The Senate

Community Affairs Legislation Committee

Additional estimates 2015-16

April 2016

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Membership of the Committee

44th Parliament

Members

Senator Zed Seselja, Chair	LP, Australian Capital Territory
Senator Rachel Siewert, Deputy Chair	AG, Western Australia
Senator Carol Brown	ALP, Tasmania
Senator Katy Gallagher (from 12/11/2015)	ALP, Australian Capital Territory
Senator Bill Heffernan (4/2/2016 – 15/3/2016)	LP, New South Wales
Senator David Johnston (4/2/2016 – 23/2/2016)	LP, Western Australia
Senator Jo Lindgren (15/6/2015 – 4/2/2016 then from 23/2/2016	LP, Queensland
Senator James Paterson (from 15/3/2016)	LP, Victoria

Substitute Members

Senator Jo Lindgren (10/2/2016 – 11/2/2016)	LP, Queensland
Senator Claire Moore (11 February 2016)	ALP, Queensland

Senators in attendance

Senator Zed Seselja (Chair), Senator Rachel Siewert (Deputy Chair), Senator Carol Brown, Senator Katy Gallagher, Senator Bill Heffernan, Senator Dean Smith, Senator the Hon. Doug Cameron, Senator the Hon. Concetta Fierravanti-Wells, Senator Richard Di Natale, Senator the Hon. Mitch Fifield, Senator Jacqui Lambie, Senator David Leyonhjelm, Senator Joanna Lindgren, Senator Scott Ludlam, Senator John Madigan, Senator Gavin Marshall, Senator Claire Moore, Senator the Hon. Fiona Nash, Senator the Hon. Marise Payne, Senator Nova Peris, Senator Helen Polley, Senator Deborah O'Neill, Senator Linda Reynolds, Senator Lee Rhiannon, Senator Janet Rice, Senator Robert Simms, Senator Dean Smith, Senator Nick Xenophon.

Chapter 1

Introduction

1.1 On 12 May 2015, the Senate referred the following documents to the committee for examination and report:

- particulars of proposed expenditure in respect of the year ending on 30 June 2016;
- particulars of certain proposed expenditure in respect of the year ending on 30 June 2016;
- particulars of proposed expenditure in relation to the parliamentary departments in respect of the year ending on 30 June 2016;
- particulars of proposed additional expenditure in respect of the year ending on 30 June 2015; and
- particulars of certain proposed additional expenditure in respect of the year ending on 30 June 2015.

1.2 The committee is responsible for the examination of the following portfolios:

- Health;
- Social Services; and
- Human Services.

Details of hearings

1.3 The hearings were conducted as follows:

- 10 February 2016 — Health portfolio;
- 11 February 2016 — Social Services portfolio (including Human Services);
- 3 March 2016 — Health portfolio additional hearing; and
- 16 March 2016 — Health portfolio additional hearing.

1.4 The committee heard evidence from the following Senators:

- Senator the Hon. Fiona Nash, Assistant Minister for Health (and representing the Minister for Health);
- Senator the Hon. Marise Payne, Minister for Defence (and representing the Minister for Human Services);
- Senator the Hon. Mitch Fifield, Assistant Minister for Social Services (representing the Minister for Social Services); and
- Senator the Hon. Concetta Fierravanti-Wells, Parliamentary Secretary to the Minister for Social Services (representing the Minister for Social Services).

1.5 Evidence was also provided by the following:

- Mr Martin Bowles PSM, Secretary of the Department of Health;
- Ms Kathryn Campbell, Secretary of the Department of Human Services;
- Mr Finn Pratt, Secretary of the Department of Social Services; and
- officers representing the departments and agencies covered by the estimates before the committee.

Questions on notice

1.6 In accordance with Standing Order 26(9)(a), the committee agreed that the date for the return of answers in response to questions placed on notice at the 10 and 11 February hearings would be 4 April, for 3 March would be 14 April and for 16 march would be 27 April 2016.

1.7 Answers to questions on notice and tabled documents may be accessed via the committee's website: http://www.aph.gov.au/senate_ca.

Hansard transcripts

1.8 *Hansard* transcripts of the estimates proceedings are accessible on the committee's website.

1.9 An index of topics covered by Hansard page number is available at Appendix 2.

1.10 References to the Hansard transcript are to the proof Hansard; page numbers may vary between the proof and the official Hansard transcript.

Changes in the PAES

Health Portfolio

1.11 In the Administrative Arrangement Orders of 21 September 2015 and 30 September 2015, the government announced the following changes to portfolio responsibilities:

- Ageing and aged care functions were transferred from the Department of Social Services to the Department of Health.
- The statutory officer of the Aged Care Commissioner and the Aged Care Pricing Commissioner were transferred to the Department of Health.
- The Medicare Provider Compliance for the Medicare Benefits Schedule and Pharmaceutical Benefits Schedule and allied health services were transferred to the Department of Health from the Department of Human Services.[1]
- Child care policy and programs and coordination of early childhood development policy to the Department of Education and Training.[2]

1 Portfolio Additional Budget Statements 2015–16 Health Portfolio, p. 3.

2 Portfolio Additional Budget Statements 2015–16 Social Services Portfolio, p. 3.

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.
>
> 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.

Chapter 3

Social Services Portfolio (including Human Services)

Department of Social Services

3.1 This section outlines key issues discussed during the 2015–2016 additional estimates hearings for the Social Services Portfolio.

3.2 Areas of the portfolio were called in the following order:

- Cross Outcomes/Corporate Matters/Grant Programs
- Social Security
- Disability and Carers
- National Disability Insurance Agency
- Families and Communities
- Australian Institute of Family Studies
- Housing

Cross Outcomes/Corporate Matters/Grant Programs

3.3 The Department of Social Services (department) grant tendering process was discussed. The department was asked whether it has a process in place to gauge community feedback of service gaps arising from the grants tendering process. The committee heard that the data exchange reporting system will provide information on the client footprint and client outcomes and that the department intends to build a client survey into the system. The department said all service providers with grant agreements have signed up to the data exchange and that an activity work plan is attached to all grant agreements. The work plans set out agreed performance indicators as part of ongoing reporting that will feed into a holistic understanding of the service system.[1]

3.4 Senator Moore inquired into advertising campaigns the department has run since the 2013 election. The department said there are currently two campaigns in the development stage. One is for the prevention of violence against women, which is a COAG campaign, and the other is for the National Disability Insurance Scheme (NDIS). The Commonwealth is contributing $16.7 million to the prevention of violence against women campaign over three years and is spending $14.2 million over two years for the NDIS campaign.[2]

Outcome 1 Social Security

3.5 The committee sought an update on the actuarial valuation of the lifetime liability of Australia's welfare system, examining both longitudinal data and future

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1 *Proof Estimates Hansard*, 11 February 2016, pp 10–11.

2 *Proof Estimates Hansard*, 11 February 2016, pp 14–15.

projections. The department has engaged PricewaterhouseCoopers to produce four valuations—a baseline valuation and three subsequent valuations, to provide three additional development modules, and to facilitate knowledge transfer to the department. The contract is worth $9.4 million over four years. The department has been provided with a final draft evaluation.[3]

3.6 The committee inquired into trends and projections of social welfare payments and heard that social welfare expenditure overall is growing and that the key growth area is care services. The NDIS is one of the key drivers of growth in expenditure. The department confirmed that working age payments are in decline as a result of a number of factors, including overall population growth, fertility rates, migration, population ageing, wages, prices, and economic growth.[4]

Outcome 5 Disability and Carers

3.1 The committee sought an update on the rollout of the NDIS. The committee heard that as a result of the bilateral agreements that have been made with New South Wales, Victoria, South Australia, Tasmania and the Australian Capital Territory, 64 per cent of the eligible population for NDIS in Australia is now covered. The Commonwealth is currently negotiating with Queensland and the Northern Territory.[5] The Chair asked the department how the bilateral agreements will mitigate the Commonwealth's financial risk. The department explained that the current bilateral agreements are more detailed than the trial agreements and that specific numbers of participants and financial contributions have been agreed based on more analysis into disaggregated costs.[6] The bilateral agreements are based on the Productivity Commission's estimates for participants. Ms McDevitt, Group Manager, NDIS, gave the following explanation:

> The Productivity Commission said that at full scheme there would be around 460,000 people in the NDIS. So we are working on those scheme estimates. You may recall that in 2017 the Productivity Commission will be undertaking a review of all their cost estimates for the scheme. So we are still working on the original estimates. For example, in New South Wales, I said their estimate was for 140,000 people. In South Australia, it is for 32½ thousand people. That is what we have reflected in the bilateral agreements.[7]

Outcome 2 Families and Communities

3.2 Proposed changes to eligibility for paid parental leave (PPL) announced in the Mid-Year Economic Fiscal Outlook were discussed. The measure will allow for primary carers who receive employer paid parental leave to be eligible for a top up

3 *Proof Estimates Hansard*, 11 February 2016, pp 26–28.

4 *Proof Estimates Hansard*, 11 February 2016, pp 31–32.

5 *Proof Estimates Hansard*, 11 February 2016, p. 52.

6 *Proof Estimates Hansard*, 11 February 2016, p. 53.

7 *Proof Estimates Hansard*, 11 February 2016, p. 53.

payment, paid at the national minimum wage, for the difference in weeks between the employer scheme and the 18 weeks provided by Government.[8] This replaces the Budget measure titled *Removing Double-Dipping from Parental Leave Pay* that proposed a similar top up scheme, up to a capped amount of $11,640 instead of a number of weeks.[9] The department said that the proposed measure will result in 7,000 carers, or four per cent of mothers, not receiving any PPL due to having an employer scheme of at least 18 weeks, as opposed to 34,000 carers under the Budget measure.[10]

Outcome 4 Housing

3.3 The committee asked for comment about delays to payments under the National Rental Affordability Scheme. The department explained that it has 'processed every application for an incentive that is compliant with the regulations for last year, 2014–14'. There are still 4,443 applications which are either non-compliant or for which the department requires additional information. The main reasons for non-compliance were identified as market rent valuations being incorrect, or late, or not in respect of a relevant period, as well as overcharging of rent.[11]

Department of Human Services

3.4 This section contains key issues discussed during the 2015–2016 additional hearing for the Human Services portfolio.

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

- Australian Hearing
- Whole of Department—Corporate Matters

Australian Hearing

3.6 Senator Cameron commenced with a series of questions about the services that Australian Hearing provide. The committee was told that last financial year Australian Hearing provided 510,000 services to 161,000 active clients and that 10 per cent of their clients, roughly 16,000, are returned veterans.[12] In response to questions from Senator Cameron, Australian Hearing indicated that they have had no discussions with the Minister's office in relation to the scoping study; that they continued to meet their KPI's; and that they were profitable and could compete with any provider.[13]

3.7 Clarification was sought regarding the five per cent reduction to the community service obligation budget of Australian Hearing—currently $65.5

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8 Mid-Year Economic Fiscal Outlook 2015–16, 'Appendix A: Policy decisions taken since the 2015–16 Budget', p. 216.

9 *Proof Estimates Hansard,* 11 February 2016, p. 76.

10 *Proof Estimates Hansard,* 11 February 2016, pp 76–77.

11 *Proof Estimates Hansard,* 11 February 2016, p. 94.

12 *Proof Estimates Hansard,* 11 February 2016, p. 98.

13 *Proof Estimates Hansard,* 11 February 2016, pp 98–102.

million—and whether this would lead to greater efficiency. Australian Hearing told the committee that they believe they are operating at a 'reasonably effective level' presently and that the saving will 'probably' mean fewer people will receive services.[14]

Department of Human Services

3.8 The committee asked the Department of Human Services (DHS) about issues with the Centrelink payment system and the Centrelink website. The committee heard that DHS had incorrectly issued debt statements to 73,000 families in January when it was rolling out the No Jab, No Pay measures. DHS told the committee the incorrect statements were the result of a 'computer glitch', which had been rectified quickly. DHS advised the committee that no one was out of pocket as a result of the error.[15]

3.9 The committee inquired into the usability of the MyGov website. DHS told the committee that the number of transactions on the MyGov website had increased from 138 million in September 2015 to 234 million in December 2015 and that users experienced an error rate of 0.13 per cent.[16] DHS also detailed past and proposed changes to the process for logging into the website to improve usability while maintaining the security of the website. DHS is investigating options to allow users more choice in determining their user identification. DHS also informed the committee that is it taking the lead on a whole-of-government project called Digital ID, which will allow people to prove their identity through an online Document Verification Service.[17]

3.10 The committee discussed wait times of the Centrelink phone line and the availability of the call-back service. Discussion revealed that the call-back service is currently unavailable due to some technological issues that have been ongoing since July 2015. DHS advised that it has addressed an issue in the telecommunications system which had resulted in incorrect approximate wait times being given to customers.[18]

14 *Proof Estimates Hansard*, 11 February 2016, p. 100.

15 *Proof Estimates Hansard*, 11 February 2016, pp 105-106.

16 *Proof Estimates Hansard*, 11 February 2016, p. 106.

17 *Proof Estimates Hansard*, 11 February 2016, pp 108–109.

18 *Proof Estimates Hansard*, 11 February 2016, p. 127.

3.11 The committee heard that DHS is currently testing a new telecommunications system and that the new system will feature a mechanism to analyse the reasons for people's calls in order to customise pre-emptive actions such as messages on the website and on social media advising people about answers to frequently asked questions.[19] DHS also said that as part of the Welfare Payment Infrastructure Transformation program, it is building an application to reduce the number of phone calls. Ms Kathryn Campbell, Secretary, DHS, told the committee:

> …as part of WPIT tranche 1, we are building an application which will give people an insight into where we are up to with processing their claim."[20]

3.12 Senator Cameron also raised concerns about the following issues:

- complaints from staff in relation to filling permanent positions and recruitment processes;[21]
- Centrelink being in a position to tender for continued delivery of the Medicare payments with a new Medicare Payment System;[22] and
- consumer leases.[23]

3.13 DHS was asked about the decision to close the Centrelink-Medicare service centre in Kingston, Tasmania. DHS told the committee that the Centrelink component at the Kingston service centre was a service for small claims only and that people with complex claims were redirected to Hobart. DHS said that simple Centrelink claims and tasks are now mostly processed over the phone or internet and, as a result, there has been a reduction in the number of people visiting Medicare offices. DHS confirmed that the centre will be closed on 4 March 2016.[24]

Senator Zed Seselja

Chair

19 *Proof Estimates Hansard*, 11 February 2016, pp 122–123.

20 *Proof Estimates Hansard*, 11 February 2016, p. 123.

21 *Proof Estimates Hansard*, 11 February 2016, p. 130.

22 *Proof Estimates Hansard*, 11 February 2016, p. 115.

23 *Proof Estimates Hansard*, 11 February 2016, p. 135.

24 *Proof Estimates Hansard*, 11 February 2016, pp 120–121

Appendix 1

Departments, entities and companies that appeared before the Committee[1]

Health Portfolio

- Department of Health
- Australian Institute of Health and Welfare
- Australian Organ and Tissue Authority
- Australian Sports Anti-Doping Authority
- Australian Sports Commission
- Food Standards Australia New Zealand
- National Health and Medical Research Council
- National Industrial Chemicals Notification and Assessment Scheme
- National Mental Health Commission
- Therapeutic Goods Administration

Social Services Portfolio (including Human Services)

- Department of Social Services
- Australian Institute of Family Studies
- National Disability Insurance Agency
- Department of Human Services
- Australian Hearing

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1 This document has been prepared based on the Department of Finance's *Flipchart of Commonwealth entities and companies* under the *Public Governance, Performance and Accountability Act 2013* as at 30 September 2015, http://www.finance.gov.au/sites/default/files/pgpa_flipchart.pdf?v=2 (accessed 22 February 2016)

Appendix 2

Index to Hansard Transcripts[1]

Page no.

Wednesday, 10 February 2016

Health Portfolio

1 Hansard page numbers referred to in this appendix are based on proof Hansards. Page numbers may vary slightly in the final official Hansard transcripts.

Thursday, 11 February 2016

Social Services Portfolio (including Human Services

Wednesday, 16 March 2016

Health Portfolio