on 15 May, and on 16 October you are happy with a hole that has now been covered.

**Mr Bowles:** Again, it is not my job to be happy.

**Senator PERIS:** Satisfied?

**Mr Bowles:** Our job here is to discharge our responsibilities under the contractual arrangements. Construction is the appointment of a contractor, Leightons, which has been done, access to a site, which has been done, and a whole range of these issues, as Ms Anderson and Mr Cormack have said, have been ticked off for payment of that $35 million milestone payment. If they do not meet the next milestone, those payments will not get made. If they do meet the milestones, the payments will be made, and we will continue to talk to the Northern Territory government along the way. We have paid $56 million of $110 million at this stage, so we will continue to monitor the project as it goes. But there is no indication from our side that there is any concern about the milestone payments to date.

**Senator PERIS:** Are you shocked by what you have seen?

**Senator Nash:** Senator, I do not know that there is anything that we can actually assist you further with.

**Senator PERIS:** It is a stairway to nowhere.

**Senator Nash:** We have now spent 26 minutes on a hole—

**Senator PERIS:** Exactly! The Northern Territory has been tricked into believing that this was—

**Senator Nash:** I know you are trying to make this into something, Senator.

**Senator PERIS:** Not at all.

**Senator Nash:** The department has very clearly outlined what the process is in terms of the contractual arrangements that have been struck. That milestone has been met according to the definition, so the payment was made. From the department, I do not know that there is anything else we can do to assist you. All has been appropriately done as per the contract.

**Senator McLUCAS:** I just want to know: will there be a follow-up to the issue that has been raised here at estimates today?

**Ms Anderson:** We talk with our counterparts in the Northern Territory government quite often. This will undoubtedly be something we will raise with them and ask for their advice as to, in fact, what has happened. Concrete pours are part of the warp and weft of building a hospital. They happen at stages and times which are the subject of detailed design planning by managing contactors.

**Senator McLUCAS:** And the filling in of holes might be part of that as well?

**Mr Bowles:** It could be.

**Senator McLUCAS:** But I am interested to know whether there will be some investigation following this being raised at estimates today. Will that occur?

**Ms Anderson:** It will be discussed with the Northern Territory officials, yes.

**Senator McLUCAS:** Can this committee then receive some information about what has transpired?

**Mr Bowles:** We can take that on notice.

**Senator SMITH:** I think there should be a gold medal at Senate estimates for Senator Peris's effort this morning. But I do think there is more to the story. In addition to you providing the senators with that information about a full account of events, my understanding is that the slab is part of the emergency stairwell. It has been covered for safety reasons while a fence is being constructed around that slab and that emergency stairwell hole. So far from being the stairway to nowhere, as Senator Peris has suggested, it is an emergency stairwell. Far from the concrete slab having been covered up, it will be uncovered once the perimeter fence is established. There should be a gold medal for effort, but it was a very poor effort around honesty. I am sure Senator Seselja and Senator Lindgren will agree with me that it is a very worthy project. If I have heard your evidence correctly, it will be built, and Natasha—

**Senator PERIS:** How would you know?

**Senator SMITH:** Evidence from the department. A commitment, based on your understanding, that the hospital is scheduled for completion.

**Senator MOORE:** I have been trying to find the milestones on the Department of Health website. I just cannot do it. I have seen lots of NT government fluff pieces, but I want to see exactly what the milestones are, as publicly printed, so that people can see them and also see whether there is a definition of some of these core issues within that milestone document. That documentation would be useful. Can the department get me that documentation?

**Ms Anderson:** Absolutely. In fact, I may have misled you; it is actually on the Prime Minister and Cabinet website, not the health website.

**Senator MOORE:** It could have been a threshold issue. Nonetheless, it would be very useful if we could get the milestones as public and the definition that is available, publicly, on those milestones.

**Ms Anderson:** I am happy to take that on notice.

**Senator MADIGAN:** My question pertains to the NATA—the National Association of Testing Authorities—accreditation of overseas laboratories. Is there anybody, here, who could respond to that?

**Mr Bowles:** We may not be able to answer all your questions, on this, because it is not our space, but Professor Skerritt might be able to help us a little bit with this.

**Senator MADIGAN:** I understand that Lyme disease-literate doctors refer some of the patients to internationally accredited overseas pathology laboratories, but the test results are deemed false positives as these overseas labs are not NATA accredited. I understand the problem is that NATA is no longer resourced to undertake international accreditation and that though they have applied for membership of the International Laboratory Accreditation Cooperation, ILAC, that could take a year or so to complete. Hence, there is a gap, as there is currently no mechanism for mutual recognition of overseas medical testing. What has the National Pathology Accreditation Advisory Council, NPAAC, done to address the current gap in Australia's ability to recognise overseas laboratories?

**Prof. Skerritt:** I will, briefly, clarify a few issues around NATA. NATA are not part of this portfolio. Indeed, they operate, largely, on a fee-for-service cost-recovery basis and are, quite deliberately, at arm's length from government. They do have a role, as you have correctly identified, within Australia in assessing laboratories and performance of laboratories. On the matter of Lyme disease, I would like to pass over to the Chief Medical Officer.

**Prof. Baggoley:** This issue of Lyme disease and, particularly, the issue relating to diagnostic testing and how a sample of blood from one patient can be diagnosed as negative for Lyme disease in one laboratory and positive in another, which is often an overseas laboratory, is one which has been of great interest and concern to us in the department. We are doing work, specifically, in this area. Dr Lum, I wonder if you could speak to that?

**Dr Lum:** Thank you. I will explain what we are doing, in terms of the department, and, if you would like, I can go through some of the background of the National Pathology Accreditation Advisory Council, its relationship with the National Association of Testing Authorities, Australia and the Royal College of Pathologists Australasia as well. In terms of the reference that Professor Baggoley made, we are aware that there have been some concerns about discordance of test results associated with Lyme disease testing, in Australia, between the accredited medical testing laboratories in Australia and other laboratories.

It should be made clear that overseas laboratories—for example, IGeneX, in San Diego, in the United States, Infectolab and ArminLabs in Germany—have sought their own certification in their own countries. I have been told that they are compliant with the international standard on requirements for quality and competence. From a recognition of their accreditation, there is no argument there. There is one laboratory, in Australia, that a lot of the patients are interested in. That laboratory has not been successful, so far, in its assessments for medical-testing accreditation but it is undergoing assessment. I am not in a position to comment on whether they will be successful or not; that is business between the National Association of Testing Authorities, Australia and the Royal College of Pathologists of Australasia.

Because of this discordance we are seeing in the testing we have contracted the National Serology Reference Laboratory, which has independent expertise in assessing in vitro diagnostic assays. It was set up as a laboratory facility that worked very closely with the Therapeutic Goods Administration. It started its work when human immunodeficiency virus and the acquired immune deficiency syndrome first came on the scene. Since then, it has

developed expertise not just in testing for HIV but also in the other viral hepatitides. For example, there is the hepatitis B virus and the hepatitis C virus and some of the others. Its expertise is in the evaluation of diagnostic assays so that from an Australian perspective we can be satisfied of the quality and safety of testing for those things.

We have contracted the National Serology Reference Laboratory to undertake an independent evaluation of the diagnostic assays that are being used. We have sought participation from IgeneX, in the United States, from Infectolab, in Germany, from ArminLabs, in Germany, from the Rare and Imported Pathogens in Public Health England, in the United Kingdom, as well as Australian Biologics and about a handful of Australian accredited medical-testing laboratories. What we hope to determine from that evaluation is whether there is any problem with the diagnostic assays, themselves, in terms of testing done here or overseas. We may also be in a position to examine some of the other differences or problems associated with those assays.

Getting back to the issue of the discordance, one of the important things in human-pathology testing is it is really important to understand, particularly with human serological testing for microbiology, that serology should rarely be used to make a complete diagnosis. Serology is an adjunctive diagnostic component to aid diagnosis of a disease. For example, with classical Lyme disease, it is really important that patients have typical symptoms. When the serology is performed in an area where there is high prevalence, a positive result is a good indication that you have true disease and a negative result is a reasonable indication that you do not have the disease.

One of the things we often have difficulty in appreciating, outside of pathology circles, is that each test has its own sensitivity and specificity but the predictive value of the diagnostic test is really determined on two things. One is the prevalence of the disease in its truer state and also in the interpretation. What we know about Lyme disease testing—classical Lyme disease testing, in Australia—is that the prevalence of true classical Lyme disease in Australia, is low. In fact, it is probably zero. The prevalence in those areas where it is endemic is high. Based on that, if you have a test with a high specificity, a negative test here is highly likely to predict true negativity—whereas a positive test is likely to be a false positive. The other important factor is interpretation. I have seen the results from patients who have submitted their specimens overseas to America, to Germany and to other places and, when I look at the results that come back and the interpretation of the results, those interpretations are often at odds with the standardised criteria that are established by large agencies, like the Centers for Disease Control and Prevention, in the United States, as well as other centres in Europe for communicable diseases. The criteria that are used need to be stringent, because they are criteria used not only for surveillance but also they assist with diagnosis.

The disharmony or discordance we see in testing is not necessarily unexpected. It is unfortunate and it is difficult for a lot of patients. Without wanting to sound prejudiced against my medical colleagues, outside of pathology it is fairly difficult for people to understand the nuances of diagnostic tests and their value, and that demonstrates the importance of having pathologists in the Australian medical system.

When it comes to the background on accreditation, Australia has a really good system of medical testing accreditation based on the international standard 15189. The policy is set by

the National Pathology Accreditation Advisory Council, which is made up of jurisdictional representatives, usually pathologists or senior medical laboratory scientists, as well as representatives from the peak bodies involved in medical testing in Australia. They set the standards and the guidelines. They also align themselves with this international standard. The operational arm of this is the National Association of Testing Authorities Australia and the Royal College of Pathologists of Australasia. That is specifically for the medical testing program, where they do assessment of laboratories. They usually spend a day in the laboratory doing assessments. If a laboratory is successful with their assessment, then they are accredited for medical testing.

**Senator MADIGAN:** Could I seek the advice of the department regarding the outcome under which the department could advise about Lyme disease and also Q fever?

**Dr Lum:** Outcome 9.

**Senator MADIGAN:** So you will have people here for outcome 9 who can answer questions about Q fever and Lyme disease?

**Dr Lum:** Yes.

**Senator SIEWERT:** Which part of the department is responsible for the Health and Other Services (Compensation) Act?

**Mr Bowles:** I will have to get back to you on that one.

**CHAIR:** Sorry to interrupt, Senator Moore has a follow-up question on the previous point.

**Senator MOORE:** Professor Baggoley and Dr Lum, you said that you are doing some specific work in the area. I want to clarify if it was specific work in the general area of diagnostic certainty, in relation to the very detailed evidence you gave us, or whether there was specific work being done on Lyme disease. I was not clear on that. Your answer looked at the whole process across certification across the whole world. I know that we have a shared passion about the Lyme disease stuff. Is there particular work being done within this field on Lyme disease?

**Dr Lum:** Yes, senator. I apologise for not being specific. The work we have contracted with the National Serology Reference Laboratory is particularly about the in-vitro diagnostic assays that are used for the diagnosis of Lyme disease.

**Senator MOORE:** Thank you. That answers my question.

**Senator SIEWERT:** Getting back to my earlier question—

**Mr Bowles:** We are checking it.

**Senator SIEWERT:** Okay. I have a couple of questions about what the process involves, if it is being used, and the amount of money that is being claimed from Medicare costs et cetera. Should I ask them here or is it better for you to come back at the end of this session.

**Mr Bowles:** Is there more about the compliance functions of Medicare—

**Senator SIEWERT:** It is under the Health and Other Services (Compensation) Act.

**Mr Bowles:** It is likely to be more around an outcome 3 issue.

**Senator SIEWERT:** I will leave it until then.

**Senator MADIGAN:** Dr Lum, with the many problems with pathology that you have just alluded to, what has the department done to educate doctors, for example, that an EM bullseye

rash is considered pathognomonic—around the world I believe that is a diagnostic sign for Lyme disease. Could you explain to me very briefly why it was removed from the diagnostic guidelines for Australia, instead of educating doctors about how to look for it and diagnose it?

**Dr Lum:** I think you are referring to the guidelines that the department recently released to the medical community in Australia. That was a guideline that was specifically around the diagnosis of Lyme disease in patients who had acquired the disease overseas. That guideline had originally been drafted by former members of the Chief Medical Officer's Clinical Advisory Committee on Lyme Disease, as well as going through the Public Health Laboratory Network and Communicable Diseases Network Australia, and was recently endorsed by the Australian Health Protection Principal Committee. That particular guideline does make reference to erythema migrans as a pathognomonic rash that is associated with Lyme disease, and it makes it very clear that that rash and that pathognomonic occurrence are related to areas where the disease is endemic. In Australia we do not have endemic classical Lyme disease—that is, we do not have actual evidence of that for patients who have rash after tick bites.

It is very common across the eastern seaboard of Australia that there are lots of ticks. Ticks contain a significant number of microorganisms, mainly bacteria, but they will also contain viruses and parasites. So it is not uncommon after a tick bite for there to be a rash. It may in fact be a circular or an annular rash and in some cases it may look like a bullseye rash, which is said to be pathognomonic for Lyme disease. The problem is that because we are not an established endemic area, it would be inappropriate for medical practitioners in Australia to make that diagnosis. To use pathognomonic signs, to use clinical signs and symptoms to diagnose medical problems really relies on a high pre-test probability, so you need to be in an endemic area or you need to have classical signs and symptoms. In this situation, we do not unfortunately have evidence of high endemicity in Australia, so it makes it really difficult.

We really feel for these patients. I am in communication with many of them regularly, as well as their doctors. At the moment it is not clear what their clinical condition is really caused by. But all of the evidence to date from the research that has been done suggests that it is not classical Lyme disease. To date there has not been found in Australia any *Borrelia burgdorferi*, the causative organism, or any of its very related organisms. You may be aware of recent research from Professor Peter Irwin, a veterinarian from Murdoch University. He did some work looking at 196 ticks in Australia, plus 30 ticks from Germany, where he readily found *Borrelia burgdorferi* in the ticks from Germany but was unable to find it in any of the Australian ticks. What he did find in one tick that was extracted from an echidna on the New South Wales coast was a probable *Borrelia* species that he thinks is probably in the relapsing fever group, which is very distinct from Lyme disease. But because the sequence that he was able to obtain from his next-generation sequencing techniques was not long enough, he was not able to characterise the organism and provide us with the species name.

**Prof. Baggoley:** To add to that, I also want to acknowledge all of those who have been diagnosed with Lyme disease in Australia, a number of whom have contacted Dr Lum and me. We continue to spend a lot of time trying to work through the varying elements of the diagnosis and the treatment. That is really important. Regarding the erythema migrans that you describe as being a pathognomonic of Lyme disease, it occurs with a whole range of

diseases. It is not as if you find that equals Lyme disease. That is important to understand. It can be part of the picture.

One of the things I do on an annual basis—in fact as recently as 20 August—is provide a progress report on Lyme disease in Australia and what we are doing about this. I do it as a letter to the AMA, the relevant colleges, a whole range of GP organisations, the chief health officers and the Clinical Advisory Committee on Lyme Disease, which I established to provide advice for this, which includes representation from the Lyme Disease Association of Australia, the Karl McManus Foundation and so on. There we give them an update as to what is happening with the evidence and diagnostic tests. We also continue to be keen to ensure that we get Australian doctors who are treating people who have come from overseas from one of those areas in Europe or the US and have had a tick bite to take the potential diagnosis for them for Lyme disease very seriously. Too often we hear of stories that members of the medical profession just do not include that in their diagnostic thinking, and we keep coming back to that.

**Dr Lum:** One of the things I forgot to mention in my earlier answer to your question was that medical testing laboratories in Australia that test patients who have acquired classical Lyme disease in endemic areas are able to readily diagnose the disease using standard serological tests. So we have a situation in Australia where many Australians who say they have never been overseas and who have non-specific symptoms look at the internet and see a whole range of people who are saying that they have Lyme disease. They initially see a general practitioner and they organise for a test to be done in Australia and it often comes back as negative. They then organise to have testing done in the United States and it comes back positive. That is the usual scenario. If a patient who is from Maine, Connecticut or another area in the north-east of the United States or from the Black Forest of Germany, who has been bitten by a tick and then travels to visit Australia and sees a general practitioner and has a blood test, we get a positive diagnosis. The same is true for Australians travelling to those areas and coming back with a rash and feeling unwell. Lyme disease is considered because they were in an endemic area, and a diagnosis is readily made in an Australian accredited medical testing laboratory.

**Senator MADIGAN:** I was speaking to a constituent only this morning who believes they suffer from Lyme disease and has gone through the testing. The doctor who was treating them believed that they had Lyme disease, but now this doctor is unable to treat them for some reason. These people are suffering. How long is it going to take before the government addresses these people's concerns? I have had numerous people come to me in my home state of Victoria claiming they have this sickness and they are suffering. They just do not see that anything is being done to address that. They have been treated for Lyme disease by some doctors and then these doctors are told by some professional bodies to back off or are harassed. These people are sick and it is debilitating for them. They are very motivated people, people running their own businesses, whose lives and those of their families have been turned upside down. Whilst there is an ongoing discourse by professionals on whatever side of the argument, these people are suffering. Quite frankly this is not good enough. When do you think you will resolve it or that these people's illnesses will be treated?

**Prof. Baggoley:** I thoroughly agree with you that there are a significant number of people out there who are quite unwell. They come from all walks of life, and we have communicated

with many of them. Dr Lum in particular spends many hours talking with them, and much of his time is taken up with Lyme disease. He is not only principal medical adviser in the Department of Health but also a specialist pathologist and still works as such at the Canberra Hospital. A significant amount of his time is taken up with Lyme disease. And the one thing that keeps Gary and I, in particular, continually focused on this amongst all the diseases, illnesses and issues there are in Australia, is that many of those patients—who you speak to and we speak to, because there are a lot of them—are unwell. And many have been given a diagnosis of Lyme disease, many on the basis of overseas laboratory testing. It is why I formed the Clinical Advisory Committee on Lyme Disease which had people from the whole spectrum of interests, opinions and involvement with Lyme disease to provide advice. We got to a certain stage and we are continuing to follow through many of the issues that are there.

The issue of doctors being warned off is one that is particularly interesting, and it is one that I have spoken about with the chief executive of AHPRA, Martin Fletcher, on a number of occasions. I think that it is important. Just recently I discussed with him this issue of Lyme disease and I have discussed this with him over the years whether the medical board have a particular issue about Lyme disease or doctors who diagnose it. I think that it is very important that I make their viewpoint clear. As he pointed out to me on Monday, the role of the Medical Board of Australia is to protect the public, and the board only imposes conditions on the practitioner's registration to keep the public safe. The Medical Board of Australia does not set clinical standards or adjudicate on the treatment of specific conditions. The board does not have a position on Lyme disease in Australia or any disease or treatment regime. The board expects medical practitioners to work within their level of competence, training and experience, and to comply with all relevant laws and with its code of conduct—good medical practice. The conditions imposed on the registration of any individual medical practitioner are always specific to that practitioner. They do not reflect the board's view about any disease state or treatment regime. That has been a constant position. The board does not have a position on Lyme disease; it does not have a position on doctors who diagnose or treat Lyme disease.

All doctors have to be accountable for the treatments of their patients. I understand there was one doctor in Queensland who was the subject of a complaint about their treatments by another doctor in a senior role in a hospital. We know that some of the treatments of people who have been diagnosed with Lyme disease can be very intensive and extensive, and involve intravenous antibiotics—sometimes for years. You need to be able to make those sorts of treatments on the basis of good evidence. All doctors are called to account there.

The other point of this is that we are putting in a lot of time, work and effort, and we liaise closely with Professor Peter Irwin of Murdoch, who is doing the key research right now in this country in relation to ticks, and he is doing further research which we are anticipating eagerly. He has found that there are lots of bugs and ticks, and he has found a new one. Whether anything he finds is associated with our own version of a disease caused by ticks, we still have to work through. It can be frustrating that it takes time to do that, but that is the nature of research. The Karl McManus Foundation—we work with and liaise with Mualla McManus, who is a champion in relation to this, at the University of Sydney's tick diseases unit and they are doing research. As soon as they have research results, we want to find it and make sure that the entire medical community is fully aware of it. We are particularly

interested in this disease. We are particularly concerned about the plight of people who suffer from a disease which has been diagnosed as Lyme disease, because many of them have very difficult and miserable lives. When will we have the answer? I think it would have been dead easy, if we had been able to find, say, the *Borrelia burgdorferi* bacterium that we know is there and readily found by our laboratories and our researchers when they have overseas tick samples, or when they have samples of blood and can do serology testing from people who have been overseas. We just have not found it yet, and it is frustrating in this country. It is not for want of endeavour or effort. We are trying.

**Senator MADIGAN:** Could you clarify one thing for me Professor Baggoley: is the department aware of the claims of bullying of some doctors out there treating people?

**Prof. Baggoley:** We were aware of a particular doctor in Queensland who was the subject of a Medical Board investigation involving his treatment. As I understand it, and Dr Lum will correct me if I have any elements wrong, he was required in future, when diagnosing Lyme disease, to have that diagnosis verified by an infectious diseases specialist in Australia.

**Senator MADIGAN:** What do you say to people in the community who have been diagnosed by some doctors as having Lyme disease and then, after treatment and their symptoms have reduced markedly, the doctors have said, 'I can't treat you because I have been told to back off and not to treat you in such a way.' How do you respond to those people who have now gone back to being as sick as they were with continuing migraine headaches, bleeding et cetera? That does not help them. If they were getting better, why is it that their doctor cannot treat them?

**Prof. Baggoley:** There is no reason that their doctor cannot treat them. I do not know exactly who is telling them that they can or they cannot. It is certainly not coming from the Medical Board. We liaise with the presidents of colleges. Many of the people in senior places keep an open mind. There are not many who believe we have *Borrelia burgdorferi* in this country, but there could be other causative organisms. The department would not condone any bullying of one doctor by another. But we are not involved in that setting. The Medical Board does not provide implied or other threats. You have just heard the view of the chief executive of AHPRA. If they are concerned, they should talk to their relevant college or their own medical board. But it is certainly nothing that comes from us or the Medical Board.

**Senator MADIGAN:** Thank you.

**CHAIR:** We are due to move on now to outcome 3, so I just want to get a sense from senators as to how many further questions there are in whole-of-government—

**Senator McLUCAS:** That was an important conversation, and I think that is worthwhile. But that would have been in—what outcome?

**Prof. Baggoley:** Outcome 9.

**Senator McLUCAS:** So let's take some time off outcome 9 when that is due. But I think we still have about half an hour on whole-of-portfolio.

**CHAIR:** I do not think we need to rearrange the schedule.

**Senator McLUCAS:** No.

**CHAIR:** Whole-of-portfolio people always take things out of other areas. We will push on, if people want to, with whole-of-portfolio. I will go to Senator McLucas.

**Senator McLUCAS:** I just want to go to questions on notice. Up until yesterday there were 10 questions on notice that were outstanding from budget estimates. Is that right?

**Mr Bowles:** Yes, that is correct.

**Senator McLUCAS:** Why were they outstanding?

**Mr Bowles:** We got 90 per cent in on time. We had a few that straggled in after that. The last 10 were ones I was trying to get more fulsome answers for. Our systems are pretty ordinary in some of our spaces, so we did struggle with some of them. I think it was 10 from memory that were only submitted yesterday.

**Senator McLUCAS:** Of those 10, seven of them related to the flexible funds?

**Mr Bowles:** Yes, that is correct. That was the biggest issue for me. We use a system called FOFMS—

**Senator MOORE:** We know it well.

**Mr Bowles:** It is a bit of an archaic system that has been around for a while. It has served as reasonably well, but what it is not good at is reporting. It is good at getting grants happening and out there. The reality is we have I think just under 14,000 grant activities that we do. They move around quite a bit. There are point-in-time issues with all of these. We were trying to get good answers on some of these things, and basically we failed to get total answers to some of the things. We have tried to give information on how the flexible funds currently sit. As I think I said last May, what we want to do this year is try and crunch that down a little bit from the current 14 that we have. We want to try and get a little bit more clarity. On the issue of trying to slice and dice: we found it almost impossible to get some of these things done.

There is a whole-of-government process at the moment around grants management. The Social Services portfolio are going to revamp the FOFM system. There is a fair bit of whole-of-government work happening at the moment around some of the common issues that we are grappling with—shared services is one; grants management is another. They are trying to bring it back to a single, or a one or two system-type issues.

**Senator McLUCAS:** Why did it take until yesterday to tell me that you could not answer my questions?

**Mr Bowles:** Because I thought I was going to be able to give you a better answer than some of the things I gave, and I cannot. So what I have been able to do—

**Senator McLUCAS:** Why did you say, 'to capture the information requested would be an unreasonable diversion of resources'?

**Mr Bowles:** Because we would have had to go manually through 14,000 grant activities to get to an outcome that we just cannot do on a system basis. What we would have to be doing is going through every single one of these—

**Senator McLUCAS:** And that took until yesterday to come to that view?

**Mr Bowles:** It took until yesterday to get the answer. I was still trying to work out how we might be able to give better answers, but we could not. I cannot remember the specifics now, but for one of them we did give you a break-up of the funding over the forward estimates around the flexible funds. We have given you the program links to a range of the flexible funds. A whole list of things about our grant activities is on the website. We just did not have

time to go through and put all of these things together. It is a pretty complex set of issues when you are dealing with nearly 14,000.

**Senator McLUCAS:** But it took until yesterday to come to that view that it was not possible to do it.

**Mr Bowles:** No, I think we had come to the view maybe a couple of weeks ago, but we were still trying. It took to yesterday to get the questions finished. That is correct. I accept that.

**Senator Nash:** I know it is always the senator's view that we should be getting all of these questions in well in time, so I completely understand that you would have preferred that. But I do have to say for the department that since early 2011, apart from May last year, this is the highest percentage of responses that have gone back to senators on time, so I think that is a pretty good effort.

**Senator McLUCAS:** Is the process of answers being approved by the minister's office still underway?

**Mr Bowles:** It is not an approval process per se, but we do run answers past the minister's office.

**Senator McLUCAS:** But not all?

**Mr Bowles:** Not necessarily. They all go up. But ultimately I have to work out what the appropriate answer to the question is. I will take views from the department; the minister's office will have a view. I try to put as much information out there as I can. We have been working pretty hard at trying to get as many answers as we can back in time. I totally understand your frustration around these things. I have the same frustration. If you ask some of my staff, they will probably be able to tell you about my frustration in this particular area, because we should be able to do things. We just cannot, at this point.

**Senator McLUCAS:** Were any of those 10 answers that came in yesterday changed in the minister's office?

**Mr Bowles:** I could not tell you.

**Senator McLUCAS:** Could you find out for me.

**Mr Bowles:** I can take that on notice. There might be nuance issues that they may have looked at. But, to be frank, something might be nuanced and I might nuance them back. I would have to take it on notice and have a look at each individual one. From my recollection of the broad strategy around how we were going to try and deal with some of these issues: there is no real change there. There are complex, difficult issues that we are trying to grapple with when we have so many grants. I think we would probably be one of the biggest grant departments in the Commonwealth, and with aged care back I think we will be the biggest grant agency. I am not even sure I want to know how many grants there might be once we get the whole lot back together.

**Senator McLUCAS:** We will come back to flexible funds later. In what outcome will that be?

**Mr Bowles:** It will depend on the question.

**Senator McLUCAS:** Yes, that is the problem.

**Mr Bowles:** They go across a number of outcomes.

**Senator McLUCAS:** All right. What I am trying to get to is the cuts of $962.8 million that were made. It is important for us to understand where those cuts will land and, to this point, we do not understand that. Can we have some clarification around where those cuts are going to land across the 16 funds that we have.

**Mr Bowles:** That is still a process that we are working through. The nature of these funds is that it gives the minister the flexibility around how we fund certain activities. The reality here for 2015-16, and I think I explained this in May, is that we are building up the cuts, if you like, over the forward estimates. We should be able to cover the amount for this year because we have already—

**Senator McLUCAS:** Sorry, I do not understand, Mr Bowles. What does it mean?

**Mr Bowles:** We have funded all of the current activities that are in place—

**Senator McLUCAS:** Until the end of 2015-16?

**Mr Bowles:** until the end of 2015-16. The issue there is: some will still have to be dealt with in the context—we will have some in different stages. We will have some that will not progress; they are just one-off funding or they are short-term funding to do certain things. There will be some that will be in a current out-to-market type arrangement. I think we have got two just about to go out, but we have got about 17 that we are preparing to go to the market. I think we have been out for about 17 already. The big one that we went out for was for peak and advisory bodies; we have nearly finalised that one. As we go to the market, we will be able to clarify more about what the funding envelope is.

In the context of 2015-16, we are confident that we can fund the current activities that are out there. Will we do new and different ones? Not necessarily at this stage; that will be a matter for the minister and the government to decide over time. The bigger reductions in funding in the flexible funds happens in the out-years and we are giving ourselves this year to try and work that issue through so we can be quite definitive. But as you will notice—let me just find the question concerned—if you have a look at the funding envelope, it goes slightly up, if you like, over the forward estimates before you actually see the cuts. What we are trying to do is to fund the current activities that are ongoing. The ones that are stopping, we will stop, and, as to the ones that we need to change, we will actually do this in the context of the work I mentioned earlier around trying to come down from the current arrangements around the 16 flexible funds. Fourteen are affected because we have already said Indigenous and medical indemnity were not affected, so 14 have the ability to be affected. I think it is also important to understand that, in the flexible funds context, it is not all about grant funding for services. There is a whole lot of stuff there about nurse practitioners or the practice nurses, there are issues there around our incentive payments and there are a range of different things that go in there that are not affected as a grant.

**Senator McLUCAS:** We do not understand that, Mr Bowles. That is why we keep asking these questions and that is why I was somewhat—

**Mr Bowles:** And that is what I am trying to do. A good one is question 489, so SQ15-000489 will give you a pretty good understanding across the current flexible funds of what the current arrangements are. I think if you go to one of the budget papers it will give you the breakdown of the funding. If you look at the 2014-15 measure and the 2015-16 measure,

which gets to that $793 million figure that you talked about, $100 million of it relates to the 2015-16 year, but it builds over time. That is in one of the budget papers. I cannot remember which budget paper that is in, but it is in, I think, our PBS book. It will be in our yellow book.

**Senator McLUCAS:** Mr Bowles, I do not know that the conversation that we have just had will give confidence to about 13,000 grant recipients that we have talked about. People who are coming to us, and I daresay coming to you, are talking about some confidence in future arrangements. They are people who are employing people and they are people who are providing direct services into the community. They want to know what is going to happen after the 2015-16 financial year. I do not know that our conversation just then is going to give them much confidence.

**Mr Bowles:** We speak to these people all the time, and of the nearly 14,000—I think it is 13,960—grant activities in total that we have going on out there, not all of them are in the phase of their funding ceasing at the end of 2015-16.

**Senator McLUCAS:** No, not all of them.

**Mr Bowles:** In fact, there are some that go over much longer periods of time. We work with all of them, and, yes, you are right, we talk to them on a regular basis.

**Senator McLUCAS:** And they are telling you what they are telling us—that is, what is happening in the future.

**Mr Bowles:** I am happy if you have a particular organisation—

**Senator McLUCAS:** I have too many; too many to do on one day.

**Mr Bowles:** Even if you have too many, I am happy for you to give me a list of all of those and we will see what we can do, or I can give you more answers on the specifics. Quite frankly it is easier to do that than to deal with 14,000 grant activities that literally do move on. If you have that many you have so many in a day every day that it changes the balance quite regularly. Every little while it keeps changing.

**Senator MOORE:** I am following up because this is an area we have looked at with Senator Siewert and that this committee has looked at in other departments. I have heard the explanation of why some of the questions were difficult, but you have just said that you know that not all of the organisations are impacted with grant funding not finishing at the end of June. One of the particular questions asked by Senator McLucas was, 'How many organisations, funded through the flexible funds, have contracts expiring on or before 30 June 2016, and can we get them listed?' If you know which are being impacted and which are not, I am struggling to know why we could not get an answer to that question.

**Mr Bowles:** Because they are influx all of the time and the fact that some of them will be dealt with on a regular and that today we will probably fund a whole lot of activities or do all sorts of things. This happens every single day when you have so many grants. I would love to be sitting here—this is the last thing I want to have a conversation about—and able to tell you quite specifically about these things, but until we get a system that allows us to manage and monitor all of these grant activities, I cannot give you a more definitive answer. If I understand a particular group, I can then send someone off to find out what the particular answer is if there is particular organisation. But when you go to what is happening in this space, being nearly 14,000 activities, it is just a really difficult thing to do with the systems that we have.

**Senator MOORE:** The whole department does not manage all of the grants.

**Mr Bowles:** No, but we have a grants services area that does manage the grant activities.

**Senator MOORE:** That works with the individual section—

**Mr Bowles:** That is correct.

**Senator MOORE:** so, if I wanted to know what grants were available under alcohol and drugs, I would hope that the people working in the alcohol and drugs area of the department would know exactly what grants are under their area, what organisations and what date they are funded to. Taking that same matrix, if it is alcohol and drugs, then you could go to preventive health, and with the other areas that are covered. Whilst, absolutely, the central group, who are struggling with the beloved FOFMS, are trying to get reports out of it, they have this massive issue. But each individual division should know what is happening. I would have thought that the department would have the resources to say to each division head when they get a question like this one, 'Can you provide us from your division level which grants will end by these certain dates.' I would have thought that bite by bite this would not be such a massive target.

**Mr Bowles:** Unfortunately, bite by bite adds up to a lot of time when you are going backwards and forwards over a range of these things.

**Senator MOORE:** But don't they have it, Mr Bowles? This is the thing we struggle with all of the time: we would have thought that this would have been a natural element of the work responsibilities of an area, that someone within each of these very significant areas—although I have to admit much restructured, so there has been much movement as well, which is another thing to balance—would almost have a personal knowledge of the kinds of things we are talking of. D&A has been under the microscope now for so long. It has been raised in priority, it has got all of those issues—I do not know, I would have thought that taking that as a pure example, just in drug and alcohol, we could have got the information.

**Ms Cosson:** The complexity with the grants is where we talk about different organisations and we talk about programs and we talk about the flexible funds. What we are trying to break it down into is the organisations against the flexible funds. You talked about the drug and alcohol program, for example: yes, we can do that, certainly the policy areas and program areas do have an understanding of that and that is why, if we can get the specifics of a particular program or an organisation, it is a lot simpler for us to be able to store that information. When we try to break it down with a general question of give us all of the grants by flexible funds, that is a little bit more challenging because some organisations, for example, get funding not only through our grants program but they can also get it through direct appropriation. It is just the complexity, and that is where FOFMS, as you know, is just a grants management system and we have a separate reporting system that pulls from that. It is just the complexity of this.

**Mr Bowles:** And it takes a long time.

**Ms Cosson:** Yes. But if you have specific program areas, then we can have a look at that by program and understand which is the flexible fund component of that program that may be affected through the rationalisation of streamlining. But to give the fulsome answer to every grant or every organisation, which is about 3,000 organisations as well, that is the challenge for us to do that.

**Senator McLUCAS:** On the basis of that, we will write some further questions on notice.

**Mr Bowles:** If you look at SQ15-000491, what we have tried to do there is give you the fund and the program to try to give you an idea of some of the crossover issues that we are actually facing. Some programs go across multiple flexible funds. We want to crunch that down to make it a bit simpler into the future. Hopefully, we can not get wound up in this sort of issue.

**Senator McLUCAS:** We will follow that up.

**Senator POLLEY:** In relation to ageing and aged care that has come back into health, can you reassure us that there will not be any cuts from ageing and aged care through this process?

**Mr Bowles:** The budget measures for 2014-15 and 2015-16 relate to specific issues within the old health portfolio. As the aged care areas come across into the health portfolio, they will bring whatever they had in the old portfolio. We are not going to slice and dice across those particular things, but that is a matter for government over time when budgets happen. But in relation to the flexible funds in the health portfolio in the 2014-15 and 2015-16 areas, there is no issue around crossover into the ageing grants.

**Senator McLUCAS:** That is a nice segue into my next question. How many staff will be transferred back to the Department of Health from DSS following machinery-of-government changes?

**Mr Bowles:** I would love to give you a definitive answer. I will turn to my colleague in a minute, but it is in the order of anywhere between 900—

**Ms Cosson:** About 1,500.

**Mr Bowles:** Around 1,500 we think. Is that just Social Services?

**Ms Cosson:** No.

**Mr Bowles:** We have also got some coming from Human Services for the compliance functions. We think it is around 350ish from DHS and around 1,200ish, but maybe a little bit less, from Social Services. We are working through the guidelines at the moment. We hope to have that finished in the next couple of weeks—middle of November hopefully. That is the guideline that we are working through at the moment: to identify money, people and we have to do the list of staff. We think across both of them it is in the order of about 1,500 additional people.

**Senator McLUCAS:** How many staff will be moving offices?

**Mr Bowles:** It is hard to say at this stage. In the first instance no-one probably. Maybe there will be a group from the human services portfolio that will move. Most of the aged care people in the Canberra office, for instance, are in the same office as they were before. They are not going to shift.

**Senator McLUCAS:** So when they moved to DSS—

**Mr Bowles:** They did not change offices largely. There has been movement of people across social services and ageing in all of things that happen in the normal course of events, but they did not move office. A lot of our regional offices are already co-located in government buildings. We will not know until around mid-December the total footprint and who has to move and who does not have to move.

**Senator McLUCAS:** Where are negotiations up to regarding the new enterprise agreement in health?

**Mr Bowles:** As you would know, we went to a vote about a month ago or maybe even five or six weeks ago. It was a no vote—60 to 40 roughly I think. We are trying to understand that, we have been doing a lot of survey work around that. We have an added complexity with the aged care and compliance people and we are trying to work that issue through.

**Senator McLUCAS:** Have the ones who are coming in from DSS had a—

**Mr Bowles:** They went up as a yes. So we need to understand the implications of that in the context of us, but we are obviously going to be keen to bring them into our arrangements.

**Senator McLUCAS:** How does that work then?

**Ms Cosson:** For the DSS staff who are moving across into the Department of Health, they will move across to the Department of Health's enterprise agreement. They will be able to take their salaries so they will not have a reduction in salary. The pay point that they were on under the new DSS agreement will come with them, but they will move onto our conditions under the enterprise agreement for health. We will then go through a process where we will start bargaining again essentially.

**Senator McLUCAS:** With that small cohort?

**Ms Cosson:** With the whole department. At health we are up to about 27 bargaining meetings, where we will start back at number one with our DSS colleagues and also DHS colleagues who have joined the department. We are still hopeful that we will be able to go for a vote by the end of the year. I know that is quite ambitious because we have to go through the process and the bargaining conversations with the unions and invite staff to be part of that bargaining arrangement.

**Senator SMITH:** A keen interest of mine is the issue of questions on notice, it will not come as a surprise to you, secretary. Just to be clear, there were 376 questions on notice, 340 of them were made available—that is a 90 per cent return rate.

**Mr Bowles:** That is correct.

**Senator SMITH:** What can you tell us about the outstanding 36 in terms of when they were made available to the minister's office?

**Mr Bowles:** I think they were due on 24 January—

**Ms Cosson:** They were due on 25 September.

**Mr Bowles:** Sorry, 25 September. They were due at the committee on 24 July. We pretty much had the lot them, so the difference is the 36. There were 10 that came in yesterday, a number went across in July, a number went across in August and there were still 10 outstanding that we are trying to sort through in the last couple of weeks that we really could not get to, as I say to Senator McLucas.

**Senator SMITH:** Of the 36 outstanding, the department made 10 of them available to the minister's office yesterday—is that correct?

**Mr Bowles:** No, 10 of them made available to this committee yesterday.

**Senator SMITH:** And of the remaining 26, when were they made available?

**Mr Bowles:** I do not know the specifics of the 26, but sometime in July and August.

**Senator SMITH:** Perhaps you might provide that information for me in terms of when the remaining 36 were made available.

**Mr Bowles:** We can do that.

**Senator SMITH:** But a 90 per cent return rate is not to be—

**Mr Bowles:** No it is not. We are trying to get better.

**Senator SMITH:** I think you are getting better, if my recollection is correct on the history over previous estimates that I have been involved with the Community Affairs Committee, which is now going on for thee and a half year. I think the department can point to improvement most definitely.

**Mr Bowles:** Absolutely. We have been sneaking up and we are up to the 90 per cent now. I think the last couple that I have been around for were mid-80s into high-80s. This time we have hit 90, so getting better. I would like to get all of them to be honest.

**Senator SMITH:** Of course, and I do not think it is necessary for me to traverse the tardiness of the previous government in responding to questions on notice—I do not expect you to comment.

**Senator MOORE:** The outrage is determined whether you are in government or opposition.

**CHAIR:** It may well be, but the comparison is a stark one between this government and the previous. Senator Polley, did you have questions in whole of government?

**Senator POLLEY:** Yes.

**CHAIR:** I just remind senators that we are half an hour over time for whole of government. I will go to Senator Polley.

**Senator POLLEY:** Thank you and, I have to say, we welcome ageing and aged care coming back to health; I think that is a good move. Could you outline to us what was achieved by moving it out of health in the first place? Quite frankly, it seems to have been fairly costly and something that has not achieved anything. Can you outline to us what the idea was of moving it out in the first place; what the achievements were and also what the cost was of bringing it back?

**Mr Bowles:** These things are decisions of government; they are not departmental decisions, so I cannot—

**Senator POLLEY:** The minister might want to answer.

**Mr Bowles:** I cannot talk on that issue.

**Senator Nash:** Certainly. My understanding at the time was that there were specific reforms that were being done that made it practical for ageing and aged care to go to the Department of Social Services. We have now seen it come back to health, and I think it is probably very appropriate.

**Senator POLLEY:** Can you outline what the issues were around the reform that you were referring to.

**Senator Nash:** I can take that on notice for you—it was before my time; I am happy to do that. However, I think there has been a very positive response to it coming back into the

health department. I think you would probably agree with that, but I am happy to take those other issues on notice for you.

**Senator POLLEY:** And the costs involved in bringing it back?

**Mr Bowles:** As I said, the accommodation issues largely stay where they are. I think some people think that we have to change letterheads; we do not. All things are generated by computers these days and, as you do a letter, you generate the headers, you generate everything. We are not changing our name back; we are staying as the Department of Health, so I am not going to change signage or anything like that. There is no overwhelming cost in that sort of context. There will be some issues around a couple of office moves but it will be on the lower side of that 1500 number rather than on the high side. It is just the nature of how it has all fallen.

**Senator POLLEY:** Could you take the costs on notice after the completion. I also want to clarify: will those officers working within aged care and ageing come back over at the same band levels?

**Mr Bowles:** That is correct.

**Senator POLLEY:** It was interesting—and perhaps this is something more for you too, Minister—that the minister is referred to as the Minister for Aged Care when previously it has been the minister for ageing. There seems to be an oversight yet again from the government about the importance of providing good policy and vision for our ageing population.

**Senator Nash:** Senator, I don't think there is that intent at all; I think it is very well understood that, when we say aged care, ageing is part of that. I know the previous government had some very long titles for ministers. We are not of the view that that is useful, and I think people are very well aware that, when we say aged care, we are including ageing in that.

**Senator POLLEY:** Ageing itself has a lot more involved than just aged care; it is in relation to keeping people in the workforce and about ensuring that those policy areas are developed. It was just a question of: it should be preferably broader than just aged care, because that is only one component.

**Senator Nash:** I understand that, Senator, but I am very much of the view that people understand that that is exactly what we mean under that title.

**Senator POLLEY:** I will leave the rest till later.

**Senator McLUCAS:** Can I understand what Parliamentary Secretary Wyatt's role is?

**Mr Bowles:** He is the assistant minister and he has multiple roles. He is across the portfolio but his predominant area is aged care.

**Senator McLUCAS:** Why is Assistant Minister Wyatt not listed on the website?

**Mr Bowles:** I am unaware of that. It is probably something that is more for the ministerial world or whoever looks after those government issues. But I will follow that up for you.

**Senator McLUCAS:** I understand, Minister Nash, that your title has changed on the website, but Assistant Minister Wyatt's existence does not appear under the drop box of ministers.

**Senator Nash:** I was not aware of that but I will follow that up.

**Mr Bowles:** Are you referring to the department's website?

**Senator McLUCAS:** Yes, I am.

**Mr Bowles:** I will follow that up. I was unaware of that. If that is the case—

**Senator McLUCAS:** I want a better explanation than that, I am sorry.

**Mr Bowles:** If that is the case, it is an oversight on our behalf and I will fix it up. I was not aware of it.

**Senator McLUCAS:** There has been an amendment to Minister Nash's title but omission—

**Mr Bowles:** I cannot give you a better answer. If that is the case, it is an oversight.

**Senator McLUCAS:** Can somebody give me a better answer, please?

**Mr Bowles:** We will try to find out.

**Senator McLUCAS:** Now?

**Mr Bowles:** Nobody can give you an answer now. I will find out and I will come back to you as soon as I find out. Someone will be looking right now.

**Senator McLUCAS:** Thank you. Was a charter letter provided to the Minister for Health, Minister Nash?

**Senator Nash:** We do not comment on charter letters. They are matters for government.

**Senator POLLEY:** Have you received one?

**Senator Nash:** I am not going to comment on the operations of the government.

**Senator POLLEY:** These are the questions you asked relentlessly when you were in opposition. Either you get a letter or you do not. We do not want to know what is in it, necessarily, just whether or not you have received it.

**Senator Nash:** Senator, I am not going to comment on charter letters or otherwise.

**Senator McLUCAS:** You are refusing to answer that question.

**Senator Nash:** Over many years now there have been different approaches from government about whether or not charter letters were appropriate, and I will not be commenting.

**Senator POLLEY:** Very secretive government.

**Senator McLUCAS:** Very secretive government. Minister Nash, you are now referred to as the Minister for Rural Health. Have your responsibilities changed since the change of leader?

**Senator Nash:** No, they have not.

**Senator McLUCAS:** So why is the word 'rural' in your title now?

**Senator Nash:** That was a matter for the Prime Minister, but I think it is something that has been very well received out there in the community.

**Senator McLUCAS:** That is not my question, Minister.

**Senator Nash:** But it is my answer, Senator.

**Senator McLUCAS:** 'What colour is the sky? I'm going to tell you about my mother'.

**Senator Nash:** Senator, I answered you question.

**CHAIR:** Senator McLucas, just allow the minister to answer the question.

**Senator Nash:** I answered your question straight up: I said, 'It's a matter for the Prime Minister as to why it was changed' and then I went on to say that I think it has been very well received and shows the government's focus in this area.

**Senator McLUCAS:** But your responsibilities have not changed at all.

**Senator Nash:** That is what I said.

**Senator McLUCAS:** You have the same list of responsibilities—

**Senator Nash:** For the third time, Senator, I have the same list of responsibilities.

**Senator McLUCAS:** that were previously the parliamentary secretary for health under the former government.

**Senator Nash:** I have no idea what was under the former government—under you? Is that what you are referring to? I am sorry, I did not pay that much attention. I do not know what the parliamentary secretary for health had under the previous Labor government several years ago.

**Senator POLLEY:** We certainly gave a higher priority and had a cabinet minister for ageing. To have a parliamentary secretary have the responsibility of aged care reflects, I would have thought, pretty badly on the government.

**Senator Nash:** Senator, I think you are actually misleading about that. It has been very clear that the senior minister, Sussan Ley, will be responsible for aged care. The assistant minister, Ken Wyatt, will have some responsibility in that area.

**Senator McLUCAS:** What we would like to understand is what Assistant Minister Wyatt's responsibilities would be, more than across the department.

**Mr Bowles:** I have answered that, saying predominantly aged care; but like all ministers and assistant ministers in a portfolio, they do talk to each other on a range of issues. There will be a range of other things, I am sure, that Minister Ley and Minister Nash might want to confer with Minister Wyatt about.

**Senator POLLEY:** Considering the track record of the assistant minister previously, we have real grounds for concern about ageing.

**CHAIR:** Senator Polley, you have made that point and I just note that we are well over time. If there are not any other substantive questions in this area, I would suggest we move now to outcome 3.

**Senator McLUCAS:** I have questions around the Medical Research Future Fund.

**CHAIR:** I think that does come under one of the outcomes, doesn't it, Mr Bowles?

**Mr Bowles:** That is in outcome 4.

[10:39]

**CHAIR:** We will come back to that in outcome 4. We will now move on to outcome 3: access to medical and dental services.

**Senator WILLIAMS:** I thank the committee for allowing me to ask a few questions. I will only be a few minutes. Who was responsible for the regulatory impact statement diagnostic imaging situation?

**Mr Stuart:** That falls under my area. I will see if I can answer your questions.

**Senator WILLIAMS:** There were three options canvassed in relation to diagnostic imaging. I am very concerned about option 2 . Mr Stuart, are you familiar with option 2?

**Mr Stuart:** Yes, we are.

**Senator WILLIAMS:** Explain option 2. Is that the situation where you would have to have a resident radiologist present at every imaging centre?

**Mr Smith:** The regulatory impact statement addressing radiology safety and quality was released in May 2005. It addressed issues raised by the radiology sector in relation to safety and quality. The regulation impact statement presented a number of options to address those issues which the sector was consulted with. Consultations closed on 25 June 2015. A total of 23 submissions were received.

**Senator WILLIAMS:** Did you say this kicked off in 2005?

**Mr Stuart:** We need to correct that. That is 2015.

**Senator WILLIAMS:** I was going to say: it has been going for a long time!

**Mr Smith:** May 2015. I am sorry.

**Senator WILLIAMS:** You would still have been at school back then, wouldn't you?

**Mr Smith:** Not quite!

**Senator WILLIAMS:** Option 2. We are pretty short of time. Option 2 is a situation where there must be a resident radiologist in all imaging centres. Is that correct?

**Mr Smith:** Option 2 would require a higher level of supervision by radiologists over diagnostic imaging services than is currently provided. That is correct.

**Senator WILLIAMS:** There is one in Inverell where I live. There is not a resident radiologist there. They have an expensive fibre system where they email them through, or however they travel them through, to radiologists to be checked. They are in high resolution. It is a very good system. Would it mean that there would have to be a resident radiologist in Inverell?

**Mr Smith:** The details subject to the ongoing consultation would need to be sorted out. As I understand it, the prospect was that a radiologist could service a specific geographical area and be available to attend a service if required to attend that service. They would need to be close enough to attend within a certain period of time. They could not be hundreds of kilometres away.

**Senator WILLIAMS:** Would option 2 make it compulsory that somebody would have to attend in the case of injecting the chemical? What do they call that? Dr Di Natale would know.

**Mr Smith:** Contrast.

**Senator WILLIAMS:** That is the word I am looking for.

**Mr Smith:** The details would need to be worked through, but there would be instances where a medical practitioner would need to be available to attend in person—for example, where contrast is being used.

**Senator WILLIAMS:** A medical practitioner or a radiologist? When I was done, I had a GP with me.

**Mr Smith:** The proposal would be that a radiologist would need to be able to attend certain items, depending on what that particular service was. They would need to be on location to be able to physically attend in—

**Senator WILLIAMS:** Here is our problem: there are 75 imaging centres around rural and regional Australia; they would have to have a resident radiologist; we would not have 75 radiologists in Australia—extra ones, I am saying. We are bringing them in from overseas now.

**Mr Stuart:** At this point this is a regulatory impact statement, which is a consultation document.

**Senator WILLIAMS:** Exactly, and that is why I am bringing this to your attention. I know my colleagues in the National Party, and I would imagine every member of the Country Liberal Party and even the Labor Party and the Greens in regional areas would be very concerned about having these imaging centres shut down. I am informed to have a resident radiologist would cost between $500,000 and $1 million a year. If the imaging centre had to close down in Inverell, pregnant women, the elderly and everyone else would have to travel to Armidale or Tamworth, and we would be furious about that.

**Mr Stuart:** Obviously this is the kind of input we are looking for. There are issues here to balance between quality and accessibility. I think we do understand that there has been a little bit of a drift away from having radiologists on site for a number of these sorts of services, and I guess the question is raised between the issue of quality and the issue of accessibility. I would say to you that our ministers care very much about both quality and accessibility, and at the moment no decision has been made in this area.

**Senator WILLIAMS:** Have there been any complaints about the quality from these regional centres? I certainly have not heard them.

**Mr Smith:** The issues outlined in the regulation impact statement are a direct result of input from the radiology sector—the College of Radiologists and the Australian Diagnostic Imaging Association and others. The sector has developed its own quality framework. The regulation impact statement consults on those—

**Senator WILLIAMS:** Mr Smith, you are being a politician. Will you answer the question please. Have you had any complaints about these regional centres and the quality of the work they do?

**Mr Smith:** I would need to take that on notice for specific complaints.

**Senator WILLIAMS:** Please do. I was speaking to radiologists yesterday, and one in eight visits to the GP lead to something else being done—it might be a blood test, it might be an X-ray, it might be a CAT scan, it might be an MRI. We will have GPs saying 'We aren't coming to your country town; there is no imaging centre.' I am sure Minister Nash is very much aware of this. I hope before you make the final decision or recommendation you consider the rural and remote exemption of 30 kilometres or more, because there will be a huge political war developing probably right around the parties, I would imagine, if you are going to leave us in a situation where you shut down the centres or make them unviable financially and there are not enough radiologists to attend. If it is not broken, don't try to fix it.

It seems to be working very well. I do not get any complaints to my office about Moree, Inverell or any of the other centres. Centres are soon to open up Goondiwindi and Longreach, I believe. We need those centres so that people do not have to travel, with enormous time costs, especially for pensioners et cetera. Please consider the regional areas when you make this final recommendation.

**Mr Smith:** Thank you, Senator.

**Senator DI NATALE:** Could you give me an update of where the MBS review is at, and then I might ask some specific questions about the review itself.

**Mr Stuart:** As you know, this is an independently led, clinically led review of the MBS. All 5,700 items will be touched on during this review. The task force leading the review, with Dr Bruce Robinson, is in place and assembled. They are meeting today for the fourth time and they have put in place I believe six clinical reference groups over the six first priority clinical areas for review. There is a report due to the minister by Christmas on how they intend to go about their work and what they will have achieved by then so far. As you can imagine, 5,700 items is a very big job.

**Senator DI NATALE:** Do you have a timeline in place? What are the major milestones and when do you expect the review to be included?

**Ms Cahill:** We have a detailed timeline for the current year, working towards the task force's interim report to government, which is due before Christmas, as Mr Stuart said. This includes the meetings of the task force itself, the meetings of a number of clinical committees that it has established, the conclusion of a consultation process that is currently underway and the preparation of that interim report. With the task force, we are currently developing one of the key inclusions for that report, which will be the proposed schedule for 2016 and its recommendations on how the review should proceed.

**Senator DI NATALE:** The 2016 schedule—what are you referring to there? Are you talking about the MBS schedule for 2016?

**Ms Cahill:** No, I am talking about the schedule of review activity that would be taking place in 2016.

**Mr Stuart:** The work program.

**Senator DI NATALE:** Tell me a bit about these clinical reference groups. What are the themes for each of the six groups?

**Ms Cahill:** The task force is in the process of establishing six initial clinical committees to look at early areas and to test the processes for the review. Those are: a clinical committee on ear, nose and throat surgery, one on obstetrics, one on thoracic medicine, one on gastroenterology, one on diagnostic imaging and one on pathology.

**Senator DI NATALE:** There are obviously huge gaps in cardiology, surgery—I could go on. Why do we have those six themes? What is the rationale for choosing those and ignoring others?

**Ms Cahill:** We could not do everything all at once. The process by which the task force identified those areas is: at the request of the task force, the department did a bit of a review of local and international literature, identifying areas where there might be low-value healthcare or areas of concern. The department looked at which of those might be relevant to

the MBS, and then provided the task force with a quite extensive report looking at some of the areas—things like services that had been identified on various lists from the Choosing Wisely process—and some advice about what was happening in the Medicare space in relation to those various services. On that basis, and also the basis of trying to look at what would be an appropriate range of different areas to test the process, to see how it would actually work, the task force then identified these as some priority areas.

**Senator DI NATALE:** In 2016, would you be looking at establishing a number of other clinical reference groups to cover all of the other areas that are not included?

**Ms Cahill:** Yes. There are currently around 30 clinical committees that the task force has identified it expects to be required. The remainder would then be established over the course of 2016.

**Senator DI NATALE:** How are you going with populating the groups?

**Ms Cahill:** Very well. Four of the groups have already had an initial meeting. ENT, obstetrics, thoracic and gastroenterology all had an initial meeting on 24 September, I think. Diagnostic imaging are having their initial meeting on Friday. We are still sorting out some details around the pathology. We have had, I think, 38 different organisations who have provided nominations of people to participate in the process. Most of those are medical colleges, but there are also a range of other professional groups.

**Senator DI NATALE:** Obviously one of the concerns is that the question of conflict of interest would be a problem, I imagine. You have a number of individuals and groups who are currently utilising the Medicare Benefits Schedule. Have you had any problems with conflict of interest? Do you have a clear conflict of interest policy? Is that proving to be a bit of a hindrance to populating the individual clinical reference groups?

**Ms Cahill:** This has been a topic of active discussion within the task force.

**Senator DI NATALE:** So I understand.

**Ms Cahill:** The task force has taken the view that it would not be appropriate to exclude clinicians who provide services that are subsidised through the MBS from contributing to the review, because those clinicians are also the people who have the best understanding of the MBS and how it works. The ways in which the task force has sought to balance the concerns about potential conflict of interest are: firstly, by seeking to have those groups balanced with clinicians from other specialties, particularly generalists, and also to have an open consultation process, so that the advice that comes out from those committees is publicly tested, and tested against the available evidence. It is still early days, so none of those clinical committees have yet settled on formal recommendations or finalised their approach. As I said, we are still testing the process, so that is one of the things that the taskforce will be looking for as the process continues.

**Proceedings suspended from 10:55 to 11:11**

**ACTING CHAIR (Senator Smith):** We will resume this public hearing of the supplementary budget estimates. We are on outcome 3.

**Senator McLUCAS:** I will continue on the MBS review issues. Professor Robinson has suggested that 30 per cent of MBS expenditure is 'not necessary, wasteful and sometimes

even harmful for patients'. What was the basis of that figure, or is that just Professor Robinson's view? I should not say 'just' Professor Robinson's view.

**Mr Bowles:** That was early days in his conversation. There is a lot of work that has been done across the world, and not in the health industry, around 30 per cent issues. He based it largely on the US issues, is that right?

**Ms Cahill:** Yes. In fact, it is quite explicit in the original quote from Professor Robinson. He referred to the case from the United States and did not specifically say that that 30 per cent applied in Australia. I think he has been quite clear that there is not a similar known figure for Australia.

**Senator McLUCAS:** But the minister quoted it in her press release, so there must have been some basis for it.

**Mr Bowles:** Ms Cahill just gave you the basis that it was based on a US study. It is not defined in Australia, but it is a representative figure that Professor Robinson was using at the time. Not wanting to pre-empt his activities, which will go forward and which will find what the real issue is out there, but not all of it is an MBS issue either: there are public hospital issues, there are private hospital issues and there is a whole health issue that would be represented.

**Senator McLUCAS:** I am just getting to where this 30 per cent came from and the fact that it was then repeated on a number of occasions by the minister. Was advice provided to the minister that was possibly misleading?

**Mr Bowles:** I am not specifically aware of the minister using it and how she uses it. She is out consulting on a range of different issues.

**Senator McLUCAS:** This was on *AM*. This is not consultative.

**Mr Bowles:** I do not necessary listen to every time the minister is on radio or TV—

**Senator McLUCAS:** She will be disappointed!

**Mr Bowles:** otherwise I would never be doing anything. She is very visible in the broader health and medical community, talking around a range of issues.

**Senator McLUCAS:** My question is: did the department provide more accurate information to the minister's office around what proportion of MBS expenditure possibly is not necessarily wasteful or sometimes even harmful?

**Mr Bowles:** No, not that I am aware of. We would have to take on notice specifically what we said at any point in time. The minister has picked up Professor Robinson's comments around the 30 per cent waste issue and gone from there.

**Senator McLUCAS:** Do you think it is more like 10 per cent, which is generally the view?

**Mr Bowles:** I am not going to make a prediction, because Professor Robinson is looking at the MBS items at the moment. Every country will have its own unique issues that it is going to have to grapple with. If I go back to my days in the state government—I worked in health in the state government—we were always talking about the 30 per cent mark. It is just a generic thing. We are not talking only about the MBS here anyhow. Professor Robinson was talking about a specific US example, but there is a general view around some of those sorts of issues in the community—but not specifically to the MBS items.

**Senator McLUCAS:** So you are going to find out whether you provided advice to the minister's office? You said no?

**Mr Stuart:** Ms Cahill has already said that there is not similar evidence for Australia. Bruce Robinson has not quoted any similar evidence for Australia. My belief is that, that being the case, we did not provide any specific advice to the minister about that.

**Senator McLUCAS:** It is in her press release.

**Mr Bowles:** Again, the minister meets with Professor Robinson. There a lot of conversations go on around there. This is a generic issue that has been in this space for quite a while. It is a reasonable thing to do.

**Senator McLUCAS:** It has caused some consternation in the medical community. I think you would be aware of that.

**Mr Bowles:** This is not a simple issue either. It is a complex set of issues around the MBS. There are varying views across professional groups. That is always going to be the case. That is why Professor Robinson is doing the work and will come up with answers over time.

**Senator McLUCAS:** Did the department have any role in drafting a document entitled 'Low-value services', which was selectively distributed to a number of journalists the night before the announcement was made?

**Mr Bowles:** I have to confirm which document you are actually referring to. If it is the discussion document that Professor Robinson put out, the department—

**Mr Stuart:** Just to clarify, this is something put out on the evening of the minister's announcement of the—

**Senator McLUCAS:** The evening prior.

**Mr Stuart:** healthier Medicare announcements, overall? Do you have a date?

**Senator McLUCAS:** It was the night before the announcement of the consultation period.

**Mr Stuart:** Okay. It is not the consultation paper itself?

**Senator McLUCAS:** I do not think so.

**Mr Bowles:** Again, I am not quite sure what you are referring to there, but Professor Robinson did put out a consultation document. Maybe there were some excerpts from that that were put out; I am not quite aware. The department would have assisted in developing some of that with Professor Robinson, but it is Professor Robinson's task group's work that was put out in the consultation package.

**Senator McLUCAS:** I will hand this out and you could have a look at it. I would like to know what role the department had in the compilation of this document, please.

**Mr Bowles:** I will have a look and take it on notice.

**Senator McLUCAS:** If we can do it today, that would be better.

**Mr Bowles:** I will try to.

**Senator McLUCAS:** Thank you. Just in terms of the drafting of press releases from the minister's office, how does that happen?

**Mr Bowles:** It depends on what we are talking about, but in the normal course of events we will provide a draft ministerial media release and the minister's office will deal with it

from there. We do plain, factual 'what are the issues'. The minister's officers go from there and do what they do.

**Senator McLUCAS:** Did the draft provided by the department include the quote from Professor Robinson about the 30 per cent?

**Mr Bowles:** I will have to take that on notice and check. I cannot recall how that particular one went. I was talking in general. That is how we do things. I would have to take on notice specifically what we would have provided in the way of a broad media release.

**Senator McLUCAS:** I am sure there is someone here who can answer that question, maybe a little later today.

**Mr Bowles:** Maybe a little bit later, yes. We will find out specifically about that particular issue.

**Senator McLUCAS:** Thank you. I will come back to that note that is being passed up to you in a moment. Where will the savings that will be found by the ultimate completion of the review end up?

**Mr Bowles:** Again, the minister has made it very clear that this is not a savings exercise, so they do not necessarily end up anywhere. There has been a lot of commentary that, if certain things stopped and there were savings, would they go into new items? The answer is, if they were deemed to be appropriate, that would be looked at. There is the broader issue. This is about appropriateness of clinical care and what we pay for through the MBS. The minister has been very clear that this is not a savings exercise.

**Senator McLUCAS:** The minister said on *Lateline* on 2 October when asked that question:

Some will go back into health and some will go back into sustaining Medicare.

Then she said:

I can't say fifty-fifty.

So it is predicted there will be savings.

**Mr Bowles:** I think it is a pretty fair bet that, if you look at some of the things that may eventually come up as inappropriate, it will make savings. If we go back in time, we have done some work in the past around vitamin D, $B_{12}$ and things like that. Those issues did make savings because they changed practice. If that happens, the minister is on record as saying what she has said.

**Senator McLUCAS:** So there is no policy decision at this point in time about potential savings to the MBS review being put back—

**Mr Bowles:** It is the minister's decision.

**Mr Stuart:** No, there is no policy decision about savings. There are no savings banked. There is no savings target.

**Senator McLUCAS:** Ms Cahill, I want to go back to Senator Di Natale's line of questioning about how many MBS items the task force is expected to review in the next two years.

**Ms Cahill:** The intent is for all the items to be reviewed.

**Senator McLUCAS:** In that period? In two years?

**Ms Cahill:** There are over 5,700. We are still working out the exact timing of that. Obviously, when we say 'reviewed', in the case of some items that would mean taking the advice of a relevant clinical committee that there was no problem with the item, as well as identifying those items where some further investigation is needed.

**Senator McLUCAS:** So you do not have a work program for how you will work through those 5,700 items yet?

**Ms Cahill:** We have a work program for the initial clinical committees that have been established, but the work program going forward is one of the key deliverables for the task force in its interim report to government, which is due in December.

**Mr Bowles:** We will review 5,700 items, but I think you will find that a range of them will be very quickly looked at and we can move on.

**Senator McLUCAS:** A 15-minute consult I think will stay.

**Mr Bowles:** Yes. There are a range of things where I think we can clearly say, 'All right—let's move on.' The intent, though, is to look at the MBS in total.

**Senator McLUCAS:** Yes, I understand that.

**Mr Bowles:** We want to test the process. That is why we have the six clinical groups meeting now, and we will develop the work program for next year based on the outcomes of that. If we identify through the clinical groups that there are things that we should add, take away or change, we will do that in that context.

**Senator McLUCAS:** Will the recommendations of the task force be made public?

**Mr Bowles:** Ultimately that is a matter for government. I think though the minister has been pretty clear that this has been a pretty open, clinical process with Professor Robinson but, ultimately, does a final document get produced and distributed more broadly—that is still to be decided.

**Senator McLUCAS:** The terms of reference of the task force—is that the way I should describe it?

**Mr Bowles:** Yes, there is a terms of reference document.

**Senator McLUCAS:** Is that public?

**Mr Bowles:** I think it is on the website.

**Ms Cahill:** And in the consultation paper.

**Mr Bowles:** And in the consultation paper.

**Senator McLUCAS:** Coming back to that paper, Mr Stuart, you had some answers for me?

**Mr Stuart:** I do recognise the material in this paper. This is based on information provided by the department to the minister's office ahead of the release of the discussion paper. It is based on national and international understanding in relation to some practices that have lower value or may be being done too frequently. And these are the kinds of issues that come up in the Choosing Wisely work that is independently done. That is not to say that these are things that should never be done, and that is part of the difficulty and the complexity. They are certainly not things that should never be done but they are things that tend to be done too often.

**Senator McLUCAS:** So because they were then compiled into the document you are telling me, I think, that happened in the minister's office?

**Mr Stuart:** No, the department compiled this document for the minister's office.

**Senator McLUCAS:** In the knowledge that it would have been used to background journalists prior to the announcement?

**Mr Stuart:** In the knowledge that it would be used by the minister's office in connection with the release of the discussion paper. The specifics of that were not necessarily known or clear to the department. The minister's office handles such matters.

**Senator McLUCAS:** Sure, I understand.

**Mr Stuart:** These are issues that are examples. They are not, at this point, conclusions or decisions of the task force. The difficulty here, of course, is that journalists want to know: 'What are you talking about here? What kind of things are you talking about?' And they are looking for examples. These are broadly drawn, relatively non-contentious issues. By way of background, they are not at this point conclusions of the independent clinical task force.

**Senator McLUCAS:** Right. Even though in the minds of some those five examples now might be seen as being not necessary, wasteful, or sometimes even harmful to patients?

**Mr Bowles:** Again, that is the outcome of Professor Robinson's work. We are not going to pre-empt that. You have got to start somewhere. These are issues that, as Mr Stuart has said, have been raised. This document is facts on MBS data—the number of services and the benefits paid.

**Senator MOORE:** Mr Stuart, can you say that there is any issue with this portfolio that is non-contentious?

**Mr Stuart:** Sorry?

**Senator MOORE:** In your answer you said these were non-contentious issues. I am raising: is there anything in this portfolio that is non-contentious?

**Mr Stuart:** Probably not. I think I may have said relatively non-contentious. They are relatively widely understood and supported kinds of conclusions. But they are, at this point, illustrative, not an outcome of Bruce Robinson's task force considerations.

**ACTING CHAIR:** I have not had a chance to read the whole note but it does look like it is authoritatively sourced. It quotes a report from the Australian Commission on Safety and Quality in Health Care, and I notice that one of the footnotes is taken from the *New England Journal of Medicine*. It looks on first blush quite an authoritative document.

**Mr Stuart:** I would agree with that.

**Senator McLUCAS:** Can I now go to the Medicare Safety Net issue please?

**Mr Bowles:** Is that the one when you are talking about the 30 per cent issue? Can I just clarify that, because I think—

**Senator McLUCAS:** It is a media release entitled: 'Unnecessary, out-dated or unsafe medical services? Tell us about it!'

**Mr Bowles:** It quotes Professor Robinson in it about the 30 per cent, isn't it. Is that the one?

**Senator McLUCAS:** Yes. Except the headline: 'Unnecessary, out-dated or unsafe medical services?'

**Mr Bowles:** That is what Professor Robinson is doing.

**Senator McLUCAS:** So it is quoted by the minister? That is the point.

**Mr Bowles:** Sorry?

**Senator McLUCAS:** It is quoted by the minister.

**Mr Bowles:** It is a media release by the minister that quotes Professor Robinson.

**Senator McLUCAS:** And uses his words in the banner.

**Mr Bowles:** Yes, but it does not specifically go to what it is. It is a question about what we are looking at in the context of the MBS that is unnecessary, outdated or unsafe. If that were to be the case, we need to have a look at that.

**Senator McLUCAS:** I agree.

**Mr Bowles:** That is what Professor Robinson is doing. I just wanted to make sure that the Professor Robinson quote is the 30 per cent in the context of that media release.

**Senator McLUCAS:** That is right. Thank you.

**Senator SIEWERT:** I want go to the question I asked before in the cross-portfolio area around the Health and Other Services (Compensation) Act. My understanding is that that act is used to reclaim some amounts of compensation where victims have had some compensation. Is that correct?

**Mr Stuart:** Yes, that is correct.

**Senator SIEWERT:** I think you will have to take some of these questions on notice. Do you collect the data about how much you have reclaimed in what categories?

**Ms Ryan:** The HOSC Act is administered on this portfolio's behalf by the Department of Human Services. I imagine they would have that data.

**Senator SIEWERT:** So I should ask them?

**Ms Ryan:** Yes, Senator.

**Senator SIEWERT:** Should I ask about policy here?

**Ms Ryan:** Yes, Senator.

**Senator SIEWERT:** I am wondering in particular about victims of sexual assault who have been compensated. Are any of their health costs that may be paid under Medicare also included?

**Ms Ryan:** The general provision is that people who have a compensable condition and who have received more than $5,000 in value of compensation are not eligible for Medicare.

**Senator SIEWERT:** If they have received more than $5,000?

**Ms Ryan:** Yes.

**Senator SIEWERT:** What about childhood victims of assault that may get some level of compensation?

**Mr Stuart:** I think we had better take that on notice. We are a relatively new team on these issues. Our extent of touch on this program has been relatively—we have a bit to learn, so I would prefer to make sure we get this absolutely right.

**Senator SIEWERT:** That is fine; I understand. Could I also ask you to take on notice, given the new situation, if you could explain what you do and what DHS does so that I am clear from both agencies who is responsible for what.

**Mr Stuart:** I think I can do that fairly simply. We manage the policy for the program, and DHS implemented and managed the transactions in relation to the clients.

**Senator SIEWERT:** From past experience, that gets bit murky. I am particularly interested in where we have had people that are compensated for assault, and particularly childhood trauma from assault. If you could take on notice any further information on that.

**Mr Stuart:** Yes, we are happy to do so.

**Senator SIEWERT:** One other quick question I have is around ophthalmology and the reduction in the rebate. Is this where I ask that question?

**Mr Stuart:** Yes.

**Senator SIEWERT:** Why was that decision made? Who was consulted? And have you had feedback about the impact of that on the provision of services, particularly remote services?

**Mr Stuart:** All right.

**Mr Bowles:** Is there a time frame you are talking about there about a reduction in ophthalmology? I know there was some activity around this a while ago.

**Senator SIEWERT:** The schedule was cut in the beginning of the year, on 1 January, for optometry—sorry I do mean optometry.

**Mr Bowles:** Now I think we are back on the same page.

**Mr Stuart:** We were slightly confused; ophthalmology was five or six years ago.

**Senator SIEWERT:** Sorry. There are the cuts and also the freezing of the indexation process—so there are both things. Who was consulted?

**Mr J Smith:** This is an area relatively new to me. I would need to take on notice the consultation process in relation to that measure, I am sorry.

**Senator SIEWERT:** Yes, if you can take on notice that process and what modelling was undertaken to justify the cut and the freezing of the indexation. I am particularly interested in what follow-up you have done. The feedback that I am getting, particularly from those optometrists that are working remotely, particularly in Aboriginal communities, is that it is significantly impacting on the model that they use to provide service to those communities. What is the modelling, can we get it and what feedback have you had?

**Mr J Smith:** Again, I will need to take that on notice to make sure that I give you the correct answer. I know that there have been discussions with the industry and that there are issues relating to rural access, and that Indigenous access is an issue. But I would just need to take that on notice to give you the correct answer.

**Senator SIEWERT:** I want to be really clear: what discussions have you had, where you are up to in those negotiations and are you considering some approaches that will enable the

current model, or an improved model, if you can work out an improvement, in communities so that these services are provided?

**Mr J Smith:** Yes, we can take that on notice. Secondly, how much are you saving from that particular cutback?

**Mr Stuart:** I think we can probably tell you that now.

**Mr J Smith:** From 1 January 2005, the measurable will achieve savings of $89.6 million over four years.

**Senator SIEWERT:** Does that include the freezing in the indexation?

**Mr Stuart:** I suspect that would be a separate measure.

**Senator SIEWERT:** Was that just a whisper in your ear about how much that one was?

**Mr J Smith:** Not how much; just that it is a separate measure.

**Senator SIEWERT:** I suspected so, which is why I asked. So you do not have that?

**Mr J Smith:** Not in front of me.

**Senator SIEWERT:** If you could take that on notice, that would be appreciated, too.

**CHAIR:** Thank you, Senator Siewert. I was going to give the call to Senator Moore but I will go to Senator Di Natale.

**Senator DI NATALE:** I was hoping—and I am sorry to do this—to go back to the Medicare benefits review. I am interested in a couple more questions on that before we get on to some dental stuff. Just very quickly, to round off the discussion around the MBS review, you mentioned that the conflict-of-interest issue was a live one within the various clinical reference groups and that you have made a decision that people who were currently using some of those item numbers under review would continue to participate within the clinical reference groups. I thought I understood your response as being: you would try to offset that by having other participants in those clinical reference groups who, clearly, did not have that direct interest. Are you doing anything beyond that? For example, with some of the item numbers actively under review, some people may be using them more frequently than their peers. Would that be a reason to exclude someone from that clinical reference group? Are you doing anything a little more sophisticated than simply saying, 'We will just to offset that by having other people involved'?

**Ms Cahill:** We would look to provide information to those clinical committees about those kinds of differences in practice, particularly where we think that might indicate that there are a minority of practitioners who may be are practising less appropriately. We would not look at an individual who has nominated to be a participant in a clinical committee and review their specific Medicare claiming pattern. That is not really appropriate. We have trusted that the colleges and the other organisations who have nominated clinicians to participate have done that with a view to nominating people who will appropriately contribute their expertise.

**Mr Bowles:** It is fair to say that the task force itself, chair by Professor Robinson, will keep an eye on the overarching issues. As we have already said, over the rest of this year, and getting up to that interim report, we are really trying to test our processes around a range of these issues as well. But Professor Robinson's group will obviously be mindful of a range of those issues as well.

**Senator DI NATALE:** I think at some stage—this may be policy—there was a statement that no new MBS item numbers would be considered as part of the review. Is that a blanket statement or this is a separate process?

**Mr Stuart:** That has been now quite significantly refined. Professor Robinson attended a meeting with all the colleges, sponsored by the AMA, where that issue was raised. Professor Robinson subsequently raised that issue with the department and with the minister, and we have substantially revised that position. We want to do two things: we want to enable Bruce Robinson and his task force to make whatever recommendations to the minister they see fit, and we want to guard the integrity of the Medical Services Advisory Committee in minding about the cost-effectiveness of significant new technology. What we have now said is that we will put in place a process to direct recommendations into three different pathways, and the minister will decide, on the basis of expert advice, which pathway a particular recommendation should take. There will be areas where there are minor changes to existing items or where current practices are reflected somewhat differently in new item sets—five items collapsed to four and things of that kind, which should not need MSAC decision. The minister may simply decide to pass those through MSAC for information. There will be other areas where there are relatively minor changes to items or otherwise new items which do not reflect significant new technology, where the minister may decide to ask for a fast pathway through MSAC. There are other ones where there might be very significant or novel new technology suggested where really MSAC needs to go through its usual process of understanding of cost-effectiveness, and the minister will decide the pathway, dependent on advice.

**Senator DI NATALE:** That clarifies things a bit for me. What you are saying is that, where there is a change in practice that you do not see as a significantly new technology, some of that will still go through MSAC but through a parallel or alternative process within MSAC.

**Mr Stuart:** Yes, a fast pathway yet to be designed in consultation with the MSAC, but a faster pathway arriving on the second floor, if you like.

**Senator DI NATALE:** I suppose it is a work in progress, and I am interested in the fact that you have said now that there may be new item numbers suggested as a result of this review, and there is now a pathway for those things to be considered.

**Mr Stuart:** The task force is not being curtailed in the recommendations that it may make.

**Senator DI NATALE:** Good. Have any other overall writing instructions been given to the task force? Does it need to achieve particular savings—

**Mr Stuart:** No.

**Senator DI NATALE:** There has not been any other—

**Mr Stuart:** No, there is no instruction about savings. It has terms of reference, and those terms of reference were part of the discussion paper recently released. No, there is no savings target. There are no savings banked in the budget. This is about having a better, more appropriate and more contemporary MBS.

**Senator DI NATALE:** Good. You know my view on that, so I will be watching it closely. I will quickly move to—

**Senator McLUCAS:** I just want to follow on from that. Does the fast pathway to MSAC that exist now?

**Mr Bowles:** Not in the way we are talking about. Largely what we are trying to do is to be flexible in how Professor Robinson can do his job, because this issue that nothing new is going on is something that sort of started from nowhere as well, and that was a conversation facilitated by the AMA with the college presidents, and out of that we clarified a whole range of things. If you look at the discussion paper, there is a bit in the discussion paper about this, but it may be just a little bit too nuanced, so we are trying to actually get a little bit more clarity around that. There will be things that will develop over time once Professor Robinson comes up with his recommendations.

**Senator DI NATALE:** Just because of time, I will be quick. This is around 3.6—dental services. I will ask just a couple of questions about that.

**Mr Stuart:** We will have to have a quick change of team.

**Senator DI NATALE:** Okay. I will have to be very quick.

**CHAIR:** I think Senator Lindgren had some—

**Senator DI NATALE:** I actually have to go in five. I just wonder: is there any prospect of asking these? Do we know when outcome 3 will finish? Do we have a sense of how much more we have on outcome 3?

**CHAIR:** I am at the disadvantage of not having been here just for the last little bit, but I am in the hands of senators. I think we will be going on outcome 3 for a while.

**Senator DI NATALE:** Okay. I will leave, so I will not ask you to change teams just now. Why don't you consider, Senator Lindgren, and I will come back.

**Senator LINDGREN:** I have three quick questions, and you may have already touched on some of these, but I want to get a really good view of how the task force is performing. Mr Stuart, is it fair to say, with respect to the MBS Review Task Force, that the schedule is clinically relevant, and can you explain why you believe this is so?

**Mr Stuart:** The task force has been asked to review whether items in the schedule are still clinically relevant, amongst other things.

**Senator LINDGREN:** Obviously, this is well demonstrated in the way in which clinicians have been engaged. Can you demonstrate that in the ways in which clinicians have been engaged?

**Mr Bowles:** In the process, yes.

**Senator LINDGREN:** Can you discuss how contemporary care to patients is being delivered, please.

**Mr Bowles:** The answer is that, once Professor Robinson comes up with some of the outcomes, it will make the MBS a more contemporary schedule because it will look at the clinical relevance and appropriateness of a whole range of activities and we could see some ons, some offs and some changes around different things. By having a look across the board at the 5,700 items, or thereabouts, we actually make the MBS a more contemporary document for people into the future.

**Senator LINDGREN:** Great. You stated earlier that no saving targets have been met.

**Mr Bowles:** That is right.

**Senator LINDGREN:** Can you explain to me in lay terms what that really means, because I am not quite sure what that means at this stage.

**Mr Stuart:** This is a clinician-led and clinician-driven process without a bottom line having been given by government. The task force is really being asked and trusted to do its best to reduce wastage and to fill up the expenditure of the MBS with benefit, with goodness and with appropriate care, and there is no fiscal target associated with that piece of work.

**Senator LINDGREN:** Thank you.

**Senator McLUCAS:** Can I go to the Medicare Safety Net? My recollection is that the 2014-15 budget was when we announced the changes to Medicare Safety Net.

**Mr Stuart:** Yes.

**Senator McLUCAS:** The effects on the federal budget of that measure are what?

**Mr Stuart:** At the time there were forecast savings. When did we originally intend to implement it?

**Ms Ryan:** The save is $266 million over five years commencing from 2013-14.

**Senator McLUCAS:** Yes. Is it still expected that those savings would go to the Medical Research Future Fund?

**Ms Ryan:** Yes, that is correct.

**Senator McLUCAS:** Has the department done any modelling on the impact of the changes on various patient cohorts?

**Mr Stuart:** I would not call it modelling, but we have an understanding of the beneficiaries under the current three quite complex and confusing safety net arrangements. We have an idea of change. Of course, that idea of change depends a lot on the behaviour of clinicians. One of the key issues here is that there has been a significant shift in the behaviour of some clinicians in the way that they undertake their charging practices in response to the incentives in what was called the new Medicare safety net about a decade ago. We expect that, with the changes to the safety net which are now proposed—in fact, the bill was tabled this morning, I believe—that bill is likely to see change in clinician behaviour again. That makes it a little harder to predict specific outcomes for specific patients.

**Senator McLUCAS:** Mr Stuart, you said that you would not call it modelling. What would you call it?

**Mr Stuart:** We have an understanding of who benefits in what way from the current safety net arrangements.

**Senator McLUCAS:** Are you looking at it by different types of patients?

**Mr Bowles:** There is always a nervousness around the word 'modelling' because there is a technical term for modelling. We do a whole lot of analysis around things.

**Senator McLUCAS:** Could we call it 'predicting' or 'analysing'?

**Mr Bowles:** We analyse more broadly around impacts. Everyone gets a bit nervous when we get into that 'modelling' language; that is all.

**Mr Stuart:** I think that is absolutely right.

**Senator McLUCAS:** So radiation oncologists have predicted that the out-of-pocket costs for people using radiotherapy could double or treble. Do you agree? Have you looked at people using radiotherapy?

**Mr Stuart:** We believe that a significant proportion of people receiving radiation oncology will be no worse off and there will be people who are currently not eligible for the safety net who will become eligible for the first time because the safety net is actually a broader safety net with a lower threshold. Radiation oncology is an area where, I believe, about half of all services are provided by the public sector and about half by the private sector. I stand to be corrected on those percentages. Of the half in the private sector, about 80 per cent of that amount is provided by one company. The billing practices that have been taking place there have shifted quite a bit over time to fit with the current operation of the safety net. This is one area where we would expect to see quite significant changes in billing practices in response to the reformed safety net. It is very difficult to say: 'Let's assume the billing practices remain as they are. What would happen?' I am afraid that that is what the estimate that you have in front of you is likely to have done.

**Senator McLUCAS:** Let's unpack the billing practice to do with radiation oncology. What are you saying will happen?

**Mr Stuart:** Not just in radiation oncology but across the health sector, not all but a range of businesses have started charging patients very high fees for initial consultations or in the early part of their consultation process. The patients then reach the safety net very early and then become relatively insensitive to further fees, which the clinicians continue to charge. The proportion of their earnings which are coming from the safety net as opposed to from the MBS items have gone up quite a lot. This is one of the significant reasons for the proposed reforms. The safety net has proven to be very inflationary. We think of the safety net as being something which is there for patients, not for the provider. The MBS is there for the provider, but they are making increasing amounts of their returns from the safety net.

**Senator McLUCAS:** What do you predict the impact in out-of-pocket costs for a person using radiation oncology to be, given that you are predicting that billing behaviour will change? What is our analysis predicting about the increase in out-of-pockets for that cohort of patients?

**Mr Stuart:** There will be a number that become eligible for the first time. There will be a number that are paying a little higher out-of-pockets. We do not expect that there will be people who are currently eligible who will no longer be. We might be able to put some numbers to that.

**Ms Ryan:** I thought it might be relevant to the conversation to acknowledge that in 2014 around 69 per cent of radiation oncology services were actually bulk billed. During that year around 80 per cent of those services were charged at the MBS fee or less.

**Senator McLUCAS:** So the small number of that cohort of patients will get a little higher out-of-pocket costs. Can we get some numbers around that?

**Mr Stuart:** We will need to take that on notice. We do not have anything like that with us today?

**Senator McLUCAS:** Okay. You said there were some people who would become eligible for the safety net. How many of those are we talking about? This is just for radiation oncology. Could you explain the different parts of that patient cohort on notice?

**Mr Stuart:** All right. I want to caution that these will be departmental estimates. We will have to see how behaviour actually changes over time.

**Senator McLUCAS:** I understand. The Fertility Society of Australia has warned that under the proposed changes the cost of IVF will rise significantly. Have you done any analysis of what will happen for IVF patients?

**Mr Stuart:** The issues are conceptually the same. The ART services are already subject to safety net benefit caps under the current arrangements, so the change would be less than you might otherwise suspect. I would have to say that, in this area, I would hope that there would not be a very significant impact on patients. We have among the most generous Medicare subsidisation in the world for ART services. Again I would say that it is the Medicare rebates that are in essence the doctor fee. The safety net is there to protect the patients.

**Senator McLUCAS:** But I still ask the question. This is the Fertility Society, not me just making this up. They are predicting that the cost of an IVF treatment will rise. They are predicting that repeated IVF cycles will not be proceeded with. They are also predicting that the number of multiple births—twins and triplets—will increase. Let's try to unpack that.

**Mr Stuart:** In respect of the latter issue of multiple births: that is something that is quality monitored in this area. There is a benchmark expectation of less than 10 per cent multiple births. If there were any change in that, we would become aware. The college might have some interest in that as well. So we do not think that is a huge risk, but we will take on notice the issue of estimates in relation to patients.

**Senator McLUCAS:** People going through ART.

**Mr Stuart:** That is right. It is the same issue as with radiation oncology, really. I think it is also worth pointing out here the considerable difference in the kinds of populations served by the MBS safety net and the PBS safety net. The PBS safety net is 80 per cent concessional clients; the MBS safety net is overwhelmingly non-pensioner, non-concessional clients. People of lower means are overwhelmingly bulk-billed in Australia, and do not reach the MBS safety net. The MBS safety net is therefore typically engaged by people of middle income and higher—I am not saying it is universally so, but much more typically so. While you might think of the PBS safety net as being very progressive, the MBS safety net tends to be more regressive and, in particular, the current safety nets have proven to be considerably so. Recommendations have been made by a couple of independent reviews that it really needs change.

**Senator McLUCAS:** They are richer; that is what you are saying.

**Mr Stuart:** Okay.

**Senator McLUCAS:** What about access to psychiatric services? Have you done any analysis of what will happen for those patients?

**Mr Stuart:** Of course, they are the same set of issues. I can tell you that, on average, across the system patients are billed a little over $260 for this service and would have to be charged $305 or more to be impacted under the new arrangements

**Senator McLUCAS:** So it is about the cost of an appointment and the frequency of service until you get to the safety net, and from there on?

**Mr Stuart:** That is right. For people who are using psychiatrists, if that is the main issue under which they reach the safety net they would need very, very frequent access to a psychiatrist at well above average cost to engage with the safety net.

**Senator McLUCAS:** That is what I am trying to get to, specifically: what is 'very frequent' and what is the cost?

**Mr Stuart:** I do not have the information here. I will have to take that on notice.

**Senator MOORE:** Following up on that last range of questions, have these issues been raised with you by the professional groups themselves?

**Mr Stuart:** Yes, they have.

**Senator MOORE:** I wanted to make sure that this is not new ground, that this is an ongoing discussion.

**Mr Stuart:** Yes, that is right. I would say that in the mix here is not only the safety net but also the review of the MBS items. We have to look to an overall outcome for a profession that ensures that they continue to be viable under future circumstances.

**Senator MOORE:** And for the consumers across the board.

**Mr Stuart:** Yes.

**Senator SMITH:** Mr Stuart, I was interested in your comments that suggested that you knew a bit about the income distribution of the Medicare safety net, or access to the Medicare safety net. If I heard you correctly—and I was not paying 100 per cent attention—you talked about middle-income and higher income earners utilising the safety net more than others. Did I hear you correctly there?

**Mr Stuart:** Yes, that is correct.

**Senator SMITH:** Could you elaborate on that evidence a bit further? I am assuming that, if we know a bit about the income distribution, we must also then know a bit about the geographic distribution.

**Mr Stuart:** Yes, we do.

**Senator SMITH:** Perhaps if we start on what the department understands about the income distribution first.

**Mr Stuart:** Looking at the estimated number of people receiving safety net benefits in 2015, the concessional is made up of: non-FTBA, FTBA and concessional single. And they are, respectively, 96,000 people, 84,000 people and 55,000 people. Under the general: general family is 229,000 people, FTBA family 286,000 people, and general single 22,000 people, for a total of 773,000 people receiving safety net benefits. So the balance there is overwhelmingly towards the general rather than the concessional. Under the new safety net, we expect the total number of benefits to go up by over 50,000, with a greater distribution towards the concessional.

**Senator SMITH:** Right. So pre the change there was greater utilisation of the safety net in the general category. As a result of the change you expect there will be greater utilisation of the safety net in the concessional category?

**Mr Stuart:** That is correct—but a shift, a relative shift. I think the predominant use will still be in the general, but there will be a comparative shift towards the concessional.

**Senator SMITH:** What do we know about the geographical distribution of that?

**Mr Stuart:** I think we could tell you the current geographical distribution of safety net benefit usage, but I am not sure we would go to whether there would be any shift under the new safety net.

**Senator SMITH:** Let's start with what we know. At a future estimates we can explore the—

**Mr Stuart:** We do not have that with us today, by the way; I think that is something we would have to take on notice.

**Senator SMITH:** Okay. The 'geographical distribution' is a broad term.

**Mr Stuart:** Yes.

**Senator SMITH:** So, you have it in what form? What form does the geographical distribution come in—postcodes, federal electorate districts?

**Mr Stuart:** The source data comes in postcode.

**Senator SMITH:** Could you please provide that in postcode? I am assuming, if it is available in postcode, it is then accessible by federal electorate distribution, because postcodes form federal electorates.

**Mr Stuart:** Yes, we can map to federal electorate. It is not something the department would routinely do, but it is possible to do. We can also use 'general metropolitan', 'outer metropolitan', 'rural' or 'remote' kinds of classifications.

**Senator SMITH:** That would be good. So we are agreed that you will provide it on a postcode basis but also with a 'metropolitan', 'regional' and 'remote' classification?

**Mr Stuart:** If you would forgive me, I would think that the postcode level would not necessarily be terribly informative. It is going to be a very long table. I would suggest we take on notice the metropolitan-regional-rural split.

**Senator SMITH:** Just explain to me why the postcode information would not be as valuable?

**Mr Stuart:** There are very many of them with small cell sizes and low numbers of people.

**Senator SMITH:** I am interested in the cell sizes that are the largest. So perhaps I will trust your judgement to draw a line in that postcode distribution where it does not provide any useful information, but I am interested in where the clusters might be at the higher end.

**Mr Stuart:** Can I suggest we do the fifty postcodes of highest usage for you?

**Senator SMITH:** Perfect. Do you have that postcode information available here?

**Mr Stuart:** Not here with us, no.

**Senator SMITH:** Okay. Thank you.

**CHAIR:** Thank you, Senator Smith. Were there further questions in this particular space, or are we looking to move on to other areas?

**Senator McLUCAS:** Senator Moore wants to go to audiology.

**CHAIR:** Senator Di Natale?

**Senator DI NATALE:** You are doing hearing services at the moment, are you?

**CHAIR:** We are going to audiology, so, yes. Senator Moore?

**Senator MOORE:** Thank you. I have some questions surrounding some issues around regulation for audiologists. There was a media article that talked about concern with purchase. I am happy to pass that document up. I am sure the health department has it. But I am happy to pass it up. It is about hearing aids being sold. I know it is a very general question to start with—hello, how are you?

**Ms Duffy:** Well, thank you.

**Senator MOORE:** It is nice to see you. What are the requirements for someone to provide hearing checks and services in Australia? Is there a national accreditation scheme for audiologists in the current system?

**Ms Duffy:** In terms of safety and quality for hearing devices and hearing services, there are three levels that we take into consideration: the practitioner qualifications and what experience and skills the practitioner has; there is a component relating to devices, whether devices are safe and appropriate for the Australian community; and then there is ethical behaviour. Each of those three components has different arrangements in place. In terms of what the Australian government Hearing Services program has jurisdiction over, we have contracts and legislation in place to cover those service providers who are contracted to the Commonwealth, and we dictate the level of safety and quality in terms of devices and service providers and understanding of practitioners registered with professional bodies.

**Senator MOORE:** Only for Commonwealth funded services?

**Ms Duffy:** Correct.

**Senator MOORE:** Not across the board in the industry?

**Ms Duffy:** That is correct. In terms of the practitioner bodies, the practitioner bodies are responsible and they do have codes of practice in place. Most recently we have been working with the practitioner bodies to agree on a national standard of practice, which will sit above the code of conduct that they have in place.

**Senator MOORE:** How many practitioner bodies are there?

**Ms Duffy:** There are three recognised practitioner bodies that the department has an association with.

**Senator MOORE:** And they are?

**Ms Duffy:** They are: Audiology Australia; HAASA, which is the Hearing Aid Audiometrist Society of Australia; and ACAud, which is the Australian College of Audiology.

**Senator MOORE:** Thank you. You were leading on, sorry. I just wanted to get my notes in the right place.

**Ms Duffy:** The other component that most recently was agreed was by COAG, looking at unregistered health professionals across all health workers. COAG agreed, and states and territories are in the process of implementing through their legislative processes a national code of conduct for healthcare workers. Progressively that will be rolled out as each state and territory adopts it into their own legislation. Audiologists are covered by that code.

**Senator MOORE:** So they would be general concerns rather than particular concerns for audiologists? It is a national code for health workers rather than a national code for audiologists?

**Ms Duffy:** That is correct.

**Senator MOORE:** Does the department have any role or engagement in that, seeing it is a COAG process?

**Ms Duffy:** We had input into the consultation and discussion papers that were circulated publicly leading up to that decision.

**Senator MOORE:** And they are all public?

**Ms Duffy:** They are public.

**Senator MOORE:** Is the department aware of any concerns about audiologists and hearing service providers upselling patients devices with additional functions, services and costs which are not clinically necessary but more profitable to the clinic? Is that the kind of issue that has been raised with the department?

**Ms Duffy:** We are aware of those issues, most notably through the media, and we understand that the ACCC is conducting some preliminary investigations into that. We have provided some data about what arrangements are in place for our program as part of their investigation. Clients and practitioners are encouraged to provide information to the ACCC to assist their investigation.

**Senator MOORE:** What kind of data has the department provided to the ACCC?

**Ms Duffy:** We have provided information that is publicly available on our website. But we have been able to explain in more detail how it operates in practice—the legislation; the contract that is in place with the service providers; explaining how the disclosure clauses operate; and also information about the TGA requirements about safety of devices.

**Senator MOORE:** You said that your awareness was mainly through the media. Have you had individual client concerns raised?

**Ms Duffy:** On regular occasions we get inquiries about the difference between fully subsidised devices and partially subsidised devices. We provide clarification to those clients who raise those concerns. There are contractual requirements for the client to be fully informed about what the conversation is between the audiologist and the client about fully versus partially funded devices and if we find that there has not been full disclosure, we have the authority to ask the provider to refund the money to the client where it is seen as not clinically necessary for that device to have been provided.

**Senator MOORE:** From the department's perspective, what is the definition of full disclosure? What needs to be in place for full disclosure?

**Ms Duffy:** That is very clear. There is a contractual requirement to have a signed quote and full disclosure of costs and services that have been offered to that client where it is a device that is in the partially subsidised category, and that client signature and acknowledgement needs to be on that client file.

**Senator MOORE:** The article there is talking particularly about a circumstance where it is alleged that a device which had more complexity and more range of access than the client actually needed was provided to the person involved. That is part of the media that has led to

the ACCC process. Is that listed? I know you have to list the cost, but this process here was talking about the kinds of links to other technologies and things, which cause a greater cost. Is that the kind of detail that is involved in terms of full disclosure?

**Ms Duffy:** That is a matter of a conversation between the clinician and the client. The disclosure and the client signature have to be on the quote outlining what the device is. In terms of features and functions of each device, this is an area where the Office of Hearing Services has been doing some research in, because we believe that we should try and support greater consumer understanding—

**Senator MOORE:** Absolutely.

**Ms Duffy:** of technology and what it can do, because the range of devices that are often offered under the program are very high in terms of their technology and advances. So we are in the process of providing some information on our website to help clients and to set the record straight about what you can expect out of a device, based on your personal preferences, the goals that you want to achieve and where you need to look in terms of your outlay.

**Senator MOORE:** You have talked about the contract and the need for full disclosure. What kind of oversight from the department is there to ensure that clients of Commonwealth hearing services programs receive impartial advice from the qualified audiologist? Is that, from your understanding, purely the exchange of information and the signed off contract?

**Ms Duffy:** Where there is a partially subsidised device that is being discussed, we encourage clients—and we also have it on our rights and responsibilities posters, which all hearing providers need to display publicly in their clinics—that, where there is a partially subsidised device being discussed, they are encouraged to shop around and see if it is actually the best advice and device for them, so getting a second opinion, because it is a big outlay for some people, depending on their leisure and other pursuits that they would require additional technology for.

**Senator MOORE:** There is no advice provided by an independent group that actually does this? I am thinking in the energy area, for instance, you can go to a showroom and have a look at a range of different stoves—or whatever—and you can get some independent advice not linked to a particular provider. Is there any such process in the audiology space?

**Ms Duffy:** Not like you have described. However, our website has a list of our partially and fully subsidised devices and the features of each, so you could go there and look at what features are on the fully subsidised list and, if after your conversation with an audiologist you can see that all of the features could be supplied for a fully subsidised device, you are armed with that information.

**Senator MOORE:** The website is good. We looked at that when we did our hearing inquiry a few years ago, and that was part of the process, but it is a pure descriptor and you do not get into the area of comparator? You actually just list them bit by bit?

**Ms Duffy:** No we do not have comparator—

**Senator MOORE:** Or advice in terms of process—it is just leaving that decision to the client?

**Ms Duffy:** It is about specifications of the device and what that technology can deliver in terms of outcomes for the client. So, if you have an interest in listening to music or in certain

types of social activities versus hearing in the workplace or hearing in a noisy environments, there is that descriptor on the website now.

**Senator MOORE:** Sure, which is one of the ongoing issues—that surrounding noise stuff—

**Ms Duffy:** Yes.

**Senator MOORE:** and some of the more expensive devices are offering protection against that.

**Ms Duffy:** So does the fully subsidised device as well.

**Senator MOORE:** Yes.

**Ms Duffy:** One of the complexities is that, when a client goes to service provider and has a conversation with the audiologist, depending on the range of devices that provider is able to offer, because there are a large number of devices on the market—

**Senator MOORE:** And it is increasing.

**Ms Duffy:** exactly—at times that service provider is limited by the types of arrangements it has in place with different manufacturers as to what it offers. Our program requires service providers to offer what is suitable for the client, irrespective of whether they have an agreement in place with the manufacturer.

**Senator MOORE:** And that is in the contract—

**Ms Duffy:** Correct.

**Senator MOORE:** with the supplier under a Commonwealth funded service?

**Ms Duffy:** Yes, and it is the rights and responsibilities of the client that they have access to any device that is on our fully subsidised schedule.

**Senator MOORE:** Is there a complaint process in place for consumers who are unhappy with an audiology service?

**Ms Duffy:** Yes.

**Senator MOORE:** How does that work?

**Ms Duffy:** There is a complaints process on our website. We have a 28-day usual best practice complaints-handling process, and that process and policy is regularly updated. Clients can raise a complaint, or even an inquiry if they do not wish to make formal complaint, via our email, their service provider, their practitioner body or their advocacy group, depending on what is going to be most appropriate for that client.

**Senator MOORE:** Could we ask for, on notice, some analysis of those complaints—the numbers, the types of complaint?

**Ms Duffy:** Last financial year, we had 125 complaints.

**Senator MOORE:** And you can take on notice the analysis of the types of issues that caused those complaints.

**Ms Duffy:** From clients?

**Senator MOORE:** Yes.

**Ms Duffy:** Sure.

**Senator MOORE:** You have said that you are aware of the complaint about the up-selling issue.

**Ms Duffy:** Yes.

**Senator MOORE:** In terms of the department's response, you have said you are aware of what you are doing now. Has there been any heightened engagement with looking at what is going on as a result of the media coverage?

**Ms Duffy:** Yes, there has, and that has led to doing some research of our own that I just mentioned, as well as being able to provide advice to all of our service providers and the practitioner bodies about the research and how it reflects on the industry. That is also feeding into the work that we are supporting through the national practice standards that are being developed by the practitioner bodies to address some of the ethical issues that areperceived are occurring in some pockets.

**Senator MOORE:** On notice, again, can we get a little bit more detail about the research you have done, with whom you have spoken and what has come out of that? Has that particular research been concluded?

**Ms Duffy:** It is concluded. We are just about to publish it on our website.

**Senator MOORE:** That is good. If there is a publication, that could provide the information I want, instead of putting it on notice. Can you give me any idea of when—very soon, before Christmas?

**Ms Duffy:** We are going to publish that information in the next week or so, and it draws on a number of research studies around the world.

**Senator MOORE:** In terms of the ongoing—

**CHAIR:** Senator Moore, I am loath to cut you off—

**Senator MOORE:** This is the last question, Chair.

**CHAIR:** That would be great, because I know Senator Di Natale is waiting and we are pushing up against the lunch break.

**Senator MOORE:** Absolutely. The last question is about the ongoing consideration of the privatisation of Australian Hearing. Is there anything written in the scoping study and so on about concerns about the potential for profits overriding service? In looking at privatising Australian Hearing, is there anything in place that would actually stop new owners putting profits ahead of the needs of clients? It seems to be in place within the Commonwealth, as you pointed out, as much as it can be. But is that part of the scoping for the possible sale of Australian Hearing?

**Ms Duffy:** Irrespective of the decision the government might take with Australian Hearing, the necessary safeguards around quality and access should be in place in the framework, no matter who provides those services. One of the gaps at the moment is national practice standards, which we are working on with practitioner bodies. It should not matter which organisation it is if you have practice standards and good ethical components in place. Australian Hearing will be treated like any other service provider.

**Senator MOORE:** Thank you. Thank you, Chair.

**Department of Health**

[12:24]

**Senator DI NATALE:** I am after an update on the national partnership agreement for public dental services. Can you outline where we are at in terms of the $200 million committed in the most recent budget?

**Mr Bowles:** It was $155 million for this year.

**Senator DI NATALE:** I think it was supposed to be $200 million but $45 million of that went to Child Dental Benefits Schedule and the remainder was for the NPA on Adult Public Dental Services.

**Mr Bowles:** The NPA was $155 million and the other active dental scheme is the Child Dental Benefits Scheme, yes.

**Senator DI NATALE:** Could you give me an update on the $155 million?

**Mr Cormack:** We have currently finalised negotiations with the state and territory governments in relation to the one-year agreement that was foreshadowed. We anticipate that being signed off any day soon.

**Senator DI NATALE:** Could you take me back? There was $200 million committed in the previous budget, the 2014-15 budget, that was spent. Is that right?

**Mr Maskell-Knight:** For which?

**Senator DI NATALE:** The national—

**Mr Maskell-Knight:** In the 2014-15 budget, a decision was made to defer the national partnership agreement by a year.

**Senator DI NATALE:** This is just to remind me. The $200 million was committed but deferred for a year.

**Mr Maskell-Knight:** Yes.

**Senator DI NATALE:** That is the $200 million that we are supposed to be seeing now; except the $200 million was also composed of a $45 million component that was to allow funding for the Child Dental Benefits Schedule.

**Mr Maskell-Knight:** The $200 million this year is $155 million under the partnership agreement and $45 million that we estimate the states will access for their Child Dental Benefits Schedule.

**Senator DI NATALE:** Explain how that works. Are there vouchers provided? Is that how that works?

**Mr Cormack:** Public dental services employ dentists as well as other health professionals. They are effectively able to access a bulk-billing arrangement through the CDBS. That is the way it works. That is in addition to any other voucher arrangement the public dental services may have in place. All states can access that arrangement on the basis that they bulk-bill.

**Senator DI NATALE:** With regard to the $155 million, you said you have entered into arrangements now with each state.

**Mr Cormack:** We have concluded our discussions and negotiations with the states. We are just at the point now of finalising a signed-off offer to bring effect to that agreement.

**Senator DI NATALE:** There were particular benchmarks to be achieved in order for the funds to be expended. Could you talk me through those?

**Mr Maskell-Knight:** Essentially, we have targets for every state in terms of their baseline throughput of dental services measured in terms of the famous DWAU. We then set targets for the additional activity we expect them to generate under the national partnership agreement and they receive funding once they reach a threshold of 65 per cent of the target.

**Senator DI NATALE:** So 65 per cent of the target needs to be achieved before funding is expended. What is projected over the forward estimates?

**Mr Maskell-Knight:** The forward estimates have, in the budget papers, a 'not for publication' next to them on the basis that we are engaging in discussions with the states and other parties at the moment. The minister, just before the budget, issued a media release where she undertook to consult with people about a reform of dental funding arrangements.

**Senator DI NATALE:** Can you give me any more information about that?

**Mr Cormack:** It is very early days. We have been focused on getting 2015-16 sorted and we have commenced our work on a longer-term set of options for public dental programs. It is early days.

**Senator DI NATALE:** I understand it is early days, but broadly what do those options look like?

**Mr Cormack:** I think it is probably a bit too early to get into any specific options. We obviously have to have a look at the funding that is available, the performance of our current program investments and also the capacity of the public dental system and the private dental system. So we have not really settled on any firm set of options, other than that we will certainly be consulting very shortly with a range of major stakeholders, including the state and territory dental people and others, to look at some options for a longer term agreement.

**Senator DI NATALE:** It seems to me a pretty straightforward proposition. We have huge waiting lists in the state public dental system. There was an agreement for the Commonwealth government to invest funds, and we saw effectively a $200 million cut from the 2014-15 budget, where none of that money was spent. It is now $155 million that has been spent, despite the promise that $200 million would be spent. Either the federal government will continue investing in this space or it will not. So I am not sure, when you talk about options, what options there are, except for, 'We're going to continue funding it,' or, 'We won't continue funding it.'

**Mr Cormack:** I think there is a lot more to it than whether we are going to continue to fund it or not. The issue is that—

**Senator DI NATALE:** Can you tell me what it is that there is to it.

**Mr Cormack:** The Commonwealth has a range of financial commitments in the dental space.

**Senator DI NATALE:** Yes.

**Mr Cormack:** It has, for example, a very significant investment through private health insurance rebates.

**Senator DI NATALE:** Half of the community, particularly those on low incomes, do not have access to that.

**Mr Cormack:** Senator, I am just trying to outline. You have asked a question and I am just trying to outline what we have to consider.

**Senator DI NATALE:** Yes.

**Mr Cormack:** We have the current agreement with state and territory governments in relation to public dental services—we have made some modifications to that this year—and we have the Child Dental Benefits Schedule.

**Senator DI NATALE:** Yes.

**Mr Cormack:** So what we need to do is to look at how the current range of options are working and also look to what will give, if you like, the best bang for the buck in terms of providing the best access to dental care services based on the need of individuals and also their capacity to contribute and pay. They are the factors, so I do not think you should assume, or anybody should assume, that the only way forward is a continuation of what we have done in the past.

**Senator DI NATALE:** With respect, half of the community do not have private health insurance, and that is skewed towards people on low incomes, so how much money the Commonwealth spends on private health insurance is really irrelevant to a significant proportion of the community, who are currently waiting on a public dental waiting list. The Child Dental Benefits Schedule is not available to adults. So you have a huge group within the community who have no entitlement to publicly funded dental care, except through the funding that is provided through the national partnership agreement.

**Mr Cormack:** Yes.

**Senator DI NATALE:** I understand the space, and what I am asking of you is: you are talking about various options.

**Mr Cormack:** Yes.

**Senator DI NATALE:** What are the possible options for ensuring that people who do not have private health insurance and who are adults get access to publicly funded dental care through the Commonwealth?

**Mr Cormack:** I can only answer that in general. To repeat what I have said, the Commonwealth invests a significant amount of money in access to dental services. We have a good understanding of the level of need out in the community there, and indeed unmet need, and we need to look and work with the different stakeholders to look at the totality of that funding available and, over the course of this year, look at whether there are different ways to manage that funding to achieve an improved outcome in terms of people accessing dental care.

**Senator DI NATALE:** Yes.

**Mr Cormack:** So that is essentially what we are looking at. The other key point, because this is a partnership agreement with the states and territories, is that we also need to have a look at the $700 million that they are currently spending on adult-related dental services.

**Senator DI NATALE:** The state governments?

**Mr Cormack:** Yes, indeed. This is a partnership. We have got a range of resources available to us and the state and territory governments have got a range of resources available to them. Our work over the coming few months, through the course of this financial year, will

be to look at better and different ways for that collective investment to improve access to dental care.

**Senator DI NATALE:** We are probably not going to get much further on that specific issue. The adult dental package negotiated by the previous government was $1.7 billion. Can you give me a breakdown of how much of that money has been spent?

**Mr Maskell-Knight:** That was for the national partnership agreement?

**Senator DI NATALE:** Correct.

**Mr Maskell-Knight:** Under the agreement we are negotiating at the moment, $155 million is to be spent in 2015-16 and the rest of it is subject to consideration.

**Senator DI NATALE:** Are you saying not one cent of the $1.7 billion has been spent yet?

**Mr Maskell-Knight:** Now that I come to think about it, I am not sure about the $1.7 billion. The national partnership agreement was $1.3 billion. I am not sure where you are getting $1.7 billion from.

**Senator DI NATALE:** I will go back and check on that. I think it was in 2012 that that was signed off.

**Mr Maskell-Knight:** It was to start in 2014-15.

**Senator DI NATALE:** Yes, it was signed off in 2012. So of that $1.3 billion that was negotiated, to date we have not spent a cent. We may look at spending $150 million this year—

**Mr Maskell-Knight:** $155 million.

**Senator DI NATALE:** with no ongoing commitment to spend any more beyond this year. Is that an accurate summary?

**Mr Cormack:** What we can say is that there is $155 million available in 2015-16 for a one-year agreement, plus approximately $45 million, through the CDBS arrangement, for access to public dental services. There is a not-for-publication figure in the forward estimates and, as the minister has advised publicly, we are in the process of having a look at a longer term agreement. That is the accurate summary of where we are at now.

**CHAIR:** Mr Bowles, do you want to add something quickly before we go to lunch?

**Mr Bowles:** Senator McLucas asked me about the 36 estimates questions on notice. Three of them were submitted in July, between 24 July and the end of July; 23 were submitted in August; and, as I said, the last 10 were submitted yesterday.

**Proceedings suspended from 12:38 to 13:40**

**CHAIR:** We will recommence.

**Senator McLUCAS:** I go now to the Medicare indexation freeze. Is it still the government's intention to continue the freeze in indexation of the MBS until 2018-19?

**Mr Bowles:** That is the current government policy, yes.

**Senator McLUCAS:** Has the department been asked to do any work or any costings on ending the freeze earlier?

**Mr Bowles:** No, not specifically, but the minister has made it clear that work of the MBS reviews may take this into account in the longer term. If there were some savings that came out of that, she would look at the options around the freeze at that point in time.

**Senator McLUCAS:** That is if there were savings out of the review of the item numbers.

**Mr Bowles:** That is right, because it is not about the savings. But if we were to find a better way of actually dealing with the MBS from an appropriateness perspective—if there were savings in that—she would contemplate looking at ending the freeze if we could come up with another funding source, if you like, through that process.

**Senator McLUCAS:** What would be the annual cost to the Commonwealth of reversing the indexation freeze from today for each of the financial years 2016-17 and 2017-18?

**Mr Bowles:** I would probably have to take that specific one on notice, I think. Have we got something?

**Mr Stuart:** We have previously taken that on notice and answered it from the most—

**Mr Bowles:** No, I have answered that bit. It is: how much is it?

**Mr Stuart:** Yes, we have not done the work.

**Senator McLUCAS:** I am sorry, I did not get that.

**Mr Stuart:** We do not have a costing.

**Senator McLUCAS:** You do not?

**Mr Stuart:** No.

**Senator McLUCAS:** Could you do it.

**Mr Stuart:** It would depend very much on the effective date, if such a thing were to be done, and that would completely change the costing, depending on whenever that effective date was.

**Senator McLUCAS:** I said 'today'.

**Mr Bowles:** We would have to take it on notice and have a look at that context—

**Senator McLUCAS:** You would be able to have a look at it?

**Mr Bowles:** but recognising that we have not costed it in that way at all. Whether we could cost it would be another matter. We will take it on notice and have a look at what we can give you. It might be in the overall context. We may not be able to break it down.

**Senator McLUCAS:** Has the department done any work on prolonging the freeze beyond 2018-19?

**Mr Bowles:** No.

**Senator McLUCAS:** What then is the estimated cost of resuming indexation in 2018-19?

**Mr Stuart:** That does not have a cost, because it is already assumed in the forwards.

**Mr Bowles:** Yes. So anything past the forward estimates would assume that it goes back, at this point. So it does not have a cost.

**Mr Stuart:** The policy has a fixed life. It has a sunset, and then 'normal transmission' is resumed.

**Senator McLUCAS:** Can you then break that down for me. With 'normal transmission' resuming, what is the extra cost?

**Mr Bowles:** There is no extra cost. It will be the cost of indexation in the year it starts again. We will take it on notice and see what we can give you back on that.

**Senator McLUCAS:** That is what I am trying to identify. Can that be broken down by GP items and non-GP items?

**Mr Bowles:** We will have a look at that.

**Senator McLUCAS:** On a related matter, has the government modelled any—I have used that word again, haven't I? 'Modelled'. Have you analysed any change to bulk-billing rates as a result of the freeze?

**Mr Stuart:** At the moment the most recent bulk-billing data for general practice shows the bulk-billing rate still rising.

**Senator McLUCAS:** Still rising?

**Mr Stuart:** Still rising.

**Senator McLUCAS:** You would be aware of commentary in the media around people changing billing practices.

**Mr Bowles:** We had this conversation in May as well and, as Mr Stuart said, we still see no rise at the moment.

**Senator McLUCAS:** What is the most recent period of bulk-billing data that we have, Mr Stuart?

**Mr Stuart:** As at 1 July 2015 is the most recent, where the bulk-billing rate was 83 per cent, up from 82.2 per cent the previous year.

**Senator McLUCAS:** For the quarter? Sorry, is that a quarter?

**Mr Bowles:** It just says at that date. At that date, that was the rate.

**Senator McLUCAS:** All right.

**Mr Stuart:** I think I had better clarify, I believe the figure I have quoted is for the financial year for 2014-15 up to 1 July 2015. Sorry to contradict.

**Senator McLUCAS:** Okay, so 83 per cent over that year compared to 82.2 per cent in the whole year previous?

**Mr Stuart:** Yes.

**Senator McLUCAS:** So the freeze kicked in when?

**Mr Bowles:** The commentary around the freeze kicked in probably late last year. That is also what drives behaviour as well, the media stuff.

**Mr Stuart:** The freeze commenced in 2014-15 from1 July 2014.

**Senator McLUCAS:** So we have a full 12 months—

**Mr Stuart:** We have a year—

**Senator McLUCAS:** of data?

**Mr Stuart:** That is right.

**Senator McLUCAS:** How did the 82.2 per cent compare to the year prior to that?

**Mr Stuart:** It was still slowly and incrementally rising from 81.1 per cent in 2012-13. In fact, if you look at the whole of the last decade, bulk-billing rates have been rising, on average, about one percentage point per year from about 72.8 per cent on 1 November 2005 up to 83 per cent presently. It looks like about a point a year.

**Senator McLUCAS:** Do we have bulk-billing rates between the period from 1 July 2015 to date?

**Mr Stuart:** I am told quarterly information will not be available until next week.

**Senator McLUCAS:** Could I ask on notice that you provide us that quarterly rate as of next week?

**Mr Stuart:** Will do.

**Senator McLUCAS:** Thank you. Have you looked at any data about the potential impact on private patients receiving treatment in hospital?

**Mr Stuart:** I am sorry, could you say it again.

**Senator McLUCAS:** Have you looked at any data on the impact, or the potential impact, of the freeze on private patients receiving treatment in hospital?

**Mr Stuart:** No.

**Senator McLUCAS:** Has there been any analysis of access to GPs? So the number of GP attendances, how is that tracking?

**Mr Bowles:** If you look at the overall MBS number of services, it is still on the way up.

**Senator McLUCAS:** But is it on the same trajectory as previous to the freeze?

**Mr Bowles:** If I recall some of the numbers, there were 368 million services in the MBS in the last year, which was three-to-one outstripping the increase in the number of patients. So services were growing at a far greater rate than the number of patients accessing them.

**Senator McLUCAS:** What I am trying to ascertain, Mr Bowles, is if there has been any impact of the freeze on the MBS on people actually attending the doctor.

**Mr Bowles:** If you look at the overall number of services, you would say 'no' at this point because they are still on the way up. Have we gone down to specific component parts of that? I think the answer would be 'no' at this point.

**Mr Stuart:** There was a growth in services from $134.2 million in 2013-14 to $139.4 million in 2014-15.

**Mr Bowles:** That is GPs only.

**Senator McLUCAS:** For GP attendances?

**Mr Bowles:** Yes.

**Senator McLUCAS:** I am asking if is it on that same trajectory.

**Mr Bowles:** We would have to take that on notice to go back a number of years, but the short answer is yes, it is still on the way up and it is roughly the same. But what we are seeing is the number of services accessed is growing faster than the number of people accessing, at about 3 to 1. That is in the overall MBS, not only GPs.

**Senator McLUCAS:** Have we looked at what the change in out-of-pocket cost for patients might be as a result of the indexation freeze?

**Mr Stuart:** Bulk-billing rates are a good proxy for that. I guess that tells you, for a start, how many people are leaving the surgery with no more to pay.

**Senator McLUCAS:** In part, I agree with you. But what we have heard, and what certainly happens with a lot of doctors who I have spoken to, is that the out-of-pocket cost for non-bulk-billed patients have grown. The patients who are bulk-billed are continuing to be bulk-billed, but the non-bulk-billed patients are paying a larger co-payment. That is anecdotal, but I wonder if there are some more data?

**Mr Bowles:** The best we can give you, on the figures that we have seen, is that there is a marginal increase of about one dollar, but nothing spectacular more than that.

**Senator McLUCAS:** One dollar per GP attendance?

**Mr Bowles:** Yes.

**Senator McLUCAS:** So, from what to what?

**Mr Stuart:** For those who are not bulk-billed the average patient contribution per service for GPs went from $31.03 to $32.16—a change of 3.6 per cent.

**Senator McLUCAS:** And that was between the—

**Mr Stuart:** Between 2013-14 and 2014-15. Again, we do not have in front of us how that differs from previous years. I do not have a time series for that here.

**Mr Bowles:** But it is likely that that is on a similar trajectory from the past. We can have a look at that.

**Senator McLUCAS:** I would like to have a look at that. Has the department considered the possibility that some private health insurers will no longer enter into a no-gap or known-gap arrangement because of the indexation freeze?

**Mr Bowles:** I do not think there is any evidence of that at this stage, that I have heard. It has not been raised in any of my conversations with private insurers.

**Senator McLUCAS:** I would like to quickly ask questions about the Child Dental Benefits Scheme. Can I get an understanding of what promotion the department is doing or requesting others to do—that is, the Department Of Human Services—to promote the Child Dental Benefits Scheme?

**Ms Anderson:** The communication strategy in relation to the CDBS is largely housed in the Department of Human Services. They have information on their website that is very comprehensive, and they are the ones responsible for communicating with the eligible families at the beginning of each year and during the course of each year. There is also information, and quite a good deal of it, on the Department of Health website, which we looked at just the other day, and there are a number of guidelines and other information briefs available to people who visit the website.

**Senator McLUCAS:** I understand that there was a mention in the family tax benefit mail out that was in the last financial year. I think we have talked about it here. Have you done anything like that this time?

**Ms Anderson:** That is not our responsibility. The Department of Human Services is responsible for advising families in relation to taxation eligibility matters. Therefore they are also in charge of communication in relation to eligibility for CDBS.

**Senator McLUCAS:** Have you asked them to do any promotion?

**Ms Anderson:** We talk with them often. The major communication is the advice they provide by letter to eligible families, which draws out very clearly the fact that, because of their FTBA status, their children, if they are between the ages of two and 17, have eligibility for this CDBS.

**Senator McLUCAS:** Has the department done any research on awareness of the scheme?

**Ms Anderson:** Not yet. We certainly have in mind looking at that, probably at the end of the first two years. If you recall, the entitlement is to a capped benefit of $1,000 over two years. We are now coming to the end of the second calendar year. We would be considering some review of that first two-year period in 2016.

**Senator McLUCAS:** Would that also include the number of eligible families who have taken it up?

**Ms Anderson:** Yes.

**Senator McLUCAS:** But you have not done any work on that yet?

**Ms Anderson:** We are keeping an eye on it. We certainly have a view of the level of participation and how it is tracking. This second calendar year the level of growth is slightly increased on last year, which is what we would expect. There is still some time to run before we come to the end of that first two-year period. We are certainly keeping it under review.

**Senator McLUCAS:** What proportion of eligible families are taking up their eligibility?

**Ms Anderson:** It is a calendar year program. In 2014 29 per cent of notified children accessed the scheme. In the year to date, as at the end of August 2015—the figures are not directly comparable because it is only eight months of the year—there have been 22.4 per cent of notified eligible children participating, which is tracking ahead of a comparable figure for the same period last year.

**Senator McLUCAS:** It is still very low, though, isn't it?

**Ms Anderson:** It is lower than we expected. There are some reasons for that that we have been reflecting on. For starters, as I said, the entitlement is for two years, so it was difficult to anticipate what the rate of take up would be across that 24-month period. I think we are still learning a bit about consumer behaviour in that regard. We also see some very significant differences in utilisation by states and territories. Two states have been particularly energetic in participating in the CDBS—South Australia and Tasmania. Some of the other states, particularly New South Wales, for their own strategic reasons, have held back, and have not been strong participants. Of course, with the greatest population in New South Wales, you would be expecting that if they were a strong participant you might see slightly higher rates. We could not foretell that when we were looking at it from 2014 out.

A couple of other points to note are that we speculate that workforce distribution may have something to do with it. If the dentists are not in the outer metropolitan, rural and remote areas, then clearly that is the precondition for accessing any service, let alone CDBS. As well, we are still looking on at the interaction between CDBS and private health insurance. We do not know what decisions are being made by parents. If, for example, they have insurance cover for dental, would they elect to use their insurance cover or possibly come into CDBS?

We are still watching to see what sorts of decisions they are making and how that might have an impact on utilisation of CDBS.

**Senator McLUCAS:** When will that work be finished?

**Ms Anderson:** We are not proposing a strategic review until calendar year 2016 when we have run the full course of 24 months and we can look back and get a full set of statistics.

**Senator McLUCAS:** The point you just made about New South Wales—I cannot understand why it would be in New South Wales's interests to not engage.

**Ms Anderson:** They would have to speak for themselves, but there have been a sequence of decisions made by the Commonwealth government about states and territories' access to the scheme. Annual renewals of access have caused states to reflect on the effort required to tool up to claim an MBS item for delivery of dental care in the public sector, versus the ongoing entitlement. They have to make business decisions, essentially, as to whether it is in their interests to go into the scheme wholeheartedly or hold back.

**Senator McLUCAS:** How many services have been provided under the scheme since its commencement?

**Ms Anderson:** 7.7 million services have been claimed.

**Senator McLUCAS:** Can you break those down over ASGC classifications?

**Ms Anderson:** Yes. We provided that information before. The most recently available data is that for 2014.

**Senator McLUCAS:** For the full year?

**Ms Anderson:** Yes. I am happy to provide that now, if you would like.

**Senator McLUCAS:** If we could pass it up, that would be great.

**Ms Anderson:** I do not have it on a separate sheet of paper. I am happy to make it available to you.

**Senator McLUCAS:** Can we break those down by federal electorate?

**Ms Anderson:** We would not normally provide information by electorate.

**Senator McLUCAS:** Senator Smith was getting something by electorate.

**Mr Bowles:** By postcode—the top 50 postcodes. We talked him out of that, if you recall.

**Senator McLUCAS:** So you do not have them by federal electorate. Do you have them by postcode?

**Ms Anderson:** I would have to take that on notice. There would be some selfsuppression because of small sizes, so there would be some counting issues, but I aa happy to take that on notice and see what we can provide.

**Senator McLUCAS:** How many people are now paying a gap under the scheme?

**Ms Anderson:** There are very high levels of fee observance under the CDBS.

**Mr Cormack:** 96 per cent of CDBS services provided by private dentists resulted in no out-of-pocket costs. 91 were bulk billed. In the public sector they are all bulk billed.

**Senator McLUCAS:** So 96 per cent had no out-of-pocket costs at all?

**Mr Cormack:** Yes.

**Senator McLUCAS:** What do you put that down to? It is very high.

**Mr Cormack:** I suspect it is probably from a business point of view. The benefit is commensurate with the business requirements of the practitioner.

**Senator McLUCAS:** What is the average gap payment?

**Mr Cormack:** We might need to take that on notice.

**Senator McLUCAS:** What are the most common treatments under the scheme? A check-up, I suppose?

**Ms Anderson:** The five most common treatments, which account for 66 per cent of all services, are fissure and/or tooth surface sealing; comprehensive oral exam; intra-oral, peri-apical or bitewing radiograph, which is an image; topical application of remineralisation and/or cariostatic agent, one treatment; and removal of calculus.

**Senator McLUCAS:** Are they item numbers?

**Ms Anderson:** Yes.

**Senator McLUCAS:** That is all I have on child dental. I think that knocks off outcome 3.

**CHAIR:** We will move to outcome 5, primary health care.

**Senator McLUCAS:** I want to start with primary health networks, please. Have all the contracts been finalised for the 31 PHNs?

**Mr Bowles:** Yes.

**Senator McLUCAS:** Were they all finalised before 30 Junes?

**Mr Bowles:** Yes, they were all completed before the due date.

**Senator McLUCAS:** Are any of those contracts being renegotiated or varied?

**Mr Cormack:** I will turn to Mr Booth for detail on that, but, across 31 funded organisations, over the life of any contract you will get agreed variations.

**Mr Booth:** In general that is correct. The contracts have been signed with the PHNs but, as Mr Cormack says, there are various things being developed through the course of the year in terms of programs that come in or programs that may move, and they may affect some of that. But, in general, yes—that is where we are at.

**Senator McLUCAS:** So how many of them are being renegotiated?

**Mr Booth:** They are not being renegotiated.

**Senator McLUCAS:** Okay; varied—it is a variation to the contract?

**Mr Bowles:** Yes. It is extra activity or variations as to what we want them to do as opposed to renegotiating their current contract arrangements.

**Senator McLUCAS:** Sure. These contracts are only four months old, yet we are having to vary them already.

**Mr Bowles:** No. We vary them on the basis that we might want them to do more activity, because how we actually will fund the activity into the future will be through—or one mechanism is through—the PHNs.

**Senator McLUCAS:** Are all of them going through a variation at the moment?

**Mr Cormack:** We could not answer that question. We do not have that kind of up-to-the-minute—you just need to understand that, managing a contractual arrangement with organisations that has many different schedules and elements to it, there are specific requirements under those contracts for disclosure and notifications, and any of those, either from the point of view of the Commonwealth or of the other party, can trigger the need to update or modify an aspect of a schedule—and to the extent that that constitutes a variation. It is part of the dynamic relationship that you have to have with funded organisations, so I could not tell you.

**Senator McLUCAS:** Let me ask the question another way. There will be requests from the Department of Health to vary a contract because you want to do something more?

**Mr Bowles:** Could be.

**Senator McLUCAS:** That is what you have just said, Mr Bowles. I understand that. The other way of looking at it is that there will be requests from a PHN to the department to vary a contract because of their requirements. How many of those circumstances do we have?

**Mr Cormack:** We will take that on notice. There is just too much detail for us to—

**Senator McLUCAS:** There are only 31 of them.

**Mr Cormack:** It goes back to the earlier conversation. There are a lot of these contracts in place. There are normal activities of reporting and disclosure, and requests from either party going to the other party, and any of those can lead at any point in time to a normal, business-as-usual variation or adjustment to a contract. We are happy to take it on notice and provide you with more detailed information. We simply do not have the information available to us to say how many contracts are currently subject to variation or likely to be subject to variation, because the answer we give you today is almost certainly going to be different to the answer we give you tomorrow.

**Senator McLUCAS:** That is fine. I am asking as of today. Of the requests to vary the contract that have emanated from the PHNs themselves, can you give me an understanding, in a general sense, of the reasons for those requests to vary a contract?

**Mr Booth:** There are probably two aspects to this area. Prior to the contracts being signed on 1 July, the department did a process where it consulted with the successful PHNs to talk through the contract, and to discuss the contract and the form of the contract, so there were various workshops held and different bits and pieces going on. Prior to the contract coming about, there was that discussion. That was then confirmed, in terms of a contract, and that contract was signed, so the discussion was held before then. In terms of the core contract, PHNs have funding for core, for flexible, and then for the schedules that sit alongside that. New schedules may come and new schedules may go throughout the year. In terms of that core and flexible funding, there has been no change there—that has continued. There has been nothing that has come back from the PHNs to say, 'Amend that; change that,' so there have been no alterations.

**Senator McLUCAS:** If the governance arrangements of a PHN change, does that mean the contract has to be varied?

**Mr Cormack:** I do not have a contract in front of me, but most of our contracts have a series of notifiable events, and certainly something like a change in the governance or

proposed changes to the constitution, all those sorts of things, would normally be events that would be required to be notified and considered by the Commonwealth.

**Senator McLUCAS:** Do you have any of those circumstances in front of you at the moment?

**Mr Booth:** There have been some where PHNs are being established and they have been discussing how they are going to be established, what their arrangements are and those kinds of things, as you would expect with new organisations just establishing themselves.

**Senator McLUCAS:** Are you surprised that there have been different arrangements for organisations that effectively tendered for these contracts and then changed their circumstances quite quickly afterwards?

**Mr Cormack:** It is not unusual for a separately constituted organisation to have adjustments to its office bearers, to its membership arrangements and to matters that could go to the constitution of the organisation. It is not unusual for those things to occur, but we would expect, and, in fact, I think require, that those sorts of significant events or changes are notified to the department. So no, the short answer is that it is not unusual for those things to happen. I cannot tell you right now—perhaps Mr Booth or others could—exactly how many of those there have been, but it is not an unusual event for an organisation to have changes of the nature that I have just outlined.

**Senator McLUCAS:** Is it possible, Mr Booth, to tell me how many—

**Mr Booth:** I could not say offhand how many of the 31 have made changes, minor changes or whatever in the past four months.

**Senator McLUCAS:** Would you mind taking that on notice? In terms of the contract, is there a standard pro forma contract? Have we seen that?

**Mr Booth:** There is basically a standard contract that the department uses, but there are parts of that contract that are specific to the PHNs.

**Senator McLUCAS:** So you just use the standard departmental contract and then schedules that sit behind it?

**Mr Booth:** There is a standard funding agreement that the department uses, but there will be specific bits for PHNs that are added on to that.

**Senator McLUCAS:** Thank you. Are the PHNs involved in any way in the MBS review or the Primary Health Care Advisory Group?

**Mr Cormack:** Certainly, in terms of the Primary Health Care Advisory Group, as you are aware—we may come to that later—there was a large consultation exercise undertaken. We had well over 1,000 responses to a survey, with a very large number of unsolicited submissions. We could check for you, but I would be very surprised if we did not get input from PHNs in relation to that.

**Senator McLUCAS:** Does the department have a final figure to date associated with the cost of closing all the Medicare Locals and establishing the 31 PHNs?

**Mr Booth:** Not as yet. As we have discussed before, we have been going through a claims determination process, whereby the Medicare Locals have been assessing the claims that they are making against the Commonwealth in terms of the contracts stopping a year early. They were required to do their initial claim for termination schedule, I think, from July. The

majority of them submitted that by then, but then there is a bit of a process of going backwards and forwards with that, double-checking and all that kind of thing. We got some final information in September, and we are just working through those at the moment and getting their audited financial results. We hope that we will have that figure by the end of November.

**Senator McLUCAS:** Could I ask on notice that, when you have that figure, we could have a look at it?

**Mr Booth:** Certainly.

**Senator McLUCAS:** Also, could you give us a bit of an understanding of how you have come to that figure, disaggregated into appropriate elements at your discretion. How many of the Medicare Locals are still operating? Do you have visibility of that?

**Mr Booth:** That is a difficult question to answer. There are a number of different scenarios here. Some Medicare Locals essentially were part of consortia that became PHNs, so they have ceased operating. Medicare Locals are not allowed to use the term 'Medicare Locals', so, in that sense, none of them has continued. However, some of them are service providers and have continued to provide services. They potentially subcontract to PHNs in the interests of service continuity in the first year, before we actually move to a commissioning environment, when they will be required to be part of the market test. I do not have the exact figures, and I suspect you are interested in that number—who is providing services—but I do not have an exact number for that. Again, we could potentially have a look at that.

**Senator McLUCAS:** Thank you—that would be helpful. What happened to the assets of the 61 Medicare Locals?

**Mr Booth:** It would depend on the different scenarios that we are looking at here. If the Medicare Local in essence transferred to the PHN, then those assets would move across. If a Medicare Local was not successful and was not part of a consortium, then there is a requirement—and from memory I think the cut-off point is $5000—that assets over $5000 move across to the PHN.

**Senator McLUCAS:** I am sorry, Mr Booth, I missed that. If it is over $5000?

**Mr Booth:** There is a $5000 threshold. Basically, and this is generalising, assets above the $5000 mark move across to the PHN. For assets under $5000 there is a bit of negotiation that goes on, because sometimes the PHN might not actually want those assets. It really is decided on a case-by-case basis. The department has been doing a fairly detailed piece of work with all of those Medicare Locals to look at all that, and that is what has gone into the termination schedule—and that is ongoing work with them.

**Senator McLUCAS:** Are you aware that there are disputes in some locations around the country about asset transfers?

**Mr Booth:** It is all part of the work that we are doing at the moment, to be honest. We have been working closely with all 61 Medicare Locals under those different scenarios. Yes, there have been differences, and we are working through those.

**Senator McLUCAS:** Does that mean that you will arbitrate in these circumstances?

**Mr Booth:** It would depend. Hopefully, we can come to a solution, but, if there were a particular issue, then we would certainly take legal advice, though the number of cases where it has actually got to that stage are minimal.

**Senator McLUCAS:** How many would that be?

**Mr Booth:** I could not tell you off the top of my head, but it would be minimal.

**Senator McLUCAS:** They would not necessarily come to you to resolve these matters, would they? They could do it through the courts.

**Mr Booth:** When this process started up around a year ago, the Medicare Locals had to complete a deed of termination and release and they had to do a transition schedule—which actually laid down and was signed off by the department—as to what they were going to do over the transition period, which is essentially six months. They had to answer all those questions. We kept a very close eye on it.

**Senator McLUCAS:** Are any organisations using the name 'Medicare Local'?

**Mr Booth:** Ex-Medicare Locals should not be using that name. I am not aware of particular organisations doing that.

**Senator McLUCAS:** I am wondering whether the name 'Medicare Local' is still owned by the government? Is there copyright on that name?

**Mr Booth:** It is the same with the term 'Medicare'—which is copyrighted. I need to double check whether we copyrighted the name or not. You might recall a couple of years ago there was a discussion about using the term 'Medicare' and so we did some work around that.

**Senator McLUCAS:** There was a lot of discussion, Mr Booth.

**Mr Booth:** There was a lot of discussion I recall around that.

**Senator McLUCAS:** What oversight does the department have for the governance structures of each of the PHNs?

**Mr Booth:** The PHNs are independent companies and so they are independent under the Corporations Act. They establish their own appropriate governance structures. The department, of course, has an interest in those governance structures to ensure those structures are fit for purpose in delivering the objectives of the PHN. We do not have a role to go in and say, 'This is what your government structure should be.' But we certainly do have an interest in those governance structures in so far as they impact upon the activities of the PHN.

**Mr Cormack:** As part of that governance arrangement, the Commonwealth imposed certain requirements associated with governance—that is, that they establish clinical councils and community advisory committees to inform the governing boards of those organisations. So while we are not, again, getting into the intricacies of specifying how they constitute themselves, consistent with the Corporations Act, we do have specific requirements that they not only engage with members of the local clinical and service community but also consumers and community members. That is why we require those two structures.

**Senator McLUCAS:** So all 31 have put those arrangements in place?

**Mr Cormack:** As far as we are aware they have, or are in the process of finalising those. I wrote to them not so long ago, just to clarify a couple of points of expectation from the Commonwealth's point of view, and most of them have responded positively to that.

**Senator McLUCAS:** Could we find out those who have not?

**Mr Cormack:** We will take that on notice.

**Senator McLUCAS:** Would you expect that each of the PHNs would publish the names of the clinical advisory committees and the consumer committees on their websites?

**Mr Cormack:** I am not quite sure whether our contract specifies that. We think that is probably good practice as a matter of principle, but there may also be some privacy issues in relation to some of the community members that some of the PHNs are engaged with. But we think that would be good practice.

**Senator McLUCAS:** What would be the conflict there, Mr Cormack?

**Mr Cormack:** In small communities or isolated communities where particular people may be nominated to be on a community advisory committee there may just be some desires by individuals. I am not aware of any, I am just speculating here because I am not entirely sure whether all PHNs are in the process of putting their community advisory committee or other membership up on their website, but I am just saying there may be circumstances where that is not appropriate. But we will take on notice the specific questions about have they got them in place and are they up on their website.

**Senator McLUCAS:** That would be good. I am a bit bemused that if you wanted to serve on a community advisory committee you would not want the world to know about that, frankly. You want the world to talk to you so that you can represent the world.

**Mr Cormack:** Sure.

**Senator McLUCAS:** I was a member of the cancer division of general practice representing the world, but we did not have websites then. If you are going to represent the community, the community has to know who is on that committee, surely? What is the salary range for a PHN CEO?

**Mr Booth:** We would not have that information to hand. That would be for the PHN to determine.

**Senator McLUCAS:** Okay. Would you expect that PHN to publish that figure? I mean, it is government money. I know that it is being channelled through a private company, but—

**Mr Booth:** In terms of recruitment, there have been a number of adverts in the paper that you have probably seen that have salary ranges in them, so, yes, they are being published, so they are being made public.

**Senator McLUCAS:** It is not a requirement though?

**Mr Booth:** It is not a requirement, no.

**Senator McLUCAS:** Does the government recommend any stipend or sitting fee for a chair or a board member of a PHN?

**Mr Cormack:** We will check on that one.

**Mr Booth:** We will just double check and find out for you, but as far as I am aware, no.

**Senator McLUCAS:** Has the Primary Health Network performance framework been finalised?

**Mr Booth:** The outlines of the performance framework have been made public and they have been finalised. There is a reference group with PHNs who are involved in inputting into

that, and that work is ongoing at the moment. That is really getting down into the detail around the four key areas that are in the performance framework.

**Senator McLUCAS:** Primary Health Network the name—where is that up to?

**Mr Booth:** For PHNs, the advice to the network is that their name is the geographical area followed by PHN. In terms of litigation that is ongoing, in terms of primary health care and primary health and the constituent parts, that is still ongoing.

**Senator McLUCAS:** But where is it up to? Is it in court?

**Mr Booth:** It is in the courts at the moment, yes.

**Ms Anderson:** It is scheduled to be heard in the Federal Court in mid-December this year.

**Senator McLUCAS:** Good luck. Back to the performance framework: when do you think it will be finalised, Mr Booth?

**Mr Booth:** We would hope, as I said, the high-level four key areas have been finalised. In the framework, there will be those four high-level areas, then there will be locally relevant indicators that will be developed by the PHNs, and then there will be the contextual information which is around aspects of performance. That has been finalised and that is being done. What we are working through now is the detail about how you actually measure those and what is included in those. I think we have discussed before how the aim for those four key areas would be that we do not have new data collection, that we use existing information—all that kind of thing. We are working through that at the moment, but I would hope that that would be done fairly soon.

**Senator McLUCAS:** When that is all completed, will that be made public?

**Mr Booth:** Yes, because the PHNs will be needing to report against that.

**Senator McLUCAS:** Are all the 31 fully operational?

**Mr Booth:** Yes, all 31 exist. Contracts have been signed with them: there are 31 PHNs in existence around the country.

**Senator McLUCAS:** How many staff are employed at all of them?

**Mr Booth:** I do not know.

**Senator McLUCAS:** Is that something you would ever know?

**Mr Booth:** It is something that we would need to specifically go and find out. Again, it is one of those tricky areas: because of the individual nature of each PHN, some of them will have schedules for specific pieces of work and staff associated with those individual schedules. It is a bit of a movable feast. We would need to do a bit of a census, I suspect, to get definitive numbers.

**Senator McLUCAS:** So it is not something that is normally being reported?

**CHAIR:** Senator McLucas, I advise you that we are due to move on. I understand there are significant further questions in this outcome, but we are somewhat behind because we went over time in some of the others. Can I just get an indication from you in terms of primary care so that I can manage other senators who are looking to come into the mental health and other parts of outcome 5?

**Senator McLUCAS:** Can we try and finish the non-mental health part of outcome 5 in about another 10 minutes and then go to mental health?

**CHAIR:** Sure. That will give an indication to others who are waiting. As you enter the room, Senator Lambie, I might indicate that we are still some way behind and we will not be coming to outcome 4 for a reasonable period of time. I am just advising. I am happy to keep you informed as we get closer to that, or you are free to wait.

**Senator McLUCAS:** Let us go to the issue that was raised at the Senate Select Committee on Health recently, and that is Aboriginal controlled health organisations and their engagement with PHNs. Is it the department's view that Aboriginal controlled community health organisations should be explicitly recognised as critical partners for the PHNs?

**Mr Booth:** We would expect PHNs to be linking in with Aboriginal and Torres Strait Islander organisations across their area.

**Senator McLUCAS:** How do you monitor that?

**Mr Booth:** There are a number of answers to that. One is that in the move to a commissioning environment they need to do a health needs assessment exercise, which builds upon previous ones. That health needs assessment exercise is intended to look at the whole of the health needs across the particular geographical area that they cover. We would expect that the needs of the Aboriginal and Torres Strait Islander community would figure strongly within that.

**Senator McLUCAS:** I understand that but how do you monitor that?

**Mr Booth:** There is an amount of funding that goes through to PHNs, in some areas there are specific schedules and some of those may be related specifically to programs for Aboriginal and Torres Strait Islander communities. There is also flexible funding within there and the flexible funding is intended to respond to that needs assessment work. What the PHNs will be doing in a commissioning environment is looking at the needs around that area and saying this is where we need to invest the money that we have. They will make that clear in terms of their annual reports and frameworks that they use.

**Senator McLUCAS:** Will Aboriginal controlled community health organisations have to tender against other providers for services and programs that are specifically designed for that population?

**Mr Booth:** There would be commissioning expected to take place and there would be market testing expected to take place. If there was a specific focus for that community then those organisations would be expected to have a very good chance of providing that service, but they would be competing in the market.

**Senator McLUCAS:** Are you aware this is very contentious in the Aboriginal controlled community health organisation sector?

**Mr Booth:** Yes.

**Senator McLUCAS:** Have you done any analysis of what the cost will be to the Indigenous health sector to tender for work that we know and all the evidence tells us is best provided by Aboriginal controlled community health organisations?

**Mr Booth:** We would expect that the commissioning that PHNs undertake will not put onerous costs on any groups who seek to tender for services.

**Senator McLUCAS:** But there is plenty of evidence out there—you are aware of it, we are all aware of it—that best health outcomes for Aboriginal and Torres Strait Islander people

are achieved when health services are provided by Aboriginal organisations. There is plenty of data around that so why are we making these organisations go down the road of having to tender for services that they currently provide and that they are now going to have to compete with non-Indigenous organisations to deliver?

**Senator Nash:** If I can just jump in there, you are quite right and I agree broadly with your statement. There are also various levels of proficiency across the organisations, so I think it is appropriate that we have a process that determines whether or not they are the most appropriate deliverer of those services being put up for at the time. I completely take your point, but I also think it is appropriate that we analyse whether or not they are best placed to deliver the services at that point in time, whatever service it is.

**Senator McLUCAS:** Are you confirming now—this is the first time we have actually had this confirmed—that Aboriginal organisations will have to tender for the work that they are currently providing?

**Senator Nash:** I do not think that is what we are saying.

**Mr Booth:** No, there are two issues here. There are the services that ACCHOs currently provide under contract to the department, that continues—PHNs are not touching that money, that carries on.

**Senator McLUCAS:** That is very comforting, Mr Booth.

**Mr Booth:** What we are talking about is where Medicare Locals are contracting at the moment and are providing services, for example in particular areas, then the expectation is that the PHNs do not provide services and they move to a commissioning environment. It is that group of services that have been provided through the Medicare Locals in the past that we are actually talking about here. We are not talking about services that are currently provided through other routes to ACCHOs.

**Senator McLUCAS:** It would be helpful then if we could get a list of those programs. Are they in flexible funds or what types of programs are they?

**Mr Booth:** I would need to double-check.

**Mr Bowles:** It could be in a range of areas.

**Senator McLUCAS:** For clarify in the community, it would be really handy for us to know what those programs are that are moving from the Medicare Local to the PHN—what you are saying is previously provided by the Medicare Local but now will be tendered out.

**Dr Southern:** The programs that are currently delivered through PHNs that were formerly delivered through Medicare Locals include the Care Coordination and Supplementary Services program, the Improving Indigenous Access to Mainstream Primary Care activities and some of the New Directions: Mothers and Babies programs. Then there are 10 PHNs which deliver Aboriginal and Torres Strait Islander specific primary healthcare.

**Senator McLUCAS:** We asked this at the Senate select committee hearing the other day as well.

**Dr Southern:** Yes, that is right. It is those programs that were being delivered through the Medicare Locals that in 2015-16 are being delivered by PHNs.

**Senator McLUCAS:** We might put some questions on notice about that.

**Senator LAMBIE:** On Aboriginal health, do you know how many Indigenous people are eligible for health care in Tasmania?

**Mr Bowles:** No. We would have to take that on notice. I do not know the specific breakdown by state of the Indigenous population offhand. Prime Minister and Cabinet might have a better clue, because they run the broader Indigenous programs. We just look at it from a health perspective.

**Senator LAMBIE:** I want those figures. I am not sure if you realise, but there happen to be some issues in Tasmania when it comes to Indigenous people. You have to be seen as Indigenous by a group of people down there—that being the TAC. There are 19,000 of us down there and they are only recognising 3,000. So I want to know whether or not you are getting the money for the full 19,000 yet only 3,000 are receiving that money. That is what I am looking for. That is the angle I am coming from. So it would be nice to see exactly how many you are funding down there.

**Mr Bowles:** All right.

**Senator McLUCAS:** I have a couple more questions on PHNs. Is the department aware that some PHNs are offering three-month contracts to service providers?

**Mr Booth:** There are a variety of different contracts in place at the moment, in this transition year, but I would need to take on notice any specifics around them. I do know that there are different contracts out there—

**Senator McLUCAS:** Could I have some reasons why someone would let a contract for three months? I am talking about service delivery.

**Mr Cormack:** I guess a general answer to that—and we will give you the specifics on notice—is that 2015-16 is a transition year where the PHNs have been established. The PHNs are assuming the pre-existing service delivery roles in addition to their new planning, integration and commissioning role throughout the course of this current financial year. Then in the following financial year they will transition the way services are currently delivered from a direct delivery model to a commissioning model, which is quite different. So in the course of that there would be a need for a series of short-term extensions to a range of service contracts. We can give you the specifics, but that would be the reason for that. We have no intention for the PHNs to enter into long-term service delivery roles. They are transitioning out of that into commissioning.

**Senator McLUCAS:** That is a good answer. When I go to my PHN, NQ, it is one of the ones that have had a governance change. Are you aware of that, Mr Booth?

**Mr Booth:** Yes.

**Senator McLUCAS:** FNQDocs is now not a partner in the consortia. Are you aware of that?

**Mr Booth:** Yes.

**Senator McLUCAS:** What visibility did you have of that? How did that all happen?

**Mr Booth:** As we said before, the make-up of the board and the membership models are an issue for the individual PHN. Yes, we did know that that was happening and PHN did talk to us about it. Our concerns, as ever in this case, were to ensure service continuity. We also wanted to confirm in that instance that general practice would be adequately looked after

across the whole of the very large, as you are aware, PHN area. We did have discussions with the CEO; I talked to him and found out information about what they are doing in terms of their relationships with general practice. They shared with us a very extensive consultation exercise they are undergoing at the moment with individual practices around the whole of the PHN to ensure that they do link in. I know they had concerns around ensuring representation across the whole of the PHN, and that was—

**Senator McLUCAS:** Did they just realise that after they had awarded the tender?

**Dr Southern:** That was one of the areas. I am not aware of everything in there—what other discussions may have been had at a board level within the PHN. But yes, we were aware of it, and our concern was to ensure that the PHN was able to meet its obligations there and to adequately have reach across all of general practice across the area.

**Senator McLUCAS:** This tender was awarded to a consortia that included the GP representative brief FNQ Docs. You knew then that FNQ Docs was the old division of general practice that only have coverage of a portion of the area that the PHN covers. Why was the contract let to an organisation that was not connected to all of the GP network, for want of a better word, from Mackay to the Torres Strait?

**Mr Cormack:** Could I answer that question, again, with a general response. When we went out to the market we got a very good, solid response. Most of the PHNs had some form of affiliation, either consortium or otherwise, with a range of different parties. Not each of those parties represented every single constituency or the full constituency in the new PHN areas. It is not at all unusual that at the time of signing a contract you would have a consortium member within the lead PHN body that is representative of only part of the new constituency, but may have been in the former Medicare Local days more fulsomely representative of the constituency.

So it is not at all unusual, and that is the value of consortia—they bring together people with different sorts of perspectives, different sorts of skill sets, different sorts of constituencies. The premise of your question is: yes, it is certainly aware, and it is not unusual. Also it is not unusual—it is sometimes regrettable, but not unusual—that self-governing, independent organisations, private companies, go through changes in partnerships, changes in shareholder arrangements, changes in constitutional requirements, memberships—all of those sorts of things. That is why we have a specification in a contract that those events are notified to us; that then triggers people such as Mr Booth being able to do the appropriate due diligence which the Commonwealth has done in this instance. I think it is regrettable that we do get these changes, but that is just the way the business world works. We have to have a contractual arrangement, a business arrangement that understands that and is able to respond to it quickly. In this instance we have been able to do that.

**Senator McLUCAS:** How many of the 31 PHNs have had the sort of circumstances that we are describing with the NQPHN?

**Mr Booth:** I think very few. I think that is the main one.

**Senator McLUCAS:** We are special, aren't we?

**Mr Booth:** I think that is the main one, but I would need to double-check whether there have been any others where there have been changes in membership.

**Senator McLUCAS:** Did you have to approve the new consortia arrangements?

**Mr Booth:** We do not approve it because they are, as we have said, an independent organisation. But as Mr Cormack said, we have to do the due diligence to see that it is an appropriate mechanism.

**Senator McLUCAS:** Are you now satisfied that the Australian College of Rural and Remote Medicine is sufficiently connected into the local GPs in our region?

**Mr Booth:** Certainly. In the discussions that we had with the PHN they were able to reassure us that they were doing that reach across their area.

**Senator McLUCAS:** Are you testing that with the GPs at the Cairns-Townsville-Mackay region?

**Mr Booth:** As with all PHNs in this year of setting up and transition, we are keeping a close eye on and very strong links with all PHNs to make sure that they are achieving the objectives that they need to be.

**Senator McLUCAS:** Have you had any complaints from GPs about their feeling that they are not represented well enough, given government's real focus was on what used to be Medicare Locals to GPs. Have you had complaints from GPs in the north?

**Mr Booth:** No.

**Senator McLUCAS:** I have.

**Mr Booth:** We have not had any.

**Senator McLUCAS:** I might send them to you. That is all I wanted to ask on PHNs. On the Primary Health Care Advisory Group, the website states that the report to government will be by the end of 2015. Is there anything more specific than that about when the report will be provided?

**Mr Bowles:** That is right—towards the end of the year.

**Senator McLUCAS:** Just by the end of the year. How were the 480 people who participated in the group's consultation process able to provide their feedback?

**Mr Cormack:** A number of opportunities were provided. First of all, as you would be aware, a discussion document was released with a consultation feedback survey associated with it. We got over 1,000 responses to that. Secondly, we undertook a large number of face-to-face consultations across the country. We had 16 public information briefings, with an estimated reach of over 450 participants. We had one national public interactive webcast, which reached 500 participants in a one-hour session; 42 briefings with peak organisations including RACGP, ACRRM, AMA, Palliative Care, Consumer Health Forum and NACCHO; and sector briefings with individual professions, PHNs and state governments. We also received 68 formal submissions from stakeholders. It provided us with a very rich source of feedback, which came in through a number of different means.

**Senator McLUCAS:** Have the MBS Review Taskforce and the Primary Health Care Advisory Group had any interactions?

**Mr Cormack:** They have common membership; the chair of both of those is a member of the other. Certainly, at the department level and at stakeholder level, we are working very closely to keep each other informed of developments.

**Senator McLUCAS:** Were there any interactions between the expert reference group on mental health and the Primary Health Care Advisory Group?

**Mr Cormack:** I would have to double check. It is quite possible that some members had some specific input in their other life, because many of the ERG people are very actively connected. Presumably we are not going into the mental health space the moment, but in the context of the expert reference group they were given briefings along the way of developments with the Primary Health Care Advisory Group. As you would be aware from the discussion documents, the reach of Primary Health Care Advisory Group and its scope included people with mental health conditions as well. It was important that we kept that interaction going with the ERG.

**Senator McLUCAS:** But did that happen almost in an ad hoc way, or was that a formalised process?

**Senator CORMANN:** We will presumably come to the mental health ERG shortly. There are a number of meetings of that group, and certainly Mr Booth and I have been very active in both of those and we have provided updates and information briefings to the ERG, and indeed to the Primary Health Care Advisory Group, on the activities of both groups. They are running in parallel time frame and they have overlapping client groups.

**Senator McLUCAS:** How were the group's terms of reference determined?

**Mr Cormack:** The terms of reference were put together by the department. They were approved and they were promulgated as part of the announcement process—just the normal approval process within the department.

**Senator McLUCAS:** Are there any nurses represented on the group?

**Mr Cormack:** Yes, there was a nursing representative: Karen Booth from the Australian Primary Health Care Nurses Association is a member of the Primary Health Care Advisory Group.

**Senator McLUCAS:** And allied health representation?

**Mr Cormack:** Marcus Dripps, who is National President of Australian Physiotherapy.

**Senator McLUCAS:** How many consumer representatives are there?

**Mr Cormack:** Leanne Wells from the Consumers Health Forum.

**Senator McLUCAS:** Will the group's report be made public?

**Mr Cormack:** It is a report to government, so that will be determined in the fullness of time.

**Senator McLUCAS:** Very quickly, how are members of the group being remunerated?

**Mr Cormack:** They are being remunerated according to one of the schedules that we apply to formal committees or to daily review rates as they apply.

**Senator McLUCAS:** How many departmental staff are providing secretarial support?

**Mr Cormack:** We can give you an estimate of that very shortly. At least half a dozen would be directly supporting that, but I will give you more precise numbers.

**Senator McLUCAS:** They will work through until the work is finished?

**Mr Cormack:** Yes, indeed.

**Senator McLUCAS:** That is all I have for the advisory group.

**CHAIR:** Some people want to move to the mental health space.

**Senator RICE:** I want to start with the government's response to the National Mental Health Commission's report released in April. In October the minister stated that the government would respond to the review by the end of the year. Why is the government taking so long to respond to it?

**Mr Cormack:** The government established an expert reference group shortly after the report was released in April. The expert reference group was established to provide specific advice to the government to inform its response and how it would progress implementation of that response. It is a very eminent senior group of people who are active in the mental health space. They gave very generously of their time, but there was certainly a lot of material to work through. The first part of their work, which is to provide some advice to government, was completed last month and the government's response is now in the process of formal government consideration.

**Senator RICE:** Do we have an accurate time line of when we to expect a response?

**Mr Cormack:** The best thing I can say is that the minister is on the public record as saying that she will be making some significant statements in this space before the end of the year.

**Senator RICE:** In her recent statements, the minister has indicated that there will be significant structural reforms. Can you say over what time frame those reforms will take place? Will they be immediate or will they be over a 10-year period, as per the commission's suggestion?

**Mr Cormack:** It is premature to speculate on the timing of those. The response is, as I said, in the process of being considered by government. The timings for any changes, any structural organisation or reworking of programs or any of those sorts of things are matters for government consideration, as is the timing of those.

**Senator RICE:** The report covers the fact, as do many other reports, that mental health encompasses many more portfolios than just the health portfolio. I am interested to know what the government is going to do to ensure cross-collaboration between portfolios?

**Mr Cormack:** An interdepartmental committee has been established and has been assisting the department in bringing the emerging response into a whole-of-government context. It is a central agency. It has DSS, Defence, Veterans and Education. It is fully represented. They have been working closely with the department to progress the development of the government's response and, of course, it will be subject to a full cabinet process in the near future.

**Senator RICE:** That level of collaboration and making sure that it has cross-portfolio and all of cabinet fully in the response?

**Mr Cormack:** That is certainly what we have been working towards—yes.

**Senator RICE:** I will now move on to issues associated with the introduction of the NDIS. According to the Mental Health Commission's report, there are around 65,000 people with severe mental illness who will fall into the NDIS, but around 625,000 people with severe

mental illness will not. The general question is: what is the government currently planning about what is going to happen to those 625,000 people?

**Mr Cormack:** I will turn to Ms Anderson, who can probably give a more fulsome response there, but I think the important point is that another government department has carriage of this work. We are working very closely with the DSS and the NDIA itself to address those transition implementation issues, but I think it is important that detailed questions about the NDIS implementation—

**Senator RICE:** It is not so much the people that are going to fall into the NDIS—I think there are going to be the programs in place through the NDIS for those—but the estimate in the Mental Health Commission's report is that that is only 65,000 people, but we have another 625,000 people who are not going to—

**Mr Cormack:** Again, with those, that will be dealt with in the context of the response to the national Mental Health Commission report, and the government's response will have something to say about that.

**Mr Butt:** Can I clarify that, in fact, in our review we were saying there were 65,000 people with severe and persistent mental illness or psychosocial disability who potentially may get into the NDIS. It does not necessarily mean they will, and there is an assessment process that will look at whether they are eligible for tier 3 or not. So it is not necessarily that we are saying the 65,000 people will get into the NDIS.

**Senator RICE:** It is just the magnitude; 10 times as many people with severe mental illness are likely to not be eligible for the NDIS.

**Mr Butt:** They are very unlikely to be eligible for the NDIS, because they tend to be the people who have got severe and episodic illness. They are not regarded as having a permanent disability. So, no, they are very unlikely. A lot of those people currently would be looked after by state specialised mental health services with support from primary health care.

**Senator RICE:** Would the expectation be that the state would end up having to carry the responsibility for the services for those people?

**Mr Butt:** The states carry a lot of that responsibility now. The models that we have recommended—and, obviously, it is up to government decisions about what they do—are about taking a more regionalised approached where you are looking at Commonwealth and states working together and about how you look after those people, because there is a real issue about that particular group. With a lot of those people, their functional impairment is not necessarily high. So a lot of them are very active in the community—

**Senator RICE:** Absolutely.

**Mr Butt:** in employment and in education and so forth. There are others who may have severe and episodic or severe depression, or whatever it might be, who are actually very functionally impaired and who need much greater levels of support. The recommendations we have made are about a stepped care approach where you match services to meet the needs to that individual—as their care needs go up, so you step up, and then you step down when you need less services. I would say about that group there are certainly issues about the different roles of the Commonwealth, the states and the territories in what care is provided for those people and how you keep them out of crisis and out of hospital. That is part of the issues that I

know the Commonwealth is looking at both in the fifth national mental health plan and in its response to the review.

**Senator RICE:** I want to move on to the services provided under the Partners in Recover program. It appears to me in discussions with stakeholders that the future of the Partners in Recovery program is unclear. I understand that from 1 July next year there are going to be in kind contributions to the NDIS from Partners in Recovery, so what is this going to mean for the future of the Partners in Recovery program?

**Mr Cormack:** There are two ways of responding to that. First up, to pick up on a final point that Mr Butt mentioned, in relation to the severe and more complex patient's mental health and their interface between the primary health care and the state health systems, that will very much be part of the fifth national mental health plan. Minister Ley, at the time of the release of the National Mental Health Commission report, also sought the approval of her state and territory colleagues to commence the development of the fifth national mental health plan. And that will focus on whole of system: the Commonwealth, state and territory approach to responding particularly to these important interface issues. That work is progressing well. It is being supported by one of the committees of the Australian Health Ministers' Advisory Council, AHMAC, and chaired by Michael Pervan, the acting secretary of the Tasmanian health department. So that work is well progressed. The Commonwealth is actively contributing to and resourcing that work. Many of those implementation issues that involve a combined Commonwealth-state response will be picked up in that piece of work.

In relation to the other issues around 'where to' with Partners in Recovery activities, day-to-day living and all those sorts of programs they will be touched on and addressed within the government's response to the National Mental Health Commission report.

**Senator RICE:** Are you able to tell me any more about the future of the Partners in Recovery program?

**Mr Cormack:** It is caught up—it is not caught, it is part of—I have just told you two stories. The third story is the implementation of the NDIS, for which the department does not have carriage but we are actively contributing to that. I would certainly recommend that those sorts of issues be taken up with—

**Senator RICE:** You can understand the concern from the sector—if there is big money being put from Partners in Recovery into the NDIS, what does this mean for the Partners in Recovery program.

**Mr Cormack:** Indeed; yes.

**Ms Anderson:** Just to add to Mr Cormack's comments, a couple of jurisdictions are already engaging in trials, which involve Partners in Recovery or their clients participating in the NDIS. So we are stepping into, in a very considered and planned way, carefully looking at the earlier experience and learning from it and working closely with the Department of Social Services to ensure that as we move further into transition we get all the benefits of that early experience and can refine the program as we go.

You mentioned the words 'in kind'. That means it is a precautionary measure. We are looking, very carefully, at not moving too many parts too quickly. We step into the trials. We move beyond trials through transition in a considered way, making sure everyone has in the forefront of their minds that this client group continues to access the services they need. That

has been signed off by all governments as absolutely the most important thing to be watched for and protected as we move into implementation.

**Senator RICE:** Given the trials and pilots that are going on, when will you have more clarity about funding for the programs that Partners in Recovery are doing outside the NDIS, what they will end up being?

**Ms Anderson:** We know this sector is very keen for information. Indeed, we are determined to provide that as quickly as we can. Mr Cormack already referred to the government response to the National Mental Health Commission review, which is material, as a timing issue, that is within our minister's control. We are also undertaking an evaluation of PIR. The final report of the evaluation is due in the middle of the next calendar year. That would be expected to inform decisions that are made about Partners in Recovery into the future.

**Senator RICE:** In terms of the areas that do not have a Partners in Recovery scheme, is that on hold, in terms of extending Partners in Recovery?

**Mr Cormack:** All—and this is consistent with the minister's previous public statements—Commonwealth funded mental-health programs are now under active consideration, in the context of the response to the National Mental Health Commission report, inclusive of Partners in Recovery. The extent to which the next stages or steps with that program—and, indeed, with any of the other programs—will be part of the government's response to the National Mental Health Commission report, and we are not in a position to pre-empt that. It is not too far away; it is before the end of the year.

**Senator RICE:** Until then, you cannot give anyone any certainty about the timing of decisions on these programs.

**Mr Cormack:** What I am saying is there are a lot of programs in the mental-health space. All of them are part of a comprehensive Commonwealth response to the National Mental Health Commission's report. We cannot go through them one by one, because they are part of the government response that is under active consideration and the minister will be making a statement about that before the end of the year.

**Senator RICE:** Can I get some clarity about the current status, in terms of rolling over funds from the Partners in Recovery program and other in-scope programs into the NDIS pool? What is happening, at the moment?

**Ms Anderson:** As I said, the service providers for PIR and day to day living are participating in trial sites in New South Wales in the Hunter Region, in the ACT and in WA—both in an NDIS trial and also in a WA design trial. We are contributing in kind, so there is no cash transfer as such. The clients of those two programs—Partners in Recovery and day to day living—who are deemed eligible to move into NDIS are continuing to receive those services as NDIS clients. Those are trial sites—data is being gathered from those sites and being looked at very closely, and lessons are being derived as appropriate.

**Senator RICE:** The information, linkages and capacity building program—can we be informed about the ongoing level of funding for that program, and how much of that funding would be available for psycho-social disability?

**Mr Cormack:** Is that within the NDIS?

**Ms Anderson:** Yes.

**Mr Cormack:** It is a matter for the Department of Social Services and for the NDIA itself.

**Ms Anderson:** Moving on. Both the Mental Health Commission and the Senate Select Committee on Health have recommended a national stigma reduction campaign for mental health. Are you able to tell us anything the government currently has planned in terms of stigma reduction?

**Mr Cormack:** I am sorry to repeat my earlier response, but the government and the minister have announced that this is landmark review, it covers all aspects of mental health programs. The government is in the process of considering its response, and no doubt aspects in that space will be considered and responded to in due course.

**Senator RICE:** Once we get a response?

**Mr Cormack:** As part of the response.

**Senator RICE:** The government talks a lot about front line services. Can you please explain what is meant in terms of mental health front line services?

**Mr Cormack:** As a general comment, they would be programs that are funded by the Commonwealth that deliver services and that support the delivery of services directly to individuals who may be affected by mental illness, to carers and to others who are involved in supporting or working with people with mental illness or who are at risk of mental illness. Front line services would fall into the general description I have just given.

**Senator RICE:** Does the government recognise peer-to-peer support for front line services?

**Mr Cormack:** I would think that it probably would. I am not deeply familiar with the program but I am sure that there is somebody in the room here who is. The extent to which the government, through its programs, is supporting the groups that I just mentioned—that would probably be considered to be a front line service.

**Senator RICE:** So you think it is?

**Mr Cormack:** There is a common, dictionary, general understanding of what the term 'front line' means. There is not a precise—

**Senator RICE:** I think that people who are concerned about peer-to-peer services—there is obviously some uncertainty as to whether they are considered as a front line service—want to know whether they are.

**Mr Cormack:** Sure.

**Ms Anderson:** By way of addendum, I am not going to reflect directly on the definition, but what I can say, categorically, is that there is an appreciation of the value of peer-to-peer services. Whether they fall in or outside of that categorisation is another question, but we are very aware of the value that individuals with mental illness and their carers place on those services, and certainly we know that there is strong therapeutic benefit from that sort of relationship.

**Senator RICE:** And you would recognise the value of supporting and resourcing those peer-to-peer services?

**Ms Anderson:** Without making a comment on the definition, yes.

**Senator RICE:** In a recent speech, Minister Ley said that it was very important the consumer remains front of policy mind. What are the minister and the government doing to ensure that people with lived experience and their carers are involved in the development of the fifth national mental health plan and the current reforms?

**Mr Cormack:** The development of the fifth national mental health plan is a partnership between the Commonwealth and the states. It is getting underway and there is some good early work. It would certainly be the Commonwealth's expectation that a fifth national mental health plan—as was the case with the fourth, the third, the second and the first—would involve significant engagement with and involvement by consumers past and present, family members and carers. That is very much part of the way Australia's mental health system does engage. It would certainly be our expectation that that would be part of the process of developing the fifth plan.

**Senator RICE:** Can you be any more explicit about the mechanisms that will be used and perhaps about any differences between this plan and the previous plan?

**Mr Booth:** To add a bit of detail to that, there already has been one consultation meeting held. It was held last week with the members of those who are tasked with writing it, plus representatives from state and territory organisations of people who have experience or who work with people with mental health issues. There is certainly that consultation being done at the moment. We are also expecting to do much more targeted consultation as the development of the plan continues. Certainly, a big part of that would be specific consumer and carer consultation sessions we are already planning to undertake. So, yes, there are going to be targeted consultations around that. We also have some representation in the organisation of the writer's group being set up. So there is some consumer representation with people who are actually going to be doing some of the drafting of the plan. So there is very strong involvement of consumer carers in the process.

**Senator RICE:** Has there been a specific focus on this compared with the previous plan? Has there been an attempt to have much more detailed involvement of people with lived experience in the development?

**Mr Cormack:** I think that is part of the way that the modern health system is evolving. Mental health is probably in many ways the leader in that area, where it has been a well-established part of policy development, program design and governance—even at a local service delivery level—to have consumers as part of that overall governance arrangement. I think what Mr Booth has just outlined is a continued development, probably even deeper than the previous iterations of the national mental health plans.

**Senator RICE:** One last topic is the issue of funding. Given we are obviously in a period of considerable change and uncertainty, is the government planning to roll over funding again for another year, as it has done for the last two years, while the changes are taking place?

**Mr Cormack:** All aspects of the government's program funding will be considered as part of the response. We are not in a position to pre-empt the different arrangements.

**Senator RICE:** There are programs whose funding is running out in eight months time. I was speaking to a stakeholder yesterday who said that they have no certainty of funding following—

**Mr Cormack:** We are certainly very aware of that and the government is aware of that. The government will be providing its response to the National Mental Health Commission's report, and all matters to do with program activity and related funding will be addressed then.

**Senator RICE:** If at the end of that there are tender processes being initiated, what will the government be doing to ensure stability in services and support during that change in the process?

**Mr Cormack:** We are very closely in touch with our partner organisations and stakeholders. We are acutely aware of their individual organisational circumstances and the extent to which they are concerned and are having to make business decisions about their future beyond their existing funding period. We are in active dialogue with them, and we will make sure that all of those factors are considered as part of the government's consideration of the response to the National Mental Health Commission's report.

**Senator RICE:** Thank you.

**Senator SIEWERT:** I have some questions for the commission, specifically in relation to the code on physical and chemical restraints and seclusion which you have put out.

**Mr Butt:** Yes.

**Senator SIEWERT:** I am particularly interested because we have been doing quite a bit of work in one of our inquiries on restraints and it has come up very significantly in the last couple of weeks, so I would like to check some information. Have you been working with and do you have an understanding of where the various jurisdictions are up to in terms of implementing your framework?

**Mr Butt:** The various jurisdictions have been working fairly closely with us through a steering group that we had which then related back to the safety and quality standing committee of AHMAC. There was quite a cooperative approach, particularly in relation to seclusion. States have quite a cooperative approach in relation to public reporting on regional variations and the variation between states, and the rates have come down quite markedly over the past few years. I think they have gone down from 13 events per thousand bed days in 2008 to eight events per thousand in 2012. So there is good cooperation there. I think public reporting has been quite useful in that area as well. Of course there is great regional variation within states in terms of that seclusion area.

Restraint is a much harder issue and quite an emotive issue. Part of our work program going forward is to continue to work with them on how you define restraint and then what measures can be put in place to measure levels of restraint. Our focus of course in that position statement that you are talking about was within a few psychiatric units. It was not about seclusion per se, because there are obviously broader issues of seclusion which occur potentially in residential aged-care facilities and a whole range of other areas.

**Senator SIEWERT:** We are trying to get a handle on that as well. Have you had a look at the voluntary code that WA has? Is there any consideration about whether you think that particular approach is adequate?

**Mr Butt:** I have not had a look at it.

**Senator SIEWERT:** I meant the commission.

**Mr Butt:** I am not aware. I would have to take that on notice.

**Senator SIEWERT:** If you could take it on notice, that would great.

**Mr Butt:** Sure.

**Senator SIEWERT:** Have you been looking at what role the Commonwealth could have, or does have, in terms of following up the monitoring of the implementation by the various jurisdictions?

**Mr Butt:** No, we have not looked at that as such, although I would expect that would work its way through the committee structures of AHMAC in terms of any reporting that is done. I am not quite clear what has occurred in that area. Again, it is very much a jurisdictional issue because it is focused on adult in-patient facilities.

**Senator SIEWERT:** In that process, have you looked at frameworks in other sectors, such as the disability sector? I will be following up this tomorrow in the social services estimates, but have you looked at other frameworks in other areas?

**Mr Butt:** Yes, we have had the disability area represented on our steering committee that looked at the development of the position statement.

**Senator SIEWERT:** How do you work your process with their process?

**Mr Butt:** I suppose through the consultation mechanism we have in place at that level. Certainly, in a lot of the public speaking that the commissioners and I had done around the country , the disability sector has been quite engaged in that process because, as you are aware, it is quite an emotive issue.

**Senator SIEWERT:** Yes, which is why we are trying to follow it up. So, at the moment, there is no overlap between the two of you.

**Mr Butt:** No.

**Senator SIEWERT:** You are running yours completely separately?

**Mr Butt:** Yes, that is right.

**Senator SIEWERT:** Jurisdictions are being followed up separately between your process and the disability process—and I am coming to education in a minute. They are relating to each one of you separately rather than in a comprehensive approach across the board on this particular issue?

**Mr Butt:** I suppose I get back to what we were focused on—seclusion rates in relation to acute adult mental health facilities, and that at a jurisdictional level the liaison, whether it is with education or with whatever else might be happening in disability services, has been left at a jurisdictional level.

**Senator SIEWERT:** I understand the riders you have just put on your answer in terms of the particular focus you have, but do you think there is a possibility that you could take a more comprehensive approach to this issue across the sectors?

**Mr Butt:** There is a possibility to do it but whether we are the right body to do it would be another question.

**Senator SIEWERT:** I am not meaning to imply that it would be you, but across the board, and we will work out who does it later?

**Mr Butt:** It is something that could be looked at. I think you are dealing with quite different issues in many ways between, for example, education and disability and the actual mental health facilities.

**Senator SIEWERT:** I will come to education and disability, because that is exactly where we are seeing restraints used. Hence my question—

**Mr Butt:** I am not an authority to say whether you could do that or not. I am saying it is something you could have a look at.

**Senator SIEWERT:** That does take me to my question about education. Have you had any interaction with Education over this issue?

**Mr Butt:** I would have to take that on notice. We may have had association with Education but I could not tell you for sure.

**Senator SIEWERT:** It would be appreciated if you could. If you have not had any interaction with schools, you probably cannot answer the next question, and that is where young people under 18 have been restrained in schools. Has anybody raised that with you?

**Mr Butt:** No, and if there had been any interaction with schools it would have been done at a jurisdictional level by jurisdictions, and those jurisdictions would have been dealing with us at a Health level. It is quite separate from what we do.

**Senator SIEWERT:** I understand that—we are just trying to get a picture of where things are at right across the board.

**Senator McLUCAS:** Mr Cormack, you were talking about the interrelationship between the government's response to the Mental Health Commission's review and the development of the Fifth National Mental Health Plan. I am trying to understand how they are going to mesh, and when.

**Mr Cormack:** The Commonwealth is very actively part of the development of the Fifth National Mental Health Plan, so while we are above one jurisdiction it was the Commonwealth and indeed our minister who secured the support of her colleagues to progress the work. We are deeply invested in the development of that program of work. We are also very well informed about the emerging response from the government to the National Mental Health Commission report. It is really up to the government when they release their response to identify those very specific linkages, but clearly the two pieces of work are very closely related and the timing that the minister has announced for the release of the government's response will be sufficient to provide the necessary context to the development and finalisation of the Fifth National Mental Health Plan. We are deeply committed and concerned to ensure that these two processes align very carefully and very closely. That is what we are doing.

**Senator McLUCAS:** Is it right to characterise the two trains of thought as the response to the National Mental Health Commission report is almost like a Commonwealth-only response whereas the Fifth National Mental Health Plan will be a whole-of-governments response?

**Mr Cormack:** Whole of governments, plural?

**Senator McLUCAS:** Yes.

**Mr Cormack:** I think that is a reasonable distinction between the two, because clearly the Commonwealth can really only totally determine what its own policy and program

investments are going to be for those things over which it has total control, but we also have a very strong national leadership role, and that will be reflected in the work and the effort that we are putting into the Fifth National Mental Health Plan.

**Senator McLUCAS:** Has the cross-jurisdictional working group for the National Mental Health Plan met since June 2015?

**Mr Cormack:** There is a working group under the Mental Health and Drug and Alcohol Principal Committee of AHMAC. That has been established and it has met on at least three occasions—in fact, I think it may even have met just last week. So it is active and certainly occupying a lot of our time.

**Senator McLUCAS:** Has the time line for the development of the plan been finalised?

**Mr Cormack:** Our minister has indicated that she would like to see the work completed by the end of the year, and we have certainly been working with our state and territory colleagues to work to that time frame. But I think it is important to note that the Fifth National Mental Health Plan is a whole-of-governments response, and the final timing of the sign-off and agreement or commitment to that is not solely in the hands of the Commonwealth.

**Senator McLUCAS:** Is there an agreed timetable?

**Mr Cormack:** We are progressing the work to be substantially completed by the end of this year, consistent with the minister's request. That is what we are working to, but I just repeat my earlier comments.

**Senator McLUCAS:** Is it going to go to the health ministers council or COAG?

**Mr Cormack:** It is being shepherded through the COAG Health Council, and that is where it will end up.

**Senator McLUCAS:** When is it scheduled to go to COAG Health Council?

**Mr Cormack:** We do not have the dates of the full program of meetings for the next 12 months, but as soon as it is completed we will get it to the next available COAG Health Council meeting, but those meetings have not been set for next year at this stage.

**Senator McLUCAS:** If it is possible, could I get a copy of the key milestones that have been agreed for the time frames for the development of the Fifth Mental Health Plan?

**Mr Cormack:** We will take that on notice.

**Senator McLUCAS:** Thank you. The interdepartmental committee that you talked about with Senator Rice—is that to inform the government's response to the commission's review?

**Mr Cormack:** That is correct.

**Senator McLUCAS:** How long has that been meeting?

**Mr Cormack:** I will have to check with my colleague Mr Booth. It has had a couple of meetings. In fact, it has been in existence for quite some time.

**Mr Booth:** Quite a while now, yes.

**Mr Cormack:** But we had a fairly solid meeting about five or six weeks ago really to ensure that the preparatory work that has been undertaken or is being undertaken to assist with the government's response has the benefit of fulsome whole-of-government input,

**Senator McLUCAS:** What month did it start working?

**Mr Booth:** From memory, it was earlier this year, towards the beginning of the year. It was last November. What has happened was that it was decided to set up the cross-departmental committee when we knew that the commission was going to be completing its report. We actually had an initial meeting round about November to just get everybody together to talk about processes and that kind of thing. As Mr Cormack says, it has met irregularly since then. There was certainly a meeting earlier on in the year, and then there was one not too long ago.

**Senator McLUCAS:** That is probably enough on those two systems. Ms Anderson, do you have any visibility of those people who are currently getting services through PIR and what proportion of them have been able to get a tier 3 package under the NDIS?

**Ms Anderson:** The data I have is as at 31 March this year. It has referrals and registrations and so on, but I will give you the bottom-line figure. It is 12,628 registered clients.

**Senator McLUCAS:** That is across the country?

**Ms Anderson:** Yes.

**Senator McLUCAS:** But I am talking about the two trial sites in Barwon and Newcastle-Hunter.

**Ms Anderson:** I am not sure—

**Senator McLUCAS:** The PIR clients in those two trial sites.

**Ms Anderson:** No, I am not sure. I would have to take that on notice.

**Senator McLUCAS:** You do not have them?

**Ms Anderson:** I can say, though, that the number I just quoted—12,628—is equivalent to 65 per cent of the total program target of 20,000 clients to be met in the first three years of operation.

**Senator McLUCAS:** Yes, but I am asking a different question. I do not know whether you will have it, but if you do it would be very helpful: how many of the people who are currently receiving services through PIR in the Barwon and Hunter trial sites of the NDIS have applied for and been successful in getting a tier 3 package?

**Ms Anderson:** There is no PIR involvement in Barwon.

**Senator McLUCAS:** Oh, that is right—yes.

**Ms Anderson:** But I will take the question on notice and see what is possible. My understanding today is that the National Disability Insurance Agency is responsible for collecting data, and we are not yet in a position to be able to provide you with advice on that.

**Senator McLUCAS:** Yes, I have asked NDIA that. I was just wondering if you have data—and I am not trying to be sneaky and make sure that their numbers are the same, but I just—

**Ms Anderson:** I am happy to see what we can provide.

**Senator McLUCAS:** If you have it, that would be fabulous—thank you.

With the evaluation of PIR, Ms Anderson, you said it was not due until next year. But I thought that they had already completed one tranche of the evaluation?

**Ms Anderson:** In fact, we have had two annual reports of the evaluation. It is ongoing. Obviously, those are formative reports. The completion of the evaluation is expected next year.

**Senator McLUCAS:** Is the first tranche going to be published?

**Ms Anderson:** My understanding is that it is on our website. The annual evaluation reports have been published on our website.

**Senator McLUCAS:** This is where you asked someone to do an external evaluation of the success of—

**Ms Anderson:** Yes, that is correct.

**Senator McLUCAS:** When did that go up?

**Ms Anderson:** The Urbis report?

**Senator McLUCAS:** The Urbis report—when was that published?

**Ms Anderson:** Just very recently.

**Senator McLUCAS:** Thank you. I am pleased about that. And it is showing pretty good outcomes?

**Ms Anderson:** Yes, the evaluation is very useful and quite favourable.

**Senator McLUCAS:** Excellent. Mr Butt, I have to ask you some questions. When did you submit your 2015-16 workplan to the minister?

**Mr Butt:** I know we did it by the due date—I am trying to remember if that was the end of August or the end of September.

**Senator McLUCAS:** But by the due date.

**Mr Butt:** Yes.

**Senator McLUCAS:** Is it available publicly?

**Mr Butt:** Yes, it is up on our website. We put our workplan and our corporate plan up on our website.

**Senator McLUCAS:** And the focus of the commission since 1 July?

**Mr Butt:** Partly the focus has been assisting in briefings for different groups in response to the national review, *Contributing lives, thriving communities*. It has also been on that workplan. Obviously, our key function has not changed since we were established. It is about monitoring, informing, accountability and looking at how we might lead in relation to reform of the Australian mental health system, to improve the system continuously.

Of course, we are awaiting the outcome of the review and what role we might play in going forward from there. We have been looking at data analysis in relation to data linkage so that we can drill down at a local level into use of mental health services by connecting the MBS, the PBS and census data, which we are working on with the ABS. That has been a large part of the focus of the work that we have been doing.

We have other work that is continuing on seclusion and restraint, with a particular focus on restraint. The core reference group, which I was calling a steering committee before, is getting together again to look at those issues of restraint which, as I said, are quite difficult—

particularly when you get outside acute settings and you start looking at things like emergency departments, aeroplane transport, police transport and all those sorts of issues.

We have a continuing role in relation to the Mentally Healthy Workplace Alliance. We have a meeting of the alliance on Monday. We have funded the appointment of a project officer within the Australian Chamber of Commerce and Industry to drive that agenda, and I think that is getting quite a bit of momentum because of the role of industry and so forth in it.

So there are whole range of things that we have in relation to following up on some of the things that were done in the review. For example, we are looking at the physical health of people with a mental illness—how do you get a more strategic research agenda and so forth. So there is a work program that we have going forward. Obviously, the thing that might change that is what role the commission has, going forward, in relation to the government's response to the review.

**Senator McLUCAS:** Have you been told when the response is going to be tabled?

**Mr Butt:** Of course not, Senator!

**Senator McLUCAS:** I had to ask! Thanks, Mr Butt. We have talked before about the Mental Health Service Planning Framework. Can I first of all get an understanding of what the cost has been to the Commonwealth to date in terms of the work that we have done on that?

**Mr Cormack:** I might need to take some of that on notice, but it is an AHMAC project. The Commonwealth makes annual contributions to the AHMAC cost-shared budget, and that is apportioned to a range of different projects. I think Ms Anderson might have a more elegant and precise answer than I have just given.

**Ms Anderson:** In its earliest versions, we provided a sum of money to NSW Health in order for the first part of the development to occur, and that was a sum of $1.235 million. I believe there has been further expenditure, and I am happy to take that on notice if you want a specific answer.

**Senator McLUCAS:** Yes, I would very much like to know how much we have spent on it. Previously, people have told me it is not complete.

**Ms Anderson:** Perhaps I can clarify. There is a framework, and it is generally agreed by states, territories and the Commonwealth that it potentially requires further refinement—and I say 'potentially' because it has undergone a degree of trialling, and the states and territories are of the view that there is probably some refinement required and some updating, potentially, given it originated several years ago now. We have had the first meeting of the steering group, which has been put together involving South Australia, Queensland, Victoria, New South Wales and WA, with the Commonwealth as chair, for the specific purpose of looking at where it is up to, understanding the further work required and then engaging the expertise required to undertake that further work so that, by no later than next June, it is a framework which is fit for purpose, updated and generally seen to be useful for implementation.

**Senator McLUCAS:** So you expect it will be able to be put out into the public arena by about mid next year?

**Ms Anderson:** That is certainly the expectation, yes.

**Senator McLUCAS:** Was that the original time frame?

**Ms Anderson:** I think that the jurisdictions have come into this process understanding that it will take a little while and a bit of effort to bring it from where it is now up to that level, and they are prepared to put in the time to get it right.

**Senator McLUCAS:** It is currently being used, I understand, in two states already. What are they reporting as to how useful it is as a service planning framework?

**Ms Anderson:** I did not have any specific information on that.

**Senator McLUCAS:** Okay. I have been advised that it is being used in WA and Tasmania. All right. We will look forward to seeing it in the middle of next year.

**Ms Anderson:** If I may just correct an earlier comment I made: the annual reports for the PIR will be uploaded this week.

**Senator McLUCAS:** That is the Urbis report?

**Senator MOORE:** Thank you. I could not find them.

**Ms Anderson:** My apologies, Senator. I am pleased I corrected the record, then.

**Senator MOORE:** My little fingers were working their way down!

**Senator McLUCAS:** I have just a few follow-ups on QoNs. The list of operational headspace centres—I understood from one of our QoNs that 83 were operational. Is that right?

**Ms Anderson:** I can now report we have 84 operational.

**Senator McLUCAS:** Could I have a list of the operational ones, please, on notice.

**Ms Anderson:** On notice, yes, certainly.

**Senator McLUCAS:** And also the number that will bring it up to the 100. Have the locations of those all been identified?

**Ms Anderson:** Yes, they have.

**Senator McLUCAS:** So I would like two lists—operational and to be operational.

**Senator MOORE:** Can we have expected dates on the others? Just what you can give us—when you give us the second list perhaps you can indicate any kind of expectation of when they will be working.

**Ms Anderson:** That is fine. They are, in fact, going to be rolled out in a couple of tranches, so we have approximate time frames around those.

**Senator McLUCAS:** In your answer to my QON 626, Mr Bowles, you told me:

There are no programmes ceasing at the end of this financial year, though individual components may reach their natural end date.

Can I have a list of those individual components that will reach their natural end date, please. I am going to get a name of an organisation out of you one day, Mr Bowles!

**Mr Bowles:** I could not possibly comment!

**Senator McLUCAS:** It is my challenge in life.

**Mr Bowles:** I will have to refresh my memory of the answer. I cannot give you an answer off the top of my head, at the moment.

**Senator McLUCAS:** Can you take that on notice, please.

**Mr Bowles:** Yes. What particular piece do you want on notice?

**Senator McLUCAS:** Can I have a list of those components that will reach their natural end date—and I am using your words because I am not quite sure—

**Mr Bowles:** That might end at the end of this year.

**Senator McLUCAS:** That will end at the end of the year.

**Mr Bowles:** We will take that on notice.

**Senator McLUCAS:** That is all I have on mental health.

**CHAIR:** That brings us to outcome 4, Acute care.

**Proceedings suspended from 15:42 to 16:00**

**CHAIR:** We will recommence. We are now moving onto Outcome 4: Acute Care.

**Senator LAMBIE:** Minister, do you agree that of all the state public health systems that Tasmania is the worst performing on a whole range of indicators from waiting times to resourcing, gynaecology, general surgery, neurosurgery, orthopaedic surgery? I can assure you: the list goes on.

**Senator NASH:** Senator, I would have to have a look at that list before I gave you a comment yes or no on that particular question. I certainly understand from your question that you have serious concerns about it.

**Senator LAMBIE:** Are you aware that the Tasmanian category 1 patients who should receive their life-saving surgery in 30 days are forced to wait more than 10 times that time? As a matter of fact, the average wait is 350 days, so we have gone from nearly a month to nearly a year for those people waiting for life-saving surgery. I am just wondering if you have any intentions to help the Tasmanian government reduce and remedy Tasmania's surgery waiting lists.

**Senator NASH:** Senator, I am not aware of those figures but I might ask the department to perhaps assist in what we are doing in Tasmania in response to that question.

**Mr Cormack:** Thank you. I will get some assistance from my two colleagues here. The published reports, for example, the Australian Institute of Health and Welfare elective surgery report—the most recently released one—indicates below par performance certainly for Tasmania. I will ask Ms Anderson to give some details of assistance that has been offered to Tasmania. Historically, however, I will just raise the point that, irrespective of the funding that is provided to any jurisdiction, the state and territory governments are the system managers—that is just an opening comment that I would make in interpreting any of this. The Commonwealth can provide funding, encouragement and incentives; and support benchmarking—all of those sorts of things—which of course we do and have done, but the Commonwealth does not operate and manage the state public hospital systems. I might ask Ms Anderson to give some—

**Senator LAMBIE:** My calculations also show that there are over 9,000 Tasmanians who are stuck on a waiting list for elective surgery. I was just wondering if you could give me the breakdown of how many of those people are category 1, are waiting for a life-saving operation in 30 days but are being forced to wait nearly a year.

**Ms Anderson:** Those statistics are actually held by the Tasmanian Department of Health and Human Services. It is not information that we maintain, collect or scrutinise closely to that extent. We are aware of the performance on elective surgery of the Tasmanian health system, and indeed the Commonwealth government has provided additional funding to the Tasmanian government specifically to assist them in reducing the long waits—the people who are waiting longest for elective surgery. They have made some inroads into their long wait queues, although, as you indicate, they have got some further distance to cover.

**Senator LAMBIE:** Actually, the waiting list for elective surgery down there under the Liberal government and Minister Ferguson has actually risen this year. This year it is the worst it has been since 2012, and I am not sure what it was before then because I do not have the statistics. But this is the worst year, so it has actually got worse. What I am asking the minister here is: would you support my call for a special intervention? Perhaps it would involve calling in a private company, Aspen Medical, who have the track record on resources and expertise to wipe out Tasmania's surgery waiting list. Obviously the Tasmanian state government has lost control of the situation. I can tell you now that if they keep going the way they are we are going to end up on life support when it comes to our health in Tasmania.

**Senator Nash:** I am certainly happy to consider that but also I am not going to make policy on the run. There are clearly some issues down there. As Ms Anderson has indicated, we have already put money into trying to assist, and I am happy to have a look at that.

**Senator LAMBIE:** Do you agree with the Tasmanian state government plan to downgrade the acute bed and accident and emergency capacity at the Mersey Hospital and to downgrade the ICU at the Burnie hospital to an HDU? I am not sure whether you are aware, but if you do that we will not have one ICU on the north-west coast of Tasmania.

**Senator Nash:** I am not aware of those issues, and clearly they are state government issues, so I cannot agree or disagree with you.

**Senator LAMBIE:** Do you agree that the national average of public hospital beds per 1,000 head of population is about 2.6 resourced and staffed public hospital beds? Do you agree with my calculations that Tasmania's ratio of public beds for every 1,000 people is 2.35? In other words, we have 1,188 public hospital beds. The Tasmanian government needs to open up about 150 more resourced and staffed public hospital beds just to catch up with the Australian average.

**Senator Nash:** I sincerely appreciate your concern about this, but they are not questions for our government. They are questions for the state government. I appreciate that in your earlier questions you asked if there was something we could do financially to assist, and that is an appropriate question for you to ask us. But questions in terms of the operational matters of how they are running their health services down there are questions for the Tasmanian government.

**Senator LAMBIE:** Just going back to question No. 5 I asked—I call for a special intervention because obviously the state government has lost control of the situation. It is getting worse down there. Something needs to be done.

**Senator Nash:** I completely understand your concern on this, but I think in answer to that I said obviously we were not going to make policy on the run but we would look at your request.

**Senator McLUCAS:** I have a question on the back of Senator Lambie's. Can you confirm that the National Partnership Agreement that saw funding provided for the NEAT and NEST targets—that is the waiting list targets—has been axed by this government?

**Mr Cormack:** There was a budget decision taken to not continue with those arrangements. It is also worth noting that under a number of the elements of those programs the performance against the sort of reward targets was not universally met. So I think—

**Senator McLUCAS:** I understand that.

**Mr Cormack:** It is a historic budget decision. It is a decision that the government took. I am not here to challenge the facts that the decision was taken. That is all I can say.

**Senator McLUCAS:** So it is not policy on the run. That was a deliberative decision. That is fine. So how much did Tasmania receive for incentive funding for NEAT and NEST targets? Senator Lambie has an important issue, so let us work out what money Tasmania is not getting now.

**Mr Cormack:** The advice I have here is that over the life of that agreement $17.9 million was provided for NEST funding and $16.5 million for NEAT funding. That is what I can report.

**Senator McLUCAS:** $34 million?

**Mr Cormack:** Across those two programs—total payments.

**Senator McLUCAS:** So they were the payments for NEST and NEAT targets—

**Mr Cormack:** That is right.

**Senator McLUCAS:** that Tasmania is now not receiving?

**Mr Bowles:** They received that up until 2014-15.

**Mr Cormack:** That was to 2013-14.

**Mr Bowles:** I am sorry, 2013-14 was it?

**Senator McLUCAS:** Until the end of 2013-14.

**Mr Bowles:** Yes, to the end of 2013-14.

**Senator McLUCAS:** The end of which coincides with Senator Lambie's point that now the elective surgery waiting lists have blown out along with—I do not know of the emergency department wait times—but imagine if you take $34 million out of a small state's budget. It is going to have an impact.

**Ms Anderson:** The senator will recall that those payments were facilitation payments and capital payments. They were to enable all jurisdictions to redesign their patient flows, to build additional theatres and to do whatever was required in order that they could achieve and sustain improved performance.

**Mr Bowles:** Therefore, it is a matter for state governments how they use that at the time to deal with the targets. Some states have done it quite well and others have not. It is a matter, though, for the state government to manage.

**Senator POLLEY:** Can you give us a breakdown to which hospitals in Tasmania that funding went for the Launceston General Hospital, Royal Hobart Hospital, Mersey Community Hospital et cetera?

**Ms Anderson:** I am not sure we have that level of detailed information. I am happy to take the question on notice but I suspect that the state was not required to be absolutely specific. We will certainly provide what we have.

**Senator POLLEY:** Thank you.

**Senator LAMBIE:** So what you are saying is the state government could not spend that money wisely. Is it the Tasmanian people's health that is now paying the price for that?

**Mr Cormack:** I think the best way to answer that is that to paraphrase what the secretary just said. They were provided with a series of facilitation payments for investment in service improvement of $16.5 million for NEAT and $17.9 million for NEST. They have invested that and I think that is what we can say.

**Senator LAMBIE:** So you give them money but they do not have to answer to you where that money goes.

**Mr Cormack:** No, there are specific accountabilities around each of these agreements and we can provide the detail of that on notice. But at the end of the day, it is the responsibility of the system manager, which is the state government, to make the best use of that. There were reward payments that were to be made available on achievement of certain outcomes. They were not achieved. But it is the prerogative of the state government to manage its system. The Commonwealth government provided significant funding to all states and territories in line with their own specific needs and their own specific planning requirements that they believed would enable them to improve their performance in those two areas.

**Senator LAMBIE:** So the bottom line is the state minister in Tasmania at this present time has failed to get the job done. That is what you are saying. And for that, we are now going to pay the price.

**Mr Bowles:** We are not making any comment about what the Minister for Health in Tasmania is doing.

**Senator LAMBIE:** I will do that myself.

**Mr Bowles:** The other issue in relation to your question around beds and the like is the Tasmanian government have a white paper on their health system down there to try to address some of those issues. Whether they are addressing all the needs of Tasmania or not—

**Senator LAMBIE:** Have you seen that white paper?

**Mr Bowles:** Yes, I have.

**Senator LAMBIE:** What you think about that white paper? It does not have a lot of substance to it does it, Mr Bowles.

**Mr Bowles:** It is not an issue of the Commonwealth. It is an issue for the state government to manage their health system. We will assist where we can but it is not an issue for the Commonwealth to interfere in how all state governments, and territory governments for that matter, manage their hospital and health systems.

**Senator LAMBIE:** With elective surgery rates of over a year, maybe it is about time the federal government did the big thing and stepped in and took over before I start losing lives down there. Who is going to take responsibility for that? Is that state or federal?

**Mr Bowles:** Again, the health system in Tasmania is the responsibility of the Tasmanian government.

**Senator LAMBIE:** I have no further questions.

**Senator POLLEY:** Seeing as we are talking about Tasmania, can we move on to the Mersey Community Hospital? The new heads of agreement for their continued management and operation under the funding for the Mersey Community Hospital is differs from the previous agreement. Can you outline the differences for us please?

**Mr Bowles:** I might call on Ms Anderson to give me a bit of a hand on that one.

**Ms Anderson:** Yes, Senator. There is, pro rata, a larger amount of money available to the Tasmanian government to run the hospital over those two years because we have factored in an indexation amount based on the 2014-15 payment, so there is more money being provided. We have also commenced the agreement on an understanding that the services which are currently available will continue to be available, subject to the changes that may come through over time as the Tasmanian government progresses implementation of its health system reform agenda. So there are specific clauses in the new heads of agreement which allow the Tasmanian government to approach the Commonwealth government with proposals for change in the services mix and the offering that the Mersey makes, and the Commonwealth judges those proposals. If we are in agreement with those proposals then that allows the Tasmanian government to implement them at the Mersey.

**Senator POLLEY:** That would relate to the white paper that the state government has brought to the table. Do you expect to receive the draft strategic plan for Tasmania by the end of November this year?

**Ms Anderson:** I am not aware that we have been provided with any timetable. They are very quick to share with us the range of documents they have produced in relation to reform, and I expect that we would receive it.

**Senator POLLEY:** But there is no time line that—

**Ms Anderson:** I am not aware that they have actually sent something to us.

**Senator POLLEY:** In Minister Ley's joint media release with the Tasmanian health minister announcing the new Mersey hospital agreement, Minister Ley stated:

This two year agreement gives certainty to the Mersey Hospital as the Tasmanian Government works through the 'One State, One Health System, Better Outcomes' reform process and is great news for the local north-western Tasmanian community.

Given that the state government have now released their implementation plan for the process, has the department been asked to do any work on options for the funding of the Mersey Community Hospital beyond the life of this current agreement?

**Ms Anderson:** Asked by whom?

**Senator POLLEY:** Have you been asked by the government or any members in the House of Representatives or senators from Tasmania from the government side?

**Ms Anderson:** I just need to be clear. The Commonwealth government clearly is already looking to what would happen at the end of the two-year agreement. Planning is underway. It is not particularly well developed yet, but, as you would expect, June 2017 is in sight, and we

clearly need to start to have a conversation with the Tasmanian Department of Health and Human Services about options for that. Does that answer your question, Senator?

**Senator POLLEY:** How far down the process have you gone? Can you outline to us the sort of thinking that the department currently has?

**Ms Anderson:** No, it really is too early. We have not yet even sought the input of Minister Ley. We are at the early stages of considering what might be possible.

**Senator POLLEY:** But at least you are working on—

**Ms Anderson:** We are.

**Senator POLLEY:** the process, because there has been some significant delay in reaching this agreement. I am sure you would be aware that the Tasmanian community have seen this hospital being used as a ping-pong ball politically for some considerable time, so they would like some certainty and to know what is going to happen following this agreement.

The member for Braddon, Mr Whiteley, has also publicly stated that, in his view, the ownership of the Mersey should be handed back to the state government. Has the department received any correspondence from the member for Braddon? Is this under consideration?

**Ms Anderson:** I am aware that Mr Whiteley has written to the minister. I would have to take on notice whether there has been anything for the department. I think it unlikely.

**Senator POLLEY:** Perhaps, Minister Nash, you might have some clarification as to what the thinking of the government is in relation to the Mersey Community Hospital?

**Senator Nash:** I would need to take that on notice.

**Senator POLLEY:** Thank you.

**Senator McLUCAS:** On the Medical Research Future Fund and the governance arrangements for it: how will the vacancies on the advisory board be advertised?

**Mr Cormack:** The process for the appointment of the Medical Research Future Fund advisory board is now a matter for consideration by the government.

**Senator McLUCAS:** What is the time frame for that to be resolved, then?

**Mr Cormack:** We anticipate that it will be resolved shortly. We do not have control over the timing for that but are certainly aware that the minister is giving very active consideration to the appointment of the other seven members of the Medical Research Future Fund advisory board.

**Senator McLUCAS:** Is there a process of advertising?

**Mr Cormack:** It is really a matter for the minister's consideration. We have provided some advice. The minister is considering that advice, and it is really a matter for the minister and the government to progress that matter.

**Senator McLUCAS:** How will the members be remunerated?

**Mr Cormack:** I will just need to check. Section 32H of the act provides for the remuneration allowances. Indeed, division 4 of the act really covers the appointment, remuneration, leave of absence, disclosure of interest—all of those sorts of things. So it is covered in the legislation.

**Senator McLUCAS:** Is the department familiar with the Australian prostate cancer research centre in Melbourne?

**Mr Cormack:** We are aware that it exists—

**Senator McLUCAS:** Good.

**Mr Cormack:** but I would have to take on notice whatever your specific requirements are there because I do not have that information at my fingertips.

**Senator McLUCAS:** Has the department received a request for funding from the centre?

**Mr Cormack:** I have to take that on notice.

**Senator McLUCAS:** You do not have anyone here who knows the answer to that?

**Mr Cormack:** The answer is: no, we are not aware of any.

**Senator McLUCAS:** You are not aware?

**Mr Cormack:** But, for completeness, we will take that question on notice.

**Senator McLUCAS:** My final question will be redundant: has any funding been committed to the centre?

**Mr Cormack:** We will take that question on notice also.

**Senator LAMBIE:** Minister, independent Parliamentary Library research I commissioned has identified a systematic problem with the reporting of important health and hospital data: 'There are a number of sources of hospital data but no single source which satisfies all your requirements. For example, one data source reports relatively up-to-date waiting times for elective surgery but does not report the actual numbers waiting for surgery. Another source reports the number waiting for each surgical category, but the data is not as current. A compounding issue is that some data is inconsistent or not mandatory to report, such as outpatient data. Overall, this makes it difficult to provide a comprehensive and fully accurate answer.' So I just have a few questions for you.

**Senator Nash:** Senator, can I just stop you there, just to clarify. You said at the start there in what you quoted that that information was for 'your requirements'. It is difficult to know what you want until I know what the requirements were—what you were trying to find information for.

**Senator LAMBIE:** Basically, we commissioned the library. We got them to do some research, and they are finding it very, very difficult to collect anything really much to do with health and hospital data. That is the problem—especially on elective surgery.

**Mr Bowles:** There would be a range of different sources, if you like, for some of the things that you are talking about, from the state government to the Australian Institute of Health and Welfare to probably some of the pricing authorities and the national performance authority—there would be a range of different sources of data around some of those things, so it is not as simple as going to one location. That is probably why they are having some difficulty with that.

That said, we are looking at the Australian Institute of Health and Welfare in a review context to see what we can do in a broad context from that perspective, but will we ever get to the point where we have all of those things that you mentioned there in the one spot? I am not quite sure at this particular point. If I were king for a day, I would probably say it would be

great to get there, but it is something we are going to have to probably work on over a period of time.

**Senator LAMBIE:** So do you agree with me that it is the federal government's responsibility to enforce a nationwide hospital data-reporting system which is simple and a single point of contact and is up-to-date and accurate, unlike the current system that the Parliamentary Library research has uncovered?

**Mr Bowles:** It depends on what we are talking about. If I look at the National Health Performance Authority, it does do some of that work. It is called the NHPA.

**Senator LAMBIE:** What about the outpatient data? Do you agree that the reporting of important data such as outpatient data should be made mandatory and not discretionary?

**Mr Bowles:** The outpatient data in the context there is a state responsibility, so they would be dealing with that. It will feed into some of the national datasets, I am sure; I just could not tell you specifically where.

**Senator LAMBIE:** So we have no central database collecting all this information?

**Mr Bowles:** Not everything in the one place; that is what I am saying. It is across a range of different—

**Senator LAMBIE:** Do you not think that would be a much better idea, a much smarter idea of what was going on, so we could see what was going on with all the hospitals around the country?

**Mr Bowles:** That is pretty much what I said. It will be great if we can start to do that. We are, at the Commonwealth level, trying to look at national data. We have the performance authority data, and we have the Australian Institute of Health and Welfare. We have pricing from the independent pricing authority. Then there is state and territory data that comes in. It is not, at this point, all in the same spot.

**Senator LAMBIE:** Yes, why not, Mr Bowles? That is what I am asking you. How difficult can it be? I just want to try and ask you.

**Mr Bowles:** Because it is a historical issue that we are progressively trying to work through from our perspective.

**Senator LAMBIE:** If it has been an issue for so long, why have we not fixed it? That is what I am asking. I think that is a fair question.

**Mr Cormack:** Just to add to what Mr Bowles has said, the datasets that you refer to are held by jurisdictions not under the control of the Commonwealth. Some of them are and some of them are not, and some of them are held by—

**Senator LAMBIE:** Mr Cormack, I do not want to hear the excuses; I just want to know why we cannot have this database.

**Mr Cormack:** No, I am just trying to explain to you.

**CHAIR:** Senator Lambie, give the courtesy of allowing the official to answer, and then you can ask further questions.

**Mr Cormack:** The way that these things are progressed is through the Commonwealth-state ministerial and officials arrangements, the COAG Health Council and the Australian Health Ministers' Advisory Council. These are the formal mechanisms to address governance

issues that cross jurisdictional boundaries—that cross state, territory and Commonwealth boundaries. There are a series of agreements in place. There is a National Health Performance Framework, and that data is reported in the annual *RoGS*, the *Report on government services*, which is put out by the Productivity Commission. There is the performance assessment framework, or the PAF, which is part of the responsibility of the National Health Performance Authority. So there are governance mechanisms in place to continually improve and make available those datasets.

I agree that they are not all in the one place, but I disagree that nothing is being done or nothing has been done. They are substantially better than they were many, many years ago, and by international standards the datasets are good; they are accessible; and they do enable international comparisons of our health system with other health systems, such as those provided by eminent organisations such as the OECD. Senator, I share your desires to make it better. We contribute to making it better. But it is not true that nothing is being done.

**Senator LAMBIE:** I guess, Minister, we are never going to have the true data and we are never going to have a true picture of what is really going on until we have a central database.

**Mr Cormack:** No, that is just incorrect. It is incorrect.

**Senator Nash:** Yes, I would agree that it is incorrect. Never say never—never say a whole range of things, Senator. I think you are just putting words in the mouth of Mr Cormack. You are saying there will never be something. I think he has been very clear in saying that there has been movement. We are trying to do things, and we are trying to improve the system. Even when you have things like outpatients, they are both public outpatients and private outpatients. Some of this is really difficult to get the quantum of. So it is not that work has not gone into it; work is clearly going into it—and I would not say 'never'.

**Mr Cormack:** Senator, you actually quoted figures comparing Tasmania's health system performance with that of the rest of the nation based on a single source of datasets. So they do exist and they do enable you and others to make valid comparisons of the performance of individual systems within Australia's healthcare system.

**Senator LAMBIE:** That is correct, and I had to use the Library to actually obtain that information—what little information I could obtain. But I could not get a true account of what is going on out there in the public system, whether it be in Tasmania or anywhere else, because there is no central database.

**Mr Cormack:** I can suggest two websites that you could start with: the Australian Institute of Health and Welfare, which has a comprehensive, vast data source on pretty much anything that is collected nationally; and the National Health Performance Authority, which also provides some very systematic regular reports at the hospital level and at the community level. I would also recommend that you look at the Australian Commission for Safety and Quality in Health Care, which also provides some good quality comparative information, and the Independent Hospital Pricing Authority. We are happy to provide those website addresses to you on notice.

**Senator LAMBIE:** I guess my question is: if you cannot measure it, how are you managing it?

**Mr Cormack:** It can be measured. It is measured systematically. It is measured annually. The methods of measurement are improving annually. Indeed, there have been improvements

across the health system. In fact, the deficiencies that you have identified in your assessment of the Tasmanian health system are based on the very availability of the data that you claim does not exist.

**Senator LAMBIE:** That is fine. I have no further questions.

**Senator MOORE:** Just noting Senator Lambie's concerns, we do acknowledge that there have been distinct improvements over a long period of time. I would just like to see whether there could be any comment about the current commitment across the states to move to improvements that you have identified. With all those data sources that you have provided, my understanding is that, with most of them, there is a little asterisk down the bottom that gives you some concerns about the fact that we cannot be certain that we have a truly comparable base. I accept all the arguments that you have made regarding that there have been great improvements, but it would be good to see what the current commitment across all the states is to ensuring that those known discrepancies and variations are, firstly, being acknowledged and, secondly, being addressed.

**Mr Bowles:** I meet quite regularly with the state and territory CEOs of the health system. They are all committed to dealing with the issues of data. We at the Commonwealth level have moved to share a whole lot of Commonwealth data with the states and the states share a whole lot of state data with the Commonwealth. It is progressively getting better. It is not perfect at this time. Will it ever be perfect? I do not know, but we are definitely making big inroads. Even in the last 12 months that I have been around, I have seen significant improvement in the engagement of the states in the data conversation. The work around many different agencies at the moment to try to improve this is getting significantly better. We are not there yet, though. There is still more work to do, and we will continue to do that. The good thing is there is a commitment across the states, territories and the Commonwealth to progress this issue.

**Senator MOORE:** Is it a priority?

**Mr Bowles:** It is a priority for us. I will go to what the Commonwealth is doing. We have moved to put data, analytics and evaluations right at the centre of our strategic policy thinking. We have changed the way we operate to make sure that we can look at data and start to do some analysis of the data to start to understand in both a predictive and a prescriptive way how the system is actually going to look, so that we can start to use our data as a policy tool—not just payments and not just recording of what is happening out there. That has informed a whole lot of the work we have done around the medical benefits reviews, the Primary Health Care Advisory Group and the Mental Health Commission. That is based on a huge amount of data. So we are starting to do that and we are starting to get really much improved system-wide data that allows us to put strategic policy about the health system at the centre of what we are actually on about.

**Senator McLUCAS:** A lot of that originated from the reform agreements that occurred—

**Mr Bowles:** None of what I just said goes to anything other than what we have been doing in the last 12 months in putting our data repositories at the centre, getting rid of ownership issues—everyone wanting to own things—and the fact that we have shared our data with the states and territories. If I were to look back over my whole life and the brownie points I have got, I got more brownie points for giving the states the data than anything else in my life. It is

such an iconic issue in the health system, and we have actually dealt with it. It is one of the things that I drive quite hard both in the department but within the health system more broadly.

There are some really good things out there. For example, the Independent Pricing Authority has done a great job in looking at a national efficient price. The Institute of Health and Welfare is quite central, and we want to lift that up. We are doing a lot of work in that particular space at the moment that will drive some of the issues that Mr Cormack was talking about and drive more broadly how we actually start to look at the health system, not component parts—which is where we have been for quite a while.

**Senator MOORE:** With IHW is a classic place with an asterisk saying that you cannot compare. That is one of the classic areas when you are looking at that.

**Mr Bowles:** Just because you cannot compare everything does not mean that you cannot make policy decisions and system policy decisions.

**Senator MOORE:** Not at all.

**Mr Bowles:** You just have to be aware of what some of the complications are, if you like, when making decisions.

**Senator MOORE:** We are all too aware. That is factual. This committee over many years has talked about data. I cannot think of a single report that we have ever written that does not have a recommendation around data. So we are aware. I am interested to see whether there is anything in the agreements with the states and territories and the Commonwealth that requires accurate data. In the negotiations and the processes around, is there anything—and I am not sure—which actually has a bottom line requirement of no data, no money?

**Mr Bowles:** I think most of our agreements have requirements for data. Sometimes they are not as accurate as we would like them to be—and that is something that we just have to keep progressively working on. If I go back to my days in the state health system, the world is quite a lot better in that space than it used to be. But I would like to say that we can be even better again, and we will continue.

**Senator McLUCAS:** I would like to go to some questions that followed the COAG leaders meeting that was held in July where there were conversations from the public commentary around extending Medicare into our hospital system. How would that arrangement operate in practice?

**Mr Bowles:** That is part of the reform of federation conversation and the subsequent white paper that is not due until next year. It is largely driven from first ministers. So, from our perspective, it is a PM&C issue. But you are right that, out of the leaders conference, came a communique that talked about a Medicare or MBS type system for the hospital system. I am not going to go into the ins and outs of that, because that is a conversation that is still happening. It is still an in issue for government to decide. But, more broadly, it is an issue for first ministers to have a conversation about, and I believe at the next COAG meeting they will have a further conversation about that. Even at health ministers, Minister Ley talks about what is happing more broadly in the work we are doing around Medicare, around primary health care and, again, more broadly in the space of reform of the federation white paper.

Two components came out of that communique. One was the hospital payment issue; the other was how we look at models of care around chronic disease and integrated care. That is

still an ongoing conversation, and probably will be an ongoing conversation for a few months yet. The next real conversation I think will be at COAG later this year.

**Senator McLUCAS:** What do you think it would mean for private hospitals?

**Mr Bowles:** Again, until we understand what the model might finally look like—and I think it is too early to say what it might look like. It could be as simple as nothing, or it could be as complex as an integrated system. What we have to understand is that the health system is not all about public hospitals. It is about a third, or probably a bit less than a third, of what we spend on health in this country.

There are always a couple of things I like to point out. When the debate is framed around public hospitals, we are talking about less than a third of the system. That is one issue. When we talk about the states and territories and the Commonwealth having a stoush over whatever we might be having a stoush over, 32 per cent is in the private sector. We have to think about all of those issues. They are active conversations, largely between first ministers, not with health departments, because there are broader implications around tax reform, education, homelessness and all sorts of things.

**Senator McLUCAS:** Has the department been doing work on potential models?

**Mr Bowles:** The department is providing advice to the minister and to the Prime Minister's office, through PM&C, on a range of ideas around different models in both the hospital and the primary care space, with a particular emphasis on chronic disease and integrated care, that might look at both the technical efficiency and allocated efficiency side of things. We are trying to address both of those issues.

**Senator McLUCAS:** Should I just go to the communique to get an indication of what sort of parameters the minister or the Prime Minister—

**Mr Bowles:** I think it is too early to go to many of the parameters at this stage. It is still an active conversation.

**Senator McLUCAS:** I am trying to understand how far you have been asked to think.

**Mr Bowles:** We are asked to think at a system level.

**Senator McLUCAS:** Right. I will leave that there. I want to ask some questions of IHPA now.

**Independent Hospital Pricing Authority**

[16:42]

**Senator McLUCAS:** How many full-time equivalent employees do you have at IHPA at present?

**Mr Downie:** As of 30 September we have 56.63.

**Senator McLUCAS:** And how does that compare to September 2013?

**Mr Downie:** In 2013 we had 52.

**Senator McLUCAS:** Is it your understanding that the authority and all the staff employed at the authority at present will continue from 1 July 2017?

**Mr Downie:** We were notified by the minister, in a letter on 4 August, that the authority and the CEO roles, which are statutory in the legislation, will be maintained as independent roles and that the staff of the agency will transfer to the Department of Health.

**Senator McLUCAS:** What implications does that have? What do you understand the rationale to be?

**Mr Downie:** My understanding of the implications is that the staff will be made available to the CEO to continue the functions of the authority.

**Senator McLUCAS:** But become your staff members, Mr Bowles?

**Mr Bowles:** That is correct.

**Senator McLUCAS:** What is the rationale for that?

**Mr Bowles:** I think the government and the department see the value of the expertise of the IHPA. We want to make sure that is maintained. We want to also look at the long term and whether there are other ways that we can use the expertise in that particular space. The importance of the authority—being the board, if you like—and the CEO's independence are vitally important. We will effectively second the staff back to do the work of the IHPA, because we recognise the importance of that independence in the context of setting a price for the state and territory systems.

**Senator McLUCAS:** Are there industrial reasons?

**Mr Bowles:** No, there are no industrial reasons.

**Senator McLUCAS:** You are seconding them back to IHPA—

**Mr Bowles:** It is not an unusual process. I have a range of portfolio agencies where there is an independent boss, if you like, and all of the staff are public servants technically reporting to me as the secretary. It is not an unusual process. We are just trying to streamline the administrative arrangements across all those arrangements like the IHPA.

**Senator McLUCAS:** Mr Downie, can you provide me with an update on IHPA's work developing the national efficient price and the national efficient cost for 2016-17.

**Mr Downie:** Our work is progressing well. Our goal is to provide the draft national efficient price determination and national efficient cost determination to health ministers on or around 30 November, which is our usual work program. They then have a 45-day period to comment, which is required under the act. We should finalise the determinations by the end of February, which has been our standard program of work for the last four years.

**Senator McLUCAS:** Is the national efficient price likely to be higher or lower than in 2015-16?

**Mr Downie:** The national efficient price for the purposes of calculating growth funding to the states will, I think it is fair to say, be likely to be higher, but the headline number will be slightly lower. The number for calculating growth, which is the important thing for the system, will be higher.

**Senator McLUCAS:** To how many hospitals does the national efficient cost apply?

**Mr Downie:** I would have to take that number on notice. We do not keep a comprehensive list because that is within the purview of the states and territories as system managers. The National Health Funding Body could provide that number. They make the payments.

**Senator McLUCAS:** All right. Can you give us an understanding of how the national efficient cost is arrived at.

**Mr Downie:** The national efficient cost is for smaller hospitals, generally rural hospitals, which, for various reasons, are not big enough for activity based funding to work. We have a model that we have constructed that assigns hospitals to a cell in a matrix on the basis of their size, their throughput, their capability, in terms of whether they provide surgical services, overnight services or just non-admitted services, and also their region. We have a group of inner, outer and remote hospitals and a group of very remote hospitals.

**Senator McLUCAS:** Have you been involved with the MBS Review Task Force?

**Mr Downie:** No.

**Senator McLUCAS:** Would you expect to be?

**Mr Downie:** No.

**Senator McLUCAS:** Is that something we would consider, Mr Bowles?

**Mr Bowles:** No. There is no real relationship between what is happening in the MBS reviews, which is largely specialists and GPs doing activity, and what happens in a hospital context. In the longer term, if things change in the MBS from a procedural perspective, that will potentially impact in the hospital sector, but it is not a particular issue that the IHPA would be engaged in.

**Senator McLUCAS:** In terms of the former Labor government's commitment to 50 per cent growth funding of the national efficient price, has IHPA done any updated projection from what the cost of that 50 per cent growth funding was expected to be?

**Mr Downie:** That is not work that we do.

**Mr Bowles:** That is not the job of the IHPA.

**Senator McLUCAS:** Has the department done it?

**Mr Bowles:** No.

**Senator McLUCAS:** Because?

**Mr Bowles:** Because it is not the current government's policy.

**Senator McLUCAS:** That is right. But it was when they got elected. In terms of your work, Mr Downie, what projections does IHPA have about the expected demand for hospital services?

**Mr Downie:** Again, that is not what we do. We set the price, and the volume is a function of the states' and territories' service level agreements with their hospitals.

**Senator McLUCAS:** But don't you think volume would impact price over time?

**Mr Downie:** In the very long run?

**Senator McLUCAS:** Yes.

**Mr Downie:** Yes, in cost. That is right.

**Senator McLUCAS:** But it is marginal?

**Mr Downie:** It is not in the short term, in the period of the forward estimates, that we make projections of price.

**Senator McLUCAS:** Can we just go back to the work you are undertaking, providing advice to both your minister and the Prime Minister about hospital funding. Can you confirm

that one of the models that you are exploring is the introduction of a hospital benefits schedule for patients with chronic disease in public and private hospitals?

**Mr Bowles:** I think there were two issues mentioned in the communique and what you have done there is put them both together. It does not quite work that way. In the communique there was work around a hospital payment system and there was work around integrated care, particularly in the context of chronic disease. The two are separate issues. But ultimately, when you introduce something, you need to be able to look at both sides. Basically, one is a technical efficiency and one is an allocative efficiency type model. We try and change the incentives in the system by dealing with people in a primary care setting rather than a hospital setting. That is one: getting the integrated care right. The other is about continuing with an efficient price mechanism to drive efficiencies, if you like, in the hospital system more broadly.

We are not in a position at this point to go into any detail because it is still advice to government and, to be honest, we are not there yet. That is still a conversation. You have conflated two issues, but they are things that we are actually looking at. We are just not in a position to say what the full impacts are and what sectors they are going to involve at this particular point, because there is a lot of work still to go. As I said, first ministers are driving this and one of the other things in the communique, the health component, was being led by Victoria and Tasmania. We are obviously working with them because they do not have access to a lot of the things we have access to.

**Senator McLUCAS:** Are you aware of the view being put by some members of the government that that could involve an abolition of the private health insurance rebate for public hospitals?

**Mr Bowles:** I am not aware of what members of parliament might be talking about. I am aware of the work we are doing and I am not going to go into whatever advice we might give to the Prime Minister's department or my minister.

**Senator McLUCAS:** I understand what you are saying, Mr Bowles, and I respect that. But does your consideration include removing the private health insurance rebate for private hospitals?

**Mr Bowles:** What I have said so far is I am not going to go into what I am doing in that space. What we are looking at is the health system. I am not going to go into whether we are looking at the private health insurance world or the public hospital world. There is enough debate going on out there at the moment and we will provide advice to both the Prime Minister's department and my minister about what our view is, if you like, on a range of the options. But remember this is a first ministers' conversation through the COAG process. While it is a health issue, there are a whole range of other things tied up with this whole conversation around reform of the Federation. There is education, there is homelessness, there is tax and there is health.

**Senator McLUCAS:** That is a lot of balls in the air. Has there been any change in direction from your minister or from the new Prime Minister since the change of leadership?

**Mr Bowles:** We are still working along the same principles. Our final model will be determined at a later point. We are not even at that point to change too much.

**Senator McLUCAS:** It stands to reason, though, that if there were a hospital schedule of benefits, and if the Commonwealth were paying directly, the need for a rebate for private health insurance would be—

**Mr Bowles:** You are assuming an outcome that we are not at yet.

**Senator McLUCAS:** What would be the risk to the Commonwealth of moving to a different funding model, like a hospital schedule?

**Mr Bowles:** We would look to manage whatever risk there might be. But there might be benefits. There are a whole range of different issues around the relationship between the states and the Commonwealth. We would obviously be trying to factor all of those issues in to risk manage whatever outcome there might be. You could come up with a model that eliminates cost and blame shifting. That would be a nice thing.

**Senator McLUCAS:** That would be wonderful. I might leave that there, thank you. We are going to be able to make up some time in private health insurance, so, Chair, you should not be terribly troubled about timing at the moment.

**CHAIR:** I do not think we will be making up two hours in private health, but we will see how we go. So we are ready to move on to private health then, are we?

**Senator McLUCAS:** Yes, thank you. Does the department have any costings for the removal of means testing of the private health insurance rebate?

**Mr Bowles:** I think the answer is 'no'.

**Mr Stuart:** Sorry, it took me a little while to figure out that what meant.

**Senator McLUCAS:** Has the department undertaken any costings for the resumption of full indexation of the private health insurance rebate?

**Mr Bowles:** No.

**Senator McLUCAS:** Minister Ley said recently—last month in fact—that:

Consumers are telling me Labor's cuts are eroding the value of the private health rebate and in turn pushing up their out of pocket costs or forcing them to downgrade.

She went on to say that she was:

… certainly listening to consumers and keen to work with them to improve their value for money.

Is the department aware of any plans to end or scale back means testing of the private health insurance rebate or to resume full indexation of that rebate?

**Mr Stuart:** No.

**Mr Bowles:** As you indicated, the minister is having broad conversations. She will continue to do that. When she forms a view, I am sure she will make that public.

**Senator McLUCAS:** Can the department rule out at this point diverting any potential savings that might be achieved through the MBS review into private health insurance rebates?

**Mr Bowles:** I am not going to get into a game of ruling in or out anything. We are not doing any work on that particular issue. The world changes regularly. But we are not doing any work to look at the MBS review in the context of private health insurance. But I am not going to rule things in or out here, because it is not my job. That is the job of government and policy decisions of government.

**Senator McLUCAS:** The two most recent rises were—and I would like you to confirm this—the highest in the past decade. Is that correct?

**Mr Bowles:** We will see if we have that.

**Mr Stuart:** Let us find our place. Please be patient with us, Senator. Our expert is unwell.

**Mr Bowles:** Unfortunately, has he not been with us for the last couple of weeks. He is just unwell.

**Senator McLUCAS:** Please send him our best wishes.

**Mr Bowles:** We will, thank you. We have been doing a little bit of swotting. But I think they have been relatively consistent over the last couple anyhow. We will take that on notice.

**Senator McLUCAS:** There has been some speculation that the government may want to move away from the oversight. There is an application by the private health insurers to increase premiums. Is there any intention or are you hearing that the government is thinking—

**Mr Bowles:** It is a policy decision of government whether they do that or do not do that.

**Senator McLUCAS:** I understand that. At the moment, there is no policy change to remove that oversight activity.

**Mr Bowles:** There have been no announcements made and governments make those decisions, and I will leave it at that.

**Senator McLUCAS:** Thank you. Following the abolition of PHIAC, does the department expect APRA to still be in a position to oversee all of the private health insurance premium rises?

**Mr Stuart:** Yes.

**Senator McLUCAS:** Given that the personnel from PHIAC moved holus-bolus.

**Mr Stuart:** Yes, there has been a like-for-like shift of functions.

**Senator McLUCAS:** Has that occurred yet?

**Mr Stuart:** Yes, it has. From 1 July, I believe.

**Senator McLUCAS:** It is proceeding swimmingly.

**Mr Stuart:** As far as we are aware, yes.

**Senator McLUCAS:** You would not have any reason to talk to them.

**Mr Bowles:** No-one has raised any noise.

**Mr Stuart:** We resolved a large number of issues on the way in. I have not been apprised of any issues subsequent to 1 July.

**Senator McLUCAS:** I now want to go to private health insurance rebate for natural therapies. The website says that any changes to the natural therapies that attract a private health insurance rebate are expected to be implemented from 1 April 2015. Can the department advise us what changes have been implemented?

**Mr Stuart:** There were no changes implemented from April. The government is still considering the report.

**Senator McLUCAS:** The report from whom?

**Mr Stuart:** This is the rebate for natural therapies. There was a review overseen—

**Senator McLUCAS:** That started in 2012.

**Mr Stuart:** by Professor Chris Baggoley which looked at the issues of the natural therapies, including the issue of the rebate. That report is before the government and under consideration.

**Senator McLUCAS:** When was that report received?

**Mr Stuart:** It was provided to the minister in February.

**Senator McLUCAS:** My briefing does not agree with that. We might be talking at cross-purposes.

**Mr Stuart:** We might be but—

**Senator McLUCAS:** There was a review commissioned in 2012.

**Mr Stuart:** Yes.

**Senator McLUCAS:** That final report was provided to government when?

**Mr Stuart:** The draft report, I think, was provided. The overview report of the review with the findings of the review advisory committee, was provided to the Minister for Health in February 2015.

**Senator McLUCAS:** Has that been published?

**Mr Stuart:** No, not at this point.

**Senator McLUCAS:** Do you expect it to be?

**Mr Bowles:** It is a matter for the government.

**Senator McLUCAS:** The purpose of that report was to identify certain therapies that, in the view of the Chief Medical Officer, may not have identifiable benefits to the consumer.

**Mr Stuart:** To determine whether certain natural therapies should continue to attract the rebate.

**Mr Bowles:** It is not Professor Baggoley's personal view. He had a whole group of people, obviously, who informed him.

**Senator McLUCAS:** I am sure. So the minister had the report in February this year. Does the website need changing?

**Mr Bowles:** Have we something different on the website?

**Senator McLUCAS:** No, it says, 'Any changes to natural therapies that attract a PHI rebate are expected to be implemented from 1 April 2015.'

**Mr Stuart:** Well, that date has obviously passed.

**Mr Bowles:** We definitely need to change our website.

**Senator McLUCAS:** Right.

**Mr Stuart:** We should say 'were expected' or change the language in some way.

**Senator McLUCAS:** To put it in the past tense. The NHMRC found last year that there is no reliable evidence that homoeopathy is effective for treating health conditions. Is that included in the review work?

**Mr Bowles:** I think we are not going to cross over into the two issues. Again it is a matter for government around that report, but if you want to ask about homoeopathy you should ask the NHMRC when they come to the table.

**Senator McLUCAS:** According to the Private Health Insurance Administration Council, PHIAC, benefits paid out by insurers in the natural therapies category increased by 345 per cent between 2002-03 and 2012-13. The $135.2 million payout in 2012-13 was actually larger than benefits for ambulance services. Is the department pushing to try and get this issue at least addressed by government?

**Mr Bowles:** The consideration of the report is a policy matter for the minister and for government.

**Senator McLUCAS:** Minister, can you give the committee any update on what is happening around first the receipt of the report and then a response to this report. It has been in the offing for quite some time.

**Senator Nash:** It has. I cannot add anything further. I know it is with the minister and she is considering it, so I cannot really add anything further.

**Senator McLUCAS:** There was a report in the newspapers earlier this year that said that the government would save about $80 million over the budget forecast period by taking a rebate from 17 natural therapies that they identified. Are you aware of that report?

**Mr Stuart:** We probably read it at the time.

**Mr Bowles:** But we are not going to make a comment on the accuracy of a newspaper report on something that is before a minister and the government to consider.

**Senator McLUCAS:** I do not understand why they are related, Mr Bowles.

**Mr Bowles:** Well, because you are quoting a newspaper report which I do not know the accuracy of.

**Senator McLUCAS:** Well, I am asking you: is that accurate?

**Mr Bowles:** I cannot recall it specifically. I probably did see it at the time. I see a lot of those things at the time, but I am not going to relate the media coverage to a report that is before government to consider.

**Senator McLUCAS:** Minister, it would be helpful to the committee if you could give us an understanding of when the minister expects to respond to that report, please.

**Senator Nash:** I can certainly take that on notice for you.

**Senator McLUCAS:** That would be great. Thank you very much. See, I told you we would pick up a bit of steam.

**CHAIR:** As I say, not the two hours, but we picked up a bit. So we are done with private health?

**Senator McLUCAS:** Yes, thanks.

[17:07]

**CHAIR:** We will now move to outcome 2, access to pharmaceutical services.

**Senator McLUCAS:** Are the increases in the PBS co-payment and changes to the PBS safety net announced in the 2014 budget still government policy?

**Mr Bowles:** Yes. I am just trying to think which ones we are talking about.

**Mr Stuart:** This is the PBS co-payment increase and the safety net.

**Mr Bowles:** Yes.

**Mr Stuart:** In relation to the safety net changes, you would be aware that the minister has expressed a view that this is unlikely to pass the Senate; it does however, remain government policy until or unless the minister can find other policy of a similar saving to replace it.

**Senator McLUCAS:** The point is that the savings are still counted as revenue in the 2015 budget?

**Mr Bowles:** As is the normal process for government budgets.

**Senator McLUCAS:** Is the department doing any work on trying to identify another source of $1.3 billion in savings?

**Mr Bowles:** Yes. We are always looking at options around the budget.

**Senator McLUCAS:** Is it in the pharmaceutical area?

**Mr Bowles:** I cannot go to advice to government. There are a range of things we will look at across the department.

**Senator McLUCAS:** As you said, Mr Stuart, the minister has conceded that the PBS co-payment increase and the changes to the safety net may not—although we cannot predict what the Senate may do—pass the Senate. Will that reality be reflected in MYEFO?

**Mr Bowles:** It may not pass in its current form, but there may be other options around that. We do not know. That is a matter for government, and our advice to government around those sorts of issues, whether that comes out of a MYEFO or a budget, is that you would have to actually take it right off the table and that is not the position at this particular point—when and until we get an alternative.

**Senator McLUCAS:** So the government position is to leave it sitting there as a government policy and count it as a saving even though the likelihood of it succeeding is low?

**Mr Bowles:** In its current form, that is absolutely correct and that is a normal process for any budget-related measure that sometimes takes longer than you would like to go through a process.

**Senator McLUCAS:** What would be the trigger for MYEFO to reflect what is in fact the real—

**Mr Bowles:** An alternative to be found, or a decision of government not find it.

**Senator McLUCAS:** And that would require a cabinet deliberation?

**Mr Bowles:** Yes, it would. A cabinet ERC process, or whatever process—a formal government decision.

**Senator McLUCAS:** Coming back to your work to find an alternative $1.3 billion in savings, I know you are providing this advice to government, Mr Bowles, but I am interested, and I think the committee would be interested, in finding out what areas are being looked at to find those savings.

**Mr Bowles:** Again, they are all policy decisions of the minister and the government. We, as the department, provide advice, and the minister and the government make those policy decisions. That is where it is up to at the moment.

**Senator McLUCAS:** Has the minister or the government indicated to you that there are any areas that are not to be looked at?

**Mr Bowles:** Not particularly or specifically. We have talked about broader issues. We have already talked about some areas where we are not looking at specific savings—I could go back to the MBS reviews. But I will go back to what I have said earlier: I am not going to rule in or rule out what the minister and the government may decide in relation to the budget, the PBS, the MBS or whatever else we might be looking at.

**Senator McLUCAS:** So everything is in scope?

**Mr Bowles:** We look at everything all the time. There are a range of issues, though, that we are not going to rule in or rule out.

**Mr Stuart:** The secretary did not say that everything is in scope.

**Mr Bowles:** No, that is right.

**Mr Stuart:** He is just unable to tell you—

**Mr Bowles:** Well, I am not prepared to because it is advice to government.

**Mr Stuart:** That is right.

**Senator McLUCAS:** Have you done any work on what affect these two policies may have on people filling prescriptions? Is there any understanding of what this might change in patient behaviour around filling prescriptions?

**Mr Bowles:** In relation to the safety net?

**Senator McLUCAS:** The safety net and the co-payment increase?

**Mr Bowles:** We would have done work around the implications of the safety net, but, again, it is advice to government, so I do not think we can really go to that. That particular piece is before the Senate. If we make changes to that or we come up with a different option we will do the necessary analysis at that particular point in time.

**Senator McLUCAS:** I am talking about the current policy settings—the proposed policy. Has any work been done on—

**Mr Bowles:** Mr Stuart might be able to help you.

**Mr Stuart:** No, we have not done any specific modelling on that issue.

**Senator McLUCAS:** Why not?

**Mr Stuart:** We have had long discussions about modelling before. Usually modelling requires—

**Senator McLUCAS:** I will remove it from my lexicon.

**Mr Bowles:** We have analysed a whole range of things, and that is probably a better way of putting it.

**Mr Stuart:** Usually modelling requires an understanding that what happens when you change a particular variable. In the absence of that understanding, you end up choosing assumptions, and the assumptions become the outcomes. There is not a history of research or

evidence in this area that would allow the department to do effective modelling of the impacts on behaviour of relatively small changes like this.

**Senator McLUCAS:** So previous policy changes cannot be mined for the potential change in patient behaviour?

**Mr Bowles:** I think it would be fair to say that you can make assumptions.

**Mr Stuart:** We have an understanding of what happened previously when there was a change in the co-payment: it was relatively minor and washed out of the system within a period of two or three years, I understand.

**Senator McLUCAS:** I think we have talked about that before.

**Mr Stuart:** I think we have.

**Senator McLUCAS:** We will leave that there. I want to go to the Sixth Community Pharmacy Agreement now. Does the department still expect the proposed $1 discount to achieve budget savings of $366 million from January 2016?

**Mr Stuart:** Yes, we do.

**Senator McLUCAS:** Is it correct that these savings are the result of patients taking longer to reach the safety net?

**Mr Stuart:** That is the factor that leads to a saving on the budget, yes.

**Senator McLUCAS:** I am sure that you are aware that the guild is firmly opposed to the measure and has described any chemist that does offer the discount as 'doing the wrong thing'. How does that campaign sit with the minister's claim that the discount will lead to cheaper medicines?

**Mr Stuart:** There is not a campaign by the guild. The guild has been uneasy about this for a while, but it has signed an agreement with the government, a part of which is the $1 discount—it is a part of the agreement with the guild.

**Senator McLUCAS:** But it is not compulsory; it is a voluntary measure?

**Mr Stuart:** Yes, and it still is.

**Mr Bowles:** It is still a voluntary measure.

**Senator McLUCAS:** Are there any predictions about how many pharmacists will voluntarily enter into the $1 discount?

**Mr Stuart:** We at this point have no reason to revise our budget estimates about the size of the expected saving.

**Senator McLUCAS:** Which is $366 million?

**Mr Creech:** That is correct. Mr Stuart is correct: we have no reason to change our original budget estimate. It is the case, and we have referred to it before, that we make assumptions when we do financial estimates. We have no reason to believe that the $366 million will change.

**Senator McLUCAS:** Right. How will you monitor that?

**Mr Creech:** One of the things, which we did get through as part of the sixth agreement but which we have not had in the past, is that we are starting to collect data on the price of under co-payment scripts. This will be a mandatory field from now on. In the future data will

be fed into DHS in relation to what all patients will be paying for their medicines—whether it be the concessional $6.10 or whether it be general patients. In the past whether they were paying under the $37.70 would not have been captured—the price field would not have been captured—but in the future it will be. So we will be able to monitor that; we will know the level of discounting that is going on, and that level of discounting will ultimately feed into the broader reviews that are happening in the pharmacy space.

**Senator McLUCAS:** The agreement was signed in May, but when does it take effect?

**Mr Stuart:** From 1 July this year. So it is in effect.

**Senator McLUCAS:** And you have got very early figures; have you had a look at the data for this—

**Mr Stuart:** I am sorry; the $1 discount is not yet in effect.

**Senator McLUCAS:** When does that start?

**Mr Stuart:** We have an implementation date—

**Mr Creech:** Of 1 January.

**Senator McLUCAS:** So we have no data on that yet. Will you be able to monitor it through DHS data?

**Mr Creech:** Yes.

**Senator McLUCAS:** As to the Administration, Handling and Infrastructure fee, can the department provide us with figures on the change in price for general consumers of the 10 most commonly prescribed medicines as a result of the move to the new Administration, Handling and Infrastructure fee, please?

**Mr Creech:** We will have to take that on notice.

**Senator McLUCAS:** Is it true to say that most of those medicines would in fact become more expensive as a result of the change?

**Mr Bowles:** I think we would wait until we see what we come up with on those to determine that.

**Mr Stuart:** The issues here are quite complex across the whole package. I would like Mr Creech to perhaps outline one example.

**Mr Bowles:** But we would want to, on notice, have a look at the broader issues that you have already raised about the top 10.

**Mr Creech:** That is right; we will take the top 10 on notice. You will remember that, at the last estimates hearing, we talked at length with Ms McNeill in relation to competition in the marketplace, in relation to the under general co-payment. We made it very clear at that point in time that this will not affect concessional patients at all; that is 80 per cent of the PBS. Atorvastatin was the example used that was provided by the senators in relation to the AHI, and I do have some information in relation to atorvastatin. I will preface that information by saying: this assumes there is no competition in the marketplace, and we do not believe that is the case. The example that was put to us was: 40 milligrams atorvastatin is the only one that was beneath the $24. So everything above the $24 will go down in price. The atorvastatin 40 milligrams was $16.43 on 1 June 2015. It was $18.83 on 1 July. There was an increase: $2.40. Price disclosure has subsequently, on 1 October 2015, brought it down again

to $16.60. So, as we predicted, in June, as to the AHI, for a certain proportion of meds for general patients, there is the potential for it to go up, if it is not in a competitive market, but price disclosure has already brought it back down to where it was. It will go down again, potentially, on 1 April next year, and then the price disclosure cycle will continue to 1 October.

**Senator McLUCAS:** We will get the top 10 on notice?

**Mr Creech:** Yes.

**Senator McLUCAS:** You will have to help me with this one: 'DPMQ'?

**Mr Creech:** Dispensed price maximum quantity.

**Senator McLUCAS:** Could we have a list of the DPMQ or the 10 most commonly prescribed medicines before and after the introduction of the new pricing arrangement?

**Mr Creech:** Yes. I will take that on notice.

**Senator McLUCAS:** I will go now to location rules. The minister announced in May that the Pharmacy Location Rules and other pharmacy regulation and remuneration arrangements would be reviewed over the next two years. So what steps have been taken to commence those reviews?

**Mr Stuart:** The department has been in a process of advising the minister and the office about how that should be conducted, and the minister is preparing to make some announcements about that.

**Senator McLUCAS:** 'Preparing to make some announcements about' the way the review will be conducted?

**Mr Stuart:** Yes, that is right.

**Senator McLUCAS:** Who is going to be involved in that review?

**Mr Stuart:** I think that will be part of the minister's announcement.

**Senator McLUCAS:** Do we have any indication of how long the review will take?

**Mr Bowles:** In the agreement we said we would do it in the first two years. So it will not take the two years probably, but it is within that two-year period.

**Mr Stuart:** The agreement says by March 2017.

**Senator McLUCAS:** I understand that the Treasurer has indicated that he wants to pursue the Harper review recommendations in health and in education. The Harper review's only recommendation regarding competition policy in health is that the location rules be abolished, so how does the Treasurer's understanding or commentary around the Harper review fit with where the health department and the health minister are up to with the review of location rules?

**Mr Bowles:** We will undertake the review of location rules and remuneration and will consider the Harper issues along the way, and we will consider every other issue that goes into those particular issues, and in March 2017 we will come up with an answer.

**Senator McLUCAS:** How did the department relate to the Harper review process?

**Mr Bowles:** In what way?

**Senator McLUCAS:** Did they ask you to talk to them? Do they understand how location rules work?

**Mr Creech:** We were not directly involved in the Harper review, in that we did not help them with it, but we did respond to requests in relation to the Harper review and we provided information as required.

**Senator McLUCAS:** Just around this issue of the location rules?

**Mr Creech:** From memory—and it is from memory; this was a little while ago now—the request for information that we got was not just in relation to the location rules, no. The request was in relation to the PBS more generally. The location rules were one component.

**Mr Stuart:** We have been in the position of being an information supplier, I think. That is probably how it is best characterised.

**Senator McLUCAS:** Thank you. I now want to move to biosimilars, please.

**CHAIR:** This is still on the pharmacy agreement?

**Senator McLUCAS:** Yes. How many biologics have been a-flagged for substitution at the pharmacy level in Australia?

**Ms Platona:** To date, we have recommendations from the Pharmaceutical Benefits Advisory Committee for two products: insulin glargine from March this year and infliximab from July this year. Those recommendations of the PBAC are yet to be implemented.

**Senator McLUCAS:** I might have a different name here. What is Basaglar?

**Ms Platona:** That is insulin glargine. It is the biosimilar produced by Eli Lilly. The reference drug name is insulin glargine.

**Senator McLUCAS:** I am not very good at pharmaceuticals. What does 'a-flagging' mean?

**Mr Stuart:** In common parlance, it means that the medicine is available to be substituted at the pharmacy level by the pharmacist should the doctor tick the 'available for substitution' box in discussion with the patient.

**Senator McLUCAS:** I remember now. And there is an issue around biosimilars and whether there is agreement that they can be substituted. That is the issue, isn't it?

**Mr Stuart:** There has been some community debate since the PBAC expressed the view that it would be a-flagging some biosimilars based on the review of the evidence on a case-by-case basis.

**Mr Creech:** Just for clarity, the PBAC in April actually considered the policy aspect of this and considered that they wanted to consider each and every biosimilar on a case-by-case basis because they were not generic medicines and they needed to consider the evidence.

**Senator McLUCAS:** So they are going to go through each one methodically.

**Mr Creech:** Each one—that is correct. If the evidence supports substitution then they will make that recommendation when they come to it.

**Senator McLUCAS:** Are there any biosimilars that have been reviewed and found not to be able to be a-flagged?

**Ms Platona:** We have had biosimilars in the past. It has been quite a while. We have not had an application prior to the two applications in 2005 that I mentioned, for about five years. At that time the PBAC considered that a-flagging should not take place. That implementation has now long been in place and no a-flagging is available for that molecule. More recently, in the two examples that I mentioned, the PBAC considered that the evidence provided in the applications would support substitution at pharmacy.

**Senator McLUCAS:** How much is the government budgeted as savings from a-flagging biologics?

**Mr Creech:** The figure that was in the PBS access and sustainability package in relation to biosimilars was $880 million over five.

**Senator McLUCAS:** Thank you. So when a GP ticks the 'not for substitution' box on a script, do you have any visibility of what they are doing in terms of these particular drugs? Is it a bit early to say?

**Ms Platona:** These particular biosimilars are yet to be listed on the PBS.

**Senator McLUCAS:** Okay, fair enough.

**Mr Creech:** There is evidence in hospitals, though, that GPs are using these products reasonably regularly and have experience with them.

**Senator McLUCAS:** As substituted drugs?

**Mr Creech:** Just for the sake of clarity, when we talk about substitution here, we are talking at the pharmacy level. In hospitals you are talking about interchangeability. The question was: what evidence do we have in the conversations that we have been having on this topic. In hospitals these products are being used.

**Senator McLUCAS:** Thank you for that. I want to go to cohealth at Collingwood.

**CHAIR:** You are moving off the pharmacy agreement?

**Senator McLUCAS:** It is not part of the pharmacy agreement.

**CHAIR:** Okay. I have some questions on the pharmacy agreement before we move off it, and others do. My questions are specific to chemotherapy and chemotherapy drugs and how they are handled under the agreement. Correct me if I am wrong, but I think chemotherapy funding in the pharmacy agreement is about $372 million over the forward estimates. Is that correct?

**Mr Creech:** That is correct.

**CHAIR:** Are you able to give me a split in each financial year of those estimates?

**Mr Creech:** Actually no, I am not. I do not have that information with me. I will have to take that on notice. Sorry—I have been corrected. My colleague to the right of me does have that.

**Ms Quaine:** It is $74.4 million per year.

**CHAIR:** So it is the same in each year.

**Ms Quaine:** Yes.

**CHAIR:** How is the $372 million derived? Is that a bucket of money that you say, 'We can afford this much' and then you split it up into how much might be used? Or, when it

comes to this chemotherapy funding, is it based on analysis of how much you expect to be used? Which way does it work?

**Mr Creech:** It is based on historical analysis. It is based on what we have used in the past. A reasonable level of estimation goes into going forward—how much we expect to use based on previous experience.

**CHAIR:** Have there been changes to the compounding fee for chemotherapy drugs?

**Mr Creech:** There is probably a point of clarity worth making. When we are talking about the $372 million we are talking about only the compounding fee for chemotherapy. In relation to chemotherapy drugs there are quite a few other fees. There is a diluent fee, a distribution fee, preparation and a dispensing fee. For chemotherapy those add up to about $80.26. You are just talking about the compounding fee, which is in addition to those, and they are based on past experience.

**CHAIR:** So when we talk about the $372 million we are talking about just the compounding fee for chemotherapy?

**Mr Creech:** That is correct.

**CHAIR:** Have there been changes to that compounding fee on a unit basis?

**Mr Creech:** There was a change under the PBS access and sustainability package. For history's sake, the compounding fee actually did not exist until the end of the chemo review in 2013. Previously, under that arrangement, the current compounding fee wasn't paid. Under that chemo review in 2013, they did a full review of the chemo arrangements to determine what was an appropriate fee going forward. In 2013, the compounding fee came into being. It was $60 at the time.

As a part of the PBS Access and Sustainability Package that was changed. There were a couple of key changes made. It was turned into a two-tiered payment arrangement—so $60 for TGA approved compounders, $40 for non-TGA approved compounders and a direct payment component added to that as well. What that means is we ensure that we know who in the supply chain is getting that money. One of things we have had trouble with in the past is when we sit here and you ask, 'Who in the supply chain is getting what portion of that taxpayer fund?' We have not been able to clearly articulate that but, in future, that direct payment arrangement in response to the ANAO audit pretty much directly will ensure that we have clarity around that payment.

**CHAIR:** I want to keep going with this but there is one thing in your answer there: you said before there wasn't a compounding payment before 2013, so that was just paid for by the individual. Who paid for that? Obviously, it still occurred.

**Mr Creech:** It was covered in the existing fees.

**CHAIR:** In what existing fees, sorry? So it wasn't separated out is what you are saying.

**Mr Creech:** One of the things that came out of the review was that there was cross-subsidy going on in relation to chemotherapy medicines. Price disclosure, as we have talked about many times in this room, has worked very well in many cases. In chemotherapy drugs, it has pushed the price down so far that the argument was that it was no longer cross-subsidising the process or the service that was being delivered.

**CHAIR:** So you went to this two tier—roughly $60; is it exactly $60 and then roughly $40? Is that what—

**Mr Creech:** In 2013, it was exactly $60; it was one fee. As part of the recent negotiations, it has been changed to a two-tiered structure: $60 for TGA approved compounders; and $40 for non-TGA approved compounders. The difference in the fee is to acknowledge the additional compliance cost.

**CHAIR:** So where did you get the $40 figure? How did you come to the conclusion that you could drop the price for non-TGA licensed compounders?

**Mr Creech:** There was a lot of work done in relation to the chemo review as a part of the chemo review in 2013. It looked at the costs of operations, not just in relation to the fee. Going through that process in 2013, they collected an awful lot of information, summarised it and published it in the report that was put out in 2013. The cost of operation as a result of that work came in at $83.96 per dispense. There was an additional cost, if you operated in rural areas—which has been discussed here before—and that came in at $93.96 per dispense. If you look at the fees now, you have got $80.26 for the multiple dispensing fees plus you have got the $40, which takes you to $120. That was how it was derived.

**CHAIR:** So the report you are talking about is the review of funding arrangements for chemotherapy services?

**Mr Creech:** That is correct.

**CHAIR:** Is there a figure in that report that suggested $41.33? Am I getting that right?

**Mr Creech:** You might be; I am not aware of that figure—I would have to look into that.

**CHAIR:** So all the work was done in that report and that was what pointed to dropping it for non-TGA licensed compounders. How many sites contributed data to be able to come to that conclusion?

**Mr Creech:** I would have to take that on notice, Senator.

**CHAIR:** Thank you. Has the department consulted hospitals and community pharmacies on the impact of that reduction?

**Mr Creech:** This is a part of the 6CPA—this was a discussion in relation to the 6CPA. Throughout the negotiations, we had broader consultation throughout the whole 6CPA process. We met with a range of stakeholders—I think we have detailed them all in the room before. Has this been discussed? Yes. Has it been discussed since implementation? Yes. We are continuing those discussions now.

**CHAIR:** Are you getting any representations—or is the government—or reorientations from providers that they may reduce or withdraw from compounding on their sites as a result of the reduction?

**Mr Creech:** There have been some concerns expressed in relation to the implementation of the administration arrangements. We are actually still working through it with them so, when you ask if we have received representation and been told that they are going to withdraw, it is in fact probably a step further than where we are at at the moment. No, we are still in discussions.

**CHAIR:** So if it is a step further, what concerns have been expressed?

**Ms Quaine:** Some of the concerns that have been expressed have been around the administration arrangements. Because of the payment of the fee and wanting to have transparency of the $60 or the $40 fee, the payment to the compounder will be outside the usual PBS payment arrangements. The PBS payment arrangements allow us to pay section 90 pharmacies whereas some of the TGA compounders are outside. They are not section 90 pharmacies, and the DHS system is set up to pay them in that way. We have set up a separate administrative arrangement for the payment. There was some concern expressed from compounders around the administrative burden associated with that, so we have been working through how to minimise that as much as possible. We have actually come up with a solution that we think is quite workable, where we have a code number assigned to each compound that is made and a code assigned to the compounder and then the compounder is paid directly by providing PBS data to an external payment agent.

**CHAIR:** Just to clarify: you are not concerned at this stage about providers reducing or withdrawing compounding from their sites?

**Ms Quaine:** I would have to say that we have had some representations with concerns around that, but we have not seen any of that at this stage.

**CHAIR:** So you have had representations to that effect?

**Ms Quaine:** Yes.

**CHAIR:** What would be the impact? If that did happen, then obviously they have to get the drugs from off site. Does that change any of the modelling in terms of wastage rates and the like, if there is less compounding happening on sites?

**Ms Quaine:** I think as Mr Creech explained, the pricing for the compounding, the compounding fee, covers the cost of the compounding. Given that we have had some representation about concerns, we are addressing the concerns about the administration arrangements. Granted we have had some concerns raised about that, but I suspect some of that is to do with some of the business arrangements when we are trying to get some clarity around who the payments are actually being paid to.

**CHAIR:** Did you want to add something, Mr Stuart?

**Mr Stuart:** Yes, Senator. We have had anecdotal concerns raised, but no-one has been able to show us compelling evidence about impacts and in particular impacts on patients. It is very common for local compounders to compound some or a small part of their needs, but, nevertheless, they do bring in materials from TGA registered compounders who do by far the highest volume of the business. We do not, and neither do those who have been making representations, have really good data to tell us whether there is really a concern here or anecdotal evidence being provided. We have been pleased to work with the sector to cut the red tape and improve the payment process. As part of this new arrangement, we will now be collecting much better data about local compounding versus importing material. If there is an issue, then it will come to light.

**CHAIR:** I guess it sounds like where you are at is: some concerns have been raised, you are not convinced necessarily that those concerns are 100 per cent valid, but you are not dismissing those concerns; therefore, there is still a discussion to take place. If you come to the conclusion that the claims or the concerns are valid, what flexibility is there then in the agreement to vary things?

**Mr Stuart:** That would be a change in government policy. We would need to go back to the government and the cabinet, but at the moment there is no evidence of a need to do so.

**CHAIR:** I am not saying that there is, but the concern has been put to me and the concern has been put to you. I am just trying to get to the bottom of it.

**Mr Stuart:** Yes, so it is not simply an agreement matter; it is a government budgetary decision matter.

**CHAIR:** Yes, in terms of whether you would up the price. The concerns have been raised and one of the questions we were just exploring is that if they were to withdraw, then obviously there can be impacts on other areas of PBS expenditure. Another concern, as has been put to me, is if there is less of it happening and more of it is being—this is the way it is described to me, and I am not an expert in the area: how do you ensure that such a situation does not restrict access of just-in-time chemotherapy and chemotherapy drugs with short half-lives, particularly in rural and remote areas where there is increased transit time for pre-ordering chemotherapy?

**Mr Stuart:** That is something that we will need to be keeping an eye on and judging in the light of evidence.

**CHAIR:** Thank you. We will keep an eye on that, but I appreciate that.

**Mr Creech:** As I said at the start, before 2013 this fee did not exist at all. The $40 is still—

**CHAIR:** But it was rolled in?

**Mr Creech:** No, it did not exist at all. This was additional; this was new money in 2013. It was dropped from $60 to $40, but it is still new money; it is just slightly less.

**CHAIR:** That was not the impression I got. Sorry, it might have been my misunderstanding. Earlier on, when I asked where the money came from, you said it was part of a larger payment. So you are saying this was all—

**Mr Creech:** It was on top of a different payment; it was additional.

**Mr Stuart:** This was a budget expenditure measure, not a budget saving measure, because the former $60 measure was terminating in the budget.

**Senator SMITH:** I am interested specifically in on-site hospital compounding. Can you talk me through the particular issues. Have you had representations from Catholic Health Australia and others? I am interested in the on-site element and the just-in-time element that Senator Seselja mentioned. I am also interested in the impact on rural and regional Australia. Could you talk me through that.

**Mr Creech:** As I just said, there will still be the additional compounding payment for on-sites; if they are not TGA approved, the $40 payment will continue. You asked whether we have had discussions with them. One of the issues that has been brought to our attention is the complexity in the administration that was being proposed. In response to the ANAO audit we were very keen to ensure we put in place full trackability and traceability. We have not had that in place prior to this and it is very important. We are working not just with the guys you mentioned but with all compounders to make sure we can put in place an administrative process that is much easier to use. One thing that has been brought to us by the compounders is that they would like to use PBS online claiming to make administration as simple as

possible. We are working now on a model to implement to ensure we use PBS online claiming. That means that regardless of where the product is dispensed, or who the compounder is, it will be claimed the same way it is now. The payment itself may be made differently, but the claim will still go into DHS. The payment might come from somewhere else, but it will go directly to the right person. Those are the issues we have been discussing to date and that we will continue to discuss.

**Senator SMITH:** What are you doing to give confidence around the criticism that rural and regional Australians will be adversely impacted?

**Mr Stuart:** We will monitor. Under these new arrangements, we have a much better flow of data than we had in the past. On the issues you are raising, I think we would have to say we have received only anecdotal evidence. We are now following the reforms to the way the payments are made, and we will be in a better position to see whether there is in fact any impact on patients.

**Senator SMITH:** Are we monitoring this monthly, six monthly, three yearly?

**Mr Stuart:** We are monitoring as data becomes available.

**Senator SMITH:** If these concerns cannot be substantiated on the data, I am keen for that to be in the public domain as soon as possible so that organisations such as Catholic Health Australia can put their minds at rest and also put the concerns of patients at rest. Also, around the rural and regional issue, the sooner we know there is no problem the sooner everyone can rest easy. But, if there is a problem, I would like to know about it as soon as possible because I would like to advocate to make sure the government changes its policy. I do not think anyone would like to see regional Australians adversely affected as a result of this change.

**Mr Stuart:** That is certainly the case and it is certainly the view of our ministers as well.

**Senator SMITH:** So at February estimates we might have some data available that you can share with us?

**Mr Creech:** The change we are talking about in relation to direct payments that will enable us to collect the data is due to come into place on 1 April 2016.

**Mr Stuart:** So sometime after that we should have another conversation in this forum.

**Senator SMITH:** I just want to put it on the record that I am concerned that the concerns that have been raised by Catholic Health Australia and others, and particularly around rural and regional Australians, are not realised. My last theme is that some criticism has been made of the report that was commissioned by the Department of Health in 2013. Are you familiar with that criticism?

**Mr Stuart:** I have been part of a meeting where we were asked about the report, but we stand by that report.

**Senator SMITH:** Let me just read into the *Hansard* the three criticisms that have been raised, and on notice you can provide a response to me in regard to those—unless of course you know the response to these points now. The first criticism is 'the data sets were not supported by any verifiable documentation and, accordingly, accuracy cannot be verified'. You might want to take that on notice. Secondly, 'only a small number of pharmacies provided data in support of their views; 20 individual sites providing an estimated 35 per cent of all chemotherapy infusions'. The third and final criticism of the report was in regard to 'a

number of consistency issues between individual data sets provided, with some providing less detail than others and some apparent differences in interpretation of each cost component. A number of the data sets appear to be part of group submissions which may impact the weighting of the average cost calculations'.

**Mr Stuart:** We will take all of that on notice.

**Senator SMITH:** Those three points are directed at the estimated $42 cost, which is, I think, what was in the report.

**Mr Stuart:** Thank you.

**CHAIR:** Senator Rice.

**Senator RICE:** Thank you, Chair. I want to ask about the cost to transgender young people to access treatment to block puberty. Accessing medical treatment—in particular, the stage 1 treatment, the puberty blockers, gonadotropin-releasing hormone analogues—is critical to transgender young people's wellbeing. They are a group at very high risk. In a recent survey half of them acknowledged that they had been diagnosed with depression, and 38 per cent acknowledged thinking about suicide. I want to know whether there is any current consideration of include puberty blockers under the PBS.

**Ms Platona:** There are a number of products already on the PBS. The main usage is of testosterone, which comes in a number of forms, including gel. That product is subsidised on the PBS for androgen deficiency, for micropenis and pubertal induction, which is delayed puberty. There are a number of other products that you have mentioned that are aimed at treating puberty and delayed puberty. We have made, at the direction of the PBAC, a number of changes to the usage of testosterone but they are mostly aimed at limiting usage—and more appropriate usage—of those products in men over the age of 40, where PBAC had in the past noticed an exceedingly large usage of the product in the past five years.

**Senator RICE:** That is a very different product. These products are for transgender young people who realise they are transgender and want to delay puberty. These puberty blockers, if they are privately prescribed, at the moment are about $5,000 per year, and transgender young people will typically be on them for a period of four years. It is a very high cost.

**Ms Platona:** Up until recently we have had no representation from the lesbian, gay, bisexual, transgender and intersex community. We have recently engaged with them in products that fall within their area of interest and will continue to work with them. I want to explain the way products become subsidised on the PBS. It is usually a pharmaceutical company that holds the data, and they make application to have these products subsidised on the PBS. The department receives that application and the PBAC undertakes an assessment of efficacy and safety and cost-effectiveness, and makes recommendations to the minister. We need to encourage manufacturers of these products to apply for the PBS subsidy, and then there are processes in place to assess their suitability for subsidisation under the PBS.

**Senator RICE:** Does it have to be the pharmaceutical company? For example, with the gender centre at the Royal Children's Hospital that is treating these clients at the moment, the hospitals are paying for them, and there is a very strong case as to why it should be the PBS covering them.

**Ms Platona:** Anybody can make an application to the PBAC and write to PBAC in support of an application with evidence that is required to support the case for efficacy and

safety and value for money assessments. For example, nicotine replacement therapy is on PBS because a number of NGOs have got together and written to PBAC. But to have a product actually subsidised, the company needs to agree that they are willing to sell that product on the PBS because we must have an agreed price. So at some point if PBAC considers the application from a third party about this product we must engage at a subsequent point the company that is willing to supply those products under the condition of subsidy.

**Senator RICE:** Can I clarify that you have not received any application or any proposal before now?

**Ms Platona:** I am happy to take all the names of the specific drugs with me and I am happy to provide an exact answer about the history of the products that you have explicitly mentioned.

**Senator RICE:** And whether there has been any consideration or any determination of them so far. Basically it is the puberty blocker, the gonadotrophin releasing hormone analogues.

**Ms Platona:** For the specific group of patients—

**Senator RICE:** For young people to block puberty until they are at an age when they are on hormones.

**Ms Platona:** I would be happy to do that.

**Senator McLUCAS:** I have some questions on ledipasvir, sofosbuvir and daclatasvir. How did I go?

**Ms Platona:** It is perfect, Senator! They are the new interferon-free regimens for hepatitis C—sofosbuvir, or sofosbuvir-ledipasvir, and daclatasvir. There are two more products that go in a pack of four that even I cannot pronounce after so many some years.

**Senator McLUCAS:** Has the department concluded a price agreement with Gilead?

**Ms Platona:** There are five products and three companies involved. There are some 250,000 people with hepatitis C in Australia. It is an exceedingly large amount of money and those price negotiations across five products and three companies with their own commercial interests have not been concluded. We do not have agreed prices with these companies. It is hard because not one product covers the entire hepatitis C spectrum. We are looking here at products that cover genotype 1, some that cover genotype 3, some that cover something else. What we are trying to achieve through these negotiations is to give effect to the recommendations of the PBAC in March and July that gave us direction that we should achieve treatment for as many people as we can with hepatitis C at the lowest possible price. That is what we are trying to do.

**Senator SIEWERT:** What happened in July at PBAC?

**Ms Platona:** It is a sequence of products. In March PBAC gave a positive recommendation to the two products made by Gilead, that is sofosbuvir and sofosbuvir with ledipasvir. In July there was a competitor AbbVie with two more products coming in, and clearly our price negotiations have to sort out these companies' commercial interests between the various subgroups and genotypes of people.

**Senator McLUCAS:** So the July application a different company—

**Ms Platona:** Correct.

**Senator McLUCAS:** But it was a similar cohort of patients, so is it a real competition?

**Ms Platona:** For genotype 1, which represents about 54 per cent of the entire groups of hepatitis C patients, there is real competition between Gilead and AbbVie, but that is only for genotype 1. For the rest of the 40 per cent of people, there is a bit of a mix of products that can cover the pan-genotypic scenario.

**Senator McLUCAS:** I am not going to ask you a question that is going to jeopardise your negotiations with these companies, but are we looking at a long time, or is it imminent? Is there any indication that you can give us when these negotiations might be completed?

**Ms Platona:** I am working hard.

**Senator McLUCAS:** I believe you.

**Senator IAN MACDONALD:** Do you only approve one, or can you approve more than one? Both are subject to commercial negotiations.

**Ms Platona:** At the moment, we are not excluding products. If we have two products for genotype 1 in direct competition with each other, we could subsidise both. Clearly, we would subsidise first the one that offers us the best price. We would not pay more for the one that is of similar efficacy or toxicity.

**Senator IAN MACDONALD:** Do both of these competitors do much the same sort of thing?

**Ms Platona:** That is correct. PBAC had already assessed their comparison with each other on safety and efficacy and considered them to be similar.

**Senator IAN MACDONALD:** I am conscious of that. I was aware of the one; I was not aware of the other. You cannot give a date, for the reason Senator McLucas mentioned. I know one doctor in Townsville who has a lot of patients in this area who is simply, in his words, warehousing people until the decision is made. Is that a common happening?

**Ms Platona:** I would not prefer to warehouse people—three years ago we had some other products for hepatitis C that people considered to be magnificent in terms of efficacy and toxicity, and three years later they were proven not to be very good. They work, but three years later, when we have reviewed them again in comparison with the very latest interferon-free regimens, they are proven not to be very good.

**Mr Stuart:** If I could interject, we would really like clinicians to continue to provide the best available care to their patients.

**Senator IAN MACDONALD:** There is a drug that works, but it has difficulties over a 48-week period, whereas the new drugs, as I understand, will be simply like taking an aspirin, and in 12 weeks you are cured. Naturally, any physician would not want to put their patient through 48 weeks of hell—but it works—if there is an alternative almost at hand.

**Ms Platona:** The alternative is clearly safer and easier to tolerate, because the current drugs are based on an interferon regimen. It is the interferon based regimen that causes a lot of side effects. That is why these new products that we name here have been assessed as being clearly a lot more efficacious, and are also safer, on a short duration of treatment. Nevertheless, they are substantially more expensive, and there are a lot of people that need to

be treated and a lot of commercial interests to be worked through following the March and July PBAC meetings.

**Senator IAN MACDONALD:** Keep up the good work. You are doing a wonderful job.

**Senator McLUCAS:** I have one issue to raise: what is the department's position on doctors and patients establishing a so-called Dallas Buyers Club—as this may be the same issue as Senator Macdonald is raising—to bypass the PBS and import hep C drugs such as Harvoni and Sovaldi from China?

**Mr Stuart:** I think you should ask that question of the TGA when they appear.

**Senator SMITH:** I had a similar line of questioning but, if I understand your evidence, we are well advanced but it is still at a critical stage. I would not want to inadvertently interfere in that, so I will refrain from asking my questions, but I recall that the minister said that a decision around this might be available by the end of 2015. Have I read that accurately? Not that there will be, but that there could be by the end 2015.

**Mr Stuart:** I think we should sketch out what other processes are still required. While at the moment we have a negotiation process over price between a committed, interested buyer and a committed, interested series of sellers, the achievement of a price agreement is then just a step in the chain. We then need to go to cabinet, because this is big dollars. The kind of drugs that are very easy to deal with are ones that are fantastic and cheap; these are fantastic and very expensive. They will need to go to cabinet as well, and there are also other processes that you might want to quickly outline, Ms Platona.

**Senator SMITH:** That would be very helpful for me, because I have had representations from potential sellers around this, so understanding clearly what the process is would be useful. What is the process between now and before they become available to a patient? That would be helpful.

**Ms Platona:** The PBAC has given us a clear instruction about the circumstances in which these products are found to be cost-effective in Australia. PBAC gave clear advice about the use—it is not only about the price but also about the volume, the likely number of people that could be treated and how to mitigate the risk on the budget for the next five years. PBAC's recommendation says that the objective is to treat as many people as we can and that treatment should occur in a primary care setting, not only through the specialist liver clinics. Therefore the negotiation with the companies about the number of people that could be treated within a certain budget envelope it is quite difficult. If any of the companies had accepted the PBAC's advice in full at this point I probably could have given you more clear advice about the timing, but they have not. Like everything, it is a compromise: price is one of them; volume is one of them; likely number of people and uptake is another element that we need to work through. Then there are the consequences of what would happen to the price if, for example, more than 100,000 people were to be treated. Should the price remain unchanged? Should the price fall and, if so, by how much? When all those details with respect to use, price and risk sharing arrangements are in place then we can put that to the government for consideration. But we have not completed that step yet.

**Mr Stuart:** Then there is the cabinet decision, companies stocking up, inclusion in the book for prescribers, software providers changing their prescribing software for pharmacists, pharmacists obtaining stock. There are a few things yet to occur.

**Senator SMITH:** Thanks very much. I appreciate that.

**Senator MOORE:** I have been approached by a person who is very concerned about the purchase of Panadol in supermarkets and has got a particular concern—and this is being replicated across the country in different areas. The person who has contacted me—and I would imagine many more—has a daughter who was able to buy 40 packets of Panadol at one of the large supermarkets and then attempted suicide. Luckily it did not occur. She asked particularly that I find out what the process is around this. I am told that should not happen. You should not be able to do that, but I wanted to get clarity about what exactly the process is and I believe this is the right area to ask.

**Mr Creech:** TGA probably.

**CHAIR:** We will come back to that. We are done with outcome 2, so thank you very much. We are going to move on to outcome 7: health system capacity and quality.

[18:11]

**Senator IAN MACDONALD:** I have two areas of very brief questioning. One is about e-cigarettes and the other is about medicinal cannabis. On the e-cigarettes: a group of people came to see me the other day—not quite sure why they came to see me but they did—and showed me an e-cigarette and a bottle of oil that they use for what they call 'vaporising.' They say there is nicotine in it but not as much nicotine as you can buy legally at the chemist or supermarket for Nicorette's chewing gum and that sort of thing. Why do we ban the sale of the oil that they put in these e-cigarettes? Is there a policy reason or what is—

**Mr Bowles:** I suppose if it contains nicotine it contains a schedule 7 poison so that is why.

**Senator IAN MACDONALD:** But I understand nicotine is sold at supermarkets and chemist shops in a chewing gum fashion.

**Mr Bowles:** The chewing gum is a slightly different issue. Maybe if we get Professor Skerritt up he might be able to give us a bit more on that one.

**Prof. Skerritt:** Nicotine is regulated under chemicals and medicine scheduling as what is known as a schedule 7 poison. It is very good insecticide among other things. However, because of the importance of nicotine lozenges and patches, for example, and proven efficacy in helping people give up smoking if nicotine is specifically either for what is known as dermal absorption—absorption through the skin such as on a patch—or if it is in a lozenge for absorption in the mouth through the cheeks known as oral limposomal absorption it is able to be sold either in pharmacies or even in some other cases at lower doses for general sale with those two specific exclusions because of the giving up smoking proven ability. However, nicotine in general such as in e-cigarettes is not included in that because the evidence is quite controversial and the jury is still out about whether nicotine contained in e-cigarettes actually contributes to the cessation of smoking.

**Senator IAN MACDONALD:** As I say, I have no particular truck in this. I was just interested how they work but the people who came to see me have turned it into more than that. Their argument is that the e-cigarettes do help people give up smoking and in fact a number of those who came to my office all attested to the fact that they used to smoke and they do not now because of this so that is that argument. But you say it is—

**Mr Bowles:** The evidence is saying it is not necessarily true at this point.

**Senator IAN MACDONALD:** No, but I understand from Professor Skerritt that there are differences of opinion. Did I understand you to say it is under review—perhaps review is too strong a—

**Prof. Skerritt:** If you get 40 doctors into a room, you will get 41 different opinions. I would say that at present the majority view is that there is not good evidence for e-cigarettes and smoking cessation. One of the challenges is that often with e-cigarettes people who are still smoking will just drop the number of cigarettes they smoke per day. If you go from two packets to one pack a day, a lot of the studies have shown that your cancer risk actually does not halve or even—in many cases—reduce. Having said that, if a company came to the Therapeutic Goods Administration with evidence from clinical trials that a product successfully causes smoking cessation, we would consider it for potential registration as a prescription medicine.

**Senator IAN MACDONALD:** Nobody has approached you as at this time?

**Prof. Skerritt:** As I remarked at the last estimates meeting, for commercial-in-confidence reasons, we do not confirm or deny whether we have received applications about particular medicines. Sometimes a company will—for whatever reason—put out in the public domain that they have applied to us, but our approach has been for decades that we do not confirm or deny until a decision to either accept or reject has been made.

**Senator IAN MACDONALD:** I accept that. People who came to my office all had their little bottle of stuff. Whether they imported it from overseas legally or if they had it illegally, I do not know. It seems to be in wide availability, but people were concerned that they might be breaking the law.

**Prof. Skerritt:** The laws you are talking about are actually administered through states and territories rather than the Commonwealth, as far as not allowing e-cigarettes containing nicotine to be sold, and it varies between states and territories.

**Senator IAN MACDONALD:** I will not go further now except to ask: if an application had been made and if it were approved or rejected, would some announcement then be made?

**Prof. Skerritt:** That would be made public. If in the late stages a product is rejected by us or if a product is accepted as a prescription medicine, we put out a detailed document of reasons, including the clinical assessment, known as an AusPAR.

**Senator IAN MACDONALD:** The second issue I want to quickly raise is medicinal marijuana. Minister, congratulations to you and your colleague, Minister Ley, on the very useful material you sent out with the minister's press release on all this, with all of the hows, whens, wheres and whys. It means we should not need to ask questions here, but I will briefly. I suppose I can do this myself, but you are in a much better position to do this than me. As you would know, Senator Di Natale had a private member's bill which was fully investigated by a committee of the Senate that I chair. That committee thought it was a pretty good idea across the board. The department had some concerns, and, as a result of that, I understand now that the department has flagged it is bringing forward its own amendments to legislation. Is it possible for someone to briefly explain the differences between what Senator Di Natale was proposing and what the government is now proposing? Could I just make it clear to anyone who might be interested that I am not taking sides at all. What we want to do is to get relief for those who do get relief from medicinal cannabis, and I am convinced, from

our inquiry, that that happens. We just want to see how we get to the end point. Could someone relatively briefly, for a simple mind, explain what the differences are?

**Dr Studdert:** Senator Di Natale's bill was a very comprehensive bill. It sought to manage the regulation of cannabis all the way from cultivation through to supply to the patient, including the manufacturing and, in some instances, importation of product that is medicinal cannabis. The department's submission to your inquiry pointed out that a lot of those aspects were already covered under existing legislation, including the Customs (Prohibited Imports) Regulations and the TGA Act, which does allow for some provision of unregistered product, such as a form of medicinal cannabis, in its current form. What the proposed legislative amendments to the Narcotic Drugs Act will do is introduce what we identified as being the one part of Senator Di Natale's bill that we do not have provision for, which is the cultivation of cannabis in Australia. That is a requirement under international treaties and is a desirable thing, given the risks around medicinal cannabis. So it is proposed that we put in place a licensing scheme that will enable cultivation of cannabis for specific purposes and with very defined requirements that ensure the security, quality and effectiveness of the medicine are appropriate for the patients who we identify, and, more importantly, who doctors identify, as being in need.

**Senator IAN MACDONALD:** Thanks for that. That was a very concise summary. I know that one the concerns with Senator Di Natale's bill was that, if it had been introduced, we might be actually making this available, Australian-grown and –regulated, sooner rather than later. Would you care to comment on that?

**Dr Studdert:** I think any bill and associated regulations and licensing will take some time. We are certainly under instructions from our minister to move as quickly as possible on that, but it will also be dependent on an application to grow a crop and that applicant putting in place the necessary arrangements to grow a crop. I understand it grows quite quickly, but obviously there will be a need to set that up—

**Senator Ian Macdonald:** If I could put in a plug for Queensland, it grows wonderfully up there!

**Dr Studdert:** I would have to take your word on that! I do not think that element of the provision will be any slower. There are already provisions for the importation of medicinal cannabis from overseas that can be accommodated, with a certain number of caveats, under the current legislation and regulations of the Therapeutic Goods Act. What we have identified, though, through a lot of inquiries to the minister, the TGA and the department more generally, is that the real constraint has been accessing product. There is a shortage of it, worldwide, through approved schemes in many countries. You also put single patients and single doctors in the position of having to track that down and make those arrangements, and the costs, of course, are more extensive when you are sourcing offshore.

**Prof. Skerritt:** I would like to correct a misinterpretation that has appeared in the media in several places since the minister's announcement about the scheme. Some media and patient-advocate commentators have said that the problem with getting these products through special access with the Therapeutic Goods Administration, or with requiring, for some manufacturers, Therapeutic Goods Administration GMP—that is, inspection of the manufacturing facilities and approval of them—is that the TGA takes a year or more to approve a medicine. What we are talking about is actually providing a range of options. As per other medicines that are not

currently approved in Australia, the therapeutic good can be made available through our Special Access Scheme. The Special Access Scheme is a request by a doctor about an individual patient. If all the information as provided is correct and the other ducks have been lined up as far as access to cannabis based medicine, it can be often be done in a maximum of 48 hours in a working week. That is if all the documentation, obviously, is correct.

If a new commercial enterprise or an existing commercial enterprise got in the business of processing the cannabis product, many established pharmaceutical companies already have TGA GMP manufacturing licences, and so they need not go through the process of registering it as a medicine. The medicine could still be provided under the Special Access Scheme, or it could even be provided by, say, a doctor who specialises in childhood epilepsy, a paediatric neurologist, for a group of patients. They can get approval. They have to have ethics committee approval and, again, submit the documentation to us, but they do not have to come back to us for a patient-by-patient request. They can have it for a cohort of 40, 100 or 200 patients who are under the direct care of that particular specialist.

If it is a new commercial facility—and we know that there is a lot of commercial interest in growing and processing cannabis—new pharmaceutical Australian facilities are assessed for TGA GMP within three months of receiving their application. Some of the rhetoric that has been around the media—disappointment with the government's suggestion or the government's proposal that, with the exception of changing the Narcotic Drugs Act, the current mechanisms for the therapeutic goods administration apply—some of the commentary has suggested that that will lead to a delay of a couple of years. That is simply not true. Clearly, as with everything, it will depend on the merits of the application. I do not want to discuss individual patient cases, but unfortunately sometimes applications for access to medicines, be they cannabis or other medicines, are incomplete when they are submitted by doctors. There is one additional thing: because medical marijuana or cannabis is a schedule 9 poison, we are going to need the states and territories to provide their express approval. As in a lot of things, this is not just the Commonwealth being able to act unilaterally. But I did want to put into the record that we are not talking about these medicines requiring a full TGA registration pathway. A company may choose to do that, as they have for a drug called Sativex, but that is a commercial decision.

**Senator IAN MACDONALD:** Thanks very much for that. I will not take the committee's time to take this further except to say that in our committee there are a number of pieces of evidence with quite tragic stories about people having to fly to North America twice a year to get relief. I just wonder if what you have told me is widely known amongst the medical profession. Perhaps the minister might even be interested in making sure that some of what you have just told me is more widely known. Thank you very much for that. That is great and very good news. Congratulations on that, Minister.

**Senator WATERS:** I have some questions for NICNAS. I am after an update on the progress and a reminder about the scope of the national assessment of CSG chemicals.

**Dr Richards:** At the last estimates, I seem to recall suggesting that we expected the reports to be released around the middle of this year.

**Senator WATERS:** I recall that also.

**Dr Richards:** The finalisation of these reports has proven to be a somewhat more complex exercise than we had imagined. The current expectation, I am advised by the Department of the Environment, is for them to be released by the end of this calendar year. That is the current expectation.

**Senator WATERS:** Can you tell me more about the complexity?

**Dr Richards:** This is work that has never been done in Australia or anywhere overseas previously. As we have discussed before in this committee, the risk presented by a chemical is a function of its intrinsic hazard and the exposure of an organism—a human or the environment—to it. Risk is a function of hazard and exposure. The hazard of a chemical is fairly well known. There are pretty well established mechanisms, many of which involve animal tests for industrial chemicals, which determine the hazards, the lethal concentrations and so on.

The difficulty in this project relates to the exposure scenarios; how we model exposures. As we have discussed before, there is no off-the-shelf model for calculating exposures from coal seam gas. A lot of the project has been in developing those methodologies, applying those methodologies and putting data in. This is why the project has involved a range of partners, including the Department of the Environment, the CSIRO well as NICNAS. Because this is groundbreaking work in terms of the methodology development, it has been trial and error, and recalculations of data. We have recently had some recalculations of some data from the CSIRO which fundamentally impact on the calculations we have done in terms of risk. We are currently reworking all our risk calculations based on the updated data from the CSIRO. It is these sorts of issues that are causing delays in the finalisation of the reports. It is really just improving the rigour and the accuracy of the results.

**Senator WATERS:** Are you able to tell me any more about the recalculations? What facet did they relate to and what have they done to your risk projections? You said that they have changed them—up or down?

**Dr Richards:** It is a recalculation of some of the predicted environmental concentrations of some of the chemicals; how much is left after certain things have happened to the chemicals and their passage through the environment.

**Senator WATERS:** Would I be correct in assuming that they are now saying that probably more is going to be left in the geology than they thought?

**Dr Richards:** I cannot comment on that. That work is still being done. I would not want to pre-empt the outcome of those recalculations.

**Senator WATERS:** We are looking forward to that very much. I am very pleased that this is now being looked at—in my view, it should have been looked at long before licences were granted for this industry to rollout, but I know that is not your doing; you have got no control over that—and I am pleased that the work is now getting done. Can you just remind me and confirm for me that the exposure is only looking at the surface. There was a second aspect that you were examining, but deep aquifer impact is not within scope of the study?

**Dr Richards:** That is correct.

**Senator WATERS:** Just remind me of the parameters, if you could?

**Dr Richards:** The assessment is primarily considering the human health and environmental risks arising from the surface handling of the chemicals used in coal seam gas. The risks to deeper groundwater and arising from geogenic chemicals—chemicals released from the coal seams and shale gas extraction methodologies—are all outside the scope of the current assessment.

**Senator WATERS:** That is right. I think that those issues are really where the concern lies. Are there any plans to expand and look at those areas?

**Dr Richards:** That is a question for the Department of the Environment.

**Senator WATERS:** So you are not yet working on that. There is no stage 2 planned that you can—

**Dr Richards:** There have been some preliminary discussions about how things might move forward but nothing in concrete. We have got no firm agreements.

**Senator WATERS:** I certainly hope that in the future you are briefed and funded to do that work, because I think that it is very important work. Can I ask what the outcome of the assessment is expected to be? Will it feed into any sort of standard setting? What will the result be?

**Dr Richards:** The assessment is looking at the chemicals that were reported by industry and determined through other means for a period of time. We originally sent out a survey to industry and said, 'Tell us what chemicals you are using in this time period.' Clearly, the coal seam gas industry is a technologically evolving industry and new chemistry emerges, and so we expect one of the important outputs from this project to be a clear and published methodology for companies or regulators to use. One output is obviously a statement about the risks of the chemicals that were reported to be used. That is really what our work in NICNAS has focused on—looking at the risks of the chemicals that were reported based on information that we could find about their hazards, and then using the exposure models that were developed by CSIRO and others. So information about those chemicals is one output but also, as a result, we will have a methodology for evaluating other chemicals to do those exposure calculations.

**Senator WATERS:** It would then be up to, say, the state governments or even the federal government under the water trigger, under our federal laws, to modify any permit conditions if they felt that that was appropriate as a result of the statement.

**Dr Richards:** That might be an outcome.

**Senator WATERS:** And that might flow from the statement or it might not. That will be up to them. In terms of the methodology, that might be something that perhaps future applicants would use in their environmental impact statements in seeking permits.

**Dr Richards:** Potentially.

**Senator WATERS:** Are there any other applications that I am not yet conceiving of that could be added to that list?

**Dr Richards:** There are a number of other outputs to the projects which are not NICNAS outputs. CSIRO has been doing work as part of this project to look at modelling fracture growth and modelling deep groundwater issues, which could lead into further work should the Department of the Environment choose to commission such work.

**Senator WATERS:** I will take that up with them; so modelling fracture growth and then the deep aquifer impact—of fracking chemicals?

**Dr Richards:** Yes. The CSIRO has also been looking at what other geogenic chemicals might be present but there have been no risk assessments done of those.

**Senator WATERS:** Do you know what the time frame is on those investigations?

**Dr Richards:** That is all part of the same first part of this project which we are expecting to publish by the end of this calendar year.

**Senator WATERS:** Pardon me for having a poor recollection of what we discussed last time, but I am confused. I thought you said that deep aquifers were outside the scope of the study.

**Dr Richards:** The risk of chemicals through being in deep aquifers is out of scope but looking at—

**Senator WATERS:** Whether they in fact go there.

**Dr Richards:** whether they might go there—

**Senator WATERS:** I see. So you are looking at whether they are there but not at what risk that might pose.

**Dr Richards:** That is right.

**Senator WATERS:** Okay. I suppose, at least, that is some information gathering because I imagine that they are in fact going to be there and it would be good to know what risk they pose. Thanks for that clarification. Can you just confirm it is just looking at coal seam gas chemicals; it is not looking at shale gas or tight gas?

**Dr Richards:** That is correct.

**Senator WATERS:** Are there any discussions underway as to possibly expanding the scope of it to include those other related gas industries?

**Dr Richards:** Not that I have been involved in at this point. That is a matter for the Department of the Environment.

**Senator WATERS:** Indeed. Thank you very much. That is all the questions I have. Keep up the good work. I wish you had some more money to expand the scope of the study.

**Dr Richards:** Thank you.

**Senator McLUCAS:** Has NICNAS completed the assessment of glyphosate using the IMAP process?

**Dr Richards:** Glyphosate is an agriculture and veterinary chemical. That is for the APVMA under the Agriculture portfolio.

**Senator McLUCAS:** You do not assess the chemical?

**Dr Richards:** NICNAS is industrial chemicals.

**Senator McLUCAS:** Okay. Done. Can I indicate that we have just had a discussion. We do need FSANZ, OGTR, TGA, OTA and issues around e-health.

**Mr Bowles:** You want to talk to TGA, OTA, FSANZ and around e-health?

**Senator McLUCAS:** Yes. Then in outcome 1—

**ACTING CHAIR:** I definitely want the Office of Gene Technology Regulator.

**Senator McLUCAS:** Yes, FSANZ, OGTR, TGA, OTA and the e-health issues. I am very keen that we stick to the timetable for aged care. That is 9.15 till whenever that gets to—and you won't like this, Mr Bowles—but we would then go back to outcome 1 for that half an hour that is now currently allocated to biosecurity, and the biosecurity people can go home.

**ACTING CHAIR:** Hang on. Before we get too excited, we are checking with Senator Madigan about Lyme disease. He did give that a fairly good shake this morning.

**Mr Bowles:** He did, but he did say he wanted to come back, I think.

**Senator McLUCAS:** In fairness, we had half an hour on Lyme disease this morning. I think that is enough.

**ACTING CHAIR:** Okay. He also had other questions on Q fever, apparently.

**Mr Bowles:** He did have questions on Q fever, yes.

**ACTING CHAIR:** We will not need 30 minutes there. We are still to resolve that to make sure that he still has questions, so I am sorry that we cannot give you more clarity on that now. We will double-check that. We also anticipate that, while we still need healthcare workforce capacity, we will not need 45 minutes there. So we are attempting to make up some time there as well.

**Mr Bowles:** So you do not need NEHTA, or you are dealing with that in the context of e-health. That is okay. NHMRC?

**ACTING CHAIR:** Yes, we do need them. Senator Xenophon and Senator Rhiannon have questions.

**Mr Bowles:** Australian Commission on Safety and Quality in Health Care?

**Senator McLUCAS:** We do not need them that we are aware of.

**Mr Bowles:** If I send them home, we can take on notice. We can deal with it that way, if you like.

**ACTING CHAIR:** No-one has indicated to us that they need them. At this time of night I think we can say that on the balance it is fair enough that you go home.

**Mr Bowles:** ASADA and the Sports Commission?

**Senator McLUCAS:** Yes.

**ACTING CHAIR:** We will endeavour to make sure that we do get to everybody that we have just outlined. We have just been told that the other questions will be put on notice. We will suspend now and come back at 7.40 pm.

**Proceedings suspended from 18:40 to 19:40**

**CHAIR:** We will recommence. We are continuing with Outcome 7.

**Senator McLUCAS:** In relation eHealth funding, what funding has been allocated for the operation of the MyHealth record from 2018-19?

**Mr Madden:** Funding for 2018-19 has not been allocated at this stage. We have funding for three years up until June 2018, but we have a return to government in early 2017 for ongoing operations at that point.

**Senator McLUCAS:** Early 2017 for that following 2018-19 year?

**Mr Madden:** For the future operation.

**Senator McLUCAS:** What is the rationale for not allocating any funding in 2018-19?

**Mr Madden:** The program—which was announced as part of the budget—had a couple of measures in it, one of which was the trialling of opt out during the 2016 year with a view to bringing back the evaluation from those trials which would give us some points towards decision whether to roll that out nationally or to maintain the opt-in registration process. The operation of both of those systems varied markedly, but it is also expected that in the period between now and 2018 the technology and the way we support that system could change and have some changes in the cost structures as well. Again, that will come back as a proposal in early 2017 as a package.

**Senator McLUCAS:** Can you confirm that the 2015-16 budget contains a $215 million cut from the personally controlled electronic health record program compared to what was in the contingency reserve for this program?

**Mr Madden:** I do not think that represents a cut in funding. The contingency reserve had a provisional estimate for operations of the system over a number of years plus some other facilities, such as potentially a national opt-out service. What was funded for 2015-16 and onwards for three years probably represents the longest funding period for the eHealth program since it was implemented in 2012, so there is three years' worth of operational funding. But there was no cut to the funding per se. There was not an allocation, there was an estimate of what that could be.

**Senator McLUCAS:** Is the figure of $250 million the difference between what was estimated to be the expenditure and that is why it is in the contingency reserve and what you now deem to be the real cost? Is that right to understand it that way?

**Mr Madden:** That is right.

**Senator McLUCAS:** Where has the money that was in the contingency reserve gone?

**Mr Bowles:** That is a matter for the Department of Finance.

**Senator McLUCAS:** Okay. What amount went to the Medical Research Future Fund?

**Mr Bowles:** There is no relationship between the two. One was an estimate of what eHealth would cost—and as Mr Madden said it is now the longest term that we have had in funding in that particular project—so it was not an issue of the Medical Research Future Fund in that particular context that I am aware of. You could ask finance that sort of question. When you have variation between what you think something is going to cost and what it does cost, it is usually a budget issue.

**Senator McLUCAS:** My advice is that the save in the budget papers went to the Medical Research Future Fund—

**Mr Martin Bowles:** That may be the case.

**Senator McLUCAS:** from the contingency reserve.

**Mr Martin Bowles:** That may be the case. You would have to ask Finance. We do not manage that issue.

**Senator McLUCAS:** That is in Finance's bailiwick?

**Mr Martin Bowles:** The contingency reserve is not ours. The contingency reserve is Finance.

**Senator McLUCAS:** You have no visibility of that at all?

**Mr Martin Bowles:** We do not manage the fund per se.

**Senator McLUCAS:** Yes.

**Mr Martin Bowles:** The fund is a Treasury/Finance related issue.

**Senator McLUCAS:** But you do not look at it? You do not have an interest?

**Mr Martin Bowles:** We have an interest, and there are a whole range of things if you go to the portfolio budget statement that says money going into the future fund.

**Senator McLUCAS:** How much went to the future fund?

**Mr Martin Bowles:** I do not know in this specific case?

**Senator McLUCAS:** You just do not know, Mr Bowles?

**Mr Martin Bowles:** No, I do not. As I said, it is a Finance issue. It is a contingency reserve. It is not a Department of Health fund.

**Senator McLUCAS:** Can I get a feel for what the government's commitment to e-health records is from July 2018?

**Mr Martin Bowles:** The government's commitment from now is a fund of three years operation. It is a fund of trials and a range of other issues, and to come back in 2017 to look at the funding envelope required to go further forward. While there is no funding for 2018-19, as you indicated, this is the longest period of operational funding we have had for this since it started in 2012. So I think there is a significant commitment. In total it was $485 million, so there is a significant commitment to make this work because you do not invest that much money and then just stop it. But it is part of a process that we will go through when we do the trials on opt-out and the evaluations thereof.

**Senator McLUCAS:** The commitment part post-2018 is still dependent on successful completion of trials—

**Mr Martin Bowles:** No. The funding going forward is dependent on which way the trials play out because—

**Senator McLUCAS:** Whether it is opt-out or opt-in.

**Mr Martin Bowles:** if they are successful it is this much and if they are not successful, and we want to go somewhere else, it is that much, and the platforms on which these things will run will be different by 2018.

**Senator McLUCAS:** The money that was in the contingency reserve was Health money, wasn't it?

**Mr Madden:** No, the money is not allocated to Health. It is held in Finance. It is held as an estimate in Finance. Then, when the allocation is made, the residual remains with Finance. What Finance do with that is up to Finance.

**Mr Martin Bowles:** Yes.

**Senator McLUCAS:** How many sites will be established as part of the opt-out trials associated at the—

**Mr Martin Bowles:** The final allocation of the opt-out trial sites is still a decision of government.

**Senator McLUCAS:** When was that meant to—

**Mr Martin Bowles:** It is not meant to start until next year.

**Mr Madden:** That is right. Operation of the trials would start in July. Communication and lead-up activities for the trials start in February/March.

**Mr Martin Bowles:** Next year.

**Mr Madden:** Yes, next year, in 2016.

**Senator McLUCAS:** That is not long away.

**Mr Madden:** No.

**Senator McLUCAS:** We do not even know how many sites we are going to be associated with.

**Mr Martin Bowles:** That is not what I said. It is a matter for government to make the final decision, and we have provided advice to government.

**Senator McLUCAS:** You have provided that advice and now it is opened. It might be soon.

**Mr Martin Bowles:** It could be.

**Senator McLUCAS:** Yes, it could be. How much has been budgeted for each of the trials?

**Mr Martin Bowles:** It is not for 'each of the trials'. It is how much is budgeted for the trials?

**Senator McLUCAS:** Okay.

**Mr Martin Bowles:** Just so that we do not say 'each of'.

**Senator McLUCAS:** Why?

**Mr Martin Bowles:** Just in case there is one, two, five or 10.

**Senator McLUCAS:** Thank you.

**Ms Konti:** The amount of money that has been allocated for trials of participation arrangements for the My Health Record system in 2015-16 is $26.4 million and in 2016-17 it is $15.5 million. Up to six trials of participation arrangements may be conducted and out of those between two and four trials of participation arrangements for opt-out and up to—

**Senator McLUCAS:** Sorry, could you say that again, Ms Konti. So up to six for?

**Ms Konti:** For trials and participation arrangements in total, and within the trials and participation arrangements there is provision to trial opt-out participation as well as innovative approaches to opt-in participation or participation as part of the current opt-in system.

**Senator McLUCAS:** How would those innovative opt-in arrangements work?

**Mr Madden:** First of all, with the opt-out ones, we have received proposals from the states and territories on possible locations. For the opt-ins, we will be inviting primary health networks to submit proposals in their terms on the ways they might inspire healthcare providers and consumers or individuals to get involved in registering and using the record and for doctors and healthcare providers across the whole health setting engaged in that. In the past we have assisted registration, where we have had people do that on our behalf and we are

looking at what the primary health networks might do to get assisted registration to happen at point of admission or point of first consultation with the GP, clinic or specialist and all of those things.

**Mr Bowles:** Or disease.

**Mr Madden:** Yes, or disease—in the chronic management space as well. We are looking at alternatives to the opt-out just to make sure that we have not overlooked any of those possibilities.

**Senator McLUCAS:** So it is up to six. If I divided 0.4 by six I would get an average?

**Mr Bowles:** Not necessarily.

**Senator McLUCAS:** I knew you would say that. When you said—I forget who said it—that PHNs would be invited to apply, we are not expecting a geographical boundary or a population size boundary to be a full size of a PHN? Is that contemplated?

**Mr Madden:** We would be looking for guidance from the PHNs on this. As Mr Bowles said, there could be innovations in looking to focus on people with particular chronic illnesses who have lots of touch points with the health community as a point of a trial. But, again, it is more how a PHN would do that and what their own values would be and whether they would seek to limit it or seek to grow it. A PHN who had a vast land mass and a very sparse population versus metro could probably deal with how they want to pull that forward. Again, we will not be telling them how we want them to do it; we will be asking them for their innovations.

**Senator McLUCAS:** So, in that 'up to six' locations, you will ensure that there is at least one remote area and one regional area?

**Mr Madden:** The criteria which has been published on the web includes that we need to have metro, or major cities, regional, outer regional, remote and rural across all of the trial sites.

**Senator McLUCAS:** How long will the trials run?

**Mr Madden:** For the opt-out, the communication/education piece will start February-March. The use or the availability for e-health records for the people in the opt-out trials will be available to the healthcare providers in July. We would be doing the evaluation from July through to October in a measurement sense to be able to get some evaluation to give us some advice for early 2017.

**Senator McLUCAS:** How will you measure the success or otherwise?

**Mr Madden:** We are appointing an independent evaluator. The evaluation criteria will be proposed by the independent evaluator, but we will be working that through the health council.

**Senator McLUCAS:** Is the department aware of concerns that have been raised by the Parliamentary Joint Committee on Human Rights around privacy changes in the bill?

**Mr Madden:** Yes.

**Senator McLUCAS:** What is the department's response to that?

**Mr Madden:** We really need to let the committee take its course and receive submissions and we need to provide a response to that committee. We have had a privacy impact

assessment done of an opt-out style system. It did raise issues of risks from a privacy and a human rights perspective but also provided some proposed mitigations. Those mitigations are the things that we would be seeking to work through in those trials. So we need to continue to work through that process.

**Senator McLUCAS:** How many e-health records do we have presently?

**Mr Madden:** For individuals?

**Senator McLUCAS:** Yes.

**Ms Konti:** As at midnight last night, we have 2,442,824 individual registrations.

**Senator McLUCAS:** Has that been tracking up over time?

There was a big burst when we were in government and a lot of people signed up in the last six months of 2013. Is there a graph?

**Ms Konti:** There is a graph. This graph is provided as at 16 October. For the week ending 15 October, the graph says that there was a total of around 1,350 registrations in that week. There was a spike in registrations, as we always tend to get, around tax time. When people come onto MyGov and do their tax they learn about the other services that are available and registrations increase by about 500 per week during the tax time period. At the last estimates hearings, we took on notice a question which asked how many registrations had been in the intervening period between estimates. Our response was that between the 25 February estimates and the 2 June estimates there had been an increase of 138,641 records, which represented an average of 1,294 registrations per day. Between the 2 June estimates and 19 October, we have 196,425 additional registrations, which represents 1,413 registrations per day on average.

**Senator McLUCAS:** So it is increasing?

**Ms Konti:** That is correct.

**Senator McLUCAS:** How many general practices have signed up for the PCEHR?

**Ms Konti:** It is hard to say exactly how many general practices. I can tell you that there are 7,975 healthcare provider organisations that are registered and connected as at 15 October and, in addition, 11,010 individual healthcare providers are also registered.

**Senator McLUCAS:** Is that also tracking up as well?

**Mr Madden:** That continues to track up. The other measure we have is general practices who register for the Practice Incentives Program. One of the incentives we had a year ago was that they were to be registered with the e-health system, and I think all of those who were part of the Practice Incentives Program are in fact registered. The Practice Incentives Program picks up about 75 per cent of GPs.

**Senator McLUCAS:** About 75 per cent.

**Ms Konti:** I beg your pardon: I do have the figure for general practice. It is 5,671 general practices of an estimated total population of 7,011, which represents 80 per cent of the total GP practice population as at October.

**Senator MOORE:** I will follow through on the questions in this area. Is the data that you have given us available on a state basis? One of the things we talked about at previous

estimates is whether any states have a higher response than others. You can give that to us on notice, if you like.

**Mr Madden:** We will take that on notice.

**Senator MOORE:** We have also talked about the hospitals that had got involved as units. Do you have data on the hospitals that have signed up?

**Mr Fleming:** In terms of public hospitals and health and community centres, we now have 452 signed up and connected to the PCEHR. Of that—and I can provide this information in detail—there are 148 hospitals in New South Wales, 13 in South Australia, one in the ACT—remembering there is only one public hospital here—219 in Queensland, four in Tasmania, 10 in Victoria, two in Western Australia and 55 in the Northern Territory.

In addition to the public hospitals, back in April we invited the private sector to start working with us. As of today, there are 22 private hospitals now connected: five from St Vincent's, four from Healthscope, Lifehouse, one from Adventist HealthCare, four from the Little Company of Mary, four from Epworth, two from the Cura Day Hospitals and one from Mater. We are continuing to work with those groups and you will see those numbers continue to increase.

**Senator MOORE:** That has only happened since April. There have been previous questions we have had—

**Mr Fleming:** We signed agreements with those groups in April, so they commenced the work then, and the first of the hospitals are now coming on board.

**Senator MOORE:** The next couple of questions are about the e-health practice incentive payment changes. I am just seeing whether anybody else has questions in that area we have just been on.

**CHAIR:** I think you were the one with further questions about No. 7—is that correct?

**Senator SIEWERT:** No.

**CHAIR:** Okay. Continue, Senator Moore, and then I will go to Senator Siewert when you are done.

**Senator MOORE:** Can you explain the intended changes to the e-health practice incentive payments.

**Ms Konti:** One of the recommendations from the review of the personally controlled electronic health record was indeed to review the eHealth Practice Incentives Program to look to move towards active and meaningful use of the e-health or PCEHR system. As part of the budget announcement, we commenced the review of the eHealth Practice Incentives Program. We commenced consultation with general practice in August and have conducted some webinars looking to ask questions of them about how they might think that we could best incent for active and meaningful use. It is important to note that there is one important clinical document in the personally controlled electronic health record system that only general practice can upload, and that is the shared health summary. One of the things that we were looking to do was seek to gain some agreement to uploads of shared health summaries as part of the review of the practice incentive payment for e-health. Consultations have now closed. We received 16 submissions, and we are in the process of finalising the recommendation to government.

**Senator MOORE:** What is the time frame for the review that you started and that you have had this range of webinars on? On notice, can we get a list of the processes you have used in the consultations and with whom you have consulted. What is the time frame for getting your paper to government?

**Ms Konti:** We are looking to have that paper to government by next week.

**Senator MOORE:** That is very quick. Okay, so next week. You mention the shared health summary. What is the rationale behind the shared health summary being the principal measure of an active and meaningful use of My Health Records?

**Ms Konti:** The shared health summary is not considered to be the principal measure. It is not active and meaningful use.

**Senator MOORE:** It is not, but it is one of the core things that come up?

**Ms Konti:** Yes. Active and meaningful use is actually considered to be contribution of clinical content in addition to the viewing of records of individuals that have a My Health Record in order to gain information that a healthcare provider might not otherwise have about the person who they are caring for.

**Senator MOORE:** Which is the 'meaningful' part of the 'active and meaningful'.

**Ms Konti:** If I could just explain, one of the constraints or one of the barriers to take-up for individuals of the PCEHR, the My Health Record, has been that once they actually register there are limited amounts of clinical content available in the system. One of the barriers to take-up for other healthcare providers outside of general practice is limited clinical content in the systems, so the contribution from general practice is that shared health summary, which gives you that overview of the clinical information for a person, and that contains or can contain information such as allergies, adverse reactions, current medications and current conditions that the person might have, if there are any chronic conditions that the person has. That is what we are looking for general practice to contribute to the My Health Record system.

**Senator MOORE:** Is that the kind of information that has been reinforced by the submissions you have received?

**Ms Konti:** I beg your pardon, Senator.

**Senator MOORE:** You talked about having 16 submissions in the consultations process. Without exposing any of the information that might go to government, was that sort of information in those submissions?

**Ms Konti:** One of the questions that we asked was whether general practice would consider the contribution of the shared health summary as a first step towards achieving meaningful use.

**Senator MOORE:** Do you anticipate reductions in practices qualifying for the EPIP after the new criteria?

**Ms Konti:** I am sorry, Senator.

**Senator MOORE:** Do you anticipate fewer practices being eligible for the EPIP payment after the criteria are amended?

**Ms Konti:** That would be a matter for the practices. They would need to make the decision about whether they would want to continue to be a part of the program.

**Senator MOORE:** If practices have to meet the target for the use of the PCHER based on the number of their patients, will practices effectively be obliged to assist some patients at least to register for the record?

**Ms Konti:** Again, that would be a matter for the practices.

**Senator MOORE:** Has that been explained to them?

**Ms Konti:** It has been explained to them. Indeed, as part of the consultation process, we asked the question about whether or not they would consider assisted registration to form part of the—

**Senator MOORE:** Their engagement.

**Ms Konti:** Yes.

**Senator MOORE:** What other ways has the department considered to encourage the uploading of shared health summaries and other clinical relevant documents to the record? Are there other ways of doing it, apart from the GPs assisting people?

**Mr Madden:** I think the key piece in Ms Konti's earlier answer that only GPs are allowed to upload a shared health summary is: other health care providers in the community would use this system if in fact there were some clinical information in there—

**Senator MOORE:** We have talked about that before—about how health providers—

**Mr Madden:** Allied professionals, private hospitals and others. This is all about coordination and integration of information available across the care spectrum for a patient. If we go back to who would most benefit from a shared health summary, it would be those people who have multiple carers because of multiple chronic conditions. Again this would be the first part of facilitation—'I have a shared health summary that gives you my headline care plan for this patient'—allergies, medications, current treatments and those things. The next part, the contribution of events summaries, can come from other parts of the health sector, together with the discharge summaries coming out of hospitals, will start to build that picture. But we really need to inspire the GPs.

The other part that is coupled with this—remembering that it is three years since we implemented this system—is that we did some training for GPs three years ago and we heard loud and clearly that there were usability problems. Our colleagues from NEHTA, together with clinicians, have done a clinical usability study to improve the usability, but three years down the track we also need to provide some training, education and communication to support the GP community to get to the point where they are capable of doing it. That is all part of the program—

**Senator MOORE:** Is that part of the support needs you identified earlier?

**Mr Madden:** We have the capacity for training and education all the way from self-led programs through to facilitated workshops through to one-on-one peer based sessions for GPs. We also have that for the rest of the health community to get them engaged. For the GPs we do need to get them to the point where they are comfortable and capable of using the system. Getting them to take the first step, as Ms Konti said, towards a meaningful use will take some training. There cannot be any meaningful use until there is some information, and

you cannot get information if people are not confident about putting it in there. So we are trying to get all of those things together. The EPIP is only one part of that.

**Senator MOORE:** I have a few questions about NEHTA. When is the National E-Health Transition Agency expected to be abolished?

**Mr Fleming:** During this financial year.

**Senator MOORE:** June 2016?

**Mr Fleming:** Yes.

**Senator MOORE:** At this stage are you planning a redundancy process for that?

**Mr Madden:** I might answer that.

**Senator MOORE:** I know; it is very hard to ask NEHTA about their own redundancy. I feel uncomfortable about that.

**Mr Madden:** We have an implementation task force and steering committee—

**Senator MOORE:** Yes. That has been operational for a while, hasn't it?

**Mr Madden:** it has been in place for six or eight weeks now—to do the design of the new organisation and to do the planning of the transition of people, functions, skills and resources from NEHTA. But do not see this as moving the function of NEHTA to a new thing. It actually functions from within the department—the operations of the eHealth system—and, potentially, other functions need to be in this new organisation. But that transition task force will be and is working with NEHTA and with the department. As for functions moving, potentially, we will move the resources or the people that go with that, and any residual effects of that will be done in consultation with the organisations, and the communication lines will be open all the time.

**Senator MOORE:** Can you provide us, on notice, with who is on that task force or where they are from? If it is identifying individual public sector workers, I do not need the names. It is just to see what its make-up is.

**Mr Madden:** The list was published in a media release, so I am happy to—

**Senator MOORE:** I am sorry; I did not read it.

**Mr Madden:** That is all right. On notice, we can share the list of names; that is fine.

**Senator MOORE:** That would be great—and also the current structure of NEHTA, on notice as well. Thank you.

**Senator SIEWERT:** I have some questions for the Office of the Gene Technology Regulator. Do you have a time line yet for the public consultation process for the proposed amendments to the Gene Technology Regulations?

**Dr Cleland:** We have not yet finalised that process. We are still at an early stage in developing the papers that would go to that consultation.

**Senator SIEWERT:** In that case, how long do think it will be before you can set that time line—in other words, develop those papers for the consultation?

**Dr Cleland:** We are hoping to hold the consultation early next year. We are currently working on the papers. There are obviously some complex scientific issues at play there, and we are hoping to come to a point where we can have a sensible discussion not just with

technical experts and technical specialists but also more widely. At this stage, I cannot predict precisely when that process will be publicly available, but we are hoping to undertake that early next year.

**Senator SIEWERT:** It is not going to be sometime this year?

**Dr Cleland:** No.

**Senator SIEWERT:** Okay. When you say you are resolving those complex technical issues, do you mean in order to enable a broader public consultation?

**Dr Cleland:** The issues at play in a technical review of regulations are detailed scientific technical ones. You would be aware that we are also heading towards a review of the act. That would be a separate process to this technical review of regulations. At this stage, we do not have a clear view of how those two things might intersect, and we are still at a fairly early stage in looking at the technical aspects around the different technologies that are at play.

**Senator SIEWERT:** Do you mean in terms of the regulations, when you make that comment?

**Dr Cleland:** Yes.

**Senator SIEWERT:** Do you need to resolve that issue between the review of the act and the regulations before they go out? Is that what I take from that comment?

**Dr Cleland:** No. The technical review is really looking at the interface between the science and the legislation. The regulator operates a legislative scheme, and the legislation determines what is captured and what is not captured in relation to specific techniques of gene technology. So we need able to describe from a scientific perspective what those techniques are and then look at how they might be captured in terms of legislation. The other thing that is important there is the level of risk posed by those different techniques, so that is part of the preliminary work that we are undertaking at the moment.

**Senator SIEWERT:** That leads nicely into my next question: in terms of the techniques that are going to be excluded, are you still going through that process?

**Dr Cleland:** That is correct.

**Senator SIEWERT:** You cannot tell me, in fact, which techniques are going to be excluded, because you are still working that out. Would that be the correct?

**Dr Cleland:** That is correct.

**Senator SIEWERT:** Once you have done that, will that be open for public comment as well?

**Dr Cleland:** Yes. What we are planning to do is an analysis of the risks posed by the different techniques. You would be aware that it is quite a complex technical area.

**Senator SIEWERT:** Yes.

**Dr Cleland:** Some of these new techniques can do things that you could regard as similar to older methods of gene technology. It is a continuum that is really at play in this space. The scientific considerations are part of that analysis but also, I guess, the response from a wider perspective and other stakeholders is part of that consideration. We will look at it, primarily, from a scientific perspective and try to make recommendations that are commensurate with risk so that the regulation is commensurate with the risk.

**Senator SIEWERT:** When that documentation goes out, the arguments around which ones are in and which ones are out—I am trying to ask which ones will be in there. Of the ones that it will not cover, that will be excluded, will the arguments for their exclusion be presented?

**Dr Cleland:** Absolutely.

**Senator SIEWERT:** So arguments for what is in there and what is excluded will be in that process.

**Dr Cleland:** That is correct.

**Senator SIEWERT:** Thank you; I just wanted to double-check that. In terms of when the regulations go out for the public-consultation process, will the technical reviews be part of that process? You said the science has to be worked through. Will the actual reviews be part of that process released?

**Dr Cleland:** I would expect that the arguments being put forward will be part of that process. It is not clear to me, at this point, in our considerations, how widely those considerations will go. But the basis under which the decisions are being put forward, or the recommendations being put forward, will be part of those papers; those arguments go to how it should be regulated.

**Senator SIEWERT:** I might have to put some questions on notice. There are some documents that I would like tabled but they are quite long technical documents. I would like to ask if you could table attachment (A) to the document MS15001381 and attachment (B) to that document, if those are available, both the legal basis for the technical reviews of schedule 1 and schedule 1A of the GT regulations.

**Dr Cleland:** I am not quite clear what those documents are, but I am happy to take that on notice.

**Senator SIEWERT:** That would be appreciated. In terms of the drafting instructions, presumably, you are going to be preparing those after you have developed the paper.

**Dr Cleland:** We have not resolved that issue yet. As I said, we are still at quite a preliminary stage in this process.

**Senator SIEWERT:** Thank you. Do you need me to give you those numbers, again, or do you have them?

**Dr Cleland:** I have the first number.

**Senator SIEWERT:** I am after attachment (A) and attachment (B) of that document.

**Mr Bowles:** We will get it off the *Hansard*, anyhow.

**Senator SIEWERT:** Thank you, Chair.

**Therapeutic Goods Administration**

[20:20]

**CHAIR:** We will move to the TGA.

**Senator McLUCAS:** Professor Skerritt, I think you were in the room when I asked a question earlier about the hepatitis C drugs?

**Prof. Skerritt:** Yes.

**Senator McLUCAS:** I asked this question: what is the department's—maybe I should say, 'What is the TGA's position—

**Prof. Skerritt:** We are part of the department.

**Senator McLUCAS:** on doctors and patients establishing a so-called 'Dallas Buyers Club' to bypass the PBS and import hep C drugs, such as Harvoni and Sovaldi from China?

**Prof. Skerritt:** Thank you for your question. Obviously, I am not going to go into the reimbursement issues, but rather to the access and supply of medicines that are not, in this case, the Australian TGA approved substance.

We have done some work looking into what is proposed and what is being discussed on websites. There is still an investigation in process, and so we cannot comment in full detail. There have been several issues raised. The first is that in some cases the medicines being imported are finished medicines from those countries. There is such a thing as a personal import scheme, where individuals with a prescription from an Australian registered medical practitioner can import medicines for up to three months' worth of personal use. That is all quite legal and quite well characterised.

Apparently, in some cases—and again, an investigation is still in train—there are substances that are being imported not in their finished form. I should explain: there is a thing known as an 'active' pharmaceutical ingredient, which is essentially the concentrated medicine. In most lab tablets we have a filler, or an excipient, otherwise tablets would be so small that even with my glasses I could not see them. In this case, it is possible that they are not being imported in their finished form but as the starting material. Again, it depends on how that is provided. If it is compounded by compounding pharmacists for individual patients, and under a doctor's prescription, that is actually regulated under state and territory law.

The other thing that has come to our attention and that, again, is still being examined, is whether there have been any breaches of advertising. As you are aware, in Australia advertising of prescription medicines directly to patients is not allowed. Recently, when we became aware of this and some other issues of advertising prescription medicines directly to patients—and it sometimes happens with Botox in wrinkle reduction and other cosmetic surgery applications—we posted on the website, as well as communicating with a number of healthcare professionals, a statement clarifying what is and what is not allowed so far as advertising health services when they contain prescription medicines or pharmacist-only medicines. Essentially, you can advertise a service, saying, 'Yes, I'm doing wrinkle reduction surgery,' to use that as an analogy, but you cannot advertise the substance.

So there is still a range of investigations in progress. We are aware of groups doing this, and there are some analogies, as you mentioned, to the *Dallas Buyers Club*. But I should emphasise that this does not make this whole package necessarily illegal. It is an investigation still in progress.

**Senator McLUCAS:** Okay—I appreciate that, thank you. And when we go to questions around Silimed prosthetics?

**Prof. Skerritt:** Silimed. I might see if my colleague Larry Kelly is also available.

**Senator McLUCAS:** I understand that Silimed manufactures a range of prosthetic devices and the TGA has acted to place any further distribution and use of those on hold. Is that correct?

**Dr Kelly:** Yes, that is correct. The manufacturer in Brazil has been audited for compliance with good manufacturing practices and has been required by the Brazilian regulator not to manufacture or distribute any more product from that facility.

**Senator McLUCAS:** I understand it started with breast implants but now is a broader investigation. Is that right?

**Dr Kelly:** It was breast implants that brought the issue to the forefront. The facility in Brazil makes a whole range of implantable devices, using silicon as the base of the implant. More than 99 per cent of the products supplied in Australia from the facility are breast implants, but there are one or two other implants also from there.

**Senator McLUCAS:** What other devices are affected?

**Dr Kelly:** The only other one in Australia is a testicular implant.

**Senator McLUCAS:** How widespread is its use in Australia? I need to understand the population that is affected. How many people are we talking about with the breast implants or the testicular implants?

**Dr Kelly:** At this stage, information from the sponsor, going back to 2010, is that they have supplied about 30,000 breast implants. That is not to say that there have been 30,000 patients. It would be something less than 30,000. In terms of the testicular implants, it is in the low hundreds.

**Senator McLUCAS:** Should patients who have a Silimed implant have any concerns at this point?

**Dr Kelly:** No. The particles that have been found on the surface appear to be microscopic pieces of cotton, we believe, and in some cases microscopic silica-like particles. There is absolutely no evidence to date to show that they would pose any health risk to patients. That is being investigated. The full analysis to do a complete toxicological assessment is underway internationally, but at this stage the international consensus is that there is no cause for concern.

**Senator McLUCAS:** So the reason that they are being investigated by the Brazilian equivalent is around good manufacturing practice rather than contamination.

**Dr Kelly:** Yes.

**Senator McLUCAS:** Those are my words, so you can fix them up.

**Dr Kelly:** They are pretty close. The idea is that facilities that make therapeutic goods should operate under good manufacturing practice arrangements. In this case, in some of the implants there was found to be the presence of microscopic particles on the surface, and that is seen to be not producing the goods under good manufacturing practice. As a precautionary measure, the Brazilian regulator and other regulators have decided, just while the investigation is underway and just as a purely precautionary measure, to suspend any further supply of those particular devices.

**Senator McLUCAS:** Thank you. That is all I need to know.

**CHAIR:** Are we done with TGA?

**Senator MOORE:** I will put my question on notice.

**Australian Organ and Tissue Authority**

[20:29]

**Senator McLUCAS:** This is more of a question to the department: how much money has been spent to date by the Organ and Tissue Donation Authority, the National Blood Authority and the Department of Health to prepare for the merger between OTA and the Blood Authority?

**Mr Bowles:** I might have to take that on notice. Do we have a cost on that? It is not a significant amount.

**Ms Anderson:** It has been largely, if not exclusively, departmental resources.

**Mr Bowles:** It was just internal.

**Ms Anderson:** There has not been any external consultancy.

**Senator McLUCAS:** I understand that. Well, I did not understand it, but I do now. Can you put a figure on the departmental cost?

**Mr Bowles:** It would not be significant.

**Senator McLUCAS:** What are the latest instructions the minister has provided to the department, and also to OTA, around preparation for the merger?

**Mr Bowles:** When I was here in May, we were still working on the premise of 1 July, and 1 July has come and gone. Ultimately, what happens with the merger is still a decision for government. We are looking at options around how they remain as separate agencies, work closer together and what we might do in the longer term, but it is still a decision for government to make.

**Senator McLUCAS:** The minister has asked you to look at another way of achieving savings without merging—am I right?

**Mr Bowles:** We provided advice to the minister along those lines around what some other options are, if government was so minded, and that is still a decision for government.

**Senator McLUCAS:** What is the time frame for that decision?

**Mr Bowles:** There is no real time frame. As we have indicated, we have not spent a lot of money on this. The savings were not all that significant.

**Senator McLUCAS:** That is correct.

**Mr Bowles:** We have been working through how we can streamline some of the issues between the Organ and Tissue Authority and the National Blood Authority. Ms Cass and Mr McJames have been working quite closely together for a while, so we will continue to do that for the time being.

**Senator McLUCAS:** Minister, is it your decision or Minister Ley's decision?

**Senator Nash:** Ultimately, it is Minister Ley's decision, but I have responsibility for the agencies.

**Senator McLUCAS:** Can you give us any indication about when a decision might be made?

**Senator Nash:** I cannot give you a definitive time line. Obviously, government is considering the best way forward at the moment. It is appropriate to look at the review into organ donation that the department has initiated, which we now have the response as part of that, so I cannot give you a definitive time line.

**Senator McLUCAS:** Have you identified what moneys would be saved with a merger?

**Mr Bowles:** There was an early indication. I cannot remember what the exact amount was. Do you know?

**Ms Anderson:** Certain figures were provided to Finance. The actual budget figures were an amalgam of a number of anticipated mergers. They were not separately identified in the budget papers.

**Senator McLUCAS:** That is right. I remember now. What savings would have been achieved if a merger had gone ahead?

**Mr Bowles:** No. It would largely be around the accommodation footprint and some corporate service savings when you merge two together, but we are already looking at corporate services issues from a shared service perspective anyhow. The size of both organisations is not so large that the figure becomes significant.

**Senator McLUCAS:** And their purposes are so very different.

**Mr Bowles:** They have different purposes, yes.

**Senator McLUCAS:** Very different.

**Mr Bowles:** Similar operating models, but different purposes.

**Senator McLUCAS:** I think that is important. Just because they are dealing with bits of bodies does not mean—

**Mr Bowles:** But, again, some of this goes to similar operating models. We have a lot of agencies. That is why we are looking at things like shared services as another way.

**Senator McLUCAS:** I think I am pleased to be reading between the lines that you are giving me. The review that was called into organ and tissue donation, Minister, you said that review report has been provided.

**Senator Nash:** It has, yes.

**Senator McLUCAS:** What was the purpose of the review from your perspective, Minister?

**Mr Bowles:** That is probably best asked of us, because we did that. Mr Cormack or Ms Anderson, have you got the specific purpose?

**Mr Cormack:** The review was focused on examining how the organ tissue donation reforms were translated into policy and practice by the authority by the state and territory health authorities DonateLife. It also looked at the delivery by hospitals and DonateLife and other staff directly involved in the donation or transplantation of organs. It was drawing out key factors that have influenced the pace and extent of the achievements to date, and the value and use of performance measures. They were the broad areas.

**Senator McLUCAS:** When was the report received?

**Senator Nash:** Are you asking me?

**Senator McLUCAS:** Was the report to the department provided to this minister?

**Mr Bowles:** The report went to the department and we provided it to the minister. I do not know the specific time. Do you have that, Ms Anderson?

**Ms Anderson:** It was in August.

**Senator McLUCAS:** It was going to be an eight-week review, but it has taken 12 weeks? I cannot rap you over the knuckles for that.

**Mr Cormack:** There was a lot of interest in it from stakeholders, and we were keen to ensure that they all got their opportunity to participate.

**Senator McLUCAS:** Minister, when did you receive the report?

**Senator Nash:** I think it was about eight weeks ago—around 22 August, latish August. It was about eight weeks ago.

**Senator McLUCAS:** Around the same time?

**Mr Bowles:** Yes. We received the report, we would have done a quick review and then handed it on to the minister probably in late August, from memory.

**Senator McLUCAS:** Will the report be made publicly available?

**Senator Nash:** I am certainly intending to do that.

**Senator McLUCAS:** When would you like to do that?

**Senator Nash:** Hopefully reasonably soon. I am considering final response at the moment, so I would not expect that it would be too far away.

**Senator McLUCAS:** In one of our questions on notice, No. 542, you detailed that, in relation to organ and tissue donation, on 29 May 2015 there was a correction made to the 26 May 2015 media release. What was that?

**Senator Nash:** From memory—and I am happy to check—there were two issues. One was a typographical error that we corrected; the other was around some information that there was some disagreement about, so that was removed from the media release. But I am happy to clarify exactly what that was.

**Senator McLUCAS:** Could we have a copy of both the original 26 May document and the corrected 29 May document?

**Senator Nash:** Yes. I will take that on notice.

**Senator McLUCAS:** In question on notice No. 544 the department confirmed that OTA was invited to comment on draft terms of reference for the review. Could you please advise on whether each of the other organisations was consulted on the terms of the review before they were finalised? That is, the Intensive Care Society, the Transplantation Society of Australia and New Zealand—

**Mr Bowles:** My recollection is that OTA was the only one.

**Senator McLUCAS:** Only OTA?

**Mr Bowles:** Only one.

**Senator McLUCAS:** No other organisations at all?

**Mr Bowles:** No, because the review was into OTA and the department has a relationship there. It was my review and I asked the OTA to comment on it, and we went from there. In

fact I met the advisory board at some stage over this issue as well. I cannot remember exactly when, but I met with the advisory board around that time.

**Senator McLUCAS:** Minister, during the last Senate estimates hearings, in reference to which specific groups or individuals that had raised with you concerns that led you to calling a review into organ and tissue donation, you said:

I am very happy to take that on notice in terms of specific individuals or groups …

We did not receive an answer to that question on notice. It goes to the question we have talked about before, Minister; that sometimes you take a question on notice and it does not appear in the listings of QONs.

**Senator Nash:** My understanding was that that was answered. I am happy to check about this before the end of this evening for you.

**Senator McLUCAS:** That would be fabulous.

**Senator Nash:** My understanding is that that was supplied, but we will have a look at that.

**Senator McLUCAS:** If we could get a number for that, that might be useful.

**Mr Bowles:** If they come up, we make sure that they are answered. If it does not come up through the *Hansard* process—

**Senator McLUCAS:** Our process.

**Mr Bowles:** and your process, we probably would miss it. But if it is there, we would be definitely trying to answer those questions.

**Senator McLUCAS:** But if you could have a look to answer that question, that would be useful. If it does not appear, I wonder if you could furnish us with that.

**Senator Nash:** My recollection is that it was done, and that it was done on time. If that is not the case, I will come back to you before the end of the evening.

**Senator McLUCAS:** And I am working from a brief, so let us make sure of the remark.

**Senator Nash:** I was very conscious of the fact that you do have concerns about things that are taken on notice during the hearings processes. I am almost certain that it was done.

**Senator McLUCAS:** That is all I had for organ and tissue donation. But if you indulge me, Ms Cass, I did say last time that I hoped to see you again, and we did. And I hope to see you again in that capacity, along with Mr—

**Mr Bowles:** Sorry, Senator, you asked the question: can you provide on notice a list of organisations from the organ and tissue donation sector that you have met with this calendar year? Is that what you are saying? Is that the one that you are asking?

**Senator McLUCAS:** No. The quote that I am reading to you—sorry, I am not quoting now. The brief says 'in reference to which specific groups or individuals that had raised with you concerns that led you to calling a review into organ and tissue donation'.

**Mr Bowles:** First of all, I will clarify some of that. I called the review.

**Senator McLUCAS:** You did?

**Mr Bowles:** My recollection was: you did ask around who the minister had met with, which is 000468. So there is a list of five or six groups on that particular—so SQ15-000468 answers that. But in relation to the review, I called it.

**Senator McLUCAS:** I understand that. At the point in our conversation last time, that was not clear.

**Mr Bowles:** That is probably right. You asked that question, and then you came back and asked me some questions later on. And then, I think, I might have said that at the time. So that is probably what has happened.

**Senator McLUCAS:** Okay. I will follow up 000468 and see if that is, in fact, the one that we have asked for.

**CHAIR:** Was there anything else on outcome 7?

**Senator McLUCAS:** Have we talked to FSANZ?

**Senator SIEWERT:** That is next—

**Senator MOORE:** That is in the next program.

**Senator McLUCAS:** Okay. Thank you. I think that is good.

**CHAIR:** We will now move onto outcome 8, healthcare workforce capacity. Senator Wang.

**Senator WANG:** What is the rationale behind the decision to transfer students under the MRBS scheme to the BMP scheme?

**Ms Shakespeare:** In the last budget in 2015, the government announced changes to streamline a range of scholarship programs and related programs operated through the health portfolio. The Medical Rural Bonded Scholarship program and the Bonded Medical Places scheme are two parts of that broader budget measure.

**Senator WANG:** What is the reason for making that decision of having that budget measure?

**Ms Shakespeare:** There are, I suppose, a capped number of medical places in Australia. There is a lot of demand for those medical places. In that context, it was decided that the two bonded schemes could be combined together so that there are still the same number of doctors entering into bonded places but that the scholarship payments associated with the 100 places under the Medical Rural Bonded Scholarship scheme will cease. There will be no further intakes to that scheme after this year.

**Senator WANG:** Are there any budget savings from this measure?

**Ms Shakespeare:** There are, except the savings relate to the broader measure to combine several scholarship programs. So it is not just these two.

**Senator WANG:** I think the budget measures mentioned a saving of $72.5 million over four years by combining nine existing allied health workforce scholarships. What is the rationale behind that decision, to combine nine existing scholarships into one?

**Ms Shakespeare:** There will be a few benefits. First of all, having greater flexibility about the types of scholarships that can be awarded allows us to respond to changes in workforce supply and demand. The government has commenced work and has started publishing information about supply and demand forecasts for different workforces. Having a more flexible scheme that allows support to be provided to different types of students rather than just students in a particular profession will allow us to respond better to changes in supply and demand over time.

**Senator WANG:** The Mason review did recommend that some of the savings should be reinvested into scholarships supporting rural allied health students. Is there any reason why the savings will not be directed into those scholarships?

**Ms Shakespeare:** The scheme that will be established from next year will have priorities set. We are still consulting with various stakeholder groups, professions and people who administer the scholarship programs at the moment to work out what those priorities should be. I anticipate that one of the future priorities will be providing support to students from rural areas, based on the feedback we have received in our consultations so far. The new scholarship program will also support rural communities because in future there will be a rural return of service attached to most of the scholarships that are publicly funded, so once the new scholarship scheme is up and running there will be an expectation for the majority of students who receive scholarship funding that they will then complete a rural return of service once they have completed their studies and are qualified health practitioners.

**Senator WANG:** Okay. The Services for Australian Rural and Remote Allied Health organisations—SARRAH—will see a $4.5 million cut to their scholarship program. Can you tell me how many scholarship places that equates to?

**Ms Shakespeare:** We are not sure at this stage because we have not conducted the approach to market as to which organisation will administer the scholarship program once it is established from next year, so I am not sure that I can say that SARRAH, which may tender through that process, will be unsuccessful. It is probably a bit early to say that they will have a funding cut.

**Senator WANG:** Will SARRAH be invited to make a bid?

**Ms Shakespeare:** We are expecting that it will be an open approach to market—that is what has been announced by the government—so there will be nothing to prevent them from tendering to administer the new scholarship program.

**Senator WANG:** I assume, Minister, the reason for having an open market tendering process is to draw the cost down eventually.

**Senator Nash:** The priority is to make sure we have the best scholarship program running and the best organisation, consortia or whoever puts in a bid actually running it. It is probably appropriate to do that. Ms Shakespeare is absolutely right: it is a bit early to make any commentary about organisations having funding or not having funding, because we are going to go through that process and so it would absolutely be expected that they probably would be part of that tender process. I am assuming that they would. So until we go through all of that process, we will not know. There are savings in this. The government do not like having to do this. We are in the process of budget repair; we have to make some difficult decisions. We came to government with a trajectory to debt of $667 billion. We do not necessarily like doing this. At the same time we are having to do this, but we are streamlining it because we think it is going to be more effective doing the scholarships this way.

**Senator WANG:** I completely agree that whenever efficiency can be improved, you do as much as you can to make sure you improve that efficiency.

**Senator Nash:** Absolutely, and, if I may: I am from a regional area, the health minister is from a regional area, you probably could not have more focus on rural and regional issues from two ministers in the health portfolio than you have at the moment.

**Senator WANG:** But, as I understand it, the administration cost under SARRAH is actually very low. What sort of percentage is the department or the government expecting to get from the successful tender in terms of the cost of admin?

**Dr Southern:** The minister talked about streamlining. One of the things we will be doing through this approach to market is reducing the number of organisations who are administering different scholarship programs, bringing it into one. There will be an overall saving through having a single administrator of the scholarship program. That is part of the arrangement to achieve some of the savings.

**Senator WANG:** Does the government have a target, a minimum threshold in terms of how many scholarship places there will be after the tendering process?

**Mr Shakespeare:** No. We do not currently have minimum numbers for most of the scholarship schemes. There are some for the rural bonded scholarship that you mentioned before. That is because there are different types of scholarship applications, which change through every round. For instance, the Nursing and Allied Health Scholarship and Support Scheme supports a range of different types of scholarships. There is full-time undergraduate study, postgraduate study, and they can also be completed part-time. There are also continuing professional development scholarships, which are much shorter, and clinical placement scholarships supported. So the numbers of scholarships awarded each year will vary based on the types of applications that are received from potential scholarship students and also with changing priorities, because the current administrators also do prioritise scholarship awards at the moment.

**Senator WANG:** That probably leads to my final question. How will the budget saving, if I can say it is a 'cut', be shared among the states and territories?

**Mr Shakespeare:** There is not any plan to attribute to particular states and territories. The scheme, like the current scholarship schemes, will operate on a national basis. Again, we would expect to see variations over time between people studying across different geographic locations as well as across different professions.

**Senator WANG:** One final comment, if I may, Chair: Western Australia is very, very large. There are very remote areas. Keep that in mind, please.

**Mr Shakespeare:** We will.

**Senator Nash:** And a great state it is too, Senator.

**CHAIR:** We now move to outcome 1, population health.

**Food Standards Australia New Zealand**

[20:53]

**Senator MADIGAN:** I have some questions for FSANZ and the Chief Medical Officer. I believe that on three occasions in estimates questions on notice FSANZ has been asked whether it believes nanomaterials being used in food are safe. On two occasions I believe you failed to answer, simply noting that you are not aware of any nanomaterials being unsafe for human consumption. I believe the third time you were asked you indicated that information about foods that are potentially unsafe should be directed to the relevant state agency. Is FSANZ responsible for setting safety standards for food?

**Mr McCutcheon:** I will address your last question first. In a constitutional sense, the states and territories are responsible for the safety and suitability of food. They have the powers and they rely on state and territory legislation supplemented by food standards that we develop and that are approved by their ministers and are given effect through their laws. Going back then to your first and second questions around the questions on notice that you have put to FSANZ, we have been quite careful in responding to those questions, because, I guess in a general sense, nanoscale materials have been in the food supply for forever and a day. There are naturally occurring nanoscale particles in things like milk and there are nanoscale particles in a number of foods that are manufactured, including food additives. For any new or novel nanoscale materials, where the application of nanotechnology itself has been used, we are not aware of any of those being on the market and, if they were on the market, then they would be subject to an assessment by FSANZ in accordance with our application handbook.

**Senator MADIGAN:** Is FSANZ responsible for pre-market approval of novel foods and food additives?

**Mr McCutcheon:** Correct, yes.

**Senator MADIGAN:** Would you agree that if a novel food or food additive is potentially unsafe in one state, it is likely to be potentially unsafe in all others?

**Mr McCutcheon:** Not necessarily. In terms of nanoparticles themselves, it is not the size of the particle that is the issue; it is the property of that particular particle. If, for example, nanotechnology were used to create a new or novel property for a particular particle, and that then would have some impact on its toxicity, then clearly there would be a safety issue that would need to be addressed. That is why when we amended the application handbook in 2008, we made it a requirement that any use of nanotechnology to produce new or novel materials would be required to undergo a pre-market assessment.

**Senator MADIGAN:** Does FSANZ maintain that the use of nanosilica in food products is safe?

**Mr McCutcheon:** Based on the evidence that we have seen—nanosilica has been in the food supply for a long time in various forms, including in nanoscale sized particles—there has not been any evidence to date that suggests that there is a problem with it. That said though, we have commissioned some research by a toxicologist to examine the safety properties of both nanoscale silicon dioxide, nanoscale titanium dioxide and nanoscale silver to basically determine whether they may pose a risk to public health and safety through the oral ingestion route.

**Senator MADIGAN:** Is it or isn't it safe for human consumption?

**Mr McCutcheon:** At this stage there is no evidence to suggest that it is not safe, but our separate assessment of that will examine that evidence. I might add that one of the strategies that we use when looking at new technologies, including nanotechnology, is that we work very closely with overseas regulators, particularly the highly reputable ones like the European Food Safety Authority and the United States Food and Drug Administration, and both those bodies have not discovered any particular safety issues with those particular compounds.

**Senator MADIGAN:** Thank you.

**CHAIR:** We will break now until 9.15.

**Proceedings suspended from 20:59 to 21:15**

**CHAIR:** We will recommence now. The minister is just getting a cup of tea, but we are on FSANZ so I will go to Senator Siewert.

**Senator SIEWERT:** I wanted to pick up from where Senator Madigan left off, on the nanoparticles and nanotechnology. I am struggling now with what is and what is not classed as nanotechnology. You were talking, as you have in the past, about how you do not think there is substantive presence of nanoparticles in food, and now you are talking about 'novel'. I think it is pretty unclear—certainly to a lot of the people I have been talking to—what you are now classing as nanotechnology, what you test for and what the basis is of your claims that there are no nanoparticles in food when there clearly are. The FOE report demonstrated that. I want—and I think a lot of people want—a better understanding of what precisely is FSANZ's approach to nanoparticles or nanotechnology when it has been clearly demonstrated that we have nanoparticles in our food. You have said we do not, and now you are saying that it depends on what type they are and what they are there for. Can you articulate that for me, please.

**Mr McCutcheon:** I will do my best. 'Nanotechnology' describes a range of technologies used to manipulate materials, that are generally less than 100 nanometres in size in one dimension—that is one-billionth of a metre. That is the technology in a very broad sense. Nano-scale materials are really a subset of all of that. 'Nano-scale materials' describes particles in that size range, and—as I said earlier—they can exist in natural form, such as in milk. They can exist in a range of manufactured compounds, particularly when they are manufactured and get very small particles that can be in that range. When they start using nanotechnology to manipulate those particles, that is what we are interested in because that can then lead to potential changes in the characteristics of those materials, biologically or chemically, in the final form of the food.

**Senator SIEWERT:** Friends of the Earth, in the 14 products that they tested, found titanium dioxide and silica. How do you know that they were not in fact manufactured in the approach that you have just articulated? How do you know, if you have not been testing—and I understand you have not been—that those are not the very types of nanoparticles or technology that you have just described in that last comment?

**Mr McCutcheon:** Something like food-grade titanium dioxide is an approved food additive in many countries, including Australia and New Zealand. It is a pigment used to enhance the white colour of certain foods such as dairy products and candy—it gives a whitening effect. Clearly, if they were going to go down the path of actually using nanotechnology to make them all nano-scale materials that whiteness would disappear. There would be no impact, the product would be useless and they would not be able to sell it. In terms of assessing the safety of foods, the first thing we would look at is whether it is an approved food additive in whatever form. In the case of that particular compound—food-grade titanium dioxide—it was. In fact, all of the ones that report looked at were approved food additives in this country. So there is no evidence to suggest that it is anything more than the normal use of those food additives in food, recognising that there has always been the

presence of some nanoscale particles. Around 15 per cent of that food additive would be in the nano-scale range. That has always been the case and there is no evidence that it has been a health issue over the years.

**Senator SIEWERT:** So you are saying that in the past those particles were there anyway, regardless of whether they were put there. But now they are putting them there. So how do you know that there has not been something else done to them?

**Mr McCutcheon:** There is no evidence that anything has been done—

**Senator SIEWERT:** Have you looked for evidence?

**Mr McCutcheon:** We do not look for evidence. There is a very clear legal obligation on companies that if they start applying nanotechnology, including to approved food additives and compounds, and they start producing different effects then they have an obligation under law to bring that forward to FSANZ for an assessment.

**Senator SIEWERT:** What have you done about FOE's report to look at whether they have done anything different to those particular particles?

**Mr McCutcheon:** We did this before that report was released. As I said earlier in my evidence, we have commissioned a toxicologist to review those compounds to ascertain whether there are any food safety concerns when they are in their nanoscale form.

**Senator SIEWERT:** So you had done that prior.

**Mr McCutcheon:** Yes. I think we started discussions with the consultant in the second half of the last calendar year—the end of 2014—and started that work soon thereafter.

**Senator SIEWERT:** So you knew those nanoparticles were in those particular products.

**Mr McCutcheon:** Yes, we have known that for years.

**Senator SIEWERT:** Yet the public out there understand that, when you say there are no nanoparticles in foods in Australia, that means no nanoparticles in foods in Australia.

**Mr McCutcheon:** No, I think we have been careful in saying that there are no new or novel nanoparticles out there.

**Senator SIEWERT:** Given that you have now commissioned this report, you still do not know whether or not they are novel.

**Mr McCutcheon:** They are not novel compounds. They are approved food additives.

**Senator SIEWERT:** Why have you commissioned the report then?

**Mr McCutcheon:** Because there have been community concerns. We wanted to be very clear about assuaging some of those concerns in the public's mind. It is about confidence in the food supply chain.

**Senator SIEWERT:** But you cannot absolutely say that they are not different and not novel.

**Mr McCutcheon:** We will not know until we see the report.

**Senator SIEWERT:** That is why I came back to the point. You said you were very careful, but the point is that you cannot guarantee that they are not, until you see this report.

**Mr McCutcheon:** We cannot guarantee anything. We are a food standards agency. We do not go testing; we have not got those powers. We rely on evidence that is gathered both here

and around the world. As I said earlier, other regulators around the world have the same questions asked of them about the safety of nanoscale materials. They are on the same page as us: there is no evidence to support those contentions.

**Senator SIEWERT:** Have they looked for it?

**Mr McCutcheon:** I do not know offhand, but certainly the USFDA has more powers than FSANZ does. I would have to take that one on notice.

**Senator SIEWERT:** Could you please take that on notice. I do have a range of other questions. I will put them on notice. I have one more though. Has any manufacturer notified you that they are using novel—

**Mr McCutcheon:** No, we have received no applications.

**Senator SIEWERT:** Thank you.

**Mr Bowles:** I received a message the ASC ASADA will not be required. Is that correct?

**CHAIR:** That is my understanding from committee members. We had a couple of people who were listed who will no longer be showing up, so, unless there is an objection, we will not need sport.

**Senator McLUCAS:** We tried to organise an agreed way forward, but I am sorry that we could not.

**CHAIR:** The reason we are not doing sport is because people who were on the list pulled out.

**Senator McLUCAS:** No, let's be really clear. We have been prevailed upon.

**CHAIR:** They are people on the list who would have been coming and they are no longer on the list. That is why I have agreed.

**Senator McLUCAS:** So Labor does not go on the list, because we ask questions everywhere.

**CHAIR:** Okay. People who were on the list have chosen not to ask questions.

**Mr Bowles:** We are happy to put them on early next time.

**CHAIR:** Senator Leyonhjelm.

**Senator LEYONHJELM:** It is my understanding that during estimates on 17 October 2012—a while ago—Senator Fierravanti-Wells asked about assessing the effect of plain packaging on smoking prevalence. Mr Smyth of your department replied that a survey by Cancer Council Australia is 'the key survey we are looking at.' Dr Michelle Scollo of Cancer Council Victoria has reported the results of this survey: 'that tobacco consumption did not change in PP year 1 among daily, regular or current smokers or among smokers of brands in any market segment.' PP year 1 is the 12 months from 1 December 2012. I think it is 'plain packaging' year. Are you aware of that report by Cancer Council Victoria?

**Mr Bowles:** None of us were here in 2012, and Mr Smyth has moved on to another job, so we will not have too much detail.

**Dr Southern:** The report from Dr Scollo that you just provided the quote from is one of the papers that were published earlier this year? Is that correct?

**Senator LEYONHJELM:** Yes, it is fairly recent.

**Dr Southern:** I think they were the *British Medical Journal* papers that you referred to.

**Senator LEYONHJELM:** That is right. I have a copy here. You are aware of it?

**Dr Southern:** I am not aware of exactly which paper. I think there were about 15 papers in that particular publication.

**Senator LEYONHJELM:** Okay. To your knowledge, is there any flaw in the survey that Dr Scollo reported from Cancer Council Victoria?

**Dr Southern:** I think we are talking about two things. One was the actual tracking survey and the data that relates to the tracking survey. The articles in the *British Medical Journal* publication are the analysis of the survey, effectively. All of those articles were peer reviewed, so, in the view of the peers of the people publishing these articles, it was reasonable analysis of the data.

**Senator LEYONHJELM:** I have a copy of it here. It is in the article 'Tobacco control'.

**Dr Southern:** I know the package you are talking about, just not the specific article.

**Senator LEYONHJELM:** To reiterate: the conclusion in that was 'that tobacco consumption did not change in PP year 1 among daily, regular or current smokers or amongst smokers of brands in any market segment.' Is it fair to say that that is a reasonable conclusion? Does the department agree with it?

**Dr Studdert:** I think it is very important to be clear that that survey was set up to measure quite a few things in relation to the Plain Packaging Act and its implementation. Included in that are the mechanisms by which we expect the public health measure to work, and the data analysis that was presented in that supplement of the *British Medical Journal* go to a whole range of indicators around the effectiveness of the measure. To take one quote out of one article, I think, is a bit hard for us to comment on when we have an array of data which overall shows that, particularly around the mechanisms of the measure, there is a positive effect.

**Senator LEYONHJELM:** I guess the question is whether you have contrary data that is of this same standard.

**Dr Studdert:** The data are all from the same survey and obviously of a rigorous standard. The publications that were prepared based on those data are all peer reviewed, as Dr Southern said, and published in a top-line medical journal.

**Senator LEYONHJELM:** As is this one, yes. Let us go to the rigour of the data, because I think that is a relevant matter. The Health website states:

Treasury has advised that tobacco clearances (including excise and customs duty) fell by 3.4% in 2013 relative to 2012 …

Treasury has advised me that it provided this data to the health department because the health department asked for it. When you asked for that data, did you specify that you were asking for data to shed light on the impact of plain packaging, which was only fully operational from 1 December 2012?

**Dr Studdert:** I think the request for that data precedes both of us, so I would have to take that on notice and get some more information. But I guess it goes again to us looking at an array of indicators and data that go to us being able to track the implementation of the measure.

**Senator LEYONHJELM:** All right. The next question is: did you ask for data for the year starting 1 December 2012 and a year prior to 1 December 2012?

**Dr Studdert:** Again, I think we would have to take that on notice.

**Senator LEYONHJELM:** If you would, yes. Did you say to Treasury when seeking that data that you were trying to distinguish impacts arising from plain packaging and also impacts arising from the tax increase on 1 December 2013?

**Dr Studdert:** Again, I cannot say what we said—

**Senator LEYONHJELM:** No, it precedes you.

**Dr Studdert:** But I assume that was broadly what we intended to look at, yes.

**Senator LEYONHJELM:** I would like you to take that one on notice, too, if you would, please.

**Dr Studdert:** Certainly.

**Senator LEYONHJELM:** On 10 August 2015, the Treasury published total tobacco tax clearances data on its freedom-of-information disclosure log. Are you aware of that?

**Dr Studdert:** I am not.

**Dr Southern:** I was aware that that information became available around that time. I am not sure that I was aware that it was as a result of an FOI log.

**Senator LEYONHJELM:** The significance of this is that the data published by Treasury in this freedom-of-information disclosure log is monthly data which enables the aggregation of data for the year starting 1 December 2012 and the year prior to 1 December 2012. I assume my next question is a little redundant, because if you are not sure that the data exists then I presume you have not looked at the data yourself.

**Dr Southern:** I have not looked at it myself, no.

**Senator LEYONHJELM:** Well, Professor Sinclair Davidson from RMIT University in Melbourne has. He has taken the rolling 12 months, if you like, from 1 December, and he calculates that the change from one period to the next, following the introduction of plain packaging, was a reduction in tobacco clearances of 0.8 per cent. Can I put on notice a request for you to please look at that result and get back to us?

**Dr Studdert:** Is Professor Davidson's report available, Senator?

**Senator LEYONHJELM:** Yes, it is. It was not in a peer-reviewed journal, on the other hand. All he did was analyse the data, so it is not really subject to—well, you can analyse the data yourself, if you like. But I am more than happy to provide you with the source of that information.

**Dr Studdert:** Thank you.

**Senator LEYONHJELM:** Now, that has certain consequences in terms of the Tobacco Refund Scheme operated by Customs. Obviously, there are also issues in relation to refunds that occurred around that time. Because I have seen the paper by Professor Sinclair Davidson and you have not, I will not question you any further about that. But, if I give you this paper and the background to it, can I please ask you to take on notice questions in relation to the reliability of the 3.4 per cent reduction that you have quoted on your website?

**Dr Southern:** Yes.

**Senator LEYONHJELM:** There is one final piece: the postimplementation review. I have talked to the OP—

**Mr Bowles:** OBPR?

**Senator LEYONHJELM:** OBPR—yes. Acronyms still kill me. I understand that the process is still occurring of reviewing that, so I will not take too much time on that. But I am wondering: has the postimplementation review been shared with people other than OBPR at this stage?

**Dr Studdert:** No.

**Senator LEYONHJELM:** I have a tender document—which I did not bring with me, but I hope you will know what I mean. Who won the tender for the provision of services regarding electronic nicotine delivery systems? It was in that tender that I forgot to bring with me.

**Dr Studdert:** The University of Sydney is doing a piece of work looking at regulatory issues and other issues around electronic nicotine delivery systems.

**Senator LEYONHJELM:** So that is the service looking at regulatory issues?

**Dr Studdert:** Yes.

**Senator LEYONHJELM:** Thank you. That is what I wanted to know. Has anyone else been consulted about this provision of service on the subject of electronic nicotine delivery systems?

**Dr Studdert:** We have been doing quite extensive consultation in the first instance with the states and territories, and we are intending to go to a broader consultation.

**Senator LEYONHJELM:** It has been with state governments so far?

**Dr Southern:** Yes, that is correct.

**Senator LEYONHJELM:** And you are planning to go wider?

**Dr Studdert:** Yes, I believe that is the intention. So there will be a discussion paper for broader consultation later this year.

**Senator LEYONHJELM:** Later this year? So that is not much time to wait really.

**Dr Studdert:** No, not much.

**Senator LEYONHJELM:** Okay. That is fine. Thank you, Chair.

**CHAIR:** Thanks. Senator McLucas.

**Senator McLUCAS:** Thank you. I have some questions around smoking. Does the department have an estimate as to the economic impact of smoking in Australia?

**Mr Bowles:** In broad terms—we would not be able to speak on the full economic impact, but there is a significant health impact that I think is estimated to be anywhere around $30 billion.

**Dr Southern:** $13 billion.

**Mr Bowles:** Sorry, $13 billion.

**Senator McLUCAS:** $13 billion annually?

**Dr Studdert:** Sorry, I think it is actually $31 billion.

**Mr Bowles:** $31 comes to mind.

**Dr Studdert:** In social and economic costs.

**Senator McLUCAS:** Dr Studdert, that is the total cost of smoking?

**Dr Studdert:** The Collins and Lapsley data, which is often what we use for these estimates, was that the cost to Australia was $31.5 billion in social—including health and economic—costs. These data are actually a few years old now, but that is the most recent estimates.

**Senator McLUCAS:** Thank you.

**Mr Bowles:** It impacts about 15,000 people a year from memory as well.

**Senator McLUCAS:** You have read my brief, haven't you, Mr Bowles.

**Senator McLUCAS:** My next question is: how many people die each year?

**Mr Bowles:** About 15,000.

**Senator McLUCAS:** And the number of people who are seriously disabled, do we have that figure?

**Dr Southern:** The burden of disease—

**Senator McLUCAS:** The whole burden of disease data.

**Dr Southern:** I do not have it with me.

**Senator McLUCAS:** Take it on notice.

**Dr Southern:** We can take it on notice.

**Mr Bowles:** I have seen it before, but I just cannot recall. I just remember the 31 and the 15,000.

**Dr Studdert:** It would be many magnitudes greater than 15,000.

**Senator McLUCAS:** What has been the trend in people under 30 taking up smoking over the last decade?

**Dr Studdert:** I do not think we have any analysis for the under-30s. The National Drug Strategy Household Survey looks at 14-plus years and 18-plus years so we can segment out that cohort between 14 and 18. But the trend has been broadly declining. So fewer young people are taking up cigarette smoking.

**Senator McLUCAS:** Is there anything you can assist the committee with—in terms of the trend being a simple trend line in one direction or are there jumps in it?

**Dr Southern:** The decline between 2010 and 2013, which were the last two household surveys that have been undertaken, was at a steeper rate, if you like, than at any time in the previous 20 years.

**Senator McLUCAS:** Has the department done any work on attributing that to any particular measure?

**Dr Southern:** Over that period between 2010 and 2013—certainly plain packaging was introduced at the end of 2012. But there were other policy measures, I think, undertaken during that three-year period. There are cumulative effects.

**Dr Studdert:** It is actually very difficult to isolate any particular measure. It is certainly something that a lot of analysis is put into. But, yes, of course, there were tax increases; there were public information campaigns.

**Mr Bowles:** I think one of the pieces of evidence from around the world—after speaking to the UK, Ireland, Canada and a number of other countries that escape me at the moment—was that a package of measures in the tobacco control sense is the most effective way to deal with reducing smoking prevalence rates. And I think, if you look at the daily smokers issue over the last 20-odd years, you start to see a steady decline based on a range of those factors. But the biggest decline, as Dr Southern said, has been between 2010 and 2013. That was when all the cumulative things really started to mount up. At 2013 you get part of the plain packaging, but you also get the graphic warnings and the tax and a whole range of these cumulative tobacco control measures which, I think, have made some significant differences over time. That seems to be borne out over a lot of the conversations with the international groups at the moment. As you would probably know, there are many countries at the moment trying to follow what we have done in this country in a broad tobacco control sense.

**Senator McLUCAS:** Fantastic. Thank you. In terms of the trend for the 14-plus and the 18-plus cohorts, I am trying to get an understanding of how the trend is going compared to particular points in time. I take your point about the cumulative effect of a number of measures, Dr Studdert, but is there some way you can provide us with a time series, perhaps that goes from about 2009 through to now?

**Mr Bowles:** We could probably even go back a bit earlier on some of this. There are some good graphs that show the decline over the last 15 or 20 years, and it is quite steady. So we could take that on notice.

**Senator McLUCAS:** Thank you. Speaking of international comparisons, the level of tax charged on tobacco in Australia compared with other countries, how do we fare there?

**Dr Southern:** The rates are within the advisory band, if you like, from the World Health Organization, through the framework convention on tobacco control. But we would have to take on notice the actual comparison with other countries.

**Mr Bowles:** I think we are equivalent to some, and better than others. But we will take it on notice.

**Senator McLUCAS:** Thank you. That is great. Senator Leyonhjelm has asked questions on e-cigarettes so I am happy to leave it there. Thank you.

**CHAIR:** Senator Ludlam.

**Senator LUDLAM:** I have a couple of questions that are general for this section but also would like to ask the NHMRC to come forward if they are in the room.

**National Health and Medical Research Council**

[21:43]

**Senator LUDLAM:** Thank you for joining us. I am not sure whether this issue has been raised yet in estimates thus far. This might be a little bit new to you. I have a couple of questions relating to diagnosis, cure, management plans and treatment of myalgic encephalomyelitis, which is maybe more commonly known as ME or chronic fatigue syndrome. Is this the first time this has been put to you?

**Prof. Kelso:** It is certainly the first time it has been put to me, Senator.

**Senator LUDLAM:** Alright, here it goes.

**Prof. Kelso:** I could find out whether we are funding any research in that area. I do not know off the top of my head. I am not sure if we have a breakdown exactly of ME here. But we certainly—

**Senator LUDLAM:** I believe there is a very small amount of funding. So, while you look into that, I might just put some general questions to the secretary. I will put these to you, Mr Bowles: in terms of outside NHMRC grants, is there any Commonwealth support for people with this condition that you are aware? First of all, I presume you are aware of it?

**Mr Bowles:** I am aware of the disease but I am not aware that we do anything specific in ME. I would have to take it on notice to see if we do anything. I cannot think of anything I have seen while I have been around.

**Senator LUDLAM:** Yes, I have not been able to come up with anything. Can you go back and check—about any kind of support at all? I think there is a very small amount of support for a group in Victoria, which comes out of the state health department. That is actually just about all I have been able to find. There is a little bit of work done out of Griffith in Queensland. Do you have a sense of how many people are affected?

**Mr Bowles:** No, I do not.

**Senator LUDLAM:** I was perusing the Emerge Australia website a short time ago. They put modern estimates at 0.4 to 2.6 per cent of the population. In an Australian context that would be between 92,000 and 598,000 people. They also say on their website that there is no collective diagnosis, there is no cure and there is no management plan. I am struggling to think of a cohort of people in our community that large for whom there is so little. That is why I fronted up tonight, to see if you can help out. Have you been able to find anything in your file?

**Prof. Kelso:** Yes, thank you. I have just been advised that the NHMRC has provided a little over $2 million in funding between 2000 and 2013. So you are correct of course that the amount of money over all that has come from NHMRC is quite small into this area. I think it is very important to point out the way funding is delivered from the NHMRC. The great majority of it is in response to applications from investigators, and so they are then all competing for money on an equal footing, whether they are cancer researchers or ME researchers or multiple sclerosis researchers or whatever. The very small funding is, therefore, highly likely to reflect a very small number of applications. So it may be that we do not have a significant body of researchers.

We can allocate some of our funding to targeted areas of research, so areas of substantial and national significance will get special funding from time to time. Up to this point ME has not been one of those.

**Senator LUDLAM:** Who gets to decide when something is characterised in that way?

**Prof. Kelso:** It is a discussion; it can be suggestions that come from outside, maybe from the public. They are issues that might be discussed at that council of the NHMRC or the research committee of the NHMRC. But the types of areas that have been covered by targeted calls for research have been, for example, prevention of youth suicide in young Aboriginal

people, or foetal alcohol syndrome in Aboriginal people—very clear issues of national significance that we invest specific funds in from time to time. Even so, those funds tend to be on a rather small scale, and the great majority of NHMRC funding is in response to investigator iniated applications.

**Senator LUDLAM:** Okay. What was the phrase that you used just before—'national significance'?

**Prof. Kelso:** Yes, we define targeted calls for research, which will generally be in areas of national significance, yes.

**Senator LUDLAM:** I guess the other criteria would have to be national significance and sustained neglect—that is, work was not already being done in areas such as those you just named.

**Prof. Kelso:** Indeed. And of course there are many such areas. So these are very difficult decisions that are made from time to time.

**Senator LUDLAM:** This is still helpful.

**Prof. Kelso:** Good.

**Senator LUDLAM:** Those are decisions that are made by the NHMRC board?

**Prof. Kelso:** Yes. On the advice of the research committee and council.

**Senator LUDLAM:** Okay. So there are two scenarios that come into my head. One is that there could be a high number of low-quality research proposals that did not make the cut and did not seem worth pursuing; the other is, as you have suggested, a small number, and you have funded a small number.

**Prof. Kelso:** Yes. Those are the two broad extremes, but it could be something in between and it may be variable from time to time. I do not know personally the researchers who are involved, so I cannot comment.

**Senator LUDLAM:** Do you have at hand a rough description of what sort of research is being funded by you guys?

**Prof. Kelso:** No, I do not—on ME?

**Senator LUDLAM:** Yes.

**Prof. Kelso:** We can certainly look into that and get back to you.

**Senator LUDLAM:** I presume that kind of thing is not going to be commercial in confidence or related to national security issues.

**Prof. Kelso:** If it was, for example, a project grant or several project grants, they will have titles and descriptions that we can certainly release. They are in the public domain. We cannot provide information about unfunded applications, but we can certainly provide information about funded applications.

**Senator LUDLAM:** Could I ask you to pop that on notice for us if you do not have it with you at the table.

**Prof. Kelso:** Yes, of course.

**Senator LUDLAM:** One of the things that has been raised with me is that, as a consequence of the condition itself and what people suffer, it does not have very high

visibility in the community because the sufferers are not very active a lot of the time or their activity is highly contingent and unpredictable and people do not know when they are going to be well or not. Obviously, there are a very wide range of symptoms and the symptoms vary greatly between people. As a result, there is not a really high profile or visible set of peak bodies arguing and clamouring for their space at the table. Maybe this is not within your remit; this might be better put to the department, or perhaps I should look to the states, but I wonder whether, at a federal level, you can help advocacy or those sorts of groups to be able to raise their profile a little given the unusual circumstances faced by people with this condition.

**Dr Southern:** Certainly the department has just been out to market for grant funding for peak bodies. That approach to market has closed, but it was widely known in sectors that there was an opportunity to seek grant funding for peak bodies. So there is a possibility, of course, that that might have occurred for the ME peak body—I do not know the name of the peak body. There are sources of funding for those sorts of organisations.

**Senator LUDLAM:** I do not want to detain the committee—this is probably stuff that I could find out offline—but, on notice, if you like, so that we can move on, would you let us know where I can find a little detail about that particular category of funding. I presume that is an annual round that opens and then closes.

**Dr Southern:** It is not necessarily annual. We have opened the approach to market this year. What I do not know is whether it was for single-year funding or longer. It was for a longer period, so it is not an annual grant round.

**Senator LUDLAM:** What is the approximate total amount of money that you are able to see some of these small groups with?

**Mr Bowles:** While Mr Cormack is finding that, one other option, Senator, might be to talk to the Public Health Association. They might be a good group to talk to as well. The CEO of that is Michael Moore. You could have a chat to him. He might have some idea about how that plays out in his world.

**Mr Cormack:** The figure is $31.2 million over four years.

**Senator LUDLAM:** Does that mean, if you are a group who either missed out or did not know that that was happening, you have to wait another four years before you can come to the table?

**Mr Cormack:** It was an open approach to the market, and we do that in a way where we publicly advertise it. It is generally meant to lock in a known funding round for a set period of time. So it is unlikely that we will be running some interim arrangement between now and when this funding comes up for renewal in 2018-19.

**Senator LUDLAM:** I might try to twist your arm and talk you into making an exception, but that is probably a conversation for another time. Thank you very much for your assistance. If anything occurs to any of you after the committee hearing that might assist, I would greatly appreciate it.

**Senator MADIGAN:** Professor Kelso, would you please briefly outline to the committee the process to ensure community confidence in the disclosure of all possible conflicts of interest, be they commercial, ideological or otherwise, of NHMRC appointed experts who are deciding who gets research funding.

**Prof. Kelso:** When people are approached to evaluate grant applications and particularly to sit on our committees, we rely on their disclosure of all relevant interests. There will be a disclosure up-front of any interests that they might have that could bear on their sitting on the committee, but, if they are faced with individual applications which might bring up an additional conflict of interest that had not been realised until they saw the nature of that application or perhaps the identities of the applicants, then they have an obligation again to declare that conflict and be removed from the assessment process.

**Senator MADIGAN:** Is there a process when members of the public believe that one of the appointed experts citing research funding has a conflict of interest and has not declared that conflict of interest? Is there a process for members of the public to approach the NHMRC with their accusation or queries? Can you direct us to that if there is one?

**Prof. Kelso:** If a member of the public were concerned, they would be welcome to get in touch with the NHMRC and we would investigate it. We will go back to the individual and explore with them the nature of that possible conflict of interest and then, if there is a conflict of interest or a perception of a conflict of interest, there will be a consideration of whether that truly is one that would prevent them being able to participate in the process. It is a point that is taken extremely seriously by the NHMRC.

**Senator MADIGAN:** Are those investigations currently available to the public to see the methodology of how you have gone about the process of investigating those public claims in the event they have been made?

**Prof. Kelso:** I invite Samantha Robertson to comment on what we could put into the public domain if it were required.

**Ms Robertson:** We have a number of processes in place. We have a complaints policy on our website and people can provide information in a named sense and also anonymously, and we do follow up any complaints quite rigorously. Obviously, where they are sometimes of a personal nature, we are very limited in the information we can feed back to the complainant. Also, sometimes it is very difficult when they have not provided their contact details.

**Senator MADIGAN:** In the event that a member of the public provides you with their contact details and they are asking a query of the NHMRC, will you disclose to them how you have gone about your investigation?

**Ms Robertson:** We can certainly talk about the process that we have taken, but sometimes that can get a little bit difficult, depending on the nature of the complaint.

**Senator MADIGAN:** Is there a defined process that the public can view as to how complaints or queries are addressed?

**Ms Robertson:** I cannot recall that we have a standard operating procedure, but we certainly have a complaints policy.

**Senator MADIGAN:** Thank you.

**Senator RHIANNON:** How many grants have been made that involve using dogs or cats in animal experiments over the last two years?

**Prof. Kelso:** I would need to take that on notice. I do not have in my papers before me in numbers of that type. The numbers will be low, from my knowledge of what we fund, but I think it is better if we provide you with some specific data.

**Ms Robertson:** There is a significant lag in the information that we get. Obviously, grants go for either a three-year or a five-year period, so, in terms of what people apply for in use of animals and what they end up using, can differ quite markedly. It is not until the research is finalised and the report comes through to the NHMRC that we can go back and look at that. The information that we would have now would be from maybe 2011.

**Senator RHIANNON:** I might ask for a longer period. I was going to request a certain breakdown, so I will put that in a notice. Are you aware of where the animals come from?

**Prof. Kelso:** For dogs and cats, we would not normally be aware of where they come from. The individual grant applications may have that information, but it is not information that we collect. The specific issues about where animals are derived from, where they are looked after and all of those issues, are handled by institutions within state jurisdictions. Apart from the final reports we get on numbers of animals used by each project, we do not have detailed information that relates to the housing or deriving of those animals.

**Senator RHIANNON:** So you do not collect that information?

**Prof. Kelso:** We do not. But the bureau of animal welfare, or the equivalent in each state and territory, would be the appropriate body to collect that information.

**Senator RHIANNON:** Since the beginning of 2014, has the NHMRC funded any research using non-human primates?

**Prof. Kelso:** Since the beginning of 2014? It is possible. Again, we would be able to provide numbers specifically on that. We will not be able to provide numbers on actual numbers of animals used, but we would be able to provide you with information about any research grants that have been awarded that proposed the use of non-human primates for the research.

**Senator RHIANNON:** Do you need to take that on notice, or do you have that data?

**Prof. Kelso:** We have some information—

**Senator RHIANNON:** I did not think it involved many animals.

**Prof. Kelso:** We do have some numbers here. I do not know how many project applications, but we know that in 2013 we had a total number of 125 animals that were requested to be used.

**Senator RHIANNON:** 125?

**Prof. Kelso:** Yes.

**Senator RHIANNON:** Which primates were they?

**Prof. Kelso:** They are most likely to have been marmosets or macaques, but I do not know from the data in front of me here. Again, we can find that out for you. What I can also tell you from the numbers we do have from earlier reporting is that, in general, the numbers used are far fewer than the numbers requested to be used in the original proposal.

**Senator RHIANNON:** Were they animals bred in Australia? Is it correct that there are three primate breeding centres in Australia to supply animals for these experiments?

**Prof. Kelso:** I know of two: one in Melbourne and one in Sydney. I do not know whether animals can be imported for any research. Ms Robertson might know the answer to this.

**Ms Robertson:** There is a requirement under the animal welfare code for the care and use of animals used in research that animals are sourced from Australia in the first instance. If animals do need to be sourced from outside Australia, then a very strong case needs to be put forward with a declaration under the CITES treaty.

**Senator RHIANNON:** I might put something more on notice, but I can come back to that. In the June 2014 budget estimates I was advised that the code of conduct for the care and use of animals for scientific purposes provided measures to avoid duplication of research involving animal experiments. This was in answer to my question about why a national database is not maintained to ensure animal experiment research is not duplicated and results made available to other researchers. I was just interested in how effective the code of conduct for the care and use of the animals is and how that is operating.

**Prof. Kelso:** It is not the role of the NHMRC to monitor that aspect of the use of the code. Our role is to provide the ethical framework and to update it from time to time based on experience with the recent version and the advice of many people in the area, whether they be users of animals or ethics experts or others. Our role is to provide that framework. Any administering institution that receives funding from the NHMRC for research that uses animals must agree to abide by the terms of that code. The code is relied on very heavily by the institutional animal ethics committees, which provide approval in each institution—in my experience, a very rigorous process—for research that is done. All of the monitoring happens at the level of the institution, the animal ethics committee and the state or territory bureau of animal welfare or equivalent.

**Senator RHIANNON:** Is that picking up this issue of duplication, or is there nobody covering that?

**Prof. Kelso:** I do not know myself how it would pick up the issue of duplication.

**Senator RHIANNON:** It sounds like it is something that may not be covered. from the way you have described how it works.

**Ms Robertson:** The code itself is premised on the three Rs. It is around reducing, refining and replacing, where possible. Certainly at NHMRC we have tried to embed the whole idea of reducing and replacing animal use where possible. We have had eminent speakers come out to Australia in the past, where we have webcast their presentations to young researchers to try and get people thinking about a reduction of animals used in research where it is possible.

**Senator RHIANNON:** From the way you have described it, it would seem as though the next step would be to be proactive about duplication. It sounds as though you are raising awareness, but there is no follow through.

**Ms Robertson:** I think the difficulty is what the remit of the NHMRC is and what we can do within the limited resourcing that we do have. As Professor Kelso has already said, we do provide the ethical guidance. Animal welfare is one area where the code has been enacted in legislation in each state and territory. We would see any action that would be taken to actively do something in that space as the bailiwick of state and territory governments.

**Senator RHIANNON:** So it is not an issue of a lack of resources; it is more that your brief does not lend itself to that work. Is that how you would describe it?

**Ms Robertson:** Yes.

**Prof. Kelso:** May I add, though: there is another level, where it is not monitored by us, but it is taken into account when assessors view grant applications for work. They take into account whether the work has already been done. If it is a straight duplication where there is no value from duplication, then that ought to be picked up by assessors during the review process. Sometimes, though, it is critical that there is duplication. The most important research must be duplicated. There cannot be an automatic exclusion of research because it repeats and builds on something that has been done before, because that is an essential part of the research process. But a straight duplication for no extra benefit would be picked up in the peer review process and would reduce the competitiveness of the application.

**Senator RHIANNON:** Thank you. That is very useful.

**CHAIR:** Senator Madigan, you have questions for the Chief Medical Officer—

**Senator McLUCAS:** I have questions for the NHMRC.

**CHAIR:** Okay. I will go to Senator McLucas.

**Senator McLUCAS:** Can I ask what discussions the NHMRC has been involved in regarding the establishment of the Medical Research Future Fund.

**Prof. Kelso:** I am aware, as CEO of the NHMRC, that under the legislation I have a seat on the medical advisory board for the MRFF, which is an excellent situation for us. I am aware that that will formally occur in due course, but in the meantime we await the work of government to appoint the other members of the board. There have been no detailed discussions at this stage, but we are not expecting there to be until the board is announced.

**Senator McLUCAS:** Will the NHMRC be responsible for administering any of the MRFF grants in any way? There have been conversations during our legislation inquiry to this effect.

**Prof. Kelso:** We understand that NHMRC presents one of the options for the minister in deciding how grants might be administered. If the minister were to seek to establish a funding scheme where it was appropriate to draw on NHMRC's peer review processes, then we understand that that is highly likely that that would occur. Beyond that, we await the advice of the minister.

**Senator McLUCAS:** So no discussions around putting that into place have been had to this point?

**Prof. Kelso:** I think at this stage, until the advisory board is appointed and can do its work to establish the strategy and the priorities and the minister can determine how to work with those priorities to establish whatever funding schemes might emerge, it is a little uncertain. It is probably premature to have those discussions.

**Senator McLUCAS:** So you have not been advised of the first meeting of the board as yet?

**Prof. Kelso:** No, I have not.

**Senator McLUCAS:** What role have you had in developing the MRFF's strategy and priorities?

**Prof. Kelso:** As the board has not been appointed yet, the work has not started.

**Senator McLUCAS:** Has the NHMRC been consulted on who should be on the MRFF advisory group?

**Prof. Kelso:** I have not.

**Senator McLUCAS:** When is the next round of NHMRC grants expected to be announced?

**Prof. Kelso:** The award of grants, or new schemes? May I confirm which one.

**Senator McLUCAS:** The next round of program grants—when are they expected to be announced?

**Prof. Kelso:** There is a package of grant announcements which will happen soon. That includes this year's program grants, project grants, many fellowships, centres of research excellence and some other things.

**Senator McLUCAS:** Has there been any delay in that announcement?

**Prof. Kelso:** No, the process is happening as it usually does. The successful and unsuccessful applicants have been advised under embargo, just in the last days—at the earliest possible point in fact, and with the approval of the minister. I apologise, the program grants will be in December; I thought that they were in the list that went—so will then be announced.

**Senator McLUCAS:** Is that the normal timeframe for those grants?

**Prof. Kelso:** Program grants are out of cycle with many of the other grants schemes, so yes. The notice is given a long way ahead of when the program grant will start. Whereas for project grants, where the funding will start from 1 January and the announcement is some time around this part of the year, the program grants are announced more than a year ahead of the funding start, because they affect people's broader strategy. When exactly it is in December, or whenever, will make very little difference to the applicants.

**CHAIR:** No more for the NHMRC, I understand?

**Senator McLUCAS:** Chair, can I just indicate we are still trying to give aged care three quarters of an hour, so I would propose that at 10.15 pm we move to aged care.

**CHAIR:** I suspect that we will get there but I am not going to be artificially cutting off Senator Madigan who may be the only person who still has questions in this area.

**Senator McLUCAS:** I have plenty more questions, but I am prepared to stop at quarter past.

**CHAIR:** If you want to give up your questions at quarter past that is fine. I think it is only Senator Madigan and yourself who have questions? Is there anyone else?

**Senator SMITH:** I have funding issues in aged care.

**CHAIR:** Sorry, no, but in where we are now.

**Mr Bowles:** Sorry to be difficult, Chair, but, Senator Madigan, I think you are more in outcome 9, not outcome 1. Is that right? Are you after Q fever?

**Senator MADIGAN:** I have questions of the Chief Medical Officer.

**Mr Bowles:** Yes, that is probably outcome 9.

**Senator MADIGAN:** No, it is not outcome 9.

**CHAIR:** What was your line of questioning, Senator Madigan?

**Senator MADIGAN:** To Professor Baggoley.

**CHAIR:** But the particular area that you will be questioning him?

**Senator MADIGAN:** Sleep deprivation.

**Mr Bowles:** Sleep deprivation.

**Senator McLUCAS:** I have that.

**Mr Bowles:** You talk about sleep deprivation. I can sometimes. Senator Madigan is asking about the appropriate time of that—exactly—very good timing actually!

**CHAIR:** We are all experiencing it.

**Senator MADIGAN:** Professor Baggoley, during the recent Senate inquiry into wind turbines, many submitters to the inquiry described health and sleep problems they were experiencing when exposed to excessive noise, not just from industrial-scale wind turbines. A number of New South Wales residents told the committee, in Sydney, about their unenviable exposure to industrial coal mining noise and described sleep deprivation and serious health problems. They raised alarm at the lack of effective regulation by state authorities and despaired at their action to prevent this excessive noise. Do you accept that excessive noise pollution can cause sleep disturbance and deprivation?

**Prof. Baggoloey:** I have no expertise in sleep deprivation or the causes of it. Obviously I think we have all been deprived of sleep when there has been noise adjacent to us—be it loud music, parties, or whatever—but this is a specific issue that you are raising in relation to wind turbines, and I think the committee that has been established—

**Senator MADIGAN:** No, I am talking about noise generally.

**Prof. Baggoloey:** 'Noise generally' is a very broad and vague term—

**Senator MADIGAN:** Industrial noise.

**Prof. Baggoloey:** I have no expertise in my clinical career or in my role here in relation to sleep deprivation. Obviously, I can take questions that you have on this on notice. I suspect that the committee that has been set up to look at the effects of wind turbines—I think there is a sleep expert that will be on that committee—and that expert will be able to answer the questions you have.

**Senator MADIGAN:** Do you accept that sleep deprivation can harm health?

**Prof. Baggoley:** Again, getting me to wander into this area is not going to be profitable. I can look things up and provide you with—

**Senator MADIGAN:** You can take it on notice.

**Prof. Baggoley:** a more complete answer, if you so wish. I think you have experts on hand and I, therefore, do not think it will be profitable to speculate on the other questions you have.

**Senator MADIGAN:** Are you able to tell the committee why the 2004 enHealth report: *The health effects of environmental noise - other than hearing loss,* published by the federal health department, was shelved and why this report's once urgent recommendation has never been acted upon by successive Commonwealth governments and state departments of health?

**Prof. Baggoley:** No, I cannot explain that to you, at all. In 2004 I was running the emergency department at the Royal Adelaide Hospital—suffering sleep deprivation during that process—but, again, that is a question that would have to be taken on notice; it is 11 years old, obviously.

**Senator MADIGAN:** Would you be able to take on notice: does the federal health department have any plans to work in this neglected area of public health in the interests of preventing further serious damage to the health of Australian citizens from excessive noise pollution, regardless of the source of that noise?

**Prof. Baggoley:** Certainly, we can take it on notice. It may well be something that the Environmental Health Standing Committee or the Australian Health Protection Principal Committee could examine and report back to that committee on. That could well be a good source and tie in with the 2004 report of the enHealth committee.

**CHAIR:** I think that is all from outcome 1.

**Senator McLUCAS:** I would just indicate, Professor Baggoley, we put some questions on notice to you around the bowel-screening program, particularly around false negatives. We have a particular issue we have raised with you.

**Prof. Baggoley:** Okay; thank you.

**CHAIR:** Before we move onto outcome 11, I just want to check on outcome 9. Senator Madigan has how long, on outcome 9?

**Senator MADIGAN:** I have a couple of questions around outcome 9.

**CHAIR:** Is it five minutes or so?

**Senator MADIGAN:** Yes.

[22:17]

**CHAIR:** We will not ask those officials to go home; we will try to get there after outcome 11. I will go to Senator Polley.

**Senator POLLEY:** I am seeking some clarification from the response, minister, you gave this morning in relation to your charter letters. You said you were not prepared to respond as to whether or not they are being received. I want to seek some clarification about the responsibilities of the parliamentary secretary on aged care. Just so we can get things into perspective about the areas he is going to look after, will he be doing ribbon cutting, will he be visiting aged care homes and will he be responsible for the Aged Care Gateway? Can you give us an indication of his responsibilities?

**Mr Bowles:** I gave an answer to this morning, that he would have responsibilities around aged care. I think he also has an interest in service-delivery aspects and things like that. I would imagine, and I think it would be up to a conversation between Minister Wyatt and Minister Ley about, specifically, some of those sorts of issues—but, if I let my mind wander for a second, it is probably appropriate that he would get engaged in some of those sorts of things.

**Senator POLLEY:** Moving on, this morning there was discussion in relation to funding of programs. I want to clarify whether or not, when ageing was over in DSS, there was a streamlining of the reform process they were going through. During that time, when ageing was exiled over there, there was an acknowledgement that largely the aged care funding programs were untouched. I just want to confirm whether the minister or the department are aware that there will not be any additional cuts to funding in that area.

**Mr Bowles:** You are referring to the question you asked me this morning?

**Senator POLLEY:** Yes.

**Mr Bowles:** That was in relation to our flexible fund budget measures from 2014-15 and 2015-16 potentially. They are quite specific to the 14 funds within that old health portfolio, not in relation to aged care in that way. That was the context of the conversation this morning, in the context of our flexible funds budget measures.

**Senator POLLEY:** Thank you for that. The health minister has been quoting the number of Australians living in residential care to be about five per cent of the population. Can you tell me what she basing that figure on? I thought it was higher than that. Or can you give me the current figures?

**Mr Bowles:** I have not heard her refer to that but I might ask a colleague to answer.

**Ms Moody:** The five per cent figure refers to the population over the age of 65. Approximately five per cent of that population is in residential aged care.

**Senator POLLEY:** Over 65.

**Ms Moody:** Yes.

**Senator POLLEY:** I thought it was somewhere around seven to eight per cent. I just wanted to clarify that that was the most up-to-date figure.

**Ms Moody:** I believe so.

**Senator POLLEY:** The new minister also has been talking about primary healthcare networks and that they will be given responsibility and benchmarks for aged-care services. Can you explain to me what that means?

**Mr Bowles:** I think that was slightly out of context. I think there was a broader issue that the minister was talking about around primary healthcare networks, and she referred to the future around the potential of some issues in the aged-care sector working with the primary healthcare networks. I am not sure that there is a direct relationship with any of that at this particular point in time. I think the broader conversation we have had in this room—the minister has been talking about primary healthcare networks—is that they are out there now, there is enormous opportunity around a range of different mechanisms when you get into a commissioning arrangement, which they will, and there might be some options into the future around future arrangements from a commissioning perspective around mental health, around aged care, primary health care, Indigenous care—a whole range of different mechanisms. I think it was in that context that the minister was talking.

**Senator POLLEY:** So it was not then in relation to the Commonwealth Home Support Program or the Home Care Packages or amalgamation of the two?

**Mr Bowles:** Not that I am aware of, no.

**Senator POLLEY:** There is a lot to get through in a short amount of time. I was wondering if we could move on to population ageing, which is terminology that has been used in the past. Can you explain to the committee what your understanding is of population ageing? I am just relating this back to the fact now that we have a minister for aged care rather than a minister for ageing.

**Ms McCarthy:** Healthy ageing, the wellbeing of people as they age, and the importance of older people having choice and control in their lives informs everything we do. Indeed, that is a common theme in the ongoing discussions we have with the aged care sector. The

department, of course, has specific responsibility for the aged-care system. There are a whole range of issues around ageing more generally that involve a range of other Commonwealth departments. So, as I said, it is something that informs everything that we do, but we are not the only department with responsibility for considering those issues. Obviously, it goes to issues, including the social security system and Treasury's responsibility for the *Intergenerational report*—a whole range of policy areas are informed by notions of population and ageing and their importance for society as a whole.

**Senator POLLEY:** I was just a little confused after Senator Nash gave evidence in response to some questions where she told the committee that ageing and aged care are interchangeable.

**Senator Nash:** I don't think I used that word.

**Senator POLLEY:** I was just wondering if you could outline whether the department—

**Senator NASH:** Senator, I don't think I used the word interchangeable.

**Senator POLLEY:** I am sorry, that is what we took from—

**Mr Bowles:** Maybe to get a little clarity: the Minister for Health, the Minister for Aged Care, the Minister for Sport and Ms McCarthy, the deputy secretary, are looking at an area within the now health department called ageing and aged care.

**Senator POLLEY:** So it is the department of—

**Mr Bowles:** Health.

**Senator POLLEY:** So when a 65-year-old visits a GP, is that aged care?

**Mr Bowles:** It will depend. There are broader issues of ageing with a 65-year-old, yes; however, when a 65-year-old visits a GP, it is a normal GP visit.

**Senator POLLEY:** Yes, I was going to say: I think anyone who is over 65 would not want to necessarily be referred to as aged care.

**Mr Bowles:** That is exactly right, and we deal with that all the time in the primary healthcare sector now, but there are specific definitions around this over-65 issue that keep coming up.

**Ms McCarthy:** The 65-year-old threshold is an artefact of the 2010 health reforms. When we talk about the aged-care system, we are talking about people in their 80s, as you would be aware, generally speaking.

**Senator POLLEY:** It is just a little confusing now with the changes. I wish to move onto dementia—and I am sure you will be able to answer all my questions on this. I want to know what is happening to the flying squads, because they do not seem to have taken off as yet.

**Ms McCarthy:** I think you may be referring to the Severe Behaviour Response Teams, which was an initiative that arose out of the Ministerial Dementia Forum, the first forum, that was held last year. The selection process has been completed, and we expect an announcement very soon.

**Senator POLLEY:** My understanding was that the funding round closed in July, so can you tell me the name of the successful tenderer or tenderers? How many tenderers were there?

**Ms McCarthy:** The form in which the name of the successful provider will be made public—I am not at liberty to share that with you tonight.

**Senator POLLEY:** So it ended at the end of July, and it has been 15 or 16 months since funding was cut for those who are caring for people with severe behaviour problems associated with dementia. We are now in October. My understanding was that it was supposed to be up and running by September, so what has been the delay?

**Ms McCarthy:** I think the applications closed in July, but then of course there had to be a selection process. Given the sensitivity of the initiative and the fact that it was the first of its kind, as with any selection process, that was done very carefully and took a number of weeks. At the last estimates, we indicated that we were looking at a September time frame. We are few weeks out from that but, as I said, an announcement will be made very shortly.

**Senator POLLEY:** How many applications were there?

**Ms Moody:** I will correct this, if I need to: I think there were just under a dozen. It is in that vicinity—it was not two and it was not 50, let me put it that way.

**Senator POLLEY:** Somewhere between eight and 12.

**Ms Moody:** Something like that—if I haven't got that quite right, I will correct it.

**Senator POLLEY:** I appreciate that. Can you tell me whether or not there will be one national provider?

**Mr Bowles:** It is a matter for the minister.

**Senator POLLEY:** So the department is not aware whether there will be one provider or providers based around the country.

**Mr Bowles:** That is not what I said: it is a matter for the minister to make the announcements and talk about those outcomes.

**Senator POLLEY:** That is likely to be when exactly?

**Mr Bowles:** Soon.

**Ms McCarthy:** Very soon, Senator.

**Mr Bowles:** It is a matter for the minister.

**Senator POLLEY:** By the minister—okay. Stage 2 of the flying squads is to begin mid-next year. Essentially, that involves rolling out DBMAS—is that correct?

**Ms McCarthy:** Stage 2 involves, essentially, bringing together the Dementia Behaviour Management Advisory Service, which is the second tier, with the Severe Behaviour Response Teams, which are the top tier in our Dementia Advisory Services. Ms Moody can provide more information on the bringing together of those two programs.

**Senator POLLEY:** That would be really good, because I would really be interested in the quantum of funding for DBMAS—what that would be from July next year and what period that would cover, if you could, please.

**Ms Moody:** Some of those details are still to be worked through, but it is certainly true that with the introduction of the Severe Behaviour Response Teams we have not quite doubled the amount of specialist dementia advice provided to aged care providers through DBMAS and the Severe Behaviour Response Teams, so we would expect the envelope of the program to be that combined envelope. If I give you the 2015-16 numbers that will move indexes out, but for the Severe Behaviour Response Teams in 2015-16 the budget is $12.7 million. The DBMAS budget for 2015-16 is $14.4 million. I can give you the indexed

numbers out if you want, but they basically just index out and increase. So the combined program would be the total of those two amounts.

**Senator POLLEY:** Will be flying squad contractor and the DBMAS contractor be the same organisation from July 2016?

**Ms Moody:** If you mean the existing contractors, not necessarily. If you mean going forward would we see that being an integrated service, while the policy design of that phase is still to be worked through it would generally be our intention that that would be so.

**Senator POLLEY:** How do you see that working?

**Ms Moody:** In terms of phase 2?

**Senator POLLEY:** Yes.

**Ms Moody:** That would involve us restructuring the program to bring together those different elements as well as, potentially, working through what a selection strategy might be for providers in that space.

**Senator POLLEY:** Can you outline—because it could not be given to us at the last estimates—how these flying squads are actually going to work in practice.

**Ms Moody:** I will give you some detail. There are actually three parties involved in this. There are the residential aged-care providers themselves and they have responsibilities under the Aged Care Act, including to provide individual attention and support to residents with cognitive impairments as well as to people with behavioural disorders to access their necessary treatment, although not necessarily to provide the treatment themselves. They also are required to provide programs to enhance the quality and life of care of such residents and ongoing support to monitor and enable their lives as well as providing access to appropriate health specialists in accordance with the care recipients' needs and preferences. That is the providers themselves, who, in fact, provide most of the care for people in residential care with dementia, and will continue to do whatever other support programs we have in place.

**Senator POLLEY:** They used to get additional funding for those with severe behavioural problems, which has been cut.

**Ms Moody:** The additional funding in residential care for people with dementia comes through the Aged Care Funding Instrument, which is the primary instrument through which residential providers are funded. The behavioural domain has a number of different layers within it that allow for increased funding for those with more complex behavioural things. The supplement that you are referring to was intended to provide extra funding for a very small number of residents who exhibit behavioural and psychological symptoms of dementia, but, as we have talked about in previous estimates, rather than being very narrowly targeted at the original intended number of about 2,000, by the time the supplement had been in place for a year it was actually being claimed on behalf of 33,000 residents.

**Senator POLLEY:** Because the government took their eyes off the ball. But if we can move on—we are going over history and we will run out of time. In September 2014 there was the Ministerial Dementia Forum, which agreed to undertake yet another stocktake. But at this time we have not seen any reporting on that. Can you give us an update of what KPMG delivered in terms of a final stocktake?

**Ms Moody:** The review of the dementia programs was a recommendation of the first dementia forum. The report was delivered to the department at the very end of September. The department is currently working through considering that and considering what advice it will provide to government in that context. We expect the report to be provided to the minister in the near future—maybe in a couple of weeks. But, clearly, when we get a consultant's report we do not just send it on; we actually like to look at that and consider the findings and recommendations, to provide advice to government about how it should respond to that. We are in that process at the moment.

**Senator POLLEY:** You are in that process at the moment. So there is no way that we are going to have that tabled for the committee's benefit now. Isn't that late? Wasn't it due in midyear?

**Ms Moody:** I think it was always due early in the second half of the year. But, certainly, there was a great deal of enthusiasm by parties to be consulted by the consultant. There is always a trade-off in these things about how quickly you can do them versus how much time you actually allow people to engage with it and be part of the process. We have certainly tried, as much as possible, to make sure that stakeholders have the opportunity to be involved and be heard in that process, and that that is reflected in the report.

**Senator POLLEY:** Yes. But you would agree that dementia is the second-leading cause of death here in Australia. So we have had forums, and surely it is not beyond expectation that the government, having cut the dementia severe behaviours issues supplement—

**Senator Nash:** There is more involved, Senator—from $11 million to $135 million—

**Senator POLLEY:** that there would not be an overarching need to have a strategy for dealing with dementia—

**Senator Nash:** That is why we have changed the way we are approaching this.

**Senator POLLEY:** in this country. So it is not beyond the expectation, surely, of the Australian community and those people who are caring in the aged care sector and within the community to have an overarching vision and policy for this country when it comes to dealing with people who are living with dementia. So when can we expect to see one?

**Ms McCarthy:** Senator, you may be aware that the Council of Australian Governments has come together and agreed on the National Framework for Action on Dementia. That was agreed recently and published. It lays out seven priority areas for action, ranging from increasing awareness and risk reduction through to promoting and supporting research.

**Senator POLLEY:** When are we going to have the announcement that actually outlines the clear national framework for those people living with dementia in this country? I acknowledge the money that has been put into research, but the reality is that there are so many people now who are living with dementia and we have seen no vision and we have seen no programs going forward that are going to give us a comprehensive framework for this.

**Ms McCarthy:** I do not want to stray into my population health colleagues' areas, but the research that the government is funding currently includes—but certainly does not only include—research into the causes of dementia and how dementia might be treated. For example, one of the grants announced recently is for a researcher to lead a trial based on some work in Sweden to better train aged-care workers to care for people who are living with dementia. So the research funding is not just about medical research.

**Senator POLLEY:** You have just opened up another area that I want to explore for the benefit of the committee, and that is: when are we going to see some progress in relation to developing a strategy for dealing with the workforce and—something that is becoming a critical issue—ensuring that we have an adequately trained, skilled workforce that also has a career path?

**Ms McCarthy:** As you are probably aware, by the end of this year the minister will be receiving a document that will be prepared by the Aged Care Sector Committee called the road map for aged care, which is looking at the future of aged care and the additional steps that need to be put in place to see the reforms that have been established come to their full fruition. One of the issues that we are discussing with our stakeholders is the issue of meeting the workforce challenge, and we are paying particular attention to getting a very clear understanding of what is within the government's remit and what is within stakeholders' remit. For example, you are aware that aged-care providers have obligations under the Aged Care Act to have the appropriate number of appropriately trained people in their employment and that it is a responsibility of all employers to put in place the leadership, governance and human resource management systems et cetera to make their workplaces attractive places to work. So we are working very closely with the sector to understand what role government should play and what role other stakeholders should play to help meet those workforce challenges.

**Senator POLLEY:** Can you confirm that there was a meeting on 5 February 2014 at which the minister and the assistant minister of the time met and discussed a proposal for a workforce supplement? That is over 20 months ago, and you are telling me now that you are still no further advanced and that we have to wait till the end of the year. In Tasmania, as you would be well aware, over the next five to 10 years we are facing a shortfall of over 5,000 people needed to work in the aged-care sector. If the sector themselves cannot alone address this issue, surely it should be the government's priority, I would have thought, to ensure that all Australians are going to be able to have the care that they need whether they are in their own home or in a residential aged-care situation. Surely, 20 months on, the government should have some idea about what they are going to do and how they are going to address this. It is not something new.

**Mr Bowles:** Let me have a go at that one.

**Senator POLLEY:** I would appreciate it.

**Mr Bowles:** I cannot talk about what might have happened in February this year or last year in the context of aged care. What I can, though, talk about in a broader sense—and my workforce people are not here anymore—is that we in the Department of Health have quite a specific workforce committee that sits under AHMAC, and there are a whole lot of responsibilities within the states and territories as well as the Commonwealth in looking at the broader workforce issues. I think the real benefit we can really bring to play now is how we have that conversation, even though there might have been conversations in the past. I am not going to get into that, because I was not there, obviously.

**Senator POLLEY:** That was still part of the experimental time in DSS.

**Mr Bowles:** Again, I am not going to go to characterisations about what might or might not have happened. It is now part of the health department. The minister will obviously get

across all of those issues. From my perspective as the secretary of the Department of Health, workforce more broadly is an important issue and we will focus on that and raise a range of issues in the context of AHMAC, because this is not purely something that the Commonwealth is going to solve. There is a broader sector issue. There is a states and territories issue. So we will deal with that. And I do know that the workforce committee of AHMAC have been having significant conversations, particularly from the states' and territories' perspectives, about what they need to do themselves to start to address the workforce needs for nursing more broadly—and I do not mean only registered nurses; I mean enrolled nurses, assistants and all of the different groups in that particular space. That will go to the long-term issue around workforce in the aged-care sector.

**Senator POLLEY:** You do, then, acknowledge that it is a priority issue that the sector themselves, let alone older Australians in the community, are looking for. I will put a lot more questions on notice because we are running out of time; there is still so much to discuss, and so little has been advanced. I will now move onto another issue that has been raised with me. I move around a lot within the sector and I am sure the department would be very much aware that there are real concerns and issues around the gateway. It does not seem to be working in the way it was perhaps intended. Could someone give me an update as to whether there has been any attempt to address the concerns? I am not the only one who is hearing that people have a great deal of trouble navigating through it.

**Ms McCarthy:** When new functionality was introduced on 1 July, including the central client record and the screening and assessment for referral to regional assessment services, the gateway did not operate in the way it should have and the performance was not up to the standards expected. The reasons for that included a much higher than expected volume of calls and correspondence; some difficulties with the ICT system itself; and some issues to do with providers not interacting with the system in the way that, through our education and communication, we had asked them to. The news as of now is much better. An enormous amount of effort has gone into dealing with those problems. My colleague Ms Buffinton can provide you with the latest statistics. I think you will find that things are much improved.

**Ms Buffinton:** Since the briefing we gave you just prior to 1 July, as Ms McCarthy outlined, the volume of calls and correspondence coming in was much higher than we expected. We have been very open and transparent with the sector, and I think the feedback from the sector has been very positive. Indicatively, we look at things like the average waiting time, which, in July and early August, was between seven and 10 minutes. The maximum waiting time was between 30 and 40 minutes. The backlog of referrals was reaching just beyond 10,000 and referrals to the assessment were well down in the early part.

The system was working as we would expect by about the end of July. But there was, of course, a lag effect on that; we acknowledge that reputational risk we took in July. But I am pleased to report that by mid-September we had a waiting time of less than two minutes and by October it was less than one minute. The absolute maximum waiting time would be under 10 minutes in the course of a day, with no backlog, and around 4½ thousand people being referred on a weekly basis through to, for example, the new regional assessment service. So we had quite a lag effect, which is understandable, from July, when people were coming through with views on that, through until October. The National Aged Care Alliance and

many other organisations, both consumer and provider, are acknowledging where that is going.

That was just worrying about the numbers through to the end of September. Clearly our focus now moves to not just quantitative but qualitative—how effective is the movement of people? Are they effectively getting the right referral and the right assessment? It is heading in a very good direction.

**Senator POLLEY:** I am still hearing concerns about the lack of referrals. I still have a heap of questions, so I will have to put them on—

**Senator SMITH:** To be fair, I think it is important to acknowledge the tremendous work the department has done in changing that original position.

**Senator POLLEY:** Could I just finish? I was halfway through something, Chair. I had not even finished.

**Senator SMITH:** But I know you are gracious, Senator Polley.

**Senator POLLEY:** You can make your point when I have finished.

**Senator SMITH:** I just think it is worth acknowledging the great work the department has done.

**Senator POLLEY:** I had not finished.

**Senator SMITH:** I just think it is good to acknowledge that they—

**Senator POLLEY:** I had not finished. I have not interrupted you and I would appreciate you not interrupting—

**Senator SMITH:** Are you about to acknowledge the great—

**Senator POLLEY:** I have very little time left.

**CHAIR:** Senator Polley, you are out of time, but was there a final comment?

**Senator POLLEY:** Yes. I wanted to thank you for that information. I have a lot more questions I will put on notice. There are a lot of questions I will put on notice about consumer directed care, because quite simply we have not had time.

**Senator SIEWERT:** I want to go issues around the continuing problems about Medicare payments. I know I have to ask DHS tomorrow, but my overarching question is: is this feedback about ongoing problems coming back to you? I have asked about this and we have had other discussions about it. Are you continuing to get that feedback? I am certainly continuing to get it.

**Ms McCarthy:** We are aware of those issues in relation to DHS, payment issues and waiting times on 1800 lines. There were issues around the accuracy of letters. There were also issues around more than one letter being received with different information in each. That information was not necessarily incorrect but simply reflected different circumstances at different times.

We have been working very closely with our DHS colleagues on these issues. I am not going to speak for them in detail, but the advice we have is that many of the issues around, for example, inaccurate payments have been resolved and are in the legacy basket. We are also working very closely with DHS to get better at communicating to providers and consumers about the process so that, when some of that information is received that looks as though it

might not be correct, there might be a better understanding of why the process causes that to be so.

**Senator SIEWERT:** What I am hearing is not about the legacy issues. I understand the legacy issues, that they are ongoing. When there is specific case management things are getting resolved, but there are current, ongoing difficulties. That is what I am being told. I will pursue that with DHS tomorrow, obviously.

**Ms McCarthy:** We will take that on board and continue pursuing these issues with our colleagues in DHS, with whom we work closely and meet regularly because we know these issues have been of concern.

**Senator SIEWERT:** Depending on where we go tomorrow, I might put some more questions on notice. I only have a very limited amount of time. I want to go back to dementia and ask about home care. I will put some questions on notice about it, but I am getting feedback that some providers think that the dementia and cognitive care supplement for home care is being underutilised. Is that the feedback you are getting?

**Ms Moody:** Ms Balmanno is probably better placed to answer that than I. There was some confusion when the residential supplement went and people were a bit concerned. The in-home care supplement clearly still exists.

**Senator SIEWERT:** The feedback I am getting is particularly that people think it is underused. There is a disconnect between different ACAT assessments and eligibility for the supplement. Have you had that feedback? What are the numbers suggesting in terms of usage?

**Ms Balmanno:** The dementia and cognition supplement, as you know, is still a relatively new supplement.

**Senator SIEWERT:** Yes.

**Ms Balmanno:** Certainly the expenditure for the 2014-15 year was below estimates for that year. Those estimates were obviously based on a general understanding of likely dementia rates rather than the sort of detailed evidence we have in residential care about rates of dementia and needs. The estimates themselves may not be 100 per cent accurate because it was such early days, but we do also seem to have lower than expected claiming at this stage. We have had some conversations with the peak bodies, for example about patterns, and we are certainly looking into the patterns of the claims to see if there is anything systemic that is causing concerns or barriers to claiming.

**Senator SIEWERT:** To follow up on that, what is the timeframe for that process?

**Ms Balmanno:** I would have to take that on notice.

**Senator SIEWERT:** Thank you.

**CHAIR:** Senator Madigan on outcome 9, wasn't it?

**Senator MADIGAN:** I will table further questions on Lyme disease acknowledging the late hour of the night, but I have some quick questions around Q fever. I understand one of the side effects from Q fever is that it can cause pregnant women to abort. Are you able to confirm that and any other side effects caused by Q fever on humans and how Q fever can be spread?

**Prof Baggoley:** Thank you for your question. I have the benefit of our pathologist colleague, Dr Gary Lum, being here. He can talk to that.

**Dr Lum:** Thank you very much.

**Senator MADIGAN:** I would appreciate just a brief thing, and then if you could take it on notice if you prefer a broader explanation.

**Dr Lum:** Sure. The spectrum of clinical manifestations of Q fever ranges from acute infection to chronic infection. You mentioned the issue of pregnant animals—it can be humans and it can also be other animals in particular—and it is a well-known cause of abortion in animals. When I say 'abortion', I mean spontaneous abortion. The other complications associated with chronic Q fever are associated with the heart and with the liver and occasionally, and rarely, with neurological symptoms. By heart, I mean endocarditis. It is usually a culture-negative endocarditis, and for the liver it is normally an acute and sometimes chronic granulomatous hepatitis.

**Senator MADIGAN:** And human abortion?

**Dr Lum:** Occasionally.

**Senator MADIGAN:** Would it be reasonable to think that Q fever can be spread at a livestock sale yard?

**Dr Lum:** It is a well-known phenomenon that when you are dealing with parturient animals, particularly with the birth products—that is, the placenta and the amniotic fluid—of animals when they are being processed, that is a time when there is risk of transmission of Q fever.

**Senator MADIGAN:** Are young people who reside close by to an area infected with Q fever at more or less risk than others?

**Dr Lum:** I am sorry, I missed the first part of your—

**Senator MADIGAN:** Are young people who reside close by to an area infected with Q fever at more or less of a risk than others?

**Dr Lum:** It is an interesting question. The people who are at most risk to abattoirs and meat processing areas are the workers in those areas. So long as there is good animal handling, body handling and disposal practices, particularly of placentas and birth products, the risk mainly occurs to those who are close to the area. We do know though that the organism that causes Q fever, *Coxiella burnetii*, is quite resistant to the environment and to disinfectants. It can survive for long periods of time in the dust and therefore can form aerosol. So dust can be transmitted in the wind, for example, and it has been know that that can occur for up to a kilometre or a little bit more. In theory, and it has happened, occasionally you will find that there are people outside of a meat works and outside of an abattoir situation who develop Q fever disease. That is why it is important from a public health perspective that people who live around those areas are aware of that, particularly the GPs who are looking after those patients.

**Senator MADIGAN:** Can children be immunised against Q fever?

**Dr Lum:** Q fever immunisation is not recommended in children. The reason for that is that the immunisation preparation is a fairly crude preparation. It is made by formalin inactivation of the organism itself, so it is quite reactogenic. There are many processes that

are required for the immunisation of people against Q fever. They include the need for skin testing or antibody testing and a quite a good history taking—asking about potential exposure.

**Senator MADIGAN:** Finally, with this in mind, would it be reasonable to build a livestock saleyard within one kilometre of a rural primary school where the area is known to be subject to flooding?

**Dr Lum:** I cannot comment on the relevance of the flooding, and I am not really in a position to comment on whether it is good or bad to have a primary school present near a meat works. As I said, a lot of the activity in terms of public health is around the proper management in the meatworks.

**Senator MADIGAN:** I will place further questions on notice.

**CHAIR:** Thank you very much. Before we conclude, senators are reminded that written questions on notice should be provided to the secretariat by the close of business, Friday, 13 October. Minister, Mr Bowles, officials, thank you very much and also to the Hansard, broadcasting and secretariat staff.

**Committee adjourned at 23:01**