COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Estimates

(Public)

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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Wednesday, 25 February 2015

Members in attendance: Senators Bilyk, Di Natale, Leyonhjelm, Ian Macdonald, Madigan, McLucas, Moore, Peris, Polley, Reynolds, Seselja, Siewert, Smith, Waters, Wright, Xenophon.

HEALTH PORTFOLIO

In Attendance

Senator Nash, Assistant Minister for Health

Department of Health

Whole of Portfolio

Mr Martin Bowles PSM, Secretary

Professor Chris Baggoley, Chief Medical Officer

Ms Liz Cosson, Deputy Secretary

Mr Mark Cormack, Deputy Secretary

Mr Chris Reid, General Counsel

Mr Andrew Stuart, Deputy Secretary

Dr Wendy Southern, Deputy Secretary

Mr Paul Madden, Special Adviser

Mr Colin Cronin, Assistant Secretary, Audit and Fraud Control

Ms Fay Holden, Acting First Assistant Secretary, Best Practice Regulation and Deregulation Division

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

Ms Sue Campion, First Assistant Secretary, Grant Services Division

Dr Richard Bartlett, First Assistant Secretary, Portfolio Investment Division

Mr Simon Cotterell, Acting First Assistant Secretary, Portfolio Strategies Division

Ms Janet Anderson, First Assistant Secretary, Acute Care Division

Mr Charles Maskell-Knight Principal Adviser, Acute Care Division

Dr Andrew Singer, Principal Medical Adviser, Acute Care Division and Health Workforce Division

Outcome 1

Mr Nathan Smyth, First Assistant Secretary, Population Health Division

Ms Kylie Jonasson, First Assistant Secretary, Office of Health Protection

Dr Gary Lum, Specialist Medical Advisor, Office of Health Protection

Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division

Professor Warwick Anderson, Chief Executive Officer, National Health and Medical Research Council

Professor John McCallum, Head, Dementia Research, National Health and Medical Research Council

Mr Tony Kingdon, General Manager, Research and Operations Group, National Health and Medical Research Council

Dr Clive Morris, Head, Policy 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 Mr Craig Duncan, Acting Chief Scientist, Food Standards Australia New Zealand

Dr Scott Crerar, Section Manager, Scientific Strategy, International and Surveillance, Food Standards Australia New Zealand

Outcome 2

Ms Felicity McNeill, First Assistant Secretary, Pharmaceutical Benefits Division

Outcome 3

Ms Kirsty Faichney, Acting First Assistant Secretary, Medical Benefits Division

Ms Fifine Cahill, Assistant Secretary, Primary Care and Pathology Branch, Medical Benefits Division

Ms Janet Anderson, First Assistant Secretary, Acute Care Division

Mr Charles Maskell-Knight Principal Adviser, Acute Care Division

Dr Andrew Singer, Principal Medical Adviser, Acute Care Division and Health Workforce Division

Outcome 4

Ms Janet Anderson, First Assistant Secretary, Acute Care Division

Mr Charles Maskell-Knight, Principal Adviser, Acute Care Division

Dr Andrew Singer, Principal Medical Adviser, Acute Care Division and Health Workforce Division

Mr Leigh McJames, General Manager and Chief Executive Officer, National Blood Authority

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

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

Dr Helen Opdam, National Medical Director, Organ and Tissue Authority

Dr Tony Sherbon, Chief Executive Officer, Independent Hospital Pricing Authority

Outcome 5

Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division

Ms Maria Jolly, Acting First Assistant Secretary, Indigenous and Rural Health Division

Ms Meredeth Taylor, Assistant Secretary, Rural, Remote and Indigenous Access Branch

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

Outcome 6

Ms Kirsty Faichney, Acting First Assistant Secretary, Medical Benefits Division

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

Mr David McGregor, Private Health Insurance Ombudsman

Outcome 7

Ms Linda Powell, First Assistant Secretary, eHealth Division

Ms Kylie Jonasson, First Assistant Secretary, Office of Health Protection

Dr Gary Lum, Specialist Medical Advisor, Office of Health Protection

Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division

Ms Janet Anderson, First Assistant Secretary, Acute Care Division

Mr Charles Maskell-Knight, Principal Adviser, Acute Care Division

Dr Andrew Singer, Principal Medical Adviser, Acute Care Division and Health Workforce Division

Mr Nathan Smyth, First Assistant Secretary, Population Health Division

Ms Felicity McNeill, First Assistant Secretary, Pharmaceutical Benefits Division

Dr Brian Richards, Director, National Industrial Chemicals Notification and Assessment Scheme

Adjunct Professor John Skerritt, National Manager, Therapeutic Goods Administration

Dr Anthony Hobbs, Principal Medical Adviser, Therapeutic Goods Administration

Ms Samantha Palmer, First Assistant Secretary, Regulatory Support Division, Therapeutic Goods Administration

Dr Larry Kelly, First Assistant Secretary, Monitoring and Compliance Division, Therapeutic Goods Administration

Dr Lisa Studdert, First Assistant Secretary, Market Authorisation Division, Therapeutic Goods Administration

Ms Philippa Horner, Principal Legal Adviser, Therapeutic Goods Administration

Outcome 8

Ms Penny Shakespeare, First Assistant Secretary, Health Workforce Division

Dr Andrew Singer, Principal Medical Adviser, Acute Care Division and Health Workforce Division

Dr Rosemary Bryant, Chief Nurse and Midwifery Officer

Outcome 9

Ms Kylie Jonasson, First Assistant Secretary, Office of Health Protection

Dr Gary Lum, Specialist Medical Advisor, Office of Health Protection

Dr Brian Richards, Director, National Industrial Chemicals Notification and Assessment Scheme

Outcome 10

Mr Jaye Smith, Acting First Assistant Secretary, Office for Sport

Mr Nathan Smyth, First Assistant Secretary, Population Health 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

Ms Sue Marriage, Deputy General Manager, Participation and Sustainable Sport, Australian Sports Commission

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

Mr Trevor Burgess, National Manager, Operations, Australian Sports Anti-Doping Authority

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

Committee met at 09:00

CHAIR (Senator Seselja): Welcome. I declare open this meeting of the Senate Community Affairs Legislation Committee. The Senate has referred to the committee the particulars of proposed additional expenditure for 2014-15 and related documents 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 is due to report to the Senate on 17 March 2015 and has fixed 17 April 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 the close of business on Friday, 6 March 2015. The committee's proceedings today will begin with the examination of the health portfolio commencing with whole-of-portfolio and corporate matters. Under standing 26, the committee must take all evidence in public session. This includes answers to question 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 the department of the Commonwealth should not be asked to give opinions on matters of policy and should be given reasonable opportunity to refer to 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).

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

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.

Department of Health

[09:03]

CHAIR: I welcome Senator the Hon. Fiona Nash, the Assistant Minister for Health, representing the Minister for Health; the departmental secretary, Mr Martin Bowles; and officers of the Department of Health. Minister or Mr Bowles, would you like to make an opening statement?

Senator Nash: No, I do not, thanks, Chair.

Mr Bowles: No, thank you.

CHAIR: All right, thank you. We will move straight to questions.

Senator McLUCAS: Thank you very much. I will first go to questions around Australia's response to the Ebola outbreak. I think we are going to get Professor Baggoley up first. Isn't that amazing? Could you describe to us the process that would normally be followed when an AUSMAT team is to be convened.

Prof. Baggoley: The process when an AUSMAT team is to be convened, particularly for work or a deployment offshore, is that the request would come through the Department of Foreign Affairs and Trade. The management would occur through Emergency Management Australia. The request would come and be conveyed particularly to the Australian Health Protection Principal Committee, which I chair, which would meet and discuss the request and how best to deploy. At any time, particularly for urgent deployments, there is a roster where the states and territories know that they may be called upon to provide a response early. We know that the Northern Territory, for example, is on duty or prepared to send deployees as part of an AUSMAT, 24 hours a day, seven days a week, 12 months a year, because we have the National Critical Care and Trauma Response Centre there, which is Australia's major facility for response for our region. Then there are usually two other states that are there with them. We work closely with the NCCTRC. We have worked closely with Dr Len Notaras there in the past. I still liaise with him in his role as Chief Executive of the NT Department of Health. Now we work with Dr Nick Coatsworth, who is running the NCCTRC.

The discussions that occur then depend on the nature of the outbreak, as you would imagine. For example, in November 2013 with Typhoon Haiyan, the nature of the deployment was particularly surgically focused early on. So we had a request for there to be an AUSMAT team, and within 18 hours a team had assembled in Darwin. Of course, if it is a communicable disease outbreak then we need different sorts of responders, and it can be infectious diseases people, people trained in epidemiology, nurses and so on. So it depends on the nature. I will stop there.

Senator McLUCAS: Thank you for that introduction. Did the minister ever request that an AUSMAT team be convened or ask what capacity there was for a team to be convened in terms of the Ebola events in Africa?

Mr Bowles: Not to my recollection. I am going back a little bit now. Professor Baggoley might know about before my arrival. I think that, subsequent to that, there were discussions around the capacity of AUSMATs and what might be there, but, as far as I can recall, there was no request to have an AUSMAT team ready to deploy, if that is what you are asking.

Senator McLUCAS: So when you say there were 'discussions around', what do you mean by that?

Mr Bowles: Understanding the capacity issues as Professor Baggoley just went through.

Senator McLUCAS: So what type of personnel we would need?

Mr Bowles: Yes.

Senator McLUCAS: But there was no request from a minister to convene an AUSMAT team?

Mr Bowles: Not to my recollection, no. It was between—

Senator McLUCAS: It was the timing issue. When you were coming on board—

Mr Bowles: From my perspective, from when I am here: no, not that I recall.

Senator McLUCAS: When did the Department of Health first discuss the possibility of Aspen Medical staffing and operating a treatment facility in Sierra Leone?

Mr Bowles: That was an issue run from the Department of Foreign Affairs. We were peripheral to that. Aspen Medical were engaged by the foreign affairs department.

Senator McLUCAS: What role, if any, did Health have in Aspen Medical being tasked?

Mr Bowles: I think I could probably describe it as advisory to the Department of Foreign Affairs.

Senator McLUCAS: When did that happen?

Prof. Baggoley: I believe, in fact, that the discussions have been rather directly between DFAT and Aspen and we have had minimal involvement with that. I can advise that just last week I went to the training of the fifth, I think, cohort of people being trained by Aspen here in Canberra. I met with the chief executive. I had a presentation in relation to what has been occurring there in Sierra Leone with the Aspen teams and saw the training in action. That was my first interaction to see the training. With the Australian Health Protection Principal Committee, I have invited Dr John Shephard, the main medical adviser at Aspen, to come and present to us on the deployment and what they are finding so that we can make sure that when Aspen deploys and, of course, when they come back, they are integrated into our border systems as well as possible. Also, we just want to keep an understanding of what is happening.

Senator McLUCAS: The secretary has said that there were some discussions around the contracting of Aspen to provide this service. I want to know what date the Department of Health—

Mr Bowles: No, I said it was run out of DFAT. We have only had peripheral engagement with them. As Professor Baggoley just said, it was pretty much run out of the Department of Foreign Affairs and Trade. Professor Baggoley and I have both met with the CEO of Aspen subsequently, but the contracting arrangement for Aspen was run by DFAT.

Senator McLUCAS: When did Health find out that this was going to happen?

Mr Bowles: I cannot remember exact dates. I cannot even remember the exact dates that it was all announced, but it would have been around that time. We can take on notice the specific date, but it was around the time that it was announced.

Senator McLUCAS: I understand Minister Dutton made the announcement.

Mr Bowles: That, again, may be true, but I cannot recall who made the announcement.

Senator McLUCAS: Is there someone here who can assist, Mr Bowles?

Mr Bowles: No. We do not know the specifics of that. Minister Dutton could have announced it, and probably did because he was the lead minister in talking about Ebola at the time. But it was a multi-department issue, and DFAT was doing the Aspen part of that.

Senator McLUCAS: So you were not asked advice about the capacity of Aspen to deliver this?

Mr Bowles: No.

Senator McLUCAS: You said—and I understand that this was around you coming on board—it was an advisory type of engagement that the Department of Health had. What were you advising about?

Mr Bowles: It would have been just general discussion with DFAT on the issues. We had an interdepartmental committee running at a certain level. I will get Mr Cameron to just give us a little bit of detail about the interdepartmental process we had running.

Mr Cameron: There has been an IDC, an interdepartmental committee, with key departmental players running since late last year. To answer your specific question about advice and the nature of advice, as the secretary has said, the input from Health, though that IDC to DFAT's decision making around its choices of providers for services in West Africa, as you have described, has been around the nature of the outbreak—the epidemiology, the case numbers, the spread and the sorts of information that we would be routinely collecting as part of our normal communicable disease surveillance activity. We have been providing that to all parties on that committee, and specifically to DFAT, in making decisions about resourcing and deployment, to best inform them on what is required.

Senator McLUCAS: I understand that the managing director of Aspen said the government was canvassing options around a range of areas. We provided some briefings and some material, as I know a lot of other companies did, but that was not provided to the IDC.

Mr Bowles: That was not an issue from a health perspective. They may have done that in the DFAT world, so that is probably a question best directed there.

Senator McLUCAS: Mr Cameron, when was the IDC established and who leads it?

Mr Cameron: I cannot give you the exact start date. I would have to take that on notice. It is co-chaired by an SES band 2 officer in DFAT, a division head, and likewise at Health. So it is co-chaired between DFAT and Health.

Senator McLUCAS: It would be good if you could find out when that was established.

Mr Cameron: I would be happy to.

Senator McLUCAS: Did DFAT approach Health in any way to discuss the possibility of Aspen, or in fact any other provider, establishing a treatment facility in West Africa? I understand that you give advice about epidemiology, the nature of the skills. I am now going to—

Mr Cameron: My recollection is no.

Senator McLUCAS: But Health probably knows most about Aspen in the government, you would imagine.

Mr Bowles: I think there is a range of agencies that know a fair bit about Aspen. They are a very broad group who provide medical care across a range of fronts these days.

Senator McLUCAS: Was Health asked about the amount of money that would be required to operate a facility in West Africa?

Mr Bowles: No. Again, you are talking about the context of Aspen and that would be DFAT.

Senator McLUCAS: Does DFAT provide Health with any ongoing information about the operations of the treatment facility being operated by Aspen?

Mr Cameron: Yes, it does. That mostly focuses on the health outcomes achieved by the provider. The IDC is briefed on numbers of patients that are discharged with a certificate that says, 'clear of Ebola', and is advised on other clinical incidents as they occur.

Senator McLUCAS: How regular are those reports?

Mr Cameron: They are now at least every fortnight when that IDC convenes. The IDC was meeting more frequently over the tail end of last year, as you would expect, during the commencement of the service provision. I would have to check whether there is other ad hoc or irregular communication.

Senator McLUCAS: How many patients have been discharged?

Mr Cameron: I am sorry, I do not have that with me. But we can easily get that.

Senator McLUCAS: It is a good news story. We should tell that.

Mr Cameron: Yes, it is a good story. I am sure we can bring that back to the committee during the course of the day if the secretary is happy with that.

Mr Bowles: And if we cannot, DFAT will be able to provide it, I am sure. You asked if Minister Dutton announced that. My recollection, and from having a look at a media release, is that it was a joint statement from the Prime Minister and Minister Dutton on 5 November.

Senator McLUCAS: Is the department aware of reports that a nurse at the Aspen Medical facility has been airlifted to the United Kingdom after reportedly breaching personal protection protocols?

Mr Bowles: Yes.

Senator McLUCAS: Does the Department of Health have any role in determining the personal protection protocols employed at the Aspen Medical facility?

Mr Bowles: I will defer to Professor Baggoley first of all, as I am not aware of that.

Prof. Baggoley: No, we do not dictate the personal protective equipment that will be used by Aspen. But from my discussions with them, I certainly am confident that they are cognisant of, and would employ, the appropriate PPE that is required for the deployment there in West Africa.

Senator McLUCAS: I have heard—and you might be able to confirm, Professor—that when the facility was first working on the ground, so to speak, the type of equipment used was not in compliance with what we would expect to be fitting for the type of personal protection required.

Prof. Baggoley: That is a comment, Senator. I am in no position to be able to respond to that definitively. I do know that it was very much a staged increase in activity in taking of patients from the outset for that facility there in Hastings.

Senator McLUCAS: You did not hear that the right face masks were not provided?

Prof. Baggoley: No, I didn't hear that.

Senator McLUCAS: Can I go back to the nurses being evacuated. Is the department aware of the welfare of that nurse?

Prof. Baggoley: Yes. I am in frequent contact with my counterparts in the United Kingdom; we do so on a regular fortnightly basis, and it happened to be last evening. The good news is that that nurse is no longer at the Royal Free Hospital. She has been discharged from the Royal Free Hospital. She is in accommodation provided there in London, and she will be staying there. Obviously, they have their monitoring processes, which would include reporting temperatures on a twice-daily basis and so on. Once she is 21 days outside Sierra Leone, she will be able to be discharged and to return to Australia, which was the outcome and the process for the other nurse when that situation occurred. As to her circumstances: her health is not of concern but of course there is ongoing monitoring but in accommodation in London is what is occurring.

Senator McLUCAS: We wish her all the very best and hope she is not being troubled by the infection. Who funded the evacuation of that nurse?

Prof. Baggoley: I cannot advise on that matter.

Mr Bowles: I could not either. It is probably best to ask DFAT. It would be through that Aspen-DFAT relationship, I presume.

Senator McLUCAS: Is the department aware of how many new cases of Ebola are presently being diagnosed?

Prof. Baggoley: In Sierra Leone—again from talking to my counterparts—the last three weeks have had numbers of 80, 76 and 70 new cases. As you are probably aware, all countries are committing to now move to zero cases, but the challenge of that is something that is not underestimated at all. I think it is fair to say that of the three countries Liberia is doing the best in its progress to zero. In Sierra Leone, the cases are concentrating particularly in the western area of the country. So it has become more localised and some counties have not had cases for some time, but outbreaks just do occur. We understand in Guinea that the situation is fluctuating more. Ongoing issues still relate to community attitudes and trust, and that is a real issue. And part of that relates to burial practices. Of course, the traditional practices have been ones that have been conducive to spread the infection. Certainly, in recent months, there is cause for optimism but no cause for complacency.

Senator McLUCAS: How many beds are operational at the Aspen Medical facility?

Mr Bowles: I think it is best to ask DFAT. I don't know.

Senator McLUCAS: That would not come in the briefings to the ICD, Mr Cameron?

Mr Cameron: It is. It is discussed each time. I just do not have that information in front of me at the moment.

Mr Bowles: It is their contract. It is probably best to get the accurate number, because it does fluctuate depending on what is actually happening.

Senator McLUCAS: Do we know how many patients are currently there?

Mr Bowles: No. Again, it fluctuates quite a bit so you had best ask them. We can try to find out, but it is their contract.

CHAIR: I know the Department of Foreign Affairs is managing the contract, but I have read reports that we are seeing successes out of what has occurred with the deployment of Aspen. I have read that a number of survivors have been discharged from the Sierra Leone centre. Is there any information you have either through the IDC or otherwise? I do not know whether this is an old report, but I have read that survivors, including an 11-year-old girl, a man in his twenties and a 67-year-old woman have been released. That sounds like good progress. As far as you are aware, are we making progress with this deployment of Aspen?

Mr Bowles: I have seen some of the same sorts of things and, yes, it does look like that is quite positive.

Mr Cameron: That general information, from what I have read, is right—I just do not have with me a detailed breakdown of the data in and out of the Ebola treatment centres.

CHAIR: Broadly, without going into the detailed data, are we seeing progress as a result of this Commonwealth spend and through Aspen Medical? What are we seeing? Is there anything you can report in terms of whether they are doing the job they have been asked to do?

Mr Bowles: Everything I have seen has been quite positive about how they have got into the country, how they have set things up. They worked themselves up to be able to achieve the gongs, and it has all been quite positive from that perspective. They are still dealing with difficult circumstances, obviously, but I have read similar things about some of their good successes—but clearly there are going to be other issues as well. DFAT should be able to give you a pretty good run-through on some of the things they are seeing through that contract.

CHAIR: Others might ask some questions of DFAT on this and see exactly how it is going.

Senator McLUCAS: Mr Cameron, you are going to come back to us if you can on the number of people who have been discharged. When you are finding that out, can you also find out how many patients have been through the facility since it was established—in early November, from recollection.

Mr Bowles: We will try to find that out and I will let you know at some stage during the day.

Senator MOORE: Professor Baggoley, are you involved in any way in an ongoing international discussion or review of what is happening around the Ebola process? My understanding is that this has drawn together people from across the world, focusing on Ebola and this kind of activity. Are you involved in that in your position, and, if not, is Australia involved in some way—particularly from the medical perspective?

Mr Bowles: Can I start that and then throw to Professor Baggoley. Recently the executive board of the WHO ran a special session specifically on Ebola and responses to Ebola. I attended that meeting and we talked through a range of issues from how the response happened, how do we look at another outbreak of something else for that matter, how do we do the retrospective look to see what lessons can be learned. It was a full day session that basically went from nine am to about six pm, with a resolution at the end that the executive board signed off on.

It was treated quite seriously. It is the first time a special session had been formed like this to deal with a specific issue. So from an international perspective, if everyone was absolutely engaged—in fact, the minister for health from Liberia is a member at the moment of the executive board, so we had some firsthand experience in the discussion that day. But Professor Baggoley is also engaged internationally on a range of different issues.

Senator MOORE: There was just a follow-up: I am wanting to know what engagement is and are those papers from the WHO public?

Mr Bowles: I am not sure if they are yet. They have to go to the WHA process.

Senator MOORE: They go through the whole process.

Mr Bowles: You know that process: you go through quite a rigmarole to get to an endpoint. So the World Health Assembly is in May. If we can get anything early, we can have a look at that.

Senator MOORE: That would be really useful.

Mr Bowles: I would have to go through that process, obviously. But Professor Baggoley has an ongoing engagement with this as well.

Prof. Baggoley: The World Health Organisation has an emergency committee on Ebola. I am a member of that committee. About 14 members that comprise the committee. It had a meeting in late January and with an update on the progress discussion about a range of issues, some of which I have canvassed about community attitudes and the importance there, and also about burial practices. There was also a strong focus on exit screening, because, as you will be aware, and others in this room will be aware, there is a process of screening of people before they leave any of the three countries. Progress was noted, but the committee is charged to provide advice to the Director-General as to whether there is a public health emergency of international concern. Now, that was declared last year, and whether that emergency should still be declared and the committee readily and unanimously agreed that that was the case, and certainly a statement from the committee's deliberations and its recommendations was posted online within 24 hours. So that was online.

Senator MOORE: So that engagement continues?

Prof. Baggoley: That continues, the committee is extant, must meet every three months, and I continue on that.

Mr Bowles: Just to add, I have just been informed that the resolution of that special meet is actually on the WHO website, so they have astounded me.

Senator MOORE: It is a huge website, Mr Bowles.

Mr Bowles: It is. We can try and find that for you, if you like?

Senator MOORE: I can do it, no worries.

Mr Bowles: But it is on there somewhere.

Senator MOORE: Can you just remind me when that meeting was?

Mr Bowles: It was the end of January, start of February.

Senator MOORE: These two meetings were about the same time. Your next meeting—

Mr Bowles: 25th of January.

Senator MOORE: Thank you very much.

Mr Bowles: I was there but everything blurs.

Senator MOORE: What time did it start, Mr Bowles?

Mr Bowles: Nine am.

Senator MOORE: The larger meeting was in January, the next one is in May—but the emergency group continues to operate and meets every three months, and information is shared in that.

Prof. Baggoley: Correct: information shared and advice to the Director-General on recommendations for the management of the outbreak.

Senator McLUCAS: I want to move from Ebola to berries.

Mr Bowles: It depends on what we are going to talk about.

Senator McLUCAS: I understand that.

Mr Bowles: The FSANZ bit is tonight.

Senator McLUCAS: We will be talking to FSANZ about their role, but I am talking to health.

Mr Bowles: I just wanted to make sure we got the right people. Fire away.

Senator McLUCAS: On what date was the first OzFoodNet notice issued regarding Patties frozen berries?

Mr Bowles: Professor Baggoley, do you want to talk about that?

Prof. Baggoley: For the time line, I think, Ms Jonasson?

Ms Jonasson: We are aware that on Thursday, 12 February 2015, OzFoodNet Victoria informed the network that Victoria had three cases of locally acquired hepatitis A, and that all had one common exposure and that was Nanna's frozen mixed berries, one-kilogram pack, with onsets between 3 January and 6 February 2015.

Senator SIEWERT: 3 January, did you say?

Ms Jonasson: Onsets, but OzFoodNet Victoria informed the network that Victoria had three cases on 12 February.

Senator SIEWERT: Yes, but you said some dates after that at the end that I did not hear the first time.

Ms Jonasson: Sorry, it was onsets between 3 January and 6 February.

Senator McLUCAS: So 3 January was the first diagnosis—is that the right terminology?

Ms Jonasson: Yes, that is what we were aware of on 12 February.

Mr Bowles: The first illness was found. Whether it was diagnosed or not is probably a separate issue, but that is when it started—on 3 January.

Senator McLUCAS: What date was the first food recall?

Ms Jonasson: On Friday, 13 February 2015, Victorian health authorities recommended to Patties, the parent company of Nana's, that they conduct a voluntary recall. FSANZ also sent a notification of hep A cases associated with this product to the National Food Safety Network on 13 February. Patties announced a consumer-level recall on Saturday, 14 February—so two days after OzFoodNet Victoria had first informed the network.

Senator McLUCAS: What was the term you used?

Ms Jonasson: It is effectively a voluntary recall. Patties effected a voluntary recall on Saturday, 14 February—that is what we have been advised.

Senator McLUCAS: How does that happen?

Ms Jonasson: You would probably have to talk to FSANZ and the food people about that.

Senator Nash: FSANZ actually coordinates the recall, so it is probably best directed to them.

Senator McLUCAS: I will. On what date was the National Incident Room established?

Ms Jonasson: The National Incident Room was activated on Tuesday, 17 February at 9 am.

Senator McLUCAS: If somebody says, 'I want a national incident room,' how long does it take to get that happening?

Ms Jonasson: Pretty much instantly.

Senator McLUCAS: So why did it take from Thursday the 12th, when you first really became aware that this was happening, to Tuesday the 17th—five days—for the National Incident Room to be established?

Ms Jonasson: There are a number of things that I think are taken into consideration about whether you will activate the National Incident Room or not. We obviously have food incidence surveillance as part of our responsibilities. We keep a very close eye on these things. We do not jump instantly when we find out there is an issue. The Chief Medical Officer considers a range of issues. Whether there is a national public health risk is a very important consideration, so we were looking to see if there were multiple jurisdictions involved in this. Professor, did you want to add anything to that?

Prof. Baggoley: I think it is important to understand that activating the National Incident Room is really a mechanism whereby we can make sure we devote resources within the Office of Health Protection to this issue. It is an organisational matter in particular. What was happening from that Thursday is that all the relevant multijurisdictional people that should be getting together were. OzFoodNet, which includes the epidemiologists around the states and territories, were talking. Communicable Diseases Network Australia had met. When this started on Thursday, 12 February, it was one jurisdiction, and then on Friday the 13th New South Wales had indicated they had one case. So it is then a judgement call as to how you organise yourself to make sure you can manage what is a coordination approach, and the role of the Office of Health Protection here is particularly coordination. I have a low threshold of getting all our relevant people together. But we had OzFoodNet, the Communicable Diseases Network Australia, and we know FSANZ was working on this. It was not a sign that serious attention was not been paid. It was really to ensure that we had ease of organisation and had all the right people working on this together.

Senator McLUCAS: What are the considerations? What is the trigger, when you get to certain thresholds, that says, 'We need a national incident room'? What is the thing that makes that happen?

Prof. Baggoley: It is a question put to me to say: 'It probably is about time. We think this could get wider. Whatever the issue is could become more spread nationally. It might require more of our own resources.' That gets put to me. I see what is happening . I try to anticipate what may be required to happen and then I get to make the decision.

Senator McLUCAS: So it is your decision; is that right?

Prof. Baggoley: Yes.

Senator McLUCAS: Minister, when did you first find out about the incident?

Senator Cash: I think it was very early on. I will have to check the actual date for you. I do not want to guess. I will provide that to you on notice. But it was at the very onset; I was advised very early.

Senator SIEWERT: On the Tuesday, by the time you instigated the national incident process, how many people had been reported as infected on that morning?

Prof. Baggoley: Again, my colleagues might be able to help me here, and please do. My understanding is at that stage there were still four, but I will take advice. Victoria remained at three cases, and has remained at three. New South Wales increased over the subsequent time. Whether we had Queensland have cases by the Tuesday I am not sure. Colleagues?

Mr Bowles: No, we do not appear to have how many were on that day, but we will find out for you. My recollection was that there were three or four; something like that.

Senator SIEWERT: Perhaps you can give us the time line as they came on—as New South Wales came on, how that escalated, and then Queensland.

Mr Bowles: Yes, we can do that.

Senator SIEWERT: Could that happen today?

Mr Bowles: Yes, we should be able to get that today. We definitely know Victoria was on the 12th and New South Wales was on the 13th, but I think there were only a couple around that early stage. We will find out for you exactly when they came on.

Senator SIEWERT: If we had New South Wales on the 13th, which is the Friday, the question still is then why wait to the Tuesday when you knew it had gone into New South Wales by the Friday or Saturday?

Mr Bowles: Professor Baggoley explained that it was not as though nothing was happening. The Office of Health Protection was working on it from the Thursday. It is a decision whether we activate a national response, because as of Thursday-Friday there was still only one here and one there sort of thing. So it takes time to make that decision, and that is Professor Baggoley's decision.

Senator SIEWERT: My question still stands. If I understand it correctly, there were still four on Tuesday and on the weekend there were three from Victoria, which you already knew, and the one from New South Wales was on the Friday or the Saturday. You knew those figures then. What happened between the weekend and Monday to then start it on Tuesday, when it sounds like there were no further cases then? Why not open up the Incident Room earlier?

Prof. Baggoley: We will get you the numbers, but it is important to put this into perspective. There are many outbreaks of food-borne illness in Australia each year. Some are just in one jurisdiction and they are managed in that jurisdiction. Where the jurisdiction has the relevant company, they are the lead group for that. But there are, for example, salmonella outbreaks that involve multiple jurisdictions. It is not a sign of something not being taken seriously if the National Incident Room is not open. We have a multi-jurisdictional approach to this and that is through OzFoodNet and Communicable Diseases Network Australia. There was a multi-jurisdictional focus on this from the very start and from when Victoria, on Thursday, 12 February, informed that network that they had these cases and then New South Wales was added.

There was CDNA, OzFoodNet and, of course, FSANZ—and remember the role of FSANZ is really important to understand here; FSANZ was certainly involved in this on 13 February—and a number of multi-jurisdictional activities were taking place. From my perspective, the issue of 'Do you open the National Incident Room?' was just to get a sense of: could this be complex? Are there a range of different organisations that may need to be involved? We certainly were communicating all through the weekend and, really, it was just for ease of organisation.

Senator SIEWERT: I understand. All of what you have just said makes sense. What I am trying to find out is what the culmination, or trigger point, of all that process was—when you said, 'It is appropriate to set that in place.'

Prof. Baggoley: I had a request and a discussion with the head of the relevant branch, Mr Cameron, who said that it was probably about time for the organisation to do that. It made sense.

Senator SIEWERT: Which branch?

Prof. Baggoley: The Health Emergency Management Branch of the department.

Senator SIEWERT: It is just that we have been talking about multiple agencies here. So, you had a conversation with the federal department, not the state department—

Prof. Baggoley: With my colleagues within the department.

Senator SIEWERT: Because by then you had access to a range of information sources.

Mr Bowles: That is right, and the Communicable Diseases Network had met on the Monday. A whole lot of things had happened and then it went to Professor Baggoley to make a decision.

Senator SIEWERT: Thank you.

Senator McLUCAS: From Thursday 12 February we knew that the infections were coming from the frozen mixed berries from this company. Is that correct?

Ms Jonasson: What we can say is that on 12 February we had three cases of locally acquired hepatitis A, and there was one common exposure.

Mr Bowles: It still remains that way. The one common exposure is the Nanna's mixed berries.

Senator McLUCAS: Yes. You are aware that the product is in every supermarket in the country?

Senator Nash: Sorry—I would hate people to be alarmed; the product has been recalled.

Senator McLUCAS: Sorry.

Senator Nash: We just want to be really careful. It is off the shelves.

Senator McLUCAS: I am trying to get an understanding of why it took some days—and I accept your point, Professor—when this was such a widely consumed product. It is sent right across the country. It is not just provided in Victoria.

Senator Nash: Sorry, what was your question, Senator? We missed the beginning of that.

Senator McLUCAS: Given it is so widespread, why did the product—

Mr Bowles: It happened on the Saturday—the recall. Patties announced a consumer-level recall.

Senator McLUCAS: I understand that, Mr Bowles. I am trying to understand why it took five days for a national incident room to be established when we know that this product is not simply a Victorian product. It is not just provided in Victorian supermarkets, it is provided right across the country.

Senator Nash: Senator, I think Professor Baggoley is trying to assist and maybe I can help a bit as well. The national incident room is not the only repository for dealing with this issue. I think what Professor Baggoley has been saying is that there were many things happening on those days. We had the recall; there were a number of steps being taken to address the issue. The national incident room, if I am correct, did not have to be instigated on the first day for all of those things to happen. I understand the concern, but I would not like there to be a perception that, because the national incident room was not operating, things were not happening. Certainly those steps were being taken immediately on those few days.

Mr Bowen: If I could just add to that. The national incident room is about the health response; it is not about the recall—that is to do with FSANZ. That it took five days for a national incident room to be stood up has nothing to do with the recall. The health response is about how we will manage outbreaks of a disease, for instance. Just because the national incident room was not set up until the Tuesday does not mean that things were not happening from a health perspective as well. That is why we have an Office of Health Protection, because it monitors and manages all of these sorts of issues from day 1. When it gets to a point, we make a decision to change the way we might attack things to make sure we have focus. It is not that we did not have focus beforehand, it is just that we want to do things in a different way. It is a way we escalate issues within the department.

Sorry, Senator, I am just getting a note here. By the end of Monday we were notified of some other cases which brought the total to nine.

Senator McLUCAS: Where were those cases from?

Mr Bowles: There were still the three in Victoria; there was a second one in New South Wales; and four in Queensland.

Senator SIEWERT: So that seems to have been the trigger to then go—

Mr Bowles: This would have all fed into how we actually manage a health response to an outbreak of disease.

Senator SIEWERT: But surely then, stretching across three states—

Mr Bowles: Queensland, Victoria and New South Wales.

Senator SIEWERT: from what Professor Baggoley and you said earlier, that is then turning it into a significant issue.

Mr Bowles: Exactly. And that is when, first thing on Tuesday morning, it opened, if you like.

Senator SIEWERT: My question before was, what was the trigger point? It does sound like those numbers in Queensland, and the escalation of numbers in New South Wales as well—

Mr Bowles: There would be a range of issues that we would have taken into account at the time. Yes, obviously, getting more numbers on the Monday evening would have been one of those decisions.

Senator SIEWERT: Was the decision made on Monday? Or was it established—can you see where I am coming from? Did it start at 9 o'clock on Tuesday? That is what I thought

Prof. Baggoley: I cannot recall exactly when I had the discussions, and whether it was on Monday evening or the Tuesday morning. All I can do is emphasise that the opening of the national incident room is solely for ease of organisation and coordination of response, understanding that—and this has been pointed out—with additional cases you get a sense that this will be an issue that will go on for some weeks, which of course it has. But all the key decision makers and all the key decisions themselves are occurring by the people who need to be taking these decisions. I get the sense that there is an overemphasis on the importance and significance of the opening of a national incident room in relation to the management of the outbreak. I would just encourage you not to go there, to be honest.

Senator SIEWERT: I understand what you are saying, but if it is not important to do it, why would you be doing it? The issue around coordination is essential.

Prof. Baggoley: It is about coordination within the Office of Health Protection. It enables them to take some of their people to make sure that they focus on this one issue. It is internal organisation. We have coordination. The Communicable Diseases Network of Australia, for which the Office of Health Protection has the secretariat, had an extraordinary meeting on the Monday. We were liaising with FSANZ and so on. This is just another step on the way of a well ordered and organised response, as we do have for food-borne illnesses.

CHAIR: I will make this the last one from now, because Senator Di Natale has been waiting. I am conscious of the time management because we are butting up against the hour for this area. People can choose to extend that if they like, but I am trying to manage it within the hour, and there are other things that people want to ask. I will come to you, Senator Di Natale. I will come back to this, if people want to extend that time. I am just trying to manage within the time frame that the committee has set out, which is one hour for this area. I will make this the final one for now, then I will go to Senator Di Natale, then if people want to continue they are entitled to.

Senator SIEWERT: By the time you made the decision to go to the incident room, from my recollection of the time frame from when we were talking to the Department of Agriculture, you did not know the full extent of where the two factories were that were responsible for generating the Patties berries. By that stage, had you identified the two sources of the berries?

Mr Bowles: That is not our field. We manage the health response.

Senator SIEWERT: I know that, but did you have that information? I know that is coordination with the department. Did you have that information?

Mr Bowles: I cannot recall. Possibly not at that stage, but I cannot recall. That would be a question for agriculture.

Senator SIEWERT: I have asked agriculture. This is the point about coordination.

Mr Bowles: We managed a health response. When it was known is maybe a question best asked to FSANZ tonight. They might be able to assist. Where the product is is largely an agriculture issue.

Senator SIEWERT: Funny, that. They were saying that a whole lot of it is yours and FSANZ.

Mr Bowles: Part of it is ours. We in the health department manage the health response to the disease outbreak; FSANZ manages the standards issues; and agriculture manages the testing and identification and whatever else.

Senator SIEWERT: That is why I am trying to piece together each of the three bits of this regulatory process.

Mr Bowles: I appreciate that, and that is why we are trying to help as much as we possibly can, but I cannot answer a question if we are not really clear, if it is not our responsibility at that point.

Senator SIEWERT: Perhaps I misphrased it then. Did you have access to that information then?

Mr Bowles: There are significant conversations between the department and Agriculture. The specific timing of when the two companies or two distribution outlets, I cannot recall. I do not know.

Ms Jonasson: I think it is fair to say that we focus on the number of cases of Hep A as opposed to the source, and I think that was what was driving a lot of the conversations within the Office of Health Protection. We were more interested to know: 'Okay, we had an outbreak. We were getting numbers in Victoria. Then we were getting numbers in New South Wales. Okay, FSANZ had coordinated. There had been a food recall; Patties had initiated

that.' We were watching the progress, but our focus is on the human element side of it, so the source of the berries in that sense is really in FSANZ and Agriculture's area.

Senator SIEWERT: I am interested in knowing whether you knew whether it was going to go wider than just Patties areas.

Mr Bowles: At that point there was the only one common link, if you like, epidemiologically to the mixed berries.

Senator SIEWERT: You knew that by then?

Mr Bowles: Yes. I think that was pretty clear right up-front.

Ms Jonasson: We had a common link in that everyone who had this had eaten these particular berries and that is what we were operating on.

Senator McLUCAS: Minister, can I find out when both your office and the minister's office were informed, and whether any instruction for action came then from your office or the senior minister's office following that.

Senator Nash: I will take that on notice for you so I get the right detail, but I am happy to come back to you today.

Senator McLUCAS: Thank you.

Senator DI NATALE: I have some questions for FSANZ later; I will pursue those through FSANZ. Just a couple of quick questions about outcome 7. Is that the appropriate place to talk about the trans-Pacific partnership and impacts on health? And the trading services agreement as well. We are getting nods.

Mr Bowles: Outcome 7, yes, I am getting nods.

Senator DI NATALE: And alcohol policy outcome 1?

Mr Bowles: I think that would be correct.

Senator DI NATALE: Good, thanks. That is all I have.

Senator REYNOLDS: My series of questions might seem a little out of left field, so if you want to take some of them on notice I am very happy for you to do that. They relate to an inquiry I initiated through this committee, on younger Australians living in aged care. You are probably not aware of the inquiry.

Mr Bowles: No.

Senator REYNOLDS: There are over 6½ thousand younger Australians living inappropriately in nursing homes and many thousands of others living in accommodation that is inappropriate for their personal circumstances. The evidence we have had to date is utterly gut-wrenching. It is almost unimaginable that people in Australia today would be living as they are. The reason I am asking you in this portfolio is that what has become very clear in the testimony—your staff can read it in the submissions to the inquiry—is that people, including their families and carers, describe themselves as living in a no man's land or a purgatory between the disability sector, the health sector, the aged sector, the housing sector and the rehabilitation sector. It is very clear that each of these systems, federally and in the states, when people have complex needs, do not meet their needs. Have you as a department looked at the complex health requirements of people—that is, people who have multiple health requirements--in Australia and how we meet them? Is that something you have looked at?

Mr Bowles: I would probably have to take some advice on that.

Senator REYNOLDS: I am happy for you to take advice or take it on notice.

Mr Bowles: It is whether the relevant people are here. On that issue, Social Services is probably the best place to start. I understand the link into Health clearly. Disability and aged care both reside in Social Services, so—

Senator REYNOLDS: I will be certainly raising them there tomorrow. For example, when we took evidence in Western Australia we had the disability sector, when we raised particular issues, because we had people giving evidence who sometimes had health issues that were quite simple, but not always simple, that were preventing them from getting out of aged care. I will just explain the context of why I am raising it here. In an aged care centre in Geelong I met Kiralee Hayward, a 20-something year old, bright, intelligent, person living successfully with a double amputation and spina bifida. That is not why she has been 2½ years in aged it. It is because in the health system no-one is taking responsibility for fixing a pressure sore. So her life has completely stopped—living amongst dying and death—because disability and aged care say it is health and health say that she is in aged care and it is not us. We have had so many stories. I know this is state based care, but because it is a national issue I think it is not just for one department. That gives a bit of context.

Mr Bowles: I am not aware of any specific work we have done on that issue. I am happy though to have a separate look at this. Going forward, with the establishment of the Primary Health Networks we might have an opportunity to actually have a look at those broader issues—can we actually look at this in a slightly different way. I am happy to take that on notice, if you like, and see what I can provide you with.

Senator REYNOLDS: Thank you. Also, perhaps on notice, have you had any direct engagement with the NDIA, in terms of how they are setting up and rolling out?

Mr Bowles: I talked to Finn Pratt, who is the secretary of Social Services. We had a meeting recently talking about the broader issues of the interaction between NDIS and aged care, between the health department and the Department of Social Services. But specifically into the NDIS? Personally, no, but the department obviously has. There is a lot of interactions around disability and mental health and things like that in this space.

Senator REYNOLDS: Could you take on notice the question of engagement with the NDIA. Visiting the NDIA trial sites might be a good place to start because it is their staff who are dealing one on one with it, but it is only in relation to disability support. If the Primary Health Networks could work with the NDIA staff to look at health needs, bringing in mental health and housing, because that is another area where people fall through the cracks, that would be of benefit. So if you could take that on notice to look at what the options are.

Mr Bowles: We can look at that.

Senator REYNOLDS: One more question on notice. It seems that the Federation white paper process might be a good opportunity to have federal and state interagency reviews of how they can better deliver an integrated service at the grassroots level. Have there been any discussions in that space yet that you are aware of?

Mr Bowles: There have been a lot of discussions around the Federation white paper in relation to health—other agencies have been dealing with it in their own portfolios. Has it gone specifically to that? I do not recall. But I can take that on notice to see if there is anything specific to what you are talking about now. Clearly, the Federation white paper is about trying to sort out the complexities between the Commonwealth and the states and territories, which have been there for a long time. I think we do have an opportunity going forward with the Primary Health Networks, because they are a different construct. I think they might take some time to get themselves up to speed on some of these issues, but I think there is an opportunity. From my perspective I am trying to look at the system more broadly to see how we might do some of these sorts of things.

Senator REYNOLDS: So if you could take on notice just where the interface could be at a local level. The other thing we have found with the inquiry already is that the various systems are spending a lot of money on these individuals, even just for aged care and other support, but it is not necessarily meeting their needs. If we did that there could be a lot of savings there and we would have a much better outcome for the individual. Thank you.

Mr Bowles: I understand what you mean.

CHAIR: We have passed the one hour allocated for this. Do senators wish to continue in this area?

Senator McLUCAS: I have quite a number of questions that would have been in whole of portfolio and across outcomes. There are the standard questions around staffing that I will put on notice. But I want to ask some questions about flexible funds. What outcome would I put that into, if I cannot do it in whole of portfolio?

CHAIR: Like you, I am keen to stick to the timetable, but I am happy for you to extend on this.

Senator McLUCAS: If we come back at another time, if we find space in the program, can we have the people in the room who will be able to answer questions around the flexible funds?

Senator DI NATALE: I also have questions on flexible funds, but I understand they are in another outcome.

Mr Bowles: It would normally come under whole of portfolio, because it cuts across the entire department effectively. We can answer some question now.

CHAIR: Is it just as appropriate in somewhere like Population Health, as Senator Di Natale has indicated? Will you have the officials there?

Mr Bowles: In the varying things you could go to the specific question you might have. While it might relate to flexible funds, in the different outcomes, like Primary Health or Population Health, we might be able to deal with it in that context if you wish.

CHAIR: I will put it to the committee. I would like to move on to outcome 4 unless someone would like to extend this area, either for this or for other reasons.

Senator McLUCAS: Senator Di Natale, will we agree to put it in Population and Health?

Senator DI NATALE: Yes.

Senator McLUCAS: So we will do flexible funds in Population Health.

[10:07]

CHAIR: We will now move to outcome 4.

Senator McLUCAS: I want to go to public hospital funding. What percentage of growth funding will the Commonwealth be providing next financial year and in 2017-18 for public hospitals?

Ms Anderson: You were asking about growth funding. I would direct your attention to the tables that were published for the 2014-15 MYEFO. They indicated an increase for 2014-15 of a total national of 1.5 per cent. I think you then asked about 2015-16?

Senator McLUCAS: Yes.

Ms Anderson: An overall change of -0.4 per cent, and then in 2017-18 there is an overall change of -3.0 per cent.

Senator McLUCAS: Just so we are clear on what we are talking about here, this is the percentage of growth funding we are talking about?

Ms Anderson: No. That is the difference between the published estimates at the 2014 budget and the published estimates at the 2014 MYEFO. So there has been a moderation, a change, in the projections of Commonwealth spending across the forward estimates between those two published figures. I am now quoting to you the change in the figures between those two points.

Senator McLUCAS: The coalition's health policy says that it will commit 50 per cent growth funding of the efficient price of hospital services. How does that coalition policy correlate to what you have just told us?

Ms Anderson: You are quoting the technical detail that underpins the application of the activity based funding model. The figures I quote are the outcomes of movements in weighted service volumes and movements in health prices. So there is a calculation of movements in the health price, the extent to which it grows or diminishes over time, and there were calculations about the throughput, the patient throughput, and the weighted service volumes of patients treated in hospitals. Those two parameters together are determinative of the amount of money the Commonwealth pays through to local hospital networks. So the movements that are charted across the forward estimates are based on projections of those two figures, as they come together.

Senator McLUCAS: So you are telling me that there is actually going to be a decrease in growth funding from MYEFO, compared with what the coalition has committed to do?

Mr Bowles: No. It is about activity, and the states determine the activity levels. They provide that and it is applied to a price. The outcome of that is what Ms Anderson is talking about. If activity levels go down you do not want to just keep paying for no activity. So it is an activity based funding model. The premise of what you are saying is built into the calculation of the numbers at the end of the day. But at the end of the day it is an activity base. So if the activity in the hospital sector in states and territories changes, which it has, and has actually been modified down over the forward estimates, you do see a decrease in the numbers, if that is the case.

Ms Anderson: Just to be clear, the commitment in the National Health Reform Agreement is for the Commonwealth to contribute 45 per cent of the additional efficient cost of additional services. That is in place, and it is one of the underpinnings to the calculations that lead to the figures I read out.

Senator McLUCAS: Is there any intent to change the funding commitments and guarantees in the National Health Reform Agreement? Where does that stand?

Ms Anderson: The Senator would be aware of the 2014-15 budget announcement, which identified a number of changes. There have not been through the changes.

Senator McLUCAS: Can you just go through the changes that were announced in the budget? Sorry, that is too broad a question, so I will retract it.

Mr Bowles: I think the broad issue is moving to more of a population based funding in 2017-18. I think that is the broader issue.

Senator McLUCAS: So it is moving away from the national efficient price models?

Mr Bowles: It is moving from a Commonwealth perspective to a broad CPI population type of arrangement. As to how the states deal with that issue, from my conversations with them I am sure they will be focused on activity driven behaviour. So it is up to the states how they manage those things. This is not something that is solely in our purview, as far as what their activity bases are.

Senator McLUCAS: But the National Health Reform Agreement was the vehicle by which agreements between the states and territories around national emergency waiting times and the national elective surgery

waiting times were arrived at, along with activity based funding. But you are telling us that that agreement has now been walked away from?

Mr Bowles: We need to go back to the budget announcements in the 2014-15 year. I do not have them off the top of my head. If you go back to those announcements, there has been no change as far as I am aware. Has there?

Ms Anderson: No, as was announced.

Senator McLUCAS: So what is the government's commitment to price setting through an annually adjusted national efficient price?

Ms Anderson: The National Efficient Price continues to provide the indication of the Commonwealth payments and will be in play until the end of the 2016-17 financial year. The government has announced that, from 2017-18, it is moving indexation onto a different footing and it will be determined through CPI and population growth.

Senator McLUCAS: So at the end of 2016-17 it just goes to CPI and population?

Ms Anderson: From the 2017-18 year onwards.

Senator McLUCAS: Going to New South Wales funding, is the department aware of reports that the government's decision to cut $17 billion in hospital funding in New South Wales is seeing that state's hospitals 'becoming swamped with increasing numbers of people suffering serious conditions at the same time as federal health cuts are creating chaos and uncertainty'?

Mr Bowles: Cutting $17 billion?

Senator McLUCAS: Yes.

Mr Bowles: I am not sure what you are referring to.

Ms Anderson: I think that was carried in the Fairfax media.

Senator McLUCAS: Yes.

Ms Anderson: I can note for the committee that, in 2014-15, as has been published in the estimates, the amount of Commonwealth funding provided to New South Wales for public hospital services has been increased. They, in fact, will receive four per cent more in 2014-15 than was indicated in the 2014-15 budget.

Senator McLUCAS: We are talking over a longer period of time.

Mr Bowles: We are talking about $17 billion. That is an enormous amount of money. I do not really go by Fairfax media, I have to say. I have never heard that figure ever mentioned and I would not pay much credence to it at this stage.

Senator McLUCAS: Over the—

Mr Bowles: It would have to be over 25 years or 100 years or something to get to that number.

Senator McLUCAS: No, it is to 2024-25, and I think that is generally regarded as what the cut will be to New South Wales hospitals over that period of time. Mr Bowles?

Mr Bowles: Not to my knowledge. I would have to look at what you are referring to and make a considered response to that. Again, I do not like responding to media articles, because they are inevitably not actually accurate.

Senator McLUCAS: That was in the government's own budget papers in the 2014-15 budget. That is where that has been extrapolated from.

Mr Bowles: We will take that on notice and have a look at that specific issue, then.

Senator McLUCAS: I would like to now go to what the cuts will be in various hospital districts in New South Wales. Have you done the calculation of what that will mean in various hospital districts in New South Wales?

Ms Anderson: No, and there is a very good reason for that. The funding arrangements are shared between the Commonwealth and each jurisdiction—each state and territory—and that is clearly set out in the National Health Reform Agreement. The Commonwealth funds around 37 per cent of public hospital costs which are in scope for Commonwealth funding. That is a national figure, but the balance is picked up by each state and territory. There is a very clear understanding between the Commonwealth and each state and territory that, in sum, the amount will be provided through to local hospital networks. So we have each other's funding in sight, but, to the extent that there are movements in Commonwealth funding, there is also an expectation set out in the agreement that the states will make their own decisions about the amount that they contribute towards the total. The Commonwealth payment is set against the National Efficient Price. The states and territories each make their own mind up about their proportional contribution to total. So, 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.

Senator McLUCAS: So you cannot confirm that, for example, in the south-west Sydney local health district, which has Bankstown-Lidcombe, Bowral, Braeside and quite a number of other hospitals, over the period to 2024-25 $1.7 billion will be cut out of those hospitals?

Mr Bowles: We do not manage the state's hospitals.

Senator McLUCAS: I know that. But you are a funder.

Mr Bowles: Exactly. And our—

Senator McLUCAS: So decisions you make will impact these hospitals.

Mr Bowles: I understand that. I have worked in a number of those hospitals in New South Wales, so I understand the impact very clearly. But that figure—whatever figure it was, $18 billion or something—I am not aware of. If it relates to a media release, I am happy to have a look at that. Our funding to New South Wales as, Ms Anderson said, will increase over the forward estimates. So there is a bit of a disconnect. I am happy to take it on notice and have a look at what that disconnect might be. But I do not want to go into the specific funding of each hospital, because it is not our responsibility as the Commonwealth.

Senator McLUCAS: So you have no visibility of, for example, the Sydney Children's Hospital Network, which has Westmead Hospital and Sydney Children's Hospital in Randwick? Their projection to 2024-25 is $647 million.

Mr Bowles: I have no visibility of what you are talking about. If you were to table that with us, I am happy to do an analysis of it for you and see what that might be, but I have not visibility of those numbers. We do not run the system, as I said—I know you know that—so it is up to the state governments to do what they do within the system. That is how it worked when I was there and I am sure that is still how it works. The Commonwealth funding to states, though, does increase over the forward estimates. We would have to look at what assessment is being made in that 2024-25 figure that you are referring to.

Senator McLUCAS: Ms Anderson has indicated that at the end of 2016-17 we move to CPI and population as the growth measure.

Mr Bowles: That is correct.

Senator McLUCAS: That is the lowest overall level of hospital funding in history, in terms of growth funding. That is what that would mean. Do you agree with that?

Mr Bowles: Again, I have no visibility of what you are talking about. If you table that document—

Senator McLUCAS: That troubles me, Mr Bowles. It has been in the media since the budget that these cuts to public hospitals have been the most vicious and harsh of any government in history. I am surprised that you—

Mr Bowles: I am surprised that you are surprised. I do not run the department by looking at media releases.

Senator McLUCAS: I understand. You have a budget. But that budget will deliver the biggest cuts to hospital funding ever seen in this country.

Mr Bowles: I will go back and say: the Commonwealth hospital funding to states will increase over the forward estimates.

Senator McLUCAS: That is not the question I am asking.

CHAIR: Perhaps I will ask a question, if I could. Perhaps you could clarify. We are talking about New South Wales. What is the increase? I have seen averages in terms of the increase in hospitals funding. But what is the increase for New South Wales in the budget period, in the forward estimates?

Mr Bowles: In 2014-15 the annual growth increases by 12.2 per cent; then, into 2015, another 7.6 per cent; 2016-17, it is 6.5 per cent; in 2017-18 by 5.9 per cent.

Senator DI NATALE: Chair, can I ask a question to follow up on that?

CHAIR: You can. I will just say—Mr Bowles, what is the total increase over the forward estimates?

Mr Bowles: Over the forward estimates: 36.2 per cent.

CHAIR: And I think that is just above the national average, from memory, over that period, which is around 35.

Mr Bowles: I think that is right.

CHAIR: I have cut in on Senator McLucas. We were coming to the end of Senator McLucas's time for now, but—

Mr Bowles: As I said, I am happy to have a look at what Senator McLucas is talking about and give some assessment of that when we can. But I am not going to use a media release to put evidence on the table here today. I am going by how we operate as a department and the funding to states according to the budget.

CHAIR: That is a 36 per cent increase for New South Wales.

Senator McLUCAS: Can I ask one more question and we can come back to it later. Mr Bowles, you offered to do some analysis of what it would mean by hospital district?

Mr Bowles: No, not by hospital district.

Senator McLUCAS: You didn't?

Mr Bowles: I am not going to second-guess states or territory governments around how they fund hospitals. That is their job. We provide funding to the states.

Senator McLUCAS: Given the abandonment of the National Health Reform Agreement and the cutting of reward funding, what will be the cut to each state and territory as a result of those policy decisions?

Mr Bowles: We will take that on notice.

Senator McLUCAS: You do not have that with you?

Mr Bowles: No.

Senator McLUCAS: Ms Anderson, do you?

Ms Anderson: No.

Senator DI NATALE: Mr Bowles, given that you are going to take this on notice—and I understand that you are new to the area—could you also, rather than simply quoting the increase in funding to hospitals, put it in the context of health inflation, population growth and the projected funding under the previous national partnership agreement?

Mr Bowles: We will take that on notice and have a look at it, yes.

Senator IAN MACDONALD: I have some questions about Medicare payments going to public hospitals and the COAG exemption under section 19(3) of the Health Insurance Act—is this the right area to be asking?

Mr Bowles: Maybe if you ask the question—it probably cuts over this acute area and our medical benefits area. I do not think they are here yet, but let us see if we can answer your question.

Senator IAN MACDONALD: I have two conflicting constituents here. One is a hospital board on the Atherton Tablelands whom I assisted some years ago. They were getting, as I recall, Medicare payments for services they delivered in Mareeba Hospital. The Commonwealth was paying them a Medicare benefit but it was going to the then Queensland government—and I think some Tahitian prince was using the money to go around the world. This was in the days of the Bligh government. We eventually got the money paid to Mareeba Hospital. That was some years ago and it was resolved. I have just had some contact from them recently—from Mr Mick Borzi, a very significant figure in the area. He says, 'I have been a chairman on a voluntary basis on the local hospital's governance committee. I learned today that the existing government policy in relation to the COAG 19(3) exemption is under review. If this is correct, we seek your assistance to ensure retention of the existing policy.' Referring back to the previous issue they had raised with me, they were using the money they got from Medicare to employ new doctors, many of whom were doing work in Aboriginal communities in Cape York. So my first question is: is that under review?

Ms Anderson: The answer is yes. I think it is section 19(2) of the Health Insurance Act. We are currently undertaking a review. The memorandum of understanding that we have in place with most but not all states is coming up for its expiry in June this year, 2015. The review is currently underway to provide advice to government enable it to make decisions about the future of that program.

Senator IAN MACDONALD: Will be that advertised? Will you be seeking submissions from all and sundry?

Ms Anderson: We have already undertaken bilateral discussions—fairly extensive consultations with every jurisdiction, including Queensland. If somebody has a particular view that has not been expressed in those consultations so far, we are more than happy to hear them.

Senator IAN MACDONALD: This is a local hospital board, not the Queensland government. Of course we do not know where the Queensland government is at the moment. There are new people in charge and they will be all over the shop for some time, I imagine.

Mr Bowles: It will largely be an issue for the Queensland government. As Ms Anderson said, we have been discussing that with them. How Queensland will operate in that is a matter for Queensland, I suppose. But we are happy to have a look at—

Senator IAN MACDONALD: Should I suggest to my constituent that he make a submission perhaps to you, Ms Anderson, or to the secretary.

Ms Anderson: That would be in order. It would probably be useful for the Queensland Department of Health to be involved in that process in order that they understood also the perspectives of their local health and hospital district.

Mr Bowles: We will only have to refer it back to them otherwise.

Senator IAN MACDONALD: I have little influence with the federal government, but I have even less with the Queensland government, particularly the current Queensland government. I will get them to contact both you and the Queensland government and put their concerns. On the same sort of subject but from the other point of view—perhaps I will not name names or towns—some general practitioners tell me that there is so much Medicare money going to the local hospital, which works in competition with a couple of very good and established private practices, that they are very concerned. The hospital, allegedly, has so much money from Medicare payments it does not know what to do with it. This has come up in the context of the government's co-payment issue, which I dare not mention here, in the general review. It has been suggested to me by some GPs that if you want to save money in the health area you really should look at the money going to public hospitals that are doing work competing with established private practitioner groups and, of course, affecting them. You are getting a Commonwealth subsidised public health system competing with private health practitioners. Does any of that make any sense or ring any bells? What should I do about that? As I say, it is a bit of a contrary one to the other one I have just raised.

Mr Bowles: It very much is. It will relate to how a hospital operates with doctors with a right of private practice. In a hospital system, doctors in certain places are employed with a right of private practice, which means they can do private work within the hospital confines and they can charge Medicare. It is largely how a hospital or a state policy works. We are clearly interested in that and, I dare not use the word, cost shifting from time to time. But there are elements of this that we are constantly looking at and it is not a surprise, let's put it that way.

Senator IAN MACDONALD: I am not sure but my impression, and I might have this wrong, is that it is not that the hospital doctors are working in private practice using, I suspect, public rooms and facilities. My understanding was that it was the public health doctors doing their public health work but then billing the Commonwealth. It was my impression that they were not personally getting the payments but that it was just going to the hospital board—

Mr Bowles: It depends on what it is.

Senator IAN MACDONALD: as in the case in Mareeba that I looked at.

Mr Bowles: It can work in multiple ways. The public hospital can accept private patients into its beds and bill the private health insurer for that matter. There are multiple ways that this sort of thing happens. If they are worried about doctors earning money and taking it away from the private sector it is usually around the rights of private practice of public doctors.

Senator IAN MACDONALD: I do not think that is the impression because it seems to be the hospital that has this pool of money that they do not know what to do with.

Mr Bowles: Mr Cormack might be able to help us.

Mr Cormack: There is a longstanding practice that has been incorporated into the various healthcare agreements between the Commonwealth and states going back many years—in fact, going back to the advent of Medicare itself—that has provided for certain categories of employees of the state systems to have a right of private practice, as Mr Bowles has said. Part of those arrangements also may involve the public hospitals raising a facility fee. Many of the hospitals I am aware of have trust fund arrangements that are established to manage these legitimate billing arrangements that are in place.

The billing arrangements can also be part of the enterprise agreement between the medical officers and their employer, the states. These fund arrangements are commonplace in virtually all the public hospitals across the countryside. The question the secretary has identified is the extent to which these cross the line and potentially

breach the arrangements. They are the areas that are always matters of great vigilance for the Commonwealth and, clearly, if there are issues of cost-shifting they can be pursued.

Senator IAN MACDONALD: I did raise this with the former health minister and got a response drafted by the department saying that if the local GP who is concerned thinks anything is untoward, here is a secret number that he can report suspected fraud to. That is not the sort of answer I wanted to send to this medical practitioner. I thought the department might have had some means of investigating it.

Mr Bowles: Just on that, the compliance is done a little bit separate from the department, for some obvious reasons, and we do not necessarily get into some of that. As Mr Cormack said, it is legitimate but if they do stray into the illegitimate we are, clearly, interested in that sort of behaviour.

Senator IAN MACDONALD: I am pleased that Minister Nash is here, because it is really a rural health issue. Perhaps it happens in the city. I am not aware. The instances I am talking about are in rural health areas where, because of the way things are, we struggle to keep medical practitioners, we struggle to keep medical services and a lot of people have done it. Both these two instances I relay have done it, but from different ends of the spectrum. It is a complex issue.

It is sort of interrelated with the Medicare Locals, which I think come on later. Perhaps I will come back and talk about it then. In my own home community, the Burdekin Centre for Rural Health has been doing a wonderful job. Medicare Locals came along and were taking money off the Burdekin Centre for Rural Health, which has a well-established volunteer-support group. I have had some correspondence with Mr Dutton and it was fixed up for a little while.

Then I heard that the local hospital, which has a lot of money from Medicare, is starting to take over work that the Burdekin Centre for Rural Health did. I may have the facts quite wrong, but they are issues that have been raised. Perhaps I will come back to Medicare Local later, but it is related.

The hospitals now seem to be—because they are getting Commonwealth money—doing things that under other arrangements had been set up some years ago by different governments, encouraging these centres for rural health that do mainly secondary health care.

Mr Bowles: This is not a new issue. I worked in Queensland and New South Wales 20 years ago and it was happening then, so it is not a new phenomenon. As you described, GPs are a little disenfranchised and they cannot get enough work to keep them in the country. Equally, the fact that some hospitals can provide rights for private practice keeps doctors in hospitals in country towns. It is really quite a tricky issue, because if you stop one you affect the other. It is the health system, more broadly. It is the system. You pluck one thing and it does have an impact.

Senator IAN MACDONALD: It is almost a case of one size does not fit all.

Mr Bowles: Yes.

Senator IAN MACDONALD: Because the right of hospital doctors to private practice is essential in smaller 400- to 1,000-person communities, but in 10,000-person communities where there is an established private GP system—

Mr Bowles: Again, my experience is dated, I will grant that; but I have worked in very large hospitals and there are rights of private practice in those, too, in metropolitan centres. It is not a rural-specific issue, if you like. It has been something that is around. I take your point, though, that the impacts in a rural setting can be different. The fact that there are rights of private practice, in my experience, has attracted more doctors into some of the local communities as well. So it is, as you say, not one size fits all. I think states—because it is not our issue—need to think about how they do that to make sure they do have doctors in all of their communities; and I know they do, because that is what they do on a regular basis.

Senator IAN MACDONALD: It is coming up, I hope, with the current review of the co-payment proposal. And for whoever is Minister Ley's officer in the room: I am trying to get Minister Ley, when she comes north, to meet with these sort of people that I am talking to you about as part of that ongoing thing. Minister, perhaps you could indicate: are these sorts of things all being—I know that being a rural person yourself, and in charge of rural health matters, these issues with the co-payment have come up—considered in the minister's current review of where we are going?

Senator Nash: I know that the minister is doing very broad consultation. She is taking in a wide range of aspects and I think particularly has a focus on rural and regional areas.

Senator IAN MACDONALD: Thanks.

Senator McLUCAS: I just want to go to Tasmania. Is the department aware of reports that 10 dementia beds in Hobart are to close because of an expiring national partnership agreement?

Ms Anderson: Yes, we are aware of that report.

Senator McLUCAS: Is that resulting from the expiry of the $325 million Tasmanian package, as it is generally called, that was announced in the 2012-13 MYEFO?

Ms Anderson: No, my understanding is it relates to the one-off funding that the Commonwealth provided for increasing subacute services under the National Partnership Agreement on Improving Public Hospital Services. As you know, that subacute funding expires at the end of 2012-13.

Senator McLUCAS: That is separate to the Tasmanian package completely?

Ms Anderson: Yes, it is.

Senator McLUCAS: Has Tasmania made any representations to the Commonwealth around doing something to reverse the closure of these 10 beds?

Ms Anderson: Not that I am specifically aware. I will just correct myself from earlier. I think that subacute funding actually expired at the end of 2013-14. But I am not aware of any explicit representations, no.

Senator McLUCAS: The $325 million package, though, when does that expire?

Ms Anderson: There were a number of elements in that package, and they run for different periods of time; some were for three years, others were for four years.

Senator McLUCAS: Right.

Ms Anderson: I think that the four years ends at the end of 2015-16.

Senator McLUCAS: Right. I wonder if you could provide us on notice a list of the elements of that package and the expiry of each of them. Also, could you indicate whether or not the department has had any conversations with the Tasmanian department of health about that package being extended.

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

Senator McLUCAS: Thank you.

Senator PERIS: My questions are around the Palmerston hospital.

Ms Anderson: We normally take those questions in a different outcome. We normally deal with those in the infrastructure outcome which is later on today. I can tell you where that is.

Senator PERIS: Do you want me to do it now?

Ms Anderson: Why don't we do it now.

Senator PERIS: Okay. There are not that many. With regard to the Palmerston hospital questions that I asked in October of last year, one of the milestones that was meant to be met was in November 2014. I wanted to know if that milestone was achieved. As part of that, a payment was meant to be made. I just want to know if that payment had been made and if the milestones have been met. It was in November last year.

Ms Anderson: Senator, you would know that in October last year, in 2014, the Northern Territory government approved a design, build, operate, maintain public-private partnership for the Palmerston site. On 22 November they issued an expression of interest, which closed on 16 January 2015. We have not had any advice from the Northern Territory government as to the outcomes of that expression of interest. I expect they are busy going through the responses and doing a very thorough evaluation of them. In terms of the funds that have been provided, as you would be aware, a total of $110 million has been committed by the Commonwealth government and that will be added to by the Northern Territory government. There is expenditure to date of the $1 million that we have talked about, in 2011-12, and $20 million which was made as of 31 December for the current financial year.

Senator PERIS: I am looking at the payment milestones. The site services commenced in July 2014 and a relevant report was due to obtain that $20 million. You are saying a report was given?

Ms Anderson: Given that the expenditure has been made, yes. I cannot confirm absolutely, but I am sure that the expenditure will not have been made in the absence of reports. I am quite sure that has happened.

Senator PERIS: Going back to the payment milestones, according to the project agreement, construction of the hospital itself, site services work is due to start in May 2015. Given that this is only two months away and we have not received an expression of interest yet, what is the Commonwealth's assessment of the chances of the NT government meeting this timeframe?

Ms Anderson: We remain optimistic.

Senator PERIS: You might give me an optimistic answer again. The project agreement says that the completion date is May 2018. Given the current circumstance that no expression of interest has been made yet, do you still stand by the agreement that the hospital will be open in May 2018?

Ms Anderson: The Northern Territory government has advised us that the project is on track and that they are expecting to commence construction in mid-2016 and to complete and indeed open the hospital in 2018. That is our understanding of what is going to happen.

Senator PERIS: You were just saying that construction will commence in May—

Ms Anderson: Mid-2015 is the advice that we have been provided by the Northern Territory government.

Senator PERIS: So within two months, hopefully, we will have an expression of interest?

Ms Anderson: We live in hope.

Senator PERIS: You are not concerned that they are going to miss deadlines?

Ms Anderson: We look to every state and territory to whom we provide funds to manage their projects as best they can.

Senator PERIS: The Northern Territory government is currently spending $6.4 million on road works adjacent to the site. Is this part of the Palmerston hospital project? Does this funding come out of the $150 million committed to the project?

Ms Anderson: I would have to take that on notice. We would not necessarily have visibility of the Northern Territory's plans for its $40 million. I am happy to take that question on notice.

Senator PERIS: You have received the plans from them and the constructions stages?

Ms Anderson: We have some detail, but it does not go down to the specifics. We may or may not have that information. I am more than happy to find out.

Senator PERIS: The agreement says that the project plans to be agreed to by the Commonwealth. The agreement says that the project plans would include details on the scope, project schedule, budget, project stakeholders, governance arrangements, a communication plan, high-level designs and a risk management plan. Has such a project been agreed to?

Ms Anderson: The detail of the project agreement is contingent on the outcome of the expression of interest process and decisions which have to be made subsequent to that. That is work ahead of us which we expect to engage the Northern Territory in fairly shortly.

Senator PERIS: That will be part of the expression of interest?

Ms Anderson: It will be one of the outcomes of that process. That is the process which is designed to identify the preferred provider, if you like, and that leads to the detailed planning which necessarily follows the engagement of the provider.

Senator MOORE: I have general questions around the Independent Hospital Pricing Authority. They are general policy initiative questions. It is a very general question, Doctor. Can you explain how the proposed introduction of activity based funding increases efficiency and transparency in the hospital system? What is the analysis of that? I know it is a big question.

Dr Sherbon: Rather than enter a promotion of the issues canvassed in your question, I could perhaps point out that activity based funding over the last three years that it has been a consideration of the Independent Hospital Pricing Authority—mindful of the fact that we have just released our fourth price this morning—has reportedly—

Senator MOORE: I am sorry, Doctor. This is a longstanding complaint in this room: I am having a little bit of trouble hearing you.

Ms Anderson: I will speak up.

Senator MOORE: It is often in this room. You said that efficiency based funding has been part of the process for a long time? Is that right?

Ms Anderson: For three years, and we have just released our fourth price this morning for the 2015-16 financial year. From New South Wales and Queensland in particular, and also WA and South Australia, we have received strong reports through state and territory ministers of the previous government in Queensland and current governments elsewhere that the work that we have done has allowed them to introduce a greater degree of transparency into their own systems as well being able to understand the nature of the Commonwealth funding that they have received for their public hospitals.

Senator MOORE: That is articulated in your fourth report that has come out this morning?

Dr Sherbon: Not that sentiment, but our work this morning releases our fourth national efficient price accompanied by a detailed policy framework that was released late last year.

Senator MOORE: Can you explain to me the arrangements that were introduced, including the incentives for states and territories to achieve the NEAT and NEST targets?

Ms Anderson: That is a separate matter from activity based funding per se. Under the National Partnership Agreement on Improving Public Hospital Services, a substantial amount of money was identified to assist the states and territories to redesign their services in order to better achieve the shorter waiting times in emergency departments and for elective surgery. We provided substantial facilitation funding, as we call it, up front—

Senator MOORE: I used the term 'incentive', but the formal term you use is 'facilitation funding'?

Ms Anderson: It was deliberately 'facilitation' because it was designed specifically to assist in the reorganisation of services, which we knew was necessary to allow the improved performance. It was moving things in order to create differences in emergency departments in the whole of hospitals in the way they manage patient flows, throughput and so on. It was up-front money in order to facilitate those changes. There was also a capital component because we were advised by states and territories that there would be some rebuilding required—new facilities and so on. All of that money was provided up front. Then, at the latter stages of the agreement as it was initially struck, there was a much smaller amount of funding, which was going to be provided as a reward for continued progress towards the targets which had been agreed by COAG.

Senator MOORE: And which were being publicly put out?

Ms Anderson: Yes.

Senator MOORE: When was the first significant injection of money, and then what was the date of the second amount of funds you have mentioned? While you are looking that up, when do you intend to publish the National Efficient Price and National Efficient Cost determinations.

Dr Sherbon: For the 2015-16 year, 9 am this morning.

Senator MOORE: Do you happen to have a copy?

Dr Sherbon: They are on our website, and I can give you the figures. The National Efficient Price is $4,971 per national weighted activity unit. That will not mean anything to you, but what will mean something to you, perhaps, is compared to the adjusted previous year figure it is a 3.0 per cent growth.

Senator DI NATALE: What are those figures based on?

Dr Sherbon: The way we calculate the National Efficient Price is an extensive process of iteration with all state and territory governments.

Senator DI NATALE: I am talking about the three per cent..

Dr Sherbon: I need to give you a bit of context, without leading you into what might be a crushingly boring technical discussion. We use the national hospital cost data collection to measure hospital costs across Australia—annual collection across over 100 hospitals throughout Australia—and we cost over a million patient episodes in hospitals. When we come to measure growth in cost, we base our measurements on the growth in average cost over the previous five years of that hospital cost data collection. The most recent year's collection is 2012-13. We have that collection available to us in our database and we measure the growth in average cost of hospital services as adjusted for complexity across the previous five years, and we use that as our indexation figure. That is where the 3.0 per cent per cent comes from. Over the last five recorded years, our hospital expenditure growth has slowed singularly.

Senator DI NATALE: We keep getting told that hospital costs are blowing out of control and hence we need to look at co-payments and so on. Is this the same measure as health inflation?

Dr Sherbon: This is only public hospital costs.

Senator DI NATALE: Health inflation is doing a similar thing, isn't it?

Mr Bowles: There are two completely different issues, as they relate to co-payments—there are the GP and Medicare systems. We are talking about a hospital price here, and that is the difference. More broadly there is a growth in health expenditure, yes.

Senator DI NATALE: I just want to know how the three per cent increase in hospital costs relates to health inflation more generally—not just hospital costs.

Mr Bowles: It contributes to it but it is not the only thing.

Senator DI NATALE: So what is the health inflation figure at the moment?

Dr Sherbon: It would include private GPs, private specialists, private hospital costs, health insurance costs—

Senator DI NATALE: What is the number?

Dr Sherbon: We labour on this in our considerations—the figure you come up with depends on what you include in your basket of goods. The Institute of Health and Welfare does publish, as does the ABS, a range of health cost indices.

Senator DI NATALE: They do have a health inflation index figure, which is an overall figure. I am asking you what that figure is.

Mr Bowles: I do not know. It is largely an AIHW figure. We can take it on notice.

Senator DI NATALE: You must use it in some of your work. Take it on notice.

Mr Bowles: I will take it on notice, I just do not have it off the top of my head.

Senator MOORE: We will have to come back to the way the NEP is worked, as I want to clarify some stuff, but I know Ms Anderson has her answer so to conclude that I should go back to that—what was the date of the significant injection of funding that you alluded to, and you also said that towards the end of the program there was more money fed in to look at particular things that were going on. I want to get the amounts and the times for those.

Ms Anderson: The first payments were made in the 2009-10 financial year, and that was $133.7 million. That was allocated for elective surgery capital and emergency department capital and what we call the flexible funding pool, which was a choice that states and territories could make about how they used the funding. Payments have been made right the way through to 2013-14, and I can give you the numbers over each successive year.

Senator MOORE: I am sure we have that somewhere, but can I ask you to table that document. Is the bit about the last payment on the same document? Table that for me, if you would not mind.

Ms Anderson: I will. I will also add that the government is in the final stages of making decisions about the final payments under this NPA. I think that decision will be made known shortly.

Senator MOORE: On the timing of that final payment, is there any ballpark estimate for when that is due or when a decision will be made on that?

Ms Anderson: No. I understand that it will happen shortly.

Senator MOORE: Does it have to be done by a certain time?

Ms Anderson: The payment should be made in the 2014-15 financial year. My understanding is that the government has made a decision but it has not yet been communicated—

Senator MOORE: So, really, it should be made before 30 June this year; is that right?

Ms Anderson: Yes. The communication of the decision will absolutely happen before then.

Mr Bowles: Can I take on notice to table those documents? I just want to have a look at them. There are a range of other issues on the papers.

Senator MOORE: Yes, that is fine. The specific question I was asking was around that final payment.

Mr Bowles: We will take that on notice.

Senator MOORE: Or you could table your whole folder for me, Ms Anderson—that would be great! That would cut out a lot of questions! But, no, that is fine.

Senator PERIS: Ms Anderson, we were talking before about the $20 million that is being paid to the Northern Territory government. Do you have a breakdown of what was achieved in the Northern Territory for that $20 million against that milestone achievement?

Ms Anderson: I am not able to provide that to you, but I am more than happy to take that question on notice. That would be available. We can give that to you.

Senator PERIS: So there would be a report that was provided from the Northern Territory government to you and you can provide that?

Ms Anderson: Yes. There would be a milestone, as you observed earlier, against which the payment is made. I can give you details on that.

Senator PERIS: Do you know how long that will take?

Ms Anderson: I am happy to provide it within the timetable that has been set. We may even be able to expedite it for you.

Senator PERIS: Thank you.

CHAIR: We will break for 15 minutes and when we come back we will move on to outcome 5.

Proceedings suspended from 11:02 to 11:16

CHAIR: We will now move on to outcome 5.

Mr Bowles: Excuse me, can I just answer some of Senator McLucas' questions around Ebola. I have just got some of the answers for you.

CHAIR: Please.

Mr Bowles: You asked about the establishment of the IDC. It was established on 22 September 2014. It met weekly until the new year. Since 9 January, it has met fortnightly. It is still meeting, but it is meeting fortnightly.

Senator McLUCAS: When was it established?

Mr Bowles: That was 22 September. You also asked, or it might have been Senator Moore, about information sharing. There are weekly situation reports that go from DFAT around the operation. The specific question was on admitted discharge. Currently, there are beds available. As of 17 September, there were 135 patients since the centre opened, 83 patients who have been discharged and 44 patients who have died. On 17 September, there were one confirmed and seven suspected cases being treated at the centre. Capacity is at 50 beds.

Senator McLUCAS: I am confused. That was on 17 September?

Mr Bowles: Sorry, that was 17 February. I obviously got confused with 22 September, when the IDC started. But those numbers are for 17 February: 135 admitted, 83 discharged and 44 have died. Currently, there is one confirmed and seven suspected cases. The bed capacity is 50. There are eight people there at the moment.

Senator McLUCAS: My advice is that the maximum potential capacity is 100.

Mr Bowles: That is correct, but there are only 50 open because there are only eight patients at the moment.

Senator McLUCAS: I am advised that there are 20 operational beds.

Mr Bowles: They are telling me that currently capacity is 50, so maybe operational beds might be 20.

Senator McLUCAS: Different words.

Mr Bowles: Yes, different words. The operational capacity might be 20. If you have got eight patients, you are only going to staff something a little bit greater than that.

Senator McLUCAS: A certain number.

Mr Bowles: Yes. It will be a patient dependency issue with the staffing.

Senator McLUCAS: Thank you. Can I go to primary healthcare networks, please. Is the announcement expected to be made about successful tenderers by the end of March, as indicated earlier?

Mr Bowles: Maybe not the announcement, but we will be ready. We are on track to be finalised by the end of March.

Senator McLUCAS: When do you expect the announcements for PHNs to be made?

Mr Bowles: We are on track to finish by the end of March. We would hope soon after that to let people know and make announcements from there, clearly, to get things running by 1 July.

Senator McLUCAS: Sorry, I was distracted. What date did you say that the announcements would be made?

Mr Bowles: I did not have a date. I said soon after that. We have not got a specific date, do we?

Mr Booth: No, we have not got a specific date, but it will be in mid to late March.

Senator McLUCAS: In the invitation to apply, there is a set of words that I would like some clarification of. It says:

Unlike purchasing models, in the context of the PHN Programme, commissioning is characterised by a strategic approach to procurement that is informed by the baseline needs assessment and associated market analysis undertaken in 2015-16.

Can you give the committee an understanding of what that really means?

Mr Booth: One of the key differences between Medicare Locals and primary health networks is the notion that they will not be providers of services, they will be purchasers of services and commissioners of services. In order to do that effectively, they need to have a good understanding of what the health needs of the population are that they are actually going to be covering. As part of that, they will be required to do a health-needs assessment process. That health-needs assessment process will go out and really come back with the characteristics of the population, the health services that are available, the health status of the population and all those kinds of areas, as well as—on the provider side—doing an assessment of the services that are available, the providers that are

available and those kinds of things. Really, that is to give them the ability to look at where need is in their particular area and to help them inform their purchasing decisions that they make.

Senator McLUCAS: It is quite an extensive piece of work, isn't it?

Mr Booth: A health-needs assessment exercise is a fairly detailed piece of work. There are fairly common; organisations like these would do them. It is a key part of community consultation as well, making sure that the community is involved in these kinds of things. It provides the evidence to the PHNs to underpin their activities.

Senator McLUCAS: But this is part of their application?

Mr Booth: It is not part of the application. They will be expected to do this as they move forward. In terms of their application, they would need to provide an understanding of the area that they are covering and what the characteristics are of that particular area. In terms of moving forward to become commissioners, then there is a need to do more formal work around needs-assessment exercises.

Senator McLUCAS: Right. I think I am starting to understand what you meant in that sentence. We did misunderstand what that was all about. Just so that you understand, I understood that to meant that an applicant for a PHN would have to undertake that needs analysis in the application.

Mr Booth: No. They were need to demonstrate an understanding. Also, just to be clear, the Medicare Locals did some work on needs assessments. Those have been made publicly available so that applications can look at those and see those.

Senator McLUCAS: In terms of the invitation to apply, can you describe to the committee the types of organisations that are eligible to apply?

Mr Booth: Certainly. The application process was an open process. Any organisation that felt it had the capability or the capacity to undertake the role of a PHN could apply either singularly or in consortia with another group.

Senator McLUCAS: So private businesses and private health insurers?

Mr Booth: Correct.

Senator McLUCAS: Health service providers in the private sphere?

Mr Booth: That is correct.

Senator McLUCAS: There are to be 30 PHNs. How many applications have been received for those 30 PHNs?

Mr Booth: In total, there were 60 applications received.

Senator McLUCAS: Of the 30, how many had one applicant?

Mr Booth: There were a number that had one applicant. I think at the moment we are not really giving that information out in terms of the assessment, because the assessment process—

Senator McLUCAS: That is why I did not ask you which one has one.

Mr Booth: is underway. It is my understanding that some of them had one applicant. I do not know the exact number, but the assessment process is underway at the moment and I would not like to give information out in terms of which areas or whatever.

Senator McLUCAS: For those PHN areas that have one applicant, is it a given that that applicant will be successful?

Mr Booth: No, certainly not.

Senator McLUCAS: What happens in those circumstances?

Mr Booth: It is the same as would happen in any PHN area, where the assessment process determines whether there is a good enough application to actually become a PHN. It is conceivable that in any area, not just one where there is only one applicant, no suitable applicant is successful. In that case—I think it is in the ATM documentation—the department reserves the right either to broker a solution, so to actually go out there and talk to who is there, or to invite a neighbouring area where someone has been successful. But, essentially, we would look very carefully and look at putting a solution forward that would try and get a successful candidate through. But there is no preconceived notion that, just because there is one application, they will automatically get it.

Senator McLUCAS: Were there any PHN areas that had no applications?

Mr Booth: No.

Senator McLUCAS: How does the department then resolve potential conflict of interest questions where an applicant may have a potential conflict of interest in provision of these services?

Mr Booth: Again, the documentation that has gone out has been very clear in that any applicant to become a PHN must address either actual or perceived conflicts of interest within their governance structures and within their organisational form. There are different permutations that you could think of coming forward here, and there will be different models and different areas depending on who is involved and everything—but, very much, a strong government structure that identifies those conflicts of interest and makes sure that they are addressed.

Senator McLUCAS: Let us go to one that potentially needs most of the focus. Private health insurers have applied to be a PHN—

Mr Bowles: I do not think we should go there. We are still in the evaluation process. I do not think we should be necessarily, at this point, going to who might have applied, because it is a defined market.

Senator McLUCAS: I am not talking about the name of a particular private health insurer.

Mr Bowles: But there are only a few in the market, so you could make all sorts of assumptions very, very rapidly.

Senator McLUCAS: Let me ask the question, and you tell me if you think I have pushed too far. If a private health insurer were an applicant, either in a consortium or individually, how would the department ensure that it unpicks that potential conflict of interest—in that the private health insurer covers individuals who live in that PHN area, has an interest in its relationship with those individuals and provides a broader service to the whole population?

Mr Bowles: Can I just re-craft it a little bit to say there is potential for conflict of interest around a range of people who potentially may or may not apply for this. It could be an insurer; it could be a current Medicare Local; it could be a group who currently provides some services in a particular area. How would we deal with the conflict of interest when people have had relationships with individuals within an area? I think we can answer that, but I would not want to make it specific to an insurer because I think the same can actually be said for a whole range of other providers.

Mr Cormack: The another point to that is that, hypothetically, in relation to an insurer, the role of PHN is a commissioning role. It commissions services on the basis of a sound needs assessment and an understanding of the market but it does not in its commissioning role identify individuals who would receive individual services. It provides a bundle of commissioning activities. I think the key to dealing with any issue of conflict of interest is contemporary corporate standards of disclosure and appropriate risk management arrangements, particularly relating to the responsibility of directors of any constituted body.

Senator McLUCAS: We will leave the conflict of interest question there. On the question of the commissioning role, Mr Cormack, I understand there has been a bit of movement around that area. There is a realisation that in some areas the PHNs may have to be the provider of some services, that the original position that the government took that the PHNs would not provide services has had to move. Could you give the committee a bit of an understanding of what has happened?

Mr Cormack: I think there is a recognition of a transition arrangement that will apply potentially in some cases. Above all, we would be very, very conscious of creating any disruptions or causing sudden gaps in essential service delivery. So part of the transition plan—and I will ask Mr Booth to give some details on this—is to focus on transition, with the full commissioning role anticipated to be fully operational after 12 months, not necessarily immediately, recognising that in some areas there would be service contracts in place and there would be arrangements affecting general practices, other health professionals and hospitals that cannot simply be turned off overnight in all cases and then converted to a pure commissioning arrangement. Perhaps Mr Booth could elaborate on those.

Mr Booth: That is correct. In terms of providing that service when PHNs commence operation, they will have a variety of services that they inherit that the Medicare Locals have been providing. But the expectation is that in first year they will market test and will become purchasing bodies as soon as possible from the year after.

Senator McLUCAS: What happens in a place where there is nothing to purchase?

Mr Booth: We are getting into the area of market failure here. I think there has been a very definite policy line throughout that, as far as possible. PHNs will be purchasers and commissioners. The advice that has been given is if the PHN is in an area where there is no provider of services of sufficient quality—because quality is an issue here as well in areas—or if there is no specific service there then the PHN needs to do what it can to try and stimulate the market to try to encourage the provision of services in that area so that it does not have to provide

them itself. They may link in with neighbouring PHNs; so they may look across borders. They may see a particular area where there is a gap and seek to see if organisations can bring people in to meet that gap. They may do that. At the end of that, if that fails as well, then the PHN would need to formally apply to the department to indicate exactly what they have done and the processes they have gone through. Only after that would we then say, yes, you could provide the service.

Senator McLUCAS: We will see how that goes.

CHAIR: Senator McLucas, you have a couple more minutes. I have a couple of people waiting to ask questions. I can come back to you after that, if you like.

Senator McLUCAS: Sure. Let us plan within this outcome that we will do mental health from, say, 12.00 to 12.55.

CHAIR: I think we will see how we go. I know there are at least three other senators who are waiting.

Senator McLUCAS: Sure. That is what I am trying to assist. Can you give the committee an update on what is happening with the ATAPS programs that are currently being provided by Medicare Locals.

Mr Booth: In line with other mental health programs, the contracts continue until the end of this financial year. What happens to the contracts after that is a decision of government in line with the recommendations of the Mental Health Commission review.

Senator McLUCAS: We will get to that later. In terms of the transition and the contracts that are in place, you do not expect that those ATAPS programs will be part of the transition arrangements?

Mr Booth: As I said, we are very conscious of the programs like ATAPS and other programs where the funding agreement comes to an end. We will be working over the next few months as soon as decisions have been made around contracts and what is happening to make sure the contracts are put in place, if appropriate, to deliver those services.

Senator McLUCAS: Does that go with Closing the Gap as well?

Mr Booth: That would be similar in terms of delivery of those by PHNs.

Senator McLUCAS: Where it is run by PHNs? And Partners in Recovery is the same?

Mr Booth: Partners in Recovery is similar, yes, although the contract for that goes through till 2016.

Senator McLUCAS: That is right.

Senator MOORE: Can I add a supplementary question to that, Mr Booth. In terms of the use of ATAPS, a lot of specialised communities that we have done work with as governments, including forgotten Australians and women who have had their children adopted, were referred to ATAPS whilst discussions were being made about what else was going to happen. It is important that their special needs are part of the discussion about ATAPS, and sometimes that gets forgotten between departments. There are quite a few of those groups that we have referred through to ATAPS as the option for service.

Mr Booth: That is correct, and we are aware of that in terms of the specific programs. As you will be aware, ATAPS has a number of streams within it in terms of specific areas where we are trying to get that access going. But we take that point.

Senator McLUCAS: Has the department done any analysis of the number of staff of the 61 Medicare Locals who will lose their positions as a result of the closure of Medicare Locals?

Mr Booth: There has been no specific analysis done. Essentially the process at the moment, as you know, is that there is an application process going through. Some Medicare Locals will be putting in for that process; some Medicare Locals will have made the decision to continue as bodies by themselves. There are a variety of permutations that could go on here, so it is very difficult to actually do that.

Senator McLUCAS: So you have done no analysis of how many people—

Mr Booth: It is very difficult to do that.

Senator McLUCAS: will transition and how many will lose their jobs? What assistance is being provided—I am thinking about redundancies—to staff who will lose their jobs if they are currently employed by a Medicare Local and are not successful in the application process?

Mr Booth: There is no specific assistance given there. Medicare Locals are independent companies and will need to take their business decisions in terms of where they decide to go. As I say, I think it is tied up with the previous answer, where there are different options that Medicare Locals have in going forward from this—they

could become a service provider or they could go into a consortium. But at the end of the day it will be a decision for them in terms of what they do.

Senator McLUCAS: So if a Medicare Local is unsuccessful in an application, or maybe the Medicare Local did not apply, and if that Medicare Local finishes on 30 June, as I still believe is the intention, will the department assist with any redundancies?

Mr Booth: No, they will not. That is a standard Commonwealth clause—that there will be no assistance there.

Senator IAN MACDONALD: Can we come down several levels of understanding and appreciation of the terminology that those of you who practise in this area treat as everyday. I struggle to understand what you are talking about. Can I confirm that the Medicare Locals, as you say, are a supplier of services—they employ doctors, they employ mental health specialists, they employ orthopaedic people and they actually deliver the service. Is that it?

Mr Cormack: The models vary a bit, but Medicare Locals have historically provided a range of support services to general practice and in some cases have—

Senator IAN MACDONALD: What do you mean by 'support services'? Can you give me some examples?

Mr Cormack: It could be assistance with implementation of population health measures. It could be assistance with implementing new program areas in mental health, in primary health care. They do not necessarily deliver the service but they work with general practices to enable them to assist with uptake of new government measures. In other instances—and I think the after-hours services are a good example—they are directly involved in procuring and organising after-hours medical services.

Senator IAN MACDONALD: They pay a private specialist to deliver that. Is that what you mean?

Mr Cormack: Yes—not necessarily a specialist. In some instances for after-hours medical services, they may work through a deputising agent or deputising service or indeed may facilitate a roster or some other arrangement to have medical practitioners available.

Senator IAN MACDONALD: Organised through the attraction of being paid for it?

Mr Cormack: They are paid for their services. That is right.

Senator IAN MACDONALD: The Medicare Local would have to say to whoever is going to supply the service, 'Here is some money that makes it worthwhile to do this after-hours work.'

Mr Cormack: The providers operate on a commercial basis in most instances, so they would expect to be paid appropriately for the services they offer.

Senator IAN MACDONALD: That is what happens now. You are saying the Medicare Locals are going to become a purchaser of services. What does that mean in ordinary language?

Mr Booth: As Mr Cormack says, Medicare Locals at the moment can supply services, so they employ staff to provide those services.

Senator IAN MACDONALD: Professional staff?

Mr Booth: Yes.

Senator IAN MACDONALD: As well as clerical support staff?

Mr Booth: Yes. I will give an example. There is a program called the Rural Primary Health Services program which was rolled into Medicare Locals. That provides allied health services in rural areas. Some Medicare Locals actually employ the allied health staff. They employ them and send them out to deliver the service. In the future, what a PHN would do in that scenario, instead of directly employing the staff, would be to look to the market to see if there are agencies available who could provide that allied health service. Rather than the PHN employing them directly and being a big employer, they would see what was available in the marketplace.

Senator IAN MACDONALD: What would be available?

Mr Cormack: I will give you a very simple example. Hypothetically if a program involved additional physiotherapy services—for example, under the current arrangement you could foresee a Medicare Local potentially employing a physiotherapist to be able to service the needs of the Medicare Local area or the practice—then, under the new arrangement, a commissioning function would go to the market and look for existing public or private sector providers of, in this example, physiotherapy services. Those providers would, if you like, through an expression of interest or tender process, bid to deliver exactly the service at the best possible price that the commissioning body—in this case the PHN—is requesting.

Senator IAN MACDONALD: Where does one go, then, with complaints about failure to pick the right people or unfairness in picking people or complaints like: 'There is no physiotherapist in my area. Who do I blame—the federal government, the local member of parliament or the primary healthcare facility?'

Mr Cormack: In my experience, people tend to blame just about everybody they can to whoever will listen. But, in this case, I would imagine that—

Senator IAN MACDONALD: Who has responsibility? Where does the buck stop? Is it with the primary health organisation?

Mr Booth: To a degree with the PHN. They will have the responsibility to try and fill those gaps.

Senator IAN MACDONALD: So if constituents come to me and say, 'I can't get a physiotherapist,' I do not complain to the minister; I complain to the—

Mr Booth: They could certainly go to their PHN in the future and discuss what the issues are. But again, it would be an issue of the resources that the PHN has available to it and the services that are needed in that area. So they can look at that.

Senator IAN MACDONALD: The Primary Health Network that I am talking about is replacing the Medicare Local that was Townsville-Mackay. I think that the new Primary Health Network is to be North Queensland.

Mr Booth: Yes.

Senator IAN MACDONALD: So when you are giving that network money, how do you assess how many people are going to say, 'I want to see a physiotherapist and I can't, so I want you to supply it'? How do you make those assessments?

Mr Booth: It gets back to the earlier questions and the work that the PHN does in terms of needs assessments. So they will assess—

Senator IAN MACDONALD: So that is the original audit that you are going to do?

Mr Booth: Yes. So that is like an audit of what is available so that they can say, 'There is a need for physio services in this particular area', they will do an assessment of what is available and, if it becomes apparent that there is a complete mismatch and there are no physio services there, then—

Senator IAN MACDONALD: Who is going to do that?

Mr Booth: The PHN.

Senator IAN MACDONALD: The PHN itself?

Mr Booth: Yes.

Senator IAN MACDONALD: How long is that expected to take? It sounds like an enormous task.

Mr Booth: In terms of doing that assessment, no. There are already existing needs assessments that have been done by Medicare Locals, and state and territory governments do these things and local hospital networks also do these things, so the PHN will link in with all of those but also do its own work.

Senator IAN MACDONALD: Staying on that, but also in this section, I see that you are talking about the Rural Primary Health Services. As I briefly mentioned earlier, the Burdekin Centre for Rural Health was set up some years ago under some government program. I am not sure which government or when. I think that there were a number of those centres for rural health set up around Australia. Clermont is one that has been mentioned to me in Queensland, and there is one in Burdekin.

Mr Booth: I am not sure. To be centres for rural health—

Senator IAN MACDONALD: It is a centre for rural health that coordinates a lot of the support services. There are the Medical Locals, the Primary Health Networks that are replacing them and these centres for rural health, which are set up and in cases have extensive real estate and buildings. For example—I do want to be specific but I do not want to be specific—the Burdekin Centre for Rural Health has programs which they organise, such as seniors support, veterans support, community rehabilitation, a mental health foundation, counselling services, prevention and health promotion programs, telehealth hubs, support groups, and transport services. They also have accommodation for residents and students working with local hospitals or local GPs. People, particularly those in need, sort of use them as a first point of contact to be sent elsewhere. Now they were funded, originally, by the government. Then it was going to be by the Medicare Local, but they are now going. I assume, from what you tell me, that the Primary Health Network will be able to come to the Burdekin Centre for Rural Health and say, 'We need a psychologist. Can you supply one?' or, 'Can you supply facilities?' I am just trying to work out how this is all going to fit in.

Mr Booth: I can clarify that.

Senator IAN MACDONALD: Change is always difficult. People who have been getting a certain amount of government money set their parameters, and, if it is going to stop, it is always difficult. But I am just trying to work out who will supply those services if they are no longer funded to do it. I guess my question is: would the Primary Health Network actually pay them to provide the service so that perhaps they are not going to be in much of a different situation financially?

Mr Booth: That is right. I can confirm, yes. The Burdekin Centre for Rural Health—it is the program that I was talking about earlier: the Rural Primary Health Services, which provides allied health services of the type that you mentioned. So they were funded by the Townsville-Mackay Medicare Local. What will happen in the future is that that process will be undertaken, so there will be a needs assessment; the PHN will look at the need for the kinds of services that are offered there, which are allied health services going out there; and then the PHN will see who is available to provide those services. That centre for rural health, then, would be a potential person who could supply those services.

Senator IAN MACDONALD: Under the Medicare Local, they cut the funding to the Burdekin Centre for Rural Health quite substantially and said, 'We do not need you to do this, because we are going to do it.' There was an organisation set up, which was to a large degree run by volunteers, so you are getting a free service, which the Medicare Local was going to provide itself. That cutback did not go ahead, principally because the minister held it because they were changing. I am just wondering now, are there, somewhere, the rules of how the primary health networks will operate and where they will get their services from, and will they take into account established, community-based, very often volunteer-based services?

Mr Cormack: Mr Booth can give the detail but, in essence, one of the defining features of the primary health networks will be a governance model that has a more focused notion of a clinical council, so that you are involving input from GPs and clinicians within the area, and also community advisory committees.

Senator IAN MACDONALD: Will that be compulsory?

Mr Cormack: It is an expectation for all PHNs that they have these governance arrangements. We believe that the problem you have identified could be best managed by having those people around the table in two ways, and first up as members of the governance arrangements. You would have a governing board, a clinical council, a community advisory committee, so they are a part of the day-to-day business of the PHN. But, critically, the needs assessment and plan, which is a requirement for the first 12 months, by its very definition requires you to identify needs and service availability and gaps in a particular area.

Senator IAN MACDONALD: Again you say the primary health network will have a board of governors and then they will have these community advisory groups. Is that mandatory, and in a primary health network as big as North Queensland is there any requirement that they should not have all of the board from Townsville or all of the board from Cairns, or that they must have someone from Cloncurry and Julia Creek and Ayr, where I live, or in relation to community advisory groups the same thing—is there any requirement for particular localities to be represented, because certainly what is relevant in Cairns is not relevant in Clermont and what is relevant in Bowen is not relevant in Julia Creek.

Mr Booth: There are two aspects to that. One is that the clinical councils and the community advisory committees that have just been described map to the local hospital network, the local hospital district boundaries. That means any one PHN could have a number of these organisations reporting to it. I do not have the map for North Queensland with me, but where there are local health districts, I think they are called in Queensland—and, as I have said, there are three— then there will be three community advisory group committees, there will be three clinical councils that would provide advice to the PHN board to make sure that you do get that breakdown of local areas. Is it compulsory? Yes, it is—they do have to set up these organisations. In terms of the board that runs the PHN itself, we have not mandated particular representation on that. We have looked at governance principles so that a board should reflect interests in terms of particular areas of expertise such as legal and financial but also clinical expertise and knowledge of the particular area. Essentially that is a decision for the PHN.

Senator IAN MACDONALD: Again, with all due respect to everyone in this room, it is one thing to plan these things with the very best of intentions and with the very best of skills, but out on the ground the whole locality is so different, particularly in a network as big as, apparently, this one in the north. I am sure the same applies elsewhere in Australia, but I am speaking about an area that I know just a little bit about! That is the real difficulty: one size does not fit all.

I will throw another spanner in the works. You are talking about health districts. Now, I do not know what the current Queensland government is going to do with health—and I suspect it does not know itself—but there was quite a change in hospital board set-ups under the Newman government. There is talk, as I understand it, of pulling all that down. That is going to have a deleterious impact on your timings for trying to get these Primary Health Networks going.

Mr Bowles: I do not think that is necessarily true. I think it could have an impact on getting them functioning as best as we possibly can get them functioning. If they want to disrupt anything like that, which I have not heard—

Senator IAN MACDONALD: And I have not heard either. I do not know and I suspect the new government does not know either. But you are coming into a period, running for the next 18 months, I might say, in which the whole thing is going to be, with respect, in complete uncertainty. I will not use any words stronger than that.

Mr Bowles: But the PHN is designed to be functionally separate from a local hospital district, for instance, and ultimately it is about how you construct the PHNs. The local hospitals will be really desperate to get in with these PHNs because they can actually leverage a whole lot of different things that they probably have not been able to leverage in the past, like chronic disease management, for instance. We need to leverage across the primary health care sector into the hospital sector and back for chronic disease. If we can do whatever we can to get the PHN stuff right—now—I think we have a really good opportunity there.

Just on your comment about each place being different: absolutely, and we need to be very conscious of that. My background is predominately in rural Australia, so I get that, quite significantly. So, whatever we do, we need to make sure that it is fit for purpose, and I think we can do that with a PHN model. It is no good us just running out a disease-specific program that does not relate to a particular area, for instance; but Indigenous smoking or Indigenous mental health is not necessarily something that you would want to focus on across the board. So how we would implement that in a really remote area would be different to how we would implement that in the centre of Sydney, for instance. We are very conscious of the need to be quite flexible about how some of these organisations will operate.

Will we get everything right first up? It is always difficult. They are almost organic beasts, some of these things. So we will need to work hard to make sure we get PHNs right, because I think they are a very good pillar that we can build on, going further forward.

Senator IAN MACDONALD: I have finished, Chair. I wish you well, Mr Bowles. I must say I am not confident. These days, Australians in general want everything from the government, and we are the front line; we are the ones they come to. But, then, a government really has no control over fixing the problem. And, as I said, with the changeover of government in Queensland and some uncertainty about what is going to happen to hospital boards and who is going to do what, good luck; you will need it. But I urge you to keep in touch with people on the ground and not just your people but—

Mr Bowles: No—more broadly.

Senator IAN MACDONALD: people who use the system.

Mr Booth: Chair, could I make a clarifying statement to Senator McLucas around the redundancies? I have just been handed the frequently asked questions from the website and I should have broken it down into two specific areas. If there are redundancies resulting from their early termination, then, yes, there is scope to pay for redundancies within that, so the Commonwealth will fund all reasonable costs resulting from early termination of the deed, including redundancies. However, if there are areas, schedules or specific programs that naturally come to an end at the end of this financial year, then redundancies cannot be funded in that. I apologise for mixing the two up, but that is where we are. That is available on the website in terms of the frequently asked questions.

Senator McLUCAS: There was no end point for the contracts with Medicare locals.

Mr Booth: We are terminating the Medicare local contracts a year early.

Senator McLUCAS: So, if a person were employed by the Medicare local in an administrative capacity, for example—

Mr Booth: For that full period.

Senator McLUCAS: the department would assist with some redundancy payments.

Mr Booth: We will assist, yes. Basically, Medicare locals at the moment are going through an exercise of looking at reasonable costs.

Senator McLUCAS: I have heard a lot about reasonable costs in the past. Has the department done any analysis of what the redundancy costs will be yet?

Mr Booth: Not specifically. We are continuing—

Senator McLUCAS: I understand that. You are not there yet.

Mr Booth: because we are not at that point yet.

Senator McLUCAS: Is it a consideration though in awarding any of the contracts?

Mr Booth: We will certainly be looking at all the reasonable cost claims that come in, but it depends on a number of things that may happen.

Senator McLUCAS: I understand.

Mr Bowles: But it is not a determining factor in our decision.

Senator McLUCAS: You understood the question I asked, Mr Bowles, didn't you!

Mr Bowles: No, it is not a determining factor in where we are going.

Senator McLUCAS: Very good.

Senator WRIGHT: I have some questions around Medicare locals as well, and also Partners in Recovery and how they interface. Please forgive me if I ask questions that have already been answered, because I am trying to run between two committees. If indeed this question has already been asked by Senator McLucas or someone else, you can just refer me to that, and I will look that up myself. What will be happening to the various Medicare local premises? Can you give us some information about that?

Mr Booth: The actual premises?

Senator WRIGHT: Yes.

Mr Booth: It will depend on the application process, because, as you know, some Medicare locals will apply to become PHNs and, if they are successful, then there are certain things that could happen to the premises there. So it really depends on what the different processes are that happen. I will ask to get a bit more specific advice on that and let you know, because it is in the deeds and the frequently asked questions. So I will just get a bit of clarification on that.

Senator WRIGHT: Thank you. You can come back to that, and I will keep moving through these. What about the transfer of patients' medical information?

Mr Booth: Medicare locals do not hold medical information on individual patients. That is part of general practice records, and they are owned by the general practice—that is my understanding—so the records of the patients stay with the general practice.

Senator DI NATALE: What about the intellectual property—the IP—associated with the existing Medicare local? What happens to that?

Mr Booth: What we are doing at the moment—the aim is to establish the PHNs, if you like, in shadow form to work alongside the Medicare locals in the last quarter of this financial year to make sure that there is a seamless transition. If there is any information that is required from the Medicare local—if it is not going to become a PHN—there will be a period of those three months of working between the two organisations to make sure that the information that is needed is transferred across.

Senator DI NATALE: What is the onus on the Medicare local to provide that information? As a private entity it is their IP. They do not have to produce it, do they?

Mr Booth: Yes. Again, it would depend on the individual circumstance that we are going through here, but, in general, we would expect that there is that sharing.

Senator DI NATALE: But that is an expectation. What I am saying is that you have a Medicare local that has invested a lot of work into the development of whatever it might be. It might be an IT process or whatever. It is a private organisation. They lose the tender, and you are just hoping that they are going to hand over all their material to the primary health network. They might say, 'Hang on, this is our business and our intellectual property and we are going to keep it.' How are you going to manage that?

Mr Cormack: Without going into the specifics of each individual Medicare local, a standard clause is in many of the Commonwealth contracts that specifies arrangements for IP and Commonwealth property. I think probably the best thing we can do is take on notice the extent to which those particular provisions in standard Commonwealth contracts actually apply in the case of individual Medicare locals. I get where you are going with this; I think it is a valid concern, but we just need to have a look at the specifics of the individual contracts because there is, in general, a standard provision in most Commonwealth contracts that manages that risk on behalf of the Commonwealth—that is, ownership of intellectual property.

Senator DI NATALE: Are you taking that on notice? Because I think it is really important, and it is a valid concern that has been expressed.

Mr Cormack: Yes.

Senator DI NATALE: You are making an assumption that this information is going to be handed over, and we would like to think that in most cases it would be. I image there could well be a likelihood that some of the organisations that put a lot of time and effort into it, and who are not awarded a contract or are unsuccessful in the tender, will say, 'Hang on, this is our business, and we are not giving it to you,' and the new primary health network has to start from scratch.

Mr Cormack: As I said, we will take it on notice. We will have a look at the contract provisions for the affected Medicare locals. In some instances—the extent to which some of them may become the PHNs—that may be a moot point, but we will have a look at all of those provisions.

Senator WRIGHT: In terms of that transitional arrangement that you talked about there where you—perhaps I should wait for Mr Booth to finish.

Senator DI NATALE: Did you want to add something, Mr Booth?

Mr Booth: No, we will take that one on notice. One thing that was just pointed out to me was that there are some patient records held if the Medicare local provides that service on some occasions. In that case, what we are going to be doing with that is dealing with it as part of the transition process to move from one organisation to another, and it will be dealt with within the contract to make sure that those patient records are transferred to whatever organisation is going to be running those services.

Senator DI NATALE: So that is where they are engaged in service provision, as opposed to commissioning?

Mr Booth: Yes, that is right.

Senator WRIGHT: I might leave my colleague to follow up more about that and I will try to focus more on the mental health aspects of the transition. Again, you may have already been asked this, but how many staff are currently employed in Medicare locals across Australia?

Mr Booth: I would need to take that one on notice. I do not know if we have that information readily available. Medicare locals are private organisations—private entities. They vary quite widely in terms of size, but we will see what we can do.

Senator WRIGHT: Thank you, and could you also give a state-by-state breakdown and how many of those employees are health workers?

Mr Booth: Okay. So directly employed delivering health services?

Senator WRIGHT: Yes, that is right, and how many of the employees are likely to be made redundant, particularly in South Australia.

Mr Booth: We did have a bit of a discussion on that. We did not concentrate on South Australia, but we discussed redundancy provisions that were in there.

Senator WRIGHT: What about numbers?

Mr Booth: Basically, we had a bit of a discussion, and it really depends on what happens, because some of the Medicare locals will be bidding to become PHNs. Some of the Medicare locals are not going to do that but establish themselves as service providers. Some of the Medicare locals are going into consulting. There is a whole range of different things happening at the moment so it is quite difficult to say what is happening to South Australian Medicare locals, because—

Senator WRIGHT: Yes, because it is still happening at the moment.

Mr Booth: it really depends on where they go. So it is kind of a moving feast at the moment.

Senator WRIGHT: I imagine in the future, and when the dust has settled a bit, that we will be able to get a snapshot about what the consequences have been of the transition.

Mr Booth: You will be able to know who has formed the PHNs, and we will know whether any Medicare locals are part of those. So we will know that and we will also know if Medicare locals were not and if they are set up as independent service providers.

Senator WRIGHT: In that case we could probably do the maths and work out who is left over, in terms of redundancies.

Mr Booth: Yes. We could look at that.

Senator WRIGHT: Has there been any modelling done to predict how much redundancies will cost?

Mr Booth: This is a part of the reasonable cost determination, so basically each Medicare Local is going through a process, at the moment, of reasonable cost assessment. There is a deed of termination that has been issued to the Medicare Locals. We are working very closely with them, and they are basically in that process at the moment. Those reasonable cost estimates are not due for a while yet because it depends on everything we have just been talking about in terms of what happens to them.

Senator WRIGHT: So, again, at some point in the future we will be able to know.

Mr Booth: At some point in the future we will know where we are—but it is moving at the moment.

Senator WRIGHT: If I could come to the Partners in Recovery contracts, there has been a lack of clarity around the future of Partners in Recovery where the lead agency is a Medicare Local. Can you confirm the number of Medicare Locals in Australia which are the lead agency for Partners in Recovery, please? And, while you are at it, if you could provide a state-by-state breakdown, that would be helpful, thanks.

Mr Booth: Thirty-five Medicare Locals are lead agencies out of the 48 PIR sites. And I have just been told that apparently the state-by-state figures are on our website, so we will be able to pull those off for you.

Senator WRIGHT: How many Medicare Locals have sought clarity from the department about future arrangements for the Partners in Recovery program?

Mr Booth: I would need to take that on notice, I think, because, clearly, we have been in discussions with Medicare Locals for the past nine months about a whole host of different areas in terms of what is happening with transition: what the processes are, what is going to happen—all those kinds of things. So we would need to kind of disentangle that a bit. I would suspect that that has been part of the general discussion that has been happening, as opposed to a specific query, but we can take a look at it.

Senator WRIGHT: If you could do that please, and if you could look for where there are indications that there have been specific concerns and queries raised about the future of the Partners in Recovery program, that would be helpful.

Mr Booth: I do not think that there are. Of course, Partners in Recovery is a consortia; it is a group together, and one of those partners is nominated as lead agency. In the majority of cases, as you know, that is Medicare Locals, but it is a consortia and they all work together. So we would expect that that could quite easily be accommodated.

Senator WRIGHT: During the last estimates hearing, I was asking about the future of the Partners in Recovery contracts and transition arrangements. Has there been any more progress in relation to those arrangements for the program?

Mr Booth: It is pretty similar to where we were last time, in that we are establishing the PHNs at the moment. They will, as I said before, run in shadow form for the last three months of this year. As soon as we know who the successful applicants are for the PHNs, then we can start to discuss with them in terms of lead agency responsibility for the PIR, but we need to get that process in place first before we can actually do the PIR section of it.

Senator WRIGHT: Can you provide a list of mental health services that are currently provided through Medicare Locals?

Mr Booth: The key ones will be the lead agencies for Partners in Recovery, the ATAPS services that go through Medicare Locals, and the Mental Health Services in Rural and Remote Areas, the MHSRRA program. Those of the big ones that I can think of. There will inevitably be some smaller services that may be Medicare Locals specific that I would not necessarily have access to. There are some running through the Mental Health Nurse Incentive Program as well, the MHNIP, but the big ones are ATAPS and MHSRRA.

Senator WRIGHT: When you say you would not necessarily have access to the smaller ones—

Mr Booth: We would know what they are, but I do not have information here at the moment.

Senator WRIGHT: That is what I wanted to clarify. I thought that is probably what you meant.

Mr Booth: If a Medicare Local has identified a particular need in a particular area and is running some kind of service—

Senator WRIGHT: Then the department would know.

Mr Booth: We would know about it, but—

Senator WRIGHT: Can I ask you to take that on notice, please? We want to understand the variety, the range and, I suppose, the prevalence of mental health services that are currently being provided by Medicare Locals. One of the reasons for that is that it has been raised with me on numerous occasions that, particularly in rural

areas, there is a real concern about services not being able to be continued because of the state of uncertainty and the transition that has been ongoing for quite some time now. Medical Locals stopped accepting new referrals at the end of last year because they have not been able to allocate new clients to mental health practitioners because those contracts will cease to exist on 30 June and they will not be able to pay invoices. There are concerns about that uncertainty, which means they are having to turn people away, or people who have been receiving services are no longer able to receive them. Obviously there is going to be ongoing uncertainty. Are you aware of instances like these?

Mr Cormack: Earlier in evidence we talked about the current invitation to apply process and the transition process. Evidence has been given that we anticipate, in March, the announcement of the successful bidders for this process. A key element of getting up and running will be a transition process that would effectively begin from the time contracts are agreed. That will necessarily pick up many of these detailed transition issues, to the extent to which they exist in all PHNs, and in some they will not because there is a likelihood that an existing Medicare Local may possibly be a successful bidder.

We are happy to take on notice the specifics of the question. We recognise that there is concern about the transition, but the implementation, that program that Mr Booth is looking after, provides a reasonable transition period of over three months to be able to manage many of those issues.

Senator WRIGHT: When you say 'a transition period' are you saying from June for the next—

Mr Cormack: No, from March.

Senator WRIGHT: From March?

Mr Cormack: We have contracts in place with Medicare Locals. As you quite correctly point out, they have arrangements in place with third-party providers in certain cases.

Senator WRIGHT: Some of them have come to an end. That is the problem.

Mr Cormack: Yes, and many of those will be finishing up in June. We will be using the period from the contracting of the new PHN providers, which we anticipate will be from March, through to June to transition all of those arrangements.

Senator WRIGHT: The problem is that on the issue that I was adverting to earlier—and concrete examples have been given to me—whereby contracts have been ceased as at the end of last year because there was a concern that those contracts would be entered into and would not be able to be honoured, we have actually had people who have had services finished and the contract has not continued from the end of last year. So we are talking about at least six months. In fact, the anecdotal evidence I have heard is that, again, particularly in country areas, there are providers who are now moving back to the city because they do not have any certainty of future contracts.

We know there is a real difficulty with workforce in the mental health sector in country areas and good people are being lost because there is such uncertainty. This transition has not been able to be done seamlessly so that those contracts have been able to continue. Have those concerns been raised with you by people in the community, practitioners or Medicare Locals?

Mr Booth: There are a couple of aspects there. One is in terms of your specific question around Medicare Locals not accepting new ATAPS referrals. Yes, we are aware of that. There were three specific Medicare Locals where we were aware of that happening. We have been in contact with those Medicare Locals and those Medicare Locals are accepting referrals through to the end of the year. So in those three areas we have spoken to them and we are aware of them.

In terms of the more general issue, as Mr Cormack has said, we are acutely aware of the need to provide certainty in terms of people's contracts and work and those kinds of things. We are just working through it as quickly as we can to try and get that transition period in place so that we can get that certainty.

Mr Bowles: It is important to point out that if the Medicare Local is funded to provide a service to 30 June 2015, they need to be providing that service. That was the issue I think Mr Booth was referring to about the ATAPS, and these three. You cannot stop something if you are funded to do it, or we will find someone else to do it. So, if something was finished at the end of June 2014, which means it is a lapsed program and it does not exist anymore, that is a completely separate issue that we would be dealing with. But Medicare Locals are funded to the end of June 2015, at which point the transition period from the end of March through to 30 June will pick up a whole lot of those transitional issues and move the funding to the PHN to continue to provide whatever level of service we are talking about going forward. And that is all to be determined through the transition period.

Senator WRIGHT: Is that a guarantee that programs that had been previously offered and provided by Medicare Locals will be continued with those contractors?

Mr Bowles: No, Senator. You cannot put words in my mouth around that.

Senator WRIGHT: I am not; I am trying to clarify—

Mr Bowles: What I am saying is that they are funded to 30 June 2015. Whatever goes forward through that transition period will be passed through to the PHN. Whether it is the exact same range of services that are there today or they are different is a matter for the next couple of months to work that through. Services do change because demographics change and all sorts of issues change in some of these areas. We will manage that through the transition period, but services in the broad will continue past 30 June. I do not want to be specific about any program because I do not have the visibility of that until we go through the transition period.

Senator WRIGHT: How many people across Australia were receiving treatment through the Partners in Recovery program?

Mr Booth: As at 12 December 2014, there were 12,234 clients in PIR services.

Senator WRIGHT: Can you provide a state-by-state breakdown of those figures?

Mr Booth: Yes. We will take that on notice.

Senator WRIGHT: Thank you. I have no further questions at this stage.

Senator DI NATALE: I have a question about Medicare Locals. I understand that we are in the middle of a tender process, and I just want to talk in general terms. I understand the commissioning function of Medicare Locals, and that is largely built on how well some of the Medicare Locals are able to manage relationships across the sector. That is probably where the more successful ones demonstrate their value—they have very good relationships across the sector. Through this tender process, for an existing Medicare Local how is it that you are able to assess what sometimes is a more intangible function of how well they are performing compared to some new player in the market who, on paper, might look okay, whether they be a private provider or not, but are competing against an existing service that is managing these relationships very well? I will be frank: I have Barwon Medicare Local in my area that do that very well. I do not want you to talk about any individual tenders, but how is it that you assess that through the tender process?

Mr Booth: I know what you are getting to, Senator. Essentially, we have an assessment process that talks about demonstrated capability to do what a PHN needs to do. There are a variety of different organisations out there who may be able to do that in different parts of the sector. They need to provide some evidence around doing that. Now, you could argue Medicare locals have been in this area so they can do that. But there are other organisations who could do that, and you are quite right that one of the key findings of the review of Medicare locals last was around variability. Some of the Medicare locals were doing an excellent job but some of them were doing a poor job, particularly in GP links and all those kinds of things. So there was that variability there. Certainly, through the assessment process there is an ability to look at demonstrated capability to do a range of different things. There is also looking at innovation and innovative ways of doing things so that new people who come in could bring some innovative practices in. There is also an ability to provide reference within that assessment process so there is a bit of checking that can go on there. So there is a variety of different ways of actually pulling that in to ensure that everybody gets a chance.

Senator DI NATALE: My concern is that, in doing it remotely, it is something that is often difficult to assess without really understanding how each of those Medicare locals is performing at the moment. The hardest bit in getting this whole thing working together is to get a player in the space who can manage all the competing organisations and service providers—state, federal, local—and can pull it altogether and make it work well. That is a hard thing to assess with a bit of a box-ticking exercise through a tender process.

Mr Booth: I would not say it was just a box-ticking exercise. I think it is a bit more than that. It is a fairly rigorous process that we have got in place in terms of bringing a lot of people together to assess the applications both from within the department and externally who have—

Senator DI NATALE: Can you explain that? I am interested in how that works.

Mr Booth: We have a tender assessment process that we go through. We have got a particularly rigorous one for this whereby we have not only people from the department who work in the primary healthcare area but also people from other areas of the department who are doing some assessments. They are aided by external probity advisers to have a look at the conflict of interest issues. We have external financial advisers. We also have external health systems advisers—people who are pretty good at looking across health systems and looking at—

Senator DI NATALE: Can you give me an example of that?

Mr Booth: Basically, they are people who work across different areas and—

Senator DI NATALE: Without naming them—but I cannot conceptualise who would fit that role—what sort of skill set are you talking about?

Mr Cormack: With any government procurement exercise, an argument could be put that there is an advantage to the incumbent in a competitive process.

Senator DI NATALE: Or a disadvantage.

Mr Cormack: Yes, whichever way you look at it.

Senator DI NATALE: It is the same with the job application process. Having a job is no guarantee that you are going to get it.

Mr Cormack: Yes. But this is not an issue that is unique to health or unique to PHNs. Government needs to undertake complex procurement activities across a range of areas that involve comparing existing providers with new players in the market. Mr Booth has outlined the process that we go through, and part of that is ensuring we get subject matter expertise backed up by on-the-ground analysis and rigorous—

Senator DI NATALE: What is the on-the-ground analysis you are talking about?

Mr Cormack: It could simply be gathering evidence and information about the performance of individual bidders consistent with the claims they have made in their application. So, it is due diligence.

Senator DI NATALE: So, it is reference checking—it is you ringing up the referees and all that sort of stuff.

Mr Cormack: Yes. It is due diligence, and, as Mr Booth has outlined, if we require financial acumen we will talk to somebody who has expertise there, if it is about community engagement we will talk to people with expertise there. With all government procurement exercises that I have been involved with you access people and organisations who can assist with that assessment process. So it is not a group of bureaucrats with the checklist that just tick and flick. There is a significant rigor associated with these processes, and that certainly is the case with this one.

Senator DI NATALE: I will take that at face value. I suppose you can understand the point I am trying to make.

Mr Cormack: I certainly can.

Senator DI NATALE: This is not like building a building. It is a lot more complicated than that, and that relationship management is probably at the heart of how well some of these organisations function. My concern is that the tender process may not necessarily acknowledge what is happening in that space, and that may be the strength of a particular Medicare Local. If that is ignored, that is going to be a problem.

Mr Cormack: If an existing Medicare Local submits a bid and application against the selection criteria and demonstrates on the basis of evidence that it is the best operator for this particular LHN, and meets all the value-for-money and other requirements, it is likely to be the successful bidder. If it does not, then it probably does not deserve to be the successful bidder, because there is a better one out there.

Senator DI NATALE: Are you suggesting that if they are already providing a good service you would be more reluctant to—

Mr Cormack: No, I am not saying that. I am saying—

Senator DI NATALE: I want to interrogate what you meant by that.

Mr Cormack: What I meant by that is that a credible, competent player in this particular market, which is the subject of testing and evaluation at the moment, is able to demonstrate that its capabilities against each of the criteria are the best in the field of applicants for that particular PHN then they are likely to get the job. That is what I am saying.

Senator DI NATALE: All right. I will not put words in your mouth.

Mr Cormack: Thank you.

Senator DI NATALE: I understand there is a review going on with regard to the PIP program.

Mr Booth: Minister Dutton, last year, announced that there would be a process of moving towards what he called a quality improvement PIP. As you know, at the moment we have 10 PIPs—

Senator DI NATALE: Yes, practice incentive payments.

Mr Bowles: Practice incentive payments—10 separate ones across a variety of areas. There has been some discussion, for some time, that you would be very aware of, about whether we can amalgamate them together to more efficiently reduce red tape—

Senator DI NATALE: Yes, I am aware—to streamline them.

Mr Booth: to streamline and come up with something that is a quality-improvement one rather than just, 'How many diabetes care plans have you done?' That was announced last year. We are doing some work on that at the moment, but it has not gone further.

Senator DI NATALE: With respect, we had this huge debate about the co-payment. It seems to me that one of the areas we can probably all agree on is streamlining the PIP system so that we can reward some quality in general practice—this is a comment—and it should have been the focus of what has been happening in primary care all along. When was the original announcement made?

Mr Booth: It was made about halfway through last year.

Senator DI NATALE: Yes, I thought it was around budget time.

Mr Booth: It was at a conference.

Senator DI NATALE: We are almost a year down the track, a couple of months away from that. How is it that we are still not any closer to moving on this? If Medicare is so unsustainable and we are so desperate to achieve quality, why is it we have had no announcement about progress on the reform of practice incentive payments?

Mr Bowles: We had a change of minister in December last year. The minister is currently consulting, as we had been talking about, on a range of issues in relation to Medicare. There is a whole range of factors that go into this.

Senator DI NATALE: I have not heard the minister, at any point, through any of her discussions, even make mention of the practice-incentive payment program. Do you have a time line that you are working towards?

Mr Bowles: I do not at this stage. There are a whole range of issues that the minister will be dealing with in her consultations with a range of different groups that she has been talking to.

Senator DI NATALE: The review was announced in roughly May last year—I am sure you can take that on notice—and you have nothing to say other than, 'We are going to review the practice incentive payment.'

Mr Bowles: At this stage, no.

Senator DI NATALE: Why is it taking so long?

Mr Bowles: I have just gone through that.

Senator DI NATALE: No, have not.

Mr Bowles: Yes, I have. I have said—

Senator DI NATALE: No, you have not. You told me there was a new minister and that there were seven months with the existing minister. Why have we taken so long before we have heard of any progress on this?

Mr Bowles: I will go over my answer again. We have a new minister. She is out consulting, and all issues are being discussed in a range of different ways with a range of different players.

Senator DI NATALE: Are you doing any work on the practice incentives payment? Is the department doing any work on—

Mr Bowles: The department is considering options around these sorts of issues.

Senator DI NATALE: Let's be clear: are you considering options?

Mr Bowles: I cannot go into what we might be doing in relation to that because it will be for government to decide.

Senator DI NATALE: Hang on, you can tell me if you are doing work in that area.

Mr Bowles: I just said we were doing work in that area.

Senator DI NATALE: You said around a range of issues.

Mr Bowles: A range of issues in relation to practice incentive payments.

Senator DI NATALE: Will you be prepared to answer this now or take it on notice: what is the nature of the work that is being done in that area?

Mr Bowles: I can take it on notice.

Senator DI NATALE: There are currently PIPs—is that right? Is work being done to reduce the number practice incentive payments?

Mr Bowles: I am not going to go into the nature of advice that we give to government at any point in time.

Senator DI NATALE: I am not asking you for the nature of the advice.

Mr Bowles: That is on the nature of the advice.

Senator DI NATALE: I am asking you specifically on the work that is being done in the department. I do not care what advice you give to government.

Mr Bowles: The work we do in the department is the very work that goes to the nature of advice to government.

Senator DI NATALE: You could say that for any question we ask in estimates.

Mr Bowles: I could, but I do not. I am saying quite specifically in this case that the work we are doing in this space will form advice to government and, as I have also said, the minister has been out consulting with a range of players in a range of different places, and all issues are being canvassed in some of those conversations.

Senator DI NATALE: Are you looking at increasing the amount of funding being provided through the practice incentive payments?

Mr Bowles: I go to my previous answer.

Senator DI NATALE: I am asking you a specific question: are you looking at increasing the amount of funding through the practice incentive payments?

Mr Bowles: I go to my previous answer, I am not going to talk about advice to government.

Senator DI NATALE: I am not asking you about the advice you provide. Are you doing work—

Mr Bowles: You are asking me—

CHAIR: Senator Di Natale, I am not looking to intervene in this dispute, but we are running out of time. You can clarify, but it will be the final question before I go to Senator McLucas.

Senator DI NATALE: There are two things at play here. There is whether you are doing work on increasing the amount of funding through the practice incentive payments and the second is the issue of the advice you provide to government. I am not asking you whether you are providing recommendations to government and what they may be. I am just asking you about whether you are doing any work—

Mr Bowles: I answered that and I said yes we are doing work. I am not going into the detail of what we are working on.

Senator DI NATALE: I am sorry, that is not good enough. I have asked questions about the Medicare co-payment and I have been given advice that the sort of work that is being done around Medicare co-payments, without being given any advice about what has been provided to government. That is why I am asking; I want to know whether the department—this is something where, I think, there probably would be tripartisanship. We all want to see more quality in general practice. In fact, it would be something positive that the department might be able to demonstrate around primary care. I am not trying to make a political point; I am generally interested, as this estimates process is supposed to be, for precisely these sorts of questions. Is the department looking at expanding the amount of funding being provided through the practice incentive payments and doing some work around that? Whatever advice you provide to government is your business.

Mr Bowles: You are asking me to talk about budget related issues in the context of expanding more money, more whatever. We are looking at best practice incentive payments, as the former minister indicated. We now have a new minister who has been consulting with the broad range of stakeholders around Medicare more broadly. Practice incentive payments do come up in those conversations from time to time. We are looking at all of those issues. I have said we are looking at all of those issues. But I do not want to pre-empt what might be an outcome through those consultation processes the minister is currently going through.

CHAIR: Thank you. We have to move on.

Senator McLUCAS: I want to move to mental health and I wonder if the commission would appear at the same time. Mr Booth, you might wait as well. I want to go back to ATAPS. Mr Booth, when you were talking to Senator Wright about ATAPS, you said three Medicare Locals had stopped accepting referrals and the department had a conversation with them and now they are accepting referrals. Did they stop accepting referrals because they had run out of ATAPS money?

Mr Booth: I think it was more around the issue that Senator Wright was talking about in terms of the length of time—

Senator McLUCAS: That is right.

Mr Booth: Yes. The time period that was left—so we made it very clear that you cannot stop, because you have got to continue delivering those services. It was around the time aspect.

Senator McLUCAS: So if someone is going to have a period of treatment that would go past 30 June—

Mr Booth: Beyond that, that is right.

Senator McLUCAS: So what are you telling them, so they stop the treatment at 30 June.

Mr Booth: No, we are saying that they need to continue taking those referrals, they need to continue those treatment plans, and, as we have said a couple of times, we will be looking at the transition period. As soon as we know what has happened in terms of the PHN assessment process and what programs are going where, then we can get into those discussions about what happens beyond 30 June.

Senator McLUCAS: But if the Medicare Locals wound up, how can they pay?

Mr Booth: It would depend on the programs which transition over to the new PHNs.

Senator McLUCAS: We will come back to that next time, I think. I want to go to, unsurprisingly, the review and some of the detail. In October—and I am talking about the datasets that we were trying to get from states and territories for the second interim report—you indicated that there was some difficulty receiving data from some states and territories. Can you update the committee on the quality of the data that you received and the fulsomeness of it?

Mr Butt: Yes. As I was talking about in October, we had not received a response from two states and territories to our initial request for data, and that was from Western Australia and the Northern Territory. So we had pursued access to further data through the Mental Health, Drug and Alcohol Principal Committee of AHMAC to get access to their mental health establishments data, which is the data they report to the Australian Institute of Health and Welfare. They report it to the AIHW on a confidential basis and the AIHW then uses it for its number crunching, its report on government services and its annual mental health report. We sought assistance through that committee and we got agreement from the committee that they would support the AIHW in providing us with that establishment's data. That data is provided on an Australian Standard Geographical Classification—Remoteness Area basis. We ended up getting data from all states and territories.

We did have a response from the ACT—which you might recall we did discuss briefly last time—that said they agreed with release of the data as part of an overall COAG national data request. Obviously this has not been a COAG request as such. However, in terms of materiality of the data that we were given from the ACT, given that we are using remoteness area classifications it actually was not important, because the ACT is treated as one region anyway. So we were actually able to get their data from public records anyway, so that data was available.

In terms of the quality of the data and its usefulness, ideally you would have said that what we would like is greater granularity. If you look at not only mental health but health more broadly, what you see is significant variation at a local level in terms of access, scope of services, outcomes, costs et cetera. In terms of where to next, we would be saying that an important approach in terms of accountability, transparency et cetera, would be to try to get greater access to that regional variation that occurs throughout states and territories. State and territory data gives you some high-level ways of looking at what is occurring across the country but it does not actually enable you to look locally at why there are differences between access for one person in one area and a person in another area or why there are differences in seclusion and restraint rates, and so forth.

Senator McLUCAS: Is the commission going to do further work on data collection, outside of the review?

Mr Butt: Data collection was part of the reason we were formed, in terms of monitoring and reporting on performance across the country. We thought it was a good demonstration of progress that the Mental Health, Drug and Alcohol Principal Committee agreed to release that data. We are looking at working with states and territories and with the various mental health commissions in the various states on how we get that greater level of granularity on the information about what is happening at a local level.

We did a project, as part of the review, with the ABS which looked at matching of MBS information on mental health use and on PBS use in relation to mental health medications and mapping that against the census data so you could look at quite a local level at what is occurring with populations and be able to break it up on the various census factors—age, sex, employment status, socioeconomic status et cetera. We would be looking at advancing that further in association with the department and the states about how we can use that data to look more closely at what is happening at a local level. You can see very much in the information that has been provided that your access to services often depends on where you live, your postcode.

Senator McLUCAS: Are you confident that the final report of the review—and also the second interim report—provides a full and accurate picture of mental health services and programs in the country?

Mr Butt: Just to be clear: there is a preliminary report, which is the one we did by the end of February; there is only one interim report, which is what we did by 30 June; and then there is the final report. We think 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 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.

Senator McLUCAS: Minister, I was wondering if you could help the committee here. When will the final report be released?

Senator Nash: As you know, the government is considering the report at the moment. I am not able to give you a date of release. The report is with the minister.

Senator McLUCAS: And the report was provided by 30 November as requested?

Mr Butt: The report was actually provided before start of business on 1 December—because 30 November was a Sunday and we were advised that there was not anyone waiting at midnight for us to get the report through to them on a Sunday night.

Senator MOORE: Senator McLucas was!

Senator McLUCAS: That means—

Mr Butt: So we got the report through at about 8.30 on the Monday morning.

Senator McLUCAS: That was 1 December. We have had December and January and we are halfway through February. Why is it taking so long?

Senator Nash: I think you would be well aware that reports—particularly a report like this, which I understand is quite complex—do take some time. I think it was four months before the Henry tax review was released by the then Minister Wong. Sometimes these things take some time, and I think that is understandable.

Senator McLUCAS: So you are going to release the report and the government response at the same time—is that the plan?

Senator Nash: No, I am saying it is with that minister at the moment for her consideration and the government's consideration.

Senator McLUCAS: So what is the plan? Is it to release the report and the government response at the same time, or just to release the report?

Senator Nash: That will be a matter for the minister.

Senator McLUCAS: Have you spoken to the minister about that?

Senator Nash: I am not going to comment on discussions I have had with the minister. But I am certainly happy to take that on notice for you and get you an answer if I can.

Senator McLUCAS: Thank you. If you can provide some information back to the committee today, that would be very useful. I am sure you are aware of the community's interest in receiving this material.

Senator Nash: I certainly am.

Senator McLUCAS: Could you also ask the minister for her view on publishing the February report and the June report as well.

Senator Nash: If it is possible we will get it today. We will certainly take it on notice for you.

Senator McLUCAS: If the two preliminary reports are not going to be published, I think the committee needs to know why.

Senator Nash: That is hypothetical. We will take the question on notice and come back to you.

Senator McLUCAS: It is not hypothetical, it is an if/then. I want to go back to the role of the commissioners in the development of the report. Can you explain what role the commissioners played in bringing the report together.

Mr Butt: Certainly. There are eight commissioners as well as myself as an ex officio commissioner. It was a different role to the process for the report cards, as you know. So there was not the same level of public meetings, round tables and so forth—although I led a fair bit of consultation as I moved around the country meeting with service providers, people with lived experience, governments, mental health commissions, researchers and the like. Basically the role of the commissioners was to receive versions of the report and provide feedback. I think we have had five meetings with the commissioners since June, in the lead-up to the submission of the report, so

that they could go through it. They have brought something to it as well, of course. They have all got different backgrounds, so they brought that to it. But they also of course brought the two years of consultation they were involved in with the establishment of the report cards. So obviously we were picking up a lot on the feedback we had in developing the report cards in terms of the directions we were going in. The commissioners were very much about reviewing the information provided to them, providing feedback and ultimately signing off on the review.

Senator McLUCAS: All the commissioners signed off on the review?

Mr Butt: Yes.

Senator McLUCAS: As any report comes to its conclusion, there is always the matter of trying to get everything right at the end. But how long was it from the final draft until 1 December?

Mr Butt: There was a meeting of the commissioners on 20 November. We subsequently had a teleconference—I cannot remember the date; I would have to take that on notice and let you know—close to the final few days.

Senator McLUCAS: Did the government see the final draft before it was finalised?

Mr Butt: No.

Senator McLUCAS: Did the government make any requests of the commission to include any particular material?

Mr Butt: The only thing we kept on getting feedback about from government was that we needed to address the terms of reference, which seemed to be a reasonable thing that we should do. That was just to make clear, in the final report, that we were addressing each of the terms of reference, which we had done. But there were no directions from government at all in relation to what the report recommendations et cetera were to be.

Senator McLUCAS: Now that the mental health review is complete, what is the role of the commission into the future?

Mr Butt: The role we were established for—which is about monitoring, reporting and evaluation, doing the public reporting in relation to performance and focusing on some of the existing projects that we have been leading, facilitating or being the catalyst for. That is in areas such as seclusion and restraint. I think the commission has been quite a good catalyst in getting public reporting on, in particular, seclusion—where do we go next in relation to trying to move towards the elimination of seclusion and restraint? Because of our independent nature, that is an area where we are seen as providing quite a good leadership role, which cuts across the country, and where we can work with states in relation to things like that. The Mentally Healthy Workplace Alliance is an ongoing process. If you think about mental health and where you can get to people, one place is in the workplace, another is in schools and the third is in communities. I chair the Mentally Healthy Workplace Alliance, which has the business council of Australia, COSBOA, the Australian Chamber of Commerce and Industry and a range of other organisations—public health, government. It looks at how you embed mentally healthy workplaces or make workplaces attractive for people with a mental illness or a mental health problem.

Senator McLUCAS: I am very alive to the time, Mr Butt. We only have 15 minutes to talk about mental health—although I did ask the chair if we could have an hour.

Mr Butt: There are a range of projects that then arose out of the review itself, and we need to have further discussions with the department about what role we will have in the running of those.

Senator McLUCAS: Do you have a forward work plan?

Mr Butt: It was discussed at a meeting of commissioners last Friday and it is being consolidated now. So we will have one. As I say, under our charter we will need to submit that to the minister. But I certainly need to have further discussions with the department about which ones we are the drivers for and which ones we are not.

Senator McLUCAS: What has the move from being an independent commission to now being in the department meant in terms of the operation of the business side of the commission?

Mr Butt: Our role as an independent commission has not changed. Previously we were in the Prime Minister and Cabinet portfolio. Now we are in the Health portfolio, but we remain an independent commission. It actually does not change what we do and the way we operate. What changed, of course, is that we got a specific tasking to run the national review of mental health programs and services.

Senator McLUCAS: I am not talking about the work you do; I am talking about the operation of the finances and—

Mr Butt: We are a small agency. Those things were done for us by Prime Minister and Cabinet. They have transitioned across to Health. There is no difference.

Senator McLUCAS: I asked you last time about your staffing. Ten full-time equivalent staff were allocated and there were 2.6 vacancies in last June. What is the current circumstance?

Mr Butt: We have dropped down to 8.6 since the review. We had a person go on maternity leave. Her position was backfilled briefly while we finished the review. We had another person seconded to another agency last month. We had a person who was seconded from a state department, and that person has gone back. We are now in the process of finalising our work plan and then we will go back to recruiting.

Senator McLUCAS: Sorry, I am not following you. What is your full staff allocation?

Mr Butt: Our staff allocation is 13.

Senator McLUCAS: What are you currently at?

Mr Butt: We are at 8.6.

Senator McLUCAS: Last June your staff allocation would have been the same?

Mr Butt: Yes.

Senator McLUCAS: What are the vacancies you currently have?

Mr Butt: For example, there was a communications manager who left. Because we changed the way we operated last year and we were not doing all of the public meetings, local consultations and local media, when the communications manager's role ended there was not a lot to do and so that person moved on. That is a vacancy that I have carried on the basis that we did not need that role at that time, but I think this year we need to get back into having that role to fulfil our charter. As I say, our deputy CEO left to run beyondblue. We had a person acting in that role. The person who acted in the deputy CEO role then went on maternity leave in late October.

Senator McLUCAS: I do not need—

Mr Butt: I am going through them all! We are down on numbers at the moment and we need to—

Senator McLUCAS: What is the vacancy rate? How many vacancies do you have?

Mr Butt: If we have a 8.6 FTEs and we are going to go up to 13, it is 4.4.

Senator McLUCAS: Mr Bowles, this is a question that I am going to ask of all the agencies. I want to know the sick leave rates across the department and all portfolio agencies. You can take that on notice.

Mr Bowles: We will take it on notice.

Senator McLUCAS: That is good.

CHAIR: When we come back from lunch, given that at least one senator has asked to extend, we will continue in this area.

Proceedings suspended from 12:59 to 13:57

CHAIR: We will recommence. We will continue with Senator McLucas.

Senator McLUCAS: I want to go, first of all, to the headspace sites, please. Could you give me an update, Mr Booth, about the 10 new headspaces, please.

Mr Booth: At a high level, you will be aware that there is an intent around 100 headspace sites. So there was an election commitment around 10 additional headspace sites. There are currently 76 operational centres across the country. As you know, it is being done in rounds. Seventy of those were from the first five rounds. There are then six from round 6. We are working our way through round 6 and then heading into round 7 and round 8. The intent is still to have the centres operational just as soon as we can. Those are the sites. Did you want to go into detail about—

Senator McLUCAS: So that is—

Mr Booth: That is the table, yes. That is the table that we provided last year.

Senator McLUCAS: Could you provide, on notice, which ones are not yet operational.

Mr Booth: You want me to go through and say where we are up to in terms of each one, and what is happening and that kind of thing?

Senator McLUCAS: Yes.

Mr Booth: Yes; we can do that.

Senator McLUCAS: Is it reasonable to ask you if there are reasons they are not operational. Is it because headpsace has not contracted to another agency, or could not find a block of land or whatever?

Mr Booth: I think there are a variety of reasons as to why it is taking some time. Having said that, rounds 1 to 5 are all up and running. We are moving there. We are heading through round 6, which was the 2013 announcement. I think it is fair to say that headspace—who at the end of the day go out and set the centres up—are working through them as quickly as they can. I do not think there is a single reason I could give you that says, 'There is a problem here'.

Senator McLUCAS: I suppose what I am asking is: for this particular location, if it is not operational, can you give me a sentence that says why?

Mr Booth: We can go through and highlight those are not yet there, and if there are any particular issues.

Senator McLUCAS: Thank you. Now I want to go to the question on notice that we talked about. This was my question SQ14-001225, in which I asked how many potential locations were in the list. Your answer was that 15 potential locations were identified in that list. The 15 that the department identified to the minister were the 15 that were—

Mr Booth: It was the announcement of the 15 sites.

Senator McLUCAS: That is correct.

Mr Booth: Yes.

Senator McLUCAS: I think we need to understand this a bit better. You indicated to me—or the department indicated to me—that there were 15 on the list, and they were the only sites that were considered. So you identified 15 sites; you gave them to the minister; the minister approved those 15. I was asking you: were there more potential sites? How did you get to that 15? Given that there is a question because only one of those sites is not in a coalition-held seat. That is the issue we need to tease out.

Mr Booth: I think last time I went through the notion that there is a methodology in terms of locations; looking at the number of young people and the services that are available and that kind of thing. That methodology has been built up in conjunction with headspace to actually do that. That is how we came up with the 15 locations. But I think what you are asking is: 'Are there any other sites on a list somewhere? Is there a long list or something like that?' Can I get back to you on that?

Senator McLUCAS: Yes. I hope we were misunderstanding each other. Sorry, I just felt that—because many different organisations and places have come to me and said: 'Why aren't we on that potential list? We've been trying to get a headspace for a very long time.' So, if you could identify any other potential sites, it would be useful.

Mr Booth: I will just need to take that on notice in terms of that notion of a list.

Senator McLUCAS: Right. You can provide that to me, potentially?

Mr Booth: Can I take it on notice and take a look at it?

Senator McLUCAS: Yes. Could you also indicate whether there have been representations, made to the Minister for Health, seeking support for headspace centres in other locations?

Mr Booth: I do not think I would be privy to that kind of information, not regarding representations that were made to a minister.

Mr Bowles: The only thing we can have a look at is: have we seen any correspondence to the minister. So we can have a look at that and take that on notice. But, if there was any direct contact, we will not have that.

Senator McLUCAS: No, of course not. I do not expect you to walk around behind the minister and check who she talks to. Can I now go to the EPPIC services, please. Once again, could you give me an update on the election commitment for the early psychosis programs—when are they rolling out, please?

Mr Booth: There are services in four locations at the moment. They are operational in Melbourne, Sydney, Gold Coast and Perth. There is ongoing work around the other sites which were announced, so there is work moving ahead on Adelaide but there are delays in terms of the other sites.

Senator McLUCAS: So that is Adelaide—what about ACT?

Mr Booth: And the other sites were ACT, Hobart and Darwin.

Senator McLUCAS: And can you talk to me about why? This is now quite a delay, isn't it?

Mr Booth: You would be aware that this process is really taken forward by headspace; they establish the sites and take the project forward. I think it is fair to say that there have been a number of issues at play here, and they

include the availability of a suitably skilled workforce to work within the centres, and finding organisations to partner with and work with to take these forward. So I think it is a variety of reasons that have come forward. But it is headspace that is taking that work forward. We obviously keep in touch with them and keep up to date with what is happening. But I think there are a variety of reasons.

Senator McLUCAS: What is the contractual arrangement between the department and headspace for these centres?

Mr Booth: The contractual arrangement goes through headspace. So it is a contract with headspace. And the EPPIC sites—the enhanced headspace sites as they are known—are being rolled out through headspace central office in a contract.

Senator McLUCAS: So is the contract between Department of Health and—

Mr Booth: and headspace central office.

Senator McLUCAS: For each separate one? Or is it one contract?

Mr Booth: One. A single contract with headspace, as opposed to nine separate potential ones.

Senator McLUCAS: Those contracts obviously are signed?

Mr Booth: The contract with headspace is signed, yes, but—

Senator McLUCAS: When do you get to the point where you start paying for services?

Mr Booth: As with any contract, there are milestones that we need to meet, and funding is only released when particular milestones are achieved. So what is the obstacle in Adelaide? What is the problem there?

Mr Booth: I do not know the exact details of the specific problems that are going on. I can just say that in general I know that there were some issues around workforce—getting people in—and the linkages with local organisations. I would need to take on notice the specifics around what the delays in Adelaide were.

Senator McLUCAS: What about in the ACT?

Mr Booth: It is similar I think. I think we need to just get the detail of the individual sites.

Senator McLUCAS: Let's go back to the contract then. What is the thing that has to happen—is there a variation to the contract, or what is the thing that has to occur in the contractual sense, before these services can be delivered?

Mr Booth: It is not necessarily contractual. The contract—

Senator McLUCAS: What does headspace have to show you before you can start?

Mr Booth: There will be a variety of different milestones that are within a contract like that. There will not be one single one. And headspace will need to—as milestones are hit, then payment will be released, as with most Commonwealth programs.

Senator McLUCAS: Is there any risk that these services will not progress?

Mr Booth: At the moment headspace are working diligently, I think, to try and roll them out as quickly as they can.

Senator McLUCAS: Can you give me an understanding of the service in Darwin then? When is Darwin meant to come online?

Mr Booth: I think all services were due to commence in January this year—July 2015. They were all due—they are behind. I think ACT, Darwin and Hobart are behind.

Senator McLUCAS: And Adelaide.

Mr Booth: Adelaide is being developed at the moment. I would need to double-check whether it is going to hit that July.

Senator McLUCAS: And that is meant to start in July as well?

Mr Booth: They were all due to start in July.

Senator McLUCAS: All four of those?

Mr Booth: July 2014. That was the original date.

Senator McLUCAS: That was the Darwin one?

Mr Booth: No, all of them.

Senator McLUCAS: This is nearly a good six months late. I am sorry, but I need more detail about why these services are not operational yet.

Mr Booth: As I said, the contract is run through headspace. I am happy to take on notice to get some more information to you in terms of what is happening in the individual areas. As I said, four of them are online and running. The other five have hit delays. But I would need to double-check and go into detail to find out the specifics of what is happening at each particular site.

Senator McLUCAS: And some prediction about when you expect them to be operational.

Mr Booth: Sure. Yes.

Senator McLUCAS: Is a deed of variation required to the contract with headspace?

Mr Booth: Not at the moment, no. It is just part of the contract. There will be, as we go through the contract, potential variations. It depends what you define as a 'variation of contract', I guess. It is not a new contract but certainly, as we have milestones that are not hit, we need to talk to headspace about what has been happening and what is going on and then look at what the milestones will be.

Senator McLUCAS: I might leave that there. But I look forward to receiving that. Mr Booth, are you aware of an organisation called Clare House in Tasmania?

Mr Booth: No.

Senator MOORE: Good name.

Senator McLUCAS: Yes, good name. But it is not spelt the same.

Senator MOORE: Their loss.

Senator McLUCAS: Clare House has advised that they are not taking any more referrals for child and adolescent mental health services. It really does point to the need for increased services in Tasmania, I think, if you have state government services that are not able to take any more referrals. I am very keen to see these EPPIC centres provided to those locations that are delayed. Can I also have an update on the Young and Well CRC e-mental health portal?

Mr Booth: Yes. The Young and Well portal—this would be $5 million election commitment for the Young and Well Centre to establish essentially a new portal. But it is basically a behind-the-scenes system which encourages better ease of use for a variety of different sites that are going there. The funding agreement was executed on 11 June last year. They are moving ahead with it, so yes it is moving ahead. And it is a three-year time frame to actually do that.

Senator McLUCAS: So it is three-year funding agreement?

Mr Booth: It was a three-year agreement, with $5 million over three-years for them to do that. I think we discussed last time areas such as: a single sign-on; better capability and better capacity, so people did not have to enter lots of different information multiple times; ease of use; those kinds of things. So, yes, they are working on it.

Senator McLUCAS: And the trial under stage 1, is that ready to go?

Mr Booth: The stage 1 pilot is due to commence—certainly early 2015. I do not think it has started yet. I have been in contact with them, and they did provide me an update earlier in the week as to how things were moving, so I will just need to double-check. But certainly they are very close.

Senator McLUCAS: Good. That is great. Could you provide me with an update on the national mental health service planning framework?

Mr Booth: I think the planning framework is as it was when we discussed it last time. So the work that was taken forward by New South Wales is still there. They are continuing to do that work. It has not yet been provided through AHMAC yet for endorsement. So really it is still a work in progress.

Senator McLUCAS: New South Wales was leading.

Mr Booth: They were leading the project and they were leading the work on it—with Queensland.

Senator McLUCAS: What is the delay to take it to AHMAC?

Mr Booth: I am not sure exactly what the delay is. I do know that there has been a fair bit of work on it that has been done. Let me see if there is any information here—no.

Mr Butt: To add to that: my understanding is each state and territory has taken away the framework and is testing it in each of their jurisdictions and that, out of that, we would expect a version 2 to come forward. It is being refined at the moment, so once it is refined I would expect it will go to AHMAC.

Senator McLUCAS: Thank you for that. What is the role of the commission in that work?

Mr Butt: I think I mentioned this previously. Our role was that we were keen to get access to the framework because it obviously was relevant for us in terms of our planning work; but, because of the fact that it was still the first edition and the states had not applied it locally, they were not keen for us to use it. So we basically are waiting on the next iteration.

Senator McLUCAS: And when do we expect that iteration to come back?

Mr Butt: I am not quite sure.

Senator McLUCAS: Will that go back to AHMAC or will that come back to us?

Mr Booth: It needs to go back to AHMAC for endorsement. That was my understanding.

Senator McLUCAS: As the second iteration.

Mr Booth: Yes.

Senator McLUCAS: Is there a time table for that?

Mr Booth: I do not know. I would need to double-check that.

Senator McLUCAS: That would be good because there is a bit of interest in the sector around that. There is a bit of a view that this has gone a bit quiet and we need to get back—ensuring that that work does not fall off the plate, so to speak.

Mr Booth: Yes. I will double-check for you.

Senator McLUCAS: Thank you. I go back to my first issue. Minister, I wonder if you had an opportunity to talk to the minister about the report—the review. When is it going to be published?

Senator Nash: No, I have not as yet. I said we will do that in as timely a way as possible, and we will get it to you on notice.

Senator McLUCAS: I am sure someone from the minister's office is listening.

Senator Nash: They may well be. As I indicated to you earlier, if it were possible today, we would try to get that to you, but we will certainly take it on notice. We did hear what you said, and I am sure the minister's office has heard as well.

Senator McLUCAS: Thank you very much.

Senator WRIGHT: I have a couple of questions that go back to the interface between the primary health networks and mental health, and then I will go to questions about the commission. Has the department done any modelling to indicate the impact of the new primary health networks on access to mental health care?

Mr Cormack: No.

Senator WRIGHT: Thank you. Are you expecting the primary health networks to deliver higher rates of access to mental health care than the Medicare locals?

Mr Cormack: The intent of the primary health networks is to establish a more informed planning approach across the primary, mental health and hospital sectors. The expectation—indeed, the requirement—for each of the PHNs is to produce a comprehensive health needs analysis in the first 12 months. It is certainly the department's expectation that mental health would be one of the key areas within the needs analysis and the plan they would be working towards. So that is certainly what we are anticipating out of the new arrangements.

Senator WRIGHT: The answer you have just given is that you assume mental health needs analysis will be part of that planning process.

Mr Cormack: Yes.

Senator WRIGHT: That does not actually answer my question as to whether there is an expectation that primary health networks will better meet and provide better access to mental health services for people. Do you have a view about that?

Mr Cormack: There is an expectation that the primary health networks should be an integrating mechanism within a defined geographical space across primary health care, mental health and the acute care sector. They would have a well-informed understanding of needs and have a governance framework in place that brought to bear the expert input of clinicians and the informed input of the community and consumers. It would be our expectation that, on the basis of a comprehensive planning process that leads to targeted commissioning of services, you would see and want there to be an overall improvement in the service offering across the area concerned, including mental health.

Senator WRIGHT: How will we know that is actually the case?

Mr Cormack: Part of the primary health networks is a performance framework. That performance framework will cover off a manageable number of indicators: population health, service access and other indicators in relation to the governance of the primary health network itself. So we would expect and in fact will require all of the PHNs to adopt a similar performance framework that will give us a good indication of how they are performing in areas of priority.

Senator WRIGHT: Has there been a previous performance framework applied to, for instance, Medicare locals so that there is some benchmark against which to measure whether or not there is actually an improvement? How will we know there is an improvement?

Mr Booth: There was not a formal performance framework put against Medicare locals. Medicare locals had five strategic objectives that they needed to achieve and they had to address those in their annual reports. The National Health Performance Authority has produced some reports which show performance in tables, but on the whole it has not been on an ongoing basis. The intent here, as Mr Cormack says, is to actually put a performance framework in place which does exactly what you just asked—which looks at a time series to see what is happening all the time.

Senator WRIGHT: But there will not be, then, any way to measure an improvement as opposed to whether or not needs are being met under the new arrangement?

Mr Cormack: No, there will be a basis for measuring performance. That is the aim of the performance framework.

Senator WRIGHT: But improvement from the status quo now.

Mr Cormack: Yes, it would. The department has contracted the Australian Institute of Health and Welfare to provide comprehensive advice to us on a manageable set of indicators. One of the key characteristics of those indicators is that they are collectable; you can measure them. So we would anticipate that that will establish a base line, and then over the life of the primary health networks, as they focus on the priority needs of the community, we would expect there to be monitoring of performance. One would certainly hope for and expect improvements in key areas of population health and access within that network.

Senator WRIGHT: Thank you. Mr Butt, I am interested in the review, as many area. Since providing the review report to government, has the commission received any further guidance or direction from the government?

Mr Butt: No we have not. As you say, it is a report to government, so the report has been provided to government and is now a matter for government.

Senator WRIGHT: Thank you. Were any draft versions of the report provided to the Department of Health or the minister's office through the process of writing the report?

Mr Butt: There were the preliminary report, the interim report and further discussions getting feedback from the department on particular aspects in relation to the review report.

Senator WRIGHT: That was after the interim report, which has not been published yet, of course. So there were further discussions.

Mr Butt: There were further discussions, yes.

Senator WRIGHT: What level of input, then, would you say the government had into the final version of the report?

Mr Butt: Basically, the departments provided us with information. That was what we were after from feedback on various things. The departments across government have been very cooperative in relation to providing us with the information we needed on certain things we were considering. But from government itself we did not other than what I mentioned earlier in relation to ensuring that we did deal with all the terms of reference which we have, which you would expect.

Senator WRIGHT: Yes. I do not want to put words in your mouth. I am trying to understand the process. Was it more of a one-way process in that you sought information and information was provided to you, or was there a process whereby government, the department or the minister's office came back with advice about aspects of the report?

Mr Butt: The department came back with advice on aspects of the report where we were seeking feedback on particular issues which we did not necessarily fully understand and where we wanted to make sure what we were doing was accurately reflecting the situation. Not from government, as I said.

Senator WRIGHT: By government you mean the executive or minister's office?

Mr Butt: Yes.

Senator WRIGHT: How many meetings were held with the government and the department in relation to the report?

Mr Butt: I would have to take that on notice.

Senator WRIGHT: I would like to come to Senator Nash and ask a few questions about the review and the consequences of not yet having the review published and then responded to by government. It has been almost a year now, and funding uncertainty is wreaking real difficulties across the sector. There was a survey by Mental Health Australia late last year showing that 40 per cent of organisations surveyed who are in receipt of Commonwealth funding had already experienced loss of staff due to lack of clarity around funding arrangements. I am going to ask both the department and the minister assisting: are you aware of the survey to which I am referring? Can we start with Senator Nash, please.

Senator Nash: I am not aware of that particular survey.

Senator WRIGHT: I guess you cannot answer on behalf of the health minister, but could you take it on notice to ascertain whether the health minister is aware of that survey.

Senator Nash: Certainly.

Senator WRIGHT: And the department: are you aware of that survey from Mental Health Australia?

Mr Booth: Mental Health Australia do a few surveys. I am not sure of the specific one that you are referring to. I would need to—

Senator WRIGHT: It was late last year. There was quite a bit of media around it. Certainly there was a media release, and there was some media reporting that 40 per cent of the organisations surveyed said they had already experienced a loss of staff. Are the department and the minister aware of this issue around staff retention?

Senator Nash: As I said, I am not aware of that particular report—

Senator WRIGHT: Not just that report. The issues—

Senator Nash: No, hang on.

Senator WRIGHT: I am sorry. I beg your pardon.

Senator Nash: I understand. There have been some views expressed around this, but the government has been very clear in saying that in terms of the report, which you specifically raised at the beginning of your commentary, we are considering that and we are working through the funding processes as quickly as possible.

Senator WRIGHT: Is the department aware of those issues being raised by organisations in terms of trying to retain staff at a time when there is great uncertainty and low morale?

Mr Bowles: Yes.

Senator WRIGHT: You are aware of that? How has the department become aware of those issues?

Mr Bowles: Stakeholders talk to us all the time

Senator WRIGHT: Can I ask what steps, if any, are being taken to ensure that mental health organisations do not continue to lose staff during this time of ongoing uncertainty and that they can maintain vital services for clients.

Mr Bowles: As the minister said, it is a decision of government and government are looking at this issue right now.

Senator WRIGHT: Will the government be consulting with the peak mental health bodies in relation to the recommendations of the National Mental Health Commission review and on how the recommendations may be implemented? Is there a plan to consult?

Mr Bowles: The advice was provided to the minister, as in Minister Ley, and it will be her decision about how she wants to take that forward.

Senator WRIGHT: I am now asking Senator Nash whether or not there is an intention to consult in relation to the review report and the implementation of any recommendations in that report.

Senator Nash: It is with Minister Ley and it will be up to her to determine that process.

Senator WRIGHT: So that is not established at this point?

Senator Nash: Do not put words in my mouth. I said it is with her under the process.

Senator WRIGHT: I am just trying to work out what that means practically.

Senator Nash: I am not aware.

Senator WRIGHT: You are not aware of what, sorry?

Senator Nash: I am not aware, in response to what you just said about what Minister Ley was going to do in relation to that particular process

Senator WRIGHT: So you do not know whether there is going to be consultation or not at this stage?

Senator Nash: That is what I said. It is with the minister and it is up to her to determine what the process will be.

Senator WRIGHT: It is difficult, because we do not have the minister here, and everyone appreciates that.

Senator Nash: That is right, but I am very happy to take things on notice.

Senator WRIGHT: That is what I am going to ask you to do.

Senator Nash: It is more difficult when it is not my portfolio area.

Senator WRIGHT: No, I appreciate that, and that is why I am trying to be really clear. Could you take on notice to ask the minister whether she is intending to consult with peak mental health organisations about the National Mental Health Commission review report and/or the implementation of the recommendations in the report.

Senator Nash: Certainly, I can do that.

Senator WRIGHT: Thank you. Since the report was handed to the government, have there been any meetings between the government and peak mental health bodies?

Senator Nash: Again, I am not aware. I would have to take that on notice for you.

Senator WRIGHT: Does the department know? Can the department give me any information about that?

Mr Bowles: I cannot respond on behalf of the minister, but we have not had any meetings from a departmental perspective.

Senator WRIGHT: No departmental meetings. Mr Butt, I want to know a little bit more about how the Mental Health Commission arrangement is working, now that it is part of the Department of Health. Can you tell—

Mr Bowles: Excuse me, Senator. It is a portfolio agency within the health portfolio. It is not part of the department as such—just to make that clear.

Senator WRIGHT: Thank you. I apologise for the sloppy language. I did not mean to mislead in that way. What are the key differences that have come about that you have noted as a result of the change to becoming an agency associated with the Department of Health?

Mr Butt: In effect there is no difference, because a lot of our backroom services were performed by Prime Minister and Cabinet; they are now performed by Health. That is basically the change. We have obviously had a transition period where we had changes in IT systems and so forth. We went from one system to another and then back again; otherwise, there is no difference. We still remain an independent agency.

Senator WRIGHT: Has there been any difference in operations, budgets or responsibilities? I am just teasing that out a bit more.

Mr Butt: No. No different, other than, as I say, we have a contractual arrangement now with the Department of Health instead of with Prime Minister and Cabinet.

Senator WRIGHT: Is there likely to be some kind of evaluation of the change?

Mr Butt: It is a decision of government in terms of machinery-of-government arrangements, so I would not expect so.

Senator WRIGHT: Finally, I have a tidy-up question about Partners in Recovery. Could I come back to the department about that. We were discussing issues arising from where Medicare Locals have been the lead agency in relation to Partners in Recovery and what would happen when Primary Health Networks replaced them. I am just trying to clarify and understand something. I understand that Partners in Recovery is a service. Is that right?

Mr Booth: Partners in Recovery is a coordination service that aims to ensure that those individuals who have severe mental health problems and have difficulty accessing services are able to access the services they need. The program, I guess, recognises that such people need services from a variety of different areas; hence, the lead agency and partnership approach of it. Some of those partners in there will provide services, but it is around coordinating the services for that individual who needs a variety of different inputs.

Senator WRIGHT: I do not want to get into semantics—I am genuinely trying to understand how it will work—but it is a service that coordinates services?

Mr Booth: It coordinates, but in some areas some of the people who are involved in there will be providing services as well, because it is a grouping.

Senator WRIGHT: I understand that Primary Health Networks, rather than actually delivering services, are designed to coordinate services. Correct me if I am wrong, but that was my understanding.

Mr Booth: Designed to commission services. So, it is the purchases of services.

Senator WRIGHT: How would Partners in Recovery, as a service, work within the mandate of a Primary Health Network?

Mr Booth: The move to a commissioning and purchasing means that PHNs do not actually employ service providers. I think the example given earlier today is around allied health professionals who are currently employed by Medicare Locals. They would be market testing external agencies to actually provide that service. If there is a situation at the moment where a Medicare Local is a lead agency within a PRI organisation and is employing professional staff to work in that area then there would need to be some kind of move to contract that out, essentially. It would depend upon the role that the individual Medicare Local is taking within that area and the kinds of involvement that they have. It is something that we will have to look at on a case-by-case basis, I suspect.

Senator WRIGHT: So that would be a case, I imagine, of understanding where the Medicare Local is the lead agency in the Partners in Recovery, whereby they are employing—

Mr Booth: That is right. That is the general principle. If the Medicare Local is employing professional staff, clinical staff and allied health staff then the intent is to move to a purchasing arrangement rather than providing, so that the PHN concentrates on the commissioning approach, looking at the needs of the population, as we have discussed. The PHN would be concentrating on that area rather than on directly employing staff.

Senator WRIGHT: That is where someone else would need to be found to have their services commissioned, who would then coordinate the—

Mr Booth: Potentially, but as I think we said earlier, for the Partners in Recovery program, typically the arrangements are that there are, as you know, a number of different bodies within there. So there is flexibility within arrangements, already.

Senator WRIGHT: The review of Partners in Recovery is currently underway. You may have answered this before, but I have been in and out a bit. Can you update us as to where that is up to and when we are likely to have a result of that review.

Mr Booth: The work, as you said, is going on. We have an evaluation framework released on 13 December 2013 and projects due to be completed 30 June 2016.

Senator WRIGHT: Is there a possibility that the Partners in Recovery program will not continue into the future?

Mr Booth: That would be a decision of government.

Senator WRIGHT: So there is a possibility.

Mr Booth: As I said, that would be a decision of government.

Senator WRIGHT: It is up to government if it does or does not.

Mr Bowles: It is a decision of government. We do not make calls on those things.

Senator WATERS: I did come in before, so thank you for staying on a little bit longer. I have some questions about the National Maternity Services Plan. I am told by your folk that this is the right spot, so hopefully we can proceed. As I understand it, that plan is meant to increase access to women's continuity of care but it expires some time this year. It seems to have an unclear expiry date. Could you clarify for me when it is due to finish.

Mr Booth: The plan was completed in 2010. It was launched in 2011 and it completes this year, from memory—in November 2015.

Senator WATERS: November 2015 is the expiry date. I notice that the Maternity Services Inter-Jurisdictional Committee has not published an updated progress on the plans since their 2011-12 annual report. Are they still doing those annual updates?

Mr Booth: I thought they were but I would need to take that one on notice. Essentially that is a subcommittee of AHMAC, so we do not really control what the subcommittee does. We can find out what is happening there.

Senator WATERS: Could you find out for me if they still are, and provide those. If they are not you could tell us, perhaps, why not. That would be useful too.

Mr Booth: Yes.

Senator WATERS: On the funding for the plan, I recollect that there was about $120 million allocated in the 2010-11 budget that I believe was for the full implementation of the plan, although I stand to be corrected. I am interested in how much of that initial allocation has been spent, what is left, and whether it is intended to spend that remainder on the plan itself.

Mr Booth: I would need to double check on that. Because it is an AHMAC cross-jurisdictional process, all states and territories were involved in that because maternity services are delivered in hospitals, primary care. It was done across that. It would be a bit of a coordination task but I will see if we have that information.

Senator WATERS: Thank you. I am obviously just interested in the Commonwealth money as opposed to the states. There is a requirement in the plan for a review of its implementation in 2015. Can you tell me what the plans are for the evaluation of that plan?

Mr Cormack: It is the same answer as the previous one. It is an AHMAC process. It is a Commonwealth, state and territory effort. It would be a matter for AHMAC to include that within its work program, but we are happy to inquire about the status of that work.

Senator WATERS: Pardon me, but I am new to this area. Can you remind me what AHMAC is?

Mr Cormack: AHMAC is the Australian Health Ministers Advisory Council. It is comprised of the secretary of the Commonwealth department and his equivalents in the state and territory jurisdictions.

Senator WATERS: The plan itself, though—the implementation of that falls within your departmental sphere?

Mr Booth: There is some coordination of the Commonwealth side of that, but implementation is done across all the jurisdictions.

Senator WATERS: I am interested in the evaluation of the plan, which presumably would fall under your auspices rather than under AHMAC per se?

Mr Booth: Potentially. It is really the subcommittee of AHMAC's decision as to how the evaluation is done, who does the evaluation and that kind of thing.

Senator WATERS: Do you know if they have made a decision about the evaluation?

Mr Booth: My latest advice is that they are currently looking at. They are looking at an evaluation plan but I do not—

Senator WATERS: Whether to do an evaluation plan or looking at one that is underway?

Mr Booth: Not that it is underway. They are looking at whether to do an evaluation plan.

Senator WATERS: Is it too early to say what recommendations that evaluation might produce?

Mr Booth: Yes, we cannot do that until we get there.

Senator WATERS: Is there any work being done on a replacement plan for when this one expires.

Mr Booth: Again, that is a decision for the AHMAC subcommittee. The plan runs to 2015. The subcommittee will no doubt make recommendations as to where it wants to go then.

Senator WATERS: Will your department have any input into that decision-making process?

Mr Cormack: Through the AHMAC process.

Senator WATERS: There is nothing you can tell me about what is being planned for when that plan expires?

Mr Cormack: The point is that AHMAC is a consensus body. It advises the COAG Health Council, the health ministers. Its business rules are for consensus decision making. The Commonwealth obviously has a very significant input into the process, but we are not really in a position to determine the outcome of every AHMAC process or every AHMAC decision.

Senator WATERS: But the Commonwealth could unilaterally decide on a new maternity services plan if it so wished, I would imagine. I am sure it would prefer to do that in consultation, with consensus decision making.

Mr Bowles: It could but it would not work, because you need the states and territories. That is why we have AHMAC to try and drive those issues.

Senator WATERS: But ultimately what the Commonwealth does will be up to the Commonwealth. No decisions have been made yet about what will happen after this current plan expires?

Mr Bowles: It is an issue of AHMAC. We will have a further conversation in the context of the Health Ministers Advisory Council.

Senator WATERS: When is the next meeting of AHMAC?

Mr Bowles: I think it is mid-March.

Senator WATERS: Will this be on the agenda for that meeting?

Mr Bowles: I cannot recall the specifics of the agenda at this stage—whether it is on or not.

Senator WATERS: Is there anybody else who can tell us whether that is on the agenda?

Mr Bowles: We do not generally publish the agenda of an advisory committee, but I cannot recall it being on there. I am on the committee and I cannot recall whether it is on or not.

Senator WATERS: You are currently looking at whether to evaluate the National Maternity Services Plan but you are not necessarily going to discuss that at your next meeting. That does not seem like a very thorough looking at. How do those two match up?

Mr Bowles: There are multiple meetings each year. I just cannot recall whether it is on the agenda for the next one.

Senator WATERS: When is the one after the mid-March meeting?

Mr Bowles: It would be three months later. There are four a year, I think.

Senator WATERS: We would be getting pretty close to the expiry date of the plan by then. Hopefully you will have locked in the evaluation and the replacement plan by then. It is getting pretty tight. Can you take on notice for me to check which meeting you will be addressing those issues at?

Mr Bowles: Yes, we will take that on notice.

Senator WATERS: I will put some more detailed questions about the positions of the states and territories on notice, but I am interested particularly in the credentialling of private midwives to operate in public hospitals. In Queensland, where I come from, we have had eight public hospitals do that already.

Mr Bowles: We just have to get the right people to come to the table.

Senator WATERS: Thank you.

Senator MOORE: Senator, can I ask a question about AHMC while you are gathering that information together?

Senator WATERS: Sure.

Senator MOORE: Mr Bowles, in terms of the AHMC agenda—it operates like other advisory councils and people put suggestions for the agenda—who actually does the agenda?

Mr Bowles: There is a secretariat.

Senator MOORE: Federally? Where is that secretariat?

Mr Bowles: It is largely independent. It is based in Adelaide at the moment.

Senator MOORE: In that process, if we had a particular issue and were wanting to have it brought forward, to whom would we write that request?

Mr Bowles: The Commonwealth and the states will decide what the agenda is.

Senator MOORE: But if we are wanting to focus it—there are people who are really keen on this—to whom would we write a letter saying—

Mr Bowles: You could try writing to the secretariat, but ultimately—

Senator MOORE: No, does the minister have any role in actually seeing whether something could go onto the agenda or not?

Mr Bowles: If any minister wishes to have something discussed with CEOs of health services, or the secretary of the Commonwealth, of course they can.

Senator MOORE: That was the intent of my questions, Mr Bowles. If we felt that this was an important issue for AHMC and we wanted to follow up on it, the process would be for us to write to the minister. Is that right?

Mr Bowles: You could do that.

Senator MOORE: Thank you.

Senator WATERS: So, just coming to the credentialling of those private midwives in public hospitals—thanks for coming to the table, officers—Queensland has eight so far, and I understand that the incoming Victorian government has made some commitments to run some pilot programs. Are there any plans to roll that out any further?

Dr Bryant: The credentialling of private midwives in public hospitals is not a Commonwealth program. It is up to the states and territories to have plans in place to credential. It is correct that Victoria had no credentialled midwives in their public hospitals, but they certainly do in Western Australia, South Australia, Queensland and New South Wales. I am not sure about Tasmania, and I do not think they do in the ACT.

Senator WATERS: The reason I ask, Dr Bryant, is that I thought that was one of the key aspects that is in the National Maternity Services Plan—the encouragement for states to work with their hospitals in order to adopt that credentialling scheme?

Dr Bryant: Yes, that is true.

Senator WATERS: Is the Commonwealth pushing that along in any way, or is it taking more of a hands-off approach?

Dr Bryant: As it is not a Commonwealth responsibility, no. The Commonwealth is involved, of course—as the secretary has indicated—with the National Maternity Services Plan, but that aspect of the plan is the states and territories' responsibility.

Senator WATERS: So, you are leaving that up to them?

Dr Bryant: Yes. We may encourage, of course, but it is not our direct responsibility.

Senator WATERS: Have there been any encouragements in that regard?

Dr Bryant: Yes, at the meetings. It is an ongoing issue.

Senator WATERS: You would not say that it is something that the Commonwealth is pushing for, though?

Dr Bryant: Again, it is not our business to push in that area. It is very much a state or territory responsibility.

Senator WATERS: Moving now to the Medicare rebates, my understanding is that they are not available for labour and birth care provided by Medicare-eligible midwives for homebirths. Is there any evaluation of whether that is an appropriate policy or any moves to review the effectiveness of that policy?

Dr Bryant: No. At the moment, we do not provide Medicare benefits for intrapartum care in the home; we do for a midwife practicing in a hospital, but not in the home.

Senator WATERS: Are there any plans to review that policy position?

Mr Bowles: Not at this stage, I think.

Dr Bryant: No.

Senator WATERS: Is that something that might be considered in the course of either the evaluation of the existing National Maternity Services Plan and/or the consideration of a replacement plan?

CHAIR: I think that is a hypothetical question.

Mr Bowles: We would need to think about what we would do in that sort of context. I do not think I could answer that at this stage.

Senator WATERS: Okay, no problem.

Dr Bryant: The main issue is that there is no insurance available.

Senator WATERS: Thank you. That brings me to my final set of questions. On the professional indemnity insurance exemption for midwives who help people birth at home, I understand that that exemption was due to expire on 30 June. I have some information that that may well have been extended—and please correct me if I am wrong—until 31 December this year.

Mr Bowles: It is still subject to some AHMAC outcomes, but there was a proposal to do that.

Senator WATERS: That is just at the proposal stage; it has not been accepted?

Mr Bowles: It has not been finalised, no.

Senator WATERS: Currently, that exemption still expires—

Mr Bowles: 30 June.

Senator WATERS: on 30 June.

Senator MOORE: Is that on the agenda, Mr Bowles?

Mr Bowles: Yes, it is.

Senator MOORE: That one is definitely on the agenda. Good.

Senator WATERS: That is on the agenda for the mid-March meeting?

Mr Bowles: Yes.

Senator WATERS: Okay. Has there been any public notification of any intention to review that exemption?

Mr Bowles: The Commonwealth does not get into that space either. This is largely a state and territory issue and about whether they would support it or not.

Senator WATERS: Great. Thank you very much.

[14:51]

CHAIR: We will move on now to outcome 3. Just before we do, we are around 50 minutes over time. I think the broad agreement of the committee is we will make up that time in the private health and biosecurity sections, so I think we will still allow the same time for this next outcome—around 105 minutes. Senator McLucas.

Senator McLUCAS: I have some questions about, first of all, the changes to rebates for short consultations.

Mr Stuart: Fire away.

Senator McLUCAS: When did the department commence work on the measure—now abandoned—changing the rebates for consultations of less than 10 minutes?

Mr Bowles: In relation to the announcements in early December, we started to have a look at this around late November, from memory.

Senator McLUCAS: How late in November, Mr Bowles?

Mr Bowles: Probably in the last few weeks of November and into early December. I think it was announced on 9 December.

Senator McLUCAS: Did the department provide the minister or the minister's office with any information about the potential impact of the measure?

Mr Bowles: The department provides advice to the minister. As I said, we were having conversations in late November, early December in preparation for what was announced on the 9th by the Prime Minister and Minister Dutton. We do not go to what advice the department gave but we definitely were providing advice around what the cost was, the savings and all those sorts of issues.

Senator McLUCAS: When was that advice provided to the minister?

Mr Bowles: In those weeks before 9 December.

Senator McLUCAS: You could not be more specific, Mr Bowles?

Mr Bowles: As I said, it was probably in the last two weeks of November or that first week of December. The announcement was made on the 9th—so, in the lead-up to the 9th. Obviously, the decision is a decision of government, and we provided advice around costings.

Senator McLUCAS: Sure. When was the department first involved in discussions with the Department of Finance about the change?

Mr Bowles: The Department of Finance? I would have to take that on notice. I cannot recall.

Senator McLUCAS: Do you recall who initiated that contact?

Mr Bowles: No, I do not. It is just part of the normal process. Whenever we go through budget processes, we talk with Finance all the time—

Senator McLUCAS: Of course.

Mr Bowles: at multiple levels of the organisation. So I cannot recall specifically who would have initiated it. It could have been anybody initiating a conversation at that point. We would, from our perspective, look at the assumptions around what happens, do the costings and work out what the issues might be, and then Finance would check that and do what they normally do.

Senator McLUCAS: You understand why I am asking, Mr Bowles, don't you?

Mr Bowles: Sorry, no.

Senator McLUCAS: You don't?

Mr Bowles: No.

Senator McLUCAS: Okay. I am trying to ascertain whether this idea grew in the Department of Finance or grew in the Department of Health.

Mr Bowles: The announcement on 9 December was multifaceted. And, at the end of the day, they are decisions of government, not of either Finance or the Department of Health. We provide advice.

Senator McLUCAS: I understand that. The process from idea or conception through to 9 December, you are quite right, will be iterative. But where did this idea of the changes to the short consultations originate?

Mr Bowles: As I said, we were providing advice to the minister, and we continue to provide advice to the minister, which I am not going to go into specifically, but clearly we were providing advice to the minister around these issues.

Senator McLUCAS: I do not know how many different ways—

Mr Bowles: 'We' as in the Department of Health—I cannot be any clearer than that, I do not think.

Senator McLUCAS: But the origin of the proposal—you are not prepared to answer that question?

Mr Bowles: I have just said the department were providing advice. We were the ones that provide advice around the types of things that should and should not be done, and it is up to government to make decisions around those things. They do. Finance cost proposals. If Finance provided further advice, I am not aware of it.

Senator McLUCAS: Had the department done any drafting of regulations around the changes in that period in the last two weeks of November or into December?

Ms Faichney: Once the decision was made on 9 December we had regulations put in place on 11 December.

Senator McLUCAS: So that was post the decision?

Ms Faichney: Yes.

Senator McLUCAS: Would you usually have done the drafting prior to it?

Ms Faichney: We would start thinking about it.

Mr Bowles: We would have been thinking about it in the lead-up, in the consultations or in the discussions with the minister, but you do not put them in place until a decision is made. It was done on 11 December.

Senator McLUCAS: Secretary, at the Select Committee on Health hearing that you attended—and thank you for that—you took on notice what analysis the department had undertaken on the impact of the government's proposed co-payments. Do you have an update for this committee on that?

Mr Bowles: Yes, I might go to some of the points that were raised on that day, because there was a lot of confusion around modelling and big 'M' and little 'm'. We had a very interesting conversation about all of those things. The normal terminology around modelling is an economic one. We do not do that; that is Treasury. Treasury can play with economic modelling. What was being referred to the other day and has been in the past—that is how we got into the big 'M', little 'm' modelling conversation—was how we look at assumptions that go to developing estimates of costs or savings, depending on the proposals that we are looking at. In this case we would have a look at a range of factors, and they will go to things like historical trends in services, what billings and expenditure might be from the knowledge that we have, available evidence about the clinical need and any behavioural responses that we have learnt over time, experience from the previous changes, industry factors and interactions from the medical professions. Within the Medical Benefits Division there are a large range of people who have a deep experience in this particular space. That then goes basically to generate the assumptions, depending on what the policy is government is actually looking at, and in this case the policy issues around the consultations and timings, and the other one at that time was the $5 co-pay. That went to calculate a financial impact, which was the saving in this context. So that is how we go about it. We got a bit confused about big 'M' and little 'm', but that is largely how it works. We do not get into the economic modelling that Treasury do in some of their activities. Our job is to look at what either the cost or the saving is within the policy position that is on the table. That is largely it .

Senator McLUCAS: Sure, and what are the savings that were little 'm' modelled at that time?

Mr Bowles: For the changes to the level A, level B?

Senator McLUCAS: Yes.

Mr Bowles: I think it was around $1.3 billion.

Senator McLUCAS: Given the other elements—that, thank you, you have provided—that you contemplate when you are thinking about changes like this, what sorts of changes to attendances did you predict would occur if the proposed co-payments were proceeded with?

Ms Faichney: I think, as has previously been mentioned at some of these hearings, we did not actually predict that there would be any major change to the volume of services because the 9 December announcement was quite a limited policy compared to what had previously been. It did not impact concessional patients, so that meant everyone who is under 16, has a concession card or in a residential aged-care home—those were not. It was a very limited number of items under the schedule—I think, only about 39 items—that were under consideration as well.

So, based on the services that are given to non-concessional patients, we did not anticipate that there would be a major change to the volume of services.

Senator McLUCAS: Thank you for that. The Select Committee on Health heard evidence on 5 February from a GP in New South Wales that, with the changes to Medicare, patients could potentially face upfront costs of $100 for a standard consultation. You would be aware of that. Have you done any analysis of that evidence that we received?

Mr Bowles: No, Senator. As you know, the minister has ruled out the consultation A and B issue and that was reversed in the PAES document. The minister is now consulting quite widely with a range of different groups in a range of different places on what might be a better solution, if you like, to looking at the long-term issues around Medicare.

Senator DI NATALE: Sorry to just interrupt. That evidence leaded up the changes made, so it did not have any bearing at all on the changes to level A and level B.

Mr Bowles: What evidence?

Senator DI NATALE: The evidence that non-concessional patients at that practice would pay $100 per consult. It was an announcement made after the changes to level A and B were introduced. It was in response to the indexation freeze and the co-payment only.

Mr Bowles: Yes, right, I understand that. Do you have a question with that though?

Senator DI NATALE: No. Your response was that the level A and B changes were changed and therefore your implication was that that evidence was no longer relevant.

Mr Bowles: Right.

Senator DI NATALE: I am saying that that change was made after the level A/B change was dropped, but it only related to indexation and to the co-payment.

Mr Bowles: I understand that, but the minister is consulting now about a broad range of issues and so we will little 'm' model or make assumptions and do cost savings estimates on whatever model we actually land on after the minister has finished her consultation and the government makes a decision.

Senator McLUCAS: Has the department received feedback from any GPs that they will need to change their bulk-billing practices and charge up-front fees because of the proposed rebate cuts?

Mr Bowles: As I have said, the minister is consulting and the minister has heard a lot of different views on this. I have attended some of those but not all of those. There are a lot of views out there and, quite frankly, they go from one end of the spectrum to the other end of the spectrum.

Senator McLUCAS: In terms of the minister's consultations, are there potential rebate cuts still on the table?

Mr Bowles: That is all subject to the minister's consultations at the moment.

Senator McLUCAS: So there potentially could be cuts to the rebate?

Mr Bowles: I am not going to rule in or out anything. The minister is consulting and once she has finished those rounds of consultations she, along with the government, will make decisions around those issues.

Senator McLUCAS: Do decisions have to be made within the savings that are proposed from the budget, within those figures?

Mr Bowles: Again, that is a decision for government. I am not privy to that. It is a decision of government. Yes, there were savings at a point in time, but the minister is consulting and it will depend on what the outcome of those consultations is.

Senator McLUCAS: We have heard, and I am sure you have heard as well, that there are people who are concerned that those savings are hard and fast and that the minister must deliver those savings however—

Mr Bowles: It is a matter for government; it is not a matter for me.

Senator McLUCAS: I understand that. Minister, do you know whether the minister has been given instructions by perhaps the Prime Minister to that effect?

Senator Nash: No, I am not aware.

Senator McLUCAS: Did you want to ask the minister if she would share that with the committee?

Senator Nash: I am certainly happy to take that on notice for you.

Senator McLUCAS: Thank you.

Senator DI NATALE: Can I just follow on from that line of questioning about the consultation. What is the policy around the co-payment as it stands?

Mr Bowles: There was the $5 issue and the indexation. They are still there. The $5 is not due to kick in until 1 July anyhow.

Senator DI NATALE: Are they official government policy as we speak?

Mr Bowles: They are at the moment, yes.

Senator DI NATALE: They are?

Mr Bowles: Yes. The minister is consulting around a broad range of issues in relation to patient co-payments. Until that consultation is finished, there is no decision one way or the other.

Senator DI NATALE: I got a little confused. I was listening to Mr Tudge in two separate interviews, and the PM's parliamentary secretary said on 3AW: 'The Medicare co-payment scheme has been dropped.' He then went on the ABC and said: 'We've dropped the Medicare co-payments and we're starting again from scratch.' Is he right? What is the actual policy at the moment?

Mr Bowles: As I said—as I have described it is as I know it. The Minister for Health is doing the consultations.

Senator DI NATALE: Would you describe it again as you know it.

Mr Bowles: The $5 issue is still there, but the minister is consulting on it and the broader issues around patient contributions. What happens at the end of that process is a matter that comes out of the consultations and a matter for government to decide.

Senator DI NATALE: Again, to be clear, you are saying the $5 co-payment is current government policy as far as you understand it?

Mr Bowles: It is subject to the consultation of the minister. It is not my job to rule in or rule out government policy.

Senator DI NATALE: This is a pretty straightforward question. Is it the current government policy to have a $5 co-payment or not.

Mr Bowles: And I have answered that in three different ways.

Senator DI NATALE: I will ask the minister: Minister, I am genuinely confused. Is the current government policy for a $5 co-payment or is it not?

Senator Nash: I think the important thing—well, there are a couple of things. The first is that the minister has been extremely clear that she is consulting widely, ranging broadly across the sector. She has also been very clear about the principles of protecting Medicare for the long term, ensuring that those people who are vulnerable and concessional patients are bulk-billed, ensuring that we maintain high-quality health care and also looking at ensuring that those who have the ability to make a modest contribution do so. I think she has been very, very clear about that, I think it has been well received that the minister has, as she said she would, been consulting widely and broadly, and I think that people are very accepting of allowing that process to run.

Senator DI NATALE: That is not the question I am asking. I understand there is consultation—I welcome that. I think that is a really positive development. It would have been nice if it had happened a little earlier, but it is a very positive development. It is a very straightforward question; it just needs a yes or no answer. Is the current government policy to introduce a $5 co-payment?

CHAIR: You have now asked the question half a dozen times.

Senator DI NATALE: And I haven't got an answer.

CHAIR: I think you have had an answer.

Mr Bowles: I have answered you and I said: it is still there, subject—

Senator DI NATALE: It is still current government policy?

Mr Bowles: It is subject to the minister's consultation.

Senator DI NATALE: It is either policy or it is not.

Mr Bowles: I do not know how to be clearer. It is still there—

Senator DI NATALE: Okay, so it is current government policy.

Mr Bowles: and it is subject to the minister's consultation.

Senator DI NATALE: It may change?

Mr Bowles: It may change; I do not know. It is subject to consultation and subject to government decision.

Senator DI NATALE: I accept that. It is pretty straightforward—it is policy at the moment and it may change after consultation. So it is current government policy?

CHAIR: It has been asked, it has been answered and, in fact—

Senator DI NATALE: Can I ask the minister—

CHAIR: You did not actually have the call. Senator McLucas was questioning and I was going to move to Senator Reynolds.

Senator DI NATALE: Can I finish this question?

CHAIR: This is an interjection.

Senator DI NATALE: I have not asked a question yet in this outcome. In fact, I have asked very few questions through the whole day.

CHAIR: There have been a number of people who have asked few questions for the day, and they have been waiting patiently. I allowed you to interject there but I am not going to allow you to ask a lot of questions in your interjection. If Senator McLucas has a few more questions in this area before I move to Senator Reynolds, then I can come to you after Senator Reynolds, if you would like.

Senator McLUCAS: Given the flow of the conversation, Senator Di Natale and I often work with each other, and it is actually faster—

CHAIR: I understand. I thought that you may have been yielding your time. I was going to give you 20 minutes. That has now passed. I will, therefore, go to Senator Reynolds. She will have some questions, and then I can come back to either Senator Di Natale or Senator McLucas, or both of you together.

Senator REYNOLDS: Mr Bowles, I was wondering if you could tell me what the current spend on the Medicare Benefits Schedule is today. I will get Ms Faichney to do that.

Ms Faichney: The current revised forecast expenditure for 14-15 is $20,260,000,420.

Senator REYNOLDS: How does this compare with a decade ago?

Ms Faichney: I do not have figures going back a decade but I do have figures to 2009-10, when it was $15.4 billion.

Senator REYNOLDS: Have you done any work on the rate of growth per year?

Ms Faichney: I can give you the growth from that. From 09-10, it was nine per cent growth. From 10-11, it was 6.2 per cent growth. From 11-12, it was 5.1 per cent growth. From 12-13, it was 1.6 per cent growth. From 13-14, it was 2.4 per cent growth. Based on current predictions, it is looking to be 6.3 per cent growth for 14-15.

Senator REYNOLDS: How much over inflation is that, do you know—of projected rates? Have you got the figures?

Mr Bowles: Roughly four. Inflation is about 2.5 or something like that these days.

Senator REYNOLDS: Significantly over inflation. What is the projected spend on MBS in a decade from now? Have you done any work on what it is projected to be if no changes are made to make it more sustainable?

Ms Faichney: We currently have figures out to 2023-24. We are projecting that it will be $34 billion.

Senator REYNOLDS: What is the rate of increase per year that that is based on? Have you got those figures there?

Ms Faichney: That will be based on whatever the growth has been today. Because it is a prediction going forward, it is just extrapolated out based on the current growth.

Senator REYNOLDS: At the moment, over the next decade, it is going from $20 billion to $34.4 billion a year without structural changes to make it a bit more sustainable. Is that correct?

Ms Faichney: It is going to $34 billion, yes.

Senator REYNOLDS: What are the current levels of the Medicare levy and the Medicare levy surcharge? What are the current rates?

Ms Faichney: For the levy, it is currently two per cent of your personal taxable income. The surcharge—obviously, depending on your income—goes up to 1½ per cent and—

CHAIR: Just to clarify, the two per cent includes the NDIS levy. Is that correct? Is at 1.5—

Ms Faichney: It went up from 1½ to two to offset some of that, yes. The current Medicare levy and levy surcharge—this is combined—was $10.5 billion in 2013-14.

Senator REYNOLDS: So $10.5 billion was raised. What is the total health expenditure then? I am just trying to work it out. Is that less than half of the total health expenditure?

Ms Faichney: MBS is not total health expenditure. Clearly, total health expenditure includes other things such as the private health insurance rebate and payments to states and territories as a broader amount. But, yes, of the MBS expenditure, it looks like approximately 50 per cent.

Senator REYNOLDS: The surcharge raises of the MBS expenditure are about, or less than half, of the money we actually spend every year?

Ms Faichney: Fifty-four per cent.

Senator REYNOLDS: Can you just remind me what the bulk-billing rates are for concessional and non-concessional patients for GP visits?

Ms Faichney: For concessionals, at the moment it is 93.7 per cent. For non-concessionals, it is 73.9 per cent. This is as of the fourth quarter, 2014. The combined figure, because of the way it falls out, is 84.2 per cent.

Senator REYNOLDS: That is an average of the two?

Ms Faichney: Yes.

Senator REYNOLDS: In dollar figures, what does that roughly work out as?

Ms Faichney: The amount spent is $20 billion.

Senator REYNOLDS: Per visit? So for a concessional patient—the 93.7 per cent—what does that work out to in a dollar amount, do you know?

Ms Faichney: I do not have figures like that, I am sorry.

Senator REYNOLDS: That is okay.

Ms Faichney: It depends, because obviously depends what items and things. It depends what the service is, so it is very hard to say it is a specific amount.

Senator REYNOLDS: Have you done any work to analyse the major reasons for whether or not a non-concessional patient is bulk-billed by a GP? Do you have any reasons or any main reasons why a non-concessional patient is bulk-billed?

Ms Faichney: No. It is a decision of the practice and the practitioner depending on how they wish to bill a patient.

Mr Stuart: Different practices have different policies for billing, sometimes dependent on where they are. In inner city areas, it is quite common for practices to bulk-bill all or most of their patients irrespective of whether they are concessional or not. In other places—as we know, in Canberra—many practices bulk-bill very few patients, depending on their policies in relation to billing of patients.

Senator REYNOLDS: Do you know, as a percentage perhaps, how many non-concessional patients are bulk-billed?

Mr Stuart: Yes.

Ms Faichney: Yes, that is the 73.9 per cent that I mentioned.

Senator REYNOLDS: I was confused. I was thinking that that was the rate.

Ms Faichney: Of all non-concessional patients visiting the GP, 73.9 per cent—nearly three-quarters—are being bulk-billed.

Senator REYNOLDS: I am just wondering if the department has done any analysis on the differences between the government's growth figures in health and for the MBS and claims that I understand the Labor Party has made in relation to a recent Productivity Commission report. Have you done any analysis on that?

Mr Bowles: Not that I am aware of.

Senator REYNOLDS: Thank you.

Senator DI NATALE: This might be a question for Minister Nash. If the $5 co-payment is government policy, did Mr Tudge just make an error when he said—

Senator SMITH: Chair, this is actually old news. This was canvassed on 12 February in *The Sydney Morning Herald*—

Senator Nash: I am fine. As far as I understand, Mr Tudge made an error and has since clarified his statement. That is as I understand it.

Senator DI NATALE: That is great. That is all I was getting at. Thank you. That is helpful.

Senator Nash: That is fine. Just to clarify as well—it is probably useful—the government policy remains the $5 co-pay, but we have paused to consult. I think that is probably a simple way of putting what the secretary said earlier.

Senator DI NATALE: Is the current government policy still to ensure that all of the revenue from the $5 co-pay will go to the Medical Research Future Fund?

Senator Nash: As I understand it.

Senator DI NATALE: Again, I am just going back to some comments that the minister made during an ABC radio interview where she said that some of the money from the co-payment may not go into the Medical Research Future Fund.

Senator Nash: I will take that on notice for you, but the minister could not have been more clear, actually, in saying that she is now going to consult on a wide range of issues. So I think that it is very well understood and very well accepted out there in the community now that there was a position of the government and there is a pause at the moment while the minister is doing that consultation.

Senator DI NATALE: I would like to go to the issue of the differential rebate for concessional patients versus non-concessional patients. The $5 co-pay will not, under the current policy, apply to concession card holders. Is that right?

Mr Bowles: That is correct.

Senator DI NATALE: The government made some commentary that said that concession card holders will not bear the impact of the $5 co-payment.

Mr Bowles: That is correct.

Senator DI NATALE: But seven per cent of concession card holders are not bulk-billed.

Ms Faichney: You are going from the 93.9 per cent? So 6.1, yes.

Senator DI NATALE: Yes. So that is correct, isn't it? Seven per cent of concession card holders do not receive bulk-billed services.

Ms Faichney: It is services we are talking about. We are not talking about patients. But yes—

Senator DI NATALE: Seven per cent of services.

Ms Faichney: seven per cent of services for concessionals are not bulk-billed.

Senator DI NATALE: Then it is not possible to say that concession card holders will be protected, because, under the current billing program, seven per cent of concession card holders do not get bulk-billed. Therefore, they may not get bulk-billed once these differential rebates come into effect.

Ms Faichney: The current policy provides that protection. It is up to a practitioner and the practice to determine its own billing policies. But the policy itself provides that, if they are a concession card holder, they can be bulk-billed without a rebate reduction.

Senator DI NATALE: But it is fair to say that that protection cannot be guaranteed, given that it is not enshrined at the moment.

Ms Faichney: Sorry?

Senator DI NATALE: All I am getting at is, if seven per cent of services for someone with a concession card are not bulk-billed, and you introduce these differential rebates so there is a five dollar reduction in the co-pay for a non-concessional patient, it will mean a higher out-of-pocket cost for that patient. Given that some concession card holders are subject to that at the moment, under this new policy those patients, those concession card holders, will not get the benefit of the five dollar reduction.

Mr Bowles: I think there are a couple of issues at play here. The policy is pretty clear that concession card holders are exempt. The seven per cent is in a completely different space. We would need to think about what the make-up of that is, because there are some services that are provided—like vaccination or something like that—that are not necessarily covered. It could be part of that. I do not know. I am just trying to work out the seven per cent issue. We can take on notice the seven per cent, but I do not think you can extrapolate from one to the other, because the policy is pretty clear that concession card holders are exempt from the five dollars.

Senator DI NATALE: That is only if they tend to bulk-bill in clinic. If they are not bulk-billed—

Mr Bowles: If a concessional patient goes to a doctor and they are charged, we would first need to make some assessment about what it is for. I think there is an issue in that context about some services that are provided to

patients that may not fit within that particular scale. We would need to think about that. But the policy position that is out there is that concessional cardholders are exempt.

Senator DI NATALE: That is the policy position. I am looking at what happens in practice. The statement has been: if you have a concession card, you do not have to worry, because this will not apply to you. What I am putting to you is that actually there are a number of concession card holders in the community who do not receive the benefit of having that concession card—they almost certainly are more likely to be in a rural area—so, under this policy change, it is likely that a number of concession card holders will face higher out-of-pocket costs.

Ms Faichney: No.

Mr Stuart: That is not correct. I think we need to disentangle this. We are slipping unfortunately into the language of co-pay, which is common parlance—and that is okay. But the current policy is for a rebate reduction. Let us start from there.

Ms Faichney: If you are concessional patient, your rebate will remain exactly the same. If you are not bulk-billed, then nothing will change in that that doctor will still continue to charge you. You will still get $37 back in the bank account. Nothing changes for you—so it does not drop by $5, the have your regardless of that. Equally, there are 73 per cent of non-concessionals being bulk-billed who would see a $5 rebate.

Senator DI NATALE: I understand that. Let me try and map this out. I am a GP in Upper Cumbukta West. I do not bulk-bill any of my patients; some of them are concession card holders. I get a reduction of $5 for my non-concessional patients, but I charge everybody the same in that practice. It is my practice. That is what I do, whether you have a concession card or not.

Ms Faichney: You will see no change. Because you are not bulk-billing anybody you are not getting the rebate.

Senator DI NATALE: Hang on, I have not finished. There is a $5 reduction for those patients. I may decide that a small number of my patients under some circumstances are bulk-billed, for whatever reason it might be, and my business decision is to increase the up-front fee that I charge. That means everybody who comes to my practice, whether they are bulk-billed or not. I am making a business decision to increase the amount I charge for everybody, whether you have a concession card or not—granted, it is only seven per cent of the community, of concession card holders, who may be affected—how is it that I am protected from that increase in out-of-pocket costs as a concession card holder?

Mr Stuart: There is a fallacy at the heart of your question—

Senator DI NATALE: Good. Point it out.

Mr Stuart: which I think we should disentangle. It also tripped us up a bit on 5 February and I think it is tripping up a few doctors who are estimating what they think they need to charge people. It is basically this: if I am currently a non-bulk-billed patient and I go to my doctor's surgery and I pay $70, as I do at my practice, I pay $70 to the practice and I get $37 back in my bank account. Should this policy continue, after the policy is in place I go to the same practice and I pay $70 to the doctor. The doctor is not out of pocket. The doctor has lost nothing. The practice has lost nothing. I get $5 less in my bank account.

Senator DI NATALE: Many practices that do not bulk-bill will bulk-bill a repeat visit, for example. Very rarely does a practice charge an up-front cost for every service delivered in that practice. So as a country GP I charge someone who is not a concession card holder the out-of-pocket cost. That person comes back to see me. I say, 'You had a cold last week. Come back and see me, because I'm worried it may develop into pneumonia.' Actually, that is a bad example. I say, 'Come back and see me in a week because I need to review you.' I am going to bulk-bill that visit because that is my practice, first visits normally are. I receive the reduction of $5. I take the hit as the doctor.

Senator Nash: Can I just point out—that might be your practice and your view and the view of how some other practices operate—but I think it is a generalisation to say that GPs will charge a full fee on the first visit and then bulk-bill patients from then on.

Senator DI NATALE: Of course it is a generalisation.

Senator Nash: I know. I wanted to make the point, because the way you said it it was a reference that most doctors do that.

Senator DI NATALE: I am talking from experience here. I know how practices bill.

Senator Nash: That is absolutely fine; so do I. I am absolutely fine for you to do that, but the inference was that most doctors did that.

Senator DI NATALE: I am talking about a group of patients. I understand your point, but the point I am making is that under a change like this a practice that provides some bulk-billing services, which most practices do, will receive a reduction in their income.

Mr Bowles: Not if they are concessional patient.

Senator DI NATALE: No, total practice income, right? As a GP I do not make a distinction.

Mr Bowles: But they are still are concessional patient, therefore it will not reduce.

Senator DI NATALE: No, but for my non-concessional patients I get a reduction. You are missing the point.

Mr Bowles: Your non-concessional point.

Senator DI NATALE: Yes. So my overall income drops, because I do not distinguish between bulk-billing and non-bulk-billing patients. Everybody gets charged the same amount. So when I bulk-bill the follow-up visit from a non-concessional patient I get a reduction in my income, and I want to reflect that in the fees that I charge in my practice. Therefore, all my first consults will go up by $2, $5, whatever it might be, and therefore the concessional patients are the ones who are going to bear the brunt of that.

Mr Bowles: I do not get that.

Ms Faichney: It is unusual for a practice not to distinguish between concessional and non-concessional, and an additional policy parameter within the existing policy is to enable—we had this conversation at the other Senate select committee. There is legislation to go forward to enable just the difference of the $5, should the GP or the practice choose to charge those non-concessionals the change in the rebate amount. They could charge them just that amount—up to $5—if they so wish. As has been said, it is up to the practice to determine its billing.

Senator DI NATALE: It is absolutely up to the practice, and I understand the intention of the policy. But I am also saying to you that, in practice, a general practice may reduce its level of income and choose to reflect that in increasing costs for all patients—concessional or non-concessional. It may differentially reflect that, but it may result in an increase in the cost to concessional patients. Do you think that is a fair thing to say?

Mr Bowles: I think there are a lot of assumptions in your scenario.

Senator DI NATALE: It is the real world. It is how the real world operates. I can tell you, because I know practices that do this.

Mr Bowles: But, Senator, you are making a lot of assumptions there.

Senator DI NATALE: No, those practices are doing this. They are not assumptions.

CHAIR: Perhaps you could allow Mr Bowles to answer the question.

Mr Bowles: I need to finish what I am trying to say. You are making a lot of assumptions, but let us not also forget that this is a pause at the moment while the minister consults. A range of issues are raised when the minister talks to different practices and different people. As I said, I have attended some of them, and there are differing views—some like yours, but a lot are completely different from yours. That is what consultation is about at the moment, and that is what is happening, but the policy position is that the rebate does not impact concessional patients. If a practice determines to do something different, that is a GP's decision.

Senator DI NATALE: But GPs already do this at the moment. What I am trying to highlight to you is that, firstly, this is government policy. I accept there is a consultation going on, but this is government policy. Secondly, this is how some practices operate. While the intent may be to protect concession card holders, in some practices, the reduction in income to those practices may be reflected in an increased cost to concessional patients. I cannot see that in any other way.

Mr Stuart: Senator, I want to remind you of the three arms of protection for concessional patients.

Senator DI NATALE: Do not mention the Medicare Safety Net.

Mr Stuart: I am going to. The rebate reduction does not apply to concessional patients, there continue to be incentives for bulk-billing in Medicare for all concessional patients, and we have the Medicare Safety Net.

Senator DI NATALE: Despite those existing policy levers, what happens in the real world is that some practices will choose to charge a cost to concessional patients—

Mr Stuart: And despite decades of relatively bipartisan policy in respect to concessional patients in Medicare, it has never been possible to ensure that no concessional patient is charged. There has been a level of private charging of concessional patients historically throughout. It has always been a feature of Medicare.

Senator DI NATALE: That is true, but you can make a bad problem worse.

Senator Nash: Perhaps I can assist. I think it is really important that we do focus on the fact that the minister has paused and is consulting. So you are quite rightly raising issues as senators are able to do, obviously, in this fora, and people around the community, as the secretary was saying, are raising a range of issues. But I think it is helpful to allow that consultation process to run. I certainly understand the issues that you are raising, but we are actually in this process where the minister has said, 'We have paused, we are consulting, we are talking about all these issues.' So I think it is really important that you look at it in this context.

Senator DI NATALE: With respect, Minister, it is either government policy or it is not.

Senator Nash: Senator, with respect back to you, I think we have been really clear. We have said it is government policy but we have paused while we are doing the consultation.

Senator DI NATALE: I am interrogating a government policy, which is my right to do at estimates.

Senator Nash: Of course, absolutely.

Senator DI NATALE: You are asking me, 'Do not ask any questions because at some point down the track we might not—

Senator Nash: No, Senator.

Senator DI NATALE: That is all I am doing.

Senator Nash: No, I am not saying that at all. Of course you are quite within your rights to ask questions about a range of things during Senate estimates. What I am simply pointing out, to make sure that everybody is well aware, is that that process has been paused while the minister consults.

Senator DI NATALE: Good.

Senator Nash: I think that is an appropriate thing to point out while we are having these discussions.

Senator DI NATALE: I agree. I am very pleased the minister has taken that decision. I think it is a sensible decision and she has got my full support through the consultation process. If you had said to me earlier, 'Actually, we've dropped the policy. It's no longer policy,' we would not be having this conversation. It is government policy, and while it remains government policy to have a $5 co-payment, and while the government continues to say concession cardholders will be protected, I am going to point out that, in the real world, some concession cardholders will face an increase in upfront costs because that is what is going to happen.

Mr Bowles: That is being fed into the consultations. I think there are a lot of assumptions in what you are saying. I get it that if all of those things fell into place what you are saying may be correct. That gets fed into the consultation process. As the minister is out there, she will get that and she will get something completely different. It is in that phase at the moment, and government will make a further decision when they need to.

Senator McLUCAS: We will come to how long this consultation will go for, but you would be aware that the Senate Select Committee on Health has received evidence around what the impact to billing behaviour of doctors will be. There is a Tamworth GP who talked to us about a $60 charge on a concession cardholder and $100 on a non-concession cardholder. Are you monitoring what is happening in GPs' surgeries around the information that they are providing to their patients about what they expect the billing will be?

Mr Bowles: We are not monitoring every one of the 25,000 GPs out there and what their current practices might be. As I said, the minister is out consulting—and consulting widely—and everyone who is anyone has a view and is expressing that to the minister whenever they can. So there is no need for anyone to do anything at this stage, because even if the decision was to take the $5 it does not even kick in until 1 July. That was the first bit. That is why there is time to consult. The minister has paused the conversation so she can consult on this particular issue.

Senator McLUCAS: But you are aware, I am sure—

Mr Bowles: We are aware, through the consultation process, to start with, that there are broad concerns.

Senator McLUCAS: Are you aware that doctors on the Sunshine Coast have posted in their surgery that a standard consultation will be $65 and a long consultation will be $105, that doctors in Woy Woy have indicated that a level B consultation will be $69 and level C will be $100? This is in the public arena.

Mr Stuart: Is this in respect of concessional or non-concessional patients?

Senator McLUCAS: I think, in both cases they are a flat rate. It does not show.

Mr Bowles: That is not the normal practice in the majority of practices out there.

Senator McLUCAS: That is a good answer because I have asked previously if the Department of Health has done any analysis of what will happen in a standard—and I know there is no standard—GP practice.

Mr Bowles: What we have found is there is no standard.

Senator McLUCAS: But there are types. There are some that are more common than others. Has Department of Health done any analysis about that internal subsidisation that happens in a GP practice where, if a concessional patient is bulk billed, that bulk billing then is often offset by a charge on a non-concessional patient? That happens now.

Mr Bowles: Clearly.

Senator McLUCAS: Have you done any work that would inform the minister about what you would expect to happen if a $5 co-payment were applied to certain patients?

Mr Bowles: I will get Ms Faichney to talk about whether we have done any work. That is why the minister is consulting as well, and she is hearing those stories, and I have heard those stories.

Senator McLUCAS: But surely you have got to go a step further than just hearing a story.

Mr Bowles: It has ever been thus, though, that a core group of non-concessional patients actually pay more. I know I pay more than that. That has always happened. It is fair and just. I can afford that. That is the context. Ms Faichney, might want to answer that.

Ms Faichney: It is where the secretary started this conversation. We undertake a range of analyses when we are doing the costings around these policies. As was pointed out, we look at the historical trends such as the bulk-billing rates between concessional and non-concessional patients and what has happened when there have been changes in those areas. We have looked at what has happened with billing and what has happened with expenditure. We look at what we think likely behaviour responses will be, knowing full well it is very difficult to predict. There is no such thing as a standard practice. There is no such thing as a standard response by a practice or practitioner. So we look at what we think those interactions will be like and we make the judgement based on that. With the current co-payment policy, we have looked at the current rates and how many services are likely to be impacted on and we have made an assumption around that.

Senator McLUCAS: So how many services will be impacted on?

Ms Faichney: Based on what we have at the moment, if it helps to break it down, 89 per cent of services are considered to be in scope, for want of a better term. Obviously chronic disease management health assessments are excluded. They are about 20 per cent of the actual expenditure but they only represent about 11 per cent of the number of services. Of that 89 per cent, we know that there is a percentage which are concessional patients. About 53 per cent of that 89 per cent are concessional patients. That brings it down to the remaining 36 per cent. Of that 36 per cent—because 73.9 per cent of nonconcessionals are bulk-billed—there is a percentage that is patient built already. So there are only fewer than one in four services now being looked at.

Senator McLUCAS: What is the department's assessment of what will happen to the billing behaviour of general practices? You cannot just send your minister out to talk about things without saying, 'We expect that this would mean an increase of this amount for a GP service for a non-concessional patient.'

Ms Faichney: That has already been discussed. This is about the policy around the $5. The minister is consulting more broadly about a range of things. This is based on the existing policies. Obviously we would expect that of that 23 per cent which are non-concessional people being bulk-billed at the moment a doctor or practice will make a decision as to how they want to change their billing practices. Whether they wish to use their ability to charge by up to $5, whether they wish to continue to bulk-bill that person because they are someone they know and they realise there are additional things going on in there lives or whether they think, 'Actually, I am going to move you to patient billing,' it will be a decision of the practice and the practitioner.

Senator McLUCAS: And you have made no judgements at all about what that will mean for the operation of that small business; is that for you are telling me?

Ms Faichney: We have made predictions. I think it is around five per cent that we expect will move to being patient billed. That is taking into account the fact that the majority of services are not included.

Senator McLUCAS: That is the first time we have heard that figure of five per cent, I think.

Senator DI NATALE: Yes. Can you explain that?

Ms Faichney: That five per cent is people who are currently nonconcessional bulk-billed. We would expect of that 73.9 per cent that around five per cent may shift to being fully patient billed, which means they may be charged $70 and get the $37 back in the bank account. Most doctors if they are already bulk-billing them would likely move to charge them only the $5 difference.

Senator DI NATALE: Sorry, you need to break that down.

Senator McLUCAS: How many people is that five per cent?

Ms Faichney: I would have to do a calculation based on the number—

Senator McLUCAS: Would you mind doing that, please.

Ms Faichney: I cannot do it in my head, but I can take it on notice.

Senator DI NATALE: It would be services, not people.

Ms Faichney: Yes.

Senator McLUCAS: Can we work out how many people that would be, though, given the average attendances?

Mr Bowles: That might be difficult.

Ms Faichney: We can estimate.

Mr Bowles: We can estimate—

Senator McLUCAS: It would be great if you could.

Mr Bowles: but we will not get it accurate as far as people go. Services are the thing.

Senator McLUCAS: But we know what the average attendance is of a person at a GP.

Mr Bowles: No. Certain patients will see a GP 20 times a year and some will see them once or not at all in a year. It is not as easy to calculate. That is what I am saying.

Senator McLUCAS: I think you could make a good stab at it. Sorry, Mr Stuart, you were going to add something.

Mr Stuart: I was going to comment that, for a level B, the range of current private billing for those who are privately billed of $60 to $70 would not be unusual, but $100 would be. It would be right out there.

Senator McLUCAS: That is what I thought too, but we have had that evidence from a number of doctors. It is not as if it is a one-off.

Mr Bowles: That would be a real stretch.

Senator McLUCAS: That is what I thought when I heard it, but, as I said, we have heard it a number of times.

Mr Bowles: There would be no reason for that to happen.

Senator DI NATALE: Just on that point, that would be a legitimate response if this were just about the $5 reduction in the co-payment. We have not spoken about the indexation changes yet, which are bigger in terms of their impact on practices by 2018 that the co-payment is. When you put those two things together, it is absolutely conceivable that that is where we are going. I come back to the five per cent figure.

CHAIR: This will be the last couple of questions.

Senator DI NATALE: Let's not get too hung up. These are assumptions and things like that.

Senator McLUCAS: But this is what we have been trying to ask for a long time.

Senator DI NATALE: It is nice to have some information. There is an estimate that five per cent of currently non-concessional bulk-billed services would become full up-front fees. That does not include legislation going through the parliament by July for a $5 co-payment, that you do not have to charge the full amount, just the $5—

Ms Faichney: That does take that into account, because we would anticipate that the majority of practices, if they are doing this to offset the reduction in the rebate—if they have already bulk-billed, that is their mindset, for want of a better word—they would only look to charge up to the $5 for nearly all of those patients.

Senator DI NATALE: I just want to be clear that I have understood this correctly.

Ms Faichney: It gets confusing.

Senator DI NATALE: The five per cent includes practices that are currently bulk-billing and say, 'We're not going to bulk-bill anymore. We're going to charge you $50 and you will claim the rebate yourself'—I plucked a number out of the air—and practices that say, 'We're just going to charge you a $5 co-payment.' Those two things are included—no? I have obviously misunderstood what you have said. This five per cent includes just practices charging a $5 co-payment?

Ms Cahill: That proportion of non-concessional patients, who we expect would be charged—going with your example—$50. That is, more than just the up-to-$5.

Senator DI NATALE: That is what I had understood.

Ms Cahill: So, as we previously discussed, we expect that in the vast majority of cases doctors would pass on the $5, seek to get the $5 and claim the rebate back from Medicare, but we estimate that for around five per cent there would be a shift to a higher level of patient charging.

Senator DI NATALE: That makes sense. So we expect five per cent of practices to just change their billing practices altogether and say, 'We're going to charge up-front—

Ms Cahill: No—that is five per cent of services.

Senator DI NATALE: Yes, five per cent of services. I will get my language correct. The second thing is: have you made an assumption that all practices will pass on the $5 or do you think that some will just absorb it? Have you done any work in that area?

Ms Cahill: We expect for non-concessional patients that, in the vast majority of cases, the $5 would be charged.

Senator DI NATALE: I am asking you specifically. You have not worked out—

Ms Cahill: We have not made an estimate as to what different practices would do. We would expect most practices would do that on the basis of individual patients or groups of patients that they think they need to protect rather than choose to absorb it for all their patients. Really, that is a difficult judgement to make.

Senator DI NATALE: Have you done an estimate on how many concessional services will switch across to up-front fees?

Ms Faichney: We would assume that none would switch because there is no rebate reduction.

Senator DI NATALE: It is happening alongside indexation freezes. Have you done any work on the impact of the indexation freeze and what that will do to billing practices?

Mr Stuart: We went through this on the fifth. The department saw no reason to make any assumption bigger than zero about what would happen in terms of changes to the bulk-billing of concessional patients.

Senator DI NATALE: Even if rebates are frozen? You are saying that, as a general practice, you are going to freeze the rebate for all my patients—concessional or non-concessional—and I am not going to change my billing practices?

Mr Stuart: I did not say that you are not going to change your billing practices. What we are talking about here is we are constantly talking about what assumptions are being fed into estimates for government expenditure and savings.

Senator DI NATALE: I am worried about patients, to be frank. I want to know what impact it is going to have on patients.

Mr Stuart: I am just talking about the basis of our work. What the department has assumed is that there are sufficient incentives in place for doctors who are currently bulk-billing concessional patients to continue bulk-billing concessional patients and that the $5 rebate reduction and the freeze in the rebate will be recouped by doctors from non-concessional patients, either by imposing the $5 with direct billing or by a small shift in the proportion of patients who move from co-payment to no co-payment among the non-concessional patients.

Senator DI NATALE: Your assumption is that all practices—because you have said zero—will make a decision that they are going to recoup the loss in income by freezing rebates to 2018 simply by charging non-concessional patients more and not imposing any additional costs on concessional patients?

Mr Stuart: What I am saying is that that is a reasonable, broad assumption to make for the purposes of estimating government costs. I am not saying that we can rule out definitely that they will not be some doctor someone who has a different view.

Senator DI NATALE: Lots of doctors everywhere would.

Senator SMITH: I just want to talk briefly about the fact that telehealth services provided by general practitioners are not currently Medicare funded. Certainly, across regional Western Australia, local councils are very keen to encourage greater uptake of telehealth services. I understand that the medical fraternity will consider face-to-face consultation as the gold standard, but sometimes you have got to win bronze to win silver to win gold. I am just wondering if we could have a brief discussion about what considerations have been undertaken with regards to the Medicare funding of telehealth consultations by general practitioners.

Ms Faichney: If it helps to begin with, I will just run through some things. There is certainly some consideration around telehealth arrangements. It does get raised with us. Anything that changes in that space would need to go through the Medical Services Advisory Committee. Up until whenever it was, there were telehealth incentives and there have been a significant number of telehealth services that have been funded.

Dr Keaney: The current telehealth arrangements enable specialist consultations through telehealth and patient-end support services provided by general practitioners and other primary care practitioners.

Senator SMITH: Patient-end support services?

Dr Keaney: In a telehealth consultation that is MBS rebated at the moment, there can be rebates provided to a general practitioner, who is sitting in with the patient while that patient is actually having a consultation with a specialist. The policy goal of the program was to increase access to specialist services and, inherent in that design, was that the principal service is one related to a specialist consultation. From time to time, we have had—

Senator SMITH: But in that, the general practitioner must be with the patient who is undergoing a specialist consultation.

Dr Keaney: It is an optional provision so patients could be sitting at home by themselves and having a traditional consultation with a specialist but the arrangements do provide for GPs to sit in and for that patient to attend their general practitioner and have the consultation from that location.

Senator SMITH: My query goes to the patient who might be wanting to have a consultation with a general practitioner.

Dr Keaney: From time to time we have had submissions from general practitioner groups and other allied health practitioner groups who seek to have an extension of telehealth arrangements. To date, governments have not decided to extend the arrangements. But that is not to say that submissions have not been made and that we meet from time to time with rural GP groups, for instance ,who want to discuss the issue. As Ms Faichney has said, one of the pathways to see funding considered by government would be an application for the Medical Services Advisory Committee.

Senator SMITH: What are some of the barriers that come up when the government does consider this type of policy initiative?

Dr Keaney: Principally, there would be financial consequences in addition to MBS expenditure if we were to extend these arrangements.

Senator SMITH: Has there been any work done around what that would actually represent, what quantum of funds that could represent?

Dr Keaney: We did some work about two years ago looking at those kinds of proposals and some estimating was done. To look at increasing services for general practitioners rurally but also—

Senator SMITH: I think that is the point. You might calculate a quantum of funds necessary but if you were to sort of apply it in certain geographical areas or certain types of communities like regional and remote, for example, you would get a different quantum of funds. I understand that there was a review done recently in regards to this?

Dr Keaney: There has been no formal review of the telehealth program per se. There have only been reviews of the type that I just talked about where there has been consideration, for instance, of the evidence around telehealth and what kind of benefit it provides to patients.

Senator SMITH: And that is what I am referring to. Who is on the Medical Services Advisory Committee? Is that a government committee? Does it have particular external stakeholders?

Ms Faichney : It is a ministerially appointed committee. It is an expert committee that provides advice to the government on whether public funds should be directed to a medical service. So they are the ones who provide advice to governments as to whether the MBS should have an item that supports that.

Senator SMITH: How many members are on the committee?

Ms Faichney : There are about 20. It is quite a high number.

Senator SMITH: It is quite a large number. My point being that if the medical fraternity has a view that the gold standard is face-to-face consultations and the Medical Services Advisory Committee is full of medical fraternity people then it is going to be hard for the Western Australia Local Government Association in the great southern that thinks that this would be a great way to support families in their local community to get through the Medical Services Advisory Committee. Who is on the Medical Services Advisory Committee?

Ms Faichney : It is chaired by Prof. Robyn Ward, a radiation oncologist. We have a range of different specialties on that.

Senator SMITH: Of course, depending on the nature of the issue.

Ms Faichney : Dr Keaney is actually the exhibition member on it as well.

Senator SMITH: You mentioned in your evidence that the matter had been looked at two years ago.

Ms Faichney : Yes, it was approximately two years ago.

Senator SMITH: And is there any effort or pressure to review the matter again?

Dr Keaney: Not currently. From time to time individuals and groups either meet with us or write to us. People are informed that there is a pathway to considering this through the Medical Services Advisory Committee. It is an application evaluation process. The Medical Services Advisory Committee looks at evidence of the safety effectiveness and cost effectiveness of potential new services that could be added to the MBS and provides advice to government about that.

Senator SMITH: I appreciate this is in competition to a variety of other worthy initiatives that might be coming in how to use the MBS. Turning briefly to the review that I mentioned, my understanding is that there was a review which examined published evidence in regards to the provision of telehealth services by general practitioners. What was that review called?

Dr Keaney: I am not sure that is the review. I am not aware of that review. We did a review in the context of looking at potentially a call for an expansion of the arrangements. As part of that review we did review the literature around the safety and effectiveness—not cost effectiveness at that point—of these services, particularly in relation to allied health services. The scientific literature did not actually provide a compelling case of the benefit of these services over traditional arrangements. That is not to say that more evidence may not become available.

Around Australia at the moment there are a number of telehealth trials, which are being funded by the government, not through the medical benefits division but through other parts of the department. Those trials are looking at the evidence base for these services and the potential for the health benefits that they may provide.

Senator SMITH: That review that you just talked about, would it be possible for someone like myself to have a copy of that review?

Dr Keaney: The previous literature review that we did, we would certainly be able to provide that to you, yes.

Senator SMITH: You mentioned that there is an application process where the committee formally considers a proposal. What was that called?

Dr Keaney: It is an application to the Medical Services Advisory Committee. The Medical Services Advisory Committee is charged with providing advice to government about the evidence supporting or not the addition of new services to the MBS and broader public funding.

Senator SMITH: When this proposal was considered two years ago, who brought forward that application to the Medical Services Advisory Committee?

Dr Keaney: I am sorry to have confused you. That was not an application for the Medical Services Advisory Committee. That was a review that the government initiated.

Senator SMITH: But in your previous evidence when I specifically asked about Medicare funding of consultations with general practitioners over telehealth, I thought you said that two years ago that had been looked at, there had been some calculations around quantums. Was that done as part of the Medical Services Advisory Committee?

Dr Keaney: No, it was done outside.

Senator SMITH: I understand. How would someone who is not a medical practitioner, not involved in the medical fraternity, try to put this on the agenda of the Medical Services Advisory Committee?

Dr Keaney: Technically anybody can make an application to the Medical Services Advisory Committee. But generally we would recommend to people that they work through the usual groups who are applicants to that process, and generally that would be medical craft groups in this particular setting. So an organisation like the Australian College of Rural and Remote Medicine may make such an application on behalf of rural general practitioners, for instance. So I would normally, if somebody sought that kind of advice, direct them to those kinds of groups.

Senator SMITH: That makes perfect sense.

Mr Bowles: This goes to the broader issue of what is the health system and how do we look at these sorts of issues. I am quite specifically looking at this in the context of how the department operates—since I am new to the department—and I am trying to really bring a strategic policy focus to how we actually look at things going forward more broadly.

I take your point about telehealth. It is a point that is made in various forums. It is not as easy as saying 'and it will be so'. But I am proposing that if we look at things from a strategic policy perspective across the system, we might be able to actually come up with some answers to this probably in the medium term as opposed to now. It is an important issue but I think there are a range of issues that feed in as well along the same lines, not only telemedicine. I think it is an approach that we really need to take around understanding the system and understanding how we can strategically move the system forward.

Senator SMITH: Or incentivise certain elements of the system so there is uptake. I just want to move briefly then to the Medical Treatment Overseas Program and I am keen to understand at a high level how many patients have been assisted in the last—perhaps you can give me a comparative—

Ms Faichney: I can give you a comparison across two financial years—I have not got it broader—if that is okay.

Senator SMITH: Yes, thanks very much.

Ms Faichney: In 2013-14, there were 15 applications received under that program. In 2012-13, there were 23 applications received under that program. As of 10 February this year, so in the current financial year, there has been eight applications lodged. It is obviously not the end of the financial year yet, but that gives you eight, 15 and 23.

Senator SMITH: I do not want to guess, but what countries are people predominantly seeking access to in order to get the treatment?

Dr Keaney: It is really around the therapies that patients are seeking, and the most common reason that we send people overseas is to access specialist radiation oncology services. Most commonly that is in the US, but it might, from time to time, be in Europe. Most recently, there is a patient who is going to Japan.

Senator SMITH: How do we reconcile the tension between someone desperate for a medical treatment for their family member or loved one that may not be well tested or robust and the expenditure of public moneys? What is our risk appetite like for testing relatively new things or testing untested things?

Dr Keaney: There are some eligibility criteria that are tested during the process. Generally, a patient makes an application with the support of their local specialist, and then there are four criteria against which the application is evaluated. Fundamentally, 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. For the example I used, which was radiation oncology treatment, there are certain technologies—one in particular called proton beam—which are not available in Australia, but there is a good evidence base that in certain rare tumours it provides a benefit that is well in excess of locally available treatments.

Senator SMITH: Who makes the ultimate decision? Is it the secretary? Where does that authority lie?

Mr Stuart: I have had the pleasure of that particular duty since I have come into this role in December and I have so far seen two or three approvals. I can tell you that I find the supporting documentation extraordinarily diligent and that it goes to the fact of (a) the need and (b) the capacity to benefit from the particular intervention.

Senator SMITH: Do you have an average cost? It is not about—I was going to say it is not about the money but I suppose there is a—

Dr Keaney: We do not have an average cost. It is quite varied.

Senator SMITH: Do you have a range? When we look at the 23 or the 15, I just think it is important for people to get a bit of a sense of what contribution public moneys make to these.

Ms Faichney: We could take that one on notice, if that is okay.

Senator SMITH: Yes, fair enough.

CHAIR: Thankyou.

Proceedings suspended from 16:08 to 16:25

Senator McLUCAS: I would like to finish off the conversation that we have had around the impact of the changes on billing behaviour of doctors. That five per cent of services, or consultations, where the currently non-concessional patients who are bulk-billed will not be bulk-billed—your determination: is that about two million services? How many services is that?

Ms Faichney: I think we took that on notice. We do not have that figure here.

Senator McLUCAS: Can we do the calculation?

Mr Stuart: It is a little more complicated than a simple piece of arithmetic because it depends on the balance of different kinds of services between concessional and non-concessional patients. We just cannot divide a total by a number.

Senator McLUCAS: But I understand from Ms Faichney that it is two per cent of currently bulk-billed services that are—

Mr Bowles: To non-concessional—

Senator McLUCAS: To non-concessional patients.

Mr Bowles: We would have to do the numbers on that.

Senator McLUCAS: So there is a figure that is the number of bulk-billed non-concessional patients. I am sure that is a number you know.

Ms Faichney: No, it is something we can calculate. We can certainly take it on notice and give it to you.

Senator McLUCAS: You do not have it?

Ms Faichney: I do not have it, no, sorry.

Senator McLUCAS: All right. We will get that soon, I expect. Thank you. Let us go then to this cohort of patients. Are you expecting a person who is a non-concessional patient who a doctor may previously have bulk-billed, because they are a low income earner or they have got 15 kids or whatever it is, which are the reasons why doctors bulk-bill non-concessional patients—

Mr Bowles: I am going to go back to what I have been saying all morning and afternoon. The minister is now consulting on these issues. We are not making any assumptions on anything about what might be the outcome of that.

Senator McLUCAS: Sure, but the current policy stands.

Mr Bowles: We calculated or made assumptions to calculate a figure for the purposes of costing. The policy position is on hold while the minister consults. We are using broad assumptions. You are trying to go down to an individual patient. That is a very difficult thing for us to do here. It is a very difficult thing when we are in the middle of trying to consult with the broader community.

Senator McLUCAS: The purpose of these estimates is to ascertain what the impact of a government policy decision will have on patients in Australia. So I think my questions are reasonable in that sense. I accept all that you have said about this being a thing that is up in the air. It may be; it may not be. But I think it is reasonable for this committee to get a true understanding of what a government policy position will mean for Australians who want to use our health system.

Mr Bowles: I agree with you, and that is why we have provided—

Senator McLUCAS: That is why I am asking the questions.

Mr Bowles: what we have.

Senator McLUCAS: Yes, and it has been very helpful.

Mr Bowles: What I am saying to you, though, is we cannot keep going further down because they are broad assumptions about a range of things.

Senator McLUCAS: All right. I will try not to describe this non-concessional but currently bulk-billed patient. Do you expect that that patient, if they are then part of the five per cent—'the small shift', I think Mr Stuart said—will just pay $5 if they go to the doctor?

Mr Bowles: I think we have talked a little bit about that. The government's policy position around that—and Minister Ley has said—is that if someone can afford to pay a modest contribution, they should. So it goes to that.

Senator McLUCAS: I am talking about the practicalities, not who it is and how it gets affected.

Mr Bowles: I am just saying that, if the policy position is that if you can afford to pay a modest contribution then you should, that does not stop a doctor making decisions, because we already know 70 per cent of non-concessional patients—

Senator McLUCAS: Sorry, you are misunderstanding me, Mr Bowles, and I am not being clear enough. I will try again. If a person goes to the doctor and is one of the five per cent of people who are non-concessional, and the doctor says, 'No, I'm going to move you on, and you'll pay the $5 co-payment,' that is fine. At the end of the consultation, you go to the receptionist and you say, 'I'm going to pay now,' and you pull $5 out of your pocket. Is that how it will happen?

Mr Bowles: I think that is what Ms Faichney was actually saying before. She described the situation before. So we have actually answered, I think, that particular question.

Senator McLUCAS: I missed it, then. I am sorry.

Ms Faichney: To enable them to only pay the $5—this is a comment I made earlier around the legislation—that is required to enable the bulk-billing to continue through the current bulk-billing channel, only the difference in the rebate—so up to $5—is to be charged. That is so the person can walk up with their $5, and that is it. Their rebate will continue to go straight to the doctor, and that is over and done with. But it requires legislation to do that, because it changes it.

Senator McLUCAS: So, if that legislation does not pass, what will happen?

Mr Stuart: I think we are now two hypotheticals away, because the government has not put this legislation forward at this point.

Mr Bowles: So we are consulting. We will go back to that argument, because we do not want to get too many assumptions away from where we are.

Senator McLUCAS: We can all read the Medicare Act. Currently the Medicare Act, from my reading, would mean that, if that legislation does not pass the parliament, it is not going to be possible for the person to pay $5; they would have to pay the full $37.05, and then they would receive a rebate from Medicare.

Ms Faichney: That is the rebate—the $37.05—so, if the doctor chooses to bulk-bill them, that will still be exactly the way it is now. That is what would happen.

Senator McLUCAS: These are the small shift. These are the five per cent of people who are not going to be bulk-billed under the analysis you have done. So the doctor is requiring the patient to pay a $5 co-payment.

Ms Faichney: Without the legislation, they would be required to pay $42, and then they would get $37 back in the bank, because without the legislation—

Mr Stuart: Sorry, I have to interject here. We are now three hypotheticals away.

Ms Faichney: Yes, so it is getting worse.

Senator McLUCAS: Ms Faichney is correct: that is exactly what would happen.

Mr Stuart: The hypothetical scenario that you have painted now would assume that the government would persist with a $5 rebate reduction, which it is currently consulting about, under conditions where the parliament did not disallow the rebate reduction but did disallow the legislation. I just want to make that really clear.

Senator McLUCAS: Mr Stuart, these are the things—

Mr Stuart: We are three hypotheticals away.

Senator McLUCAS: These are the things that we as legislators have to think through, and that is the purpose of these committees: so that we can have a conversation.

Mr Stuart: I appreciate that, but we have to get to that point too.

Senator McLUCAS: We have to know what is going to happen if I vote yes or no on that particular regulation.

Mr Stuart: When it gets there, though.

Senator McLUCAS: I would like to do a little bit of prethinking if that is okay.

Mr Stuart: I am very happy for there to be prethinking, but we are in a consultation phase that will potentially take us down some different pathways.

Senator McLUCAS: Thank you, Ms Faichney. That is correct: the person would not just pay the $5. You would have to pay the full amount and then get the reduced rebate back from Medicare.

Ms Faichney: Not a reduced rebate, no. It depends. Again we are back to exactly where we just left.

Senator McLUCAS: You have answered my question, and I appreciate that. Let us now go to the consultation period that the minister is embarking on. What is the time of that? How long is that going to go for?

Mr Bowles: At this stage, the minister has not put a time frame on consulting. She has been doing this for a couple of weeks, and I would not pre-empt how long that might go. There is no defined period. She did not say, 'I'm going to do this for three weeks.' She just said, 'I'm going to consult.' If she thinks she needs to have some ideas and talk some more, I am sure she will.

Senator McLUCAS: Are there any principles—not rules—in who is being consulted or where people are being consulted?

Mr Bowles: I do not have them with me, but when the minister made a media statement, she had four principles. I do not know if someone has those? Good—someone has.

Ms Faichney: Her press release on 15 January stated that she would begin a wide-ranging consultation with doctors and the community and that these consultations would be guided by the following principles:

•We must protect Medicare for the long term

•We must ensure bulk billing remains for vulnerable and concessional patients

•We must maintain high quality care and treatment for all Australians

•We must insert a price signal of a modest co-payment into the health system for those who have the capacity to pay

Senator McLUCAS: What happens, though, if we get to 1 July and the consultation is still going?

Mr Bowles: Again, that is hypothetical. The minister is aware of her responsibilities within the context of making decisions.

Senator McLUCAS: So, it will not go into 1 July?

Mr Bowles: I think you can guarantee that—even if that is my guarantee not hers!

Senator McLUCAS: Minister Nash—are you participating in this consultation process as well?

Senator Nash: Not specifically at meetings with the minister, but in my role as the minister responsible for rural and regional health, obviously, I am having discussions with people out in the communities.

Senator McLUCAS: Right—is that a formalised—

Senator Nash: But not the formal process, no.

Senator McLUCAS: That is not a formalised process. What is your role then? Do you feed into it somehow?

Senator Nash: As the assistant minister: the senior minister is doing the consultation and I will give feedback on issues to the senior minister.

Senator McLUCAS: Have you found in your discussions with regional stakeholders any who are in favour of the GP co-payment, who think that this will improve health outcomes for regional Australians?

Senator Nash: I am getting a range of views, I have to say.

Senator McLUCAS: Yes, but have you found anyone that wants a GP tax?

Senator Nash: There certainly have been people in the sector who have expressed a view that is not averse to doing that, but it is very much a range of views across communities.

Senator McLUCAS: I live in regional Australia too and I have not found anyone yet who thinks this is a good thing for regional health.

Senator Nash: Well, you asked me the question and I answered you. You may have a different experience. I was answering your question.

Senator McLUCAS: Have you consulted on it with the Rural Doctors Association of Australia?

Senator Nash: I consult with the Rural Doctors Association constantly on a range of matters.

Senator McLUCAS: Sure—but on this issue?

Senator Nash: On this issue and on others.

Senator McLUCAS: And with the National Rural Health Alliance?

Senator Nash: Not recently.

Senator McLUCAS: Services for Australian Rural and Remote Allied Health—the SARRAH group?

Senator Nash: I would need to check that for you. I will take it on notice.

Senator McLUCAS: And the Rural Doctors Association in the states? I am specifically talking about the GP tax and how it will affect rural and regional health.

Senator Nash: I will need to take that on notice and come back for that question.

Senator McLUCAS: I find that amazing. I think that finishes off that—

Senator Nash: Just if we are going to finish it off: I think it would be fair to say that there is a widely-held view that doing nothing is not an option. That certainly comes through when I am talking to people out in the communities—in terms of the sustainability of the system.

Senator DI NATALE: I have a question about the fact that we have pressed pause on the co-payment. Is the government still banking on the savings over the forward estimates?

Mr Bowles: There is a pause as we go forward. You would have seen that the AB was reversed in the pays. If there are different decisions—up, down or sideways—

Senator DI NATALE: Sorry—the AB?

Mr Bowles: Yes.

Senator DI NATALE: But the $5 co-payment is not—

Mr Bowles: No. As we have already established, it is still government policy. But if we go through a process that actually determines a different way forward—up, down or sideways—I am sure it will be taken into account. That is the normal way it works.

Senator DI NATALE: I know it is the normal way it works, but if there is a genuine desire to adopt the new policy is it just convenient that it happens to be hanging around on the books in the lead-up to the budget?

Mr Bowles: Again that is not a comment I can make.

Senator DI NATALE: Okay. Just on the issue around the legislation which needs to get through the parliament. In order to be able to actually charge a co-payment, which is the five dollars that GPs cannot do at the moment, there needs to be legislation through the parliament—

Mr Bowles: That is correct.

Senator DI NATALE: If that legislation does not get through the parliament—

Senator McLUCAS: We did this.

Mr Bowles: We have gone there.

Senator DI NATALE: Have you? Sorry, well we probably already have the answer to that.

Senator McLUCAS: I will say she was very helpful.

Senator DI NATALE: Okay, and the answer was?

Senator McLUCAS: It was $42: the meaning of life universally—

Senator DI NATALE: Okay, $42!

Mr Stuart: The answer was three levels of hypotheticals!

Mr Bowles: We are starting to extrapolate into territory not known to human kind at this point!

CHAIR: I do not think we want to go back there, Senator Di Natale.

Senator DI NATALE: No worries! It sounds like I missed a fun conversation!

CHAIR: You did. You can enjoy reading *Hansard* tomorrow. If there is nothing else then we might move—

Senator McLUCAS: There are a lot of questions about indexation that I will punt on notice.

CHAIR: Thank you, Senator McLucas.

Private Health Insurance Ombudsman

[16:41]

CHAIR: We will move to private health.

Senator McLUCAS: Mr McGregor, thank you. Your annual report for 2013-14 talks about your office having 12 full-time equivalents; is that still the case?

Mr McGregor: Yes. It is the equivalent of 12, with some doing part-time hours—so it is 15 people.

Senator McLUCAS: As I mentioned to Mr Bowles before I am going to ask a general question around sick leave and generally how people are progressing, but I will put that on notice. What is the timetable that you are working on with respect to the intended merger with the Commonwealth Ombudsman?

Mr McGregor: The date of the merger is expected to be 1 July this year.

Senator McLUCAS: And what are you doing between now and then to facilitate that outcome? What is the change that you are having to enact?

Ms Faichney: There is legislation required that is done by the department to facilitate the change of the functions of the Private Health Insurance Ombudsman to the Commonwealth Ombudsman, and that is currently in parliament.

Senator McLUCAS: Yes, but in terms of your office, Mr McGregor: what is happening in your office to prepare for that change? I know it is a bit hypothetical—and Mr Stewart will have a go at me in a minute—

because it has not passed the parliament, but I am sure you are not just sitting and waiting until we make a decision. You must be doing something?

Mr McGregor: Yes, there is a working group which I am involved in: the department, the Department of Prime Minister and Cabinet and the Commonwealth Ombudsman are just doing some planning ahead of time. As far as the office is concerned, it is business as usual because all of our functions are being transferred.

Senator McLUCAS: That is right. Will you physically move? Is this going to necessitate a physical move?

Mr McGregor: No.

Senator McLUCAS: Do you expect the role of your office to change in any way following the merger?

Mr McGregor: No.

Senator McLUCAS: Okay. Now, I understand that at present the subject of a complaint may request additional time to report to the Private Health Insurance Ombudsman, but that ability will not be transferred because it is not consistent with the Commonwealth Ombudsman's existing powers. Is that a true assessment of what the status is?

Mr McGregor: I can answer it as far as the current process, which is, yes, they can. I am not able to answer as far as the Commonwealth Ombudsman is concerned. I did not think it was different.

Senator McLUCAS: My advice—and it is advice—is that the ability for the subject of a complaint to request additional time is not within the Commonwealth Ombudsman's existing powers. That is not something you are aware of, Mr McGregor?

Mr McGregor: It is not something that I have looked into. In practice we do not make use of that power very often so we have not worked through how we would manage that yet. I was aware that the exact definition of the information-gathering power is different in each act but the advice that I received is that it will not affect the running of the complaints service.

Senator McLUCAS: I wonder if you could take that specific question on notice and do some analysis of whether it will affect. I take your point—you do not use it very much. Just see if the legislation reflects that or the Commonwealth Ombudsman's legislation allows those opportunities.

I also understand that there is currently a provision for the minister to intervene where the Private Health Insurance Ombudsman decides not to investigate a complaint. This has been, I understand, omitted from the bill transferring your powers to the Commonwealth Ombudsman. Is that the case, and if so, why?

Mr McGregor: I would have to refer to the department.

Ms Faichney: I am sorry, I do not have that detail. I would have to take that one on notice.

Senator McLUCAS: Are you aware of that discussion?

Ms Faichney: My understanding is that the functions or role are moving but I can take that in detail.

Senator McLUCAS: Is that power used very much?

Mr McGregor: I have worked for the office for over 10 years. It has never been used.

Senator McLUCAS: It has never been used in that time.

Mr McGregor: It is more of an informal arrangement where, if someone wants to raise the matter with the minister, we will look into it without being formally advised to.

Senator McLUCAS: My brief basically indicates that the minister can direct the Ombudsman to investigate a complaint if you made a decision not to.

Mr McGregor: That is right. And we have never formally been advised that. I do not think it is absolutely necessary.

Senator McLUCAS: The provision for the minister to request the PHI Ombudsman to undertake an investigation is also omitted. Is that accurate and is there a reason for that? That is quite similar to the other power.

Ms Faichney: Sorry, I was just getting some advice around that one. It is to do with the difference in the status of the Private Health Insurance Ombudsman versus the Commonwealth Ombudsman, being a statutory office holder themselves, and who therefore does not take direction from a minister. So, it is those specific things around it but I will have to get further written advice for you, because that is clearly not sufficient.

Senator McLUCAS: So the Commonwealth Ombudsman cannot be directed by any person to do anything.

Mr McGregor: That is my understanding.

Senator McLUCAS: That makes sense. I can see why with respect to the Private Health Insurance Ombudsman the powers of the minister might have been written into the act in the beginning, though. How many occasions has the minister—any health minister—requested that the PHI Ombudsman undertake an investigation?

Mr McGregor: I will have to take that on notice. You are asking me to go back several years.

Senator McLUCAS: I am, and I am sorry about that. It is an important consideration in dealing with the legislation.

Mr McGregor: Yes. I would like to take that on notice and say: not recently.

Senator McLUCAS: Will your office, under the proposed legislation, have greater capacity to request information from the subject of a complaint following the merger with the Commonwealth Ombudsman?

Ms Faichney: I would not have thought greater. No. There is no intention to increase powers.

Mr McGregor: My current understanding is that the approach was that there would be as little change as possible. They specifically looked at that issue and made sure that we did not gain greater powers.

Senator McLUCAS: Have you had any feedback from the stakeholders that you ordinarily deal with about the merger?

Mr McGregor: Yes, and I have been providing similar answers as I am now—that it is the intention to have a change with as little impact on consumers or the industry is possible.

Senator McLUCAS: Let us talk about the insurance industry first. Is the feedback from the stakeholders that they are nonplussed, happy, thrilled, disturbed?

Mr McGregor: I think nonplussed, as in ambivalent, yes.

Senator McLUCAS: Thought they might like you all to themselves! What about health consumers? They are a funny group, because that is all of us, and we do not tend to talk with one voice except through our representative bodies. But, in terms of health consumers, what is the feedback you have had from that part of your stakeholders list?

Mr McGregor: We have not had any feedback. We have had one complainant already try and lodge a complaint with the Commonwealth Ombudsman, so they are keen.

Senator McLUCAS: Is there a backstory to that that the committee could understand or is it just that the person has made a mistake?

Mr McGregor: They just want to continue with the complaint in another—

Senator McLUCAS: They are taking another avenue. Thank you for all of that. That was very helpful. How many complaints has your office handled to date this financial year?

Mr McGregor: Up to 31 January 2015, 2,243.

Senator McLUCAS: In a trend sense, is that on track with last financial year to January? Are they increasing? Are they decreasing?

Mr McGregor: It is hard to say, because we had a strangely busy last quarter and then it became very quiet. But, if it continues at that trend, complaints will go up.

Senator McLUCAS: By how much?

Mr McGregor: It is hard to say. The projection I have got here is 3,800.

Senator McLUCAS: Compared to last year?

Mr McGregor: Last year was 3,427.

Senator McLUCAS: So that is quite a big jump. What are the categories of complaints that you have had? Can you talk to me about the last quarter—why there was bit of a jump there? Let us get an understanding of what happened there.

Mr McGregor: Are you talking about the complaint numbers from the last quarter?

Senator McLUCAS: The nature of them. Can you read the numbers to say they were all about premium levels or they were all about—

Mr McGregor: We call those complaint issues. I can go through all of them. Are you asking about the top ones?

Senator McLUCAS: Yes, and I am suppose I am asking: is there anything that is unusual?

Mr McGregor: We had a high number of complaints about health insurer rule changes. We had 144 of those. We had a high number of complaints about oral advice—128 complaints. Hospital policy exclusions and

restrictions—we had 79 complaints. Pre-existing conditions—we had 77 complaints. Level of cover fund rule restrictions—we had 51 complaints. So we identified that those were the cause of the increased complaints.

Senator McLUCAS: But there is nothing unusual in that list is there, by my reading, in terms of the nature of the complaints? That is as you would expect them to be.

Mr McGregor: No. Complaint numbers go up and down and, at the moment, complaints have gone up, and we identified that this is the issue that consumers have expressed they have had a problem with.

Senator McLUCAS: What is the time period for response for this financial year? Do you do an average response time to closure?

Mr McGregor: I would have to take it on notice for this financial year because I do not have that with me. Last financial year is in our annual report, which I can look up.

Senator McLUCAS: We have that, but could you take it on notice for this financial year.

Mr McGregor: Sure.

Senator McLUCAS: Is it still the intention that the publications you currently produce will continue to be produced and according to the same schedule? You do a quarterly report, if I recall correctly.

Mr McGregor: Yes.

Senator McLUCAS: Is it expected that that will continue?

Mr McGregor: Yes.

Senator McLUCAS: And you have an annual report, of course?

Mr McGregor: Yes.

Senator McLUCAS: And that will continue?

Mr McGregor: It will be included In the Commonwealth Ombudsman annual report, because half the report is the statutory requirements and half the report is regarding complaints statistics. I do not think we have decided exactly in what format the complaints statistics will go and whether it will sit within the Commonwealth Ombudsman report or be a separate report. The intention is for it to be available.

Senator McLUCAS: But the quarterly reports will be published as they are now, as documents?

Mr McGregor: Yes.

Senator McLUCAS: Do you produce any other documents that I am not aware of?

Mr McGregor: There is the State of the Health Funds Report, which is required under the act. That is a comparative report on the performance of health funds. That is due out by the end of March, and that is expected to continue because it is in the functions of the office.

Senator McLUCAS: Would you still continue to do the individual health fund report cards?

Mr McGregor: Yes. They appear on the website privatehealth.gov.au.

Senator McLUCAS: Written and authorised by Mr McGregor!

Mr McGregor: Yes!

Senator DI NATALE: What were the average premium increases for the last financial year?

Ms Faichney: The premium round increase in 2014 was 6.2 per cent.

Senator DI NATALE: Was that the 2014 calendar year or financial year?

Ms Faichney: It is April to 30 March.

Senator DI NATALE: I was interested that the Independent Pricing Authority said that there was a three per cent increase in hospital costs as reflected in the efficient price. I am interested to know why there is such a big disparity. I sense from looking at what various insurers are doing at the moment that they are still looking at that sort of number, in the order of five to six per cent. Why is there is a disparity with the three per cent figure for hospital costs and the six per cent figure for premium increases?

Mr Bowles: You are talking apples and oranges, to start with.

Senator DI NATALE: No I am not.

Mr Bowles: Let me explain: the three per cent figure is public hospitals only. Private health insurance is private hospitals; work happens in public hospitals, plus ancillary services that go right across the board. All of that goes to make up what a private health insurer might increase its costs by. We do not know what the figure is at this particular point and, as Ms Faichney said, it was 6.2 per cent last year.

Senator DI NATALE: With respect, the advice provided by Medibank Private—I can go back and check this—was that it had nothing to do with any of those factors and it was to do with the fact that we saw a change in the level of coverage by policyholders, so that people were reducing the level of coverage from having a high level of cover to a lower level of cover, and that was the primary driver of the increase.

Mr Bowles: That is another factor—that is what I am saying. The three per cent is not the only issue in a public hospital context—

Senator DI NATALE: It is a subset of. So it is not apples and oranges, it factors in because the costs of providing services in public hospitals—the bulk of the drivers of our hospital costs—exist within the private hospital system.

Senator DI NATALE: But we are not talking about the same thing when we talk about three per cent for a public hospital and a private insurance. That is my point, and that is why I said it was apples and oranges.

Senator DI NATALE: The reason I wanted to move in that direction was to see whether anything was being done. What is the rebate worth to government at the moment? What is the private health insurance rebate worth at the moment?

Ms Faichney: As in its value?

Senator DI NATALE: Yes, in total.

Ms Faichney: It is about $6 billion but I can get you the exact figure.

Mr Porter: It is around $5.6 billion this financial year.

Senator DI NATALE: Is that the same period for which we were discussing the increase in private health insurance premiums?

Mr Porter: Private health insurance premiums increase on 1 April to—

Senator DI NATALE: So it is different period.

Mr Porter: They go to 30 March the next year. Obviously, in line with government accounting, we work on a financial year basis. So the crossover is not completely the same.

Senator DI NATALE: Can you give me a sense of what the value of the rebate has done over the last three financial years? Do you have that information to hand?

Mr Porter: I do not think I have that information with me, but we can certainly take that on notice.

Senator DI NATALE: It is fair to say it has been increasing significantly over that time?

Mr Porter: It has been increasing each year, yes.

Senator DI NATALE: Has any work been done to model what impact that increase will have over time? Are you looking at projections over the forward estimates?

Mr Stuart: I am not completely clear on whether you are talking about the value or the rate.

Senator DI NATALE: The cost to government of the rebate over the forward estimates.

Mr Stuart: What we are projecting in terms of the cost of the rebate?

Senator DI NATALE: Yes.

Mr Stuart: In the portfolio additional estimates statements, for 2015-16 we are estimating private health insurance rebate expenditure of $6.149 billion.

Senator DI NATALE: That is $5.6 billion going up to $6.149?

Mr Stuart: I have the exact figure here now. The revised budget figure from the PAES is $5.918 billion.

Senator DI NATALE: That was for the last financial year.

Mr Stuart: That was for the 2014-15 revised budget. For 2015-16, it is $6.149 billion. For 2016-17, it is $6.411 billion, and for 2017-18, it is $6.671 billion.

Senator DI NATALE: What assumptions feed into that? I do not know if you will be able to answer this, but do you make some assumptions about what premium increases will be over time—based on what they have been in recent years? Is that the general approach?

Mr Porter: In general, yes.

Senator DI NATALE: You are probably working on about a five or six per cent increase each year?

Mr Porter: In line with what has happened over the previous number of years, it is around that mark, yes.

Senator DI NATALE: This is one of those issues where, if people are downgrading their cover, it starts a spiral. It compounds the problem because we are going to see increasing costs for consumers—and that will potentially mean people will continue to downgrade their cover. Have you done any work to look at what impact that is going to have on level of coverage?

Mr Porter: We have been working with Private Healthcare Australia on getting some datasets together in respect of downgrades, to use that term. It is a complicated area because insurers, for their own business purposes, see a downgrade as being a reduction in premium revenue. From our perspective, that is not necessarily a good indicator of downgrades because, for example, an individual insured person could move from a $500 excess to a $750 excess, with no change in their coverage, as a way of reducing their premium. It is debateable whether that is a downgrade. Similarly, to use a personal example, we have finished having children, so we have got rid of our obstetrics cover. We are paying a lesser premium, so we are still covered for everything else. Again, from an insurer's perspective that would be a downgrade—because we are not paying as much in premiums. But, from a health system or a health policy perspective, it is debateable whether or not that was a downgrade—because our level of hospital cover is maintained. We have been working both with Private Healthcare Australia and the Health Insurance Restricted Membership Association of Australia on understanding and better defining the downgrades issue. We are certainly seeing, through the data, an increase in exclusionary products and excesses and it is not entirely clear to us—and I do not think it is to insurers either—what is driving that.

Senator DI NATALE: There has been a lot of focus on this general question of the costs of Medicare, but we are talking almost $7 billion in the cost of the rebate. What are you looking at doing to try and reduce that cost to government?

Mr Porter: There have been budget measures almost every year over the last few years looking to rein that in. The most recent one has been what is colloquially termed the 'base premium measure', which, in essence, means that the government contribution to the rebate is limited to the CPI increase and not to the premium increase. That in itself brought significant savings. I do not have the exact figure in front of me, but it is around $600 million or so solely from that measure. The private health insurance rebate has also now been removed from the lifetime health cover loading component of a premium, whereas previously a person who had a lifetime health cover loading—which, to refresh your memory, is if you do not have private health insurance by the age of 31 there is a two per cent increase in the cost per year—

Senator DI NATALE: It is the thing that actually changed the increase in coverage rather than the rebate, but that is another story.

Mr Porter: Yes, and there is a very neat chart that you and I both know of.

Senator DI NATALE: That is right. Free money to people who have already decided to take it up—

Mr Porter: Yes. Removing the rebate from the lifetime health cover loading was another budget measure in recent years with significant savings. Obviously, given the size of the expenditure that it is, we are working as closely as we can on understanding what the drivers are and, in turn, where it could go.

Senator DI NATALE: But that $6.7 billion is based on pegging the rebate to CPI rather than the average cost of premiums.

Mr Porter: That is correct.

Senator DI NATALE: That is actually taking into account a massive saving that was already introduced. You have said there have been measures. And I supported that measure. I think it is a sensible measure. Anything in this area that is going to drive down that huge figure is worth looking at, but that measure is already factored into that $6.7 billion increase.

Mr Porter: That is correct.

Senator DI NATALE: What else is being looked at? Is any work being done? I do not understand why we keep talking about Medicare and co-payments and putting a cost in front of a consumer to go and see a GP, and we are almost at $7 billion for a private health insurance rebate that is of questionable benefit.

Mr Porter: The principal driver of the rebate is how many people are insured and how much they are paying. We are continuing to see an increase in both the number of people who are covered by private health insurance and the proportion of the population that is covered. Those demographics are the principal driver of the increase in the rebate.

Senator DI NATALE: The demographics are more of a factor than the total level of coverage, aren't they?

Mr Porter: I did not say they are more of a factor; I said they were a factor.

Senator DI NATALE: I had assumed that the biggest problem is that the people who take the cover are the ones who are effectively going to be users of the policy. Isn't that a bigger factor than the total number of people who are covered? Perhaps on that front: have you got figures around coverage?

Mr Porter: Percentage coverage and numbers of coverage?

Senator DI NATALE: Yes.

Mr Porter: Yes, we certainly have those.

Senator DI NATALE: Do you also project that out over the forward estimates?

Mr Porter: No, we do not project the numbers of people. We solely base it on expenditure. It is difficult, given that the nature of the rebate has been either claiming it back from your insurer on your premiums—whether that is monthly, quarterly, six-monthly or yearly—or claiming it as a tax rebate. So the data that we have to actually forecast where the rebate expenditure is going is very lumpy. We have been working closely with the Australian Taxation Office to refine our model and the data on which that is based. What we do find in terms of rebate expenditure is that there is significant variation, both month to month and year to year, in the pattern of expenditure over time because of how people claim it. While we are projecting, at this point in time, there being increases in the rebate overall, it is very hard to gauge how accurate those projections are given the nature of the data that we have.

Senator DI NATALE: It sounds like every estimates hearing on almost any topic.

Mr Porter: I used to have responsibility for Medicare forecasting and that is, in concept, a much simpler and more sophisticated way because of the data that is available.

Senator DI NATALE: Is that $6.7 billion—or close enough to it—assuming that the level of coverage stays the same?

Mr Porter: No, it is assuming that there is an increase—yes.

Senator DI NATALE: It does assume an increase in coverage.

Mr Porter: Yes.

Senator DI NATALE: And you are not looking at potential downgrades and what impact that is going to have?

Mr Porter: No, because we are not looking at the type of coverage. I am hesitant to use the word 'model', based on conversations and discussions in this room and previously. The estimates are based on the expenditure because that is the most direct way of doing it. In terms of understanding what the drivers are, we certainly look at a whole range of different things, but it is very difficult at this point in time to unpick it.

Senator DI NATALE: How do we get it under control? What work is being done? Given how this is tracking compared to other areas of health expenditure, this is the one that should be flashing in lights.

Mr Stuart: I think that Shane has pointed out to you that there have been a number of things done in recent years, and it is a matter for government whether it wishes to do any more.

Senator DI NATALE: Are you doing any work in this area?

Mr Stuart: The department is always considering all areas of the policy in its charge, but I do not think that, in terms of answering the specific question about that, we can go there.

Mr Bowles: I will just make a broader point. Private hospitals and private health care more broadly is an important part of the Australian healthcare landscape.

Senator DI NATALE: No-one is arguing otherwise.

Mr Bowles: And we do think about it in that sort of context.

Senator DI NATALE: That is a separate question to whether we are getting good value for money out of the private health insurance rebate.

Mr Bowles: Exactly. But they all come together when we actually need to look at the system in toto because it is a large component of health care today is the private sector.

Senator DI NATALE: We have already referred to a graph that demonstrates that Lifetime Health Cover was what drove increased coverage and the rebate had almost nothing to do with the increased numbers in private health insurance.

Mr Bowles: I was not referring to that.

Senator DI NATALE: No, I know.

Mr Bowles: I was saying it is an important part of the healthcare landscape.

Senator DI NATALE: Absolutely.

Mr Stuart: I would just point out there, though, that those things that have an influence on an increase are not necessarily the same things that have an influence on a decrease.

Senator DI NATALE: Correct. I accept that.

Mr Stuart: So, if you were to take something away from someone they might have quite a strong reaction.

Senator DI NATALE: Yes. Governments have experienced that all the time. Is it the government's policy, Minister, to continue to abolish the means test on the private health insurance rebate?

Senator Nash: I just need to take some advice on that.

Mr Porter: My understanding is that the government is committed to reinstate the rebate when fiscal circumstances allow.

Senator Nash: Indeed.

Senator DI NATALE: 'When fiscal circumstances allow'. When money starts raining from heaven. I am done.

Senator McLUCAS: I have some questions regarding the Private Health Insurance Administration Council. The 2014 premium increase was announced in December 2013. Why has the 2015 announcement still not been made.

Mr Porter: To turn that question around, the 2013 announcement was exceptionally early.

Senator McLUCAS: I was surprised as well.

Mr Porter: The more traditional time for announcement of premium increases is in February.

Senator McLUCAS: When were the health funds informed that their premium prices had been approved?

Mr Porter: For this year's premium round?

Senator McLUCAS: Yes.

Mr Porter: When the minister has made a decision.

Senator McLUCAS: So they have been informed?

Mr Porter: No, the minister has not made a decision as yet.

Senator McLUCAS: You can confirm that private health providers have not been informed that their premium rise has been approved.

Mr Porter: The minister has not made a decision on premiums yet.

Senator McLUCAS: This goes to the question of timing. Funds have to give members one month notice of any rise, and the rise would start on 1 April. What is the last date the minister can make a decision and publish it?

Mr Porter: The legislation does not actually define a time period. The legislation says that, for any change to a policy, the insurer must provide the insured person with reasonable notice. The Private Health Insurance Ombudsman has issued guidelines in respect of what 'reasonable notice' means. For premiums and the annual round for premium increases, they do suggest four weeks, or 30 days or so. So, again, we would be looking at around the end of February, start of March.

Senator McLUCAS: That is an ombudsman suggestion rather than a legislated—

Mr Porter: They are guidelines; that is correct.

Senator McLUCAS: It is not legislated?

Mr Porter: No.

Senator McLUCAS: We would expect, though, that we would have this information by this Sunday. Is that the time frame that you are looking at as well?

Mr Stuart: I think Mr Porter has been clear that it is a matter for the minister's decision.

Senator McLUCAS: Thank you. Maybe this is a question for you, Minister. Can you confirm that that oversight role—the fact that, when there is an application, the minister has to make a judgement to approve or not approve premium rises to whatever level the company has asked for—will be maintained?

Senator Nash: I will need to take that on notice for you, it not being my area. I am happy to do that.

Senator McLUCAS: There was speculation that the previous minister wanted to stop that process. That is why I am asking the question.

Senator Nash: We are happy to do that.

Senator McLUCAS: That is all I needed to ask. Thank you.

[17:16]

CHAIR: I think we are done, then, with private health. We are now going to move onto outcome 2, access to pharmaceutical services. We have allowed about half an hour for this outcome. I might kick off. I know that one of the election commitments of the coalition before coming into government was about improving the Pharmaceutical Benefits Advisory Committee processes and listing medicines more quickly. I am wondering if someone can give me an update as to how we are tracking. How did we go in 2014 in terms of listings on the PBS and how does that compare to the last couple of years before that?

Ms McNeill: Certainly. Since October 2013, 489 new or amended PBS items, as well as four co-dependent health technology Medicare Benefits Schedule items, have been listed or will be listed imminently under the government's new process. This includes the 55 PBS price changes that have also been approved. Of all these medicines, three have required the consideration of the cabinet and 486 were able to be agreed by the Minister for Health under the new process. To 1 February 2015, the government is averaging 29 new and amended listings per month under its new process, since coming into office. For the same period from 2012, the previous government listed 341 new or amended items on the PBS, not including price changes, all of which required the consideration of the cabinet. This represents an increase of 93 medicines over the period.

CHAIR: So you have taken two periods that are the same length?

Ms McNeill: The same time period—and compared them.

CHAIR: It is roughly an 18-month period, is it?

Ms McNeill: Approximately 14 months, yes, and an additional 93 items.

CHAIR: Because we do not have totally up-to-date figures; is that right?

Ms McNeill: That is up until February 2015, and that includes the items that the minister has approved up to the 1 April listing period.

CHAIR: Okay.

Ms McNeill: That is about as current as it gets.

CHAIR: So we are seeing it speed up, which is a good thing. Obviously, the government, like all governments, is trying to make sure that the PBS remains sustainable, and it is one of the great challenges. We want to see more stuff listed, but of course there is a cost every time things are listed. We have seen the simplified price disclosures. Now, those changes started to impact—was it in October 2014? Is that correct?

Ms McNeill: That is correct.

CHAIR: What is that delivering in terms of additional savings? What are the forecasts, and is it on track with those forecasts?

Ms McNeill: The savings from the simplified price disclosure measure have already been factored into the PBS forward estimates, which were published at the budget process and again updated at the additional estimates period. We are tracking exactly on schedule at that moment. The price changes that were announced of October 2014 and the prices that will come into effect on 1 April 2015 are realising savings as forecast. So no changes are required to the forward estimates for them.

CHAIR: I think there is another round of price disclosure changes due on 1 April.

Ms McNeill: Yes.

CHAIR: What are we expecting the additional savings will be for budget forecasts from 1 April?

Ms McNeill: That is realising price changes to the value of approximately $800 million over four years. That is already factored into the forward estimates. So the only change we have made to the forward estimates in recent times is actually an increase to the cost of the PBS, rather than a decrease.

CHAIR: Going back to the fact that we are seeing more listed, I wanted to ask about a specific recommendation that I do not think has yet been resolved. The Pharmaceutical Benefits Advisory Committee I think recommended the listing of Zostavax on the National Immunisation Program. I think it is to prevent shingles and post-herpetic neuralgia. Where is that up to? That has been recommended by PBAC but not approved by government at the moment.

Ms McNeill: That is correct. It is a vaccine that was recommended at the November PBAC, along with $1.6 billion worth of other listings. That has a cost over the $20 million threshold, so it will need to be considered by

cabinet. But, importantly, medicines for the National Immunisation Program go through a different process than listing as items on the Pharmaceutical Benefits Scheme.

CHAIR: I am fairly new to this are, so maybe you could take me through that different process?

Ms McNeill: This is normally handled by the Office of Health Protection, with the CMO, but he will correct me if I make a mistake here. What happens is that anything to be listed on the National Immunisation Program has to be found clinically effective and cost-effective by the Pharmaceutical Benefits Advisory Committee, whereas when you are applying for the PBS listing that goes through the processes of pricing negotiations and either to the minister for approval or to the cabinet for approval, and then listing. The National Immunisation Program, because it is administered through the states and territories as well, goes through a tender evaluation process as well, before those are actually released. It requires a lot of liaison and working with the states and territory governments as to how those programs would be administered—for example, whether they are in school or early childhood or, as in the example of Zostavax, in the elder community, and how that will actually be administered through the states and territories.

CHAIR: In this case is the additional process you are talking about yet to be gone through, or has that already been gone through before you get to the PBAC?

Ms McNeill: That is done after the PBAC, so if first of all has to go through ATAGI, the Australian Technical Advisory Group on Immunisation. They are the ones that will first of all look at immunisation and vaccines with respect to the Australian community. Then that comes forward to the PBAC. As to how that is then administered through the states and territories in conjunction with the committee, it is then actioned only after a positive recommendation is received from the PBAC.

CHAIR: So we are at the point where the PBAC has made a positive recommendation and you now go through this process of working out how it would be administered if it were to be approved. So those negotiations and discussions go on with states and territories before it goes to the cabinet?

Ms McNeill: That is correct.

CHAIR: Is there an expected time frame for how long it would take for a drug of this type—one that would benefit about 100,000 people. Is that the correct number?

Ms McNeill: That is potentially correct. I would actually have to take the question on notice. Whilst I have a lot of expertise on the Pharmaceutical Benefits Scheme, the National Immunisation Program and the intricacies of that are best handled by my colleagues in that division. But there is a lead time to that. It tends to also be timed in to calendar years rather than financial years, as opposed to the Pharmaceutical Benefits Scheme, which has monthly listing opportunities.

CHAIR: Thank you.

Senator REYNOLDS: Thank you, very much, for those figures, Ms McNeill. I would like to move to the community pharmacy agreement. I, like many of my colleagues, I suspect, have had some very strong representations from community pharmacies as a result of the changes to price disclosure. First of all, could you provide me with a background on the last—the fifth?—community pharmacy agreement. When did it come into effect and when does it expire?

Ms McNeill: The current Fifth Community Pharmacy Agreement came into effect on 1 July 2010 and expires on 30 June 2015.

Senator REYNOLDS: In response to Senator Seselja's question you said that there had been $800 million worth of savings, which had been reflected in the forward estimates. Were those savings derived from the price disclosure scheme or was that more generally across the PBS?

Ms McNeill: That was specifically to the simplified priced disclosure, which came into effect in 2014. Price disclosure commenced in 2007. It was a Howard government reform. In 2010, as part of the negotiations on the memorandum of understanding with Medicines Australia, and with respect to the Fifth Community Pharmacy Agreement expanded and accelerated price disclosure—

Senator REYNOLDS: As the simplified price disclosure, okay.

Ms McNeill: There was expanded and accelerated price disclosure and simplified price disclosure bills on that program, and now we like to just refer to them—

Senator REYNOLDS: Which came into effect in October last year?

Ms McNeill: October last year, yes.

Senator REYNOLDS: In addition to savings under this program, have any additional savings been sought from the sector or is this the main cost saving?

Mr Stuart: Are we talking about the medicine sector or the pharmacy sector?

Senator REYNOLDS: Both.

Ms McNeill: In the Fifth Community Pharmacy Agreement there were $1 billion worth of savings negotiated over the life of that agreement, with $277 million reinvested in additional pharmacy programs to support patient services. At the same time that that came into effect, the memorandum of understanding with Medicines Australia came into effect. That was to achieve $1.9 billion in savings with respect to expanded and accelerated price disclosure and some amendments to the statutory price reductions that apply to medicines on the formularies and when medicines first go off patent.

Senator REYNOLDS: You mentioned Medicines Australia and the agreement the government reached with Medicines Australia. Were there other consultations taken with the sector for the $1.9 billion worth of savings?

Ms McNeill: There were consultations undertaken with a variety of stakeholders during that time. With respect to the community pharmacy agreement, as opposed to the Medicines Australia memorandum of understanding, there were approximately 22 individuals or groups that we consulted in the lead up to the negotiations on the Fifth Community Pharmacy Agreement.

Senator REYNOLDS: That was the $1 billion worth of savings you are talking about?

Ms McNeill: That is correct.

Senator REYNOLDS: So 22 individuals—

Ms McNeill: Individuals or organisation representative groups.

Senator REYNOLDS: On the $1.9 billion of savings, was that just with Medicines Australia or was there wider consultation?

Ms McNeill: There were consultations with a variety of stakeholders in the lead up to the budget in 2010. In the end, the memorandum of understanding was negotiated with Medicines Australia. It evolved out of discussions that occurred with a variety of stakeholders, and in the end discussions that had transpired between the government and Medicines Australia resulted in the memorandum of understanding.

Senator REYNOLDS: Given that the fifth one is due to expire in June, I would suspect the consultations are now underway for the sixth agreement.

Ms McNeill: When you are talking about the Sixth Community Pharmacy Agreement, that is correct. The minister recently convened a forum with key stakeholders on the 12 February to invite discussions on the PBS in general and on its future, as well as to discuss the future of the Sixth Community Pharmacy Agreement. Based on that initial meeting, she has invited a wide range of stakeholders to consult further with us. That includes my meeting with some of those who were already present at that meeting as full as a variety of other stakeholders who have expressed an interest in sharing ideas and putting forward opportunities for consideration, not just for the Sixth Community Pharmacy Agreement but their perspectives on the PBS in general.

Senator REYNOLDS: In terms of that, is the department initially through the consultations looking at other options for community pharmacies? We had understood that the impact of this, for smaller pharmacies particularly, is about $90,000 a year in income, which obviously for very small community pharmacies is a very significant impact of the price disclosure. There are a couple of issues. One is the impact of price disclosure and how that could possibly be offset for pharmacies, and the types of services that they might be able to provide to compensate for that. Secretary, has that issue been looked at?

Mr Bowles: It is probably best that we do not go down a pathway of talking about some of the issues that we may want to deal with in the context of the negotiation of the sixth pharmacy agreement. That said, the pharmacists are always talking about how they can have a look at different ways of doing business themselves. They have made that publicly known on a regular basis. But I would not want to talk too much about anything while we are in a negotiating phase with anybody.

Senator REYNOLDS: No, I understand the reasons for that. I have one last question. I am not sure if it falls into that category or not, and I am sure the minister will also tell me if it does. In the context of this agreement, is it being considered what services pharmacists may be able to do, like the trials on giving injections—to any other services that might currently be provided by doctors' surgeries or by their nurses? Or does that just fall into the last answer?

Mr Bowles: I think we are getting into the same territory. There are a broad range of conversations going on—

Senator REYNOLDS: On a wide range of issues.

Mr Bowles: around all of those sorts of issues. I would not like to tread into something that might give it away.

Senator REYNOLDS: That is all right. Nothing ventured, nothing gained—but thank you very much for that.

CHAIR: Senator McLucas needs to go, so I was going to give her priority. Are you saying, Senator McLucas, that you now no longer need priority?

Senator McLUCAS: I do need consideration, and I appreciate that, but I am allowing Senator Di Natale three minutes.

Senator DI NATALE: When are we going to see the National Audit Office audit into the Fifth Community Pharmacy Agreement?

Mr Stuart: I think that is a question for the Audit Office.

Senator DI NATALE: You are in the middle of negotiations around—what is it worth? What is the Sixth Community Pharmacy Agreement worth?

Mr Stuart: That is yet to be determined.

Senator DI NATALE: Okay. What was the fifth one worth?

Ms McNeill: $15.6 billion—

Senator DI NATALE: We can assume it is in that ballpark. You have an audit into that agreement. Surely you would not sign on to the Sixth Community Pharmacy Agreement until you have seen the audit into the fifth agreement?

Mr Bowles: We obviously have a lot of dealings with the Audit Office. I just want to be very careful that I do not trip into something that would have a detrimental impact on us negotiating the sixth pharmacy agreement. Clearly, we have had conversations with the Audit Office. That has been going on all the way through. That is how audits work. When the Audit Office put that out is their business. I do not think we have been given a date, have we?

Ms McNeill: No, we have not.

Mr Bowles: No, we have no date for when they are going to put it out, but that does not mean we have not had conversations that might inform our thinking about how we would negotiate a further agreement. But I do not want to go into that at this point.

Senator DI NATALE: I accept that, but, with respect, it is a $15 billion agreement. You have an audit process that is looking at that agreement. I understand that you are having those discussions, but don't we as parliamentarians have the right to actually look at where we might get better value for money out of the sixth agreement, rather than it being negotiated behind closed doors without us even having seen the audit into the Fifth Community Pharmacy Agreement?

Mr Bowles: It is not up to me or my department to pre-empt the ANAO and what they might do with their audit. I accept that you have a right to understand what that is. They will release that whenever the time frame is, which I just do not know.

Senator DI NATALE: It was due in autumn 2014.

Mr Bowles: Again, it is a question for the Audit Office.

Senator DI NATALE: Okay. But isn't it a question for you in negotiating the Sixth Community Pharmacy Agreement to say, 'Before we actually sign on to any agreement, we want to see the audit being released publicly so that people can see why we have made the decisions we have made around the Sixth Community Pharmacy Agreement'?

Mr Bowles: Again, I am not going to pre-empt when the Audit Office may or may not put something in the public arena. That is their business, and it is a question best directed to them. For us, you are right. We need to understand. This is a contract with the department, and it has traditionally been that way. We will take all sorts of issues into account to try and get the best deal—

Senator Di Natale interjecting—

Mr Bowles: No, Senator—

Senator DI NATALE: That is what you are saying.

Mr Bowles: to try and get the best deal for the Commonwealth.

Senator DI NATALE: When do we get to see what—

CHAIR: Senator Di Natale, you are talking over Mr Bowles a little bit. Perhaps just let Mr Bowles finish and then you can ask further questions.

Mr Bowles: We do what we always do in negotiating large, complex agreements. We will continue to do that. There are a range of things that factor into that. I do not want to go into specifics around some of those issues today, when we have just started meeting with a range of the players in this space.

Senator DI NATALE: Do you have a time line for when the Sixth Community Pharmacy Agreement needs to be signed?

Mr Bowles: The fifth will finish on 30 June 2015, so it has to be ready by 1 July 2015.

Senator DI NATALE: All right. I will leave it. Senator McLucas has been very generous, thank you.

Senator McLUCAS: On the parameters around the conversation, I understand that you are in negotiations with the guild and others. Let me ask that question. Who else will the minister consult outside of the big meeting that I understand was held?

Mr Bowles: We had a meeting on 12 February. There were a range of different players in that, from the guild to the different groups.

Ms McNeill: I can read them out, if you like.

Mr Bowles: Yes, you can read them out, if you like.

Ms McNeill: The attendees were the Consumers Health—

Senator McLUCAS: Sorry, Ms McNeill; I am not asking who was at that meeting.

Ms McNeill: You would like to know who else?

Senator McLUCAS: Who will be consulted now as part of this?

Ms McNeill: I can actually help. All the parties that were present are ones that I am continuing to meet with on behalf of the minister. There is the Consumers Health Forum, the Pharmacy Guild of Australia, the Pharmaceutical Society of Australia, the Society of Hospital Pharmacists of Australia, Chemist Warehouse, Medicines Australia, the Generic Medicines Industry Association, the National Pharmaceutical Services Association, the Australian Medical Association and the Royal Australian College of General Practitioners. Others that have expressed an interest that I will also be meeting with over the coming weeks are the royal Australian college of general practice, the Australian Private Hospitals Association, the Australian Medical Association, the Australian Council of Social Service, the National Prescribing Service, Diabetes Australia, Australian Healthcare Associates, the Australian Health Practitioner Regulation Agency, the National Aboriginal Community Controlled Health Organisation, the Community Pharmacy Chemotherapy Services Group, the primary health networks consultations, the National Australian Pharmacy Students' Association, and Australian Self Medication Industry—and that list is to continue.

Senator McLUCAS: Thank you. The last agreement, as Senator Di Natale has indicated, was worth $15 billion. Minister, is it the intent of the government to be looking to make savings in this agreement?

Senator Nash: They are matters for the minister in negotiation.

Mr Bowles: I might just assist. It would be careless of us to talk about anything that might lead to a bad outcome from a negotiation with the 4,000 people that Ms McNeill just read out. This is a very complex issue. We do not want to put our position in a negative way.

Senator McLUCAS: I understand that, Mr Bowles, and I understand how sensitive these things are at this time. I will ask this question: will the discussions involve any review of the existing ban on supermarkets operating pharmacies?

Mr Bowles: I think, again, I would not want to pre-empt what might be in and might be out, because that then just might weaken our position in a negotiating outcome.

Senator McLUCAS: I will leave it there. Thanks very much.

CHAIR: I have just a couple of follow-ups, and then, presuming that no-one else has anything on the pharmaceutical area, we will be able to move on to outcome 7. I just have a few minutes of questioning to finish. It goes back to where I was in my questioning earlier. Perhaps it is a question for either the minister or Mr Bowles at first instance, and then there are just a couple more specifics. It is about the sustainability of the PBS going forward.

I think it is great that we are listing more medicines. That is a good result. Australians want to see the PBS work well. It has great benefits for millions of Australians. But obviously there is always that balance of how we pay for it, how we make it sustainable, what we ask people to contribute—that sort of thing. I am just interested in some of the challenges that you see, Minister or Mr Bowles, on the horizon for the PBS in terms of drugs in the pipeline and how we pay for them, because I am sure that everyone at this table wants to see the PBS continue to be a success.

Mr Bowles: On the PBS: as we have heard, the fifth pharmacy agreement is $15.6 billion. Ms McNeill also talked a little bit about the pipeline that comes with the PBAC process and mentioned a figure of 1.6 from the November PBAC meeting. Clearly, we will have another group of things flowing through in the March meeting, and then I think there is another one in July. There are pressures on the system around hepatitis C drugs. If we look at the broader pharmacy issue, one in six dollars is now in cancer drugs. So there is significant pressure on the system, and that is why I do not want to compromise our position in talking too much past that—

CHAIR: Sure.

Mr Bowles: in what we might want to deal with in the context of the agreement. But we are always looking at these new drugs that are coming on—what are the different ways that we can manage some of the dynamics within the pharmacy process more broadly? It is a constant issue across the health system that we are looking at: how do we maintain the stability and sustainability of these very large programs?

CHAIR: Is the PBS at the moment set up to cope with some of those high-cost, complex medicines like the hepatitis C drugs and high-cost cancer medicines?

Mr Bowles: It will depend on how well we negotiate the agreement, I suppose, at one level. We are set up to understand it. I think price disclosure has been a good thing in the system. Ms McNeill talked a little bit about that. But we have to be ever vigilant because the pipeline can be quite daunting sometimes.

CHAIR: Can I ask a more specific question. It might be for Ms McNeill. What percentage of applications for listing new medicines is the Pharmaceutical Benefits Advisory Committee recommending?

Ms McNeill: We are averaging around 65 per cent of applications to each meeting being recommended.

CHAIR: I do not know how that compares to previous years, whether that is up or it has been pretty constant. Is that roughly what we have seen over a period of time—around two-thirds that come are being recommended?

Ms McNeill: It is a steady increase in the percentage. We have always been over the 50 per cent mark, depending on whether they are first-time submissions or second-time submissions. It is slightly higher than previous years, but it is about the ballpark.

CHAIR: Are there more conditional recommendations for listing than in previous years?

Ms McNeill: I am going to correct you there; I apologise, Senator. We do not talk about conditional recommendations, because legally that is not what the Pharmaceutical Benefits Advisory Committee are allowed to do under the National Health Act. What I think industry refers to is that there can be a recommendation from the PBAC to reject outright. There can be a recommendation where they say, 'Yes, we've accepted exactly what you've put before us and we recommend it as is.' What we have seen more of, and there has been some media discussion about this, is that the PBAC—where it is close to understanding the patient population clinical effectiveness and close to agreeing what the cost effectiveness of that drug is—rather than rejecting a drug and expecting the supplier or the sponsor to then go through another two cycles and come back in, have been quite clear in saying, 'This is what we recommend on this; this is the patient population and these are the pricing parameters,' where it is very close. They are giving industry the opportunity to either accept that and take that recommendation and list immediately, which a lot of companies do, or alternatively some companies have chosen not to accept those recommendations and to come back to PBAC as well. A classic drug for that was Abraxane, which came back on multiple occasions rather than accept the actual recommendation. So we have seen more of them, but that is a decision of the Pharmaceutical Benefits Advisory Committee and how they choose to make their recommendations. It is not a matter for the department.

CHAIR: We are not calling them 'conditional recommendations'. What do we refer to them as? Is there a name, a term, that we can use?

Ms McNeill: We still call it a recommendation of the PBAC. They just specify quite clearly the basis of their recommendation. We deviate slightly from what the industry sponsor has requested.

CHAIR: Some would call them call 'conditional' and others would call them something different, I suppose.

Ms McNeill: That is correct.

CHAIR: You said that the number of those has been growing. Is there a reason for that? Was there a policy change somewhere that led to that?

Ms McNeill: Like I said, the decisions and the recommendations of the PBAC are a matter for that independent committee. It is their choice as to how they choose to recommend or reject a drug, whether they choose to convene stakeholder groups to discuss a drug further or whether they choose to defer and work with a pharmaceutical company to try and expedite a listing. That is a decision that the committee themselves have taken as to how they have been choosing to recommend. It is a matter then for the department to give effect to those recommendations.

CHAIR: Just finally from me on this: I think the PBS is broken down into—you might correct me if I am wrong because I might have a poor briefing again—innovative and generic.

Ms McNeill: Yes.

CHAIR: Are we seeing a difference in the growth between those two and, if so, why?

Ms McNeill: Yes, we are. We affectionately call them the F1 and the F2 formulary. That is not because we like Formula One racing; it is just that is what we call them. F1 is the area that we talk about being predominantly the on-patent medicines and F2 is predominantly the off-patent medicines. What we start to see is that because the price disclosure is having the effect that it was intended to have, which is in the F2 off-patent market, it is driving the prices down. We are seeing a dramatic reduction in the average script cost in that space; whereas as we list new medicines on the F1 space we are having fewer scripts in that area but they are costing us an awful lot more. For example, for new medicines on patent, the number of scripts are declining by 10 per cent. That is because a lot of drugs are moving from the patent to the off patent. But the average is increasing by 30 per cent on the last financial year.

Mr Stuart: The average cost.

Ms McNeill: Yes, the average script cost is going up by 30 per cent per year; whereas at the F2 formulary the script numbers have increased by 13 per cent and the expenditure per script on these drugs has actually decreased by 10 per cent over the same period. So we are having more scripts dispensed in F2, but it is costing us less per script to subsidise; whereas in the F1 formulary we have got fewer scripts being dispensed but the cost per script is going up by 30 per cent.

CHAIR: Thank you very much for that. I will leave it there. Unless anyone has anything else, we are done with outcome 2.

Ms McNeill: Can I just make a correction? My colleague has just pointed out to me that I said the drug 'Abraxane' for a drug that had come back to PBS and a recommendation. It was actually Abiraterone.

Therapeutic Goods Administration

[17:47]

CHAIR: Thank you very much. We now move on to outcome 7, health system capacity and quality. We have allocated 50 minutes. Unless the committee deems otherwise, we are looking at sticking to that 50 minutes.

Senator MOORE: I have some questions around TGA and the reviews and also the issue around accepting regulations from overseas. We know that there is an expert review into medicines and medical devices regulations underway. Can you tell us what the status of that review is? Where is it at?

Mr Skerritt: The review was announced by the government in October last year to look into aspects and potential improvements to the regulatory framework for medicines and medical devices in Australia. They released a public discussion in mid-November. Both prior to that discussion paper and in the period since the release of that discussion paper they have been having meetings with stakeholder groups, either one-on-one or with groups of people, every week or two. They have to report to government by 31 March on matters relating to prescription medicines, over-the-counter medicines and regulation of medical devices. They have a second reporting deadline, and that is to do with the regulation of complementary medicines and other matters such as the shape and future of TGA committees. For that matter, they released a second discussion paper, or, more correctly, chapter 9 to their original discussion paper, last Friday on complementary medicines.

Senator MOORE: Is that on the website?

Prof. Skerritt: That is on the health department website. The public submissions have been requested to appear by about the first week of April. The first lot of public submissions closed in early January. They have now been published, with the exception of those where submitters did not request for them to be public. They have now been published on the departmental website. I should emphasise that, quite appropriately, this expert

panel review is being carried out significantly at arm's length—or, perhaps, I should say a few bodies' length from TGA. And that is appropriate. The secretariat for this review is actually in a separate part of the department.

Senator MOORE: Locked away in a separate room?

Prof. Skerritt: They do let them out sometimes.

Senator MOORE: But they are department staff?

Prof. Skerritt: The secretariat is, but—

Senator MOORE: Because of the probity issues, they are not co-located with TGA.

Prof. Skerritt: Yes. They are not co-located with TGA and they are not in one of our three divisions.

Senator MOORE: I will read that in *Hansard* in terms of the actual dates, and a lot of it is on the website. But I just wanted to get it on record exactly what it is, and have not got across the Friday publication. This committee, as you know, has had a lot to do with various regulatory issues around the TGA and a number of committee hearings and so on. There is a great deal of interest, and we have noticed that in the community in those areas. So we welcome the review. The area that I want to go into is the principle that:

… if a system, service or product has been approved under a trusted international standard or risk assessment, then our regulators should not impose any additional requirements for approval in Australia …

We have talked about that at a number of hearings.

… unless it can be demonstrated that there is a good reason to do so.

Seeing that that principle is being reinforced, it would be useful to have a look at our current product recall system, which has been the subject of a couple of discussions in this committee. Can you tell us how many therapeutic products have been recalled to date in 2015, 2014 and 2013? Is that something you have to find?

Prof. Skerritt: I will not have the figures for each here. I think I do have the figure—and I might ask my colleague, Dr Larry Kelly, to join me—for medical devices. We may have it for recalls overall. We certainly would have to take the other figures on notice.

Senator MOORE: So you would be able to provide to us in a format a number of—

Prof. Skerritt: Yes, maybe it would be better for us to provide more structure—

Senator MOORE: That is fine. What can you give us, Dr Kelly, quickly? What have you got to hand in terms of recalls in your area in 2015, 2014 and 2013?

Dr Kelly: The latest statistics I have in front of me here cover the period July to December 2014.

Senator MOORE: So that is half a year?

Dr Kelly: That is the last half of the year—

Senator MOORE: And that was 2014? Yes.

Dr Kelly: With the total number of recalls, we can go via medicines if you like?

Senator MOORE: Yes.

Dr Kelly: Recalls for medicines was 45 for that period. For medical devices in the same period, it was 592. For biologicals, it was two.

Senator MOORE: We will put on notice those other data things.

Prof. Skerritt: The other thing we would be able to do would be to explain the different types of recalls. People often associate a recall—

Senator MOORE: I am wanting to go on to class 1—

Prof. Skerritt: to consumer levels. But some, for example, are only recalled to hospital level or to wholesale level—and for different purposes, too.

Senator MOORE: And that is stimulated by different circumstances?

Prof. Skerritt: You could imagine that if it was a minor product correction, it would be very different from if, say, metal filings have been found in a medicine and you have to take it off shelves for consumers.

Senator MOORE: Has that happened?

Prof. Skerritt: There are sometimes metal filings found in products because so often the equipment to produce them is made out of stainless steel.

Senator MOORE: And they shed.

Prof. Skerritt: Fortunately, very rarely.

Senator MOORE: It is not good if you have got one. Can you tell us the number of class 1 product recalls that have occurred in the same period.

Dr Kelly: No.

Senator MOORE: You won't. Can you tell me how many class 1 products were in that data you gave for July-December 2014.

Dr Kelly: No, I don't have that with me.

Senator MOORE: I will put that on notice. I want to ask about what stimulates things. What is the recall process? How does it work? Who stimulates it? How does it work? What initiates the public stuff that you put out about it?

Dr Kelly: Almost all recalls in Australia and globally are voluntary recalls. They are initiated, usually, by the sponsor.

Senator MOORE: Which is part of their contract, in a way, isn't it, if they know something is going wrong?

Dr Kelly: For the high-risk medicine and for high-risk medical devices, they are legally obliged to conduct recalls and are legally advised to notify us about the process of the recall. We facilitate the recall. We make sure that the recall is effective, and we publish the details of the recall to the website.

Senator MOORE: When you say that you facilitate the recall, once the sponsor or whoever it is—it is often the sponsor—initiates an issue, what do you do?

Dr Kelly: They will advise us of what the issue is. We will look at the assessment of the issue. We will agree with them, after negotiation, on the level of recall, the depth of the recall or the extent of the recall.

Senator MOORE: You make that decision?

Dr Kelly: They propose a decision to us. We look to see whether that decision is justified in the particular circumstances. If we disagree with them then we will get them to a point where either we will get them to agree or we will have to use a mandatory recall power.

Senator MOORE: The final delegation is with the TGA. Either you agree with their recommendation or you do not.

Dr Kelly: That is right.

Senator MOORE: The final delegation is the TGA on the process of the recall.

Dr Kelly: Correct. And then we will disseminate the information through our networks. The sponsor will disseminate the relevant information to the end users.

Senator MOORE: You use your own network knowledge. You would understand this particular committee has done stuff on the PIP implants and we also did stuff on PIP. Is it the responsibility of manufacturers wholesalers retailers if they know something is wrong to contact you and say there is a problem?

Dr Kelly: Yes.

Senator MOORE: What happens if they are not cooperative or they are an international company not based in Australia? How does the process work?

Dr Kelly: As I mentioned before, the vast majority of recalls are undertaken on a voluntary basis. History shows that we are able to reach a position with the sponsors—

Senator MOORE: A negotiated outcome.

Dr Kelly: Yes. This happens very quickly. For the high level recalls this has to happen within two days of being notified. We deal with the Australian sponsors, so every medical device and every medicine here has to be supplied by way of an Australian sponsor.

Senator MOORE: By a local response.

Dr Kelly: If it is an overseas manufacturer there will be a local sponsor. They are the person we deal with for the recall in Australia.

Senator MOORE: What coercive powers does the TGA have to insist on an action?

Dr Kelly: We can end up with a mandatory recall if the company does not agree with our position.

Senator MOORE: So they are the coercive powers: you have a mandatory recall. Does that have to go through the minister?

Dr Kelly: No.

Senator MOORE: You have that independent delegation to do that.

Dr Kelly: We have that power.

Senator MOORE: Does Australia automatically accept a product recall notice from overseas? If someone in the FDA, for instance, has a recall process, you do not keep an eye on that and then do a complementary one in Australia?

Dr Kelly: We keep an eye on it. We get notified of those overseas recalls. The local sponsor is obliged to inform us about the overseas recalls. But, in many cases, the same product is not being supplied in Australia. If it has been supplied then we do the risk assessment to see whether we need to do the same level of recall here in Australia.

Senator MOORE: At the moment, you do your own assessment.

Dr Kelly: Absolutely.

Prof. Skerritt: For example, it could be the same medicine, the same trade name and even the same package—everything—but it is made in a different factory. This has caused a lot of confusion when recently people have said, 'Why haven't you cancelled that product or recalled that product?' and it has actually come from a different plant from, say, that supplied to North America. That is just the nature of the global supply chains for medicines.

Senator MOORE: The question is: why don't you accept another regulator's decision for a recall? What is the shorthand answer to that? If the FDA has said, 'ACME should be recalled, 'why don't you just say, 'ACME should be recalled in Australia'? Can you put a little on record as to why you take your own decision.

Dr Kelly: Chances are we will end up with the same decision. We just need to see what the local impact is, what the local distribution arrangements are and whether or not the same product, the same batch, is being supplied here in Australia.

Senator MOORE: This is a question that came directly out of one of our previous inquiries. If a hip implant has been tested and has been determined to be safe in northern Europe or Canada, would you accept that assessment or would you do your own assessment of that hip implant? And that is used as an example; I am not using a particular brand name. It is because hip implants are one of the more common devices.

Dr Kelly: What that goes to is not so much a recall power; that is the market approval process I think you are talking about in that case. If it has been tested and found to be safe, why should we not find it so and use it? That is the market approval process.

Senator MOORE: Sure. I take that point, yes.

Dr Kelly: We have a process here for a hip implants, to continue with that example, whereby the sponsor has to make the application, they have to provide the data, and we will go through an assessment process to see whether it satisfies our legal requirements here in Australia.

Senator MOORE: Right. I know there is a review going on of the general operations of the organisation. Would the recall process be part of that review?

Dr Kelly: I think that might be down to the panel to think about. At the moment, it is already a streamlined approach. It works well, I have to say. Whether or not there are opportunities for improvement—

Senator MOORE: But it is an operation of the organisation, so—

Dr Kelly: Sure. So whether the panel turns its mind to it—

Senator MOORE: it could be part of the review. Actually, I cannot remember whether it was—

Prof. Skerritt: It was not an express term of reference to review the recall process. But, clearly, the work that is done before a product reaches the market, especially for things like medical devices—where you, for example, cannot do double-blind clinical trials most of the time—is very interactive with what we do post-market in terms of post-market surveillance and recalls.

Senator MOORE: So, going back to that original premise, the quote that 'the government will adopt a new principle' and all those things, the last phrase is 'unless it can be demonstrated that there is a good reason to do so'. At this stage, you investigate that by looking at the impact on the local situation?

Prof. Skerritt: Yes. For example, with the higher-risk medical devices, we use the conformity assessment report from—let us continue to talk about hips as an example—the European notified body but we will still do what is known as an application audit. In other words, that is checking the information we have been given and asking any further questions. What the panel and the submissions to the panel, which are public, have pondered is: in looking at new products like medicines coming to the market, how, if Australia made greater use of, say, assessments by Europe or Canada or the US, would it work for Australia to utilise those assessments to a greater

extent; and what Australia-specific work would need to be done? That is really one of the main areas of deliberation of this expert panel, and as I mentioned earlier they have been consulting widely. But, obviously, I have no insight into where their thinking is.

Senator MOORE: Thank you.

Dr Kelly: Chair, can I just correct the numbers I gave the senator at the start, the numbers of recalls.

Senator MOORE: Yes.

Dr Kelly: Can I change the three numbers I said, which were 45, 592 and two. That was for a previous period. The July to December figures are 22, 290 and zero for medicines, devices and biologicals.

Senator MOORE: So in what period were 45, 592 and two?

Dr Kelly: That was 2013-14 as a full calendar year.

Senator MOORE: Okay. I thought that second one, 592, was a bit high. Thank you.

CHAIR: I will now go to Senator Leyonhjelm and then Senator Xenophon.

Senator LEYONHJELM: Thank you. These are questions for the TGA. I understand that nicotine is classified as schedule 8; is that right?

Prof. Skerritt: It depends. With nicotine, it does depend on the nature in which it is provided. But generally it is scheduled as a poison, which I think is schedule 7—

Senator LEYONHJELM: Schedule 7, is it? Right.

Prof. Skerritt: if my memory serves me right—because it is largely used as an insecticide, a pretty useful one too.

Senator LEYONHJELM: Yes, that is correct. Am I right in assuming that nicotine in chewing gum and patches is a different schedule or exempt from scheduling?

Prof. Skerritt: No. The way scheduling works is that it relates to not only the form of the substance but also the amount of a substance and the concentration of a substance. And it has been down-scheduled in recent years. Nicotine for chewing gum, for example, or other smoking cessation devices are available anywhere from being now unscheduled—I stand to be corrected there—through to being on pharmacists' shelves through to being behind the shelf of a pharmacy. That will depend on the amount of it and the format in which it is delivered.

The idea of course with scheduling is to manage availability and access. Many of these products are sold in pharmacies rather than petrol stations, because then the pharmacist can give advice about the appropriate use in a smoking cessation program.

Senator LEYONHJELM: Right. I do not know the TGA very well but I know the APVMA. The APVMA is under an obligation to provide pre-submission advice. If I want to get this product onto the market, what are my obligations in terms of my submission? I am assuming the TGA has the same service?

Prof. Skerritt: We do, especially prescription medicine applications, but also for a number of other products.

Senator LEYONHJELM: If I or somebody else wanted to register an e-cigarette containing nicotine. If I did not want it scheduled as 7 any longer but instead wanted it scheduled less restrictively, so I came to see you and asked what kind of submission would I be required to make and what you would expect in that submission. What advice would I receive?

Prof. Skerritt: Firstly, the approach with smoking cessation products is that they usually enter the market as prescription only medicines, or schedule 4, as it commonly is. To bring a schedule 4 prescription medicine to market it has to go through the new medicines market authorisation pathway. Essentially you have to show that you can manufacture the product consistently to a high quality and it also satisfies good manufacturing practice. You have to show safety and you have to show efficacy. One of the big challenges where I think the medical jury is still out is the contribution or potential contribution of e-cigarettes to smoking cessation. There are rather divided views and rather limited hard evidence to show that there is a strong impact on smoking cessation.

Senator LEYONHJELM: Yes, there is a large amount of anecdotal information, which is not much help.

Prof. Skerritt: But at the end of the day a company would have to bring—and I am sure that there are companies globally doing this—quality rigorous evidence to show that their product has a role in smoking cessation, if it is to be a medicine.

Senator LEYONHJELM: And you would anticipate that in the first instance that it would be is S4?

Prof. Skerritt: Generally, products containing nicotine would go on as S4. Going back in history, a lot of the things we are now able to purchase from our pharmacist started their commercial lives as prescription medicines.

As comfort grew with the safety of those products they were down-scheduled to be obtainable from, say, your pharmacist, rather than through prescription. One of the things about the e-cigarette that is different from a gum, which would have to be considered by the doctors and the biologists and so forth in any medicines regulatory authority, is that when you vaporise a product it goes right down to your lungs. Gums, of course, are absorbed through the cheeks and under the tongue, and a little bit is swallowed. So the root of administration nicotine is actually quite different for vaporised nicotine as opposed to chewed gum.

Senator LEYONHJELM: I know the veterinary area well, and I am also familiar with the S4 pathway as an introduction to the market. But I also know that there is a kind of pragmatic element that is not applied as often as I would like, but it does get applied from time to time. In the case of e-cigarettes you can import them already for personal use. Would that affect the decision regarding scheduling?

Prof. Skerritt: There is generally not a direct interaction because, yes, medicines for which a prescription has been obtained can be imported for personal use, with limitations—usually up to a three-month period only, with no more than 15 months supply within a 12-month period, if you are, say, a frequent traveller in and out of Australia. For example, medicines that are not approved for use in Australia can be imported for individual personal use. The other thing I would add is that the scheme is more focused on those who carry the products with them on an aeroplane or a ship. If you are trying to bring materials in through the internet, you actually have to have a copy of a prescription from a doctor and so forth, so it is more involved.

Senator LEYONHJELM: For an e-cigarette?

Prof. Skerritt: No, for a prescription medicine.

Senator LEYONHJELM: Yes, I understand.

Prof. Skerritt: So the two are actually not interactive. But the usual approach—and this does not just relate to nicotine products; it relates, for example, to many now-common painkillers—going back in history, medicines like ibuprofen, which is now available—

Senator LEYONHJELM: OTC.

Prof. Skerritt: at your supermarket chains, started life as prescription medicines.

Senator LEYONHJELM: That is right. I am assuming that I am not the first person to have ever asked this question: would you like to offer a view as to why nobody has so far applied—I am assuming—for registration of an e-cigarette?

Prof. Skerritt: We have a policy of neither confirming nor denying. I know that phrase has been used elsewhere—and, no, I am not the US military! We have a policy of neither confirming nor denying whether medicine applications have been made. That is the current policy. It has been the policy of TGA for decades. That is because of the commercial value of that. I cannot confirm or deny whether or not we have an application for a product.

Senator LEYONHJELM: Maybe I can rephrase it. This is not a policy decision or a policy matter; this is an administrative matter. In your view, why is there no e-cigarette registered and available on the Australian market?

Prof. Skerritt: Because no one has applied to us and the cycle been completed.

Senator LEYONHJELM: So you are neither confirming nor denying they might have tried, but no-one has got out the other end?

Prof. Skerritt: No-one has gotten out the other end, to put it in technical terms!

Senator LEYONHJELM: I think I have got the picture. Thank you.

Senator XENOPHON: I just wanted to ask some questions, following on from the previous estimates in October, in relation to Birmingham Hip Resurfacing devices—in particular, the question on notice ending with the digits 001248, if that is of assistance to you.

Prof. Skerritt: It is top of my list.

Senator XENOPHON: It is top of your list? That is good. I put a number of questions on notice regarding the metal-on-metal joint prostheses, in particular the Smith & Nephew Birmingham Hip Resurfacing devices—the BHRs—after my office was contacted by a number of women who shared the shocking stories of their experiences. In the question on notice that I have just referred to, I asked the TGA whether the Birmingham Hip Resurfacing device was still in use and was advised:

The Australian Orthopaedics Association National Joint Replacement Registry (AOANJRR) reports a low rate of revision for BHR and so it remains available as a surgical option…

However, I refer to the TGA hazard alert dated 6 February 2015, just a couple of weeks ago, 'advising of additional warnings when used in certain patient groups', including females, who are 51 per cent of the population; males aged 65 or greater; patients requiring an implant head of a size equal to or less than 48 millimetres; patients who have a diagnosis of avascular necrosis; and patients who have congenital dysplasia. That is a pretty wide group of people. You would agree with that, wouldn't you?

Prof. Skerritt: Yes, that is a wide group of people.

Senator XENOPHON: The warning advises that these groups are at greater risk of requiring early revision surgery. My first question is: when did the TGA initially receive communication from Smith & Nephew that led to the issuing of the hazard alert? What was the turnaround time?

Prof. Skerritt: I might ask Dr Kelly about timing.

Dr Kelly: I cannot be precise about when we received information from Smith & Nephew.

Senator XENOPHON: You may want to take that on notice, then.

Dr Kelly: Yes, okay. I was going to explain that the way we normally get this information is through the national joint replacement registry. They do the analysis with us, and then we make decisions around it. Separately, there is a UK registry, and they have also done some analysis, and I believe Smith & Nephew combined the analysis from various registries to come up with that advice.

Senator XENOPHON: I just want to put it on the record that the registry does outstanding work. I have not spoken to Professor Graves for a few years; is he still running it?

Dr Kelly: Yes, he is.

Senator XENOPHON: He does simply outstanding work. But there has been a problem in the past in terms of the work that the registry is done. There is no question of the quality of their work, but it is whether the TGA has acted appropriately in respect of that. Can you, on notice, assure us in respect of that action?

Prof. Skerritt: Sure. I would be very happy to provide some statistics. We systematically review every report. The annual report of the registry comes out and when it comes out we get three classifications of joints. We systematically review which one of those were higher than the standard revision rate.

Senator XENOPHON: You do not look at it more urgently sometimes than an annual report if there is a trend that emerges? If a dramatic trend emerges, do you look at it more quickly?

Dr Kelly: We depend entirely on the statistical data from the registry. They produce their report on 1 October each year. As Professor Skerritt mentioned, once they issue the report, we collate the data, we convene a group of expert orthopaedic surgeons, we analyse the data and we take regulatory actions as quickly as possible. For example, in the report that was released in October 2014, all of those newly identified were before our committee at the first available meeting, which was in December; 14 were or the list and 14 had been scrutinised. For the ones where the committee believed action should be taken, that action is now in process.

Senator XENOPHON: I will put some of these on notice, but just to further that, if I can get some further details in respect of the turnaround times. Does this mean there is a medium or high rate of revision for BHR amongst these groups have been being referred to? That is, women, males aged 65 or greater and a number of categories.

Dr Kelly: Relative to the remainder of the population, so excluding those groups, there is a slightly higher chance. If you have a combination of those factors, then clearly the risk increases. We are talking about a very small increase over an already low value.

Senator XENOPHON: If you could give me details about the extent of that increase on notice, I would be grateful. What does this mean for people in these patient groups who did not receive additional warnings at the time they received the implant?

Dr Kelly: The orthopaedic surgeons who have implanted those devices have all been notified. There is standing set of instructions for orthopaedic surgeons in relation to metal or metal implants as a class. We understand that the surgeons will use this latest data in conjunction with the standard device to adequately treat their patients.

Senator XENOPHON: Would it be reasonable to assume that, had these additional warnings been in place earlier, patients within these groups may have not gone ahead with the BHR?

Dr Kelly: That is a bit of a hypothetical.

Senator XENOPHON: It is an informed consent issue, isn't it?

Dr Kelly: If the information was available and the surgeon had the conversation with the patient, then some degree of informed consent may have been involved. You need to put this into perspective. This device has been in use since the year 2000. The evidence accumulates over time. It is only recently that the accumulation of the evidence has pointed to these particular additional risk factors.

Senator XENOPHON: Because some of the questions I ask you are of the statistical nature, I think it is best to put them on notice. I will do so. At what point is there a tipping point, if you like, where you are likely to see an emergence or a spike in problems with a joint? Is it at 10 years or 15 years? What sort of period of time do you start seeing it?

Dr Kelly: No, it is not calculated that way. It is calculated on the number of observed patient years. So the total number of patients using the implant and the number of years all of those patients are using it. That is then measured against the average for devices in the same class. The register itself sets the tipping point. They say, 'Once it goes beyond an average of 1.7 times the normal rate of revision, that then is a point where something needs to be looked at.' It is not necessarily regulatory action, but it now goes beyond the point where it is slightly worse than the rest in the class so that it needs to be additionally scrutinised.

Senator XENOPHON: I will put the rest on notice, as it is more appropriate. Thank you very much for your time.

Senator REYNOLDS: I have just got one question in relation to medicinal marijuana, if I could. I have not got a lot of background in this, but I know it has been a subject of public debate over the last six to eight months and that it was discussed at the last COAG meeting. Western Australia and Victoria may have put forward a proposal to reschedule it from schedule 9 to schedule 4. That is what I just wanted to clarify, because that was the information I had. Could you clarify what the situation is?

Prof. Skerritt: Yes. The situation actually does not relate to medical marijuana—the actual raw material. What it does relate to is cannabidiol, which is a substance extracted from marijuana. It is not the psychoactive one, so it is not the part of marijuana that gives you a high. What it is is a substance where there is some evidence—although, again, the evidence is very mixed—that it has potential use for children with various types of refractory epilepsy, but even that is still somewhat controversial. Having said that, there was an application. It is unusual; generally, the applicants for the scheduling or rescheduling of substances do so in confidence, but both state publicly made the announcement that they have applied. A final decision on that is still pending.

Senator REYNOLDS: So that is change from schedule 9 to schedule 4?

Prof. Skerritt: Yes. It would then be available, if there was a source of the material coming into the market, as a prescription medicine. Currently, that product is going through clinical trials in the US. I think those trials are ongoing. That will then provide a level of rigour so that a company could then come to Australia, or to the FDA or anyone else, and apply for it to be a prescription medicine. Currently, parents and kids with refractory epilepsy, who I know are desperate and have tried everything else, are tending to have to get extracts of different strains of raw marijuana to provide this stuff for their kids. You could argue that a standardised dose, known concentration, check the safety purity and, through these clinical trials, check the efficacy is a sound way forward.

Senator REYNOLDS: Is medicinal marijuana a colloquialism or is that something completely different altogether from the cannabidiol?

Prof. Skerritt: It is one of those terms that means different things to different people. I am just going to comment on the regulatory issues, because that is my remit. As far as refining the term, there are some people who refer to raw cannabis or cannabis oil as medicinal marijuana, there are some people who talk about medicinal cannabis or medicinal cannabinoids and then there are a number of substances that have been either chemically synthesised or extracted from marijuana. In some countries, there is marijuana grown commercially under secure conditions—the same way this country has a secure poppy industry—and marijuana is extracted.

Senator REYNOLDS: So they would have a psychoactive effect?

Prof. Skerritt: Different strains differ. There is a Dutch company, for example, that has five or so different strains. They claim some strains have almost none of what is known as Delta-9-THC, which is the stuff that gives you the high, and has mainly the CBD—cannabidiol—which is the one that is being trialled in the kids with epilepsy. There are different strains with different mixes. On the other hand, some groups who advocate for pain relief or the suppression of nausea—although, again, this is very controversial; if you put two doctors in a room, you will get two different views—say that Delta-9-THC is valuable for those things. That is why these companies in Holland and elsewhere—there is another group of companies in Israel and there are some in Canada—have these different strains of cannabis sativa; that is the botanical name of the plant.

Senator REYNOLDS: As you said before, you will neither confirm nor deny who is going through the process. However in this case, because Western Australia and Victoria has publicly said that they are, have they formally put applications in to do the rescheduling?

Prof. Skerritt: Scheduling and a medicine coming on to the market are two different things. A medicine can be scheduled without there being a product available or even a product going through a process.

Senator REYNOLDS: It is scheduled first. A supplier could come in and then apply to go through the process to get it approved.

Prof. Skerritt: If and when the final decision is made, if the final decision is positive and it is scheduled as schedule 4, it would then be possible for a company with a purified product of cannabidiol—there is a company based in the UK that operates globally and that is, as I say, clinically trialling such a product in the US and Europe—to put in a submission to TGA for that product.

Senator DI NATALE: I thought the scheduling was for both the THC and cannabidiol, but it is just for the cannabidiol component. I was not aware that cannabidiol was scheduled as schedule 9.

Prof. Skerritt: It is currently. The application is just for cannabidiol. Because we do publish applications for rescheduling, to my knowledge there has not been an application in the last couple of years or currently—there may have been some years ago—for the THC, the psychoactive one. Remember, however, that there is a product called Sativex, which does contain that, and that got a special exemption through the scheduling system to be schedule 8.

Senator DI NATALE: Can you explain that. Obviously Sativex has THC as well as cannabidiol in it. how did the exemption work? I do not understand that.

Prof. Skerritt: When prescription medicines come onto the Australian system they either go on as schedule 4 or schedule 8. The schedule 8 are usually the ones that may have abuse dependence or other things, like opiates most classically, but there are a few others. When that medicine was approved by TGA, it was also scheduled into schedule 8, but it was not a blanket scheduling for THC. It was a product containing a certain percentage of each, which basically fit, but fitted the profile of the Sativex product. That does not mean that someone else with THC could come along and get their product scheduled as schedule 8. They would have to put in an application.

Senator DI NATALE: To follow up from the comments of Senator Reynolds, what you are saying is that you could potentially get an application for a particular product that contains both cannabidiol and THC, if it is demonstrated to be effective for whatever it might be the application is listed for. Then post that process they could apply for an exemption and then be scheduled on schedule 8.

Prof. Skerritt: It is not technically an exemption. That was probably a poor choice of words on my part. What normally happens with prescription medicines is that the scheduling decision is made by the scheduling delegate, who is a separate person looking at separate issues, because scheduling is about access, not about safety, efficacy et cetera. Safety obviously comes into it, but more in terms of abuse dependence and so forth, and toxicity. At the time of the prescription medicine application coming through the TGA system—whether it is one that is going to be a schedule 4 or a schedule 8—a separate set of decisions are made about scheduling contemporaneously with the decision to approve it as a medicine on the ARTG.

Senator DI NATALE: Given that it is listed as schedule 9—THC and cannabidiol are listed as schedule 9 drugs—you are saying that that does not stop a proponent from putting in an application to have something registered, and that scheduling could be changed at that same time, or simultaneously, or afterwards, whatever the case might be.

Prof. Skerritt: It is usually roughly simultaneously. We have an application from Victoria and WA without a product in their hand, so to speak, for rescheduling of cannabidiol. It could have been done a different way. A company could have turned up with a product and put it into our system as a new gee whiz product for epilepsy, if they have the evidence. If that had got through our system and registered as a prescription medicine, that scheduling decision could have been made at that time.

Senator DI NATALE: What is the benefit of trying to change the scheduling beforehand?

Prof. Skerritt: You would really have to ask Western Australia and Victoria. As we all know a number of states are interested in clinical trials and other things, and also for special access. It was really a decision made by those jurisdictions, not the Commonwealth. We can accept applications for scheduling from individuals, companies, clinical groups and state governments.

CHAIR: Thank you for your evidence.

Australian Organ and Tissue Donation and Transplantation Authority

[18:30]

Senator PERIS: I want to look at the *Performance report 2014* for the Australian Organ and Tissue Donation and Transplantation Authority. Is it right that there was a decrease in organ donors in 2014 compared to 2013?

Ms Cass: You are right. The 2014 performance report on organ and tissue donation was released on 10 February, and that shows the outcomes for the number of deceased organ donors, transplant recipients and organs transplanted in 2014 compared to the prior years back to 2009. One of the key outcomes for 2014 was that there was a three per cent decline in the number of deceased organ donors compared to 2013 but a one per cent increase in the number of organs transplanted and basically a comparable number of transplant recipients in 2014.

Senator PERIS: Why does the department think that the decrease has happened?

Ms Cass: There are a range of reasons that explain those outcomes. It is probably also worth noting, to put it in context, that they are outcomes for one year and that over the period of the national reform program since 2009 there has obviously been a 53 per cent increase in the number of deceased organ donors in Australia and a 39 per cent increase in the number of organs transplanted. So the context is one of growth over the last five years. Obviously, in human terms, that has had a really significant impact. If you look at 2014, 28 per cent of the transplant recipients last year had a second chance at life because of the growth in the number of organ donors since 2009.

But there are two key reasons that really go to explaining what might be behind those 2014 outcomes in terms of a decline in the number of deceased organ donors but an increase in the number of organs transplanted. The first is that there remains significant variability in terms of outcomes between states and territories in Australia. That is also outlined in the performance report, which you would have seen.

Senator PERIS: Yes.

Ms Cass: The donation rates between states and territories vary in terms of the population rate: 28.6 donors per million population in the Northern Territory, down to 12.6 donors per million population in New South Wales. What really happened last year is that we had five of the eight states and territories either increase their donation outcomes or stay the same—the Northern Territory stayed the same, but the other four increased their outcomes. But there was a decrease in terms of deceased donor outcomes in New South Wales, Queensland and Western Australia. So state variability in terms of outcomes is one key explanation, and the key for us is to make sure that there is consistency of practice and outcomes nationally between states and hospitals so that that sort of variation, which we saw in 2014, is addressed, because it also shows the potential. If all states and territories achieved rates of growth seen in Victoria, for example, we would have had a significantly different outcome.

The second factor that I wanted to raise with you that sort of explains those outcomes, or puts them in context, is that a consequence of having fewer donors but more organs transplanted is that the organs-per-donor ratio goes up. It means that from every deceased donor last year there were 3.2 organs transplanted, while the year before it was three. Looking at the data shows us that the age profile of donors got younger in 2014. They are younger and more healthy, and more organs are being transplanted. That is a real issue for us around: what are the criteria for determining medically suitable potential donors? It requires a discussion with the transplantation sector as well as the donation sector, because we are seeing a circumstance in which the proportion of donors in Australian who are 60 years and over and 70 years and over is getting smaller. It is markedly different to the donor-age profile that you would see in international leaders such as Spain.

For example, in Spain, 52 per cent of their donors are 60 years and over, while in Australia it is 26 per cent. In addition, 32 per cent of donors in Spain are 70 years and over, while in Australia it is seven per cent. We are basically seeing that, in terms of the older-profile donors, we are at half the rate in donors who are 60 years and over and a quarter the rate you would see in Spain, for example, for donors who are 70 years and over. That has been emphasised recently by Raphael Matesanz of ONT—the comparable national organisation in Spain—in an article published in *Newsweek* where he basically said there is a significant reliance upon older donors. So that is another issue which requires some consideration. It is partly being raised now in the NHMRC process of looking at the ethical guidelines for Australia for transplantation from deceased donors by asking questions of the transplant sector and the community around: what are the criteria that should be applied in Australia for definition of medical suitability of potential donors? For the community: what are the risks and benefits of shifting the criteria for standard criteria to potentially older donors? I hope that made sense.

Senator PERIS: Yes, it did and it answered a number of my questions around the jurisdictions as well. You touched on just before that you had a target of 25 donors per million for the population. We have not quite reached that target. I guess the question is: do you still retain that target?

Ms Cass: The target of 25 donors per million of population was established between the Commonwealth and states and territories to be reached by 2018. It was based upon a recommendation in the 2011 midpoint implementation review that, at that time, said Australia had the capacity to reach 23 to 25 DPMP within five to 10 years. Each year health ministers look again at the targets to be set for that calendar year and the projected growth trajectories going forward. That is happening again this year. It will go to AHMAC in March and health ministers in April. That has not been determined yet, but it is a Commonwealth-state process that is happening again.

Senator PERIS: Is the merger between the Organ and Tissue Authority and the National Blood Authority still intended to proceed?

Mr Bowles: It is still underway. It is due on 1 July, so we are still moving along on those sorts of lines.

Senator PERIS: Has work commenced on the drafting of legislation to effect this change?

Mr Bowles: I believe so, but I will confirm that. I am pretty sure it has.

Senator PERIS: When do the terms of the members of the authority's advisory council expire?

Ms Cass: I would have to check for you. It has just escaped my memory. We will have to take that on notice and get back to you.

Senator PERIS: Will the advisory council continue so long as the Organ and Tissue Authority does?

Mr Bowles: I think we will have to think about that in the context of a new organisation, because it might cover both. I do not know; I do not think we have done any work on that, have we?

Ms Anderson: These are all good questions and they all go to the level of planning which is being undertaken now with both the Organ and Tissue Authority and the National Blood Authority. We are fairly advanced in our thinking, but we are still providing advice to government. Minister Ley, a minister who has not been there terribly long, is getting her mind around the issues, and, indeed, Minister Nash has been very involved in an ongoing conversation about the best way of achieving the outcomes which are being sought by government. I think these decisions are pending but they are absolutely on the page and being considered as part of this detailed planning.

CHAIR: I have a quick follow-up, and I think Senator Di Natale does on this as well. The experts I have spoken to—and I am also new to this area—say that where we are falling down compared to Spain, Croatia and a bunch of other countries that have higher rates of organ donation is effectively at the hospitals where the communication between the families and the medical professionals and others is not as advanced as it could be. I may be wrong on this—and you can correct me if I am wrong—but was there a particular measure where states and territories would be funded with a position for that kind of liaison? Am I right in thinking that?

Ms Cass: You are right. The national reform program is basically about changing clinical practice at the hospital level. The bulk of Commonwealth money is actually paid to states and territories to employ DonateLife Network specialists in 73 hospitals, who have roles and responsibilities that relate to changing end-of-life practice in that hospital, identifying potential donors and supporting families to make a decision to proceed with donation.

CHAIR: Am I right in thinking that they are not full time in that role—that they would have a role in the hospital in clinical practice, and then part of that role would be liaising with and supporting families?

Ms Cass: Most of the staff in the DonateLife Network are part-time or fractionated positions. That is not dissimilar to what happens in Spain, nor in Croatia.

CHAIR: When you say 'fractionated positions', does that mean they are doing other things in the hospital but that is also part of their job?

Ms Cass: That is actually a very specific strategy, because you want staff who actually have expertise in and are part of the intensive care unit or the emergency department—all their colleagues are there—and they work for DonateLife for a defined period of their time. It might be 0.5 per cent of their time. They know the practice in that hospital, they know the executive in that hospital and they can actually spearhead the process of change as the reform instigators at the hospital.

CHAIR: There is so much pressure on hospital staff, as we know. So, if they are in other parts of practice within a hospital, the natural tendency—and not unreasonably in some ways—will be to prioritise the saving of lives by more immediate means of saving of lives in terms of their time rather than another way of saving lives, which, as we know, is through organ donation. How do we monitor and ensure that there is not a creep there where, even if you are funding at 0.5, they are doing those other duties because they are simply seen as more important.

Ms Cass: There are a range of strategies. First of all, it is key for you to note that those staff are engaged under Commonwealth-state funding agreements, so it is the state government who receives funding to employ a

particular FTE distribution of staff across a specific number of DonateLife hospitals in their jurisdiction. They are largely hospitals with the most critical care, the largest intensive care units and the greatest potential to find donors. They basically acquit to us on a quarterly basis the number of staff who are engaged in funded positions and reach an agreement with us if they seek to shift money so that there is a shift in resourcing between hospitals.

But, at a much more practical level—as well as states being accountable for the money that they receive from the Commonwealth—there are specific roles and responsibilities established for every single role in the DonateLife Network that are used by the states to create their position descriptions and their governance for those staff. We have agreed, basically, that there is a clinical practice improvement program that outlines the key elements of reformed hospital practice that is expected and is implemented by each hospital. Under that, each hospital gives us six-monthly performance reports of what they have implemented and what the outcomes are against specific KPIs. They are also meant to develop a hospital activity plan, which is basically the reform strategy for that hospital, and they report to the state agency on how it is going.

CHAIR: Are you saying 'is' or they 'are meant to'? Is that happening?

Ms Cass: That is happening. We get those six-monthly reports—

CHAIR: Sorry, I just was not sure of the terminology when you said 'meant to' rather than 'they do'.

Ms Cass: They do. We monitor the KPIs, and the state governments ensure that the hospital activity plans are implemented. There are other strategies as well, obviously. There is intensive training that we provide nationally to donation specialists on how to conduct the family donation conversation, and we have trained a significant number of critical care specialists in both the core—the theoretical and family donation conversation—workshop and practical training program. You can see in the consent-rate data that we collect that that has an impact in terms of the consent outcomes in donation conversations with families. So there are a range of measures in place to monitor that the staff that are engaged are there and are doing their job so that we know the outcomes at a hospital-by-hospital level. As I mentioned before, variation in practice is clear both between hospitals and between states. It is that consistency of practice which is most critical and will continue to be a priority.

CHAIR: Senator Di Natale this is on organ donation. We will finish organ donation and then we will break.

Senator DI NATALE: In the explanation of the decrease in the donation rates, you say it is due to jurisdictional variation. You say New South Wales, Queensland, Western Australia account for a 7.7 per cent decline.

Ms Cass: That is right.

Senator DI NATALE: That does not actually explain what we all want to know, which is: why have we gone backwards, and in particular why have those three states gone backwards by 7.7 per cent? You have not given us any explanation as to what is going on there, which is really what I am most interested in.

Ms Cass: Let's take New South Wales as an example. New South Wales had a 15 per cent increase in the referral of potential donors in 2014 but at the same time they had a decline in the number of actual donors due to both a decline in the consent rate and an increased number of referred donors who were deemed not medically suitable. They are the two key explanations for why there was a drop in performance in New South Wales last year, even though they had an increase in the number of referred potential donors.

Senator DI NATALE: Why is that happening?

Ms Cass: It is happening because you can see a distinction between in terms of consent rates, the consent rates achieved where a trained requester is talking with the family and is offering donation and where a treating clinician is offering donation.

Senator DI NATALE: What are you suggesting there? Are you saying that we are not involving treating clinicians enough? The trend has been upwards; it is very slow.

Ms Cass: The trend has been upwards.

Senator DI NATALE: The target is 25. We are nowhere near that and we have gone backwards. We have got three big states that have gone backwards. That is not enough to say, 'Oh, those three states have gone backwards so the target has gone backwards.' It is: why have they gone backwards? I want to get to the nub of what is going on in those states that explains why they are actually going backwards. New South Wales is a shocking result.

Ms Cass: New South Wales is a poor result and they have been historically poor in terms of their outcomes compared to other states and territories.

Senator DI NATALE: But they are going backwards.

Ms Cass: They did in 2014. The issue that they have identified with us is that there has been an increase in the number of potential donors referred but, because they did not achieve the same consent rates as the prior years—

Senator DI NATALE: Why do you think that is happening?

Ms Cass: Their argument to us is that there needs to be more reinforcement—that is, trained requesters who have to manage the family donation conversation.

Senator DI NATALE: But isn't the whole point of this to get more trained—

Ms Cass: It is.

Senator DI NATALE: It is not happening. Where is the breakdown?

Ms Cass: In fact, it is happening. We have seen it happen—

Senator DI NATALE: But not in New South Wales.

Ms Cass: in a whole series of states and territories. That is correct. We have seen in Victoria, for example—

Senator DI NATALE: No, forget Victoria. I want to know about New South Wales.

Ms Cass: an 80 per cent increase in terms of—

Senator DI NATALE: We have gone backwards. We want to get to what is going on New South Wales. You say they have got more people coming through but fewer people consenting—

Ms Cass: More people being referred as potential donors.

Senator DI NATALE: Do we have enough trained personnel in New South Wales?

Ms Cass: What we have to do is to make sure that there is a reinforcement with both the executives of hospitals in New South Wales, treating clinicians in critical care and the DonateLife Network staff, that there are a range of roles and responsibilities and training available and that we expect people to undertake the training and to apply the family donation conversation model, which has been seen to be effective across Australia.

Senator DI NATALE: I agree with the model, but what is your view as to why it has broken down in New South Wales?

Senator McLUCAS: Is it still that the legacy of the registration of the 'intend to donate' on your drivers licence?

Ms Cass: New South Wales has sought to correct that issue in the course of the last year, as you know. They now have a legislative provision that allows them basically to override an objection on the drivers licence register—for example, if the family knows the donor changed their mind. There is an attempt to address what had been an impediment that was specific to New South Wales, and that was a greater number of objections listed on the register. That is one issue that New South Wales has sought to address. The other explanations are effectively that there needs to be more work and a much tighter priority placed upon training and re-training—

Senator DI NATALE: What do we do to fix that?

Ms Cass: There is immediately a program of training donation-specialist doctors in the DonateLife Network, which is commencing from next week in New South Wales.

Senator DI NATALE: Is that in recognition of the numbers going down?

Ms Cass: That is right. That training is occurring on a two-monthly basis, which is a model that is similar to that which has been adopted in Victoria. It is now being adopted in New South Wales. Obviously the second issue that appears key in New South Wales is that there is an increase in the number of potential donors deemed not medically suitable. The answer to that is not specific to a single state. That requires a conversation with the transplantation sector much more broadly. We will be doing that in March, when we have a donation and transplantation workshop to talk about the criteria for medical suitability of potential donors.

Senator McLUCAS: I just want to say that what Ms Cass has been talking about is exactly why we need to retain the Organ and Tissue Authority as a separate entity from the National Blood Authority. We need to have an organisation that is absolutely focused on ensuring that our clinicians are trained in the best way that they can be. You know, Ms Cass, what is happening at certain hospitals that you can intervene in and encourage and persuade.

CHAIR: Is there a question?

Senator McLUCAS: There is no question. It is a statement.

CHAIR: We will try to stick to questions.

Senator McLUCAS: The statement is that Labor is completely opposed to the amalgamation of—

CHAIR: I will cut you off there, because it is not a time for statements.

Proceedings suspended from 18:57 to 19:48

Department of Health

CHAIR: Senator Nash, please go ahead.

Senator Nash: Senator McLucas, this relates to the question you asked earlier about berries—I know there were a couple. Both my office and Minister Ley's office were notified on Friday the 13th that there had been hep A outbreaks in Victoria and New South Wales. Both offices have been kept up-to-date with the situation since then.

Senator McLUCAS: The second part of that question was: what did you do after you received the advice?

Senator Nash: I think we have stepped through all of those, but I do not think there was a second part of the question, because we went back and checked exactly what you asked. You said, 'Minister, when did you first find out about the incident?' and 'When were both your office and the senior minister's office informed?' You also asked if any instruction from your office or the senior minister occurred. The processes were—

Senator McLUCAS: The second part was: did any instruction from your office occur? That is what I mean—what did you do?

Senator Nash: What did we do? Well, it was in FSANZ's hands then to take the appropriate steps. They advised us of what they were doing. We might just wait until we have the CEO, Mr McCutcheon, here. Can I give you that now, and then we will revisit it again at 9 o'clock?

Senator McLUCAS: Yes, we will reconvene when we get back at 9 o'clock.

Senator Nash: That would great.

Senator McLUCAS: Chair, thank you for being a lot more cooperative, if we can put it that way. We have to get through this .Can I talk to the Australian Institute for Health and Welfare, please?

Mr Bowles: They are not on our list; they were not called.

Senator McLUCAS: That is a shame. Can I ask you some questions about them then?

Mr Bowles: I can try and answer. I can commit them to a whole lot of things!

CHAIR: Tell us what you think about them!

Senator McLUCAS: Is the department still working toward an intended merger of the AIHW with the Health Productivity and Performance Commission?

Mr Bowles: It is still subject to conversations with government about the exact outcome for these issues. So, it is still before government.

Senator McLUCAS: As it was in the budget, there were a number of entities that would form into a new thing.

Mr Bowles: I think it said something like 'it would explore the opportunity to'. It is still a conversation before government.

Senator McLUCAS: Have there been any conversations between the department and states and territories about that merger?

Mr Bowles: Only informally, because I know I have had some informal conversations.

Senator McLUCAS: Is there any intention for the way the AIHW collects data from states and territories to change if there were to be a merger?

Mr Bowles: At this stage, I could not really say one way or the other, but I would not see it dramatically changing, no.

Senator McLUCAS: Is it too early to ask a question about staffing at AIHW?

Mr Bowles: Yes, it is.

Senator McLUCAS: Okay. I will ask the questions about staffing on notice.

Mr Bowles: On notice, yes.

Senator McLUCAS: What consideration has been given by the department in these deliberations to the fact that 40 per cent of AIHW is in fact W—welfare? If it were subsumed into a health productivity and performance commission, what would happen to that work?

Mr Bowles: I think everyone recognises the importance of the health and welfare components of that, and, as I said, it is still a conversation before government.

Senator McLUCAS: Are you aware, Mr Bowles, of a proposal to merge the Australian Institute of Health and Welfare with the Australian Bureau of Statistics?

Mr Bowles: As I said, there are a whole range of conversations before government on AIHW and where it might sit.

Senator McLUCAS: But I think that the proposal to merge AIHW with the ABS is a different question to what was contemplated in the budget papers.

Mr Bowles: Exactly, and, as I said, there is a conversation before government about what is the best way to look at AIHW.

Senator McLUCAS: Where did this suggestion come from?

Mr Bowles: You would have to ask government, I presume. I read something in the paper the other day, but, as I said, I know I have had that conversation with the minister—and the former minister for that matter—and it is a conversation government is still having, as far as I am aware.

Senator McLUCAS: And that is a live option—to merge with the ABS?

Mr Bowles: Again, it is a conversation before government.

Senator McLUCAS: I thought you would say that was not going to happen, Senator.

Mr Bowles: I cannot confirm or deny. It is a conversation before government, and government makes those decisions.

Senator McLUCAS: Mr Kalisch, who used to be the CEO of the AIHW and did that job very well, has now gone to the ABS, and it looks like he might take the AIHW with him.

Mr Bowles: Again, that is a conversation before government.

Senator McLUCAS: When was the potential merger of AIHW and ABS first discussed in the department?

Mr Bowles: Again, that is advice to government.

Senator McLUCAS: No, I do not mean in terms of advice to government. When was work started in the department about the potential?

Mr Bowles: I do not want to confirm one way or the other, because we have talked about the Health Productivity and Performance Commission and the ABS. As I said, this is an issue before government for government to make.

Senator McLUCAS: Minister, are you, or your senior minister, having conversations with—ABS is in Treasury, isn't it?—

Mr Bowles: Yes, Treasury.

Senator McLUCAS: the Treasurer about this potential merger?

Senator Nash: I am not aware.

Senator McLUCAS: Can you find out for us?

Senator Nash: I can take that on notice, certainly.

Senator McLUCAS: Did we talk to the TGA before dinner?

Mr Bowles: Yes, we did.

Senator McLUCAS: Did we talk about the trusted regulators issue?

Mr Bowles: I do not think so, no. And they have gone.

Senator McLUCAS: Okay. I am sorry. I missed it.

Senator DI NATALE: Regarding eHealth, where are we up to following the May 2014 review? What progress are we making on the implementation of those recommendations?

Mr Bowles: It is a decision before government again. It is in that process.

Senator DI NATALE: May 2014?

Mr Bowles: Yes.

Senator DI NATALE: A year?

Mr Bowles: Yes.

Senator DI NATALE: You still have not decided?

Mr Bowles: That is correct.

Senator DI NATALE: What was Mr Dutton doing, for all the time he was health minister? It seems like he was sitting on a bunch of reports.

CHAIR: Senator Di Natale, I think you know that a public servant is not going to be answering the question, so perhaps you should move on to questions that can be answered.

Senator DI NATALE: I know, but you have got to wonder. Of the $140 million that was available in 2014-15, have all those funds been spent? And what have they been spent on?

Ms Powell: To go to the second part of your question about how it is allocated: of the $140 million, $103.9 million is set aside for, primarily, the health department, but some goes to The Department of Human Services and some goes to DVA to operate the PCEHR. I will give you those splits: $82 million of that goes to Health; $21.8 million goes to the Department of Human Services; $0.1 million goes to DVA; $2.3 million goes to the Office of the Australian Information Commissioner; $34.4 million goes to NEHTA as part of our COAG contributions to pay for the eHealth foundation work that is done by NEHTA—and that adds up to 140. Sorry, you also asked about expenditure. We would expect that that would be close to spent.

Senator DI NATALE: Fully expended.

Ms Powell: Yes.

Senator DI NATALE: In terms of progress, the last I heard—it might have been mid-last year or so—there were 260-odd hospitals that were connected. How many have been connected since then? What are we at?

Ms Powell: We have hospitals in every state that are connected at the moment. We recently had all five hospitals in the Northern Territory come online.

Senator DI NATALE: The total number of public hospitals?

Ms Powell: The total number of public hospitals—and some are major health centres—is 274.

Senator DI NATALE: So, in seven or eight months we have had nine more hospitals connected?

Ms Powell: I am not sure what the figures were last time, but the way hospitals have been coming on board has been as part of natural rollouts of software and IT related activities.

Senator DI NATALE: How many healthcare providers are currently registered to use it? I think in June there were 6,500 or so, out of a total of 57,000 who were eligible.

Ms Powell: As of 19 February, there are 7,645 providers—that is, healthcare provider organisations.

Senator DI NATALE: Healthcare provider—

Ms Powell: Organisations. That is, general practices; it might also be a hospital, and it might also be a lot of hospitals.

Senator DI NATALE: So we are still a long way short of the total number of 57,000 healthcare provider organisations. Is there any reason—

Ms Powell: I am sorry, I do not understand.

Senator DI NATALE: I am advised that there are 57,000 healthcare provider organisations that are eligible to register.

Mr Bowles: Providers, maybe.

Mr Madden: Not organisations.

Ms Powell: That does not sound right to me.

Senator DI NATALE: The advice I have is 6,500 out of a total of 57,000.

Mr Madden: Regarding the numbers and the way that we break them up: an organisation, as Linda Powell said, could be a hospital. It could be an area health network. It could be a series of hospitals. It could be a GP Super Clinic, or it could be just a sole practice. It means all of the providers within those organisations can have access to the system.

Senator DI NATALE: Okay. But it is counted as one healthcare organisation?

Mr Madden: That is right.

Senator DI NATALE: Can you tell me how many in total would be eligible? Can you take that on notice?

Mr Madden: Sure.

Senator DI NATALE: If you have—you are saying it is 7,400 or so?

Mr Madden: It is 7,400 organisations.

Senator DI NATALE: Organisations, okay. And that is out of a total of how many that might be eligible?

Mr Madden: We will take that on notice.

Senator DI NATALE: Great, thank you. What about the number of clinicians? The sense I get is that momentum is completely stalled on this: GPs have gone cold on it and there has not been much progress. I am asking because I think it is important; it is a really important reform. Is that consistent with what you are seeing? Has the number of clinicians who are accessing the PCEHR plateaued?

Ms Powell: We currently have 10,721 individual practitioners—who are not necessarily GPs; they are a variety of practitioners—registered to use the system. In terms of your question about use of the system, we are finding that the number of documents that are loaded into the system continues on a slow but steadily upward trend.

Senator DI NATALE: Is there any money allocated to this beyond the end of this financial year?

Ms Powell: There is some money that has been set aside to continue the operation of the PCEHR.

Senator DI NATALE: How much has been set aside, beyond this financial year?

Mr Madden: The funding beyond 30 June is still subject to that decision by government, that Mr Bowles mentioned earlier.

Senator DI NATALE: How much has actually been committed so far?

Ms Powell: In the next financial year, approximately $28 million.

Senator DI NATALE: In the next financial year?

Ms Powell: That is for the costs of continuing to operate the system—just the technical work.

Senator DI NATALE: Just to basically operate it?

Ms Powell: Yes.

Senator DI NATALE: How much have we invested in it so far?

Ms Powell: It depends on what you count and when you want to count it from.

Mr Madden: I think total spend so far is a complicated issue. There was the investment in the Personally Controlled eHealth Record System to establish it, and there is the operation for the 2012 through to the 2014 period, now the 2014-15 period.

Senator DI NATALE: Those figure would be good.

Mr Madden: Can we pull those figures on notice?

Senator DI NATALE: Yes. Tell me what you have in front of you at the moment, just as it is..

Ms Powell: I can tell you that the budget in 2012-13 was $233 million. From 2012-13 to 2015-16, total eHealth program funding was $538 million—that is the four-year total.

Senator DI NATALE: And that does include all—

Ms Powell: That is all of eHealth, not just the PCEHR. That is all of eHealth activities.

Senator DI NATALE: What I am getting at is that we have committed hundreds of millions of dollars into this and we seem to have consistent support, and now we have committed—what?—$20 million to keep it going?

Mr Bowles: There is a decision of government to come forward for the future, so we cannot pre-empt what that might be.

Senator DI NATALE: We had an announcement in 2013 that there would be a review. We spent six months hanging around for the outcome of that review. We got the review not even half way through the year. We are now coming into March. We are a few months away. This is supposed to be the thing that is going to take healthcare into the 21st century and beyond, and we still do not know what we are doing with it. I just cannot believe it.

Mr Bowles: It is before government.

Mr Madden: In the midst of 2014 we did go out to consultation with the broad community on the key recommendations in the report, just to make sure that we had the right views. The outcomes of that consultation have been provided as input to the government for the decision which they need to decide on at the moment.

Senator DI NATALE: Is there any indication that NEHTA will be closed come the end of June?

Mr Bowles: Again, it would be a decision for government. But I think it would be a pretty tall order to close NEHTA between now and then—the end of the financial year.

Senator DI NATALE: No, by the end of June.

Mr Bowles: Yes, by the end of the financial year.

Ms Powell: NEHTA is also funded by other jurisdictions as well.

Senator DI NATALE: I am waiting with bated breath to see what happens in this space. It is very important. I am happy to finish on that. I have another couple questions on international policy engagement, and then Senator Waters had a few questions for NICNAS. I do not normally come to estimates armed with media reports, but one thing in particular that struck me—and I did not know much about it—was the report around the training services agreement and the question of whether the report on medical tourism that was based on the training services agreement had anything I should be concerned about.

Mr Cotterell: There are a couple of things I have to say first. One is that the Department of Foreign Affairs and Trade has the lead on all of these trade and investment agreement negotiations. The second is that we cannot comment on leaked text in any of those negotiations, because all of the text is confidential. Having said that, the Australian government does not have a position that it is pursuing anything in relation to medical tourism in these negotiations.

Senator DI NATALE: That sounds like a fairly clear statement. The Australian government is not pursuing anything in the medical tourism space as part of these negotiations, so we can rest assured that Medicare or other government health services will not be part of the discussions around the training services agreement.

Mr Cotterell: I think that is a slightly different question.

Senator DI NATALE: Then I am asking you a different question.

Mr Cotterell: I think we would have to take that on notice because it is quite a broad-ranging agreement. I could not say categorically that it would not affect Medicare in any way ever. So we would have to take that one on notice.

Senator DI NATALE: I am happy if you take that on notice. It was just interesting to me. The Trans-Pacific Partnership Agreement is one that I am much more concerned about. Again I accept that it is probably as much a question for the Department of Foreign Affairs and Trade, but I am particularly interested in the impact on health and in particular patents. Has the department been requested to provide some advice in that area?

Mr Cotterell: Yes.

Senator DI NATALE: Is the department considering extending any changes to patent law here in Australia that are consistent with that agreement?

Mr Cotterell: The Department of Industry is the lead on patents policy. IP Australia is the lead agency on that issue.

Senator DI NATALE: What about data exclusivity?

Mr Cotterell: Like I said, Department of Foreign Affairs and Trade is the lead. IP Australia has the lead on patents issues, including the issue of data exclusivity. We have provided input on that issue.

Senator DI NATALE: Have you recommended any changes be made in any of those areas?

Mr Bowles: I do not think we can talk about things that are in play with DFAT.

Senator DI NATALE: I figured you would say that, but you can't blame me for asking! I suppose you are not going to tell me about any impact on the PBS and what potential costs might occur in that space.

Mr Bowles: No.

Senator DI NATALE: I will leave that for tomorrow. Thank you.

Senator WATERS: I am after the folks from NICNAS if they are still in the room. I have some questions about the national assessment of chemicals associated with coal seam gas extraction in Australia. The department told me the other day that, even though that was due to be delivered last year, it is now on track to be finalised approximately mid-2015. Is that your understanding as well?

Dr Richards: That is correct.

Senator WATERS: The department currently has in front of it an application from Santos for an extra 6,100 wells in Queensland. Have they asked you to move along that national assessment of chemicals so they can consider the results when they make decisions about the latest coal seam gas project in Queensland?

Dr Richards: I have had no correspondence with the Department of the Environment in those terms.

Senator WATERS: I might take up with them how they intend to make a decision without all of the relevant information about chemical impacts on health and environmental health, but thank you for confirming they have not given you a hurry up. Will the assessment include shale and tight gas?

Dr Richards: No.

Senator WATERS: Why is that?

Dr Richards: It is out of the scope of the funded project. The project, as you know, is funded by the Department of the Environment, and the scope was defined at the beginning of the project.

Senator WATERS: By the Department of the Environment?

Dr Richards: By the Department of the Environment. At that stage, my recollection is that there was not much in the way of shale exploration in Australia.

Senator WATERS: There is certainly a lot now. Have you made any representations to them about the usefulness of extending the scope of the study to try to get ahead of the rush of shale and tight gas applications?

Dr Richards: We have not made representations to the Department of the Environment. It is important to understand that the way the industrial chemicals regulation scheme works is that there are chemicals listed on the Australian inventory of chemical substances which can be used for any industrial purpose subject to any conditions that are set out in that inventory. Chemicals used in such exploration need to be on that list in order to be used unless they are submitted to us for an assessment prior to their use. If it is proposed to use existing chemicals, it does not require any assessment prior to that.

Senator WATERS: It is right that you are still not looking at combinations of chemicals?

Dr Richards: That is outside the scope of this project. There are no internationally agreed methodologies for looking at mixture effects.

Senator WATERS: Is looking at impacts on aquifers also outside the scope of the project?

Dr Richards: Yes.

Senator WATERS: What is within the scope of the project? It does not seem to be looking at much.

Dr Richards: The scope of the project has been explicitly defined and is listed on our website. It is an assessment examining the human health and environmental risks from chemicals used in drilling and hydraulic fracturing for coal seam gas extraction in Australia. It is primarily related to examining the surface related human health and environmental risk from chemicals.

Senator WATERS: That does seem a very strange distinction to make given that you are blasting the fracking chemicals underground. Ergo, wouldn't it be sensible to look at the effect on aquifers rather than just surface water?

Dr Richards: When a risk assessment is done, it is fundamentally a combination of considerations of the hazard of a chemical, which are the intrinsic properties of the chemical, and the exposure. Exposure needs to be modelled unless it can be directly measured, and when this project was initiated there were no suitable exposure models for doing deep groundwater. As part of this project the CSIRO has been developing methodologies and models for such work, but the actual risk assessment of the chemicals for that use is not part of the current stage of the project.

Senator WATERS: Okay. Could you provide on notice a bit more information to the extent of your ability—and perhaps I will take up with CSIRO as well the work they are doing on developing models and how and if that is going to feed into a risk assessment in the future.

Dr Richards: All the information about those models will be part of the final report of the project, which we expect to have released, as you suggested, in mid-2015.

Senator WATERS: So you will look at the modelling but not actually apply the modelling to find out what the risk is.

Dr Richards: That is correct in the scope of the funded project today.

Senator WATERS: Interesting. Thank you. Let's hope you get some more funding to do a more comprehensive project in the future. I will just confirm that you are not looking at the impacts of mobilising underground contaminants in fracking. You are just looking at what gets blasted in rather than what—

Dr Richards: There is work being done by CSIRO in identifying geogenic chemicals—that is, the chemicals in the coal seam or in the rock that are mobilised during the fracking process. Examination of the risks of those chemicals is outside the scope of NICNAS. They are not industrial chemicals. They are not chemicals that are being used for an industrial purpose.

Senator WATERS: Okay. I will take that up with CSIRO then.

The Department of the Environment told me last estimates that the national assessment would include a risk based assessment of what might go wrong in relation to chemicals used in the CSG industry. Can I confirm that that is in scope as to those surface health issues?

Dr Richards: Surface and shallow groundwater.

Senator WATERS: Your website says you will consider the preliminary environmental risk from geogenic contaminants to the extent of the availability of data. In your work to date, how comprehensive is the data?

Dr Richards: The environmental risk assessment component of the project is actually being undertaken by the Department of the Environment. I am responsible for the human health risk assessment components. NICNAS is coordinating the overall project. My understanding is that there were insufficient data available during the course of this project to do that particular component of the work.

Senator WATERS: Indeed, so they probably should not be issuing so many approvals if they do not know the answer to the risks.

Dr Richards: I cannot comment on that speculation.

Senator WATERS: Yes, it is not a matter for your scope. So, to confirm: it is the Department of the Environment that is going the environmental risk analysis of how fracking is likely to mobilise those naturally occurring carcinogens.

Dr Richards: That is correct.

Senator WATERS: Okay, I will take that up with them.

Am I right that the assessment is also going to develop models to predict the extent of fracture growth within coal seams in different locations?

Dr Richards: Yes, that is part of the work that is being undertaken by CSIRO.

Senator WATERS: Can you tell me anything about what you have found so far, or shall I take that up with them?

Dr Richards: The outcomes of that part of the project will be described in the project report when it is published.

Senator WATERS: There are no indications yet that you can share.

Dr Richards: The release of the report contents is a matter for government.

Senator WATERS: Okay. Thank you very much for your time.

CHAIR: If there are no other questions in this outcome, we will move to outcome 8.

[20:17]

CHAIR: Senator McLucas.

Senator McLUCAS: I want to talk about the movement of the activities of Health Workforce Australia into the department. Thank you for the question from me that you answered; as a result of that answer I understand that 108 staff took redundancies from Health Workforce Australia when it closed, at a cost of $4.8 million. Is that correct?

Dr Southern: I am assuming that you are quoting from our response to the question on notice.

Senator McLUCAS: I think I am.

Dr Southern: If that is the case then, yes, that is correct.

Senator McLUCAS: How many of those were involuntary redundancies and how many were voluntary?

Ms Shakespeare: All staff at HWA were offered the opportunity to transfer to the department, so we are not considering that any of the redundancies were involuntary.

Senator McLUCAS: Being offered a position in a different city—

Ms Shakespeare: Assistance with relocation was offered to all staff.

Senator McLUCAS: But for many of those people it was not even contemplatable. How many people did transfer from HWA into the department?

Ms Shakespeare: There were four permanent staff that transferred across to the department. There were also some contract staff that remained until the expiry of their contracts.

Senator McLUCAS: Is that too small a number to ask at what level?

Ms Shakespeare: I would have to take that on notice; I am not sure of all of the levels of the staff.

Senator MOORE: Were the offers of transfer at level? You said that all staff were offered the opportunity to move and there would be a system—so that takes care of the offer of moving from Adelaide to Canberra—but were they offered at-level transfer?

Ms Shakespeare: Yes.

Senator McLUCAS: Has all of the work that HWA was doing transferred to the department?

Ms Shakespeare: That is correct.

Senator McLUCAS: I daresay you have had to employ a lot more people?

Ms Shakespeare: Yes, we have been recruiting staff to fill vacant positions to take care of the work that has transferred into the department from HWA.

Senator McLUCAS: How many will you employ to do that work?

Ms Shakespeare: Again, I think I would have to take that on notice. We have several recruitment processes underway and I would need to check the numbers of staff that we have already recruited to work in those teams.

Senator McLUCAS: Have there been internal movements within the department to complete that work?

Ms Shakespeare: Yes.

Senator McLUCAS: What will be the complement of staff doing the work that HWA was doing? I know it is a hard question, but they had a work program and, from what you are telling me, that work program has moved holus-bolus into the department, so how many staff will deliver that work program?

Ms Shakespeare: We have taken advantage of the fact that there were some staff already working in the department on similar pieces of work that were being done at HWA, so it is not the case that we have entirely new sections just working on things that were at HWA. We have taken the opportunity to move people into different teams. So, where we had people working on rural health workforce issues, some of the projects that came from HWA have also been given to those people to look at, with some additional support. So it is not that easily identifiable. I can give you overall numbers for the division and how those have changed before and after the merger of HWA, and then we have also had General Practice Education and Training move into the division, but I would have to take that on notice.

Senator McLUCAS: I would like you to do that if you could, thank you. Can you give the committee an understanding of what work is being done in the department which was exactly the same as what was being done in HWA?

Ms Shakespeare: I can give you an example around data and workforce planning, which is one of the key functions that the department has picked up from HWA and that we are strongly committed to continuing. For instance, the department is now supporting the updates of the National Statistical Resource, which includes an online data tool for people outside government to use, including employers and other interested stakeholder groups, such as education providers. This is a comprehensive resource for health workforce planners and researchers and it gives access to data stored on the National Health Workforce Dataset. So far we have uploaded all 2013 workforce data since that function has moved into the department. We recently sent out the clinical placements survey for all higher education providers. That happened on 9 February. That then allows updates on clinical training activity to be entered into the National Statistical Resource.

We also have a lot of work continuing on workforce planning and projections. The department is now providing support to the National Medical Training Advisory Network, which has been established, first of all, to assist with the development of long-range projections for the medical workforce but also to develop advice to governments and others on what sorts of strategies should be adopted in response to what those projections are telling us.

Senator McLUCAS: That piece of work was happening in the department prior to HWA being abolished?

Ms Shakespeare: No. The National Medical Training Advisory Network was established and had support provided by HWA. That has now transferred across to the department.

Senator McLUCAS: Sorry, I think we are talking at cross-purposes here. The assertion is that we did not need HWA because we were doing all that work in the department anyway—a lot of that work was being duplicated—so I am trying to get a feel for what was happening in the department that was also happening in HWA that necessitated such a move.

Mr Bowles: I think there is also a broader issue with government policy on smaller government that also drove some of the thinking about amalgamating some agencies within the Department of Health. That is a contextual piece. I will hand over to Ms Shakespeare.

Ms Shakespeare: I think my earlier example relating to rural health workforce policy was an area of overlap. Health Workforce Australia had projects looking at how we could address some of the workforce areas in rural areas of Australia and the department also had quite a lot of resources, both staff and financial, dedicated to improving the rural health workforce.

Senator McLUCAS: Let me ask the question in a different way. How many staff within the department were working on health workforce policy at the time of the budget last year?

Ms Shakespeare: As I recall, it was between 80 and 90.

Senator McLUCAS: Will you take it on notice to give me the number who are currently working on workforce issues?

Ms Shakespeare: Yes.

Senator McLUCAS: The PBS also identifies 255 ASL for outcome 8. That is where you aim to get by the end of 2015. Is that correct?

Ms Shakespeare: Those are not all ASL located in the Health Workforce Division. That also includes corporate services and IT staff who help support outcomes across the department, including outcome 8. They are not all staff in Health Workforce Division.

Senator McLUCAS: With the new structure, are all health workforce issues being done in one area?

Ms Shakespeare: In one division. Health workforce is a policy area that intersects with many other parts of the health department, so there are people in other parts of the department as well who work on issues that relate to workforce. There are people, for example, who work in the primary care division on programs such as the PIP teaching incentives. Such programs clearly have an impact on workforce. There would be other examples like that. But the majority of health workforce programs and policies are now consolidated in the Health Workforce Division.

Senator McLUCAS: Most of those would be in the section called Health Workforce Reform—is that right?

Ms Shakespeare: I have obviously misunderstood the question.

Senator McLUCAS: Most of the people doing work that was previously done by Health Workforce Australia would be in the section called Health Workforce Reform—is that right?

Ms Shakespeare: Some of the staff and some of the projects from Health Workforce Australia will be in that section. There are also other staff in a section that deals with clinical training funding with many of the other projects that came from HWA, such as simulated learning environments and integrated regional clinical training networks. We have other people and projects from HWA in with our rural teams. We have separate workforce planning and workforce data teams, so they are not all located in one single team.

Senator McLUCAS: But they are all in your part of the structure?

Ms Shakespeare: Again, with that caveat I gave you before—and we do have people working in Grant Services Division who also provide inputs to health workforce programs. They are managing the funding agreement side of things. I have to correct something I said earlier. It was not four staff; it was six staff who transferred from HWA.

Senator McLUCAS: I will now move to the impact of university deregulation on the health workforce. Has the department briefed the government on what the impacts of deregulated university fees will be on the health workforce? What is the nature of those briefings?

Ms Shakespeare: We have provided information to ministers in our portfolio about what the proposals entail. As far as the impact on the health workforce is concerned, there are potentially different areas. First of all, for medicine, because medicine is subject to a cap on university places, it is not necessarily the case that there would be any changes in the number of students wanting to study medicine. It is fairly well set through that cap process at the moment. For other professions where the funding provided to universities has been on a demand-driven basis since 2012, it is not possible for us to determine what the impact will be, particularly because we do not know what the outcome of the proposals is.

Senator McLUCAS: Have you done any speculative work on what it will do to career paths or decisions made by undergraduates, for example?

Ms Shakespeare: No.

Senator McLUCAS: Do you intend to?

Ms Shakespeare: We have regular conversations with our colleagues in the department of education so that we can keep up to date with how things are looking from their end. I think it would be necessary for us to factor

in a whole range of other policy changes, for instance, around the additional scholarships that would be provided. We do not have any certainty that would allow us to, I suppose, project with any certainty what would happen.

Senator McLUCAS: So these could be quite significant changes to the way we train our health workforce, but we are unsure, from the Department of Health's point of view, what impact that will have on the future workforce.

Ms Shakespeare: No, there would not be changes to the way that health professionals are trained. There would still be, depending on the level of qualification and the standards of education required by the national registration boards where the profession is registered—

Senator McLUCAS: I am not talking about how they are going to be trained; I am talking about who is going to be trained. Who is going to make decisions to train in certain professions with this very changed landscape around the cost to the student to train? I am sure you have heard from the Rural Doctors Association. I am sure you have heard that there is a lot of concern about people practising in general practice because of the amount of money they will owe in their HECS following the changes that the government is proposing.

Mr Bowles: It is a policy decision of another portfolio. It is best asked of the Education portfolio.

Senator McLUCAS: But it will impact on the future health workforce of this country. That is the assertion made by many in the sector. I am somewhat surprised that the intellectual capital of the Department of Health has not been applied to making some assumptions about what might happen into the future. Some of the assertions that are being made are quite calamitous outcomes for parts of the health workforce, particularly the streaming into specialisation of doctors, because of the large amount of HECS to be paid back. I hear what you say, Ms Shakespeare, but I am somewhat surprised that we have not done any work on that.

Can I go to the Medical Rural Bonded Scholarship program. Will higher university fees for medical students increase the costs of the rural bonded scholarship program?

Ms Shakespeare: The Medical Rural Bonded Scholarship program is a set scholarship announced each year. It is adjusted by indexation, but it is around $26,000 a year. There would be no necessary change in the parameters for that program.

Senator McLUCAS: Has the minister—either the former minister or the current minister—requested the department to do any analysis of the impact of deregulation of university degrees on the future health workforce in the country?

Ms Shakespeare: As I said earlier, we have been asked and have provided advice about the proposals, but it has not been in the context of projecting an impact on the health workforce. Of course, there are variables such as the additional investment in scholarships that would need to be considered.

Senator McLUCAS: And incentives currently exist for medical graduates to locate into rural areas through reduction in their HECS debt—what is the name of that program again?

Ms Shakespeare: It is called the HECS Reimbursement Scheme.

Senator McLUCAS: Thank you. And what will be the impact on the cost of that program if HECS debts increase as a result of the deregulation of university fees?

Ms Shakespeare: The program is more in the nature of an incentive. It is a particular amount of money that is paid, it is not linked to any particular HECS debt. And, in fact, doctors can be eligible for it even when they do not have a HECS debt.

Senator McLUCAS: Right. So it is a flat rate?

Ms Shakespeare: That is right.

Senator McLUCAS: Has the department received any representations from professional organisations about the deregulation of university fees? And what are the nature of those representations?

Ms Shakespeare: I do not think we have had any formal written representations. It gets raised with us in the normal discussions that we hold with stakeholders, particularly in the university sector.

Senator McLUCAS: And the concerns that I am expressing have been expressed by them as well?

Ms Shakespeare: Some parts of the university sector, yes; other parts, no.

Senator McLUCAS: Okay. Is the department aware of a survey by the RACGP that has found that the government's proposed changes to Medicare have seen 64 per cent of medical students, interns, registrars and new GP fellows reconsider their interest in or decision to pursue general practice as a vocation?

Ms Shakespeare: I have seen a reference to the fact that this was a finding in a newsletter on the RACGP's website. We were unable to locate any details of how the survey was conducted or the sample size.

Senator McLUCAS: Have you written to them?

Ms Shakespeare: I think we only saw this a few days ago. I have tried to call a person from the RACGP to discuss it, but she was ill.

Senator McLUCAS: Okay, thank you. That is all on that issue for the moment. Once again on health workforce: when can we expect the government to provide contracts for the Specialist Training Programme for 2016 and beyond?

Ms Shakespeare: That is a matter currently being considered by the government, so I cannot answer that.

Senator McLUCAS: So it is still that a decision is being made?

Ms Shakespeare: It is under consideration.

Senator McLUCAS: And the nature of the decision is about the future of the program, or who will receive contracts?

Mr Bowles: It is a decision of government, Senator.

Senator McLUCAS: So all of the above?

Mr Bowles: It is a decision of government; we do not talk about advice to government.

Senator McLUCAS: No, I understand that. Can you tell me what the Specialist Training Programme does please, Ms Shakespeare?

Ms Shakespeare: Certainly. It operates under funding agreements the department has with 12 medical specialist collages. It funds training posts—so they are not full-time training places for individuals registrars—to allow particular types of specialists to gain experience towards their qualification as a fellow of a medical specialist collage.

The objectives have, I suppose, developed over the life of the program. The current STP is an amalgamation of earlier specialist training programs. But in the last few rounds, where additional positions were funded, the objectives have clearly been to expand training capacity by providing training posts in non-traditional settings such as private hospitals and community based practice, and in rural and regional areas as well. And we have had priority rounds where we have targeted specialties that are considered to be in greater shortage: to encourage training for Aboriginal and Torres Strait Islander doctors and also posts where services can be provided to Aboriginal and Torres Strait Islander people.

Senator McLUCAS: Thank you. So has the department considered that any further delay in signing contracts may well result in an inability for STP positions to be recruited for the start of 2016?

Ms Shakespeare: No.

Senator McLUCAS: It is a timing issue.

Ms Shakespeare: Yes. The funding agreement runs through till the end of the current year. There have certainly been examples in the past where funding agreements have been, I suppose, reached later than we are in the year now, which is February, and training has still continued.

Senator McLUCAS: So what is the deadline? When do you expect we would need to have this decided by in terms of what needs to happen following a decision?

Ms Shakespeare: I think to allow an orderly recruitment process for trainee registrars for next year we need to have this settled in the first quarter, so by the end of March.

Senator McLUCAS: Thanks. That is very helpful. A bit of discipline is a good thing.

Senator REYNOLDS: I have some questions on behalf of Senator Smith, who has been called to another inquiry. They relate to the new Districts of Workforce Shortage system, which we understand took effect on 2 February this year. His first question is: why was it necessary to make the changes in the way the districts of workforce shortage are calculated?

Ms Shakespeare: Some improvements to the Districts of Workforce Shortage system were made that took effect from 2 February. First of all, the underlying population statistics that were allowing us to compare the numbers of full-time equivalent doctors in particular areas were out of date, so first and foremost we updated the population data used under DWS to that available from the most recent census. The underlying statistical geography to calculate districts of workforce shortage has also been made more sensitive, so we updated from the

old geography, which used statistical local areas, to statistical areas 2, which are actually quite a bit smaller than the old geographical areas in many cases and allow us to distinguish between communities more easily.

The other significant improvement related to areas that are quite close to the national average for Medicare billed services, which is how we determined whether an area is a district of workforce shortage. If it is receiving Medicare services above the national average then it is not considered to be a district of workforce shortage. Now we have capacity for us to test for those districts that are within 10 per cent of the national average to look at whether the doctors within that area are billing Medicare at 30 per cent above the average billing rate per doctor and that actually allows us to work out if an area is just getting above the average because you have a small number of doctors working very long hours to provide services needed by their communities. So now those areas where there are a small number of doctors working very long hours will also be considered districts of workforce shortage.

Senator REYNOLDS: He also wanted to know what were the limitations of the previous Districts of Workforce Shortage classification system. I think you have almost answered that question. Is there anything more—other limitations you might not have mentioned—that is going to be addressed?

Ms Shakespeare: I think I have covered the main areas which are more up-to-date population data than the old system and more granular geography.

Senator REYNOLDS: He asks: following the government's sensible changes to calculating the districts, as you have just mentioned, what are the advantages in the new approach in terms of outcomes for locals?

Ms Shakespeare: The Districts of Workforce Shortage system is used for the allocation of Medicare provider numbers to overseas trained doctors—so people who are subject to Medicare restrictions under the Health Insurance Act—and it allows those doctors who want to work in Australia with access to Medicare to be directed to the areas that are genuinely experiencing the greatest need for additional doctors. It is also relevant to other workforce programs—for instance, bonded medical places. Each year 25 per cent of our medical students have agreed to work in a district of workforce shortage after they graduate, so it allows those doctors is to be directed to the areas that are genuinely experiencing the greatest need. It allows those doctors to be directed to the areas that are genuinely experiencing the greatest need.

Senator REYNOLDS: He wanted to know how this program could ensure or improve the way doctors get allocated to areas of greatest need. But I think you just answered that, so thank you.

CHAIR: There are no further questions for this outcome, so we will move to outcome 1, population health.

Food Standards Australia New Zealand

[20:46]

Senator McLUCAS: Mr McCutcheon, how have you been?

Mr McCutcheon: Very busy.

Senator McLUCAS: Right answer. Could you explain to the committee the risk level classification process? How do you risk foods?

Mr McCutcheon: That is a very broad question. In a broad sense, the work that we do in developing food standards or in providing advice to particular agencies works on the Codex risk analysis principles. So we go through a process of assessing risk and looking at appropriate risk management options, recommending those and then putting any risk communication around those particular aspects of it.

Senator McLUCAS: I understand there are three levels of risk that foods are generally classified into.

Mr McCutcheon: Yes. We generally talk about low, medium and high risk. Risk is consideration of both the chance of getting sick, the likelihood, and how sick—in other words, the severity—someone will get from eating food if it contains a harmful virus or bacteria. All foods have risks. Mainly those risks are mitigated by actions such as applying good hygienic practices during production, cooking or refrigeration. If you are looking at particularly microbial risk—doing a risk assessment on microbiological pathogens of concern—there are two things that we would look at there. One is the actual hazard itself—the bacteria or the virus, its growth and survival characteristics, how much and how often it is found in food, the types of food it can be found in, how much of the bacteria or virus is required to cause illness, the type of illness it causes and how long or how severe that illness is within different population groups. The second aspect we look at is the food, how the food is produced and the effect this has on bacteria or virus levels, how much or how often a person eats that food and therefore how much of the micro-organism is consumed—that is, the dose.

The terms low, medium and high are commonly used to describe the nature of a risk associated with a type food and this can be determined in many ways with the result being dependent on the context of the assessment—

so the risk of foods within a particular commodity or across a range of commodities—and on the methodology that is used.

Senator McLUCAS: What was the risk classification of frozen berries when the contaminated produce was imported, prior to identifying that there was a problem?

Mr McCutcheon: Berries in general, fresh or frozen, are generally recognised as a low-risk food.

Senator McLUCAS: So that was the classification of imported frozen berries prior to this event?

Mr McCutcheon: In the context of the Imported Food Inspection Scheme, they fitted into I think the surveillance category, which is low-risk foods.

Senator McLUCAS: The other term is surveillance—

Mr McCutcheon: Surveillance and risk. The risk category of foods under the Imported Food Inspection Program are medium- and high-risk foods.

Senator McLUCAS: What are frozen berries classified as now?

Mr McCutcheon: Frozen berries in general are still classified as low-risk, with the exception of the product that is implicated in the recall by the company in Victoria, and that particular product line that has been sourced from the two processing plants in China. So those particular berries, right through to the production areas where they came from, are classified as medium risk.

Senator SIEWERT: So the two—the processing plants implicated?

Mr McCutcheon: That is correct, yes. So the ones that are suspected—and I emphasis 'suspected'—to be the cause are the ones that we have rated as a medium risk to public health.

Senator McLUCAS: But they have been withdrawn from the shelves, so that is more of an internal issue for yourselves?

Mr McCutcheon: Those products are the subject of the recall—that is correct—but anything else that comes from those two processing plants, that supply chain, are all within that medium risk.

Senator McLUCAS: So there are other products coming from those sources into the country?

Mr McCutcheon: Not at this stage that we are aware of. The factory has actually shut down for Chinese New Year.

Senator SIEWERT: We were told the other day that there is a holding order on them. Is that different?

Mr Bowles: The agriculture department have put a hold on all produce out of those two companies.

Mr McCutcheon: That is correct.

Senator McLUCAS: Out of those two factories?

Mr Bowles: That is correct, yes.

Senator McLUCAS: How long does that go for?

Mr Bowles: I think from memory it is sometime in June, when it will be reassessed. But that is an issue for Agriculture.

Senator McLUCAS: And that is a decision by the Department of Agriculture?

Mr Bowles: That is right.

Senator McLUCAS: I am advised that the Prime Minister said in question time on Monday that the classification—that is, low surveillance—was an interim classification. What do I read from that? What does that mean?

Mr McCutcheon: I will read out to you the advice that we provided the Department of Agriculture, but first I will go back a step. The Department of Agriculture wrote to us wanting risk advice regarding the category of product 'frozen ready-to-eat berries'. So it is a very broad class of product. In our interim advice to them on 22 February we said:

Based on information from the Australian Department of Health, and investigating jurisdictions, epidemiological links to cases of hepatitis A infection with this product—

meaning the product subject to the recall—

in combination with uncertainty regarding food safety controls implemented by the affected supplier, would indicate this product poses a medium risk to public health and safety, until further information becomes available. Accordingly, we would recommend that RTE—

ready-to-eat—

berry products from the producers implicated in the current recall constitutes food that poses a risk to public health.

That is our preliminary advice. Under the arrangements that we have with the Department of Agriculture when they request assessment advice from us on food, we have a template approach where we conduct a full-blown risk assessment, and we are still to complete that for all ready-to-eat frozen berries.

Senator McLUCAS: Who conducts that review?

Mr McCutcheon: We are undertaking the assessment. We provide the scientific assessment of the risks associated with frozen ready-to-eat berries.

Senator McLUCAS: How long will that take?

Mr McCutcheon: It will take some weeks. The assessment process is quite complex because we have basically got to gather information from around the world—and there is quite a bit of information to collect. We then have to assess that and analyse that in the context of the Australian situation, and then we will make our assessment on that and provide advice to the Department of Agriculture.

Senator McLUCAS: And that will make a judgement about whether the classification of 'low, surveillance' is the right one to have.

Mr McCutcheon: That is right—whether there should be a change from the current low risk rating of those products. We will be guided very much by the scientific evidence. We are a science based organisation, we are obliged to adhere to international rules around conducting risk analyses and so we will look at the evidence and make our assessment on that.

Senator SIEWERT: Is it correct that there is not a test for hep A, or am I misunderstanding what the Department of Agriculture was saying on Monday?

Mr McCutcheon: 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.

Senator SIEWERT: You are not, under 'surveillance', testing for microbial activity, I understand from what we were told on Monday.

Mr McCutcheon: As the secretary just said, the product is on hold—

Senator SIEWERT: I mean in general frozen berries.

Mr McCutcheon: FSANZ does not do any testing—

Senator SIEWERT: Sorry, it is not required as part of the testing that is being done at the moment.

Mr McCutcheon: Not part of the regulatory testing, no. The important point to note here is that no country in the world uses hep A testing as part of a regulatory mechanism. Its value is best served when you have an outbreak and you are able to use it as a tool to identify the source of the outbreak. It is also used particularly with, say, quality assurance programs to test the different points of the production chain to make sure that things are working. Because it is not a reliable test, it is not seen as a good tool in a regulatory sense.

Senator DI NATALE: Do we know what the source of the hep A was?

Mr McCutcheon: No, we do not.

Senator DI NATALE: There is talk about different possibilities, but you are no closer to finding out?

Mr McCutcheon: The epidemiological evidence points towards the frozen berries.

Senator DI NATALE: No—

Senator SIEWERT: At the factory?

Mr McCutcheon: No, that is part of the investigation that both the company is doing, obviously, and also the Department of Agriculture. Because they are responsible for the imported food program, that is where they get involved in doing the investigation. My understanding is that they have also been in contact with the Chinese government, and so the Chinese government is also involved to some extent in helping. Again, it has been Chinese New Year and I think there will be some limits to how much they can do because a lot of the production areas are under snow at the moment. Going back and checking the farming area is going to be difficult.

Senator McLUCAS: I understand there have been outbreaks in Europe and North America related to frozen ready-to-eat berries. When were they?

Mr McCutcheon: There have been a number of outbreaks. I must say, before I move onto berries, that Australia has had its own experience in dealing with hep A contamination of food some years ago with semi-dried

tomatoes. We actually learnt a lot from that experience. I guess the biggest learning was that it is very difficult to get to a conclusive outcome in terms of finding the source. I guess that experience has been repeated with these outbreaks associated with berries in North America. For example, in 2013 there was an outbreak linked to berry mix sold through Costco in the United States. They were able to identify a frozen berry blend containing pomegranate seed as the likely cause of the outbreak. Then they basically took action to stop that product—it was imported from Turkey—from being offered for import into the US. Again, it was the likely cause of the outbreak; it was not definitive. In the European Union, they have had a multicountry outbreak of hepatitis A associated with berries, from January 2013 to September 2014. Again, it is confirmed and probable that the berries were the source of the outbreak, and it was reported in 12 other European Union or European Economic Area countries. Ninety per cent of those cases were reported from Italy. Again, they have really struggled to trace back the source of the contamination. But, based on the epidemiological evidence, berries seem to be in the frame.

Senator McLUCAS: In those two cases they cannot definitively say that the source of the contamination is the frozen berries?

Mr McCutcheon: That is correct.

Senator McLUCAS: Whereas we can, can't we?

Mr McCutcheon: No, we cannot. We are using the same evidence. We are using epidemiological evidence. That is what the Europeans have been using—the same approach that we—

Senator McLUCAS: So we are in the same circumstances?

Mr McCutcheon: That is right, yes. I think partly as a result of the issue we had in Australia some years ago with semi-dried tomatoes, we were able to take some of those learnings to the Codex Alimentarius Commission, the Codex Committee on Food Hygiene, and as part of that process feed into the development of some guidelines on the application of general principles of food hygiene to control viruses in food. They were released in 2012 and they specifically had annexes in that international guidance for dealing with these sorts of issues related to the control of hepatitis A virus and Norovirus in bivalve molluscs, so oysters. We know they are a source. In fact, we have had that in Australia ourselves. Secondly, there is the control of hepatitis A virus and Norovirus in fresh produce. Again, I guess the key outcome of all that work was that, if you want to manage risk within fresh produce—in this case berries—it is all about supply chain management and being very clear at each point of the production and processing chain that all the appropriate steps are taken to make sure you use clean water and you have healthy people working with the food, so hygiene is really important. So you go all through that, because end-point food inspection, testing, is not going to be able to provide you with the level of confidence that you would want to be able to say, 'That food is safe.'

Senator McLUCAS: I understand that, but following those two events that happened in North America and Europe, which are quite contemporary, did that trigger FSANZ to start thinking about doing a review of the risk rating of frozen berries?

Mr McCutcheon: In those instances and because of our linkages with international networks, not just the multinational ones but with individual countries, we certainly looked at those cases. The first priority was to see whether any of this product was coming to Australia, which, thankfully, it was not. We looked at that and we looked at our work that we had done with semi-dried tomatoes and there was not any thought, that I am aware of, that we should change the risk rating of berries to something higher than it is. Under the Imported Food Inspection Scheme, changing the risk from low to medium and high is for the purposes of inspection and testing, and we know that the testing is not an effective way of identifying and providing confidence that a particular product is safe. But what it did do was inform not just our overseas supply chains but even our domestic production chains that they need to continue to focus on managing every point of the production chain to ensure that personal hygiene, water and those sorts of things are appropriately managed.

Senator McLUCAS: Has there been any consideration of changing the risk rating on other foods that might present a similar sort of risk—that is, carry the hepatitis A virus? I am talking about frozen fruit and vegetables.

Mr McCutcheon: Not at this point. In light of what is happening with berries, this is the first time we have had to confront it on this scale. We will certainly as part of the follow-up to this be having a look at what other ways we can do it. That will include working closely with Agriculture because, in my view, this is going to boil down to putting in place and/or strengthening the certification systems and the like that underpin the supply of these sorts of products to Australia.

Senator McLUCAS: Attacking the supply chain rather than the surveillance mechanisms?

Mr McCutcheon: Yes, that is right. Testing can play a role in underpinning the supply chain assurance; but it is a check, not a guarantee; it can give you confidence.

Senator McLUCAS: Is that because of the amount of product that is actually tested? Is that part of it as well?

Mr McCutcheon: No, I do not believe so. It is not an issue of volume. It is an issue of the feasibility of testing.

Senator McLUCAS: Low surveillance means five per cent?

Mr McCutcheon: That is right.

Senator McLUCAS: Is that five per cent of a shipment?

Mr McCutcheon: It is five per cent of consignments. But that is getting into the Department of Agriculture's area of expertise and I do not want to venture down that path.

Senator McLUCAS: I accept that. If the risk rating were raised to medium, what would it mean in terms of surveillance activity?

Mr McCutcheon: If ready-to-eat frozen berries were put into the medium to high risk category, that would mean all imported frozen ready-to-eat berries would be subject to 100 per cent testing.

Senator McLUCAS: And they are not at the moment?

Mr McCutcheon: No, they are not at the moment.

Senator McLUCAS: I think the Prime Minister said 100 per cent were being tested. That was not happening at the time?

Mr McCutcheon: My understanding is that he was referring to that particular supply chain.

Mr Bowles: That is right.

Senator McLUCAS: Okay. Does the Australia-China free trade agreement have any implications for the safety, inspection and certification of foods grown in either country and exported to the other?

Mr McCutcheon: I have not seen the Australia-China free trade agreement. But I would comment that the rules around sanitary and phytosanitary measures sit under the World Trade Organization, so WTO rules apply.

Senator McLUCAS: I do not know whether the FTA does anything to the current arrangements. I would like to come back to the review you are doing of the risk rating. You said it will take a few weeks. Have you been allocated additional resources to conduct that work?

Mr McCutcheon: No. It is part of our normal business.

Senator McLUCAS: And once that work is done, where does that review go?

Mr McCutcheon: We provide our advice to the Department of Agriculture.

Senator McLUCAS: Do they make a recommendation to FSANZ to change the risk rating if that were to happen?

Mr McCutcheon: No.

Senator McLUCAS: So how does a risk rating get changed?

Mr McCutcheon: We provide the advice—again, this is all set out in the agreement we have with them—and they take that into account and make their own decision. They are the ones with the regulatory powers under the Imported Food Control Act.

Senator SIEWERT: Which decision are you saying Agriculture makes?

Mr McCutcheon: They make decisions on the categorisation of food for the purposes of the Imported Food Inspection Scheme.

Senator SIEWERT: On whether it goes into surveillance, to medium?

Mr McCutcheon: Correct.

Senator SIEWERT: So what advice are you providing?

Mr McCutcheon: We provide them with advice on the risk of the food. That will generally include whether it is a low risk or a medium to high risk. They then consider that advice and make their decision. That is the way the legislation is constructed.

Senator SIEWERT: Yes. What we were told on Monday could have been interpreted a little differently.

Senator LEYONHJELM: I understand that there are chronic carriers of hep A virus and the issue is identifying them and not having them work on these fresh foods. Is that right, in terms of controlling the source?

Prof. Baggoley: I am not aware that there are chronic carriers of hepatitis A at all. I missed the rest of your question.

Senator LEYONHJELM: If there are no chronic carriers, that cancels the second part of my question. So you cannot identify in the population working with the berries people whom the suppliers of the berries can exclude from their workforce in order to avoid contamination?

Prof. Baggoley: Correct.

Senator SIEWERT: You provide advice to the department on the risk level and they then determine what level of testing will be done. Is that correct?

Mr McCutcheon: That in effect is correct. They determine what category of food it sits in—it is either surveillance or a risk food. Once they have made that determination, a certain testing regime automatically comes into effect.

Senator SIEWERT: We have generally been using the term 'surveillance'. But you do not use that term? You say it is low risk and then they put it into the surveillance category?

Mr May: The process is that FSANZ has a function under its act of providing risk assessment advice in relation to imported food. Under the Imported Food Control Act, which Agriculture administers, the Food Inspection Scheme has been established. One of the provisions in the Food Inspection Scheme regulations says that, if we give advice that food is rated a medium or high risk, that food will be classified by Agriculture as risk food and be treated under the regulations as risk food. That is where the inspection regime established in those regulations kicks in.

Senator SIEWERT: Given what has happened, if you had said the food was low risk, can the department make a decision to up the level of inspection before you provide further advice?

Mr May: They cannot make a decision to change the risk rating of the food without having sought advice because the Imported Food Control Regulations require them to seek our advice before—

Senator SIEWERT: Before they up it. So they have asked you for advice—

Mr May: They have.

Senator SIEWERT: And you said it will take weeks?

Mr May: Some weeks.

Senator SIEWERT: How many weeks?

Mr May: At this stage it is not known.

Senator SIEWERT: Is that because of your workload?

Mr May: It is because we are not quite sure how long the piece of string is.

Senator SIEWERT: Before June?

Mr May: We are certainly aiming to get the result out as soon as possible, but what we cannot do is commit to a certain date.

Senator SIEWERT: Okay. You commented that the processing plants in China are currently under snow. When I asked on Monday whether anybody has visited the plants—I am also interested in the other 29 importers of berries –I was told that no-one had been to visit. I presume you are going to say that if you went over now it is all under snow.

Mr May: As I understand the evidence from Agriculture on Monday, it was that they had imposed a holding order which was described as an open order. They said that they would review the holding order towards the end of that period, and one of the things that they will obviously take into account is whether we have been able to give advice. Also they will take into account the evidence that they have from the audits that are being conducted, including, I understand, an agriculture department officer who is going over there, and there will be a range of material that will be considered at that time.

Senator SIEWERT: My question on Monday was: had anybody visited some of the processors in China. The committee was told no. Have you visited?

Mr May: No.

Senator SIEWERT: Do you intend to visit as part of this assessment process?

Mr McCutcheon: No.

Senator SIEWERT: How can you carry the review of the risk assessment if you are not going over there, which is where we think the source of contamination is?

Mr McCutcheon: The scientific risk assessment process does not require us to visit the country. We can do that on the basis of all the information that we are gathering that is well known in the scientific field. I think the only benefit of visiting would be at the risk management end of the spectrum where they are looking at how the mechanisms that manage risk are being implemented, for example.

Senator SIEWERT: Surely if management is poor that impacts on the risk assessment, and where the management is beyond our control, surely you have to factor that into the risk assessment?

Mr May: Senator, the risk assessment that we have been asked to do in the longer term is an assessment of all ready-to-eat frozen berries from all sources.

Senator SIEWERT: Yes, that is what I understood. Not just China.

Mr May: It is confined to looking at that factory in China, or looking at a province in China, or at China as a country.

Senator SIEWERT: I understand that. We established that there are 29 importers from China. Are you just doing the risk assessment for the Chinese berries?

Mr May: No.

Senator SIEWERT: It is from everywhere.

Mr May: All RTA frozen berries.

Senator SIEWERT: How many other importers of berries are there?

Mr McCutcheon: I understand it is 29 other sources.

Senator SIEWERT: I understood from the answers that I got—and I may have misunderstood what was said—I thought we confirmed that they were from Chinese importers, not from the same factories, but different.

Mr McCutcheon: The Department of Agriculture are doing a lot of investigation through their systems as the risk managers in this sense. You would have to either ask them or check what they are doing.

Senator SIEWERT: I will go back and put some questions on notice. My question still stands in terms of, given what you said about risk management, given that we have problem, surely that must cause you to rethink how you carry out risk assessment, given that there are issues around management that you cannot be sure about.

Mr May: The role of FSANZ in the risk assessment is precisely assessment. FSANZ is not in the assessment material it does.

Senator SIEWERT: Sorry, I missed that.

Mr May: We are not risk managing. We are not determining how the processor or the grower will in fact work in the field. What we will say is that to mitigate the known risks in relation to berries—and the reference point would be documents such as the *Guidelines on the application of general principles of food hygiene to the control of viruses in food* which talk about all of the steps that need to be taken in any fresh produce production or any other process to ensure that, in particular, viral contamination does not occur.

Senator SIEWERT: I understand what you are saying. I think there are some issues here in the system when—and I understand the issue about certification—you have provided a risk assessment for the management of an imported process, and we have no way of controlling that management.

Mr May: The process we have is we provide a template where we set out what the risks are and we indicate what the known mitigation steps are in relation to those risks. The Department of Agriculture is the risk manager and it has to determine how those risk management or mitigation steps will be applied. They will look at that our advice and say: 'The advice says the mitigation step needs to be the provision of latrine facilities in paddocks; it needs to be the provision of cleaning facilities in paddocks and changing rooms; it needs to be the provision of training and the like.' The question then is: how is that applied to any producer or processor anywhere in the world? The recognised method of doing that is by having QA programs or audit programs and the like. That is how Agriculture, as a risk manager, is likely to apply our assessment advice.

Senator SIEWERT: The problem with that is that that has failed in this circumstance, because we were told that those measures were in place.

Mr May: In this case it would appear that it has failed.

Senator SIEWERT: We have the process up to now. We have the review of the risk assessment process. There is no provision, as an interim step for other produce—not the produce that we know came from the two implicated processing sources—for a higher level of inspection from the department until you have carried out

your process? There is not an emergency step that you can take to say you are going to inspect these products coming in at a higher level until you carry out your review?

Mr McCutcheon: When you are talking about inspection, that is the Department of Agriculture.

Senator SIEWERT: Yes. But there is no process that you can take to provide advice urgently to the department?

Mr McCutcheon: If there was evidence that came to FSANZ that suggested there was a problem elsewhere, we would look at that and then provide advice to Agriculture.

Senator SIEWERT: You can do that?

Mr McCutcheon: We have a very close working relationship with the Department of Agriculture. We are constantly in discussion with them on imported food. That is part of the agreement we have. We will often talk to them about current developments around the world including issues that might have arisen, what it means for Australia and whether there is a need for us to provide advice and so on. We do not just meet whenever there is a crisis. We have an ongoing dialogue and regular contact with them.

Senator SIEWERT: I am not suggesting that you do not. If, during the risk assessment review, there are further issues, can you provide an interim advice to the department which they could then use to increase the risk level beyond surveillance?

Mr McCutcheon: We would look at the evidence and frame our recommendations to them on the basis of that evidence. Whether that is in the final report or an another interim report—

Senator SIEWERT: You can do an interim report to do that?

Mr McCutcheon: We can do as many reports as we want providing we get to the end point where they have the full report.

Senator SIEWERT: If there are issues identified and you provide that advice, the department could increase the risk level to medium risk or high-risk inspection of berries while you are carrying out that review?

Mr McCutcheon: If we provided that advice, and they made that determination. They have the final decision.

Senator SIEWERT: I understand that, but we have already established that they cannot do it without advice from you.

Mr McCutcheon: That is correct.

Senator SIEWERT: How many cases of hepatitis A we currently have now.

Mr Bowles: Eighteen. I think that is still the number.

Senator SIEWERT: Could you tell us where they are?

Mr Bowles: There are seven in Queensland, seven in New South Wales, three in Victoria and one in Western Australia.

Senator SIEWERT: How often are those numbers updated? Are we still seeing new cases?

Mr Bowles: I cannot remember. We have not seen new ones in the last few days.

Prof. Baggoley: They are updated daily.

Mr Bowles: It has been 18 for the last few days though. There have not been any new ones in the last few days.

Senator SIEWERT: What is the time frame before—

Mr Bowles: Every day.

Senator SIEWERT: No, sorry. The berries were taken off the shelves. What is the incubation period?

Prof. Baggoley: The range of the incubation period takes us up to 50 days, so we would continue to look for cases up to 50 days, because, if we ever had any information beyond that, then certainly our people in OzFoodNet would provide advice. But, for practical purposes, 50 days after the recall would be the time we would expect not to see more cases.

Senator McLUCAS: Professor Baggoley, or maybe even Ms Jonasson, we are pretty sure that everyone in Australia knows we have had a big event, but how confident are we that everyone has thrown them away?

Prof. Baggoley: I am not sure there is ever any way of know that. I agree with you though—the publicity has been widespread in all media, and lots of people are talking about it. I do not think we could gain any more publicity about this issue.

Senator McLUCAS: Minister, I asked a question earlier, and you took on notice the second part of that question and you were going to address it in this section. Did you not have anything to add?

Senator Nash: No, my office requested FSANZ and the department to keep me updated of their actions to manage their responsibilities.

Senator DI NATALE: I have some more general questions. My sense is there is nothing special about berries. Any food that gets washed or handled by people could be subject to similar issues, so I am just more interested in the overall framework. You do not do hep A testing, because you cannot really do that on food, but you can do *E. coli* testing as a marker for faecal contamination, so I image that gets done. You test for *E. coli* pretty regularly, is that right?

Mr McCutcheon: Yes, the Department of Agriculture does test for *E. coli* on a number of the risk-category products.

Senator DI NATALE: So you do not do any *E. coli* testing routinely on low-risk foods?

Mr McCutcheon: Not to my knowledge.

Mr Bowles: It is an issue for Agriculture. FSANZ provides advice; they do not do the testing.

Senator DI NATALE: I know—

Mr Bowles: But we do not know enough about what their business is.

Senator DI NATALE: Okay. I will ask a few more general questions. You said *E. coli* testing would be done routinely on high-risk foods, is that right?

Mr McCutcheon: It is done routinely on some high-risk foods.

Senator DI NATALE: What happens if you get an *E. coli* reading? What is the next stage in the process?

Mr McCutcheon: Again, that is a question for Agriculture. What we do is provide assessment advice on all those risk foods. In fact, we are going through a process of reviewing. We started that a year or so ago.

Senator DI NATALE: Seafoods, I would image, would be a high-risk food product.

Mr Bowles: Yes. A number of seafood products.

Senator DI NATALE: We get a lot of imported farm product—prawns, fish fillets and so on—mainly from South-East Asia.

Mr McCutcheon: Yes. A lot of it comes from South-East Asia, but not exclusively.

Senator DI NATALE: I am aware that there is routine antibiotic use in aquaculture. What testing is done on imported seafood? What are your recommendations in terms of what should be done?

Mr McCutcheon: I can only give you a general response. Again, this is really a question for Agriculture because they have the risk list and what they test for, but I do know with some of the seafood products—crustaceans—they do some antibiotic testing. Again, I do not have the details. That is a detail that Agriculture—in fact, it is available publicly.

Senator DI NATALE: My interest is more in what happens once you detect, for example, a high *E. coli* reading. What is the process that happens beyond that? What is the process that happens when you detect, for example, fluroquinolones, which are tested for in imported prawns? Given that we are testing only a small fraction of those products, which are high-risk products—and we know a significant percentage of those fail—how does that inform what you do with other imported products?

Mr McCutcheon: Again, that is the Department of Agriculture. I am sorry I cannot—

Senator DI NATALE: Fair enough. I figured I probably was not going to get to ask the most questions during Ag so I left it to others. I might ask them next time.

Senator LEYONHJELM: My questions are not on berries; they are on plain packaging of cigarettes.

Mr McCutcheon: Is that all for FSANZ?

Senator McLUCAS: Very, very quickly—

CHAIR: I think that is all, so we will have one very quick one—I thought we were done.

Senator McLUCAS: You might want to take this on notice Mr McCutcheon. What percentage of your budget is spent on staffing?

Mr McCutcheon: Approximately 73 per cent.

Senator McLUCAS: You received a 10 per cent cut in your last budget. How many positions did that equate to?

Mr McCutcheon: As a result of a smaller budget, we lost 12 employees.

Senator McLUCAS: Are there any functions not being performed as a result of those cuts?

Mr McCutcheon: No.

Senator McLUCAS: So it has just delayed—things will take longer.

Mr McCutcheon: It is a combination of things. What we have done over the years because of our budget is tended to lose more in the risk management areas, rather than the risk assessment areas, because the risk assessment areas—they are our science areas—are the foundation of what we do. We have managed to retain our capability there, but we have lost some in the risk management areas, and corporately, which just means that it takes longer for us to do some of the standards development work, applications and those sorts of things.

Senator McLUCAS: So you have not ceased doing things.

Mr McCutcheon: No, but, as you know, we have a range of functions in our act. Some of those functions get more resources allocated to them than others depending on the issues.

Senator McLUCAS: Thank you very much, and good luck with the berries.

Department of Health

[21:33]

Senator LEYONHJELM: My question is about plain packaging cost-benefit analysis. I understand the department has engaged Siggins Miller consultants to work on this. Did the department invite organisations to bid for the work and, if so, how did the department invite organisations?

Mr Smyth: We went through a select tender process off a pre-approved panel list to receive proposals from a number of organisations.

Senator LEYONHJELM: A pre-approved panel?

Mr Smyth: That is right. There are a number of qualified panel lists for particular economic evaluations, and the like, that are available to departments, so we utilised that panel.

Senator LEYONHJELM: How many were invited?

Mr Smyth: I would have to take that on notice There is at least three in the first instance, I think.

Senator LEYONHJELM: Can you tell me how was Siggins Miller selected?

Mr Smyth: There was an evaluation process with criteria that was set down in the terms for the piece of work and they were assessed as all government contracts are around value for money, their capability to do the work et cetera.

Senator LEYONHJELM: If you can take on how many were invited on notice please, that would be good. Has a contract or other agreement been entered into with Siggins Miller?

Mr Smyth: Yes, it has. They are actually in the field doing work at the moment, so there is a public consultation process going on at the moment.

Senator LEYONHJELM: When did they start work?

Mr Smyth: I will just grab that for you.

Dr Southern: The public consultation period started on 16 February.

Senator LEYONHJELM: 16 February, so it is a quite new thing.

Mr Smyth: It will run until the end of March.

Senator LEYONHJELM: This year?

Mr Smyth: Yes, that is correct.

Senator LEYONHJELM: Well, I understand it is a consultation with stakeholders and a cost-benefit analysis of plain packaging. Have you required Siggins Miller to quantify benefits and costs using a common metric such as dollars—

Mr Smyth: Part of the cost-benefit analysis is to undertake that kind of work.

Senator LEYONHJELM: You quantify in terms of dollars?

Mr Smyth: Yes.

Senator LEYONHJELM: On that basis, in doing the cost-benefit analysis, is Siggins Miller free to account for all the possible variables that might come in? Now, I am thinking here of defending the plain packaging regulation in the challenge before the WTO—any change in the value of intellectual property?

Mr Smyth: That is not part of the work as such; that is separate work.

Senator LEYONHJELM: The cost of defending it, changing the value of intellectual property—not included?

Mr Smyth: No.

Senator LEYONHJELM: Any cost attributable to consumers having less ability to discriminate between packets of cigarettes?

Mr Smyth: That will be assessed through the process and the evidence will be looked at. Interviews will be looked at and the like but—

Senator LEYONHJELM: The cost benefit, the quantification aspect, is what I am interested in.

Mr Smyth: I would have to take that question on notice, in terms of the actual technical details that they are going to go through.

Senator LEYONHJELM: I would like it on notice, if you would.

Mr Smyth: Sure.

Senator LEYONHJELM: I am also interested to know if the cost-benefit analysis, the quantitative aspect, will take into account any change in the black market tobacco?

Mr Smyth: That is an interesting point. We would highly dispute a number of claims that have been made by organisations, in particular the tobacco industry, as to the size of the illicit market in Australia. We would estimate it to be somewhere between two and four per cent. I know there is a KPMG report that we have some serious concerns about regarding its validity and the work that was undertaken there—the process that they went through. So we utilise the national drug and alcohol survey that is conducted by the Australian Institute of Health and Welfare, and that has a representative sample of 22,000 people versus the KPMG study that looked at picking rubbish out of litter bins and had a survey sample size of around 2,000 to estimate their 14 per cent. So we would hold the AIHW figures as being more representative. We would dismiss the KPMG report.

Senator LEYONHJELM: So has Siggins Miller been told not to account for that?

Mr Smyth: No, they will look at all the evidence available and see how it stacks up.

Senator LEYONHJELM: Let's see how it stacks up, but it sounds like if they came back and said the cost benefit needs to include the black market tobacco side of things, we might not find a very receptive audience.

Mr Smyth: They can look at that, but if I could just draw your attention to some tobacco industry statements that were made to Sir Cyril Chantler, who was doing the British study into whether or not the British government would go. He interviewed British American Tobacco Australia. When they were asked a question, they responded by saying, 'We did believe that there would be a blow-out in the size of plain packets number because there was a lot of counterfeit of our brands before. That does not occur.' The question was, in this case, 'Do you see this having anything to do with standardised packaging?' They said, 'I think the majority of it has to do with price. I think that in Australia you have got one of the most expensive tobacco markets in the world.' The industry itself discounted the fact that plain packaging was contributing to any increase in illicit trade.

Senator LEYONHJELM: My question was whether Siggens Miller is free to account for that?

Mr Smyth: They will look at all the evidence presented to them.

Senator LEYONHJELM: And take into account in the cost-benefit analysis the impact of the black market, no matter what you think it is or what KPMG think it is, its impact on tax revenue, law enforcement costs and criminality?

Mr Smyth: As I said, they will look at where the evidence base is and assess information on its merits.

Senator LEYONHJELM: You have not limited this?

Mr Smyth: I have not even met with Siggens Miller.

Senator LEYONHJELM: I understand the work of Siggens Miller is to inform the development of a post-implementation review. Do you consider the work of Siggens Miller to actually be the post-implementation review?

Mr Smyth: They will provide information to us, but the post-implementation review is a process that is done by the department and that is in accordance with the Office of Best Practice Regulation's requirements.

Senator LEYONHJELM: You said they are due to complete their fieldwork at the end of March?

Mr Smyth: They should complete their fieldwork by the end of March.

Senator LEYONHJELM: Correct if I am wrong, but I understand the department has obtained an extension of the Office of Best Practice Regulation to the due date for this to June 2015—is that not the case?

Mr Smyth: We liaise with the OBPR and, at this stage, yes, we are due to complete the post-implementation review by June.

Senator LEYONHJELM: Is the post-implementation review of plain packaging referred to on the health department's website?

Mr Smyth: I am sure it is, but I will have to check on that. I am sure it would have been because we have advertised for public submissions and the like. There were advertisements that were placed on 16 February. There is a Twitter feed on our website that advertised it and it was advertised in the Adelaide *Advertiser*, *The Australian*, *The AFR*, *The Courier-Mail*, *The Canberra Times*, the *Mercury*, *The Age*, the *NT News*, *The Sydney Morning Herald* and *The West Australian*.

Senator LEYONHJELM: I understand that in its consultation document, Siggens Miller lists the objectives of the plain packaging measure and that this list includes reducing the attractiveness and appeal of tobacco products to consumers, particularly young people. Are you aware of this?

Mr Smyth: Absolutely. They are the objects of the act. There are a number of objects of the act. They are: to reduce the attractiveness and appeal of tobacco products to consumers, particularly young people; to increase the noticeability and effectiveness of mandated health warnings; to reduce the ability of retail packaging of tobacco products to mislead consumers about the harms of smoking; and, through the achievement of these aims in the long term—and I want to emphasise that—as part of a comprehensive range of tobacco control measures, to contribute to efforts to reduce smoking rates.

Senator LEYONHJELM: Yes, I understand that this case. Do you consider the guidance notes on the post-implementation review to be satisfied. They state that the review should assess how effective and efficient it has been in meeting its original objectives.

Mr Smyth: That is correct.

Senator LEYONHJELM: The guidance notes state that post-implementation should, where relevant, discuss the set of objectives stated in the act associated with the change.

Mr Smyth: Correct.

Senator LEYONHJELM: Does the objective section of the Tobacco Plain Packaging Act refer to an objective or an intention to reduce the attractiveness of tobacco products to consumers, particularly young people?

Mr Smyth: That is what I just read out to you, Senator.

Senator LEYONHJELM: I am understand the act does not say that—does it?

Mr Smyth: It is in the objects of the act.

Senator LEYONHJELM: Does it include the noticeability of health warnings?

Mr Smyth: Yes, it does. It increases the noticeability and effectiveness of mandated health warnings.

Senator LEYONHJELM: The health department website states under a heading entitled 'Tobacco consumption':

> The Commonwealth Treasury has further advised that tobacco clearances (including excise and customs duty) fell by 3.4% in 2013 relative to 2012 when tobacco plain packaging was introduced.
>
> Clearances are an indicator of tobacco volumes in the Australian market.

Is the health department aware that at the previous estimates round I asked Treasury about this reference to Treasury on the health department website?

Mr Smyth: I am not aware that you asked that of Treasury, but that information was obtained by Treasury.

Senator LEYONHJELM: I asked about the process where branded products were destroyed and replaced by newly imported plain packs and asked whether this process boosted clearances in 2012 and refunds in 2013. The Treasury replied that it is not possible to infer the effect of plain packaging refunds on annual tobacco clearances. Are you aware of this view of Treasury?

Mr Smyth: I think you have to look at a time when you are going from 2012 through to 2013 and there was a significant changeover of stock. Plain packaging, in terms of its retail provisions, commenced 1 December 2012. There was significant stock changeover around that period. So we are getting towards the end of 2012 and into the year 2013 that the Treasury are referring to. They would be the experts in relation to excise, duty, clearances,

refunds, destruction of product et cetera. I would not be able to comment on it. I would just say that around that period some of the stock volumes may have not been on the trajectory that they may have normalised at now.

Senator McLUCAS: Chair, I know Senator Leyonhjelm is very interested in this, but we have only about another 20 minutes on this outcome.

Senator LEYONHJELM: I am just about finished.

Senator McLUCAS: Thank you.

Senator LEYONHJELM: The gentleman has answered some of my questions in advance so I am just reading ahead to make sure I do not ask for stuff he has already talked about. I will leave it there; thank you.

CHAIR: Senator McLucas.

Senator McLUCAS: Just on notice, please, Mr Smyth: this committee has been interested over many years in FOI applications by big tobacco. We do not have time tonight to talk about it, but can you give an update to the committee about FOIs that big tobacco might have put into the department since our last estimates?

Mr Smyth: We have only got one tobacco related request on hand at the moment. The requests that we have received lately are from law firms, which may well be representing tobacco—we do not know, of course—and newspapers in relation to the monthly tracking survey that was commissioned by the department. But, overall, if I could just say that we have had 77 freedom of information requests that have commenced since May 2010 and we know that 56 of those are from the tobacco industry.

Senator McLUCAS: At enormous cost, I understand.

Mr Smyth: At significant cost to the department.

Senator McLUCAS: Thank you.

Senator DI NATALE: Can I ask you about the drug and alcohol strategy which expired four years ago? What work have you done on the new strategy?

Mr Smyth: We still have a national drug strategy that runs until the end of this year, 2015, and alcohol is contained within that—issues around supply, harm reduction and demand reduction, of course. The next phase of the national drug strategy, which will contain a national alcohol strategy, will commence shortly and the aim is to have that completed by the end of this calendar year and to commence the next five-year phase of the national drug strategy.

Senator DI NATALE: But wasn't there a dedicated alcohol strategy?

Mr Smyth: There was to be an alcohol substrategy, as such, that became a statement of principles, a framework around alcohol.

Senator DI NATALE: I will not pursue that because I know we are running short of time. Can you let me know what is going to happen with the Australian National Preventive Health Agency reviews of a minimum price for alcohol and the effectiveness of the regulatory codes on advertising now that ANPHA is gone? What is the department doing with both of those pieces of work?

Mr Smyth: They are under consideration by government.

Senator DI NATALE: They are under consideration by government. Let me ask you about a specific issue that has been brought to my attention, and it is the issue of spirit-like products. Are you aware of these spirit-like products that are basically made from wine? They are made like wine, which allows them to be taxed through the WET, the wine equalisation tax, meaning they attract a much lower taxation rate, but they effectively mimic the look of spirits. I have a couple here.

CHAIR: Oh, a prop! I hope it's not open.

Senator SIEWERT: He is turning into Bill Heffernan, bringing a bottle of samples.

Senator DI NATALE: All right, laugh. There is the vodka—

Senator Nash: That is a big step up from Senator Heffernan's prawns.

Senator SIEWERT: Exactly.

Senator DI NATALE: there is the Malibu and here is the Baileys, except they are not called those things. Are you aware of those products?

Mr Smyth: I am not. I do not purchase those, I have to admit, and I am not aware of them as such. They have not been brought to my attention.

Senator DI NATALE: You can see that looks like a bottle of vodka, and in fact I think it is marketed as 'not like your cheap vodka', implying that it tastes like expensive vodka. That looks exactly like a bottle of Baileys. It has almost as much alcohol in it. They are made from grapes, so they are very, very cheap. I think that vodka is $10. By the way, this is not an ad! So what is being done about that?

Mr Smyth: I would have to take that on notice, to be honest. I think that, if you are dealing with taxation arrangements, that is an issue for the Treasury. I would refer you to the Treasury.

Senator DI NATALE: It is not really a tax issue. It is effectively about how we regulate something. It is made from grapes, so it is legal, but it is clearly designed to exploit a loophole in the taxation of alcohol.

Mr Smyth: And that is where I would refer you to the Treasury.

Senator DI NATALE: But it is legal, so how is it dealt with through an alcohol strategy? What do we do about something like that?

Mr Smyth: Again, if I could take that on notice. Like I said, I have not come across those products previously.

Dr Southern: Are they imported?

Senator DI NATALE: No, I do not think so.

Senator McLUCAS: This one is made in Ireland.

Senator DI NATALE: 'Wine product of Australia'. That is the vodka.

Senator McLUCAS: And so is this one—it is Australian as well. But that one is Irish.

Senator DI NATALE: I did not realise that was Irish.

Senator McLUCAS: Grapes in Ireland?

Senator DI NATALE: The vodka is not Irish. They are wine grapes from Australia, being sold as vodka, at $10 a bottle. We had this big debate about alcopops and we decided we would regulate them differently, and we now have this stuff coming onto the market and being marketed pretty heavily.

Mr Smyth: Can I ask what the alcohol content is?

Senator DI NATALE: The vodka's is lower than normal. I think standard vodka is 37 per cent and that is 22 per cent, from memory. That one is 15 and the Baileys is 17. So it is effectively the same alcohol content as Baileys and half the price. Look at the bottle—O'Mara's. You would think you were buying a bottle of Baileys. It just makes a mockery of our taxation system. I thought you were going to handball it to Treasury. Treasury will say, 'Well, it's a legal product. It's taxed appropriately. There's no reason they can't do that.' What do we do about it?

Mr Bowles: Let's take it on notice and try and understand the issue a bit more. As Mr Smyth said, he is not aware of the specifics of those. So we will take it on notice and have a bit of a look at the issue more broadly.

Senator DI NATALE: All right. I will leave it there. I look forward to your response on that.

Senator PERIS: Mr Smyth, you would be aware of the new study released this week, *The hidden harm: alcohol's impact on children and families*?

Mr Smyth: I am. That was the FARE report—Foundation for Alcohol Research and Education.

Senator PERIS: Yes. The report gave some staggering statistics. It says that more than 10,000 children are in the child protection system partly or wholly because their parents or carers had abused alcohol, and almost 30,000 cases of domestic violence are alcohol related in Australia. And this is only the data for half of the country. The *Hidden harm* report supports the development of a model of care to allow services in the alcohol and other drug sector and the family and domestic violence sector to work closely together. Will the government support an initiative such as this?

Mr Smyth: Again, that would be obviously a decision of government, but that report will certainly be a topic of discussion at the next IGCD, the Intergovernmental Committee on Drugs. We always look at those kinds of reports and what their relevance is to drug and alcohol policy recommendations and the like. But I could not comment for what the government may or may not do in response to a report like that.

Senator PERIS: When is the next meeting?

Mr Smyth: It is next month, 5 March.

Senator SMITH: Could you just provide me an update in regard to the Communicable Disease Prevention and Service Improvement Grants Fund? I understand that we provided six-month extensions to that.

Mr Smyth: I would have to refer you to my colleague from OHP Ms Jonasson in relation to that.

Senator SMITH: I just wanted an update in regard to where that fund is up to. My understanding is that we provided a six-month extension in December.

Ms Jonasson: Yes. That is correct. A six-month extension of funding was agreed by the previous health minister, Minister Dutton, for those organisations. Any further funding beyond the end of June this year is under consideration by government.

Senator SMITH: We are in February now, close to March. What sort of time frame are we looking at before we can give applicants a sense of what the future is?

Ms Jonasson: What I can say is that we are talking in the department, talking with the various applicants or the recipients of this funding at the moment—we are in constant contact with those recipients of the funding. But I would not want to put a time on it and pre-empt any government decision on this.

Senator SMITH: I would not want it to be the last week of June or anything like that for these applicants. Is it open for applicants to be in discussion with the department about where the process is up to so they can provide some certainty to people that are involved in the organisations or the programs that are affected?

Ms Jonasson: Just to clarify: you are talking about the organisations that are currently funded?

Senator SMITH: Yes.

Ms Jonasson: Absolutely. I am in constant contact, as I said, with those organisations. They are very welcome to contact me, and I am very happy to talk to them about it.

Senator McLUCAS: Can I ask Mr Cotterell some questions about flexible funds? Could we have two minutes with him and then the NHMRC?

CHAIR: We are going to run out of time, but we have got about five minutes till we break and we are due to move on.

Senator McLUCAS: I will be very quick, and anything left will go on notice. On what basis were five of the 16 flexible funds not subject to the $197 million cut that happened in the budget? What was the rationale? Why wasn't it shared equally across all the flexible funds?

Mr Cotterell: As I recall, the decision to take the savings from some of the funds was made because other funds had already had savings taken from them via other measures. Some of them were demand driven, but I would have to take on notice further detail on that.

Senator McLUCAS: An explanation of that would be fantastic. When will organisations that are funded up to 30 June be advised of what their ongoing funding allocation is?

Mr Bowles: It is the same answer as Ms Jonasson gave before: it is a decision of government and we would expect that soon.

Senator McLUCAS: So, the final question then is a timing question. When will organisations be advised of what their funding is beyond 30 June? It is a decision of government, but there is the issue that staff have to be advised if there is not going to be funding beyond 30 June, and my understanding in another area is that the various employment arrangements would require people to be given three months notice.

Mr Bowles: I think we have started to notify some areas. Is that right?

Mr Smyth: Some, yes, in palliative care.

Mr Bowles: And we are aware of the issues and we are having constant conversations with many of these organisations. So, as I said, it is a decision of government, but we would expect that in the near future.

Senator McLUCAS: But the three-month issue is an issue that affects the industrial arrangements for a lot of these organisations. Is that agreed?

Mr Bowles: I do not know the specifics of each of them, but I would imagine that that would be the case in some of those cases, yes.

Senator McLUCAS: Thank you.

CHAIR: I am in the hands of the committee as to whether we move on to HMRC now, or after the break.

Senator McLUCAS: We can find a compromise here. I do not have much except my normal questions of Professor Baggoley around tuberculosis and the border issues. Perhaps I could ask that we get an update on what has happened since last estimates around that, on notice. That would mean that we do not actually need outcome 9.

Mr Bowles: And I can send the biosecurity and emergency response people home—is that right? We have taken the other bit on notice.

Senator McLUCAS: Thank them very much. I am sorry; we did expect that we would get to see them.

Proceedings suspended from 22:03 to 22:13

CHAIR: We will recommence. Mr Bowles wanted to make a clarification, was it?

Mr Bowles: Yes, just on something I said to Senator McLucas. I think I said 22 September was the first meeting of the Ebola IDC; it was actually 18 September, not the 22nd, and it was largely weekly up until Christmas and then fortnightly from 9 January 2015. But it was the 18th not the 22nd.

Senator McLUCAS: Thank you.

National Health and Medical Research Council

[22:14]

CHAIR: Professor Anderson, I understand this is your last estimates—is that correct?

Prof. Anderson: Regrettably, Chair.

CHAIR: Regrettably!

Senator McLUCAS: Professor Anderson, you are not allowed to lie!

CHAIR: I understand your new position is Secretary-General of the Human Frontier Science Program? Is that correct?

Prof. Anderson: That is correct.

CHAIR: That sounds intriguing. I am not familiar with that, but I will not ask you to talk about that. Congratulations on your time with the NHMRC and I wish you well in the future role.

Prof. Anderson: Thank you.

Senator McLUCAS: Can I just add my comments to this important recognition of nine years of service that you have given, Professor Anderson, to the NHMRC under both governments?

You have served both governments well. In the time that you have been there, there have been huge changes. There have been changes in the way the grant system works. You have presided over increased transparency. I have observed an absolute scientific rigour that we can all be very proud of as Australians.

On behalf of the Labor Party, I want to thank you very much for your service to our country. I wish you all the very best as Secretary General of the Human Frontier Science Program and welcome you back, if you ever want to come back and sit at the back at estimates! You would be very, very welcome. But I really want to underline those thanks on behalf of us and also the people of Australia.

CHAIR: Thank you for that, Senator McLucas.

Senator MADIGAN: Thank you, gentlemen. I note that the NHMRC was aware of Steven Cooper's research at Cape Bridgewater commissioned by Pacific Hydro. Given the endorsement of Mr Cooper's acoustic investigation by senior acousticians internationally, such as Dr Paul Schomer and Dr George Hessler, both of whom worked for the wind industry, I would like to know what your acoustic expert Dr Norm Broner thought of Mr Cooper's report.

Prof. Anderson: Thank you to the chair and Senator McLucas for those very kind words. It is actually a great privilege to be able to serve the people of Australia in this job and, I hope, use the taxpayers' money as effectively as possible, so thank you.

Senator Madigan, thank you for your question. Specifically on Dr Broner's membership of the reference group, the reference group has finished its work now, so I am not sure whether I can specifically answer your question. I could ask Dr Broner, I suppose. We are of course aware of that particular study. We are not aware that it has been published in peer review papers at this moment.

I suppose the general point is that, when we do rigorous scientific analysis of the literature, we try and take all the literature into account. Of course, any individual piece of research will have its own place and its own finding, but I am sure you will understand that one piece does not wipe out previous pieces of research. Of course, we are pleased to see that more research is being done in this topic as time goes by, but, with us and our expert reference committee and so on, we always have to have a line at some stage and make the conclusions at that time.

Senator MADIGAN: I am aware that the NHMRC insist on strict confidentiality clauses in their contracts with some parties involved in this process, such as Emeritus Professor Colin Hansen, who refused to sign such an agreement. How does this requirement help ensure transparency and accountability to the Australian people and robust and open scientific debate in such a difficult area?

Prof. Anderson: We have many committees on many topics from ethics through to science, health advice and public health advice. We always ask people to sign confidentiality so that other members of the committee can engage in robust conversation with confidence that their views will not be represented or perhaps misrepresented externally. So there would be nothing unique about that particular matter, and certainly we are aware of Professor Hansen's work.

Senator MADIGAN: I have been advised that the NHMRC is refusing to make the independent expert peer reviewers' reports public, despite indicating to some of the peer reviewers that it would do so. Could the NHMRC make all expert peer review reports public immediately? If you will not do so, could you please explain to the committee why you are refusing to do so and how that is open and transparent?

Prof. Anderson: To make a person's opinion available, we have to ask them whether they consent to that. We are in the process of doing that. I believe—although I am subject to correction—that the reports are already in the public domain, and there have been some questions around the individual ownership of those. That is a matter of privacy for those people, but we are, right at the moment—in fact, I gather, quite close to—getting permission, with those who do consent, to make it available. I think things are moving along there.

Senator MADIGAN: Why were the public comments made by key spokespeople for the NHMRC—you and Professor Armstrong—prioritising research for residents in homes within 1.5 kilometres of wind turbines, when Mr Cooper's acoustic survey included one home which is unliveable at 1.6 kilometres because of the infrasound from Pacific Hydro's wind turbines, and also when Professor Colin Hansen has measured excessive levels of low-frequency noise out to 8.7 kilometres, in the case of Waterloo, which would cause sleep disturbance at that distance?

Prof. Anderson: Quite a lot of research was accessed that has been done on noise and distance as part of the report. You have mentioned a couple of studies, but there are quite a lot of others documented in our report as so-called parallel evidence. The overwhelming bulk of the evidence shows that, up to 500 metres, there are indeed effects on health of noise at the level that wind turbines do. From 500 to 1,500, the evidence is that there probably are, although they are probably modest. And the bulk of evidence shows that, after 1,500 metres, although some people may indeed individually attribute their sleep to the wind turbine noise, the likelihood is low. I want to assure you that the research we are going to call for is not going to restrict people from any of those conclusions. We will be looking for the very best research we can.

Senator MADIGAN: Miss Mary Morris's research at Waterloo demonstrated that rural residents were reporting impacts on their sleep out to 10 kilometres at Waterloo, which is consistent with Professor Hansen's acoustic data. Miss Morris's research was one of the very few studies included by the NHMRC in its very selective literature review. Why is this acoustic and population survey information out to 10 kilometres being ignored by the NHMRC, which has a responsibility to adopt a precautionary approach in order to protect the health of the public?

Prof. Anderson: With respect, Senator, we did not ignore it. If you look at our documentation, it has been taken into account. What it did not do was fulfil the criteria we set up at the beginning. This is the way you properly do systematic reviews. You set the criteria at the beginning, and then you look at the evidence. What the group found was really only seven studies, 13 publications, that fell within the criteria of adequate scientific validity and relevance to health, because not all the studies were relevant to health. But, having said that, nothing else was ignored. The committee went over thousands of submissions from all sorts of bodies. There were two calls in the public for submissions, and the committee looked at all of that. So I would not accept your suggestion that those studies were ignored.

Senator DI NATALE: Let me also go to the statements made earlier by colleagues. I want to thank you for your many years of great service. It is with a bit of a heavy heart that I have to finish on this note, and I think we both know where this is going to go.

Prof. Anderson: You flagged it in the press.

Senator DI NATALE: I wanted you to be prepared! I am going to ask about the statement made by the NHMRC which says:

After careful consideration and deliberation of the body of evidence, NHMRC concludes that there is currently no consistent evidence that wind farms cause adverse health effects …

However, the statement then also says:

Given the poor quality of current direct evidence and the concern expressed by some members of the community, high quality research into possible health effects of wind farms, particularly within 1500 metres, is warranted.

Let me go firstly to some concerns expressed by some of the people who were involved in helping to formulate those findings. Did the NHMRC receive correspondence from any of the New South Wales Director of Health Protection, Jeremy McAnulty; Wayne Smith, the director of the Environmental Health Branch at New South Wales Health; or Rosemary Lester, the Chief Health Officer of Victoria? If so, can you tell me what the content of those emails was?

Prof. Anderson: I am not aware of the first names, so I would have to take that on notice. Wayne Smith of course was a member of the reference group, not a member of council. The reference group delivered a signed off version to the NHMRC—our information paper—which was released at the time. I am assuming that Professor Smith had agreed to that document. I am aware that, since then, he has had some disagreement with the wording, but it is not the reference group that agrees to the wording; it is the CEO of the NHMRC on the advice of the council. I have been around academics a long time. Hardly any of them ever agree about anything. I respect different views that people might have had, but we did get formal advice, agreed in the information paper, from a committee that included Professor Smith. That is that issue.

As you would be aware, the chief medical officers of all the states and territories and of the Commonwealth are members of council. In the usual way, when members of council are sent something to discuss, they often discuss it inside their department. I do not know if those conversations went in, but of course the Department of Health have a different view to us, because they might be involved in state regulations. We are not involved in that at all. We just try to make comments on the basis of the evidence and the conversation that occurs at council. There certainly were some comments back from a couple of the chief medical officers when we were finalising this, including from Dr Lester. But, at the end of the day, Dr Lester and the other CHOs and CMOs signed off and agreed with the statement.

Senator DI NATALE: What was the basis of their concerns?

Prof. Anderson: You had better ask them. My understanding of it was that, for some reason, they disagreed with us mentioning that there was community concern. I do not understand that. You are about to have a third Senate committee on windfarms. I would have thought that the Senate would not go to three committees unless it—the Senate—recognised this community concern around it. I have been terribly aware, because we have been involved in all three of these Senate committees, of the many comments that have been made about this area. So I do not resile at all from the position that, when you are a body that advises in public health, you base it on two things—the science primarily and then the second thing is the community concern. On the science, the expert committee said, 'The science is not good; there is not much of it and it is all poor quality'. If you get that from a scientific body, what are you going to do, dismiss it? Then, as I said, the second thing is the community concern, particularly as exemplified by the Senate itself.

Senator DI NATALE: There are so many things that I would like to go to there, but we will go to a couple of them. The basis of their concern, as far as I understand it, was that any recommendation from you to suggest that there may be a link has the potential to cause harm.

Prof. Anderson: Yes, and—

Senator DI NATALE: Do you accept that?

Prof. Anderson: I think there is harm both ways.

Senator DI NATALE: No, specifically about a recommendation to suggest there may be a link when there is no evidence to suggest there is one—that such a recommendation has the potential to cause harm.

Prof. Anderson: I am sorry; I do not agree with your comment that there is no evidence there is a link. That is what I am saying. The evidence is not strong enough to say that, especially on the annoyance side, the social-cultural side and the implications of that. So I do not accept the premise on which you are asking me the question, with respect.

Senator DI NATALE: Okay, so annoyance. On the basis of annoyance, are we going to recommend having studies done into people who live next to busy motorways because they are annoying, or tall buildings?

Prof. Anderson: Many such studies have been done.

Senator DI NATALE: Are you suggesting that we do that on the basis of annoyance?

Prof. Anderson: We are going to call for research. If the research community, which I guess is where you are coming from, feel that this is not worth studying then we will not get applications that are worth doing.

Senator DI NATALE: You are offering money to do research, in a pretty fiscally constrained environment.

Prof. Anderson: We are also going to peer-review it at our usual high quality, and we are not going to spend that money, let me tell you, unless there is high-quality research. But can I come back. Put yourself—sorry, I should not say that. If you were in my place—

Senator DI NATALE: I know exactly what I would do if I were in your place, and it would not have been to make those recommendations. It would have been consistent with the advice from Rosemary Lester and the other chief health officers.

Prof. Anderson: It was not the other chief health officers, with respect again.

Senator DI NATALE: With one of the chief health officers

Prof. Anderson: There are two that expressed some concern and then eventually agreed with the statement.

Senator DI NATALE: I have the email, and the email was very clear about their concerns.

Prof. Anderson: If you like, we can share with you the final comments by both those chief medical officers.

Senator DI NATALE: How much are we talking about in terms of the amount that is going to come from the NHMRC budget? Is it half a million?

Prof. Anderson: We will, hopefully, release it soon; we are just going through the last bureaucratic processes. May I interpolate that you are talking about the statement. The council signed off 100 per cent on the targeted call for research, and that happened before.

Senator DI NATALE: Surprise, surprise!

Prof. Anderson: The council members are not going to get any benefit out of that. So the call will be up to $2.5 million over five years.

Senator DI NATALE: Is that additional money? Is that new money?

Prof. Anderson: No, that is part of our—

Senator DI NATALE: From the existing money?

Prof. Anderson: That is part of the Medical Research Endowment Account.

Senator DI NATALE: So that is money that would have gone to cancer research or diabetes research or ischemic heart disease research or research for eye disease or research for—

Prof. Anderson: Or a fellowship or a partnership project. But that will be $5 million over five years when our total expenditure—

Senator DI NATALE: Sorry, $2½ million?

Prof. Anderson: Sorry, $2.5 million—$500,000 a year—while, according to our forward estimates, we will spend about $4¼ billion on cancer and diabetes in those—

Senator DI NATALE: Yes, but it is still $2½ million not going into any of those areas and being diverted into an area that is highly questionable.

Prof. Anderson: Yes. It is out of a small group that we keep for targeted calls for research which are driven by the council and the principal committees of the NHMRC.

Senator DI NATALE: I suppose getting to this—

CHAIR: This will have to be the last question.

Senator DI NATALE: I actually have a few questions here, and I made it really clear. You said we would have half an hour for this. We convened at quarter past—

CHAIR: Sorry, Senator Di Natale. I did not say. I said we would have about 20 minutes and we would have about 25 minutes left. Senator McLucas says she will come if there is time. So, if she is going to yield her time, we have till 25 to, if we are still cooperating. If you want to keep going, we will not get to—

Senator DI NATALE: Till when, sorry?

CHAIR: Till 25 to. We were initially going to go till half past, but we are going to—

Senator DI NATALE: I have been waiting all day for these.

CHAIR: Senator Di Natale, you have had no shortage of opportunities to ask questions. I said I would split the time roughly evenly. You have had more time than Senator Madigan had, so I am not sure what part of that is not fair.

Mr Bowles: I have my sports people, who have been waiting all night.

Senator DI NATALE: There is $2½ million going towards questionable research.

CHAIR: There is a lot of money in sport as well.

Senator DI NATALE: What is the macro policy environment that dictated this decision? What is the macro policy environment? Samantha Robertson, who is the executive director of evidence, advice and governance, said that, when making this decision, they took into consideration 'the macro policy environment'.

Prof. Anderson: I do not think I should be held responsible for what some of my staff said. It is what I said previously: we have spent a lot of time at the NHMRC working with Senate select committees over that period of time. I may be wrong, but I thought it was disrespectful to the Senate to think that that amount of focus on this issue—and I know there are different views around the Senate—but the fact that there have been three or will be three Senate select committees meant that as a responsible—

Senator DI NATALE: But aren't you a scientific body? Don't you make your decision on the basis of science, and not on the basis of some whim of parliamentarians, who might have an axe to grind. I thought that was the whole point of the NHMRC: you are at arm's length from government.

CHAIR: So a decision of the Senate is now a whim when the Greens don't agree with it?

Senator DI NATALE: This is the whole point of the NHMRC.

Prof. Anderson: It was available—

Senator DI NATALE: That is right. It is a Senate committee. You are a scientific body—

CHAIR: It was a majority of the Senate; it was not a whim of some. It was not a couple of Greens getting together—

Mr Bowles: We have heard different views tonight. I think that is a little unfair on Professor Anderson.

Senator DI NATALE: You either think science is a thing that exists or it does not. You are a scientific organisation and you are saying you are making a decision on the basis of what the Senate has decided. That is a disconnect.

Prof. Anderson: With respect, I do not think I said that. What I said was that as a scientific body an expert group gave us a report that said, 'We are going to make conclusions on this but there is not much research and it is poor.' The scientific committee also said, 'Here is what needs to be done in research.' It is in the reports in the public domain and I could read it out. Think about the situation where an expert group you have set up gives you a report and says, 'There is not the evidence here and it needs a lot more work, and here is the research that needs to be done.' That is the main thing—

Senator DI NATALE: Based on the macro policy environment.

Prof. Anderson: Please, I have not said that. I made the decision—

Senator DI NATALE: Your staff members said it. The executive director for evidence, advice and government has said that we are making this decision on the basis of the macro policy environment. The report says that 'we are going to make the decision on the basis of community concern'. You are a scientific body. I do not understand how—

Prof. Anderson: You seem to be implying that we have made all the decisions on community concerns. I am saying that we made almost the majority of the decisions on the scientific feedback we got—that evidence is not very good. I think there is another issue here that I will put to the committee. With a lot of new technology—and I assume this is the sort of new technology that is supported by some people here—health issues often arise, and health issues can sometimes be used to try to stop a new technology. So, surely if you are a supporter of the new technology you want the best evidence there is so that if such ideas come up they can be brushed aside. We commission the best research in Australia. That is an issue. It is not the issue that we decided, but it is an issue others have put to us.

Senator DI NATALE: It is an argument to persist indefinitely with this sort of research, because you can continue to maintain this argument that we do not have strong evidence in this area, so we are going to continue researching the area.

[22:38]

CHAIR: Senator Di Natale, we have 20 minutes left, so I would now like to move on to outcome 10: Sport and Recreation.

CHAIR: I am going to go to Senator Peris. So Senator Peris—sorry, Senator Madigan, you also have questions in sport. We are going to try and do a few minutes each then. Senator Peris, are your questions to ASADA?

Senator PERIS: Not to ASADA; Australian Sports Commission.

CHAIR: The Sports Commission, and yours?

Senator MADIGAN: ASADA.

CHAIR: I have got a couple of ASADA questions, so we might start with the Sports Commission and then we will move to ASADA.

Australian Sports Commission

[22:40]

Senator PERIS: Thank you. My question is to Mr Hollingsworth. In the last estimates in October we spoke about the Active After-school Communities program, now the Sporting Schools. Can you please give an update as to where we are up to with that, because a lot of information has come through that it has not actually been rolled out yet. According to the website, there is a process that is currently open with a portal being opened and the grant funding being opened on May 15th and then the first practical sessions beginning in July 15.

Mr Hollingsworth: As you mentioned, Active After-school Communities ceased on 31st December last year; and Sporting Schools commenced as from 1 January. As I mentioned in the last assessments hearing, there is a transition phase for the first six months of this year whereby we shift from active after-schools to Sporting Schools—and I will ask Sue Marriage to speak about it in more detail as she is the program director. We are working over these six months, specifically with 12 sports to pilot the Sporting Schools operation in a number of schools, primarily primary schools but also a select number of secondary schools.

We have assessed which sports have the capacity to deliver in the short term and we intend to expand the number of sports available under the program to 35 as from 1 July. It is our intention to enable all schools that had the Active After-schools Communities program on their site last year to be able to continue to provide activity in this first six months of the year. Sue will say something about that in a second, but our intention is to keep activity going while we ramp up the pilot, make sure the website is sufficiently operational and enable the sports to be ready to kick off Sporting School as from 1 July. I might just get Sue to say a bit more about the operation of the program.

Ms Marriage: The program is in its build phase at the moment, so we have kicked in from January. We have worked with identifying the schools that were the AASC schools and we are in an intensive program at the moment of trying to transition them over into the new program.

Senator PERIS: What is an AASC school?

Ms Marriage: The AASC schools, the active after-schools—I work in the acronyms on that one. We worked with those schools at the end of last year and we made contact with them directly to make sure they understood that Sporting Schools was on in the horizon. What we have done in this period of time from January is made contact again with those AASC schools to work with them with our funding model phase that is coming out to them. The important part is making sure that we have got a build period for this next six months up until July while making sure that we are not losing the continuity with those school that were involved with the active afters program. So we are looking at putting out a transitional funding arrangement for those schools so that they can have a term 2 of activity coming up very shortly. Material is going out to the schools now.

Senator PERIS: So the active after-school schools that were active last year are in a transitional phase at the moment. So how many schools do you have in that phase?

Ms Marriage: There were 2,300 schools in the active afters program up until December of last year, and we gone back to that database and made the contact with that database of schools. Importantly, when we made contact with them before Christmas, the majority of them are still eager to be part of Sporting Schools. So we have got pilot project activities going with 12 sports at the moment and we are also putting out a funding cycle so they can access money to continue some practical activity in this gap phase while we prepare to bring in Sporting Schools in July.

Senator PERIS: How many of those 2,300 schools were rolling out as of term one?

Ms Marriage: They are not rolling it out in term one—they are rolling out for term two. We are going through a cycle of preregistration with them, so we are saying that you were loyal to AASC, rolling them over into a sporting schools activity, and what we want to be able to do is give them a practical funding cycle so that they can put more activity into play in term two. Term one in school tends to be a time when everything is in a bit of turmoil, getting kids settled into school, and normally under the active afters program we would have put the funding cycle out before Christmas so that schools can prepare for term one. We are looking at putting out double the amount of funding so that they can put in more activity for a term two activity.

Senator PERIS: Mr Hollingsworth said last year that you had 175 full-time staff in the Active After-School Communities program, and that was going to be reduced to between 80 and 90. Is that still currently the case?

Ms Marriage: At the moment we have 77 staff in sporting schools, and we have got some corporate support as well—it is a total of about 85 staff across Australia.

Senator PERIS: What is the funding model for Active After-School?

Ms Marriage: The transition funding?

Senator PERIS: Yes.

Ms Marriage: The way it has been provided to the schools is by identifying the size of the school and the number of participants they want to have in the program. It is a slightly different model from the old program but it will allow for us to encourage schools to get more of their population of kids involved in the program.

Senator PERIS: Senator Di Natale put some questions on notice regarding the continuation of Reclink—obviously it has ceased. Has there been any talk of reinstating Reclink funding?

Mr Hollingsworth: That is a question for the department.

Mr Smith: The answer is no.

Senator PERIS: And you are not looking at any similar programs for the next budget?

Mr Smith: I would not speculate what is in the budget coming up, but funding for the Reclink program is terminating and it is not being continued.

CHAIR: We thank the Australian Sports Commission for appearing.

Australian Sports Anti-Doping Authority

[22:48]

CHAIR: I welcome ASADA. There are a couple of high-profile issues, and obviously the most recent one is the cocaine issue that is happening in some sporting clubs at the moment. I am aware of police investigations and the like and I do not want you going anywhere near any of that, but what is the role of ASADA when allegations—and they are just allegations—like this emerge? Is there anything that ASADA does, given that some of these would be banned under the WADA code and the like?

Mr McDevitt: First and foremost I should point out that what we have at the moment is a police activity and potential criminal prosecution, and so obviously that takes primacy. We are in conversations with the CCC and with other law enforcement agencies, as we do. An issue of importance here is that cocaine is an illicit substance under the various criminal codes but it is also a banned substance, as a stimulant, within competition under the WADA and ASADA arrangements. Technically, possession or use out of competition would not fall within ASADA's jurisdiction. I might point out, though, that an offence of trafficking, even if it is out of competition, would come within the jurisdiction of ASADA and WADA. I guess I would best describe our position at present as one of interested observer.

CHAIR: Just to clarify then: so ASADA is only interested in in-competition use because it is a stimulant and then the more serious out-of-competition charges, such as trafficking, could then therefore attract ASADA's notice?

Mr McDevitt: That is correct.

CHAIR: I will not push you any more on that. We have spoken obviously before about where things are up to in the supplements issue with the AFL in particular. Is there any update you can give us on that as to where things sit?

Mr McDevitt: Are you talking about the AFL tribunal?

CHAIR: Yes.

Mr McDevitt: The AFL issued infraction notices to 34 current and former Essendon players and one former Essendon support person on 14 November last year. On 5 February this year that support person identified himself as being Stephen Dank in a media interview with the ABC, so that is now in the public domain. ASADA have been involved in the hearing before the AFL antidoping tribunal in relation to all of these matters and we have presented our case against Mr Dank and the 34 current and former Essendon players. The AFL tribunal commenced its hearings on 18 November and they were completed in about mid-February. The tribunal has now reserved its decision as to any findings of violations against either the players or Mr Dank. We are not sure when they will come back with that decision, but we expect possibly the end of March or April.

CHAIR: Is that the end of ASADA's role then? Now that you have presented all of the evidence, there is a finding to be made by a tribunal. Regardless of what that finding is, is there a further role in this matter for ASADA?

Mr McDevitt: There potentially would be. There are, depending on the findings of the tribunal, appeal opportunities open to any of the players before the tribunal, including ASADA and WADA.

CHAIR: So ASADA could appeal if you were not satisfied—

Mr McDevitt: Technically that option would be open to us.

CHAIR: And that appeal goes where?

Mr McDevitt: My understanding is that in the first instance an appeal by ASADA would actually go to the AFL antidoping appeals tribunal, so still within the purview of the AFL antidoping arrangements, whereas an appeal by WADA could go, as I understand it, directly to the Court of Arbitration for Sport.

Senator MADIGAN: There is a public perception that aggressively pursuing players is possibly heavy-handed and unfair. Many believe that ASADA would be better off putting more resources into pursuing those who administered and supplied the drugs. Do you believe this approach would be more effective or are you satisfied with the status quo?

Mr McDevitt: It is a good question. ASADA always has to look at its balance of activity. For a start we have about 85 sports that we cover. That is a lot of sport. We make quite sophisticated decisions in terms of the spread of our activities—our testing activities and our intelligence activities—across the various sports. Of course my background is in law enforcement so I have been brought up to look at the higher level infrastructure above athletes. That said, at the end of the day athletes are personally responsible for what goes into their bodies. At the end of the day, whilst there is infrastructure above them that needs to be targeted, we need to make sure that we are effective in doing our job. Every time an athlete runs onto a stadium with banned substances pumping around their body they have an unfair advantage against their competition, and we have to make sure that that is not the case.

Senator MADIGAN: Does ASADA think it is acceptable that two years after the issue was made public, players are still awaiting certainly about their fates?

Mr McDevitt: Again, this, in my view, is not about decisions made by ASADA in 2014 or 2013; it is about decisions made by athletes in 2012—athletes and their support personnel and their clubs and so on. There have been delays. I am a big believer in justice delayed is justice denied. At the same time, a lot of the delays are actually due to the mechanics, the framework and the appeal mechanisms. People have those opportunities to take those up, but of course those of themselves actually serve to create quite significant delays in the processes. In an ideal situation, these issues should be resolved as quickly as possible. And in an ideal situation, it should not be played out in the public eye and that is what has made it particularly difficult not only for the players but for ASADA.

Senator MADIGAN: Thank you.

Senator DI NATALE: Just on the time line—you said the end of March, perhaps early April, is when you are expecting the matter to be determined by a tribunal. Is that your understanding of where the time line is at at the moment?

Mr McDevitt: I do not want to put words in the mouth of the tribunal, but the indications that we got from the chair of the tribunal was that they understood that there were pressures and that they wanted to come down with their decision as soon as possible. But they did give warning that it will take time, that they have got significant material to work through and obviously there is significant impacts on the decisions that they come out with.

Senator DI NATALE: Will any of the penalties be retrospective or prospective? Could they potentially be served during the pre-season competition or would they have to necessarily involve the regular season?

Mr McDevitt: It is a complex arrangement. I will try to simplify it as best I can. The offence of possession or use, which is what we are talking about here, normally would carry a two-year ban.

Senator DI NATALE: So we are not at cross-purposes, are we talking about the cocaine or the peptides?

Mr McDevitt: I am talking about the AFL matters.

Senator DI NATALE: The peptides issue not the cocaine issue?

Senator DI NATALE: Good. When you said possession I just thought you—

Mr McDevitt: No. In this case, there is no trafficking of—

Senator DI NATALE: Yes.

Mr McDevitt: Well, sorry, not in relation to players. Normally, an offence of possession or use would carry a penalty of two years. Where it becomes complicated is there are a number of factors which can then be taken into account. For example, a player or an athlete can claim no fault or no significant fault, which can cause reductions. They can make a claim of substantial assistance, which can lead to reductions. If they have been provisionally suspended, as players have in this case, then that time can be taken into account. They can claim—

Senator DI NATALE: Suspended—are you talking about the pre-season competition now?

Mr McDevitt: Backdated even further than that. My understanding is that most of these players have been on provisional suspensions back to November.

Senator DI NATALE: But that was at the end of the actual competition, so they have not actually missed any game time? So you are saying during the—

Mr McDevitt: That can still count as a credit.

Senator DI NATALE: Right. So the penalty is you do not miss a game of football. If you happen to miss enough, it could potentially be you have missed a—

Mr McDevitt: We are talking in the sort of—

Senator DI NATALE: Yes, hypothetically.

Mr McDevitt: Yes, hypothetically, it could. As to whether or not that would be an acceptable outcome, people would have different views on that.

Senator DI NATALE: Do you think that is appropriate? If the result is that they have been found guilty, would you think it would be appropriate that they would not miss a game of regular home and away football?

Mr McDevitt: You are asking for my opinion. This will need to be looked at very, very carefully. We will need to look at the provisions of the code and take that into account. At the end of the day, Ben McDevitt's opinion really is not relevant; it is what do the code provisions allow.

Senator DI NATALE: But I thought you said you could apply it, could you not?

Mr McDevitt: That would be an option open to us, yes.

Senator DI NATALE: So your opinion is relevant because if the AFL say, 'We think they've done—the punishment has been they have missed a few pre-season games,' you could potentially come in and say, 'We don't think that is an acceptable penalty.'

CHAIR: It is probably not appropriate that we ask Mr McDevitt for his legal strategy either, aside from—

Senator DI NATALE: No, I am just trying to understand the process.

Mr McDevitt: My position really will be to listen to the tribunal, listen to and read carefully examine the reasons for the decision that they come up with then look at the situation in its entirety against the backdrop of the code and the provisions of the code, and then come to what we think would be a reasonable decision.

Senator DI NATALE: Okay.

CHAIR: It is 11 o'clock. Unless anyone really wants to stay for a bit longer, even if you do, bad luck, we are finishing. Thank you, Mr Bowles. Thank you, Minister. Thank you to all the officials who have been here today and to all of the support staff who help.

Committee adjourned at 23:00