Chapter 2

Health and Ageing portfolio

Department of Health and Ageing

2.1 This chapter contains the key issues discussed during the 2011-2012 additional estimates hearing for the Health and Ageing portfolio.

2.2 The committee heard evidence from the Department on Wednesday 15 February 2012. Areas of the portfolio were called in the following order:

- Whole of Portfolio/Corporate matters
- Australian Commission on Safety and Quality in Health Care
- General Practice Education and Training Ltd
- Primary Care
- Private Health
- Mental Health
- Aged Care and Population Ageing
- Aged Care Standards and Accreditation Agency Ltd
- Hearing Services
- National E-Health Transition Authority
- Cancer Australia
- Health Infrastructure
- National Health and Medical Research Council
- Medical Services
- Australian Institute of Health and Welfare
- Australian National Preventive Health Agency
- Australian Radiation Protection and Nuclear Safety Agency (ARPANSA)
- Food Standards Australia New Zealand (FSANZ)
- Office of the Gene Technology Regulator
- Therapeutic Goods Administration
- Population Health
- Access to Pharmaceutical Services
- Acute Care
- Organ and Tissue Donation and Transplantation Authority

- Rural Health
- Health Workforce Capacity
- Biosecurity and Emergency Response

2.3 The committee agreed to provide any questions on notice to the following outcomes and agencies:

- Private Health Insurance Administration Council (PHIAC)

Whole of Portfolio/Corporate Matters

The Independent Hospital Pricing Authority

2.4 The committee made a number of inquiries of the Independent Hospital Pricing Authority (IHPA). These included whether IHPA had completed its recruitment process, its final staffing numbers, and if a breakdown by staffing levels and classifications was available. The committee also noted the difficulties involved in achieving the 1 July 2012 deadline for activity based payment.[1]

2.5 Dr Sherbon, Acting Chief Executive Officer of the Independent Hospital Pricing Authority, stated that IHPA is presently fully staffed for its current role. Dr Sherbon added that there were currently 37 full time equivalents and they included technical positions to assist with statistical modelling.[2] Dr Sherbon gave a breakdown of these positions: 'APS4, three FTE; APS5, two FTE; APS6, five FTE; E01 executive level 1, 13 FTE, executive level 2, 11 FTE; SES band 1, two FTE; and one holder of the public office.'[3]

2.6 Ms Jane Halton, Secretary of the Department of Health and Ageing, reinforced Dr Sherbon's position that the deadline of 1 July 2012 would be met for the activity based payments for agreed classifications.[4]

2.7 The Department was asked why it had contracted a company $420,000[5] to develop a comprehensive pricing framework. Ms Halton reassured the committee by explaining that a number of public discussions are required when attempting to set a certain price.[6] Policy and philosophical debates are needed to create framework, and it is important that they are publicly discussed. Ms Halton stated that:

> The authority will [then] marry together a draft of framework, feedback from all the interested parties, [...] ultimately that all comes together as a

1 *Proof Estimates Hansard,* 15 February 2012, p. 10.

2 *Proof Estimates Hansard,* 15 February 2012, p. 10.

3 *Proof Estimates Hansard,* 15 February 2012, p. 10.

4 *Proof Estimates Hansard,* 15 February 2012, p. 10.

5 *Proof Estimates Hansard,* 15 February 2012, pp. 12–13.

6 *Proof Estimates Hansard,* 15 February 2012, p. 13.

proposition, as a debate, however the authority will run this. They will then decide on what it looks like.[7]

Australian Commission on Safety and Quality in Health Care

Health Reform Agreement

2.8 The committee sought information on the Health Reform Agreement, with regards to the transparency of funding agreements and how these would evolve under the new agreement reached by Council of Australian Governments (COAG). Mr Charles Maskell-Knight, Acting Chief Executive Officer of the Health Reform Transition office, explained that Commonwealth funding is reported in budget papers and is allotted to hospitals on a basis of activity, while block funding is appropriated to a few other hospitals.[8] The funding is to flow into state accounts within the national health funding pool. The states make their payments for activity based funding into the same account and this is dispersed to local hospital networks. A monthly report is produced on the amount of money spent and on what basis spending has occurred.[9]

Primary Care

2.9 The committee inquired about the number of GPs currently employed at the Springwood Super Clinic. In addition, information was sought as to whether these positions were full-time and if it was possible for a super clinic to open without the presence of GPs.[10] Ms Meredeth Taylor, Assistant Secretary of the GP Super Clinics Branch, assured the committee that there were several GPs available when the clinic opened and more were going to be recruited. Ms Taylor added that there would be approximately two GPs currently working at the clinic, that the super clinic had to open for certain hours, and that there were always GPs present.[11]

2.10 The committee sought clarification as to the reason for the removal of dates from a copy of an agreement between the government and the Redcliffe Hospital Foundation, which was supplied in response to a question on notice to the committee at a previous estimates hearing. The committee also sought the reason behind classing these dates as commercial-in-confidence.[12] Mr Mark Booth, First Assistant Secretary for the Primary and Ambulatory Care Division, responded by stating that as many dates and as much information as possible is provided to the committee for answers to questions, but that external parties may want to keep some information from being

7 *Proof Estimates Hansard,* 15 February 2012, p. 13.

8 *Proof Estimates Hansard,* 15 February 2012, p. 17.

9 *Proof Estimates Hansard,* 15 February 2012, p. 17.

10 *Proof Estimates Hansard,* 15 February 2012, pp. 21–22.

11 *Proof Estimates Hansard,* 15 February 2012, p. 22.

12 *Proof Estimates Hansard,* 15 February 2012, p. 23.

released to the public so that the information does not negatively impact on their business.[13]

2.11 The committee sought an update on HealthDirect, concerning the amount of callers that had requested medical care within one to four hours of the call. The committee added a request for information on the options given to these callers and whether the advice was followed by the caller.[14] Officers stated that from 1 July 2011 to 12 February 2012 the service received approximately 97 000 calls and that 60 per cent of these were referred to a GP within four hours.[15] These callers usually have three options, consisting of: consultation with a GP after-hours service, the medical deputising service or attendance at an emergency department. The Officers explained that it was difficult to record compliance, however the National Health Call Centre Network are conducting a study that follows up with callers in order to identify whether advice was followed.[16]

2.12 The committee asked for information concerning the funding formula for Medicare Locals based on characteristics from individual Medicare Local communities.[17] Officers explained that a number of characteristics were taken into account including: age, socioeconomic status, English as a second language and Indigenous population.[18] The funding formula is population based.[19]

Mental Health

2.13 The committee asked officers about the reduction in the number of treatment sessions available for Better Access and whether there are any other current programs that will be able to replace the need for services created by the changes that take effect on 1 January 2013.[20] Officers identified several programs that would be able to achieve this:

> Some of the programs that will meet the needs of those patients include the Partners in Recovery measure, [...] the expansion of the Support for Day to Day Living in the Community program, [...] and the early Psychosis Prevention and Intervention Centre program.[21]

13 *Proof Estimates Hansard,* 15 February 2012, pp. 22–23.

14 *Proof Estimates Hansard,* 15 February 2012, p. 30.

15 *Proof Estimates Hansard,* 15 February 2012, p. 30.

16 *Proof Estimates Hansard,* 15 February 2012, pp. 30–31.

17 *Proof Estimates Hansard,* 15 February 2012, p. 35.

18 *Proof Estimates Hansard,* 15 February 2012, p.35.

19 *Proof Estimates Hansard,* 15 February 2012, p.35.

20 *Proof Estimates Hansard,* 15 February 2012, p. 43.

21 *Proof Estimates Hansard,* 15 February 2012, p. 43.

2.14 In addition, officers stated that funding for the Access to Allied Psychological Service (ATAPS) program has been more than doubled and that:

> ...both Better Access and ATAPS have the same client group. A decision about whether a client should be referred to Better Access or to ATAPS would need to take into account what the needs of the client were. ATAPS has been specifically designed and developed to complement Better Access and to deliver psychological services and other allied therapy services to people who would not otherwise be able to access them under Better Access. It particularly targets the hard-to-reach groups like rural and remote people, people in low socioeconomic positions, and Aboriginal and Torres Strait Islanders.[22]

2.15 Officers updated the committee on actions taken after a number of suicides in Mount Isa. The department held community forums at the end of 2011 and created a suicide prevention coordination group. A group was established by the Commonwealth and the Queensland governments to work on a local action plan.[23] A critical response service was provided by a locally based organisation called United Synergies and a final report issued by StandBy is being assessed. [24]

2.16 The department later added that Queensland Health has staff based at Mount Isa, that includes relevant mental health counselling qualified staff. A suicide prevention group also operates in Mount Isa.[25]

Hearing Services

2.17 The committee sought information on hearing aid usage, noting that some hearing aids supplied are often not used. Using a National Acoustics Laboratory additional analysis of client surveys, officers corrected a previous statistic of hearing aid non usage of 30 per cent to being approximately 13 per cent.[26]

National E-Health Transition Authority

2.18 The committee had queried surrounding the introduction of personally controlled e-health records. The committee sought clarification on whether the problems occurring within the smaller e-health system being trialled by NeHTA, which is not personally controlled and has a small number of health records, would be exacerbated when the more complex, personally controlled system is introduced.[27] Mr Peter Fleming, Chief Executive Officer of the National E-Health Transition Authority,

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22 *Proof Estimates Hansard,* 15 February 2012, p. 43.

23 *Proof Estimates Hansard,* 15 February 2012, p. 53.

24 *Proof Estimates Hansard,* 15 February 2012, p. 54.

25 *Proof Estimates Hansard,* 15 February 2012, p. 94.

26 *Proof Estimates Hansard,* 15 February 2012, p.65.

27 *Proof Estimates Hansard,* 15 February 2012, p. 72.

reassured the committee that the issues arising were due to the testing of the specifications.[28] This testing is done to ensure that problems such as the one that was found do not arise later in the more complex system:

> It is very early days. It is not yet in production. That is the reason why we are doing it in those early wave sites, to pick up and make sure it is scalable. We are not implementing a component of it; we are doing the full build with them to see how it works in a local environment and therefore how it will scale.[29]

Cancer Australia

2.19 The committee asked the department if any resources had been provided towards prostate cancer screening. Associate Professor Christine Giles, Executive Director of Cancer Australia, informed the committee that it had received $3.97 million over three years to 2014.[30] This funding will help provide national evidence based information, resources and psychological support for men and their families who are affected by prostate cancer.[31]

National Health and Medical Research Council

2.20 The committee asked officers to clarify the Australian Dietary Guidelines report, particularly with regards to the research that the report was based on, the public consultation process and the manner in which information is communicated.[32] It was noted that the report was based on international best practice standards and it has undergone extensive review. Professor Warwick Anderson, Chief Executive Officer of the National Health and Medical Research Council stated:

> The important thing here is that there was an extraordinary amount of work to get to these guidelines. All the recommendations were built on all the work that was put together for the 2003 guidelines. Then 55,000 pieces of additional published peer-reviewed research since 2003 were analysed by our expert groups, all graded in terms of the evidence in support of it, and then that ranked A, B, C, or D, depending on the strength. Any of the recommendations in there are based on level A or level B evidence. I am not the expert, but I can assure you that the work that underpins any of these recommendations is extremely—I was going to say dense—well done.

28 *Proof Estimates Hansard,* 15 February 2012, p. 72.

29 *Proof Estimates Hansard,* 15 February 2012, p. 72.

30 *Proof Estimates Hansard,* 15 February 2012, p. 75.

31 *Proof Estimates Hansard,* 15 February 2012, p. 75.

32 *Proof Estimates Hansard,* 15 February 2012, pp. 78–79.

> One of the reasons for putting this out to public consultation is that, not only does our act require it, but we always know that people pick up things. Committees are looking intensely at the evidence.[33]

2.21 The department added that in order for the Guidelines to be successful, they need to be easily comprehensible for consumers and that the public consultation process aids this goal.[34]

Australian Radiation Protection and Nuclear Safety Agency

2.22 The committee noted that while processes unfold around a nuclear waste dump in central Australia, nuclear material is coming back from Europe and being stored temporarily in Sydney.[35] Dr Carl-Magnus Larsson, Chief Executive Officer of the Australian Radiation Protection and Nuclear Safety Agency, told the committee that the work ARPANSA is currently undertaking covers both the storage of the nuclear material as well as its disposal.[36]

Food Standards Australia New Zealand

2.23 The committee sought clarification as to why the use of the chemical carbendazim has been banned for Citrus growers in Australia for two years, and yet Australia accepts orange juice imports from Brazil that can contain up to 10 parts per billion Maximum Residue Limits (MRL).[37] Mr Steve McCutcheon, Chief Executive Officer of Food Standards Australia New Zealand, explained that there are also chemicals used in Australia that are not used in some of its export markets and as a result Australia seeks import tolerances in those markets.[38]

Population Health

2.24 The committee queried officers as to the international response regarding the implementation of plain-packaging procedures for tobacco.[39] The department responded that there had been a large amount of international interest and support:

> We are definitely a world leader with this particular initiative, as I think is well known and acknowledged. [...] We have had a great deal of support from a number of countries that are similarly tackling some of these issues [...].[40]

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33 *Proof Estimates Hansard,* 15 February 2012, p. 78.

34 *Proof Estimates Hansard,* 15 February 2012, p. 79.

35 *Proof Estimates Hansard,* 15 February 2012, p. 103.

36 *Proof Estimates Hansard,* 15 February 2012, p. 103.

37 *Proof Estimates Hansard,* 15 February 2012, p. 108.

38 *Proof Estimates Hansard,* 15 February 2012, p. 108.

39 *Proof Estimates Hansard,* 15 February 2012, p. 121.

40 *Proof Estimates Hansard,* 15 February 2012, p. 121.

Workforce Capacity

2.25 The committee sought information on the criteria used in addition to the national average of medical practitioners per capita to determine if a location is categorised as having a district workforce shortage (DWS).[41]

2.26 Officers explained that DWS is defined as a location where there is less access to medical services rather than medical practitioners compared to the national average:

> This is worked out by using ABS population data for an area and comparing that to Medicare billing data. The district of workforce shortage will be an area where the Medicare billing per population is below the national average.[42]

Biosecurity and Emergency Response

2.27 The committee discussed the closure of TB clinics in the Torres Strait Islands, particularly noting the effects this would have on TB patients arriving from Papua New Guinea. [43] Professor Chris Baggoley, Chief Medical Officer for the Department of Health and Ageing, explained that it is important for Papua New Guineans to receive treatment in their local communities rather than in the Torres Strait in order to reduce drug resistant TB:

> The concern is that the best treatment for tuberculosis is what is called directly observed treatment, which can only occur when someone is being treated within their local community [...] when someone goes offshore to get their medication and takes some of it but in fact is not observed to take it because they are not part of a treatment program, they may then either discontinue taking the treatment or provide that medication for others. [...] That is the greatest risk for developing multi drug resistant TB.[44]

Death of Jenny Bryant

2.28 The committee took the opportunity to offer its commiserations to the staff of the department and the family of Ms Jenny Bryant who passed away on 20 January 2012. The committee remembered Ms Bryant by her compassion, intelligence, patience and focus.

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41 *Proof Estimates Hansard,* 15 February 2012, p. 131.

42 *Proof Estimates Hansard,* 15 February 2012, p. 131.

43 *Proof Estimates Hansard,* 15 February 2012, p. 132.

44 *Proof Estimates Hansard,* 15 February 2012, p. 132.