Chapter 2
Health Portfolio

Department of Health

2.1 This chapter outlines key issues discussed during the 2014–2015 additional estimates hearings for the Health portfolio.

2.2 The committee heard evidence from the Department of Health (department) on Wednesday 25 February 2015. Areas of the portfolio and agencies were called in the following order:

- Whole of Portfolio/Corporate Matters
- Acute Care
- Independent Hospital Pricing Authority
- Primary Health Care
- National Mental Health Commission
- Medicare Locals
- GP Superclinics
- Access to Medical and Dental Services
- Private Health
- Private Health Insurance Ombudsman (PHIO)
- Access to Pharmaceutical Services
- Health System Capacity and Quality
- Australian Organ and Tissue Donation and Transplantation Authority
- Therapeutic Goods Administration
- National Industrial Chemicals Notification and Assessment Scheme (NICNAS)
- Healthcare Workforce Capacity
- Population Health
- Food Standards Australia New Zealand (FSANZ)
- National Health and Medical Research Council
- Sport and Recreation
- Australian Sports Commission (ASC)
- Australian Sports Anti-Doping Authority (ASADA)

Whole of Portfolio/Corporate Matters

2.3 The committee began by discussing Australia's response to the Ebola outbreak. The committee heard that the World Health Organisation (WHO) has an emergency committee on Ebola of which the Chief Medical Officer, Professor Chris Baggoley, is a member.[1] The Ebola committee is charged to provide advice to the Director-General of the WHO as to whether there is still a public health emergency of international concern, which the committee unanimously agreed was still the case.[2]

2.4 The department advised the committee that as of 17 February 2015, 135 patients had been admitted to the Aspen treatment facility since it opened, with 83 patients being discharged and 44 patients who had died.[3] The department outlined that all three West African countries—Sierra Leone, Liberia and Guinea—have committed to move to zero cases, but challenges of ongoing issues of community attitudes, traditional practices and trust should not be underestimated.[4]

Outcome 4 Acute Care

2.5 The committee discussed the shared funding arrangements between the Commonwealth and each state and territory as set out in the National Health Reform Agreement in regards to hospital cuts.[5] In regards to a question on cuts to various hospital districts in New South Wales, the committee was informed that:

> …in any discussion of cuts, we cannot possibly have visibility of the budget agreed between a state or territory department of health and their local hospital networks. That is a matter for them.[6]

Outcome 5 Primary Health Care

2.6 The National Mental Health Commission (NMHC) discussed the quality of data they had received for the review of mental health programs and services.[7] Mr David Butt, NMHC Chief Executive Officer, explained that 'if you not only look at mental health but health more broadly, there is significant variation at a local level in terms of access, scope of services, outcomes and cost'[8]. In terms of the review providing an accurate picture of mental health services and programs in the country, Mr Butt explained that:

> …it provides a very good analysis, particularly of what the Commonwealth is doing. Again, in all of these areas, there is a lack of the type of data that is required to drill down about what is happening locally and how you bring

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1 *Proof Estimates Hansard*, 25 February 2015, p. 9.

2 *Proof Estimates Hansard*, 25 February 2015, p. 9.

3 *Proof Estimates Hansard*, 25 February 2015, p. 26.

4 *Proof Estimates Hansard*, 25 February 2015, p. 7.

5 *Proof Estimates Hansard*, 25 February 2015, p. 17.

6 *Proof Estimates Hansard*, 25 February 2015, pp. 17–18.

7 *Proof Estimates Hansard*, 25 February 2015, p. 42.

8 *Proof Estimates Hansard*, 25 February 2015, p. 42.

> together data on what the Commonwealth is funding with data on what the states are doing and what the private sector is doing. It is not a complete picture of what is occurring across the country but it is I think the most comprehensive picture that has been done.[9]

Outcome 3 Access to Medical and Dental Services

2.7 The department discussed with the committee the Medical Treatment Overseas Program. The committee heard that for the program, a patient makes an application with the support from their local specialist, with the application then evaluated against four criteria.[10] They go to:

> …whether there is proven evidence that the treatment overseas provides benefit and that that treatment, or a suitable alternative, is not available in Australia.[11]

The department used the example of a certain technology called a proton beam, which is not available in Australia but for which there is good evidence that in 'certain rare tumours, it provides a benefit that is well in excess of locally available treatments'[12].

Outcome 6 Private Health

2.8 Under this outcome, the committee discussed with the Private Health Insurance Ombudsman (PHIO) the intended merger with the Commonwealth Ombudsman.[13] The committee heard that legislation is currently in Parliament to facilitate the change of the functions of the PHIO to the Commonwealth Ombudsman, with no intention of the proposed legislation to increase the powers of the PHIO. Mr David McGregor, Private Health Insurance Ombudsman, explained that the intention is that the change with have 'as little impact on consumers or the industry as possible'[14]. The PHIO will continue to produce publications, including their quarterly and annual reports and State of the Health Funds Report, and individual health fund report cards will continue to appear on the website.[15]

Outcome 2 Access to Pharmaceutical Services

2.9 The committee sought an update on the Pharmaceutical Benefits Advisory Committee's recommendation that Zostavax be listed on the National Immunisation Program to prevent shingles and post-herpetic neuralgia.[16] The department explained that medicines for the National Immunisation Program go through a different process than listing an item on the Pharmaceutical Benefits Scheme. As the National

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9 *Proof Estimates Hansard*, 25 February 2015, p. 43.

10 *Proof Estimates Hansard*, 25 February 2015, p. 72.

11 *Proof Estimates Hansard*, 25 February 2015, p. 72.

12 *Proof Estimates Hansard*, 25 February 2015, p. 72.

13 *Proof Estimates Hansard*, 25 February 2015, p. 76.

14 *Proof Estimates Hansard*, 25 February 2015, p. 78.

15 *Proof Estimates Hansard*, 25 February 2015, p. 79.

16 *Proof Estimates Hansard*, 25 February 2015, p. 84.

Immunisation Program is administered through the states and territories, the medicine goes through a tender evaluation process. The process requires liaison with the states and territory governments as to how programs would be best administered, for example in schools, early childhood or in the elderly community.[17]

Outcome 7 Health System Capacity and Quality

2.10 The committee discussed with the Therapeutic Goods Administration (TGA) what the process is for a recall in Australia and internationally. The committee heard that 'almost all recalls in Australia and globally are voluntary recalls', usually initiated by the sponsor.[18] Once the TGA is advised of what the issue is, they look at the assessment of the issue and after negotiations, agree with the level, depth and extent of the recall. The final delegation is with the TGA and if no agreement can be met, the TGA can use their mandatory recall power.[19]

2.11 The TGA outlined that they are notified of overseas recalls through the local sponsor who is obliged to inform the TGA of overseas recalls.[20] The TGA will do their own risk assessment to determine whether they need to do the same level of recall in Australia, considering factors such as what the local impact would be, what 'the local distribution arrangements are and whether or not the same product [or] batch in being supplied in Australia'[21].

Outcome 8 Healthcare Workforce Capacity

2.12 The department discussed with the committee the role of the Specialist Training Programme. The program operates under funding agreements the department has with 12 medical specialist colleges to allow particular types of specialists to gain experience towards their qualification as a fellow of a medical specialist college.[22]

In the last few rounds, the objectives of the program have been 'to expand training capacity by providing training posts in non-traditional settings such as private hospitals and community based practices and in rural and regional areas as well'[23]. There have been priority rounds to target specialities that are in greater shortage such as 'training for Aboriginal and Torres Strait Islander doctors and also posts where services can be provided to Aboriginal and Torres Strait Islander people'[24].

17 *Proof Estimates Hansard*, 25 February 2015, p. 84.

18 *Proof Estimates Hansard*, 25 February 2015, p. 92.

19 *Proof Estimates Hansard*, 25 February 2015, p. 92.

20 *Proof Estimates Hansard*, 25 February 2015, p. 93.

21 *Proof Estimates Hansard*, 25 February 2015, p. 93.

22 *Proof Estimates Hansard*, 25 February 2015, p. 114.

23 *Proof Estimates Hansard*, 25 February 2015, p. 114.

24 *Proof Estimates Hansard*, 25 February 2015, p. 114.

Outcome 1 Population Health

2.13 The committee discussed with Food Standards Australia New Zealand (FSANZ) frozen berries in relation to the recent hepatitis A outbreak. FSANZ explained the risk level classification process, with frozen berries in general being classified as low-risk, with the exception of the suspected product to be the cause being classified as a medium risk to public health.[25] Mr Steve McCutcheon, Chief Executive Officer of FSANZ, explained to the committee that:

> There is an international test for hepatitis A. You can use it, but it is very limited in its ability to detect the virus in food. It is very different to, say, testing for chemicals or contaminants, where the technology can take you down to very low levels of detection. In the case of microbial contaminants, particularly viruses, the technology is not able to do that.[26]

He further explained that they did not know what the source of the hepatitis A was, but 'epidemiological evidence points towards the frozen berries'[27].

2.14 As at 25 February 2015, there were eighteen cases of hepatitis A in Australia. Professor Baggoley explained that after the 50 day incubation period, they would not expect to see more cases.[28] In regards to a question if the department was confident everyone had thrown the product away, Professor Baggoley outlined that whilst that cannot be known, there was widespread media and discussion about the recall and they would not have been able to gain any more publicity about the issue.[29]

Outcome 10 Sports and Recreation

2.15 The committee discussed with the Australian Sports Commission (ASC) the transition from the Active After-School Communities program to Sporting Schools.[30] The ASC stated 'there is a transition phase for the first six months of this year', with the commission working with '12 sports to pilot the Sporting Schools operation in a number of…primary schools [and] a select number of secondary schools'[31]. The commission intends to expand the number of sports available in the program to 35 as from 1 July 2015.[32]

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25 *Proof Estimates Hansard*, 25 February 2015, p. 116.

26 *Proof Estimates Hansard*, 25 February 2015, p. 117.

27 *Proof Estimates Hansard*, 25 February 2015, p. 117.

28 *Proof Estimates Hansard*, 25 February 2015, p. 122.

29 *Proof Estimates Hansard*, 25 February 2015, p. 122.

30 *Proof Estimates Hansard*, 25 February 2015, p. 135.

31 *Proof Estimates Hansard*, 25 February 2015, p. 135.

32 *Proof Estimates Hansard*, 25 February 2015, p. 135.