COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Estimates

MONDAY, 29 MAY 2017

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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Monday, 29 May 2017

Members in attendance: Senators Dastyari, Di Natale, Dodson, Duniam, Griff, Hanson, Hinch, Leyonhjelm, Lines, Ludlam, McCarthy, O'Neill, Polley, Reynolds, Siewert, Singh, Smith, Urquhart, Waters, Watt.

HEALTH PORTFOLIO

In Attendance

Senator Nash, Minister for Regional Development, Minister for Regional Communications, Minister for Local Government and Territories

Whole of Portfolio

Mr Martin Bowles PSM, Secretary

Professor Brendan Murphy, Chief Medical Officer

Dr Tony Hobbs, Deputy Chief Medical Officer

Ms Alison Larkins, Deputy Secretary, Chief Operating Officer Group

Mr Mark Cormack, Deputy Secretary, Strategic Policy and Innovation Group

Mr Shane Porter, Assistant Secretary, Strategic Policy, Department of Health

Mr Andrew Stuart, Deputy Secretary, Health Benefits Group

Dr Lisa Studdert, Acting Deputy Secretary, National Program Delivery Group

Mr Paul Madden, Special Adviser, Strategic Health Systems and Information Management

Adjunct Professor John Skerritt, Deputy Secretary, Health Products Regulation Group

Dr Margot McCarthy, Deputy Secretary, Ageing and Aged Care

Mr Matt Yannopoulos, First Assistant Secretary, Portfolio Investment Division

Mr Craig Boyd, Chief Financial Officer, Portfolio Investment Division

Mr Charles Wann, Chief Budget Officer, Portfolio Investment Division

Ms Rachel Balmanno, First Assistant Secretary, People, Capability and Communication Division

Mr Robert Wright, Assistant Secretary, Ministerial, Parliamentary, Executive Support and Governance Branch, People, Capability and Communication Division

Ms Jodie Grieve, Assistant Secretary, Communication and Change Branch, People, Capability and Communication Division

Ms Donna Moody, First Assistant Secretary, Health State Network

Mr Paul McCormack, Assistant Secretary, Frameworks Branch, Health State Network

Ms Marianne Cullen, First Assistant Secretary, Medicare and Aged Care Payments Division

Ms Kerrie-Anne Luscombe, First Assistant Secretary, Legal Division

Mr Daniel McCabe, First Assistant Secretary, Information Technology Division

Ms Janet Quigley, Acting First Assistant Secretary, Health Systems Policy Division

Outcome 1

Ms Bettina Konti, First Assistant Secretary, Digital Health Division

Mr Graeme Barden, Acting First Assistant Secretary, Research Data and Evaluation Division

Ms Erica Kneipp, Assistant Secretary, Health and Medical Research Branch, Research Data and Evaluation Division

Ms Natasha Cole, First Assistant Secretary, Health Services Division

Dr Andrew Singer, Principal Medical Adviser

Professor Anne Kelso, Chief Executive Officer, National Health and Medical Research Council

Mr Tony Krizan, Executive Director and Chief Financial Officer, Corporate Operations and Information, National Health and Medical Research Council

Mr Tim Kelsey, Chief Executive Officer, Australian Digital Health Agency

Mr Ronan O'Connor, Executive General Manager, Core Services Systems Operations Division, Australian Digital Health Agency

Mr Terence Seymour, Executive General Manager, Organisational Capability and Change Management Division, Australian Digital Health Agency

Ms Bettina McMahon, Executive General Manager, Government and Industry Collaboration and Adoption Division, Australian Digital Health Agency

Mr Tony Kitzelmann, General Manager, Cyber Security, Australian Digital Health Agency

Outcome 2

Mr Jaye Smith, Acting First Assistant Secretary, Population Health and Sport Division

Dr Bernie Towler, Principal Medical Officer, Population Health and Sport Division

Ms Elizabeth Flynn, Assistant Secretary, Preventive Health Policy Branch, Population Health and Sport Division

Ms Alice Creelman, Assistant Secretary, Cancer and Palliative Care Branch, Population Health and Sport Division

Mr David Laffan, Assistant Secretary, Drug Strategy Branch, Population Health and Sport Division

Mr George Masri, Assistant Secretary, Tobacco Control Branch, Population Health and Sport Division

Ms Bobbi Campbell, First Assistant Secretary, Indigenous Health Division

Mr David Hallinan, First Assistant Secretary, Health Workforce Division

Ms Lisa La Rance, Assistant Secretary, Rural Access Branch, Health Workforce Division

Ms Fay Holden, Assistant Secretary, Health Training Branch, Health Workforce Division

Ms Lynne Gillam, Assistant Secretary, Health Workforce Reform Branch, Health Workforce Division

Ms Janet Quigley, Acting First Assistant Secretary, Health Systems Policy Division

Mr Graeme Barden, Acting First Assistant Secretary, Research Data and Evaluation Division

Mr Shannon White, Assistant Secretary, Health System Financing Branch, Research Data and Evaluation Division

Ms Natasha Cole, First Assistant Secretary, Health Services Division

Dr Andrew Singer, Principal Medical Adviser

Ms Bettina Konti, First Assistant Secretary, Digital Health Division

Dr Peggy Brown, Chief Executive Officer, National Mental Health Commission

Mr James Downie, Chief Executive Officer, Independent Hospital Pricing Authority

Outcome 3

Mr Jaye Smith, Acting First Assistant Secretary, Population Health and Sport Division

Dr Bernie Towler, Principal Medical Officer, Population Health and Sport Division

Mr Andrew Godkin, Sports Integrity Adviser, National Integrity of Sport Unit, Population Health and Sport Division

Ms Narelle Smith, Assistant Secretary, Office for Sport, Population Health and Sport Division

Ms Judith Lind, Acting Chief Executive Officer, Australian Sports Anti-Doping Authority

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

Ms Kate Palmer, Chief Executive Officer, Australian Sports Commission

Mr Matt Favier, Director, Australian Institute of Sport

Mr Geoff Howes, Acting General Manager, Participation and Sustainable Sports, Australian Sports Commission

Ms Carolyn Brassil, General Manager, Corporate Operations, Australian Sports Commission

Ms Fiona Johnston, Chief Financial Officer, Corporate Operations Division, Australian Sports Commission

Outcome 4

Ms Maria Jolly, First Assistant Secretary, Medical Benefits Division

Mr Andrew Simpson, Assistant Secretary, Medicare Reviews Unit, Medical Benefits Division

Ms Tracey Duffy, Assistant Secretary, Private Health Insurance Branch, Medical Benefits Division

Ms Trisha Garrett, Assistant Secretary, Office of Hearing Services, Medical Benefits Division

Ms Natasha Ryan, Assistant Secretary, Medical Specialist Services Branch, Medical Benefits Division

Ms Teresa Gorondi, Acting Assistant Secretary, Medical Specialist Services Branch, Medical Benefits Division

Mr Jack Quinane, Acting Assistant Secretary, Primary Care and Diagnostics Branch, Medical Benefits Division

Ms Penny Shakespeare, First Assistant Secretary, Pharmaceutical Benefits Division

Mr Nick Henderson, Assistant Secretary, Pharmaceutical Policy Branch, Pharmaceutical Benefits Division

Ms Julianne Quainne, Assistant Secretary, Pharmaceutical Access Branch, Pharmaceutical Benefits Division

Ms Louise Clarke, Assistant Secretary, Pharmaceutical Evaluation Branch, Pharmaceutical Benefits Division

Mr Simon Cotterell, First Assistant Secretary, Provider Benefits Integrity Division

Ms Janet Power, Assistant Secretary, Office of Chemical Safety

Ms Janet Quigley, Acting First Assistant Secretary, Health Systems Policy Division

Ms Susan Azmi, Acting Assistant Secretary, Private Health Insurance Taskforce, Health Systems Policy Division

Dr Andrew Singer, Principal Medical Adviser

Outcome 5

Ms Sharon Appleyard, First Assistant Secretary, Office of Health Protection

Dr Gary Lum, Principal Medical Adviser, Office of Health Protection

Associate Professor Tim Greenaway, Principal Medical Adviser, Health Products Regulation Group

Ms Jenny Francis, Principal Legal and Policy Adviser, Health Products Regulation Group

Dr Larry Kelly, First Assistant Secretary, Medicines Regulation Division, Health Products Regulation Group

Ms Jane Cook, First Assistant Secretary, Medical Devices and Product Quality Division, Health Products Regulation Group

Mr David Weiss, First Assistant Secretary, Regulatory Practice and Support Division, Health Products Regulation Group

Mr Bill Turner, Assistant Secretary, Office of Drug Control, Health Products Regulation Group

Ms Janet Quigley, Acting First Assistant Secretary, Health Systems Policy Division

Ms Gill Shaw, Assistant Secretary, Best Practice Regulation Branch, Health Systems Policy Division

Ms Janet Power, Assistant Secretary, Office of Chemical Safety

Dr Andrew Singer, Principal Medical Adviser

Ms Masha Somi, Assistant Secretary, Immunisation Branch

Outcome 6

Ms Catherine Rule, First Assistant Secretary, Ageing and Aged Care Services Division

Dr Nick Hartland, First Assistant Secretary, Aged Care Policy and Regulation Division

Ms Fiona Buffinton, First Assistant Secretary, Aged Care Access and Quality Division

Mr Nigel Murray, Assistant Secretary, Funding Policy Branch, Aged Care Policy and Regulation Division

Mr Patrick Newton, Acting Assistant Secretary, Prudential and Approved Provider Regulation Branch, Aged Care Policy and Regulation Division

Ms Shona McQueen, Assistant Secretary, Home Care Reform Branch, Aged Care Access and Quality Division

Ms Rachel Goddard, Assistant Secretary, My Aged Care Operations Branch, Aged Care Access and Quality Division

Ms Amy Laffan, Assistant Secretary, Quality Reform Branch, Aged Care Access and Quality Division

Mr Nick Ryan, Chief Executive Officer, Australian Aged Care Quality Agency

Ms Ann Wunsch, Executive Director, Operations, Australian Aged Care Quality Agency

Ms Rae Lamb, Australian Aged Care Complaints Commissioner

Committee met at 09:01

CHAIR (Senator Duniam): I declare open this meeting of the Community Affairs Legislation Committee on 29 May 2017. The Senate has referred to the committee the particulars of proposed expenditure for the 2017-18 financial year for the portfolios of health and social services, including human services. The committee may also examine the annual reports of the departments and agencies appearing before it. The committee is due to report to the Senate on 20 June 2017 and has fixed 21 July 2017 as the date for the return of answers to questions taken on notice. Senators are reminded that any written questions on notice should be provided to the committee secretariat by close of business on 9 June 2017. The committee's proceedings today will begin with its examination of the health portfolio, commencing with cross-portfolio outcomes and corporate matters. The committee will then continue with the Department of Health and other portfolio agencies as listed on the program. On Thursday at 9 am the committee will move to examine the social services portfolio, followed at 6.30 pm by the Department of Human Services.

Under standing order 26 the committee must take all evidence in public session. This includes answers to questions on notice. I remind all witnesses that in giving evidence to the committee they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee, and any such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to the committee. The Senate by resolution in 1999 endorsed the following test of relevance for questions at estimates hearings: any questions going to the operations or financial positions of the departments and agencies which are seeking funds in the estimates are relevant questions for the purposes of estimates hearings. I remind all officers that the Senate has resolved that there are no areas in connection with the expenditure of public funds where any person has a discretion to withhold details or explanations from the parliament or its committees unless the parliament has expressly provided otherwise. The Senate has resolved also that an officer of a department of the Commonwealth shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude questions asking for explanations of policies or factual questions about when and how policies were adopted. I particularly draw the attention of witnesses to an order of the Senate dated 13 May 2009 specifying the process by which a claim of public interest immunity should be raised.

The extract read as follows—

Public interest immunity claims

That the Senate—

(a) notes that ministers and officers have continued to refuse to provide information to Senate committees without properly raising claims of public interest immunity as required by past resolutions of the Senate;

(b) reaffirms the principles of past resolutions of the Senate by this order, to provide ministers and officers with guidance as to the proper process for raising public interest immunity claims and to consolidate those past resolutions of the Senate;

(c) orders that the following operate as an order of continuing effect:

(1) If:

(a) a Senate committee, or a senator in the course of proceedings of a committee, requests information or a document from a Commonwealth department or agency; and

(b) an officer of the department or agency to whom the request is directed believes that it may not be in the public interest to disclose the information or document to the committee, the officer shall state to the committee the ground on which the officer believes that it may not be in the public interest to disclose the information or document to the committee, and specify the harm to the public interest that could result from the disclosure of the information or document.

(2) If, after receiving the officer's statement under paragraph (1), the committee or the senator requests the officer to refer the question of the disclosure of the information or document to a responsible minister, the officer shall refer that question to the minister.

(3) If a minister, on a reference by an officer under paragraph (2), concludes that it would not be in the public interest to disclose the information or document to the committee, the minister shall provide to the committee a statement of the ground for that conclusion, specifying the harm to the public interest that could result from the disclosure of the information or document.

(4) A minister, in a statement under paragraph (3), shall indicate whether the harm to the public interest that could result from the disclosure of the information or document to the committee could result only from the publication of the information or document by the committee, or could result, equally or in part, from the disclosure of the information or document to the committee as in camera evidence.

(5) If, after considering a statement by a minister provided under paragraph (3), the committee concludes that the statement does not sufficiently justify the withholding of the information or document from the committee, the committee shall report the matter to the Senate.

(6) A decision by a committee not to report a matter to the Senate under paragraph (5) does not prevent a senator from raising the matter in the Senate in accordance with other procedures of the Senate.

(7) A statement that information or a document is not published, or is confidential, or consists of advice to, or internal deliberations of, government, in the absence of specification of the harm to the public interest that could result from the disclosure of the information or document, is not a statement that meets the requirements of paragraph (1) or (4).

(8) If a minister concludes that a statement under paragraph (3) should more appropriately be made by the head of an agency, by reason of the independence of that agency from ministerial direction or control, the minister shall inform the committee of that conclusion and the reason for that conclusion, and shall refer the matter to the head of the agency, who shall then be required to provide a statement in accordance with paragraph (3).

(d) requires the Procedure Committee to review the operation of this order and report to the Senate by 20 August 2009.

(*13 May 2009 J.1941*)

(Extract, Senate Standing Orders)

Witnesses are specifically reminded that a statement that information or a document is confidential or consists of advice to government is not a statement that meets the requirement of the 2009 order. Instead witnesses are required to provide some specific indication of the harm to the public interest that could result from the disclosure of the information or the document. An officer called to answer a question for the first time should state their full name and the capacity in which they appear and witnesses should speak clearly and into the microphones to assist Hansard to record the proceedings. Mobile phones should be switched off or at least to silent.

Department of Health

[09:06]

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

Senator Nash: I do not; thank you, Chair.

CHAIR: Welcome; thank you. Secretary, is there a statement from you?

Mr Bowles: No, thank you.

CHAIR: We are starting with cross-portfolio questions and it is my strong hope, desire and intention to truly stick to cross-portfolio and then go to outcomes after that. Senator Watt, would you like to kick off questions.

Senator WATT: Thank you, Mr Bowles and Senator Nash, for coming along today. You have no doubt seen reports this morning about a secret government task force that is developing a so-called Commonwealth hospital benefit. I helpfully have copies of that report here, if you have not seen it.

Mr Bowles: I have seen it, thank you.

Senator WATT: Do you need copies of that provided?

Senator Nash: No.

Senator WATT: I will pass that around the committee, if you would like. Are those reports accurate?

Senator Nash: No, they are not. Minister Hunt has been out this morning categorically saying that it does not reflect government policy, it will not be government policy and it will never be government policy.

Senator WATT: So it is not true that, to quote the article, the nation's most senior health bureaucrats are part of a secret task force developing a proposal for a 'Commonwealth Hospital Benefit'?

Mr Bowles: There is a task group, as you identify, but not secret. There is nothing secret about it. This relates—

Senator WATT: Have you told anyone about it?

Mr Bowles: I tell a lot of people about this work. It related originally to the federation reform work that was done a couple of years ago and one of the options in that was around a Commonwealth hospital benefit model. The department did enter into an arrangement through there to do some broad policy work, mainly because the states and territories are interested in

some of these things. Not all think it is a good idea but all think it is a good idea to explore options for the future. AHMAC, which is the Australian Health Ministers' Advisory Council, which I sit on but which is chaired currently by the Queensland Director-General of Health, has set up a national health reform working group that has been working through a whole range of options. This was one that was done and, as Minister Nash just mentioned, in the context of getting this through that process, Minister Hunt did rule it out at that particular point.

Senator WATT: When did he do that?

Mr Bowles: In the context of the last COAG Health Council meeting, I would say about two months ago or maybe even longer. I would have to go back and check the exact date. But in the preparatory work around what we were taking forward under the national health reform working group, that was one of the items and he asked for that to be removed from the paper. That would have been about at least two months ago, I would say. I can get the date.

Senator WATT: Could you ideally by the end of today come back to us about that?

Mr Bowles: Yes, I will get the date.

Senator WATT: Thank you. He did that in a meeting with you?

Mr Bowles: With me.

Senator WATT: So this work had been taken to AHMAC prior to it being ruled out?

Mr Bowles: Yes. AHMAC had discussed a range of these issues. It goes back to the federation reform working arrangements from about 2½ years ago. The AHMAC working group had been dealing with that, along with a whole range of other issues, and it was just one of those processes through there. The GAP group was broader than that; a whole range of different players were involved in that. It was just about looking at future models. It clearly was not government policy because it had never been before government in that context.

Senator WATT: So the department was undertaking work that, among other things, would abolish the private health insurance rebate, charge consumers more for extras cover and force the states to find more money for public hospitals?

Mr Bowles: No, I would not characterise it in any way, shape or form like that. There was a group looking at a Commonwealth hospital benefits model that looked at how you would configure the system. To be very frank, it was in its infancy in its conversation. I have talked publicly about this, the Commonwealth hospital benefits model, many, many times and it is always in the context of just future gazing. These things would take a long time, if you were ever going to do them. It is not about abolishing anything; it is about how you would reconstruct the system, if you like, if you were to change it into the future to actually enhance the system and not to destroy anything, as is indicated there.

Senator WATT: So you were future gazing about ideas like abolishing the private health insurance rebate?

Mr Bowles: Again I say that I did not say that. We future-gaze. My job, as the head of the department, is to develop policy advice for government to make decisions. I will not walk away from our thinking about the future of health care. I will not walk away from policy work that we will continue to do on a whole range of issues until they are ruled out by government. This has been ruled out by government and, therefore, we will not do any more work on it.

Senator WATT: What made you think that future gazing about abolishing a private health insurance rebate, charging consumers more for extras cover and forcing the states to find more money for public hospitals would be acceptable to government?

Mr Bowles: I must object to the basis of the question.

Senator WATT: All I am asking—

Mr Bowles: You are reading from a newspaper article. I am telling you what my view of this is. I am rejecting what is there about the abolishment of all of these things that you are talking about. I have said that we were looking at a Commonwealth hospital benefits model. This, as I said, started back when the Prime Minister and Cabinet, through their normal process of the federation reform, put out a paper on this.

Senator WATT: In 2015?

Mr Bowles: Yes. This is not a secret; this is work that goes on. Departments do policy work on all sorts of things until they get to government. When government makes decisions, some things get picked up and some things do not. This has not been.

Senator WATT: But departments also generally undertake policy work that is fairly consistent with parameters set by government. If a government says, 'This is generally where we want to go,' you do not kind of go over here. So what was it that made you think that these sorts of proposals like abolishing the private health insurance rebate, charging consumers more for extras cover and forcing the states to pay more money for public hospitals were within the parameters allowed by government?

Senator Nash: I think the secretary has been very clear to say that all departments do a range of work to provide information and policy advice to government. At the end of the day, as you well know, governments are responsible for determining that policy. In relation to the article this morning, as much you try and beat it up, the minister has clearly ruled it out and said that it is not government policy and it is not going to be government policy.

CHAIR: Before you go on, I just want to make sure that everyone is happy for news crews to be here. I am particularly concerned about you, Senator Watt. I know that you have an aversion to news cameras.

Senator WATT: I do.

CHAIR: Is everyone happy with that? Okay.

Senator WATT: I have only just dealt with the first paragraph of this article. It goes on to say:

> Under the plan, the Commonwealth would 'pool' the approximately $20 billion it currently gives to public hospitals each year with the $3 billion it pays to private sector doctors and the $6 billion it spends on the rebate … It would use the money to pay a standard benefit for services regardless of whether they are performed in a public or private hospital, or whether people choose to be treated as public or private patients.

Again, have those sorts of proposals been considered?

Mr Bowles: That was option 2 under the Federation reform white paper options that were dealt with in 2015. Subsequent to that, AHMAC has been looking at a national health reform process through a working group to advise COAG's Health Council, which is the ministers of health across the country, and that was one of the issues. As I said before, about two months

ago—and we will get that date—in the conversation in the lead-up to the last COAG Health Council, Minister Hunt said that he did not want to take that forward to that group and it was removed at that point. Now, states and territories will deal with issues that they wish to deal with. We are a member of AHMAC and, obviously, the COAG Health Council will continue to have conversations until they are ruled out. At the COAG Health Council, that was ruled out. It has not been discussed any further from that point.

Senator WATT: I have a transcript of Minister Hunt's press conference this morning, where he tried to pass this off as long pre-dating him. He said:

> I know that the issue was raised with me coming out of officials meetings with the States as a possible item for COAG and I struck it out. I rejected it.

You are taking on notice the date that he instructed you to rule it out?

Mr Bowles: It was some time in March. I cannot remember the exact date.

Senator WATT: Early March or mid-March?

Senator Nash: As he said, we will take it on notice and get back to you.

Mr Bowles: We will get the date, but some time in March there was a COAG Health Council meeting and it would have been probably in the week before that meeting, whenever that was.

Senator WATT: It would have been in the week leading up to the COAG meeting?

Mr Bowles: Yes, because we would have briefed the minister. Actually, it probably would have been before that because it would have been when the agenda was being developed and when we looked at what the papers were going to be.

Senator WATT: I understand that there was a COAG meeting of health ministers on 26 March.

Mr Bowles: Yes.

Senator WATT: You are saying that it would have been a couple of weeks before that?

Mr Bowles: It could have been a couple of weeks before that.

Senator WATT: So the minister ruled it out and said 'nothing further to happen on it' a couple of weeks before that?

Mr Bowles: Yes. In relation to the COAG Health Council, he asked for it to be removed from the papers that went forward; it was removed from the papers that went forward.

Senator SMITH: Just to be clear, AHMAC is what?

Mr Bowles: The Australian Health Ministers Advisory Council, which is all of the secretaries and directors-general of health across the country.

Senator SMITH: It is comprised of officials?

Mr Bowles: That is correct. We provide advice to the COAG Health Council, which is all the ministers from all states and territories. By the way, it also includes New Zealand.

Senator SMITH: Who is it chaired by?

Mr Bowles: The COAG Health Council is currently chaired by Victoria and the AHMAC is chaired by Queensland. The Commonwealth never chairs AHMAC or the COAG Health Council.

Senator SMITH: The Queensland Director-General of Health chairs AHMAC?

Mr Bowles: That is correct.

Senator WATT: Just to clarify—

Senator Nash: I do not think I can be any clearer, Senator.

Senator WATT: Senator Smith understandably asked some questions, but just to get back to where I was, there was a COAG meeting of health ministers on 26 March?

Mr Bowles: The 24th, I think it was.

Senator WATT: 24 March, was it?

Mr Bowles: Yes.

Senator WATT: You are saying that the minister told you, 'Don't take this any further', a couple of weeks before that and it was removed from the agenda at the COAG meeting?

Mr Bowles: Yes.

Senator WATT: And it has not been looked at since?

Mr Bowles: In the context of the COAG Health Council, no, it has not.

Senator WATT: But what the minister has told us today, or told the world, is that it was raised with him coming out of officials meetings with the states as a possible item for COAG, which met on 24 March, and he struck it out; he rejected it. I would like to table an agenda for a meeting of this GAP task force that appears to have occurred on 28 March. Was that about four days after the COAG health ministers meeting?

Mr Bowles: Yes.

Senator WATT: You have just told us, and the minister has told people, that he instructed you that he ruled out that proposal a couple of weeks before the COAG meeting; it was not to go any further. But four days after that COAG meeting, this task force—you are a member of it, I presume?

Mr Bowles: I am. I have been probably once or twice; I cannot remember.

Senator WATT: Is there anyone else from your department who is a member?

Mr Bowles: Mr Cormack is usually there.

Senator WATT: So you and Mr Cormack are members of this task force. Four days after the COAG meeting, where you were told not to take it any further, there was a meeting of the task force. You will see that the agenda items include 'summary of the Commonwealth hospital benefit'—and it was to be presented by the Department of Health—'group discussion, including impact of Commonwealth hospital benefit on the following stakeholders: consumers, insurers, hospitals, healthcare providers and state governments; any potential changes to the model to achieve stakeholder consensus and alternative models to consider'. Why was this still being discussed by this task force four days after that meeting, if the minister had said it was to go no further?

Mr Bowles: First of all, it is an independent task force that works and operates. Again that obviously was my call. We continued to participate in the independent task force.

Senator SMITH: Just to be clear, what does 'GAP' stand for?

Mr Bowles: Global Access Partners.

Senator WATT: The minister claims that he told you, prior to that meeting on 24 March, 'not going any further; not happening'.

Mr Bowles: What I have said is that it was removed from the COAG Health Council agenda.

Senator WATT: He has gone out this morning in a press conference and claimed that it long pre-dated him, was nothing to do with him, and it was raised with him—

Senator Nash: He did not claim it, Senator; it is fact.

Senator WATT: I am starting to wonder about his claims because he says that it was raised with him—and I quote:

> ... coming out of officials meetings with the States as a possible item for COAG and I struck it out. I rejected it. ... If it ever comes forward, I'll reject it again. I made that clear ...

And that it was not to proceed. Why is this task force still considering it?

Mr Bowles: Again it is Global Access Partners, which is the GAP task force. It is an independent task force that we participate in, as do a whole lot of private sector and other people; states and territories are involved. It is like a lot of things: we consider a whole range of options.

Senator WATT: Have there been any more meetings of this task force since 28 March?

Mr Bowles: I think so, but I cannot remember when.

Senator WATT: When have those meetings occurred?

Mr Cormack: There was a meeting about two weeks ago.

Senator WATT: Is that the only meeting that has occurred since 28 March?

Mr Cormack: I believe so, but I will check the diary.

Senator WATT: I should mention that this agenda is dated 28 March 2016, but I am presuming that is a typo and it was 28 March 2017, given that it is the third meeting.

Mr Cormack: I think that is a typo. There was a meeting—

Senator WATT: So there has been one more meeting of the task force since that date. Did either of you attend that meeting?

Mr Cormack: I attended the subsequent meeting; the secretary did not.

Senator WATT: Was this item about the Commonwealth hospital benefit discussed at that most recent meeting?

Mr Cormack: Yes, it was.

Senator WATT: Why was that happening?

Mr Cormack: The arrangement with the task force is that it has a beginning and an end. The task force was convened by GAP, with support from the Commonwealth and others, to undertake a dialogue around the hospital funding and the Commonwealth hospital benefit model. It had already been in the public arena, as the secretary has said. The process is that the GAP task force need to bring that to conclusion and they will bring that to conclusion by preparing a summary of the deliberations and inputs that they have received to the process. So it will come to a logical conclusion.

Senator WATT: So it is still being considered by the department?

Mr Bowles: No.

Mr Cormack: No. I think the minister has made that very clear. What I am saying is that the task force will wind up its work, which is to undertake a consultation and analysis process with a range of stakeholders. They will complete that report and deliver it to the department, and that will probably conclude the matter.

Senator WATT: Why are you still spending time in meetings talking about something if the minister has said, 'Don't do it'?

Mr Bowles: Again the department does look at policy options all the time. We participate in a range of different forums on a range of different issues right across the board all of the time. The minister has made it very clear that this will go no further. We will not be dealing with this anymore. This was an independent thing and Mr Cormack has said it will come to a logical conclusion. It will go nowhere from there. From the Commonwealth's perspective, the minister has ruled it out.

Senator Nash: Senator, the task force could meet another hundred times, if they wanted to, but it would not change the government's position. It might assist the committee if I read into *Hansard* part of the minister's doorstop this morning, because not everybody, like you and I, will have been able to spend time reflecting on this. For the benefit of the committee, this morning Minister Hunt said:

> The story does not reflect Government policy. It will not be Government policy. It will never be Government policy. Our commitment to private health insurance is rock solid. By contrast we've seen that only a few weeks ago Labor was reported as wanting to abolish the private health insurance rebate.
>
> It's clear and categorical. Not Government policy. Won't be Government policy. Will never be Government policy.

I thought that might assist, Chair.

Senator WATT: That is fine. Mr Bowles, I think you told us a few minutes ago, around what the minister had said to you, that the discussion occurred in the context of that forthcoming COAG meeting of health ministers on 24 March. I think you said something like the minister said to take it off the agenda and that it was not to be discussed there. Is that pretty much what he said?

Mr Bowles: I cannot recall the exact conversation other than it was removed from the agenda at the end of that conversation; he said that he did not want to take it forward.

Senator WATT: He did not want to take it forward at that meeting?

Mr Bowles: At that meeting, no.

Senator WATT: It is one thing to rule out taking something forward at a particular meeting; it is another thing entirely—

Mr Bowles: He was not interested in having a future conversation about it at that point.

Senator WATT: About what exactly?

Mr Bowles: About the Commonwealth hospital benefit model. But we are talking about all points in time here, Senator.

Senator WATT: Yes.

Mr Bowles: And we are talking about a specific meeting at that particular time. It has not been raised again in that context because the minister had ruled it out and that is where we were.

Senator WATT: So what the minister said to you prior to that COAG meeting effectively was, 'It's not to be discussed at that meeting,' but has he ever directed you that it is not to be considered further in any context, whether it be at that COAG meeting as a policy proposal—

Mr Bowles: He was not interested in taking it forward anywhere—

Senator WATT: At that COAG meeting.

Mr Bowles: Anywhere, at that particular time, including that COAG Health Council meeting. We had been participating in this task force for a while and we had continued to do that. Sometimes it is actually better to participate in things to see where they are going than not to participate at all. I made that call. That is it; I made that call.

Senator WATT: I noticed that in the transcript that Minister Nash just read from—and she has read it accurately—what the minister is talking about there is the proposal to abolish the private health insurance rebate.

Mr Bowles: Yes.

Senator WATT: It is interesting. He starts out by saying:

> I just want to respond to a story in the papers this morning about private health insurance and public hospitals.
>
> The story does not reflect Government policy. It will not be Government policy. It will never be Government policy.

Every other comment that he goes on to make is about private health insurance:

> Our commitment to private health insurance is rock solid. By contrast, we've seen that only a few weeks ago Labor was reported as wanting to abolish the private health insurance rebate.

I could obviously say something about that, but I will not. He continued:

> It's clear and categorical. Not Government policy. It won't be Government policy. It will never be Government policy.

It is interesting that he confines most of his remarks to the proposal around private health insurance. Does that mean that the remainder of these proposals remain on the table?

Senator Nash: No, it does not. It means that he has clearly ruled it out. We can go around this for hours and hours, for as long as you like, trying to draw some bow for some fairyland that is not going to happen, because I know that is what you like to do. But, for people listening out there, it cannot be clearer, from what the minister said this morning, in that it will not be government policy and it will never be government policy. He was responding to the story in total about private health insurance and public hospitals. End of story.

Senator WATT: So what exactly will never be government policy?

Senator Nash: The reference this morning that was in there, to the paper that we are talking about.

Senator WATT: So every item that is referred to in that article will not be government policy?

Mr Bowles: The media article is taking a whole range of issues and not necessarily in any particular context. The conversation is around the Commonwealth hospital benefit and a summary of what that actually means. With some of the components you mention in there, I cannot even recognise some of them, but that is as it may be. What the minister has said this morning is that he is ruling out that option of a Commonwealth hospital benefit model.

Senator SINGH: Mr Cormack and Mr Bowles, with the meetings that you both attended as part of this GAP task force, both in March and the one that you attended two weeks ago, Mr Cormack, did the minister give you instruction to make it clear to that task force the ruling out of these Commonwealth hospital benefit changes?

Mr Bowles: We are a participant in these conversations. We have always made it clear, and, in fact, from memory, when I went to the meeting—I cannot remember whether it was the March meeting—I made a statement right up front that said, 'This is not government policy; this is'—I cannot recall exactly what I said.

Senator SINGH: But did you go further to say that it will never be government policy, like the minister has done today in his transcript?

Mr Bowles: We are talking about semantics now. I actually said at the meeting I attended—

Senator SINGH: But we are not though, Mr Bowles, because—

Mr Bowles: Senator, can I finish? At that particular meeting, I made a statement up-front as a participant that said: this is not Commonwealth government policy.

Senator WATT: Which meeting did you do that at?

Mr Bowles: I cannot remember; I will have to think about that one.

Senator WATT: You were not at that most recent meeting, I think you said, Mr Bowles.

Mr Cormack: Can I just clarify the second meeting?

CHAIR: Yes. After that, we will move to Senator Di Natale.

Mr Cormack: It is important that we get this clear. I did say earlier that there was a subsequent meeting of the task force; I wish to correct that. What I wish to say is that there was a subsequent meeting involving members of the task force, which was not a task force meeting, on 18 May. That meeting was the Australian National Consultative Committee on Health, which is one of the governance committees of GAP, which has a look at, overseas, the full range of health-related matters. I did say earlier that there was a subsequent meeting of the task force; I am now saying to you that there has not been a subsequent meeting of the task force that I attended. But I did attend a meeting at which it was discussed, and that was on the 18th of the fifth.

Senator DI NATALE: Thank you, Mr Bowles and Mr Cormack. Can I begin with a bit of a time line here? The proposal for a hospital benefit was first discussed in the federation reform paper?

Mr Bowles: That is correct.

Senator DI NATALE: Just so that we are clear about what the hospital benefit basically looks like, because people will not understand what that means, it is effectively, if we are going to use an analogy, having something similar to a Medicare item number; for somebody

who has a hospital admission the Commonwealth decides what the item number is worth and the states then make up the shortfall in terms of the funding for that patient.

Mr Bowles: Again, we are in the very early days of a conversation about what a model might look like. But you could conceivably construct it like the MBS for general practice, if you like, or for the MBS type items in the hospital context irrespective of whether it is a public or private hospital. That was the genesis of the idea in the white paper in, I think, 2015.

Senator DI NATALE: I am just a bit confused. Are we in the early days of a conversation about what a hospital benefit model would look like?

Mr Bowles: Yes.

Senator DI NATALE: We are.

Mr Bowles: Yes. It literally has gone almost nowhere, other than it having been discussed at this GAP and at AHMAC.

Senator DI NATALE: We are in the early days of a conversation but, as far as I could tell, the conversation was supposed to end in March when the minister ruled it out. Just explain that to me, please.

Mr Bowles: GAP is an independent task force.

Senator DI NATALE: You are both members of it.

Mr Bowles: That does not mean anything. We are members and we participate in it; it is still an independent task force, task group, whatever it is called. We participate in it. At the March meeting, as I said before, and I am pretty sure it was the March—

Senator DI NATALE: Perhaps you misspoke or perhaps I misheard. You have said, 'We are in the early days of a conversation about it.' I will be very clear with you. Clearly there needs to be reform in this area, so I am not coming at this from the point of view of wanting to—

Mr Bowles: No, no; I understand that.

Senator DI NATALE: Are we in the early days of a conversation around what a potential funding model for hospitals would look like, and is that an ongoing conversation that we have?

Mr Bowles: A conversation was happening in the Gap task force, task group, and it has been on the agenda for AHMAC in relation to the national health reform working group, which is a subgroup underneath AHMAC; we have been having that conversation. In the lead-up to, I think it was, the 24 March COAG Health Council, a conversation was had with the minister where he said, 'I don't want to take that forward to COAG,' and it was removed from the agenda. Subsequent to that, the task group met, and we still participated because it is an end-to-end process—

Senator DI NATALE: So it is the early days of a conversation about what that would look like and it is an ongoing conversation.

Mr Bowles: It had been an ongoing conversation; that is correct.

Senator DI NATALE: Is it still an ongoing conversation?

Mr Bowles: The GAP task force has been talking about it; the COAG Health Council has not.

Senator DI NATALE: The AHMAC subgroup council?

Mr Bowles: No.

Senator DI NATALE: The subgroup of AHMAC?

Mr Bowles: No; it stopped talking about that in the lead-up to the COAG Health Council. Just to be clear, the AHMAC working group is a formal group and the COAG Health Council is obviously a formal part of government; it stopped then. The GAP task group, an independent group, continued to talk about it. We participate, absolutely. I made it very clear, though, to the task group that it is not government policy and it is not intended to use any form of this task group to implement government policy.

Senator Nash: Senator, perhaps I can just clarify there. The government is not in a conversation about the Commonwealth hospital benefits model; the minister has ruled it out.

Senator DI NATALE: The department is here, so we are asking questions of them.

Senator Nash: I am just clarifying so that we are absolutely—

Senator DI NATALE: It is a problem, isn't it? The department is having a conversation with—

Senator Nash: No, Senator. It is important that we get this absolutely clear.

Senator DI NATALE: Yes.

Senator Nash: That is why I just put those comments on the record.

Senator DI NATALE: It is absolutely critical that we get it clear.

Senator Nash: Absolutely critical.

Senator DI NATALE: That is why I am trying to be very clear about whether we are having a conversation or not about this.

Senator Nash: Senator, the government is not having a conversation about this.

Senator DI NATALE: I am putting this, Minister. I just want to go to the question of the tender. I want to establish the time line. We had the federation reform paper, which raised the prospect of the hospital benefit. As we have said, it is a bit like a Medicare benefit, an item number for patients in hospitals. Then it seems that the department engaged in a tender to recruit Global Access Partners; is that correct?

Mr Bowles: Yes.

Senator DI NATALE: When did that tender occur?

Mr Cormack: I will have to check the records for that. I do not have the document in front of me, but I can—

Senator DI NATALE: Can you give me a rough timetable?

Mr Cormack: It would have been probably towards the end of 2015, possibly early 2016, but I will need to get—

Senator DI NATALE: That is fine. I will wait for that. Who participates in that? Obviously, Mr Bowles and Mr Cormack, you are both participants. Who else?

Mr Bowles: Consumers; insurers; hospitals, both public and private.

Senator DI NATALE: Can you give us a full list of the participants?

Mr Cormack: I will need to take that on notice, because we do not actually control those particular documents. But the secretary is right: it picks up people representing private hospitals, the insurance sector, consumers, state governments, territory governments and the Commonwealth. But I do not have the records in front me.

Senator WATT: Senator Di Natale, I can help you out here. I also can table a copy of the minutes of the second meeting of this GAP task force, and that occurred on 14 September 2016. That at the very back does include a list of participants in that task force.

Senator SMITH: It can hardly be called a second task force—

Senator DI NATALE: Can we table that?

Senator SINGH: It is interesting when an opposition senator has more information than the department.

CHAIR: Order! The document has been tabled. Senator Di Natale, would you like to continue with your questions?

Senator DI NATALE: We will have a look at the list of participants. The cost of the tender, as reported, was $55,000; is that correct?

Mr Cormack: Yes, about that.

Senator DI NATALE: How do you square the fact that this is an independent group that you are paying for?

Mr Cormack: In the process of developing policy options and in the process of undertaking research for a range of purposes to inform potential policy considerations, we engage a range of organisations. We engage consulting companies—

Senator DI NATALE: But it is not independent if you are paying for it.

Mr Bowles: I would tend to disagree.

Senator DI NATALE: How can something be independent if the department is paying for it?

Mr Bowles: Because you pay for that independence. You pay to get—

Senator DI NATALE: You pay for independence?

Mr Bowles: Senator, you do.

Senator Nash: You do.

Senator DI NATALE: Maybe in parliament but not in the real world. You do not pay for your independence in the real world.

Mr Bowles: I am afraid that the rest of the world deals with issues in a similar way. We get independent advice from research institutions and from all sorts of different bodies that we pay for all of the time.

Mr Cormack: Including the Consumers Health Forum, for a consumer's perspective, if we have to do market research.

Senator DI NATALE: But you are paying for and participating in this group. How on earth can you claim it to be independent?

Mr Cormack: We are paying for work to be undertaken by a group that is independent from government, and they do not do it for nothing.

Senator DI NATALE: But you are on the panel. You are participants of the group.

Mr Cormack: We are not denying that we are participants in the group.

Senator DI NATALE: So how on earth can it be independent of government when you are participating in the group?

Mr Cormack: If you check the company records, you will find that it has nothing to do with government; it is an independent company.

Senator DI NATALE: Except that you pay for it and participate on it.

Mr Cormack: And so do other companies where we pay for services. That does not make them not independent of government. It is an absurd proposition.

Senator DI NATALE: If you have people participating in the meetings and directing or influencing the outcome of those meetings, how on earth can it be claimed to be independent?

Mr Bowles: This happens on a regular basis—

Senator DI NATALE: I am not talking about whether it is happening regularly or not.

Mr Bowles: Can I finish?

CHAIR: Please allow the secretary to finish his answer.

Mr Bowles: I have hardly been able to finish a sentence this morning, Senator. Government departments, a whole range of places, do this all of the time, where they contract research based organisations, task groups and different forums to actually deal with policy issues. This is one of those things. We participate because it is best that we participate. We do not guide, as you have indicated. We do not chair it, we do not guide it and we do not run it, but we participate in it. I have made it clear to the task group that it is not government policy and the task group will not influence government policy at the end of the day. However, if there are groups that want to have a voice in healthcare, I do not have a problem with people having a voice in the future of the health system. It is a group of people who play in the health system all the time. That does not mean that it is government policy and it does not mean that we are influencing something.

Senator DI NATALE: Given your statement that the minister had rejected this proposal, it is a waste of public funds, isn't it, to be paying for an organisation to be engaging in policy work that, in the words of the minister, will never be government policy?

Mr Bowles: It was tendered and paid for either at the end of 2015, or early 2016, well before the minister ruled it out. It was in the context of having a conversation around the federation white paper at that particular point in time. It has continued and, as I indicated earlier, the minister ruled out any further government action in the context of what we were dealing with at that point in time.

Senator DI NATALE: Mr Bowles, why wouldn't you instruct an organisation where the government has paid for the work of that group to be discussing policy that has a prospect of being implemented by government? At the point that it became clear to you that, in your words, this was ruled out by Minister Hunt, why didn't you instruct the task force to make better use of public funds and direct their attention to an area that may in fact be implemented as government policy?

Mr Bowles: First of all, I do not direct the task group; it is not mine to direct. I am a participant. I provided the advice to the group that it was not government policy in that March meeting just after the minister had said that.

Senator DI NATALE: Let me just be clear about this, because I do not know that we have heard that so far.

Mr Bowles: I have said that a few times.

Senator DI NATALE: I am sorry; I might have missed that.

Mr Bowles: I have said that about four times.

Senator DI NATALE: Well, let me be clear. You were advised by the government, or instructed by the health minister, that this was not government policy.

Senator WATT: I do not think he did go that far, actually.

Senator DI NATALE: Let me confirm that.

Mr Bowles: Confirm what?

Senator DI NATALE: Did the minister instruct you to advise this group that this was not government policy?

Mr Bowles: No. In the context of that, we had a conversation in the lead-up to the COAG Health Council, in the few weeks before that, that it would not go forward in the context of the COAG Health Council.

Senator DI NATALE: In the context of the COAG Health Council?

Mr Bowles: Again, I have not finished.

Senator DI NATALE: Okay.

Mr Bowles: March 24, I think, was the COAG Health Council. I think March 28 was the GAP meeting. They followed in quick succession. The meeting was already arranged; it continued. At that meeting I advised the group that it was not government policy and it would not be going forward in that particular context. If the group wanted to continue to have a conversation, it could have that conversation, but it was not government policy. I cannot remember the exact words that I said, but it was something along those lines.

Senator DI NATALE: What was the forum in which you advised—

Mr Bowles: The GAP task force meeting. I went to it and I made that statement to make it clear.

Senator WATT: I thought you told us earlier that it was at one of the earlier meetings of this GAP task force that you said it.

Mr Bowles: No, I did not say that at all. I said that at a meeting I said something. I think now, looking at the minutes of the 28 March meeting, I did say something along the lines—and these are not my exact words, but this is how I think it was minuted—the Commonwealth health benefit is not government policy and there is no intention to formally progress the idea through GAP, although GAP is welcome to undertake informal analysis.

Senator WATT: Could you table those minutes please?

Mr Bowles: You do not have those?

Senator WATT: I do not have those.

Mr Bowles: We can table those minutes.

Senator Nash: It might assist if I add as well from the minister's statement this morning in relation to this because I think this might add a bit of clarity. He said this morning:

> I know that the issue was raised with me coming out of officials meetings with the states as a possible item for COAG and I struck it out. I rejected it. I've rejected it once. If it ever comes forward, I'll reject it again.

That might add some clarity.

CHAIR: Thank you, Minister. Senator Di Natale, you have a couple of minutes left before you will have to desist.

Senator DI NATALE: Just to confirm, there were a number of elements to the proposal, and two in particular. One was that the work that was done was based on a 35 per cent contribution to the hospital funding from the Commonwealth.

Mr Cormack: Our estimate at that time was around 40 per cent. I am not quite sure where the 35 per cent came from.

Senator DI NATALE: I believe that the 35 per cent is actually part of the minutes.

Mr Cormack: It might be part of the minutes but I guess what we are saying to you is that, in the initial consideration of this proposal, the components for the benefit included the Commonwealth's contribution to public hospital funding, which was around 40 per cent.

Senator DI NATALE: If the work was done on 35 per cent, which is clearly a reduction—

Mr Cormack: No. I am sorry—

Senator DI NATALE: I have not finished my question.

Mr Cormack: Okay.

Senator DI NATALE: If the work was done on 35 per cent, that would represent a reduction in the current funding from the Commonwealth to its share of hospital funding; is that correct?

Mr Bowles: I could not really say what it would mean in the overall context.

Senator DI NATALE: You have just said that 40 per cent of the Commonwealth—

Mr Bowles: If you look across the board at the moment, the Commonwealth contribution to public hospital funding is around 40 per cent.

Senator DI NATALE: Correct.

Mr Bowles: It varies across states; it is lower in some and higher in others. Again, we have not been modelling 35 per cent. I will categorically say that.

Senator DI NATALE: But this report states 35 per cent.

Mr Bowles: This report can state anything it likes. It is not—

Senator DI NATALE: You are paying for these people to do this work.

CHAIR: Order! We have to move on to Senator Smith.

Mr Cormack: The work is not finalised. This is an iterative process which has not been finalised by GAP. They have not produced a final summary of the—

Senator DI NATALE: When do you anticipate that they will produce a final report?

Mr Cormack: They will produce it fairly quickly because the work is effectively complete.

Senator Nash: But I would add that it is finalised as far as the minister is concerned.

Senator DI NATALE: It is just that here we have the government saying that we are not going to do it and we are still waiting on a final report from a government tendered—

Senator Nash: The official is talking about a process that will come through to a conclusion. I do not think he can be any clearer. You know the department has done work.

Senator DI NATALE: Are you comfortable with the fact that the department is doing work on an area of government policy that you say is not government policy?

Senator Nash: That is a question for the minister responsible. What I can absolutely—

Senator DI NATALE: You are here as the minister responsible. It is a question for you.

Senator Nash: What I can be absolutely clear about is, referring to the remarks that I have made this morning quoting the minister directly, that this will not be going ahead.

Senator DI NATALE: But can you understand—

Senator Nash: I know that as senators you like to try and draw long bows and conclusions where there are not any but I cannot have been any clearer on behalf of the minister than I have been that this will not be government policy.

Senator DI NATALE: Minister, can you understand that, when a member of this government stands up and says, 'This won't be government policy,' and the department that nominally works for him is conducting or has paid for work that directly contradicts what the minister is saying, members of the general public would be particularly concerned, given the track record of broken promises around health care by this government?

Senator Nash: I think the officials were talking in the context of bringing it to a conclusion but I will allow them to answer on behalf of themselves.

CHAIR: Then we will move to Senator Smith.

Mr Bowles: Again, let us get the context straight. This started a long time ago in the context of the COAG Federation white paper arrangements and we had participated in this. We first of all contracted it, we participated in it and it has met once since we talked about it not going forward to the COAG Health Council context and, at that point, being an independent group, I told them that it is not government policy and we will not be dealing with it in that context in that group. That does not mean that group cannot deal with issues. Government departments and all sorts of groups think broadly about government policy. If we are not thinking broadly about policy of the areas, we are not providing advice to government who make decisions. The government have clearly made a decision on this thing; it will not go forward. The group can finalise its work and that is what they should do because that is what they were contracted to do. They will finish their work and it will go no further because that is now the government's decision. That is clearly the government's decision.

CHAIR: Senator Smith.

Senator SMITH: Just to be clear, GAP is Global Access Partners.

Mr Bowles: That is correct.

Senator SMITH: The first meeting of the GAP task force on hospital funding was when, what date?

Mr Bowles: I would have to take that on notice, but it was—

Senator SMITH: That is a bit disappointing because—

Mr Bowles: 2016.

Senator SMITH: Most of us read the clips at 2 am et cetera.

Mr Bowles: It was some time in 2016. I do not have all the dates.

Senator SMITH: There are 12 months, 365 days.

Mr Bowles: Yes, I understand that.

Senator SMITH: Just to assist me, early or late 2016?

Mr Bowles: There probably would have been one earlier in the year. It probably only met every four or five months; I cannot recall. There have not been that many meetings. If the second one was in December of last year, the first one might have been six months before that. I would have to take that on notice.

Senator SMITH: Let us say it was, just to keep it easy for people. The cost?

Mr Bowles: $55,000.

Senator SMITH: Which was the meeting where you articulated the—

Mr Bowles: The one on 28 March.

Senator SMITH: 28 March this year. Just to be clear, the document that Senator Watt has kindly shared with us makes it very clear in the second paragraph on the first page:

> The group will consider the structural redesign of the Australian government rebate on private health insurance under the federation reform focusing on the proposed Commonwealth hospital benefit.

Secondly, at the bottom of the page under 'Disclaimer', it says:

> Statements made during discussions are the personal opinions of the speakers and do not necessarily reflect those of Global Access Partners and its sponsoring organisations.

Then on the second page, just to assist, at the top under 'Proceedings', it says:

> Attendees represent themselves and—

interestingly—

> should pursue self-interest to achieve results.

Senator SINGH: What is the point of the question?

Senator SMITH: I am just making the evidence much clearer. Let us be clear about this. In late 2015, as a result of the Federation white paper process and the announcement of the Federation white paper process under former Prime Minister Abbott, the Department of Health went out and contracted services valued at $55,000 to conduct a series of private discussions and personal opinion-gathering in regard to the Commonwealth hospital benefit proposal that was in the Federation white paper. There was a meeting in mid-2016, there was another one on 14 December 2016 and then there was a final one on 28 March 2017 where the secretary made it very clear that the government has no policy position. In fact, the government, to quote the minister this morning, rejects it and rejects it into the future as well.

Senator Nash: Just on that, because your point about the federation reform is a very good one, this work started well before Minister Hunt became minister. It came out of the Federation white paper. He was clearly briefed on the matter and, as soon as the minister was aware of this, he ruled it out.

Senator SMITH: News travels very slowly to the Department of Health, does it, Secretary?

Mr Bowles: I do not get—

Senator SMITH: You only have to go to media reports on 28 April 2016 to know that the federation reform process was scrapped.

Mr Bowles: Yes.

Senator SMITH: You only have to go to the website to know that you cannot even find the reform of the Federation white paper anymore.

Mr Bowles: That is correct.

Senator SMITH: So I think Senator Di Natale is right. Why would we continue to expend public money, why would we continue to waste the time of officials at meetings at which they are expressing personal points of view when the government's position is to abandon the federation reform process and then the minister has made it very, very clear that he is not accepting the advice of officials in this regard?

Mr Bowles: There are a couple of things there.

Senator SMITH: Were you freelancing?

Mr Bowles: As I went through earlier, this has been a process also discussed at AHMAC—the Australian Health Ministers' Advisory Council—by officials, and we provide advice to our governments across the nation on healthcare reform. It was part of the national health reform working group under AHMAC and, yes, we continued to do the work on this as an exercise because people thought it was a good thing to do some policy thinking on. I do not apologise for that. Our job is to provide policy advice. Government's job is to make decisions around policies. They have clearly made a decision. The white paper issue had been brought to a conclusion, yes. AHMAC—the states, territories and the Commonwealth—gets together every three or four months and we had that conversation.

Senator SMITH: So you agree that the primary motivation for the GAP task force on hospital funding, the Federation white paper reform process, which was abandoned in April 2016—some could argue that the justification for this no longer existed.

Mr Bowles: Policy thinking should always happen and we need to find forums for that to happen. It is in the document here that the task force is an initiative of the public policy and implementation institute, Global Access Partners. We work with them, yes; we contracted them, yes; we are participating in that group, yes, in thinking around future health policy.

Senator SMITH: As a result of your contribution on 28 March, stakeholders would have been very, very clear then and will be crystal clear now as a result of the minister's announcement that this work is not now and is not going to be government policy.

Mr Bowles: Absolutely. I made it very clear at the March meeting—

Senator SMITH: Could you just read out what you said at the March meeting again?

Mr Bowles: This is one sentence out of a statement I would have made. I would have to go back and think about it.

Senator SMITH: You can produce all those minutes?

Mr Bowles: Can we take that on notice? This one has scribble all over it but we will get that to you. It is:

> The Commonwealth hospital benefit is not government policy and there is no intention to formally progress the idea, although GAP is welcome to undertake informal analysis.

That is a broad summary of what I said but I made it very clear at the time that it is not government policy and we are not going to progress it through this process. Again, being an independent public policy and implementation institute, they do what they need to do to continue that conversation. It has not met since 28 March, as Mr Cormack mentioned earlier.

CHAIR: Senator Singh.

Senator SINGH: Mr Cormack, just to go back to the meeting that you attended two weeks ago, which you corrected was not a GAP task force meeting but was a national—

Mr Cormack: I will get the correct title but its acronym is ANCCH, which is the Australian National Consultative Committee on Health. It is a committee of GAP and it has a number of people who are affiliated with or invited by GAP to participate in various aspects of their work. It reviews the range of health programs that they are looking at. It could be about health privacy. They have done work on hospital procurement and a range of topics. It meets a couple of times a year. It oversees and provides advice to GAP on their work program.

Senator SINGH: This is a committee within government?

Mr Cormack: No. GAP is a private company.

Mr Bowles: A public policy and implementation institute, they describe themselves as.

Senator SINGH: I am just trying to understand what this committee is that is advising GAP.

Mr Cormack: The committee is part of its governance committee structures.

Senator SINGH: So the Department of Health sits on the GAP task force and it sits on this committee?

Mr Cormack: Yes, that is right.

Senator SINGH: At that meeting two weeks ago, the Commonwealth hospital benefit reform discussions were on the agenda?

Mr Cormack: Yes.

Senator SINGH: At that meeting did you make the minister's position clear—that this was not government policy?

Mr Cormack: It had already been made clear. In essence, the purpose of having that item on the agenda was simply to say that the work was winding up and that the GAP people would submit their final report. That was pretty much the extent of it. There were a number of items on the agenda—I do not have it in front of me—but it was essentially that they had had the meeting on 28 March and they were just completing their report. They would send that report through and that would pretty much be it.

Senator SINGH: So you did not make it clear that this was not government policy because—

Mr Cormack: It had already been made clear.

Senator SINGH: You felt that it had already been made clear?

Mr Cormack: It was in the record of the meeting. It had already been made clear. They had a contractual responsibility to write up the report and submit it to the Commonwealth, and that is effectively where the matter would end.

Senator SINGH: Do you provide advice to the minister as to the deliberations of these meetings?

Mr Cormack: Not specifically, no. We provide advice to the minister on a number of things, but I cannot recall ever having provided the minister with any specific advice on the deliberations of that committee.

Senator SINGH: Was the minister aware that the GAP task force and this committee were deliberating on this particular Commonwealth hospital benefit reform?

Mr Bowles: I doubt that he would, Senator.

Senator SINGH: So he was not aware—

Mr Bowles: I cannot remember.

Senator SINGH: That there were departmental officials attending a GAP task force to deliberate, debate and discuss a particular major Commonwealth hospital funding reform that he had declared, and you had known he had declared, was not government policy?

Mr Bowles: That is a very interesting—

Senator SINGH: The minister was in the dark—is that what you are saying?

Mr Bowles: Again, lovely emotive language, Senator. First of all, the department participates in a range of different forums having conversations about policy all of the time. I cannot recall a conversation specifically with the minister around GAP. Particularly, the minister has only been the minister for a short period of time. There has been the one meeting that followed the ruling out of it, going forward to the COAG Health Council, where I indicated that it was not government policy. So I probably have not specifically said to the minister, 'These are the deliberations of the group,' because at that point it was not government policy and I did not really take it any further.

Senator SINGH: I just find it interesting. If you compare it to a different policy area, it is like the government has a direct action policy on climate change, yet there would be a departmental official being part of a task force to pursue an emissions trading scheme.

CHAIR: Do you have a question?

Senator SINGH: I find it peculiar—

Mr Bowles: I do not accept that.

Senator SINGH: that the department would not advise the minister that it was continuing to pursue a major piece of reform that the minister had ruled out.

Mr Bowles: Again we are dealing with an independent group that had been tasked to look at a particular thing, in the context of something that was a while ago, coming to a conclusion

around 28 March, at that last meeting of the GAP task group, where I made very clear that it was not government policy. Probably, in my own head, I ruled it out. It was not that relevant anymore; it was going effectively nowhere but we were doing policy thinking on it at that point in time.

Senator WATT: Let us talk a little bit about what is in this plan. Have you already told us whether any other meetings of this task force have been scheduled?

Mr Bowles: Not that I am aware of.

Senator WATT: Do you have in front of you a copy of the minutes of the meeting of 14 December 2016?

Mr Bowles: Yes.

Senator WATT: Page 3 of those minutes, right down at the bottom, states that the department's working hypothesis is that the CHB, or Commonwealth health benefit—

Mr Bowles: I am sorry; where are you talking about?

Senator WATT: Right down at the bottom of page 3.

Mr Bowles: The last paragraph?

Senator WATT: Yes, the very last line of page 3. It states that the department's working hypothesis is that the Commonwealth health benefit should have no net effect on the expenses paid by individuals. Was that what was intended?

Mr Cormack: In terms of the state of development of this model—and it was the same model that was released publicly as part of the federation white paper consultation process, the discussion document on the PM&C website—that was the working hypothesis, that there were three primary sources of funding, that those three programs would be pooled and that the total funds would be redirected towards a Commonwealth hospital benefit. The working hypothesis, certainly at that stage—it has not really changed—was that, as there is no withdrawal of funding from the system, there should be no net impact on individuals. That was the working hypothesis. Having said that, it was a very preliminary model, a very preliminary program design, and it needed to be further developed, tested and worked through, and that was in many ways what the GAP process was about.

Senator WATT: Putting that altogether, the working hypothesis in this plan was that these changes should have no net effect on the expenses paid by individuals?

Mr Cormack: That is the principle we were working on.

Senator WATT: The reason I ask is that you will see that, at the bottom of page 4, there is a footnote, footnote 6, which links back to that statement. This footnote says it was later noted that the Commonwealth health benefit will have an effect on individuals' expenses. Can you explain what that means?

Mr Cormack: I can explain. The question is that you are delving into a policy discussion that the government has said has been ruled out, so I would just ask—

Senator WATT: My questions are to the department about the work of the department. They are entirely in order.

Mr Cormack: Okay.

Senator WATT: We have heard what the minister has said, but I think it is entirely in order to ask the department questions on its work.

Mr Cormack: I am happy to answer on that basis. In essence, the funding sources were, as I said, the three programs. The model, certainly at that time, was to roll those three into one program and direct that funding directly towards the hospitals for private hospital care. And, at the top of page 4, there would be no net effect on the expenses paid by individuals. The clarification point down below was relating to the two types of insurance products in question. There is private hospital insurance and then there are extras, general benefits or ancillaries. The working hypothesis at that time was to roll the entirety of the private health insurance rebate funding into a payment that went direct to hospitals. So the point of clarification there—and I think that was probably raised by one of the private health insurance people—was to say, 'What would the effect be on individuals' access to insurance for extras or ancillary that are not covered by the hospital payment?' That is clearly a matter that would require further consideration.

Senator WATT: The footnote goes on to explain that.

Mr Cormack: Yes.

Senator WATT: The footnote reads, 'It was later noted that the Commonwealth health benefit will have an effect on individuals' expenses.' I interpret that to mean it would cost individuals more. It goes on to say, 'Currently the Commonwealth health benefit proposal is to cash out the rebate for hospital and ancillary products and use the money to pay for a proportion of all hospital treatment. As a result either individuals will miss out on ancillary cover, which covers the costs of dental, optical, physiotherapy et cetera, or there will need to be additional costs charged to individuals to continue cover for ancillary treatments.' Does that mean that, should this plan be put into effect, either—

Senator SMITH: It is not going to happen. The minister has made that clear.

Senator WATT: We have heard that. But, under this plan that was worked up by the department, either individuals would miss out on some cover or they would actually have to pay more.

Senator Nash: Maybe I can come in here because it is an interesting discussion around the detail.

Senator WATT: Chair, is it not possible to ask the department questions about their work?

Senator Nash: I am answering the question.

CHAIR: It is.

Senator WATT: I think I know exactly what you are going to say.

Senator Nash: Unless you can read my mind, Senator, let us give it a whirl.

Senator WATT: Sure.

CHAIR: Let's allow the minister to respond.

Senator Nash: Thank you. It might assist the committee. Indeed it is an interesting discussion around the detail of what is in the papers that we have in front of us, but it is effectively hypothetical because we have said it is not going ahead.

Senator WATT: That is what I thought you would say.

Senator Nash: I think it is clear that it is not going ahead. The contract for GAP came out of the federation white paper. The federation white paper is no longer going ahead and neither is this. The contract has simply been concluded, as would a normal contractual arrangement. So we can have a hypothetical discussion around what is in these papers in front of us, but none of it matters at all.

Senator WATT: I think it does matter.

Senator Nash: No, it does not because it has been completely—

Senator WATT: I think it matters a lot.

CHAIR: Order!

Senator Nash: What you are trying to do—

Senator WATT: If you are going back on your—

Senator Nash: Senator, you are trying to draw the conclusion that, because this has been discussed, in some way, shape or form it may be going ahead. The minister has categorically, absolutely ruled that out.

Senator WATT: So it does not matter—

Senator Nash: So you can continue your questioning for as long as you want to, but it will not change the fact that the minister has ruled this out.

Senator WATT: So it does not matter that a government department responsible for health is continuing to discuss plans to gut Medicare months after the Prime Minister has said that he would protect Medicare and never gut it. It does not matter?

Senator SMITH: Personal opinion.

Senator Nash: It is simply being concluded as a process of a normal contractual arrangement and it does not matter because it is not going ahead. It is not government policy.

Senator WATT: I think it matters a lot that government departments continue to meet and discuss—

Senator Nash: I do not know how many times the minister has to say it or I have to say it—you might not want to accept it—but it is the fact. This is not going ahead. It has been ruled out. Indeed the minister said—and I refer again to his statement—'I have rejected it once. If it ever comes forward I'll reject it again.'

Senator WATT: Thank you.

Senator SMITH: Dead, buried, cremated.

Senator WATT: And then resurrection follows, under this government.

Senator Nash: Don't mix religion and politics.

Senator SMITH: Dead, buried, cremated.

Senator WATT: Malcolm Turnbull on Medicare: dead, buried, cremated and resurrected. That is what we are seeing here today.

Senator Nash: We've now got the Medicare guarantee, but that is another discussion.

Senator WATT: What impact would this plan have on public hospitals, Mr Bowles or Mr Cormack?

Mr Bowles: Again this was very early days. There has been no modelling; nothing. We are talking about a concept, at a point in time, which is no longer going ahead.

Senator SMITH: Personal opinions.

Senator WATT: No, I am asking questions. I know the government wants to cover up work done to gut Medicare. I am asking questions—

Senator SMITH: This will delay the committee.

Senator WATT: Chair, I ask for your ruling on this. I am properly asking questions of departmental officials about work they have conducted at public expense. I think that is entirely appropriate. I know it is uncomfortable for the government, but it is entirely appropriate to ask these questions, and I will continue doing so.

Senator Nash: We are merely trying to get the facts on the record.

CHAIR: I think Mr Bowles answered the question.

Mr Bowles: I did answer the question.

Senator WATT: I did not catch it because of the interruptions.

Mr Bowles: I said this work was done at a point in time. There has been no modelling done on this at all because it was a concept that was being discussed at this group. That is it. We have not progressed it.

Senator WATT: I do not think I could be any clearer about that. You have progressed it because you continue to have meetings about it.

Mr Bowles: No, we are not continuing to have meetings. We had one on 28 March where I made it clear that it was not government policy.

Senator WATT: Then you had another one in May.

Mr Bowles: No, we did not.

Senator WATT: Okay; it was not the same body but you set up a different group or—

Mr Bowles: No, we did not. No, Senator.

CHAIR: Allow the Secretary to answer the question.

Mr Bowles: No, Senator. Mr Cormack clarified his answer. There was a subsequent meeting on the GAP governance process; they had this as an agenda item to update their governance process on where it is at, and where he said it was bringing their deliberations to a conclusion. As part of the conclusion, at the 28 March meeting I said that it is not government policy.

Senator WATT: I know that. But on 14 May another meeting occurred—

Mr Bowles: No, no.

Senator WATT: Not of the same body, but of a different arm of this GAP, whoever they are, where this was discussed again.

Mr Bowles: No. It was referenced because it is the governance body of GAP. We have no control over GAP and how they run their business. At a governance meeting, they referenced it because that is what they do; they bring things together that they discuss.

Senator WATT: So page 2 of the minutes of this December meeting state that a Commonwealth health benefit 'would have a significant impact on the whole industry, given

the importance of private and public hospitals'. Are you now saying that there would be no impact on public hospitals under this plan?

Mr Bowles: I am saying that we do not know the answer, because this was a concept that came out of the Federation white paper—one of the options that was put together around how we could fundamentally rethink the system. That is what this was.

Senator WATT: You do not know whether this plan would have an impact on public hospitals?

Mr Bowles: No, because we have not gone any further than the concept.

Senator WATT: Then, at page 4, the minutes state that it was underlined that the Commonwealth health benefit would not take money out of the private health system. Why don't the minutes include the same assurance to public hospitals?

Mr Bowles: Again, these are the minutes of an independent group of GAP where everyone would have had a view—that is how they get expressed—but, at the subsequent meeting, we have said quite categorically that it is not government policy. Yes, we have been dealing with this group for a period since the end of 2015 or early 2016, whenever it was—I cannot remember. There have been three meetings. The last one was on 28 March, which was just after that COAG Health Council arrangement, as I mentioned earlier, and the minister had it withdrawn from that meeting. I went to the meeting and categorically said that it was not government policy.

Senator Nash: Senator, it is a shame that you are not as good at listening as you are at scaremongering. This is hypothetical questioning around something that is not going ahead.

Senator WATT: I could not be clearer on that. We have heard it over and over. This was work that was done by the department. It has carried on after the minister said it was not going any further. We are going to keep asking questions about it.

Senator Nash: Again, back to the listening thing, Senator, as I think the official would explain—

Senator WATT: I know that you do not want to talk about it—

Senator Nash: And I have commented—

Senator WATT: But guess what?

Senator Nash: Under a contract—

Senator WATT: This is estimates; we ask questions.

Senator Nash: contractual arrangements conclude. I am answering your question, Senator, with very useful comments.

Senator WATT: This is my last question in the time I have available. The minutes of this meeting state that it was underlined that the Commonwealth health benefit would not take money out of the private health system. Can you give a guarantee today that there is no work being undertaken by your department which would see a removal of Commonwealth funding to the public hospital system?

Mr Bowles: Absolutely. If you go to the budget estimates, you will see that $2.8 billion extra has gone into the public hospital system over the forward estimates.

Senator WATT: So no work in GAP—

Mr Bowles: I can categorically say—

Senator WATT: No work is being done.

Mr Bowles: I can categorically say—

Senator WATT: None of these people behind you are doing any work?

Senator Nash: Perhaps let the secretary finish his answer.

Mr Bowles: Can I finish answering? I can categorically say, as I have said a number of times: we are not doing any further work. There is no work that is being done to take money out of public hospitals. In fact, in the budget papers, there is $2.8 billion worth of extra funding that goes into public hospitals over the forward estimates. That is the only work we have been doing. We will continue to do more work because the next round of agreements will need to be negotiated over the next 12 to 18 months ready for 2020, when the next agreements are ready. So there is absolutely no work being done to take money out of public hospitals, absolutely.

CHAIR: Excellent. Thank you, Secretary.

Senator DI NATALE: Perhaps I can go to one more point that is in the minutes. The minutes of the meeting say that the policymakers should take care of the losers to secure their support, as the winners will take care of themselves. That is on page 4, about halfway down.

Mr Bowles: Yes.

Senator DI NATALE: Who were identified as the losers in this package?

Mr Bowles: I do not really know. But, if you think about the broader system, I think the hospitals and insurers will be both winners and losers, depending on where they would go. That depends, really. Again, it was a concept at a point in time.

Senator DI NATALE: I am asking questions about it. There is no need to be defensive.

Mr Bowles: I understand that, but I do not know the answer.

Senator DI NATALE: I am asking you a question about detailed minutes of work that has been conducted.

Mr Bowles: I do not know the answer.

Senator DI NATALE: I do not want to basically agree with Labor on this issue because we have differences over some of these policy areas, but I think it is entirely appropriate that we ask questions about work that the department is doing.

Mr Bowles: Yes, I agree. I do not have a problem.

Senator DI NATALE: There is a clear statement here that policymakers should take care of the losers. I am interested. Are we talking about consumers and, if so, what sorts of consumers?

Mr Bowles: No.

Senator DI NATALE: Who are identified as the losers in this proposal and who are identified as the winners?

Mr Bowles: I do not believe that we would have reached a conclusion on who are winners and losers. I think the answer is more likely that it will have impacts across the sector. From a personal perspective, I do not believe that consumers would be a loser because, if you come

up with a system that puts the patient at the centre, which is what we always try to do, I think the consumer would win. I think inevitably, if you look at our system, particularly the private system, the insurers and private hospitals come at things from different perspectives, so I am sure that there would be swings and roundabouts in that space. We do not know the final answer because it was a concept and these were the deliberations of all parts of the sector.

Senator DI NATALE: I understand that. I think, when there is a statement in the minutes about losers and then it talks about how it is going to have an effect on individuals' expenses, it is worth asking the question—

Mr Bowles: Absolutely.

Senator DI NATALE: Who was identified? Perhaps, Mr Cormack, given that you have been more closely involved, are people who have ancillary cover the ones who would most likely lose out under a proposal like this?

Mr Cormack: I think it is largely hypothetical, but what I can say is that, at each of these meetings, you have had a range of different perspectives around the table. You have had Commonwealth and state governments, consumers, insurers, private health insurers and the medical profession. So, when you are floating a policy idea, people will interpret it from, I guess, an overall perspective; they will also interpret it from their own personal perspective. At the stage of development that this project got to, I do not think we were able to definitively identify any particular group that was going to necessarily win or lose. I think the other point to note is that any stage in a policy development process is a point in time. What really matters in any policy development process is the government decision on it—

Senator DI NATALE: Yes, I get that. We understand the point. Mr Cormack, we have limited time. We absolutely understand that point and we are not disputing that point. We are just asking questions about the work that has been done. I would like to get back to that. The federation paper where this was first identified as a proposal outlines some issues with it. It is correct to say that it would, as stated in the federation paper, reward activity rather than outcomes. So there is a risk of overservicing. It is correct to say that?

Mr Cormack: It was correct to say that in the absence of other policy measures that would accompany a package.

Senator DI NATALE: And it is correct to say that it does not address the fragmentation between primary care and specialist care?

Mr Cormack: It was not designed to do that.

Senator DI NATALE: or to provide incentives—

Mr Cormack: There were other measures. Go to option 3 in the same paper. Do you see option 3? Option 3 looks at the integration between primary and secondary care—

Senator DI NATALE: As it needs to.

Mr Cormack: and the reduction in demand as a package. So do not just look at one thing; look at the whole package.

Senator DI NATALE: It also says in the reform of federation paper that the impact on private health insurance needs to be considered because it will have an impact on consumers through charges to premiums. Is that correct? That was one of the issues identified in the federation paper?

Mr Cormack: It proposed very significant changes to private health insurance; therefore, you have to look at the impact on premiums, the impact on insurers and the whole system. That was why it was floated as an idea.

Senator DI NATALE: They are very serious criticisms and they were dropped; the federation reform paper was effectively dropped. Why did the department decide to continue engaging consultants in this work?

Mr Bowles: Again, I mentioned that. It was because at AHMAC, the CEOs of the national health system decided that it was worthwhile having a little bit more colour and light, if you like—

Senator DI NATALE: Even though the Commonwealth dropped it from their own proposal.

Mr Bowles: The Commonwealth dropped the notion of a Federation white paper, yes. But we do not control AHMAC or the COAG Health Council.

Senator DI NATALE: But this reform cannot go ahead without the Commonwealth.

Mr Bowles: Clearly—

Senator Nash: And it is not.

Mr Bowles: And it is now not.

Senator Nash: It is not going ahead.

Senator DI NATALE: There is work being done on it, so that is what we are asking questions about.

Senator Nash: No; the work was done.

Mr Bowles: The work was done.

Senator Nash: Not 'being done' but 'was done'.

Senator DI NATALE: When was the last meeting?

Mr Bowles: 28 March.

Senator DI NATALE: No; was there a meeting subsequent to that?

Mr Bowles: No; it was 28 March. There have not been—I have said this four times now—subsequent meetings. There was a meeting of their governance committee, which referenced this. It is not this GAP task force. The last meeting was on 28 March.

Senator DI NATALE: Let me ask you about the GAP meeting; this is the Global Access Partners. You have described yourself as independent of the process, despite the fact that you have paid for it and despite fact that you have participated in it—

Mr Bowles: Yes.

Senator DI NATALE: But you are independent of the process. Have you made a detailed presentation to the group?

Mr Bowles: I think Mr Cormack probably would have made presentations to the group to give them an idea of what the Commonwealth hospital benefit would be.

Mr Cormack: That is right.

Senator DI NATALE: What was the nature of that presentation?

Mr Bowles: The Commonwealth hospital benefit model that is described in this paper.

Mr Cormack: Yes, that was part of my presentation.

Senator DI NATALE: How long was that presentation?

Mr Cormack: I do not know. It was probably about 10 or 15 slides; I am not sure exactly.

Senator DI NATALE: So you gave a detailed presentation to the group—

Mr Cormack: Yes.

Senator DI NATALE: Outlining the Commonwealth's funding arrangements; is that correct?

Mr Cormack: We gave a detailed presentation on the Commonwealth hospital benefit model.

Senator DI NATALE: Let me point you to page 7 of that presentation.

Mr Cormack: What are you referencing?

Senator DI NATALE: The PowerPoint presentation: do you have that in front of you?

Mr Cormack: Yes.

Senator DI NATALE: Where you detail 'hospital episode, indicative example', there is note 1: 'assumption that the hospital benefit is 35 per cent of the national efficient price'. Why did you select 35 per cent?

Mr Cormack: I will have to check the basis for that.

Senator DI NATALE: But that represents a reduction on what is currently spent.

Mr Cormack: Yes. I will have to check why that assumption was taken.

Senator DI NATALE: This is very significant because I asked you this question earlier and you said that there was not anything that indicated a reduction in the Commonwealth expenditure to our public hospital system. Yet you have given a presentation to this group with the assumption that Commonwealth spending would be reduced and set at 35 per cent.

Mr Bowles: I am sorry; that page is actually talking about private hospital episodes, and it talks about current and future being exactly the same.

Senator DI NATALE: I point you to note 1: 'assumption that the hospital benefit is 35 per cent of the national efficient price'.

Mr Bowles: In the context of the whole slide being private hospital episode indicative—

Senator DI NATALE: But that is still a reduction.

Mr Cormack: No, it is not. We do not pay private hospitals that way any more—

Senator DI NATALE: So why have you chosen 35 per cent?

Mr Cormack: I will have to check the underpinning assumptions of the model—

Senator DI NATALE: Because that represents a reduction—

Mr Bowles: No, no.

Senator DI NATALE: In terms of what is done within the public system, and we are talking about a model that treats the system as a whole, which therefore represents a reduction to 35 per cent.

Mr Bowles: No. If you look at the slide, it is in the context of the private hospitals.

Senator DI NATALE: So why would you set the price currently lower than where it exists at the moment?

Mr Cormack: We do not pay a national efficient price—

Senator DI NATALE: But you are talking about a model that actually does this. You are talking about a model that includes the private hospital sector within a broader Commonwealth hospital benefit.

Senator Nash: You are talking about a model that is not going ahead. That is what you are talking about.

Senator DI NATALE: I want to know why the assumption is based on a lower price than you currently spend within the public hospital sector.

Mr Bowles: Again, a point in time: it is talking about the private sector, which we do not fund in this way—

Senator DI NATALE: This is going to confuse people.

Mr Cormack: If it does not go ahead, it will not.

Senator DI NATALE: You have been doing work on it for a long period of time, including right at the start of the Federation reform paper. We have engaged these consultants at a cost of $55,000 to the taxpayer. You are both participating in the panel. You have then given a nine-page presentation to this group and one of the assumptions in this group is a 35 per cent expenditure, which is a reduction on what the Commonwealth currently spends within the public hospital sector.

Mr Bowles: I reject that, because we are not talking about public hospitals—

Senator DI NATALE: So why was the 35 per cent—

Mr Bowles: and we are talking about a point in time on a concept and what a concept would look like.

Senator DI NATALE: I understand that.

Mr Bowles: And if you do look at the end figures there, they are equal. So it is probably just about—

Senator DI NATALE: Why was 35 per cent chosen as the national efficient price in this example?

Mr Cormack: I would have to go back and check the underpinning of the model. But the secretary is correct; this is a worked-up example for private hospital payments. The way that private hospitals are paid is very, very different to the way that public hospitals are paid and supported by the taxpayer. I will have to go back, and I am happy to take that on notice, but I do not have an answer for that. There was no intention in any way to disadvantage public or private hospital patients through this particular model; it was through an attempt to use the different pools of funds to get a more efficient way of delivering hospital care.

Senator DI NATALE: But it would have been appropriate to have set it at the price that the Commonwealth currently spends on the public system.

Mr Bowles: It depends. Because we are talking about two separate—

Mr Cormack: Two separate systems.

Senator DI NATALE: But the whole point of this model is to basically get rid of the two systems and have one system.

Mr Bowles: No, it is not.

Senator Nash: The whole point is that it is a model that is not going ahead.

Senator DI NATALE: And it is a model that the department have done a lot of work on, and the point of Senate estimates is to ask questions of the department on the work that they are doing.

Senator Nash: Absolutely.

Senator DI NATALE: And that is what I am doing.

Senator Nash: And I completely understand that.

CHAIR: Let us stick to questions and answers.

Senator Nash: But it is just important to clarify what is actually—

Senator DI NATALE: I think you have clarified that on a number of occasions.

Senator Nash: And I will keep on clarifying it as you all keep trying to drag it off to somewhere else.

Mr Bowles: We are answering the question.

Senator DI NATALE: I know you are. Not for a moment—

CHAIR: Okay.

Senator Nash: And I am just adding clarity on occasion.

CHAIR: Senator Di Natale.

Senator DI NATALE: Can I ask you, on notice, why that 35 per cent figure was chosen as the national efficient price?

Mr Bowles: We will take on notice the contents of the concept at that particular point in time. But I do want to make a clarifying point, because you said we are talking about one system. We are never talking about one system.

Senator DI NATALE: We are talking about a model for funding both the private and public systems.

Mr Bowles: That is right.

Senator DI NATALE: As a single model for funding both of them.

Mr Bowles: A similar model for funding both, but not dealing with both exactly the same.

Senator DI NATALE: No, but we are talking about—

Mr Bowles: Because they are fundamentally different.

Senator DI NATALE: But we are choosing a proportion, the 35 per cent of the national efficient price, when federally we are, through the public system, currently contributing more than that.

Mr Bowles: Yes.

Senator DI NATALE: It is a reasonable question to ask why the 35 per cent figure was chosen.

Mr Bowles: It is, and we will take that on notice. But I want to make the point that it was in the context of how we would fund private hospitals.

Mr Cormack: That is right.

Senator DI NATALE: Yes, and this is different—

Mr Bowles: You can fund them—

Senator DI NATALE: And under this model we would be talking about a similar funding formula.

Mr Bowles: No, that is not—

Senator DI NATALE: We are going around in circles, so I will—

Mr Bowles: That is not correct. You can fund different parts of the system in different ways. But we—

Senator DI NATALE: Totally for the purpose of this proposal—

Mr Bowles: We are not anywhere near that. We never were anywhere near that. It was a concept. The presentation was in concept only.

Senator DI NATALE: I want to get to this point, because I think this is, in part, driving where some of this reform is coming from: do you think the private health insurance sector is in crisis at the moment?

Mr Bowles: I would not use emotive language. We have—

Senator DI NATALE: Do you agree that there are problems with the current arrangements with private health insurance?

Mr Bowles: We have a group under the chairmanship of Jeff Harmer looking at private health insurance more broadly. That is very publicly known. It is in the context of what are the best long-term arrangements for private health insurance. I would not describe anything as crisis.

Senator DI NATALE: Have that group had any involvement whatsoever with the Global Access Partners group?

Mr Bowles: No.

Senator DI NATALE: Is there any overlap with committee members?

Mr Cormack: No.

Senator DI NATALE: Is there any work—

Mr Cormack: Sorry. I have attended each of the GAP task force meetings, the three of them. I am a member of that same group that Jeff Harmer chairs. That is pretty much the only overlap. Sorry, there will be one other member who represents the private health insurance industry.

Senator DI NATALE: Would that be BUPA?

Mr Cormack: No.

Senator DI NATALE: Who would that be, given that the list of members is now public?

Mr Cormack: I think it Rachel David who is head of Private Healthcare Australia, the private health insurers body. She has attended certainly at least one or two of the GAP task

force meetings, and she is a member of the private health ministerial advisory committee. There may be some other people who have gone to both, but they are separate processes.

Senator DI NATALE: How much have private health insurance premiums risen over the last five years? Have you got that information handy?

Mr Bowles: I do not have that off the top of my head but, when we get to the outcome, we could give you that. But I think over the last five years you would probably have to say on average it would be around six per cent a year. But I think we can go to the specifics later.

Senator DI NATALE: Private health insurance coverage has been falling consistently, has it not, for a number of years?

Mr Bowles: No. I think it has fallen in the last 12 months, but I do not think consistently for a number of years. Again, we can talk about that later.

Senator Nash: Perhaps we will—

Mr Bowles: My recollection is: probably in the last 12 months it has dropped off a couple of points of a per cent. But that has only been over the last 12 months, from memory. But I stand corrected on that, but we can come back to that in the outcome.

Senator DI NATALE: I think my questions are finished.

Senator SMITH: Let us just be very, very clear that the first time Minister Hunt knew about the Commonwealth health benefit proposal was when AHMAC sought to put it on the COAG meeting of health ministers?

Mr Bowles: He could have been briefed in an incoming sense. There could have been some papers that would have went to him in a that context. The only conversation I have had with him was in the context of CHC.

Senator SMITH: In your previous remarks you said that some people at AHMAC were interested in giving a bit of 'colour and light', to use your words, to this particular concept, which is how you have described it. You went on to say that the Commonwealth does not control AHMAC.

Mr Bowles: That is correct.

Senator SMITH: Perhaps you could share with us or characterise the attitudes of other jurisdictions in regards to this concept, because you did say in your earlier evidence that AHMAC is chaired by the Queensland Director-General of Health.

Mr Bowles: That is correct. First of all, the construct of AHMAC is that it is never chaired by the Commonwealth; it is chaired by a state or territory. It usually shifts between large states and a small state or territory. It happens at the moment that the director-general of Queensland does that. I am not saying for one second that any state or territory agrees with any of the proposals. Neither does the Commonwealth at that particular point. The conversation was, 'We need to have a look at would this work'.

Senator SMITH: How would you characterise the enthusiasm or otherwise of other jurisdictions for the Commonwealth health benefit concept?

Mr Bowles: I think some would say, 'Let's keep going', because this is an interesting model, and I think some would probably say, 'Don't bother'.

Senator SMITH: Who would say, 'Let's keep going'?

Mr Bowles: I really could not answer that. I could not answer—

Senator SMITH: You are the Secretary of the Department of Health at the Commonwealth level.

Mr Bowles: I am but I am not the director-general or secretary of a state or territory arrangement.

Senator SMITH: No but you participate in AHMAC.

Mr Bowles: I do.

Senator SMITH: Because you were able to share with us earlier your observation that some at AHMAC wanted some colour and light.

Mr Bowles: Yes.

Senator SMITH: So if you were to give me a road trip around the continent and describe for me the enthusiasm or otherwise of particular jurisdictions for the proposal?

Senator WATT: I note, Senator Smith, that the participants in this GAP task force include representatives of the New South Wales government. Perhaps they are the ones who are—

Senator SMITH: I am genuinely curious, because, let us be clear, I favour reform of the federation. Health policy is central to that. So take us on a little road trip.

Mr Bowles: Again, nobody is out there saying, 'Let's go and do this.' They want to have a look. New South Wales, yes, have been interested. I think Victoria have been interested but cautious. Queensland, interested and cautious. The others have been non-committal, I would suggest in a lot of ways, but are happy to continue having a conversation.

Senator SMITH: And does the caution arise because of the way that it was characterised in the reform of the Federation white paper?

Mr Bowles: I do not necessarily think that. I think it is more cautious because we have not really done any of the work to go any further. It was a concept. Secretaries and directors-general of health across the country are interested in reform of the health system in one way, shape or form. So they want to continue to have the conversation. And you have to have those sorts of detailed conversations to actually come up with an answer.

Senator SMITH: So the interest in progressing the conversation is by those larger states?

Mr Bowles: It would be, yes. They are probably more interested in thinking about how that would actually operate in those sorts of contexts. All states have been participating in the working group, though.

Senator SMITH: Of course.

Mr Cormack: Just to add what the secretary said—you can find this on the COAG Health Council website—COAG Health Council has expressed interest in progressing a range of long-term health reform options. All states have been participating in those. So it has really been about encouraging a discussion rather than people drawing their position at this point in time. I do not think we could accurately say New South Wales is in and Victoria is out. That is up to those jurisdictions to speak for themselves, not for us.

Mr Bowles: And remember, this is one of about 20 items that we really talk about in the health system.

Senator SMITH: In regard to the GAP process, then, the $55,000 project money, why were states not more actively engaged in that? I notice at the back that they are not listed as attendees.

Mr Cormack: I can answer that one. The process of inviting members to join the task force was undertaken by GAP itself. I am certainly aware that a number of jurisdictions were invited; it was not just New South Wales that was invited. All jurisdictions were invited to send people. Obviously—

Senator WATT: All or other?

Mr Cormack: I am pretty sure all. I would have to check with GAP. We did not suggest to them which states should be invited or which states should not be invited. They invited a number of jurisdictions to participate in that.

Senator SMITH: Just on notice, if you could let me know, if it is known to you why some were more or less interested in participating in the GAP process.

Mr Cormack: All I could do would be to check who was invited and who chose to attend. You appear to have access to the records as to who chose to attend. We can—

Senator SMITH: No, I have only got one participant list. Is that the participant list just for this meeting?

Mr Bowles: Yes.

Mr Cormack: Yes. I am happy to follow that up further.

Mr Bowles: We will take that on notice.

Senator WATT: Perhaps when we get the minutes for that third meeting, whichever it is, that might have a participant list as well, which might let us know who was there that time as well.

Mr Bowles: Yes.

Senator WATT: Can I clarify one point that just came up: Mr Bowles, I think your answer was that Minister Hunt could have been briefed on this in his incoming minister briefs. Do you know whether he was?

Mr Bowles: No. We may have actually provided a paper. I would have to go back and have a look. I just do not want to say that we never did anything and then find out we have actually done something.

Senator WATT: Could you take that on notice?

Mr Bowles: If there was an incoming brief, we may have referenced the fact that something is happening, but the only conversation I had with him was in the context of briefing him for the COAG Health Council meeting.

Senator WATT: Could you take on notice whether he was provided with a briefing in his incoming briefs?

Mr Bowles: Yes.

Senator WATT: To pick up on some of the points that Senator Di Natale was asking about funding arrangements, I would also like to table a copy of a presentation which I understand was provided—I am not sure whether it was by Mr Cormack or by someone from the department—at that meeting in December. Whom should I provide that to?

CHAIR: The secretary.

Senator WATT: Have you got a copy of that?

Mr Cormack: I do not know what you are referring to. We probably should get a copy.

Senator WATT: I will get a copy over to you.

Mr Cormack: If we a copy, that would be great.

Senator WATT: It is obviously Commonwealth health hospital benefit. It is on government crest, Australian Government Department of Health. It would appear to be an official departmental document.

Mr Bowles: Highly likely.

Senator WATT: From the minutes of that meeting in December, it would appear that that presentation was provided at that meeting. Page 2 of the minutes refers to this presentation. Do you remember, Mr Bowles or Mr Cormack, whether that presentation was provided?

Mr Cormack: I can certainly recall providing the presentation. The extent to which time allowed us to fully go through the presentation, I cannot confirm. But certainly a presentation was made available for the purposes of that meeting.

Senator SINGH: You provided it, Mr Cormack?

Mr Bowles: Yes.

Senator WATT: And you prepared that or ultimately signed off on that presentation?

Mr Cormack: It was prepared within the department and I would have signed off on it.

Senator WATT: Mr Bowles, did you see that presentation before it was provided?

Mr Cormack: I could not recall.

Senator WATT: But you did go to that meeting, didn't you?

Mr Bowles: I do not know whether I went to the December meeting. Am I on the agenda?

Senator WATT: According to the participant list, you did.

Mr Bowles: I am on the list, yes. I must have gone.

Senator WATT: Again was the minister—I understand at the time it was Minister Ley—briefed on that presentation?

Mr Cormack: What I can say about that, Senator, is that Minister Ley was briefed on the Commonwealth hospital benefit—naturally, because it was part of the reform of federation process. So I can be pretty certain that either I or the secretary had briefed Minister Ley on the Commonwealth hospital benefit model. I certainly cannot recall briefing her specifically on this slide pack, but she would certainly have been briefed about the Commonwealth hospital benefit on at least one or two occasions. Certainly, the minister was part of the COAG Health Council process. I think this would almost certainly have come up at some point during the meeting.

Senator WATT: Was Minister Hunt ever briefed on that presentation?

Mr Bowles: No.

Mr Cormack: I do not think on this specific presentation, but, as the secretary said—and we will need to check the records—we had very comprehensive briefings at the commencement of Minister Hunt's appointment. We took him through a whole range of

issues, and it is quite possible that we would have touched on private health insurance, private health insurance reform, public hospital funding and this. But we would have to go back and check what information he was provided with. He was provided with a lot of information over that couple of days.

Senator WATT: I have received incoming government briefs, in happier days, when we were in government, in another place. I understand they are very comprehensive. Just to take you through some things in this presentation that was prepared by the department, I notice that on page 2 it states that the Commonwealth pays a case-mix adjusted hospital benefit for all hospital services regardless of setting or insurance status. That is what was being proposed under this new Commonwealth hospital benefit?

Mr Cormack: Under a central model, yes.

Senator WATT: What does 'regardless of setting or insurance status' mean?

Mr Cormack: The proposal there was that, irrespective of whether it was a public hospital or a private hospital—so that is what was referred to by the term 'setting'—with 'status', I think it is pretty obvious what that means.

Senator WATT: So the proposal was that funding from the Commonwealth would be equalised between private and public hospitals. Whether you got treated in a private or a public hospital, the Commonwealth funding would be equalised?

Mr Cormack: The idea was to make available a Commonwealth hospital benefit that could be used in either a public or private hospital setting. We had certainly gone nowhere near—and still to this date have not gone anywhere near—the detailed specification of what the costs of that would be or, indeed, whether there would be any difference between the amount paid to a public hospital or a private hospital. But the concept was to have a benefit that could be used by the citizen in either public hospitals or private hospitals.

Senator WATT: On page 1 of that presentation, the second last dot point reads, 'The objective of this Commonwealth hospital benefit is to improve technical efficiency and competitive neutrality'. By 'competitive neutrality' are you referring to a desire to equalise the Commonwealth funding between—

Mr Cormack: No, it is just to say that the two systems do very similar things. In fact, a lot of what they do is completely identical. They are paid completely differently due to the way that the Commonwealth dispenses its funding in the public hospital system. It is quite different to the way that it invests on behalf and with the citizen and the taxpayer in the private system. So it was essentially saying that the two systems do the same thing but they are funded completely differently. This model, as it was proposed, could address competitive neutrality.

Senator WATT: To some extent we have gone over this a little bit with Senator Di Natale, but I want to try to get to the bottom of it. What proportion of hospital costs, private or public, would the Commonwealth pay under this plan?

Mr Cormack: We had not got to that level of specificity, and that goes to the 35 per cent question, which I will need to take on notice, because there were obviously some assumptions made to come up with that figure. But it was never specified that it would be this specific amount or that specific amount. It was simply a recognition that when you combine the three sources of funding and effectively divide them by the total hospital activity that could be

purchased with that, you would come up with some kind of Commonwealth contribution based on a national efficient price. Further developing that out to specify whether it was going to be 40 per cent, 35 per cent or whatever was work that needed to be done and, to date, has not been done.

Mr Bowles: I want to reiterate this, Senator, because we can keep going through this, and I will keep answering your questions till the cows come home.

Senator WATT: Until 11 pm anyway.

Mr Bowles: And 11 pm tomorrow night, if you like. I am happy to keep answering questions. I have not avoided one of these answers.

Senator WATT: No.

Mr Bowles: So I want to make that point. The reality is that this was a concept. We have not done the detailed analysis because it is still in a very early concept stage. We have wanted to think about the health system. We have used this mechanism to think about the health system as a department. It is not government policy. I made that clear a number of times, and I know you accept that. But the more we keep going through a concept, about which we really will not be able to answer most of your questions, because we have not done any detailed work on this particular proposal, is not—

Senator WATT: It seems pretty detailed.

Mr Bowles: But it is a concept. It is not detailed in the way you would have to go through quite deliberate thinking about the impacts on the large part of the system. If we go back to how the nationally efficient price was introduced in the former government, for instance—

Senator WATT: I probably do not need to know—

Mr Bowles: No, I think it is an important analogy, though, Senator. The way we operate is that we would do detailed analysis. We would understand the numbers and how they impacted. We would shadow it. We would go through a process. We have done none of that. This is very early days of a concept that came out of the Federation white paper process that we have been thinking about as a department. The minister at the table has made it clear that it is not government policy. My minister has made it clear that it is not government policy. We have brought that to a conclusion effectively on 28 May by me saying—

Senator WATT: Except you kept meeting about it?

Mr Bowles: No, we did not keep meeting about it. I absolutely reject that. On 28 May I made it clear to the group that it was not government policy, and, yes—

Senator WATT: 28 March.

Mr Bowles: Sorry, yes, 28 March—it was not government policy. There are a lot of independent players who want to keep talking about reforming the health system. I suppose the real fear I have, in us continuing to have these debates, is that people get gun-shy about any change in thinking to the system, and I think that would be a pretty sad reflection on our society.

Senator WATT: Perhaps it is more about this work not being done in a transparent way.

Mr Bowles: I absolutely disagree with that. How could it not be seen—

Senator WATT: The first time I knew about it was when I read it in the paper this morning.

Mr Bowles: You are not in the department, and you are not in government at the moment. To be frank, I have talked about this publicly in a broad sense, in a concept sense, since the Federation white paper. I have spoken about it many times. There are minutes of meetings. They have not been hidden. It is an independent process to us.

Senator WATT: We have only got a few minutes before the break, so let us try and get through—

Mr Bowles: I want to reject this notion that everything was done in secret. That is not true.

Senator WATT: We might come back to that.

Mr Bowles: No, it is not true. I want to make it absolutely clear—

Senator WATT: That is your assertion. That is okay.

CHAIR: That is his answer to your question—not an assumption.

Senator WATT: I understand what you are saying, but the fact is that, on page 7 of this presentation prepared by your department, in note 1, as Senator Di Natale has already said, the assumption is that the hospital benefit is 35 per cent of the national efficient price, and you are going to take on notice the reasoning behind that. What proportion of public hospital expenditure does the Commonwealth fund now, and what proportion of the private?

Mr Bowles: I mentioned that before. On average, about 40 per cent in the public system. But it varies, and quite dramatically, across all the different states. Some will be less than; some will be greater than.

Senator WATT: And private is about 30 per cent?

Mr Bowles: We have a 30 per cent rebate issue. That is what we put into private insurance. It is not 30 per cent per se; it is the rebate.

Senator WATT: So, in a general sense, Commonwealth funding for public hospitals is about 40 per cent of expenditure; private, it is about 30 per cent, because that is the rebate?

Mr Bowles: In the context of the rebate, yes.

Senator WATT: If it is the case that this plan involved a proposal to bring in an across-the-board 35 per cent, that would mean, inevitably, a reduction in funding to public hospitals and an increase to the private sector?

Mr Bowles: I am categorically saying that is not the proposal.

Senator WATT: It is in your document.

Mr Bowles: No, it is not. It is an example—

Senator WATT: It is. It is note 1 of your document.

Mr Bowles: No.

CHAIR: Order!

Mr Bowles: Senator, it is an example in a—

Senator WATT: Why would you do examples that are not based on reality?

Mr Bowles: It is an example about how private hospitals could be funded. It was done in a particular context and for a concept. We said we would take on notice about how it actually came together. But even with that, if you look at it, on the current model, the funding is $5,000 total episode costs. And in the future model it is $5,000. There is no reduction.

Senator WATT: You are right; I was going to ask you about this. This example that is given does say that the current cost of treating a hypothetical patient would be $5,000 and under this new model the future cost would also be $5,000—so no change in the overall cost. But what is different is the Commonwealth contribution and the reduction in the private contribution.

Mr Bowles: In the context of private hospitals.

Senator WATT: Yes.

Mr Bowles: This is an example about private hospitals. As you rightly pointed out, the current arrangement is 30 per cent of the rebate. The current arrangement is the rebate, which equates to something like that; it is not quite 30 per cent. But this is a concept about how you might actually look at things differently, in the context of—

Senator WATT: In the private sector.

Mr Bowles: In the context of the private sector, not public sector.

Senator WATT: I understand that. My point is that this indicative example prepared by the department would see currently a private patient treated privately, Commonwealth funding, $1,710. Under the future proposal that was being worked up—

Senator Nash: That has been ruled out by the government, to clarify, Senator.

Senator WATT: Yes, but under the future proposal—

Senator Nash: It has been ruled out by the government.

Senator WATT: I think that is about 38 times we have heard that.

Senator Nash: I know, and you have asked a lot of questions about 10 times, too.

Senator WATT: No, I am asking different questions.

Senator Nash: So we are being clear. It's called estimates.

Senator WATT: I am asking different questions. I might start that again. Under the current model, total Commonwealth funding to this private patient would be $1,710. Under the future model—

Senator Nash: It is not a future model.

Senator WATT: It would be $1,750—it says 'future'.

Senator Nash: Yes, it says, 'future' in there, but it is not a future model.

Senator WATT: $1,750.

Senator Nash: The model has been ruled out.

Senator WATT: Should we delete that? What word would you like to insert there?

Senator Nash: No, I accept that is on the paper.

Senator WATT: It is a document of the department.

Senator Nash: I accept that is on the piece of paper, Senator.

CHAIR: Order!

Senator Nash: I would hate anyone anybody listening to this to misconstrue what you are saying.

Senator WATT: So an increase of $40—

Senator Nash: Is not going ahead.

Senator WATT: An increase of $40 from the Commonwealth to this private patient and a reduction in the premium of this private patient—so the private contribution—of $40. So that indicative example, if carried out, would lead to increased Commonwealth funding of private patients in private hospitals and a reduction in their private costs.

Senator Nash: And to clarify: it is not being carried out, Chair.

Mr Bowles: Again it was a concept at a point in time. You are construing a range of issues now, and we have already said this was an example worked up for private insurance.

Senator SMITH: But based on your previous evidence, it is a concept that the governments of Victoria and Queensland were happy to pursue?

Mr Bowles: I do not want to get this wrong. All governments are happy to have further conversations, not pursue the outcome necessarily.

Senator SMITH: Have they ruled this concept out, in the same way that the Commonwealth Minister for Health has?

Mr Bowles: I would not have a clue how they have dealt with their issues.

Senator WATT: It is not their proposal.

Mr Bowles: It is not their proposal. It was in the context of the national health reform working group and it was one of those issues that we were talking about. It has no longer gone forward through that process.

CHAIR: That concludes our consideration of cross-portfolio outcomes. We will break now and come back on outcome 4.

Proceedings suspended from 11:00 to 11:19

CHAIR: We will recommence. Senator Watt will kick off questions, but just to try and ensure that we are not causing chaos and carnage for the department and officers next door, the intention of the committee is to move through the programs under outcome 4, which is where we are at. Senator Watt and Senator Singh have some questions, and I think Senator Watt wants to find out how best to try and fit this into the program.

Senator WATT: Yes. One option is to continue asking questions under cross-portfolio, but we think the questions that we had remaining under cross-portfolio could be asked under 4.1. We can all agree that cross-portfolio is done and move to 4.1 so long as we are going to be able to ask those questions. We have still got some more questions about the stuff we have been talking about so far this morning. But we also do have some questions about the Medicare compacts, which could be either cross-portfolio or probably could fit under 4.1, or at least outcome 4 anyway.

Mr Bowles: Outcome 4 is best, if we can.

Senator WATT: Yes.

Mr Bowles: If we can stick as close as possible, it is just trying to manage—

Senator WATT: I understand. If I get to ask the questions, it does not really matter where.

Mr Bowles: If we need to mix 4 up a little, we can do that. It is just that if we start to go outside of that, it gets a little difficult to manage over two days, that is all.

CHAIR: Best to, if we can, stick to the program in order.

Mr Bowles: Yes.

CHAIR: Senator Watt, if you want to kick off.

Senator WATT: Let us keeping working through this presentation that the department prepared. If you have a look at page 1, it states that the proposal is to 'pool' Commonwealth public hospital funding and in-hospital Medicare benefits and the private health insurance rebate. So this proposal, as it was put, would be funded within the existing health funding envelope?

Mr Bowles: Yes.

Senator WATT: At the moment, we have already talked about the fact that the Commonwealth funds a higher proportion of public hospital costs than it provides for private—roughly 40-30.

Mr Bowles: Yes.

Senator WATT: If this proposal was to use the existing health funding envelope, then under this plan wouldn't the Commonwealth have to cut its contribution to public hospitals and increase its contribution to get to an equalised sort of arrangement?

Mr Bowles: No.

Senator WATT: Why not?

Mr Bowles: You are using 'equalised' in a completely different context. We are talking about looking at a model that treats the system the same; it does not say everything is funded the same. We have not even gone close to modelling the impacts across those different sectors. Yes, we have looked at 35 per cent in the context of private. There was and never has been an intention to change how we fund public hospitals. In fact, it goes to another point: this option has been reported in the press before, where it quite categorically talks about 40 per cent in the broader context. Again I understand why, but the 35 per cent in there was obviously a modelling we had done at a point in time in the context of private. Again, it is all speculation on something that is at a concept stage.

Senator WATT: So the plan—

Mr Bowles: There is no plan. The concept. How about we agree on 'the concept'?

Senator WATT: The concept prepared by the department—

Senator Nash: Rejected by the government.

Senator WATT: Allegedly rejected by the government—

Senator Nash: Not allegedly, no. Correct that record, thank you.

CHAIR: Senator Watt.

Senator WATT: But then discussed at another meeting after it was allegedly ruled out by the government—

Senator Nash: It is not 'allegedly ruled out'. It was completely ruled out by the minister this morning very clearly.

Senator WATT: And as we know, four days later it was discussed at another task force meeting and then there was another meeting in May of members of the task force, a separate body, where it was discussed again.

Mr Bowles: Not 'members of the task force'.

Senator WATT: Sure, but it was—

Mr Bowles: One member of the task force.

Senator WATT: It was still being discussed as recently as May.

Mr Bowles: No. There was a report back in May of a March meeting.

Senator WATT: So the plan or concept pools three sources of funding, and there is even a diagram on page 3, where public hospital funding is pooled with in-hospital medical benefits schedule funding and private health insurance rebate funding.

Mr Bowles: Yes.

Senator WATT: All into the one pool and then to be distributed between public and private hospitals. Obviously the public hospital funding that is referred to there and was proposed to be pooled is only available to public hospitals. So would not this plan make public hospital funding available to private hospitals by mixing it altogether and then—

Mr Bowles: It depends on what the model is. Again, we are at a concept stage. No modelling has been done. But public hospitals do not only get the public hospital funding; they actually get some of the in-hospital medical benefits as well.

Mr Cormack: And private health insurance rebates. And also, just to add to the complexity here, the Commonwealth's payment to the states under the National Health Reform Agreement is agnostic in terms of the sector in which public patients will be treated. There are a number of states across the country that use the NHRA funding, the public hospital funding, to treat public patients in private hospitals under contracted arrangements.

Mr Bowles: Which are all their arrangements, not ours.

Mr Cormack: That is right. And we do not—

Mr Bowles: Total flexibility.

Mr Cormack: We are agnostic on that, as long as the reporting arrangements and their public patient status are identified.

Senator WATT: Let us go back to how this all came about. You have tried to characterise this as an independent task force separate to government—what was the word—future gazing?

Senator SMITH: Freelancing.

Mr Bowles: I said future gazing.

Senator WATT: I understand this originated on 23 February 2016 when the department published a contract notice for the Global Access Partners Taskforce on hospital funding, and I have got copies of that here. I do not know if you have got that before you.

Mr Bowles: I do not have that before me.

Senator WATT: We can get that sent over to you. This contract was for $55,000 worth of work and the contract period was 11 February 2016 to 30 June 2016. What services did GAP provide in that period?

Mr Cormack: I think the initial services provided were to develop a program or consultation and to start to shape up the work that we had asked them to do and also within that time frame the first meeting of the task force took place. The work was stalled—when I say 'stalled', it was paused—over the election period for obvious reasons due to the caretaker convention. That work was stopped. Then it was recommenced in the second half of 2016.

Senator WATT: When did you say the first task force meeting was?

Mr Cormack: 9 June 2016.

Senator WATT: Was that in caretaker? I think it probably would have been, would it not? The election was 2 July.

Mr Bowles: It could not have happened then. If that is the case, it did not happen. There was no meeting in caretaker.

Senator WATT: What was it that made you think the first meeting was 9 June?

Mr Bowles: Maybe that was when it was scheduled and we cancelled it. Maybe that is what it is.

Mr Cormack: I will double-check on that.

Mr Bowles: Because I think there was from memory—I am going on memory now—one scheduled, and then the election was called and we cancelled it.

Mr Cormack: That is right.

Senator WATT: I am led to believe that the task force did not meet until October 2016, so perhaps it was pushed back.

Mr Bowles: That is possibly right.

Senator WATT: It would be helpful if we could just get the dates of each of the task force meetings, I think.

Mr Bowles: Yes. Again, it is not under our control, so we will find that out. If the second meeting was in December I doubt if we would have had one in October, but who knows? We will find that out.

Senator WATT: Okay. You have said that the work that was conducted between February and June 2016 was essentially preparatory work.

Mr Bowles: Yes.

Senator WATT: Why was this contract awarded via a limited tender?

Mr Bowles: Under the procurement rules, we can.

Senator WATT: Sure, but why did you make a choice to do so in this instance?

Mr Bowles: I think I had a conversation with these people and I entered into the arrangements. I cannot remember the specifics. I cannot remember the actual step by step that happened. We enter into arrangements with different groups on a range of different things all the time, so I cannot remember the specifics. But the normal process is that I would probably have had a conversation with the head of the GAP thing around—

Senator WATT: Let's not worry too much about 'would have had'. Did you? Before this tender was issued—

Mr Bowles: I cannot remember the specifics, but I would suggest that I did, because it says in the minutes you handed out for December that it was an initiative of the group. I would say that, after a conversation, we have entered into an arrangement.

Senator WATT: I think the head of GAP is a Mr Peter Fritz.

Mr Bowles: That is correct.

Senator WATT: So you think that you probably had a conversation with Mr Fritz prior to this contract being awarded?

Mr Bowles: That is possibly right.

Senator WATT: To the extent you remember, did he suggest to you or did you suggest to him that his firm might do some work around future public hospital funding and—

Mr Bowles: I cannot recall the specifics, but I know I did have a conversation with him about the broad nature of health reform, and maybe together we came up with that as an answer. To be honest, I really cannot remember. But that is likely, too.

Senator WATT: I might get you to take that on notice—the circumstances that led to this contract being issued.

Mr Bowles: It will be mostly my recollections, but I do know I had a conversation with Mr Fritz, and that was about broad health reform. We may have settled on this as an outcome. That could be right.

Senator WATT: Why did you not seek these services by open tender?

Mr Bowles: Again, under the Commonwealth procurement guidelines, we can procure items like this, and we do for items under, I think, $80,000.

Senator WATT: Policy work concerning the future funding of hospitals is a pretty significant piece of work.

Mr Bowles: Yes.

Senator WATT: You do not think it would have been more appropriate to put this out to the market, to see who the best people are to provide the advice?

Mr Bowles: If this was the only thing we were going to do, that might be a good idea, but this was a specific issue that we wanted to look at. That is in the context of a whole range of policy advice that we provide to governments over time.

Senator WATT: You said 'if this was the only thing we were doing', or something like that. Are there other pieces of work—

Mr Bowles: Nothing in this space.

Senator WATT: Around the future funding of hospitals?

Mr Bowles: No.

Senator WATT: Or private health?

Mr Bowles: We do policy work all the time, Senator. We did a lot of policy work around developing the current hospital agreement that is in place at the moment, that has delivered another $2.8 billion over the forward estimates. We will do more work into the future on how we actually deliver a future funding arrangement for public hospitals.

Senator WATT: Could you take on notice what other contracts or consultancies have been either issued or put out to tender, if they are still underway, for work relating to the future funding of hospitals or private health?

Mr Bowles: We can take that on notice. I am trying to think. We do not have a lot that is specific to that. Most of that will be internal policy thinking that we do. There would be some things on private health insurance, I am sure. Let me take that on notice.

Senator WATT: Take that on notice.

Mr Bowles: We will have to trawl through the records.

Senator WATT: I remember that you and I had a conversation at the Health estimates, I think it was, about the National Cancer Screening Register.

Mr Bowles: Yes.

Senator WATT: I have just had a look. In that instance you said:

It is more usual than not that we go to open tender ...

You were talking there about IT stuff. You said:

... we would go to open tender.

Mr Bowles: Yes.

Senator WATT: IT projects would ordinarily go to open tender?

Mr Bowles: A lot of things go to open tender. It depends on what we are talking about, and depending on what the rules are. If we are talking about tenders that are going to cost hundreds of millions of dollars, open tender. If we are talking about things that are quite—

Senator WATT: This could cost billions of dollars.

Mr Bowles: No, it will not.

Senator WATT: Not this particular contract—

Mr Bowles: This contract—

Senator WATT: But where it might lead.

Mr Bowles: We are talking about the contract; we are not talking about what the system might do. The contract was for $55,000. Legitimately, through Commonwealth procurement rules, we can do this.

Senator WATT: Was anyone else invited to apply for a contract to do this work?

Mr Bowles: No.

Senator WATT: Why not? Were they the only organisation that you thought could do the work?

Mr Bowles: That was the group I thought could do the work because it was independent in nature. Through the Commonwealth procurement rules, I can do that.

Senator WATT: But wouldn't there be many consultancies and other groups out there who could do this work?

Mr Bowles: There possibly are.

Senator WATT: Why was it that you thought these were the best people to do the job?

Mr Bowles: It is a judgement call at a point in time.

Senator WATT: Do you know Mr Fritz? How long have you known Mr Fritz?

Mr Bowles: I met him at around that time, I think.

Senator WATT: You issue a contract to a consultancy to look at the future funding of hospitals, without going to a tender, to a person you had only just met?

Mr Bowles: I do not know the specifics of when I met him, Senator. If you are trying to say that I have done something odd, that is not the case.

Senator WATT: I am genuinely trying to uncover why these people were preferred over—

Mr Bowles: Because they have a track record of doing policy work, in a public policy sense, in a range of areas.

Senator WATT: In health?

Mr Bowles: I think they have done some other work in health. I do not know the specifics. I know they have done work in employment and other places. So, yes, they have a track record of doing things in that space.

Senator WATT: Don't you think, again, for a piece of work about the future funding of hospitals, it would be wise to select a group with a track record in health and hospital funding?

Mr Bowles: If we were going to look at how we would implement something of this concept size, we would do a whole lot more work. This is the point I am making. This was a concept conversation. This was not an implementation conversation. If we were going to implement something like this, we would have done a range of different things. We have not progressed that at all.

Senator WATT: This contract expired on 30 June 2016. Was another contract issued after that date for work to be performed after that date?

Mr Bowles: I am not sure specifically. They would be fulfilling the contractual arrangements for that particular period, even though it flows on after the period.

Senator WATT: Mr Cormack, do you know whether another contract was issued?

Mr Cormack: I do not think another contract was issued. I need to check whether we varied the delivery date from the end of June 2016. But I do not believe another contract was issued.

Senator WATT: So the work that GAP was still doing, as recently as that meeting in May—

Mr Bowles: March.

Senator WATT: No, there was—

Mr Bowles: No, March.

Senator WATT: The task force's last meeting was in March.

Mr Bowles: We are not funding the other meeting. We do not fund the other meeting.

Senator WATT: But representatives of GAP, in May—

Mr Bowles: At a governance meeting which we had nothing to do with, had no control of and we do not fund.

Senator WATT: I know, but representatives of GAP met with representatives of the Department of Health in May about a range of matters.

Mr Bowles: Yes.

Senator WATT: But this was one of the matters that was discussed at that meeting?

Mr Bowles: It was an update on the March meeting.

Senator WATT: But you think that any of the work they have done past 30 June is covered by this—

Mr Bowles: Yes.

Senator WATT: $55,000 contract that expired then?

Mr Bowles: Absolutely.

Senator WATT: Could you check that for me?

Mr Bowles: I am saying to you that we have not paid any more.

Senator WATT: How much have you paid them? $55,000?

Mr Bowles: $55,000. And just because the work did not finish, they finished it after the due date. We will check whether we varied the arrangements, but it is not unusual for people to deliver after the end of a particular period.

Senator WATT: Are you aware of the ties between GAP and the Australian Centre for Health Research?

Mr Bowles: Personally, no. I do not even know what the Australian—

Senator WATT: Do you know, Mr Cormack?

Mr Cormack: No.

Senator WATT: I will come to that. I have had a look at GAP's website, and it suggests that it and the Australian Centre for Health Research have done a number of research projects together. Do you know what role the Australian Centre for Health Research has within the GAP task force?

Mr Bowles: I do not.

Senator WATT: The very first participant is Rebecca Bartel, Executive Director, Australian Centre for Health Research.

Mr Bowles: I personally do not know her. I might have met her on the day, I suppose, if I was there.

Senator WATT: Mr Cormack, is it fair to say that that centre does have involvement in this task force?

Mr Cormack: If they attended the meeting, certainly, they would. As I said to you before, we do not control the invitees. In fact the reason why GAP were chosen was due to the broad engagement they have across a range of different industry segments. We do not really determine who they invite.

Senator WATT: Do you know whether, apart from having their executive director attend at least one meeting, the Australian Centre for Health Research has had any other involvement in this task force or the work that it has conducted?

Mr Cormack: I would have to check, but the work that has been undertaken has been confined largely to GAP itself. It has a small staff. The most visible part of the work to date has been at the task force meetings, and a number of people contribute to those meetings.

Senator WATT: You do not recall the Australian Centre for Health Research having prepared any papers that were presented at meetings of the task force or anything like that?

Mr Cormack: I would have to check records that may have been taken to confirm that. I do not specifically recall that. What I can say is that the process that was undertaken was meant to be inclusive of a wide range of different sectors and interests—government, non-government, insurers, consumers, medical profession et cetera. They all made contributions because they all have interests in this sort of policy proposal or policy concept. So it would not be at all unusual for a group like that to make a contribution if they were invited.

Senator SINGH: Was this $55,000 contract taken to cabinet?

Mr Cormack: No.

Mr Bowles: No.

Senator SINGH: So you just signed off on it, Mr Bowles?

Mr Bowles: A delegate would have, in the department. Cabinet does not sign off on those sorts of things.

Mr Cormack: No.

Senator SINGH: But—

Mr Bowles: Never.

Senator SINGH: What about just the contractual arrangements and details?

Mr Bowles: No.

Senator SINGH: None of that was taken to cabinet?

Mr Bowles: No. There is no need for it. We contract thousands of different things every year.

Senator SINGH: I am sure you do.

Mr Bowles: None of them go to cabinet. These are issues for the department to manage under the Commonwealth procurement rules.

Senator SINGH: Is it common that no tender process is used?

Mr Bowles: No, it is not common, but it is not uncommon either. Under the Commonwealth procurement rules, if it is under $80,000—but I will be corrected by someone if it is wrong—it can be direct sourced. We do that for a range of different things. It will depend on the particular topic. We have been doing that forever.

Senator WATT: I have not come across the Australian Centre for Health Research before. What can you tell us about them?

Mr Bowles: I can tell you absolutely nothing. I really do not know anything about them at all.

Mr Cormack: I do not know a lot about them. I have seen a publication or two which seem to focus on private health insurance, but I do not have a great degree of familiarity with them.

Senator WATT: I understand they have pretty close ties to the private health insurance industry. Do you know if that is correct?

Mr Cormack: I think I just suggested that that is the case. I do not know them particularly well, but I do understand that they have an interest in research related to private health insurance.

Senator WATT: I understand, for instance, that the address of the Australian Centre for Health Research is the same address as a private health insurer. Do you know if that is the case?

Mr Cormack: I do not have that information available to me. If that is the case, that is the case. I am happy to take any further questions.

Senator WATT: I understand that the Australian Centre for Health Research is funded by a private health insurer as well.

Mr Bowles: I do not know.

Mr Cormack: That may be the case.

Senator WATT: Do you think it is a conflict of interest for the department to outsource public hospital policy to representatives of private health?

Mr Bowles: No, we are not outsourcing anything. I have made this point a number of times now. This is an independent group that we contracted to do some independent thinking across the broad sectors in the healthcare arrangements. Anything that will come back to the department will be considered in the context of policy advice we may or may not give to government, and government make decisions. It is absolutely incorrect to characterise it the way you have.

Senator WATT: Just to come back to Mr Fritz, who is Chairman of GAP and Group Managing Director of TCG, who is perhaps the parent company or—

Mr Bowles: I do not know the company structures of Mr Fritz.

Senator WATT: Mr Fritz is obviously a very successful businessman. His website says that the TCG companies have an annual turnover of $1.3 billion, and he has also written books like *The Profit Principle*. You are saying, though, that you are not sure that he necessarily has an expertise in hospitals or health policy?

Mr Bowles: No, again, he is obviously a wealthy individual who has set up a public policy type concept. This is not unusual. You might know the World Economic Forum, which was set up by Karl Schwab; a similar type concept in a much, much bigger scale. There are people who do this sort of stuff. I do not know the intricacies of Mr Fritz's business dealings. He is not providing policy advice; he is providing a forum where we can have a conversation.

Mr Cormack: Senator, subsequent to your questioning of the secretary, GAP has had some significant engagement and involvement in the sector. If I can mention a couple of those: a congress on wellness and aging in 2007, an oncology steering committee in 2007, a primary health care and private patient journey workshop in 2011, the Australian healthcare system as a market in 2014, the GAP congress on Australia's health in 2009, the GAP task force on productive ageing in 2014, the GAP task force on government health procurement in 2015, implementing a rationally led health system in Australia GAP forum in 2007. They are a group that has a track record of public policy debate and public policy research in health and in a range of other areas. No doubt you can find that on their website. So they do have some experience.

Senator SINGH: Who is GAP owned by?

Mr Bowles: I have no idea. I presume Mr Fritz has something to do with it. It is possibly part of that. GAP is a public policy institute that Mr Fritz deals with.

Senator WATT: You have talked about the work that has been done by GAP in this space previously. Their website suggests that they have collaborated with the Australian Centre for Health Research on a number of research projects.

Mr Bowles: Yes.

Senator WATT: I have just pulled up the members of the board of the Australian Centre for Health Research. I will not name the people because I do not want to cause them any issues individually, but the chair of the board of this centre is from Australian Unity Ltd, as is another director. Another director is from Bupa. Another director is from Epworth Health Care. Other directors are from Epworth Health Care, the Pharmacy Guild, and Cabrini Health. It does seem very much to be an organisation run by and for the private health sector. They have a track record of collaborating with the consultants you appointed to come up with a policy around funding hospitals, public and private, into the future.

Mr Cormack: GAP and other organisations that we may fund for deliberative policy processes also collaborate with the Australian Medical Association, state governments, Commonwealth governments, representatives of the private hospital markets, and aged-care providers. So they do have an engagement role with a number of groups that clearly have specific interests. As part of the policy process, it is important that government understands the different range of interests and their views on emerging policy processes. That is an inherent part of undertaking policy analysis—to understand those interests and perspectives.

Mr Bowles: Senator Watt, are you are talking about one group that participated?

Senator WATT: Yes.

Mr Bowles: As you have seen on the participant list, a lot of people participate.

Senator WATT: Yes.

Mr Bowles: So it will not necessarily get skewed in one direction if you have all of those other players in the space.

Senator WATT: What I am more pointing to is GAP's website, which says that they seem to be regular collaborators in research projects with this organisation. I accept that they were only one attendee.

Mr Bowles: Yes.

Senator WATT: But there does seem to be a pretty clear link. And again, that's their website.

Mr Bowles: Again, that is not unusual in this space. The list of people or groups you mentioned are insurers and private hospitals. It is not unusual that they have groups that get together and think about policy.

Senator WATT: Sure. About funding of public hospitals as well?

Mr Bowles: No. You are talking about two separate issues. You are talking about a group who exist independently and who happen to participate in this process.

Senator WATT: In the minutes that I tabled earlier of the meeting in December 2016, about halfway down it talks about how the GAP task force on hospital funding operates under the Chatham House Rules of non-attribution and in accordance with the principles of the 'second track process'. What does that mean?

Mr Cormack: The Chatham House Rules I think you are probably familiar with.

Senator WATT: Yes, secret.

Mr Bowles: No.

Mr Cormack: It does not mean that at all. It means that people are free to express their views to contribute to a deliberative policy idea or debate but to have that done in such a way where the comments are not specifically attributed to the individuals. It is not—

Mr Bowles: I will make a better point. People do not understand what Chatham House Rules. It is not secret. If you think it is secret, that is incorrect.

Senator WATT: It was not broadcast to the Australian people at large, that is all.

Mr Bowles: I beg your pardon, but this has been in the public media since about November 2015.

Senator WATT: Not these minutes.

Mr Bowles: You do not put minutes—

Senator WATT: Or the presentation.

Mr Bowles: You do not put minutes in public forums. You do not do that in public forums.

Senator WATT: What does 'second track' mean?

Mr Bowles: That is not correct. We do not operate in the media cycle. We are a department of state where we provide policy advice to governments who make decisions. I totally reject this notion of secrecy.

Senator WATT: I will let people draw their own conclusions.

Mr Bowles: No, Senator. By saying that you are inferring something about what I am saying.

Senator WATT: Well, it is secret. It has not been out there in the public domain until this morning.

Mr Bowles: That is not correct. This notion of a Commonwealth hospital benefit has been in the media since about 2015, even after the federation reform stuff finished.

Senator WATT: I think you and I could argue about that all day.

CHAIR: I would rather go to questions.

Mr Bowles: I can actually show you articles where it has been in the paper since 2015.

Senator WATT: What are the principles of the second track process?

Mr Bowles: I do not personally know what a second track process is.

Senator WATT: Do you, Mr Cormack?

Mr Cormack: It is a term that GAP used to describe the particular process. My understanding from our perspective is that when government is, I guess, progressing a deliberative policy engagement process, it typically does the standard government consultation mechanisms right up until the very formal process, for example, of a green paper or a white paper, if you want to take it to that level. In fact, this started with a green paper process—the reform of federation process.

My understanding of the second track process is that it effectively uses a range of other networks that are not necessarily fronted or organised by government; they are organised by other organisations who seek to contribute to a policy process using mechanisms that are not necessarily confined to the way government traditionally does its policy development process. I think you are probably best to ask that question of Mr Fritz and GAP.

Senator WATT: I do note in passing that every page of the minutes of this meeting is watermarked 'Confidential'. I am not sure if that means it is not secret.

Mr Bowles: Again, we are talking about minutes versus the concepts. The concepts have been in the public domain. Let me clarify something I said earlier, again, about my attendance at these meetings. I was at the December meeting. I was not at the 28 March meeting. I think I said that I indicated something at the March meeting. I actually indicated that at the December meeting.

Senator WATT: It was at the December meeting that you indicated that it was not government policy?

Mr Bowles: That is right.

Senator WATT: That is what I thought you said originally. It was not at the March meeting, which occurred after you had had the discussion with the minister. There was no reference to it not being government policy?

Mr Bowles: Sorry? In the March meeting there was reference to it.

Senator WATT: I thought you just said there was not?

Mr Bowles: No. I did not attend the March meeting.

Senator WATT: Yes.

Mr Bowles: But at the March meeting there was a reference to how it is not government policy.

Senator WATT: By whom?

Mr Bowles: It does not attribute names to anything. It was just said that it was not government policy in March. At the December meeting I specifically addressed the issue of this is not government policy.

Senator WATT: So in December—

Mr Bowles: 'Or under active consideration', I think I said.

Senator WATT: So you made that point in December?

Mr Bowles: Yes.

Senator WATT: But the work continued—

Mr Bowles: Yes.

Senator WATT: beyond that, went to a meeting in March, which occurred after the COAG ministers council?

Mr Bowles: Yes.

Senator WATT: Which was after the minister had said, 'Don't go any further.' And it has come up again in a meeting in May, six months after—

Mr Bowles: No—

Senator WATT: you had said it was not going any further.

Mr Bowles: Let me go back. It was referenced in a governance committee of GAP, which has got nothing to do with the department, about a March meeting. I have said that at least 20 times now. I do not want it to keep being referred to as another meeting of the GAP task force. It was not.

Senator WATT: So back to these minutes. On page 1 they talk about this GAP task force: 'It is currently chaired by Mr Peter Fritz'. Is he still the chair of this GAP task force?

Mr Bowles: Yes. So far as I am aware.

Senator WATT: This task force which is ongoing?

Mr Bowles: It last met on 28 March. I am not aware of any future meetings planned. We said before that they are in the process of finalising their process.

Senator WATT: On page 2 of the minutes it says: 'A permanent chair for the task force is still being sought.' Have you or GAP asked anyone else to chair the task force?

Mr Bowles: I have not had anything to do with who chairs what. It is not my meeting.

Senator WATT: Has a permanent chair of the task force been appointed?

Mr Bowles: Not to my knowledge.

Senator WATT: Do you know, Mr Cormack?

Mr Cormack: No.

Senator WATT: Okay.

Mr Cormack: All I can say is that Peter Fritz has chaired the meetings that I have attended.

Senator WATT: So to the best of your knowledge, Mr Fritz remains the chair of the task force. Has anyone else declined the offer to chair it?

Mr Cormack: I do not know, because we do not organise it.

Mr Bowles: We do not organise it.

Mr Cormack: It is organised by GAP.

Senator WATT: Have you got a view on who should be the chair going forward?

Mr Bowles: No. It is not our meeting.

Senator WATT: Given that they are saying a permanent chair is still being sought.

Mr Bowles: It is not our session.

Senator WATT: At the back of those minutes it did have a list of the attendees, and we have referred to that a couple of times. Did anyone other than those participants attend either the first or third meetings of the task force?

Mr Bowles: I would have to take that on notice. I would not have a clue.

Senator WATT: How are we going getting a copy of those minutes, by the way, for the third meeting?

Mr Bowles: We have not got there yet, Senator.

Senator WATT: Could we get one of the people behind us to organise a copy of those?

Mr Bowles: We will see what we can do.

Senator WATT: And we might as well ask for the minutes of the first meeting as well?

Mr Bowles: I am still trying to clarify whether the December meeting was the first or the second meeting. Because it was definitely not held in that June.

Senator WATT: It says, 'second meeting'.

Mr Bowles: I know it says 'second meeting', but I am just trying to clarify whether it was the first or the second.

Senator WATT: Okay.

Mr Bowles: I have a funny feeling it was probably the first.

Senator WATT: It would be very helpful if we could get those minutes.

Mr Bowles: We are trying to find them.

Senator WATT: Okay.

Mr Bowles: Again, it is not our process so we are trying to find them.

Senator WATT: Sure. In all of that, I missed your answer to my question, which was: did anyone, other than the participants listed in this second meeting, attend the other meetings of the task force?

Mr Bowles: I do not know the answer to that.

Senator WATT: Do you know, Mr Cormack? Do you remember anyone else? It sounds like you were a bit more of a regular attendee. Do you know whether there was anyone else?

Mr Cormack: I would rather check the records of the meeting. I am sure there would have been a number of people who were regular attendees. But I do not feel confident to just work my way through the list and say that person was or that person was not. I would prefer to check the record for that.

Senator WATT: As I think we have talked about before, there are 21 participants listed here. Seven are from Commonwealth and state governments, three from the private health insurance industry, two from the private hospitals industry, seven from consultancies like GAP, Ernst & Young and others, and two others. Did you have any input into the list of participants who were invited?

Mr Bowles: I did not, no.

Senator WATT: Mr Cormack, did you?

Mr Cormack: Yes, certainly when the task force was being established I do recall being provided with an indicative list of names and I provided some comment on those. It was quite a broad, large list that they had had from, I presume, previous task force activities unrelated to this one.

Senator WATT: Do you remember who the additional names you suggested be invited were?

Mr Cormack: No, I cannot recall that. I will have to check the list that was given to me.

Senator WATT: I do not know; you might have sent something in an email with some suggestions?

Mr Cormack: As I said, we will take that degree of detail on record.

Senator WATT: Was there anyone whom you suggested not be included?

Mr Cormack: I may have but I will take that on notice.

Senator WATT: Do you remember anyone?

Mr Cormack: Not off the top of my head.

Senator WATT: Do you think this mix of people is the right mix of people to be coming up with public hospitals policy?

Mr Cormack: They are not coming up with public hospitals policy. We have a far—

Senator WATT: Public and private.

Mr Cormack: We have a far more expansive range of activities every day within the department and with other engagements to look at and develop policy options. The secretary earlier referred to the work we do with AHMAC, which is a regular source of information. This is an isolated piece of work and it was essentially to get views on a concept that the government has clearly decided not to go ahead with.

My sense is that it needed to be representative of government, non-government, healthcare providers, healthcare insurers, consumers and professional groups. And I believe that the list, even though the attendees have changed a bit from one meeting to the next, has been broadly reflective of that. But we do not control whether those people that are invited end up taking up their invitation to join. At the end of the day, GAP puts out invitations. Some people accept them, some people do not. And the mix of people who attend may be not exactly the same as the list that were originally invited.

Senator WATT: You have taken on notice the additional names you suggested be included and anyone you suggested not be included.

Mr Cormack: Yes, to the extent to which I have made those suggestions, I will check the records for that.

Senator WATT: Are there any groups that you suggested be included that ultimately were not?

Mr Cormack: I do not know.

Senator WATT: Can you take that on notice as well?

Mr Cormack: Yes, I can have a look at that.

Senator WATT: What the outcome of those suggestions was, I suppose, is what I am asking for.

Mr Cormack: Sure.

Senator WATT: Are there any groups that are not on this task force about the future of health funding that you think should be included in that kind of discussion?

Mr Bowles: Let me go back again—

Senator WATT: I know it is not your process but—

Mr Bowles: It is not our process and it is not about the future of health funding.

Senator WATT: Really?

Mr Bowles: No, it is about the Commonwealth hospital benefit model quite specifically, and that is what it talks about.

Senator WATT: Which is the future of health funding. Do we need to go back to the presentation?

Mr Bowles: We do not have to go back. We are talking about a concept that one group is looking at. If that was to proceed in any way, shape or form, there would have been a completely different set of considerations. As we have said 400 times now, it is not government policy.

Senator WATT: Are there any groups that are not on this task force that you think should be part of this kind of discussion?

Mr Bowles: I have no view on that because this is just one process in a broad range of things that we will deal with. This is an independent group, not selected by us, but, yes, we might have had some input into who should and should not be on there. But ultimately, they come or not come based on their own decisions.

Senator WATT: Why were doctors not invited to participate?

Mr Bowles: Again, you would have to ask—

Mr Cormack: They were.

Mr Bowles: They were.

Senator WATT: They were invited but they did not come?

Mr Cormack: I am not going to play this game of who was invited and did not come, who should have been invited and did not come. I said I would take that on notice, but I can categorically say that the College of General Practitioners for one were certainly invited as part of this process. And I will take on record others. Yes, we think that certainly representatives of the medical profession were quite appropriate to consult on this and, indeed, were invited.

Senator WATT: I can see there is a rep of the College of GPs here, but GPs generally do not practise in hospitals, do they?

Mr Cormack: They are representative of the medical community that have a very valid role to play in referring their patients to a whole range of services, including those provided in the public and private hospital sectors. They are regularly asked to interpret the complexities

of our healthcare system to their patients and, indeed, they bring a unique and valued perspective to a process such as this.

Senator WATT: I understand that—

Mr Bowles: And if you look at rural health, GPs operate in hospitals all the time.

Senator WATT: Sure. I understand that you might not remember every organisation who was invited to participate but let us narrow it down to some pretty well-known ones. Was the AMA invited to participate?

Mr Cormack: I have given my answer. I am not going to keep going through this process of you asking the same question and expecting a different answer. I said I will give you a list—

Senator WATT: I think the AMA is a fairly significant health stakeholder.

Mr Bowles: We are going to take it on notice.

CHAIR: They have said they will take that on notice.

Mr Bowles: We have said we will take on notice who and why. Again, this is one process, an insignificant process in the overall scheme of issues.

Senator WATT: But the department was funding this work. Surely it would ultimately be the party that would implement the recommendations of this work, subject to government processes. Surely you had some sway over who was going to attend this and participate?

Mr Bowles: Again, we have indicated that we have provided some advice. Again, this is one small part of a process around a concept at a point in time.

Senator SMITH: Mr Cormack, that information you are going to make available to us will include state government health officials?

Mr Cormack: It will include the list provided to me by GAP plus or minus any additions or amendments to that that I suggested back to GAP. But I do not have the ability to recall the list.

Senator SMITH: I have heard that.

Mr Cormack: And the additions to the list.

Senator SMITH: But it will include state officials?

Mr Bowles: If they were invited—and my understanding is they all were—it will be on the list.

CHAIR: Senator Watt, can I get an indication from you how much longer you have? You have been going since 11.20, and I have other senators waiting to ask questions.

Senator WATT: I would say on this item probably 15 to 20 minutes.

CHAIR: Fifteen would be great.

Senator WATT: Okay.

CHAIR: Then hopefully we can move to other issues.

Senator WATT: I will do what I can. The minutes of this meeting in December, page 3, state:

> The Commonwealth health benefit would change the remuneration arrangements for private doctors.

That being the case, would it not be appropriate for them to be part of this discussion?

Mr Bowles: I go back again, this is a concept. It is very easy to pick particular things out of context and ask why someone else was not there. This is not a decision-making body. This was not even a final policy-developing body. This was an independent group who were thinking about the health system more broadly in this context.

Senator WATT: And then at page 4, the minutes warn that significant hurdles would have to be overcome, including opposition from private doctors and medical specialists. So this discussion is occurring in the absence of any representatives of those groups?

Mr Bowles: I do not accept that at this particular point. There are representatives—

Senator WATT: But they are not there.

Mr Bowles: There are representatives of doctors.

Senator WATT: Who?

Mr Bowles: There are representatives of doctors there.

Senator WATT: Which one?

Mr Bowles: This—

Senator WATT: I am talking about private doctors. Who?

Mr Bowles: There are representatives of the different private groups in there.

Senator WATT: Yes, private hospitals.

Mr Bowles: There are some representatives of hospitals and insurers, the RACGP and a range of other things.

Senator WATT: Not private doctors, though. Private hospitals and private insurers, sure, but not private doctors who—

Mr Bowles: I am going to go back to what I have been saying. This is a concept. It was a broad-ranging conversation about a concept. I cannot give you any further detail on who, why or when people said things. And you can go to every paragraph and every page and I will give you the same answer.

Senator WATT: Mr Cormack, I think you said that an attempt was made to make this a fairly broad group, including consumer representatives. Who were they? Was that Mr McGowan?

Mr Cormack: There were representatives, I think, invited from the Consumers Health Forum or people associated with them, and certainly Russell McGowan was a regular and I think a very well-known representative on a number of consumer groups.

Senator WATT: So you do remember that reps from the Consumers Health Forum were invited, but you do not remember whether AMA reps were invited?

Mr Cormack: No, what I am saying is that I was provided with a list of suggested invitees. I made comments on those. I forwarded them back to GAP, and I will make that available on notice.

Senator WATT: Again, there is no-one here from any of the public hospital providers, any of the state health departments?

Mr Cormack: I will go back—

Senator WATT: There is New South Wales Treasury.

Mr Cormack: I will go back to the list. It is quite possible that there were invites that went out, from my recollection, to a number of public hospital providers in the states. And it may well be that at a whole-of-government level they decided how their representation would be managed. But again, I will just give the same answer that I gave before. We will get you the list.

Senator WATT: Again, just coming back to the former minister's role, you said before that the work commenced under her in, was it, December when she said it was not to proceed? What was the way you put that?

Mr Cormack: I do not recall saying that she said it was not to proceed. I think what I—

Mr Bowles: Who is this?

Mr Cormack: Minister Ley, I think, the senator is referring to.

Senator WATT: Sorry, I think what it was, Mr Bowles, was that you said that in that December meeting of the task force you said that to that meeting that the policy would not go ahead.

Mr Bowles: No, I said it was not government policy and it is not under active consideration.

Senator WATT: But work continued for months afterwards?

Mr Bowles: Yes, that is correct. We have gone over that.

Senator WATT: Yes.

Mr Bowles: Because it is an independent group that, yes, we funded and all of that sort of stuff and, yes, we participated. But it was an independent group doing thinking around reforming the health system.

Senator WATT: And then the new minister took over in, what, January I think it was?

Mr Bowles: I believe so. I cannot remember the exact date.

Senator WATT: And we have gone over what conversations were had. The last time you have discussed this with the current health minister was that conversation in the lead-up to the March COAG meeting or health ministers meeting?

Mr Bowles: I had a conversation with him in the lead-up to the COAG health meeting and I had a conversation with him this morning when he told me what he was saying.

Senator WATT: Nothing in between?

Mr Bowles: No.

Senator WATT: Can you assure us that no-one within the department has spoken about this with the minister or his office?

Mr Bowles: If it was anyone, it would be me or Mr Cormack. You have not spoken to him since then on this issue?

Mr Cormack: I do not recall speaking to the minister subsequent to the preparation we went through for the COAG Health Council meeting. That would have been probably late February, early March that we would have had that conversation with the minister.

Senator WATT: What about with the minister's office?

Mr Cormack: I do not recall any specific conversations with the minister's office subsequent to that. But we talk to the minister's office about a lot of things.

Senator WATT: That meeting on 18 May where it came up again, just remind us exactly what that was a meeting of?

Mr Cormack: Yes. If you can imagine GAP as—well, not imagine. GAP is a company, it has a body of work and it sets up governance arrangements or committee structures to oversee a body of work that it is doing in the health space. It currently has interests in privacy, for example, which we are not currently doing any specific work on. It has interests in work that it is currently completing, such as the hospital benefit. And it has interests in work that it has completed in the past and is interested to see how that work has influenced or not future government policy. And it also considers ideas for future work. So it is like a clearing house for all of the activities that GAP does or is planning to do or has done in the health space. It goes through a list of items like a work plan and talks through those particular issues. Within that was obviously the hospital benefit work that we have been talking about.

Senator WATT: What are some of the other projects they are working on with you?

Mr Cormack: They are not necessarily working with me on it.

Senator WATT: With the department.

Mr Cormack: They are not necessarily working with the department on anything else. What they do is, because they have an active policy or think-tank in health, they find it useful to have a representative from the health department to be able to give them perspectives and views on different matters to do with health. If an item comes up and I have a reasonably good working knowledge about what is going on in the health policy world, I will provide some input if asked. It can be a range of issues, but I think that is probably a question best asked of GAP because, again, that is not our process. I am simply an attendee at that committee meeting.

Senator WATT: Could you take on notice the other items of work that GAP are undertaking that you are in communication with them about?

Mr Cormack: Certainly.

Senator WATT: I have a few short questions about the impact of this proposal on private health insurance. What effect would abolishing the rebate have on premiums?

Mr Bowles: We have not done the work on that, Senator.

Senator WATT: Again, in that proposal, it is clearly contemplated—

Mr Bowles: Again, in that concept—

Senator WATT: Concept, proposal, plan; whatever you want to call it.

Mr Bowles: I have said many times this morning that we have not done modelling on what the impacts are on any of it. It is a concept.

Senator WATT: So you do not know what the impact of this concept, plan, proposal—whatever you want to call it—would be on private health insurance premiums?

Mr Bowles: I think I have answered that at least—

Senator WATT: Or membership of private health insurance?

Mr Bowles: Again, same answer: we are talking about a concept. No modelling has been done. Clearly, we would need to do all of that if we were to contemplate that. We are not contemplating that. It is not government policy, and the minister has said that a number of times.

Senator WATT: What do private health insurers think of this concept?

Mr Bowles: You would have to ask them.

Senator WATT: They are—

Mr Bowles: I am not going to verify—

Senator WATT: The task force is stacked out by private health insurers. Surely, you know what their view is?

Mr Bowles: The group is not stacked out by anybody. I refute that.

Senator WATT: Well, there is a large number of them there.

Mr Bowles: I refute 'stacked out'. That is an emotive term, again.

Senator WATT: There is a large number of them there.

Mr Bowles: There are a number of people on this group that represent the broad industry.

Senator WATT: I am asking about the view of private health insurers.

Mr Bowles: And you should ask them.

Senator WATT: But you have been at the meetings.

Mr Bowles: I have been at one meeting. You should ask them.

Senator WATT: Mr Cormack has been at the meetings.

Mr Bowles: You should ask them.

Senator WATT: Why can't I—

Mr Bowles: We are not paraphrasing what—

Senator WATT: But—

Mr Bowles: We would have to paraphrase.

Senator WATT: What view was put by private health insurers when this was discussed at the task force meetings that you and Mr Cormack—

Mr Bowles: Again the minutes are the best reflection of that. We have taken on notice the second lot. Again I do not believe it is appropriate for me to paraphrase what they have said.

Senator WATT: Why?

Mr Bowles: Because I did not take any verbatim record of what they said.

Senator WATT: But you must have some recollection—and Mr Cormack must as well—

Mr Bowles: It is answered.

Senator WATT: I notice that hirmaa, which, as you know, is the peak body for not-for-profit health insurers, said of option 2 in the federation reform discussion paper, which this links to:

... there are risks of damaging unintended consequences, possibly to the future viability of the sector as a whole.

What is your understanding of those concerns from not-for-profit health insurers?

Mr Bowles: That is their view at that point in time. Again we are talking about a concept where no real detail work has been done.

Senator WATT: Has their view changed?

Mr Bowles: I do not know.

Senator Nash: I am sure it has. We have ruled it out.

Senator WATT: No, I was asking about their view of this concept—

Mr Bowles: You would have to ask them. I have not heard anything since.

Senator WATT: As it was discussed in the last couple of weeks.

Mr Bowles: I have not heard from them.

Senator WATT: The last question from me: you argue that the rebate under this concept would be reinvested in hospital services, but the minutes that I have tabled note that the rebate would be removed from general services like dental, optical and physio, without any reinvestment in those services. Wouldn't that make those services unaffordable?

Mr Bowles: Again we are talking about a concept. No, there was no decision about any of that. The concept was to look at the pools of funding that go to both public and private hospitals. That is all. There was no decision made around ancillaries within the private health insurance arrangement. That was one thing that was identified in there. Sure, there are a number of issues, risks, concerns and a whole lot of things. That is why you have public policy debate. That is why this is important.

Senator WATT: Okay, I think—

Mr Bowles: Can I just finish on this: there has been that independent process and it is not government policy. That needs to be very clear because—

Senator WATT: I hear what you say.

Mr Bowles: Thank you.

CHAIR: Excellent.

Senator REYNOLDS: It has only taken three hours; well done, Senator Watt.

CHAIR: Order! Thank you, Senator Watt.

[12:19]

CHAIR: Moving from concepts, we will go now to program 4.1. Senator Griff, would you like to kick off, please?

Senator GRIFF: Thank you, Chair. I have a couple of directions I want to take, but a brief one, first, relates to an MBS item, 55850.

Mr Bowles: I will get those people to come the table. That is beyond my knowledge, that number.

Senator GRIFF: I thought you would be able to remember that one off by heart!

Mr Bowles: I would love to be able to!

Mr Stuart: Senator, could you repeat the number?

Senator GRIFF: 55850, which is musculoskeletal ultrasound guided injection.

Mr Stuart: Perhaps you could tell us what the issue is. It is not ringing any bells at the moment.

Senator GRIFF: My understanding is that the benefit cost per 100,000 population for this item has increased from $2,036 in 2000-01 to $114,650 in 2015-16; in other words, in that time frame there has been a 56-fold increase in cost. Is the department aware of this increase?

Mr Stuart: We track a range of data. I could not say whether the department as a whole is aware, but it is not something that I have recently dealt with.

Senator GRIFF: So you would not be aware of the reasons for the increase?

Mr Stuart: Not here at the table today.

Senator GRIFF: What is interesting is that the RANZCR, the college of radiologists, has warned about the abuse of point-of-care musculoskeletal ultrasound and has provided a position paper on it. I am not sure if you or your department have seen this. I would be interested to know if the department is taking, or plans to take, any preventive action or any actual action on this, or is looking at this position of the RANZCR. I know it is a difficult one that not everyone here is going to be aware of, but a 56-fold increase is quite substantial. I am aware of specialists who state that this particular procedure has effectively bought them their Porsche because quite simply they can effectively just do the injection, do a very quick ultrasound and claim a substantial amount.

Mr Bowles: Senator, it would be best for us to take the specifics of that one on notice.

Senator GRIFF: If you could take that on notice, that would be—

Mr Bowles: It would be likely that that would come up in the context of our MBS review group, anyhow, if it would spark those sorts of numbers. We may not have even got to that particular area yet, but we will take that on notice.

Senator GRIFF: It is obviously a key area.

Mr Stuart: Senator, I am advised that there has been thought, in the context of both the MBS review and MSAC to date, but the specifics of it are not available to us right now.

Mr Bowles: We will take it on notice.

Senator GRIFF: On notice would be fantastic. The next item I would like to cover off is that I understand there is no Medicare rebate for key brain cancer pathology tests recommended by the WHO. Two tests, in particular, that assess molecular alterations in brain tumours—ID8 sub sequencing test and 1p/19q co-deletion testing—are the tests that they recommend. Does MSAC make reference to WHO classifications when deciding which tests to approve?

Ms Jolly: The Medical Services Advisory Committee has an application-based process, so an application would come forward, that would be considered and a range of evidence would be considered by the committee. I am not sure that those individual tests that you have indicated have come forward. We could take on notice providing some details about that. Certainly, MSAC would consider a range of evidence, and, if other bodies had looked at that sort of testing, that would form part of the information in front of the committee.

Senator GRIFF: So you would not look to see what WHO is recommending? Would you factor that in to any decision that you are making?

Ms Jolly: MSAC has its own process of evidence consideration, so it would go through its process. If other organisations like the World Health Organisation had evidence in front of it then that could also come forward to MSAC. But it is not a reference process, if that is what you mean, Senator.

Senator GRIFF: I understand that an actual application was made for this. I have received an email from the Royal College of Pathologists regarding this application, which is application 1459. They state that they submitted the application on 19 May last year. They thought it was going to be tabled in December, and on inquiry in March this year they were advised that the application was not suitable. Why does it take so long to get an application processed?

Ms Jolly: I would need to take the details of that on notice. MSAC considers about 40 applications a year. I am not sure of the specifics of that particular application, but I could certainly take that on notice and get some information for you.

Senator GRIFF: If you could take that on notice, that would be fantastic. There have also been concerns within the medical fraternity about the level of expertise that the department has for this kind of application. Do you regularly review your panels to determine whether the expertise that you have is appropriate for this kind of thing?

Ms Jolly: We outsource and seek external advice on the health assessment elements of applications.

Senator GRIFF: Who do you outsource it to?

Ms Jolly: We have a health assessment panel that we seek advice from on individual applications. That expertise would be sought application by application.

Senator GRIFF: Do you have targets for how quickly you expect an application to be processed or assessed?

Ms Jolly: We do not have specific targets through MSAC. If there is an application that goes through MSAC and PBAC, often it is picked up by the PBAC targets that that committee has, but not in MSAC specifically.

Senator GRIFF: Why is that?

Ms Jolly: MSAC is not a statutory committee in the way that PBAC is. So it does not have the same targets and requirements that that committee has. The MSAC process has a different committee structure and arrangement.

Senator GRIFF: I look forward to receiving those answers on notice.

CHAIR: It being almost 12.30, we will suspend. We will then continue our consideration of program 4.1.

Proceedings suspended from 12:27 to 13:31

CHAIR: We will kick back off with examination of program 4.1. Senator Hanson.

Senator HANSON: Thank you very much, Chair. I would like to inquire about Medicare cards. Whoever can answer my questions on this, can you just explain to me how Medicare cards are applied for? Are they automatically given out or does someone apply for one?

Mr Bowles: Firstly, it is not a function of our department; it is actually the Department of Human Services that deal with that part of Medicare. The issuance, the whole process—it is

all part of Human Services, and I think they are on Wednesday or Thursday this week. They will follow us.

CHAIR: Thursday.

Senator HANSON: All right. I will leave the Medicare card till then. I want to talk about the 24-hour doctor service that is available. At the moment, someone can actually get a 24-hour doctor service. The doctor comes to their home, and it costs $128 for that service. There is talk about cutting back that service. Is that correct?

Mr Bowles: I will ask my colleagues to talk a little bit about the process we are going through.

Mr Stuart: We are going through a process of reviewing all of the items in the MBS at the moment, through the MBS review. It is being managed by an independent, clinically led task force, and one of the areas that they have been reviewing is in relation to urgent after-hours services. There is concern about the urgent after-hours services and the way they are currently being managed, not only in the department but also among some of the key medical groups like the RACGP, and so one of the committees working under the task force has been examining urgent after-hours care. There has been very significant growth in expenditure in that area, and the key concerns that the GP college would have are that the majority of the items are being charged as urgent when they are not necessarily urgent and that the majority of the items—albeit being urgent—are being delivered by non-vocationally registered doctors who only work in the after-hours area, and the third area of concern is that there is not always adequate feedback to the usual GP about what happened at the particular visit, what medications might have changed or what diagnoses might have been made. Those are the three areas of concern that the review is responding to.

Senator HANSON: Do you agree that a call-out visit is $128?

Ms Jolly: There are four after-hours items that you are referring to, and they have a different fee structure according to the time, but the professional attendance one you are referring to is $129.80—that is the rebate after-hours. There are others. The item that is available between 11 pm and 7 am is actually rebated at $153. In Medicare, there are a range of after-hours items. There is a whole suite of them. The ones that Mr Stuart spoke about that are currently being reviewed are the urgent ones, and there are four of those. But they sit as part of a whole set of after-hours items.

Senator HANSON: Is it true that a lot of these items are for use by elderly people who cannot drive or cannot get to hospital, or possibly by single parents with children needing attention—but who have lots of other young children who are still in bed and so want to avoid having to get all the children out of bed to take them to emergency? Is it correct then to say that, if someone goes to the emergency department, there is a cost to the taxpayer of $368?

Ms Jolly: There are a couple of parts to my answer to that. We have certainly had a look at who is using the items, and, yes, elderly patients and parents with young children are among them. When you are a GP and you provide an after-hours service, undertake an attendance, to look after a family or an older Australian, there are a range of items you can charge against. You can charge against an urgent item or you can charge against an after-hours attendance item, and they have different rebates. The reason I make that point is that it

is only the four urgent items that are being reviewed. But there are a whole set of items for after-hours care which are also available and not currently being reviewed.

The comparison to hospital costs is a difficult one to make. The figure you are quoting as a hospital cost is not one I am familiar with. The hospital funding arrangements are different from the MBS arrangements, so we do not have that direct comparison.

Senator HANSON: On the figures I have, if they were to be taken by ambulance and did not have ambulance cover, that would be a cost of $1,351. What I am saying in general is that it is more beneficial to keep this service, especially in rural areas where there are no hospitals close by and doctors are less available, than it is to get rid of it.

Mr Stuart: There is no proposal to get rid of after-hours doctor visits. The intention of the review is to make sure we are only paying for urgent items when an issue is urgent. There are other home visit items that can be charged against when the item is not urgent. We also want to make sure that, if the item is urgent, the doctors who are attending are qualified to deal with those urgent issues and that the information about what happens ends up back with the usual doctor. It is not about stopping something; it is about making sure there is safety and quality and appropriate value for money in the services that are provided.

Senator HANSON: And that the service is not being abused?

Mr Stuart: That is right.

Senator HANSON: Who is to say that the Medicare card is not being abused by people who are visiting this country or who are illegally here? You said that comes under Human Services, but is there any way that your department—

Mr Bowles: We look after the compliance functions relating to the behaviour of doctors and things like that, but Human Services look after the issue of patients possibly abusing the system.

Senator HANSON: What about the doctors, then? What system do you have in place for dealing with doctors who abuse a Medicare card or have people making numerous visits under that Medicare card? What happens to the doctors?

Mr Bowles: There is a process. We have a compliance function that reviews all the activity of doctors. If they are found to be in breach, they will be dealt with in a range of different ways. We have a professional services review mechanism that would review them. It is quite a formal process. It is a separate, independent agency in my portfolio that would make assessments about the behaviour of those doctors if in fact there has been some sort of breach.

Senator HANSON: I have just been informed that we have a reciprocal arrangement with other countries as far as hospitals are concerned. When someone comes to this country and is hospitalised here, what is in place to assure that we are paid for that?

Mr Bowles: I will get my colleagues to talk a bit more about that.

Mr Stuart: We have reciprocal arrangements with a number of countries. They are the United Kingdom, New Zealand, the Netherlands, Ireland, Italy, Malta, Sweden, Finland, Belgium, Slovenia and Norway. They are reciprocal arrangements where if they are visiting our country they have access to Medicare, and if our citizens are visiting their countries they have access to health care. Citizens of other countries can receive appropriate health care in Australia but they are not going to be covered by Medicare in doing so.

Senator HANSON: Does it have to be noted or signed off for someone from another country? What is the procedure for the countries you have just named?

Ms Jolly: In terms of a process, visitors from those countries apply for a yellow Medicare card. It is a particular Medicare card that identifies them as coming from a country that has a reciprocal healthcare agreement. That Medicare card is for medically necessary treatment while they are here in Australia, and it says that on the card.

Senator HANSON: So when they go to the hospital they must present that card.

Ms Jolly: Yes.

Senator HANSON: Is it noted?

Ms Jolly: It will flow through the system. If they visit a doctor or it has that reciprocal arrangement then when they present the bill through the Medicare system it will be picked up by the Medicare system.

Senator HANSON: I raised this because I was told of someone who was visiting this country from the United Kingdom. They had a service provided and when they went to pay they were told, 'Don't worry about it.' So nothing was done about it.

Ms Jolly: Sorry, they didn't have to pay?

Senator HANSON: No documentation, nothing about it. Is there an exchange of money anywhere along the line or is it just noted, or what is expected?

Ms Jolly: If you have a yellow Medicare card, so you are identified as someone from a reciprocal healthcare agreement, and you appear for a health service that is deemed to be medically necessary, if the health practitioner you are seeing accepts the government payment as the full payment for that service, then, you might not hand over any money at that point of service. The Medicare system will then pay similar to a bulk-billed service for that service. It would depend on the nature of the service as to whether or not there were other components of the payment. But it should be treated under the reciprocal healthcare arrangements.

Senator HANSON: So anyone who goes into a healthcare facility or hospital should present documentation or information as to who they are. Is that correct?

Ms Jolly: Yes. That would be my understanding of the arrangements.

Senator HANSON: Australia is one of the highest in the world for charging for prosthetics. My understanding is that we have not reduced the cost of this for payments compared to the rest of the world. Is it true that we are at a higher level and remain at that level yet the rest of the world has come down in cost?

Mr Bowles: I might answer that and then hand to my colleague. It is different in different parts of the system. The public health system is managed by the states and territories. They, generally, will do some sort of procurement activity to try and get the best value for money for prostheses that they use in their hospitals, and they will drive a particular bargain or price for the delivery. That is within the state system.

In the private health sector we have a group called PLAC, the Prostheses List Advisory Committee, that looks at the pricing structure for prostheses in the private sector. There has been a recent reduction for prices in Australia, but I will ask Ms Jolly to talk a little bit more about that process.

Ms Jolly: The government has introduced reduced benefits for hip and knee prostheses by 7.5 per cent and cardiac devices and intraocular lenses by 10 per cent. Those benefit reductions took place on 20 February 2017.

Senator HANSON: So that is a reduction that the patient can claim back from the government. Is that right?

Ms Jolly: That is a reduction to the benefit paid. If you go into hospital and your prosthesis device is implanted, what the PLAC does is set the benefit for that from your private health insurance. The reduction was from the benefit category.

Mr Stuart: If prostheses prices get lower, in the end, patients start paying lower private health insurance premiums.

Senator HANSON: Who determines the price of these prostheses?

Mr Stuart: That has been set over time in the private sector. It has been set over time by the Prostheses List Advisory Committee, the PLAC. I should tell you though that there is a big process underway to review the way PLAC does its work and to review the prices in the prostheses list. The government has targeted this as a very significant area of effort over the coming months.

Senator WATT: Mr Stuart, I want to clarify one thing in the evidence you just gave Senator Hanson. I think you talked about this after-hours-care measure being reviewed in the context of a broader review—how did you put that, again?

Mr Stuart: Yes, it is being conducted under the aegis of the MBS review, chaired by Bruce Robinson. A working group of that body has been undertaking the review of the after-hours items.

Senator WATT: What are the other items being considered in that MBS review?

Mr Stuart: The review is working through the entire MBS book of 5,700-plus items.

Senator WATT: So every one of those items currently covered by Medicare is currently being reviewed?

Mr Stuart: It is being considered in some way, yes, as to whether it needs to be reviewed or not. If it does, it will be reviewed by, first, a working group, a clinical committee, reporting to the task force and then through the task force and then recommendations made to government.

Mr Bowles: Part of the broader review of the MBS looking at 5,700 items.

Senator WATT: Are there any items within that 5,700 that have been put aside not to be reviewed or is the whole lot being considered?

Mr Bowles: The whole lot will be reviewed; that does not mean the whole lot will be changed. In fact, as we have progressively rolled this out, numbers of things have stayed exactly the same.

Senator WATT: Have you had any luck tracking down the minutes of those task force meetings?

Mr Bowles: I have not seen anything yet.

Senator WATT: If we could keep working on that, that would be great.

Mr Bowles: Yes.

Senator WATT: I have a range of questions about the Medicare compacts that the minister referred to, I think, around the time of the budget. You will be familiar that within the budget the government announced it had signed five compacts with health stakeholders. What exactly is a compact?

Ms Jolly: You will find the documents on the website from the department. There are five agreements. I have two in front of me and my colleague will have the other three. They are headed 'Agreement'. They are an agreement with The Royal Australian College of General Practitioners. The AMA document is referred to as a shared vision for Australia's health system, principles agreed to by the government and the Australian Medical Association.

Senator WATT: And there are three others.

Mr Stuart: Yes, there are three other agreements as well. There is an agreement with Medicines Australia, with the Generic and Biosimilar Medicines Association, and with the guild. Two of those—with the GBMA and the guild—are extensions of existing agreements, and the agreement with Medicines Australia is a new one. We have not had an agreement with them for a few years.

Senator WATT: Without wanting to get too caught up with words, is a compact the same as an agreement?

Mr Stuart: These are five differing documents. They share an orientation and a value set but they are at different levels of detail and contain different matters within them.

Senator WATT: Are they, sort of, agreed to different extents as well? With some groups certain matters are agreed and with some groups not so much.

Mr Bowles: The documents spell out what is agreed.

Senator WATT: Yes. So, technically, a compact is not necessarily an agreement.

Mr Bowles: They are an agreement between parties. It does not matter what you call them. There are things that have been agreed between the parties.

Senator WATT: I just noticed, for instance, that the compact with the Royal Australian College of General Practitioners is called an 'agreement', whereas the one with the AMA is called a 'Shared vision for Australia's health system: principles agreed to by the government and the AMA.' Is there any reason for a distinction between what they are called?

Mr Bowles: Just the words that would have been negotiated between the parties.

Senator WATT: Was the AMA comfortable to have their compact referred to as an agreement with the government?

Mr Bowles: They are the words. The 'shared vision' are the words that were agreed with between the parties.

Senator WATT: You are probably aware that the president of the AMA is adamant that an agreement has not been signed with the government. Are you aware of that?

Mr Bowles: I have heard speculation.

Senator WATT: I can confirm your speculation. I have a copy of an article here from *Australian Doctor* dated 11 May. I am just trying to remember the date of the federal budget.

Mr Bowles: It was 9 May.

Senator WATT: Yes, 9 May. So it was two days after the federal budget. Would it help you if I gave you a copy?

CHAIR: Yes, I think that would be helpful.

Senator WATT: I do not have multiple copies but I can certainly give one to the secretary. We might have one that we can hand over to members of the committee as well. There is an article here from *Australian Doctor,* a publication, dated 11 May and there is a quote from the president of the AMA saying that the AMA has not signed an agreement with the government.

Mr Bowles: I cannot speak for the president of the AMA.

Senator WATT: You probably know that the health minister has repeatedly referred to these documents as agreements and he has certainly created the impression than an agreement has been reached with the AMA among other groups. In fact he has talked about it as 'the landmark' agreement that the government has signed with the Royal Australian College of GPs and the AMA, but we have the AMA saying, very clearly, that they have not signed an agreement with the government.

Mr Bowles: We have a shared vision, colloquially called 'a compact', one of the five. It is an agreement between the parties. You will have talk to the president of the AMA for any further detail.

Senator WATT: So it is a shared vision—

Mr Bowles: Yes, that is what the document is called.

Senator WATT: not an agreement.

Mr Bowles: I am not getting into semantics about it.

Senator SINGH: I do not think that is semantics.

Mr Bowles: I do, I am sorry, Senator.

Senator SINGH: The word 'agreement' has a fairly specific meaning, I would think.

Mr Bowles: They are called compacts.

Senator WATT: Who drafted these compacts, the ones that you are referring to, such as the AMA one.

Mr Bowles: It was a process between the department, the minister's office and the organisations.

Senator WATT: Okay. We have the minister on the one hand saying 'landmark agreements' with the AMA and others. We have the AMA denying that they have signed an agreement. Who is right?

Mr Stuart: Senator, the terms of the text that you have in front of you with the AMA is the entire document, and it stands for itself.

Senator WATT: How many pages is that shared vision? I have one page here.

Mr Stuart: I think it is three, from memory. Two pages, and I think there is a covering letter.

Senator WATT: Okay, but according to the AMA it is not an agreement with the government, that it is not what the minister says.

Mr Bowles: You should ask the AMA president.

Senator WATT: It is pretty clear, isn't it, given what they said in the article?

Mr Bowles: Again, you should ask the AMA president. There is a shared vision document called 'a compact' that has been agreed.

CHAIR: Senator Watt, I was just looking at what you have tabled. It says that the AMA has not signed an agreement with government, but there is a shared vision statement, which is what the secretary said.

Senator WATT: It seems to be important to the AMA as to what the distinction is. Whereas the minister is going around saying that we have signed an agreement with the AMA.

Mr Bowles: Again, there is a shared vision that is agreed between the parties. That is what it is.

Senator WATT: Are there any other differences between the compacts.

Mr Bowles: There will always be. They will all be different. They are dealing with different sectors from a guild to the Medicines Australia to generics to GDPs to the AMA.

Senator WATT: Right. I can just see there are quite a lot in this inquiry. Yes, I am talking about the AMA and the College of General Practitioners.

Mr Bowles: There will be, because they are different bodies, they represent different groups and they have different issues.

Senator WATT: When did the government first begin discussions with the AMA and the College of General Practitioners on signing a formal document?

Mr Bowles: Pre-budget. The minister has been talking about this. I cannot remember the exact date, but the minister has been talking about this almost since he has been sworn in—how he wants to talk to the doctors.

Senator WATT: I presume someone at the table knows when departmental representatives first started negotiating these compacts with the AMA and the College of General Practitioners.

Mr Bowles: Again, the minister has had some personal involvement as well. The department, obviously, prepares final drafts of the issues. That would have been done in the run up to the budget, and it would have been in the month preceding that and then there would have been iterations and it probably would not have been finalised until just before the budget.

Senator WATT: So it was in within a month before the budget that the department first sat down.

Mr Bowles: I could not give the exact date.

Senator WATT: Do anyone else, who might have been a bit more closely involved, know?

Mr Stuart: As the secretary said, the minister was very significantly involved at the beginning, and the department assisted him with advice and drafting, and there was an iterative process. It may have been March when the department first became actively involved

with the minister on this, but we stand to be corrected on that. We would really have to take that on notice.

Senator WATT: You mention that the minister was involved in the beginning of the process.

Mr Stuart: Throughout the process.

Senator WATT: Sure. I am just trying to pinpoint when this all started. What you said was that the minister was involved at the beginning of the process and, I understand, throughout the process. Roughly, when would you say the beginning of the process was?

Mr Stuart: Again, I would have to take that on notice. The minister had very significant personal leadership and involvement on the issues, particularly with the doctor groups. He began discussions with them very, very early in his ministry. We would have to take on notice when that turned to a discussion about the potential of a compact with those groups.

Senator WATT: Was the department involved in developing the documents with the AMA and the College of General Practitioners?

Mr Stuart: Over the period we provided advice to the minister, we participated in drafting parts, we reviewed suggestions that had been made by the other parties and provided advice about that, and we participated in providing advice to the minister on the final form of the documents.

Senator WATT: Did the inclusion of these compacts arise out of the department's usual budgetary process, or was it done at the instigation of the minister or his office?

Mr Bowles: I do not understand the context.

Senator WATT: I am still just trying to get to the bottom of how this process started.

Mr Bowles: We have done this in other cases. We have always had agreements, like with the guilt. We have had previous agreements with Medicines Australia. It was just similar types of issues to that. Yes, the minister was actually engaged in arrangements with the AMA and the RACGP. It was not unusual in that sort of context.

Senator WATT: Just taking a step back to where this first started, and I accept you are going to take on notice when it started, did these negotiations occur because the department advised the minister, 'We think this would be a good way forward to enter into compacts,' or was it something that came the other way from the minister?

Mr Bowles: There were conversations that the minister had earlier in his appointment as Minister for Health. He had significant personal contact with all of the parties. He has made that very publicly clear, and I would say it was an iteration over time about how we came up with the final form and structure of what we would do. It was in the context of budgets, obviously.

Senator WATT: Is it fair to say that the idea of entering these compacts was an idea of the minister?

Mr Bowles: Ultimately, it is the minister's decision, yes.

Senator WATT: I know, but I am not talking about 'ultimately'. Again, just going back to the process—

Mr Bowles: I would suggest that, in some of those, the answer is yes. In the context of others, it is normal practice that we have had in other areas and it has really just started to go from there.

Senator WATT: So the compacts we are talking about, or the shared vision with the AMA and the agreement with the College of GPs, were specifically ideas of the minister?

Mr Bowles: Yes.

Senator WATT: Doesn't that mean that these are essentially political documents rather than policy?

Mr Bowles: They were done in the context of the budget and that is the way they are. We have one with Medicines Australia, and we have always had these things on and off through history. We have them with the guild. They manage a particular set of circumstances.

Senator WATT: But we have been talking about these two and the whole thing was kicked off by the minister, really.

Mr Bowles: Yes, and the department has been actively engaged in providing policy advice from day 1.

Senator REYNOLDS: I have a point of clarification on what Senator Watt is asking. What you have just described to me sounds like a very typical process for a new minister seeking to have productive engagement with health professionals in the portfolio. Is that—

Mr Bowles: Yes, that is absolutely right.

Senator REYNOLDS: Thank you. Sorry, Senator Watt.

Mr Bowles: He made very clear from day 1 that he wanted a better relationship, and that is what he has done.

Senator REYNOLDS: With doctors, pharmacists and a range of other stakeholders?

Mr Bowles: Yes.

Senator WATT: How many times did the minister's office and the AMA meet in relation to this compact?

Mr Bowles: You would have to ask the minister's office.

Senator WATT: Unfortunately, the minister is in the other chamber.

Mr Bowles: I do not have his diary.

Senator WATT: Minister Nash, do you know?

Senator Nash: I will take it on notice for you, Senator.

Senator WATT: Yes, could you get back to us about that? How many times would you say the department has met with the AMA about this compact?

Mr Bowles: We would probably have to take that on notice. We have met with many parties many times. We will take that on notice.

Senator WATT: I accept that you will come back to me with a precise number on notice. Are we talking up to five or 10?

Mr Bowles: As to the main process with a lot of these things, we would provide advice to the minister's office which would have managed the process, but we will take on notice how

many we did. We met the AMA on other issues. Sometimes we talk about everything and sometimes we talk about one specific issue.

Senator WATT: From what you just said—I cannot remember exactly how you put it—you provide advice to the minister and his office, but they are essentially take the running of it. So the meetings—

Mr Bowles: In some cases, that is the way it goes—yes.

Senator WATT: I am talking specifically about the one with the AMA. Did the department ever meet with the AMA about the compact?

Mr Stuart: That is what we have on notice.

Mr Bowles: I will take that on notice.

Senator WATT: So you are not sure whether anyone in the department ever met with them?

Mr Stuart: I am not certain at this point.

Mr Bowles: Not specifically on that issue. We do meet with them.

Senator WATT: Sure.

Mr Bowles: We would have to go back and find out whether we specifically met on this.

Senator WATT: Okay. But we know that the minister and his office met with the AMA about this compact, and you are coming back to us about how often.

Mr Bowles: We do not; through the minister's office.

Senator WATT: Were there any occasions when the department met with the AMA with the minister about this?

Mr Stuart: No, we do not believe so.

Senator WATT: You do not believe that the department met with the AMA about this compact?

Mr Stuart: With the minister.

Senator WATT: And you are taking on notice whether you met separately?

Mr Bowles: That is right.

Senator WATT: What about the college? Did you meet with the college together with the minister about the agreement?

Ms Jolly: I think we would need to take on notice some of those questions. There were obviously a lot of discussions over the period and things went backwards and forwards from the office. Several of us were involved at various times in working with the office on elements of the documents that you have. You will see that they cover a broad range of issues across health, so we would need to check to make sure we were giving you accurate information. There was not a single person involved, but there were obviously a lot of issues covered. Any attempt to give you a sense of exactly how that played out would not give you the full picture.

Senator WATT: Sure. Again, I am happy for you to take on notice to give me some precise numbers of meetings.

Ms Jolly: Sure.

Senator WATT: In general terms, do you know whether the department at any point met with the College of GPs about the compact, the agreement?

Ms Jolly: I meet with the AMA frequently. I meet with the College of GPs frequently on a variety of issues throughout the period. There would be other people in my division. We run the Medicare division. That would be dealing with both of those organisations.

Similarly, there are issues of workforce in some of these documents. There are issues of My Health Record. A lot of those parts of the departments would also have been having conversations. I guess that is why I am keen to make sure we have given you a full picture rather than indicate a particular set of means.

Senator WATT: Sure. Let's confine it to you then. You are the first assistant secretary in charge of this area. In the various meetings that you have with the AMA, have you discussed the shared vision with them?

Ms Jolly: At points there would have been discussions about that amongst other things, yes.

Senator WATT: In the meetings you have attended with the college, the agreement struck with them has been discussed?

Ms Jolly: Yes.

Senator WATT: Okay. And you will take on notice the number of times the minister has met with the college as well as the AMA.

Ms Jolly: The secretary has indicated we will do that.

Senator WATT: Okay, the minister will take that on notice. How many versions of each document with the AMA and the college were created before it was finalised?

Mr Stuart: There was an iterative process with drafts going to and fro between the organisations and the minister's office and then the minister's office and the department. I think that would be a very difficult question to answer even if we reviewed the entire document trail. However, I think it is probably fair to say for the purposes of this hearing that there were quite a few iterations.

Senator WATT: There were quite a few iterations of the shared vision compact with the AMA and quite a few versions of the agreement ultimately signed with the college?

Mr Stuart: Yes. I think it is just part of the process of coming to a clear, shared view with clear, shared words.

Senator WATT: And the department was involved in drafting those various iterations of both documents?

Mr Stuart: At times, yes—and so were the parties on the other side of the agreement and so were people in the minister's office and the minister himself.

Senator WATT: The minister personally drafted terms of these compacts?

Mr Stuart: He had significant sway over the terms of the documents.

Mr Bowles: He is the Minister for Health.

Mr Stuart: Of course he is the final decider and signatory to those documents in consultation with his colleagues.

Senator Nash: I think it might be helpful to add there that the minister was looking to work very constructively with the sector from day one. I think everybody has appreciated that. The partnership with the five key stakeholders here—the AMA, RACGP, Medicines Australia, the Pharmacy Guild and also the Generic and Biosimilar Medicines Association—is the first time anything like this has been done, and I think a lot of credit needs to go to the minister to be able to pull all this together and outline a set of agreed principles. I absolutely appreciate your desire for questioning, but I think it is very important to get on the record that it is the first time anything like this has been done, and I think all credit to the minister.

Senator WATT: Sure. I might hand over my remaining time to Senator Singh.

Senator SINGH: I want to go to some specifics of these documents. In both the AMA compact and the college compact there are references to encouraging doctors or GPs to have further uptake of the use of the My Health Record system. Specifically how will the AMA and the college encourage further uptake of the usage of the My Health Record system?

Mr Bowles: I think that is a matter for the AMA and the RACGP. They think it is a good idea to increase the usage of My Health Record and they have their normal processes that they would deal with, I presume.

Senator SINGH: Okay. I thought the department may have—it is obviously listed in the document.

Mr Bowles: We will not necessarily know the intricacies of what they do, but they were just as keen to see the uptake of that improve. In fact, with the budget we saw the opt-out arrangement come into place.

Senator SINGH: Would it mean that GP performance will in some way be linked to the usage of My Health Record?

Mr Bowles: If you want to talk specifically about My Health Record, we could probably come back to that. The people will not be here at this stage. It is probably outcome 1 later this evening. We can talk quite specifically about My Health Record and its links to a whole range of places.

Senator SINGH: Okay.

Mr Stuart: Clearly, though, in these documents the minister and those organisations have agreed that there is something very good to be done in the area of My Health Record. The minister has documented that with these groups.

Senator SINGH: All right. We will come back to that later tonight. Both the AMA compact and the college compact say the groups will support tightening of access to high-value after-hours MBS items in line with the MBS review recommendation and support the government's actions. Specifically what are the government's actions that these compacts are referring to?

Mr Stuart: As we were saying earlier, the government through the MBS Review Taskforce, which is an independent, clinically led task force, is reviewing the whole of the MBS, including the after-hours items. There is a particular concern with the urgent after-hours items as to the rate of their growth and whether they are truly being used for urgency, whether appropriately qualified doctors are delivering the urgent items and whether there is sufficient information about what happens at those home visits going back to the GP who is

the usual treating doctor for that patient. These documents set out that RACGP and the AMA will cooperate with the government in seeing that review completed and implemented in an agreed way.

Senator SINGH: Will there be further consultation?

Mr Stuart: Yes, there will. The independent task force generally consults before providing its final recommendations to the minister, but at this point that recommendation has not been made.

Senator SINGH: Why include it in these agreements if government has not finalised these actions?

Ms Jolly: Looking at the urgent after-hours is an issue that both the RACGP and the AMA have themselves raised as concerns. They are also both involved in the work that the MBS Review Taskforce is undertaking. It is an area of work that they have themselves indicated an interest in, and they are actively involved in that review process.

Mr Stuart: It is in fact documented here as a shared concern of the minister and of these two organisations.

Senator SINGH: Finally the AMA's compact has a reference to Health Care Homes, but the college's compact has no reference at all to Health Care Homes. Why is there no reference to Health Care Homes in the college's compact?

Mr Bowles: I do not know specifically.

Senator SINGH: Was Health Care Homes referred to in any version of the college's compact?

Mr Bowles: I would have to take that on notice. I do not know.

Senator WATT: Is there anyone here who was involved in the final document who knows why it was left out?

CHAIR: They have said they will take it on notice.

Mr Bowles: We will take it on notice.

Senator DI NATALE: I go to the issue of compacts again. To be clear, you have got five: AMA, college of general practice, Pharmacy Guild, Medicines Australia and generic medicines. Is that correct?

Mr Bowles: Yes.

Senator DI NATALE: How were those five organisations chosen?

Mr Stuart: That answer differs in respect of differing organisations. The agreement with the guild is a longstanding historical agreement of which we are up to the sixth iteration, and the latest agreement is an extension of the Sixth Community Pharmacy Agreement.

Senator DI NATALE: So I am clear: the compact with the guild is an extension of the Sixth CPA?

Mr Stuart: Yes.

Senator DI NATALE: Okay. Can you talk to me about what differs from the Sixth Community Pharmacy Agreement in their compact?

Mr Stuart: There are some specific additions to the agreement to cover the specific agreement struck between the minister and the guild.

Senator DI NATALE: Yes. What are they?

Mr Stuart: Penny can speak to that.

Ms Shakespeare: There are a range of changes to matters that were covered under the Sixth Community Pharmacy Agreement. There are changes to funding for community pharmacy programs. There are changes to the administration, handling and infrastructure fee, which was agreed under the Sixth Community Pharmacy Agreement. There is some funding for pharmaceutical wholesalers, and that is also covered by the Sixth Community Pharmacy Agreement. So there are changes in a range of areas which will require changes to some of the matters that were agreed back in 2015 under the Sixth CPA.

Senator DI NATALE: Is this a reflection that the process for negotiating the Sixth CPA was problematic and that there were obviously deficiencies in that agreement?

Mr Stuart: No. They are probably in response to two different kinds of issues. One is that the guild is always an interested party when we change medicine pricing policy. The agreements struck with Medicines Australia and with GBMA have ramifications for the guild, and so—

Senator DI NATALE: Sorry to interrupt, but time is limited. You mentioned the first point was around the delivery of programs.

Ms Shakespeare: That is correct.

Senator DI NATALE: That has got nothing to do with pricing.

Mr Stuart: No, that is right. I was saying there are two kinds of issues. The second kind of issue is not that there was something wrong with the original agreement but more that there has been an outworking from that agreement. For example, the original agreement provided for the potential for the $600 million for program funding, which was put into the contingency reserve, and the more recent agreement extends how and when that is going to be made available.

Senator DI NATALE: What was the process for negotiating that compact? How does it differ from the negotiation around the Sixth Community Pharmacy Agreement?

Mr Stuart: The process does not differ all that much in that the department undertook very detailed discussions with the Pharmacy Guild and then provided advice to the minister in respect of a range of these clauses. There were other issues, probably where the minister more directly dealt with the guild.

Senator DI NATALE: Who were the parties involved in those negotiations?

Mr Stuart: Me and Ms Shakespeare and a number of Ms Shakespeare's staff.

Senator DI NATALE: And from the guild?

Mr Stuart: Senior members of the guild secretariat.

Senator DI NATALE: Were any professional pharmacy representatives involved? The PSA?

Mr Stuart: Not in those discussions with the guild, no.

Senator DI NATALE: They are normally a party to those discussions. They might not necessarily sign off, but they are normally a party to discussions around the community pharmacy agreement. Why weren't they involved in this process?

Ms Shakespeare: The Pharmaceutical Society of Australia is not a party to the community pharmacy agreement.

Senator DI NATALE: They are not a party to the agreement, but they are required to be part of the discussions around the agreement. So why weren't they involved in this process?

Ms Shakespeare: This was a compact that was discussed between—

Senator DI NATALE: I have just heard it is an extension of the community pharmacy agreement.

Ms Shakespeare: The compact covers a range of matters that will now require amendment to the Sixth Community Pharmacy Agreement.

Senator DI NATALE: This is not where I was going, but this is worrying. To be clear, you have the community pharmacy agreement—which is worth how much?

Ms Shakespeare: At the time it was negotiated, it was estimated that it provided for pharmacy remuneration, across all aspects, of $18.9 billion over the life of the agreement.

Senator DI NATALE: So we are talking $19 billion, and we now have some extension to the $19 billion community pharmacy agreement, which itself has been subject to a lot of scrutiny. We are now entering into this new phase, which has, as far as I can tell, not happened before, where we are having compacts with key stakeholders. One of them is around an extension of a $19 billion agreement, which is itself subject to a particular set of processes. Even though, Mr Stuart, you indicated it was the same process, we are now hearing that groups like the Pharmaceutical Society of Australia were not involved or a party to those negotiations. I understand they are not a signatory to the negotiations, but they are a party to them. Why weren't they a party to these negotiations?

Mr Bowles: Firstly, the sixth pharmacy agreement is a much bigger issue to negotiate because it is across the whole value chain, if you like, in that process—

Senator DI NATALE: And we are just talking about modifying it.

Mr Bowles: and this is about specific issues.

Senator DI NATALE: This is about modifications that, we have just heard, may require legislative change. So it is about the Sixth Community Pharmacy Agreement.

Mr Bowles: It is about it, but it is not going back to taws and going through the entirety of the sixth pharmacy agreement.

Senator DI NATALE: No, but, given that there are a set of processes around negotiating the agreement, one would think that the professional organisation representing pharmacists would be a subject to a negotiation around a compact that is going to change a $19 billion agreement.

Mr Bowles: Again, I think—

Senator DI NATALE: Is that an unreasonable expectation?

Mr Bowles: It depends on what we are talking about. We are not talking about changing the sixth pharmacy agreement; we are talking about modifications.

Senator DI NATALE: Sorry, hang on. Ms Shakespeare, are we talking about changing the agreement? You just said a minute to go that it would require change to the legislation around the Sixth Community Pharmacy Agreement.

Ms Shakespeare: There are some payments that are referenced in the Sixth Community Pharmacy Agreement that will need modification.

Senator DI NATALE: Mr Bowles, you need to make sure you are correct. It does involve changing the Sixth Community Pharmacy Agreement.

Mr Bowles: It does not involve changing the entirety of the sixth pharmacy agreement, which is what you were really referencing at the time.

Senator DI NATALE: It involves changing the agreement.

Mr Bowles: It requires some modifications to the agreement—

Senator DI NATALE: Yes, changing it, modifying it.

Mr Bowles: Again, I do not want the inference to be that this is fundamentally unpicking the pharmacy agreement because it is not.

Senator DI NATALE: There is inference; I am just making a statement of fact.

Mr Bowles: I am sorry, Senator, that is the inference of that.

Senator DI NATALE: A $19 billion agreement that struck less than two years ago. We now have a separate process through compacts—and I do not know who dreamt this stuff up. Apparently the compact with the Pharmacy Guild is an 'extension of', to use Mr Stuart's words, the Sixth Community Pharmacy Agreement that is going to involve changes to that agreement—a completely separate process involved for negotiating those changes. The professional body representing pharmacists is not even represented there—is that correct?

Mr Bowles: I am a little perplexed about you talking about that body, the professional pharmacy body, being a party to the agreement in the past. I have participated in differing rounds of these agreements over time and there have been different practices at different times—

Senator DI NATALE: Yes, some of which have been subject to a National Audit Office review, which has been damning in their criticism of their process.

Mr Bowles: Over time.

Senator DI NATALE: Yes, I am fully aware of that.

Mr Bowles: We respect the professional association and we will consult with them about the rollout of these programs. We always do. We talk with them in detail. This is more by the nature of a high-level arrangement with the guild simply to take this funding forward.

Senator DI NATALE: How were those five representative bodies chosen?

Mr Bowles: I do not think there is any real issue there. The minister came in; he wanted to deal with a whole range of issues around the Medicare freeze. That affects the AMA and the RACGP. We have negotiated different pricing arrangements for medicines and that involved Medicines Australia, the generics group and the pharmacy group. That is how they were selected.

Senator DI NATALE: Why have patient groups not be consulted and formed part of a compact? There is the Consumers Health Forum, for example. One would have thought that if

you are going to engage in compacts there are other stakeholders who should be represented—for example, patients; allied health; the nursing profession; pharmacists themselves through their professional representative body, the PSA; and public health groups. Is this a sign of the government's priorities in terms of who they are consulting with and who they are not consulting with?

Mr Bowles: These were quite specifically around specific issues, as I said, around the freeze in Medicare and the budget.

Senator DI NATALE: Moving on from the issue of compacts, the government has described the national Health Care Homes as a flagship health policy—is that correct?

Mr Bowles: Yes, I believe so. I cannot remember the exact language but many people have reference to them, yes.

Senator DI NATALE: So it is a flagship reform of primary care. The RACGP represents the interests of general practitioners and is a training body and an advocacy body for general practice—is that correct?

Mr Bowles: That is correct.

Senator DI NATALE: Can you explain to me how a compact with the body that represents general practice would be silent on what the government describes as its flagship program in primary care—that is, the hospital homes program? How can it be silent on that key issue?

Mr Bowles: It is a program that is already running out in the system. I cannot specifically go to that.

Senator DI NATALE: It is a very contentious program—isn't it—within general practice?

Mr Bowles: In some areas of general practice there is some contention, not in all.

Senator DI NATALE: If this is a flagship reform program, why is it not mentioned as part of the compact with the College of General Practitioners, given that they are the central body—

Mr Bowles: Again, these were negotiated terms between the parties. That is where it is.

Senator DI NATALE: Do we take that to mean that the College of General Practitioners do not support the government's flagship?

Mr Bowles: You would have to ask them what they support or do not support.

Senator DI NATALE: There is a compact, an agreement, with the College of General Practitioners that excludes the flagship primary care program.

Mr Bowles: It does not exclude it; it just does not include it—to be cute. It does not put it in there and cross it out, so it does not exclude it. It was never in there to start with. This was a separate agreement that was developed. It just does not include reference to that.

Senator DI NATALE: Is there any commitment from the body that represents Australia's general practitioners to support the flagship program?

Mr Bowles: You would have to ask them.

Senator DI NATALE: This is an area of government policy. I am sorry, that answer is not going to cut it. This is an area of government policy—

Mr Bowles: There has been contention. You have already said that.

Senator DI NATALE: I am asking you for the College of General Practitioners' position, given that you are consulting with them—

Mr Bowles: They are supporting the rollout of a trial of Heath Care Homes.

Senator DI NATALE: So why is that not included in the compact?

Mr Bowles: I have no answer to that other than these were the terms agreed by the parties.

Senator DI NATALE: I am going to move to the government's national health plan. Can you outline what the four pillars of national health plan are?

Mr Bowles: Have you got those there?

Senator DI NATALE: They are the four pillars of the national health plan; as secretary of the department, surely you know what they are.

CHAIR: He is checking with his colleague.

Senator DI NATALE: The four pillars of the government's national health plan and the secretary needs to consult on those!

Mr Bowles: We are in the process of going through a whole range of activity, and they are in the agreement. It revolves around research, Medicare, medicines and hospitals.

Mr Stuart: And mental health.

Mr Bowles: Sorry, mental health is in there.

Senator DI NATALE: Thank you, Mr Stuart. I appreciate that. It is remarkable that a government would spruik four key pillars and we need to take advice on what they are.

Mr Bowles: That is unfair.

Senator DI NATALE: It is also true.

Mr Bowles: No, it is not true.

Senator DI NATALE: How so?

Senator REYNOLDS: A point of order: Senator Di Natale has been sitting there not only badgering the secretary on the same question over and over again—I think, quite inappropriately; now he has actually called him a liar. I would ask whether that was his intention to call the secretary a liar or whether he had some other intent. I do not think it is appropriate.

Senator DI NATALE: They are your words.

Senator REYNOLDS: That is why I am asking.

Senator DI NATALE: They are your words.

Senator REYNOLDS: A point of clarification: because you clearly intended that he was not telling the truth.

Senator DI NATALE: I am pointing out just so it is read into *Hansard,* the facts are: I asked the secretary of the department what the four pillars were and he needed to seek advice on the four pillars of the government's national health plan.

Mr Bowles: That is not true. I can refer to my colleagues as many times as I like, and I told you what they were.

Senator REYNOLDS: Point of order, Chair. There is a debate between the two of them.

CHAIR: Order! If we could retain a degree of decorum in the transactions occurring here—questions, answers and no commentary.

Senator DI NATALE: Where is the government's long-term national health plan, that the minister has referred to? Where does that exist?

Mr Bowles: That is what the minister has been referring to in the development stage. It is not finalised.

Senator DI NATALE: Is there a document somewhere?

Mr Bowles: There is a range of references to this, including in the compacts and in his budget speech.

Senator DI NATALE: So the compacts are the national health plan?

Mr Bowles: No. That is not what I said.

Senator DI NATALE: Where is it?

Mr Bowles: We are in the process—

Senator DI NATALE: I am asking a question. One would be forgiven that if the health minister is out there spruiking a long-term national health plan that there would be some reference for us to look at. Where is it?

Mr Bowles: The minister has been very clear that he is working on developing a national health plan, in his context. It goes to—we are the PBS now. The strategic direction statement, starting on page 14, starts to go through a range of these issues. The four pillars, as we talked about before, are all in there. It is about guaranteeing the Medicare, it is about supporting hospitals, it is about the prioritising mental health and it is investing in medical research. They are all in there. And there is a fifth element which is aged care. They are all in pages 14 to 22 of the PBS. That is the start of this conversation.

Senator DI NATALE: The budget papers are effectively where the long-term national health plan is?

Mr Bowles: This is how it starts. The strategic direction statement, which forms part of the PBS, is the start of that conversation.

Senator DI NATALE: Is there a separate document outside of the budget papers called the long-term national health plan?

Mr Bowles: Not at this stage. This is the start of a process.

Senator DI NATALE: In the budget papers, the government references the $10 billion investment in the long-term national health plan but there is no such document that exists outside the budget papers—that is correct isn't it?

Mr Bowles: The minister has constantly talked about those four pillars, and it includes aged care in the context of the strategic direction statement. He has also talked about waves, and aged care is all part of that as well. You can't do everything right at day 1. He wants to do this over a period of time.

Senator DI NATALE: Three years would be long enough. I do not think you mentioned prevention as one of the four pillars. I think you said, just then, mental health, but it is mental and preventative health.

Mr Bowles: Yes.

Senator DI NATALE: Given that is one of the key pillars, and given that it has been identified as such, can you describe to me the investment, in prevention, in the national health plan?

Mr Bowles: Again, we are talking about investment, currently, in a budgetary context. You keep referring to the national health plan. It is not really in this item, I do not think. Anyhow, if you go to Budget Paper No. 2 there are a range of issues in there that relate to preventative-type health.

Senator DI NATALE: Where is the increased investment in prevention in the budget?

Mr Bowles: It goes through a range of different items. There is cancer screening, breast screening, greater choice at home for—

Senator DI NATALE: Programs we have had for many years.

Mr Bowles: And some have had additional funding—

Senator DI NATALE: I am asking you to outline the increased investment in prevention. Can you take that on notice?

Mr Bowles: I refer you to Budget Paper No. 2, where all of the measures for the budget are. You will see there is additional support around a range of items that fit into the preventative health care.

Senator DI NATALE: There was, I think, a $5 million payment to the college of general practice as well. Is that part of the prevention pillar?

Mr Bowles: There is an element—I am just trying to think of it. We have 50-odd measures and all sorts of items here. There is a $5 million payment for GPs through the college to look at obesity, overweight.

Senator DI NATALE: Can you outline this? There is a $5 million payment to the college of general practice, and I just want to know what that spend is on.

Mr Bowles: To deal with educating patients around obesity and overweight and all that—

Senator DI NATALE: Could you take on notice some details of that program?

Mr Bowles: I will take it on notice. There is a whole heap of fact sheets, on every single measure, that are available on the website.

Senator DI NATALE: I think you can take it that if I am asking these questions this information is not easily available.

Mr Bowles: They are all on my website, all 50-odd of these fact sheets.

Senator DI NATALE: Then it should be very straight forward for you to provide me on notice what the $5 million is for the college of general practice?

Mr Bowles: I will provide the fact sheets to you on notice.

Senator DI NATALE: If there is a fact sheet available on that specific issue. The minister in his lock-up statement talked about three waves of reform. Can you tell me what he meant by that?

Mr Bowles: Basically, that everything cannot be done at once—I would have to refresh my memory there—what fits exactly in every location. The first wave was this budget,

dealing with the freeze, Medicare, guaranteeing Medicare and all of the issues that revolve around that. The second phase is around primary health insurance—

Senator DI NATALE: Sorry, primary health insurance?

Mr Bowles: Sorry, private health insurance, mental health workforce, Indigenous—all of those fit over the next two areas. Aged care fits in that.

Senator DI NATALE: I have the third wave of reform. Do you have timing?

Mr Bowles: I do not have it in front of me.

Senator DI NATALE: When does wave 1 kick in? When does wave 2 kick in?

Mr Bowles: They have tried to go around some of the budgets cycles, so we can look at the funding arrangements for each.

Senator DI NATALE: It looks like in the third wave of reform you have a reference not on a time, but it is a sub point of preventative care, which is Indigenous health. Is that correct?

Mr Bowles: Yes.

Senator DI NATALE: Why does Indigenous health, given the woeful state of Indigenous disadvantage, belong in the third wave of reform? Is it not an urgent priority?

Mr Bowles: It is an urgent priority and there is a lot of work happening in there, and that is just a reference to specific work at that point in time. Indigenous funding is increasing year on year. I cannot remember off the top of my head the exact percentage but the increase this year is something like nine or 10 per cent, which is much higher than any other item, at the moment. That is being prioritised as an issue.

Senator DI NATALE: Can I go to the Medicare Guarantee Fund?

Mr Bowles: Largely, that will be a matter for Treasury. We are not responsible for the establishment of the Medicare Guarantee Fund.

Senator DI NATALE: Are you aware of its existence?

Mr Bowles: I am aware of its existence, yes.

Senator DI NATALE: What does it do?

Mr Bowles: Again, it is a matter best described by Treasury, it is not a measure of ours.

Senator DI NATALE: Did you give any advice in the development of Medicare Guarantee Fund?

Mr Bowles: It is a matter for Treasury.

Senator DI NATALE: Were you involved—

Mr Bowles: It is a fund.

Senator DI NATALE: I understand. I am asking you a separate question.

Mr Bowles: No. It is a fund. I do not get involved in that.

Senator DI NATALE: Was there any discussion with the health department?

Mr Bowles: No. It is an issue for Treasury. We do not deal with funds. We deal with the outcome of health care, not the funds.

Senator DI NATALE: Sure. I am just—

Senator Nash: I might be able to assist a little bit there. It was very much about safeguarding the future of Medicare. It means that Medicare gets the first call on the budget every year. It includes the NDIS. It was very much about safeguarding the future of Medicare.

Senator DI NATALE: Can you explain to me how it safeguards the future of Medicare.

Senator Nash: I will take the detail of that on notice for you. Obviously I am not the minister responsible. But, by the very fact that we have a fund, it shows the certainty of the funding into the future, as I understand it.

Senator DI NATALE: How so?

Senator Nash: That will all be in the detail of the legislation.

Senator DI NATALE: The funding exists already. There is a bucket of money that goes into health. If we call it something, that does not guarantee it. So I am just asking: how does it guarantee funding for Medicare?

Senator Nash: I am happy to take those details on notice for you to get them absolutely right.

Senator DI NATALE: It is a pretty broad question, and you have said that it is there to guarantee funding.

Mr Bowles: And, again, funds—

Senator DI NATALE: I am not asking you, Mr Bowles; I am asking the Minister representing the Minister for Health—

CHAIR: Senator Di Natale!

Senator DI NATALE: who volunteered—

CHAIR: and said she would take it on notice.

Senator DI NATALE: to answer this question.

Senator Nash: Absolutely. Certainly I have attempted to assist by giving you a high-level response. The detail is a matter for Treasury, obviously, as the secretary has indicated.

Senator DI NATALE: Let me ask you at a high level: how does it guarantee funding for Medicare?

Senator Nash: By putting into legislation the future certainty around the funding. But I am very happy to provide to you the details of that.

Senator DI NATALE: But how does the fact that money is going into a bank account guarantee funding for Medicare?

Senator Nash: I am very happy to provide the detail on notice.

Senator DI NATALE: Not detail. I am asking just generally.

Senator Nash: And that is my answer.

CHAIR: The minister has answered.

Senator DI NATALE: So there is no answer.

Senator Nash: It is not that there is no answer.

CHAIR: She said she would take it on notice, Senator Di Natale. How long do you have?

Senator Nash: I have attempted to be helpful and I will provide more information for you on notice.

Senator REYNOLDS: It is being quarantined for a purpose. It seems pretty obvious.

Senator DI NATALE: I have some questions that were supposed to be asked in whole-of-portfolio, but we ran over time with a range of other issues. I have some issues around the Special Access Scheme and the TGA that I wanted to ask in whole-of-portfolio. Are the departmental officials here?

Mr Bowles: No. According to the schedule it is on at 5 o'clock.

Senator DI NATALE: And you do not have the departmental officials here?

Mr Bowles: No. We are organised around the agenda.

Senator DI NATALE: Okay. Thank you.

Senator SINGH: Why is there no agreement with any other health professions?

Mr Bowles: Again, I said there were specific issues around the doctors and the Medicare freeze and the arrangements there. The minister has made that very clear. We looked in the pharmaceutical world, the medicines world, around better pricing. That is why those are there. There are no other specific issues that we needed to deal with in the broader context at this particular point in time to warrant a compact of that sort.

Senator SINGH: Why is there no agreement with anyone representing public hospitals?

Mr Bowles: That is what the national health funding arrangements are with the states. That is what we already did through COAG last year. We put an additional $2.9 billion in last year and an additional $2.8 billion in this year over the forward estimates. Those are the arrangements.

Senator SINGH: Why is there no agreement with groups representing rural health?

Mr Bowles: They are part of the broader health system, last time I checked. The doctors fit under those categories. The public hospitals fit under the public hospital agreements through COAG.

Senator SINGH: But there are specific rural health groups, aren't there?

Mr Bowles: There are.

Senator SINGH: So why not have an agreement with those groups?

Mr Bowles: This was in the context of the budget, do not forget. There are a whole range of other issues that will come up at later points around work force, and that will be a particular focus for rural as well. So I would not rule in or out anything that we might want to do to try and get a better outcome for health consumers in Australia.

Mr Stuart: These were the minister's—as the secretary said—immediate priorities in just four months of his ministry heading into his first budget, to deal with a number of issues that were on his plate going into the budget. He has not ruled out other agreements with other parties over time.

Senator SINGH: Why is there no agreement for Indigenous health?

Mr Bowles: We already have a whole range of things for the Indigenous health plan. We can talk later about that. I think on Friday we have cross-portfolio on the agenda, which talks

about Indigenous quite specifically. There are a lot of plans around that—one is called Closing the Gap—and there is a whole range of funding arrangements that sit around those.

Senator REYNOLDS: I listened with great interest to the discussions, although it was a bit of a lecture. I just wanted to clarify the issue of the compacts. There are five compacts. Would you characterise that as being a productive thing in terms of government and departments working with the individual organisations?

Mr Bowles: Yes, absolutely.

Senator REYNOLDS: So they are a constructive, positive thing, and they are all about the department and the minister seeking to work as collaboratively as possible with the industry associations.

Mr Bowles: Yes, that is correct. Obviously we have been dealing with some difficult issues. This was a mechanism to deal with them. I think, yes, it has been quite productive.

Senator REYNOLDS: Could you characterise them all as being positive in terms of progressing relationships with those organisations on behalf of their members?

Mr Bowles: I would think so.

Senator REYNOLDS: In relation to the six community pharmacy agreements, there was some discussion about that. That compact is not inconsistent with the latest pharmacy agreement, is it?

Mr Bowles: No.

Senator REYNOLDS: And that is not being changed, as I understand. Is that in place until 2020? It might be 2019 or 2020.

Mr Bowles: Yes, 2020.

Senator REYNOLDS: I am struggling. There seems to have been another mighty effort by my colleagues to find something where there is nothing—much ado about nothing. Good practice, transparent, good working relationships—that is it.

Mr Bowles: Yes, that is about right.

Senator REYNOLDS: I would like to move on to bulk billing, if I could. I always like to get updated facts and figures on bulk billing. Could you please outline, secretary or the appropriate official, the latest bulk billing figures nationally? And then if you could give us a quick breakdown by state.

Mr Bowles: I will get my colleagues to go into those specific details.

Ms Jolly: We recently released the Medicare statistics for the first nine months. We release them cumulatively. They were published on 15 May. The July to March figure for GP bulk billing increased to 85.4 per cent, from 84.8 per cent compared to the same period last year.

Senator REYNOLDS: Can I just clarify that? Bulk billing is up again.

Ms Jolly: Yes. And for total services the bulk billing rate remained constant at 78.1 per cent. That is comparing the first nine months of the year with the same period from the previous year.

Senator POLLEY: Could we have a breakdown of state by state?

Senator REYNOLDS: We are thinking alike. I have just asked for one as well.

Mr Quinane: Again, these are the year to date figures to March this year. Running through the states from largest to smallest, for New South Wales the total Medicare rate is 79.5 per cent, and the GP rate is 88.6; for Victoria, total Medicare is 77.4 and for GP is 85.0; Queensland, total Medicare is 78.4 and GP is 85.1; South Australia, total Medicare is 78.8 and GP is 84.5; Western Australia, total Medicare is 75.2 and GP is 81.9; Tasmania, total Medicare is 74.5 and GP is 76.0; the NT, total Medicare is 88.3 and GP is 88.7; and the ACT, total Medicare is 67.5 and GP is 60.9.

Senator REYNOLDS: Just out of interest, how do those figures—nationally, to start with—compare to the 2012-13 year? Have they been going up, down, around?

Mr Quinane: If we take the total Medicare rate, again comparing July to March in 2012-13, the total Medicare was 76.5 in 2012-13 and it is now 78.1 in 2016-17. For GP, the July to March 2012-13 figure was 82.0, and for July to March this year it is 85.4.

Senator REYNOLDS: So I think it is safe for me to unequivocally say that over the last few years not only the total numbers but also the numbers for GPs have been steadily increasing.

Ms Jolly: That is correct.

Senator REYNOLDS: Thank you. Its is very clear.

CHAIR: Thank you, Senator Reynolds. Senator Watt, do you have further questions on program 4.1?

Senator WATT: Yes. I still have a couple. Just dealing with the freeze on the Medicare rebate, obviously the government made some announcements about this in the context of the budget. Why is the freeze on GPs, specialists and allied health services not ending on 1 July this year?

Mr Bowles: Because the arrangements are a gradual unfreezing over the next number of years, until the time when it was due to lift anyhow. It has been quite clear: it starts to unfreeze this year, with the bulk-billing incentives, and then on 1 July next year it is about standard GP consultations and specialist attendances. It is next for specialist procedures and allied health services, and then 1 July 2020 is when everything else was due to come back in—also diagnostic imaging for certain items.

Senator WATT: Given all the complaints about this, why not lift it across the board on 1 July this year?

Mr Bowles: At the end of the day, this was a negotiated outcome; we needed to work out how to best deal with this issue.

Senator WATT: Negotiated within government?

Mr Bowles: No—well, ultimately within government. Governments make the decisions on these things.

Senator WATT: So what exactly is changing on 1 July? Is it only the re-indexing of the bulk-billing incentive for concessional patients?

Mr Bowles: It is re-indexing of bulk-billing incentives, yes.

Senator WATT: Have you seen the comments of Dr Bill Coote, who was a former AMA secretary general and one-time adviser to former health minister Sussan Ley?

Mr Bowles: No, I have not.

Senator WATT: Again, I have got a copy of that here. On 15 May, after the budget, in *Medical Observer*, his comments were: 'After 1 July, if you bulk-bill three patients in the morning, the extra money you will earn from re-indexation will just about cover one of those tiny tomato sauce sachets to go with your lunchtime pie.' Do you agree that the re-indexation of those incentives is worth less than a tomato sauce sachet?

Mr Bowles: I am not answering that. I am not responding to a media article like that.

Senator WATT: Why, because it is critical of the government?

Mr Bowles: I made it clear, and it is in the budget papers, that the re-indexation starts on 1 July for GP bulk-billing incentives.

Senator REYNOLDS: You can find a negative spin on everything.

Mr Bowles: Over the forward estimates, the total package is about a billion dollars. It starts small in 2017-18—that is correct. And I would not be so flippant as to reference it that way.

Senator WATT: So that is a former secretary general of the AMA; you are describing him as flippant?

Mr Bowles: No, I did not describe him. I said I would not reference anything in that way.

Senator REYNOLDS: I think that was your comment.

Senator WATT: No, they are his comments. I can show you them, if you would like.

CHAIR: Minister, do you have something to add?

Senator Nash: Thank you. I might be able to assist a little bit, Chair. I think firstly it is a phased approach, in agreement, obviously, with the AMA and the RACGP, so that is, I think, the first thing to note—that there has been the agreed basis on doing this. It is a fiscally responsible way of doing it, in terms of phasing it in over the three years, and I think it is very important to note that it was actually Labor who brought the freeze in and the coalition government that is ending the freeze.

Senator WATT: How many years will the government keep relying on Labor governments to excuse its own policy decisions?

Senator Nash: Sorry, I did not hear you.

Senator WATT: How many years will you need to be in office before you stop referring back to what happened under the federal Labor government?

Senator Nash: Well, unfortunately, you cannot change the bad decisions of the Labor government previously, so we have to keep referring to them.

Senator WATT: You mean bad decisions over the last three or four years of this government?

Senator Nash: No, not at all, Senator. But I think it is interesting that you are asking questions about a freeze that your own Labor government put in place.

Senator WATT: My daughter, when she has a pie, likes two tomato sauce sachets. So the amount of indexation would not cover both of those tomato sauce sachets?

CHAIR: Senator Watt, I think that we need a serious question. There is a point of order here from Senator Polley.

Senator WATT: These are comments—

Senator POLLEY: Senator Watt had the call—

CHAIR: Yes, and everyone else is interrupting him, including you.

Senator POLLEY: and those sorts of interjections do not help the situation.

CHAIR: Thank you. There will be no interjections.

Senator WATT: I am just picking up on comments by a former adviser to the former minister, Minister Leigh.

CHAIR: You are asking about sachets of sauce.

Senator WATT: Those are his comments.

Senator Nash: We could focus on other comments as well, like the comment that we are investing an additional $2.4 billion in this budget, with $1 billion as part of the return of the indexation. I think there would be far more useful comments to focus on than tomato sauce.

Senator WATT: If the analogy of two tomato sauce sachets is not one that the government likes, how much is this indexation that is going to apply from 1 July this year actually worth to GPs?

Mr Bowles: If you go to page 109 of Budget Paper No. 2, which has been available from 9 May, it will tell you the exact answer, and the first year is $9.5 million.

Senator WATT: That is in an overall sense. What I am asking is: in dollar terms, for a consultation with a GP, what does that mean? I am not talking about an aggregated figure.

Mr Bowles: I have not worked it out on an item number, so I will take that on notice. The issue is, there is $9.5 million in that first year, in relation to bulk-billing services. So it is not insignificant. But I would add that in the second year it is $146 million, when you start to bring in the other services. Then it is $403.4 million in 2019-20 when you bring in the next lot, and in 2020-21 it is $443.4 million, for a total of $1,002.3 million, roughly $1 billion.

Senator WATT: Are they aggregated figures? All of the indexation, across every procedure, across every year.

Mr Bowles: Everything that is indexed; yes.

Senator WATT: What I am trying to get to is what this means for an individual consultation with an individual GP. But you do not know that, is that correct?

Mr Bowles: No, not specifically to each individual item. You are asking for one item; what one bulk-billing incentive—

Senator WATT: Well, the one that is starting this year.

Mr Bowles: We are going to re-index—at whatever the rate of indexation is—for either the $6 or the $9 and a bit rates for bulk-billing incentives. So it is small, in that context, but we actually deliver 365 million services a year.

Senator WATT: I am trying to get to this: what is the benefit to an individual patient and an individual GP?

Mr Bowles: I will take it on notice. I have already said that.

Senator WATT: I also have an article from the *Herald Sun* dated 15 May, which states that the measure being brought in this year is only worth 12 cents per consultation. Does that sound about right?

Mr Bowles: I have taken it on notice. I am not going to speculate on what it is. I have told you that, over the bulk-billing incentives, which is the smaller part of this measure, it talks about re-indexing the $6 or the $9—depending on where you are—of the bulk-billing incentive.

Senator WATT: Is anyone at the table able to tell us whether—

Mr Bowles: I have said I will take it on notice.

Senator WATT: So, if it is 12 cents, that is where this comment about a tomato sauce sachet would have come from. I think they retail for about 20 cents.

Senator Nash: The secretary has outlined very clearly that over the forwards it is $1 billion extra.

Senator WATT: You are talking in aggregate terms; I am trying to get—

Senator Nash: It is $1 billion extra. I understand what you are asking, Senator. You are asking about the changes as they apply on 1 July this year, and the secretary has undertaken to take that on notice for you, to get you that exact figure. But do not trivialise the fact that this is a billion-dollar investment. This is a billion-dollar fund.

Senator WATT: Not the one that is happening on this year, it is not.

Mr Bowles: This is an arrangement that happens over a number of years.

Senator Nash: Are you saying we should not be indexing the bulk-billing incentive, Senator?

Senator WATT: I am trying to understand—

Senator Nash: Is that what you are saying?

Senator WATT: No. You know that is not what I am doing.

Senator Nash: I do not know what you are doing, Senator!

Senator WATT: I do not think the average person on the street is thinking: 'What does this mean in aggregate terms for the federal budget?' They are actually thinking: 'What does this mean for me when I go and see my GP?' The average GP is thinking: 'What does this mean for me when I bill a patient?' And we do not have an answer from the department about what it means—

Senator Nash: Perhaps I can go back to the beginning—which you might have missed—when I said that this was done on a basis agreed with the AMA and the Royal Australian College of General Practitioners. I would say that they are the exact bodies who represent the doctors you are talking about. They agreed to this. We are removing the indexation freeze that the Labor government started, that the Labor government put in place—and it has been agreed by these organisations.

Senator WATT: Let us deal with this claim from the government that it is all Labor's fault, even though you have been in power for four years.

Senator Nash: I did not say it was 'all Labor's fault'. I was merely pointing out for people who may not know—as you say, people out there listening do not always hear everything—that it was in fact the Labor Party that started the indexation freeze.

Senator WATT: When was the last time Medicare rebates for GPs, specialists and allied health providers were indexed?

Mr Bowles: We have answered that many times.

Senator WATT: Can you tell us again?

Mr Bowles: We can try again.

Ms Jolly: In the 2013-14 budget—

Senator WATT: That was brought down by the former federal Labor government.

Ms Jolly: indexation of all MBS schedule fees was paused for eight months. In the 2014-15 budget, the indexation of specialist and allied health schedule fees was paused for two years. In the 2014-15 MYEFO, the indexation of schedule fees for all MBS items was paused until 1 July 2018. Then, in 2016-17, all MBS schedule fees were paused until 1 July 2020. Then this budget decision reversed that.

Senator Watt: The 2013-14 budget, brought down in the last months of the federal Labor government, realigned indexation but provided for that to recommence on 1 July each year. That is correct?

Ms Jolly: It was paused from November 2013 to June 2014.

Senator WATT: That budget provided for indexation to recommence on 1 July each year?

Ms Jolly: That is correct.

Senator WATT: Senator Nash, how then can you get away with saying federal Labor froze it when in fact that budget provided for the reintroduction of indexation?

Senator Nash: Because you did, and then it was actually—

Senator WATT: But the budget papers do not say that.

Senator Nash: Hang on! Let me finish. You have asked a question. Let me answer it. It is because you did. I said you introduced the indexation freeze.

Senator WATT: I know you say that, but where is your proof?

Senator Nash: Hang on!

Senator WATT: Does the proof not show exactly the opposite?

Senator Nash: Hang on! If you are going to ask questions, it is question and answer time.

Senator REYNOLDS: On a point of order: Senator Watt might not want to hear the answer to the question he asked of the minister, but I am very interested. So it would be very good if he could let the minister answer the question—

Senator WATT: I really want to hear her answer to get out of this one.

Senator REYNOLDS: before he rolls over the top of her again.

CHAIR: On the point of order: if we can go with questions and answers and be as civilised as we possibly can be, that would be excellent.

Senator WATT: You should try Legal and Constitutional Affairs.

Senator Nash: I am happy to stand by what I said. You froze indexation. We fixed it. That is a fact. That is correct.

Senator WATT: Can you explain to me your claim that federal Labor 'froze' indexation? How can that be the case? This 2013-14 budget paper says:

MBS fees will be indexed on 1 July each year. The next indexation date will be 1 July 2014.

Is that not actually about bringing back indexation? You say that is a freeze?

Senator Nash: It was in the first place, and you know it full well. You are trying to play semantic games. You froze it in the first place. I refer you to what Tanya Plibersek—sorry to use the name—said. She said that doctors earned enough money to bear the freeze in the first place and that she thought bulk-billing rates would stay very strong. She said:

The average doctor gets $350,000 a year in Medicare billings. It's a fairly substantial payment.

I point to that quote as indicating that it was indeed Labor that started the indexation freeze.

Senator WATT: The 2013-14 budget brought down by federal Labor provided for indexation to recommence on 1 July 2014 and it allocated about $150 million to $170 million in each year of the forward estimates to allow that to occur. So it was going to be recommenced on 1 July, and money was brought in but of course there was an election in the meantime. When was the Abbott government's four-year freeze introduced?

Mr Bowles: We just gave you the dates before.

Senator WATT: That would have been in the 2014-15 budget.

Senator Nash: I think we jolly just ran through all of that.

Mr Bowles: Let me go through it. Yes, in the 2013-14 budget, it was eight months to finish at a point in time. Every one of these has a start and finish date—Labor and the current coalition. It followed on from the first one in 2013-14 and it continued to there, until this budget where it was reversed over the forward estimates.

Senator WATT: The indexation was to recommence on 1 July 2014. Did that happen?

Mr Bowles: No it did not.

Senator WATT: Was it because of the decision made by the first budget of the Abbott coalition government?

Mr Bowles: Which everyone has already said.

Senator Nash: Senator, are you denying that Labor paused indexation?

Senator WATT: No, what I am saying—

Senator Nash: Good, so you are agreeing that Labor paused indexation?

Senator WATT: What I am saying is that, under Labor, indexation was to return—

Senator Nash: Yes, in the out years that we never got to under your budget because you were no longer in government.

Senator WATT: No, and you froze it, did you not?

Senator Nash: But we never got to those years under your government. We know your hypothetical fairy's at the bottom of the garden money, Senator.

CHAIR: If I may, I wonder whether anyone at this table would like to talk about the 2017-18 budget instead of a history lesson?

Senator WATT: Minister Nash keeps throwing back that it is a Labor freeze but—

Senator Nash: Are you saying that it is not a freeze? Are you saying that Labor—

Senator WATT: Yes, I am saying that in the 2013-14 budget, we provided for indexation to reoccur.

Senator Nash: I said that Labor introduced the indexation freeze. Are you denying that?

CHAIR: Senator Singh, did you have some questions?

Senator SINGH: I do.

Senator Nash: You cannot deny because it is correct.

Senator SINGH: It follows on from what you are referring to in relation to the Medicare freeze. I would like if you could provide us with a time line, or an outline at least of the time line, of the MBS indexation.

Mr Bowles: We will take on notice to provide to time line but we have already given that to you verbally today and last estimates and the one before that. It starts with the 2013-14, eight months to 1 July 2014.

Senator SINGH: I want to see where it ends, you see, so a time line is useful. I understand it is available.

Mr Bowles: It clearly ends at the moment based on the 2016-17 budget on 1 July 2020 but in the 2017-18 budget, it progressively unfreezes over that same time period where everything is reindexed on 1 July 2020 but progressively.

Senator Nash: We are re-indexing diagnostic imaging for the first time since 2004 that the Labor Party refuses to commit to.

Senator SINGH: So the freeze is not ending on all GP items on 1 July 2018?

Mr Bowles: It was never ever said that that was the case. They are progressively coming in. The standard GP consultations are in July 18; allied health, which is obviously a range of those services as well in July 19; specialist procedures in 19; special attendances in 18. It is progressively. That is what has been said from minute one.

Senator SINGH: Let's go to how many GP items will remain frozen after July 2018.

Ms Jolly: We have on our website a fact sheet which actually outlines all of the MBS items by year. I would be happy to provide that on notice. It is a long list of numbers that indicates specifically which come on and off at each year. That is available on our website, and we would be happy to provide that to you.

Senator SINGH: What sorts of GP items will remain freeze on? Are they things they GP mental health services?

Mr Stuart: None will remain frozen after 2020. They will all recommence indexation.

Senator SINGH: I am asking about July 2018, after July next year.

Ms Jolly: In July 2018, your standard GP consultations are the ones for which indexation would be applied. They are your consultation A to D items. They represent about 90 per cent of GP services. The remaining items are probably some of the ones that you are referring to. Some of the chronic disease management, health assessment and management plan items are the ones that will have their indexation switched on later. They form a smaller part of the services provided by general practice in terms of overall—

Senator SINGH: Are mental health services included?

Ms Jolly: In terms of the plan, not in terms of the consultation items. By far and away, the most common general practice item is item 23, which we often talk about, which is the standard consultation. It, plus your short- and long-term consults account, as I said, for about 90 per cent of services provided by GPs. There are a bunch of other services which GPs provide. They would include the development of plans and some other items which are listed on that sheet. That is a smaller proportion. Their indexation applies in 2020.

Senator SINGH: I am asking about this because the government made a lot of fanfare about it lifting the Medicare freeze and now we find out, when we dig into the detail, that there is a range of really serious items, which you just referred to—like chronic diseases, mental health disease management and the like—that are not being unfrozen until 2020, which is years away.

Mr Bowles: I do not accept the characterisation that we—

Senator SINGH: What—that it is not years away?

CHAIR: Please allow the secretary to answer.

Mr Bowles: I do not accept the characterisation that we now find this. The cascading effect of this was known as of the budget.

Senator SINGH: Mr Bowles, you keep referring to Budget Paper No. 2. It says:

... standard consultations by General Practitioners and specialist attendances will be indexed from 1 July 2018 ...

Correct?

Mr Bowles: Yes.

Senator SINGH: Isn't this a bit dishonest about the items that are not indexed until 2020?

Mr Bowles: No. Standard consultations, item 23 and others around that; as Ms Jolly just said, 90 per cent of the MBS schedule.

Senator SINGH: What we can be clear about here is that the full indexation freeze on GP items will not be lifted until mid-2020. Is that correct, Mr Bowles?

Mr Bowles: They progressively start from 1 July 2017, 2018, 2019 and then, yes, everything is finally done by 2020.

Senator SINGH: I just want to ask this question again, because I need to get this clear in my head: can you confirm that the full indexation freeze on GP items will not be lifted until mid-2020? Is that correct, Mr Bowles?

Mr Bowles: I just answered that question by saying it progressively starts from 1 July 2017 and everything is finally done by 1 July 2020.

Senator SINGH: So the full list of GP items will not be lifted until mid-2020?

Mr Bowles: As was stated from minute 1 of the budget. I have a fact sheet that spells that out.

Senator Nash: Senator, this is not a newsflash. This was obvious at the time of the budget. It might not have been obvious to you at the time of the budget.

Senator SINGH: I want to understand this clearly.

Senator Nash: Absolutely. I understand that.

Senator SINGH: We know that you want to put some spin on it, Senator Nash, but I am trying to get some—

Senator Nash: Don't make out that this is some newsflash. We are spending $23 billion on Medicare next year, rising to $28 billion, compared to Labor's $18 million in 2012-13. I think it is very important to get the facts on the table here, Senator, and one of the facts is that the phased approach is not a newsflash today. It is something that has been clear since the budget, as the secretary pointed out, and this government is also a government that is committed to being fiscally responsible, unlike Labor, which is why it is a phased approach. I go back to where I started, Senator: this is being done on an agreed basis with the Australian Medical Association and the Royal Australian College of General Practitioners, who have agreed to this approach.

Senator SINGH: I want to actually get to the heart of what is clear and what is not clear, and that is what this is about. Why are specialist consultations and specialist procedures outlined separately, but GP items are not detailed in that same way? I am referring again to this Budget Paper No. 2 that you refer to. Why have you got that separate?

Mr Bowles: They are the characterisations of the activities that we look at.

Senator SINGH: But why wasn't it in any of the budget documents—

Mr Bowles: Because specialists—

Senator SINGH: GP items?

Mr Bowles: I do not understand the question.

Senator SINGH: You have specialist consultations and specialist procedures—

Mr Bowles: Yes. Specialists are the ones who mainly do the procedural work.

Senator SINGH: but in the budget papers, to get the breakdown of the GP items, which Ms Jolly has just referred to, it is on a website somewhere—

Mr Stuart: Senator, just to repeat—

Mr Bowles: No, it is not on the website somewhere.

Senator SINGH: I am talking about the budget papers.

Mr Bowles: It is on the Department of Health website.

Senator SINGH: This is the budget estimates.

CHAIR: Allow the secretary—

Mr Bowles: It is on the Department of Health website, where they always remain.

Senator SINGH: Yes but, Mr Bowles, this is budget estimates. I am referring to the budget paper item No. 2 that you keep referring to. I am referring to the budget papers—

Senator Nash: Good. We are all referring to the same papers. There is a good start.

Senator SINGH: and I am asking why—

Mr Bowles: We are all talking about the same thing.

Mr Stuart: The budget papers say very clearly, on page 109 of Budget Paper No. 2:

- standard consultations by General Practitioners and specialist attendances will be indexed from 1 July 2018;

Standard consultations—

Senator SINGH: Yes, I know. I have just referred to that.

Mr Bowles: So what is your question?

Senator SINGH: We have just had a breakdown that some of those consultations refer to mental health services, to health disease management, to chronic disease management, which do not lift till 2020.

Mr Bowles: No.

Mr Stuart: Perhaps I should explain that they are not generally known as the standard consultations. The standard consultation items are the most commonly used GP items, such as item 23 and the levels A, B, C and D consults. The department has published on its website an exhaustive list of which items will be indexed from when, and that has been available from very close on the budget announcement. The reference to standard consultations is a very clear piece of language. It is a technical reference to a particular group of consultation items.

Senator WATT: It obviously does not include every type of consultation that someone would see a GP for—

Mr Bowles: No.

Senator WATT: and there are a whole range of consultations, such as urgent after hours, mental health, pregnancy support, telehealth—nothing will be done about them until 1 July 2020?

Mr Bowles: If they are seen in a normal consultation, they are dealt with. We are talking about 90 per cent, or nearly 90 per cent, of the activity of the MBS—

Ms Jolly: Of GPs.

Mr Bowles: of GPs, in that context—are dealt with in consultations A, B, C, D.

Mr Stuart: The issue that we are addressing currently is whether there has been any obfuscation or hiding of information and whether there has been a later 'aha' surprise, and we do not believe so. We believe we have been very open from the get-go about what is being indexed when.

Senator SINGH: You have specialist consultations reindexed in 2018 and specialist procedures are reindexed in 2019—that is all fairly clear. Why isn't the same thing done with other GP items?

Mr Bowles: Because it is; they are called standard GP consultations and are in 2018.

Senator WATT: No, we are talking about the ones from 2020.

Senator SINGH: Yes, I am talking about these extra—

Senator WATT: Why do the budget papers give the impression that—

Mr Bowles: I do not agree that they do give the impression.

Senator WATT: We are talking about page 109 of the budget papers, aren't we?

Mr Bowles: Yes, that is right.

Senator WATT: There are two references there to changes being made that will affect GPs. It says that there will be reintroduction of indexation for bulk-billing in centres for GPs from 1 July 2017. The ordinary reader would think that that is referring to all bulk-billing incentives for GPs. And then standard consultations by GPs will be indexed from 1 July 2018, but there is no reference at all to the fact that there are a whole range of other services provided by GPs where indexation will not occur until 1 July 2020.

Senator SINGH: Exactly right.

Senator Nash: Senator, perhaps if I can assist a little bit. I think it is important that we get this clarity issue resolved, and the clarity has been there since the budget. Certainly all of those in the sector had no questions. They were very clear about what was being put forward in the phased approach by the government. It might just assist to provide the committee with that. The Consumers Health Forum said:

The staged removal of the Medicare freeze should reduce pressure on Australia's high out-of-pocket health costs.

The RACGP said:

The lifting of the freeze was exactly what the RACGP's #youhavebeentargeted campaign was aiming for.

The AMA said

The AMA … commends the government for taking action on the Medicare rebate freeze.

The Australian Healthcare and Hospitals Association said:

Tonight's Budget is a winner for doctors and pharmacy interests as the Medicare rebate freeze is lifted and a new collaborative approach is embedded in a series of compacts with industry groups.

And the Royal Australasian College of Physicians said:

It is pleasing that the Government has begun the process of lifting the freeze on rebates. The change will mean that MBS rebates will again keep pace with inflation and the cost of running a quality medical practice.

So I do not think there is any issue at all with regard to the clarity when the sector obviously understood exactly what the government was proposing, and I thought it might be useful, Chair, just to have those comments on the record.

Senator WATT: Thank you, but you have not answered my question, which was: why, in designing its budget papers, has—

Mr Stuart: I can answer that question.

Senator WATT: Okay.

Mr Stuart: Budget papers describe what is the measure, and the measure is what makes a difference to the budget, to the costing, to the numbers in the bottom line. The item here that makes a difference for GPs to the budget bottom line is that standard consultations will be indexed from 1 July 2018. The other items were always due to recommence indexation from 1 July 2020, and they will be. That does not make a difference to the government's bottom line, hence not a reference in the government's budget papers, which are compiled by the Treasury department.

Senator WATT: That makes sense. Just before I hand back to Senator Singh, what proportion of GP services would be covered by the services which will not be re-indexed until 1 July 2020?

Ms Jolly: As I have said, about 90 per cent of GP services are the standard consultation items.

Senator WATT: And they are the ones where indexation will recommence on 1 July 2018?

Ms Jolly: That is correct, yes.

Senator WATT: Right. Thanks.

Senator SINGH: How have out-of-pocket costs increased for GPs over the last two years?

Mr Stuart: We did a question on notice on out-of-pocket costs, if I can just find that. The first important thing to say about out-of-pocket costs is, of course, they are only paid by people who are not bulk-billed. And, with the bulk-billing rate going up, that obviously represents a lesser cost to a range of patients. In terms of the out-of-pocket costs for GPs, have you got that there?

Ms Jolly: Yes, I do. As part of the bulk-billing announcement in May, we published a standard set of tables. They also include the average patient contribution, and it compares the nine months up to the data provided with the nine months from the previous year. So I have 2015-16 and 2016-17 data. For the non-referred GP attendances, which are the ones we have been discussing, the average out-of-pocket costs for year to date 2016-17—for those who pay an out-of-pocket cost—is $34.54. The same period last year was $32.97.

Senator SINGH: Last year being 2015-16?

Ms Jolly: 2015-16—for that same nine-month period. We compare the same period to the period previously.

Senator SINGH: So it has gone up a couple of dollars, there—yes?

Ms Jolly: Yes.

Senator SINGH: Have you done any modelling on expected increases of out-of-pocket costs for GPs for this next financial year, or next nine months?

Mr Stuart: We have not.

Senator SINGH: Sorry?

Mr Stuart: No, we have not done any modelling. What we do observe is that, for the reducing proportion of patients who do pay an out-of-pocket cost, there has been a reasonably consistent trend over a long period of time for increases at around a similar level over about the past decade. We answered detailed questions on that, I think, at the last hearing. I just cannot find my particular answer at the moment. But it has been in the order of a four to six per cent per annum increase every year for about the last decade.

Senator SINGH: Four to six per cent per annum increase. What will be the expected out-of-pocket costs for an unreferred GP visit in July 2018?

Mr Stuart: We cannot answer that question.

Senator SINGH: Why?

Mr Stuart: What we do with our data is track what has happened in the past. We do not have a specific facility to project that cost. It is not something that we must do in order to calculate the government's expenditure. So it is not something that we regularly do. We do not project forward on that particular item.

Senator SINGH: But it is a four to six per cent increase per year. All right. I might hand to Senator Watt.

Senator WATT: We have more on 4.1, but we are happy if someone else wanted to go there.

CHAIR: I do not think anyone else has questions on 4.1. I note that we are breaking at 3.30. As discussed previously, my intention is to move to outcome 5 at 5pm. But there are senators who have questions on other programs in outcome 4.

Senator WATT: Is it worth us trying to knock off at least one topic before the break at 3.30?

CHAIR: Yes, let us aim for that.

Senator WATT: Senator Di Natale asked some questions about the Medicare Guarantee Fund, which I think you referred to Treasury. You may not be able to answer some of these questions. What does Health know about this Medicare Guarantee Fund?

Mr Bowles: It was a measure of Treasury. It is not one that we manage. We do not manage the establishment of funds. We deal with the MBS and PBS context, how it gets spent and all of those things. We do not manage the fund. So you are better off asking them. I do not know any technical details of the fund. Literally, it is not something we get involved in. If I liken it to the MRFF, we get involved in the distribution of funding. We have no clue about how the fund operates, how they get their returns and all that sort of stuff. That is one best asked of Treasury. This is the same sort of thing.

Senator WATT: Did Treasury discuss this new Medicare Guarantee Fund with Health?

Mr Bowles: It is not normal practice that we get involved in Treasury related issues. It has nothing to do with how Health spends. It is about how government and Treasury operate themselves, and that is a government call and a Treasury call.

Senator WATT: Your answer was that you would not normally get involved in Treasury matters. But I am asking you specifically: this Medicare Guarantee Fund, which I certainly assumed was a whole-of-government thing that Health was involved in, Treasury has not discussed with Health?

Mr Bowles: I have already answered that but, no, not prior to the budget.

Senator WATT: What about since the budget?

Mr Bowles: Personally, no. People in my organisation I am sure would have at some stage, but again we are not experts on the management of the fund and how that will operate. You are best placed to ask Treasury.

Senator WATT: So no-one in the health department knows anything about this Medicare Guarantee Fund of the government?

Mr Bowles: You need to ask Treasury, because we are not experts in this space.

Senator WATT: I will not prolong this part of the questioning too much longer, but I have seen the Treasurer's press release about this, issued on budget night, and it makes no reference to hospital funding being included in the Medicare Guarantee Fund. Is there any reason hospital funding is not included?

Mr Bowles: It is a separate arrangement that is part of the national hospitals reform agreement, that I referred to before, through COAG. It has been there for quite a while. There is already an agreement in place with that. This is a separate arrangement. We have the national funding body and the national funding administrator, and we have the Independent Hospital Pricing Authority. We have a range of things that deal with hospitals, on that hand, and the funding body that deals with the funding to public hospitals through that arrangement.

Senator WATT: Okay, but there is no similar guarantee fund, if you like, for hospital funding.

Mr Bowles: That is dealt with through COAG and it is guaranteed with the capping of 6.5 that we have talked about many times over the last 18 months.

Senator WATT: Okay. It might be best if we save the rest of our questions there for Treasury. I have not too much more on 4.1. We touched earlier on the Medicare Benefits Schedule review. I think it came up in the context of the after-hours care. I notice that the budget includes $44.2 million to continue that review until 2020. Can you give us an idea of how that money will be spent, such as how much is for consultants, how much is for the department?

Mr Bowles: We may not have the answer to that.

Ms Jolly: I think we are still mapping out that over the coming years. At the moment the work is done by a combination of departmental officials, who support the taskforce through a secretariat, and we have some companies on board also assisting.

Senator WATT: Like consultants?

Ms Jolly: Yes, consultants. At this stage I would not think that that would change, but those decisions are yet to be made into the forwards.

Senator WATT: Okay. Could you take on notice what the breakdown of those figures year-on-year is between consultants and department.

Mr Bowles: As much as we know at this point.

Senator WATT: Sure.

Mr Stuart: Probably the easiest thing to get an indication is for us to tell you that over the past year rather than going forward.

Senator WATT: Are the figures for the past year fairly similar?

Mr Bowles: They would be.

Ms Jolly: We can include those.

Senator WATT: You must have a bit of an idea, at least, for the next financial year.

Mr Bowles: They are roughly the same proportion, I would imagine.

Senator WATT: Is there any money allocated for the clinicians that are leading the review?

Mr Simpson: The clinicians are paid a sitting fee and the chairs are paid a higher sitting fee. Obviously all their costs are covered in terms of meeting attendances and flights.

Senator WATT: Okay. I understand that your portfolio budget submission does say that that $44.2 million is split into $21.6 million in administrative expenses and $22.6 million in departmental expenses. I take it that the money is essentially being split half between departmental officers and half to external consultants and other external people. Is that right?

Ms Jolly: In regard to that split that you have outlined some of the departmental funds may also go to specific contracts for services, but we can provide some of that detail, but, yes, it is as you outlined.

Senator WATT: How much has been budgeted for the MBS review so far?

Mr Simpson: The initial budget allocation was $34 million.

Senator WATT: That was in the 2015 budget?

Mr Simpson: Yes.

Senator WATT: Was that for a one-year amount?

Mr Stuart: That was over two years.

Senator WATT: So 2015-16 and 2016-17?

Ms Jolly: Yes. That also includes funding for MSAC, the Medical Services Advisory Committee.

Senator WATT: Has that money been spent? Is that the amount that did end up being spent?

Ms Jolly: We can provide you with some information on that. We have previously updated the Senate on expenditure against those items.

Mr Simpson: In terms of administered spending it is about $10 million for the two years so far, but there are some contracts and other deliverables that will be finalised over the next couple of months of this financial year.

Senator WATT: So $10 million of that $34.3 million is administered?

Mr Simpson: Sorry, $10 million of the allocation to the MBS review component, not the MSAC component.

Senator WATT: Yes. I was going to ask you if you could break that down, that $34.3 million. Could you break it down between the MBS review and the MSAC process?

Ms Jolly: Yes, we can do that.

Senator WATT: You do not have those figures handy?

Ms Jolly: I do. I have some figures to date, so obviously the year is not yet finished. Mr Simpson mentioned the $10 million that it breaks into. In 2015-16 there was $3.9 million under the MBS review and in 2016-17 there was $6.15 million in the MBS review. In the Medical Services Advisory Committee there was $3.5 million in 2015-16 and $4.1 million in 2016-17.

Senator WATT: Are they all the allocations to the department?

Ms Jolly: That is the administered expenditure.

Senator WATT: Administered, right. So that is external to people outside the department?

Ms Jolly: That is correct.

Senator WATT: Okay—I think I interrupted—and the remainder is to the department?

Ms Jolly: I do not have separately here the departmental.

Senator WATT: Okay. Perhaps if you could take that on notice for us as well.

Mr Bowles: The important thing here is that we do use the externals because we pay the clinicians and all of the others to be part of this process.

Senator WATT: What is the total quantum of savings that the MBS review has achieved so far?

Ms Jolly: There was a decision on obsolete items.

Mr Stuart: The measures came in in July last year and that was $5 million.

Ms Jolly: In that time also MSAC have made a number of decisions. We have indicated that the funding was for the MBS review as well as MSAC, and MSAC in this budget and in the previous has listed also a range of changes to the MBS.

Senator WATT: What items were those savings?

Mr Bowles: Sorry, Senator, I just might flag that the MBS review is not all about savings. It is about appropriateness. You will see some increases, some decreases and some changes. I would not want anyone to be left with the opinion that this was about savings. That is not what it is about.

Senator WATT: Sure, although when the former minister announced the review she said that doctors and patients alike have raised various issues from over-testing and outdated or unproven treatments to unnecessary referrals, duplication, inefficiencies and systemic waste.

Mr Bowles: That is one side of the equation. The other side is that there are some things that have not been on there or on there at a lower rate that are also going to be looked at in the context of the MBS review.

Mr Stuart: We are looking for a better evidence, less wasteful, better bang for buck MBS, and the taskforce has an enormous amount of work in the pipeline. The reference to the $5 million is about a particular tranche of work that has been completed. There is an enormous amount of work either underway or about to come to completion.

Senator WATT: The $5 million in savings that has been generated so far, what items does that $5 million relate to?

Ms Jolly: We would need to take that on notice. There were quite a few. The first look was at what items were obsolete, so items that were not used or were used in very small numbers. That was the very first tranche of work. There has been quite a lot of work done since. We have just recently published on our website the forward workplan for the MBS review taskforce including a series of reports that are coming out over coming months. They go to some of the issues that have been talked about. So there will be a progressive rollout of reports which will have within them a range of recommendations.

Senator WATT: To date we have spent not all of that $34.3 that was on the review.

Ms Jolly: That is correct.

Senator WATT: What total did we have for to date?

Ms Jolly: I thought it was $10 million in administered for the review.

Senator WATT: We do not have to hand the figure spent by the department. At least $10 million has been spent for $5 million in savings. Is your answer to that: there will be more savings to come?

Mr Stuart: The lifetime of a clinical committee is probably a year or even a little bit longer, so you need to think about this as a pipeline of work. The clinicians that give their time to this are some of Australia's leading clinicians, and there are health economists and consumers as well. They are doing this in their spare time for love. The money we pay them probably does not really recompense for what they would have earned had they been seeing patients at that time. It takes a number of months for these clinical committees to produce their recommendations to the taskforce. The taskforce then considers them. They are then subject to public release and consultation, and only after that is there a recommendation to the minister. So, yes, there is a lot of work in the pipeline and about to emerge.

Senator WATT: If these savings do ultimately exceed the cost of the review itself at some point, how will those savings be used? Will they be reinvested in the health system or are they going to consolidated revenue?

Senator Nash: The minister has actually been really clear to say that they will be reinvested in the health system.

Senator WATT: What is the overall predicted savings to be generated from the review?

Mr Bowles: We do not have an overall prediction because we are very mindful that this is not about savings, this is about more appropriate care, so we will see some savings and some spends over the time. We really cannot predict what we do not know at this particular point because it is clinician driven and it is not based on anything that we have actually orchestrated.

Senator WATT: So it could be that the cost of the review is ultimately more than the amount saved.

Mr Bowles: If that was the outcome and we ended up with a more appropriate use of the MBS I would be very happy, but we just have to wait and see.

CHAIR: Senator Waters is going to seek some clarification around an item.

Senator WATERS: I have some questions about the National Maternity Services Framework and I am wondering if that is outcome 4 or program 2.5 tomorrow or some other spot.

Mr Stuart: I do not recognise it.

Mr Bowles: It is program 2.5.

Senator WATERS: Thank you.

CHAIR: The committee will break now until 3:50 pm when we will commence with Hearing.

Proceedings suspended from 15:35 to 15:50

CHAIR: We will return to 4.1 for the final bracket of Senator Watt's questions and then we will go to Hearing Services. My apologies for any confusion.

Senator WATT: I have a couple of questions regarding IVF treatment and the way it is being handled through this review. I see there was a report in *The Daily Telegraph* yesterday that the MBS review was looking at changes to MBS items around IVF treatment and specifically considering proposals to put a cap on the number of IVF treatments and an age limit on accessing publicly subsidised IVF. Can you confirm if these proposals are under consideration by the review?

Ms Jolly: The review is looking at this group of items. I understand it is currently with a clinical working group. They will be reviewing a range of issues and it is yet to work its way up to the task force or out for public consultation. So it is a review in some early stages of consideration and it is not yet even ready for public consultation at this point.

Senator WATT: But is it the case that both of those matters—a proposal to put a cap on the number of IVF treatments and a proposal to put an age limit on accessing publicly subsidised IVF—are under consideration?

Mr Bowles: Ms Jolly just said it has not come back to the task force; it is out for discussion with clinicians. It will come back to the task force before it is decided to even go out to a public consultation. We are a long way off that.

Senator WATT: So they have not been presented to the minister for consideration or release?

Mr Stuart: No, we are a long way away from that yet.

Senator WATT: So those proposals are being worked on by the clinical committee?

Ms Jolly: That is correct.

Senator WATT: Are there any other aspects of IVF services that that committee is considering at the moment?

Ms Jolly: Like any clinical committee, they would be looking across the items that they have been asked to consider. There will be a range of issues that will be in front of that committee for discussion. It is a standard process, as with any set of items.

Senator GRIFF: Would it upset you if I asked a very question on 4.1?

CHAIR: I am going to pretend I did not hear that.

Senator GRIFF: I would like a bit of clarification. I understand that for GPs who are focused on psychological strategies their patients are allowed to have 10 visits—I understand that is what is permitted. I would like to know why you do not allow telehealth consultations for patients with GPs in rural and remote locations.

Mr Bowles: I do not know. We might—

Ms Jolly: I can talk a little bit about that. We have telehealth arrangements in the MBF. In this particular instance we would need to get some further information about how it works in relation to that.

Mr Bowles: That said, there was a measure in the budget in relation to telehealth psychology services. I do not know—

Senator GRIFF: But that did not relate to remote and rural locations.

Mr Bowles: No, but it related to psychological services. Let's take that one on notice.

[15:56]

CHAIR: We are moving on to 4.2 Hearing Services now.

Senator GRIFF: I imagine the department is aware of the ACCC March report into issues around the sale of hearing aids.

Ms Jolly: Yes.

Senator GRIFF: One of the key issues identified was that sales may be driven by commissions and other incentives rather than consumer need. Does the department have a position on whether devices such as hearing aids should be sold on commission or should prices be regulated?

Ms Jolly: I could ask Ms Garrett to talk about the current arrangements under the program—that is probably the most helpful. It is not really an opinion; it is really about how our current program operates in relation to what is available.

Senator GRIFF: I am primarily interested in whether you believe a self-regulated hearing sector is the best thing for the industry and for consumers, given that ACCC report.

Mr Stuart: We generally do not answer questions about what our opinions are about things. We are here to—

Senator GRIFF: Is the department looking into the sector?

Ms Garrett: The department does not regulate the entire hearing services industry. It only regulates compliance with the hearing services program. We only really have the remit to cover off on the service providers who provide services under the program. Those service providers within the program have to meet all of the rules and legislation of our program. Some of those rules include that the providers must offer to the clients of the program a fully-subsidised device in the first instance. Should there be a breach of the rules or of the legislation then we would investigate that. I guess the regulation is around the rules of the hearing services program.

Senator GRIFF: So you do not—

Ms Garrett: We do not regulate the entire industry.

Senator GRIFF: What was interesting in the ACCC report in relation to price discrepancies was that it showed that Australian Hearing is able to provide hearing aids fitted for $349 but private providers are selling them to elderly people for up to $12,000-$15,000. I imagine that would be a concern to all of us. Is there something that warrants further investigation or action by your department?

Ms Garrett: The ACCC is continuing to investigate and we are working with the ACCC on that.

Senator GRIFF: So you are looking into that with them. Does the department provide any information sources for people who require hearing aids to help them in their decision-making process?

Ms Garrett: Yes. There is extensive information for clients or potential new clients for the program on the website, as well as hardcopy fact sheets that are given out.

Senator SIEWERT: For once I have got show-and-tell; I do not usually have show-and-tell.

Senator Nash: Oh god, it is not Senator Heffernan!

Senator SIEWERT: No, it does not smell, sorry—unlike the prawns. He used to bring frozen prawns, amongst other things. We will just send the copies around. They are hard to read, but basically it is along similar lines to what Senator Griff just asked. Have you seen the ads—in this case, it is here in life. They clearly talk about a government program—although it is hard to read, I will admit—the government hearing services program, and then an offer: win one of 100 $50 Coles Group and Myer Group Myer gift cards. Are you aware of these sorts of promotions around a government program that is basically hyping up the government program and trying to sell people hearing aids from the government program. You will know that I am a long-term supporter of this program, so I am not having a go at the program at all. Are you aware of this? If you are, have you spoken to this company or any other that is doing the same thing?

Ms Garrett: No, I have not seen this particular advertisement before. We are aware that there are certain service providers who advertise particular arrangements such as this. In regard to the rules that apply around advertising, there is one in the rules of conduct for service providers and that does not prevent service providers from advertising things like this. What we usually do is we would take something like this, we would investigate, and we will talk to the service provider in question about what it is that they are doing, and whether or not we think it fits with the rules around advertising.

Senator SIEWERT: Have you undertaken that sort of discussion with the provider in the past over something like this?

Ms Garrett: We have undertaken discussions with providers around a range of different things around advertising and marketing. As I said, there is just one rule within our rules of conduct. It is a fairly generic rule and it is not specific about what might be allowed or not allowed.

Senator SIEWERT: So this would not be classed as an inducement to get someone to go into the program?

Ms Garrett: There are no rules around inducements.

Senator SIEWERT: When you talk about the rules of conduct, which ones are those?

Ms Garrett: The Hearing Services Rules of Conduct apply to service providers that are providing services under the program.

Senator SIEWERT: Presumably those rules can be changed?

Ms Garrett: Yes, they can be changed.

Senator SIEWERT: When were they last reviewed?

Ms Garrett: The current edition is from 2012.

Senator SIEWERT: When you say current edition, did you consider whether this type of thing is an issue when you looked at the rules then?

Ms Garrett: I would not be able to answer that.

Ms Jolly: We would have to take that on notice.

Senator SIEWERT: Could you take that on notice. Is there a plan to review the rules?

Ms Garrett: As you know, there is a plan to look at the program because of the transition to the NDIS.

Senator SIEWERT: Yes.

Ms Garrett: So the legislation that supports the program will be part of that review.

Senator SIEWERT: What is the time line for that particular review?

Ms Garrett: There are two reviews underway. One is around service items and fees, and one is around the assistive hearing technology supply. The next packages of work that we will be looking into will include the legislation, probably in the next 12 to 18 months.

Senator SIEWERT: Ready for 2019?

Ms Garrett: That is right.

Senator SIEWERT: Basically, these rules are still going to be going for the next 12 to 18 months?

Ms Garrett: That is correct, yes.

Senator SIEWERT: In the meantime, I take it from what you have said as part of your discussion that you will be there for the talks with this particular provider about this particular process?

Ms Garrett: Yes.

Senator SIEWERT: Are you looking for any others?

Ms Garrett: Yes. The ACCC have put out a call for any types or examples, such as this, to come to them as well. I know that they are continuing to gather examples for their investigation.

Senator SIEWERT: You could take some action in the meantime. My next question may be too broad. With the government's decision not to sell Australian Hearing, what implications or what impact does that have for the program at the moment but also the planning that you have already been undertaking in the transition with NDIS?

Ms Garrett: There are no implications; it is business as usual. They continue to be the provider of the community services obligation part of the program.

Senator SIEWERT: Presumably there is a different discussion happening now in planning for transition because they, in fact, are not going to be sold?

Ms Garrett: They are part of our planning for transition, yes. It just means that it is simplified in that we now know the status of Australian Hearing, and so our planning continues.

Senator SIEWERT: Over the years we have had a discussion about people getting their aids and not using them. I had a discussion with some people just the other day—

Mr Stuart: Could you please talk to my mum about that!

Senator SIEWERT: Yes, okay! Over the years, you have been doing quite a bit of work in that space. Have you seen some improvements in people actually using the aids when they get them so that the aids do not sit in a drawer?

Ms Garrett: Yes. The National Acoustics Laboratories has undertaken some studies. I do not have the figures here, but there has been an improvement in the number. I would be happy to provide that on notice.

Senator SIEWERT: If you could provide that on notice, and if there are some key things that have happened that have been the most effective in terms of getting people to use their aids, that would be great. Thank you.

[16:08]

CHAIR: We will move to program 4.3.

Senator HINCH: This question is for either for Minister Nash or the secretary, the TGA has now approved the sale and use in Australia of a new drug for women with incurable metastatic breast cancer. It is called palbociclib, and it has been approved. It has been on sale since last week. The problem is that it costs $5,000 a month, so $60,000 a year, for any woman who uses it. It is an innovative drug and it does prolong women's lives for some time. I have had talks with the Breast Cancer Network of Australia and Christine Nolan about this. They are saying that they welcome the decision that the drug has been put on sale, but they are also very disappointed that the Pharmaceutical Benefits Advisory Committee did not recommend that palbociclib be listed on the PBS. Of course, if it was, that would mean that a lot of Australian women who cannot afford to buy it could then benefit from the drug. Pardon my ignorance as a newcomer, but will the PBAC, when they reject a drug like this, give us some idea as to why?

Mr Bowles: I will ask Ms Shakespeare to explain the system. It is a two-stage thing, with the TGA being the original approval and then through the PBAC for the rest.

Ms Shakespeare: The Pharmaceutical Benefits Advisory Committee has considered the listing of Palbociclib on one occasion, and that was in March this year. As you say, the PBAC has on that occasion rejected the application by the sponsor to list the medicine. I can give you some information as to why the PBAC rejected the listing. It was on the basis that, to date, no improvement in survival has been demonstrated by the evidence brought forward by the sponsor of the medicine. Treatment with Palbociclib can lead to serious side effects. So the PBAC has raised some concerns about comparative safety of this medicine. Also, it is not presently possible to identify who will benefit from treatment out of the group of women who would potentially benefit from the medicine—that is, people with hormone receptor-positive, human epidermal growth factor receptor 2-negative advanced or metastatic breast cancer. It is not possible to determine out of that group who will benefit from the medicine and who will not at this stage. That rejection at the March meeting does not necessarily represent the final position of the PBAC and it is in fact quite normal for a company to bring back further clinical information and other information that addresses the concerns of the PBAC.

Senator HINCH: So would Pfizer go and do other tests and things like that?

Ms Shakespeare: The other piece of relevant information here is that there is a related medicine; it is not the same; it is called Ribociclib. That has applied for listing to treat the same group of women with breast cancer and that is being considered at the July meeting of the Pharmaceutical Benefits Advisory Committee. We do not know what the outcome of that will be, but it may be that there is an alternative treatment for that group.

Senator HINCH: When you talk about side effects or about how much effect this drug has had, the TGA has said it can be sold here, as of last week, if you have got $60,000 you can get it, but if you have not got the money you cannot. It does not seem fair.

Ms Shakespeare: The TGA considers safety; the Pharmaceutical Benefits Advisory Committee, which is the statutory committee and has performance functions as set out in the National Health Act, has to consider comparative clinical effectiveness, comparative safety and comparative cost effectiveness. So they look at slightly different considerations to the TGA.

Senator HINCH: Because it is an innovative drug, Breast Cancer Network Australia say:

We are very disappointed that the PBAC has overlooked the recommendations of the 2015 Senate inquiry into innovative and specialist cancer drugs and not consulted more widely with consumers around quality of life benefits in their evaluation of this medicine.

Ms Shakespeare: The PBAC accepts submissions from consumers on all of the agenda items that it considers. There was a submissions period in the lead-up to the March meeting where consumers could make submissions. All of those submissions are considered by the PBAC. That does not necessarily mean that in performing its statutory obligations under the National Health Act it will reach the same conclusion as put forward in those submissions, but they would have been considered. Similarly for the medicine that is being considered at the July meeting of the PBAC, submissions are currently open. They will be open until 7 June and consumers and consumer groups are able to put their views forward to the PBAC, and they will be considered as part of that process.

Senator HINCH: If the drug is rejected, there is nothing to say that you cannot come back in five years? It is not permanent; you can come back?

Ms Shakespeare: Yes. A resubmission would be accepted and, in fact, encouraged by the government.

Senator HINCH: I would like to know if this is fact or fiction: is it true that when one new drug goes on the PBS, one old drug has to come off?

Mr Stuart: No. Untrue.

Ms Shakespeare: No.

Mr Bowles: No.

Senator HINCH: I got three noes and Senator Nash.

Senator Nash—

Senator SINGH: Looking at the agreement the government signed with Medicines Australia, clause 4.3 says that the agreement is expected to achieve a saving of $1.8 billion—is that correct?

Mr Bowles: Over five years of the agreement, yes.

Senator SINGH: Is there anything in this agreement that guarantees that every dollar of the savings will go to new listings on the PBS?

Mr Bowles: Not specifically like that but the whole notion of how we have structured the arrangement has funded a whole range of drugs that have come through, in this particular budget as well.

Ms Shakespeare: There is a relevant clause to the issue you are asking about, which is clause 6.2. It talks about reserved savings. A component of the savings that have been achieved through measures agreed in the five-year strategic agreement will be kept in the contingency reserve and made available for future medicines listings. Some have already been

applied through new medicines listings and other medicine-related costs in the 2017-18 budget.

Senator SINGH: That is right. So nothing in this clause guarantees that every dollar of savings will go towards new PBS listings; does it?

Ms Shakespeare: I have read out to you what the clause says.

Senator SINGH: Is there any guarantee in this clause that every dollar of savings will go towards new PBS listings?

Ms Shakespeare: I have already told you what is in the clause. There is a related government policy, that lists all PBS recommended listings that are made by the Pharmaceutical Benefits Advisory Committee. The costs of those listings may be drawn from the reserved savings that are referenced in clause 6.2 or, I think as the agreement also canvasses, the costs of those might be met from other initiatives.

Senator SINGH: Why is the supply chain included in this clause?

Ms Shakespeare: Because the costs of a new PBS listing include not just the costs to the manufacturer of the medicine; it is also the costs that are then required to deliver the medicine to the end user—the patient—through the supply chain, including wholesaler mark-ups and fees that are paid to pharmacists for dispensing medicines.

Mr Stuart: This is quite a remarkable program structure. The government decides what level of reimbursement it will give for the medicine, and it also sets the amount that a patient can be charged for any medicine—$6.30 for a concessional until they reach the safety net, $38.80 for a non-concessional patient. In order to achieve those two outcomes, the government regulates the return to every player in the supply chain, including the medicine company, the wholesaler and the pharmacist.

Senator SINGH: What is included in that definition of the supply chain?

Ms Shakespeare: It is the costs of bringing the medicine to Australia, which is met by the supplier or the manufacturer if it is made locally; the distribution through the wholesaler network that operates in Australia; and then the costs to the pharmacists who stock the medicines and dispense it to the patients.

Senator SINGH: Can you rule out any of the savings going to pharmacy programs, as an example?

Mr Bowles: If you are referring to the other agreement around the $600 million in relation those agreements, absolutely. That is a separate issue.

Senator SINGH: Will GP training be included in this?

Mr Bowles: No.

Senator SINGH: No? But they are kind of the first steps in supplying a medicine.

Mr Stuart: No. We draw a distinction between referrers and suppliers and dispensers. The GPs are the referrers, they refer a patient for a medicine or prescribe a medicine, but they are not seen as part of the medicine supply chain, which starts with the company that brings it to the market and finishes with the patient. In between there is a wholesaler and a pharmacist.

Senator SINGH: What about research into new medicines? Would that be included?

Mr Stuart: No.

Senator SINGH: Is there anywhere in the agreement that defines how much of these savings must go to new medicines rather than just the supply chain stuff?

Ms Shakespeare: The agreement has been developed not to identify particular amounts. For new medicines listings we always have commercial negotiations with sponsors. We generally do not identify amounts of money that have been set aside for new listings because it could impact on those commercial negotiations.

Senator SINGH: What is stopping the government from using the money in the contingency reserve for other things?

Mr Stuart: An agreement with Medicines Australia that that will not occur. Medicines Australia came to the government seeking five years of stability and certainty for business and its operating environment. They were willing to offer savings to achieve that, and the government was very willing to have that discussion, and I think the agreement that has been struck is very good for the industry, government and taxpayers. So, essentially, the government wishes to honour its agreement with Medicines Australia, and the department will be operating in a reasonably open way with the leadership of Medicines Australia to achieve that outcome and to make sure that we maintain a very good, positive working relationship with Medicines Australia over the five years going forward, on the basis of this agreement.

Senator SINGH: Okay. To achieve that positive relationship going forward, what kind of oversight will there be for this agreement?

Ms Shakespeare: Again, under the clause I referred to before, clause 6, the government has agreed to establish what is called in the agreement a joint oversight committee, including representatives of Medicines Australia, which will review annual expenditure on medicines a couple of times each year and have a look at how the reserve savings that have been established under the agreement have been applied. So there is a formal consultative group that has been agreed on and will be established under that clause.

Senator SINGH: Okay, and that group will also look at where the savings end up. Is that right?

Ms Shakespeare: It will look at what has able to be achieved under the agreement, including the establishment of this pool of reserved savings in the contingency reserve.

Senator SINGH: How will we know where the savings actually end up?

Ms Shakespeare: I think we will be able to account for what new listings have been made on the PBS twice a year—and that is what we have committed to do—and the overall costs of that to government, and then compare that to the amount of savings that have been made under this agreement, through the measures agreed with Medicines Australia.

Senator SINGH: You talked about guaranteeing funding for medicines and not cutting funding for medicines. Where in the Medicines Australia agreement does it specify that that will not occur?

Mr Stuart: There is a broader government commitment that lies outside of the agreement with Medicines Australia and that it is done in the background of, and the government's agreement is that it will list every medicine that is recommended by the Pharmaceutical Benefits Advisory Committee. So, if the PBAC recommends it, the government has agreed to

list it. Either it can draw the offsets required from this reserve or, if the minister wishes, he can bring alternative savings to the table to pay for medicines. But the core asset here for the industry is that every recommendation from the PBAC will be listed by the government from one of those sources.

Senator SINGH: Okay. So is that in the Medicines Australia agreement?

Mr Stuart: No, this is a longstanding government commitment that goes back to pre-election times in 2012.

Ms Shakespeare: It has been there for a long time.

Mr Stuart: Yes, some years.

Ms Shakespeare: There are references to that in the policy in the agreement, and I can draw those to your attention. If you would like, I can take that on notice.

Senator SINGH: Okay.

Ms Shakespeare: I think it is referenced in a couple of places, and also the continuing support for the National Medicines Policy, which is timely access to new medicines for Australians. It is in several places.

Senator SINGH: Okay thank you. I appreciate that.

Senator GRIFF: Can the department outline the reasons why the safety net for an individual is set at the same amount as it is for couples and families?

Ms Shakespeare: This is a longstanding policy around the safety net, based on, I think, considerations of the impact of the cost of medicines on a household.

Senator GRIFF: Doesn't this disadvantage singles versus couples'?

Ms Shakespeare: I am not sure that it does. I do not have any data with me to indicate.

Senator GRIFF: But a single has to get to the same amount of money as a couple, so that effectively means a single person has a greater hurdle to jump over.

Mr Stuart: I think the policy probably comes from the alternative way of thinking, which is: what if a family is unlucky enough to have more than one family member who is a high medicine user and only one source of income? How they are going to manage their medicine costs?

Senator GRIFF: But take the situation of older people that might be by themselves now. Previously it was much easier for them to reach the threshold and then not have financial issues with it after, but now that they are single again—I am not thinking of young people; I am thinking of older people—they are being significantly penalised.

Ms Shakespeare: The policy has been developed based on costs for a household—

Senator GRIFF: Have you done any modelling to look at any other options?

Ms Shakespeare: We have had a look at other options, and there are quite a lot of issues around the government's capacity to track who is single and who is in a family. There are issues—

Senator GRIFF: Is that not a fairly easy thing to sort out through, say, Centrelink?

Ms Shakespeare: No. I think that would require officers at the Department of Human Services to get access to information about someone's marital status, and that is not currently

collected there. There are some practical issues about the capacity to have differential co-payments and the costs to the administration of the PBS.

Senator GRIFF: What did your modelling show?

Ms Shakespeare: It was done at the Department of Human Services. We may have had access to it. I do not have that here with me.

Senator GRIFF: Could we see that?

Ms Shakespeare: How about we take on notice what we looked at and what issues were raised?

Senator GRIFF: On notice would be great. I would like to raise the issue of insulin pumps. I understand that they improve outcomes and can increase life spans by 10 years at least. I know that Minister Hunt announced that the government would fully subsidise continuous glucose monitoring products to type 1 diabetics aged under 21. I believe the estimate in the release was that there are 15,000 under-21s, and the expectation was that 4,000 would be able to go on this subsidy program. Why do subsidies stop after the age of 20, when diabetes is a lifelong disease?

Ms Shakespeare: The government commitment was to fund continuous glucose monitoring technology for young people and children under 21. I think that is also based on clinical advice that we got from our expert reference group, which was established to advise on this program, that this is the group that has the greatest need in terms of their capacity to monitor their own insulin levels and whether or not they need to take any action to manage those.

Senator GRIFF: So that is the group that will have another 10 years added to their life, but when they hit 21 they will have to deal with it all themselves; that is an interesting concept. What subsidies, if any, are available to those over 21 who wish to use the pumps? Are there any subsidies?

Ms Shakespeare: For the insulin pumps, yes, for people with private health insurance. I think, though, what has been funded under the NDSS—National Diabetes Services Scheme—is consumables to allow continuous glucose monitoring, which may be in conjunction with an insulin pump.

Senator GRIFF: Has the department conducted any other assessments regarding insulin pumps possibly being listed on the PBS?

Ms Shakespeare: Insulin pumps are currently not considered medicines. They are listed on part C of the prostheses list, which is a list of devices that can be subsidised by private health insurance. I think it would probably be a stretch to consider an insulin pump to be a medicine as set out in the National Health Act, which is what the PBS funds.

Senator GRIFF: Have you done any form of costing to list it on the PBS?

Mr Stuart: We would not have costed that because, as Ms Shakespeare has outlined, it is not a substance that qualifies under the legislation to be considered for the PBS.

CHAIR: Thank you, Senator Griff. I believe that concludes consideration of program 4.3. I think Senator Dastyari had some questions for program 4.4?

Senator WATT: We are trying to chase him, but in the meantime Senator Dodson has some questions.

Senator DODSON: The Australian Prudential Regulation Authority put out its quarterly report on private health insurance two weeks ago. There are obviously some media stories of insurer profit. What did the report show on that front?

Ms Duffy: The most recent report from APRA showed that the private health insurers showed a profit before tax of around 19 per cent. APRA indicates in its report that that is due largely to investment revenue, the majority of which is in equities.

Senator DODSON: So in monetary terms what was that?

Ms Duffy: I am sorry, I do not have the monetary terms with me.

Senator DODSON: How does that compare to a year ago?

Ms Duffy: I do not have the profit numbers with me—I just have a percentage. I will take that on notice.

Senator DODSON: You have neither the quantum nor the percentage, is that right?

Ms Duffy: I would need a copy of the report. I do not have a copy of the exact report with me.

Senator DODSON: As we discussed at the last estimates hearing, the minister had just approved a premium increase of 4.84 per cent, bring the total under this government to 23 per cent. Those increases are based in part on your advice to the minister. Do you consider those sorts of profit results in your advice?

Ms Jolly: APRA has a role in assessing requests from private health insurers in terms of whether or not they would be prudentially sound. That advice forms part of the advice that would go to a minister when they are considering the premiums scenario. That would be included as part of that broad advice.

Senator DODSON: So there is a consideration of the profit margin?

Ms Duffy: APRA under the standard considers a number of documents and sources of data that private health insurers submit as part of their submission process. APRA provides advice to the government and to the department about whether or not, if the premium is put forward, it would leave the private health insurer in a state of being able to cover all its future commitments. That is the advice that is brought forward to the government. It does not take a role in making judgement on the amount of profit per se.

Senator DODSON: What proportion of the total private health insurance premium does the Commonwealth pay via the rebate?

Ms Duffy: The Commonwealth rebate is paid on the number of policies, and the overall total amount of expenditure is around $6 billion a year. The amount of rebate per person who has private health insurance would vary, depending on the policy they have, because the amount of rebate is based on that policy.

Senator DODSON: Is the amount of rebate that is being paid concerning the government?

Ms Duffy: The overall question of affordability and complexity of private health insurance is something that the government is currently looking at. It established the Private Health Insurance Ministerial Advisory Committee, which is looking at those key areas of concern.

Senator DODSON: I guess the question I am trying to get to concerns taxpayer moneys that flow to the insurer, and in some cases overseas. Is there a breakdown of that?

Ms Duffy: The department would not have that level of information. That would be something that perhaps APRA could potentially provide advice on. APRA is part of the Treasury portfolio—I am not sure what day they are here.

Senator DODSON: I want to ask about some natural therapies. In 2015 the then Chief Medical Officer conducted a review on why the rebate is paid on natural therapies like homoeopathy and herbalism. He found next to no clinical evidence that these therapies actually work. Why on earth does the government continue to pay a rebate on them?

Mr Cormack: The government, through the private health insurance rebate arrangements, supports extras, or ancillary cover, and the content of that is largely specified by the private health insurance funds. The amount that is paid out each year in benefits is a relatively small component of the overall approximately $6 billion that is paid out in benefits—about $170 million for a range of complementary therapies. There is no government policy decision at this stage to remove or alter specific items from the range of things that are covered under ancillary; however, I would say that—and you can follow this on the health website—there is a Private Health Ministerial Advisory Committee that is going through a whole range of potential private health insurance reforms. That includes having a look at the range of products that are offered by the private health insurers, the descriptions that they use, and it will also have a look at the scope of extras cover. That work is ongoing—it has not been concluded yet—and any change to private health insurance arrangements, including extras, will be a matter for upcoming government consideration.

Senator DODSON: I am just trying to figure out: if the Chief Medical Officer does an analysis and says that these natural remedies are not working, why are we still paying a rebate on them?

Mr Cormack: As I said before, the government is currently taking advice, and will further consider comprehensive advice from the Private Health Ministerial Advisory Committee, on a range of matters to do with products that are supported by the government through its private health insurance policies, and it will consider advice from that group in due course.

Senator DODSON: When you say due course, there are some—

Mr Cormack: It is anticipated that that will be completed this year, and the government will consider the advice from the Private Health Ministerial Advisory Committee before the end of 2017.

Senator DODSON: I might defer to my colleague Senator Dastyari, Mr Chairman.

Senator DASTYARI: Senate precedent is the only space in which I have seniority over Mr Dodson over here! Mr Bowles, take me back for a second to private health insurance. Last estimates, we had a long chat about the increase. It has gone up every year. This year has gone up less than it has in previous years; that is a welcome thing—hopefully, next year it will be even less again. That is good news, but it has consistently gone up higher than inflation. As you know, and the minister knows very, very well, as it goes up every year, understandably, people get frustrated that their private health insurance cost keeps going up. It is going up higher than inflation, and that has a whole lot of other social consequences that we all know about and have traversed to death.

I want to touch a little bit on the APRA report that recently came out. Mr Bowles, I broadly understand the process, but I understand it is clearly more detailed than what I understand it to be, and I apologise for that, so if you could explain it to me. Every year the private health insurers come and make a claim for the increase that they want–correct?

Mr Bowles: They put in a submission through that APRA process and, ultimately, the minister makes a decision.

Senator DASTYARI: At the moment are there 36 of them now—or 37? What are we up to?

Mr Bowles: Thirty-six.

Senator DASTYARI: You get 36 who put in applications, and everybody makes their case for what percentage they want. Is that correct?

Mr Bowles: It is something like that, yes.

Senator DASTYARI: I assume each one of them is making a commercial decision about how they want to increase it but, if you increase it too much, you lose customers. They are making those decisions. The government is also assessing whether or not this is a trial, legitimate or needed—all of those things. All of these things go into what I imagine is a complicated and difficult process. Is that correct?

Mr Bowles: Largely, it is a market, so that is how it operates.

Senator DASTYARI: Okay. What visibility do you have, or the minister, of the information that is collected? APRA is before Senate estimates tomorrow. I understand APRA pretty much has everything. I am simplifying what is more complex, but APRA has their back end. APRA has got the lot about where their finances are, liquidity and all of those kinds of prudential questions—survivable or not. That is all, obviously, APRA's business, because they are the experts in it. What did it used to be called before APRA took over a few years ago?

Mr Bowles: PHIAC.

Senator DASTYARI: What was it called?

Mr Stuart: Private Health Insurance Administration Council

Senator DASTYARI: And APRA took it over?

Mr Stuart: Yes.

Senator DASTYARI: Here is the thing that evades me about all this. What level of visibility does the minister have of what is going on inside these organisations when these decisions are being made? What I want specifically are things like advertising and executive pay, not just the profitability—all those kinds of questions. When these decisions are being made, obviously, APRA collects all that, but how does it work from a departmental perspective? What do you see and what do you not see? I imagine you do not see everything that APRA sees, because that is not really your specialty—whether they are prudentially—

Mr Bowles: No.

Senator DASTYARI: Can you explain that.

Mr Bowles: I will get Ms Duffy to try and explain that issue to you.

Ms Duffy: Yes. This was actually a question on notice that we took last time as well. Our answer to that question was that we did not get the level of detail that you have referred to.

Senator DASTYARI: Yes.

Ms Duffy: We understand that there are management or administration expenses that we have access to, but we do not have the information to break it down into the categories that you have suggested,.

Senator DASTYARI: On that: can you get that level of information? Is there a process reason why you can't?

Ms Duffy: I will have to take that on notice. I think there are process matters that need to be looked at but also legislative requirements. Much of the information that is provided by private health insurance is protected information under the act. Even if we did have access to the information, it would still be considered protected and therefore that would limit the use and the ability to share that information.

Senator DASTYARI: Sure. But there are two separate questions there, right?

Ms Duffy: Yes, there are.

Senator DASTYARI: One is whether or not you could make that publicly available. I understand what you are saying, Ms Duffy—if you can take this on notice—you are saying that there may be a legislative reason why you could not make that public anyway for privacy or commercial in confidence; I completely understand that. There is also what information we allow our ministers to have when informing themselves of decisions. Let's be honest here: from a public policy perspective, surely there must be a sense of frustration. It is going up 4.84 per cent, which again is lower than it has gone up in previous years, which is good news. But APRA reports that annual profits are 18 per cent. Naturally, people go, 'Hang on. If they're this profitable, why does it need to go up 4.8 per cent?' Is profitability something that is visible to the minister while making the decision?

Ms Duffy: We provide information that comes from APRA as part of APRA reports, so that profit figure would be available to the minister. As I said, APRA explained that this profit margin and profit figure relate to mostly equities on investments. Whether or not that is cash or noncash, I do not have that level of information.

Senator DASTYARI: With the 5.6 per cent increase in 2016—which obviously fits into the 18 per cent profit that was recently announced by APRA—surely there is a link between the two. They are increasing their fees by five per cent, and their profitability is 18 per cent. I am a layman here, but it strikes me that clearly there is a link.

Mr Cormack: I think Ms Duffy provided you earlier with good information about what is behind the profit results for the current reporting year. It is important not just to look at a single year. These are complex organisations. They are insurance companies and we need to look at their trend, in terms of what they receive from their premium revenue and what they pay out in premium benefits. We are happy to take that on notice and give you some figures on that.

Senator DASTYARI: If you can.

Mr Cormack: What we can tell you is that it is a very slim margin between what they receive, in terms of premium income, and what they pay out. That is due to the nature of the organisations themselves.

Senator DASTYARI: This may be more of a question for APRA than it is for you, and I will understand if that is the case. So the health insurance companies do not provide you with any information; they provide it to APRA, and you get it from APRA. Is that correct?

Ms Duffy: Correct.

Senator DASTYARI: Are they independently audited?

Ms Duffy: They have to be, under the rules.

Senator DASTYARI: But by APRA, not by you? APRA looks after that part of it?

Ms Duffy: Correct.

Senator DASTYARI: These are questions that I can ask APRA when they come tomorrow. The other issue—and I do not know the solution to this, but it is not a legislative one—is what percentage of the 36 private health insurers are mutual or, allegedly, not-for-profit and how many of them are private companies?

Ms Duffy: I do have that information. It might take me a while to find it.

Senator DASTYARI: That is okay. Mr Bowles, the public reporting requirements vary so massively between what is a publicly listed private company and what is a not-for-profit structure, in terms of what consumers have access to. For a publicly listed company all the information like executive remuneration is obviously there for shareholders, as it should be. But you end up with this quirky situation where the private health insurers that are not structured in that way do not have to reveal that level of information. I am not sure if this is something that has come across your desk before. Personally, I think this is a quirk of how these things were created. We have just treated them differently when, for all intents and purposes, it strikes me that the government treats them the same. Is that correct?

Mr Bowles: It depends on what we are talking about. As operators in a market they are dealt with by APRA and ASIC, and however else they are dealt with—

Senator DASTYARI: When you are assessing a decision as to whether or not you are going to increase private health insurance premiums—'you' meaning the collective, as it is the minister's decision but you obviously are intimately involved in that process—you have a level of visibility, through APRA, and the public has differing levels of visibility, based on the structure of the company. Is that correct?

Mr Bowles: Yes, I would say that would be right.

Senator DASTYARI: Do you have that number, Ms Duffy?

Ms Duffy: Yes, 25 not-for-profit and 11 for-profit.

Senator DASTYARI: Okay. I hear stories and inside intel telling me that some of the executives in the allegedly not-for-profit's are earning $10 million, $15 million or $20 million on top of their bonuses. The 11 for-profit's have a requirement to report this to shareholders and they have a requirement to put this in their annual return. My issue is not that people are being paid exorbitant amounts—that's fine. My issue is that the structure of them allows them to hide what they are being paid, whereas 11 of them cannot hide it. Mr Bowles, it sounds like

what you are telling me is that, out of the 36, you treat them all the same for the purposes of determining premiums, regardless of whether they are a not-for-profit or a for-profit. Is that correct?

Ms Duffy: Yes.

Mr Bowles: Yes.

Senator DASTYARI: And you do it case by case—each individually.

Mr Bowles: Yes.

Senator DASTYARI: Minister, I do not know the answer to this, but the frustration for consumers is that, while with the 11 for-profits, because of the nature of how companies have to report—and I think this is a good thing—there is visibility for the public in terms of what is going on inside the company, questions like executive remuneration and whatnot, for the 25 that have structured themselves as not-for-profits, the public has no visibility of that at all. Can you comment on that? Is there a way we can reconcile that going forward?

Senator Nash: That is something that I am very happy to take on notice to get a comment on from the minister.

Senator DASTYARI: Yes, if you can. The significance is this. If these not-for-profits, or these companies, are private businesses behaving privately—fine. There is an argument there. In the most recent budget figures—and I could be slightly wrong here, Minister and Mr Bowles, so correct me—private health insurance rebates are $6.2 billion a year.

Mr Bowles: It is around that figure.

Senator DASTYARI: So $6.2 billion of taxpayer money goes into this. There are 36 providers that essentially have access to that $6 billion. It goes through the consumer, but providers are the ones getting the access to it. You have 36 companies getting access to $6.2 billion of taxpayer money a year, and right now we do not even have the basic information that we would have for any publicly listed company on what the CEOs and that are getting paid, even though there is such a huge taxpayer—I would use the word—subsidy. Is that the word you would use?

Mr Bowles: Rebate.

Senator DASTYARI: Let me reword it then: there is such a huge taxpayer contribution. I do not want to make this too political of a point, because I think it is actually a public point to make. Minister, you are taking on notice—and I may write to you about this, if that is okay, in a bit more detail and with a few more questions—how we reconcile the discrepancy between the information that is available for public companies as opposed to not-for-profit companies. To be clear, I think this is a quirk of company structures and how reporting goes on. Mr Bowles or Ms Duffy, could you take on notice too a bit more detail about what information it is you get from APRA around the visibility of these kinds of questions? You say you get breakdowns. Do you know how much they have each spent on advertising?

Ms Duffy: No. That is wrapped up in management expenses.

Mr Cormack: On that point, management expenses account for about 10 per cent, and that has been trending downwards in recent years. Our view is it is not excessive.

Senator DASTYARI: Sure. Who is the largest not-for-profit health provider in the country?

Ms Duffy: Probably HCF.

Senator DASTYARI: What size are we talking about with HCF? I am sure I could Google this in a minute, but how many billion dollars are we talking about with HCF?

Ms Duffy: I think they are the fourth largest in market share.

Senator DASTYARI: Let us say the largest is around 10 per cent of the market. How big is the market?

Ms Duffy: The top two have around 20 per cent of the market.

Senator DASTYARI: But 20 per cent of what?

Mr Bowles: It is about $18 billion.

Senator DASTYARI: These are multibillion-dollar companies we are talking about, the larger ones. I am sure out of 36, like any kind of thing, there would be a handful that are huge and then there will be a tail end, as is always the case.

Mr Stuart: The three largest ones really dominate. HCF is moderately sized and then they start to get much smaller very quickly.

Senator DASTYARI: And HCF is the largest of the not-for-profits?

Mr Stuart: Yes.

Ms Duffy: Yes.

Mr Bowles: Just on those questions you have asked us to take on notice, I would ask them of APRA as well because—

Senator DASTYARI: I will tomorrow.

Mr Bowles: they will have a cleaner view, if you like, than we would on some of those sorts of issues. We may not be able to give you much detail, but, if you ask them the same questions, they may have greater visibility of that. I do not know. ASIC might be the other one, particularly from a company perspective.

Mr Stuart: We get summary information from APRA but, at the table here today, we are not certain of what exactly they receive.

Senator DASTYARI: I think what Ms Duffy was going to take on notice—and it sounds like there has already been a similar question on notice that, in part, answers this—was the granularity of the information you get: why it is at that granularity, whether you could get more information were you to ask for more information and what the legislative restrictions on the minister before it is released. And it sounds like there are some. It makes sense that there would be some around some of this. The minister has very kindly said that she is going to take this on notice and get Minister Hunt provide a more detailed answer. I may leave it at that.

Senator SMITH: On a similar point, could you confirm for people in this hearing, Secretary, that the premium increase has been the lowest in 10 years.

Mr Bowles: That is correct.

Senator SMITH: That is right. The premium increase of 4.8 per cent is actually the industry average weighted premium increase—

Mr Bowles: That is correct.

Senator SMITH: so some funds themselves will be getting a smaller increase than that. That is the critical thing.

Mr Bowles: Across all products, that would be correct.

Senator SMITH: That is the critical consumer point.

Senator DASTYARI: You had to do it, Dean, didn't you? I have a follow-on question.

Mr Bowles: Could I just keep going, because there is another—

Senator SMITH: Yes, please.

Senator DASTYARI: Is it fair to say, then, that the total under this government, in terms of increases since this government was elected, is 23 per cent?

Mr Bowles: I do not know exactly, but it would be around that figure.

Senator SMITH: I can read out the premium increases since 2008 if you like.

Senator DASTYARI: Senator Smith, can you explain to me also—if you could take this on notice—not only the premium increases every year but also the calculation as to why a premium increase of, say, five per cent this year is a compound increase and may in real terms be a much higher increase than it was in previous years. But, again—

Mr Bowles: That was an answer to a question on notice, so you already have that.

Senator DASTYARI: I know, but I was doing it for Dean.

Senator SMITH: I know he has got it because we all get the answers to questions on notice.

Mr Bowles: Senator Dastyari, we love answering your questions but the answers are the same.

Senator DASTYARI: I think the point I was making, Senator Smith—through the chair—was that there are some questions, about things like transparency, that I believe do not necessarily need to be political. Some people at this table like to play politics and some of us are here to get answers.

Senator SMITH: Some people love the theatre; some of us like the facts.

Senator DASTYARI: I will take you to Hamilton with me.

Senator DI NATALE: I have some questions on PHI, but I have another question, which is short, on the previous outcome. It is around the community pharmacy agreement and squaring off that conversation we had earlier.

CHAIR: Are we okay to jump back to 4.3 very briefly?

Mr Bowles: It depends how technical it becomes.

Senator DI NATALE: It should not be too technical. It is quite straightforward.

Mr Bowles: Let's see how we go.

Senator DI NATALE: I was going through the budget papers. I want to understand this:

The Government will also provide $225.0 million over three years to community pharmacies and pharmaceutical wholesalers as a result of prescription volumes being lower than forecast in the Sixth Community Pharmacy Agreement (6CPA) and in recognition of the impact of the package of price reduction policies …

That is what I think you were getting at before, Mr Stuart. I suppose I just want to understand how that works. That is a big increase. Does it reflect the fact that there was an underspend on the PBS that was projected? Just explain to me how that works.

Mr Stuart: In the Sixth CPA there was a clause that said we would come to agreement with the guild about what happens if there are fewer scripts than anticipated. They had an expectation under the agreement of earning some $18.9 million over the period of the agreement, and if script volumes are lower then that earning is lower, and there was to be discussion between the department and the guild about that. In the event, the minister has chosen to negotiate directly with the guild to arrive at a settlement number rather than play that out over a five-year period and arrive at a number that kind of satisfied honour on both sides in terms of both the spirit of the original agreement and the affordability for the government.

Senator DI NATALE: Why were script volumes down?

Ms Shakespeare: The PBS is a demand driven program. The number of medicines that have scripts written for them is something that we can forecast, but sometimes those forecasts are lower.

Senator DI NATALE: Why were the forecasts inaccurate? I am interested to know the reasons, because there is quite a big difference; it is a couple of hundred million.

Ms Shakespeare: That is over multiple years.

Senator DI NATALE: Yes, but there is still a significant difference. Obviously, you have to do this again. I do not know that there has been a significant difference like this in the past, so what was the reason for the script volumes being down on what was forecast?

Ms Shakespeare: It is just: what scripts were written by doctors did not match up with the forecasts.

Mr Stuart: It is the mix of scripts, Senator. Unfortunately, we got the expenditure low and the script volume high in our estimates. The reason for the expenditure low was the very expensive hepatitis C medicines, which have made such a big difference in the community. The script volumes' low just goes to the mix of different kind of prescriptions which have been given by doctors.

Senator DI NATALE: But you have not done any work to look at why the script volume is lower than you—

Mr Stuart: We do not have a singular specific answer to that question.

Senator DI NATALE: Do you have a sense of what might have contributed to it?

Ms Shakespeare: I think price disclosure and the operation of that has contributed to the number of scripts that are now not subsidised through the PBS, because they fall under the general patient co-payment. There has been, I suppose, a decrease in the number of subsidised scripts under the PBS which has contributed.

Senator DI NATALE: So more private scripts?

Mr Stuart: Obviously, we tried to estimate that. These are small movements within a very large program.

Senator DI NATALE: That is fine; I am just interested to know how it works. The issue was around the healthcare home trial as well, because I think you were talking about one of the changes to the 6CPAs around some of those programs. Does the new agreement require the community pharmacy to be involved in healthcare home trial in some way?

Ms Shakespeare: Yes. Some of the funding that was in the contingency reserve for community pharmacy programs, through this agreement, has now been provided for a range of revised and extended programs. One of those includes including medication management services in healthcare home trials, and $30 million has been provided for that over the remainder of the Sixth Community Pharmacy Agreement.

Senator DI NATALE: What is that specifically for?

Ms Shakespeare: Medication management services can mean a range of different things—and I think that needs to be developed with the participants in the healthcare home trials—but can be things like medications checks that happen in a pharmacy to try and identify medicines that a patient might be taking that are not interacting very well. It could be dose administration aids being provided to patients who have complex conditions and require a lot of medicines to manage their complex conditions. But, I do not want to say that this will definitely work in a particular way, because it still needs to be developed with the people who are involved in the trials and their local pharmacies.

Senator DI NATALE: Do I take it from that that the compact with the community Pharmacy Guild specifically talks about the healthcare home trial?

Ms Shakespeare: It does.

Senator DI NATALE: But absent within the college of general practice compact? That is obviously something we established earlier. Okay, it is going to be interesting to see how that develops. You said that there was a process through which the Sixth Community Pharmacy Agreement would be reviewed—I cannot remember the words you used—in the absence of the assumptions materialising, but that the minister chose to negotiate directly with the guild. What was the process outlined in the agreement? What was supposed to happen—or what is supposed to happen?

Mr Stuart: Several steps, but I will just refer to my brains trust here.

Mr Henderson: The first step in the process was to do an annual reconciliation of actual prescription volumes versus those that were forecast in the Sixth Community Pharmacy Agreement. We need the full year's worth of data, so that occurs in September following the financial year. We undertook that annual reconciliation process with the Pharmacy Guild. That came out with a 2.14 per cent shortfall in the actual script volumes compared with those forecasted in the 6CPA. The next step in the process was then to agree on a materiality threshold.

Senator DI NATALE: What does that mean?

Mr Henderson: To come up with an agreed level of either an excess in script volumes or a shortfall in script volumes and then go through to the next step of coming to government about whether or not they would want to enter a risk-sharing arrangement with the Pharmacy Guild.

Ms Shakespeare: So what proportion of variance was considered material.

Senator DI NATALE: Is there an established threshold?

Ms Shakespeare: We did not reach agreement on that with the Pharmacy Guild at that point in the discussions. This was overtaken by discussions with the minister.

Senator DI NATALE: Just going back to price disclosure—the whole point of price disclosure is to save money on the PBS. Right?

Ms Shakespeare: It follows actual prices charged in the market for medicines where there is multibrand competition and to make sure that the savings being offered through the market are also flowing on to taxpayers.

Senator DI NATALE: Correct. So ultimately it is a benefit for the taxpayer. Doesn't it defeat the purpose if you save a bit of money there but then you have to go and make another deal with the CPA?

Mr Stuart: The savings from price disclosure are very considerable.

Senator DI NATALE: I accept that.

Mr Stuart: I think we have accounted for over $20 billion over the period.

Ms Shakespeare: We are expecting that; yes.

Senator DI NATALE: Over a number of different rounds. Obviously not specifically around this round.

Mr Stuart: Over the period; that is right. So the price disclosure policy impacts on community pharmacies. A part of the Sixth Community Pharmacy Agreement was to find a number of ways to start to insulate the community pharmacy sector from ongoing impacts of price disclosure on them, because things were becoming very difficult for parts of the community pharmacy sector.

Senator DI NATALE: They are always difficult.

Mr Stuart: Part of that was to disassociate the fee to the pharmacist from the price for the medicine, which had previously been linked. That was pushing remuneration to the pharmacies down over time. That link was severed. There was agreement reached about an $18.9 billion envelope. The government's view is that, were the government to honour over the period the $18.9 billion envelope, that would be very expensive by comparison with the minister's $200 million deal.

Senator DI NATALE: Sorry. Can you explain that. The $18.9 billion has to be honoured, doesn't it? That is the point of the agreement.

Mr Stuart: The agreement has an $18.9 billion estimate. Then there are these clauses that Mr Henderson outlined about what happens if the script volumes start to fall below the estimates. That could have become very expensive for government. The minister has chosen to get on the front foot—

Senator DI NATALE: Expensive for government?

Mr Stuart: To meet the $18.9 billion that was originally budgeted.

Senator DI NATALE: Right.

Mr Stuart: As you would understand, the normal business of government is that at budget updates the forward estimates are adjusted in accordance with actual experience. So the government chose to get on the front foot and come to a mutually beneficial arrangement to

address the uncertainty on both sides of this agreement and essentially to resolve it going forward.

Senator DI NATALE: But there is a disagreement about when it becomes material. What were the words used?

Ms Shakespeare: That was in the Sixth Community Pharmacy Agreement as part of the compact negotiated with the Pharmacy Guild. That process will not be conducted in future. Those provisions will be removed—not actioned—from the community pharmacy agreement. But having an annual reconciliation of the script volumes—

Senator DI NATALE: Just explain it to me again: what will happen from this point on?

Ms Shakespeare: The compact with the Pharmacy Guild—the government is committed to provide an additional $200 million in remuneration to pharmacies, or an adjustment to the administration, handling and infrastructure fee. That will replace the process under the Sixth Community Pharmacy Agreement for annual reconciliation of script volumes and any expectation of adjustment of remuneration in future. The compact says $200 million—no more, no less.

Senator DI NATALE: Mr Stuart, I do not understand how this is a saving. You are saying it represents a saving to government, with the minister getting on the front foot.

Mr Stuart: It is an expenditure. The simplest way I can say it is: we thought we were going to spend $18.9 billion. There was a chance we were going to spend less—quite a bit less.

Senator DI NATALE: Significantly less; yes.

Mr Stuart: That was going to be a net additional cost to the government's budget.

Senator DI NATALE: What—spending less, or making up the shortfall?

Mr Stuart: Making up the shortfall.

Senator DI NATALE: But making up that shortfall is contested, isn't it?

Mr Stuart: Yes; that is right.

Senator DI NATALE: So the minister chose, rather than contesting that—

Mr Stuart: Rather than contesting a large amount—

Senator DI NATALE: And clearly there was a disagreement—

Mr Stuart: Yes.

Senator DI NATALE: I am just trying to simplify it. You saved a lot of money because of changes to price disclosure. You were going to get into a blue with the Pharmacy Guild—perhaps I am using cultural language here. There would have been a disagreement with the Pharmacy Guild about whether there was an expectation that those savings needed to be returned to the guild. What sort of savings are we talking about? What quantum?

Ms Shakespeare: It was too early to tell. There was only one year's worth of script volume data, so I would not like to—

Senator DI NATALE: Based on that year? You must have done some figures.

Mr Henderson: There was a 2.14 per cent shortfall in the script volumes.

Senator DI NATALE: Was that 2.14 per cent of $18.9 billion?

Mr Henderson: No; that is script volumes.

Mr Bowles: Our assessment was it was a lot more than $200 million.

Senator DI NATALE: I know. But I am just asking how much.

Mr Stuart: We do not have a specific number.

Mr Bowles: We do not have a specific number. But we believed that it was a lot more.

Senator DI NATALE: So we have a situation where under the existing agreement there was an argument about whether that saving should or should not be passed on to the community pharmacy guild. Instead, what happened was the minister decided to give the guild $225 million for a range of programs, and you have come to an agreement that no-one is going to argue about the potential money that could have flowed on to the guild if they contested the script volumes and, therefore, requested that they be reimbursed for what was less than the $18.9 billion envelope.

Mr Stuart: The minister addressed a significant uncertainty for government in what could have been the liability from those clauses—

Senator DI NATALE: Did you seek legal advice?

Mr Stuart: and the guild addressed a significant uncertainty in that there was no guarantee in the agreement but a significant expectation.

Senator DI NATALE: But the taxpayer would like to know that it was not just us trying to get rid of a politically expedient issue. Health care has become such a contested space that it may be that the taxpayer could have expected a saving of, I do not know, $1 billion or $2 billion. We do not know. I am not sure whether or not we are in the ballpark. But if we are talking about the quantum here then we have a right to understand whether that is a sensible investment from government, or whether it is just the minister deciding he did not want to have another fight in health care and foregoing—

Mr Stuart: We are explaining it as best we can. The minister addressed a significant risk of future liability.

Senator DI NATALE: How did you assess the risk?

CHAIR: Before we get an answer, Senator Di Natale, can I just get an indication from you about how much more on program 4.3 you have.

Senator DI NATALE: Not very much. This is the end of the questioning. I just want to get to the bottom of this.

CHAIR: Okay.

Mr Stuart: I am using the word 'risk' advisedly. We will ultimately, in a few years time, be able to assess what it might have been in retrospect. But at the moment looking forward we can assess, as a department, that it was a significant risk.

Senator DI NATALE: I am not talking about the quantum now. Clearly there is some disagreement about the contract you have with the Pharmacy Guild if both parties are not clear about who bears that liability. So that, in itself, reflects a problem. But did you get advice as to whether the Commonwealth was in a position to be able to argue that case?

Mr Stuart: No. We did not get legal advice about that issue.

Senator DI NATALE: Any other advice?

Mr Stuart: The department certainly provided a range of advice to the minister.

Senator DI NATALE: Why wouldn't you get legal advice? If we are talking about potentially billions of dollars, wouldn't you get legal advice on something like that?

Mr Stuart: The issue here was one about good faith between the government and the guild. This is not an unusual situation in a dispute between parties who wish to retain good faith about a major agreement.

Senator DI NATALE: But, Mr Stuart, the Audit Office went through the Fifth Community Pharmacy Agreement and tore it to shreds—the processes, all of these sorts of backroom arrangements that have no transparency. You need to understand that we are coming from that perspective. Here we have the Sixth Community Pharmacy Agreement being signed by two parties. We are told they have taken into account the National Audit Office's concerns and now the guild will potentially, as a result of changing government policy, lose—I do not know—a billion dollars or maybe more. Clearly, you do not have the information here, but it is significantly more than $200 million. And we are being asked to accept that it is a good investment because it removes risk between both of the parties: the Commonwealth government and the Pharmacy Guild.

Mr Bowles: It has been explained that there is a clause in there to do a reconciliation of the numbers and then come to an agreement about how you would pay for that difference. That is where the—

Senator DI NATALE: Not anymore.

Mr Bowles: No. That is why we made the decision to actually remove that part of it. As Mr Henderson said, there was a 2.1 percentage drop already and, if you play that out over the forward estimates, that would be a large amount of money.

Senator DI NATALE: Ms Shakespeare, your view was that the department did not see this as actually at odds with the agreement. What was the language that you used—you did not think it was material?

Ms Shakespeare: No. The agreement set out that the parties, the government and the guild, would reach agreement on what the materiality of the threshold was. I was explaining to you what a materiality threshold was. So it is whether or not we considered the variation of material.

Senator DI NATALE: And in your view was it material?

Ms Shakespeare: That was something to be established by agreement between the parties. Rather than establishing that by agreement, there was an alternative approach taken to reach agreement on the variation to the administration handling and infrastructure fee.

Senator DI NATALE: I will move on from here. The concern here, of course, is that we have another $200 million that conveniently avoids another public blue with a medical stakeholder. That is the concern we have: whether that was an appropriate use of public funds. You have given me no confidence to suggest otherwise.

Mr Bowles: I can accept that you have no confidence in that, but I do not agree with your analysis.

Senator DI NATALE: Is it unusual for a minister to intervene like this? Has that happened before with the Community Pharmacy Agreement?

Mr Bowles: The minister is the decision-maker.

Senator DI NATALE: With the Community Pharmacy Agreement, has the minister intervened in this way before or are these disputes normally resolved—

Mr Stuart: Ministers have always been involved in community pharmacy agreements.

Senator DI NATALE: No, but you just said this was taken out of a process that was agreed to with the Sixth CPA and the minister basically decided to give the $200 million to the guild.

Mr Bowles: Ministers always make decisions on these things.

Senator DI NATALE: We are going to move to PHI. How much is the rebate worth now?

Mr Bowles: If you go to the PBS, it will be there, but I will read out what the 2017-18 budget is for private health insurance: $6.189 billion-odd.

Senator DI NATALE: How does that compare to last year?

Mr Bowles: It was $6.069 billion, so it is up about $120 million. Then it goes to $6.324 billion and $6.469 billion.

Senator DI NATALE: What is the coverage? How does coverage for PHI sit at the moment, in terms of hospital and general cover?

Ms Duffy: According to the figures which came out in the March quarter 2017, 46.5 per cent of Australians had hospital cover and 55.5 per cent had general cover.

Senator DI NATALE: That does not look like it has changed much from last year.

Mr Stuart: No, it is very similar. Could I draw your attention to an answer to question on notice 32 from the last hearings, where we set this out going back to 2009—

Senator DI NATALE: Yes, I saw that. That is why I say it does not like there is much change from last year. Do you have any reason? The coverage seems to have been falling away slowly and this year it has plateaued.

Mr Stuart: Two things are true. One is that the number of people covered continues to rise, in both hospital and general treatment, but the proportion of population covered is falling off very slightly in relation to both.

Senator DI NATALE: You have talked about increasing private health insurance premiums. Could you give some figures over the last five years? I am not sure where you got to with Senator Dastyari on that.

Ms Duffy: The national figure over the last five years?

Senator DI NATALE: Yes—the percentage increases.

Mr Stuart: We provided a 10-year series, I think. The summary is at point—

Senator DI NATALE: I will get that. That is fine. The rate of exclusions is something that I want to get to. I think the January rate of exclusions was about 38 per cent of hospital policies. I know that is—

Mr Stuart: This is nagging at me—I need to correct my previous answer. It was broadly correct, but in the most recent data to 31 March, there is a slight kick up in general treatment

policies from 55.4 per cent previously to 55.5 per cent, in the context of an overall slightly lower trend.

Senator DI NATALE: The issue of exclusions of specific procedures from premiums—the rate of exclusions was 38.1 per cent of hospital policies, which I understand is up from 27.3 per cent in 2014. We have seen a 10 per cent increase in the number of exclusions. Is that correct?

Ms Duffy: Are you reading from the APRA report?

Senator DI NATALE: I suspect that is where that information is taken from, yes. Do you have any updated numbers on exclusions?

Ms Duffy: No, I would have to go back and have a look at the report. I do not have that part of the report with me.

Mr Stuart: In the absence of the specific numbers, the number of exclusions has been rising in recent times.

Senator DI NATALE: They have been rising in recent—and continues to go up, as far as you are aware?

Mr Stuart: Yes.

Senator DI NATALE: I am interested in the process through which insurance companies need to notify customers about exclusions. I think one of your answers to a question of mine that was given on notice was that there is no legislated time frame that constitutes reasonable time to notify customers. That remains the case, is that right?

Ms Duffy: That is correct, yes. The reasonable time frame is something that is raised with the Ombudsman quite often and was looked at by the ACCC—what was reasonable in terms of what a consumer would expect.

Senator DI NATALE: A company can take as long as they like, can't they, to notify customers of exclusions?

Ms Duffy: I do not think that is the view that the ACCC or the Ombudsman take. They would think that a certain number of months would be reasonable, not as long as they would like.

Senator DI NATALE: But wasn't Medibank Private not telling their customers at all?

Ms Duffy: That is part of the case that is currently before the court.

Senator DI NATALE: At the moment, is the notion of reasonable time frame being tested?

Ms Duffy: It is.

Senator DI NATALE: Do you have any indication as to when you might be closer to an answer on that?

Ms Duffy: I do not, sorry.

Senator DI NATALE: In your view, what is a reasonable time frame?

Ms Jolly: I think that is a matter for the courts. If it is being tested, I do not think the department would have a separate view.

Senator DI NATALE: I want to come to the PHI review quickly, and then I am done. Can you give me an update as to the status of the review and when you expect it to report?

Mr Bowles: I will get Mr Cormack to the table.

Mr Cormack: Yes. The Private Health Ministerial Advisory Committee is well advanced in its deliberations, and we anticipate that that work will be concluded before the end of this calendar year, and a report will be provided through to the minister and the department.

Senator DI NATALE: Concluded this calendar year?

Mr Cormack: Yes.

Senator DI NATALE: You are expecting a report by the end of this year? Do we have any indication obviously, then it becomes a matter for government?

Mr Cormack: It does become a matter for government but, as we have indicated to the committee previously, we publish regular summaries of the progress to date, and they are reasonably detailed. So it is possible to keep track of the sorts of issues that are being progressed.

Senator DI NATALE: And are we still looking likely to be outlining three broad categories of products?

Mr Cormack: Well, the committee has certainly been asked to explore that issue in depth, and they are working through that at the moment. That requires a fair bit of detailed work, some actuarial analysis; but that is what the committee has been asked to have a look at.

Senator DI NATALE: Are you expecting that the bronze category would list significant exclusions like obstetric care?

Mr Cormack: The work to date indicates that what we are trying to do is to standardise the sort of coverage that would be available under each product type. As you progress down from, I guess the working title, gold down to bronze there will be a greater number of exclusions for that particular category. The committee has not finalised its work; neither has the government considered that to date, but clearly, some items that will be available in gold will not be available in bronze.

Senator DI NATALE: And do you have any indication as to whether obstetric care or indeed mental health would be—

Mr Cormack: We are just working through those issues at the moment. We have not landed a position on that.

Senator DI NATALE: I think I am done with my health insurance questions, so I will leave it there.

CHAIR: Nothing on program 4.5 from around the table? If not, we will move to Dental Services, program 4.6.

[17:27]

Senator SINGH: Turning to the NPA on Adult Public Dental Services, Budget Paper 3 confirms funding of just $321 million over three years. In comparison, Labor's 2012 MYEFO budgeted $391 million in one year, in 2016-17 and 2017-18. So by my maths, there is a cut of almost $300 million a year; does that sound right?

Mr Cormack: No, that is not quite how I would calculate it. The high point that was reached in terms of annual money granted to the states and territories was $155 million per year. That was the most recent National Partnership Agreement, and that was the high point of Commonwealth contributions under the National Partnership Agreement.

Senator SINGH: I am reading from the 2017 budget figures, which is in Budget Paper 3, page 26, where it says figures of $107.8, 2017-18; $107.8, 2018-19. So where are you—

Mr Cormack: Yes, they are less than the $155.

Senator SINGH: Much less.

Mr Cormack: Yes, that is right, but I think you have quoted a much higher figure than that in your opening comments.

Senator SINGH: I added all the figures up that are in that table, and that equated to $321 million over three years. Then I compared that to Labor's 2012 MYEFO measure, which was $391 million a year. That was what I wanted to confirm with you: I did the maths on that, and that equals a cut of almost $300 million a year.

Mr Cormack: The figure that I am using is the maximum amount of Commonwealth money that went to the states and was spent by the states under a national partnership agreement: $155 million is the high point. Irrespective of what may have been allocated in the past, what was actually committed to the states by virtue of national partnership agreements came to a high point of $155 million. Over the next three years the amounts that are made available are for 2016-17 at $104.5 million, 2017-18 at $107.8 million and 2018-19 at $107.8 million.

Senator SINGH: That is right. That is exactly right, but our 2012 MYEFO was $391 million per year. I am trying to confirm with you—I have done the maths—that is a cut of around $300 million.

Mr Bowles: We do not have your figure for 2012.

Senator SINGH: I can give it to you.

Mr Bowles: We can take that on notice, if that is what you wish, but the numbers in the budget are the numbers Mr Cormack read out for the NPA.

Senator SINGH: I am happy to table it. It is from the 2012 MYEFO measure.

CHAIR: On that basis, would it be better to take it on notice, given you are asking them to factor in numbers they do not have?

Senator SINGH: I am trying to get a confirmation from Mr Bowles. Taking 2016-17, for example, Labor budgeted $391 million, but this budget includes just $105 million—that is rounding it up. That is a correct cut of $286 million in one year alone. That is just in one year.

Mr Bowles: You are going back to something in 2012. What Mr Cormack has said is that the actual expenditure in the national partnership agreements that were reached with the states and territories was $155 million. Yes, there is a reduction from $155 million to $104 million. That is where that comes from.

Senator SINGH: Using the national partnership agreement, even $155 million compared to $391 million is a massive cut, but now this budget cuts adult dental health even further.

Mr Bowles: It is not a cut if it never went to the states and territories. The money negotiated through NPAs with states and territories maxed out at $155 million. That is what went to them. Irrespective of what might have been budgeted in 2012, the NPA value at the high point was $155 million. Even if there was a higher figure in that budget context, it was never negotiated in the context of an NPA.

Senator SINGH: This is a massive cut to adult dental health—massive.

Mr Bowles: I have just explained the situation.

Senator SINGH: Let us look at page 26 of this budget—

Mr Bowles: Yes, I have got 26 in front of me.

Senator SINGH: which outlines the massive cut.

Mr Bowles: No, it tells us what is actually in the budget for 2016-17 and the forward estimates.

Senator SINGH: Yes, it does, which is a massive cut to what Labor's MYEFO budgeted, as I just outlined. Can I just go to:

(a) State allocations from 2016−17 have not yet been determined.

That is the state by state allocations under the NPA.

Mr Bowles: That is right.

Senator SINGH: Why?

Mr Bowles: It is still being negotiated.

Senator SINGH: So states still do not have any certainty?

Mr Cormack: We have reached agreement with them for the first six months of the financial year, and that is approximately 50 per cent of the $155 million of the previous year. We are now negotiating with them for the balance of this financial year plus the amounts that will be made available in 2017-18 and 2018-19. That is what we are doing at the moment. We cannot publish them, because we have not reached agreement with them.

Senator SINGH: How is that affecting service planning?

Mr Cormack: We are working as closely as we can with the states to try to reach agreement with them on the amount of funding. That is to do with pricing arrangements per dental weighted activity unit. They are matters that we are negotiating through with the states. We are also taking into account, at the request of the states, some adjustment for rurality and remoteness. We will reach agreement with the states and then make available the funding consistent with the agreement that we aim to reach.

Senator SINGH: Your portfolio budget submission says the reduced funding will fund 'the states and territories for an additional 89,000 adult public dental patients'. Is that per year or over three years?

Mr Cormack: That related to the six-month extension while we were going through the various budget MYEFO changes. That relates to the agreement for the six months from July 2016 through to December 2016. You may recall that there was one proposal that was not supported in the 2016-17 budget, and then the government went into caretaker. A commitment was given to the states for, effectively, a six-month extension of the then current

arrangements, which was $155 million a year prorated for six months. That figure takes us up to the end of December 2016 and delivers the additional activity, the 89,000 that you refer to.

Senator SINGH: So it is not per year, it is just for that six months?

Mr Cormack: It is for the period of the agreement—that is right. We are now in the process of negotiating and finalising agreements with the state and territory governments for the balance, the 2½ years, that remain under this measure.

Senator SINGH: When will that be finalised?

Mr Cormack: We have to reach agreement with the states. We are hoping to do that as soon as possible.

Senator SINGH: This is a massive cut to adult dental. Another way of looking at this impact is the effect on waiting times. What is the national average waiting time for adult dental services?

Mr Cormack: The national weighted average was 12 months at 31 December 2016. That is the average waiting time for general treatment.

Senator SINGH: That is across the country?

Mr Cormack: That is the national weighted average.

Senator SINGH: So it is longer in some states than in others? I can tell you that it is longer than 12 months in Tasmania.

Mr Cormack: And shorter in others, that is right.

Senator SINGH: Do you have that breakdown?

Mr Cormack: Yes, I can give you that breakdown.

Senator SINGH: How long is it in Tasmania?

Mr Cormack: Tasmania is 9.4 months.

Senator SINGH: Not from the constituents that I have had come through my door.

Mr Cormack: That is just the advice that we have been provided by the states.

Mr Bowles: These numbers come from the states and territories, by the way. They manage this, not us.

Senator SINGH: Take on notice the list, if that is okay.

Mr Cormack: Sure.

Senator SINGH: Do you have any more-recent data for each state and territory than the 2015-16 report on government services?

Mr Cormack: The data that I just read to you is from 31 December 2016. That is the latest available information.

Senator SINGH: In my home state of Tasmania, the report on government services, from the Productivity Commission itself, shows that people wait an average of 2.5 years—and some people wait up to 8 years. Do you think that that is acceptable, Mr Cormack?

Mr Cormack: I can only give you the facts, that the states are responsible for managing their activity, their waiting times and also the majority of the investment in public dental—

Senator SINGH: Managing the waiting times based on the massive funding cut of $300 million a year? Why is the government cutting the NPA in that context, with people having to wait up to eight years?

Mr Cormack: It is a decision that the government made in the budget context. I am explaining the figures. I am explaining the process that we are going through to reach an agreement with the states. The budget decision is a decision taken by government.

Mr Bowles: The dental services are also funded by the states and territories, and the figures relate to that as well.

Senator DI NATALE: Can I ask about the CDBS? Last year, it was probably this time last year, the government was indicating through fact sheets that the CDBS would no longer be accessible to patients—is that correct?

Mr Cormack: I think that there is a fair bit on the record about that one. Things have moved on, though. We have now got a new measure that returns the cap to $1,000 over two years. That matter is now settled. That information has been made available.

Senator DI NATALE: A new measure? You mean it is the old measure that you are not touching?

Mr Cormack: I am simply saying that—

Senator DI NATALE: It is not a new measure; it is the existing measure that we have had for a long time.

Mr Bowles: It is a measure in the budget.

Senator DI NATALE: Yes, but there was never agreement to change it. I am getting back to the fact sheet. The fact sheets—I think you indicated that people no longer have access to it. We know now that they had access all along. What are you doing now to ensure that people know that the scheme is available?

Mr Cormack: What we are doing is working with the Department of Human Services, which is responsible for communicating the annual entitlements. Each year, they put out advice directly to individuals based on the information that they have. They will continue to do that. To the extent to which anyone was inadvertently caught up in that period between an announced cap of $700 and then a return to $1,000, we are working through that with the Department of Human Services to ensure that if anybody had had their claims rejected—and we think it is extremely unlikely, given the short window that that was in place—we would rectify that and they would have access to the full $1,000 over two years.

Senator DI NATALE: That is undoing the previous damage. I am asking about what the department is doing to ensure that people know that this scheme is available.

Mr Cormack: What we are doing is working with the Department of Human Services, who undertake a direct communication to all eligible families, and we will continue to do that. They directly mail out to all eligible families once a year.

Senator DI NATALE: Are there any fact sheets that tell patients that the scheme is available now, that they should use it and how it works?

Mr Cormack: The fact sheets that were in existence and have been in existence for some time—albeit there was a period where a different figure was quoted than is the case now—have been restored. That information is available to people to advise that the cap is now

$1,000. As I indicated, the Department of Human Services has conducted a mail-out to advise people of their entitlements.

Senator DI NATALE: What work are you doing with dentists to ensure that they know what is going on with the scheme?

Mr Cormack: Certainly the Australian Dental Association were very engaged with the government when they revised this decision. I would be very surprised if there was a dentist who was not aware of the change in arrangements.

Senator DI NATALE: Can I ask you about the national partnership agreement, specifically about waiting lists. Do you have a breakdown of the last three years of waiting lists?

Mr Cormack: I can get that for you, but I have a fair bit of other information available now.

Senator DI NATALE: Yes, that would be helpful.

Mr Cormack: I will give you the weighted average. At the moment it is 12.05, for 31 December 2016.

Senator DI NATALE: Sorry, what does that figure represent?

Mr Cormack: That is the national weighted average.

Senator DI NATALE: Explain that to me.

Mr Cormack: Essentially, you have a raw national average and then you have a weighted average that takes into account the complexity and type of service. It is a statistical measure.

Senator DI NATALE: But what does the actual number mean? Twelve what?

Mr Cormack: Months.

Senator DI NATALE: That is what I needed.

Mr Cormack: Sorry, I thought you were asking a more technical question.

Senator DI NATALE: No. So the weighted average is 12?

Mr Cormack: It is 12.05.

Senator DI NATALE: So pretty much a year.

Mr Cormack: Yes. The year before that, at 31 December 2015, it was 11.05.

Senator DI NATALE: Yes, 11 months.

Mr Cormack: And at 31 December 2014 it was 9.62. That is three years.

Senator DI NATALE: Just give me the year before.

Mr Cormack: At 31 December 2013 it was 15.01.

Senator DI NATALE: So that nine was when the money from the national partnership agreement kicked in.

Mr Cormack: That would have been associated with that, yes.

Senator DI NATALE: So now we are creeping back up. We are at 12 months. So we have gone nine, 11 and 12 over the past three years, yes?

Mr Cormack: Yes.

Senator DI NATALE: Thank you, that is all I have.

CHAIR: That sees us out for outcome 4. Is that right, Senator Watt?

Senator WATT: Yes.

CHAIR: Thank you very much to all officers.

[17:47]

CHAIR: We will now move to outcome 5, Regulation, safety and protection, starting with program 5.1, Protect the health and safety of the community through regulation.

Senator SINGH: I wanted to ask some questions about the Special Access Scheme for medicinal cannabis.

Dr Skerritt: I should clarify that the Special Access Scheme covers all sorts of unapproved medicines, of which we get 20,000 requests a year for approval.

Senator SINGH: Yes, I understand. I just wanted to let you know so that you knew where I was coming from.

Dr Skerritt: Thank you.

Senator SINGH: Let us just start generally. Since the regulatory changes to the Special Access Scheme late last year, how many applications has the TGA received for access under category B? And how many have you approved?

Dr Skerritt: I have the figures from 1 January 2016 to the present. I do not have them from another point in time. We can take that on notice. I actually have seen an acceleration since the regulatory changes in the number of applications per month. To answer your question, since 1 January 2016 to 26 May 2017, last Friday, we have had 66 approvals. Of those, 34 are still pending, where we have asked for further information. So they are not sitting with us. We have gone back and said, 'You've written "medicinal cannabis" on this form. What form of medicinal cannabis?' That is an example where we have asked for further information. We have had 19 applications withdrawn—by the doctor, not by us. That brings it to a total of 119.

Senator SINGH: 119 received or—

Dr Skerritt: All together—applications received.

Senator SINGH: And 66 approved. Okay.

Dr Skerritt: And zero rejections, I should add. We have not rejected a completed application.

Senator SINGH: But you have 34 pending?

Dr Skerritt: We have 34 pending where we have gone back to the clinician and said, for example, 'You have written "medicinal cannabis"; what do you mean?'

Senator SINGH: I understand. What is the TGA's average processing time for medicinal cannabis applications under category B of the scheme?

Dr Skerritt: The average processing time during calendar 2017 for applications is 2.38 days—don't you love scientists; they always give you too many figures. That is two days and a couple of hours.

Senator SINGH: Okay. But obviously some applications would take longer to process.

Dr Skerritt: That is the average with us. Of course they do take longer to process if we go back to a doctor and ask what type of medicinal cannabis and they take a week to come back to us.

Senator SINGH: So what is the average time for all applications?

Dr Skerritt: I do not have the figures with me. We would have to take on notice the time that it is with the actual doctors.

Senator SINGH: You can take that on notice. Thank you. That would be good. One of the issues here is that clinicians do not necessarily understand the current pathways for accessing medicinal cannabis. In February, the minister undertook that the TGA would rework information on its website to provide simple guidance on the application process. Firstly, has that happened?

Dr Skerritt: Yes, it has. We have reworked the information on our website and provided a simple flowchart. We have also had a number of clinicians' meetings around the country. Just a week and a half ago we had a meeting in Melbourne. Before that we had one in Sydney. We have some planned in South Australia and Queensland. We also have met with the individual state departments and asked them to simplify the information available on their websites. Some have, and some unfortunately are still a bit complex.

Senator SINGH: Could you table the old and new versions of website?

Dr Skerritt: I can certainly table our website. I think we will have captured the old version but I can certainly table what we have now. If we are able to give you what it looked like pre-February, we can table that.

Senator SINGH: I would like both of those. Thank you. The minister also undertook that the TGA would publicise the existing 1800 number for any clinicians who require personalised advice. How are you doing that? And do you have any examples of this kind of publicity?

Dr Skerritt: We have publicised a consumers' number and a clinicians' number as well as an email address. We have advised different clinical colleges of that number. We talk about that number when we have meetings of clinicians. But, most importantly, as you know, almost every day of the week there is something in the media on medicinal cannabis and the existence of a number—or numbers—and often the number itself has been described in the media. So the media has actually done a good job here in spreading the message. Is it on everyone's lips? No. But we have also spoken fairly regularly with the President of the College of General Practitioners and the president of the AMA about the importance of communicating the availability of these numbers if clinicians want to contact us for further information.

Senator SINGH: So do you have any examples—other than the free media you have received—of how you are doing this or how you plan to do this? The publicity, I mean, not the numbers.

Dr Skerritt: It is working with the doctors, so the publicity is first of all working with the clinicians' associations and colleges; having public meetings involving the clinicians; working with the state departments of health, because remember they have significant outreach into clinicians. And also it will be important to work with the pharmacists. For example, we have asked—and they have said yes—to have a major article in the next month or two, depending

on when they go to publication, in the *Journal of pharmacy* that goes to every pharmacist in this country through the Pharmaceutical Society of Australia.

Senator SINGH: I understand that. I understand you work with clinicians and colleges and in the states and territories to provide more information on clinical evidence and so on, as minister's letter said, to assist them in prescribing medicinal cannabis. But how exactly how are you doing this? How are you working with these colleges?

Dr Skerritt: I think I have given a fairly specific description. We sit and meet with them, talk about the aims of getting the information out there to doctors. They highlight opportunities where we could talk about it. So our principal medical adviser was invited to speak at the college of physicians congress in Melbourne recently at a special session they organised on medicinal cannabis. That gave him an opportunity to talk through the access pathways to Australia's main conference of specialist physicians. So part of it, frankly, is getting yourself invited to speak at places, and getting invited to put information into magazines, newsletters and so forth.

Senator SINGH: Another issue is this duplication between Commonwealth and state processes. In February, the minister undertook that the TGA is 'working with every jurisdiction to seek further harmonisation'. What are you doing about that?

Dr Skerritt: In March, we met with senior representatives of each jurisdiction here in Canberra—with the exception, I think, of the Northern Territory, who were on the phone; I think all the others came and met face to face—for a full day meeting. That was one of the key subjects of the meeting. I need to preface this by saying that, of course, there are specific issues in state law that are the responsibilities of the states; they regulate pharmacies. They also have better information than the Commonwealth will ever have on whether there are particular prescribers they want to watch because of questionable prescribing behaviours. So there is a valid and important role for states here.

However, the meeting in March talked through the elements of the state systems and where there is, in our view, some duplication. The other thing that we covered at that meeting was the need to unpack the state processes. Many of the states have also followed our lead in putting simplified information up on their websites, explaining their processes to patients and doctors. After that, we have also done an analysis of the situation in every state and territory, and we provided the minister with advice on where, in our view, there is potential duplication. He has made a public commitment to contact, speak with and write to every minister about those issues. He has made that commitment publicly.

Senator SINGH: Okay. But at this point in time, there have not been any duplications removed?

Dr Skerritt: For example, the new South Australian scheme, which does not bring any additional requirements for a physician—unless someone has a history of drug abuse—for prescribing cannabis for up to two months. They had a range of options in front of them but South Australia had been at those meetings. I do not want to say it is due to our leaning on them but they reached a view that they did not need to put any additional framework in place. Similarly, other states, like Western Australia and Tasmania, have also brought in relatively streamlined systems. And, in states where on the surface of things the delays may have been considerable, it has been clarified that, even though there might be a legal maximum—for

example, a 90-day approval period in Queensland—the real time is a matter of four or five days on average. So I think we have made progress but a key thing will be the minister communicating with each state and his equivalents, the state and territory health ministers.

Senator SINGH: Moving to the other scheme, cannabis is also available through the authorised prescribers scheme. As of February this year, I understand, there were only 23 authorised prescribers around Australia. How many are there now?

Dr Skerritt: We now have 25. It would have been good to have a greater increase but again we are responsive to what applications we receive from ethics committees. So we cannot write these things ourselves. What is quite exciting is that we now also have an authorised prescriber for chemotherapy induced nausea and vomiting in palliative care. That actually breaks new ground, because earlier—to date—the authorised prescriber approvals had been for paediatric epilepsy.

Senator SINGH: I did ask you last estimates for a breakdown by state and I remember it was very New South Wales centric. Considering there are only two more from last time, I would imagine it is still very New South Wales centric.

Dr Skerritt: Yes, the New South Wales people have not withdrawn their authorisations.

Senator SINGH: But perhaps you could say what states those two extra authorised prescribers come from—the two new ones?

Dr Skerritt: I will just get that information.

Senator SINGH: Also, how many applications to become an authorised prescriber are outstanding at the moment?

Dr Skerritt: I do not believe there are any outstanding, but I will just double-check that.

Senator SINGH: I am a bit perplexed as to why you are not making more progress. You have not really moved very far since February, if you have only got two more.

Dr Skerritt: As far as authorised prescribers go, I go back to my comment that we are responsive to hospitals, state health systems, and individual doctors or groups of doctors in a practice putting up a submission through an ethics committee—because, for authorised prescribers, the application needs to go through an ethics committee—and then we receive the application and we review it. So we are fully responsive to what we get. It is the same as asking, 'Why haven't you received 50 applications for new medicines this year?' We review things as we receive them.

Senator SINGH: Yes, but how can you point to this as a viable pathway for accessing medicinal cannabis when it is not available in a number of states across the country?

Dr Skerritt: Well, there are both the Authorised Prescriber Scheme and the Special Access Scheme pathway, but, more importantly, there is a piece of work that we are working on together with clinical groups over the course of 2017, and this is the development of clinical guidance for the use of medicinal cannabis for a range of conditions. That will not only summarise the available evidence but also develop a fairly simple approach for where it fits in to therapy. That will extend the range of conditions into, as I have mentioned, palliative care, and epilepsy—both childhood and adult. It will look at areas such as nausea and vomiting, whether it is HIV treatment, although that is less these days, or chemotherapy induced. It will also look at a range of other forms of pain, which is an area of very significant

interest. Working with clinical groups on this guidance will certainly increase the level of awareness, but, at the end of the day, it will be up to the clinicians to decide whether this particular form of therapy is appropriate for a particular patient. It is a clinical decision.

Senator SINGH: I understand that. Firstly, have you got that information on the breakdown by state; and, secondly, how many applications are outstanding?

Dr Skerritt: I will just check. I do have it somewhere. I have SAS approvals by state and territory. There have been approvals in every state, but none in the Northern Territory or ACT yet.

Senator SINGH: We are not talking about SAS; we are talking about the Authorised Prescriber Scheme.

Dr Skerritt: Okay—authorised prescribers. As we said, 22 are New South Wales. I suspect the other three is Queensland, but I need to check that in another part of my documents.

Senator SINGH: So there are still no authorised prescribers in Tasmania, South Australia, Western Australia, Queensland, the Northern Territory, Victoria or the ACT?

Dr Skerritt: No. We would be very happy to consider submissions from those states, but, again, we have to react to what we receive rather than write the submissions ourselves. It is a reaction to the submission of a proposal.

Senator SINGH: Yes. That is why I was asking before about your publicity and your website and all of those other things.

Dr Skerritt: Again, it is a careful balance as a regulator. In the same way, we would not advocate for one particular cancer medicine over another. We have to provide information—and I agree with you wholeheartedly that there is a shortage of information among clinicians about these products. I have talked about the range of activities that we are doing, but it is also important that we are doing them jointly with clinicians. But, at the end of the day, it is not for us to advocate, the same way it would not be for us to advocate use of a particular unapproved cancer medicine. The clinical colleges and the groups of GPs or others have to come to us.

Senator SINGH: Okay. Obviously, the pathways that we have been talking about for medicinal cannabis products are yet to be approved by the TGA. Ultimately, approved products will be available under the national licensing scheme. What is your estimate of how long it will be before that scheme is operational?

Dr Skerritt: Again, we are reactive to receipt of a submission for an application.

Senator SINGH: How many licences have you?

Dr Skerritt: Are you talking about the licences for cultivation in Australia, or are you talking about approval of a medicine through TGA so, for example, it can be dispensed at every suburban pharmacy? Sorry, I am a bit unclear of your question.

Senator SINGH: Under the national licensing scheme, I presume.

Dr Skerritt: The national licensing scheme is registration of medicines—that is one thing. I think what you are talking about is approval of licences for the cultivation of medicinal cannabis in Australia. I am just trying to clarify the question.

Senator SINGH: I would like both figures, to be honest.

Dr Skerritt: Okay, we will give you both. I might call my colleague, Bill Turner, to the table.

Senator SINGH: And a breakdown by category and state would be useful.

Mr Turner: There are three types of licences under the scheme. One is called the medicinal cannabis licence. That is for cultivation of cannabis for use in humans, through the Special Access Scheme, authorised prescribers or clinical trials. Seven of those licences have been issued. There is the cannabis research licence, which allows research into the plant and its medicinal properties. Three of those have been issued. And there is the manufacture licence, which allows the extraction of the cannabinoids. Two of those have been issued, at this time.

With respect to state by state, can I take that on notice? I have the figures as a breakdown but we do not, generally, release those—because there are commercial sensitivities as well as security issues with location, so I would like to consider that before releasing those figures.

Senator SINGH: If I could ask for it to be taken on notice and then the committee can consider the answer as far as our release of the information—is that something we could do, in relation to this?

Mr Turner: If I could, I can tell you where there have been announcements. The companies are allowed to publicly announce. We do not, but companies have. There have been announcements in Queensland, Victoria, Tasmania and Western Australia.

Senator SINGH: To do with one of those licences?

Mr Turner: Yes, with those types of licences.

Senator SINGH: I will finish on this because, obviously, the national scheme is redundant if state laws prohibit access. Labor has been calling on the government to work with the states to harmonise those laws. I understand harmonisation is not specifically in your portfolio, but are you aware of any progress on this front?

Dr Skerritt: To go back to my question, the minister made a public undertaking, earlier this month, that he would discuss the issue of removing any potential duplication between Commonwealth requirements and state requirements. He was going to speak with each state and territory health minister individually. I understand that those discussions will happen over the coming weeks. He has made a public undertaking.

Senator SINGH: But that is about duplication. I am asking about where access is prohibited to medicinal cannabis.

Dr Skerritt: Where is access prohibited? There is no state that prohibits access to medicinal cannabis.

Senator SINGH: Are you sure about that?

Dr Skerritt: There are states that have requirements for certain prescriber types and so forth, but there is no state in which it is prohibited to access medicinal cannabis.

Senator SINGH: But all the laws are different in each state, so what we have been calling on is for government to harmonise those laws so that we do not have these differences in each state to—

Dr Skerritt: If ever it be the case—of course, the Commonwealth can only go so far. Even poisons handling in pharmacies are regulated by state-by-state legislation. This is a power that sits under the states rather than under the Commonwealth. What the minister has made a public undertaking to do is to talk with his counterparts about removing any duplications and inconsistencies.

Senator SINGH: Yes, I know about the duplication. I was not asking about that.

Dr Skerritt: But there is no way for the Commonwealth to ride over the states.

Senator DI NATALE: How many people in Australia do you think—we have had this discussion before—would benefit from access to medicinal cannabis?

Dr Skerritt: I will not give a personal opinion. There have been various studies. I think one of the most comprehensive studies was done in partnership with the University of Sydney, and I think it gave a figure of about 30,000. A lot will depend on clinical evidence in pain conditions.

Senator DI NATALE: But we are talking about tens of thousands of people who, we have established, would benefit from medicinal cannabis.

Dr Skerritt: No. You have used the words, 'we have established'. I think that is a bit overstated.

Senator DI NATALE: The evidence indicates that—

Dr Skerritt: No, I disagree.

Senator DI NATALE: You have just quoted a study from the University of Sydney.

Dr Skerritt: I have quoted a study in which the University of Sydney estimated that they felt up to 30,000 may benefit from medicinal cannabis.

Senator DI NATALE: Quite, and your department has approved 66.

Dr Skerritt: We have not rejected a single licence.

Senator DI NATALE: Sixty-six?

Dr Skerritt: Correct.

Senator DI NATALE: You have rejected category A. We will get to that in a moment. This becomes very complicated and people do not get it. Authorised prescriber status has largely been given within the context of clinical trials, mainly based out of New South Wales.

Dr Skerritt: No, they are separate from clinical trials.

Senator DI NATALE: Explain to me who gets authorised prescriber status.

Dr Skerritt: A group of clinicians who may be specialists—for example, a group of neurologists—may initiate it themselves. It could be initiated by their regional health state service or even their state department of health, but they do not have to be civil servants. It can be a single clinician. It can be a single authorised prescriber. They identify that they have a significant and ongoing need to use an unapproved medicine. They then receive ethics committee approval for use of such a medicine and, subject to that ethics committee approval—

Senator DI NATALE: Why are they getting ethics approval?

Dr Skerritt: Because it is an unapproved medicine and to check that the requirement is ethically appropriate.

Senator DI NATALE: Who is the accrediting body?

Dr Skerritt: We provide the legal authorisation, but the requirement is that it goes through an ethics committee.

Senator DI NATALE: Are any of those 25 engaged in clinical trials?

Dr Skerritt: I believe that some of them are also doing clinical trials, but their access to the product for the purposes of clinical trials is quite separate.

Senator DI NATALE: You have 66 scripts being approved—

Dr Skerritt: No.

Senator DI NATALE: through category B.

Dr Skerritt: Through category B? Yes, so far.

Senator DI NATALE: Sixty-six?

Dr Skerritt: Yes.

Senator DI NATALE: The evidence points to the fact that there may be tens of thousands of people who would benefit.

Dr Skerritt: No. You keep on saying 'the evidence'. I quoted a study—

Senator DI NATALE: There is a published study from the University of Sydney we are both familiar with.

Dr Skerritt: Yes.

Senator DI NATALE: That is evidence.

Dr Skerritt: No.

Senator DI NATALE: It is not evidence?

Dr Skerritt: It is an opinion from that study—

Senator DI NATALE: It is not an opinion; it is a published piece of research.

Dr Skerritt: It is not in any refereed medical or scientific literature. It was a commercially sponsored study done by a group of business students and business lecturers published on the internet. You keep on saying 'the evidence', but—

Senator DI NATALE: In a briefing with me you have indicated you believe it is 20,000 people.

Dr Skerritt: You asked me for an estimate of the number of people, and I quoted this study.

Senator DI NATALE: In a separate briefing you indicated to me that you thought that 20,000 people would benefit from medicinal cannabis.

Dr Skerritt: I do not believe I have ever given you that figure.

Senator DI NATALE: We will disagree on that point. So far, through category B, we have 66 approvals.

Dr Skerritt: Yes.

Senator DI NATALE: Sixty-six?

Dr Skerritt: Sixty-six since 1 January 2016.

Senator DI NATALE: And in total?

Dr Skerritt: I will have to go to the numbers.

Mr Turner: It is 89 under SAS category B since the first application in July 1992. We should also add into that 41 patients who have received it through authorised prescribers. There is always a lag with our figures on authorised prescribers because they only report six-monthly.

Senator DI NATALE: So far in Australia we have 89 people who have got it through category B. Is that right?

Mr Turner: Yes, 89.

Senator DI NATALE: Through authorised prescribers, of those 25, you said there were how many scripts?

Dr Skerritt: That is as of December last year.

Mr Turner: Forty-one were authorised prescribers. That is cumulative—it is the 89 plus the 41.

Senator DI NATALE: Yes, that is right. So we are effectively talking about 130 scripts in total.

Dr Skerritt: I expect that there are somewhat more because—

Senator DI NATALE: There might be some more because of the lag.

Dr Skerritt: Because that figure was as of December, yes.

Senator DI NATALE: It might be an extra dozen or so on top of that 130. The issue that I think Senator Singh was trying to get to is that this was established in an effort to try and ensure that people got access to medicinal cannabis, and so far, under what has been managed through the TGA, we have seen 130 scripts.

Dr Skerritt: The scheme was established to ensure that individuals who were assessed by their clinicians, with appropriate clinical oversight—and I talked about the ethics committee oversight for authorised prescribers, for example—were able to have access to this as a treatment option. But, of course, it is not a system for every individual who feels that they should benefit from the drug to get access to.

Senator DI NATALE: No-one is suggesting that. Regarding the authorised prescriber status, do they belong to one particular class of specialty?

Dr Skerritt: No, there are neurologists as well as people working in palliative care who have received authorised prescriber status.

Senator DI NATALE: The answer to a question on notice that I got from you was that all the authorised prescriber individuals were paediatric neurologists.

Dr Skerritt: That is because the question on notice was probably submitted in February or March, and today is 29 May.

Senator DI NATALE: How many of the 25 are paediatric neurologists?

Dr Skerritt: All but one are neurologists.

Senator DI NATALE: So there is one palliative care physician?

Dr Skerritt: At that stage. I do not know if you were listening earlier, but I mentioned the work we are doing with groups of clinicians on clinical guidances for ranges of different conditions, but, again, the clinicians will reach their own judgements having reviewed those guidelines.

Senator DI NATALE: You will forgive my cynicism here because earlier on you said that you believe that we should not be discriminating between classes of drugs. That was your proposition to Senator Singh.

Dr Skerritt: My proposition to Senator Singh is that we have a system for unapproved medicines, and the reason why these medicines require an approval is that they do not have clinical experience internationally as prescription medicines.

Senator DI NATALE: We have a system that exists for unapproved medicines, both through category B and through category A.

Dr Skerritt: Correct.

Senator DI NATALE: And it was the view of the department that we should not support access to medicinal cannabis through category A. Can you tell me what category A is, or would you like me to perhaps summarise?

Dr Skerritt: No, I think I know what category A is. The reason why—

Senator DI NATALE: Perhaps just explain, for people who might be listening, what category A is.

Dr Skerritt: The reason why, in the department's view, it was not appropriate for medicinal cannabis products to be through category A—

Senator DI NATALE: Can we explain what category A is for people who might not be familiar with it?

Dr Skerritt: It is a system for access to medicines where people are at imminent risk of death.

Senator DI NATALE: They have a terminal illness—

Dr Skerritt: A terminal illness, yes.

Senator DI NATALE: and the patient might die without early treatment.

Dr Skerritt: Without early treatment, yes.

Senator DI NATALE: And people through that scheme can get access to unregistered medication.

Dr Skerritt: They can, but the medicines that they can get access to are those where there is a significant experience with those medicines being registered, for example in Europe for 20 or 30 years or by the FDA, or they could be recently approved cancer or other drugs that have been through the full FDA process.

Senator DI NATALE: With respect, this is a drug that has had a long track record in many other jurisdictions, and just because it is something that the TGA might not believe—

Dr Skerritt: I disagree with you. It is not approved as a registered or equivalent medicine in European countries or in the US or in Canada. So I do not know what these equivalent jurisdictions are.

Senator DI NATALE: It needs a track record of clinical efficacy in those jurisdictions. Are you disputing that?

Dr Skerritt: I am disputing that. I am saying—

Senator DI NATALE: So you are disputing that medicinal cannabis has a track record of clinical efficacy for particular conditions?

Dr Skerritt: It does not have the same track record of clinical efficacy as medicines that have received registration, by and large. There was a very exciting trial on the use of cannabidiol in children with Dravet syndrome, co-authored by Australians, just last week—that was exciting. I was actually with one of the lead authors last week, just before it was published. But, in general, we do not include products that have not been approved as having had a track record of clinical evidence sufficient to get US FDA or European Medicines Agency or Health Canada or Japanese approval—the major global regulators.

Senator DI NATALE: Firstly, have any medicines that are used through the category A scheme—which is for terminally ill people who cannot get their medicine through a normal script through their doctor—not been approved by one of those regulators?

Dr Skerritt: We do not believe that that is the case, no—not that we know of.

Senator DI NATALE: You are not aware of any other—

Dr Skerritt: I am not aware of any others.

Senator DI NATALE: What you are saying then is that, despite the fact that we have gone through this process that says that we are going to start treating medicinal cannabis like we treat other medicines—which is that we are going to ensure that we have access available to people through a scheme like category A—we are going to treat medicinal cannabis differently?

Dr Skerritt: We are going to treat it differently until the time that there is the same sort of evidence for the other medicines that are under category A.

Senator DI NATALE: Let me just talk through what some of the safeguards are against category A. If you have a terminal illness, you have to go and see a doctor first; is that correct?

Dr Skerritt: Yes.

Senator DI NATALE: The doctor then says: 'You have end stage cancer. You are having chemotherapy. Drugs that we have given you to try and treat your nausea are not working.' You cannot, under those circumstances, go to a doctor and say, 'I've got a terminal illness. I know this stuff works. I am getting it illicitly because at the moment it is the only thing that is preventing my nausea', and, through the category A scheme, get a doctor to prescribe that?

Dr Skerritt: Not through category A. But remember that we are taking, on average, two days to approve category B. And also that there are now three companies with significant stocks of material in this country—

Senator DI NATALE: But why would you deny access to somebody who can get it quickly through category A, given that we have seen only 66 approvals through the category B scheme?

Dr Skerritt: As I said, we take 48 hours to approve. In the last couple of months there are now stocks of these products available in Australia. So there is not a delay in accessing these products from overseas.

Senator DI NATALE: You have only issued 66 approvals?

Dr Skerritt: We have not rejected a single application.

Mr Cormack: Chair, I think this is going round and round in circles. I think Professor Skerritt has clearly outlined to the Senator the tests that he applies as a regulator. He has applied them consistently. It appears to be the case that there is not sufficient demand from prescribing doctors to be able to access the scheme as structured—

Senator DI NATALE: I am not worried about the doctors; it is the patients I am concerned about.

Mr Cormack: In this country, as you would know, Senator—

Senator DI NATALE: It is the patients who cannot get access to it.

CHAIR: Senator Di Natale, are you going to move to other questions?

Senator DI NATALE: I am going to continue. I have some other questions on category A.

CHAIR: Other senators also have questions.

Senator DI NATALE: Just to confirm, through category A the doctor needs to make an application to the Office of Drug Control; is that correct?

Dr Skerritt: No.

Senator DI NATALE: What happens?

Dr Skerritt: In category B the application is to TGA—

Senator DI NATALE: Category A.

Dr Skerritt: Category A is not an application; it is a notification. We get told afterwards. When we get those notifications—because, of course, with a notification system you are never sure whether you actually get the notification.

Senator DI NATALE: What does that mean?

Dr Skerritt: When you are told that you have already done something, human nature is such that, well, we have no idea whether 90 per cent, 99 per cent or 100 per cent of people actually send in the forms. We have no way of knowing that.

Senator DI NATALE: You have said you have this wonderful safeguard through the category A scheme—

Dr Skerritt: No, category B—

Senator DI NATALE: Let me finish now. You indicated that there is a safeguard that these medicines must be approved oversea by overseas jurisdictions, and now you are indicating that there is a flaw in the scheme, that you would not even know if somebody, through category A, got access to a drug that is unregistered here in Australia?

Dr Skerritt: They are committing an offence if they do not notify us within a certain period, and of course that would be viewed rather negatively, apart from the straight offence, by AHPRA and by their own professional bodies. We also can trace importations of

medicines through companies that specialise in importing unapproved medicines. There are some audit trails available to us, and we are able to use those, but can I say that we get 100 per cent versus 99 per cent or whatever? I cannot.

Senator DI NATALE: Given all of the checks and balances; given that you have got to, ultimately, have a doctor see a patient and the patient then needs to send a notification to you to indicate that they have done that; and given that they also need to ensure that, in terms of getting the substance over here, there are a range of other safeguards—the rationale that was used against providing access through the category A scheme was that it would open up the floodgates.

Dr Skerritt: I think that you are confusing a couple of things. The recent disallowance motion had three parts to it. Where there was significant concern was around personal importation, which also would have been opened up had disallowance been successful. This is personal importation of cannabis-based products.

Senator DI NATALE: Medicinal cannabis, for use—

Dr Skerritt: Medicinal cannabis-based products. There was also concern given the challenges of working out what an appropriate quantity was and the practical challenges of customs and border service people working out whether it was appropriate personal use for a period of three months.

Senator DI NATALE: But we do that all the time.

Dr Skerritt: Yes, we do it all the time, because—

Senator DI NATALE: We do it all the time in medicine. We make those distinctions all the time.

Dr Skerritt: If I can answer—there is personal importation all the time. Someone may have a personal importation. They have a prescription and it says that they are personally importing some medicine that is not available here, or that they are travelling. Their script will say, 'Two tablets a day.' Now, you are allowed to bring up to three months in. Three months, ninety days, two tablets a day: 180 tablets. The challenge with medicinal cannabis products is, of course, that they vary hugely in the concentration of THC and cannabidiol and so forth in them. Whether you are a customs officer or a 10-year-old, you can count 180 tablets. Someone can count 180 tablets, but what you cannot do, if you have a kilogram, five kilograms or whatever of cannabis, in a practical sense—unless you sent it off to a lab to say, 'Yes, that is 22.4 per cent THC.'—is confirm whether or not it is a dose just for yourself or a much larger trafficable quantity. That is where it is not practical.

Senator DI NATALE: Well, with respect, you could draw the threshold at the higher limit if you were interested in getting this support through, couldn't you?

Dr Skerritt: The higher limit of what?

Senator DI NATALE: Well, you could choose the highest potential concentration of THC and say, 'We're going to base our three-month quantity on that.'

Dr Skerritt: I would suggest that that would open the prospect for very significant diversion.

Senator DI NATALE: Hang on. This is a whole other argument against it. Why isn't that an issue for people who get scripts in Australia?

Dr Skerritt: The people who get scripts in Australia are receiving material that is provided by an Australian pharmacist, dispensed by a pharmacist and provided—

Senator DI NATALE: It is still the same thing.

Dr Skerritt: It is very different turning up at an airport with a suitcase of cannabis and saying, 'Oh, look, this is only one per cent, so I need a whole suitcase.'

Senator DI NATALE: Please! That is disrespectful to those people who—a suitcase of cannabis? We are talking about a three-month supply. If you are talking about a high quantity of THC, it would be a very small amount. Many of these substances come in oils and other preparations.

Dr Skerritt: I disagree. If it is raw cannabis and a standard strain—if it is fairly low in cannabidiol—

Senator DI NATALE: I just said that you could base it on the strand that has the highest concentration of THC.

Dr Skerritt: Senator, if you would let me finish. A three-month supply for a low-cannabidiol product could well be a suitcase.

Senator DI NATALE: We have just established that you could draw that threshold at a very high level.

Dr Skerritt: If you drew the threshold at a very high level and said, 'Well, okay, we're going to assume that it is very high.' It may be that the person is only bringing in enough for one or two weeks. What would happen then, if they are thinking that they have got three-months worth of medicine?

Senator DI NATALE: It is better than not bringing it in at all.

Dr Skerritt: Why would you go through that pathway when there are already stocks of this material available, sitting under pharmaceutical companies in secure pharmaceutical storage, for schedule 8 and schedule 4 drugs?

Senator DI NATALE: Where people cannot get access to it. Did you actually remove from category A the drugs nabiximols and nabilone?

Dr Skerritt: They were available under category A prior to the regulatory change. However, let us go to nabiximols. It is primarily prescribed for multiple sclerosis—a chronic condition, not a palliative care condition. There are two drugs that were there. There is a third one: dronabinol. Between the two of them, there has only ever been one request under SAS B for that drug. These were not exactly high-demand drugs, especially in a palliative care situation.

Senator DI NATALE: Is it fair to say that it is now harder to access medicinal cannabis or related products than it was prior to this legislation through category A?

Dr Skerritt: I think that there is a clear pathway for patients to be able to access the product. There is product sitting—

Senator DI NATALE: For 66 people.

Dr Skerritt: in warehouses in major capital cities of Australia. The Commonwealth is taking two days in its approvals.

CHAIR: The committee will suspend for dinner and resume at 7.30, examining the same program.

Proceedings suspended from 18:30 to 19:33

Senator WATT: I have some questions about the TGA. You will remember we recently had a short Senate inquiry into the therapeutic goods amendment bill. In summary terms, the purpose of that bill is to fast track patient access to new medicines and other discoveries. We had that inquiry in February and March and the committee reported in March. Are you aware of why the government has not bothered to pass this bill through the Senate now that it has been reported on by the committee?

Dr Skerritt: I cannot comment on parliamentary processes. It is basically up to the amount of business in the Senate. What I do know is that at your inquiry, some members expressed concern that they had not seen the underlying regulations—

Senator WATT: I was one of those members, as I recall—

Dr Skerritt: You were one of them, Senator Watt. I do know that the minister and his office have shared those draft regulations with senators and members, and I hope that you have received them.

Senator WATT: I certainly have not myself, but it could be that our shadow minister has. I will check that out.

Dr Skerritt: I think they have been sent through Catherine King's office.

Senator WATT: I did express reservations at that inquiry because it did appear that a lot of important details about how this scheme would work were going to be dealt with via regulation, and we were being asked to approve legislation without seeing the regulations. My recollection is we were told that it was important to get this legislation through because patients were depending on it.

Dr Skerritt: It is, and patients are depending on it. There are still sittings of the Senate—apart from sittings in committees like this—as a whole before 30 June. It will be up to the Leader of the House and the Leader of the Government in the Senate, but there are still opportunities to pass it. I want to add that we did remind senators at that inquiry that the balance of detail between the act and the regulations was entirely aligned with the rest of the Therapeutic Goods Act versus the regulations, and entirely aligned with other safety regulators, whether it be the Maritime Safety Authority legislation and regs, the airline safety authority legislation and regs, or the Biosecurity Act and regs. The balance of detail in the regulations and in the act is consistent with other regulatory regimes, including the rest of our own.

Senator WATT: During that inquiry, I asked whether, rather than rushing this legislation through the committee process, the Senate could consider the bill in its May sittings, which would have given us an opportunity to review these regulations that we did not have before us. You responded:

I think that that would mean a delay in the care of patients—these could be cancer patients or rare-disease patients—having access to a pathway.

Given the government has not sought passage until June at the earliest—being the next sittings—do you stand by that view?

Dr Skerritt: I stand by the view that it would have been preferable for it to have been introduced in May. I am also aware that it was on the *Notice Paper* and that there was other Senate business. I also remind you that the regulations are available for senators across the chamber to review through the minister's office. He has made that offer to share the draft regulations.

Senator WATT: The reason I am harping on about it is that I have not even been in the Senate 12 months, and this was the second time that this committee was asked to rush through legislation because of the dangers to patients if it was not done—the other instance being the cancer register. So we do the right thing, the committee reports on it, and, what do you know, it does not end up being quite so urgent after all. I am getting a little bit sceptical about these justifications.

Dr Skerritt: I cannot comment on the order of Senate business. I can re-emphasise that what the bill, if it is enacted, does is provide earlier access to medicines with the same amount of regulatory oversight, but with the review done in a shorter period of time, and that would benefit people who are waiting on those medicines. I stand by that comment.

Senator WATT: You also said in that inquiry:

For the early access to the high-priority medicines, you would not even get that started in 2017 if the bill was not debated until the May or budget sittings.

Do you still stand by that view?

Dr Skerritt: I think the question I was asked was when the first medicines would appear. The intent is that we would be, and are—assuming passage of the legislation and assent to the regulations—in a position to take applications for priority review starting in the second half, or even in the third quarter, of this year. But we clearly cannot do that until the legislation and regulations are in place. But I think I was asked when medicines would be on the market, from memory—

Senator WATT: No, I have gone back and had a look at the transcript. I said:

Again, given the importance of these regulations, you do not think it would make sense to deal with this legislation in the May sittings so that by that time we would potentially have access to those regulations and be making a more informed decision?

Your response was what I said before:

I think that that would mean a delay in the care of patients—these could be cancer patients or rare-disease patients—having access to a pathway. I will use one example. For the early access to the high-priority medicines, you would not even get that started in 2017 if the bill was not debated until the May or budget sittings.

Dr Skerritt: That would be the normal course of events, that it would delay it significantly until early next year. There are pathways—that will be subject to the Governor-General sitting in Executive Council—to approving regulations very soon after the passage of a bill, but that requires special application to the Executive Council, which cannot be guaranteed.

Senator WATT: Is that something you are considering?

Dr Skerritt: It is, if the legislation were passed. We have already been in discussion with the secretariat to the Executive Council and explained the situation, but it is subject to the passage of legislation.

Senator WATT: So you are considering, for want of a better term, emergency passage through Executive Council or urgent passage?

Dr Skerritt: It is not emergency; it is urgent passage. Normally, with Executive Council, you need to give them four to six or even eight weeks notice, but for highly urgent items they can—if you request them and they are able to accommodate it on their schedule—deal with them more quickly. That also depends on the availability of the Governor-General and other members of the Executive Council.

Senator WATT: Stakeholders have told the opposition that the regulations are not ready yet. Is it the case that they are not finalised?

Dr Skerritt: They are finalised as far as we see them. They are finalised to the extent that the minister has shared them with, I believe, the shadow minister.

Senator WATT: I am told that is not the case, at least in relation to shadow minister King. We are just checking whether there are other shadow ministers in the health space that this might have been shared with.

Dr Skerritt: Please do. The regulations may have the word 'draft' on them because clearly we are seeking to see if there are any issues of concern from the opposition or the crossbench. And then, obviously, the government will consider those issues. The drafting work is essentially complete and regulations have been circulated to various people in the Senate. I cannot name the list of people. That is something that the minister's office has taken carriage of, not us, which is the appropriate thing.

Senator WATT: Sure. Do you expect that these regulations will take effect from 1 July?

Dr Skerritt: Again, I cannot predict what bills do or do not get through the Senate, and I cannot guarantee that the Governor-General and the secretariat of the Executive Council will agree to an urgent appeal, but we have been told that, if they were passed through, they would consider that. There are two unknowns here.

Senator WATT: What do you consider would be the impact of a delay in those regulations?

Dr Skerritt: A delay in regulations brings in a delay in reforms. There are a number of reforms that are of particular interest to patients, consumer groups, healthcare professionals and industry. We have talked about the new priority pathways for medicines and other products; the ability to make simple variations to certain medicines without having to go through TGA to approve that variation; the ability of healthcare professionals to supply certain unapproved medicines from a list without approval by TGA, so that would streamline some of the healthcare professional prescribing behaviour; and the ability of people to have an additional approach for reviewing new medical devices for Australia.

There are things that are of interest here for industry, for healthcare professionals—doctors and pharmacists—and for patients. Really, as in every activity the Senate does, commencing a new regulatory scheme depends on the passage of bills and implementing regulations.

Senator WATT: You have mentioned that they would have an impact on the reform process. What would be the impact on patients of a delay in these regulations?

Dr Skerritt: An impact on patients if the regulations were delayed—and, of course, the passage of a bill—is that new medicines that might be suitable for priority review would not

be able to be submitted through a formal priority review pathway to TGA because the act, the enabling regulation, set up this priority pathway. That is the main one. There are some other ones, but that is the main one.

Senator WATT: Again, in the inquiry, when I asked you about this, you said:

> … if we want patients in 2018 to be able to get access to these high-priority medicines earlier we are going to need to have regulations in place from 1 July 2017.

Do you stand by that view?

Dr Skerritt: Yes, because remember we have to count the period for TGA to review the medicines for a priority pathway. With that priority pathway, instead of it taking a calendar year, it is reduced down to, say, eight or nine calendar months and, if something happens from 1 July, eight or nine calendar months is therefore early 2018. So I stand by that statement.

Senator WATT: I do not think any shadow minister has been provided with the draft regulations themselves. It is possible they have been provided with a list of regulations, but not the actual draft regulations.

Dr Skerritt: That is really a matter you need to take up with Minister Hunt's office.

Senator WATT: Minister Nash, would you be able to take that up for us with the minister's office?

Senator Nash: I certainly can.

Senator WATT: We are keen to see the draft. Oh, this is a miracle! One minute ago they were sent by the minister's office to the shadow minister's office! Hello, minister's office! You are obviously listening in. That is good. Thank you for doing that. That is just amazing. Dr Skerritt, my other questions concern medicinal cannabis. We have gone over that in some detail. I just want to check a couple of details about the activity of the TGA in relation to the recent vote on the disallowance motion on medicinal cannabis regulations. Dr Skerritt, I understand you were here Parliament House on the day of the vote. Is that correct?

Dr Skerritt: I was requested to be here to accompany members of the minister's office in briefings that were agreed to by crossbenchers.

Senator WATT: So the minister's office requested that you attend those briefings?

Dr Skerritt: Yes. It is quite normal for senior officials to attend briefings of opposition backbenchers, crossbenchers and so forth.

Senator WATT: You were asked to attend to assist and brief crossbenchers on the disallowance motion and the regulations?

Dr Skerritt: Correct.

Senator WATT: Was anyone else from the TGA here to assist in that regard?

Dr Skerritt: I was the one who was invited. I should explain. The implications fit across both TGA and the Office of Drug Control, both of which fall under my purview. Other members were busy preparing written briefing material, so the office requested that only I come up. There were some other pieces of written briefing that again, crossbenchers requested. But the minister's office requested that they stay back on their computers and prepare for review by the minister.

Senator WATT: So you were here in person?

Dr Skerritt: I was here in person, as I have often been for briefing senators and members.

Senator WATT: Which senators or parties did you brief in relation to the regulations on the day of the vote?

Dr Skerritt: Again, we briefed at the request of those senators. We basically briefed Senator Xenophon and his team and Senator Hanson and her team.

Senator WATT: Not any of the Independent senators?

Dr Skerritt: Again, it was on request and so forth. We did not knock on people's doors hoping they were in their offices.

Senator WATT: You briefed Senator Hanson herself?

Dr Skerritt: Yes.

Senator WATT: And Senators Roberts and Burston?

Dr Skerritt: I will have to check my notes as to who was at both meetings. I will take that on notice. I know that it is possible that not all members of all teams, of NXT or One Nation, were present at all those briefings. Together with advisers, they made for reasonably full offices.

Senator WATT: Mr Ashby was there, no doubt?

Dr Skerritt: Yes, he was.

Senator WATT: Did you brief anyone on the day of the vote other than political parties or senators—anyone external to government?

Dr Skerritt: No, it was pretty busy. I came straight out of a meeting and the request for briefing came in, so there was not much time to work the phones or anything like that. It was really for us to brief senators on the request from them and the minister's office.

Senator WATT: Did you or anyone else from the TGA brief any journalists on the day of the vote?

Dr Skerritt: I was interviewed by a journalist from *The Courier Mail* at their request and the interview was essentially: 'Can you explain what the changes to the regulations are and what the disallowance is?'

Senator WATT: Which journalist was that?

Dr Skerritt: I talk to a lot of journalists. I would have to take the name on notice.

Senator WATT: If you could, that would be great. Did you say that the interview was conducted at the request of the journalist?

Dr Skerritt: Yes, the interview was requested. Again, it was requested through the minister's office, as is quite normal. Many of our requests from the media come from a minister's office; some come directly to the department; some come to both at the same time.

Senator WATT: Was it the minister's office who requested that you conduct an interview with the journalist?

Dr Skerritt: The journalist had asked the minister's office that I speak with them. I accepted that request. It was a fairly factual interview which, I think, was reported in print in the *Courier Mail*.

Senator WATT: Is it usual for you to brief journalists directly?

Dr Skerritt: Yes. For example, in the last few months I have spoken on *60 Minutes* and on *Four Corners*. We do a certain amount of media. I think it is important for there to be greater awareness of the regulatory framework and reasons for regulators' decisions.

Senator WATT: Is that the only interview you did on the day of the vote?

Dr Skerritt: That was the only interview I did on the day of the vote.

Senator WATT: Did you provide any written comment to journalists?

Dr Skerritt: No.

Senator WATT: So it was the only verbal or written one.

Dr Skerritt: I just provided verbal. Obviously, I have no knowledge of what anyone else may have provided, either from the department or from a minister's office.

Senator WATT: Did you brief the *Courier Mail* before or after the vote had taken place?

Dr Skerritt: Before. The request was, 'Can you explain what the regulation change was, and can you explain the implications depending on which way the vote went?' It was a statement of facts.

Senator WATT: It was a statement of facts; it was an on-the-record interview.

Dr Skerritt: I do not do off-the-record interviews; they do not exist.

Senator WATT: You should tell a few other people around here that! I am not a backgrounder; you see me coming. So there was just the one interview you did with—

Dr Skerritt: Just the one.

Senator WATT: Sorry, was it before the vote or after?

Dr Skerritt: Before, as I said.

Senator WATT: And you did not take any media requests after the vote?

Dr Skerritt: No, I did not. The department and minister's office may have, but I did not do any media relating to the subject. A vote had been made and we are moving on. It is not for me to run a commentary on the political process.

CHAIR: Before I move to Senator Leyonhjelm, Senator Rhiannon wanted some clarification around exactly where some questions related to—

Senator RHIANNON: Yes, to do with the testing of cosmetics on animals and the announcement that was in the budget.

Mr Bowles: That is NICNAS the chemicals regulator. I do not think they are even down to appear so we can take anything on notice, if you would like.

Senator RHIANNON: Seriously? I thought that because it was a budget announcement it came in under some of this in section 5: 'Protect the health and safety of the community through regulation.'

Mr Bowles: It depends on what you want to ask. We can talk about the legislative side of it.

Senator RHIANNON: Yes, it was only about the legislation.

Mr Bowles: We can do that. It is in this outcome, Chair; it is up to you whether you want to go there next.

Senator RHIANNON: We are in outcome 5.

CHAIR: I was going to go to Senator Leyonhjelm and then to Senator Reynolds, and then to you, Senator Rhiannon.

Senator RHIANNON: Okay, thank you.

Senator LEYONHJELM: I am going to return to the same subject that Senator Watts and Senator Di Natale were talking about before we broke for the dinner break. I listened carefully to what you said in response to Senator Di Natale's questions. I am hearing from people who have sick family members—in many cases children, or youngsters anyway—with severe epilepsy, and I cannot remember what else. They are using cannabis or cannabis extract to deal with those symptoms. They are telling me that they cannot get it by prescription and that their only option is to buy it illicitly and that their suppliers are being raided by the police. I acknowledge that is a state issue. The New South Wales police are doing that, and it is not a federal matter. Why would that situation be arising?

Dr Skerritt: It is hard to see, and it depends where you are. But as we discussed earlier, there are something like 25 authorised prescribers, who—

Senator LEYONHJELM: For the entire country, though?

Dr Skerritt: There are that many for the entire country. We would love there to be more, but as we mentioned before the dinner break, it is dependent on receipt of applications.

Senator LEYONHJELM: Perhaps that explains their difficulty.

Dr Skerritt: Their doctor can seek supply for that individual patient under the Special Access Scheme B. There are suppliers of the cannabidiol-rich medicines sitting in Australia sufficient to treat many hundreds if not thousands of children. So they basically have to go through the process, and I often muse on the time spent complaining about the process of a one-page form with some attachments when applying for access. You would get the access much faster that way.

Senator LEYONHJELM: Who has to apply, the patient or the doctor?

Dr Skerritt: The doctor, the same way with any other medicine. But prescription of a medicine is obviously based on medical opinion. The doctor has to submit the Special Access Scheme B form to us, which, as I said, is a one-page form that may require some attachments. Sometimes those attachments are only one page as well. So it is not a weighty a lot of paperwork.

Senator LEYONHJELM: Would most GPs be familiar with this process?

Dr Skerritt: We believe they would, because in last year, across all types of unapproved medicines, there were near to 20,000. I can give the exact figure for the last six months. I think I have it on me, and it was about 10,500. There were 20,000 applications made in the last financial year or in the last calendar year. It is running at about 20,000 per year, no matter how you measure it. If 20,000 applications are made, I would venture that this is not some obscure scheme.

Senator LEYONHJELM: You mentioned a relatively small number of people who are licensed to prescribe it, so if it—

Dr Skerritt: No, I should clarify: there are authorised prescribers who can provide for a hundred children, if they so wish. We do not require information on the individual children

once they are an authorised prescriber. The terminology is sometimes a little bit confusing. They are people who are largely paediatric epilepsy specialists. They, or their employer if they are employed through a government health service, have gone to the trouble of filling out the forms, getting ethics committee approval and applying to us. But on top of that, any—let's use the example of neurologists—paediatric neurologist who see these kids could apply for access for any or all of their patients to prescribe these medicines. But, again, it comes down to their clinical judgement as to whether they believe that it is the most appropriate treatment.

Senator LEYONHJELM: Could a GP who is not a specialist prescribe it?

Dr Skerritt: It depends on the state, and this is one of the issues where our minister made a commitment to talk with his counterparts to streamline the system. In some states GPs can, and in other states GPs with advice from a specialist can. That does not mean a consultation, but just advice. In other states it is only specialist physicians.

Senator LEYONHJELM: If a patient had been using cannabis extract from an illicit source and wanted to obtain it from a legal source, would they require their GP to prescribe it, or would they have to be referred to a specialist, depending on what state they were in?

Dr Skerritt: Again, it depends on the state, but—

Senator SINGH: But it is only in New South Wales that you are authorised to prescribe it anyway.

Dr Skerritt: That is because it is only where they have come to us. But, remember, in the other states, a GP or a specialist, depending on the conditions, can go to us. We have doctors in every state. We have not had any in any of the territories yet, but we have had doctors in every state of Australia prescribe medicinal cannabis to patients legally.

Senator LEYONHJELM: If a patient was located in regional Queensland, outside Brisbane, and went to their GP, are you saying that they could legally access cannabidiol to treat childhood epilepsy?

Dr Skerritt: The answer is yes. If a patient has been going in occasionally to Brisbane under the care of a specialist, they might have to have a phone call to the specialist, as is quite common in complex and difficult medical conditions. These serious paediatric epilepsies are serious conditions. Queensland Health would also have to sign off. That is a thing that is unique to Queensland and Victoria for cannabidiol.

Senator LEYONHJELM: And if they were in New South Wales?

Dr Skerritt: I am just checking. I believe New South Wales does not require any specific New South Wales approval for cannabidiol to be prescribed. Again, they can go—let us say they are rural in New South Wales. If it was a kiddie with serious epilepsy, they would be seeing a neurologist at their local centre—like Dubbo if the kid was at Broken Hill or Nyngan or somewhere—and so the doctor would consult with them and then an application would be filled out. These are quite common processes for when medication changes are done anyway. If you are a GP seeing a kid, or even an adult, with epilepsy, you do not generally change their medication without at least a telephone call with that person's neurologist because of a risk of seizures, and for adults of course that means you cannot drive.

Senator LEYONHJELM: Are you able to give us any information as to why suppliers who are endeavouring to provide these patients or the parents of these patients with cannabidiol are being raided by the police?

Dr Skerritt: I think the suppliers who are being raided by the police are actually those who are supplying the product illegally. Remember, cannabis is an illegal drug in all states and territories. The medicinal cannabis scheme carves out its approval, as an unapproved medicine, when provided through medical prescription and pharmacist dispensed. It is not saying that anyone who has cannabis and says they are using it for medicinal purposes is somehow immune from the law.

Senator LEYONHJELM: Changing topic for a moment, when the disallowance motion of Senator Di Natale was considered by this Senate, it was relevant to category A approvals, which do not relate to epilepsy, as I understand it, but to cancer patients facing imminent death.

Dr Skerritt: A range of people utilise the category A pathway, and a range of physicians prescribe under it. Quite often it is more relevant to palliative care than, say, a longer term condition like seizures.

Senator LEYONHJELM: In answer to questions from Senator Watt, you indicated you had briefed Senator Hanson and Senator Xenophon, or some people from their parties. In the context of consideration of that bill, I was lobbied by a local producer, or an intending local producer, of cannabidiol. The gist of the lobbying or the gist of the message that was presented to me was they did not want the regulation to be disallowed because it would facilitate the entry of cannabidiol by import and that, as a consequence, they would be uncompetitive. Are you familiar with that argument?

Dr Skerritt: Yes, because there are different provisions that apply to the ability to prescribe imported medicinal cannabis products versus homegrown medicinal cannabis products. The Narcotic Drugs Act amendments that were passed in this place in February 2016 actually closed or did not make available the category A route to homegrown products. So, had the disallowance been successful, you would have lost a level playing field. You would have had access to category A from imported product but not from Australian grown product. That would have been the lines along which I imagine your constituent was lobbying you.

Senator LEYONHJELM: The constituent was not actually very concerned about the patients. They were mainly concerned about their loss of business opportunity. Was that discussed in the context of your briefing with either Senator Hanson's group or Senator Xenophon's group?

Dr Skerritt: The differences between the frameworks are well-known. Again, we responded to questions that the senators asked us.

Senator LEYONHJELM: What do you think about the argument that the purpose of category A was to, as you put it, create a level playing field or, as others have put it, inhibit foreign competition?

Dr Skerritt: I do not think category A is set up to inhibit foreign competition. I guess I was reflecting on a provision in the Narcotic Drugs Act that was passed by this parliament.

Senator LEYONHJELM: I will leave it there.

Senator REYNOLDS: Good evening, Secretary, Minister and Professor Skerritt. I would like to change topics a little bit. I am probably going onto a subject that does not get as much attention as it should at these estimates. The issue is that of male and female sexual dysfunction and approval for drugs. Does the TGA have guidelines for the industry on male sexual dysfunction?

Dr Skerritt: Guidelines in general or guidelines for the review of medicines?

Senator REYNOLDS: Both. I will just explain. It has been brought to my attention that there is a very successful pharmaceutical company in Western Australia that for many years has been a TGA-approved facility and has been producing what is called AndroFeme medication for both men and women. Due to some oddities between state and federal guidelines, it has been manufacturing and successfully selling here and overseas the male product, for male sexual dysfunction, but its identical product for women, while approved in Western Australia—it is called AndroFeme, is perfectly legal to prescribe in Western Australia and is prescribed in rather large quantities—is also then prescribed in WA for women interstate. I understand the company has been going through the merry-go-round because, it has advised me, there are no guidelines for industry on these types of medications for women, but there are for men. It just makes me wonder why it is okay to sell these products in WA for men and women but nowhere else.

Dr Skerritt: I will seek some further comment from Larry Kelly, if he is here. While we follow a lot of European Medicines Agency guidelines for general disease classes and so forth—Australia, as part of not duplicating international regulatory effort, tends to follow the EMA, the European Medicines Agency, guidelines for a range of diseases and conditions; medicines for bronchitis, medicines for this and medicines for that—I am not aware that there is a guideline as specific as relating to male and female sexual dysfunction. I will check with my colleague. I would also add that, when a medicine is only supplied within a state's borders, even as large a state as WA, different regulations, largely controlled by the state, apply. Remember, our role as a Commonwealth body is obviously limited by the constraints under the Constitution.

Senator REYNOLDS: I understand that, but I think it is safe to say that women with sexual dysfunction problems do not just reside in Western Australia. If there is a medication that has been produced there for many years that has so far proved to be very safe—

Dr Skerritt: Again, Senator, as I have said in the case of medicinal cannabis products and so on, it is open to a company to submit a dossier. There is detailed information on our website—indeed, we can provide it through our regulatory assistance people—on how to submit an application for a medicine.

Senator REYNOLDS: I would just like to clarify. I understand that that is the process, but there is no draft guideline or guidelines for women. The FDA have issued draft guidelines for women, because this is not a problem just for women in Australia; it is a problem for women internationally. There are now draft guidelines out for the FDA.

Dr Skerritt: We do not have to wait until there is a specific guideline. We have some medicines for some fairly weird and wonderful things. Each product is assessed on its merits.

Senator REYNOLDS: Are you saying that this is a weird and wonderful thing?

Dr Skerritt: No. We have medicines for some very rare and unusual conditions for which no-one has ever written a condition.

Senator REYNOLDS: I think this is part of the problem, that blokes assessing these for women—

Dr Skerritt: But we can still assess it.

Senator SINGH: It sounds very unfair—

CHAIR: Order!

Dr Skerritt: We do not have any guideline. We would very much welcome an application from this company, and it is welcome to pick up the phone and talk to us.

Senator REYNOLDS: I understand that the company has not—maybe you could take this on notice.

Dr Skerritt: We will.

Senator REYNOLDS: I understand that the company has gone through a number of rounds of processes with the TGA, and something happens and then it has to go right back to the beginning again. If you could take that on notice—

Dr Skerritt: We will take it on notice.

Senator REYNOLDS: I think the women of Australia would be very happy with you. Thank you. Now I would like to move on to my perennial question about e-cigarettes. I will leave some of the questions for Senator Griff, and I am sure that Senator Leyonhjelm will be back about it as well. Since we last traversed this subject, I notice that New Zealand has now introduced legislation and, I think, some very sensible guidelines about this. They say:

Scientific evidence on the safety of e-cigarettes is still developing but there's a … consensus that vaping is much less harmful than smoking.

The—

New Zealand—

Government is taking a cautious approach by aligning the regulations around vaping with those for cigarettes. This ensures cigarette smokers have access to a lower-risk alternative while—

continuing—

to discourage people from smoking …

They have very strict guidelines, but they are using this as part of their goal to have a smoke-free New Zealand by 2015.

Mr Bowles: I think it is 2025.

Senator REYNOLDS: 2025, yes. I'm going back to the future! Thank you very much, Secretary. Every time we have estimates, it just seems that there is another country now that is doing more work on this and is adopting a similar position, so I am just wondering if you could advise this committee whether we are getting any closer to looking at this a bit further.

Dr Skerritt: The secretary can give us an update on the WHO because he has just returned very recently from the WHO World Health Assembly. I would draw the senators' attention to some of the recent Australian statements on it, given that we are in Australia. Professor Kelso, the Chief Executive Officer of the NHMRC, issued a statement updating an earlier NHMRC statement. It said:

There is currently insufficient evidence to conclude whether e-cigarettes can benefit—

Senator REYNOLDS: With respect, Professor Skerritt, I have seen a lot of the Australian statements. The point of my question is that we get Australian experts who reinforce each other saying that this is a bad thing and we cannot look at it, but there is progressive and increasing evidence from overseas. To me—just to me—it just seems that we are very closed to what is happening overseas.

Mr Bowles: I could probably give you some update, yes. I have just returned from the assembly. At that, I meet with some like-minded countries around tobacco control. Of the seven countries, I think, which have this conversation, New Zealand is the only one that has moved in that direction. Most are still in the same place that we are. Those are the UK, New Zealand, Canada and a range of other countries. They are still in that space of concern. While there is probably thinking that vaping, as long it is not using nicotine in a normal form, is better than smoking, there is still a lot of concern about it. Most countries have actually extended their smoking bans to vaping in all public places as well. So there is not a lot of movement internationally. There is some. I think this is one of those things that are going to bounce around for the next couple of years.

Senator REYNOLDS: I have just come back from the UK, and it was very obvious there. There were a lot of people vaping, but there are also a lot of people in Australia who are now vaping. Given that there is not a position on it, (1) we are losing tax revenue, and (2) are they breaking the law? How are they actually getting it in here? It is being sold freely and people are using it quite openly. It just seems that there is a bit of a mismatch here.

Dr Skerritt: They are breaking the law if it contains nicotine, in most states. In some states, they are breaking the law if the thing resembles a cigarette, even without nicotine. I just want to put on the record what I may have put on the record at earlier estimates, and that is that we would very much welcome an application for one or more e-cigarettes for smoking cessation, in the same way that we have reviewed and approved applications for chewing gums, for sprays, for lozenges and for other products for smoking cessation. There is absolutely nothing stopping a company with a dossier of evidence. We are going on hearsay, but, if a company can submit evidence, they could be the first company in the market with an e-cigarette for smoking cessation. That avenue is open to them.

Senator REYNOLDS: Nobody has actually put an application in?

Dr Skerritt: We cannot confirm or deny whether companies have put applications in for any prescription medicine. It is a longstanding practice.

Senator REYNOLDS: While you cannot confirm or deny, your previous statement sounded very much to me like you were saying, 'Someone, anyone, put an application in, because we haven't got one yet.' So you may or may not have had applications, and, if you have, they have not been approved. They have not met the standard.

Dr Skerritt: I would not want to speculate down that line. But, again, I would very much welcome a decent dossier of evidence and a submission of an e-cigarette product for smoking cessation—accompanied by robust enough evidence for a registered medicine that the product is suitable for use in smoking cessation. Even though you might buy your lozenges and chewing gums in Woolworths and Coles, they have still been through the TGA's medicines evaluation process for smoking cessation.

Senator REYNOLDS: Thank you. I think you could work for our security agencies, Professor; you are so oblique. But I have got your point, thank you. I am not trying to make fun of it. Thank you. That was very discreet.

I have one final question. I would just like to come back to the issue of medicinal marijuana and some of the discussions you had with Senator Leyonhjelm and Senator Di Natale. I just want to ask you a bit further about the Greens disallowance motion and what you think—or maybe not, sorry.

Dr Skerritt: No, no.

Senator REYNOLDS: Of course, you are not asked for personal opinions, but what would the outcome of the recent Greens disallowance motion have been from a departmental perspective?

Dr Skerritt: Senior bureaucrats do not have opinions.

Senator REYNOLDS: No.

Dr Skerritt: I can only comment on what the practical outcomes in law would have been, and that was precisely the sort of thing we were asked to brief on. There would have been three outcomes. First, imported products would have been available through the Special Access Scheme A system. Second, there would not have been any Commonwealth controls on extemporaneous compounding of medicinal cannabis products. That sounds a bit obscure. That is where pharmacists compound products. While most pharmacists are honourable people, there have been significant problems with the compounding of certain substances, be they hormones, peptides and so forth. The third implication which I talked about before the recess relates to the fact that it would have opened medicinal cannabis products up for personal importation, and the challenges it has—

Senator Reynolds: Yes. How does that—

Dr Skerritt: It is because many of the dose forms are not defined tablets or capsules. It could have been raw leaf coming in, and it is very hard to know whether a kilogram or 20 kilograms is the right amount for three months supply.

Senator REYNOLDS: Between those three potential consequences, are there law enforcement or border control implications for that?

Dr Skerritt: There would have been border control implications for all three, but particularly the personal importation. The potential disallowance was well known. As you know, it was out there for longer than the normal period of time. We had meetings with the states and territories, and they were essentially unanimous in saying: 'We don't want this. It will just create a nightmare at Brisbane airport, Darwin airport or wherever.'

Senator REYNOLDS: So the state and territory governments were supportive of this position?

Dr Skerritt: They were supportive of the position that ended up prevailing. I should say that that was at officials level. We have to be careful when defining governments.

Senator REYNOLDS: But at the officials level they were supportive—

Dr Skerritt: At the senior officials level they were supportive of the changes. They were consulted before the changes to the regulations were made, and they were supportive of the regulations staying as they were following the change.

Senator REYNOLDS: I want to make sure I have got it right. One of the implications of those three issues that you have been talking about this evening is that it would have actually made it harder to control the cannabis being provided in terms of quantity and quality?

Dr Skerritt: Very much so. It was particularly timely because there had been one and possibly a second death in California because of fungally contaminated medicinal cannabis. Also, very recently in Canada, some bright spark decided to use a fungicide that is used for lettuce on medicinal cannabis. You might say, 'So what?' People do not smoke lettuce—well, most people don't. When the fungicide on the cannabis is heated, smoked or vaporised, it breaks down and turns into cyanide. Some millions of dollars of medicinal cannabis had to be recalled and destroyed in Canada when this was discovered.

Senator REYNOLDS: Like any other medication that you get, you need to be able to control the dosage so you know exactly how much and what you are getting.

Dr Skerritt: And the quality. The view of the government, and I think it was echoed across people who spoke to the bill in February 2016, was firstly that this would be a medicine prescribed by doctors and dispensed by pharmacists and would be produced to certain quality standards. That was the whole advantage of a medicinal cannabis pathway versus a grow-your-own or get-it-through-the-black-market pathway.

Senator REYNOLDS: Thank you.

CHAIR: Thank you very much, Senator Reynolds. Senator Rhiannon.

Senator RHIANNON: I have some questions about cosmetic testing on animals. Will the ban on the use of animal testing data for cosmetics, as announced in the budget, apply to both products and ingredients?

Mr Cormack: I will start this one off. It applies to ingredients that would be used within cosmetics.

Senator RHIANNON: Thank you. Will the legislation to implement the ban only apply to ingredients to be used exclusively for cosmetics or will it also apply to all newly tested ingredients introduced for use in cosmetics irrespective of their other uses?

Mr Cormack: I might just ask my colleague Jillian Shaw to field that one.

Ms Shaw: The intention is to align Australia's regulation in this space with how the Europeans regulate cosmetic ingredients.

Senator RHIANNON: It sounds like the answer to my question was yes, that it will be all-encompassing in terms of ingredients. It will not be just ingredients used exclusively for cosmetics; it could be newly tested ingredients that may have been initially developed for other purposes and are now being used for cosmetics. Is that fair to say?

Ms Shaw: Could you repeat your question?

Senator RHIANNON: Will the legislation to implement the ban only apply to ingredients to be used exclusively for cosmetics or will it also apply to all newly tested ingredients introduced for use in cosmetics irrespective of their other uses?

Mr Cormack: The advice I have is that the legislation enables a national ban on the use of new animal test data to support the introduction of chemicals used exclusively as cosmetic ingredients. That will be introduced into parliament as part of broader reforms to industrial chemicals regulation.

Senator RHIANNON: I will look closely at the wording. Thank you. I notice the cosmetics industry has long stated that cosmetics testing on animals in Australia ended 30 years ago, with that testing now occurring overseas. Will Australian or overseas cosmetics companies still be allowed to animal-test their ingredients or finish products overseas for importation into Australia under this measure?

Ms Shaw: In terms of meeting Australian regulatory requirements under the new regulatory scheme that has been put forward, if the animal testing is occurring after 1 July 2018, no, they will not be able to do that.

Senator RHIANNON: Does that mean that this does ban the importation and sale of finished cosmetic products or their ingredients that use new animal testing data?

Ms Shaw: I think it is important to recognise a distinction between what Australia's regulatory scheme can do in terms of product versus ingredient. Within the Australian regulatory environment, we regulate ingredients; we do not regulate the product. So, from that perspective, from 1 July 2018, an introducer cannot introduce an ingredient in a cosmetic-only related context, if you like. They cannot use animal-test derived data to support the introduction.

Senator RHIANNON: I am still coming to grips with this. Does this ban the use of new animal-testing data from overseas to manufacture, develop or sell cosmetics products?

Ms Shaw: Yes. The majority of imported ingredients come from overseas. From 1 July 2018, that will be the case for a cosmetic-only ingredient.

Senator RHIANNON: So it means the ban applies to Australian and imported products?

Ms Shaw: Yes, if that introducer wishes to introduce an ingredient to Australia. But this is an Australian law that cannot have impact internationally.

Senator RHIANNON: Just to be really clear, I would like to ask this: will the use of new animal-tested data be banned in the manufacture of cosmetics ingredients and finished cosmetics products?

Ms Shaw: Again, I think it is really important to draw a distinction about what Australia's regulatory scheme can do. It is about ingredients and not about banning the end product. But, through the ingredients, it, therefore, in effect, affects the product. But we do not regulate the cosmetic product in Australia.

Senator RHIANNON: I am certainly not trying to verbal you. I am trying to understand this. Is it fair to say that it is effectively a ban on the final cosmetics because all the ingredients are captured under the ban?

Ms Shaw: I think the way that we look at the policy is: it delivers the outcome. Technically, it is not banning the product, but it is banning the ingredient that goes in that product.

Senator RHIANNON: So, therefore, the use of the new animal-tested data can be banned in research and the development of ingredients—is that correct?

Ms Shaw: If it is covered by our scheme. For example, there are a lot of regulatory schemes that exist within the Australian context. Industrial chemicals are defined in the scheme because they do not fit anywhere else. For example, there might be agvet chemicals that fit into that scheme. Therapeutics, as Dr Skerritt just outlined, would fit into that scheme.

If they do not fit into any of those schemes, they actually then end up in the industrial chemical scheme, which is actually where cosmetic ingredients then sit.

Senator RHIANNON: I want to go to the voluntary industry code of practice. Will animal-test-free labels clearly apply to ingredients and finished products?

Mr Cormack: The approach that the government proposes is to work with the cosmetics industry, in consultation with key animal welfare stakeholders, to develop a voluntary code of practice on the sale of cosmetic products after the introduction of the ban. That will include an information package for consumers and industry around the promotional claims that can or cannot be made on cosmetic products in relation to the ban. So this is yet to be developed. If will just highlight the three elements of this package. First up, there is a testing ban. The Australian government will work with states and territories to incorporate a testing ban through their respective legislation triggered by changes to the NHMRC's animal ethics code. It is expected that that will be finished by the end of 2018. The second element is the voluntary code that we have just talked about. The third element is the legislative piece that enables a national ban on the use of new animal-test data to support the introduction of chemicals used exclusively as cosmetic ingredients. They are the three elements of the package. The industry code, as the name suggests, is one that we will work through in consultation with industry.

Senator RHIANNON: Probably, the main area of concern that has been raised with us is the word 'voluntary'. You have gone through three aspects. Does one lead to the other or does the voluntary standing remain? Do the three aspects all live together and the voluntary aspect is on an ongoing basis or does it lead to a point where the voluntary aspect is no longer the case?

Mr Cormack: No, what we are saying is that there is a package. I have outlined the three elements of the package. That is the government's proposed approach to ban cosmetic testing on animals. As the name suggests, it is a voluntary code of practice that is developed with industry to ensure that the sale of cosmetic products after the introduction of the band comply. And there is provision of information to consumers, so that they are fully aware. At the moment, as you would certainly be aware, there can be a range of claims you can put on the label. You can say 'ethical'. You can say 'essential', 'natural' or something that like that does not really have any meaning. This part of the package is to ensure that there is a consistent nomenclature that describes the way that the cosmetics comply with this important measure to implement a ban on cosmetic testing on animals.

Senator RHIANNON: Can you confirm that misleading cosmetics labels falsely claiming to be animal testing free cannot be penalised under any intended legislative instruments?

Mr Cormack: That becomes an ACCC matter. Any claim that is false and misleading, about the nature of any good or service sold, would come under that legislation.

Senator RHIANNON: Does that set out legislative penalties?

Mr Cormack: I am not familiar with the precise nature of the legislative penalties for the different offences. They have their piece of legislation and they are responsible for prosecuting against that. The question would best be put to the ACCC.

Senator RHIANNON: I think that you have probably covered it, but I noticed that there were the two announcements. There was one in the budget and there was one in MYEFO. I

will check about the MYEFO announcement. Will Australian companies be banned from manufacturing, developing, importing or selling animal tested cosmetic products, or ingredients, under the last MYEFO announcement that set out a ban on the sale of cruel cosmetics?

Mr Cormack: What we have said today covers the lot, and that is the way the government proposes to deal with that issue and to implement their election commitment.

Senator RHIANNON: What about the advertising for sale of these products via the internet. Will what you are doing also capture that?

Mr Cormack: I will take that question on notice, specifically in relation to that aspect of it.

Senator GRIFF: I am going to ask about the Electronic Nicotine Delivery Systems or ENDS. There are a growing number of countries, including the UK, that have a two-track regulatory system in place where ENDS can be sold as either a consumer produce or gain approval as a therapeutic good. I think you have indicated that you would be keen to receive an application for a therapeutic good, but what is your position on a two-track system—putting something like that in place?

Dr Skerritt: Again, I can only comment on my own regulatory system and these products have the option of coming through TGA as a therapeutic good. It is for the state and territories. Again, this is a case where states and territories, and the Commonwealth, have an involvement in deciding if it is appropriate to have a second track system. But it would not be under the purview of the TGA, or, probably, the health department writ large.

Senator GRIFF: If you did receive an application for a therapeutic good would it be treated in the same way as gum and other products?

Dr Skerritt: The essential evidence of showing efficacy, that there is a significant and sustained reduction in smoking cessation and evidence of harm—

I should add that while these products have often been touted as harmless, it is quite important to note that just recently the ACCC successfully prosecuted a number of companies for making a claim of that sort. They found a number of harmful substances in non-nicotine-containing e-cigarettes. We would, as we would for any device or medicine, look at the balance of benefits and harms, and some of those harms would relate to the nicotine but some of the harms might relate to other things in the e-cigarettes depending on what the composition was.

Senator GRIFF: Would you require long-term safety data?

Dr Skerritt: Generally for products we require long-term safety data. How long long-term use is is discussed with the applicant and it depends on the nature of the type of product.

Senator GRIFF: Do you require that with the gum and other equivalent products?

Dr Skerritt: When those products were assessed by TGA, going back some stage, there was safety data over a period. I would have to take on notice how long term long-term was for those products. But, superficially, a smoking cessation product would be assessed. Obviously you want the effect to be both sustained, but you also do not want harm to appear in the longer term. It was some years ago that some of those gums and patches were assessed by

TGA, but certainly we could take on notice the sort of toxicology and long-term safety studies that were required.

Senator GRIFF: That would be good on those. Thank you.

[20:36]

CHAIR: We will now move to program 5.3, Immunisation.

Mr Bowles: I will get everyone to the table.

Senator REYNOLDS: Just while we are moving, I have a question or two on Lyme disease. What program does that fit in, or have we gone past it?

Senator SINGH: I think we have missed that.

Senator REYNOLDS: I saw we had the CMO here. While we are changing, can I ask a quick question?

CHAIR: Very quick.

Senator REYNOLDS: The committee report was delivered in November last year. I wonder whether you have an update for us on progress on the recommendations since that time. All of us on that particular inquiry get daily calls from those people the committee heard from.

Prof. Murphy: The department has prepared its response and signed a consideration by government. We would be hopeful that the government response could be tabled—really, it is a decision of government about when it is going to be tabled. But we have certainly provided extensive input into our response and we have drafted that.

Senator REYNOLDS: I have to give the minister's office a call.

Prof. Murphy: Yes.

CHAIR: Thank you, Professor, for waiting all day for that question.

Senator REYNOLDS: If there is anything more!

CHAIR: No, that was not an invitation.

Senator SINGH: I want to ask about meningococcal vaccines, which I asked about in February estimates as well. Could you provide us with an update on when Bexsero vaccine will be available.

Prof. Murphy: Bexsero vaccine is the vaccine against meningococcus type B. It has been put to the PBAC for consideration under the national immunisation program on three occasions, and on each of those occasions it failed to meet the effectiveness criteria of the PBAC and it was rejected. The main reason for that is there has, to date, been no real data on the effect of this vaccine on reduction of carriage. The challenge with meningococcus is that five to 25 per cent of us carry meningococcus bugs. So plenty of us in this room will have meningococcus bugs. The most effective immunisation strategy is to prevent carriage—so transmission from one individual to another—and there is no data on Bexsero in preventing carriage.

There is a carriage study being undertaken at the moment in South Australia with the company. There has been some recent data from the UK on the effectiveness of this vaccine in preventing meningococcal meningitis in infants. That is really the first data that has shown that it did seem to reduce the incidence of the disease in infants in the UK.

At the moment, for the vaccine to be put on the National Immunisation Program under the National Health Act, the companies have to reapply to the PBAC for another listing. The company has indicated that, at present, they do not feel that they have the evidence to put back an application in the near future and they are also facing a significant international shortage of the vaccine which is still not resolved. So we do not have any information. The single supplier of GSK have indicated to us in a recent meeting that they do not intend to reapply to the PBAC in the near future.

Senator SINGH: When was the last time the vaccine was considered by PBAC?

Mr Bowles: Professor Skerritt might be able to help.

Dr Skerritt: I will not get into PBAC consideration, but I wanted to give you an update on the shortage of Bexsero with some information as recent as about four or five hours ago. On 11 or 12 May GSK announced that 200,000 additional doses of the vaccine were going to be shipped to Australia. As you know, this has been an on-and-off shortage for several months. I am pleased to announce that two lots of those arrived on 16 May, one arrived last Thursday and one arrived—at least with us; when I say arrived, it could have arrived at Sydney or Melbourne airports earlier—literally today at morning tea time. We have to do a thing known as batch release for vaccines to check that they are still in good shape. We have provided batch release within a few days for the ones that arrived on 16 May. The first two lots of 200,000 in total are now released, so they can be provided for the private market. Again, I should not prejudge outcomes of testing and checking, but, all going well, the batch release for the other two batches will be done in the next few days. That means the shortage will alleviate itself in early June.

Senator SINGH: So can you guarantee the supply issues will be resolved then?

Dr Skerritt: I cannot guarantee supply and demand. It is not for us to determine the number of patients that request a product, and there are no powers within the Therapeutic Goods Act that guarantee supply of medicines or vaccines.

Senator SINGH: Are you concerned that parents are able to buy one dose of the vaccine but then are not able to buy subsequent doses?

Dr Skerritt: This is why 200,000 extra doses of the vaccine are coming into Australia. The company has also announced that, because of unprecedented global demand, they are spending $175 million to build a second plant to manufacture this vaccine in Germany to service worldwide demand. This problem with demand—and I think at last estimates I talked about this product being manufactured 24/7—is that it has significantly exceeded supply. We would hope that the construction of this new $175 million plant will help alleviate that, but we have no powers in the Therapeutic Goods Act that can force a company to supply medicine or a vaccine.

Senator SINGH: I go back to the PBAC. Professor Murphy, when was the last time Bexsero vaccine was considered by the PBAC?

Prof. Murphy: We will take that on notice, but we think it was late 2015. I should point out that the incidence of meningococcal B last year was the lowest it has been in probably 20 years. There were only 92 cases in the whole of Australia, and in fact it has been steadily dropping from a 2001 peak of nearly 300 cases to 92 cases last year despite the absence of a vaccine on the National Immunisation Program. Our actual concern is more about

meningococcal W, which has been increasing in recent times and last year was more prevalent than meningococcal B.

Senator SINGH: Has the government been in contact with the supplier of Bexsero?—I guess that is GSK—

Prof. Murphy: Yes, we had a meeting with GSK—

Senator SINGH: about submitting a new application?

Prof. Murphy: We had a meeting with them several weeks ago, and they said that they did not feel that they were in a position in the near future to submit another application, because they wanted to gather more evidence of efficacy and carriage.

Senator SINGH: So this is about a shortage of data.

Prof. Murphy: A shortage of data, yes. There is also a cost-effectiveness consideration that the PBAC puts over any vaccine application, and that reflects the number of cases, the cost of the vaccine and the likely impact it reducing cases. So there is a cost-effectiveness and an efficacy line to it as well.

Senator SINGH: It is also about the carriage of the bacteria and the projected herd immunity effect.

Prof. Murphy: Yes. All of that is part of the valuation. It is unlike almost any other vaccine-preventable disease in that the vast majority of people who carry the bacterium never get the disease. It is only a very small number of people who actually get the invasive disease

Senator SINGH: Is the department aware of any proposals to look at some kind of carriage study to fill the gap?

Prof. Murphy: There is a carriage study being undertaken in South Australia. I think it started just recently. The company is actually funding that. They are doing a study in South Australia to examine that question exactly.

Senator SINGH: Has the government been in contact with the supplier about the meningococcal ACWY vaccine.

Prof. Murphy: There are three supplies of ACWY, one of which is GSK. There are two others. There is significant interest about submitting to the PBAC. We have not yet received any application, but there is certainly interest in submitting an application probably this year.

Senator SINGH: So you do not know when supply with be restored for that vaccine.

Prof. Murphy: That vaccine's supply is restored in the private market already. There is sufficient supply of that vaccine for the private market, but consideration for the National Immunisation Program will require a PBAC submission and then a whole review of the immunisation schedule, because we would have to take out the C, which is one of the ACWY components. It is already in our National Immunisation Program in infancy, and that would have to be replaced with a quadrivalent. So there is quite a complex re-analysis of the immunisation schedule.

Senator SINGH: Okay. Have either the ACWY or the B vaccine been recommended by the Australian Technical Advisory Group on Immunisation?

Prof. Murphy: The Australian technical advisory group considered the increase in W cases last year and they suggested that one way to address the rise in instance of

meningococcal W was to consider a vaccination program targeting adolescents in whom the carriage is most prevalent. Again, we cannot put that under the National Immunisation Program under the National Health Act without a company's submission, but, as is sometimes the case when the National Immunisation Program consideration is still pending, most of the states have started to initiate such a program in adolescents. I think Western Australia, Queensland, New South Wales and Victoria have already started a program. A similar thing happened with the maternal pertussis vaccine. Whilst the PBAC process was pending, the states started their own program.

Senator SINGH: What powers does the minister have to add a vaccine to the immunisation register?

Prof. Murphy: The national immunisation register legislation requires a PBAC process.

Senator SINGH: But what if there is not a positive PBAC recommendation?

Prof. Murphy: There is currently no power under the act to do it. If there is a national health emergency—

Senator SINGH: That is kind of what I was getting at.

Prof. Murphy: If we have an epidemic of swine flu or something with thousands of cases, there are emergency powers, but that requires quite a lot, including the Governor-General. Perhaps Sharon Appleyard can describe those emergency situations, but it is quite complicated.

Ms Appleyard: Under the emergency powers, the department could recommend to the minister that a vaccination program be approved in response to a particular disease. As Professor Murphy outlined, though, a case would have to be made for the need for that, especially since it would be circumventing the PBAC process, and it would have to be based on the severity of the disease, the transmissibility of the disease and the fact that it actually was a public health emergency.

Senator SINGH: Under the act that can happen?

Ms Appleyard: It is not under the pharmaceutical benefits act; it is under the Biosecurity Act, and there are powers that can be exercised.

Senator SINGH: And that is regardless of there being an application before the PBAC—

Ms Appleyard: That is correct.

Senator SINGH: or a supplier making an application?

Prof. Murphy: Correct.

Senator SINGH: In the case of a public health emergency such as an outbreak of meningococcal, do the department or the minister have any authority to make that vaccine—like the ones we were just talking about—available under the National Immunisation Program?

Prof. Murphy: It would not be under the National Immunisation Program. We would be making an emergency vaccination program. To be put into the National Immunisation Program as a regular, long-term vaccination, it needs to go through the PBAC process. What we are talking about is a situation where there is an emergency where we need to vaccinate a lot of the population quickly to deal with the emergency. That is a different situation to this.

Senator SINGH: So there is a thing called an emergency?

Prof. Murphy: Under the Biosecurity Act.

Ms Appleyard: Yes. The Biosecurity Act relates to what is called listed human diseases, but there may also be other diseases that are not listed human diseases that would be considered serious enough by the minister to warrant an emergency vaccination response, so the minister would have that authority.

Senator SINGH: I want to move to No Jab, No Pay. From 1 January last year, an additional $6 incentive payment was made available to vaccination providers and GPs who followed up and vaccinated children who were more than two months overdue for their childhood vaccinations. How many payments have been made?

Ms Appleyard: We will have to take that question on notice.

Senator SINGH: How long are these payments continuing for?

Ms Somi: That is an ongoing program, so the payments are ongoing.

Senator SINGH: So there has been no decision made to stop the payments at a certain date?

Ms Somi: No.

Senator SINGH: There is nothing in the budget that says, 'We'll keep paying until a certain date and then stop'?

Ms Somi: No. The program is ongoing.

Senator SINGH: How will the National Immunisation Program catch-up measures announced in the budget be delivered?

Ms Somi: The program basically enables children 10 to 19 to access catch-up vaccines. That would be primarily through general practices. Local councils also run immunisation clinics, and community health centres et cetera. It is through the existing service delivery mechanism that is provided through the states and territories.

Senator SINGH: But it is only up to the age of 19?

Ms Somi: It is up to the age of 19 for all Australian children, and then for refugees and humanitarian entrants it is a program for all ages.

Senator SINGH: Are pockets of low coverage prioritised?

Ms Somi: We work really closely with the states to look at low-coverage areas and undertake a range of activities to try and improve coverage rates in those areas.

Senator SINGH: How do you address specific community needs and issues, including inequities, which obviously create barriers to accessing the immunisation?

Ms Somi: Do you mean how do we look at different local—

Senator SINGH: Yes. Do you have approaches tailored to certain communities and so on?

Ms Somi: States work really closely with their public health units and with GPs and other experts to try and understand the needs in local areas and then to tailor programs work for those areas. For example, the Byron Bay area has very low coverage rates, and the New South Wales government works really closely with NGOs and the Primary Health Networks in those

areas to try and look at local solutions that will help encourage parents to vaccinate their children.

Prof. Murphy: I should point out that the government has also recently announced a $5½ million education program, which is starting this month and which will continue over the next two financial years, to target misinformation on immunisation, particularly targeting childhood information and correcting some of the misconceptions people have. You have to have a number of approaches to get at people who are vaccine hesitant. We think the majority of people are more vaccine hesitant than directly antivaxxer, and we need to have a lot of strategies to get at them and to deal with their anxiety. We hope that program will have a significant impact as well.

Senator SINGH: Does that include posters and things like that?

Prof. Murphy: There are a range of initiatives, including social media—probably using conventional media as well, but social media will be a strong element of it—because it is very clear that is where a lot of these communities get their misinformation. We are going to try to address that with real information.

Senator SINGH: Professor Murphy, you will have to send me one and I will send it to Senator Hanson's office.

Prof. Murphy: We will be delighted to do that when we have produced something.

Senator SINGH: What measures are in place for catch-up vaccinations for children below the 10 to 19 age range?

Ms Somi: The new measure extended the existing catch-up program. Under the current arrangements, all children up to nine are able to access catch-up vaccines. This just takes it up to 19.

Senator SINGH: What percentage of currently unvaccinated 10- to 19-year-olds are expected to have completed catch-up schedules by the end of the program?

Ms Somi: Can I take that on notice? We did do some calculations to try to estimate the number of children we expected to take up the catch-up program. It is a little bit complicated because we anticipate there will be some children who might be missing one vaccine; whereas other children may not have received any vaccines at all. It is a little bit complicated. We have not done a lot of work in this 10 to 19 age group, so we know we need to do some research to better understand their needs.

Senator SINGH: When does the catch-up program conclude?

Ms Somi: It is an ongoing program.

Senator SINGH: I thought it was only ongoing for refugees.

Ms Somi: For refugees and humanitarian entrants it covers people of all ages.

Senator SINGH: But this program is ongoing?

Ms Somi: Yes, it is ongoing both for refugees and for adolescents.

[20:57]

CHAIR: We will now move to outcome 1: health system policy, design and innovation. We will go to program 1.1: health policy and analysis.

Senator SINGH: I want to ask about the Medical Research Future Fund. The budget includes the first disbursements from this fund. What was the process for deciding upon those disbursements? Was there a call for applications? Who were the decision makers?

Mr Cormack: Under the Medical Research Future Fund Act, the Australian Medical Research Advisory Board is required to do two things. The first is to develop a five-year Australian medical research and innovation strategy, plus a set of priorities with a two-year duration. That was the foundation work, and the Australian Medical Research Advisory Board produced that work and it was tabled in parliament in November 2016. In accordance with that, the Australian government is required to take those priorities into consideration when making funding decisions for MRFF disbursements. The disbursements were announced, in the main, on budget night. There are still a couple of activities that have not been formally announced, but the overall scope of funding and the range of projects to be funded under that out of the first year have been made in accordance with what the act requires.

Senator SINGH: Yes, but I was asking about the process. Did you call for applications?

Mr Cormack: The legislation does not require a call for applications.

Senator SINGH: So who were the decision-makers?

Mr Cormack: In essence, ministers sought advice, consistent with the priorities and the strategy.

Senator SINGH: So the minister was the decision-maker?

Mr Cormack: The minister, under the act, takes measures through cabinet. That is what has been undertaken. But I have to say a number of the measures—a number of the projects—require a subsequent process. I will ask one of my colleagues to join me to perhaps talk through some of the issues with these measures, but a number of the projects that were announced on budget night will require involvement by the NHMRC. Indeed, a number of the measures—in particular the Advanced Health Research and Translation Centres—are in fact funding newly established, newly accredited organisations that the NHMRC has set up to receive funding for the rapid translation of medical research. So, in that sense, there is already an open, contestable platform for a number of the measures that have been established. But I might just ask either Graeme Barden or Erica Kneipp to talk through them in some detail.

Ms Kneipp: The announcement on budget night of $65.9 million includes eight strategic programs. As Deputy Secretary Cormack said, there are a range of different approaches to granting that money under those programs. The MRFF Act allows some flexibility as to how the disbursements can be administered. It can use the expertise and skills of the National Health and Medical Research Council, which it is going to do for the clinical trials registry grant program, as well as the clinical research fellowships, as well as the targeted call for antimicrobial research. It can also directly fund other Commonwealth entities, states or territories, or institutions that operate competitive approaches and respond to competitive approaches to market.

On the whole, whoever the MRFF identifies as an administering entity, it will use a range of mechanisms for funding specific projects. That will include, where appropriate, an open competitive process or a merit based peer review situation. So there was no open call, although, in the lead-up to developing the strategy and the priorities, the Australian Medical Research Advisory Board did a public call for submissions. That happened in May 2016, and

there were over 300 responses. Then, after that submission closed, they did a national tour where they conducted open forums, roundtables, engagements with state governments and the like to inform their deliberations on the strategy and the priorities.

Senator SINGH: So is this a separate kind of process for the MRFF, or is it part of the normal regular budget process?

Mr Cormack: This is the first disbursement from the MRFF, and the act allows for the minister to bring forward in the budget process—or indeed any time, really, provided there is money available—proposals for consideration by cabinet. That is what happened on this occasion. You will see in the budget papers that there is $1.43 billion in disbursements—

Senator SINGH: Yes, we will get to that.

Mr Cormack: available over the coming years. The minister will no doubt bring forward measures in future.

Senator SINGH: The MRFF measure says these disbursements 'will be consistent with the Australian Medical Research and Innovation Priorities 2016-18, which have been identified by the Australian Medical Research Advisory Board'.

Mr Cormack: That is right.

Senator SINGH: So did the board specifically recommend these disbursements?

Mr Cormack: No, it is not the role of the board. Under the act, the—

Senator SINGH: So the government identified them?

Mr Cormack: No. There is a very important context, Senator. The board is required to develop a strategy which lasts for five years and priorities which last for two years. They have completed all that, as Ms Kneipp said. They were tabled in parliament and, if you like, they are the benchmark against which the measures that the minister brings forward in the budget process can be assessed. Those priorities and the strategy were the subject of extensive national consultation and calls for submissions. The priorities, of course, in the very near future will be refreshed because they are required to be refreshed every two years, so that makes sure that the benchmark or the guiding documents for government are informed by an ongoing independent process to identify the priorities that pertain at that point in time, consistent with the objects of the legislation.

Senator SINGH: Okay. There is not a lot of detail in the budget papers on the disbursements. That is why I am asking these questions. If you could give a more detailed breakdown of the projects—

Mr Cormack: Sure.

Senator SINGH: by project.

Ms Kneipp: There is a fact sheet on the health department website for each of the announced measures.

Mr Cormack: Is there any one in particular you would like to—

CHAIR: Would you be able to table those for us?

Ms Kneipp: Yes.

Senator SINGH: How did you settle on the dollar figures for the disbursements? If you were not thinking about which projects they would fund, how did you get to the dollar figures for each of those?

Mr Cormack: We work backwards from what is available. In 2016-17, there was a figure of $60.9 million available, and, over the forward estimates, considerably more than that. So, broadly, the government had a relatively modest amount of money available, and they took advice from a range of sources, including the department, and obviously took guidance from the priorities and strategies and were able to shape a range of measures that ensured a series of, I guess, quick wins. I draw your attention to the Advanced Health Research Translation Centres. They have been established just recently by the NHMRC. Indeed, the measures around the next generation of clinical researchers, which are fellowships, can be deployed very, very quickly, using the NHMRC's well-established processes for finding the best researchers to be able to support through this kind of funding.

So it was really looking at the strategy, the priorities, what could be deployed fairly rapidly, noting that the life cycle and the journey for the MRFF as a program has many years to run. It will grow in size, consistent with the disbursements, and it can also take account of other priorities in the legislation around alignment, overall innovation and science priorities for the nation.

This is a starting point, and the government will no doubt seek further advice from the department, from the research community and from other research bodies to inform the next round of disbursements.

Senator SINGH: Did that include funding for global medical research as a priority?

Mr Cormack: I will ask Ms Kneipp to specifically reference that, but there is a measure in here that looks at national security against pandemic risk and tackling AMR. Ms Kneipp, could you just outline that for us, please.

Ms Kneipp: Some of these measures will have international collaboration elements to them, as they roll out, but two in particular that deal with global health challenges. One is a $2 million contribution to the Coalition for Epidemic Preparedness Innovations, known as CEPI—still have to do a fact sheet on that one, to be honest—and the other one is stimulation of research, the effect of $5.9 million for antimicrobial resistance, which is a global health challenge.

Mr Cormack: We may hear from the NHMRC later on, but the nature of health and medical research is that it is a global business. All the best researchers are collaborating nationally and internationally and that is implied, certainly within all of the work that is a subject of these—

Senator SINGH: But I am interested in global diseases, like TB, which is an ongoing and growing problem in our region, particularly in PNG and Indonesia. There has been a lot of medical research into new ways of treating these diseases. I want to know where something like that fits into this fund.

Mr Cormack: It potentially could. Certainly, the priorities and the strategies allow for that and there is no reason why those sorts of measures could not be considered by government in subsequent rounds of the MRFF.

Prof. Murphy: Even then, microbial resistance is highly relevant to TB. It is one of the biggest challenges in the TB field and it is quite possible that that area of research funding could be targeting TB, as well as other areas.

Senator SINGH: So it would definitely fit within this fund?

Ms Kneipp: I would remind you, too, that clinical trials and registries grant program would be an open program targeting burden and unmet need, amongst other things. Anyone doing work in that space would be welcome to apply.

Senator SINGH: The government promised that the MRFF would disperse $1 billion a year, but the budget papers show that will not happen over the next five years. When will it happen?

Ms Kneipp: The capital accumulation of the Medical Research Future Fund is on target to reach its $20 billion capital base in 2021.

Senator SINGH: As you probably are aware, since the budget some stakeholders have raised concerns that the MRFF will never disburse $1 billion a year. Can you guarantee that it will?

Mr Cormack: It is not the job of the department to guarantee what happens in budgets out into the future, but what we can say is that 2016-17 is $61 million, going up to $642 million in the final year of the forward estimates. I think that demonstrates a pretty good trajectory towards a target of $1 billion per year. So, over four years we will be roughly two thirds of the way to that figure.

Senator SINGH: The budget papers repeat the government's claim that the MRFF will eventually be worth $20 billion, but they do not mention the $1 billion a year in disbursements. Why is that? Why is there a backing away from that?

Mr Cormack: The actual management of the fund is done by the Future Fund and that is not something the department controls. What the minister has access to is the annual disbursements from the Future Fund, the Medical Research Future Fund, and from that the minister is able to bring forward measures. But, as Ms Kneipp has indicated, the advice we have been given, is that in—

Ms Kneipp: 2020-21.

Mr Cormack: —the capital base will reach its target of $20 billion and then it is dependent upon what the prevailing return rate the overall Future Fund is able to generate off a capital base of $20 billion. But the indications are that we will be there on time.

Senator SINGH: The budget papers show that the current balance of the MRFF is $4.4 billion. You are saying that the government will find the $15.6 billion in four years out of the Future Fund?

Mr Cormack: All I can say is what the projected closing balances are, and I will read those to you—$4.6 billion for 2016-17; $6.9 billion in 2017-18; $9.2 billion in 2018-19; $17.2 billion in 2019-20; and $20 billion and a little bit in 2020-21. That is the projected closing balance, which is obviously a combination of credits less disbursements.

Ms Kneipp: And you will find that information in the Department of Finance portfolio budget statements as they are the custodians of the fund and the legislation.

Senator SINGH: The concern is where exactly this $15.6 billion is coming from. Unless the government can outline a credible pathway, shouldn't Australians be worried about further health cuts?

Mr Bowles: No. There is no reason to go down that particular pathway. It is set out in the Department of Finance's budget papers that it will reach there. If you have any questions about that, you should ask of them. We have reported every year that we are on track to meet the $20 billion figure. I have not seen anything that would indicate we are not going to get there.

Senator SINGH: Okay, Mr Bowles, we move on then.

CHAIR: Excellent. Thank you. That concludes program 1.1. We will now move to program 1.2, health innovation and technology.

[21:16]

Senator SINGH: Turning to eHealth—we will wait for the relevant officials to come up.

Mr Bowles: Certainly. We might then need the digital agency at the same time—is that right?

Senator SINGH: We may indeed.

Mr Bowles: We will see where we go with this, but we have the digital agency and the department.

Senator SINGH: Yes. Labor set up the Personally Controlled Electronic Health Record and remains very supportive of that concept. I am a bit concerned by the budget measure on the My Health Record, which I am looking at. What is the net spend on the My Health Record over the next four years?

Mr Madden: For the next two years, we have funding to cover operation of the My Health Record system for next year and the year after plus we have the funding to move the system from opt-in to implement a national opt-out scheme for Australia and to make significant changes to provide a registration scheme. The values of that are $195 million for opt-out, $182 million for the operations across the two years—that is additional to the already appropriated for next year—and $6.8 million for the provider registration redevelopment.

Senator SINGH: Can you answer the question of: what the net spend on My Health Record over the next four years will be—that was the question I just asked you.

Mr Madden: Sure.

Ms Konti: Net spend is $68.7 million over the four years.

Senator SINGH: Thank you. That is spending of $374.2 million minus savings of $305.5 million. Is that correct?

Mr Madden: Could you repeat that, please?

Senator SINGH: Spending of $374.2 million minus savings of $305.5 million.

Ms Konti: Yes.

Senator SINGH: The 2015 budget included $485.1 million over four years for the My Health Record, and it is now providing $69 million. Isn't that a massive cut to My Health Record of over $400 million?

Mr Madden: I think the spend on the My Health Record system will increase. We now have access to offsets and saves in the same budget period, which nets against that overall cost.

Mr Bowles: This system is designed to develop efficiencies in the system over time because of less duplication, fewer medical errors, and so on and so forth, over the life of this. There is a significant benefit to the health system for the long-term use of My Health Record.

Senator SINGH: With all due respect, Mr Madden, saying the spend will increase where there has been $400 million cut—

Mr Bowles: That is not true.

Senator SINGH: It is true, because—

Mr Bowles: No, it is not.

Senator SINGH: I have the 2015 budget measure here—

Mr Bowles: You need to understand that there are revenue and expense measures in these things.

Senator SINGH: I do understand that.

Mr Bowles: That is what makes the difference.

Senator SINGH: All right—take me through the spending of My Health Record, year by year, from 2015-16 to 2020-21, so that I can understand it.

Mr Madden: We do not have the—

Senator SINGH: You do not have it?

Mr Madden: budgetary figures for 2015, but what I can offer you is that the 2015 measure was a three-year funded program. The last year of funding for the program is, in fact, next year. We have appropriations of about $137 million for next year from the 2015 measure. We have additional budget to spend on the My Health Record system for the next two years in operations—a total of $182 million additional, plus there is an additional $185 million to implement national opt-out arrangements for the My Health Record system. As Mr Bowles pointed out, the netting effect is that we have actually calculated offsets and savings that will be recognised during this estimates period, which does, in fact, give us a reduction in diagnostic tests which would otherwise have been duplicated because GPs or hospitals would not otherwise have access to tests that have been taken within the last six-week period. There is, in fact, additional expenditure, but some of that expenditure is, in fact, offset by savings that are expected to be recouped by the operation of the system.

Mr Bowles: Which has been the design of the system—to get better patient outcomes, which mean less duplication and less medication errors. That is the whole basis of the system.

Senator SINGH: The budget measure that includes the $305.5 million in savings—does that come from the My Health Record itself or elsewhere?

Ms Konti: It comes from elsewhere. Sorry, I will clarify—there is a calculation about reduced spending in the medical benefits system for reduced pathology and diagnostic imaging, which comes to a total of $136.8 million over the forward estimates period.

Senator SINGH: So the savings are coming from diagnostic imaging?

Ms Konti: Reductions of the duplication in pathology and diagnostic imaging that will be able to accrue when that information is in the My Health Record and once the My Health Record system has moved to opt-out participation.

Senator SINGH: The measures say that some of the savings come from health system efficiencies.

Ms Konti: That is the other area of savings.

Senator SINGH: What exactly are they?

Ms Konti: We will have to take that on notice.

Senator SINGH: Are they savings from Medicare?

Mr Bowles: No, this has got nothing to do with MBS or PBS.

Senator SINGH: I am trying to give you examples.

Mr Bowles: I have already said that it is efficiencies across the health system, particularly hospitalisation issues—the whole range of issues across the system. It will impact on all parts of the system—yes, probably MBS, PBS, hospitals and the whole lot.

Senator SINGH: It will?

Mr Bowles: It has to, because if you reduce duplication of testing, it has to have an impact. Again, this is about improving health care for patients. If you reduce duplication and stop people getting the wrong drugs and getting adverse events from the wrong drugs, you get a benefit to the system and, most importantly from my perspective, you get a benefit for patients.

Senator SINGH: I think you were taking on notice to provide the savings coming from the health system efficiencies.

Ms Konti: Yes.

Senator SINGH: Could I have a breakdown by program and year, when you provide that on notice?

Mr Madden: Yes.

Senator SINGH: Going back to the efficiencies, do you really not know where they are coming from? How can you bank on them if you do not know where they are coming from?

Ms Konti: They are part of the overall budget for the health portfolio.

Mr Madden: The categories we have included, as Mr Bowles has said, avoided hospital admissions, through fewer adverse drug events; reduced duplication of tests; better coordination of care for people seeing multiple providers; and better-informed treatment decisions. All of those things will reduce pressure on the health system. So there are things across the entirety of the health system across this period, and we will break those down into programs.

Senator SINGH: What does a reduction in the duplication of pathology and diagnostic testing really mean?

Mr Madden: There are categories where there are tests that would not necessarily be repeated within finite periods, which we find through the statistics in Medicare claims. We have people who have the same test repeated in a period of less than six weeks in two

different settings—one in primary care and one in acute care—testing for the same condition, and the same results are available. But because today those results are not available in those two settings—the GP will have access to the results taken six weeks ago—a person turns up in hospital and the hospital currently does not have access to those so they have to run the tests again.

Reducing the duplication means that if the hospital finds that they have had that test within the last period—many of them are around about six weeks—they might observe those results rather than running the test again. Similarly, if hospital pathology tests are taken and the patient comes back out after discharge, the results of those things are available to the GP without running those tests again. So these are reductions that we achieve by looking at the current statistics for specific tests, which are not usually repeated. Repeat diabetes tests and those sorts of things are not picked up. They are those things you would not expect to see repeats of.

Senator SINGH: But My Health Record is still relatively new, so is it not incredibly speculative to be banking savings based on how GPs, specialists and hospitals might behave?

Mr Madden: I think the key to this, in where we have set the trajectory over the last three years—we did the review of My Health Record in 2013; it was very new at that point and usage was low. Recommendations to that review were to look at opt-out as an arrangement for consumers in the system on the basis that healthcare providers gave us an assertion: if the majority of our patients were in the system and you improve the usability we will use it.

We trialled opt-out last year and the usage rates by GPs, hospitals and other healthcare providers in the sites was phenomenally higher than we found in the rest of the opt-in part of the world. So we have modelled based on the expected results of opt-out, where we have an exponential take-up by healthcare providers. With all of the consumers in the system we actually will get a higher usage across the whole sector. Again, the benefit here is not a GP seeing what the GP put in there last week. It is when another GP, a hospital, an allied health professional or a specialist can see that same information, which otherwise would have been obscured from them.

In terms of use, the other thing we have moved in the last 12 months is the electronic incentives for practices. It has taken the GP community from a non-user sector of the system to a point where we have nearly a million shared health summaries in the system that represent those people with chronic illnesses that need care on a regular basis by multiple carers. So the take-up rates have already started to show.

With our opt-out trials and the modelling we did for the benefit series, if we continued with opt-in we would be waiting for another several years before we would pulled those benefits forward. But in opt-out we modelled those benefits from years 2, 3 and 4 from opt-out, and that is where those things start to accrue. There will be further savings we will calculate as we go stepping further into it.

Senator SINGH: What if you do not achieve these savings? Can you rule out cuts elsewhere in the health portfolio to make up the difference?

Mr Bowles: We are not going to go into that. We have modelled this. We are confident around these measures—

Senator SINGH: I know, but it is only a model, Mr Bowles.

Mr Bowles: We are confident around these measures and we will re-look at these all of the time, like we do with every one of our programs.

Senator SINGH: I will hold you to that.

Mr Bowles: You can.

Mr Madden: Part of the measure will give us those measurements as we go, as well.

Senator SINGH: We will see. The measure also says that some savings come from utilising 'uncommitted health program funds'. Which programs are they? Can you provide a breakdown?

Mr Bowles: We would have to take on notice specifically where they would be, but if we have uncommitted funds in some of our program areas we would look to use those. We can take that on notice though.

Senator SINGH: If you could take on notice some kind of a breakdown.

Mr Bowles: Yes.

Senator SINGH: In 2019-20 and 2020-21 the measure only shows savings—that is, there is no funding for the Digital Health Agency. Is the government planning to abolish My Health Record in June 2019?

Mr Bowles: No.

Senator SINGH: The government will need then to spend more money on My Health Record in 2019?

Mr Bowles: Yes.

Senator SINGH: And 2021?

Mr Bowles: Yes.

Senator SINGH: How much will it need to spend?

Mr Madden: We have some variables in the cost of the system, which we will work through in the next 12 to 18 months. Our commitment is to come back to the budget in 2019 to paint out those costs for the four years beyond. The variables in there include the re-platforming of the system to an open source environment, using cloud technology, which is expected to net some significant dividends, and there is also the establishment of call centre operations to integrate administrative clinical calls and the clinical incident management, which will be something we will not know the cost of until we hit the market to get a view on that. Once we know those things across the next 12 months—and those costs will only really come out of testing the market—and those costs to be tested are factored into the process as well.

Senator SINGH: So you are banking the savings without budgeting for the spending that will be necessary.

Mr Madden: As I said, we have a commitment to come back to the budget for 2019 to bring that forward, again on the basis—

Senator SINGH: But isn't that going to be a black hole in the government's books?

Mr Bowles: No, because again—

Senator SINGH: Why didn't you include it in the budget then?

Mr Bowles: Obviously, as Mr Madden said, we are doing more work. There actually will be additional savings over time as the system ramps up. Every extra year you get, savings across that system will increase, because of the introduction of My Health Record.

Senator SINGH: I cannot see why you did not put that in the budget, when you are banking on savings. I am going to move on because it is getting late.

Senator REYNOLDS: Senator Singh, can I ask one question for clarification?

Senator SINGH: Yes.

Senator REYNOLDS: The modelling and the costing process you have just described to me sounds like what you always do. In terms of new programs and new situations, it sounds like a normal fastidious process that you go through. Is there anything out of the ordinary in this process in terms of how you do it?

Mr Bowles: Not particularly. We do this. We do benefits realisation on all major programs like this. It is part and parcel of what we do.

Senator REYNOLDS: And there is no exact science down to the dollar, is there?

Mr Bowles: In fact, we will probably find over time, because we are being quite conservative, that there actually will be greater savings to the system overall. The states and territories believe that. They are all absolutely signed up to getting My Health Record. They are very keen. They are fighting about who goes first.

Senator REYNOLDS: And they would not do it if they thought they were going to have to spend a lot more money I guess. Thank you, Senator Singh.

Senator SINGH: Thank you, that 'dorothy' is over with.

Senator SINGH: Just getting back to this quote from the minister, in his speech at the AMA conference on Friday, he said:

> But the great challenge is the issue of ensuring it works for the medical workforce. And so now we are going to a consultative period over the next few months on real initiatives to assist the medical workforce in their work…

Can you tell me about these consultations.

Mr Kelsey: I was actually at the conference last week. The point the minister was making is that the agency is working very closely with colleagues in states and territories in peak bodies in frontline clinical service to develop a whole range of improvements to My Health Record that will drive increased clinical benefits on which this measure is dependent. For example, we now have the first uploads of public pathology in New South Wales into My Health Record. We will shortly be announcing the first uploads of private pathology, private radiology and views of medications dispensed in community pharmacy. These are the kinds of content that will drive clinical practice, which has been sought after by peak bodies and clinicians on the ground. That is what the minister was referring to. It is certainly a period of very close collaboration as we design the program for implementation of the national expansion in close collaboration with clinical leaders.

Senator SINGH: So he was not referring to financial incentives?

Mr Kelsey: Not as far as I know.

Senator SINGH: Just with this opt-in or opt-out: the government is moving from the current opt-in, as you said, to the opt-out model. When will the national opt-out model be?

Ms Konti: It will be implemented before the end of 2018 calendar year.

Senator SINGH: So that has been accounted for in the budget?

Mr Kelsey: Yes.

Senator SINGH: What happens when someone opts out?

Mr Madden: Part of what we went through in the trials was to make sure we knew the best methods for communicating to the community to let them know that they are going to get a record. They will be getting information about the opt-out arrangements about the My Health Record and the reasons why it would be good for them. They will get a set of resources for them to learn about the My Health Record, and then it is up to them to make a choice.

Senator SINGH: But I am asking: say, I want to opt out.

Mr Madden: You want to opt out?

Senator SINGH: I want to opt out; I have decided.

Mr Madden: You will be able to go online.

Senator SINGH: What happens?

Mr Bowles: I encourage you not to, first of all.

Senator SINGH: Are my records erased?

Mr Madden: You do not actually have a record until we get past a period where you have had an option to opt out. If you flag that you wish to opt out, we just will not create one for you.

Senator SINGH: Everyone in Australia has a Medicare record. The My Health Records would be created on the basis that those with a Medicare record would get a My Health Record, unless you opt out, in which case we will not give you one.

Senator SINGH: So you opt out before there is a record created—is that you were saying?

Mr Madden: Yes.

Senator SINGH: What if the record has already been created?

Mr Madden: You have opted out, so we do not give you a record. You have a Medicare record. After that, if we create one and then you choose to not want one, you can delete that record or cancel that record at any time into the future.

Senator SINGH: You delete that record?

Mr Madden: You can. As the consumer, you can call the call centre or go online and say, 'I had this created. I don't want it any more. Cancel.' And then it becomes unavailable

Senator SINGH: So I call a call centre, and my record is erased from the system.

Mr Madden: Your record will no longer be available to anybody to view.

Senator SINGH: Is it erased from the system though?

Mr Madden: On the basis that it existed for you, it will continue to exist as a record for while you were in the system, but it will not be available to any healthcare providers. What that allows you to do is, at some time in the future you, if you say, 'I didn't want it then, but I think I want now,' you can have it reinstated.

Senator SINGH: Just to understand this correctly: it is not deleted from the system; it is just effectively closed—is that right—it is still there?

Mr Madden: If you did not opt out before it was created, it would be closed. It would be there but not available for anybody to view. If you opted out you would not have a record. Nothing would be sent to that record. Nothing would be stored. Nothing would be available to any healthcare provider or to yourself through the My Health Record system.

Senator SINGH: Last question: does it become unavailable or is it deleted?

Mr Madden: Unavailable.

Mr Bowles: Unavailable.

Ms Konti: Unavailable.

Senator REYNOLDS: I am wondering whether you can advise us what the COAG position is on the issues we have been discussing with opt in and opt out.

Mr Madden: The COAG Health Council met on 24 March and unanimously agreed that opt out would be the future model for the My Health record. That was, of course, pending a decision from the Commonwealth government. So we have support from all states and territories for a national opt-out implementation.

Senator REYNOLDS: This is not a frolic of the Commonwealth's own out there somewhere doing this?

Mr Madden: No. This was consulted and collaborated on with the states and territories before it was taken to the Commonwealth government, on the basis that we needed solidarity.

Senator REYNOLDS: Great project; well done. Thank you.

CHAIR: We will move to the National Health and Medical Research Council.

National Health and Medical Research Council

[21:46]

Senator GRIFF: How many proposals for funding would the NHMRC receive each year, on average?

Prof. Kelso: Quite some thousands—of the order of 5,000, I believe.

Senator GRIFF: Around 5,000?

Prof. Kelso: We receive more than 3,500 each year for our major scheme.

Senator GRIFF: In answer to a question on notice we put in February, the NHMRC said that the proportion of grant requests funded by you have declined from 25.9 per cent of applications in 2010 to 17.9 per cent. Is it still sitting at 17.9 per cent?

Prof. Kelso: I think that was the figure for 2016. It is too soon to say for 2017.

Senator GRIFF: You advised that this was due to an increase in applicant numbers, an increase in requested budgets and an increase in the number of funded large clinical trials and cohort studies. What percentage of those funded grants were large clinical trials and cohort studies, approximately?

Prof. Kelso: Most of the large clinical trials and cohort studies we fund come through the Project Grants scheme, which is 50 per cent of our budget. Of the order, I think, of 18 per cent or so of the budget goes on those large clinical trials and cohort studies, but they are on the whole the larger grants, so I think that it is about eight to 10 per cent of the grants—

Senator GRIFF: Sorry, how much was it?

Prof. Kelso: I do not have those figures easily accessible, so I am relying on memory that roughly eight or 10 per cent of the project grants that are funded are large clinical trials and cohort studies, but they account for somewhat more of the budget because, on the whole, they are the most expensive of the project grants which are funded.

Senator GRIFF: Why is there an increase in funding to these more-expensive trials and cohort studies? Is this an NHMRC policy decision?

Prof. Kelso: No, it is not a policy decision. It reflects their relative competitiveness in the competition for funding each year going through expert peer review. Over the last three years, the total budget spent on clinical trials and cohort studies through the Project Grants scheme has been between $60 million and $80 million. It was $60 million one year, $80 million another year and $70 million in another year.

Senator GRIFF: Looking at the number of unsuccessful applicants—there were a little bit over 80 per cent—have you considered stretching your dollar further to give more researchers a share of funding?

Prof. Kelso: The policy decision was taken some time ago, and I believe it is a sound policy decision, to attempt to fund grants to the level that is necessary to enable them to achieve their goals. We could of course simply say, 'We give every fundable application half its budget or a third of its budget,' but I do not believe that that would lead to the outcomes that we expect from that investment. So the decision was taken to have peer review panels consider the budget that is requested, consider whether it is reasonable for the work that is

proposed to be done. The peer review panel can suggest a cut if they think that the budget is in any way inflated, but otherwise they will recommend funding of the budget as proposed.

Senator GRIFF: During the inquiry into funding for research into cancers with low survival rates, which both of us were at, the committee heard that outcomes for some rare cancers have not improved in a hundred years. One suggestion put forward by some witnesses was that the NHMRC quarantine a pool of money for rare diseases that relatively few researchers currently look at but are certainly still important for progressing knowledge and improving outcomes. Have you considered doing anything like that? Would you consider it to be prudent?

Prof. Kelso: I think that a decision like that has to be taken with a great deal of care, because there are many different ways that one could divide the budget. One could say that the budget should be divided based on the burden of disease or on the particular gaps in the country or on the particular strengths in the country. There are many different ways it could be divided. If we are to divide, for example, based on the burden of disease, then there might not be funds left for discovery research, which is also a critical part of what we fund and which often leads to the greatest long-term outcomes. It also often leads to the surprising outcomes that cross-fertilise between different areas of research. So we take an approach of not dividing the Medical Research Endowment Account into packets according to particular diseases.

Senator GRIFF: At the same rare cancer inquiry we heard that 30 per cent of clinical trials in New South Wales had no patients, mostly due to delays in getting ethical approval. Have you considered ways to streamline that process, particularly with multicentre trials, or to provide standard assessment used by all facilities?

Prof. Kelso: NHMRC has had two budget measures to contribute to Australia's streamlining of clinical trials processes. That work is now essentially complete. It has led to significant improvements and streamlining of the ethics application process. It is now really handed over to the sector and others—the jurisdictions—to ensure that the full benefits of those streamlining measures are brought into play.

Senator GRIFF: When a trial does not complete—we know that 30 per cent do not—what happens to the grand funds that you have given?

Prof. Kelso: We do not know that 30 per cent of NHMRC trials do not complete. At the moment, the process delivers the funds, and there isn't a formal process for monitoring whether the trial has succeeded in recruiting all the patients that were originally proposed. We are now in the process of implementing a new process, separating out clinical trials and cohort studies into a new funding scheme in which there will be a number of additional requirements, both in the application stage and then in the monitoring stage, to ensure that there is the best possible use of those funds. There are several reasons to separate out those trials into a new scheme. One of them is precisely so that there is more clarity and transparency of the benefit of that investment.

Senator GRIFF: So at this point with trials you do not necessarily know that they were completed or that the funds were used 100 per cent for that purpose, but the new process going forward is going to attempt to do so.

Prof. Kelso: Yes. Ultimately, we can determine the outcomes of every trial that we fund based on what is finally published or otherwise promulgated about the outcomes of the trial, but it is not a formal process of monitoring during the funding stage. We also recognise that in many cases the work will continue beyond the funding phase. It sometimes involves the team getting further funds from another source. So it can take a little while for the final outcomes to be available. Our immediate concern in introducing a new scheme is that there are some milestones along the way, so, if necessary, funding can be made contingent on achievement of the next milestone.

Senator GRIFF: Have you made progress payments for specific trials? Have you done that in the past?

Prof. Kelso: Not for trials up to this stage, but in the new scheme we plan to make payments contingent on achieving milestones, such as achieving all the necessary ethics approvals, particularly if it is a multi-institutional trial, and, secondly, recruitment of patients at an adequate rate to meet the goals of the trial.

Mr Cormack: If I could just add a point to build on what Professor Kelso has mentioned. The government has a $7 million measure encouraging clinical trials in Australia. This measure was initiated by the Commonwealth to work with the states and territories that clearly oversee where most of the clinical trial activity is undertaken. This measure is to try to streamline many of the administrative processes and the data collection processes, and even to support some of the work that Professor Kelso mentioned around ethical approvals. It is a sector in which Australia does very well, but we could be doing a lot better. This investment is to establish a series of state based one-stop-shops that enable a much simplified entry point into the clinical trial world into Australia through that. I might just get Ms Kneipp to mention one measure out of the MRFF that builds on that.

Ms Kneipp: Of the eight measures under the first MRFF package, one is for the clinical trials and registries grant program. It is going to be an open program. The NHMRC will be assisting us with that administration. It is $13 million. In addition, as Deputy Secretary Cormack said, the other feature of the $7 million investment and partnership with the states is to assist sponsors—international sponsors coming in and investigators—to navigate the use of the clinical trials sector. Also, it will speed up and deploy creative strategies for enhancing recruitment, and getting trials starting faster.

Senator GRIFF: Professor Kelso, do you actually collect data for all the trials and research that you fund?

Prof. Kelso: The NHMRC itself does not collect data from the trials.

Senator GRIFF: One of the comments made by people at that inquiry last time was that there is not a single repository for data. That was seen to be quite a big issue amongst researchers. Do you believe that there should be such an entity or such a capability?

Prof. Kelso: There is now a register, which is capturing a great deal of data. I cannot be certain whether it is capturing all of it yet. But there is certainly an intention that there be capture of all clinical trials data—recording data for trials that will be registered and then capturing of data. I am not sure whether the department can add further to that.

Ms Kneipp: There is a cross-jurisdictional working group under the COAG Health Council that is dedicated to clinical trials. Some of the work they have been doing is

developing national aggregate statistics to try to understand trial performance—for example, the time between ethics attainment and start-up. That data asset is still building.

Senator GRIFF: Could the NHMRC actually set up a website that publishes the outcomes of the research you fund?

Prof. Kelso: The website australianclinicaltrials.gov.au captures a lot of data. The NHMRC, together with the Department of Industry, Innovation and Science, has established that website, but our involvement in it will now reduce as our involvement in the measures declines. It finishes on 30 June.

Senator GRIFF: Okay. Not all the research that you fund has a commercial outcome, but in instances where it does, and only when the product of that research is commercialised and goes to market, would there be any impediment to seeking a return of some kind for the taxpayer's investment? Is that perhaps an option?

Prof. Kelso: NHMRC does not take any share of intellectual property that is produced through NHMRC-funded work. The Commonwealth does not have a direct interest in the intellectual property, and we at NHMRC do not seek to capture any direct return. I think Australia captures the return in all sorts of ways from commercialisation of research that is funded by NHMRC and other Commonwealth or private sources. That return of course comes through economic expansion and through jobs in start-up and other companies, through royalties and other forms of commercial return, but the NHMRC itself does not seek to capture that return. There are significant complications, in my view, in NHMRC being a co-owner—the Commonwealth being a co-owner—of intellectual property that is produced through institutions in Australia. It would be a very substantial step that would require a great deal of care if the NHMRC were to become a participant in the ownership and development of the intellectual property itself.

Senator GRIFF: However, public funds are going to these studies which are being commercialised, and someone is making money out of it. It would seem to make sense that the Commonwealth receives some form of recognition for something that might be a huge success. Would one option be to perhaps treat them like grants, for instance, or loans which could be repaid, perhaps, in those instances?

Mr Cormack: There is a measure that was announced as part of the national innovation strategy about 12 months ago, and that is the Biomedical Translation Fund. That is a $250 million investment by the Commonwealth, matched by $250 million from private sector investment managed by venture capital funds. It seeks to address that final step of commercialising very promising and, in fact, proven research activity. And what I would say is that through the work that the NHMRC has been doing for many years, with its particular focus on research excellence, the incredible network of investigators and its very strong emphasis on discovery, we now have the second phase in place with the MRFF, which has a much stronger focus on applied and translation research. And then the final piece, which is part of the government's innovation strategy, is the $250 million plus $250 million from the private sector to convert that incredible intellectual capital into economic returns and actually stimulate an Australian investment community that has an appetite to invest in these incredibly promising biomedical discoveries. We have now got those elements in place. They have not been in place before. Indeed there were some announcements just over the weekend about the very first investment from the BTF, which was a promising commercialisation of a

peanut allergy treatment. Australian research, translated, proven: now it is on the path to commercialisation and there will be a very significant return to the economy from that sort of activity in the long term.

Senator GRIFF: One final question for Professor Kelso. Are you intending to ensure, as a condition of trial funding, that they publish any negative results as well? There seems to be very little of those negative results published which of course are very important for researchers.

Prof. Kelso: Yes, they are, and I think there is really a worldwide movement now about ensuring that results of clinical trials, whether positive or negative, are published. We at NHMRC would not impose different requirements on clinical trials, as we do on any other grant that we give, but we do have an expectation that results will be published. But there can be barriers that NHMRC cannot control to the publication of results in that area.

Senator GRIFF: But it is not a requirement in whatever contract you actually have when you issue grants?

Prof. Kelso: It is a requirement that results will be published, but the exact way that that will be achieved is not something that is spelt out in our funding agreements with administering institutions. We have a broad funding agreement which covers the full range of the type of research that NHMRC funds. We do not have a specific funding agreement for clinical trials.

Senator GRIFF: On notice, could you provide a standard agreement that you would have?

Prof. Kelso: Yes, of course.

Senator LUDLAM: Professor Kelso, you can probably guess what I am going to ask you about. Thank you very much, firstly, for the response you provided from estimates on 1 March. We were on the subject of myalgic encephalomyelitis/chronic fatigue syndrome, ME/CFS, I asked about diagnostic criteria and you have given us a bit of detail on how it works in theory—and I will probably ask a few more detailed questions about how it could work in practice. Also in the last session, we went into a bit of detail about TCR, targeted calls for research, where you take areas where there are evident gaps and get feedback from various advocates and the general community about what most needs work. You put a bit of info to us about ME/CFS and Lyme-like illness back in March. Can you provide us with an update of how that assessment process is going, and particularly whether there is any good news?

Prof. Kelso: Thank you, Senator. We appreciate your continuing interest in this very difficult disease. As we discussed last time, the particular issue we face with ME/CFS is the wide range of questions that need to be answered—the absence of a regulated diagnostic test being generally available, despite the fact that there is clearly some research progress, which is promising and exciting, the lack of a clear, simple set of diagnostic criteria and the lack of clear treatment protocols. The range of research questions that the patient group wish to have answered is very broad and the difficulty for us is how to define exactly which questions would be tractable with the type of budget which could be applied to such a targeted call for research.

Senator LUDLAM: That is useful. Before you go on, what kind of budget are we talking about?

Prof. Kelso: A standard budget for a targeted call for research, of which we can run a couple each year, is $3 million to $5 million to be spent over three to five years.

Senator LUDLAM: I took from your answer from last time—you have sketched very similar conditions—that it is precisely for the reason that those things do not exist that this is such an important area. How is it progressing?

Prof. Kelso: At this stage, there are a number of different approaches we are taking to try to define exactly what we can do that would be a really useful investment. That includes consulting with the Department of Health and others in the Commonwealth to determine what data are being collected and what policy needs there might be.

Senator LUDLAM: Great.

Prof. Kelso: We have contacted the National Institutes of Health in the US, who are now spending a significant amount of money, more money than we are able to spend—

Senator LUDLAM: Including here in Australia?

Prof. Kelso: Yes. We want to understand whether there is a way that we can collaborate with the NIH to ensure that the right work is done. That could be a way that we could leverage their broader expertise and, of course, broader budget.

Senator LUDLAM: That is brilliant. You are aware that they are invested in the NCNED laboratory at Griffith University—they are one of the funding partners.

Prof. Kelso: I did not know that the National Institutes of Health in the US were co-investing.

Senator LUDLAM: I believe they are.

Prof. Kelso: Okay, that is good news.

Senator LUDLAM: Twitter will strike me down if I have got that wrong, but I believe they are a funding partner up there.

Prof. Kelso: Good.

Senator LUDLAM: Yes, I think that is extremely good news.

Prof. Kelso: We think that there may be a way that, subject to their interest in collaborating with the NHMRC, we may be able to do something more efficiently than we could on our own. We are very aware of the broad scope of the issues and the difficulty we would have with our budget and even with the small research sector in Australia to address those questions. We have a number of approaches that we are taking. We are also consulting the medical colleges to find nominees for people who could assist us in forming a special committee, an expert advisory committee.

Senator LUDLAM: That sounds very similar to where we were at in March. Has that progressed at all?

Prof. Kelso: It has progressed. It was more conceptual at the time we spoke in March. It is more actively happening now. We are also consulting with the new AHMAC—the Australian Health Ministers' Advisory Council—working committee we have to advise us on priorities

for targeted calls for research. We are making progress. We have also had a meeting with Emerge Australia to talk about some aspects of this issue.

Senator LUDLAM: Brilliant. Not to get too carried away here, but it sounds as though a decision has been made to proceed in this area and that decision had not been made in March. Can you just confirm that for us, or otherwise? It sounds extremely promising.

Prof. Kelso: We are serious about trying to identify what we could fund that would be effective. It is only a decision at the point where we actually say, 'Now we're going to put out a call for research and this is going to be the scope.' But, at the moment, this is serious exploration.

Senator LUDLAM: That is fantastic. It does sound like it has moved on a fair bit. It is less conceptual than it was back in March.

Prof. Kelso: Yes.

Senator LUDLAM: Okay. This is a different session to what I thought we were going to have. Carry on. Anything more?

Prof. Kelso: Well, that was a good start.

Senator LUDLAM: It was, wasn't it?

CHAIR: You are going to jinx it.

Senator LUDLAM: No, do not tell me I have jinxed it! This has been such a long time coming, so it is great. How far away are you from some kind of decision? What is it that you are waiting on?

Prof. Kelso: I think the conversation with the National Institutes of Health is a very important one, so we hope to be able to have that soon. We have contacted them, but, as far as I have heard, we do not have specific feedback yet. As I discussed last time, we have to stagger these targeted calls to manage within our budget. We have a couple that are already in train this year in Indigenous health and in dementia. We also have, as you have mentioned already and we discussed last time, the Lyme-like illness in Australia issue which the minister has asked us to fast-track.

Senator LUDLAM: As a separate TCR?

Prof. Kelso: As a separate TCR, yes.

Senator LUDLAM: Really?

Prof. Kelso: So, we have to manage the ordering of these and manage the work of forming expert advisory committees and making some quite critical decisions based on expert advice about how to proceed. It will take some time because we do have to stagger those, obviously, alongside our business as usual.

Senator LUDLAM: Yes, I understand, but we are talking months not years, right?

Prof. Kelso: We are talking months, not years.

Senator LUDLAM: You did mention the advisory panel just now. You were concerned when I asked you back in March about whether the researchers at the NCNED would have some kind of conflict of interest. I have correspondence from them and I presume they have corresponded with you as well, clarifying that they do not see any conflict. Has that discussion with them progressed any further? The reason I am harping on about them a little

bit is that they are literally the best in the world, at least at the diagnostic side of this thing. It would be a shame to have them on the sidelines.

Prof. Kelso: As we discussed last time, we would want the best in the world to be able to apply for the funding, and we have a strict guideline that the group which designs the targeted call for research will not be people who would apply. I think that is a very important separation.

Senator LUDLAM: Yes, I get that. I do not think I am giving away trade secrets here. The NCNED is not intending—as far as I am aware—to apply for any of the funding that they would be designing the guidelines around. Rather than me being some kind of awkward intermediary, have you had any discussions with them directly about their participation in the reference group?

Prof. Kelso: I have not personally. I would need to seek the advice of our team as to whether there has been any such discussion.

Senator LUDLAM: If you could.

Prof. Kelso: I would be surprised if there has been at this stage, but, if there has been, we can let you know.

Senator LUDLAM: That would be good. I hop up and down about these folks a little bit because they are doing exceptional work and they are based right here in Australia, with some support, I think, from the Queensland state government. Do groups like Emerge find a way onto advisory panels like this or are you looking for clinical experts rather than advocates or patient groups? What is the makeup of an advisory panel for something like this?

Prof. Kelso: In a case like this it would be important to have appropriate consumer representation on the committee. We do that with very many committees, so it would be appropriate in this case without pre-empting a decision about where those consumers should come from. It is important to have a patient and consumer perspective.

Senator LUDLAM: That sounds great. I am not going to press you on time lines; I understand that there are some matters that you cannot pin down yet. Is updating the clinical definitions and guidelines that GPs are given to work with around the country going to have to wait until this targeted research is under way, or could we, for example, adopt the Canadian consensus guidelines or those used by other governments? Is that even within your bailiwick?

Prof. Kelso: First of all, I think that until we work out the scope of the targeted call for research, if there is to be one, it is hard to answer the question of whether any possible guidelines should wait for that research to be done. I understand the existing guidelines that have been developed internationally have not been strongly evidence based. Guidelines promoted and badged by the NHMRC have to follow certain international standards of quality of evidence, and my understanding is that that evidence base has not yet been developed.

Senator LUDLAM: You mentioned before the National Institutes of Health in the United States. We danced around this area last time, in that some research money in past years has been spent by the NHMRC in New South Wales on research and treatments that encourage people to exercise, and that that is incredibly damaging for people with this condition. The director of the National Institutes of Health, Dr Francis Collins, has said that any exertion just makes you worse, and that is why I am harping on about it, even though I am not doing a particularly articulate job of it. The sooner we can get solid, consistent information into the

hands of GPs, the sooner people with this condition will not be prescribed harmful treatments. Does that need to wait for a targeted call for research, or could that happen much sooner on the basis of already-existing evidence?

Prof. Kelso: I do not think I can answer that question. I do not have the detailed scientific expertise, and that sounds like a clinical question that would be beyond our remit.

Senator LUDLAM: Whom can I put that to? That is probably an unfair question as well. Is there anybody else at the desk who could answer? I know it is late.

Prof. Murphy: We will take it on notice. It is a very disputed area. I think there are still some Australian experts on this disease who would dispute the assessment that you describe, but I have not looked at the evidence recently.

Senator LUDLAM: There are no patients who dispute it, though.

Prof. Murphy: I am sure there are patients who dispute it too. I am very happy to take on notice and review the basis of the evidence for that statement by Dr Collins and get back to you.

Senator LUDLAM: I think the people that you are assembling for your reference group which we have been speaking of hopefully will put this question to bed once for all. I will be keeping an eye on your web page for press releases.

CHAIR: That concludes today's hearing and examination of the Health portfolio. I thank the minister, the officers of the Department of Health and our friends in Hansard and broadcasting. Senators are reminded that written questions on notice should be provided to the secretariat by close of business on Friday, 9 June.

Committee adjourned at 10:19