Chapter 2
Health Portfolio

Department of Health

2.1 This chapter outlines key issues discussed during the 2015–2016 additional estimates hearings for the Health portfolio.

2.2 Areas of the portfolio and agencies were called in the following order:

- Whole of Portfolio/Corporate Matters
- Australian Institute of Health and Welfare
- Access to Medical and Dental Services
- Primary Health Care
- National Mental Health Commission
- Medicare Locals transitioning to Primary Health Networks (PHNs)
- Ageing and Aged Care
- Private Health
- Access to Pharmaceutical Services
- Health System Capacity and Quality
- Organ and Tissue Authority
- Therapeutic Goods Administration
- National Industrial Chemicals Notification and Assessment Scheme (NICNAS)
- Population Health
- National Health and Medical Research Council
- Acute Care
- Sports and Recreation
- Australian Sports Commission (ASC)
- Australian Sports Anti-Doping Authority (ASADA)
- Food Standards Australia New Zealand (FSANZ)

Whole of Portfolio/Corporate Matters

2.3 Proceedings commenced with questions regarding a report in the *West Australian* newspaper that the Department of Health (department) is undertaking analysis around the payment systems of Medicare and aged care. The department confirmed that it is undertaking work into improving the payments system and that it has 'gone to market to engage consultants'.[1]

Outcome 3 Access to Medical and Dental Services

2.4 The committee sought clarification on the work the department is undertaking in reviewing bulk-billing incentives for diagnostic imaging and pathology. The department told the committee it does not expect to see a significant change in the costs of pathology tests as a result of changes to bulk billing. Mr Andrew Stuart, Deputy Secretary said:

> [O]ur understanding is that bulk-billing rates tend to be driven in a significant degree by work force supply and by competition. Pathology and diagnostics are both highly competitive sectors with good supply in the marketplace. In particular, in pathology the bulk-billing rates, if you don't include the in-hospital services, have been in the high 90 per cents for a considerable period of time. There was no discernible effect at the time the bulk-billing incentive was implemented. We, therefore, don't see the likelihood of any significant movement in the bulk-billing rate from the removal of what is actually a relatively minor payment in the grand scheme of things for pathology.[2]

2.5 Senator Gallagher asked the department whether there would be a difference in impact between metropolitan and regional areas. The department said there is no basis for expecting a marked difference and noted that in rural areas most testing is undertaken by the regional public hospital and is commonly provided free of charge.[3]

Outcome 5 Primary Health Care

2.6 The department was asked to provide the committee with an update on the transition from Medicare Locals to PHNs. The committee heard that the total cost for closing the Medicare Locals was $44 million and that all the contracts are now in place for the 31 PHNs, which are funded for three years.[4] The department also outlined the main difference in the role of the PHN to the former Medicare Locals:

> The main difference is that they undertake a commissioning role. The former Medicare Locals undertook a range of contracting functions and they also undertook direct service delivery. Many of the former Medicare Locals, in addition to their overarching kind of coordinating planning and integrating role with the primary healthcare sector, actually ran and

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1 *Proof Committee Hansard*, 10 February 2016, p. 14.

2 *Proof Committee Hansard*, 10 February 2016, p. 29.

3 *Proof Committee Hansard*, 10 February 2016, pp 29–30.

4 *Proof Committee Hansard*, 10 February 2016, pp 58–59.

> delivered services. Under the new arrangements that direct service delivery function ceases and they become commissioners. I guess commissioning is really a more strategic approach to procurement, and so the PHNs need to do a very detailed needs assessment population health planning. They need to do a detailed market analysis and then they are required to go out to the market to test the market for the particular services that they will be commissioning. That is quite a different feature to the role undertaken by the Medicare Locals.[5]

Outcome 11 Ageing and Aged Care

2.7 Senators sought clarification about the $472 million measure designed to address non-compliance related to the Aged Care Funding Instrument. The department said that the measure is not a cut to funding, and that funding continues to grow for that Instrument.[6] Mr Nick Hartland, First Assistant Secretary, Aged Care Policy and Reform Group, explained how the measure will work:

> The $472 million measure changes the way in which the instrument that providers use to assess needs works, so it makes the criteria to get to a higher level of funding more stringent and it responds to the fact that we have seen growth in one area of the needs assessment instrument that did not appear to us to be caused by an underlying increase in need. That helps moderate the growth that we are seeing in the outlays. In addition, at the same time, the government announced some measures to increase its scrutiny and compliance and the scrutiny of those scoring processes in order to make sure that they were being properly administered by aged-care providers.[7]

Outcome 2 Access to Pharmaceutical Services

2.8 The committee discussed the delisting of medicines that are available both over-the-counter and through a Pharmaceutical Benefits Scheme (PBS) prescription as part of a savings measure estimated to save $513 million over the five years of the agreement.[8] The department explained the analysis behind the delisting savings measure:

> As part of implementing that measure, the departments and the government sought advice from the Pharmaceutical Benefits Advisory Committee about any clinical issues that were associated with delisting any of the over-the-counter medicines. So the Pharmaceutical Benefits Advisory Committee developed some principles which were considered at its July meeting. That is where it recommended that over-the-counter medicine should remain available for certain patient groups like Aboriginals and Torres Strait Islanders; in some cases, palliative care patients; quadriplegics; and paraplegics. Another principle it recommended was not delisting medicines

5 *Proof Committee Hansard*, 10 February 2016, p. 60.

6 *Proof Committee Hansard*, 10 February 2016, p. 90.

7 *Proof Committee Hansard*, 10 February 2016, p. 89.

8 *Proof Committee Hansard*, 10 February 2016, p. 109.

> that were available over the counter or considered available over the counter because they were not scheduled by states and territories as scheduled poisons, but generally they were provided in hospitals, so intravenous drugs and things like that, and also drugs that were primarily used in emergency situations, like adrenalin and Ventolin.
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> The other principle that the PBAC advised is that drugs should only be delisted if access would be unlikely to change appreciably in the absence of a PBS subsidy.[9]

2.9 Senator Gallagher sought clarification as to whether the measure was intended to reduce the cost of some medicines for patients. Ms Penny Shakespeare, First Assistant Secretary, Pharmaceutical Benefits Division said:

> I do not think that the case was ever that the PBAC advised that medicines should only be delisted if no patient was ever going to pay any more. In terms of what they considered affordable, they referred to the ex-manufacturer price for over-the-counter drugs and advised that where the ex- manufacturer price—which is not the price paid by the patient; it is the manufacturer selling to wholesalers or retailers—was below the concessional patient co-payment, which at the time was $6.10, then those were medicines that were suitable to be delisted.[10]

2.10 The committee heard that in some cases, administration, handling and dispensing fees were leading to a situation where the medicine, if purchased with a PBS script, cost the government and the patient more money than if it was purchased over-the-counter. The department gave the example of aspirin 100 milligram tablets:

> For a concessional payment patient we would pay a total cost of $11.68 under the PBS. That includes a $6.20 co-payment from the patient and $5.48 payment by the Commonwealth for things like dispensing and the administration by the pharmacists. Over the counter, usually those medicines would cost about $3 or $4.[11]

Outcome 7 Health System Capacity and Quality

2.11 The Therapeutic Goods Administration (TGA) was asked questions on the reclassification of codeine and medicinal cannabis. The committee heard that the TGA has commenced a review into the scheduling of codeine to consider giving it a higher classification. The TGA also confirmed that the government announcement on 10 February 2016 about the framework to facilitate access to medicinal marijuana is focussed on production and manufacturing and that rescheduling the drug is another matter.[12]

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9 *Proof Committee Hansard*, 10 February 2016, pp 109–110.

10 *Proof Committee Hansard*, 10 February 2016, p. 110.

11 *Proof Committee Hansard*, 10 February 2016, p. 111.

12 *Proof Committee Hansard*, 10 February 2016, pp 115–117.

Outcome 1 Population Health

2.12 Senators inquired into the recommendations of the Ice Task Force and the programs that are being rolled out as a result. The department told the committee that the Ice Task Force's recommendations include an expansion of funding for drug and alcohol services more broadly, acknowledging that people engage in polydrug use. The committee heard that of the $300 million in funding, $241.5 million will be allocated to PHNs from 1 July 2016 and that implementation work is underway to develop program guidelines for PHNs in relation to service funding.[13] Dr Wendy Southern PSM, Deputy Secretary told the committee:

> There will be a set of program guidelines around what the funding is intended to do. The PHNs are doing their needs analyses at the moment and you would expect that depending on the population needs of a particular PHN there might be variation in the services they are delivering. But as long as they are within those broad program guidelines and they are meeting the needs of their target populations then you would expect there would be some variation. But we want to be flexible in how it is rolled out.[14]

2.13 Food Standards Australia New Zealand (FSANZ) was asked to clarify answers provided at the Budget Estimates regarding potential conflict of interest of members of the expert panel on New Plant Breeding Techniques workshop. FSANZ told the committee they take conflict of interest very seriously but also that all experts engaged have 'some connection or involvement with research work and scientific work in this area'.[15]

2.14 The findings of the report produced by the New Plant Breeding Techniques workshop were also discussed. FSANZ told the committee that the findings were that 'some techniques do not produce that result and therefore are not the subject of the code at present and the subject of the framework for dealing with [genetically modified] foods, while other techniques are likely to result in that'.[16]

Outcome 4 Acute Care

2.15 The department was asked to provide an update on the funding arrangements beyond the current agreement for Mersey Hospital in Tasmania. The committee heard that funding expires on 30 June 2017 and that no formal discussions have commenced. However, the department indicated that if the Tasmanian Government wished to make changes to the current agreement in order to align the hospital with their state-wide strategy, then the Commonwealth is willing to accommodate sensible changes within the existing policy.[17]

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13 *Proof Committee Hansard*, 10 February 2016, pp 124–126.

14 *Proof Committee Hansard*, 10 February 2016, p. 126.

15 *Proof Committee Hansard*, 16 March 2016, p. 4.

16 *Proof Committee Hansard*, 16 March 2016, pp 6–7.

17 *Proof Committee Hansard*, 10 February 2016, pp 6–7.

Outcome 10 Sports and Recreation

2.16 A number of senators asked questions of the Australian Sports Anti-Doping Authority (ASADA) regarding ASADA's involvement in court and tribunal decisions in relation to the imposition of bans on current and former Essendon Football Club (Essendon) players for the use of a prohibited substance. In January 2016, 34 players were found guilty of taking the banned substance thymosin beta-4 during the 2012 season as the Court of Arbitration for Sport upheld the appeal lodged by the World Anti-Doping Agency. The committee heard that all 34 players said they received injections and signed a consent form for various substances including thymosin beta-4.[18] When asked whether the players were told that the substance was legal, Mr Ben McDevitt, Chief Executive Officer of ASADA, gave the following response:

> There have been various accounts about exactly what players were or were not told…ultimately the onus rests always on the individual. If they were unsure then they should have sought advice from their doctor. Their doctor gave evidence to say that none of them did.[19]

2.17 Mr McDevitt said he made the decision to refer the matter to the World Anti-Doping Agency to initiate an appeal to the Court of Arbitration for Sport because it would save almost $1 million of Commonwealth funds.[20] The committee heard that the total cost of Operation Cobia, the investigation into the taking of banned substances which resulted in show cause notices being issued to the Essendon players as well as 19 National Rugby League players, has been $5.947 million. This included the Federal Court cases and appeals by Mr James Hird (former senior coach of Essendon) and Essendon. However, ASADA has recovered $1.26 million of those costs from Mr Hird and Essendon.[21]

18 *Proof Committee Hansard*, 3 March 2016, p. 22.

19 *Proof Committee Hansard*, 3 March 2016, p. 22.

20 *Proof Committee Hansard*, 3 March 2016, p. 19.

21 *Proof Committee Hansard*, 3 March 2016, p. 25.