# Chapter 2
# Health Portfolio

## Department of Health

2.1 This chapter outlines key issues discussed during the 2015–2016 budget 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
- Primary Health Care
- National Mental Health Commission
- Medicare Locals
- GP Superclinics
- Acute Care
- Independent Hospital Pricing Authority
- Access to Medical and Dental Services
- Private Health
- Private Health Insurance Administration Council
- Private Health Insurance Ombudsman (PHIO)
- Access to Pharmaceutical Services
- Health Infrastructure, Regulation, Safety and Quality
- Organ and Tissue Authority
- Therapeutic Goods Administration
- National Blood Authority
- National e-Health Transition Authority (NeHTA)
- National Industrial Chemicals Notification and Assessment Scheme (NICNAS)
- Healthcare Workforce Capacity
- Population Health
- Cancer Australia
- National Health and Medical Research Council
- Food Standards Australia New Zealand (FSANZ)
- Sports and Recreation

- Australian Sports Commission (ASC)
- Australian Sports Anti-Doping Authority (ASADA)
- Australian Sports Foundation (ASF)

### *Whole of Portfolio/Corporate Matters*

2.3 The committee asked for details on the funding cuts to Flexible Funds. When asked whether all 16 flexible funds co-funded by the department will be affected, Mr Bowles said:

> That is the work that we will do over the next few months, working out exactly how we would attack every single fund through that process or every single program within there. I would expect that the majority will be but some may actually not be. So we will use the next couple of months to do that. As you would probably be aware, we have actually funded a whole range of these programs for the next 12 months for that very purpose, to actually do that. The funds and how the $596 million is actually calculated steps up over the four years. Basically there is a $57.8 million implication for the 2015-16 year and it builds up over the four years. So we have time to have a look at that, and all of the existing arrangements that we have in place can be honoured within that arrangement. We will work on it over the next couple of months to see how we do that.[1]

2.4 Small government initiatives were examined, with questions focussing on the merge of the Therapeutic Goods Administration's core corporate services into the department. When asked how many staff are going to be impacted, Professor Skerritt answered:

> …the main implication is actually a change in reporting lines, not termination of these jobs. For example, the IT people and the legal branch will now, instead of reporting to one of the first assistant secretaries who reports to me as a deputy, report to the first assistant secretaries who report to Ms Cosson here.[2]

2.5 Mr Bowles added:

> At the end of the day I do not see any great change in the numbers. If you have a look at what we have done over the last little while, the numbers have actually been coming down. We are this close to the number that we need to take forward. As we go forward in the latter part of the forward estimates, if you like, we will continue to step down. I think that is what you will see. But for the 2015-16 year I do not see any major change because we have actually made a concerted effort, over the last six months in particular, with our recruitment activities, to get to a number that is going to be sustainable for 2015-16. We are roughly around that number now.[3]

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1 *Proof Estimates Hansard*, 1 June 2015, p. 9

2 *Proof Estimates Hansard*, 1 June 2015, p. 37

3 *Proof Estimates Hansard*, 1 June 2015, p. 37

***Outcome 5 Primary Health Care***

2.6 Senator Wright asked the department about the transition from Medicare Locals to Primary Health Networks (PHN). The department was asked about the capacity for commencement on 1 July 2015 for the three applicants yet to be confirmed and Mr Cormack answered:

> The process of signing up the Primary Health Network arrangements is progressing well: 11 have signed up. Many more will follow very shortly. We have actively commenced the transition process from Medicare Locals through to PHNs. That matter is already under way. We believe there will be an orderly transition over the coming months. In relation to the three that have not yet been announced, we are very close to finalising those arrangements. We will be working both with the existing Medicare Locals that continue to provide the services that will be subsumed into the new PHNs and the new parties. We will make sure that there is no disruption to the support and the services they provide. We have a significant team of people who are working very closely right across the countryside to ensure that this transition takes place well and in a timely fashion.[4]

2.7 The committee asked the department what the role and purpose of the Primary Health Care Advisory Group (PHCAG) was. Mr Bowles explained:

> In relation to the Primary Health Care Advisory Group, what we are trying to do—and this was informed by all of those consultations—is to look for opportunities to reform primary healthcare to support better management of patients, particularly in the chronics and complex space. We are trying to make sure that Medicare and primary health care in those broader issues are sustainable into the future. We want to have a look particularly at the complex and chronic care conditions and at whether there are other ways of looking at those. Ultimately, that will look not only at models of care; it will look at the issues between the hospital sector and primary care and it will also look probably at some of the funding mechanisms that currently go to how we pay for services, particularly in that chronic disease space.[5]

2.8 Senator Reynolds then asked the department if PHCAG has a patient-focused review, similar to the NDIS model. Mr Bowles said:

> Yes; largely that is correct. If you have a look at some of the models of primary care around the world, some of them are enrolment based and some of them are quite specifically around chronic disease. There are different models. We want to have a look at all of those. A real conversation has started in the broader GP world around the enrolment model for families in GP practices and how you actually come up with funding. I think the one that really sticks out, though, is the chronic disease one. It starts usually with a GP, but it could end up with a physio [sic], some other allied health, someone who just facilitates the care, and a specialist because of certain activities that go on. So you end up with this very complex set of issues.

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4 *Proof Estimates Hansard*, 1 June 2015, p. 44

5 *Proof Estimates Hansard*, 1 June 2015, p 50

> We currently have things called care plans within the MBS. This is about taking that to another level and actually starting to think broadly about how we handle those patients. I think we will have opportunities to use the primary health networks, to be honest. I think the primary health networks are almost perfect timing for us to trial different ways of looking at this, which ultimately has to be about reducing admissions to public hospitals, because that is not the best way to deal with these people.[6]

### *Outcome 4 Acute Care*

2.9 Questions were asked about the Commonwealth agreement with the Northern Territory on the financing of the Palmerston Hospital. Senator Peris asked the department to respond to claims by the Northern Territory government that an extra $50 million was needed for the project. Ms Anderson responded:

> I am aware that there have been conversations between the Commonwealth and the Northern Territory in relation to this claim and we have looked closely at the claim. We can find no-one in the Commonwealth at a bureaucratic or political level who is aware of any discussion in that regard. We have also sought and received assurances from the Northern Territory government that they will, in fact, build the hospital with the amount available, the $150 million, and that it is still running on track to achieve practical completion in 2018… There is no knowledge within the Commonwealth of any discussion around $50 million and the Northern Territory makes its own decisions as to how it is going to deliver the project.[7]

### *Outcome 3 Access to Medical and Dental Services*

2.10 The committee asked about the Child Dental Benefits Schedule. The department was asked to explain how it will work. Ms Anderson said:

> It is a fee-for-service which is available to dentists in the public or private sector for provision of services to children between the ages of two and 17 who are rendered eligible by virtue of a range of criteria, including that they are a family receiving Family Tax Benefit A. There is an amount of $1,000 payable over two years. They obviously accumulate service value up to that cap over the two-year period. It is a benefit schedule, and so there are schedule fees associated with particular service items, dental items. A dentist providing services to a child who is eligible for CDBS claims the scheduled fee for that particular item.[8]

2.11 When asked what the behaviour of dentists will be if the Schedule is frozen, Ms Anderson answered:

> We have a very high fee observance among dentists delivering services to the eligible population. In other words, the vast majority bulk bill; 96.5 per cent of services have no out-of-pocket costs now. We do not expect that

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6 *Proof Estimates Hansard*, 1 June 2015, p. 51

7 *Proof Estimates Hansard*, 1 June 2015, p. 90

8 *Proof Estimates Hansard*, 1 June 2015, p. 98

> there is going to be a significant change by dentists to introduce a copayment by the patient to access those services. Presumably, patients and the families of children will make decisions in relation to where they access care.[9]

2.12 The committee inquired into the removal of the Healthy Kids Check provision. Senator Moore asked whether the department proposal was 'that you would be able to get the full services of what used to be a Healthy Kids Check with another appointment with the GP?'.[10] To which Mr Stuart said:

> Yes. You could always take your child to a doctor and use an ordinary GP item, but we would prefer to see parents taking their children to state and territory government child health and maternal services, which are set up with a range of cheques [sic] and are funded by states for doing so and which provide continuity of care over a period of time.[11]

2.13 Questions were asked about Australian Hearing's proposed privatisation and the committee heard that Minister Cormann announced a deferral of the consideration until late 2015 to allow further consultation, which will involve information sessions with relevant departments in the coming months.[12]

2.14 Senator Moore asked about funding to Cocklear implant processor upgrades. Asked how the amount of funding for Cocklear upgrades was determined, Ms Duffy answered:

> The government makes an appropriation every year to Australian Hearing and that is a capped amount of money that goes to Australian Hearing. Australian Hearing has the responsibility under its own legislation to use that money in an efficient and effective way across the different cohorts that are eligible to access that funding. In terms of Cochlear implant processor upgrades, that is a decision that Australian Hearing makes within its funding cap and also in recognition of when clients actually require an upgrade.[13]

### *Outcome 6 Private Health*

2.15 The committee inquried into the discussions of an expression of interest to have commercial operators provide health payments. The department indicated that the discussions have been deferred due to the review of the Medicare Benefits Scheme.[14]

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9 *Proof Estimates Hansard*, 1 June 2015, pp. 98–99

10 *Proof Estimates Hansard*, 1 June 2015, p. 110

11 *Proof Estimates Hansard*, 1 June 2015, p. 110

12 *Proof Estimates Hansard*, 1 June 2015, pp 117–118

13 *Proof Estimates Hansard*, 1 June 2015, p. 119

14 *Proof Estimates Hansard*, 1 June 2015, p. 124

2.16 The abolition of the Private Health Insurance Ombudsman was discussed. Senator McLucas asked the department what this will mean to PHIO, and Mr McGregor said:

> We are co-locating our offices for the Commonwealth Ombudsman and the Private Health Insurance Ombudsman, so we will have a few more staff in the office. It probably will not cause many changes in the short term, but in the longer term we would be expecting to combine our administration with the Commonwealth Ombudsman.[15]

2.17 Mr Porter added:

> Part of the policy intent of the transition is to generate efficiencies in corporate functions, as has been discussed throughout the day. That is going to be achieved through a very slight reduction in staff and also, as Mr McGregor has outlined, consolidation of corporate functions with the Commonwealth Ombudsman…. There will be a reduction of one staff member.[16]

2.18 The committee inquired into the abolition of Private Health Insurance Administration Council and merger with Australian Prudential Regulation Authority. Mr Gath gave the following update:

> The arrangement we are working towards at the moment entails the loss of the council, obviously, as the governance body. My position will be removed as well, so I do not go across. Four other staff at various levels with the organisation will be redundant at the time of transition. Once the transition occurs, there will be another group of about five staff who will be attending to what we are calling 'tying up loose ends'—in other words, helping APRA discharge the final reporting and other obligations that are residual elements of the PHIAC period. And then about 18 staff, most of whom are working in prudential supervisory roles, but also policy and legal and other industry facing functions, will be offered continuing employment in APRA.[17]

### *Outcome 2 Access to Pharmaceutical Services*

2.19 Senator Di Natale sought clarification of the department's response to the Australian National Audit Office report into the Fifth Community Pharmacy Agreement, noting that the processes for the negotiation of the fifth agreement were not consistent with sound practice. Mr Stuart responded:

> …during the negotiation of the Fifth Community Pharmacy Agreement, there was a small group of staff working under considerable pressure in a short time frame who apparently took the view that this was a kind of policy exchange that was occurring with the Pharmacy Guild. I think the audit was very clear in putting that much more inside a purchasing framework. I think what we have learned from that and what Ms McNeill

15 *Proof Estimates Hansard*, 1 June 2015, p. 127

16 *Proof Estimates Hansard*, 1 June 2015, p. 127

17 *Proof Estimates Hansard*, 1 June 2015, p. 130

> has very effectively implemented is a set of procedures that are much more tender-like and negotiation-like in their structure than a kind of policy discussion.[18]

2.20 Mr Bowles added:

> We took quite a bit of notice of the broader issues and that is why we set the stage on 12 February for a meeting with a range of players from RACGP to the AMA, to the guild, to Medicines Australia, to GMiA and to the consumer groups… When you do open things up to have a broader consultation and a broader range of stakeholders, of course, you are going to get people who are not going to be totally happy because they were not met with every second day like some players. But, at the end of the day, this was a much more open and transparent process across a broad range of stakeholders, some of whom had never been involved and some of whom were probably only peripheral to the final outcome. But we were keen to make sure that they were part of a process at that point in time. I will accept that there were 20 different stakeholders, or something like that, that were engaged through this process and not everyone was met with the same number of times, clearly. The Pharmacy Guild, Medicines Australia, GMiA and some of the wholesalers, I suppose, would be the key groups, if you like, and they were front and centre in this arrangement.[19]

2.21 The committee asked about the new Administration, Handling and Infrastructure (AHI) fee and what the cost of this will be to consumers. Ms McNeil said:

> With the way that the process is structured, around 50 per cent of medicines will cost more under this arrangement and around 50 per cent will cost less. In particular those medicines that are currently valued at $23.90 will see some increase in their cost to the government, whereas those that are over $23.90 will actually reduce in cost to the government.[20]

### *Outcome 7 Health Infrastructure, Regulation, Safety and Quality*

2.22 The implementation of NICNAS reforms were canvassed by the committee. Senator Moore asked what the $4.2 million over four years will be spent on and Mr Richards replied:

> Government has, in the budget process, agreed on the resourcing that NICNAS should have, both to employ sufficient staff to run business as usual as well as to engage in all the consultation and write all the materials and develop all the new processes as well as, obviously, the consultants required and the resources to manage the consultation process.
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> Part of the reforms also includes the establishment of a new IT system to improve the efficiency of the process. Currently, NICNAS is exempt from the Electronic Transactions Act and we require data on chemicals to be

18 *Proof Estimates Hansard*, 2 June 2015, pp. 4–5

19 *Proof Estimates Hansard*, 2 June 2015, p. 5

20 *Proof Estimates Hansard*, 2 June 2015, p. 10

> submitted in paper documents. The government has agreed, as part of these reforms, for us to build an IT system that would allow electronic lodgement of data by companies, electronic registration of companies, electronic payment of their levies and fees through NICNAS. The government has allocated a capital injection to allow us, in the next two years, to build an IT system. The costs of the initial reform activities in terms of the staff and the consultation processes will be recovered from industry during those two years. So the NICNAS levies registration charges will increase in the next two years to pay for the cost of implementing those reforms.[21]

2.23 The Australian Organ and Tissue Donation and Transplantation Authority was asked about donation rates. Dr Opdam provided the following information about potential donor information in Australia:

> Collecting data on deaths in Australia to ensure that we understand the potential donor pool and that we can learn where there is potential to change practice and increase donation rates is something that is being done nationally. We conducted the DonateLife audit of deaths in 72 hospitals in 2014. That audit revealed that last year there were only 500 patients who developed brain death and could be organ donors through that pathway. Note that the DonateLife audit captures nearly all brain dead donor potential in Australia in that it captured 96 per cent of that donor pool last year. We have a very good handle on which hospitals have the potential for donation. We review every death so that we understand if there are missed opportunities. Of the 500 potential brain dead donors last year, there was identification and approach to the family to request donation in 98 per cent of them. In 12 instances there was not a discussion with the family, and that was because, for example, the family did not accept brain death or the poor prognosis of their relative, or the treating staff considered the patient medically unsuitable or too old in three cases, or physiologically too unstable to be able to support to the point of organ donation in three cases or various other reasons, including no family contactable or families were threatening staff.
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> We have an excellent capacity to identify potential donors. Staff are approaching families and ensuring that there is a discussion about donation and that a decision about donation is made. In those 488 patients, there was a 59 per cent consent rate. Obviously in this pool of potential donors in Australia, which is the majority of potential donors, the biggest impact that we could make in gaining additional donors is to increase the consent rate.[22]

### *Outcome 8 Healthcare Workforce Capacity*

2.24 The committee inquired into the recent announcements of the Curtin Medical School. Senator Reynolds asked the department if they had been in discussion with the school about encouraging more training positions in the eastern suburbs of Perth and rural and regional areas of WA. Ms Shakespeare responded:

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21 *Proof Estimates Hansard*, 2 June 2015, p. 33

22 *Proof Estimates Hansard*, 2 June 2015, p. 49

> Yes. We are still at an early stage of those discussions with Curtin. Curtin has voluntarily indicated that it will have intakes of students that are focused on the people from a rural background and outer metropolitan background—around the midlands area in Perth. They have certainly flagged that they would like to participate in the Rural Clinical Schools Program. That is still something that needs to be considered and decided by the government, though.[23]

2.25 The Health Workforce Scholarship Program consolidation and administration was discussed, including the Aboriginal and Torres Strait Islander scholarships and the impacts on rural workforce doctors and medical professionals working and living in rural and remote areas. When asked why the department is consolidating the scholarships, Ms Shakepseare said:

> First of all, it is to allow greater flexibility in the direction of scholarships to workforce planning data and projections, so that we can respond to the work that the department now does in projecting expected shortages and over-supplies in health workforces. We can then target resources at those we expect to be in undersupply. Also, the change to the scholarship program is going to introduce a rural return of service for most of the scholarship recipients under the new program. It will also reduce administrative costs associated with having a lot of smaller scholarships programs by having a single administrator.[24]

### *Outcome 1 Population Health*

2.26 Senator Moore asked the department questions on the recent TV advertising campaign to prevent drug use of ice. The department was asked what research had been done about the effectiveness of this tool, and Mr Davey said:

> We did conduct research to inform development of the campaign and we have of course conducted evaluation research on earlier campaigns we have run on ice and other drugs. The research we conducted earlier this year specifically to inform the development of the current campaign did show us that the advertising being proposed—which is now being used—was seen as highly credible and likely to be effective in reaching the target audiences. For this campaign, that includes young people, parents of young people—about age 14 to 17—and young adults who are at high risk of being exposed to drug use, particularly ice. The research showed clearly that the proposed advertising material was highly likely to be effective. That is consistent with previous campaigns we have run.[25]

2.27 The committee sought an update on the Hepatitis A outbreak from frozen berries and asked questions about the review process underway. Professor Baggoley provided the following update:

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23 *Proof Estimates Hansard*, 2 June 2015, pp 71–72

24 *Proof Estimates Hansard*, 2 June 2015, p. 74

25 *Proof Estimates Hansard*, 2 June 2015, pp 98–99

> As at late last week, 29 May, there have been 33 notified cases of hepatitis A virus infection, 14 from Queensland, 11 from New South Wales, four from Victoria, two from WA and one each from South Australia and the ACT. They had all consumed Nanna's frozen mixed berries. Twenty-eight of the 33 cases were found to be genetically identical, indicating a common source. All these had hepatitis A and all had eaten Nanna's berries. Of the five that were not genetically identical, one had a different sequence and it was felt almost certainly that they had obtained their infection overseas. Two had different sequences, and different from each other, but had not travelled, therefore thought to be locally acquired from other sources. Two were unable to be genotyped as they were diagnosed on serology only. That brings it up to the 33.
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> Testing of food is said to be an unreliable way to detect the virus, because it is not so easy to find, but testing confirmed evidence of the hepatitis A virus at trace levels from a sealed packet of the product and the outbreak strain was also confirmed in an open packet retained from a case. The only other thing to report is that, on 24 March, given the number of cases had certainly levelled off, you will recall there was discussion at last estimates about the activation of the National Incident Room; I deactivated it at that stage, and there have been no further cases since.[26]

### *Outcome 10 Sports and Recreation*

2.28 Senator Peris asked ASADA about the costs that have arisen so far as a result of the Essendon and Cronulla investigations. ASADA confirmed their forecasted operating loss will be $750,000 and that the legal costs to date are $3.9 million.[27] When asked what assistance was being provided to World Anti-Doping Agency, Mr Burgess replied:

> ASADA is supporting WADA with support in kind. We have provided two lawyers for a small period of time to brief WADA, and WADA's legal representatives, to hand over the full brief of evidence. At the moment that is a couple of weeks work for two senior lawyers. And we have, at this stage, agreed with WADA to contribute a capped amount up to US [$100,000].[28]

2.29 Senator Xenophon asked whether the department will investigate allegations around a Football Federation Association payment that was made to the Confederation of North, Central America and Caribbean Association Football. Mr Stuart said:

> I think we will need to see what comes out of the current investigations. We will cooperate very fully with whatever investigations take place. Mr Reid I think has appropriately said that we will look at and rely upon anything which is produced. But, at this particular moment, there is no chain of funding or chain of control between the federal government funding and the

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26 *Proof Estimates Hansard*, 2 June 2015, p.104

27 *Proof Estimates Hansard*, 2 June 2015, p. 115

28 *Proof Estimates Hansard*, 2 June 2015, p. 115; A letter of clarification received from ASADA indicated that the capped amount was $100,00 not $50,000 as originally stated.

money which was misplaced into Mr Warner's account—there is no link there.[29]

29 *Proof Estimates Hansard*, 2 June 2015, p. 120