
COMMONWEALTH OF AUSTRALIA

# Official Committee Hansard

# SENATE

## COMMUNITY AFFAIRS LEGISLATION COMMITTEE

**Estimates**

WEDNESDAY, 22 OCTOBER 2014

CANBERRA

BY AUTHORITY OF THE SENATE

**INTERNET**

Hansard transcripts of public hearings are made available on the internet when authorised by the committee.

To search the parliamentary database, go to:

**http://parlinfo.aph.gov.au**

**SENATE**

**COMMUNITY AFFAIRS LEGISLATION COMMITTEE**

**Wednesday, 22 October 2014**

**Members in attendance:** Senators Bilyk, Carol Brown, Di Natale, Leyonhjelm, Madigan, McLucas, Moore, Peris, Polley, Reynolds, Rhiannon, Ruston, Seselja, Smith, Whish-Wilson, Wright, Xenophon.

# HEALTH PORTFOLIO

## In Attendance

Senator Nash, Assistant Minister for Health

**Whole of Portfolio**

Mr Martin Bowles PSM, Secretary

Professor Chris Baggoley, Chief Medical Officer

Ms Kerry Flanagan, Deputy Secretary

Mr David Learmonth, Deputy Secretary

Mr Chris Reid, General Counsel

Mr Adam Davey, Acting Deputy Secretary

Ms Mary McDonald, Acting Deputy Secretary

Mr Paul Madden, Chief Information and Knowledge Officer

Dr Rosemary Bryant, Chief Nurse and Midwifery Officer

Mr John Barbeler, Chief Financial Officer

Mr Colin Cronin, Assistant Secretary, Audit and Fraud Control

Ms Celia Street, Acting First Assistant Secretary, Best Practice Regulation and Deregulation Division

Mr Robert Wright, Acting First Assistant Secretary, People, Capability and Communication Division

Ms Sue Campion, First Assistant Secretary, Grant Services Division

Ms Bettina Konti, First Assistant Secretary, Information Technology Division

Mr Simon Cotterell, Acting First Assistant Secretary, Portfolio Strategies Division

Mr David Kalisch, Director, Australian Institute of Health and Welfare

Mr Andrew Kettle, Head, Business and Governance Group

**Outcome 1**

Mr Nathan Smyth, First Assistant Secretary, Population Health Division

Dr Bernie Towler, Principal Medical Adviser

Ms Kylie Jonasson, First Assistant Secretary, Office of Health Protection

Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division

Professor Helen Zorbas AO, Chief Executive Officer, Cancer Australia

Professor Warwick Anderson, Chief Executive Officer, National Health and Medical Research Council

Professor John McCallum, Head, Research Translation Group, National Health and Medical Research Council

Mr Tony Kingdon, General Manager, Research and Operations Group, National Health and Medical Research Council

Dr Clive Morris, Head, Strategic Policy Group, National Health and Medical Research Council

Ms Samantha Robertson, Executive Director, Research and Operations Group, National Health and Medical Research Council

Professor Debora Picone AM, Chief Executive Officer, Australian Commission on Safety and Quality in Health Care

Dr Brian Richards, Director, National Industrial Chemicals Notification and Assessment Scheme

Mr David Kalisch, Director, Australian Institute of Health and Welfare

Mr Andrew Kettle, Head, Business and Governance Group, Australian Institute of Health and Welfare

**Outcome 2**

Ms Felicity McNeill, First Assistant Secretary, Pharmaceutical Benefits Division

**Outcome 3**

Dr Richard Bartlett, Executive, Medical Benefits Division

Ms Kirsty Faichney, Acting First Assistant Secretary, Medical Benefits Division

Mr Nathan Smyth, First Assistant Secretary, Population Health Division

Dr Bernie Towler, Principal Medical Adviser

Ms Janet Anderson, First Assistant Secretary, Acute Care Division

Mr Charles Maskell-Knight, Principal Adviser

Dr Andrew Singer, Principal Medical Adviser

**Outcome 4**

Ms Janet Anderson, First Assistant Secretary, Acute Care Division

Mr Charles Maskell-Knight, Principal Adviser

Dr Andrew Singer, Principal Medical Adviser

Mr Leigh McJames, General Manager and Chief Executive Officer, National Blood Authority

Ms Yael Cass, Chief Executive Officer, Organ and Tissue Authority

Ms Judy Harrison, Chief Financial, Organ and Tissue Authority

Dr Tony Sherbon, Chief Executive Officer, Independent Hospital Pricing Authority

**Outcome 5**

Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division

Ms Fay Holden, Acting First Assistant Secretary, Indigenous and Rural Health Division

Mr David Butt, Chief Executive Officer, National Mental Health Commission

**Outcome 6**

Dr Richard Bartlett, Executive, Medical Benefits Division

Ms Kirsty Faichney, Acting First Assistant Secretary, Medical Benefits Division

Mr Shaun Gath, Chief Executive Officer, Private Health Insurance Administrative Council

Mr Paul Groenewegen, General Manager and Deputy Chief Executive Officer, Private Health Insurance Administrative Council

Mr Neil Smith, General Counsel, Private Health Insurance Administrative Council

Ms Samantha Gavel, Private Health Insurance Ombudsman

**Outcome 7**

Ms Linda Powell, First Assistant Secretary, eHealth Division

Ms Kylie Jonasson, First Assistant Secretary, Office of Health Protection

Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division

Ms Janet Anderson, First Assistant Secretary, Acute Care Division

Mr Charles Maskell-Knight, Principal Adviser

Dr Andrew Singer, Principal Medical Adviser

Dr Brian Richards, Director, National Industrial Chemicals Notification and Assessment Scheme

Professor John Skerritt, National Manager, Therapeutic Goods Administration

Dr Anthony Hobbs, Principal Medical Adviser, Therapeutic Goods Administration

Ms Elizabeth Flynn, Chief Operating Officer, Therapeutic Goods Administration

Dr Larry Kelly, Head, Monitoring and Compliance Group, Therapeutic Goods Administration

Dr Lisa Studdert, Head, Market Authorisation Group, Therapeutic Goods Administration

Ms Philippa Horner, Principal Legal Adviser, Therapeutic Goods Administration

Mr Bill Turner, Head, Office of Scientific Evaluation, Therapeutic Goods Administration

Mr Steve McCutcheon, Chief Executive Officer, Food Standards Australia New Zealand

Mr Peter May, General Manager, Food Safety and Regulatory Affairs, Food Standards Australia New Zealand

Mr Dean Stockwell, General Manager, Food Standards, Food Standards Australia New Zealand

Dr Scott Crerar, Acting Chief Scientist, Food Standards Australia New Zealand

**Outcome 8**

Ms Penny Shakespeare, First Assistant Secretary, Health Workforce Division

Dr Andrew Singer, Principal Medical Adviser

Dr Rosemary Bryant, Chief Nurse and Midwifery Officer

Ms Megan Cahill, Chief Executive Officer, General Practice Education and Training

**Outcome 9**

Ms Kylie Jonasson, First Assistant Secretary, Office of Health Protection

**Outcome 10**

Mr Jaye Smith, Acting First Assistant Secretary, Office for Sport

Mr Andrew Godkin, First Assistant Secretary, National Integrity of Sport Unit

Mr Nathan Smyth, First Assistant Secretary, Population Health Division

Dr Bernie Towler, Principal Medical Adviser

Mr Simon Hollingsworth, Chief Executive Officer, Australian Sports Commission

Mr Matt Favier, Director, Australian Institute of Sport

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

Mr Ben McDevitt, Chief Executive Officer, Australian Sports Anti-Doping Authority

Mr Trevor Burgess, National Manager, Operations, Australian Sports Anti-Doping Authority

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

**Committee met at 09:00**

**CHAIR (Senator Seselja):** I declare open this hearing of the Community Affairs Legislation Committee. The Senate has referred to the committee the particulars for proposed expenditure for 2014-15 and related documents 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 has fixed Friday, 12 December 2014 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 Friday, 31 October 2014.

The committee's proceedings today will begin with its examination of the Health portfolio, commencing with whole-of-portfolio and corporate matters. 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 such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to a committee.

The Senate by resolution in 1999 endorsed the following test of relevance of 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 purpose of estimates hearings. I remind officers that the Senate has resolved that there are no areas in connection with the expenditure of public funds where any person has 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 of 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, pp 124-125)

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 requirements 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.

**Department of Health**

[09:03]

**CHAIR:** I welcome Senator the Hon. Fiona Nash, representing the Minister for Health; the department's secretary, Mr Martin Bowles; and officers of the Department of Health. Minister, would you like to make an opening statement?

**Senator NASH:** No, thanks, Chair.

**CHAIR:** We will move to questions.

**Senator McLUCAS:** Can I start by congratulating you, Mr Bowles, on your appointment as Secretary of the Department of Health. I look forward to working with you through this committee in the months ahead.

**Mr Bowles:** Likewise, Senator.

**Senator McLUCAS:** We are going to start talking about staffing questions, and I will defer to my colleague Senator Moore.

**Senator MOORE:** Mr Bowles, in the past we have received some standard information from the department, sometimes in printout form, and I am wondering whether we have anything this year on staffing numbers, redundancy numbers and all that kind of stuff. We have sometimes had a hand-out. I am happy just to go through the questions, but I was checking whether Mr Davey had come prepared with a document.

**Mr Bowles:** As you would appreciate, it is day 8 for me. I am still trying to work through how the department actually operates.

**Senator MOORE:** It will probably take you till day 10, Mr Bowles, and then you will be fine!

**Mr Bowles:** That is right! I should be up to speed by next Monday, I hope.

**Senator MOORE:** There is no problem. It would be stupid if I were asking questions—

**Mr Bowles:** I do not think we have a prepared document per se—

**Senator MOORE:** That is fine.

**Mr Bowles:** but Mr Davey will be able to answer a lot of those questions, I believe.

**Senator MOORE:** Sure. Good morning, Mr Davey. I will just run through these; they are standard updates. Can I just double-check when the annual report, where sometimes there are tables of this nature, is going to be available for your department? Again, I am sorry; it is probably something that somebody else is responsible for.

**Mr Bowles:** The annual report is due by 31 October—

**Senator MOORE:** I know, yes.

**Mr Bowles:** which is roughly next week.

**Senator MOORE:** Which is one of stupidities of this program.

**Mr Bowles:** It is unfortunate that we could not get it out before then. It will be out by the 31st. We are still on track for that.

**Senator MOORE:** And that will be within the time that questions of notice can still be sent as well, I believe. We can go from there.

**Mr Bowles:** I believe so.

**Senator MOORE:** Okay, Mr Davey. What is the department's current FTE and could we have that by state as well as nationally, because I am really interested in getting a snapshot of the department currently, as it is, across the board. I refer you to the Department of Social Services annual report, which for the first time has a delightful map of Australia with how many staff there are in the department in each state—just for future reference.

**Mr Davey:** Okay. Thank you.

**Senator MOORE:** I am sure you read all the others!

**Mr Davey:** At 30 September this year, the department's FTE is approximately 3,116.

**Senator MOORE:** 3,116, yes.

**Mr Davey:** That is correct. In terms of the staffing levels in our various jurisdictions, we did provide an answer on notice following last estimates that provided that breakdown, and I do not think it has changed greatly. So for the New South Wales-ACT region, which is based in Sydney, the FTE is 25.92—and that is at 30 September, as it is for all of these figures. The Victorian-Tasmanian region, which is Melbourne-Hobart, is 31.48. The Queensland regional section, based in Brisbane, is 27.35 FTE.

**Senator MOORE:** You do not have a Townsville office any longer?

**Mr Davey:** No, we have a Brisbane office.

**Senator MOORE:** I was just double-checking. So the staff for your department in Queensland are now in Brisbane?

**Mr Davey:** I would have to double-check but that is my understanding.

**Senator MOORE:** Okay—so 27.35.

**Mr Davey:** Correct. For the Northern Territory regional section, based in Darwin, it is 15.85—

**Senator MOORE:** And no office in Alice Springs?

**Mr Davey:** No, that is Darwin.

**Senator MOORE:** This is for clarity. I am just working out where staff are located. So the NT FTE is 15.85, and they are in Darwin.

**Mr Davey:** Yes. I have just had confirmation that that is correct about Brisbane. We do not have the Townsville office; it is Brisbane only.

**Senator MOORE:** Okay.

**Mr Davey:** For the South Australia region, which is based in Adelaide, it is 15.19 FTE; and, for the Western Australia region, based in Perth, it is 24.01 FTE at 30 September.

**Senator MOORE:** All right. So, if you add those all up and take them away from 3,116, you will have the national office FTE?

**Mr Davey:** That would be right.

**Senator MOORE:** Okay—and we have the comparisons from the question on notice. Does this include the staff that have come across from Health Workforce Australia?

**Mr Davey:** Those figures are current at 30 September, so that should include them.

**Senator MOORE:** It also includes all the portfolio agencies in this estimates program—so TGA, FSANZ and all those are in that list?

**Mr Davey:** Just to clarify, TGA is not counted as a portfolio agency; that is part of the department. Those FTE figures that I have just given you for the department and for our regions are for the Department of Health, which includes OGTR, NICNAS and the TGA. That does not include the portfolio agencies. They would be figures that they would provide to you.

**Senator MOORE:** Right. The agencies that were scheduled to be abolished or absorbed into the department as of 30 September—since last estimates, what is the progress there? They were Health Workforce Australia and the National Preventive Health Agency. In terms of the numbers and what has happened, what is the progress now?

**Mr Davey:** ANPHA, the preventive health agency, has effectively been closed down. Staff have come across to the department as part of the merger of that work into the department. The number of staff who came across from that agency was 19. With respect to Health Workforce Australia, similarly, that agency has closed, the work has come across to the department and seven staff have transferred from HWA.

**Senator MOORE:** Can we get, on notice, the levels of the staff that have come across—the 19 and the seven?

**Mr Davey:** Yes, we can do that.

**Senator MOORE:** Certainly, I know that we have discussed in the past the planning that goes on within the department about what your budgeted staff reductions are going to be to meet the various requirements that you have. What is the current proposal? You have 3,116 staff as at 30 September. What is the current staff plan for future reductions and over what period?

**Mr Davey:** In the current year, we are actually in the process of recruiting in some areas. We have been looking at our workforce profile for some time now, as you would be aware. So there are some areas in the department where we are currently recruiting from within the APS.

**Mr Bowles:** Given that I am relatively new, I am trying to have a broad look at the department and how it operates, which might impact on some of those numbers as we go forward. By February estimates, I will obviously have a much clearer picture of where we might go with that. Clearly, there is a lot of work being done in the department around workforce. I think that we need to do quite a bit more as we deal with some of these agency issues and the broader effectiveness of the department.

**Senator MOORE:** In some areas, for workforce needs, you are doing internal recruitment—that is, within the APS at this stage?

**Mr Davey:** In the department, our policy remains that the first thing we do in terms of recruiting is look for mobility opportunities for staff within the agency. Then, of course, we look to the APS redeployment register for staff that might be available for movement at level. Then we go to the APS more broadly to look for opportunities for people to move as well.

**Senator MOORE:** Within that, there are special areas. In terms of your overall plan at this stage, what is your understanding of the need for a reduction to meet the various requirements of the efficiency dividends and so on that all of the public service is facing? From 3,116 in September, what are your projected staff numbers to meet the requirements of reduction at this stage?

**Mr Davey:** I do not think that I can give you an exact number. As you would appreciate, when we are looking at an overall workforce profile, the various levels of staff that we need will change as we go through business planning and working out what our needs and skills are as part of our workforce planning. So, of course, the cost of that workforce does vary. We do not have an exact FTE number that is set in concrete today.

**Senator MOORE:** What is the efficiency dividend that Health is facing for the financial year 2014-15? For 2014-15, what is the process for the efficiency dividend that Health has to meet?

**Mr Barbeler:** The efficiency dividend for this year was increased by 0.25 per cent.

**Senator MOORE:** What does that translate to in dollars?

**Mr Barbeler:** We had to take up an extra 0.25 per cent, which is equivalent to $1.1 million.

**Senator MOORE:** Are you are telling me, Mr Davey, that at this point you cannot tell me how that will impact on staffing levels? But Mr Bowles, you are telling me that by February you should have a clear picture of the overall staffing needs of the department.

**Mr Bowles:** Yes, Senator. From the look I have had so far at the budget, staffing is on track with our budget. I am not sensing that there is any great variation between the two issues. There might be some minor movements downwards over time but, until I get a good picture of the out years, if you like, I am not quite sure where we need to land for the end of 2014-15 yet. Definitely by February I should have a reasonable understanding.

**Senator MOORE:** How many staff have accepted voluntary redundancies since September 2013? Have they been in the national office or in state offices?

**Mr Bowles:** I know there has been none since 1 July this year.

**Mr Davey:** That is correct. The figures I have here are for the full year 2013-14. A total of 157 staff accepted voluntary redundancies for the 2013-14 financial year.

**Senator MOORE:** And for 2014-15?

**Mr Davey:** None. We have not had any voluntary redundancies this financial year.

**Senator MOORE:** Have there been any forced redundancies?

**Mr Davey:** No, not across any of the areas.

**Senator MOORE:** Has anything happened with the process?

**Mr Davey:** No, we do not have a program underway for voluntary redundancies.

**Senator MOORE:** Last year we had extensive discussions at various estimates about the process that the department was using. Some people were working on special projects and identified that their areas may change. Are there any staff in that situation at the moment?

**Mr Davey:** Are you referring to the Business Services Centre?

**Senator MOORE:** Yes, I am.

**Mr Davey:** As at 30 September, we have eight staff who are in unfunded positions in the Business Services Centre undertaking work across the department and they remain the priority staff for redeployment to other roles. I expect we will continue to be successful in placing those remaining eight.

**Senator MOORE:** Can you on notice give me the levels of those people?

**Mr Davey:** Yes, I can do that.

**Mr Bowles:** I have also asked for a comprehensive review for my understanding of those people so I can understand how they can fit back into the organisation if possible.

**Senator MOORE:** On notice can we also get information about the specialist situation in Health Workforce Australia, because we know they were not part of the Australian Public Service. I would like to get some information—only seven have transferred into the department and I cannot remember what the actual numbers were in the agency. Can we get information about levels and any kind of redundancy costs for the staff from Adelaide?

**Mr Davey:** We can take that on notice.

**Senator McLUCAS:** Do you have that with the you, Mr Davey?

**Mr Davey:** I do not have that detail on me, no.

**Senator SIEWERT:** To clarify, are you the lead agency or do you contribute data to the reporting process of the UNICEF early childhood report?

**Mr Bowles:** We might have to take that on notice.

**Senator SIEWERT:** If you do, I would like to clarify where I ask it in the program. If you could get that to me, I would appreciate it.

**Mr Bowles:** We will try to find out soonish. If someone back there could try to find that out, we will see what we can do for you.

**Senator DI NATALE:** My question is on the government's response to the Ebola crisis. I suspect those questions would be for the Chief Medical Officer. Can I ask those questions here?

**Mr Bowles:** The specific time, I think, was under the population health area which I think is later this evening.

**Senator DI NATALE:** I have been advised that I should ask the question first here and then potentially also ask it during that time slot.

**Mr Bowles:** If you want to ask some early questions now, Professor Baggoley is here.

**Senator DI NATALE:** I should say, Mr Bowles, congratulations on your new appointment.

**Mr Bowles:** Thank you.

**Senator DI NATALE:** Let me begin by asking about who it is that advises the Prime Minister and Cabinet on the response to the Ebola on our national response.

**Mr Bowles:** I might start and then we can go broader, if you wish. I suppose there are a range of different departments and agencies that will advise the Prime Minister on these issues. Clearly, Health has a lead role in the health related issues but there are also issues that fit in with Foreign Affairs and agencies like that. I suppose that is the big lead agency in this. Clearly, Professor Baggoley, as the chief medical officer, deals with the broad issues of health and health related issues, in relation to our Ebola response but there are some things in this response that we will not, as this department, have carriage of—that someone like DFAT would.

**Senator DI NATALE:** I imagine logistical support and so on.

**Mr Bowles:** That is right.

**Senator DI NATALE:** Have you provided advice to PM&C on the medical component of our response?

**Prof. Baggoley:** Yes, I have.

**Senator DI NATALE:** Are you consulting with other medical agencies, with groups like the AMA and other NGOs like MSF and potentially Oxfam, in terms of compiling that advice before providing it to PM&C?

**Prof. Baggoley:** I have had discussions with the AMA; I am yet to have the discussion with MSF. Paul McPhun has been overseas. I am planning to catch up with him, in general terms, not specifically about advice to government. Of course, I am interested in the experiences that are being undertaken by NGOs overseas. I am interested in the welfare of their health-care workers when they return to Australia.

**Senator DI NATALE:** Obviously this is a very specific issue that many people within the health committee have very little knowledge of, here in Australia, because it is a new and emerging infectious disease. Who are you taking advice from before providing advice to government?

**Prof. Baggoley:** In general terms, I need to have—and have developed—quite an understanding of the epidemic itself in West Africa. That is particularly important. I have developed an understanding of the nature of the illness and why it is that West Africa has had such an outbreak compared to outbreaks that have occurred elsewhere in Africa since 1976. As you would be aware, this is by far the worst outbreak that has occurred in Africa. Most have occurred in the Democratic Republic of the Congo, in the Republic of the Congo and in Uganda. This is the first time there has been such an outbreak in West Africa. I have been particularly interested to understand the nature of the epidemic and its epidemiology and to understand more about the virus, how its symptoms occur and the periods of infectivity.

There has been a range of conversations I have had. I have been appointed to the emergency committee on Ebola of the World Health Organization. I have had discussions with colleagues in the United Kingdom and also discussions with colleagues in the United States. I have developed a broad understanding of the disease and of this outbreak in particular. The understanding that why this outbreak is worse than others is because it has been in such an area where they have never had before; so it is the social circumstances and

the practices. It is an area where there has been a fragile health system that is being put, as we know, under severe strain.

I think it is important very early on to reinforce the nature of this virus and this illness, because there are concerns that somehow this epidemic is showing a different virus or a different side of the virus than previously. I think it is important to emphasise that this is a very serious disease. It is hard to be sure, but the mortality rates quoted still tend to be around the 50 per cent mark. The incubation period is from two to 21 days, although mostly if people are going to show signs they do so at about the eight to 10 day mark. Although it seems a paradox, this is not particularly contagious in its behaviour in that someone must have exposure to body fluids to become infected. We have seen that in previous epidemics and we continue to see that. Someone is not contagious unless they have got symptoms.

In contrast with a number of other diseases—such as influenza, for example, where people are almost certainly contagious because they are showing symptoms and perhaps more contagious early in the disease than they are later—the sicker you are, the more contagious you are. That is why the issue for healthcare workers is that—it does not matter whether the healthcare workers are in Africa or here—they are then particularly at risk because they are working with patients who are at their sickest and at their most contagious. In fact, it has been said that someone is at their most contagious at the point of death and that is why funeral practices are a source of infection.

There was a paper referred to me just recently by an infectious diseases colleague here in Canberra, which showed that in the Democratic Republic of the Congo in mid-1995 there was a study of 27 households. They followed up all the household contacts, which were several hundred contacts. Only 16 per cent of that household's contacts developed an infection. No-one who did not have direct contact became infected. Those who were infected had the direct contact with the patient at their sickest.

I think it is important also in just setting the scene here to reflect on what we have seen in recent weeks. As we know, hundreds and thousands of patients have been infected in Liberia, Sierra Leone and Guinea. But we have just heard yesterday that Nigeria has been declared Ebola free. That is a really significant achievement; it was achieved through good public health measures. They have developed 20 cases, 8 of whom died. They achieved that by establishing an emergency operation centre, taking on 1,000 healthcare workers, following up over 850 contacts and then ensuring that the temperatures of those contacts were taken. After 42 days—that is, two incubation periods—the WHO has been able to declare Nigeria free of Ebola, which is, I think, a remarkable achievement. It demonstrates the importance of good public health measures in controlling this wherever it occurs.

We do know that Thomas Duncan went from Monrovia to Dallas and that there have been infections in two healthcare workers there, and that is something that we are keen to understand. I am keen to hear more through the WHO as to what has happened there. There will be another meeting of the emergency committee tonight, and I will be taking part in that. CDC are clearly reflecting on what has been learnt from that and looking at modifying their understanding of how this should be tackled in their health system. We need to understand what they have learnt. But what we do know is that Thomas Duncan's household contacts themselves have not developed the disease, and they were in close contact. It is important to

emphasise that, because we do hear of people who are very, very fearful that a case, or several cases, could all of a sudden become an epidemic in other countries. That is not the case.

In relation to healthcare workers and, in general, the disposition of Australian healthcare workers overseas, it is my role as chair of the Australian Health Protection Principal Committee to bring that committee together whenever there is a request from government for Australia to dispatch healthcare workers overseas. We have done so most recently in the Philippines, to Tacloban, as a result of typhoon Haiyan. We know what we need to do in that circumstance is to understand the setting and we need to understand the challenge. We know we have hundreds of Australian Medical Assistance Teams trained personnel—doctors, nurses, paramedics, logisticians and so on—whose skills we all understand. We know that we need to fit their skills to the task required. As a result of a major trauma incident, such as a typhoon, we would send surgeons and anaesthetists in particular, with nurses trained to assist, work and care for patients in trauma. We know that if there is a flood situation then public health measures become more important.

We also know that the people that go need to be trained to deliver health care in difficult environments, and that is the case for those trained with AUSMAT. They need to be fit. Their vaccine status is important. We also know that their security needs to be ensured, and this is personal security as well as health security. To be in an environment where they are free from physical danger or physical harm is important, and that needs to be secured. We also know if they have health needs, they need to be able to be delivered. The health needs, of course, can relate to any illness or injury that can occur to anyone in any part of the world, but there may be health needs that arise from the particular setting. In relation to any consideration of sending healthcare workers to West Africa, clearly this is a circumstance where there is a risk that healthcare workers could contract the Ebola virus disease. If that is the case then an understanding of the disease, an understanding of exposure risks and an understanding of how to protect the healthcare workers are important. If they do become exposed or ill, an understanding of how to best care for them is required.

That is a summary of the circumstances and the situation overseas. Obviously the advice I give is tailored around all of those areas.

**CHAIR:** Thank you. We are out of time on this. We are beyond time for whole-of-government.

**Senator DI NATALE:** Just on that: that was a very long statement, which went outside of the question that I asked—so I have actually not had an opportunity to ask questions on this.

**CHAIR:** Well, we had half an hour for whole-of-government/corporate; we are now past time. None of the government senators who have been waiting have had an opportunity to ask questions. The time for getting into more detail is in outcome 9. I have allowed some latitude with asking questions here, but we are now beyond time. This is the timing that the committee agreed to, so I am going to try and stick to it—otherwise there are a number of things we will not get to cover today.

**Senator CAROL BROWN:** Just previously, we changed the agenda for this estimates because some people have to leave for a teleconference. My understanding is that Professor Baggoley and the Secretary will be leaving at around 10 o'clock. If that is the case, I think that questions on Ebola should be given some preference at this point.

**CHAIR:** Well, they will be back at outcome 9. That was the point made by Mr Bowles.

**Senator CAROL BROWN:** But the point is that they are here now, and people want to ask the questions.

**CHAIR:** The problem with that is that we are beyond time for the first section. I have allowed latitude within that section but we now have another area that we need to move to, and if we stretch it out half an hour past our time, then there is a range of measures that will not get covered. And that is not how—

**Senator CAROL BROWN:** We understand that. As a committee, I am sure that we will manage to get through the things we need to.

**CHAIR:** Sure. But that is not how I am going to run things. We are going to try and stick to the schedule. If people wanted to change the schedule, they could have moved that within private committee meetings.

**Senator CAROL BROWN:** We asked whether Professor Baggoley be here for the morning, so that we could—

**CHAIR:** Sure. And Professor Baggoley is here, and he has just answered a long question—

**Senator DI NATALE:** No; he has not answered a long question; he has made a long statement—

**CHAIR:** Sorry; he has made a long statement.

**Senator DI NATALE:** which was appropriate, but it was not actually in response to my question.

**Senator McLUCAS:** He made a very long statement, to one question. I have some further questions.

**CHAIR:** Senator Di Natale, thank you. Professor Baggoley is entitled to answer the question. He was giving information to the committee. If you thought that his answer was going for too long, you could have raised a point of order and I would have sought to bring him to a close. I thought the information was useful.

**Senator DI NATALE:** Yes, so did I. I did not want to do that.

**CHAIR:** We have a situation now where we are well beyond time for whole of government/corporate.

**Senator DI NATALE:** If we are going to have to deal with this issue in outcome 9, why can't we use the opportunity to deal with it now?

**CHAIR:** Because it is not scheduled now. We are 10 minutes into the time allocated for acute care. If committee members would like to have a private meeting to discuss it, you are welcome to. But this is now eating into more of senators' time. I would like to run broadly to the schedule that we have. We have now passed whole-of-government. None of the government senators who were waiting have had the opportunity to ask questions, so they are now going to miss out on that opportunity. I would like to move to acute care. We have outcome 9 later on, so there will be ample opportunities to ask questions of the Chief Health Officer on all of these issues. If there had been a desire to change the schedule, that could have been be moved, but it has not been.

**Senator MOORE:** Chair, could I make one comment: I am not going to waste time on calling a private meeting now, because I think we can do that at morning tea. But I think it is important that we as a committee understand the new standing order. My understanding is that if we are working to a series of questions, we have the right to continue in that series of questions. But we will have that discussion at morning tea time.

**Senator McLUCAS:** I think we should have it now.

**CHAIR:** I will give you my brief understanding of the standing order, because we have not closed this area of expenditure; it is actually scheduled to come later on this evening. So I am not closing that area; I am closing whole of government/corporate. Now, if the committee would like to stretch out whole of government/corporate with questions that are directly related to whole of government/corporate, not going to outcome 9, then the standing order will allow you to do that.

**Senator MOORE:** Yes, we do.

**Senator McLUCAS:** That is exactly what we want to do.

**CHAIR:** That is my understanding of the standing order. But it will not allow you to go into matters of expenditure that are scheduled for later on this evening. I have allowed latitude here, but that is not going to allow you to bring forward whatever things you would like into this area.

**Senator McLUCAS:** There are two issues, Chair. The first issue is, do we want to extend whole of government/corporate areas—

**Senator MOORE:** Yes.

**Senator McLUCAS:** and the answer is yes. So we will have another half an hour on this. The second issue is, does Ebola fit into whole of portfolio, and the answer is yes.

**CHAIR:** Well, that could be argued for everything. That is why we only have half an hour. If we thought everything would fit within whole of government/corporate, we would not bother splitting it up. Whole of government/corporate does go to things like staffing, and a range of other things. I have allowed some latitude here, and this will not be closing this area of expenditure, because it is in outcome 9, and there will be ample time for us to deal with that. That is my ruling on that standing order.

**Senator McLUCAS:** We are saying that we want to talk about this issue now, for two very important reasons, Chair. It is a pretty important issue.

**CHAIR:** Absolutely. There are many, many very important issues.

**Senator McLUCAS:** It will have implications rights across this department—

**CHAIR:** I am seeking to run a schedule here, Senator McLucas. There are two options here. If you want to invoke the standing order—

**Senator McLUCAS:** We do—

**CHAIR:** to stretch out whole of government, corporate, I am going to ask you to ask questions that are related to whole of government, corporate, not to outcome 9. I am not going to allow you to stretch out outcome 9 when we have not even come to it.

**Senator McLUCAS:** So you are shutting down a discussion about Ebola?

**CHAIR:** No, I am not, because it is scheduled to come on this evening.

**Senator McLUCAS:** With the department of health? People are watching this. That is what you are doing—

**CHAIR:** Senator Smith on a point of order.

**Senator SMITH:** No-one doubts the severity of the issue—

**Senator McLUCAS:** That is right—good.

**Senator SMITH:** and the requirement for public discussion and discourse around Ebola. Senator McLucas, my concern would be that, if we have published a program and other senators who are not currently here are expecting an opportunity to discuss Ebola at outcome 9 this evening and we proceed to a discussion now, they might be excluded from participating. We have a program and people understand that Ebola will be done, as well as the biosecurity and emergency response. It is not about not having a discussion; it is about where it is most appropriate to have discussion and allowing other senators, who may not be here presently, to participate in that discussion with the chief medical officer—

**Senator DI NATALE:** I have a point of order on that. Senator Smith, if people were interested in discussing Ebola, they would have contacted the committee and they would have been advised that this morning was an opportunity to have that discussion, as was biosecurity—

**Senator SMITH:** Senator Di Natale, you understand that—

**Senator DI NATALE:** I have not finished my point. If anybody was interested in having that discussion, they would have been advised that this morning was the opportunity. We have asked one question. We have had a long opening statement, which was appropriate because it is an important issue and it gives the issue context. We were not given the opportunity to ask questions. That was the advice that we were given earlier, so I think it is appropriate that we take the opportunity to ask those questions.

**CHAIR:** Your views are noted. Senator Smith briefly and then we will move on.

**Senator SMITH:** Senator Di Natale, you will know that unfortunately estimates does not happen as efficiently as that. I do not think that you can guarantee that there are some senators not currently here who would like to be able to participate in the discussion.

**Senator DI NATALE:** They will have that opportunity as well.

**CHAIR:** Senator McLucas, are you invoking a standing order to extend whole of government, corporate?

**Senator McLUCAS:** I want to continue these questions—

**CHAIR:** That is fine, but I would ask you to ask questions around whole of government, corporate, not outcome 9, because we will come to outcome 9.

**Senator McLUCAS:** I am going to ask questions about Ebola.

**CHAIR:** We are going to adjourn and have a private meeting and we can discuss this.

**Proceedings suspended from 09:42 to 09:52**

**CHAIR:** The committee has agreed that we will continue with questions on Ebola until such time as Professor Baggoley and yourself, Mr Bowles, are required to absent yourselves, at which time we will move to the next outcome. Senator Reynolds, did you have—

**Mr Bowles:** Sorry, Chair, just before you go on. The only issue is that not all of the staff that are involved in this topic area are here. Professor Baggoley and I are, but the rest are not.

**Senator REYNOLDS:** In light of the time constraints and in deference to your officials who are not yet here because we were not scheduled to have this discussion now, I will hold over my questions until we formally deal with outcome 9 and your officials are here, because I do have a long series of questions for you. But I would also just like to thank Professor Baggoley very comprehensive and informative statement up-front. Thank you.

**Senator McLUCAS:** Thank you for your opening statement, Professor Baggoley. How many times have you convened meetings with state and territory chief health officers?

**Prof. Baggoley:** We are having weekly meetings, mostly by teleconference, and also some face-to-face meetings. There is a face-to-face meeting in Sydney tomorrow. That has been occurring since early August. I cannot give you the specific times. I am also in daily contact with my chief health officer colleagues, and I make sure that if there is any issue being raised we can address it on the spot.

**Senator McLUCAS:** What is the purpose of those meetings?

**Prof. Baggoley:** The purpose of the meetings is to make sure that we understand the issues that are arising in each of the states and territories. It is important that we are as well prepared as we can be. It is important that I make sure that we develop national guidance in relation to this. We have subcommittees, or standing committees, of the HPPC. We have the Communicable Diseases Network of Australia, which has produced guidelines on the management of the Ebola virus disease. We have the Public Health Laboratory Network, which has also produced guidelines on the management of laboratory specimens in appropriate tests.

We are making sure that we are looking at the evidence that emerges during the management of this disease, particularly in West Africa but also in other parts of the world. We are looking at practice that has developed overseas. We want to make sure that we understand this evidence and this practice; then we can modify, or see if we need to modify, anything we do at the time. So it is a constant state of keeping alert.

Within the states and territories, of course, it is their role to deliver the care. They run the public health units. Those public health units, for example, would be involved in contact tracing. They run the hospitals. Each state and territory has designated hospitals, and each state and territory is running practices and drills and training, because we know that is important in those designated hospitals, in the event they get a case of Ebola. We find it is important that we learn from each other, and so there is great wisdom among the members of the Health Protection Principal Committee.

**Senator McLUCAS:** Professor, how many times has the minister participated in these meetings?

**Prof. Baggoley:** The minister was present at the introduction of the last teleconference, last Friday.

**Senator McLUCAS:** Last Friday. That is the only meeting he has attended?

**Prof. Baggoley:** That is correct.

**Senator McLUCAS:** Has the minister requested AUSMAT teams be ready to travel to West Africa or anywhere else?

**Prof. Baggoley:** Not of me.

**Senator McLUCAS:** And that is the process, I understand—the minister has to request it?

**Prof. Baggoley:** As I understand that process, the decision to send and the request to send come through the foreign minister through Emergency Management Australia. It comes through that route. Wiser people may be clearer on that.

**Mr Bowles:** I think it is a broader issue for Foreign Affairs. It is one of those questions that will more than likely be an issue across other departments as well.

**Senator McLUCAS:** Thank you, Secretary. Professor, you talked in your opening comments about the skills that are required for potential deployment of AUSMAT teams. What work have you done to identify what skills would be required, should a request come?

**Prof. Baggoley:** There are a range of skills that may be required; it depends on the task that is provided. If it is a team that is to provide clinical care, the overwhelming need there is for nurses. In my discussions with colleagues at the World Health Organization, it is often said you need a ratio of about 10 nurses to one doctor because nursing is the key task that is being provided. Of course, the range of clinical activities that are occurring in West Africa for patients with Ebola is quite different to the range of activities that would occur if we had an Ebola patient in this country, because patients here would be managed in intensive care units, as we have seen in Spain, as we have seen in the United States and as would occur here. In West Africa, we know that it is very unusual, if it happens at all, for intravenous fluids to be given to patients in their Ebola treatment centres, so that range of skills and so on is not required. We know you need what they call logisticians, people who make sure that the physical plan moves well, that all the supplies are there and so on. They are the skills that are needed.

**Senator DI NATALE:** Professor Baggoley, there are obviously some very specialist skills for the treatment of Ebola patients. What specific training has there been for health personnel to ensure that they are appropriately skilled to be able to work in the field?

**Prof. Baggoley:** As I would see it, the particular training that would be required would be training to work in the personal protective equipment that needs to be worn.

**Senator DI NATALE:** That is one of the skills. For example, many NGOs will send their health personnel to Europe for intensive training before they are deployed in the field.

**Prof. Baggoley:** Correct. That is absolutely right.

**Senator DI NATALE:** None of these people who are on registers, like they are on AUSMAT, would be deployed directly to the field—

**Prof. Baggoley:** Correct.

**Senator DI NATALE:** without that specialist training, which can take weeks. Have we been engaged in a process where we are actively skilling up our AUSMA team in preparation to work in the field?

**Prof. Baggoley:** No, and the training as it is usually provided by the NGOs or WHO and so on would include typically a couple of days in a lecture style, a couple of days of doing it and then mentoring in the field, so it is about a week.

**Senator DI NATALE:** So we have not done that training?

**Prof. Baggoley:** Correct.

**Senator DI NATALE:** We had the Prime Minister visit PNG on his way to Indonesia, saying we are ready to help, but we do not have any Australian health professionals who have been skilled up with the appropriate knowledge to be able to manage an epidemic in PNG if it were to occur tomorrow.

**Prof. Baggoley:** I will take that as a comment.

**Senator DI NATALE:** I am asking a question. Do we have any Australian health personnel who are now skilled and ready to be deployed in the field tomorrow if an epidemic were to occur in PNG?

**Prof. Baggoley:** We have not trained the AUSMA team specifically in the wearing of the PPE. Many may have already had that because they would have significant roles—

**Senator DI NATALE:** But you have already acknowledged that there needs to be specialist training for health professionals for the AUSMA team. We have said that we are ready to help PNG, yet we are not because we have not trained our AUSMA team in the appropriate PPE field and other things—mentoring, as you said. There are a range of things. This is a unique setting. These AUSMAT health professionals will not have the skills necessary to go from Australia to PNG. I just want to be clear about this. You are saying that we have not deployed any of our AUSMAT professionals to be skilled to be able to combat an epidemic if it were to occur in the near future?

**Prof. Baggoley:** That is correct.

**Senator McLUCAS:** How long would it take to get a team ready to be deployed? If the Prime Minister asked today, how long would it take from today to have a team ready to be deployed?

**Prof. Baggoley:** It could take, I think, up to two weeks. What would be required would be an understanding of the skill set that is needed. We would then need volunteers. People going on this—they are all volunteers—would specifically need to be volunteering to go for such an assignment. We would then need to be effecting the training that would occur for them to be comfortable wearing the PPE equipment. That, in essence, is the skill set required to work in such a field.

**Mr Bowles:** Can I just add that there are also a whole range of things that happen around logistics and all those things before the medical people hit the ground. People are trained in that. We do that all the time in different disaster-type things. You have different time frames for people to hit the ground running, if you like. You cannot just appear there in a medical sense. There are people who are already trained in that. Our hazmat teams are trained in the broader issues that they need to deal with. There will be some specific training, as Professor Baggoley talked about, and that would be underway while people are preparing the logistics and all the other stuff that goes on.

**Senator DI NATALE:** But there would not be an NGO working in this environment who would not have sent their team for specific training in this area. I would just like to know: why have we not been proactive in this? If we are saying we are ready to help with an

outbreak, and we are saying our focus is on the region, why haven't we got our AUSMAT health professionals already trained and skilled up, ready to hit the ground running?

**Mr Bowles:** What I was saying is that it is a broad approach from government that is well beyond the health department, and as a government we have responded to many issues in our region in the past.

**Senator DI NATALE:** How many Ebola epidemics have we responded to? This is a unique situation, Mr Bowles.

**Mr Bowles:** It is a unique situation which has similar characteristics in how you approach these things.

**Senator DI NATALE:** Not for the health professionals involved. I am asking specifically of the health professionals involved. I understand the logistical support. I understand all of those issues. I am talking—

**Mr Bowles:** But it is really important that we see this in context, because there are things that need to happen before the health workers do anything.

**Senator DI NATALE:** One of them is that the health workers need to be trained.

**Mr Bowles:** One of them is that; that is correct. Professor Baggoley also said a lot of this happens in country as they familiarise themselves with the local environment, because local environments are different.

**Senator DI NATALE:** Other NGOs spend weeks training these people because we know that the risks involved are significant. Professor Baggoley, have you provided any advice to government or to the department about the need to ensure that our AUSMAT health professionals are trained if we are to be, indeed, ready for an epidemic?

**Mr Bowles:** That would be advice to government; Professor Baggoley cannot go to the advice—

**Senator DI NATALE:** He does not need to tell me about the nature of the advice. Have you provided advice to government?

**Mr Bowles:** I think that he has already said that he has.

**Senator DI NATALE:** On the need to train—

**Mr Bowles:** On a whole range of issues.

**Senator DI NATALE:** I am not asking for the nature of the advice—

**Mr Bowles:** Again, you are going to a whole range of issues that are advice to government, which will cover many issues in this particular space.

**Senator DI NATALE:** I am not asking about the nature of the advice. I am asking whether Professor Baggoley has provided advice to government about the need to train health professionals in this area.

**Mr Bowles:** If I may, that is—

**Senator DI NATALE:** I cannot see why Professor Baggoley cannot answer that. It is a very straightforward question and I am not asking for the details of the advice.

**CHAIR:** Senator, allow Mr Bowles to answer.

**Mr Bowles:** Professor Baggoley has already said that he has provided a significant range of advice to government. We do not go to the nature of that, and we do not go down to listing all of the separate issues that we will provide advice to government on. Needless to say, the department and many other departments across the Commonwealth have provided significant advice to government, which is the normal thing that happens.

**Senator McLUCAS:** Do you think that the government understands that it will take two weeks from asking for an AUSMAT team to be deployed to having it deployed?

**Mr Bowles:** What I can say is that the department and many departments have provided significant advice to government. I am not going to go to what the government understands and how they understand it. That is not my remit.

**Senator McLUCAS:** Minister, do you know if the minister understands that it will take two weeks to action a deployment request?

**Senator Nash:** I am not aware. I will take that on notice.

**Senator SMITH:** Professor, I want to go to some opening remarks that you made. You talked briefly about the Ebola threat in West Africa being unlike previous Ebola experiences in other parts of Africa. Could you illuminate us on that particular point? I want to then get to a better understanding of the risk as it currently exists.

**Prof. Baggoley:** There have been around 26 outbreaks of Ebola virus disease in Africa since 1976. This is the first occasion that there has been an outbreak in West Africa. What we have heard—particularly in relation to the response in Nigeria—is that these outbreaks are brought under control with strong public health activities and measures. The World Health Organization described the health systems in the countries of Guinea, Sierra Leone and Liberia as being fragile. Of course, now they have been overwhelmed. What has been of concern in relation to the spread of the disease, particularly in West Africa, has been some of the practices, burial rites and funeral rites, where there is a practice of touching the dead body. Of course, the dead body is highly contagious, as I have explained. The virus just increases as the disease progresses. That has been an issue.

One of the major concerns has been that it has got into the capital cities there of Monrovia and Freetown, where the opportunity to spread has been greater. The health system has been overwhelmed. We have seen healthcare workers infected in their hundreds—certainly, more than 100 healthcare workers have died in those areas. They have been infected and died as a result of not having personal protective equipment, not being properly trained in it or because—in the circumstances in West Africa—it is very hard to wear that personal protective equipment in the heat for long periods of time, and there can be lapses there. So a combination of not being used to it, of it getting into the capital cities and of the system just not being able to cope makes this quite different to any other outbreak.

**Senator SMITH:** You, in your additional evidence, talked about preparation of the health workforce and the importance of understanding the setting and understanding the challenge. Is it that the uniqueness, if you like, of the West African experience means that we do not yet properly understand the challenge or the setting?

**Prof. Baggoley:** I think we have come to an understanding of both the challenge and the setting. The World Health Organization quite frequently spells out the nature of the challenge

there. It is then just a matter of being able to respond sufficiently to make a difference—that is the challenge.

**Senator SMITH:** Through the work that you were doing through the WHO, can you share with us what the attitudes of other nations or other NGOs have been in regard to our participation and our response to date?

**Prof. Baggoley:** I do not think other nations have expressed to me any comment one way or the other with regard to Australia's response to date. I would note that the World Health Organization at very senior levels has two Australians providing significant response. Dr Ian Norton is leading quite a significant part of the work now in Ghana but also from Liberia. His input, understanding and analysis of the situation, particularly earlier on in Monrovia, have had international importance. We also have Dr Rick Brennan, who has a senior role in the World Health Organization and who has spent a decade working in Liberia. His expertise has become most valuable in this outbreak as well. Both of them have made significant inputs. In relation to what one country is saying to another, I think that is a matter for other departments.

**Senator SMITH:** I accept that. Thanks.

**Senator McLUCAS:** Can I ask what support the government is providing to Australians who are in West Africa now?

**Prof. Baggoley:** I am not sure that is a question I can answer.

**Senator McLUCAS:** Are you aware of medical personnel who are currently volunteering in West Africa?

**Prof. Baggoley:** We are aware of people who are working with Red Cross and MSF who go to West Africa. We are particularly aware, working with both Red Cross and MSF, of when they are coming back. So both organisations are letting us know when they are coming back, and we are working with them to get an understanding of when they are going.

**Senator McLUCAS:** So your committee monitors that sort of movement?

**Prof. Baggoley:** That sort of movement is particularly monitored through the state and territory public health units.

**Senator McLUCAS:** So, if a nurse wants to go and volunteer with the Red Cross, she would tell her state committee? What is the process?

**Prof. Baggoley:** I think she would be encouraged to tell but not required. That is why we are working with both organisations in relation to understanding better the personnel who are going. Clearly their employers will know and many of them will be in the public sector, and so they will know.

As I said, we now know in advance. We get told each week when people are coming back, because they have different terms of rotation. They are met at the border when they are at the airport, and an assessment is made of their experience in West Africa and as to how they should then settle in—in the next few weeks in particular—on their return to Australia.

**Senator McLUCAS:** Did that happen with the nurse who eventually ended up in the Cairns Base Hospital?

**Prof. Baggoley:** Correct.

**Senator McLUCAS:** Do you have any comments about the way Cairns Hospital dealt with the nurse who came back from West Africa?

**Prof. Baggoley:** Not particularly. I know that the hospital and the Chief Health Officer there, Dr Jeannette Young, liaised closely. I know that there was some significant fear in the community. Senator, I would hope that all senators would be very keen to ensure that through any of their discussions they do nothing to exacerbate unnecessary fear in the community about the potential presence of such a disease if it were to come to their area.

**Senator McLUCAS:** Can I suggest that it was not a senator who did that.

**Prof. Baggoley:** No, absolutely. I am just talking with senators here. It is a general comment. I am really concerned about the level of fear that is in the community, which is unfounded, and the need for a clear understanding from all of us, if you like, in senior positions in society, of the mechanism of transfer of the disease and of the very, very low likelihood of any disease spreading within the community. I think it is important that at every opportunity we indicate that.

**Senator McLUCAS:** I agree with you that accuracy in terms of public pronouncements is important. That possibly led to a number of medical personnel trying to clarify the circumstance. Are you aware that those two medical personnel are still stood down from the Cairns Hospital?

**Prof. Baggoley:** Again, that is a matter for Queensland Health.

**Senator McLUCAS:** Has the government sought any agreement to embed Australian personnel with any other country's contingent, such as the United States or the UK?

**Mr Bowles:** Senator, I think we are getting into advice to government. That would not necessarily be an issue that would even be dealt with in the health context, because I think Professor Baggoley has already said there are people in the WHO, for instance, who are Australians and who work there in a normal sense. I do not think we could answer that question.

**Senator McLUCAS:** I do not know that it is advice to government, Secretary. I think it is actually—

**Mr Bowles:** I do not think we would know either.

**Senator McLUCAS:** You do not know, because it is actually a whole-of-government decision.

**Mr Bowles:** It will be a whole-of-government issue and it depends on what is happening across the board around, 'Do they want other sort of logistical expertise earlier?'—which in most cases they do.

**Senator McLUCAS:** Let us go to the question of medical evacuation. Has the government had any discussions through WHO or through diplomatic channels about evacuation from West Africa to another location should a person become infected?

**Mr Bowles:** That is a matter for Foreign Affairs.

**Senator McLUCAS:** So Health has no idea about this?

**Mr Bowles:** It is a matter for Foreign Affairs. They have the lead on diplomatic issues and how that might operate.

**Senator McLUCAS:** Has Health provided advice to Foreign Affairs about the health related elements of that?

**Mr Bowles:** Again, advice to government—

**Senator McLUCAS:** No, it is not advice to government, Secretary.

**Mr Bowles:** Well, I am afraid it is because it is an issue that is discussed at the National Security Committee across government-to-government agencies.

**Senator McLUCAS:** I would have thought it was advice between departments.

**Mr Bowles:** Departments exist to provide—

**Senator McLUCAS:** I understand national security and I respect that; that is fine.

**Mr Bowles:** It is advice in the context of a broad government decision. We do not have the lead on a lot of these issues. Any of the diplomatic issues is a foreign affair issue. It will best be asked of them.

**Senator McLUCAS:** But you have the technical knowledge—

**Mr Bowles:** Yes, that is correct—

**Senator McLUCAS:** about what should happen in best practice around health.

**Mr Bowles:** And we have provided and would continue to provide advice to government through the normal mechanisms of government on what should and should not happen if in fact we could get a solution on whatever that might be.

**Senator DI NATALE:** I have a couple of questions about the specific issue of medical evacuation. Are there any circumstances in which a medical evacuation to Australia may not in fact be dangerous? I put to you the scenario of a health professional who is very early on in the course of the illness, who may have developed a fever but who is still many days away from developing the serious complications that are associated with the progression of the illness. In that setting, would it not be appropriate to evacuate someone to Australia?

**Prof. Baggoley:** The short answer is no. That is because the progress and the rate of progress of the disease is unpredictable; it can be quite rapid. I do know, for example, from discussions with my counterparts in the United Kingdom, where it is a five hour flight from West Africa to London, that they would be most reluctant and, in fact, do not plan to evacuate to London someone who has already got symptoms. The window to take someone out of the West African situation is at the time there has been an initial exposure. After that, you probably have 48 hours. Basically, the United Kingdom is looking to treat everyone in country.

**Senator DI NATALE:** That is an interesting point. So the UK have made a decision that they think it is preferable to treat anyone who is infected in country.

**Prof. Baggoley:** Correct.

**Senator DI NATALE:** Have they identified specific facilities in which they would be treated?

**Prof. Baggoley:** That is what they are planning. That is what they are trying to erect in Sierra Leone in Freetown. They are looking to erect a facility which will cater for healthcare workers. It is still under construction. We understand that even the ability to construct at the

moment is difficult because of the range. My understanding through my discussions with my counterparts is that it still may not be until mid-November, if not later.

**Senator DI NATALE:** That is also my understanding.

**Prof. Baggoley:** It may be possible if they can get a flight—and getting flights in and out of Freetown is not easy—for them to contemplate taking someone out someone who has just had a needle-stick injury. That is if they can get a plane. But if they are showing symptoms, they plan to leave them to be managed in country.

**Senator DI NATALE:** Why is that appropriate advice for the UK and not appropriate advice for Australian health personnel?

**Prof. Baggoley:** It is relevant advice. I am not quite sure—

**Senator DI NATALE:** We have been told the only reason we cannot send health personnel is because we cannot evacuate them. Now you are telling us that in the UK they have made a decision that they will not evacuate. They think it is in the best interests of the patient to treat them in the field. So it seems to me that the single reason we have stated for not sending health personnel, which is the inability to evacuate them, is not relevant.

**Prof. Baggoley:** That is not the case. Evacuation can be at the time of exposure. The UK is five hours away—

**Senator DI NATALE:** But you have just said that they do not want to evacuate people.

**Prof. Baggoley:** That is the UK.

**Senator DI NATALE:** Yes. So why is that not appropriate for Australia? That is my question.

**Prof. Baggoley:** Because there may well be other facilities where someone could go that are closer. We know some Red Cross workers can go early on to Geneva.

**Senator DI NATALE:** Let's be clear about this. You have just said very clearly that in the UK a decision has been made that if a health worker is infected they will be treated in the field. I understand that there are field facilities. The treatment is supportive—

**Prof. Baggoley:** The treatment they are looking to providing in country is equivalent to First World treatment for international workers. They have yet to have such a facility.

**Senator DI NATALE:** There is no cure. When I say 'supportive treatment', I am talking about intensive care facilities and so on. There is an effort to create that facility in the field so that people do not need to fly. As you said, particularly later on in the course of the illness it can progress very rapidly. So it is, in fact, in the best interests of the patient for them to be treated quickly in the field. The UK have already made a decision that they are going to do that. Let me be specific. Given those circumstances, have you provided advice to government that says, 'We have that option available to us'?

**Mr Bowles:** Again, that is advice to government. As I said before, this comes from a range of different areas—

**Senator DI NATALE:** In your professional opinion, Professor Baggoley, given that you have engaged with a number of facilities and are communicating regularly with the World Health Organization and others—and obviously you have just talked about the policy of the UK—is it best practice if somebody is able to receive treatment that is equivalent to, in your

words, the treatment they would receive in their country of origin for them to be treated in the field?

**Mr Bowles:** I think that is—

**Senator DI NATALE:** I am asking for a professional opinion, Mr Bowles.

**Mr Bowles:** I understand that.

**Senator DI NATALE:** He is the Chief Medical Officer. I think I am—

**Mr Bowles:** I think it is unfair to ask for a personal opinion.

**Senator DI NATALE:** It is not a personal opinion; it is a professional opinion. He is the Chief Medical Officer of the country. He is employed to provide his professional opinion on these matters. I think it is an entirely appropriate question.

**Mr Bowles:** He is employed to provide his professional opinion to the government of the day.

**Senator DI NATALE:** So we cannot ask Professor Baggoley what he thinks is an appropriate medical practice? I am not asking what advice he is providing to government. I am just specifically—

**CHAIR:** Please allow Mr Bowles to answer. You can ask further questions. There is no restriction there.

**Mr Bowles:** Again, you are putting Professor Baggoley in a situation that I think is unfair.

**Senator DI NATALE:** Professor Baggoley has just told us what the situation is in the UK at the moment.

**Mr Bowles:** Exactly. He has told you—

**Senator DI NATALE:** He has also indicated to us that he is involved with a number of international committees. He is involved with committees here in Australia working with a range of different organisations. I just want to know whether, in Professor Baggoley's view, the UK policy of ensuring that people are treated in the field if they can get access to those facilities is appropriate for Australia? Is that best practice?

**CHAIR:** In asking these questions, I would remind senators and witnesses of the resolution on this matter, and that is that officers of a department of the Commonwealth shall not be asked to give opinions on matters of policy.

**Senator DI NATALE:** I am not asking about the Australian government's policy. I want to know whether Professor Baggoley thinks that it is good medical practice—

**CHAIR:** It is asking for an opinion on a matter of policy.

**Senator DI NATALE:** I am not asking about the government's policy. I am asking whether Professor Baggoley thinks it is appropriate medical practice to treat someone in the field once those facilities become available.

**Prof. Baggoley:** I think the importance is the context of the situation. We have spoken about the UK response. The UK is five hours from West Africa. In the European context, there is a European centre for disease control. In their algorithm they would have patients at the early phase coming out of country. But also they would assess a patient in the early phase of clinical symptoms as to whether they could evacuate them to a country in Europe which

would be closer than London. The options of treatment in country or evacuation to somewhere nearby can still be considered.

**Senator McLUCAS:** There are two types of potential patients, Professor. There are those who have had a known exposure. You are suggesting that those potential patients would be evacuated, in the case of British medical personnel, to Britain or to Europe if they are from Europe. I accept that. What I am trying to understand is the barrier for a potential Australian patient who has a known exposure to also be evacuated to potentially London or Europe where it is a five-hour trip. I cannot see what the barrier to that is.

**Mr Bowles:** I do not think we are necessarily talking about barriers. That is more of a diplomatic issue. It goes to the context of discussions with foreign governments, which we do not have in this portfolio. I totally understand the context of your question. But it is one of those questions that will go to Foreign Affairs. They deal with the diplomatic side of all of this.

**Senator McLUCAS:** As a committee, we are trying to understand what the Department of Health has done in those conversations across government around how Australia does what it can to assist with this Ebola outbreak. That is what I am trying to understand.

**Mr Bowles:** I appreciate that.

**Senator McLUCAS:** Can you provide our committee with any information about what has happened in the Department of Health to inform that sort of decision making from a whole-of-government point of view.

**Mr Bowles:** What I can say is that the Department of Health has provided significant advice to the government in relation to the health related aspects of the Ebola issue in West Africa. It goes to significant detail that you would normally expect a health department to provide. But it is advice to government, and the government is yet to make decisions on a range of different issues. That is where we are.

**Senator McLUCAS:** I cannot see that Health would have been saying to Foreign Affairs or PM&C that there is a problem for Australians to be treated if they are known exposed patients. I want to go to the second category of patients in a moment.

**Mr Bowles:** As I said, we would provide that advice to government. Foreign Affairs, PM&C and other departments would provide advice to their ministers for a conversation that usually happens in an NSC context, for instance, or whatever context the government decides it should be discussed in and all of those issues then come together. We will continue to provide all of those sorts of advice as and when required. As government makes decisions, we will move to implement those decisions.

**Senator McLUCAS:** The second part of my question is on those patients, let's say they are Australians, who contract Ebola in-country. This is a conversation that you have just had with Senator Di Natale. I cannot see what the obstacle would be, providing we had appropriate treating conditions—like a hospital. What would be the problem for an Australian to be treated in-country should they become infected with Ebola?

**Prof. Baggoley:** It then would depend on the nature of the illness and the nature of the facility, access to the facility and the level of care that can be provided. Understanding all of that would be very important for any Australian healthcare worker who would be volunteering to go to work in a circumstance such as that.

**Senator McLUCAS:** Does Australia have a responsibility? If they are volunteering, say with Red Cross, does Red Cross have a responsibility to provide care for that Australian health worker? Who is responsible?

**Prof. Baggoley:** Red Cross and MSF undertake all of that. Anyone healthcare worker that would be deployed through an AUSMAT would need to be advised and fully understand, before they volunteered, the issues about their physical and health security and how—if they became unwell for any reason—they would be cared for. They need to have a clear understanding beforehand. They want to know the nature of the facility. We have been concentrating on Ebola disease; any healthcare worker can get any other illness and they want to know what facilities there are to be treated in.

**CHAIR:** This is probably a reasonable time for us to suspend for 15 minutes.

**Proceedings suspended from 10:32 to 10:47**

**Senator SMITH:** I am keen to know how many questions on notice were lodged with the Department of Health at the May 2014 budget estimates.

**Ms Flanagan:** There were 562, and 91 per cent of those were provided on time.

**Senator SMITH:** Thank you—that was my second question. My third question is how many questions were lodged at the last budget estimates under the previous government?

**Ms Flanagan:** There were 241.

**Senator McLUCAS:** I am reading this from the tabled document in the Senate, so this is time wasting.

**Senator SMITH:** Is Senator McLucas brave enough to tell me what the response rate was?

**Senator McLUCAS:** Thirty-one were provided to the Community Affairs Committee by the appropriate date.

**Senator SMITH:** So the response rate was?

**Ms Flanagan:** Thirteen per cent.

**Senator McLUCAS:** It is in a document tabled in the Senate, so let's not waste the committee's time.

**Senator SMITH:** I am bringing it to an end. Senator Ludwig had spent quite some time on these issues generally in the Senate in the last Senate sitting week. So 562 questions and a response rate of 91 per cent, compared to 241 questions and a response rate of 13 per cent?

**Ms Flanagan:** Those are the figures I have in front of me.

**Senator SMITH:** Thank you. I want to move on briefly to the issue of the efficiency dividend. But, as I see the officials are not here, I will put the questions on notice rather than wait.

**CHAIR:** Thank you. Are there any other questions in whole of portfolio or corporate matters?

**Senator MOORE:** I will put mine on notice too.

**CHAIR:** That being the case, we will move to outcome 4, acute care. Senator McLucas.

**Senator McLUCAS:** Thank you. I have some questions around public hospital funding. I understand there was a letter that Minister Dutton sent to states and territories concerning an additional $100 million in hospital funding. Can I have some background to that letter? When was it sent? What was its purpose?

**Mr Sebar:** There were at least two letters sent on the matter of additional public hospital funding. Under the National Health Reform Agreement Commonwealth funding is paid under a formula, which adjusts; and during the 2013-14 year various parameters moved downwards, which meant that the Commonwealth would be providing less funding to states and territories. The government made a decision to provide additional funding outside the National Health Reform Agreement to states and territories to ensure that there was no volatility in payments to local hospital networks. The minister wrote after MYEFO, when the first adjustment was made; and he wrote again shortly after budget, making a second offer because of secondary adjustments that had occurred to parameters in the budget process.

**Senator McLUCAS:** So there were two events where funding was going south?

**Mr Sebar:** The formula for national health reform funding meant that national health reform funding was reducing, yes.

**Senator McLUCAS:** You said that the parameters meant that the funding moved downwards. What were the parameters that were changed?

**Mr Sebar:** For the 2013-14 year, public hospital funding was calculated using the formula for the old National Healthcare Agreement, and there were three parameters: service weighted population growth; a health price index calculated by the Australian Institute of Health and Welfare; and a technology factor. Of those factors, population and health price index were lower.

**Senator McLUCAS:** How did that happen? How does that work?

**Mr Sebar:** The Treasury receives information—estimates—regarding the population factors from the Australian Bureau of Statistics. ABS estimates of population growth were lower than the previous estimates that had been provided—

**Senator McLUCAS:** And they are provided by the state to Department of Health?

**Mr Sebar:** No, they are calculated by the Australian Bureau of Statistics.

**Senator McLUCAS:** Righto.

**Mr Sebar:** And the health price index is calculated once a year by the Australian Institute of Health and Welfare. The way the institute calculates that is by collecting cost information from a range of sources, including states and territories.

**Senator McLUCAS:** So the bottom line is that after MYEFO Minister Dutton wrote to states and territories. What was the content of that letter?

**Mr Sebar:** It was offering states and territories an agreement to provide them with additional funding, which offered them the balance of funds to counteract the reduction of funding that was being seen through the operation of the National Health Reform Agreement.

**Senator McLUCAS:** What are the details of that first-round offer?

**Mr Sebar:** I am afraid I do not have the letter on me, but, speaking from memory, the main requirement of states and territories was that, for the funds that were being provided

through the separate agreement, states would make those payments through the National Health Funding Pool to local hospital networks and that the Administrator of the National Health Funding Pool would record in his reports that those funds had been paid to states and territories, although they were nominally Commonwealth funds.

**Senator McLUCAS:** Did the letter identify health and hospital districts? What was the level of granularity?

**Mr Sebar:** No. The detail was that the funding was offered at the level of the state.

**Senator McLUCAS:** At state level. What was offered to each state and territory? What was the quantum?

**Mr Sebar:** I am afraid I have only got the budget figures in front of me. I do not have the break-up between the two, between the MYEFO amounts and the budget amounts, but—

**Senator McLUCAS:** Sorry, Mr Sebar, are you telling me that you have got the whole amount rather than the disaggregated amount?

**Mr Sebar:** That is correct, yes.

**Senator McLUCAS:** Let us start there.

**Mr Sebar:** New South Wales was offered $44.5 million; Victoria was offered $43.2 million; Queensland was offered $41.5 million; Western Australia was offered $17.8 million, South Australia was offered $17.1 million; Tasmania was offered $5.2 million; the ACT was offered $4.4 million; and the Northern Territory was offered $0.2 million—and that is a total of $173.9 million.

**Senator McLUCAS:** What was the formula used to come to that disbursement of funds?

**Mr Sebar:** The way in which each state's amount was calculated was by calculating for each state the amount of money that they would have received under the National Health Reform Agreement following the parameter adjustment and comparing that to the amount that had been published in the 2013-14 budget.

**Senator McLUCAS:** Can you say that again for me, please?

**Mr Sebar:** Certainly. In the 2013-14 budget, in Budget Paper No. 3, each state had a figure published in terms of how much funding they would receive under the National Health Reform Agreement. When Treasury applied the parameters to the funding formula—it has a differential impact on states depending upon population shifts—that then resulted in revised national health reform figures published in MYEFO and in the budget papers for 2014-15. The amount that was offered to the states was taking the difference between the figures published in 2013-14 and the amounts published in either MYEFO in 2014-15. Unfortunately, there is one added complication and that is that the 2012-13 final budget outcome also resulted in some adjustments to state funding.

**Senator McLUCAS:** That is right.

**Mr Sebar:** So all three components were added to make sure that, in a cash sense, no jurisdiction was worse off as a result of the parameter adjustments.

**Senator McLUCAS:** Is there a way that you could provide that to me in a table?

**Mr Sebar:** Certainly.

**Senator McLUCAS:** Because the other part of it is the Queensland and Victoria 2013-14 issue. I would like to get a better understanding of what the government has done around that.

**Mr Sebar:** Certainly.

**Senator McLUCAS:** So the total of that amount of money is $173.9 million. The Department of Health or the Commonwealth minister did not direct how that went down to local health networks. What was the nature of the agreement between the minister and the states?

**Mr Sebar:** I am sorry; I would need to check the detail of the letter. However, my recollection is that there was no specific statement that required states to spend the funds in a particular local hospital network in a particular way. I think the extent to which the Commonwealth may have placed any requirements on the states would have been to say, 'in line with the service agreements that you have agreed with your local hospital networks', because that is already a requirement under the National Health Reform Agreement. But I would need to check the detail of that.

**Senator McLUCAS:** Could the committee receive a copy of the letters that the minister has sent to the states and territories on public hospital funding?

**Ms Flanagan:** We would need to check with the minister's office. I am not sure what sort of marking they had on them, but we will certainly check. If we can do it, we will certainly do it.

**Senator McLUCAS:** Thank you. That agreement was just for the 2014-15 year?

**Mr Sebar:** It was 2013-14.

**Senator McLUCAS:** The 2013-14 year alone. What is in store for this year?

**Mr Sebar:** There is a significant difference between the 2013-14 and 2014-15 years. Under the National Health Reform Agreement, in 2013-14 Commonwealth funding was set at the level of the payments that would have otherwise been received under the old National Healthcare Agreement. From 1 July 2014 the payment arrangements changed, and the Commonwealth moved to funding growth in activity, using the national ABF system. What that meant was that the old formula no longer applied. The things which now impact on how much the Commonwealth pays are growth in the National Efficient Price, which is calculated by the Independent Hospital Pricing Authority, and state decisions about how much activity they choose to deliver. Variation in Commonwealth payments, within a financial year, will now only occur when a state or territory either changes its service agreements to increase or reduce activity, or where a local hospital network does not deliver the exact amount of activity that they have agreed to in their service agreement. The Commonwealth payment formula is no longer based on external parameters. States have control over the extent of the increases or decreases in Commonwealth funding, based on the decisions on how many and which services they wish to provide.

**Senator McLUCAS:** Could you then explain the new national efficient pricing arrangements and how they will work. What does the Commonwealth pay?

**Mr Sebar:** Dr Sherbon might assist in some of the detail. From 1 July 2014 the Commonwealth has agreed that it will pay 45 per cent of efficient growth in public hospital services. What that means is that the amount that the Commonwealth paid in 2013-14 will be

provided to states at a rate which the Commonwealth already pays, but for all new activity and all cost growth from that point in time the Commonwealth will pay 45 per cent of the cost. The Independent Hospital Pricing Authority calculates the National Efficient Price. That tells us how much the average cost of services grows by, and my recollection is that it was 3.9 per cent last year.

**Dr Sherbon:** The efficient costs.

**Mr Sebar:** The efficient costs. That is applied to all old services, if I can call them that, and the Commonwealth pays 45 per cent of that growth. Then there are additional services that were not provided last year. Those services are weighted by a national weighted activity unit.

That national weighted activity unit is then multiplied against the national efficient price and the Commonwealth then funds 45 per cent of that additional cost. Then those two components are added together, also added to the amount of funding that we provided in the previous year—the base year—and that provides the Commonwealth with its estimates for how much it expects to spend over the course of the year.

At the end of any particular year there is a reconciliation process, where states and territories advise the administrator of the National Health Funding Pool of the actual level of activity that they delivered, rather than estimates. The administrator then manages the same calculations to come to a final or an actual payment amount. He then advises the Treasurer, and adjustments are made to ensure that the level of funding paid appropriately captures the policy position.

**Senator McLUCAS:** Or the activity.

**Dr Sherbon:** That is right.

**Senator McLUCAS:** That is the final reconciliation. What I am trying to understand is what the trajectory of Commonwealth payments into public hospitals will be over time, given that very complex 45 per cent of growth and something else and add it altogether—what does it mean overall?

**Ms Flanagan:** On health we did provide these figures. We are happy to do those as are published in the budget papers. They actually show what is happening. They are based, in my simplistic description, on what is happening to the national efficient price multiplied by the growth in activity which is provided to us by the states. So it is an estimate of what the states think will occur in terms of growth in activity. The Commonwealth pays 45 per cent of that. We can give you the figures that were published in the budget, which give you an idea of the aggregate of what is actually happening to growth in public hospital funding over the coming years.

**Senator McLUCAS:** Thank you, Ms Flanagan. We had this conversation at the Senate select committee. It will be a bit duplicative between estimates and the Senate select committee because we are different committees and we have to go through the same work.

**Ms Flanagan:** I understand. I am just wondering if it would help if we refer you to responses that we have made to questions in that committee somehow or other. If you want to ask the same questions here, somehow or other we can cross-reference them so that we do not duplicate the work.

**Senator McLUCAS:** Can you provide the table that you provided to the Senate select committee to this committee?

**Ms Flanagan:** Yes, we can do that.

**Senator McLUCAS:** Would you do that on notice, or now?

**Ms Flanagan:** I have the table with me. I can read the figures into the *Hansard*.

**Senator McLUCAS:** Or is it something we could table, Ms Flanagan?

**CHAIR:** Are you still going?

**Senator McLUCAS:** Ms Flanagan is about to answer my question.

**Ms Flanagan:** If you can give us a moment, we will find the budget table in the paperwork.

**Senator McLUCAS:** Thank you. I will stop there until we get this document.

**CHAIR:** Senator Peris?

**Senator PERIS:** I have questions around the Palmerston hospital. It does not exist yet.

**Ms Anderson:** I believe that might be better handled in another outcome. My thoughts are it might be outcome 7 under the Health and Hospitals Fund.

**Senator PERIS:** Yes, the funding.

**Ms Anderson:** It is currently scheduled for 10 past three, but the chair will make decisions about timing.

**Senator PERIS:** That is okay, I can ask it under outcome 7.

**CHAIR:** Senator Brown, we have got a few more minutes for opposition senators before I will give Senator Smith some time.

**Senator CAROL BROWN:** I want to ask some questions around the merger with the five other agencies. Can you outline to the committee what discussions you have had concerning the proposed merger.

**Ms Anderson:** In line with the budget announcement in May, we have had fairly wide-ranging discussions and consultations. We have, of course, spoken to each of the agency chief executives, their board chairs and, in many instances, members of their boards or advisory structures. We have also spoken to each of the chief executives of the state and territory health departments and some of their senior executives and have also taken the opportunity of a broader consultation with a select group of both Commonwealth and state departments which have involvement specifically with the Australian Institute of Health and Welfare. They include the Commonwealth Department of Social Services, Housing South Australia, the Victorian Department of Human Services and the New South Wales Department of Family and Community Services. As well, we have spoken to senior members of the Productivity Commission and the Australian Bureau of Statistics. Finally, we also have spoken to the Australian Private Hospitals Association. So we have had fairly broad-ranging consultations.

**Senator CAROL BROWN:** Are you operating on the basis that you will continue beyond 2016?

**Ms Anderson:** The timing of the decisions the government is going to make is a matter for government. We have no decision yet on the timing of decisions about the future of any of the six identified agencies, or indeed the new agency which is mooted—the Health Productivity and Performance Commission.

**Senator CAROL BROWN:** Are you able to explain to me the national efficient pricing arrangements—the former government's commitment to the efficient pricing and contribution to the NEP?

**Ms Anderson:** That is moving back to activity based funding.

**Dr Sherbon:** The Independent Hospital Pricing Authority, IHPA, sets, or determines, the National Efficient Price on an annual basis following a consultation period involving the general public, national stakeholders, clinicians, states, territories and the Commonwealth.

**Senator CAROL BROWN:** Those are the arrangements, but what is the former government's commitment to the efficient pricing and contribution to the NEP?

**Ms Anderson:** I am sorry, Senator, could you clarify the question?

**Senator CAROL BROWN:** I wanted you to explain to me the NEP arrangements, which I think Dr Sherbon has just done, but I also wanted to have an understanding of the former government's commitment to the NEP.

**Ms Flanagan:** The current government is rolling out the arrangements under the National Health Reform Agreement. It has signalled that from 2017-18 it intends to move to a different way of funding. Certainly, the National Efficient Price is being rolled out, in effect, as envisaged under the National Health Reform Agreement.

**Senator McLUCAS:** That is paid at a different price, as Dr Sherbon has just explained.

**Ms Flanagan:** It is not paid at a different price. It was always that the Independent Hospital Pricing Authority would update the price. That is its function.

**Dr Sherbon:** The Independent Hospital Pricing Authority is in the process now of setting the National Efficient Price for the 2015-16 year. That will soon be circulated to all jurisdictions for comment. Should we still exist, we intend to set the price for the 2016-17 financial year. Thereafter, there is no role for the National Efficient Price in the Commonwealth funding arrangements of states and territories for public hospitals.

**Senator CAROL BROWN:** Can you explain the effect of reward funding towards meeting the emergency access targets and the elective surgery targets?

**Ms Flanagan:** Can you perhaps be a little more specific about what aspects of reward funding you are interested in.

**Senator CAROL BROWN:** How is the reward funding going to work?

**Ms Flanagan:** Under the National Partnership Agreement on Improving Public Hospital Services, a range of targets were agreed and signed up to by states and territories in terms of improving the wait times in emergency departments and also elective surgery. Elective surgery is a little more complicated because there are targets set within triage categories and there was also interest in trying to reduce the number of people that had waited the longest, so there were a couple of different targets in that. A baseline was set in the agreement of what current state activity was and then, in effect, increments were set over a number of years for states to actually improve that. Some states and territories had asked and had their targets

slightly amended. So you would still hit the end point, but perhaps because they were bringing on a new hospital or that they wanted to move more slowly to the target. So those were also reflected in the agreements if they wanted to change.

The COAG Reform Council—I think I have it right—monitored the achievement of targets over time and would report on those, and if targets were met then the government would pay reward funding under that agreement. Unfortunately, to date, many states and territories have not received reward funding because they have not been able to meet their targets. In fact some have fallen below baseline, so they have actually gone backwards, even though there was an up-front investment under that agreement. A number of reward payments have been made already for those states that have achieved, or partially achieved, their targets. I think payment still needs to be considered for 2013, so there is a lag while you assess whether they have reached their targets, and the government announced in this budget that it would not pay reward funding for the future years—I think there were two more years to run—because they had seen poor performance and it was unlikely that states and territories would receive their reward funding, because they had not achieved their targets.

**Senator CAROL BROWN:** When does reward funding stop?

**Ms Flanagan:** The last payment for reward funding, I think, was 2013—if I have that correct. It is done on a calendar year.

**Senator CAROL BROWN:** As a calendar year?

**Ms Flanagan:** Yes.

**Senator CAROL BROWN:** How many states did you say actually achieved their targets?

**Ms Flanagan:** I think Ms Anderson might answer that. I think, Senator Seselja, you were at the last committee, where I think the ACT was the only one to achieve on NEST and WA was the only one to completely achieve on emergency.

**CHAIR:** I think it was off a low base in the ACT, it must be said, but putting that aside.

**Ms Flanagan:** Ms Anderson can give you the details of what states' performance looked like?

**Ms Anderson:** I can confirm Ms Flanagan's response that, for the access target for emergency departments, WA was the only state in 2012, and for access to elective surgery ACT was the only state or territory to achieve the targets. For 2013—and the reports are in—no jurisdiction achieved all their targets for emergency departments and no jurisdiction achieved all their targets for elective surgery.

**CHAIR:** Are we expecting the table that was asked for by Senator McLucas? That is coming? Okay.

**Senator CAROL BROWN:** I think you mentioned the 2013 year. What was the reward funding for the ACT and WA in dollar amounts?

**Ms Flanagan:** In 2012?

**Senator CAROL BROWN:** 2012, sorry.

**Ms Flanagan:** I do not know whether we have it here, but we can give you what the payments were to the various states and territories.

**Senator CAROL BROWN:** I have lots more questions, but I will see how we go.

**Senator SMITH:** Excuse me, I was not paying a lot of attention to the discussion prior to the tabling of this document. What is this table that has just been provided?

**Ms Flanagan:** This table is taken from the budget papers and it shows the breakdown, state by state over the forward estimates period, of the payments that are to be made to states and territories for public hospital funding under the National Health Reform Agreement. And there is a little amount for public health too, which continues.

**Senator SMITH:** If I look at my own state of Western Australia, using the table that has been distributed, it says that the funding for Western Australia from 2013-14 to 2014-15 will go from $1,516.5 million to $1,722.3 million. Have I read that correctly?

**Ms Flanagan:** I have 1,516.5 in 2013-14 to 1,722.3 for WA, yes.

**Senator SMITH:** Then, if you go from 2014 to 2015-16, it goes from $1,722.3 million to $1,919.0 million.

**Ms Flanagan:** That is correct.

**Senator SMITH:** Then, from 2015-16, we go from $1,919.0 million to $2,134.4 million.

**Ms Flanagan:** Yes.

**Senator SMITH:** That shows an increase in funding of states for hospital services and public health.

**Ms Flanagan:** It does. The figure on the next page is the 2017-18 estimate of $2,188.8 million.

**Senator SMITH:** Which is an increase again.

**Ms Flanagan:** Which is an increase again.

**Senator SMITH:** So this table that you have distributed shows an increase in Commonwealth funding of hospitals?

**Ms Flanagan:** Of hospitals, and you will be pleased to know that for WA over that time it is an increase of 42.8 per cent.

**Senator SMITH:** So Western Australia will over the period 2013-14 to 2017-18 receive an increase in Commonwealth funding for hospitals of what figure?

**Ms Flanagan:** Forty two point eight per cent.

**Senator SMITH:** Starting with New South Wales, would you provide me with a percentage figure of the increase or decrease for each of the states going from left to right: New South Wales, Victoria, Queensland—Western Australia we have just done—South Australia, Tasmania, the ACT and the Northern Territory.

**Ms Flanagan:** It varies by state—

**Senator SMITH:** Of course, yes.

**Ms Flanagan:** but for New South Wales the increase is 35.3 per cent. For Victoria the estimated increase is 33.9 per cent. For Queensland the estimated increase is 34.8 per cent. WA, as I say, is very lucky at 42.8 per cent. South Australia is—

**Senator SMITH:** We would be luckier with GST distribution reform, but that is another estimates.

**Ms Flanagan:** That is for another day. South Australia is 28.6 per cent. Tasmania is 28.4 per cent. The ACT, unfortunately, Senator Seselja, is 12.7 per cent. The Northern Territory is 44.8 per cent. They are the estimates.

**Senator SMITH:** So if we look at those percentage figures that you have provided—putting territories aside for a second—the range of increase of Commonwealth funding to states for hospitals ranges from a 28.6 per cent increase—

**Ms Flanagan:** It was 28.4 in Tasmania.

**Senator SMITH:** through to 42.8 per cent for Western Australia.

**Ms Flanagan:** That is correct.

**Senator SMITH:** Let us be clear: the table that has just been distributed demonstrates that there is an increase of a minimum 28.4 per cent rising to a maximum of 42.8 per cent, depending on which state you might live in over the forward estimates.

**Ms Flanagan:** That is correct.

**Senator SMITH:** So that challenges this suggestion in the community that Commonwealth funding is decreasing over the forward estimates to states and territories.

**Ms Flanagan:** Certainly across the forward estimates, all of the estimates suggest it is increasing.

**Senator McLUCAS:** In cash terms.

**Senator SMITH:** So we just discussed there were the percentage increases. Correct me if my maths is not perfect. So the hospital funding for Queensland is projected to increase each year from $3.1 billion in 2014-15 to $3.8 billion in 2017-18?

**Ms Flanagan:** Queensland is $2.8 billion. Sorry, just to be clear, the table I am reading from has a slightly different base because it includes the figure that we have been talking about in the additional funding that was provided in 2013-14, so there might be a very slight variation on that but not a lot in the percentage figures I have quoted you.

**Senator SMITH:** Does this table come out of the portfolio budget statement No. 1.10 or does it come out of the budget measures paper?

**Ms Flanagan:** We will check where it came from but it is out of a budget paper.

**Senator SMITH:** It is a budget document; that is right, but I think it is a public budget document.

**Ms Flanagan:** They are public figures, yes.

**Senator SMITH:** Would someone be able to quickly do the calculation for me in what that percentage represents in dollar terms for each of the states and territories? That is not included anywhere.

**Ms Flanagan:** Again, because my table is slightly different because I have got the $160 million or $170 million in it. The dollar increase over the forward estimates is $4.8571 billion.

**Senator SMITH:** Is it true to say that that represents a nine per cent increase over 2015-16 or about $1.4 billion a year?

**Ms Flanagan:** Between what years?

**Senator SMITH:** Just for the year 2015-16 over the previous year.

**Ms Flanagan:** Again, the total I have here is, yes, it is 9.5 per cent.

**Senator SMITH:** So it is approximately a nine per cent increase in Commonwealth funding of hospitals in states and territories as a result of the government's most recent budget measures.

**Ms Flanagan:** They are certainly the estimates.

**Senator McLUCAS:** What would it have been under the previous national hospital reform agreement?

**Ms Flanagan:** I think in the other committee this was a question asked of Treasury, which had done some modelling of that, but Senator Di Natale asked for some further work to be done. I do not have that with me and it is a question that needs to be directed to Treasury but I think it is coming back through the other committee.

**Senator McLUCAS:** But has health done that work? You would have done it previously in order to produce budget papers for the 2012-13 budget.

**Ms Flanagan:** We did not do a comparison with what I think you are asking about—the old way of doing things—because the previous government had announced the move to these new arrangements so there was no need to do the calculations anymore. What we were doing was making estimates based on the new funding formulas.

**Senator SMITH:** I would like to go back to some of the previous evidence, and in particular I would like to understand what a couple of comments might mean for the future funding of hospitals across the Commonwealth. The first comment was that the new arrangements provide for state decision making on how much they choose to deliver and the second statement was about where the level of activity occurs in those local health area networks. Can you elaborate on those two points a little more for me, and on what that means for Commonwealth versus state control over funding.

**Mr Sebar:** Under the National Health Reform Agreement it is recognised that states are the system managers of the public hospital system. That essentially means that state governments make decisions regarding the level of services which they wish to provide through their public hospital system. They then, having made those decisions, enter into negotiations with local hospital networks, or whatever they happen to be called in that particular jurisdiction, to agree with the local hospital network on both the number of the services—typically how many additional services might be delivered in that local hospital network compared to the previous year—and also the mix of services that might be delivered depending on the facilities available within the LHN. That is structured to be a negotiation so that at the end of the day the system manager can make the best use of all of the public hospital facilities within the state to be able to direct funding to pick up pressure points and to react to particular issues that have arisen with their population base or their patient base.

The Commonwealth is very clearly standing back from those agreements. It asks that the states publish those agreements and that those agreements be provided to the Administrator of the National Health Funding Pool, but it is very clearly written in the agreement that the Commonwealth is not party to those agreements—the state has full control over how it chooses to deliver services. The Commonwealth has committed that, where a service has been identified as eligible for Commonwealth funding, we will provide a share of that funding based on the national efficient price.

**Senator SMITH:** What are the benefits of that approach over alternative approaches?

**Ms Anderson:** It is generally agreed among jurisdictions including the Commonwealth that the benefits lie in proximity to need—that states and territories and indeed local hospital networks are close enough to local populations in order to understand the need and also understand changes in the need as it presents, and therefore be in a position to best respond to that need.

**Senator SMITH:** So the local decision making allows the approach of health organisations, in this case hospitals, to be more responsive to the particular health needs or health outcomes that are required in that particular community—so for example the health outcomes that might be required in Tasmania as a result of an ageing population, et cetera, might be different from the health outcomes that might be required in Western Australia, where a high proportion of the population is Indigenous or there is a younger cohort of families, et cetera?

**Ms Anderson:** Generally speaking, yes.

**Senator McLUCAS:** The ability to drive efficiencies has now been moved, essentially.

**Ms Anderson:** I do not think that is generally understood. States and territories have an enormous stake in the game. They are the majority funders of public hospitals. They are watching very closely the delivery of services and the cost of that delivery, and I am sure, communicating regularly with their local hospital network chief executives from the department of health and states and territories as to how that work is being undertaken and how efficiencies can be achieved.

**Senator McLUCAS:** But the policy shift is clear from the previous government to this government in relation to the ability to drive change through national efficient pricing. The foot has now been taken off that accelerator to some extent.

**Ms Anderson:** I think that might be a matter of opinion.

**Senator McLUCAS:** Sure, it is a policy question. That is what has happened.

**Senator SMITH:** The Commonwealth's requirement that these local health networks make publicly available information to a central authority allows states and territories and, indeed, the Commonwealth to look at and better understand where efficiencies can be achieved and, as a result of that public exchange of information, perhaps moderate or amend their practices in states and territories to get the maximum outcomes or better efficiencies.

**Ms Anderson:** Yes, that is generally acknowledged.

**CHAIR:** Senator Smith asked for a bit of a breakdown of the states and territories and the increases. Senator Smith referred I think to a perception out there about cuts, but it is more than a perception because there are claims of cuts. I want to go to two jurisdictions. In the ACT you have said that the increase is not as high as the others, unfortunately. We would love to see obviously in the ACT always higher increases. The ACT government though has specifically claimed in a brochure to all people in the ACT that there is $240 million—I think that is the figure—of cuts from the Commonwealth to hospitals. Is that figure correct because I cannot see it in these ACT figures? Is that reflected in the figures that you have outlined to the committee?

**Ms Flanagan:** Certainly the ACT has raised that with us. I think we have been in discussion with them to try to understand how they have arrived at that figure because we cannot quite find it. I do not know if the officers who have been discussing it with the ACT have any more information on how they think it might have been derived.

**Ms Anderson:** We have had those discussions with the ACT officials and it would be fair to say that we have not run the figure to ground.

**CHAIR:** Okay. So they have put it out there in the brochure, the figures we do have show an increase in funding over the forward estimates in the ACT and they have not been able to identify what that $240 million is. I think it is important we have that on the record because I think every household in Canberra received something saying that it is a $240 million cut from the Commonwealth. It sounds like that is not based on fact at all and they have not been able to back it up, as far as I am aware, publicly. Likewise—

**Senator McLUCAS:** Well it is a cut. Everyone agrees.

**CHAIR:** They have claimed a $240 million cut and they cannot point to any of the figures.

**Senator SMITH:** It is not based on the table—

**Senator McLUCAS:** Compared to what they were going to get under Labor it is a cut.

**CHAIR:** They have not even been able to identify that.

**Senator SMITH:** Under Labor they were going to get budget deficits and debts. It is hard to imagine that the Commonwealth would have been able to—

**Senator McLUCAS:** You can have an argument about that, but we were going to get more money under Labor going to our hospitals. It is indisputable.

**CHAIR:** They clearly are not getting cuts. It would be good if they could identify that. The South Australian Premier has been very outspoken. We have referenced that. He is claiming that there are cuts, but we have heard there is a 28.6 per cent increase. The states and territories are majority funders of hospitals at the moment. South Australia are claiming cuts but are getting a 28.6 per cent increase. Do we know how much South Australia is increasing hospital funding in the same period? Do we have a comparison of that? Is that available to the department?

**Ms Flanagan:** Senator, we can have a look at that. We do analyse state and territory budgets when they come out each year, but sometimes there are different accounting conventions, which make it quite hard to do those kinds of comparisons. But we will see what we can get, in terms of a comparison and in terms of what is happening to the health budget of South Australia, certainly in the last analysis. And we can table that, or put that on notice.

**CHAIR:** I think that is important. Given that much of this is done in partnership, and that there are agreements in this area: is that something the Commonwealth seeks: instead of having to interpret the budget papers of various state and territory governments, do you actually ask for like-for-like figures—that is, how much states and territories are planning on funding their hospitals in the out years?

**Ms Flanagan:** That is probably more a question for Treasury, because under the agreement there is a 'maintenance of effort' clause where states and territories are expected, I think via their treasuries, to demonstrate that they are maintaining effort. I do not think that it

was set in concrete how maintenance of effort would actually measured, but Treasury certainly are engaging on that particular issue.

**CHAIR:** Okay. To the extent that you are able to get those figures; if it is appropriate for you to have those figures, it would be useful to have a comparison between what the Commonwealth is planning on investing in hospitals in the out years versus any figures you for have the states and territories. I think that would be a very good comparison for the committee.

**Senator CAROL BROWN:** Are you able to tell me how you assess the progress towards meeting the NEAT and NEST targets?

**Ms Anderson:** Senator, we receive progress reports from each jurisdiction. They undertake measurements across their hospitals and provide routine updates on how they are travelling against their targets. So it is a reporting function undertaken by states and territories through collation of information from individual LHNs.

**Senator CAROL BROWN:** Okay. So they report to you. But how do you assess their reports?

**Ms Flanagan:** Senator, the COAG Reform Council, the CRC, if I have got that right, is the organisation which assesses it. We do not as a department assess it—for reward funding.

**Senator CAROL BROWN:** All right. What functions of the Independent Hospital Pricing Authority will continue to be performed by another government agency?

**Ms Flanagan:** We are still discussing with government how it wants to merge the functions of the various agencies. So it is a work in progress at the moment. There has been no final decision on how the merger will occur. We are still discussing that with government.

**Senator CAROL BROWN:** And we do not know when there is an endpoint to that?

**Ms Flanagan:** No, Senator. There was not actually an endpoint announced for this particular merger. So we are still—as I say, the government is considering what to do here.

**Senator CAROL BROWN:** In terms of the Independent Hospital Pricing Authority's requirements under the National Health Reform Agreement, how has this changed? Or has it changed, following the government's decision to abandon the agreement?

**Ms Flanagan:** First of all, the government has not abandoned the agreement. The agreement remains. The Independent Hospital Pricing Authority continues to operate.

**Senator CAROL BROWN:** Does it operate in exactly the same way?

**Ms Falk:** At the moment, yes. Until the government has decided what it wants to do, in terms of managing functions, and how that is going to be carried on into the future, the independent hospital authority is getting on with business.

**Senator CAROL BROWN:** Is that correct, Dr Sherbon?

**Dr Sherbon:** Yes. We publish a work program every year under a requirement of our legislation, the National Health Reform Act. We are required to consult the public prior to formulating a work program, and that includes all nine jurisdictions. The work program is proceeding, however we are encountering one difficulty and that is an indication from the states and territories—most of them—that they are yet to decide whether to participate in our teaching and training costing study, which would inform the design of an activity-based

funding system for teaching and training. Apart from that impediment, we are working to a work program published recently, so, yes, we are proceeding. As I answered in a previous answer, our role will be relevant under the proposed arrangements for at least 2015-16 and 2016-17 but not thereafter.

**Senator CAROL BROWN:** What are the reasons that there are the issues with the states and territories that you have just indicated?

**Dr Sherbon:** It varies. States and territories vary in their approach to our teaching and training work. Just to back up a little bit: hospitals provide clinical care, and they provide a range of other services, one of which is teaching and training, and obviously research as well. We are intending to design a teaching and training activity based funding system. We have received a response from some jurisdictions that they will not participate in that costing study to inform that process, one on the basis that they are preoccupied with other work of ours. We are currently in the field on a major mental health costing study to inform a mental health classification system, so some jurisdictions say they are too busy with that. In the case of New South Wales, they have informed us that they do not feel that we have the mandate to proceed with a teaching and training costing study.

**CHAIR:** Are there any other questions in this outcome?

**Senator CAROL BROWN:** I have some, but I will put them on notice.

**CHAIR:** Thank you for that.

[11:46]

**CHAIR:** We will now move to outcome 5, Primary health care.

**Senator McLUCAS:** I want to go to Primary Health Networks first of all, please. When was the decision made that there would be 30 Primary Health Networks?

**Mr Booth:** The official announcement and maps and boundaries were made public about a week ago, and that was when the decision was announced.

**Senator McLUCAS:** No, that is not really my question, Mr Booth. My question is: when was the decision made that there would be 30?

**Mr Booth:** That would have been in discussions with the minister's office, and the minister would have decided at some point before the public release. I do not have an exact date as to when that decision was made.

**Senator McLUCAS:** So that is the minister's decision?

**Mr Booth:** It is the minister's decision. Absolutely.

**Senator McLUCAS:** And what is the rationale for 30?

**Mr Booth:** Professor Horvath, in his review that was released earlier this year, clearly indicated that in his opinion the current number of 61 Medicare Locals was too many. He felt that there was a strong case to be made for reducing the numbers, and he felt that the number should be reduced significantly. He came up with a number of principles for doing that and felt that the Primary Health Networks, as they came to be called, should be based on an alignment with a number of local hospital networks and also state boundaries. Work was then done to look at particular boundaries. Work was done to look at patient flows and alignment with local hospital networks and boundaries. That figure came up.

**Senator McLUCAS:** So do all the proposed PHN boundaries align with local hospital networks?

**Mr Booth:** They align with local hospital networks. In Victoria, as you will be aware, there are a large number of local hospital networks. There are larger clusters of local hospital networks there that they align with. There are different terms used in different parts of the country, but they do align with the LHNs.

**Senator McLUCAS:** I understand that the notion of the clusterings, but I am advised that they do not.

**Mr Booth:** In Victoria they should align and in Victoria as well, because of the large number of LHNs and the slightly different system that they have there, we try as far as possible to align with the hospital networks there but—taking into account populations, patient flows, ABS statistics for population size—we try to align with those hospital areas.

**Senator McLUCAS:** I understand New South Wales wanted a one-for-one establishment of PHNs. Why was that rejected?

**Mr Booth:** As I said, at the end of the day the number was the decision of government. Different people have different views in terms of numbers.

**Senator McLUCAS:** What was the government's view? Perhaps, Minister, you could answer this question.

**Senator Nash:** I am not aware of Mr Dutton's view. I can certainly take it on notice. I think it is worth traversing for the moment the reason we had the review. There was some concern on the ground that some of the Medicare Locals were working well but a lot were not. Certainly from the early days of reporting back there was very little direction in what they were supposed to do and how they were supposed to perform—

**Senator McLUCAS:** I think a lot of that was hearsay.

**Senator Nash:** No, it was not. A lot of it was quite correct and that is what led to the review. I am quite happy to take that on notice for you, but there were very sound good reasons that we moved to the PHN.

**Senator McLUCAS:** Will they all be established by 30 June next year?

**Mr Booth:** Yes, Commonwealth funding for Medicare Locals ceases on 30 June and so Primary Health Network funding commences from 1 July 2015.

**Senator McLUCAS:** Will they all begin to operate on 30 June?

**Mr Booth:** That is the intent, Senator.

**Senator McLUCAS:** That was not the question I asked. Minister, will they all be operational by one July next year?

**Senator Nash:** I think that is a very fair comment from the official to say that is the absolute intent. That is exactly what we are planning to do.

**Senator McLUCAS:** Are contingencies in place for that not to occur?

**Senator Nash:** I would say: we are in October at the moment and we are of the view that it will be able to be done at this point.

**Senator McLUCAS:** That was not my question.

**Senator Nash:** That is the answer I have given you.

**Senator McLUCAS:** Has there been any contingency planning?

**Senator Nash:** I am not aware of that, Senator.

**Senator McLUCAS:** How were the boundaries arrived at?

**Mr Booth:** As I said, the principles behind it were in alignment with local hospital networks' alignment with state boundaries. We did an analysis that looked at patient flows—both secondary care patient flows and primary care patient flows—and came up with options to group those different areas together to come up with the PHNs.

**Senator McLUCAS:** I understand that state boundaries were one consideration. Was any consideration given to patient flows not to follow state boundaries? I am thinking here of Albury-Wodonga or the Tweed and Coolangatta.

**Mr Booth:** We did look at patient flows and we were very aware of patient flows that go across boundaries in a number of areas in the country. I think it is fair to say that the intent for the PHNs and one of the strong drivers we have is the establishment of the clinical networks at a lower level. The purpose of the clinical networks is to assist the patient pathway to improve outcomes for patients at the ground level. We would expect that if there were significant cross-boundary issues then the clinical councils would cooperate with each other and the PHNs would cooperate in looking at those issues. Boundaries are always going to be an issue.

**Senator McLUCAS:** Can you confirm that McGrathNicol have been contracted to assist Medicare Locals with their windup?

**Mr Booth:** Medicare Locals have been contracted by the department to look at reasonable costs.

**Senator McLUCAS:** Okay. So this is the question about the potential costs of wind-up that Ms McDonald and I had a long conversation about. Do we have the answer to that question, Ms McDonald?

**Ms McDonald:** The Senate Select Committee on Health asked those questions, and we have prepared some answers—I think virtually all of them are over with the committee at the moment. I think that one is probably in transit.

**Senator McLUCAS:** What is the figure?

**Ms McDonald:** Sorry, Senator, I do not have it with me at the moment, but you will receive it, hopefully in the next day or so.

**Senator McLUCAS:** So you are answering, 'I can't answer that question'. How much is the contract with McGrathNicol?

**Mr Booth:** Sorry; I did have the figure, and I am pretty sure I know what it is; I just want to double-check the documentation I have here—it was $193,000.

**Senator McLUCAS:** What were they contracted to do?

**Mr Booth:** They were contracted to work with the department to analyse reasonable costs with Medicare Locals.

**Senator McLUCAS:** Has that work has been done now?

**Mr Booth:** They have been completing that work, yes.

**Senator McLUCAS:** Where was that contract funded from?

**Mr Booth:** That would have been from departmental administered costs, within the department. I can double-check that location.

**Senator McLUCAS:** That is okay. Did McGrath provide a report of the summary of those costs to the department?

**Mr Booth:** There is a report. I am not sure if it is the final report yet or if it is still in draft format. But they will do; yes.

**Senator McLUCAS:** I am going to try again, Ms McDonald—and I am starting to get a little bit troubled about the answer to this question. I am asking you for the figure of the potential cost of wind-up for 61 Medicare Locals. I do not think it is satisfactory that you just say that you are not going to give it to me.

**Ms McDonald:** Senator, the actual cost to wind up Medicare Locals, as I have explained before, depends on a number of factors.

**Senator McLUCAS:** That is not the question I have asked, Ms McDonald. Please just answer the question.

**Ms McDonald:** Senator, we do not have the actual cost.

**Senator McLUCAS:** No, that is not the question I asked.

**Ms McDonald:** Senator, can you explain the question as to what you are after?

**CHAIR:** What is the question, Senator? It is not clear to me.

**Senator McLUCAS:** McGrathNicol was contracted to negotiate with each of the 61 Medicare Locals what the reasonable costs of wind-up would be. McGrathNicol have provided a report to the department which enumerates those numbers. I think it is reasonable for me, as a member of this committee, to ask what that figure is—and I have asked it before.

**Ms McDonald:** Senator, I think the reason that we keep talking at cross-purposes on this is that there are two separate concepts which I think are getting confused. What we asked McGrathNicol to have a look at was the identification of the broad range of costs and commitments that might be potentially within scope for each Medicare Local, that could then be counted or considered in terms of a calculation of reasonable costs. That is not the level of reasonable costs that the government would pay for, at the point of wind-up. The reason for that is that whether or not the full scope of what might be in range is actually eligible for consideration of reasonable costs is dependent on a whole lot of factors. So where there are, for example, existing leases in place, you would expect that a large number of those would be used for PHNs or for the continuation of service delivery—because the Medicare Locals have contracts which are contracted services, where the service delivery would continue.

**Senator McLUCAS:** We have had this conversation, Ms McDonald. It is very clear in my mind. You have made it very clear to me. But I am asking for the figure of the projected wind-up cost for each of the 61 Medicare Locals, as provided to McGrathNicol and as provided by McGrathNicol to the department. I understand all of what you have described.

**Ms McDonald:** The actual wind-up cost is not a figure that we have at this point.

**Senator McLUCAS:** That is not the question I am asking.

**Ms McDonald:** That is a modelling exercise. The information that McGrathNicol got from each Medicare Local and worked with them on was clarity about the range of things that might be potentially in scope. That is different to what the actual wind-up cost would be for—

**Senator McLUCAS:** I understand that, Ms McDonald. I am asking you for that figure.

**CHAIR:** Senator McLucas, it is not clear what figure you are asking for.

**Senator McLUCAS:** Ms McDonald knows exactly which figure I am after, and so does Mr Learmonth and so does Mr Booth.

**Ms McDonald:** Senator, as with the previous committee, I had agreed to take it on notice. The work has been done. We are going through the process now of getting a figure to you that explains what it is and the context.

**Senator McLUCAS:** Just for the committee to know, this is an addition sum of 61 numbers. This is not a hard piece of work to do, Ms McDonald. I suggest that the report from McGrathNicol—and I have not seen it—has got that figure in there. I really think that the processes of this committee, as with the other one, the select committee, are being abused by the Department of Health. I really think we have just gone a bit too far.

**Senator Nash:** Senator, if I can just say, I think the official has been at pains to explain quite clearly the difference between the two processes. You are asking for a figure. She has very clearly explained that the McGrathNicol report is providing what is in scope and that it is not a specific figure.

**Senator McLUCAS:** Yes it is.

**Senator NASH:** It is not figure of cost. Senator, you might not like the answer, but the official has undertaken to take it on notice and again informed you that the answer is on its way to you. I think she has answered the question fairly. If you do not like the answer, that is unfortunate, but she has answered the question in her best endeavours.

**Senator McLUCAS:** I will take advice from the Clerk on this. In terms of the boundaries, I note that in the state of Queensland there are seven PHNs proposed but that four of those could be bid into one. Am I reading that correctly? Northern Queensland, western Queensland, Central Queensland, Sunshine Coast, Darling Downs and West Moreton could be amalgamated into one Primary Health Network. Have I read that correctly?

**Mr Booth:** Yes, Senator. The issue is with the geography of that particular area and that the patient flows in terms of patient population size is fairly small, so it could operate under a number of different permutations which may be that it could be part of one of the neighbouring PHNs or it could be bid for by itself. It was just making the point that they could be as part of one of those or as a stand-alone one.

**Senator McLUCAS:** So the second-largest state of Australia could end up with three Primary Health Networks?

**Mr Booth:** I do not think it is three. I think it is more than that.

**Senator McLUCAS:** Four.

**Ms McDonald:** Can I just clarify: the western Queensland one, which covers a large geographic area and has had three LHNs within it, could be bid for individually or it could be bid for as an extension of any of the other three. There is not a proposal that all of those be combined together. From the numbers I have here, you would either have six or seven.

**Senator McLUCAS:** That was the point of clarification I was seeking.

**Ms McDonald:** Yes.

**Senator McLUCAS:** So Western Queensland could be amalgamated with Northern, Central or Darling Downs?

**Ms McDonald:** Or any of the three LHNs that make it up could be bid for with their corresponding PHN.

**Senator McLUCAS:** Are you proposing that there could be a subdivision of Western Queensland?

**Mr Booth:** Yes, but those three down the coast would not be combined. They would remain as single PHNs.

**Senator McLUCAS:** Okay, that is news to me. Western Queensland has three LHNs in it, so who would make the decision then? How is that going to work?

**Ms McDonald:** In the procurement process, people would be able to bid for Western Queensland if they felt they had a business model to cover that area, and they could put in a bid separately. Those people who put in a bid for Darling Downs and Western Moreton, Central Queensland and Sunshine Coast and Northern Queensland could choose to put an extension bid into their proposal. They would bid for the whole thing and they would be considered for that, but they could also say that, in addition to that, we could also extend our area to cover either the whole of Western Queensland or one of the LHNs, and they would give us the advice on that. Then we would have a look and provide advice to the minister on the various options that came forward for covering the Western Queensland area.

**Senator McLUCAS:** Is it proposed that you will receive bids to provide a PHN for Western Queensland as a stand-alone?

**Ms McDonald:** Yes.

**Senator McLUCAS:** Right. So we will work it out when we see what the bids are.

**Ms McDonald:** That is right. It would be the option that would best meet the needs of the people of Western Queensland.

**Senator McLUCAS:** In terms of who can tender, and I understand the department is making no judgement at the moment around who could tender—anyone can, essentially—what about state governments? Can state governments tender?

**Mr Booth:** Yes, a state government could tender.

**Senator McLUCAS:** What are you going to do around—and this is a broader question, not just around state governments—managing conflict of interest, when a tenderer may have a conflict of interest? How will you manage that—not only in the tendering process, but then in the service delivery into the future?

**Mr Booth:** Certainly, that will be part of the tender process that we are going to be going through. We are doing a lot of development, as you can imagine, in terms of the tender around how the people who are bidding address conflicts of interest within the bid that will come in. And of course when we are doing the assessment we will take a look at actual and perceived conflicts of interest within those bids, to make sure that they have been addressed.

**Senator McLUCAS:** Do you see that there would potentially be a conflict of interest for a state government bidding for a primary health network?

**Mr Booth:** We cannot really say, because it would depend upon the nature of the bid that came in. We cannot say as to what kind of bid they would put together to actually do that and to address any conflicts of interest.

**Senator McLUCAS:** Was Queensland Health made aware of the PHN boundaries before they were announced?

**Mr Booth:** No.

**Senator McLUCAS:** No?

**Mr Booth:** We had discussions with state and territory governments around boundaries because we needed to look at hospital flows, but the boundaries that were released last week were all released to everybody at the same time. There was no prerelease to any party whatsoever.

**Senator McLUCAS:** But consultation with the states has occurred?

**Mr Booth:** We talked to states, as we do on a whole series of things, and they had opinions and views. We needed to talk to them about the hospital flows.

**CHAIR:** I will now move to Senator Smith.

**Senator SMITH:** Thanks very much, Chair.

**Senator McLUCAS:** (Indistinct)

**CHAIR:** You had a block of 20 minutes, and so now I am moving on to Senator Smith.

**Senator McLUCAS:** I just want the committee to know that I had not finished.

**Senator SMITH:** I was interested to read in the report the suggestion that the term 'Medicare Local' was confusing. Can you elaborate on that?

**Mr Booth:** That is correct. The report found that people confused 'Medicare Local' with Medicare more generally and there were occasions where people got offices confused and that kind of thing. Professor Horvath felt that the name was not—

**Senator SMITH:** Not necessary for the success of the Primary Health Networks?

**Mr Booth:** Yes.

**Senator SMITH:** Am I correct in saying that an audit was also undertaken of some or all Medicare Locals?

**Mr Booth:** There was an audit undertaken, yes. As part of the supporting analysis done for Professor Horvath's report, an audit was done of the Medicare Locals, yes.

**Senator SMITH:** That audit, if I am correct, found that some Medicare Locals had expended moneys outside their funding agreements.

**Mr Booth:** It did. The audit that was undertaken was essentially a basic audit, with more intense work done on a number of side visits. I think it was six Medicare Locals in total. At the higher level things were pretty much okay. But there were occasions and instances of expenditure not being entirely appropriate.

**Senator SMITH:** What were some examples of some of that expenditure?

**Mr Booth:** The area that was highlighted in the report was some expenditure around travel expenses that were not for core functions.

**Senator SMITH:** I suppose the important part is what has been learnt as a result of that discovery. Having done the audit and come across instances where expenses have been used not in accordance with the funding agreement, how has that informed the department's opinion around the work that the PHNs should now do?

**Mr Booth:** We have used the results of that work to inform the policy development that is going on with the Primary Health Networks. That work also fed into the grants area. As you will be aware, the department has a Grant Services Division that does a lot of work in the grants area, and there are a lot of linkages with individual grant recipients. That work has been shared and has certainly been involved in the policy development that we are doing at the moment.

**Senator SMITH:** There is a view that larger organisations make corporate governance easier to do and easier to monitor.

**Mr Booth:** Yes. I think Professor Horvath's view was that the 61 Medicare Locals unnecessarily duplicated administrative functions and corporate functions across the country and that you could gain economies of scale by having a smaller number of larger organisations. You would not need as many boards, for example, and you would not need as many administrative areas. That was his key argument, I think. Also, his argument was that the staff that were needed could be better deployed in a smaller number of larger organisations.

**Senator SMITH:** Under the competitive tender arrangement process, if an existing Medicare Local is unsuccessful, it does not necessarily mean they have to close. They could still transform themselves into a service provider, couldn't they? Is my understanding of that correct?

**Mr Booth:** That is correct. The Medicare Locals have a number of ways forward they could go. They could, in some cases, bid to become a new PHN by themselves as a single bid. They could collaborate with either other Medicare Locals within the area or other agencies or organisations from outside. They could decide to just cease. You are correct: they could also decide to not bid for a PHN but turn themselves into a service provision organisation. That is a decision they could make before determining whether they are going to bid or not or afterwards if they are unsuccessful.

**Senator SMITH:** In all honesty, I was surprised to see that Western Australia would have one organisation outside the Perth metropolitan area. I owe it to myself as a regional Western Australian senator to discuss this.

How would Mr Horvath or the department justify one network over an area that captures the Kimberley region in the north, with very high levels of Indigenous population; Albany in the far south, with a large non-Indigenous but ageing community; then young families spread across the Western Australian wheat belt and mining towns like Kalgoorlie? How do we envisage an organisation like that working with such variant health needs, big differences in population characteristics and the sheer distance? For those who are not familiar, the Kimberley of Western Australia is at the tip of the Australian continent and Albany fronts the Great Australian Bight. So how do we justify that?

**Mr Booth:** The key role there is where the clinical councils come in, in terms of operating at a more local level. Those clinical councils are based on existing WA Country Health Service boundaries. So they all link in with the boundaries that already exist. I take on board what you are saying. It is a huge geographical area but we would see the organisation that runs that being very dependent on the more local intelligence—both clinical and consumer—that it gets from the clinical councils and the consumer advisory committees in those areas.

**Senator SMITH:** So when someone comes to me and shows me the map, that would give me a limited understanding of how the new arrangement will work, because underpinning that will be these clinical councils that will be closer to local communities and will capture those particular health needs or health outcomes that are unique to those particular parts. Am I correct in saying that those clinical councils will be modelled on the existing Western Australian model?

**Mr Booth:** Yes.

**Senator SMITH:** So, at a sub-level we are trusting a model that is used by the Western Australian state government to deliver health outcomes.

**Mr Booth:** That is correct. The boundaries for the clinical councils were all based upon existing local hospital networks or the boundaries that were used within WA, which, I understand, align with WA Country Health Service boundaries.

**Senator SMITH:** As a result of that we can expect greater symmetry or alignment between what the state government might be doing in those primary health areas and what this model will seek to do.

**Mr Booth:** That is correct. Yes.

**Senator Nash:** It might be worth adding just a couple of points. One is around the funding. Reducing the administration and duplication is going to free up more funding for the provision of actual services. The other thing to point out is that they are going to have a much closer alignment with GPs. One of the criticisms of the existing Medicare locals in many of these areas is that there has been little, if any, relationship with the GPs. We see that as absolutely crucial in making sure that we have that regional delivery.

**Senator SMITH:** The Horvath report made it clear that seeing the GP as central was critical to the future success of any network. You are quite right, the new model will be administratively more efficient and, as a result of that, will free up more money to deliver better health outcomes.

I am wondering whether the map could include some of those—what is the right word?—sub-networks so that people can get a sense that the structure is a little bit more decentralised than might first appear on those maps.

**Mr Booth:** We can certainly take a look at that and see if we can highlight how that may work.

**CHAIR:** I wish to follow on briefly from Senator Smith's questions about where there is evidence of expenditure on things prohibited by the deed of funding. Under the deed of funding is there an ability to recoup that expenditure. What happens in those cases?

**Mr Booth:** It would depend upon the seriousness of the situation. The department, the Commonwealth, always has the ability to go in and audit particular areas and recover funds if

it is considered a particularly difficult area or if there are large sums of funding involved. I guess it would depend upon the sums involved. We monitor organisations through their funding agreements and through the reports and different bits and pieces that come back to the department.

**CHAIR:** That is what could happen. What has actually happened in the cases where it has been identified?

**Mr Booth:** I do not think these sums involved were large. We have certainly, in a couple of areas—we are working with some of the Medicare Locals to say, 'Overall, things are okay but there were some instances here where you were not complying with the deed.' We have a grant-services division with regional offices. We have highlighted who the regional officer is. The regional officer has been going in and working with the Medicare Local to make sure that everything is compliant. They understand the terms of the deed and do that.

**CHAIR:** I can read from that, then, that in no case that you are aware of has any funding been recovered.

**Mr Booth:** Not as far as I know, but I will double-check.

**CHAIR:** Does the deed itself provide provisions for that kind of process, if someone breaches—are there provisions in the deed as to the ability of the Commonwealth to recoup or is that something that is handled in other ways?

**Mr Booth:** I would need to double-check the exact wording of deed in that area.

**CHAIR:** Thank you.

**Senator WRIGHT:** I have been in other committee, so if I ask questions that have already been asked just let me know. I understand the department has been unable to advise what plans they have for the future of Partners in Recovery contracts where the lead agency is a Medicare Local. I am interested in whether the department can provide any information about what will happen in these instances.

**Mr Booth:** The Medicare Locals exist until 30 June and then Primary Health Networks take over. There are a number of areas, in terms of transition, in a number of services which come to an end at the end of that particular period or, as in the case of Partners in Recovery, where the contract goes for a further year and lead agencies in that area are Medicare Locals.

The answer is that we are working closely with Medicare Locals and Partners in Recovery consortia to look at how we deal with that. Our key aim with Medicare Locals, in working with them over the next six months, is to ensure that service delivery is prioritised and that there is no reduction in service delivery that they need to do. We would certainly make sure that was happening, as far as we could, with Partners in Recovery.

**Senator WRIGHT:** So at this stage you are working with them closely, but there is no answer for those organisations.

**Mr Booth:** Not yet. As we are doing with a number of different areas, we are working with the Medicare Locals; we are working with the consortia to work out the transition period.

**Senator WRIGHT:** When will that information definitely be available?

**Mr Booth:** We are working to get tender information out, as soon as we can, for the establishment of Primary Health Networks. The work we are doing in Partners in Recovery and a number of other areas is moving alongside that. We are very conscious of the need to do

this as quickly as we can, and we are working as fast as we can. I do not have a specific time frame that I can give you for that, but we are working on it.

**Senator WRIGHT:** It is the Primary Health Networks that will deliver the Partners in Recovery program when the Medicare Locals no longer exist.

**Mr Booth:** It would depend. There may be a number of different options that might come out of that. Primary Health Networks are intended to be purchasers of services primarily and not providers of services, so we will need to work through with Medicare Locals exactly what happens. We discussed, a few minutes ago, the different permutations that might happen. Some Medicare Locals may bid to become a PHN and continue, in which case there is one conversation there with them as a lead agency. A Medicare Local may bid and not be successful, in which case there is another conversation with the consortia as to what happens to that contract. We need to work through all of these on a case-by-case basis, in terms of Partners in Recovery.

**Senator WRIGHT:** I will reiterate the concerns raised by my colleague Senator Smith. I am from a fairly large state too, South Australia. I was pretty concerned to see that there are going to be two Primary Health Networks there: one for the Adelaide metro region and one for the rest of South Australia, which is from the APY lands in the north down to Mount Gambier in the south and across. What guarantee is there for clients of Partners in Recovery that they will have continuity of care, notwithstanding these changes?

**Mr Booth:** To take the first part of your question in terms of South Australia, the answer is very similar to the WA answer. The PHN outside of Adelaide conforms to the country South Australia boundaries. There would be clinical councils and community advisory committees established within South Australia that conform to the boundaries of country South Australia as it operates at the moment. We would anticipate that that would work well and that we could get that work going. In terms of the specifics around Partners in Recovery, I can reiterate what I just said—that we will work with old Partners in Recovery agencies that are affected by the move to primary health networks with the intent of ensuring that nobody falls through the cracks. We are aware of the issue and we are working to do that.

**Senator WRIGHT:** It is my understanding that the government will defer the establishment of the remaining 13 Partners in Recovery organisations for two years, from 2013-14, saving $53.8 million. Could you confirm that that is the intention and the saving? I also understand that the money will be invested in the medical research fund. Is that correct?

**Mr Booth:** Yes, that is correct.

**Senator WRIGHT:** Will the money be invested in mental health research in the medical research fund?

**Mr Booth:** I do not know the answer to that question, I am sorry. It would be another area of the department.

**Senator WRIGHT:** Who should I ask about that? I wonder whether Senator Nash could assist with that. Is that a decision that the research fund itself would make or is that a decision that government would make?

**Senator Nash:** I am not aware of that, but I am happy to take it on notice for you.

**Senator WRIGHT:** Thank you. I will wait. Let me know if there is someone else I could ask today. I come to the National Mental Health Commission review. Will the government respond to the National Mental Health Commission review?

**Mr Booth:** As you know, Senator, the review is due to report at the end of November. I would imagine that the report will be presented to government. I cannot say exactly what the response would be, but I would expect that there would be some response.

**Senator WRIGHT:** Would the response be by the department or the minister?

**Mr Booth:** It is a report to government, so the government would respond. The department will certainly do the work the department does in terms of analysis and advice—

**Senator WRIGHT:** By government you mean the executive government?

**Mr Booth:** It is a report to government.

**Senator WRIGHT:** So you would imagine that it would be the executive government that would respond?

**Mr Booth:** I would need to double-check, but it is a report to government.

**Senator WRIGHT:** So we really do not know whether there will be a response or when that response might be and what the expected time frame for that might be?

**Mr Booth:** We do not have time frames yet.

**Senator WRIGHT:** Mr Butt, do you have any indication?

**Mr Butt:** No, I know nothing further other than the fact that we need to deliver the report to government by 30 November and that it is a report to government. It is then up to the government as to what it does with it.

**Senator WRIGHT:** Certainly the sector has indicated concerns. It seems that a lot of things have been put on hold pending the review. People are concerned that there is a risk that this might—with respect, Mr Butt, and with regard to all the work you are putting into it—end up being just another report that sits on the shelf gathering dust. Is there any way that we know that is not going to be the case? Is there any guarantee that we can have that there will be a response and that there will be a meaningful response to the review?

**Senator Nash:** The government will consider it in the way we consider reports in the usual process. There has been a very clear intent from government that this is a very important review and it was commissioned for a range of reasons that were very important. I can certainly indicate to you the level of importance of the review.

**CHAIR:** We will have to leave it there. We are due to suspend for lunch. I advise that we still have some time to go on this outcome. After lunch, we would expect to go to outcome 5 for a little while longer.

**Proceedings suspended from 12:29 to 13:31**

**CHAIR:** Welcome back. We will continue with outcome 5.

**Senator McLUCAS:** I am going to go back to the estimation of the liabilities for the winding up of Medicare Locals. I ask again: what is the total figure identified in the McGrathNicol report for the potential liability of winding up of the Medicare Locals?

**Ms McDonald:** My understanding of what you are after is the funding that is within scope for consideration of reasonable costs for the 61 Medicare Locals. It is not the actual cost that

you are after. You are after what the figure is if you add up all the funding the 61 Medicare Locals have that is within scope.

**Senator McLUCAS:** I am asking for the figure that each of the 61 Medicare Locals has identified in their discussions with McGrathNicol that is their potential liability should they be wound up.

**Ms McDonald:** As I said earlier, there are two concepts here. I have the figure for the whole funding which is within scope for consideration of reasonable costs for the 61 Medicare Locals. We do not have the figure for what the cost will be for the changeover because—

**Senator McLUCAS:** No, that is not what I am asking.

**Ms McDonald:** there are a whole lot of factors that influence that. All we have is the funding each of the Medicare Locals has identified through the work with McGrathNicol and what is potentially within scope, knowing that what is likely to be the actual requirement will be significantly less than all of this. We have the figure if you add up the 61.

**Senator McLUCAS:** What is that figure please, Ms McDonald?

**Ms McDonald:** That figure is $112 million.

**Senator McLUCAS:** How did you come to that figure? What is in scope?

**Ms McDonald:** The sorts of things that are within scope—and it was McGrathNicol who worked with the Medicare Locals to do this—are all existing leases, the arrangements for staffing and other liabilities that the organisation has. It is the whole gamut of the sorts of things that you could potentially reasonably consider within scope. However, as I said before, it is not the amount that we would expect would be paid out because a lot of things would continue. Infrastructure would continue to be used et cetera. We would expect a range of programs to be transferred across and existing staff to continue to operate those.

**Senator McLUCAS:** Are any of the Medicare Locals contesting the figure that McGrathNicol has identified?

**Mr Booth:** As far as I know, no, but it is a process that they are working through with the Medicare Locals to come up with that number. As I said before, we have various drafts, and they have been working through that.

**Senator McLUCAS:** Thank you, Ms McDonald. That has taken a lot of time. $112 million is very different to the $250 million that has been discussed. May I have the list—no, I will not ask that question. That would then identify various Medicare Locals.

Let us go to the tender now. When is the tender expected to be released for the PHNs?

**Mr Booth:** We are aiming to have the tender out towards the end of this year. We are working through process at the moment and policy. At the moment, aiming toward the end of this year and hopefully the end of November is what we have been saying.

**Senator McLUCAS:** Hopefully the end of November?

**Mr Booth:** We would be looking to as soon as we can, yes.

**Senator McLUCAS:** How long do you expect it to be open for?

**Mr Booth:** It would be open for the six weeks—well, we would need to take into account when the tender actually went out to work out how far towards the end of November or early

December, because then you are getting into Christmas. We will just need to look at timescales when we actually release it.

**Senator McLUCAS:** So merry Christmas!

**Mr Booth:** That is the issue. You cannot just do it tightly over Christmas. Obviously if anything is there then you need to take that into account.

**Senator McLUCAS:** So a minimum of six weeks, but potentially more if it is going to include the Christmas period?

**Mr Booth:** If that happens, yes.

**Senator McLUCAS:** Who will be eligible?

**Mr Booth:** The intent is that the tender is open to any organisation to be able to apply, either singly or as consortia.

**Senator McLUCAS:** Have you had any interest from overseas health organisations?

**Mr Booth:** Not to my knowledge, no.

**Senator McLUCAS:** Do you want to take that on notice?

**Mr Booth:** I can. We can have a look at some of the responses that came through, but in terms of expressing interest I have not got that list with me. I am sorry.

**Senator McLUCAS:** How much has the department allocated to the development of the tender?

**Mr Booth:** I think it is within departmental resources. I do not think we have a separate budget for it. It is work that the department is doing within the primary care division and the Grant Services Division.

**Senator McLUCAS:** So there have not been any external contracts or consultancies engaged?

**Mr Booth:** For development of the tender, yes, there is some external consultancy work that has been done in terms of working with the department around the development of the tender. Yes.

**Senator McLUCAS:** Who are they, and what are they doing?

**Mr Booth:** There is a contract at the moment with Deloitte, who are working with the department in looking at that.

**Senator McLUCAS:** And what are they doing, Mr Booth?

**Mr Booth:** They are looking at tender documentation. They essentially are looking at experience of running similar kinds of tenders, models from overseas and best practice—the best way to approach a market in doing this kind of procurement.

**Senator McLUCAS:** Are there any other external consultancies or contracts?

**Mr Booth:** Specifically on the tender, no, but I will double-check.

**Senator McLUCAS:** How much has been spent on external consultants?

**Mr Booth:** I will need to take that on notice.

**Senator McLUCAS:** How will the tender be assessed?

**Mr Booth:** We are working through a tender assessment process at the moment. As you would be aware, we have quite strict probity rules and issues around this as to who can do this. We would anticipate that the lead will be taken by our Grant Services Division in terms of doing that, but there may be external probity advice and possibly external financial advice in terms of the financial analysis that needs to be done. We are looking at that at the moment.

**Senator McLUCAS:** And the time frame for the assessment of the tender?

**Mr Booth:** Again, we are working that through. There is a time frame that we need to do in terms of when the tender goes out, when they come back and what space we then have to play with in terms of ensuring that we can get the PHNs established from 1 July. We will work within that time frame that we have available. We have not got an exact time frame.

**Senator McLUCAS:** I cannot imagine, Mr Booth, that you have not done a planning document that says: 'Today is the middle of October and 1 July will be there and this is what's going to happen in those months and weeks between now and then.'

**Mr Booth:** That is correct.

**Senator McLUCAS:** I am sure you have got one of those?

**Mr Booth:** We do have a rough idea but, as you were saying before, if a tender goes out for a minimum of six weeks then you need to work from the date that the tender actually goes out.

**Senator McLUCAS:** What do you expect will be the time frame for the assessment of the tender?

**Mr Booth:** We would be looking to assess in early 2015.

**Senator McLUCAS:** How many weeks do you think that will take you to do?

**Mr Booth:** I cannot answer that at the moment. As I said, we are working with colleagues in other divisions in terms of how we will do that and the process that we would actually undertake.

**Senator McLUCAS:** When will successful tenderers be advised of their success?

**Mr Booth:** Again, it really depends on the time frame. But if we are looking at assessing within the early part of the year, then as soon as possible within the year to ensure that we can get that transition process in place and working.

**Senator McLUCAS:** What is the department's assessment of the time required from approval to actually being able to start as a PHN?

**Mr Booth:** At the moment we have indicated that we would see the final quarter of this financial year as a period when the PHNs will know that they are operating and, depending on the configuration of which consortia or individual group is successful, they can work together with the Medicare Local or whoever. So about a three-month window.

**Senator McLUCAS:** So you would expect that, by the end of March, people would be advised?

**Mr Booth:** Yes.

**Senator McLUCAS:** Coming back to the Queensland circumstance where we have got that big slice of western Queensland, how are you going to assess applications if entity A says: 'I'm going to do North Queensland and the top half of the west,' and someone says, 'I'm

going to put in for Central Queensland and all of west.' How will you work through that? Is there an iterative process whereby you can work with applicants or is it a case of, once the tenders are in, it is a closed tender?

**Mr Booth:** That is not necessarily very different from other competitive tenders that we have run in the past where you have a number of different applications which come in. We will work through that issue as it comes up. I cannot predict what the bids will be that come in.

**Senator McLUCAS:** No, that is right. But I am trying to understand how, if there is half of one bid that is good and half of another that is good, do you then negotiate through a strict competitive tender?

**Mr Booth:** As with any procurement exercise, we will have a protocol for going through an assessment, assessing the tenders that come in and we will work towards that. What you are getting at is that it may be unequal—if I can use that word—because some people may be bidding for part of it and some for the whole of it. It will be a case of assessing each bid on its merits and working through that and seeing how that fits together.

**Senator McLUCAS:** My understanding from the material is that it is only Queensland that faces this question.

**Mr Booth:** It is certainly possible for more than one organisation to bid. It is certainly possible for a consortia to bid for more than one PHN. But in terms of having a small population size within a geographic area like that, I think it is a fairly unique issue.

**Senator McLUCAS:** We will see what happens.

**Senator MOORE:** Just in terms of that same process and I understand the complexities of the assessment process, should the circumstance that Senator McLucas described occur—and I am sure that it is not peculiar to this particular one—does the department have the opportunity to consider them all and recall at that stage?

**Mr Booth:** We have not established final procurement documentation yet. But certainly in procurements that have been undertaken previously, the Commonwealth reserves the right if there is no bid that comes in that actually meets all the—

**Senator MOORE:** I cannot remember where something of that nature occurred. But the department gave the people who bid some feedback and then they talked to each other and came up with a composite bid. So that step is available to the government in this process, as with others?

**Mr Booth:** That has certainly happened with the move from divisions to Medicare Locals.

**Senator MOORE:** Do people who are applying know that that is a possibility?

**Mr Booth:** We are working through the tender documentation at the moment, so I cannot say whether that will happen.

**Senator MOORE:** The communication process would be that, if it comes to a stage where there is no clear person who meets all the requirements, you then communicate at that time to the people who—

**Mr Booth:** If that were going to be the hypothetical—

**Senator MOORE:** I am trying to get the standard process on record. Then there is the opportunity within the standard process that you can communicate at that stage within the business models, and what you can do within that process, to re-establish what you need and then try to get that met by the people in the circumstance?

**Mr Booth:** Yes, in that kind of model. But, as I say, we have not actually got that developed yet.

**Senator MOORE:** It is good to be prewarned.

**Senator McLUCAS:** Will the potential conflict of interest issues that we were talking about earlier today be written into the tender material?

**Mr Booth:** We would anticipate that if there are potential or perceived conflicts of interest within a consortia or a bid coming together, that they would need to be highlighted.

**Senator McLUCAS:** So the applicant would need to expose that potential in their application?

**Mr Booth:** You would expect that.

**Senator MOORE:** If they do not and it is found that they have not been completely transparent, that leads to a legal situation?

**Mr Booth:** I would need to take advice on that. But certainly under any procurement process if somebody applies and does not tell the truth, then—

**Senator MOORE:** And misrepresents the process so that automatically leads to a legal situation?

**Mr Booth:** Clearly, yes, you would need to put processes in place for that.

**Senator McLUCAS:** We have previously talked about market failure. Have the FAQs that were on the website around market failure been updated?

**Mr Booth:** We have not updated that particular area.

**Senator McLUCAS:** So it still says, 'We're trying to work out what market failure is.'

**Mr Booth:** It still says that we are looking at the issues of market failure and, again, that will be developed within the tender documentation as well.

**Senator McLUCAS:** Will there be a clear definition of 'market failure' by the time people apply?

**Mr Booth:** Yes, the approach to market failure will be within the tender documentation.

**Senator McLUCAS:** So we will not know until the tender material is out?

**Mr Booth:** We are working on it at the moment, as we have said, within those frequently asked questions. We update them as often as we can. But at the moment we are still doing policy work around how that works.

**Senator McLUCAS:** With respect to the frequently asked questions, I think July was the last iteration?

**Mr Booth:** I thought there was an update more recent than that. Yes, there was an update last week.

**Senator McLUCAS:** That came out with the actual—

**Ms McDonald:** 15 October is the latest version.

**Senator McLUCAS:** How long will the contracts for the new PHNs be awarded for?

**Mr Booth:** Again, we are working through that issue at the moment. We will confirm that within the tender documentation.

**Senator McLUCAS:** What will PHNs be funded to do, given the government's expressed view that they will not deliver services except in places where there is market failure, whether undefined?

**Mr Booth:** If you look at Professor Horvath's report and also the frequently asked questions where it goes through the functions of Primary Health Networks, as primarily purchasers of services, you will see they include: to have a clinical focus on working with GPs and other clinicians to ensure that patient outcomes are maximised within the area that they are responsible for, to work with local hospital networks, to work between the primary, secondary, tertiary and community sectors to ensure that patient pathways are appropriate and as good as they can be and to look at needs. I think there is quite a bit of information within that report.

**Senator McLUCAS:** It has been put to me, Mr Booth, that it is pretty much what Medicare Locals do. But that is a comment.

**CHAIR:** If you could make this your final question, then I will move to Senator Di Natale.

**Senator McLUCAS:** The last issue I will try to explore is: what is the thinking behind how funding will be applied? Will it be on a population basis? How will funding will be applied to each of the 30 PHNs?

**Mr Booth:** Again, that is work that we are undertaking at the moment. It is policy-development work that we are working through.

**Senator McLUCAS:** What are the options, in your mind?

**Mr Booth:** As you said, there are a variety of options within any funding model you can look at, such as population based funding formulas that have been used in a number of areas or direct funding, but it is a policy-development process we are looking at, at the moment.

**Senator McLUCAS:** So we do not know; okay. Thank you.

**Senator DI NATALE:** Just to get to that issue of the clinical councils, can you give me a rundown on the average number of clinical councils per Medicare Local—sorry, PHN?

**Mr Booth:** The intent is to have one clinical council per LHN area. If there is a PHN that covers three LHNs you would have three. That is the intent. It may differ in rural and remote areas if there is an overlap of the same clinicians, so basically doing work in a number of different areas, but the intent is to have one per LHN area.

**Senator DI NATALE:** What about in Victoria, where there are huge numbers?

**Mr Booth:** As you will see from the boundaries we have done, we have done a clustering of the LHNs together there to come up with the boundaries. We are working through—and I think it is on the maps that have been produced—where those boundaries would be. We were trying to link in with existing Victoria boundaries and groups within there.

**Senator DI NATALE:** Regional boundaries?

**Mr Booth:** Yes, the existing ones.

**Senator DI NATALE:** It seems to me that there are now two layers, where there was previously one and a smaller Medicare Local. We have this overarching PHN and then underneath it we have this number of clinical councils. Is that not another layer of bureaucracy?

**Mr Booth:** We have larger PHNs—larger moving down, as you know, from 61 to 30. The intent of the clinical councils and community advisory committees is to provide advice and to really ensure that the PHNs have that local clinical input, at the local level, to enable them to do that.

**Senator DI NATALE:** In total, how many clinical councils would you—

**Mr Booth:** I do not have the number off the top of my head, in terms of LHNs they are linked to, but as much as possible we would expect the PHNs to be linking in with the LHN, to see if there are existing processes that may be there—existing councils or groups that actually do some of this work and do not duplicate activity that is already happening.

**Senator DI NATALE:** Could you explain that a bit further?

**Mr Booth:** In some areas, in some states—in some LHN areas—each hospital will have its own Senate committee, for example—

**Senator DI NATALE:** Its own—

**Mr Booth:** Senate—clinical Senate—within the hospital. But in some areas we know that there are existing groups of clinicians who come together to do a similar kind of function, and 'Can we link in with those?' to ensure that we are not duplicating.

**Senator DI NATALE:** So that work is not developed yet. How far—

**Mr Booth:** Again, we will be looking through the tender process for the applicant to come forward and say how that would run.

**Senator DI NATALE:** But if you determine the boundaries and are not aware of where there are these existing networks of clinicians, how do you know you have not sliced in half one of these existing networks?

**Mr Booth:** Because they are linked into the hospital boundaries. What I am saying is that the intent is to have clinical councils that are aligned to those LHN areas. If, within that LHN, there is an existing council or group that may do some of this work, that can be linked into, then the PHN would be expected to look at that.

**Senator DI NATALE:** You have already, I think, had a number of questions around some of the issues I wanted to address, but do you have a time line of when you expect the number of clinical councils to be established and up and running, so we know exactly how many we are talking about?

**Mr Booth:** We would expect, within the response to the tenders, for the responses to come in and indicate how the clinical councils will run. We would be expecting from 1 July that there is a significant move to establishing those or at least knowing what that structure will be.

**Senator DI NATALE:** Have you determined whether you will have to develop specific guidelines for any of the private health insurers who may choose to tender for one of the PHNs?

**Mr Booth:** We are not developing specific guidelines for specific groups; it will be an open tender for a consortia of different groups.

**Senator DI NATALE:** Do you identify that there may be any possible issues for specific PHNs, a tender from a private health insurer for a PHN?

**Mr Booth:** I think that maybe covers the previous questioning where we were talking about conflicts of interest and issues that may arise there that we would expect to be identified within the tender approaches and we would look at as part of the assessment of the application.

**Senator DI NATALE:** If there was an existing arrangement for a private health insurer with a number of general practices, for example the Queensland model where we have got Medibank Private working closely with a number of general practices, would you be comfortable if there was an application by Medibank Private for a tender of the PHN that covered that jurisdiction?

**Mr Booth:** I cannot answer that.

**Senator DI NATALE:** Do you see that there would be a serious conflict in that setting?

**Mr Booth:** As I said before, if applications are coming from individual groups, individual organisations or consortia then within that application we would expect them to identify actual or perceived conflicts of interest and to indicate how they would be dealing with those.

**Senator WRIGHT:** I want to go to the recommendations of the *'The hidden toll: suicide in Australia'*, the Senate report into suicide in 2010. This might be a question for Senator Nash to start with. I note that their National Party's 2013 federal election policy platform included a commitment to implementing the recommendations of the *Hidden Toll* report. Is the minister able to comment on the government's intention to keep that commitment?

**Senator Nash:** Not at this stage. We are certainly well aware of those issues, but not at this stage.

**Senator WRIGHT:** When you say you are 'well aware of those issues', do you mean the issue of the National Party making that pre-election commitment?

**Senator Nash:** I mean the issues contained in the report. It would be a matter for the senior minister, and I would be happy to take that on notice for you.

**Senator WRIGHT:** Leaving aside that particular issue of her pre-election commitment, does the government have any intention to implement the recommendations of that report at any time and what sort of time frame might that have?

**Senator Nash:** Again, it is the responsibility of the senior minister and I am happy to take that on notice.

**Senator WRIGHT:** I would like to ask now about the fact that it has emerged that there will be around about $20 million, arguably possibly more, of mental health program funding which will have its indexation frozen for up to four years. Is that correct?

**Mr Booth:** I am not sure. Could you give me some more information?

**Senator WRIGHT:** I might have to wait and get some more information about that.

**Mr Booth:** If you could get us some more information around the specific centre specific programs than I would be very happy to look at that.

**Senator WRIGHT:** There is a reference to a document but I do not have that handy. I will now come to the issue of eating disorders. I am interested to know what data the department has in relation to the prevalence of deceit eating disorders in Australia in 2014 or recently.

**Mr Booth:** Again, I do not have that information on me. We would need to take that on notice and see who the appropriate organisation is that collects that type of data. We can certainly look into it and we would be happy to make that information available.

**Senator WRIGHT:** When you say 'the appropriate organisation', would that be a part of the department or an NGO?

**Mr Booth:** That is what we will look at. I do not have the eating disorder information with me at the moment but I am aware that a number of different organisations and a number of different NGOs work in the area of eating disorders. I am not clear and I cannot think off the top of my head whether there is a consistent data collection across all of them to pull that information together, but I will certainly look into it.

**Senator WRIGHT:** What is the current level of government funding allocated to address eating disorders in Australia?

**Mr Booth:** I would need to take that on notice.

**Senator WRIGHT:** Could you separate that into direct and indirect funding?

I come back to some questions in relation to advice. There have been a lot of concerns raised about the potential effects on mental health and mental ill health of young people particularly who will be subject to proposed changes under the budget in terms of not being able to be in receipt of payments under Newstart and so on. I am interested in what consultation and work might have been done between the Department of Social Services—who have the carriage of that particular legislation, of course—and the health department in relation to those proposed changes to welfare and the impact those changes will have on people with episodic mental illness, for instance. Was there any consultation undertaken? Was there any advice sought from your department?

**Mr Booth:** Again, I would need to take that on notice. As you said, this is an initiative that other agencies do, and I know that they run a number of their own mental health services in various areas, but I do not have the answer to that question, I am afraid.

**Senator WRIGHT:** I am trying to work out how executive government operates, I suppose. I am interested in the consideration of those budget measures which were proposed in the budget. Was there any procedure in place whereby the Department of Health, which is the federal government department that is responsible for mental health programs and mental health data, had its advice sought—or was any modelling done—from the department of social security or the government in terms of those proposed budget measures?

**Mr Booth:** Again, I would need to take that on notice. I do not know the answer to that. In terms of general budget areas, it is not this division that would look at issues around general budget issues or decisions.

**Senator WRIGHT:** I suppose it is not specifically, necessarily, a financial issue.

**Mr Booth:** Yes, there is the impact.

**Senator WRIGHT:** I am interested in what, I think, people increasingly are seeing as a concern, which is the silo approach to governing, whereby something that seems like a good

idea to some people might have predictable flow-on effects—not just financial but human. That is why I am interested when you respond and say there may be some NGOs or some other organisations that are doing this work. I am also interested in understanding what the role of the Department of Health is in terms of that work or pulling that information together and giving good advice about policy. If you could take that on notice, that would be good.

**Mr Booth:** Yes.

**Senator WRIGHT:** Does the Department of Health plan to offer any programs or any training to the department of social security in relation to young people with mental illness to ensure they are not improperly cut off from their benefits? Would it be envisaged in any way that the expertise that the Department of Health might have could be utilised in that way?

**Mr Booth:** There are no specific plans for training to be offered by the Department of Health to other departments in that way. We would not do that kind of training, no.

**Senator WRIGHT:** I am interested in whether the department, or indeed the minister, is aware of recent research which indicates links between austerity measures—which have been undertaken in other countries, for instance—and an increase in suicide rates. There are some publications that have come out recently. Is any work being done in that area, or is there any information that is known to the department or the minister?

**Mr Booth:** As you know, the issue of suicide is a kind of multifaceted issue. Really, suicide rates, we know, are impacted by a whole host of different societal areas. We are aware of research that is done both within Australia and internationally around suicide rates, particularly among different groups in different areas. As you know, the government, through its Taking Action to Tackle Suicide policy and the Suicide Prevention Program, funds a number of different organisations—quite a large number of organisations—to work within different groups in society and also within different areas to try and minimise the impact and to do as much work on suicide prevention as possible. It is quite a wide question as to research that has been done. We are aware of a lot of research that has been done, and we use that to inform policy and to inform policy advice to government.

**Senator WRIGHT:** I am interested in what policy advice to government has been requested. The reason I am asking it is that there has been significant concern raised by credible and experienced mental health commentators throughout Australia particularly in response to the proposed changes to Newstart for young people under 30 and, if the legislation were to be passed, the consequences for them not being in receipt of income for periods of up to six months. It is a really important issue to know whether or not the Department of Health has had any input or is using any of its resources to talk not generally about suicide—because of course we are all concerned about suicide strategies—but about the fact that there may be a government policy that could inadvertently lead to such a significant consequence. I do not get the feeling that you are going to be able to answer my question in any more detail at this point, but I am specifically asking about research in Scandinavia and other places that have linked austerity measures to an increase in suicide rates among the population. You are not aware of anything like that, specifically, as I understand it.

**Mr Booth:** Certainly we are aware of research that links suicide rates through to different areas and different situations.

**Senator WRIGHT:** What about that particular issue?

**Mr Booth:** Off the top of my head, there is nothing that I have read or looked at very recently from the Scandinavian research in particular. As I said, there is a lot of Australian research and that kind of thing that we do look at, but I am not aware of the Scandinavian research. Having said that, I am not across all the research that comes into the department. I can certainly have a look and get some advice from our experts in the mental health area to see if they are aware of research that has been done overseas, particularly in Scandinavia, to do that. The other comment I would make is that there is often interdepartmental work being done on some of these issues but I do not know the specifics around that particular area as to what work has been done and what has happened there, so I would need to look at that.

**Senator WRIGHT:** You will take that on notice for me; thank you. That is really what I would like you to do. Also, perhaps you could help me understand whether this is the sort of situation where—and forgive my ignorance of how government departments work—you would have to wait to be requested to provide that kind of input, or it is one where, if people within your department were concerned about that and it was within your bailiwick, I suppose, they could offer to provide information or policy advice to another department. How would that work?

**Mr Booth:** I will have a look at that, Senator.

**Senator WRIGHT:** I would like to come back to those other questions at some point. I will quickly get them, but I will pass now.

**CHAIR:** Before we move on to other questions, I understand the Secretary has a statement in relation to Ebola.

**Mr Bowles:** I want to clarify some information that is, I think, misconstruing a range of things that were said this morning. From a domestic perspective, the country is well prepared to deal with Ebola. I want to make that very, very clear. States and territories have been training their staff and running exercises in the designated hospitals for a while now. They are very experienced in these sorts of things. The systems have been tested, and obviously the experience around the nurse in Cairns is an example of where that actually worked. The guidelines were followed. The responses went along the lines that we would expect. They have been reviewed. From the perspective of the Chief Health Officer and the Chief Medical Officer that system performed well. I want to make it very clear that we have confidence that the states, territories and the public health system more broadly in Australia is very well prepared for that.

In relation to regional preparedness, the speculation around Australia not being prepared is not correct. Australia is prepared in a regional sense. As I said this morning, there have been a number of occasions when we have responded to regional issues of one sort or another. In specific relation to Ebola, I have asked for a few clarifying points to drive home some of the messages we were trying to give.

There are a number of caseworkers—around the 20 mark—who are fully trained to care for Ebola patients, and we would obviously use them, in the first instance, for any immediate response. To say that we are not ready to do what we need to do is not true. These people have been vaccinated, they are used to the climate and they have been doing all sorts of work in this area to be prepared. What would normally happen in circumstances like this is that you have your immediate response. While these people would be dealing with the immediate

emergency, the department has a national incident room and that would be stood up. We would then be looking at assessing what additional support would be required.

I said this morning that there are a whole lot of logistical issues and forward planning things that do swing into action. Every time there is a disaster in the region, these things swing into action. They are things like deploying field hospitals and a range of those sorts of activities. We are well prepared and well versed in those sorts of issues.

We clearly have to make some assessments around the security required when people are on the ground, because we obviously want to make sure our people are safe. While we have got immediate response and a whole lot of things happening—field hospitals and the like—at the same time we will be training a whole range of other people who are ready and rearing within a broader health network to do these sorts of things. This is, again, something that has been around for a long time. There are some hundreds of people who are prepared. After the immediate response, we would make sure they are all trained in the latest PPE. We would make sure a range of those things are in place.

I just want to be very clear that we are prepared to deal with the issues within the region and we are prepared within the domestic response to deal with any cases, or suspected cases, within the country. I wanted to get that on the record because I know that there is a whole lot of stuff out there saying that we are not prepared. That is not true. We can come back to the specifics when I have got more people here this evening in outcome 9 if you want to challenge any of those issues. Thank you very much, Chair, for your indulgence.

**CHAIR:** It is reasonable that there be a couple of brief follow-up questions on that, given that you have brought it back to Ebola. We will not go into a lot of detail, but I will give senators the opportunity to ask a couple of questions.

**Senator McLUCAS:** I want to agree with you that, from a domestic perspective. I live in Cairns. We experienced, a couple of weekends ago, an inappropriate response from a certain political leader in our town. As a result there was fear in our community about what may or may not have happened. It is my view, from speaking to a number of the players, that the response from Cairns Hospital—with probably some exceptions—has been fine. I am in email contact with the nurse herself. She is fine; the hospital dealt with it properly. The only thing that concerned me is that, because of the ill-informed commentary from a certain person, the response from some of the medical staff was a desire to clarify the circumstances. That has now resulted in what I think is an inappropriate situation where those medical personnel have been stood down. They can have an argument about whether or not someone was following protocol—speaking to the media or not speaking to the media—but the net result is that we have got two medical staff who should be at work and they are not, and they are really significant, important players. That is not an issue we can discuss here. But I want to confirm, from my perspective, that the domestic preparedness is as it should be for a First World country, and that is great. These estimates were about trying to get the good information out there. What I am concerned about, though, is: what is the ability for Australia to respond, either on direction from government through AUSMAT deployment into West Africa or—heaven forbid it happens—where we have a necessity to react in a regional sense?

I am now pleased to know that there are 20 people who are trained. I will ask later what their skill sets are and if they are an AUSMAT team ready to go should the trigger happen. I will ask how long it will take for them to deploy. Those are questions for later in the day. That is

the purpose of these estimates: to provide some clarity to the public about what is going to happen.

**Mr Bowles:** As I said, I want to get some figures on the table because this issue is really, really important. It is no good sparking fear in the community—

**Senator McLUCAS:** No.

**Mr Bowles:** or communities more broadly.

**Senator McLUCAS:** That is right.

**Mr Bowles:** We can come back this evening to deal with any of those questions you have. That would be great. We will have the experts here then. I do not think I will call myself an expert on day 8!

**Senator McLUCAS:** Thanks, Mr Bowles.

**Senator DI NATALE:** I have one quick question. Sorry, I only caught—you are saying there are 20 trained Australian health personnel. Are they AUSMAT staff, or are you talking about people working within the international NGO settings?

**Mr Bowles:** They are people who are healthcare workers trained in the treatment of patients with Ebola.

**Senator DI NATALE:** We know that already because we know that we have deployed MSF workers from Australia. We have had briefings from nurses who have returned.

**Mr Bowles:** They will be in the hazmat system. It will be best to wait until this evening so I can get the details.

**Senator DI NATALE:** All right. Yes.

**Mr Bowles:** I just do not have all the detail, but they are within our system. Just to understand the system: these people work day to day in our hospitals all across the country. They are pulled in based on experience, based on a whole lot of things.

**Senator DI NATALE:** Correct.

**Mr Bowles:** The fact is that there are 20 people available who are fully trained, acclimatised, vaccinated and the like to deal with these sorts of issues and who could be deployed if and when or whatever is required.

**Senator DI NATALE:** Again, I do not want to go over this ground, but there is a distinction between whether these are people who—we know already that we have Australian trained health personnel because some of them have been in the field with NGOs. I think the more important question is: if Australia needed to call on its AUSMAT team—

**Mr Bowles:** The short answer is yes, but let us wait until tonight to get that.

**Senator DI NATALE:** All right.

**Mr Bowles:** But the short answer is: yes, Australia is ready. Obviously all these things are graduated responses.

**Senator DI NATALE:** My question—

**Mr Bowles:** You do not go from zero to a thousand overnight, but we have an immediate response capability. The big issue in a lot of these things when you do have disasters is things

like field hospitals and the like that you need to get in place. That is already available and can move quite rapidly.

**Senator DI NATALE:** Can I just say one more thing, just to agree with Senator McLucas's comments. My questions this morning were not at all intended to generate any anxiety within the Australian community. To be frank, I think Australia is in one of the best positions anywhere in the world to respond to a domestic outbreak. I think the issues are more about how we can respond regionally and in West Africa.

**CHAIR:** Senator Wright, were you cut off before?

**Senator WRIGHT:** I was not cut off, but I just did not have the information to assist the department with the questions. I now have it, so I could perhaps go to those programs.

**CHAIR:** Yes, you can have a few more minutes.

**Senator WRIGHT:** Thank you very much, Chair. Mr Booth, if you remember, I was asking you about the fact that it seems that there is around $20 million, arguably more, of mental health program funding which will have its indexation frozen for up to four years. I am going on a response to a question that was asked by Senator Wong of Senator Cormann after the budget. It was a question on notice on 2 July. It was with reference to the budget measure 'administered program indexation pause'. Are you familiar with that program?

**Mr Booth:** I know that there was an indexation pause across a number of programs, yes, but I am not certain of the detail.

**Senator WRIGHT:** That is the document I am referring to. I am just interested in understanding better what it means. I will take you to some of the programs that are mentioned in the Health portfolio. There were 32 programs altogether. I am interested in the mental health ones. In the national depression initiative, it looks like the total savings from the commencement date on 1 July 2015 for the following three years would be $1.020 million. There is the Better Access to Psychiatrists, Psychologists and GPs MBS program. The saving there appears to be $0.873 million. There is COAG Mental Health—additional places; COAG Mental Health—support for children; COAG Mental Health—support for day-to-day living in the community; COAG Mental Health—telephone counselling; Leadership in Mental Health Reform; Mental Health More Options Better Outcomes; and the National Mental Health Program. That might be it for the mental health area. They are the types of programs I am talking about. Are you familiar with what I am talking about?

**Mr Booth:** Yes, Senator. I can make some comments and my colleague Mr Cotterell may make some comments as well.

**Senator WRIGHT:** Thank you for that. I am interested in knowing what model was done to inform the government's decisions about which programs had their indexation frozen.

**Mr Cotterell:** This was a whole-of-government exercise where the indexation was frozen across a large number of programs across all portfolios. It was a decision taken at whole-of-government level, that large programs would need to freeze indexation as part of the general fiscal discipline. There was not specific modelling on these programs. The indexations are a very small percentage of the overall size of the programs. Each program is taking a save.

**Senator WRIGHT:** Who determined which programs were going to be targeted in the Department of Health? Was that a Department of Health decision or was that a decision from elsewhere?

**Mr Cotterell:** It was a whole-of-government decision and, as said, it applied to programs right across government, not just the Department of Health.

**Senator WRIGHT:** But not every Department of Health program was affected, so I am interested. I do not know what a whole-of-government—

**Mr Cotterell:** It is in relation to grants programs.

**Senator WRIGHT:** Was it every grants program or just some of them?

**Mr Cotterell:** Every grants program.

**Senator WRIGHT:** Is there any possibility that some service providers who are operating under these programs may not have enough funding to meet need as a result of the freeze to indexation?

**Mr Booth:** As Mr Cotterell said in terms of the mental health area, my understanding is that, regarding indexation, the savings do not come in until 2015. They are not there yet. There are indexations set. They are a fairly small amount of the total that is coming on. We will work with organisations to look at how they use their funding to try and ensure that there is no impact on service delivery.

**Senator WRIGHT:** I suppose I am coming from the viewpoint that, in terms of the allocation of funding for mental health in comparison to the burden of disease, many people argue that it is about half of what it should be, if you are going to do a direct contrast between burden of disease and the amount of funding that mental health gets. So we are looking at programs that have had their funding further reduced by having a freeze on the indexation. There will potentially be services that cannot be provided because less money sometimes means fewer services, but you do not have any modelling at this stage about what the effects will be?

**Mr Booth:** Not at this stage.

**Senator WRIGHT:** Where will the savings from that freeze go?

**Mr Cotterell:** All of the savings publicly announced in the budget will go into the Medical Research Future Fund.

**Senator WRIGHT:** My question is: how much, if any, of the funds of the medical research fund are going to mental health research? Would program 1 tonight be the time to ask about that?

**Mr Booth:** I think it is program 1. I think it is Acute Care, who were on this morning.

**Ms Flanagan:** Senator, your questions are going across whole of portfolio, in terms of the budget strategy and the budget decisions that were taken across the portfolio. If you specifically want to ask about Medical Research Future Fund, I think it is an outcome 1 later on today.

**Senator WRIGHT:** What I want to ascertain is: if mental health is an area that has been required to effectively take a cut because the indexation has been frozen, who is going to

benefit from that? Will it actually go to mental health research? Where does it go? That is in the context of arguments that mental health does not get enough funding as it is.

**Ms Flanagan:** We can answer that later on.

**Senator WRIGHT:** Thank you very much.

**Senator BILYK:** We are talking about rural health services now—is that correct?

**CHAIR:** Yes, we can do rural health services now.

**Senator BILYK:** Is the GP tax still government policy?

**Mr Bowles:** I think that is a question for the government, not for officials at the table. I am not quite sure who to refer to.

**Senator BILYK:** Can the minister answer?

**Senator Nash:** Can you just clarify what you are asking about?

**Senator BILYK:** I am asking about rural health services and I want to know if the GP tax is still government policy.

**Senator Nash:** You mean the GP co-payment?

**Senator BILYK:** Yes, the GP tax.

**Senator Nash:** Yes, it is.

**Senator BILYK:** If that is the case, what work has been completed since the last estimates hearings on the impact the GP tax will have on rural communities?

**Ms McDonald:** We are not in a position to answer that. Questions in relation to the GP co-payment are under the medical benefits outcome, which is later today.

**Senator BILYK:** So you cannot tell me if any work has been done in regard to how it will affect rural communities?

**Ms McDonald:** Work would not be done in our area. That is a matter for the Medical Benefits Division.

**Senator BILYK:** Is anyone able to point to any support for the GP tax among regional and rural stakeholders?

**Mr Bowles:** Again, Senator, we are officials. We do not talk in that sort of vein.

**Senator BILYK:** Am I still getting this information later on in the same area that Ms McDonald referred to?

**Mr Bowles:** We can talk about the practical issues and implications around the co-payments, but we are not going to policy decisions of government. That is not in our purview. It is in outcome 3. It is in the next area. The experts will be—

**Senator BILYK:** So I can ask in outcome 3?

**Mr Bowles:** Yes. Co-payment issues are in outcome 3.

**Senator BILYK:** We will come back to that in outcome 3. I want to ask about the Wagga Wagga prostate cancer specialist nurse. Can I get answers to that?

**Ms McDonald:** It is in outcome 1.

**Senator BILYK:** Why is it in outcome 1, just so that I know?

**Mr Bowles:** Population health?

**Senator BILYK:** It does not come under rural health services at all?

**Ms McDonald:** Prostate cancer nurses are—

**Senator BILYK:** For Wagga Wagga, which is a rural area.

**Ms McDonald:** Rural areas are also serviced through mainstream programs.

**Senator BILYK:** So that is in outcome 1?

**Mr Bowles:** It is in outcome 1.

**Senator BILYK:** What about incentives for rural health—incentives to GPs?

**Senator Nash:** I think that is in workforce capacity, which is in outcome 8.

**Senator BILYK:** Thank you very much. You have done well for me.

**Mr Bowles:** This is good education for me, too!

**Senator BILYK:** I am glad to have been of assistance.

**CHAIR:** Do any senators have further questions in outcome 5?

**Senator SMITH:** I was just reflecting on which Labor rural and regional MPs might have supported the Medicare co-payment when it was first introduced under the Hawke government and voted on it in the parliament, but we might leave that for the next outcome. I think Mr Howe introduced it into the House of Representatives some time ago. I want to go to the issue of GP superclinics, if I could, to get an update on progress.

**Mr Booth:** Of the original 64 GP superclinics, as you would be aware, three of those are not continuing now so we have 61. Out of the 61, 58 of those GP superclinics are either fully constructed, under construction or providing early services.

**Senator SMITH:** So 58 are either fully constructed, under construction—

**Mr Booth:** Or are providing early services.

**Senator SMITH:** Or providing early services. It is a very generous categorisation. Perhaps we might just break that down a little.

**Mr Booth:** The number that are fully open and providing services is 46.

**Senator SMITH:** Forty-six, yes.

**Mr Booth:** Eleven are under construction and four are in planning.

**Senator SMITH:** And four are?

**Mr Booth:** In planning.

**Senator SMITH:** In planning still. So when we say 'providing early services'—

**Mr Booth:** Providing early services is that the consortium or the group that is running the GP superclinic has established services under the GP superclinic banner. They may not providing those from that facility because it has not yet been built. But it may be a part of that facility or being provided somewhere else within the area.

**Senator SMITH:** Can you just provide me with an update on the Karratha GP superclinic in my home state of Western Australia?

**Mr Booth:** The Karratha GP superclinic early services commenced in May 2012. Services have been provided since that time. I will just get you an update on expectations—

**Senator SMITH:** So it is not fully operational—

**Mr Booth:** It is not fully operational yet, no. There have been some issues—at the beginning, from memory—about land and lease to actually build that. I think they have been working through those and trying to do that.

**Senator SMITH:** Is there an expected time frame around it becoming fully operational?

**Mr Booth:** I am just double-checking on that one. The latest estimate is that commencement of construction is hoped to be later this year—late 2014. That would be November or December, with a date of practical completion approximately nine months to a year following that. So, we would hope that the GP superclinic is up and running in late 2015.

**Senator SMITH:** Do you have the information there about what some of the delays associated with that are?

**Mr Booth:** As I said, my understanding—

**Senator SMITH:** Land access, that is not relevant is it?

**Mr Booth:** There was no suitable land available initially. As you will know from the GP superclinic program, people bid for it before they—

**Senator SMITH:** Exactly.

**Mr Booth:** Yes. There was a delay with the state government in releasing land that was identified. I am informed that there was a two-year delay on that. That was actually worked through in late 2012 and the design work commenced in late January 2013. There were issues around cost of construction to actually complete the design within the funding that was available. There were all those kinds of issues that have worked through.

**Senator SMITH:** So there are 61 that are—

**Mr Booth:** There are 61 that are planned.

**Senator SMITH:** So there are 15 that are yet operational.

**Mr Booth:** That is correct.

**Senator SMITH:** But in that 15 there are various stages—

**Mr Booth:** There are various stages of development within the 15, so we tend to talk about those that are under construction—

**Senator SMITH:** Yes, I understand.

**Mr Booth:** Some are under construction and offering services from the site.

**Senator SMITH:** Could we just go through those 15 that are not yet fully constructed—just their locations? Can we do it on a state-by-state basis?

**Mr Booth:** Yes. I do not know if I can pull them all together by state as we go through, but—

**Senator SMITH:** Yes, that would be the right way.

**Mr Booth:** Coburn in WA is under construction with no early services, but is hoped to be fully completed within about a month.

**Senator McLUCAS:** We previously used to receive this information in a table. We have only got one day. Is it possible that we could be provided that?

**Mr Booth:** We could provide that information on notice, if you would like.

**Senator McLUCAS:** It used to be handed up at the start of this outcome.

**Mr Bowles:** I think this goes to Senator Moore's question this morning about some of these things. I think, partly because I am new, I probably do not understand the whole system—

**Senator McLUCAS:** I am sure it is not your fault.

**Mr Bowles:** We can provide these things on notice if you wish.

**Senator McLUCAS:** When they are routine things like this, we just historically handed them up.

**Senator SMITH:** I am keen to get a sense of the 15 that are not yet fully operational. Thank you for providing me for some information around Karratha, which is of interest to me. I was there with Senator Reynolds no less than on Friday and Saturday just gone. My question is: of the 15, can we just identify where they are?

**Mr Booth:** That is Coburn in WA. There are three under construction and providing early services. Those three are Hume in Victoria, Lismore in New South Wales and Northam in WA. There are seven under construction with no early services. That is Adelaide, Blacktown in New South Wales, Gerringong in Northern Beaches, Townsville in Queensland, Mount Barker in South Australia and Port Macquarie in New South Wales, Nowra and Mackay in Queensland. There is one providing early services, but no construction, and that is Karratha in WA. There are three just in the planning stages. They are Caboolture in Queensland, Emerald in Queensland and Liverpool in New South Wales.

**Senator SMITH:** Is there anything that is common to those 15? Are there elements that are common to those 15 around why there is a delay? I can understand why on a case-by-case basis they might be experiencing different reasons for a delay. The land access issue in Karratha is not a surprise to anyone who has been up there. But are there any common traits?

**Mr Booth:** After looking at a number of these sites and working on this, it does tend to be issues around land. It tends to be actually the availability of the land in the first place and then the approvals that are needed from local governments and states governments in terms of construction actually commencing. It is a complex process in terms of, as I said before, it being a project that does not start with a piece of land. It starts before that. A lot of delays have been around finding appropriate land and then getting the approvals to actually build.

**Senator SMITH:** In the 46 then that are fully constructed, do we have a best-case example of one that was efficiently delivered and do we have a worst-case example around time?

**Mr Booth:** It is a difficult one to generalise. It is difficult to generalise because there were a number of different sizes of construction. Some of them were very large facilities, up to $12.5 millions and $15 million constructions. Others were $1 million to $2 million. The smaller ones tended to go through faster. It is difficult to do that. In the information that we provide, I think there is a kind of breakdown of when things happened. We can certainly let you know when—

**Senator SMITH:** Okay, in addition to the table on page 15, you will give us a table that has the 61?

**Mr Booth:** Yes, we can. I think that is a table that the senator is referring to.

**Senator SMITH:** That is fine.

**Senator McLUCAS:** I want to go to questions around mental health and perhaps have Mr Butt up here as well, please. I refer to question on notice SQ14813. Can I find out which part of the organisation provided the answer to that question: did that come from the commission or from the department?

**Mr Booth:** What was the subject?

**Senator McLUCAS:** I asked the question:

Will the National Mental Health Commission's first report be published by government? If not, why not?

**Mr Butt:** Yes, that was a department response.

**Senator McLUCAS:** Can you have look at it, Mr Booth, because I am a bit intrigued by the answer. The answer refers to—

**Mr Booth:** A decision of government.

**Senator McLUCAS:** No, the answer says:

The release of the final report of the review of mental health services and programmes will be a decision of Government.

I did not ask about the final report.

**Mr Bowles:** It is the final report that will be released, not any others. That would be my reading of it, but I am happy to take that on notice and clarify.

**Senator McLUCAS:** Mr Bowles, it is the first time that has been said.

**Mr Bowles:** I am happy to clarify. I am speaking a bit from ignorance here, but I am happy to clarify on notice.

**Senator McLUCAS:** I will ask the question then: will the first report be published?

**Mr Bowles:** I will take that on notice. I do not know the answer to it.

**Senator McLUCAS:** Do any of the other officers know the answer to it?

**Mr Booth:** I think we will take that on notice.

**Mr Bowles:** That is what they didn't know.

**Senator McLUCAS:** That was asked a long time ago and—

**Senator MOORE:** She is six months to get an answer to her question. If you take it on notice, can we have some agreement that we get an early answer and not have to wait for another three months before we get an answer to this one?

**Mr Bowles:** Senator, I think our performance in answering questions is not too bad. We will try definitely to get things done as soon as we can.

**Senator McLUCAS:** The statistical response is not bad, but whether or not you read the question and give me the right answer is another question.

**Senator MOORE:** To be absolutely clear, we asked at the last estimates. It was taken on notice. We got that answer back—

**Senator McLUCAS:** In time—whatever.

**Mr Booth:** There is a further QON as well, which is: 'Will the National Mental Health Commission's first report be published by government?' The answer is: 'The report will not be released as it was a preliminary report to government. The release of the final report to the

review of mental health services and programs will be a decision of government.' So the first report will not be—

**Senator MOORE:** The first report is an interim report.

**Mr Butt:** The first report was a preliminary report in February.

**Senator MOORE:** I take my comments back then.

**Senator McLUCAS:** My next question is: has the second interim report been provided to government? Mr Butt.

**Mr Butt:** The interim report was provided on time on 30 June.

**Senator McLUCAS:** And the scope of that report, from memory, is an assessment of current activity at state and territory level. Is that right?

**Mr Butt:** It is an assessment across the country of federal, state, territory, private, NGO, consumer and carer organisations' performance. It is an input into the final report. It was an information gathering and question raising issue. It did not have any recommendations in it, for example.

**Senator McLUCAS:** It is a bit like the first report. It is just a statement of what is there.

**Mr Butt:** That is right.

**Senator McLUCAS:** How do you fact check it? How do you prove it up? Let me ask the question: is the government going to publish the second interim report?

**Mr Booth:** Again, senator, I will take that one on notice, but it was preliminary advice to government. So we would probably answer in the context of the answer that we have given previously that it is a preliminary report and the government will be waiting for the final report.

**Senator McLUCAS:** I do not think it is a preliminary report, Mr Booth.

**Mr Booth:** I'm sorry.

**Senator McLUCAS:** These are separate tranches of work that are being done. My concern is that if they are not published, how does the community have faith in it? I am sure Mr Butt and his team is fantastic, but let's make sure that we bring the community with us on this big review and let's publish it so that people can go, 'Yes, they have got it right'—or not. That it is not a preliminary report, Mr Booth, is my take on it. This is a piece of analysis that should be, in my view, in the public arena. You are telling me that you will take on notice whether or not it will be published.

**Mr Booth:** Yes.

**Senator McLUCAS:** Is the review on track to be completed by the end of November?

**Mr Butt:** Absolutely.

**Senator McLUCAS:** Let's go to the question of submissions, which we have canvassed here before. We know there are more than 1,800 submissions that have been received. I have asked previously if they are going to be published and the February estimates answer was that it is a matter for government. Has the government had any further thinking about being able to publish those submissions?

**Mr Butt:** Sorry, Senator, I would have to go back and have a look at that. What we did in the call for submissions was ask people whether they would be prepared for us to quote from their submissions—first off, whether they would be prepared for us to quote from them and, secondly, whether they would be prepared for us to use their names in the final report. We actually did not ask them whether they were prepared to have their work released. We were asked about whether the reports were going to be released, particularly given that we got about 1,500 from individuals—a lot of those people with lived experience—so there were concerns about putting things forward which may be released. We had said, 'The release of that information is up to you individually; if you would like to release it that is up to you.' We certainly have not asked 1,800 different individuals and organisations who have submitted submissions whether they would like to have their submissions released and we would have to do that. We were not planning to do that because we have spent four months on quite in-depth analysis of the various submissions, and there will be a report on the submissions within our final report.

**Senator McLUCAS:** I totally agree with you that the people who have made individual submissions to the inquiry should have been asked at the outset if they want to publish their submission, and that did not happen. By and large, I dare say, most of those people would have said no. But for the peak bodies and organisations that have made fulsome submissions to the inquiry there is no one central point that people can go to and say, 'This is my commentary on the future of mental health services in Australia', because they are not published. Many of them have individually published them on their own websites but there is not one point where people can go, 'Oh, that's what so-and-so said. I don't agree with that—let me make a further supplementary submission because I don't want to be seen to be agreeing with their commentary.'

**Mr Butt:** That is absolutely right. You would recall that it was an online survey, so people were filling it in electronically.

**Senator McLUCAS:** By and large that is for the individuals.

**Mr Butt:** And for the organisations. We did get separate submissions—I think the latest one I got was on Friday; they are still trickling in—but for the people who filled in the survey it was an online electronic survey and to actually access those different surveys is extraordinarily complicated.

**Senator McLUCAS:** That is not the group that I am worried about. I am worried about the major organisations which have made significant and well-researched submissions. There is no way for the community at large to have a bigger conversation and it is a very closed inquiry because of that fact. But we did not ask, so we cannot do it.

Can you update the committee on how the information sharing with states and territories is proceeding? I understand that back in July the commission had yet to receive any response from Western Australia or the Northern Territory. Is there an update on that?

**Mr Butt:** We still have not received responses from Western Australia or the Northern Territory in relation to our original request for information which occurred back in January. However, we followed up through the Mental Health, Drug and Alcohol Principal Committee of AHMAC and talked with them about access to data, because there were concerns raised by some of the states about the level of data being asked for. We worked with MHDAPC about

what access we could get to their data and all states and territories have agreed to provide us with data from their mental health establishments data collection set except for the ACT; we are still waiting on them. We have actually got the first of that data which has come through from Western Australia, Victoria, Queensland and Tasmania; the other states have now agreed and we are just waiting on the ACT. I would be expecting that we would be receiving that data over the next couple of weeks.

**CHAIR:** Sorry, just a quick follow-up on that: is there a reason why the ACT has not yet agreed to provide that data?

**Mr Butt:** No. It is just a timing issue. We are expecting that they will agree. The first data came in yesterday, and that was from those four states that I mentioned. As of today, we have heard that a number of states have also agreed to release that data to us. It comes through the Australian Institute of Health and Welfare. They do mental health establishments reporting to the AIHW. The AIHW has been doing the crunching of the numbers on it to provide us with more of a regional profile of what is occurring in those states and territories. ACT is probably a bit less of an issue because we get ACT-wide data anyway. There was no problem getting access to state-wide data which is on the public record, or through the AIHW. It was actually drilling down on a regional basis to look at what was happening—on a metropolitan basis, a regional basis or a remote basis and the like.

**Senator McLUCAS:** The second interim report was meant to capture, as I understand it, expenditure on mental health services funded by state and territory governments. I think we are talking about two separate things here, aren't we?

**Mr Butt:** To a degree, because for the interim report we were not able to get the level of data that we were after from the states and territories. That was a bit of an issue for us in putting together the interim report. As I say, we are now getting more data on expenditure, activity, infrastructure and those sorts of things. It is coming through now through this mental health establishments work that has been done.

**Senator McLUCAS:** Are you telling me that the second interim report was not complete?

**Mr Butt:** I would say it would have been enhanced if we had received access to further information from the states and territories early on. Generally, what they provided us with was data that was publicly available about what they spend. They had not gone into detail about what is happening at a regional level, or with particular NGOs and the like, which would have given us a more complete picture.

**Senator McLUCAS:** Are you intending to supplement the second report?

**Mr Butt:** Not to supplement it. We are taking into account—as I say, that interim report is an input into the final report. We will be lifting up large parts of it and putting it in the final report anyway.

**Senator McLUCAS:** You will add to it.

**Mr Butt:** We will be updating the information for the final report.

**Senator McLUCAS:** Coming back to the fact checking of the material, how do you confirm the accuracy of the material? You asked the states and territories to provide you with material—sure, AIHW will have a look at it as well. We do not publish it. How do people see that it is accurate?

**Mr Butt:** As you say, we get information through the AIHW collections, which again is largely publicly reportable data anyway, except for the regional breakdown, which is additional information. We are also basing it on the previous work we did through two years of developing the report cards. That information has obviously been made public in November last year and in November the year before. We have had the feedback through the submissions process. We are checking information with states and territories as we go. We are checking with the mental health commissions that exist in Western Australia, New South Wales and Queensland. Indeed, they are providing good input, particularly because Queensland and New South Wales have just released their own reports on mental health, and a strategy in Queensland as well. We have done face-to-face consultations with a lot of organisations and a lot of individuals over that period as well. So as much as possible it is a collection of information data from organisations, individuals, and states and territories that we are checking as much as we can as we go along.

**Senator McLUCAS:** I will leave the actual review at that. I look forward to the government publishing the final report. Can we go to your commission's membership. Can you go through who is a commissioner at the moment, please, Mr Butt.

**Mr Butt:** The chair is Professor Allan Fels. We also have Professor Pat Dudgeon from Western Australia; Jackie Crow from Victoria; and Rob Knowles from Victoria. In April we had Professor Ian Hickie reappointed as a commissioner, and we also had the appointment of Dr Kay Patterson and Mrs Lucinda Brogden. Last month we had the appointment of Nicole Gibson as a commissioner with a lived experience and a young person's perspective. In addition to that I am a commissioner as well.

**Senator McLUCAS:** The final commissioner, Nicole Gibson, was appointed when?

**Mr Butt:** In September.

**Senator McLUCAS:** Why did that take so long? I probably should not ask you the question.

**Mr Butt:** No.

**Senator McLUCAS:** Why did that take so long?

**Mr Bowles:** I am afraid I cannot answer that question.

**Senator McLUCAS:** Please do take it on notice.

**Mr Bowles:** Yes.

**Senator McLUCAS:** I want to go to the timetable and this traverses both the commission's report and the department's closing of the Medicare Locals. Can you tell me how many of the Medicare Locals are lead agencies in the Partners in Recovery program? 'Lead agents' is probably the wrong language, but you know what I mean.

**Mr Booth:** Out of the 48 organisations, 35 are Medicare Local led.

**Senator McLUCAS:** Out of 48, 35 are Medicare Local led. The report of the Mental Health Commission—their analysis—into mental health services is due to government on 30 November. How will that feed into the work that you are doing around the re-establishment of the Medicare Locals and then the re-contracting. As I understand it, if a Medicare local is disbanded, their PIR contract ceases.

**Mr Booth:** The contracts for PIR continue until the end of the next financial year.

**Senator McLUCAS:** What if a Medicare Local does not exist?

**Mr Booth:** That is something we need to work through with each of the organisations in terms of the consortia that is in place. Again, there may be a number of different options that come out of this. In some cases, the Medicare Local may bid to be part of a consortia to be a PHN or a PHN by itself, in which case it is one option because they are there. There is one path that you go down there. The Medicare Local may not be successful, in which case you may look at one of the other partners to see who could be a lead agency. There are a variety of different options that we have in taking that forward. We do not have a single one to say: this is what will happen. It depends on circumstances.

**Senator McLUCAS:** What surety do the providers of Partners in Recovery program have of the continuation of their program between now and the end of this current year, the financial year, and then after that?

**Mr Booth:** As I said, the funding is available for this financial year and next financial year. The funding is there. Our administrative arrangements may change around the lead agency in terms of the Medicare Locals.

**Senator McLUCAS:** There is a lot of uncertainty and a lot of fear out there. I do not know that that answer—I am not being critical of you at all—gives them a lot of confidence about what is happening in the future.

**Senator Nash:** It is useful, though, to understand that there is a transition period. The government is aware that there is some uncertainty out there. But the intent is certainly to make the transition process as seamless as possible and, as Mr Booth has indicated, the financial arrangements are there for this financial year and the next financial year. I think that should give a level of comfort to those who are caught in a bit of uncertainty while we go through the transition period.

**Senator McLUCAS:** Let us just talk in a legal sense. As of 30 June, the name 'Medicare Local' cannot be used. So if the contract is between a Medicare Local and the Department of Health, how do you work through that? Does it have to be retendered?

**Mr Booth:** As I said, we will work through the different options, as we come through to them. The time frame that we discussed earlier in the morning was that there would be a transition period, that there would be a period after the successful bids for the PHNs are known and a period before they are established. We will use that period to work through them. Having said that, we are very aware of the issues. We know who is affected and we know which are the lead agencies, so we are working through those options and what the potential responses would be.

**Senator McLUCAS:** Minister, I am told that a number of Partners in Recovery programs have closed their books to new patients because of this uncertainty.

**Senator Nash:** I am not aware of that.

**Senator McLUCAS:** I ask the department: has this been brought to your attention?

**Ms McDonald:** A number of things were raised at the Senate select committee. At that committee hearing we said that we were happy to look into any service issues, because the government's commitment is continuity of service. I had understood that the committee was either going to give us the examples or ask the organisations or the individuals that were

concerned to contact the department and give us the information so that where we needed to we could look at it and clarify things with the organisation.

**Senator McLUCAS:** Did the department do any investigation?

**Ms McDonald:** No-one has provided us with any information to follow up on. We are happy to receive it so, if you do have some, that would be useful.

**Senator McLUCAS:** Have you asked anyone whether there are problems out there?

**Ms McDonald:** We have our advisory committee and issues around service continuity are discussed with them. We are providing information to the Medicare Locals through our system about the arrangements as updates are available. We continue to do that. We encourage the Medicare Locals, if they have any concerns or questions, to come forward and talk those through with the department. As I said, that commitment is for a smooth transition and to ensure continuity of those contracted program services throughout the changeover.

**Senator Nash:** Senator, if you do have information that the department is not privy to, as Ms McDonald just said, it would be useful to provide it to the department and then they can follow up any specific concerns.

**Senator McLUCAS:** Permission has not been given to hand on information provided to me.

**Senator Nash:** If we have specific things that we can refer to or specific cases, it is a lot easier for the department to follow up rather than having just an anecdotal, general statement to the effect, 'There may be some out there.' So, insofar as you could, it would be useful.

**Senator McLUCAS:** I have sought that and it is not forthcoming. The reason is that we are about to go into a very competitive tendering round and people are very, very concerned that if they are identified they will feel disadvantaged in future tender rounds. That is the state of the circus out there.

**Mr Bowles:** Can I respond to that. One of the things that I believe the broader Public Service are very good at is being very fair, open and transparent around our tendering processes. I would never like to think anybody would prejudice anyone who has a view. I would appreciate it if you would pass on my view about these things to any of your constituents whom you talk to. I have been around the traps a little while and it goes to the professionalism of the Public Service that I hold very dear: we do not discriminate against people because they have a view. Quite frankly, if we did, nobody would get anything because everybody has a view.

**Senator McLUCAS:** Mr Bowles, I concur with you that the Australian Public Service are an excellent, fair and principled organisation. But their fear still remains.

**Mr Bowles:** I accept that.

**Senator McLUCAS:** It is not the Public Service about which they are worried. Can you confirm that the new clinical councils and the local consumer advisory committees that are being established within each PHN will include a person with lived experience of mental health and someone from the mental health profession?

**Mr Booth:** We would certainly anticipate that the make-up of the clinical councils and the community advisory committees would be addressed through the PHNs and they would, as part of the tender process, define what the make-up of those committees would actually be.

**Senator McLUCAS:** You are not making that a requirement?

**Mr Booth:** We do not have a hard-and-fast rule that says: 'You have to have this, this in this profession.'

**Senator McLUCAS:** There are 13 regions that do not have Partners in Recovery programs. What is being proposed for those regions?

**Mr Booth:** As we discussed earlier, those have been subject to a delay and there is no Partners in Recovery program being rolled out in those 13 areas. That was delayed for two years.

**Senator McLUCAS:** They were delayed in the first rollout for a period of 12 months, is my recollection.

**Mr Booth:** The funding was for two years, yes.

**Senator McLUCAS:** And now they have been delayed for another two years, just to be clear.

**Mr Booth:** I thought it was two years; I will double-check that.

**Senator McLUCAS:** In this current round, funding goes to 2015-16. Are there any plans for the other regions to be included after that?

**Mr Booth:** I think the response to that is it would be looked at in the light of the Mental Health Commission's review.

**Senator McLUCAS:** I want to now go to the recent headspace announcement.

**CHAIR:** Before you do, I will remind senators—as I have done in the past—that we are about two hours behind. I acknowledge that if you want to continue, invoking standing order 26, you are entitled to do so, but it will mean less time for other outcomes.

**Senator McLUCAS:** Could the committee receive some advice on how the decision was made to allocate those headspaces to those locations please?

**Mr Booth:** Is that within the final—that have just been announced?

**Senator McLUCAS:** The last 15.

**Mr Booth:** The final decision is a decision for the minister. The minister makes the final decision. It has been a process for a number of rounds since 2011, where the department works with headspace and looks at potential locations—based on population, youth population and a variety of other measures—and also takes into account the views of states and territories. It comes up with a potential list of site locations. At the end of the day, it is a decision for government.

**Senator McLUCAS:** How many potential locations were in that list?

**Mr Booth:** I do not have that information with me, I am afraid. I would need to take that on notice.

**Senator McLUCAS:** Do you remember, in the ballpark?

**Mr Booth:** No, sorry. I would not like to try to remember. I would rather double-check.

**Senator McLUCAS:** If you could take that on notice, that would be good.

**Mr Booth:** Yes.

**Senator McLUCAS:** Headspace was involved in providing advice to that overall list.

**Mr Booth:** The department consults with headspace, certainly, in looking at potential location sites.

**Senator McLUCAS:** Are you aware that of the 15 there are 14 in coalition seats?

**Mr Booth:** I have not done that analysis.

**Senator McLUCAS:** So you were not asked to identify which electorate the potential sites were in, as part of giving that advice.

**Mr Booth:** No.

**Senator McLUCAS:** You have answered my question. The minister made the decision: 14 out of the 15 are in coalition seats.

**CHAIR:** Of the 15, how many are in rural and regional areas, Minister?

**Senator Nash:** My understanding of the selection process for this was that it was a look at where the gaps were based on the historic allocation of the original ones. It was based on population, distance, location and all of that. That was the assessment, and the advice was provided on that basis.

**Mr Booth:** Absolutely.

**Senator McLUCAS:** I think Mr Booth has answered the question. There was a potential list drawn up. It was given to the minister. He picks the 15 that he wants and 14 out of the 15 are in coalition seats.

**Senator Nash:** It would be useful to look broadly, in context, over the numbers and the point Ms McDonald made about looking at the gaps and where things were. I am happy to have a look at what we can provide you, but my understanding is that the number of headspace sites pretty much reflects—across government and opposition—the numbers out there. To just take the last 15 and say 'They're in coalition seats,'—to be fair to those listening, particularly, we need to look broadly across. The balance seems to be fairly moderate, I must say.

**Senator McLUCAS:** Do you know that or are you just saying that?

**Senator Nash:** I will have a look and see what I can provide you.

**Senator McLUCAS:** I think you are just saying it, frankly.

**Senator Nash:** I am not just saying it; I would not waste my time. I am very happy to look at what we can provide the committee, to make sure we can provide some balance in looking at the numbers of how these have worked out. It is a very fair comment that for these last 15, that were funded in the budget, we have looked at where they are most appropriately placed to do the most good for the communities. That is a very sensible approach.

**Senator McLUCAS:** Were any of those sites identified prior to the 2013 federal election?

**Mr Booth:** As for as I know, Senator, the rounds that were done—the announcements were in October, so—as far as I know, but I will double-check—the advice was more recent than that.

**Senator McLUCAS:** Yes. But there may have been some that were election commitments.

**Mr Booth:** No, I do not think there were any that were election commitments.

**Senator Nash:** Senator, if it assists, I think that before the announcement, there was also an agreement with headspace. But I am happy to clarify that for you and come back to it.

**Senator McLUCAS:** Well, that is not what Mr Booth has just told us.

**Senator Nash:** Before the minister made the announcement.

**Mr Booth:** Oh, before the minister made the announcement—I thought you were saying, before the election.

**Senator Nash:** Yes. I was saying before the announcement. Sorry if I confused you, Senator McLucas.

**Senator McLUCAS:** I was talking about before the election—to see if any of these were election commitments, and Mr Booth tells me no. That is fine.

**Senator Nash:** And I just assisted with further process, Senator.

**Senator McLUCAS:** Yes, which we had covered earlier. I am happy to stop there on mental health. There are some questions that I will put on notice. Thank you very much, Mr Booth.

**Mr Bowles:** Chair, Senator Siewert asked earlier whether health is the lead agency for, or does it contribute to, the UNICEF early childhood report? DFAT is the lead agency. I do not believe they have asked us yet to contribute, but that could still happen.

**Senator SIEWERT:** I just need to follow that up. I want to ask about the previous report. Where would I ask you about whether you have contributed to previous reports?

**Ms Flanagan:** Senator, the advice I have is that we have not contributed to previous reports.

**Senator SIEWERT:** You have not contributed; not at all—that partly answers one of my questions. Thank you very much.

**CHAIR:** There being no other questions on outcome 5, we will now move on to outcome 3, access to medical and dental services.

[15:13]

**Senator REYNOLDS:** Good afternoon, Mr Bowles, and congratulations on your appointment.

**Mr Bowles:** Thank you, Senator.

**Senator REYNOLDS:** In relation to the MBS, first could you give me an idea of what the current Commonwealth outlays are, on health, and then specifically on the MBS?

**Dr Bartlett:** Senator, I can give you outlays on the MBS. I am afraid I—

**Senator REYNOLDS:** On the MBS is fine, thank you.

**Mr Learmonth:** Senator, it has gone from $8 billion per year 10 years ago; it is currently $19 billion.

**Senator REYNOLDS:** Thank you. What are the annual growth trends? Have they been fairly steady?

**Dr Bartlett:** The growth trends have varied between 2012-13, when it was $18,6 billion, and 2013-14, when it was $19.1 billion. It grew by about 2.6 per cent, but that was affected by the closure of the Chronic Disease Dental Scheme, which slowed the rate of growth down. If

you look at a range of other areas, growth continues at around a six to eight per cent rate for a number of specialties, which is not inconsistent with earlier years.

**Senator REYNOLDS:** So the rate of growth is six to eight per cent for a number of specialties. What sorts of specialties are growing at that rate?

**Dr Bartlett:** Pathology, diagnostic imaging, operations and assistance, anaesthetics grew at 5.1, specialist attendances grew at 5.6, total non-referred attendances including GPs grew at 6.5—these are the benefits, other MBS services grew at 5.3.

**Senator REYNOLDS:** Are there any trends in why they are increasing—particularly these ones—at such a high rate?

**Dr Bartlett:** It is a combination of increasing services and an increase in the benefits paid for the services. It is a mixture of more people getting services and the services they are getting being more complex.

**Senator REYNOLDS:** So more services and being more complex makes them more expensive?

**Dr Bartlett:** Yes.

**Senator REYNOLDS:** How does that growth compare with OECD countries? Do you know where we sit, relatively?

**Dr Bartlett:** The OECD comparisons are usually done on the basis of percentage of GDP. On that basis we are about average. But one of the factors there has been that Australia's GDP growth until quite recently has been well above OECD average, which means that growth in health services as a percentage has not grown rapidly.

**Senator REYNOLDS:** Okay. So taking that into account, we have not grown rapidly in comparison to the OECD in terms of percentage?

**Dr Bartlett:** Our growth as a percentage of our GDP has not grown rapidly, although it increased in the most recent AIHW figures for 2012-13. It increased as a percentage of GDP—and this is from memory—from 9.1 to 9.4 per cent, but I can confirm those numbers for you.

**Senator REYNOLDS:** Thank you. Can you give me a bit of background on how many services are accessed annually and by how many Australians? Do you have those figures there?

**Dr Bartlett:** I do not have an accurate figure on the number of Australians. I can get you those. In terms of the number of services: in 2013-14 there were—sorry I am starting to struggle with print size!

**Senator REYNOLDS:** That is all right, I sympathise!

**Dr Bartlett:** It is a factor of age! It is 356,135,218.

**Senator REYNOLDS:** Can you say that again?

**Dr Bartlett:** It is 356,135,218 MBS services in 2013-14.

**Senator REYNOLDS:** Could you take that on notice and could you get someone, even today, to provide how many Australians have accessed that and if there are any trends in terms of averages? I imagine there would be a lot more people who access many more

services than others. So if you do have those figures I am happy for you to take that on notice or to provide them later.

**Dr Bartlett:** We have a range of figures that we can provide to you. Some of the things that we provided before have been that concession card holders are higher users of health services than non-concession-card holders. There has been an overall growth in the use of MBS services—and I can give you some figures on that, although I do not have the 2013-14; I only have them up to 2012-13. In 2012-13 there were 14.9 MBS services per capita, which was up from 14.6 the year before; 14.2 the year before that; 13.9 the year before that; 13.5 the year before that; and so on back. So you can see a steady growth in the services per capita.

**Senator REYNOLDS:** Okay. It has grown substantially both in terms of the actual number of services and in the amount per person accessing them.

**Dr Bartlett:** That is correct.

**Senator REYNOLDS:** And a lot of them are becoming increasingly expensive as well?

**Dr Bartlett:** That is correct.

**CHAIR:** Sorry to interrupt: is there a breakdown at all of different demographic groups in terms of their average MBS numbers?

**Dr Bartlett:** There was an answer to a question on notice on that and if you give me a second I can probably find it. No, I may be able to put my hand on it later but I do not have it with me. We can certainly give you that, we have provided before.

**Senator REYNOLDS:** And when you provide that—I think you said that you may have already—but could you also provide the figures broken down by concession and non-concession holders?

Dr Bartlett, could you also give me a bit of an update or a briefing on the current Medicare levy and the levy surcharge and what is their purpose is?

**Dr Bartlett:** I found the first of the things I was talking about. In 2012-13, there were 7.8 million people who had a concession card at some stage during that financial year who had at least one Medicare service in a period. Of those, 3.1 million had more than 10 services. In terms of the 7.8 million people with a concession card, of those who received at least one GP service, which is 7.6 million, 2.18 million were healthcare card holders, 5.115 million were pension card holders and 272,000 were seniors health card holders.

**Senator REYNOLDS:** So you have 3.1 million who had more than 10 services.

**Dr Bartlett:** That is correct.

**Senator REYNOLDS:** Do you have that broken down further into—

**Dr Bartlett:** Not with me.

**Senator REYNOLDS:** Would you mind taking that on notice?

**Dr Bartlett:** Sure.

**Senator REYNOLDS:** Thank you. Could you just explain for me—I am new to this estimates committee—the current Medicare levy and levy surcharge and what their purposes are.

**Dr Bartlett:** The Medicare levy is effectively a levy that was put in place when the Medicare arrangements started. It was designed initially to fund a significant part of the

Commonwealth's costs in terms of the MBS. It has been changed a number of times over the years, most recently when an amount was added to cover the cost of the NDIS. The Medicare levy surcharge was introduced more recently. That was designed to encourage people to take out private health insurance. Those above an income threshold who did not take out private health insurance incurred a surcharge which they had to pay. That has also changed. There are now means testing arrangements in place and, as part of those arrangements, the amount of surcharge that you have to pay goes up with your income.

**Senator REYNOLDS:** What proportion of the Commonwealth's current health expenditure does the surcharge cover as a proportion of expenditure on the MBS?

**Dr Bartlett:** I have that data, but you may have to bear with me. I might actually take that on notice; otherwise I am going to be digging through figures for some time.

**Senator REYNOLDS:** That is fine, or if someone could get that and come back to it that is absolutely fine. Another question that relates to that is how much will the levy have to increase to fully cover the cost of the MBS?

**Dr Bartlett:** I would have to take that on notice. I do not know the answer to that question.

**Senator REYNOLDS:** If you could take that on notice and if someone could come back either today or later on notice that is fine. I would like to ask you a question in relation to the MBS. Have additional services been added to the MBS in the last 12 months—added or expanded?

**Dr Bartlett:** There is a standard process we go through that involves the addition of new items to the MBS as a result of MSAC recommendations. I know that there have been some added in the last 12 months but I would have to take that on notice and come back to you with a comprehensive list of what was there.

**Senator REYNOLDS:** Thank you. If you could advise of additions, increases or substantial changes that would be great, thank you. In relation to the proposed co-payment, have you got any history in relation to proposals for the co-payment for the MBS itself? Is this a new concept or proposal for the department?

**Dr Bartlett:** The MBS from its inception has involved the notion that doctors can set their own fees. So doctors can determine what they charge, which obviously involves the potential for a patient to make a payment. That has been a factor from the beginning. It continues to be a factor. It is fair to say that in recent years the number of bulk-billed services continues to increase significantly.

**Senator REYNOLDS:** Do you have any figures on the increase in bulk-billing?

**Dr Bartlett:** There again, it is a mix of things. The 2013-14 bulk-billing rate overall was 77.2 per cent. That was up from 76.5 per cent the year before.

**Senator REYNOLDS:** So that is an increase in the actual numbers of services bulk-billed and also in the amount paid in terms of the total paid?

**Dr Bartlett:** There are a range of things in terms of what is paid. I do not have a breakdown as to what services correlate to that 77 per cent. What it is essentially saying is that, of the 356 million services, 77 per cent of them were bulk-billed, whereas in the year before, of the 343.6 million services, 76.5 per cent of them were bulk-billed.

**Senator REYNOLDS:** In doing a bit of reading for this hearing, I went back and had a look at this concept of a co-payment. As you rightly point out, Australians have pretty much always paid co-payments to their doctors in accordance with how much the doctor charges for their fee. I went back and had a look. It was interesting that back in 1991 a previous government also put forward the concept of a co-payment for the MBS. I would just like to read out one of the factors that were put forward at the time, because I would like your thoughts on whether those circumstances still exist in relation to the MBS. The minister at the time said:

> The major problem facing Australia's health care system is the growth in use of medical services per person. This growth means that every 20 years the number of medical services per person doubles. That growth is not caused by Medicare. The national health strategy has shown that growth has been occurring fairly constantly since … 1976. The cause is an open-ended fee for service system underwritten by insurance … The result has been that, as doctors' numbers have grown, so too has the use of medical services.

That was said in 1991 by the then minister for health, Brian Howe, who indicated that that was a reason for making changes to the Medicare system. Do you still see similar circumstances in Australia?

**Dr Bartlett:** You are asking me for an opinion on policy, and I am afraid I—

**Senator McLUCAS:** It might be useful if the Chief Medical Officer were here to make some commentary, because he would be able to talk about this—rather than from a health economics point of view—from an access-to-health perspective. Secretary, is there a reason—is the CMO still in the meeting?

**Mr Bowles:** No. He is just dealing with a range of other issues that happen on a regular basis for us. He will be back a bit later on.

**Senator McLUCAS:** It is unusual for the CMO not to be here.

**Mr Bowles:** He will be back. We just have a range of issues that we are trying to deal with at the moment. In relation to that, I think Dr Bartlett is right: it is not something that we would normally comment on, because it is a comment on a policy position of a government. That is not something that we—

**Senator REYNOLDS:** I understand. In deference to that, I will reframe the question slightly. Back in 1991, it was noted that the growth in medical services had been doubling and doubling frequently. Is it still the case? I think Dr Bartlett pointed out that there is evidence that MBS services are increasing both in number and in cost. I guess that is the same as the situation in 1991. But the basis for that was then that there was a requirement for reforms to ensure that Medicare remained a sustainable, equitable and efficient universal health insurance system. I believe that it would still be a requirement today to make it sustainable. That is the background to my question. On that basis, if the MBS were to continue increasing every year according to the current rates that Dr Bartlett has quoted, what would the situation for the MBS be across the forward estimates in the next 10 years?

**Senator DI NATALE:** Chair, I raise a point of order. Dr Bartlett did not in fact say that. He said 'in some areas'—

**CHAIR:** What is your point of order?

**Senator DI NATALE:** My point of order is that Senator Reynolds has misrepresented Dr Bartlett's position.

**Senator REYNOLDS:** I am sure that, if that is the case, Dr Bartlett will be able to tell me that himself, Senator.

**CHAIR:** There is no point of order. The question has been put to Dr Bartlett. He can answer it in whatever way he chooses to answer it. There is no point of order. Were you finished with the question, Senator Reynolds?

**Senator REYNOLDS:** Dr Bartlett had said that it had gone from $8 billion 10 years ago to $19 billion currently. He had also indicated that there was an increasing trend over the last 10 years and in fact in some services it was six to eight per cent per year. My question is: based on that trend in growth across the forward estimates and across the next 10 years, without any changes to the system, what do we anticipate the MBS increasing to?

**Dr Bartlett:** The current estimate as to where it would be in 10 years' time, and I have to emphasise that it is an estimate, is at about $34 billion.

**Senator REYNOLDS:** Going from $19 billion to $24 billion a year, without any changes.

**Dr Bartlett:** That is correct.

**Senator REYNOLDS:** This might be a question for the PBS, but I will take your guidance on that. It is on out-of-pocket expenses.

**Dr Bartlett:** It depends on the out-of-pocket expenses!

**Senator REYNOLDS:** In relation to the MBS, are out-of-pocket expenses incurred in the MBS or are they more in the PBS?

**Dr Bartlett:** There are clearly out-of-pocket expenses in the MBS, as we have talked about. Out-of-pocket expenses have been a feature of the MBS essentially from the date of its inception. The most recent out-of-pocket expenses report from AHW—looking at costs in 2012-13 of the MBS or medical services, which is actually broader than the MBS—accounted for $3.1 billion of the $26 billion in out-of-pocket expenses. That was around about 11.6 per cent. The average out-of-pocket expense per person was a $135 and the increase in average out-of-pocket expense per person from 20011-12 for medical services was one dollar. That compares to total out-of-pocket expenses, which were $23.6 billion; average out-of-pocket expense per person was $1,164 and an increase in average for out-of-pocket expenses per person from the year before of $51 dollars or 4.6 per cent.

**Senator REYNOLDS:** Have you got a breakdown of what those average per person costs are or the total? Have they got categories?

**Dr Bartlett:** Yes.

**Senator REYNOLDS:** What are the major categories of that $26 billion?

**Dr Bartlett:** Of that $26 billion, the single biggest category is other over-the-counter medicines, which makes up $8.7 billion or 32.4 per cent. Benefit paid medicines, which is essentially the PBS, is $1.5 billion or 5.8 per cent. Dental is $5.1 billion or 19 per cent. Aids and appliances are $2.6 billion or 9.7 per cent.

**Senator REYNOLDS:** Can you just drill down further in other medicines. That is quite a significant percentage of all of the out-of-pocket expenses. Of that 32.4 per cent, do you have any categories of what has been going up in that area?

**Mr Learmonth:** There is almost nothing about what is in that category in terms of individual contributors to the overall growth. It is the general category of over-the-counter medicines, which could be anything from your analgesics to vitamins to complementary medicines. It is not something that is funded, therefore we have little information about it

**Senator REYNOLDS:** That would include things that people are going to buy at the pharmacy.

**Mr Learmonth:** Sunscreen, aspirin and vitamin D. It is all over-the-counter medication.

**Senator REYNOLDS:** What sort of complementary medications are you talking about there? What sort of things would that include?

**Mr Learmonth:** It is not my area of expertise. I would imagine that apart from vitamins there are certainly the St John's worts of the world and that sort of thing.

**Senator REYNOLDS:** Just in terms of the MBS, I am just wondering if you could tell me what safeguards or safety nets are currently in place and who they are designed to support.

**Dr Bartlett:** There are currently three safety nets in place for the MBS. There is a thing called the greatest permissible gap, which is currently $76.20. Essentially, that says that the gap between the scheduled fee and the so-called 85 per cent rebate can never be more than $76.20. If you are scheduled fee gets up above about $540, the greatest permissible gap kicks in. There is a thing called the original Medicare safety net, which essentially says that once you have met a threshold your rebate is increased from 85 per cent of the scheduled fee to 100 per cent of the scheduled fee. It is determined by the scheduled fee and the usage of that safety net is very small. It dates back essentially to the beginning of the MBS.

There is also the extended Medicare safety net, which is based on fees charged, although there are a series of things there at moment where the amounts that are eligible to be considered towards getting to either the threshold or what is paid when you get to the threshold are capped. There are two thresholds for the extended Medicare safety net. One is a concessional threshold. I will get the detail on that. In 2014 the concessional threshold for the extended Medicare safety net is $624.10. The upper non-concessional threshold is $1,248.70. A bill that passed both houses of parliament on 26 June 2014 means that from 1 January 2015 the upper threshold will increase to $2,000.

**Senator REYNOLDS:** For nonconcessionals.

**Dr Bartlett:** For nonconcessionals. On 1 January 2016 there is a budget measure that will essentially move that to what is called a single Medicare safety net, whereas with new thresholds—

**Senator REYNOLDS:** That is extending the extended safety net into the single safety net or to all three?

**Dr Bartlett:** Essentially all three will go into a single safety net, which has a $400 threshold for concessionals, a $700 threshold for FTBA families and non-concessional singles and a $1,000 threshold for non-concessional families. It is an accumulation to the thresholds based on 150 per cent of the scheduled fee. And the payment, once you are through the

threshold, is a calculation based on 150 per cent of the scheduled fee. What it means is that you will get a significantly increased number of people who will access the safety net based on current behaviour but they will get less than they get now because some of the very high fees that are charged will no longer attract the sort of coverage under the safety net that they have today.

**Senator REYNOLDS:** So, overall, more people will be able to access the safety net with these changes.

**Dr Bartlett:** That is correct.

**CHAIR:** Senator, can you make this the last question. You will have the opportunity to come back, if you like.

**Senator REYNOLDS:** Thank you. Have you got the numbers for how many Australians are eligible for concessional entitlements and rates?

**Dr Bartlett:** The answer I read out earlier said that, in 2012-13, there were, I think, 7.1 million people who had concessional access to the MBS for that year. I can confirm that.

**Senator REYNOLDS:** How many of those 7.6 million, I think you may have said, are in what categories and, under the new arrangements, will they all be entitled or will there be differences?

**Dr Bartlett:** All of those in the categories which I am talking about will be. For safety net purposes there is an additional concessional group, FBTA families—and that is all FBTA families. FBTA families at the maximum rate get into the concessional group generally, but this is all families eligible for any payment of FBTA. So you have got that addition to the group. They attract the $700 threshold as opposed to the $400 for the other concessionals.

**Senator XENOPHON:** I have some questions on pathology and diagnostic imaging services and radiation oncology. You may be aware that there is a strain on small independent providers—for instance, I think an issue has been raised publicly about Adelaide Pathology Partners in my home state of South Australia—who process lower volumes in areas such as blood tests and who are unable to benefit from economies of scale that the large corporate pathology providers can. Adelaide Pathology Partners provides specialist histopathology services and cancer diagnosis. What measures are in place to ensure that small independent laboratories, particularly those who provide these specialist services, do not disappear and there is not a possible shift to a duopoly? Senator Nash is very familiar with the effects of a duopoly in a completely different sector. We are trying to avoid a duopoly situation in pathology services.

**Mr Learmonth:** Dr Bartlett might go further into this, but there are a couple of different things going on there. In pathology, there are a couple of different kinds of—

**Senator XENOPHON:** You will have to speak up, I am sorry.

**Senator Nash:** This room is terrible.

**Mr Learmonth:** In pathology, there are a couple of different kinds of sectors, broadly. There is the large, automated chemical sector. That is very scale dependent in terms of efficiency—market share and scale are important. The smaller, dare I say almost boutique, histopathology—people with microscopes looking at cancer samples—is not scale dependent and the evidence we have is that it is fundamentally viable. Indeed, there was a shift in the

rebate away from the large, automated side of things to that histo a few years ago, but, nonetheless, it is not amenable to scale economy in the same way as the big automated sector.

**Senator XENOPHON:** So that is your information regarding the way that the business models might work. You are saying that, if they have low volumes of bloods, they can still survive if they do histopathology.

**Mr Learmonth:** I am saying, if it is the chemical—if it is the automated—scale is important. The histo is not scale dependent.

**Senator XENOPHON:** I am just getting information from my constituents, who say it makes them more vulnerable. Has any modelling being done—and I invite either of you to take this—as to the effect of the introduction of a co-payment for bulk-billed pathology services in small, independent labs, as this is the majority of their revenue and they may be too small to absorb the costs of a co-payment? Has any modelling being done?

**Dr Bartlett:** No modelling has been done. Again, as Mr Learmonth has just gone through, a significant number of the smaller labs are effectively working in the histopathology area. There are significantly higher rates of patient billing in the histopathology area than there are in the chemical pathology areas with the economies of scale that he described. So the expectation would be that the effects there will be limited, but no specific modelling has been done.

**Senator XENOPHON:** So it is an expectation but the expectation is not based on any particular facts?

**Dr Bartlett:** The expectation is based on the understanding that we have of the sector, but the difficulty that we have with this is the difficulty we have in looking at a whole range of medical practices. We do not get comprehensive detail about people's business models, about their P&Ls, about the way in which they are spending their money or about the effects that various things have.

**Mr Learmonth:** Senator, that judgement is based on facts in that those types of pathology operations are not as amenable to economies of scale and, therefore, changes in the volume, and they also exhibit substantially higher degrees of patient billing already. So, on those bases alone, you would conclude that, in the light of the modest co-payment, there is unlikely to be a significant impact.

**Senator XENOPHON:** It is based on the facts of the method of payment, but you have then hypothesised as to what the impact of the co-payment would be. You have not actually tried to draw a nexus around the impact of a co-payment on those smaller pathology practices.

**Mr Learmonth:** As Dr Bartlett suggested, that would be beyond the capacity of the knowledge that we have—or that is available, I should say, in that sector.

**Senator XENOPHON:** But it could be obtained in assessing—

**Dr Bartlett:** No, it could not be obtained. We do not get that level of detail from practitioners. In fact, practitioners will go out of their way to ensure we do not get that level of information.

**Senator XENOPHON:** Can I put something else to you that is related to this. Unlike radiology and GP practices, pathology tests are not usually undertaken in the collection centres and, therefore, patients do not interface with the collection staff and the co-payment is

not collected up-front. How do you plan to mitigate this risk for pathology tests, for example, should there be a co-payment and, in particular, the impact on the smaller operators?

**Dr Bartlett:** As we said regarding the histopathology providers, there are significant levels of patient billing now. We assume—

**Senator XENOPHON:** What is that assumption based on?

**Dr Bartlett:** There are significant levels of patient billing now in areas like histopathology; they are billing patients now.

**Senator XENOPHON:** So, when I get blood taken out of me at a pathology centre, usually it is at a collection clinic; it is not—you are smiling, Minister. What is the breakdown of where it is easy to collect a co-payment and where it is not, where it is a nurse in a medical centre who just takes the blood and sends it off and there is no-one in an administrative sense to collect a co-payment?

**Dr Bartlett:** I think the way I would describe it is that the smaller providers—as Mr Learmonth described them, the boutique providers—are essentially working in areas where there are significant patient billings now. That would suggest they have the means of dealing with this.

**Senator XENOPHON:** You cannot give me a breakdown of that, can you, or an approximate breakdown?

**Dr Bartlett:** I think I could give you an approximate breakdown, but I would have to take that on notice.

**Senator XENOPHON:** I am very happy for you to take it on notice.

**Dr Bartlett:** In the other cases you are talking, essentially, about three very large providers who have a series of relationships with all of the people who are collecting samples on their behalf.

**Senator XENOPHON:** QED. That is what I am trying to say. It seems to me a case that the big providers will do quite well—will be able to absorb a co-payment or cope with it—whereas it could push the smaller providers to the wall.

**Dr Bartlett:** I should also say that everybody who, essentially, has a collection arrangement with a GP clinic or someone else has a relationship with those people and can put things in place. What I am suggesting is that the smaller clinics are operating in areas like histopathology where they have arrangements in place to collect payments now. In those areas that we are talking about that are high volume, which have high bulk-billing rates, we are talking overwhelmingly of very large businesses that we believe can put in place the infrastructure to collect co-payments and have the relationships with the people they are dealing with to make that occur.

**Senator XENOPHON:** That might mean having a debt collection service in place to collect outstanding accounts.

**Dr Bartlett:** That can happen now.

**Mr Learmonth:** They have some infrastructure now. Even with the larger ones, there is a very high level of patient billing—not bulk-billing but patient billing—for in-hospital episodes. There is a whole infrastructure there which is designed around sending people bills and collecting the money. This is not new.

**Senator XENOPHON:** So you are saying the concerns of the smaller providers are unwarranted?

**Mr Learmonth:** I am saying to you that the concerns, as expressed by those providers, need to be seen in light of context—which is that they are not, by and large, scale dependent and that they have already levels of patient billing. It would not be a new thing for them to do.

**Senator XENOPHON:** Perhaps we will agree to disagree. How would you expect a laboratory to collect a co-payment from nursing home patients?

**Dr Bartlett:** There are arrangements in place at the moment in nursing homes to deal with pharmaceutical co-payments and a range of other payments.

**Senator XENOPHON:** It would be an extension of that?

**Mr Learmonth:** Specialist co-payments are already paid. There are arrangements for those things to be paid, and there always have been.

**Senator XENOPHON:** Does the co-payment apply for outpatient pathology ordered by specialists?

**Dr Bartlett:** It applies for all out-of-hospital pathology.

**Senator XENOPHON:** What systems would be in place to monitor when a concessional patient reached their 10 visits?

**Dr Bartlett:** DHS is developing a system that essentially makes that information available to—

**Senator XENOPHON:** How close are we to that being developed—to the software being up and running?

**Dr Bartlett:** As I understand it they are developing it. I think you would actually have to ask them to give a specific update as to where things are at the moment. I have not talked to them about it.

**Senator XENOPHON:** I am happy if you could take that on notice. What measures are in place, or are planned, to ensure that access to advanced services such as diagnostic imaging will be maintained for all Australians, should the co-payment be successful?

**Mr Learmonth:** We do not expect a significant impact on access.

**Senator XENOPHON:** Have you done some modelling in respect of that?

**Mr Learmonth:** We do not expect a significant impact on access.

**Senator XENOPHON:** Have you done any modelling on that?

**Dr Bartlett:** Senator, as we have talked about it previously—

**Senator XENOPHON:** Sorry, Mr Learmonth, 'significant' means different things to different people. Is it five per cent, 10 per cent, 20, 30 or 40 per cent? 'Not significant' can be under 50 per cent, by some definitions.

**Dr Bartlett:** We have indicated at previous estimates that we anticipate that the introduction of a co-payment for GP services will slow the rate of growth by one per cent. We anticipate something similar for DI.

**Senator XENOPHON:** Okay. So there will be fewer pathology tests undertaken?

**Dr Bartlett:** No. The rate of growth will slow.

**Mr Learmonth:** There will be more undertaken.

**Senator XENOPHON:** Right. With an ageing population and the like.

**Mr Learmonth:** There will be more undertaken.

**Senator XENOPHON:** Finally, has any assessment been undertaken as to whether a lesser increase in the number of tests would have any impact on avoiding an adverse outcome that could have been determined by a test?

**Dr Bartlett:** There is no way we could undertake such an assessment. I would have to say, for a start, there are a significant number of pathology tests that are essentially given by GPs to patients that are never filled. I cannot tell you what the impact of those is in terms of what is happening here. What we are anticipating here is a very small change on the margins of things. Whether or not that has any more or less of an effect on what is already happening, we could not—

**Senator XENOPHON:** Please take on notice how this will work administratively, because that is a complaint I have had, which I believe is a legitimate concern.

**Senator DI NATALE:** I would like to return to the earlier line of questioning from Senator Reynolds around health expenditure. I refer specifically to the Australian Institute of Health and Welfare health expenditure report for 2012-13. I go, again, to the federal contribution of health spending during that period. Could you tell me whether it increased or decreased, in real terms, and if so by how much?

**Dr Bartlett:** I will check whether I have that information.

**Mr Bowles:** We are just trying to get that for you. It was more in the whole of portfolio, but we will try to find that out for you.

**Senator DI NATALE:** By the calculations I have—and you could confirm these for me—federal health spending in 2012-13 has fallen by about 2½ per cent, in real terms.

**Mr Learmonth:** We will get the figures for you. The other thing is, a single year on year—one swallow does not a spring make. So a single year-on-year change might reflect such things as changes in large NPAs and so on; it does not actually change the underlying structural growth rate—

**Senator DI NATALE:** I want to talk about the overall long-term trends as well, so I will come to that in a moment. It is important to get a few basic facts on the record. The decrease in health spending over 2012-13, I have calculated as about 2½ per cent in real terms—this is the federal contribution—but I will wait to see—

**Dr Bartlett:** I am sorry, I have the MBS figures; I do not have—

**Senator DI NATALE:** I will wait to get that. If we do have a significant decrease—sorry, Ms Flanagan, did you want to say something?

**Ms Flanagan:** We have an analysis of the AIHW report. In terms of the analysis of the change from 2011-12 to 2012-13, the result in 2012-13 is, in part, because of some phasing issues. For example, many people prepaid their 2012-13 health insurance.

**Senator DI NATALE:** I just want the number, to start with. I will get to the issues in a moment.

**Ms Flanagan:** I am just trying to see whether I can give you the actual figures. Total Australian government expenditure was $61.022 billion and it was lower, in real terms, by 2.3 per cent.

**Senator DI NATALE:** So we have seen a decrease—let us be clear about that—in the federal contribution to health spending by 2.3 per cent in 2012-13.

**Ms Flanagan:** There are reasons for that.

**Senator DI NATALE:** Yes and let us go to some of these reasons. Perhaps you might want to talk us through some of those.

**Ms Flanagan:** The information I have here shows that part of that was due to the fact that—again, comparing year on year—there was prepayment of the private health-insurance premiums, which then put up the rebate in the base year that we are comparing against. This artificially increased Australian government expenditure on the PHI rebate, and then it was decreased. There would also have been issues around the national partnership agreements that I think Mr Learmonth talked about, where a number of them were coming to an end. They were time limited. There would be a range of different things when you are just comparing one year against the other.

**Senator DI NATALE:** I think it was Dr Bartlett who mentioned the Chronic Disease Dental Scheme.

**Dr Bartlett:** There were issues with chronic disease dental but my understanding, in this year, is that apart from the things Ms Flanagan mentioned the other issue that was important was price disclosure and pharmaceuticals.

**Senator DI NATALE:** Yes, that is right, and the price we were paying for some drugs coming down. We are talking about 2012-13. Do you not think the Chronic Disease Dental Scheme was a factor?

**Dr Bartlett:** I would have to check that.

**Senator DI NATALE:** Please take that on notice. What about the changes to the means-testing arrangement?

**Dr Bartlett:** As Ms Flanagan said, one of the things that happened with the means-testing arrangement—and there are some issues here about what AIHW covers in its report: it covers rebates but it does not appear to cover premiums—was that there was a significant pre-payment made the year before—

**Senator DI NATALE:** Because of the changes to means-testing?

**Dr Bartlett:** That is right. It enabled people to effectively avoid the effects of means-testing for a period.

**Senator DI NATALE:** So we think that may have been a factor as well. Can I talk to you about the longer term trends. Again, we have a decrease of 2.3 per cent, I think you said. If we look at the rate of growth over the last decade, it looks like what we are seeing is a slowdown in growth. If you break it into five-year blocks, we have a significant decrease in total health spend for the second part of the last decade. We have an annual rate of about 4.8 per cent over the first five years of the decade, and over the second five years of the decade we have an annual growth rate of 4.1 per cent. Are those figures accurate?

**Ms Flanagan:** I do not have the report with me, and I only have selected figures, so I cannot confirm those here.

**Senator DI NATALE:** The point we made earlier is about long-term trends. Health inflation is the other thing, of course—health inflation is coming down and becoming much closer to CPI, which is a big change. Health inflation was, I think, 0.7 per cent and has now dropped to 0.2 per cent during that second period. If we are seeing health inflation come down and we are seeing the growth in total health spend coming down, isn't it possible that, if we were to look ahead five years and that trend from over the last five years continues, in fact the projections the Treasury have made will be significantly downgraded?

**Mr Bowles:** I do not think we can comment on Treasury projections; that would probably be best asked of them. That would be a starting point.

**Dr Bartlett:** The only thing I would be adding is that, if you look back at pathology over the last five or six years, it went through a period in the middle of it where its growth rates flattened significantly for a range of reasons, not least provider behaviour. It has now returned to a trend growth of six per cent. We see variations in rates of growth, but it would be difficult. We have seen similar things happen with CT ordering, but it is difficult to argue, or it is risky to argue, that that represents a long-term change in trend. We tend to see over time a reversion back to what has been a normal growth pattern, and I suspect that, if we talked to our colleagues in Treasury, that would be their way of dealing with it.

**Senator DI NATALE:** I am not suggesting that we should bank everything on what we have witnessed over the last five years. My point is that we extrapolate from what we have experienced before and we project forwards, and if what we are experiencing now is maybe an adjustment then in fact the projections looking forward will be very different from the ones we anticipate.

**Dr Bartlett:** The difficulty for me is that I cannot talk about the whole-of-health spend. I can talk about the MBS and, if I look at what the MBS is like, I have gone through some of the figures about the rate of growth in services, the rate of growth in benefits and the rate of growth in services per head. That has held true.

**Senator DI NATALE:** Let us look at the Chronic Disease Dental Scheme. We were looking at an increased spend—I think it was roughly a billion dollars per annum we were looking at, and that scheme was wound up. Why aren't we looking at other expensive item numbers within the MBS that provide little value? Surely that is a fruitful area in which to look for some savings.

**Mr Learmonth:** We do, Senator.

**Senator DI NATALE:** Can you talk about what we are doing in that area?

**Mr Learmonth:** We have an MBS quality management framework which involves a revisiting of the evidence-coverage relationship for a number of identified items.

**Senator DI NATALE:** But it is very narrow in terms of the number of item numbers we are looking at at the moment. I understand there are only a very small number of item numbers that are being looked at actively at the moment.

**Dr Bartlett:** There is a pipeline, to be sure, and that pipeline has been informed by a committee of stakeholders—clinicians and consumers and others. That pipeline is

progressively working its way through the Medical Services Advisory Committee. At the end of the day there is a limit if you are going to have a reasonable process which involves consultation and appropriate expert input; there is a certain width of pipeline you can generate at any one point in terms of the volume of these things. But, nonetheless, there is a rolling program of MBS reviews through the Medical Services Advisory Committee.

**Senator DI NATALE:** How many item numbers are being actively reviewed at the moment?

**Dr Bartlett:** There are 21 reviews going on at the moment. They do not all cover a single item number. A number of them cover multiples. The other point I would make is that, in terms of the things that are going on, if you look at some of the things that people are suggesting are areas that need to be reviewed in the MBS, some of the reviews that are being undertaken at the moment are looking at areas like lower-back pain and use of scanning for lower back pain, vitamin D testing, vitamin B12 and folate testing—

**Mr Learmonth:** Diagnostic arthroscopy.

**Dr Bartlett:** yes—

**Senator DI NATALE:** Excellent. Terrific—all very good, very worthwhile exercises.

**Dr Bartlett:** and various procedures where there is, shall we say, a narrow dividing line between cosmetic surgery and plastic surgery. I think that to say that is a narrow brand band is—

**Senator DI NATALE:** I did not say that. I thought you were saying that there are only so many we can—

**Mr Learmonth:** I am saying that there are a finite number that we can deal with at any one time, because to do this properly they need to draw on clinical input from the relevant colleges. They need consumer input. They need the health economists to do their bit. This is not just about a casual disinvestment. This is bringing evidence to bear in term of the relationship—

**Senator DI NATALE:** Absolutely, and that is a good thing.

**Mr Learmonth:** and there is only so much of that that you can do at any given time.

**Senator DI NATALE:** Why is that?

**Mr Learmonth:** It is just the availability of people to do it, the availability of time from the specialist colleges and the availability of the reviewers. We have a huge demand on the resources of health economists and others, in from Australian universities and other bodies. We have the Pharmaceutical Benefits Advisory Committee; we have the Medical Services Advisory Committee; we have the Prostheses List Advisory Committee. We make use of contracted reviewers. There are only so many of them out there, and there is only so much time from those august bodies—the Royal Australasian College of Surgeons and so on. There is only so much time and resources that we have that we can use to drive this pipeline, bearing in mind that we also have to maintain the access machine, which is new items and new listings.

**Senator DI NATALE:** How—

**CHAIR:** This will be the last question and then we will suspend for afternoon tea.

**Mr Learmonth:** If I may, there is one more point. The value of the committee that we established to do that is not—

**Senator DI NATALE:** When was the committee—can you give me some details about that?

**Mr Learmonth:** The committee was established a couple of years ago. It is called the Safety, Quality and Sustainability Forum. It has the AMA, the college of surgeons, the college of GPs, the Consumers Health Forum and a range of other groups—some pop in and out. Part of it is to do the environmental scan. I do not know if you are familiar with Adam Elshaug—I think you may have mentioned him in a previous discussion: came back from the States, evidence based medicine, one of the gurus of—

**Senator DI NATALE:** Yes, sorry.

**Mr Learmonth:** He is on the group. It is about going through, drawing on international evidence and their own analysis of what is actually spiking growth in the MBS, and it is about targeting. While we have a limited pipeline, we try and target the things that are likely to have high pay-off. They are either blatantly not worth it, or they are spiking growth with no particular evidence base—

**Senator DI NATALE:** With very little benefit.

**Mr Learmonth:** or they have an impact in terms of the risk profile for consumers.

**Senator DI NATALE:** I think that is terrific. I think that it is a great initiative. I think that it is where the focus needs to be. The point is: we have had this thing going for two years. We talk about capacity constraints. We are talking about, at the same time, whacking in a great big co-payment to restrict access. Surely the focus needs to be on the low-hanging fruit which you have just described: things that cost a squillion but actually provide very little value and benefit to patients and in fact, in some cases, pose significant risk. Why is it that we are not investing in that part of the system—that is, making sure we deliver quality, evidence based health care that is good for patients and that is also good for taxpayers—building that and giving it a chance to work, rather than making these claims of unsustainability within the health system and introducing a co-payment at the same time?

**Mr Learmonth:** Ultimately, that is a choice and a matter for government. It is a decision for government. The quality and sustainability angle is there. It is delivering results in terms of both patient outcomes and sustainability, though its impact is always going to be comparatively modest in terms of sustainability. As Dr Bartlett said, whatever occasional fluctuations there might be, the long-term structural growth rate of the MBS is in excess—on any reading—of the growth rate in revenue and GDP.

**Senator DI NATALE:** Yes.

**Mr Learmonth:** You always have to consider sustainability in that context.

**Senator DI NATALE:** We will come back to that, hopefully, after the break.

**CHAIR:** We can come back to some further questions on that, if you would like, afterwards.

**Proceedings suspended from 16:04 to 16:22**

**Senator McLUCAS:** I want to go to the question of the exemptions from the GP co-payment. Has any work being done around certain patient groups that the government is considering might need to be exempted from the GP co-payment?

**Dr Bartlett:** We have provided advice about the GP co-payment to the government over a period of time. I cannot really comment on specific parts of it.

**Senator McLUCAS:** Is the minister requesting consideration of various cohorts who may need to exempted from the GP co-payment?

**Senator Nash:** I am not aware of that, but I am happy to take it on notice insofar as I can.

**Senator McLUCAS:** It is very hard to actually run estimates when you take everything on notice.

**Senator Nash:** I do not think I am taking everything on notice. There are things that are the purview of the senior minister, the Minister for Health. I am assisting the committee as far as I can in taking things that I am not aware of or privy to on notice for you.

**Senator McLUCAS:** Three questions I have asked you and you have taken them all on notice. It makes it hard to run a line of questioning if it stops because you just take it on notice. It is very hard to do.

**Senator Nash:** You would know that historically I assist the committee as much as I possibly can. Where I am not able to assist the committee with information, I will take it on notice as part of the process. That is the only reason I am doing that.

**Senator McLUCAS:** I will go to a clinic in Perth that provides GP services to homeless people. I understand they have written to all members and senators, indicating that if the co-payment is introduced their service will become unviable and would have to close. Are you aware of this service? It is called Mobile GP.

**Dr Bartlett:** I am not; I certainly have not seen that correspondence.

**Senator McLUCAS:** They are saying that the reduction would equate to 42 per cent of their income for a short consultation, 19 per cent for a standard consultation, and 10 per cent for a long consultation. This is because of the way the bulk-billing incentive is removed—along with the fact that they are talking to homeless people, who have got no money. They cannot pay, and so they have to be bulk-billed, in the old scheme. So the clinic will lose a lot of money for each consultation. My question is: have you done any work looking at how this type of service might be able to be delivered? They are suggesting that they would need an exemption or a subsidy, if the GP tax were to be applied.

**Dr Bartlett:** Senator, I do not know about the specifics of the practice. I do not know about the places it is getting its income from; we talked at some length last estimates about AMSs and their various income sources. I do not know enough about the practice in question to offer any meaningful opinion.

**Senator McLUCAS:** I am sure that they are using their chronic disease system as best as they can, but we are talking about people who are very vulnerable.

**Dr Bartlett:** But, Senator, I do not know whether they have alternative funding that is also helping them; I do not know their item mix; there is a whole range of things about them that I have no idea of, so I cannot comment in any meaningful way.

**Senator McLUCAS:** And their assessment of a 42 per cent reduction in remuneration for a short consultation: do you have any comment about that?

**Dr Bartlett:** Senator, I could not comment on the exact percentage. But in terms of what you are describing—which is the percentage effect of the $5 reduction in the rebate, and any low-gap incentive if that is not payable—that will obviously be higher on the lower rebate items.

**Senator McLUCAS:** Yes. So 42 per cent is about right.

**Dr Bartlett:** I do not know. The logic is right, but I do not know whether the actual numbers are right. I would have to take that on notice to check it.

**Senator McLUCAS:** Okay, thank you. I also have a series of questions I want to ask about Medibank Private's Carepoint program, and the impact of that on MBS billing. Is the department aware of the Medibank Private care trials involving Victoria and Western Australia?

**Dr Bartlett:** I have heard about a trial they are doing in the Barwon region in Victoria. I do not know about a trial in WA. It may well be that I have got people in the private health insurance branch who have a greater understanding of that than I do, but I am not in a position to provide you with particular information about it.

**Senator McLUCAS:** Basically, these trials employ nurses in GP practices, as well as providing a telephone concierge service with a nurse triage call, remote monitoring services and a care navigator service. Essentially, it is managing a very small cohort of people through the health system. I will ask the questions, and if you do not know the answers, Dr Bartlett, then that is fine. What is your knowledge of the way GPs, practice nurses and others who are involved in the program are remunerated?

**Dr Bartlett:** Sorry, Senator, I can't answer that.

**Senator McLUCAS:** You cannot answer that. Is there anyone in the department who would be aware of that?

**CHAIR:** We are coming to private health in outcome 6.

**Senator McLUCAS:** Yes, except it is not really about private health; it is about the impact of this program on the MBS.

**CHAIR:** Sure. But the detail of that, I assume, is in the private health area.

**Senator McLUCAS:** It sort of is not.

**Dr Bartlett:** Chair, I think we would have to take the question on notice. We will have had some briefing from Medibank Private as part of starting the program. Whether it goes to the detail that the senator is asking for, I cannot say. We would have to go back and look at that. I do not know the answer.

**Senator McLUCAS:** All right. I will put all of those questions on notice for you, Dr Bartlett; thank you. I would like to go to the Jackson review.

**Mr Bowles:** Chair, before we go to the review, can I table a statement from Professor Baggoley, who appeared this morning? It is in relation to the issues I raised this morning as well.

**CHAIR:** There being no objection to that being tabled; yes.

**Senator MOORE:** Is that the same as the evidence of Professor Baggoley this morning, or is it supplementary comments?

**Mr Bowles:** It is supplementary; it is in relation to what I talked about earlier on. Professor Baggoley was looking at that detail for me.

**Senator McLUCAS:** I have some questions on the Medical Services Advisory Committee. When was MSAC due to meet this year?

**Ms Faichney:** They had an executive meeting on 3 October and there is a three-day meeting on 26 to 28 November.

**Senator McLUCAS:** Did the meeting scheduled for 31 July and 1 August occur?

**Ms Faichney:** No, they were cancelled.

**Senator McLUCAS:** Why?

**Dr Bartlett:** The appointment process for the committee had not been completed at that point.

**Senator McLUCAS:** Okay.

**Dr Bartlett:** As Ms Faichney just said, there was a meeting held on 3 October, which dealt with any urgent business that had not been able to be dealt with because of that meeting, and there is a longer meeting scheduled for December that will deal with the rest as well as other new applications that have come forward and reviews that have come forward in the interim.

**Senator McLUCAS:** So the meeting on 3 October was not a scheduled meeting?

**Dr Bartlett:** It was meeting that was essentially scheduled to ensure that any urgent matters were dealt with.

**Senator McLUCAS:** It was not in the original schedule, though.

**Dr Bartlett:** It was not in the original schedule.

**Senator McLUCAS:** When was the minister provided with the list of potential MSAC appointees?

**Dr Bartlett:** I would have to take that on notice.

**Senator McLUCAS:** When was Professor Ward advised of her reappointment as chair of MSAC?

**Dr Bartlett:** Again, I would have to take that on notice and come back to you.

**Senator McLUCAS:** How are MSAC appointees identified? I dare say you provide a list of potential appointments to the minister.

**Dr Bartlett:** That happens. There is a range of ways in which they are organised, but part of it is that we have a range of subcommittees that work to MSAC or to, actually, the evaluation subcommittee and the protocol advisory subcommittee. They tend to be a source. There are people who have worked in other areas that involve health technology assessment. Mr Learmonth talked about some of the other areas where we have committees. There is a fair amount of cross-fertilisation that we try to encourage there to make use of what is a fairly limited pool of expertise.

**Senator McLUCAS:** And you try to get a breadth of experience.

**Dr Bartlett:** We try to get a breadth of experience, we try to get a breadth of expertise and we try to get a breadth of specialties.

**Senator McLUCAS:** Were all appointees recommended by the department?

**Dr Bartlett:** We put up a range of people for government to consider and government considered them.

**Senator McLUCAS:** That is not the question I asked.

**Dr Bartlett:** There were names that have gone forward to government in various pieces of advice.

**Senator McLUCAS:** So there was not one list where you said to the minister to select from?

**Dr Bartlett:** There was no one single list; there were a number of pieces of advice that were provided.

**Senator McLUCAS:** So, out of all of those pieces of advice, were all of the appointees recommended by the department?

**Dr Bartlett:** All of the people appointed were reflected in the advice that was provided.

**Senator McLUCAS:** So in all of the advices you provided the names of all the appointees appeared in those documents?

**Dr Bartlett:** They will have appeared in at least one of the documents at one stage, yes.

**Senator McLUCAS:** That is a very long way of answering a pretty simple question.

**Dr Bartlett:** Sorry, Senator; I am sort of tying myself up in knots—and I am not quite sure why.

**Senator McLUCAS:** It makes people get intrigued. My question was: were all appointees recommended by the department?

**Dr Bartlett:** As I said, advice went to the minister and the government from the department that included all of the names of people who were subsequently appointed and other names.

**Senator McLUCAS:** So the answer is yes. Did the department provide a list of potential consumer representatives?

**Dr Bartlett:** Yes, it did.

**Senator McLUCAS:** I understand that there is not a consumer representative who has been appointed yet. Is that correct?

**Dr Bartlett:** My sense is that we are on the point of finalising a consumer appointment.

**Senator McLUCAS:** So you did provide the minister with a list of potential consumers?

**Dr Bartlett:** We provided the minister with a list of potential people. We had somebody who went forward and was on the point of being appointed. She decided that she did not wish to be appointed, which meant that we had to go and find somebody else—which we have done. My understanding is that, if that is not finalised, it is on the point of being finalised.

**Senator McLUCAS:** And you expect that to happen soon. In the past, how many health economists have been appointed to MSAC at any one time—just as a general rule?

**Dr Bartlett:** Typically, we have had one health economist on MSAC. Although we have had people with a range of health economics expertise, certainly there has been at least one health economist at any given point of time.

**Senator McLUCAS:** And now we have one, I understand from the list.

**Dr Bartlett:** We have two at the moment, as I understand it.

**Senator McLUCAS:** Were any of the appointees appointed outside of that process by the minister or the minister's office?

**Dr Bartlett:** No.

**Senator McLUCAS:** Have there been any changes to the make-up of the MSAC secretariat?

**Dr Bartlett:** Yes, there have been a number of changes. Mr Carlile was the assistant secretary for the relevant branch. He started in that role on 1 December last year. He has recently moved to Portfolio Strategies Division. Ms Santiago has just taken over from him. Mr Wootton, who is the—

**Senator McLUCAS:** Dr Bartlett, I do not need to know the names of individuals. I just want the general feeling—was it just normal movement in the department or what has happened?

**Dr Bartlett:** It was normal movement within the department.

**Senator McLUCAS:** Thank you. I have no further questions about MSAC.

**Senator MOORE:** I have some standard questions around the Jackson review. They are just the ordinary questions about reviews. Is the review of after-hours access—

**Dr Bartlett:** Sorry, if it is about the after-hours access, that is outcome 5. I cannot help you, I am afraid.

**Senator MOORE:** Thank you. That makes it very easy. I will just cross the top off and make it outcome 5.

**Dr Bartlett:** I am sorry.

**Senator MOORE:** Have we got to outcome 5 yet?

**Senator McLUCAS:** It is the review of after-hour GP services. That is in outcome 5.

**Mr Bowles:** We have already done outcome 5.

**Senator MOORE:** I will put them on notice. How do I go with dental? Shall I give it a go?

**Unidentified speaker:** Ask away.

**Senator MOORE:** With regard to the current National Partnership Agreement on Adult Public Dental Services, can the department advise whether the partnership will proceed in 2015? At this stage, do you have information about the time frame?

**Ms Anderson:** We have had consultations with all state and territory dental staff, dental directors. We have spoken to them at some length individually around current issues in relation to the delivery of publicly funded dental services in each of those jurisdictions. We have also done significant preparatory work. We have yet to commence formal negotiations.

We certainly fully expect that the new national partnership agreement will be on foot, as planned, by the beginning of 2015-16.

**Senator MOORE:** Ms Anderson, what is the time frame? You started the preliminary discussions with the states, so we know it is getting close. There is no formal negotiation started. When does that have to be signed off by to actually meet the requirements for it to be operational in 2015-16?

**Ms Anderson:** There is no specific date. It will be concluded when negotiations have finished and we achieve multilateral agreement on the terms and conditions.

**Senator MOORE:** So will that be prior to June 2015?

**Ms Anderson:** June 2015, that is correct. It starts in—

**Senator MOORE:** For it to be for 2015-16, as an end date, it will have to be negotiated and signed by 30 June, 2015.

**Ms Anderson:** Yes.

**Senator MOORE:** I do not want to verbal you. You feel confident that that will be achieved; were those the words you used?

**Ms Anderson:** We will do the best we can.

**Senator MOORE:** I will just write that down.

**Ms Flanagan:** Noting that we have got to negotiate with eight states and territories.

**Senator MOORE:** Yes, I think that is the same number as always.

**Ms Flanagan:** The same number as always. And, having done a number of negotiations, sometimes you can get a number of states to participate fairly readily. Then there are sometimes some laggards that you need to do some work with.

**Senator MOORE:** And the department has extensive experience with that.

**Ms Flanagan:** We do, we do.

**CHAIR:** Can you tell us about any of the laggards?

**Ms Flanagan:** We do not know who they are at the moment, in particular with regard to the dental agreements.

**CHAIR:** We will find out soon.

**Senator MOORE:** But we do tend to name them if it goes on too long. We have had that in the past about which states have agreed. At this stage, we are still at the first stage.

**Ms Flanagan:** Yes, we are in productive discussions at the moment with the dental directors. It will be when we get the state governments involved—

**Senator MOORE:** From the department's perspective, it is a deferment for one year rather than the end of a partnership.

**Ms Flanagan:** Sorry?

**Senator MOORE:** From the department's perspective it has been deferred by one year—

**Ms Flanagan:** Yes.

**Senator MOORE:** It does not contend that there will be an end to this agreement. The work is going on.

**Ms Flanagan:** Yes, the work is going on. The government has announced that the agreement will commence in 2015-16.

**Senator MOORE:** Has the department held any discussions with the states about altering the partnership? Is it all open in terms of the next round?

**Ms Flanagan:** This is a completely new agreement.

**Senator MOORE:** So it is a whole new agreement. Nothing is guaranteed and nothing is set in concrete.

**Ms Flanagan:** That is correct. We need to get into negotiations.

**Senator MOORE:** Minister, can you tell us what the decision was for deferring the funding? Was it a financial decision?

**Senator Nash:** I would need to take that on notice. I am not privy to that discussion.

**Senator MOORE:** We just want to know in terms of this bit.

**Ms Flanagan:** I think we have talked about this in estimates before. The reason why it has been deferred for a year is that there is currently a national partnership agreement on dental.

**Senator MOORE:** It is a different agreement—

**Ms Flanagan:** It is a different agreement but it is still going. We wanted to phase it in a more sensible way. We were worried about the impact on the states and territories from the current agreement still running and then adding this one on top of it in terms of their capacity to deliver dental services.

**Senator MOORE:** Were there significant differences in the target groups' expectations of the agreement that had not finalised and the proposed new agreement?

**Ms Flanagan:** As I say, we have not negotiated the new agreement. Again, because states and territories mainly provide services to concessional people, that is of course the main target,.

**Ms Anderson:** I might just add that the coming national partnership agreement is targeting adults, which the first did not.

**Senator MOORE:** From my preliminary reading, this availability to adults is the expectation that is significantly different in the new agreement.

**Ms Anderson:** When we go into the negotiations—yes.

**Senator MOORE:** And that is the basis of the negotiations—a wider coverage of that area.

**Ms Anderson:** It would certainly be—

**Senator MOORE:** What is the overall impact on public dental services from all the budget decisions in combination? That would probably be one to be taken on notice. It would be identification of the budget decisions that have immediate impact on dental services. Can we get some indication of what the proposed impact of that would be? The department has that information?

**Ms Anderson:** I thought you were asking about those initiatives already underway. Are you talking also prospectively?

**Senator MOORE:** Anything in the budget. Any budget decisions that impact on public dental.

**Ms Anderson:** That presents certain challenges. Because we have not yet commenced formal negotiations on the national partnership agreement for our adult dental services, we do not know where we are going to land. We are not sure of the impact on the existing configuration of publicly funded services.

**Senator MOORE:** Of what we know, Ms Anderson—decisions that we know will impact. I totally take the point that, until you have negotiated the national partnership, you do not know what you are going to achieve, but there are other budget decisions that did have impact on dental.

**Ms Flanagan:** The one that was in the budget was the cessation of the dental flexible grants program. It was the one—

**Senator MOORE:** It is so that we can get some information on what the proposed impact of the decisions will be, even with just an asterisk to say that some of these elements could be part of the negotiations of the new scheme. As we do not know what the impact of the new scheme is going to be, we should know what the impact will be on ending the flexible arrangements, which had a particular client group. We would like to know what the impact of that would be.

**Ms Flanagan:** We will take that on notice. The dental flexible grants program had not actually started, so it is quite hard to work out what the impact might have been.

**Senator MOORE:** My understanding is that we had looked at what this program was going to do when the flexible grants were announced.

**Ms Flanagan:** We will take it on notice.

**Senator MOORE:** See what you can do and we will question it later. Has the department modelled any likely impact on public waiting lists from this period of change? We have not implemented the new program, the other one is winding down and the flexible grants are not happening. Has there been any modelling done to look at what the impact on public waiting lists would be in that time?

**Ms Flanagan:** I think that under the current agreement we are monitoring the number of services delivered. Mr Maskell-Knight might be able to talk about whether we are looking at waiting times as well.

**Senator MOORE:** You have been passed the ball, Mr Maskell-Knight. Are you ready for that?

**Ms Anderson:** I will pick up first—and the news is good. The news is that, under the National Partnership Agreement on Treating More Public Dental Patients, every single jurisdiction has achieved a reduction in waiting times for access to publicly funded dental care. In relation to the overall national averages, at the beginning of the national partnership agreement the baseline figure—which was as at June 2012—was an average waiting time of 18.93 months.

**Senator MOORE:** Is that across the country?

**Ms Anderson:** Yes, nationally. So we are talking a year and a half. The average waiting time as at June 2014 is now 10.55 months.

**Senator MOORE:** Do we have state breakdowns of that, Ms Anderson? You can take that on notice.

**Ms Anderson:** We do; and we are happy to do that.

**Senator MOORE:** Do you have a nifty little table that gives all of that information?

**Ms Anderson:** Yes.

**Senator MOORE:** Is that regarding the impact of the program that was in place—is that right?

**Ms Anderson:** Yes.

**Senator MOORE:** My question remains: at this stage, where we do not know exactly what is going to be in place in the future in relation to that good work—and that is a very impressive reduction in terms of waiting times—has there been any consideration of the impacts, firstly of the winding down of one program and secondly of the fact that the new one will not be in place until 1 July 2016?

**Ms Anderson:** One of the areas that we are very keen to engage with in relation to our negotiations with states and territories is their efforts. They are partners in this endeavour. They put substantial resources into public dental services. The maintenance of or further improvement in waiting times is as much about what they are prepared to do as it is about what the Commonwealth is prepared to contribute.

**Senator MOORE:** Absolutely.

**Ms Anderson:** It is very difficult for us to hazard a guess about that without engaging directly with them.

**Senator MOORE:** Would that not be part of the engagement that you would be having around the negotiation of the new plan?

**Ms Anderson:** It is; definitely.

**Senator MOORE:** I would have thought that that was the kind of interaction that you would be having as a matter of course. Could we ask for that to be part of the discussion?

**Ms Anderson:** It will inevitably be; as it was for the first national partnership agreement.

**Senator MOORE:** To come up with—whatever the figure is that I have written down.

**Ms Anderson:** Yes. And I have just been corrected: I said every jurisdiction went down; there was a slight movement upwards by the Northern Territory. I do apologise for that error. This is absolutely on the table for discussion as we negotiate national partnership agreements. It would come as no surprise to learn that where there is a payment jointly from the Commonwealth and each jurisdiction, we are very keen to know their share and how their share travels forward over time, compared to the Commonwealth's share.

**Senator MOORE:** Ms Anderson, do we have any information that shows us what the state-federal breakdown was over the life of the previous scheme? I would like to confirm how much the states invested—taking up the point that you raised about the importance of partnership, and also my understanding of the expectation of governments of all flavours that partnerships are real. It would be useful to have some data about how much each of the states invested over that period of time, as well as the Commonwealth. Can I get that information?

**Mr Maskell-Knight:** All of these things happen with a lag, so we have health expenditure data from the Institute of Health and Welfare for 2012-13, which was the first year of the current agreement. We will not get any more information until September next year, which will cover 2013-14, and so on.

**Senator MOORE:** So in relation to the information on which the partnerships are implemented, do you still have to wait for the data from the Institute of Health and Welfare to tell you what went into it?

**Mr Maskell-Knight:** For the expenditure we do, because we do not have a provision in the agreement requiring them to report that, and the states would probably resist having that in the agreement because they are already reporting it elsewhere. What we do have is information on what the total volume of services delivered was.

**Senator MOORE:** And you would have the information on what the federal government was expending, would you not?

**Mr Maskell-Knight:** We know what the federal government was expending, yes. The agreement was predicated on the states continuing to invest what they were and maintaining the level of activity that they were. We then paid for additional activity on top of what the states were already putting in.

**Senator MOORE:** On that basis, the Institute of Health and Welfare's study from 2012-13 should give at least some indication of what the states will be doing in the next year?

**Mr Maskell-Knight:** No, not necessarily.

**Senator MOORE:** I know that we have had this discussion in the past about what states are or are not prepared to give in information over a number of the partnership agreements going back in time. But in the negotiations you have next time, are you going to give it a go again to see whether they are prepared to tell you what they are doing?

**Ms Anderson:** It will definitely come up in the conversation. We would prefer to monitor at a distance and look at outputs and outcomes, but we also look for them to continue maintaining effort because there is no value in substitution. Really, the yield here is additive.

**Senator MOORE:** We will put something on notice to see whether we can tease out some more information, but I think that gives the idea that the consultations have commenced and the negotiations are about to commence in terms of a start-up date in 2015-16. Going to the next item, headed 'Child dental benefits scheme'—is the proposal that this scheme will be continued with funding?

**Mr Maskell-Knight:** Current government policy is to continue the scheme.

**Senator MOORE:** Is that the current status, Minister—that this scheme is continuing as part of ongoing policy?

**Senator Nash:** That is my understanding.

**Senator MOORE:** What, if anything, has been done to promote this scheme to parents?

**Mr Maskell-Knight:** This is a question perhaps better addressed to the Department of Human Services, because they are the people who promote the scheme.

**Senator MOORE:** It is not a joint effort, Mr Maskell-Knight? It is not a joint effort? Promotion is purely with Human Services?

**Mr Maskell-Knight:** Yes.

**Senator MOORE:** Okay. I will cross-reference that.

**Mr Maskell-Knight:** The one exception is that there were things on the Department of Health website that were referring to it but, in terms of direct contact and mail-outs, it is the Department of Human Services.

**Senator Nash:** If it assists, I think $177 million has been paid out to about 600,000 children, for I think 2.7 million services, so it has been—

**Senator MOORE:** You are getting ahead of my questions here, Minister.

**Senator Nash:** And there I am trying to be helpful!

**Senator MOORE:** Unless I do it bit by bit, I will get lost.

**Senator Nash:** I will park it and come back to you.

**Senator MOORE:** The fact is that you have that information, so I am looking forward to it.

**Senator McLUCAS:** Has the department requested the Department of Human Services to promote the child dental program at all?

**Mr Maskell-Knight:** There is agreement between us about who does what and the government decision establishing the scheme set out roles and responsibilities. Their responsibility was promotion of the scheme in the sense of informing people about it and they received a budget allocation to carry out that work.

**Senator McLUCAS:** How much was that?

**Mr Maskell-Knight:** Wrong department, Senator.

**Senator McLUCAS:** Health did not pay DHS?

**Mr Maskell-Knight:** We did not pay DHS. The money was appropriated directly to them.

**Senator MOORE:** Is there an IDC on this one, Mr Maskell-Knight? When the steps are taken, is there consultation between Human Services and Health about the content—whether you agree with what they are saying?

**Mr Maskell-Knight:** We work very closely together.

**Senator MOORE:** Who represents the Department of Health in that interaction?

**Mr Maskell-Knight:** A range of officers, depending on the level of what is being discussed.

**Senator MOORE:** But in your branch?

**Mr Maskell-Knight:** Yes, in the Acute Care Division.

**Senator MOORE:** How many services have been provided under the scheme since its commencement?

**Mr Maskell-Knight:** Senator, 2,743,430—

**Senator MOORE:** Up to what date?

**Mr Maskell-Knight:** Up to the end of August.

**Senator DI NATALE:** Are they individual item numbers?

**Mr Maskell-Knight:** Yes.

**Senator DI NATALE:** Do we know how many kids? There are obviously a range. Are there a small group of people who use a significant number of item numbers? The distribution would be helpful.

**Mr Maskell-Knight:** We would have to take that on notice. I would need to take advice about what information is available on that.

**Senator MOORE:** Is their availability of the ASCG classifications across the country, so we can trace which regions are being serviced most in this area?

**Ms Anderson:** I think we took that on notice last time. I am happy to take it on notice again and provide that out of session.

**Senator MOORE:** Do you keep stats by federal electorate? There are some services you do and some you don't. Is this one you do?

**Ms Anderson:** No.

**Senator MOORE:** Does the MBS indexation freeze affect the child dental benefit item numbers?

**Mr Maskell-Knight:** It is not part of the MBS. The rates of remuneration are set in a separate instrument made by the minister. The minister will have to make a decision whether or not to index.

**Senator MOORE:** A question about higher out-of-pocket costs would be responded to by the same answer: it is not linked to the MBS freeze. So higher out-of-pocket costs would be determined by any indexation of the ministerial instrument.

**Mr Maskell-Knight:** So far, the level of bulk-billing is very high and the level of schedule fee observance is very high as well.

**Senator MOORE:** Do we know how many people are paying a gap at the moment? Is that the kind of data you keep?

**Mr Maskell-Knight:** Senator, 3.7 per cent of services are billed higher than their schedule fee.

**Senator MOORE:** That seems a very small amount—3.7 above schedule fee. Do you have any idea what the average gap is?

**Mr Maskell-Knight:** The average out-of-pocket per service—and I am not sure whether that is per occasion item number or per occasion of service. I am looking at the back row for assistance!

**Senator MOORE:** Someone has got that information.

**Mr Maskell-Knight:** The 3.7 per cent is only for the first quarter, so the average out-of-pocket per item number is $24.83.

**Senator MOORE:** What is the date of the first quarter?

**Mr Maskell-Knight:** January through March 2014

**Senator MOORE:** Obviously, you are keeping that data?

**Mr Maskell-Knight:** Yes.

**Senator McLUCAS:** So $24 per item number—

**Mr Maskell-Knight:** Senator, $24 per item for which there was an out-of-pocket expense.

**Senator MOORE:** So $24 of the 3.7 per cent of the treatment—

**Mr Maskell-Knight:** It excludes the bulk-bill.

**Senator MOORE:** Do you have any information on the most common treatments received under the scheme?

**Mr Maskell-Knight:** We would probably have to take that on notice to do it justice.

**Senator MOORE:** That is fine. Are you aware of whether you do keep that information? I am happy for you to take it on notice.

**Mr Maskell-Knight:** Yes.

**Senator MOORE:** Minister Dutton has outlined his concerns in relation to the operation of the scheme. Can you explain the concerns that he has stated publicly? Do you have the media release or the statement?

**Mr Maskell-Knight:** I have no insight into the minister's mind. With any new scheme I think we need to carefully monitor it to ensure that it is working as it was intended to.

**Senator MOORE:** Minister, do you have information about the concerns that Minister Dutton has stated?

**Senator Nash:** I do not have that with me.

**Senator MOORE:** Is the department working on any changes to the scheme?

**Mr Maskell-Knight:** No.

**Senator MOORE:** Given that it is very early days, has a review process been put in place with respect to how it is going to be reviewed and evaluated?

**Mr Maskell-Knight:** The Dental Benefits Act requires a three yearly review of the operation of the act. We are in the early stages of planning for the next triennial review.

**Senator MOORE:** Maybe the next Senate estimates there could be some more information about that.

**Mr Maskell-Knight:** Yes. The next Senate estimates will be in February. By that stage, the scheme will have been in operation for a full calendar year. It would make sense to actually carry something out.

**Senator MOORE:** In terms of an effective review process, it should actually be established by the end of the first year. We will come back on that.

**Mr Maskell-Knight:** Ms Anderson just reminded me that there is actually a bill in the other place at the moment that is changing the Dental Benefits Act. It is not actually changing how the scheme works; it is more about the supporting infrastructure.

**Senator MOORE:** The core expectations of the scheme and the operations are staying the same even with any bill that is going before the lower house.

**Mr Maskell-Knight:** Yes.

**Senator DI NATALE:** Can I go to an issue that was raised at a previous inquiry. It was the issue of some work done by both the South Australian health department and the New South Wales government about the impact of a co-payment on their emergency departments. In South Australia, they say that 290,000 patients will access public hospital and emergency departments if a co-payment is introduced. New South Wales have estimated 500,000 people

per year. At a previous inquiry, we raised this issue. I think it was with Ms Flanagan. You endeavoured to go and look at the work that was done in both of those situations and provide your opinion of that analysis.

**Ms Flanagan:** I have actually formally written both to South Australia and to New South Wales and said, 'Senator Di Natale is going to ask me this today. Therefore, could you please send me your analysis of how you arrived at the figures.' I have not received a response from either jurisdiction.

**Senator DI NATALE:** When did you write to them?

**Ms Flanagan:** I wrote to them last week after the meeting that we had had down in Melbourne. I thought it was better that we formally get their analysis. We have seen media reports of it. I think that one of the media reports of the New South Wales analysis was that even Minister Skinner said that it was rudimentary. I still need to formally receive from them how they have arrived at those figures.

**Senator DI NATALE:** One of those reports might have even been released on the day.

**Ms Flanagan:** The New South Wales one had been released on the day. The South Australian one had actually been in evidence before the Senate select committee earlier on. I thought it was better, as I say, that we got from them directly how they had done their calculations. We have not been able to do an analysis because we have not received that.

**Senator DI NATALE:** Have you been able to do any work on the basis of what was reported or what your understanding of that is?

**Ms Flanagan:** It is really difficult to do that. The figures to us sound very, very large. We just would need to see what sort of the assumptions they might have made. We do not find them credible on the raw numbers. Again, we are giving them the opportunity to show us what their analysis was and then we can give you our assessment of that.

**Senator DI NATALE:** That is helpful. I want to come to the issue of radiology. I want to specifically address the issue of how the co-payment and bulk-billing incentive will work in radiology. The removing of the bulk-billing incentive for a number of practices does not just mean that those practices lose $7, but they lose more than that depending on the procedure that is done. Is that correct? Can you just explain that to me? I think it is yours, Dr Bartlett.

**Dr Bartlett:** The low gap incentive will apply to concessional patients. The current bulk-billing incentive applies to all patients where they are bulk-billed.

**Senator DI NATALE:** Again, just tell me a little about the bulk-billing incentive. If the bulk-billing incentive is removed from a radiology practice, can you tell me what the impact of that will be on what that practice receives for the different diagnostic imaging procedures that are done?

**Dr Bartlett:** It will vary significantly depending on the practice. At the moment, when they bulk bill, they get an incentive that increases the rebate from 85 to 95 per cent for all modalities, except MRI where it increases to 100 per cent. However, that only applies where they bulk bill. When we look at the overall bulk-billing rate for diagnostic imaging in the September quarter it was 76.8 per cent, but that varies significantly depending on who requested the scan be done.

For GP-requested scans, the bulk-billing rate is 83 per cent. For specialist-requested scans, the bulk-billing rate is 61.5 per cent. Given that we have a rate that is concessional at about 54 per cent of the total, you would be finding that for specialist-requested scans the overwhelming majority of non-concessional people, I assume—and we have not done the detailed work. The practices are not getting a bulk-billing incentive now because they are choosing to charge a patient out of pocket, so the effect for them should be minimal.

**Senator DI NATALE:** Yes, but that is one group. There is also a significant group that is being bulk billed. Have you seen the study by the University of Sydney that looked specifically at the impact of the co-payment on imaging? It concluded that the cost to patients who are non-concessional will be significantly more than the proposed $7 co-payment.

**Dr Bartlett:** I have not seen it so I cannot comment on that I am afraid.

**Senator DI NATALE:** Do you agree that for non-concessional patients the impact will be significantly higher than $7?

**Dr Bartlett:** That will depend very much on decisions that are made by individual practices about what they choose to bill people.

**Senator DI NATALE:** Just to be clear about this: at the moment, if you are seeing a non-concessional patient, under these changes the loss to the practice will be about $5 for a chest x-ray, $30 for a chest CT and $60 for a head MRI. That is the loss to the practice.

**Dr Bartlett:** If they bulk bill.

**Senator DI NATALE:** Yes, that is right. For a bulk-billing practice that has a non-concessional patient come to see them under these changes that will be the additional cost to that practice.

**Dr Bartlett:** No, that will be the additional loss of income to that practice.

**Senator DI NATALE:** Okay, well that is—

**Dr Bartlett:** Sorry, I am being pedantic because, if you have a look at what has happened over a long period of time with diagnostic imaging, we have seen steady increases in the bulk-billing rate. They predated the introduction of bulk billing incentives in 2009-10, I think it was, and they have continued since. Throughout that period the diagnostic imaging people have said that their fees are inadequate and that practices are struggling. They continue to bulk bill despite that, and the bulk-billing rates continue to increase. It is a highly competitive environment. So, in terms of what they will do and what they can do, it is very difficult to make a definite statement that they will pass it on or that they will not, because that will depend on what their assessment is of what the market will bear.

**Senator DI NATALE:** Nothing is certain, but we do know that, if you are a bulk-billing practice and see someone who does not have a concession card, under the changes that practice will get $60 less if they do an MRI of someone's skull. That is an accurate statement.

**Dr Bartlett:** That is correct.

**Senator DI NATALE:** They will get $30 less than what they would be getting now if they do a CT of someone's chest.

**Dr Bartlett:** For a bulk-billed service where they are getting a bulk-billing incentive at the moment, and it is a general patient, yes.

**Senator DI NATALE:** So the loss of income to that practice will be significant. Are you concerned that that significant out-of-pocket cost will be passed on to the patient?

**Dr Bartlett:** As I have said, I think there is a range of things happening in that sector at the moment that reflect the competitiveness of that sector. I think that—

**Senator DI NATALE:** But they have not taken this sort of hit before. This is a big hit.

**Mr Learmonth:** Sorry, Senator, that is not quite true.

**Senator DI NATALE:** What is not true?

**Mr Learmonth:** That they do not make these choices already. As Dr Bartlett said, they operate in a fairly competitive environment where scale and volume—or volume at least—are important. They make these decisions all the time in an environment where they say—

**Senator DI NATALE:** Sorry, what decisions? Just to be clear.

**Mr Learmonth:** I am going to explain.

**Senator DI NATALE:** Okay.

**Mr Learmonth:** In an environment where that competition clearly exists, and where they claim rebates are in any event inadequate, bulk-billing rates have continued to increase—and that, as Dr Bartlett said, predated the bulk-billing incentive. Every time a practice makes a decision to bulk-bill a higher amount, they are already choosing to forgo income that they could otherwise obtain if they wished to and if the market supported it by way of a co-payment. Lots do not; lots do. It is a choice that they each make. And, every time the bulk-billing rate shifts, so too is their income forgone. They make that choice now.

**Senator DI NATALE:** They could choose not to charge anything.

**Mr Learmonth:** Correct.

**Senator DI NATALE:** They could choose to become a charity that says, 'Come and see us and we will rely on donations.' That is the sort of straw man—

**Mr Learmonth:** And they have chosen progressively—

**Senator DI NATALE:** This is a big hit. This is a massive hit to the—

**Mr Learmonth:** And they have chosen progressively over the last few years to steadily forgo a larger proportion of patient contributions by bulk-billing more.

**Senator DI NATALE:** Have any of these bulk-billing practices faced the sort of hit that we are talking about with the changes under the co-payment?

**Mr Learmonth:** Given some of the average co-payments with some of the average modalities, when they choose to bulk-bill someone they are forgoing whatever co-payment they could otherwise attract in the market.

**Senator DI NATALE:** That is right. We are talking about practices that are already bulk-billing practices. You have just said they have chosen to forgo a significant degree of income.

**Mr Learmonth:** Sorry, I am talking about practices that bulk-bill some and do not others—in other words, a typical practice.

**Senator DI NATALE:** Okay. They have chosen to bulk-bill patients in many instances, and they have made that choice. But they have made that choice on the basis of the income being, for a bulk-billing service, what it is. That is going to drop significantly. Their income,

for a bulk-billed service, is going to drop significantly. We are talking, as I said, $60 for a service. So, even though we are talking about a $7 co-payment, the loss to the practice is $60.

**Mr Learmonth:** You are working on an assumption of income replacement. At the end of the day, there are a whole lot of different decisions that an individual practice will choose to make: who to bulk-bill; who not to bulk-bill; if they do not bulk bill, how much the co-payment is. Those things are affected by a whole lot of other factors: what local demand is; what local competition moves in down the road; whether the local public hospital outsources its radiology.

**Senator DI NATALE:** Whether there is a recession; whether we are hit by an asteroid. All those things are going to be factors.

**Mr Learmonth:** That is right. They make all these decisions.

**Senator DI NATALE:** There is one thing here that we know is going to change, and it is going to change significantly. And, to be frank, I am not going in to bat for the practice.

**Mr Learmonth:** All we are saying is we cannot be definitive about what the consequence will be, given that it exists in this multivariate environment.

**Senator DI NATALE:** Agreed, but it is a big risk, isn't it? It is a risk that we are going to see $60 from a practice being handed over, and that loss of income is going to be compensated for by the patient. That is the risk I am trying to get at. I am not particularly concerned about the practice. My concern is for the patient. If a practice loses $60 for each head CT they do, you are just saying: 'Well, you know, there's a lot of competition. They will just suck it up.' I am saying to you: actually, it may be that they decide that they cannot suck it up, and that cost has to be passed on to the patient.

**Mr Learmonth:** We are saying you cannot be definitive about the consequences.

**Senator DI NATALE:** I agree with that. I would say you cannot be definitive about almost anything. But this is a significant risk. Would you agree that there is a risk that this $60 cost—this loss of income that will be incurred by the practice—will be passed on to the patient?

**Mr Learmonth:** I would say that it depends on the circumstances.

**Senator DI NATALE:** Do you think it is a risk?

**Mr Learmonth:** It depends on the circumstances.

**Senator DI NATALE:** I will take that as a yes, because that sounds like a yes to me.

**Mr Learmonth:** No, do not verbal me, Senator. It depends on the circumstances.

**Senator DI NATALE:** Mr Bartlett, why are you confident that that cost will not be passed on to the consumer? What is that confidence based on?

**Dr Bartlett:** As Mr Learmonth has indicated, there has been a significant period of time where we have seen DI providers make decisions about market behaviour that reflects a competitive environment. That competitive environment continues. We have more practices setting up all the time. They make decisions about how to attract business. They will continue to do so.

**Senator DI NATALE:** You are talking about changes occurring where the bulk-billing continues to be a feature of the system. Has there been a loss of income of the scale of $60 for

each MRI and $30 for each chest CT? Can you point to a circumstance where a loss of income of that scale has occurred in the recent past?

**Dr Bartlett:** The point that Mr Learmonth was making, and I think it was a point that ADIA made when they talked to the standing committee on health, is that there are average co-payments charged currently for those various services. Every time one of those providers makes a decision—that this patient that they have previously patient-billed they will now bulk-bill—they forgo a larger sum of money than you are describing. Do that now; do it regularly.

**Senator DI NATALE:** Yes, and—

**Dr Bartlett:** You have seen a bulk-billing rate that has gone from just over 50 per cent to now over 75 per cent. That decision has been made by a lot of people. It involves a significant change to how they derive their income; they manage their business models accordingly.

**CHAIR:** Senator Di Natale, before you go on: we have passed the end of the time allocated to outcome 3, so would you like to invoke standing order 26 in order to keep this item of expenditure open?

**Senator DI NATALE:** I am okay; I will leave it there.

**CHAIR:** I will put that question to the committee: would any senator like to keep this open, as per standing order 26?

**Senator BILYK:** Yes; I want to ask about hearing services. What advice have you received on the possible privatisation of Australian Hearing services, as recommended by the Commission of Audit report?

**Dr Bartlett:** The Department of Finance is responsible for a scoping study that is being done into the possible sale of Australian Hearing. As I understand it, that scoping study has not yet been completed. The Department of Health has been represented on the steering committee that is overseeing the process but, as I say, it is an incomplete process at this point.

**Senator BILYK:** So the Department of Health is represented in the steering committee, along with the Department of Finance—that was my next question. And how are those arrangements working so far? Is everything all right there? Are there any issues there?

**Ms Faichney:** Yes; very well.

**Senator BILYK:** I am just checking. Can you give me a bit more of an example, or perhaps a comment on what the department's role has been in the scoping study to date? And when is that scoping study due to be completed?

**Ms Faichney:** Senator, you would have to ask the Department of Finance about the timing regarding the scoping study. Regarding the first part of your question, around our role in it, we have been engaged with the scoping study, through the steering committee, to basically ensure that the business advisers who have been hired by the Department of Finance fully understand the role of Australian Hearing and understand the program itself, so that they can, in providing their advice through that scoping study, provide advice that is fully informed.

**Senator BILYK:** Have any staff from the department actually been seconded to the Department of Finance to work on the scoping study?

**Ms Faichney:** No.

**Senator BILYK:** Can you tell me how is that working, then?

**Ms Faichney:** We have provided a number of briefings directly to the business advisers, as well as our participation at a higher level in the steering committee itself.

**Senator BILYK:** So how many staff within your department have been allocated to work on the scoping study?

**Ms Faichney:** No-one is being allocated per se. We have a national manager of the Office Of Hearing Services in the department, who is an SES band 1. She has been closely engaged with it, including her staff as required when we have to provide information.

**Senator BILYK:** You said there have been a number of briefings. Can you tell me how many, and when they were?

**Ms Faichney:** We have provided five briefings. They were on 13 August, 2 September, 11 September, 2 October, and 9 October.

**Senator BILYK:** And are there more to come?

**Ms Faichney:** Not necessarily; no. There have also been two steering committee meetings—this is at the higher level—and there is a third meeting is due.

**Senator BILYK:** And when is the third one due?

**Ms Faichney:** I have not actually got a date for that, because that will depend on the speed with which the advisers are able to pull together the scoping study.

**Senator BILYK:** Okay. So I am presuming the department did not receive any extra funding in the budget to cover the costs associated with the scoping study?

**Ms Faichney:** No.

**Senator BILYK:** So can you then tell me: from what programs would any resources that are being used—in order to participate in the scoping study—be reallocated?

**Ms Faichney:** They have not been reallocated. This is just normal work, in that, as information is required, officers will move from what they are doing at the time, to provide that information. There is no reallocation; it is just something that is absorbed within the work that they do at the moment.

**Senator BILYK:** Has the department undertaken any analysis to look at the impacts of the possible privatisation?

**Ms Faichney:** No, we have not.

**Senator BILYK:** So how have you come to some comments that you have been giving in these meetings in regard to what effect the impact of the privatisation would have on Australians with hearing impairments?

**Ms Faichney:** We are not providing that kind of information. We are providing factual information as to how the program works so the business advisers who have been hired to do the scoping study and consider the future options for ownership can actually be informed as they develop those options. We are not providing information itself on the impacts of those options. That is up to them.

**Senator BILYK:** The terms of reference for the scoping study identifies one of the considerations in the possible privatisation as the conflicting reporting requirements on Australian Hearing to two different parts of government. This concern seems to centre on the

conflicting aims of Australian Hearing in meeting its obligations to deliver services under the Voucher program and the Community Service Obligation program under its MOU with the Office of Hearing Services, and being accountable for its financial performance to the Department of Human Services. Do you think that is correct? Do you agree with that?

**Ms Faichney:** I would have to take that on notice. I am not aware of the details.

**Senator BILYK:** You will take that on notice?

**Ms Faichney:** Yes.

**Dr Bartlett:** I think that what you have there is a factual statement of the fact that Australian Hearing has responsibilities to the office about delivery of the components of the program that it delivers and that it is responsible for its financial performance to DHS.

**Senator BILYK:** I have not finished my questioning yet, Dr Bartlett. Do other programs the department delivers not have to work within particular financial constraints?

**Dr Bartlett:** It depends on the programs that you are talking about. We are talking here about—

**Senator BILYK:** Any other programs that the department delivers. It would seem that all programs the department delivers would have the competing priorities of working within a particular budget while delivering the best possible service outcome and meeting the required service standards as required under the legislation. Why is the case so different with Australian Hearing?

**Dr Bartlett:** The difference between that and the programs covered under the Medicare Benefits Schedule is that under the Medicare Benefits Schedule the government provides a rebate to patients, and doctors and others run their own businesses. In this particular case, Australian Hearing is a government owned entity that in effect operates, certainly for its Community Service Obligation side, with a fixed budget.

**Senator BILYK:** So it is a government owned entity?

**Dr Bartlett:** Yes.

**Senator BILYK:** But not for much longer, possibly.

**Dr Bartlett:** It operates with a fixed budget for that side of its business and has the requirements to deliver what is required as set by that. It is different to many of the other programs that we run for that reason.

**Senator BILYK:** Have the departments ever discussed the competing obligations on Australian Hearing?

**Dr Bartlett:** I was briefly the national manager of the Office of Hearing Services something over five years ago. There were discussions then with Australian Hearing about what they could do with the money that they were getting. My sense is that those discussions have gone on forever and under the current arrangements will go on forever.

**Senator BILYK:** Why can't the competing priorities be resolved, then?

**Dr Bartlett:** You could ask that question about any business.

**Senator BILYK:** Well, I am not. I am asking it about Australian Hearing.

**Dr Bartlett:** If you want to use the purchaser-provider analogy, you have a purchaser in the Department of Health, through the Office of Hearing Services, that is seeking to get a

certain level of performance delivered, and you have an agency as the provider that is basically seeking to negotiate what it can do. That is not an unusual position to be in.

**Senator BILYK:** Do you think these departments are siloed? They are, aren't they? They are quite siloed. Let us put it this way: does the department support the privatisation of Australian Hearing? You have just said it is a government run entity working for—

**Mr Bowles:** That is a decision for government.

**Senator BILYK:** community services, and obviously not for much longer.

**Mr Bowles:** They are decisions for government.

**Senator BILYK:** Disgraceful.

**Senator McLUCAS:** I have a question around identification of the risks that a privatised Australian Hearing may present to the requirements of the Office of Hearing Services. Has work been done on that?

**Dr Bartlett:** Senator, as Ms Faichney went through, we have provided significant levels of advice to the scoping study about the interaction between the Office of Hearing Services and Australian Hearing and the role that Australian Hearing currently plays in the hearing arrangements, including and particularly the community service obligation components.

**Senator McLUCAS:** But have you looked at the potential risk in terms of market failure if AHS is privatised?

**Dr Bartlett:** The responsibility for providing that sort of advice to government sits with those business analysts who are effectively delivering the scoping study.

**Senator McLUCAS:** So you are not doing that work in Health.

**Dr Bartlett:** No.

**Senator SIEWERT:** Surely it impacts on the community service obligation.

**Ms Faichney:** We are aware that that needs to be taken into account, which is why we provide briefing to the business adviser, so that any decisions or recommendations that they may put into the scoping study are fully informed.

**Senator SIEWERT:** I am missing something here. Does that mean that they will be taking that into account in their scoping study? Is that your understanding?

**Ms Faichney:** That is our expectation—that in providing them the information on how the programs work, including the community service obligation, that needs to be considered in providing their advice to the Department of Finance.

**Senator SIEWERT:** And that includes the scope of the activities of Australian Hearing and, in particular, rural and regional provision of services?

**Ms Faichney:** All elements.

**Senator SIEWERT:** What is your understanding of the extent that that business analysis will be done in terms of the extent of social impacts as well—that community service obligations will meet?

**Dr Bartlett:** The difficulty for us with a number of these questions is that we can tell you what we are doing to support it. We cannot tell you what they are doing; and in effect the questions you are asking I think you really have to ask the Department of Finance.

**Senator SIEWERT:** I understand what you said. My question is then: did you include, in your briefings, looking at the social impacts as well?

**Ms Faichney:** We provide information generally on how the program works. The program has a social element; that is why it has a community service obligation. I could not tell you—if that makes sense—the degree to which the social impacts were done. We would not do that. We just provide the factual information as to how the program works.

**Senator SIEWERT:** Okay. But that then obviously has impacts on clients. Was that brought to their attention?

**Ms Faichney:** The underlying basis for our advice each time is to ensure that the clients who are currently covered are understood and that any decision around privatisation—which has got broader implications, because the National Disability Insurance Scheme also happened without clear advice around that. All these things are needing to be taken into account as they do this. How that impacts their advice is something that we cannot presume.

**Dr Bartlett:** The other thing I should say is that they are getting advice from a range of sources, not just us, and that is why I would be suggesting that you really should be talking to the Department of Finance about where it is going, because they can comment on that in a way that we cannot.

**Senator SIEWERT:** Thank you. In terms of NDIS, I presume—judging from the comment you just made—you also included in your briefing issues around NDIS.

**Ms Faichney:** We provide in our briefing the fact that they need to take it into account and that we are working with the Department of Social Services and with DHS as well, who are responsible for Australian Hearing, to make sure that they understand that where there is uncertainty or knowledge around that NDIS at this stage, they need to take that into account as business advisers.

**Senator SIEWERT:** Thank you. My other question is in terms of the issues around access particularly to paediatric audiologists—of which I understand there are not that many in private practice. Were those issues also canvassed?

**Ms Faichney:** Workforce and the concerns with regard to very young, absolutely.

**Senator SIEWERT:** Thank you. That is what I have got for that particular area of hearing. I have got more in hearing.

**CHAIR:** Senator Smith has been waiting, so I will go to Senator Smith and then come back to others.

**Senator SMITH:** My question goes to the establishment of the NDIS prior to the 2013 election. Was there any funding diverted from Australian Hearing Services?

**Dr Bartlett:** There was no funding diverted from the hearing arrangements at that point. There is an arrangement in place at pilot sites where they are delivered and funding is delivered in kind.

**Senator SMITH:** Just explain to me what you mean by that statement.

**Dr Bartlett:** My recollection—I might have the numbers slightly wrong, but it will not matter particularly—is that either 16 or 19 clients of the NDIS pilots have received hearing services. So there are arrangements in place to essentially fund those clients out of the hearing

services arrangements, in kind. Essentially, that funding is transferred to cover those at that point.

**Senator SMITH:** When we project forward to 2019-20 what is the impact on funding for Australian Hearing Services as a result of the NDIS?

**Dr Bartlett:** That is one of the issues we are working on with the Department of Social Services at the moment.

**Senator SMITH:** So there will be an impact.

**Dr Bartlett:** Again, there is a significant proportion of particularly the paediatric clients of Australian Hearing, under the community-services obligation, who are likely to meet NDIS criteria and therefore move into the NDIS program rather than the hearing services program.

**Senator SMITH:** How does that impact the community-service obligations and the funding of those community-service obligations for hearing services?

**Dr Bartlett:** That will have to be worked through, but there is an assumption that if the service is going to be delivered by NDIS rather than the hearing services program the funding will need to be with NDIS rather than with the hearing services program.

**Senator SMITH:** So there will be a decrease in funding for Australian Hearing Services in 2019-20.

**Dr Bartlett:** There will be a decrease in funding for the hearing services program's community service obligation. Australian Hearing may well be the service delivery agent for NDIS. What happens to their funding is not at all clear at this point, which is one of the areas of uncertainty that Ms Faichney was referring to earlier.

**Senator SMITH:** Do we know at what point those funds will divert from Australian Hearing Services to the NDIS?

**Dr Bartlett:** Not at this stage. That is still to be worked through, as I understand it.

**Senator SMITH:** And we do not know the quantum of those funds.

**Dr Bartlett:** That is the subject of considerable work to be done, as you gather—

**Senator SMITH:** Considerable work?

**Dr Bartlett:** Given the very small numbers that have gone through pilot sites, at the moment, the sort of extrapolation about likely take-up and things like that is incredibly subjective right now. There is a piece of work to be done with DSS to go through that, and we both need to get a level of confidence about how it is going to work. That is work that is being undertaken but has a fair way to go.

**Senator SMITH:** Do you have any back-of-the-envelope ideas about what sort of quantum of funds?

**Dr Bartlett:** None I would be confident in saying. There are extrapolations, but the extrapolations are based on such limited data at the moment that it is highly speculative.

**Senator SMITH:** That is because we are in trial sites.

**Dr Bartlett:** We have a limited number of trial sites with a very limited number of clients, so it is problematic to extrapolate from that.

**Senator SMITH:** So we do not know the quantum of funds but we do know that there will be a reduction in Australian funding to Australian Hearing Services in 2019-20, because those community-service obligations, for example, will be done by the NDIS.

**Dr Bartlett:** That is the assumption that has underpinned the sort of work that has been done, yes.

**Senator SMITH:** How does that affect the market presence of Australian Hearing Services then in a context of the scoping study and privatisation, if that is where we end up?

**Dr Bartlett:** That is difficult to say, because it has a long way to run. One of the issues—and it was a point made a minute ago—is that if you are looking for paediatric audiology services, Australian Hearing is, because of the community-service obligation, one of those areas that has more expertise than pretty much anywhere else. NDIS will obviously make its own decisions about how it sources services, but Australian Hearing at the moment sits there as that source of expertise. It is logical you would expect they would try to utilise it.

**Senator SMITH:** No funds have been diverted from Australian Hearing Services to the NDIS.

**Dr Bartlett:** As I said, there are funds being provided to reflect services delivered to NDIS clients, in trial sites, but there has not been a specific transfer of funds from the hearing services program to NDIS saying 'Okay, this money has gone from here to there.' That has not occurred.

**Senator SMITH:** But there is money partitioned inside Australian Hearing Services for NDIS?

**Dr Bartlett:** There is money that is paid, but in terms of an actual budget, at this point, as I said, we have a hearing services program that has hundreds of thousands of clients, and we are talking at the moment about 19. So, it is not something for which we will go through an elaborate accounting process. In effect there will be a funding transfer, which will be journaled. It can be identified, but we are not going to set up a separate budget line for something of that size. It just does not make a lot of sense.

**Senator SIEWERT:** I think Senator Smith has just traversed some of the NDIS questions I was going to ask, so I will leave any further work there. Do you have an up-to-date table of response to the Senate hearing? You know how you usually do me a table? I am seeing nods! But there is not a table update?

**Dr Bartlett:** I think we can provide you with a table update.

**Senator SIEWERT:** If you could provide me with a table update, that would be appreciated, because I do pay attention to those things when you do them. So, rather than traversing it now, I will just ask that you update that table for me.

**Dr Bartlett:** Yes.

**Senator SIEWERT:** Thank you.

**Senator SMITH:** Dr Bartlett, did I hear you correctly in your previous evidence that the department had provided advice to government with regard to a co-payment over time?

**Dr Bartlett:** The department has provided advice to government about patient billing within the MBS over time. It has been a feature of the MBS from day one and continues to be a feature. To the extent that that is a co-payment—and it clearly is—yes, we provide ongoing

advice about that. We provide advice about bulk-billing percentages, we provide advice about out-of-pockets—all of that. That is ongoing routine work for the department.

**Senator SMITH:** So, the department has been providing ongoing advice to government with regard to co-payment arrangements in the MBS, over time.

**Dr Bartlett:** Yes, within the parameters I have described.

**Senator SMITH:** Does that include prior to September 2013?

**Dr Bartlett:** Again, the capacity for doctors to charge patients out-of-pockets has been a feature of the MBS basically since it started. So, we have been providing advice on that basically since the MBS started.

**Senator SMITH:** So, between 2008 and 2013, has the department provided advice to government with regard to increasing the co-payment in the PBS?

**Dr Bartlett:** If you are asking me about whether the department provided advice to government about a co-payment measure of the sort that was announced at the last budget, I cannot answer that question. I think you canvassed that extensively with the previous Secretary at last estimates, and I have nothing to add to what she said.

**Senator SMITH:** I am guilty of being tenacious!

**Dr Bartlett:** And I am guilty of just saying, 'I can't go further.'

**Senator SMITH:** Okay; thank you.

**CHAIR:** If there are no other questions in outcome 3, we will move to outcome 2—access to pharmaceutical services.

[17:38]

**Senator McLUCAS:** Perhaps while the outcome 2 people are coming to the table I could ask the Secretary a quick question. It has been brought to my attention that there is a media release on the website entitled 'Primary health networks to drive better primary health care'. It says that the page was last updated on 15 October 2014. Can you find out when that media release was actually posted on the website? When I looked at the website on 15 and 16 October there was no media release there; it is a technical question.

**Mr Bowles:** I am unaware of all that, but I can have a look

**Senator McLUCAS:** I am surprised you do not know that!

**Mr Bowles:** Well, there you go—but I will endeavour to find out for you.

**Senator McLUCAS:** For the *Hansard* record, that was my joke.

**CHAIR:** Thank you for the light relief. We will move to Senator Reynolds now.

**Senator McLUCAS:** Chair, I think it is Labor's turn.

**CHAIR:** No.

**Senator McLUCAS:** Do you want to have a fight about this now?

**CHAIR:** I would love to! The Labor Party has really been getting as much questioning as it would like. I think at the moment I have you down as—

**Senator McLUCAS:** I am talking about order now.

**CHAIR:** I will tell you what has been happening, since you have raised it. You have had roughly 207 minutes, compared with the Liberal Party's 78 minutes and the Greens' 90 minutes of questioning. I think that is a pretty fair split. I will give it to people as they go.

**Senator McLUCAS:** It is a question of order.

**CHAIR:** Yes, thank you. Your comments are noted. I will go to Senator Reynolds.

**Senator REYNOLDS:** In relation to the Pharmaceutical Benefits Scheme, I was wondering, Mr Bowles or Ms McNeill, whether you could tell me what the current cost of the scheme is and what the current trends are in terms of increases.

**Ms McNeill:** In 2013-14 there were 209.8 million prescriptions subsidised under the PBS and dispensed through community pharmacy, at a cost to government of approximately $9.15 billion. This was an increase in PBS expenditure of over $150 million, or 1.7 per cent. Over the longer term, PBS expenditure is expected to average four to five per cent.

**Senator REYNOLDS:** Per annum?

**Ms McNeill:** Per annum, yes.

**Senator REYNOLDS:** Can you tell me how many new medicines have been listed by the PBS over the last 12 months, or for the term of this new government?

**Ms McNeill:** Since September 2013 we have had 456 new or amended listings to the Pharmaceutical Benefits Scheme.

**Senator REYNOLDS:** 456?

**Ms McNeill:** 456.

**Senator REYNOLDS:** How does that compare with perhaps the previous year, and what was the rate under the previous government?

**Ms McNeill:** Perhaps it is best if I use the monthly average, because we do get variations at any particular point in time. Under the current government we are averaging 24 new or amended listings per month, versus eight per month under the previous government.

**Senator REYNOLDS:** Just so I get this right: in the last 12 months there have been 456 new listings, and on average under the previous government there were eight new listings per month, and now it is 24 listings per month, on average.

**Ms McNeill:** I would need to clarify that that is new and amended listings, just for specificity.

**Senator REYNOLDS:** Thank you. Have there been previous one-off increases to the patient contribution for pharmaceuticals under the PBS?

**Ms McNeill:** Yes, there have.

**Senator REYNOLDS:** When have these been? And have they generally received support from the parliament?

**Ms McNeill:** Consistent with testimony in previous inquiries, in 1983 there was the introduction of a $2 concessional co-payment arrangement for concessional patients as well as some subsidy for those people in their pensions, as well as an increase in the general beneficiaries co-payment from $3.20 to $4. There was also the introduction of the safety net threshold of 25 scripts for general beneficiaries. In 1986 the co-payment for concessional beneficiaries increased from $2 to $2.50 and a safety net threshold to 25 scripts was

introduced, and the general beneficiary co-payment was increased from $5 to $10. In 1990 they introduced the co-payments for pensioners, who up until that time had been exempt from payments under the PBS. It was $2.50, which was the same as the concessional co-payment, and the safety net threshold was set at 52 scripts, or the equivalent of $130 that year. The increase for the general beneficiary went from $11 to $15, and the 25-script safety net threshold remained. In 1997 the concessional beneficiary co-payment went to $3.20 and the general payment went from $17.40 to $20. It was also introduced that the general beneficiary went to a financial threshold rather than a number-of-scripts threshold, which was $612.60.

In 2005, the concessional beneficiary was increased to $4.60, the general payment was increased from $23.70 to $28.60 and the new safety net was $874.90. In 2006, the concessional beneficiary went to $4.70 and they increased to the 54 scripts—this is when we started the two-script increase per annum for safety nets for concessional patients—and the general safety net threshold went up to $960.10. These all required legislative amendments.

**Senator REYNOLDS:** To go through?

**Ms McNeill:** Yes.

**Senator REYNOLDS:** So what you are saying is that there have been patient contributions in the Pharmaceutical Benefits Scheme since 1983?

**Ms McNeill:** They have predated that. The changes that actually introduced it for concessional beneficiaries started in 1983. Prior to then it was only for general patients. I think it started at 50 pence.

**Senator REYNOLDS:** Fifty pence?

**Ms McNeill:** Yes, pre-14 February 1966.

**Senator REYNOLDS:** Who currently has access to the Pharmaceutical Benefits Scheme?

**Ms McNeill:** All Australians have access to the Pharmaceutical Benefits Scheme, residents of Australia, and there a number of reciprocal arrangements with other countries.

**Senator REYNOLDS:** Do you know how many people have accessed it in the last 12 months?

**Ms McNeill:** I know that there are 16.3 million general patients and 7.8 million concessional patients.

**CHAIR:** But that is not who accesses; that is the entire population, presumably.

**Ms McNeill:** That is the number of people who can claim a benefit under the PBS.

**CHAIR:** In the past 12 months?

**Ms McNeill:** Yes.

**Senator REYNOLDS:** How many scripts have been access through pharmacies under the PBS in the last we months?

**Ms McNeill:** The number was 209.8 million.

**Senator REYNOLDS:** Is that an increase?

**Ms McNeill:** Yes. That was an increase on the previous year. It was 197.3 million in the previous financial year.

**Senator REYNOLDS:** Are you seeing changes over time in the types of medication and the costs of some of the individual medication?

**Ms McNeill:** There are two points to that. First of all, the average cost of a script to government across the entire formula is decreasing. This financial year, 2013-14, the average script cost to government was $34.82. That is down from 2011-12, when it was $38.70. Likewise, the cost per script to patients is averaging $7.38 in 2013-14 compared to $7.74 in 2011-12. That is an example of the changes that are going on with respect to price disclosure. However, the number of drugs that are in the under-$20 category versus the over-$50 category versus the over-$1,000 versus over $5,000 per script is increasing quite significantly.

**Senator REYNOLDS:** Do you have exact numbers for that?

**Ms McNeill:** I am afraid I do not have them with me. I will have to take them on notice.

**Senator REYNOLDS:** There have been a lot of reports in the media about the number of high-cost medicines coming through the pipeline at the moment—some of those ones you are talking about in the $5,000-plus range. Are those high-cost drugs finding their way onto the PBS or is the cost prohibitive in some cases?

**Ms McNeill:** There have been a number of high-cost listings that have been made to the PBS in the last 12 months. There are drugs such as Dabrafenib, which would otherwise cost a patient over $110,000 a year. There are a number of drugs, such as the minister's announcement of funding for Soliris, or eculizumab, for aHUS, which would cost patients in excess of $500,000 a year. Those are all making it through.

**Senator REYNOLDS:** What is the agreed criteria for listing Soliris? What are the criteria considered to list that?

**Ms McNeill:** First of all, any listing on the PBS must first receive a positive recommendation to do so by the Pharmaceutical Benefits Advisory Committee, which, under the National Health Act, must consider both clinical effectiveness and cost effectiveness of the drug. That recommendation then is negotiated with the department and the drug company, and risk-share arrangements et cetera are put into place. Restrictions have to be drafted that are consistent with the advice of the PBAC, depending on whether or not the drug costs over $20 million in any one of the forward estimate years; if it is less than $20 million per any of those years then the health minister is able to approve that listing; if it is greater than $20 million then that must go to the cabinet for consideration.

**Senator REYNOLDS:** So how many would go through that process, right through to cabinet consideration?

**Ms McNeill:** Of the listings that we talked about in the previous 12 months, there have been three that have required cabinet approval, and 81 have gone to the Minister for Health. Then there have been what we would call 317 with no financial impact. That can be an example of where a new brand lists, or of what we affectionately call a 'me too' drug—a drug that intends to replace another drug on the PBS. A common example is gliptins for diabetes treatment, where we have four or five of those medicines and we do not expect to grow the market; we expect that it will replace the use of another drug.

**Senator REYNOLDS:** Do patient contributions under the PBS increase each year?

**Ms McNeill:** Yes. The current legislation provides that co-payments will be increased by CPI, which is recorded at the 12-month mark at the September quarter—sorry to get very technical, but that is exactly what it is. That is basically then applied and rounded up to the nearest 10c mark.

**Senator REYNOLDS:** Are you able to take us through a comparison of the patient contribution versus the Commonwealth contribution for a few commonly used drugs—for example, something for insulin?

**Ms McNeill:** Certainly. If you were to look at insulin glargine 100 units injection for diabetes, the PBS price is $433.06. At the moment, a general patient would pay $37.70 for that and the government pays $390.36. Alternatively, the concession payment payer would pay $6.10 and the government picks up $426.16 of that cost.

**CHAIR:** Senator McLucas?

**Senator McLUCAS:** Chair, I just want to make an observation. We have just spent a good 10 minutes—

**CHAIR:** Twelve minutes.

**Senator McLUCAS:** twelve minutes, having a conversation about things that are, by and large, on the public record. This is Senate estimates. Senate estimates is designed for non-government senators to ask the executive government of the day about the budget, not time-wasting by government senators—and we have just seen a fantastic piece of evidence of that. When we were in government, we had very few government senators asking questions—usually around things in their own patch. We did not encourage time-wasting, and I need to put it on the record again that your government is intending to waste the time of the Senate committees in order to stop non-government senators asking questions.

**CHAIR:** Thank you. I would just, again, point you to the way proceedings have gone today. The time that has been taken by non-government senators has been about three to one—

**Senator McLUCAS:** That is not my point, and you know it.

**CHAIR:** Well, you did just—

**Senator McLUCAS:** My point is that government senators—

**CHAIR:** If you will let me finish—

**Senator McLUCAS:** No, I do not need to; I know exactly what you are going to say.

**CHAIR:** Order! Order! I will finish, and if you want to make another point of order, you can.

**Senator McLUCAS:** I am not making a point of order; I am telling you what is happening.

**CHAIR:** We deal with questions—

**Senator McLUCAS:** Government senators—

**CHAIR:** We deal with questions and we deal with points of order. So if you do not have a point of order we will move to questions.

**Senator McLUCAS:** Okay. Outcome 2—

**CHAIR:** This is not a platform for you to just sit there and make statements, but I will respond, given that you have raised an issue. I would say and confirm that non-government senators have had more than enough time—some would say excessive amounts of time—to question officials, on all manner of issues, and in fact, as I understand it, it is about three to one, and the Greens have had a good opportunity when they have asked for it as well. So no-one has been denied that opportunity. I think the record will clearly show that.

**Senator McLUCAS:** This is about the spirit and intent of estimates. This committee is not following that.

**CHAIR:** If you would like to ask some questions, you are welcome to.

**Senator SMITH:** Critiquing the quality of senator's questions is a very dangerous precedent to set, Senator McLucas.

**Senator REYNOLDS:** Senator McLucas, I have very patiently and very graciously not asked questions for most of this morning in deference to the opposition and the Greens' questions. I have asked several minutes of questions on this and I think it is highly inappropriate that you are critiquing my questions. They are absolutely valid questions on the PBS. I have a new senator and a new member of this estimates committee. It is entirely inappropriate for you—

**Senator McLUCAS:** A library brief would have answered all of that.

**Senator REYNOLDS:** to make a political point out of that. They were absolutely in order. The chair certainly did not bring me to order on any of the questions.

**Senator McLUCAS:** Why would he? He is in the Liberal Party.

**Senator REYNOLDS:** It was entirely appropriate and there was not a single question that did not relate to the funding of the PBS and aspects of the PBS.

**Senator McLUCAS:** I have reflected on your line of questioning and I do say that you were intentionally wasting time.

**CHAIR:** That is your opinion.

**Senator REYNOLDS:** That is your opinion, but it is absolutely not true. It is highly offensive and I think it is totally inappropriate that you have raised it in this way.

**CHAIR:** If we are going to get into the business of critiquing others, then I guess we will see that go back and forth. I am sure it will be a great spectacle for all of those who are watching. If you would like to ask questions, please proceed.

**Senator McLUCAS:** I want to go to the payments for wholesalers and pharmacy programs in the 2013-14 and 2014-15 budgets. The payment for wholesalers and pharmacy was were forecast to be $216 million in 2014-15, which was in the 2013-14 budget. The 2014-15 budget reveals that the payment has increased to $406 million. Can someone explain to the committee what happened?

**Ms McNeill:** Could you please point me to the direction of which page you are referring to?

**Senator McLUCAS:** I have page 623 from the 2014-15 budget papers and page 628 from the 2013-14 budget papers.

**Ms McNeill:** They are whole-of-government budget papers and not our portfolio budget statement? Sorry to be specific, I just do not have that page reference. That is why am struggling with the number.

**Mr Bowles:** It is not in ours. There is no 623. I am just trying to work out where it has gone.

**Senator McLUCAS:** I just been given the briefing papers.

**Ms McNeill:** I might have to take on notice. If you say it again, I might be able to help. But otherwise I might have to take it on notice if I cannot find a relevant paper.

**Senator McLUCAS:** It is payments for wholesalers and pharmacy programs. You are across that?

**Ms McNeill:** I am aware of that, yes.

**Senator McLUCAS:** In the 2013-14 budget, it was identified as going to be $260 million and then the payment increased to $406 million in the 2014-15 budget.

**Ms McNeill:** I might have to take it on notice. I have got my portfolio budget statements here and I do not have those numbers here in front of me. I am terribly sorry. It is just not a number that I have.

**Mr Bowles:** I am trying to find a reference to the number you mentioned, but I cannot find it. If you could give us a guide as to whether it is in our PBS or is that somewhere else, we may be able to help.

**Senator BILYK:** I want to ask questions in regard to the review of the Life Saving Drugs Program.

**Ms McNeill:** Yes, that would be me.

**Senator BILYK:** When do you expect the Life Saving Drugs Program review to be completed?

**Ms McNeill:** We are in the middle of the public consultations at the moment, which close on 10 November 2014. I think it is—

**Senator BILYK:** Sorry, could you just speak into the microphone a bit better, please?

**Ms McNeill:** We are currently in the middle of the public consultation process, with the call for public submissions. They close on 10 November 2014. We have had two meetings of the reference group in anticipation of that. It has also included a session that we attended, I think, on 14 September, with a combination of Rare Voices Australia and patient groups affected by the Life Saving Drugs Program. In those discussions we have talked about allowing sufficient lead time for those very small patient groups to participate, which is why we have an open process.

We do expect that once the public submissions are in and we have evaluated those, that we will have another meeting of the reference group. We have committed to reconvene those stakeholders in early 2015, which would probably be in February, based on availability of those patient groups. We will then look to finalise the report shortly thereafter.

**Senator BILYK:** Have the submissions been advertised? Is that correct?

**Ms McNeill:** Yes.

**Senator BILYK:** In media and larger newspapers?

**Ms McNeill:** I think it did pick up some traction that it was there. Most importantly for us, we wrote to all the patient groups affected or which were looking at being on drugs that may be listed there in the future. That is why we asked Rare Voices, which is the peak body for those small patient groups, to convene that meeting on 14 September to help them.

**Senator BILYK:** Sure, yes. What happens to the Life Saving Drugs Program requests while the review is underway?

**Ms McNeill:** With respect to individual patient requests, those are continuing: it is business as usual, but under the new streamlined process that the government introduced and which I think we talked about at the last hearing. We have removed the disease advisory committee, and the specialists themselves now put in the application. I can inform you that nine applications have been accepted by the department since that process took place. So that process is working very well for us.

With respect to possible listings for consideration on the Life Saving Drugs Program, new drugs or new indications continue to be considered. You are probably aware that the forthcoming agenda for the Pharmaceutical Benefits Advisory Committee is on the PBS website. We have four drugs and indications being considered for future listing on the Life Saving Drugs Program, and they will continue—

**Senator BILYK:** Sorry, it is just a bit hard for me to hear. You might note that I did ask questions about hearing earlier, and there is a reason for that! Seriously, I do have a bit of a hearing impairment so I do just need to be able to hear. Sorry, can you just repeat that for me?

**Ms McNeill:** That is okay. We talked about the patients. Those are being assessed and we have had nine new patients since the review was underway and the new streamlined were introduced. And on the Pharmaceutical Benefits Advisory Committee's website for the forthcoming November the PBAC agenda, we have four drugs and indications that are seeking application either for PBS listing under section 100 or, if not successful in that space, for consideration for the Life Saving Drugs Program.

It is really important, and we have spent a lot of time with patients and clinicians on this, to make it clear: it is business as usual. The review is about the future of the program; we continue to deliver as expected.

**Senator DI NATALE:** Can I jump in there?

**Senator BILYK:** Please do.

**Senator DI NATALE:** My understanding is that the review was due to be completed months ago. What is the status of the review? Just fill me in on where we are?

**Ms McNeill:** It was never envisaged to be completed months ago; we had always made it very clear to clinicians and to patient groups that because of the longer lead times and consultations that we would have in this area that it would be a 12-month review. It was only announced by the Minister for Health on 9 April 2014. We had two meetings of the reference group to prepare the discussion papers. We also had to appoint people to actually do the clinical assessment work that feeds into the discussion papers and advice for the reference group. We have had an extended period on the call for submissions. Traditionally, we only allow six weeks in a post-market review space but because of the small patient groups and because these are people who tend to be doing this in-between looking after their own children or own health, we have extended that for a longer period so that they have time to

contribute. We convened this special meeting on 14 September with these patient representatives to talk through the process and to help them put in their submissions. We also talked through when we would convene a stakeholder group, how we would do it and what kind of lead times people would need to be available and to participate. We still expect that, following that stakeholder feedback meeting—which we expect will be in early February 2015, but again it will depend on the availability of the patients—we would then finalise the report and give that to government shortly thereafter.

**Senator DI NATALE:** But you are saying it is business as usual—haven't there been a number of changes made to the process?

**Ms McNeill:** I talked about the fact that it is business as usual under the new streamlined process that was announced as part of that, which was about the fact that we removed the disease advisory committee so the clinicians could freely advocate for their patients during this process. We introduced the same measures that we use for other complex authority drugs in a variety of areas from rheumatology to oncology, where the specialist—who is the expert in their field—fills in the paperwork, determines whether or not the patient qualifies for the subsidy arrangements and puts those in directly. What I said is that, since we introduced that process, we have had another nine patients come through.

**Senator DI NATALE:** On what drugs?

**Ms McNeill:** We have had one patient on Cerezyme, two patients on Elaprase—that is for MPSII—sorry; I should have clarified for those who are not familiar with it. Cerezyme is for Gaucher disease. We have had two patients for Elaprase on MPSII. Three patients accessed Fabrazyme, and one patient accessed Replagal—both of those are for Fabry disease. We have had one patient access Soliris for PNH and one patient access VPRIV for Gaucher disease.

**Senator BILYK:** How many requests are currently before the department for listing of these drugs?

**Ms McNeill:** For consideration under the PBAC? That would be four. They are the ones that are currently before the PBAC in November. Just to be clear on process: first of all you must apply for listing on the PBS under section 100 and be found to be clinically effective. It is only if you are found not to be cost-effective but to be clinically effective that the second process is undertaken to determine whether or not you should be listed on the Life Saving Drugs Program.

**Senator DI NATALE:** Could I interrupt again?

**Senator BILYK:** Please.

**CHAIR:** Senator Di Natale, I was going to go to you now, anyway. If you guys want to share your time, that is fine.

**Senator BILYK:** I am more than happy to. Senator Di Natale has much more experience in this area, I am sure.

**CHAIR:** You guys split it up however you like.

**Senator BILYK:** As Senator Reynolds is, I am new to the committee and was not here last estimates for it, so I am happy for any extra input we can get.

**Senator DI NATALE:** Thank you; I appreciate that. It just saves us going over the same questions. Just so I am clear: section 100 just means a drug that can be used in emergencies, in urgent cases? Tell me about section 100.

**Ms McNeill:** Section 85 and section 100 are the two ways that we provide access to PBS-subsidised medicine. Section 85 is what you would commonly experience when you go to a community pharmacy. Section 100 is where the PBAC recognises that some specialist intervention may be required in administering or having access to that drug. So oncology is a common space for that, where it is a treatment in a hospital. IVF can often be in that space. It is not about the fact that it is used in an emergency situation—

**Senator DI NATALE:** It is just highly complex conditions?

**Ms McNeill:** Yes. Hepatitis C drugs used to be in that space.

**Senator DI NATALE:** Basically, the process that you have described is: you apply for listing through the PBAC; they say, 'Your drug works but it is too expensive—it is not cost-effective.' So there is the opportunity to try to get the drug listed through section 100 under the Life Saving Drugs Program?

**Ms McNeill:** No. First of all you go to PBAC for PBS listing under section 100. What drug companies tend to do is to put in both at the first instance—so they will say, 'Please consider us for section 100 on the PBS.' The PBAC will then say, let us hope, 'We find you to be clinically effective.' The second question is, 'Are you cost effective?' and the third question is, 'If you are not cost-effective, do you meet the criteria for the Life Saving Drugs Program?'

**Senator BILYK:** You said there were four drugs currently before the department for listing. Is that correct?

**Ms McNeill:** Sorry to be specific, but they are before the PBAC. Because it goes to our independent expert advisory committee, the PBAC—yes, it is between them at the moment.

**Senator BILYK:** You might need to take this on notice, but are you able to tell me how many life-saving drugs have been listed in the last five years, and at what cost? I am happy for you to take it on notice.

**Ms McNeill:** I might be able to help you. Just one moment, Senator, if you would just bear with me. I can certainly say that since 2011 we have had Soliris for PNH and VPRIV for Gaucher disease. As to the previous five years, I will have to take on notice.

**Senator BILYK:** If you could, thanks. Is it correct that the health department is budgeting for a cut in spending on these drugs?

**Ms McNeill:** That is not correct.

**Senator BILYK:** Does the department expect that the review will make the process for listing drugs quicker? Do you think that part of that review is to make the process quicker?

**Ms McNeill:** I cannot pre-empt what quality of evidence or type of information a drug company may put before the PBS in the first instance to demonstrate clinical effectiveness. There are some drugs, whether on the PBS or on LSDP, that make it through the first time around and there are some that need several opportunities to demonstrate their clinical effectiveness with respect to listing on the PBS or the LSDP. One of the things we are looking at is the current criteria for the Life Saving Drugs Program review and how the targeting of evidence in that space when you are dealing with very small patient populations can be

considered. The PBAC already does a lot of work in extrapolating evidence in dealing with five, 10 or 15 patients over a lifetime, but one of the things that the discussion paper talks about is how you extrapolate that type of evidence to assist drug companies and patient groups in gaining access to these drugs.

**CHAIR:** We have come to our half-hour, so would you like us to extend?

**Senator BILYK:** Yes, please. I will not be much longer, but I do not know how much Senator Di Natale might have—just so you know, Chair. The genetics clinician and researcher Jack Goldblatt suggested that the criteria for the Life Saving Drugs Program make it unlikely that new drugs would be listed. Are you able to comment on that?

**Ms McNeill:** I think you are referring to criterion 4, which is about the fact that a drug must demonstrate substantial life extension. One of the things that has been discussed by the patient groups and by some of the drug representatives is that having to demonstrate significant or substantial life extension makes it difficult to list a drug. We would point out that Soliris for PNH and VPRIV for Gaucher are examples of drugs that actually have been listed under those criteria, but it is specifically one of the areas that consumers, clinicians and pharmaceutical companies are responding to with respect to this submission process.

**Senator BILYK:** Sorry, in layperson's terms, was that a yes or a no?

**Ms McNeill:** Our point is that we have listed two drugs under that criterion, so there have been drugs that are able to demonstrate substantial life extension achieved on the Life Saving Drugs Program. For drugs that have not been successful, we tend to have Myozyme used as example in this for late-onset Pompe. This is a drug that was assessed under the old criteria and the new criteria and achieved the same outcome, which is, unfortunately, to not receive a recommendation. So, from our perspective, we have not seen that those criteria have made it any more or less difficult to list a drug, but I appreciate that there are perceptions elsewhere in the community about that.

**Senator BILYK:** Is the expectation that the review will result in financial savings?

**Ms McNeill:** That is not an expectation for going into the program. One of the things that has been clear is that for life-saving drugs, because they are in such small patient populations and because when the treatments are available they are in their formative stages, the evidence moves on and changes. One of the things that we look at is to make sure that the people who are accessing a drug now and the people who are accessing a drug that was assessed on criteria 15 or 20 years ago are being treated equally in both their access opportunities and what data might need to come forward in the future. We are very mindful of the factors that the terms of reference make clear—that rare diseases are an emerging and growing area and that this is something for which there are a number of pipelines of drugs coming in the future. We need to get ready for that and how they need to be prepared for, and that is one of the objectives of the review.

**Senator DI NATALE:** I have a couple more questions about the process, firstly. Given that the disease advisory committees have been abolished, who makes the decision in the end? It has been shown to be clinically effective but not cost-effective. Where does it go next? Does it just go to the minister?

**Ms McNeill:** The disease advisory committee has never provided advice to government on whether or not a drug should be listed. Their role was after the drug was listed on the Life

Saving Drugs Programme review to assess the clinical information that you, as a practitioner, had put together to say, 'I think my patient qualifies for this drug.' That committee would say, 'Yes, your evidence says that your patient qualifies for a subsidy that is already provided.' That, I think, is where there is some misunderstanding of the role of those disease advisory committees.

**Senator DI NATALE:** Under the old system, it was the minister who would decide after the drug had been through the PBAC process?

**Ms McNeill:** Or cabinet, yes.

**Senator DI NATALE:** So it is effectively at their discretion. I am sure they would have some advice from the department.

**Ms McNeill:** If there is a positive recommendation, it has been our experience that those drugs have been listed.

**Senator DI NATALE:** A positive recommendation?

**Ms McNeill:** It is a positive recommendation from the PBAC recommending that the drug should be listed on the Life Saving Drugs Programme. Those recommendations have been actioned by government, which is why we have the drugs on the LSDP

**Senator DI NATALE:** But there is that issue around 'substantial', though. You said 'at the direction of the PBAC to decide what is substantial'?

**Ms McNeill:** The PBAC has been interpreting the evidence provided by the drug companies. They are clinical experts.

**Senator DI NATALE:** Yes, but 'substantial' is not a clinical decision; 'substantial' is a very value based decision, and it can mean anything. It is true to say they can determine whether it is clinically effective but then you are asking them to make a judgement on whether a drug is going to substantially increase someone's life. What does that mean? I don't know.

**Ms McNeill:** They do this with the oncology drugs, too.

**Senator DI NATALE:** I just want to be clear about how that happens. So the PBAC would make the recommendation, it would then go to the minister and then the minister would sign off on it?

**Ms McNeill:** That is what has occurred, yes.

**Senator DI NATALE:** You said only one patient has been funded to have Soliris.

**Ms McNeill:** We are talking for PNH. That was one new patient. Remember Soliris is used in two different indications, PNH and aHUS. I am referring to the Life Saving Drugs Programme listing, which is the PNH disease.

**Senator DI NATALE:** And you are saying there is only one person under that listing?

**Ms McNeill:** No, that was one new person who has been listed. The question asked of me was: why the Life Saving Drugs Program review is underway, are people still gaining access and are drugs still being listed. I had pointed out that, since 1 May, nine patients had access to six different drugs, and one of those was PNH Soliris.

**Senator DI NATALE:** I would have assumed there were more people who would have qualified under the Life Saving Drugs Program. Why does only one person have access to the drug?

**Ms McNeill:** No, Senator, one new person. There are, I think, already approximately 68 patients. I will go on notice and double-check that.

**Senator DI NATALE:** So you are saying there is one new diagnosis?

**Ms McNeill:** Yes, one new diagnosis.

**Senator DI NATALE:** I am clear on that now. Can I ask you about the argy-bargy that went back and forth around the announcement. The government announced that it would make funding available for Soliris—and correct me if this is not the right sequence of events—and then I think on the same day the drug company said: 'Actually, we haven't agreed. We've got some concerns.' And then I think on the following day the PBAC chair, Suzanne Hill, put out a statement. Is that the right sequence of events?

**Ms McNeill:** That is correct.

**Senator DI NATALE:** In your experience, has a minister ever put out a media release announcing funding for a drug before actually agreeing on that with the drug company or the sponsor?

**Ms McNeill:** I think as the minister previously stated himself, and I quote: 'The government will not stand by when the PBAC has recommended patients should be provided with subsidised access under life-threatening circumstances. The government has funded the drug ready for listing and has intervened when necessary to ensure patients get lifesaving treatment when the company has not.'

**Senator DI NATALE:** But doesn't this happen all the time? Doesn't this happen when clinical effectiveness is demonstrated and there is a backwards and forwards around the agreed price? And isn't it only after there is an agreement on price that the drug is made available for listing on the PBS?

**Ms McNeill:** That is the usual process.

**Senator DI NATALE:** Isn't it unusual for the minister to pre-empt an agreement between the minister and the sponsor and to make that announcement until the agreement has been reached?

**Mr Bowles:** I think that is an unfair question to ask an official. Ministers are part of the government. They make decisions.

**Senator DI NATALE:** I asked if it was unusual.

**Mr Bowles:** Again, it is not something that we would comment on what ministers—

**Senator DI NATALE:** Has it happened before?

**Mr Bowles:** We would not comment on what ministers decide, when and how.

**Senator DI NATALE:** I thought it was just a statement of fact. It has either happened or not happened before.

**Mr Bowles:** I think you are putting the official in a very difficult spot by asking questions like that.

**Senator DI NATALE:** Perhaps I can ask you.

**Mr Bowles:** You can ask me and I will say the same thing. I am not going to comment on when ministers make decisions. It is their prerogative, and that is the way the system works.

**Senator DI NATALE:** Of course it is their prerogative. I am just asking whether this has happened before or not. It is a fairly straightforward question. I am not asking about whether it is right or wrong. I am not asking you to provide an opinion. I am asking for a statement of fact: has this happened before?

**Mr Bowles:** I beg to differ. Ministers will make decisions around different things at different points in time.

**Senator DI NATALE:** Yes.

**Mr Bowles:** My long experience working with many sides of government is that decisions are made in all sorts of different ways.

**Senator DI NATALE:** Can I ask then, perhaps not a question about the minister, is it unusual for the PBAC chair to make a public statement about a sponsor's application?

**Ms McNeill:** The PBAC chair did not make a statement about a sponsor's application. She made a statement about the recommendation provided by the PBAC.

**Senator DI NATALE:** I will read it:

… I am deeply concerned by Alexion's response to the Minister's approval of funding for Soliris …

We do not need to argue about what the statement was about. I am reading from the statement. I do not recall the PBAC ever issuing a statement like that after a recommendation had been made.

**Ms McNeill:** The PBAC, or any particular PBAC chair, has made statements in the past on particular drugs.

**Senator DI NATALE:** After a decision by the minister to fund them?

**Ms McNeill:** The PBAC chairs make statements on particular drugs. I would have to take on notice as to what point in time, whether it was before or after the minister had made the decision, or government had made a decision, to fund the listing.

**Senator DI NATALE:** Was the PBAC chair asked to do that on advice from the government?

**Mr Bowles:** We cannot answer that.

**Senator DI NATALE:** I am not asking for the nature of the advice. Was any advice provided to the PBAC chair?

**Mr Bowles:** From who?

**Senator DI NATALE:** By anyone.

**Mr Bowles:** We do not advise people. We might have conversations all the time—I cannot talk on behalf of the government.

**Senator DI NATALE:** Okay, let us talk on behalf of the department.

**Mr Bowles:** Again, we do not advise anybody like that to make statements. If they are aware of issues it is their prerogative. They will make that decision to make statements.

**Senator DI NATALE:** Did the department have a conversation with the PBAC chair in relation to Alexion's statement?

**Ms McNeill:** Yes, we did.

**Senator DI NATALE:** What was the nature of that advice or conversation? Was it minuted?

**Ms McNeill:** No. The PBAC chair was overseas at the time that the statement came out. We did advise her, because she had been approached about what the information was while she was overseas. We clarified for her what the public statements had been.

**Senator DI NATALE:** Did you provide any advice about what sort of response might be appropriate?

**Ms McNeill:** The PBAC chair asked me about the material and she asked me for a copy of the public summary document and the decision of the PBAC with respect to this drug. I provided that.

**Senator DI NATALE:** Did you provide any advice about what sort of response might be appropriate?

**Ms McNeill:** No.

**Senator DI NATALE:** Did you provide any advice at all about whether a public statement should be issued?

**Ms McNeill:** The chair is an independent chair.

**Senator DI NATALE:** Yes, that is right.

**Mr Bowles:** I think that question has been answered. The answer is no.

**Senator DI NATALE:** It is a different question. I want to be really clear about this: did you provide any advice to the PBAC chair about whether a statement should be issued? Honesty is the best policy here.

**Ms McNeill:** Yes.

**Senator DI NATALE:** What was your advice about the sort of response that should be issued?

**Ms McNeill:** The PBAC chair asked me to check the statement that she had prepared, to check that it was factually accurate.

**Senator DI NATALE:** Did you provide any feedback on the statement?

**Ms McNeill:** Yes, I did.

**Senator DI NATALE:** Was that feedback taken on board?

**Ms McNeill:** I corrected the factual inaccuracies, because I had access to the full suite of documents, and she did not. She asked me specifically to check material that was in the PBAC minutes with respect to that drug.

**Senator DI NATALE:** I want to ask about the Community Pharmacy Agreement. Has the Audit Office report been tabled yet, or can you give me an update?

**Ms McNeill:** No.

**Mr Learmonth:** It is still in progress.

**Senator DI NATALE:** Is it overdue? I thought we were supposed to get that yonks ago.

**Mr Learmonth:** I think it has gone beyond their planned date.

**Senator DI NATALE:** What was the planned date?

**Mr Learmonth:** I think they were expecting to table it last year.

**Ms McNeill:** No, they were planning to—July-August.

**Mr Learmonth:** Fieldwork done by last year, and July this year to table it.

**Senator DI NATALE:** What is the hold-up?

**Mr Learmonth:** It is a large and complex area. They would have to—

**Senator DI NATALE:** They knew that before they were doing it. It is hardly a revelation.

**Mr Learmonth:** They would have to speak to the process; I cannot.

**Senator DI NATALE:** Have you seen a draft?

**Mr Learmonth:** It depends on what you mean by draft. There have been, I think, two issues papers so far. We have not seen the formal section 19 statement, I think it is.

**Ms McNeill:** Yes.

**Mr Learmonth:** It has not yet been provided. I think there may be another issues paper coming. You would have to speak to—

**Senator DI NATALE:** Have you seen the issues papers?

**Mr Learmonth:** Yes.

**Senator DI NATALE:** Have they been something you have considered, in relation to any further discussions around the sixth Community Pharmacy Agreement?

**Mr Learmonth:** Our focus for the issues paper has been on dealing with matters that were raised there. Anything, obviously, that comes out of the ANAO is a concluded view we would take into account, in relation to the sixth CPA.

**Senator DI NATALE:** Are the issues raised in the issues paper—or papers—issues that will influence your negotiations on the sixth Community Pharmacy Agreement?

**Mr Learmonth:** We will wait to see what comes out of it. At the moment, they are still in process. They are still engaged in looking at the various aspects of the fifth CPA. When they reach a concluded view—and they have not done that yet—I am sure there will be some things we will take into account.

**Senator DI NATALE:** What is the status of negotiations on the sixth Community Pharmacy Agreement?

**Mr Learmonth:** Negotiations per se have not started yet.

**Senator DI NATALE:** What has started?

**Mr Learmonth:** There has been some preliminary discussion with the guild about getting clear on baselines, for example—an agreed view about financing underpinning five CPA and potentially six. There are baseline aspects to the sixth CPA but there have not been negotiations yet, no.

**Senator DI NATALE:** What is the nature of the discussions that have been had?

**Ms McNeill:** We have had discussions with respect to the guild's expected growth levels of scripts into the future, so they have the same access to the portfolio budgets statements as everybody else, looking at the options of future program development. I am sure you are aware of their public statements with respect to looking at the primary-care space as well as

the Pharmaceutical Society of Australia, which is also looking at that as the primary health-care model for pharmacy as well. So there have been broad discussions about those materials.

**Senator DI NATALE:** Given that the role of community pharmacy in primary care is a fairly controversial area, there are obviously a few turf wars that go on in this space. Are you involving other groups in those discussions?

**Mr Learmonth:** As always, there will be very significant consultations that will go on during negotiations and in the lead-up to negotiations about the positions that might be taken in the negotiations. We have traditionally consulted with a range of other stakeholders in forming views about what ought to go forward, in terms of the CPA—so with the Pharmaceutical Society of Australia and others. We would anticipate the same arrangement.

**Senator DI NATALE:** What structured process is there to ensure that the views of those various stakeholders are heard? Is this an informal, 'We will talk to you. Tell us what your issues are and we will consider them,' or do you have a structured process where you have got a formal committee that involves a range of representatives?

**Mr Learmonth:** It is a little of both.

**Senator DI NATALE:** A little of both?

**Ms McNeill:** There is the programs reference group, which was specifically set up under the Fifth Community Pharmacy Agreement to actually gain the input from a variety of stakeholders, including the Pharmaceutical Society, the nurse practitioners, rural and remote health providers and Indigenous health providers. That particular group was also formative in helping us develop the evaluation framework for the Fifth Community Pharmacy Agreement. We currently evaluate the programs, a number of which the tenders are out for. The PRG met two weeks ago and they sat down with two of the evaluation teams to actually provide their direct input into programs that are under the 5CPA and what the future of those programs may or may not look like. We use the programs reference group as a formal space and we have regular meetings with respect to the stakeholders that Mr Learmonth was talking about.

**Senator DI NATALE:** I know there has been some criticism of the programs reference group. Is there any consideration being given to changing the structure of that group?

**Ms McNeill:** With eight months left under the current community pharmacy agreement, it is staying in its existing form. But one of the things that we are evaluating under the Fifth Community Pharmacy Agreement is the governance structures. One of the discussions that was held in the most recent meeting was that exact issue: the governance arrangements supporting 5CPA, including the agreement consultative committee and the program reference group and their contributions in that space.

**Senator DI NATALE:** Are you actively looking at whether it is working?

**Ms McNeill:** Yes.

**Mr Learmonth:** We did last time as well. For example, under 4CPA, one of the significant problems was that the governance was very unwieldy. As a consequence, our ability to manage the program was hampered. Indeed, there were regular underspends in the program, which was essentially an opportunity forgone to get a health outcome.

**Senator DI NATALE:** What were the barriers there? You do not have to go into great detail.

**Mr Learmonth:** It was essentially unwieldy decision making. It was a little bit before my time, but I negotiated the 5CPA. One of the shared objectives for us and the other stakeholders was to streamline the governance of that. Indeed, we have almost overachieved. We have good, streamlined arrangements now and the programs flow much better. But, again, we will revisit that.

**Senator DI NATALE:** What is the sixth community pharmacy agreement worth? What sort of numbers are we talking about?

**Ms McNeill:** With indexation, $16.1 billion. The programs are $663 million.

**Mr Learmonth:** Did you say the sixth or the fifth CPA?

**Senator DI NATALE:** The sixth.

**Ms McNeill:** Yes, it was $15.7 billion negotiated, with indexation taking it up to $16.1 billion.

**Senator DI NATALE:** Yes, with indexation taking it up to $16.1 billion.

**Ms McNeill:** Yes.

**Senator DI NATALE:** Under the fifth agreement, what process did the department use to support moving the $2.1 million professional pharmacies payment from the department to the guild? How did you make that decision?

**Ms McNeill:** Which payment was that?

**Senator DI NATALE:** There is a $2.1 million professional pharmacies payment. That function was moved from the department to the guild.

**Ms McNeill:** One of the things we discussed in the February hearings was that we had some issues with respect to keeping the programs within their budgets and that we had looked to try and remodel the programs to ensure that we live within our means. Unfortunately, the current provider of those administrative services, the Department of Human Services, were not in a position to make those changes to their system in sufficient time for us to be able to adapt the programs and still deliver the services and come in on budget.

The Pharmacy Guild, because they already administer some programs on behalf of the government with respect to the fifth community pharmacy agreement, had the capacity and infrastructure in place to do that and to give effect to it immediately. By 'immediately', I mean that we did that within three months. That was the decision that was taken. We had a transition arrangement with the Department of Human Services. The project was overseen by a team in my division. We work together to transfer those payments and services.

**Senator DI NATALE:** I want to quickly go to hep C. I want to ask you about some of the drugs that are currently before the PBAC and one in particular, Sovaldi. I am interested in it because it seems to be a fairly significant breakthrough in that it is able to clear hep C at a significantly higher rate than previous drugs. But I understand its first application has been knocked back.

**Ms McNeill:** Yes, it was rejected at the July meeting. We had a number of meetings thereafter with the drug company. The chair of the PBAC had a meeting with the sponsor, and the department worked with them as well, to try to respond to the concerns that PBAC raised so that we can get it back onto the next agenda as soon as possible. I cannot comment on when that next consideration will be, but it is not in November.

**Senator DI NATALE:** What were the grounds for it being knocked back?

**Ms McNeill:** It was found to be clinically effective but not cost-effective at the price that was asked.

**Senator DI NATALE:** Is it simply a question of negotiating on price? Is that where we are at?

**Ms McNeill:** Some of it is, but it is a little more complex than that with respect to dosing and expectations of dosing.

**Senator DI NATALE:** How do the costs of these new oral treatments compare to the existing treatment with interferons? What are we talking about?

**Ms McNeill:** Whilst I cannot disclose the actual price that we were offered for this particular drug as part of the PBAC consideration, we are currently expecting that kind of listing would be somewhere in the vicinity of over $1 billion over four years.

**Senator DI NATALE:** We have a hep C strategy that commits us to trying to achieve significant reduction in the disease. We have a huge burden of disease.

**Ms McNeill:** We do. We have other drugs on the PBS, such as Boceprevir and Telaprevir, which clinicians and the patient community advocated very strongly for. They were at a cost of over $200 million over five years. They are on there as well as the interferons you were referring to.

**Senator DI NATALE:** I am out of time. I have a few other questions I will put on notice.

**Mr Bowles:** Just to respond to Senator McLucas's question earlier on about the media release, I understand it was up on the 15th. That is what I have been told.

**Senator McLUCAS:** I can confirm it was not.

**Mr Bowles:** Our system says it was up there on the 15th. I am happy to have a broader look on notice and come back, but we have had a look and it was posted on the 15th.

**Senator McLUCAS:** I will get you to come back on notice because it certainly was not on my screen. Maybe my system has different glitches to yours, but it certainly was not there on the 15th or even the 16th.

**Mr Bowles:** Where were you looking?

**Senator McLUCAS:** At a computer.

**Mr Bowles:** Which particular website?

**Senator McLUCAS:** Minister Dutton's Department of Health media drop-down.

**Mr Bowles:** Being a ministerial release, the first place it would have gone is on Minister Dutton's website.

**Senator McLUCAS:** I will follow that up. My staff have done the research.

**Mr Bowles:** It may not have been on the department's drop-down straightaway, but if it was a ministerial media release it would be on Minister Dutton's website and I understand it was.

**Senator McLUCAS:** We will find it. I want to go to these payments for wholesalers and pharmacy programs—the difference between $216 million, which grows to $406 million, which, as we now know, is in Budget Paper No. 1, in statement No. 6. In the 2013-14 budget

the allocation was to be $216 million, then in the 2014-15 budget it grew to $406 million. Can you explain how that happened? What was the expense that occurred?

**Ms McNeill:** If you could just give me 20 seconds to read something. I will need to take this on notice and talk to my Treasury colleagues who actually publish these papers. My staff cannot actually work out where the numbers are. We think it may have something to do with material put into 'other' under previous years and then a correction entered. But that really requires me to go back through the material and confirm that for you. We do not actually publish Budget Paper No. 1s.

**Senator McLUCAS:** I understand that. If you could provide me with an explanation of what occurred between those two years; when the department became aware the funding would need to be increased; what accounts for the increase in funding; and what mechanisms does the department have in place to keep account of that funding?

**Ms McNeill:** I have written those down and I will get back to you on those.

**Senator McLUCAS:** I wonder—and this is quite unusual—whether we could have as much information as possible after dinner about this question. Would that be possible?

**Ms McNeill:** I will try. It will depend upon my capacity to actually contact my Treasury colleagues. But I will do my best.

**Senator McLUCAS:** Can I now go to the Trans-Pacific Partnership Agreement. What role is the department playing in the TPP discussions?

**Ms McNeill:** The Department of Foreign Affairs and Trade has lead responsibility for all aspects of international free trade negotiations. We provide advice, as appropriate, with respect to our particular program areas.

**Senator McLUCAS:** What position is Australia taking on the US request to extend patents on pharmaceuticals?

**Mr Bowles:** This would normally come up, I think, under outcome 7, which is the next outcome.

**Senator McLUCAS:** That is, 7.3 International policy engagement.

**Mr Bowles:** International policy engagement, so it is in outcome 7.

**Senator McLUCAS:** We will leave it until outcome 7.

**Mr Bowles:** If you do not mind. If you want the answer now—

**Senator McLUCAS:** We will break for dinner!

**CHAIR:** Is there any more in outcome 2? No? Then we have finished on outcome 2, thank you very much. We will come back at a quarter to eight, but I will just deal with the procedural point from Senator Reynolds before we suspend.

**Senator REYNOLDS:** Thank you. I just wanted to seek your indulgence to ask a procedural question on standing orders, if I may, as a new member of this committee?

**CHAIR:** Sure.

**Senator REYNOLDS:** It relates to Senator McLucas's comments at the the conclusion of my questions on outcome 2. The fact that they were somewhat gratuitous and offensive aside, I find myself a little perplexed, if not flummoxed, by the nature of the comments. So my question on the standing orders relates to the clear inference that government senators have

lesser rights to ask questions in these committees. I cannot find any reference to that and it also seems quite contrary to the changes to the standing orders—standing order 26(4) on the closure of items of expenditure. It seems that the intent is to allow more time for questions on individual outputs. If you could provide some clarification for me on that I would be very grateful.

**CHAIR:** Sure. My understanding is that there is nothing in the standing orders about questioning. It is questioning by senators; it does not delineate in the standing orders, as far as I can tell. In relation to standing order 26(4), which has been invoked a number of times today: it is a new standing order and it allows any senator—government, crossbench or opposition—effectively to extend a line item for as long as is necessary for them to ask questions, until they are satisfied. That is my understanding. But, no, there is nothing in the standing orders that says government, opposition or crossbench in terms of time allocations or anything.

**Senator MOORE:** In terms of process that is quite right: there is nothing directly in the standing orders. However, there is a long-standing convention in the estimates process that it is a chance for senators who are in opposition to get clarification of issues from government, on the expectation that government senators have the opportunity within their own processes to talk with their ministers at any time about the issues on record.

What we have done in community affairs over a long-standing period is come to an agreement. It is by agreement; it is not formally in the standing orders, as Senator Seselja is quite correct in saying. But we have come to a long-standing agreement which can be attested to by many senators of all flavours, in this committee at least, that at least two-thirds of the questions go to opposition senators.

I have to admit, to my shame, that when I was the chair a lot more than two-thirds went to the opposition senators on my personal belief as a chair that we needed to let opposition senators have the opportunity. That is the background. I understand that it is something that is new.

**CHAIR:** No agreement has been made in the time that I have been chairing, but on today I think it is about three-quarters to one-quarter. But that is the way it has gone and I do not think that anyone could argue that anyone has been shut down. But thank you. On that we will suspend until a quarter to eight.

**Proceedings suspended from 18:47 to 19:50**

**CHAIR:** We are in outcome—

**Senator McLUCAS:** Chair, can I make a suggestion that we begin now with biosecurity and emergency response and do that for 30 minutes. Then we will go to health system capacity and quality, which we will also do for 30 minutes; healthcare workforce capacity for 20 minutes; private health for 10 minutes; and population health for 35 minutes. That will bring us to 10 o'clock where we will do Sport and Recreation for one hour.

**CHAIR:** Why would Sport be stretched out—it is only half an hour at the moment—to one hour?

**Senator McLUCAS:** Pardon me; I have misread that.

**CHAIR:** It is half an hour.

**Senator McLUCAS:** I have made a mistake. That would then allow me to fix my error, which was to not remember that we have a break.

**CHAIR:** Which can be 10 minutes.

**Senator McLUCAS:** So we have 20 minutes to play with. We have 20 minutes slack with that proposal.

**CHAIR:** I am interested in other committee members' views.

**Senator SMITH:** I have some questions on population health. I am not opposed to the suggestion.

**CHAIR:** Other committee members or participating members? That is fine. I will just put the proviso that if a senator insists, whoever they may be, I do not have any discretion in terms—

**Senator McLUCAS:** I understand, Chair. We are just trying to work out a way to get through this. It is not our desire to spill over. We have the standing order, if we need it. That is the intent of my proposal.

**CHAIR:** If that is agreed to by the committee—if there is no objection—then I do not have an objection. We will start with Biosecurity. How long did you say?

**Senator McLUCAS:** I suggest we do biosecurity and emergency response for 30 minutes; we then go to health system capacity and quality for 30 minutes; healthcare workforce capacity for 20 minutes; private health for 10 minutes; population health for 35 minutes; 10 minutes for a cup of tea; half an hour for sport and a few minutes left over for slippage.

[19:53]

**CHAIR:** That is agreed. We will move on to Biosecurity.

**Senator McLUCAS:** Before we settle into that, can I quickly, Mr Bowles, talk about this media release. It is quite interesting. You asked me where did I go to—the Ministerial Media Centre, on 15 and 16 October. Another thing that is of interest is that I get the minister's alerts—like these—and I actually file them. There is no alert for the PHN announcement. The PHN page says that it was updated on 15 October, but it refers to a 13 May release from the minister. The question in my mind is: was it uploaded but not published? I will leave that with you. You can sort that out.

**Mr Bowles:** I will have a look at that. As I said, I got advice that it was there, but I will definitely have a look at what has happened.

**Senator McLUCAS:** These things are technical and can be traced. Thank you for the update on the professor's statement of clarification. Professor, you said, 'I have learnt today.' I am interested in that you learnt that today.

**Prof. Baggoley:** As you aware, right around the country preparations for the management of Ebola disease in case it should come to this country are ongoing and rapidly evolving. As you know, I seek updates and I received—it may well be as a result of this morning—an update from Darwin from the head of the National Critical Care and Trauma Response Centre, who provided me advice as to what they were doing.

I think, if I may, it is important to put into perspective what would happen if Ebola was to occur in one of our regional countries. We have the Ebola naive in this situation, if you like.

There are no cases of Ebola anywhere. If a case or several cases developed and the government of a country sought help from Australia and the Department of Foreign Affairs and Trade asked for a health response, then what would happen in that situation where you have just a few patients is a forward assessment team. Obviously, as chair of the Health Protection Principal Committee, I would bring that committee together. With the resource that we have in Darwin at the National Critical Care and Trauma Response Centre, we know that they would be ready to go to provide a forward assessment team of around four people. They can do that immediately.

**Senator McLUCAS:** That was about four people?

**Prof. Baggoley:** Just as an assessment team.

**Senator McLUCAS:** As a first step.

**Prof. Baggoley:** Yes. That would be an immediate response. That is important to understand. Obviously, this morning's discussions were flicking between West Africa and regionally. It is important to understand that in our region you would need senior people who are well-trained in understanding how to analyse circumstances. They would go to the area where there was the case and they would be able to make an assessment of the clinical situation; an assessment of the public health situation, as to how contract tracing was going; and an assessment of the clinical situation, so of the clinical facilities and the need for equipment. If in fact a broader team was required to go, then they would make that assessment as well. Then they would need to liaise with that government. We would then liaise and we would be in constant touch with them. In that circumstance in our region, that would be an immediate response.

If then there was a requirement for a larger team to go to assist, there would be usually an expectation of working with the team that would come from Australia and working with local clinicians. In a circumstance where 20 staff were required, that would probably be reasonable. Remember, what we are dealing with is a disease early on that is still slowly evolving. It is up to a three-week incubation period. It is not a cataclysmic thing; it is not a typhoon, where all of a sudden you have hundreds of people who are affected. There is time to assess the situation and to provide clinical imports.

If it was deemed necessary that a team would be required to go, then there is certainly time to prepare and to have people who would be able to go. What we do know—and this is from the head of the National Critical Care and Trauma Response Centre—is that currently 20 AUSMAT staff from NT health have been trained in Ebola-specific personal protective equipment use over the past week as part of ongoing preparedness and their mandate to be aware of and capable of responding to any domestic or international health emergencies. The staff that would be able to go would be 16 nurses with the following backgrounds: critical care and emergency nursing, trauma nursing, ward and general nursing, medical staff—

**Senator McLUCAS:** Sorry to interpose, Professor; that is important detail, but we only have a little bit of time. I wonder if we could get to some of the—

**Prof. Baggoley:** The point is that it is a rapidly evolving process. In a situation like New Guinea or another nearby country, you would want a forward assessment team in quickly, and that can be done.

**Senator McLUCAS:** Would that forward assessment team start the contact tracing?

**Prof. Baggoley:** They would analyse—and of course there would be clinical staff and public health staff in-country, and they would be able to provide advice, if advice was needed, about the contact tracing.

**Senator McLUCAS:** Well, Professor, you and I have talked about PNG a lot—

**Prof. Baggoley:** Yes.

**Senator McLUCAS:** and they have a very developing, growing health system. Does PNG have the capability to do contact tracing now?

**Prof. Baggoley:** That is what they would assess when they got there.

**Senator DI NATALE:** Professor Baggoley, you say it is unlike a natural disaster where there is an urgent need for intervention immediately, but the whole nature of this is that every day we wait means that more and more people may be exposed. I would have thought that the time was actually very critical in this setting, in that what could be a small and manageable outbreak if addressed in a timely way, if left for a week or so, could actually become an outbreak that grows exponentially, and then the whole process of contact tracing, quarantine, isolation and so on becomes much, much more difficult.

**Mr Bowles:** We did talk a little bit about this this morning. I do not think that anyone is suggesting that this is a week. There are 20 people who are trained. They can go. What Professor Baggoley is talking about is: you would send an immediate response team. The assessment is done very, very rapidly.

**Senator DI NATALE:** Yes, but Professor Baggoley made the point that time was not critical in the same way as it is with a natural disaster.

**Mr Bowles:** I do not think he quite said it that way.

**Senator DI NATALE:** I am quite happy to go back and check the *Hansard*. That was exactly as it was presented. My ears pricked up when I heard that. So I am happy for us to go over the *Hansard*, but in fact a comparison was made with a natural disaster, indicating that time was not critical in the same way. I just think it is important—

**Mr Bowles:** I think it is probably just a nuance issue. Clearly, if we have people trained and ready to go, and the assessment of the people who go there first up to do whatever assessment is needed says, 'We need more people,' obviously more people will be sent.

**Senator DI NATALE:** How can they be sent if they are not trained?

**Mr Bowles:** We are just saying: there are 20 people already trained—

**Senator DI NATALE:** Yes, but they are in this rapid assessment team; they are not working on the ground.

**Mr Bowles:** No, that was not what was said. Professor Baggoley said—

**Senator DI NATALE:** Sorry; that was what was said.

**Mr Bowles:** No, it was not. Professor Baggoley said four people would go and do a rapid assessment, and if required we could then put the 20 people in—as, at the same time, if you are sending people into a situation you start the training immediately. So, by the time you have all those things happening—again, remember we do not go from zero to 400 overnight. So we do have some time.

**Senator McLUCAS:** Mr Bowles, we do, with this disease, if it is really badly—

**Mr Bowles:** No, I do not think that has been proven in any of the cases. If we are talking about contact—

**Senator McLUCAS:** Well, in a worst-case scenario—

**Mr Bowles:** If we are talking about contact tracing, that is a different issue.

**Senator DI NATALE:** But that is the crux of what we are doing. That is how you respond to the epidemic. That is what containment is.

**Mr Bowles:** That is one part of it—

**Senator DI NATALE:** It is the most critical part of it.

**Mr Bowles:** It is one part of responding.

**Senator DI NATALE:** It is the most critical part of it.

**Mr Bowles:** The point is, we can do those sorts of things. We have been talking about clinical staff trained to deal with Ebola-specific issues. If you do a rapid assessment, you get your first team in, and you then start to roll them right the way through.

**Senator DI NATALE:** What training have the 20 staff members received?

**Mr Bowles:** I think Professor Baggoley went through that.

**Prof. Baggoley:** Well, I had not got to the medical staff. There are two specialist infectious disease physicians who would be very critical to that part of the assessment—

**Senator DI NATALE:** But let me ask more specifically: what specific Ebola training have these staff received?

**Prof. Baggoley:** They are trained infectious diseases physicians, so they understand the nature of the disease—

**Senator DI NATALE:** But we are having a different discussion again. Earlier today, you made it very clear, and corroborated what is happening at the moment in the field is that every doctor or health professional who is deployed in West Africa has undergone several weeks of very specific training, some of them in Europe, followed up by some mentoring in the field. What specific Ebola training have these 20 staff had?

**Prof. Baggoley:** They have all had training in Ebola-specific personal protective equipment.

**Senator DI NATALE:** Where has that been conducted?

**Prof. Baggoley:** That has been conducted in Darwin.

**Senator DI NATALE:** They have not undergone the training that every other health professional who is deployed in the field—

**CHAIR:** How about we let the chief medical officer answer?

**Prof. Baggoley:** The training has been conducted according to MSF and WHO guidelines. That is what has been underway.

**Senator DI NATALE:** In-house?

**Prof. Baggoley:** In-house.

**Senator DI NATALE:** We heard earlier that every other NGO that is involved in this effort has deployed their staff to embark on very specific training around Ebola. That involves not just a series of lectures and tutorials on the use of personal protective equipment but also

some mentoring in the field. Are you suggesting that some in-house training around personal protective equipment is enough preparation for what could be a very serious outbreak in our region?

**Prof. Baggoley:** What I am saying is that the training course has been conducted in Darwin. There is no Ebola within our region, which is important and we are grateful for that. Then there would be ongoing mentoring with people while they were working with Ebola in our region.

**Senator DI NATALE:** We went through this in some detail earlier. We both acknowledged that it was critical that very specific training be provided. It is currently being provided in Europe and in the field. That is the context for which the response around Ebola is occurring. Then in response to a statement earlier on which said, 'We do not have anyone who has undergone that specific training,' we then get a clarification to say, 'Actually, there are 20 people who have been trained.' Now we hear that they have been trained in-house in Darwin.

**Mr Bowles:** I think we are confusing a couple of issues here. People are trained in West Africa because there is Ebola in West Africa in a certain way. There is no Ebola in our region or in Australia at this stage. The professor has said these people are trained according to WHO—

**Senator DI NATALE:** It is remarkable that we are having this conversation.

**Mr Bowles:** It is remarkable that we have 20 healthcare workers fully trained. It is a professional healthcare system. I went through earlier on about our domestic response and domestic preparedness and a lot of work has gone into that. Part of that is having people trained who understand the specifics of what they will be dealing with. We do not have Ebola in this country or in this region. You are conflating what is happening in West Africa with—

**Senator DI NATALE:** No, no.

**Mr Bowles:** I beg to disagree.

**Senator DI NATALE:** I am telling you the protocol that is going on at the moment for MSF workers involves training in European settings and then they are deployed in the field under a mentoring program so that before they actually engage in active work on the ground they have got some exposure to people who are clinically unwell under the tutelage of experts. It is a very different scenario to what you are describing.

**Mr Bowles:** Professor Baggoley has also said that they have been trained under WHO and MSF guidelines.

**Senator DI NATALE:** With absolutely no experience of what it is like to work in the field.

**Mr Bowles:** I would disagree.

**Senator DI NATALE:** I have been a medical practitioner. It is one thing to be in a laboratory or a lecture theatre and it is another thing altogether to be in an operating theatre. That is why we have internships.

**Mr Bowles:** I beg to disagree. These people are trained people. We have a response capability in this country. We have gone through it and I think you agreed that our domestic preparedness was very good to cope with all of this.

**Senator DI NATALE:** We are not talking about domestic preparedness.

**Mr Bowles:** We are also not talking about any part of our region that has Ebola either.

**Senator DI NATALE:** We are talking about an outbreak in a developing country.

**CHAIR:** Senator Di Natale, allow Mr Bowles to answer.

**Mr Bowles:** We are also not talking about anyone in this region or in this country who has Ebola.

**Senator McLUCAS:** But we are talking about preparedness. That is the issue.

**Mr Bowles:** That is exactly what Professor Baggoley was saying.

**Senator McLUCAS:** That is what we are trying to get to. It is that the level of preparedness that our country has for a regional outbreak. It is unlikely, but if we do not work and make sure it is prepared for then if it were to happen it could be catastrophic. I am not trying to make this into something that it is not.

**Mr Bowles:** I was not suggesting that you are.

**Senator McLUCAS:** I reaffirm my view that our domestic preparedness is fantastic. I hope I am right.

**Mr Bowles:** Absolutely.

**Senator McLUCAS:** My assessment is that we have done a good job for domestic infections in Australia.

**Mr Bowles:** Senator, I was not responding to your claim; I was more responding to Senator Di Natale—because, again, we are sort of attacking the professionalism of the medical and professional staff.

**Senator McLUCAS:** We are trying not to.

**Senator DI NATALE:** We are actually looking at what our government is doing to be adequately prepared.

**Mr Bowles:** We have a group in the Northern Territory who have been training people—and you just said that they could not possibly be trained. You said it was incredible or something like that.

**Senator DI NATALE:** No, I said that what other countries have been doing and what NGOs have been doing is a very different model—

**Mr Bowles:** As they deploy into an Ebola infected country.

**Senator DI NATALE:** No; they are effectively having a process whereby people who have the orientation program, the tutorials and so on are then working under the supervision and the mentorship of people who are experienced in this situation. You are saying to me that we are going to take someone who has had a couple of lectures about how to put on some personal protective equipment and deploy them immediately into a field setting in a developing country.

**Mr Bowles:** I think that is grossly unfair about what I said. No-one has said that. They said they were trained.

**Senator McLUCAS:** Okay; let's go to that. The clarification document says that these 20 healthcare workers have been recently trained. I think, Professor, you said that it was last week that they were trained.

**Prof. Baggoley:** It has been occurring over the past week and will be ongoing, including training in wearing the equipment for hours on end in the heat and acclimatising to that—because that is required. The international standards and practice through the World Health Organisation and the MSF and other agencies indicate that there is a period of in-country set-up and training that is required in that circumstance to guarantee staff and patient safety for this very specific response. In-country training proceeds concurrently with field facility set-up.

**Senator McLUCAS:** Could you repeat that last sentence, please?

**Prof. Baggoley:** You train in your own country, as all our healthcare workers who are in our major hospitals, the designated hospitals, are training in the absence of their being any Ebola patients—and long may that be the case. In the situation there is Ebola—in this postulated circumstance overseas—you have in-country training in that circumstance, which is an absolute necessity and that is what would occur. So it is not a couple of lectures in Darwin and then off you go; it is ongoing training and supervision. I think that is important to understand. The professionalism of the people who run and lead the National Critical Care and Trauma Response Centre and who work in our region would guarantee that.

**Senator DI NATALE:** I do not want to be disrespectful, but that I am trying to make is that there is a process set up for people in Australia who are going to be deployed in an NGO setting. It is an established process. Working in an environment like that is very different to working in a tertiary hospital in a country like Australia. It is a very different environment. To be deployed without having firsthand knowledge and experience of what it is like to work in the field is not something NGOs are doing. They are not sending people into the field cold. They are not saying, 'We're going to provide some training to you here in Australia or in the UK or wherever your country of origin is and we're going to send you to West Africa.'

**Mr Bowles:** Professor Baggoley just went through that. This is an ongoing issue. There is no Ebola in our region.

**Senator DI NATALE:** There may be.

**Mr Bowles:** There may be.

**Senator DI NATALE:** That is the whole point.

**Mr Bowles:** Exactly, and he just went through that where he said we would have ongoing training and, if there were to be a case, people would deploy and would get that training on the ground as well.

**Senator DI NATALE:** Let me be clear: are they going to be getting training in PNG from PNG medical staff while an outbreak is occurring?

**Mr Bowles:** Professor Baggoley just went through the issue, so he can go through it again if we like.

**Senator McLUCAS:** We are not trying to be difficult, Mr Bowles. From whom would they receive that training if there were a deployment into, for example, PNG?

**Mr Bowles:** Again, I think Professor Baggoley talked about the Northern Territory groups.

**Prof. Baggoley:** They would get training from people who do have experience in managing infectious diseases and working in the high-level personal protective equipment,

which includes the head of the National Critical Care and Trauma Response Centre, Dr Nick Coatsworth, and the infectious diseases physicians who have worked in the area.

The point that we do make about the MSF training and so on is that people would have two days of training, say, in Brussels in the lecture-theatre style environment and then they go into a classroom situation, if you like, or a simulated environment for further training to see that they can put on and take off the equipment, which all can be done out of country. Then there is mentoring in country where the Ebola cases are. That is the process that occurs, and that is a similar process to what would occur here. It is a different situation here to West Africa obviously, but West Africa sadly has the hospitals full with patients.

**Senator DI NATALE:** Can I ask—

**CHAIR:** This is your last question.

**Senator DI NATALE:** I have a couple of questions to go.

**CHAIR:** There might be time to come back. You have one question, and then I am going to Senator Reynolds.

**Senator DI NATALE:** Who in Australia is involved in the training and has experience of working with Ebola?

**Prof. Baggoley:** I would need to take notice exactly that in relation to the National Critical Care and Trauma Response Centre. I will take that on notice and get back to you.

**Senator DI NATALE:** Could you provide that. As of this moment—I am not talking about what may happen at some point in the future—who is conducting the training and what experience do they have specifically in working in an Ebola outbreak setting such as the one we currently have before us?

**Prof. Baggoley:** I will take that on notice.

**Mr Bowles:** We do not have it before us in this region. I just make that point. I know you are not saying that, but—

**Senator DI NATALE:** An outbreak setting before us globally.

**Mr Bowles:** Globally.

**Senator REYNOLDS:** Mr Bowles, this is in relation to some of your comments earlier on this morning. It is clear to me from your evidence that we are well prepared domestically and regionally, and it seems that the issues that you were talking about in terms of logistical issues and forward planning issues relate to our support for any Australians in West Africa. I am wondering if you could go through in a bit more detail for us what some of those logistical issues are in terms of the whole process—getting support there, providing support, returning home et cetera. I think you talked about the difficulty of getting airport access et cetera. Could you go through what some of those challenges that we face are?

**Mr Bowles:** I probably will not be able to give you an exhaustive list, but—

**Senator REYNOLDS:** No, just indicative is fine.

**Mr Bowles:** I think there is a range of issues to assess around any country that you go in. First of all, the country has to invite you in. That is an obvious first. There is a range of security issues. You need to ensure that the people you are sending into, let us say, harm's

way—for want of a better phrase—remain safe. So you have to have a range of assessments around that.

You have to understand the infrastructure that is available. Do you need to build something? Do you need to rapidly deploy a field hospital, if I talk about an army or military style activity? Australia is very good at that sort of stuff both in the military and in the civilian world, as you would know. It is trying to get all of those things in place. I am not saying this takes a long time. Because we have done this in a range of circumstances like tsunamis, floods, all sorts of earthquakes and things like that, I think Australia and its emergency response activities have become very good at the logistics and pre-preparation, which is always there with a lot of these groups, and then the on-the-ground rollout of what is required around security, infrastructure, safety and the like.

There are obviously a million and one little things that will happen on the ground around all of those things, but the point I was trying to make earlier is that we are first rate in doing this in emergency circumstances. I am not suggesting we are expert at doing this in Ebola circumstances in the broad, but we are expert at the initial rollout around logistics, set-up, security and infrastructure assessments. There have not been a lot of Ebola outbreaks, particularly anything like the one we are dealing with in the world today, but there have been many circumstances where we have deployed for tsunamis, earthquakes, floods and other disasters. Really, I just want to drive the point that we are very, very experienced at that.

Given the issues in West Africa, we have been doing a lot of work—'we' being the royal we of states, territories and the Commonwealth—around preparing ourselves for potential issues that might arise if there were a case, either in Australia—that is, our domestic response—or in our region—that being our regional response and our regional preparedness to do whatever is required.

**Senator REYNOLDS:** The regional response, given the testimony of Professor Baggoley earlier about the Nigerian experience, requires good public health programs. So, presumably, a regional solution, if there were to be an outbreak in our region, would involve assistance and advice on public health and protocols for their local health system.

**Mr Bowles:** I think that is absolutely correct. Again, the Australian public health system is probably second to none around the world. You did reference Nigeria. The fact that they were able to bring a circumstance under control, I think, over 42 days—so two cycles, if you like—to a point where they are now Ebola free is a pretty good ad for public health, good sanitation and good hygiene around these issues.

**Senator REYNOLDS:** One of the issues for the Australian government, and for you, to think about is the distance between here and West Africa. My understanding from the testimony is that one of the issues is that it is not just a five-hour flight and that the ISO-PODs last for five hours, so they provide support for five hours. Is that correct?

**Mr Bowles:** I am not sure about the ISO-PODs, but I think the critical point—Professor Baggoley, correct me if I am wrong—is that the first 48 hours is quite critical. To evacuate somebody you have to get there and get them in a plane. If they were to come back to Australia, for instance, it is probably a 30-odd-hour flight, I presume. So I think that was the point that was made around that.

**Senator REYNOLDS:** It is also in terms of the stage—how long it has been since they were exposed and started displaying symptoms. So there is not a one-size-fits-all approach; it would always have to be a patient-by-patient solution.

**Mr Bowles:** That is right, and Professor Baggoley said earlier that it does not follow a standard time frame. Sometimes, it can move rapidly. I suppose, if you were in one of those ISO-PODs and in a plane for a long period of time, that would be a little unattractive.

**Senator REYNOLDS:** Earlier on today at the Defence hearing the VCDF stated that in mid-November he would have an interim short-term solution for C-17s and C-130s, but he said that it would still only be for five hours because that is all an ISO-POD could sustain somebody. So it was not so much the distance that the airframe had to travel but the actual pod itself, which would presumably mean it would only be a solution for regional evacuation and not evacuation from West Africa.

**Mr Bowles:** I think you are right. I will take his advice on what his aircraft and equipment within his aircraft can do, but, clearly, I think all the evidence that we have been hearing and talk about says: the shorter the time for evacuation to get somewhere, the better off you are. Therefore, from a regional perspective, that would be equally the case, I presume.

**Senator REYNOLDS:** The more somebody is into their symptoms being apparent, the more infectious they become. Is that correct?

**Mr Bowles:** I think that is right.

**Prof. Baggoley:** Yes.

**Senator REYNOLDS:** And they become a greater threat to the healthcare workers who are working with them, rather than —

**Mr Bowles:** Yes, that is correct.

**Prof. Baggoley:** Correct.

**Senator REYNOLDS:** Thank you.

**CHAIR:** That is the half an hour, so assuming nobody wants to push on we will—

**Senator McLUCAS:** I want to push on for five minutes, and this is my slippage time I think I am jumping into.

**CHAIR:** We had an agreement that we were not going to go beyond this time. That was what we discussed post dinner break, so, if you are going to start taking the extra time, there will be very little ability to control others from taking the extra time in other circumstances, but I cannot stop you.

**Senator McLUCAS:** It is a different issue. I want to talk about tuberculosis in the Torres Strait.

**CHAIR:** That is fine, but we have gone to 30 minutes now, which we all agreed, and you got most of that time along with Senator Di Natale. So, if you want to insist under standing order 26, feel free, but I do not think that is what we agreed about half an hour ago.

**Senator McLUCAS:** I am sure the spirit of getting answers on notice will deliver itself tonight. Can we ask some questions about tuberculosis in the Torres Strait and Cairns? I want to go to a best practice question, Professor, around the management of tuberculosis. There has been a debate about whether or not we should centralise contact tracing and the patient

management process and whether it needs to be devolved into health regions. Can you advise the committee of your view about the best practice around a very infectious disease like tuberculosis?

**Prof. Baggoley:** Thank you for the question. As you point out, there has been a debate, and you are referring to set-up in the state of Queensland in relation to how they manage their tuberculosis services. I suspect two things: (1) it is not for me to comment specifically on matters in relation to how any state or territory is doing things; and (2) the fact that there is a debate means that there is probably no correct answer.

**Senator McLUCAS:** Is there no literature around best practice of highly infectious diseases that you could point the committee to?

**Prof. Baggoley:** Not that I can point you to, but I can again take that on notice—

**Senator McLUCAS:** That would be helpful. Thank you.

**Prof. Baggoley:** and see if I can find anything.

**Senator McLUCAS:** Is it your view that the management of multidrug-resistant TB can be managed by general practitioners, or should that be managed by specialists?

**Prof. Baggoley:** Again, it is my understanding that the oversight of the management of tuberculosis, including MDR-TB, would certainly require specialist oversight. The actual delivery of the care and the required treatment can vary, and, as we know, the directly observed treatment regime which occurs, and is WHO recommended, is one where the village community can oversight the actual delivery. Setting up the treatment regime requires the skill of a tuberculosis specialist, and then how it is delivered and the direct care, I think, is something—

**Senator McLUCAS:** I was actually referring to in-country Australian managed MDR-TB, because we now know that we have had transmission of MDR-TB in Australia.

**Prof. Baggoley:** I understand that the Cairns TB control unit has been very actively involved with the oversight, management and contact tracing of those cases in the Torres Strait.

**Senator McLUCAS:** Great. I have two more very quick questions. There have been some reports that are unsubstantiated from my perspective of people being sent back to Papua New Guinea from the Torres Strait without treatment in a palliative sense. Have you heard similar information? That would seem to be a significant shift in policy if it is true.

**Prof. Baggoley:** I have not heard that.

**Senator McLUCAS:** Thank you. My final question goes to the clusters that have been reported in the media. There are two clusters that have been described, one being on Saibai Island and the other on Yam Island. There has been commentary around who should have been told about who was infectious and by whom. Do you have advice to the committee about what is the proper process for communities being told that members in their community have tuberculosis?

**Prof. Baggoley:** I am aware of the cluster on Yam Island. I am not aware of a cluster on Saibai Island, unless you are referring to the origin of the woman who died in Cairns Hospital. I am not sure where she—

**Senator McLUCAS:** I use the words 'media reportage' very carefully. There has been media reportage of it. I do not necessarily agree with it.

**Prof. Baggoley:** As you pointed out, there has been a cluster identified on Yam Island, which is a population of about 360 people. I understand it is being managed and contained by the health authorities over there. There have been close contacts identified and people treated, and additional inquiries into cases reveal links to three extended family members who were diagnosed in 2010 and 2011. So altogether there have been nine people identified as belonging to this cluster. What the practice is in relation to advising a more general community that others in the community have tuberculosis will go to the practice there in Queensland and also to issues of privacy. So the ability to talk about that more openly is one that would require careful consideration.

**Senator McLUCAS:** So you would suggest that calls from another leader, so-called, in our community, different to the one we were talking about earlier today, for people to be told would contravene that patient confidentiality that you refer to?

**Prof. Baggoley:** We would need to fully understand the processes, protocols and legislation in Queensland on that matter, and I do not have that knowledge.

**Senator McLUCAS:** There is a sensitive line here.

**Prof. Baggoley:** Absolutely.

**Senator McLUCAS:** This is a small community. There are 300-odd people who live on Yam Island, and the councillor from the TSRIC was not aware, according to reportage in the newspaper. However, there are real concerns about patient confidentiality that I think you are telling us about.

**Prof. Baggoley:** I cannot add any more.

**Senator McLUCAS:** Thank you, Professor.

[20:33]

**CHAIR:** Were there any other questions in this outcome? No? That being the case, we will move on to outcome 7, where we have now allocated 30 minutes—but that is, of course, subject to change.

**Mr Bowles:** In this outcome, there are a range of different elements and therefore different people. So, if people have something specific, we will just get them up one at a time. We only have 30 minutes.

**CHAIR:** Sure. We will do our best to shuffle people in and out.

**Senator WHISH-WILSON:** I would like to ask a question of FSANZ on hemp for food. It has been a regular fixture, asking these questions for the last two years. I understand based on the last estimates that the Legislative and Governance Forum on Food Regulation was going to meet in June to make a decision on hemp in food but that the forum agreed to extend the review period of the use of hemp until 5 December 2014. Can you provide details on why further time was needed, why there was an additional extension?

**Mr McCutcheon:** The information you just provided is correct. FSANZ was given an extension to finalise its review by 5 December 2014. I am not able to provide any comments on why ministers gave us that extension or indeed the detail of that because FSANZ is not

involved in those discussions. We have been given a deadline, we will meet that deadline and then it will be over to the ministers.

**Senator Nash:** If I can assist, I am happy to provide to you, so far as I can, the discussions around it, but I would need to discuss it with the forum in terms of what they would be happy to share. There was further information that was required. The forum did ask FSANZ to come back with that information and, just to clarify for you, at the forum we also agreed to have the next meeting on 20 January. At that point we will again examine the report from FSANZ, but I expect at that point we may have a determination.

**Senator WHISH-WILSON:** You will get the report on 5 December and then you will review it and release it.

**Senator Nash:** The reason it was December—normally the meeting is held in December, but at the previous forum meeting it was determined to hold the next meeting in January. I just want to clarify for you: we are not expecting the forum to meet in December; it will be January.

**Senator WHISH-WILSON:** Senator Nash, can you give us any of the issues that were raised as to why—

**Senator Nash:** I would prefer to get agreement from the forum before I canvas those, but I am happy to look at that for you in so far as I can.

**Senator WHISH-WILSON:** I have asked in previous estimates and the answers were basically around policing issues.

**Senator Nash:** They were. Rather than guess exactly what they were, I would rather look at those in detail for you and come back to you with some clarity around that answer.

**Senator WHISH-WILSON:** So 20 January is when the forum will meet next. Are you expect to have a deliberation by then?

**Senator Nash:** We are expecting to have the further information from FSANZ to consider at that point.

**Senator WHISH-WILSON:** You will not necessarily make a decision on 20 January?

**Senator Nash:** It will be a decision of the forum, but I can certainly indicate to you that at that point in time we will be considering the information provided to us by FSANZ.

**Senator WHISH-WILSON:** Obviously there is a real buzz around the hemp industry at the moment, particularly in Tasmania. There has been a lot of media; the state government has been talking positively about it, Senator Colbeck has been talking positively about it. Can you proceed at a state level without federal approval or does it require this forum's approval for any commercial industry to be established? I know there are limited trials at the moment, but is it absolutely necessary?

**Senator Nash:** I might defer to Mr McCutcheon for that.

**Mr McCutcheon:** Under the *Australia New Zealand Food Standards Code*, which is the primary reference document for states and territories, hemp is a prohibited substance for sale, so it is not allowed to be sold as a food.

**Senator WHISH-WILSON:** I suppose hempseed oil is only classified for food?

**Mr McCutcheon:** That is correct. Any derivatives of hempseed presented for sale as food would be non-compliant with the *Food Standards Code*.

**Senator WHISH-WILSON:** But hemp for fibres is a different matter?

**Mr McCutcheon:** That is correct.

**Senator WHISH-WILSON:** That is perfectly okay under current rules and regulations?

**Mr McCutcheon:** As far as I understand, yes. I know hemp is grown for a range of other uses.

**Senator WHISH-WILSON:** Thank you; that is all for me. Next time I look forward to getting a thumbs up.

**Senator MOORE:** This is Carol Brown's question; she just cannot be with us. It must be a Tasmanian thing.

**Senator McLUCAS:** That is TGA.

**Senator MOORE:** That is TGA, sorry.

**Senator McLUCAS:** I have a couple of questions on labelling logic. Can we have an update on the progress in preparing a response to the six recommendations of the *Labelling logic* report that was referred to FSANZ? In the shortest possible time you can, Mr McCutcheon.

**Mr McCutcheon:** FSANZ was given a total of 12 recommendations to progress. We have completed the work on recommendations 14, 15, 20, 40 and 43. Work is continuing on the other projects.

**Senator McLUCAS:** When will a final report be made available to government?

**Mr McCutcheon:** There will not be a final report per se from FSANZ. Essentially, FSANZ is addressing each of those recommendations separately and the report then goes to the Ministerial Forum on Food Regulation, not to the Australia government.

**Senator McLUCAS:** When do you expect that to be?

**Mr McCutcheon:** There is at least one that will go to the ministerial forum in early next year. There are two or three other reports that will go to the forum in mid-2015. The point I would make is that FSANZ is pretty much on track with the timetable that was given to us by the ministerial forum to respond to those particular recommendations, most of which were to provide technical evaluation.

**Senator McLUCAS:** If the committee could get a copy of that timetable, that might assist us in making some judgements about where we are up to.

**Mr McCutcheon:** Yes.

**Senator McLUCAS:** Can you update us on the technical considerations around recommendation 12, which goes to fats and sugars being separated out, in terms of the type of fat—such as palm oil versus sunflower oil?

**Mr McCutcheon:** Yes, work has commenced on that project. This is a technical evaluation and advice that we have been asked to provide to the forum. We expect to report to the forum in mid-2015.

**CHAIR:** We will move on.

[20:41]

**CHAIR:** We ask NICNAS to come forward.

**Senator RHIANNON:** I was just trying to understand how the importation of cosmetics work. Do importers and manufacturers wishing to obtain permission to use substances in cosmetic products in Australia provide information to NICNAS confirming that their specific intention is to use the substance in cosmetic product and is NICNAS subsequently able to identify and list substances used in cosmetics? Is that how it works?

**Dr Richards:** Broadly speaking, the way the NICNAS scheme operates is by differentiating between new chemicals and existing chemicals. The Australian Inventory of Chemical Substances is a list of existing chemicals and anybody can use any of those chemicals for any purpose, including for use as a cosmetic, without notification to or assessment by NICNAS. There are currently around 40,000 chemicals listed on the Australian Inventory of Chemical Substances and many of those are commonly-used cosmetic ingredients. They are not notified to NICNAS and NICNAS is not aware of the extent to which they are used.

For new industrial chemicals, which are chemicals that are not listed on the inventory, a company, an individual or a business wishing to introduce a new chemical for any industrial purpose—which includes cosmetics—does need to notify NICNAS of that. Unless exempt from assessment under the act, they need to undergo some form of assessment. For those chemicals, those are disclosed as for cosmetic use. To put this in context, last financial year a total of 5,752 new industrial chemicals were introduced into Australia for the purpose of being used in cosmetics. Of those 5,752 chemicals, 5,701 were exempt from assessment by NICNAS under the act. NICNAS was aware that they were introduced but undertook no assessment of those chemicals because under the act they are exempt from assessment. Of the remaining 51 new chemicals, only seven were subject to a full standard assessment, 11 were subject to a limited assessment, seven were polymers of low concern and 26 were low-volume chemicals. In terms of a percentage split across those different categories, 99 per cent of new industrial chemicals introduced into Australia last financial year for the purposes of use as a cosmetic were exempt from assessment. About 0.1 per cent was fully assessed with a standard assessment, about 0.2 per cent were given a limited assessment, 0.1 per cent came in as polymers of low concern and 0.5 per cent came in as low-volume chemicals.

**Senator RHIANNON:** Thank you, that is useful. Can I go to the ones that are exempt from assessment, the bulk of them. Is that because they are the same as ones that have already been tested or they are similar to ones that have been tested or both?

**Dr Richards:** Neither.

**Senator RHIANNON:** Neither?

**Dr Richards:** This includes low-volume chemicals where there is less than 100 kilograms of the chemical in total imported by that introducer into Australia in that year and, for those chemicals, the introducer has to assert that those chemicals are nonhazardous. And then it also includes exemptions for low-concentration chemicals, so chemicals that are proposed for use in a cosmetic at a concentration of less than one per cent are exempt from assessment.

**Senator RHIANNON:** How many of the approximately 40,000 substances listed in the Australian Inventory of Chemical Substances are permitted for use in cosmetic products?

And, I was interested in how many new industrial chemicals or those pending a AICS listing are currently permitted for use in cosmetic products?

**Dr Richards:** Most of the chemicals on the inventory do not specify use.

**Senator RHIANNON:** You cannot specify that, right.

**Dr Richards:** We cannot give you an answer on that. For the chemicals assessed by NICNAS last year, we issued a certificate. A certificate allows the introducer to introduce that chemical for a period of five years as the sole introducer; anyone else wishing to introduce that chemical has to come as a new chemical to NICNAS with the data necessary for the assessment. Once the assessment has been completed and the certificate has been issued, after a period of five years the chemical is added to the inventory. Where an assessment has taken place and the NICNAS assessment, for whatever reason, restricted the use of a chemical to a cosmetic—there are some chemicals on the inventory that may only be used for cosmetic purposes. But the vast majority of chemicals are not so labelled, so we would not be able to give you a number of chemicals on the AICS.

**Senator RHIANNON:** You would not be able to give the list of chemicals that can be used in cosmetics?

**Dr Richards:** No, that is right.

**Senator RHIANNON:** If a company wishes to use a substance in a cosmetic ingredient for the first time in Australia when the ingredient is already in use in a cosmetic product in the European Union, how does NICNAS assess the quantity and quality of safety data that may be required before the substance can be used in cosmetics in Australia?

**Dr Richards:** NICNAS assesses chemicals for use in Australia in accordance with the act. The act requires the introducer to supply data to NICNAS to allow the evaluation to occur. Where an introducer has marketed that chemical in other jurisdictions such as in the EU and has those data packages readily available, they submit those data packages to NICNAS, and often NICNAS receives in effect the EU chemical data package for the purposes of the assessment.

**Senator RUSTON:** You mentioned before that there were a number of reasons why a chemical would be exempt and you said that low-volume chemicals than those that had been deemed to be nonhazardous. Are there any other reasons why a chemical would have fallen into that exempt category?

**Dr Richards:** There are some other exemptions to assessment which relate to research and development and transhipment. If a chemical is only being imported into Australia for the purposes of sitting on a dock and then being exported immediately, it is not subject to assessment.

**Senator RUSTON:** Of the 99 per cent of ingredients that have come in that you are saying do not require full or limited assessment—

**Dr Richards:** Or any assessment.

**Senator RUSTON:** Why is it such a large number? Surely, they are not just transhipment and low volume?

**Dr Richards:** Those figures exclude research and development and transhipment. Those figures only include the low-volume and low-concentration exceptions.

**Senator RUSTON:** So the 99 per cent that are allowed in without any assessment are because they have already been assessed?

**Dr Richards:** No, because they meet the exemption criteria under the act.

**Senator RUSTON:** What is that exemption?

**Dr Richards:** Those exemption criteria are what we have just been discussing, that they are proposed for use in cosmetics at a concentration of less than one per cent or the total amount is less than 100 kilograms and it is a nonhazardous chemical.

**Senator RUSTON:** Sorry, I only heard you say about the quantity I did not hear you say at the one per cent level. In terms of a difference, you assess industrial chemicals as well as you assess cosmetic use—

**Dr Richards:** They are all considered industrial chemicals.

**Senator RUSTON:** Therein lies my question. There seems to be a massive discrepancy between an assessment for a face cream as opposed to something that is a toxic cleaning element that gets poured down your drain. How do you balance that?

**Dr Richards:** Some of those exemptions from assessment that I mentioned are specific to cosmetic use. The less than one per cent exemption and the less than 100 kilograms and nonhazardous exemptions apply to cosmetic ingredients. The act actually recognises and defines what a cosmetic is and recognises that chemicals that fall into those categories can be exempt from assessment. It is important also to realise two other things. One is that the way the Commonwealth's raft of legislation around chemical regulation in Australia works is that there are a number of acts of parliament that define the categorisation of chemicals. There is the Therapeutic Goods Act, which defines pharmaceuticals—chemicals for therapeutic use; we have the APVMA legislation that relates to agricultural chemicals and veterinary medicines; and we have heard about the chemicals used in foods and food additives. Industrial chemicals, under the act that I am responsible for administering, define an industrial chemical as anything else that is not those. The reason cosmetics and things like chewing gum and tattoo inks are considered industrial chemicals is because that is a decision of parliament in how the regulatory framework applies. Parliament defined industrial chemicals by exclusion. An industrial chemical is any chemical that is not one of the others.

Having said that, the second point I make is that it is important to recognise that chemicals that are used as ingredients in cosmetics are really the only chemicals that are designed to be directly applied to the body and repeatedly for lifetimes, and also are designed to be flushed into the sewer and through sewerage treatment plants into our rivers and wetlands. So to characterise cosmetic chemicals as being, therefore, inherently not a problem and not requiring assessment, which we hear sometimes, goes against comments that were made at a conference today in Sydney by the ACCC, which talked about the large proportion of complaints about injury from chemicals being from cosmetic chemicals. On the other hand, most chemicals used for what most people would characterise as industrial processes, like use in factories and for manufacturing polymers and plastics and things, are actually usually used under highly controlled conditions for which exposure to workers and exposure to the general public is minimised under quite strict workplace controls. One could see the legitimate argument for the need for assessment of all of those chemicals, but it is a matter for parliament to determine under what regulatory arrangement each of those occurs. Currently,

under the act as it stands, which is what I am responsible for administering, industrial chemicals are defined as not therapeutic, not agvet and not food.

**Senator RUSTON:** I think you are heading down a track that I was not actually necessarily going down; I was just trying to define the fact that they are two quite separate groups because their uses are quite different. In the 0.1 per cent of those that were imported last year that you said required a full assessment, how many of those would have required testing on animals?

**Dr Richards:** The 0.1 per cent was actually seven individual chemical assessments. The Industrial Chemicals (Notification and Assessment) Act 1989, which is the legislation that we are talking about, has a schedule to the legislation which defines the tests and type of data that are required to be submitted. Australia, as a member of the OECD, accepts test data generated according to OECD test guidelines. The act, as I explained at the last estimates, also allows an introducer of a chemical to apply for a variation to the schedule's data requirements and say: we do not have data on that, can we use these sort of data instead, and they are often not OECD guideline compliant. Of those seven, to answer your question, three came with the complete set of toxicology data in relation to that particular chemical, the other four came with some of those data and other data related to analog chemicals or in-vitro tests, or in-silico modelling.

**Senator RUSTON:** Of those seven, three and four, can you tell us whether they were intended entirely for cosmetic use?

**Dr Richards:** These were chemicals that were submitted for use as cosmetics.

**Senator RUSTON:** Seven of them were for cosmetics.

**Dr Richards:** When an introducer notifies a chemical to NICNAS for assessment, it is in relation to a particular use. They propose the use and we assess it in relation to that use and if the use is only cosmetic, when a certificate is issued and ultimately when it goes on the inventory, it is usually restricted for cosmetic purposes.

**CHAIR:** I thank the witnesses. I now call the TGA to the table.

**Therapeutic Goods Administration**

[20:58]

**Senator MOORE:** I have questions cannot around the medical cannabis issue. Has the TGA received applications from any sponsors for cannabis, or cannabinoids, to be approved for the Australian Register of Therapeutic Goods?

**Prof. Skerritt:** There is a long-standing practice for 'commercial-in-confidence reasons' that we do not disclose the name or nature of medicine applications to us.

**Senator MOORE:** I do not want to know any names, I just want to know if any applications have been made.

**Prof. Skerritt:** Similarly, we do not confirm or deny around particular products.

**Senator MOORE:** Have any cannabinoids been included on the ARTG?

**Prof. Skerritt:** If you include the product Nabiximols, which is Sativex, it is included on the ARTG and it is and it is indicated for spasticity in multiple sclerosis that is resistant to drugs such as baclofen.

**Senator MOORE:** At this stage the only one approved is for MS?

**Prof. Skerritt:** That is the only indication that has been approved in Australia for that drug.

**Senator MOORE:** Has the TGA reviewed an application to extend the approved uses of Sativex?

**Prof. Skerritt:** We do not describe for commercial reasons whether applications for extension of indications have been received. That has been long-standing practice since our establishment.

**Senator MOORE:** Has the TGA been asked to provide advice to government on therapeutic claims for medical cannabis?

**Prof. Skerritt:** We have been asked to provide advice to government and indeed also to opposition and crossbench senators and members on regulatory options.

**Senator MOORE:** In what period has that been?

**Prof. Skerritt:** The first request came through Senator Nash's office in June this year, if my memory serves me right, and we addressed senators and members from several parties.

**Senator MOORE:** I was there. Before that time you had not been asked for advice on this issue?

**Prof. Skerritt:** No we had not been. It has really only bubbled to the surface 'as everyone realised' in the last four or five months.

**Senator MOORE:** There has been an increased public interest in a lot of media. What steps would need to be taken if a person wanted to use cannabis as a medical product?

**Prof. Skerritt:** For clarification, are you talking about raw leaf cannabis?

**Senator MOORE:** I would think anything that was of a cannabis base because of the nature of the process.

**Prof. Skerritt:** It varies very much depending on the nature of the product and depends on what is known as the scheduling of the product. Some cannabinoids have been scheduled to schedule 8, the same sort of schedule that is used for medicines like morphine and so forth. Others are in the prohibited schedule, schedule 9. For example, raw leaf cannabis is in schedule 9, which is the prohibited schedule, whereas the medicine I mentioned called nabiximol—Sativex—is in schedule 8, as are another medicine called dronabinol and another one called nabilone.

**Senator MOORE:** And they all have the same base?

**Prof. Skerritt:** They are slightly different. Some of them are synthetic. Some of them have been modified for what is in the natural cannabis. Others are exactly the same as a pure THC, the major psychoactive component of cannabis.

**Senator MOORE:** Are you aware of any clinical research that supports the need for there to be a separate body to regulate supply, distribution and access to medical cannabis?

**Prof. Skerritt:** It is not actually the clinical research that has led to a separate body. This comes from the agreement we have with the International Narcotics Control Board. Back in 1961 countries agreed to establish a separate agency, although that does not mean it has to be a statutory authority; it can be part of a department and a very small team.

**Senator MOORE:** But separately identified.

**Prof. Skerritt:** Separately identified.

**Senator MOORE:** And it was a long time ago.

**Prof. Skerritt:** We are often subject to treaties that were established in very different times.

**Senator MOORE:** Thank you. Those are my questions.

**CHAIR:** We have come to our 30 minutes, so is someone proposing that we extend?

**Senator McLUCAS:** Yes.

**CHAIR:** Okay. Senator McLucas.

**Senator McLUCAS:** I want to talk about the proposal by government for the TGA to accept approvals under USFDA or the EMA for implantable devices.

**Prof. Skerritt:** The announcement relates to acceptance of European conformity assessment, which is one process to evaluate the performance of medical devices. It is done by organisations in Europe known as notified bodies, which are actually independent of government, rather than the European Medicines Agency. This proposal has been around for some time. It was actually publicly consulted on earlier, and there was quite strong support for it. There were some concerns in some areas of the medical fraternity, but we believe they have been addressed. This proposal enables Australian manufacturers of medical devices to have the same conditions apply to them as a manufacturer of a medical device anywhere in the world. We had this anomaly where devices manufactured in Australia were subject to different approval processes just because they were manufactured in Australia and not in Canada, the US or Europe. Now a manufacturer, irrespective of the country of manufacture, can choose the pathway they want in having this conformity assessment evaluation done.

**Senator McLUCAS:** My understanding, though, is that the government has announced that medical devices will be approved for use in Australia if they have been approved in the EU. Is that accurate?

**Prof. Skerritt:** No, the announcement is not that there will be an automatic approval. But what acceptance of the European conformity assessment, if a company chooses to go that way, is it will significantly speed the path to market because of the resources and the approach that conformity assessment bodies there can apply.

**Senator McLUCAS:** We are not just talking about Australian manufactured devices; we are talking about devices to be imported into Australia as well?

**Prof. Skerritt:** Any device that is imported into Australia has had the ability to go through European conformity assessment for many years, ever since the device regulatory framework was set up. What this change does—and it has not come through yet because the regulations have to be changed—is actually put Australian devices, whether they are manufactured here or imported, on a level footing. Because before this time, actually imports had the upper end, if you can have an upper end of a non-level playing field, they had the advantage as far as choice of regulatory pathways over devices manufactured in Australia. We did not have a level playing field.

**Senator McLUCAS:** That is logical though. So an Australian manufactured device, if they had gone through the pathway of being registered in the EU, irrespective of the country

of manufacture, could they be recognised in the same way that a European manufactured device would be able to be registered?

**Prof. Skerritt:** If a device is manufactured in Europe or a device is manufactured in Australia, it can be treated the same way if the manufacturers choose to take it to a European notified body for conformity assessment. It then does come to TGA for further checks. This is not a rubber stamping, but it is significantly accelerating the pathway.

**Senator McLUCAS:** The policy intent is to equalise the attention given by TGA to Australian versus European manufactured products; is that the total policy intent?

**Prof. Skerritt:** The total policy intent is to treat devices based on their risks and benefits in their assessment rather than having a non-level playing field and treating the Australian devices differently from devices from anywhere else in the world.

**Senator Nash:** If it assists, the Australian manufacturers basically had to duplicate the process compared to the overseas body. It has just basically put them on the same footing with the Europeans. It has take a step out, if you like, that they were required to do and the overseas competitors were not, so it has put them all on a level playing field now. But we are still absolutely focused on making sure that we have the safety and that there are still the oversight requirements from the TGA.

**Prof. Skerritt:** I would add that this excludes the very highest risk devices. If a device, for example, has a medicine in it or a biological component from an animal or a human, or something or other in it, it is not subject to this pathway.

**Senator McLUCAS:** In the event that a European regulator removes or recalls a device on the basis of safety or efficacy, how would that be treated in Australia under the proposal?

**Prof. Skerritt:** Regulators worldwide have a very strong network of both public and confidential communication on product safety issues. It is a common thing to come into work at eight o'clock in the morning and receive these, because they come through during European working hours. We immediately look at what the issues are and our time frame and nature of action depend on the severity of what has been found overseas—the nature of the problems.

**Senator McLUCAS:** It is still not perfectly clear. Irrespective of the country of origin—put that to one side—under the proposal, a device that has been approved by a notified body in Europe would then get an almost automatic approval into Australia?

**Prof. Skerritt:** It is not almost automatic. Again, it depends on the risk of the devices. You can imagine that devices vary hugely between, say, a bandaid, which is also a medical device, and an implanted pacemaker. There are essentially four classifications of device, including several subclassifications, so that is quite a gradation of risk. The higher-risk products are still chosen if there are questions around them, for audit and further assessment here in Australia. This is not a rubber-stamping process.

**Senator McLUCAS:** But for those lower risk—I am not saying low risk, but lower risk—approved devices in the EU, they will get a somewhat automatic approval in Australia.

**Prof. Skerritt:** For the lower-risks devices—

**Senator McLUCAS:** These would include implantable devices?

**Prof. Skerritt:** No, implantable devices range—they are usually what we call either class IIb or class III—and many of those devices are selected for further audit examination. But

having had the European notified body pathway to do what is known as the first step of the process—the conformity assessment—it actually does overall speed it up. But there is still this scrutiny on the higher-risk implantable devices.

**Senator McLUCAS:** What about a hip? They are pretty standard, off-the-shelf.

**Prof. Skerritt:** Hips were upclassified from class IIb—full-hip replacements—to class III. As a result, for example, the clinical evidence summary and so forth now has to be looked at. TGA retain a team of in-house clinicians as well as engineers and others who review that evidence.

**Senator McLUCAS:** I am very aware of time. Under the proposal, a pretty standard hip—

**Prof. Skerritt:** There will still be that scrutiny—whether it is a European-made hip, an American-made hip or an Australian-made hip.

**Senator McLUCAS:** The same scrutiny as previously?

**Prof. Skerritt:** For the higher-risk products, yes. I will not mention company names, but there is one particular significant company in Australia that makes hips and they were at a competitive disadvantage because they were forced to go down one regulatory pathway, and they did not have the choice. However, for example, hips from a number of the major US companies—I am actually going to be visiting a hip manufacturer from the US based in St Leonards tomorrow—are at a competitive advantage—

**Senator McLUCAS:** A terrific life, Professor.

**Prof. Skerritt:** It is an interesting life looking at hips, Senator.

**Senator McLUCAS:** I might leave it there. Thank you.

**Prof. Skerritt:** Thank you.

**CHAIR:** Just a quick follow-up on the implantable devices—I am aware that in Western Australia they have these naltrexone implants. Are these regulatory changes going to affect the regulatory regime on that at all?

**Prof. Skerritt:** No. The naltrexone implants are not approved, they are not on our register of therapeutic goods—they come through our special access scheme. They are treated separately in a regulatory sense.

**CHAIR:** So, this will not change their arrangements?

**Prof. Skerritt:** No, it will not change their treatment.

**CHAIR:** Thank you. That might be an opportune time to suspend. So we will finish up with Outcome 7. We will come back in 10 minutes from now, at about 9.22 pm, for Outcome 8.

**Proceedings suspended from 21:13 to 21:23**

**Department of Health**

**CHAIR:** We did have a line of questioning for Health Infrastructure, so we will very briefly deal with that before moving onto outcome 8.

**Senator PERIS:** At the last estimates we were talking about the Palmerston hospital in Darwin. In May it was announced that an expression of interest would go out for the hospital in July. Do you know if that happened?

**Ms Anderson:** We have been advised by the Northern Territory government—I think they have put a media release out—indicating that that expression of interest has been issued.

**Senator PERIS:** I think that media release was issued in August. The Northern Territory government also promised that a master plan of the hospital would be released to the public. Has that happened?

**Ms Anderson:** My understanding is that that is still under development.

**Senator PERIS:** When one does come into fruition, will that be made available to the public?

**Ms Anderson:** Certainly that is my understanding of the intention of the Territory government.

**Senator PERIS:** Are you aware of any preliminary draft master plan at all being presented to the government?

**Ms Anderson:** We, in the Commonwealth government, have not received that as far as I am aware. I will certainly correct that if that is wrong.

**Senator PERIS:** That it is incorrect?

**Ms Anderson:** No. What I am saying is that I do not believe we have received any early drafts. I am happy to correct that if I am wrong, but that is my understanding.

**Senator PERIS:** So, if the NT government has received a preliminary draft, it is that something you could find out?

**Ms Anderson:** We would not necessarily know about that. That would be a matter for them.

**Senator PERIS:** I guess a question would be: do you think it would make more sense to have a master plan developed before an expression of interest?

**Ms Anderson:** The Northern Territory government has to run this construction project the way it is going to work for them. We do not presume to step in and make decisions for them. They have a project plan. We have a funding agreement with them. Their obligation is to meet the milestones on which they get paid. The way in which they run the details of the project really are a matter for them.

**Senator PERIS:** At the last estimates, in June, it was outlined that the Commonwealth would be spending $55 million on the Palmerston hospital this financial year 2014-15, subject to the construction milestones as negotiated and agreed between the two governments. Have these milestones been achieved so far and, if so, are you able to table those milestones?

**Ms Anderson:** My advice is that we have paid the Northern Territory government $1 million to date, and they delivered a project plan which was the milestone they had to achieve in order to get those funds. No other funding has been provided yet which indicates that the subsequent milestones have not yet been reached.

**Senator PERIS:** Are you able to table the agreed milestones? What you are expecting for your $46 million? Are you able to table those? Are they for the public?

**Ms Anderson:** Yes, I believe we could make those available. We have milestones and I think we could probably make those available to you. I have just been advised that the report in relation to the next milestone is in relation to site services commencing. That report is due

in November and, subject to achievement of that milestone, there will be a further payment made. We do not yet know whether they have done that, as obviously we have not reached November.

**Senator PERIS:** You are saying that you had $55 million on the table for milestones being achieved between 2014 and 2015. Given that we have also seen press releases that the construction of the hospital is now not actually due to start until 2016, how much money do you now anticipate will be provided of the $55 million this financial year?

**Ms Anderson:** In terms of the funding agreement that we have negotiated with the Northern Territory government it remains the case that there is $55 million available to them in 2014-15 subject to achievement of milestones. I have already mentioned the first milestone which is the project plan. That has been delivered and $1 million has been paid. The second milestone has already been mentioned as well. That is the November 2014 one which is the commencement of site services. The final milestone for this financial year is a commencement of construction. That milestone has been scheduled for May 2015. If that is not reached, and we would await the advice of the Northern Territory government in that regard, then that payment would not be able to be made.

**Senator PERIS:** If milestones are not achieved for that $55 million, I just want to make it clear, then money be taken off the table?

**Ms Anderson:** Then the funding, which has been agreed for that milestone, will be held back until the milestone is achieved.

**Senator PERIS:** Okay. But you are expecting everything to be done.

**Ms Anderson:** We are in their hands.

**Senator PERIS:** Thank you.

[21:28]

**CHAIR:** We will now move on to outcome 8. We have allocated 20 minutes for outcome 8.

**Senator McLUCAS:** Can we go to medical internships, please. Thank you for the answer to the question on notice which said that there were 225 international full-fee-paying medical graduates last year. Can I get an understanding of where they are and then what the plan for this cohort of graduating students is and where they will be placed for their internship?

**Ms Shakespeare:** Sorry, could you just repeat the number?

**Senator McLUCAS:** There would 225, I understand. That was last year's international full-fee-paying graduates.

**Ms Shakespeare:** That was the number of interns, which was found in a survey conducted by HETI, who are managed the intern data matching process in 2013 and again this year. As at 18 November that many students were still on their, I suppose, application list as not having been placed. Subsequent to that there was a survey completed in January 2014, and 44 of those 225 had accepted an internship position after that. That is the state of intern positions. Others had applied overseas and seven had accepted an offer overseas. So it is not necessarily the case that that was the number of international medical graduates who did not get internships.

**Senator McLUCAS:** No, I did not mean that.

**Ms Shakespeare:** Other than that, we do not really have any information to give you about where those people are now.

**Senator McLUCAS:** How many international full-fee-paying graduates do we expect to graduate at the end of this current year?

**Ms Flanagan:** We, as you know, have a program for a specified number of interns that we place in the private sector. We do get this information, because we basically work with the states and territories, but it is really information collected from the states and territories by HETI, an organisation in New South Wales. We can approach HETI, but it is not something that we collect on a routine basis.

**Senator McLUCAS:** Was Health Workforce Australia doing that work?

**Ms Flanagan:** No, I think HETI was charged by all states and territories to collect the information.

**Senator McLUCAS:** That is just on the international full-fee-paying, or all?

**Ms Flanagan:** All graduates. They were trying to manage all placements right across Australia.

**Ms Shakespeare:** It would be a little difficult to give you numbers of international graduates at this point because people are still completing their studies for this year.

**Senator McLUCAS:** Let's hope that most of them graduate.

**Ms Shakespeare:** We know that a number do not pass their final exams each year, and it varies each year.

**Senator McLUCAS:** Rule of thumb, you would get it pretty close, I dare say. You are aware that AMSA, the Australian Medical Students' Association, are saying that 240 Australian medical graduates will not be offered a state or territory internship position for next year. Are you aware of that, Ms Shakespeare?

**Ms Shakespeare:** The number that AMSA have provided to you comes from a survey from the same organisation, HETI, that is doing the intern matching across all the states and territories this year. That, I suppose, represents an earlier survey in the process from the 225 figure that you mentioned before which was in November of last year. The 240 figure relates to the last survey done which would have been last month. There are still a number of unfilled state and territory internship places. The Commonwealth is still conducting the application assessment process for the Commonwealth medical internships for next year. That number will change and, of course, it does not take into account failures to complete courses, people that may decide to apply for internships overseas, and a number of other factors.

**Senator McLUCAS:** I am ready from my notes here, which say that AMSA is saying there are 240 Australian medical graduates. They are not talking about international full-fee-paying students; they are talking about Australians.

**Ms Shakespeare:** That is not my understanding.

**Senator McLUCAS:** That is not your understanding?

**Ms Shakespeare:** Absolutely not. We have been assured that, this year, all Australian medical graduates will receive an internship offer or have already accepted one.

**Senator Nash:** Senator, if it assists,—and you may already know this but other senators may not—the states and territories are responsible for the intern placements for the domestic students, and it is the international students that the government has created the extra $40 million for, for up to 100 places specifically for those international students, recognising the need at the last election and in the budget.

**Senator McLUCAS:** So, there are up to 100 places. I understand that AMSA is saying that there will still be some international graduates who do not get an internship, even outside of that contribution, Minister.

**Ms Flanagan:** The question is whether the international students are going to stay and work in Australia. If they have an internship, and this happens with many of them, we lose them. We have had them as students. We would like them to stay and work in Australia but a number of them do their internships and immediately leave Australia and we do not get any value, so to speak, out of them in terms of being able to keep them in our workforce. One of the reasons why we have a return of service on the internships that we offer is to exactly ensure that the investment—up to $100,000 I think it is—in a student is actually realised in our health system by having those students continue to work in Australia.

**Senator McLUCAS:** So what data do we have on the number of people who would do an internship in Australia and then depart?

**Ms Flanagan:** We can see whether we can get this for you. There is certainly anecdotal evidence. For example, the internship year for Canadian students—and we have talked to AMSA about this and they recognise that it is a problem—does not in fact start until March so they will take up an internship place here and leave some months into the internship, so that place could have been taken by somebody else. I also understand that Singapore students often need to go back to their country too. There are a number of cases like that. We can see whether HETI does keep figures, but certainly my state and territory colleagues get quite frustrated when that sort of thing occurs and they lose an intern halfway through an intern year.

**Senator McLUCAS:** Sure. You are talking anecdotally and so am I. The anecdotes that were given to me by AMSA say that, if they do their internship in Australia, the likelihood of them staying in Australia is very high. We are both talking about anecdotes so we probably need to get some data.

**Ms Flanagan:** We will see whether we can get some information.

**Ms Shakespeare:** I do have some data. The survey in 2014 by HETI relating to graduates that were placed in 2014 indicated that 19 interns did not commence or resigned after commencement of their internship. That does not include those who resigned from the Commonwealth program as well. There were an additional four.

**Senator McLUCAS:** Out of how many?

**Ms Shakespeare:** That was the 76.

**Senator McLUCAS:** So 19 plus four out of the 76 who were placed out of the—

**Ms Shakespeare:** No, four from the 76 Commonwealth internships.

**Senator McLUCAS:** So 19 out of 76 did not—

**Ms Shakespeare:** No. Four out of 76.

**Ms Flanagan:** The 19 is out of the states and territories. What we need to look at is the number of overseas students—

**Senator McLUCAS:** That is quite a large number of though, isn't it?

**Ms Shakespeare:** I think it is about 200-odd. We have a large cohort of domestic students, so what we would be looking at is the number of Australian trained international students and looking at the attrition rate from that group.

**Senator McLUCAS:** Can I get that question answered on notice then?

**Ms Flanagan:** We will do that.

**Senator McLUCAS:** So 19 out of how many and four out of how many.

**Ms Flanagan:** Four out of 76.

**Senator McLUCAS:** So four out of 76 did not complete?

**Ms Flanagan:** That is our particular program.

**Senator McLUCAS:** That is pretty good. We did not lose many.

**Ms Flanagan:** It is such a huge investment.

**Senator McLUCAS:** I daresay, but it is not a huge attrition rate.

**Ms Flanagan:** And we have got return of service on ours, which hopefully means that if they do sign up they do intend to stay.

**Senator McLUCAS:** What is the status of the PGPPP at the moment?

**Ms Shakespeare:** PGPPP continues to operate until the end of the current calendar year, 2014. After that it will cease. However, there are some PGPPP placements that start in 2014 that will be allowed to continue until completion in early 2015.

**Senator McLUCAS:** And its policy intent was what?

**Ms Shakespeare:** PGPPP was originally established to encourage junior doctors employed in hospitals, those working largely in public hospitals, to consider taking up general practice as a vocational training career. It provides people with a supervised placement in general practice for an average period of 12 weeks.

**Senator McLUCAS:** What is the rationale for closing that program?

**Senator Nash:** Maybe I can assist there. I think the original intent of the PGPPP—what Ms Shakespeare was saying—was to encourage those junior doctors to look towards taking up a career in general practice. By and large over the years that very much happened, so that particular policy intent from the beginning really had been met. The other reason was that it was incredibly expensive. It was around $60,000, I think, from memory—and I will come back and correct that if it is not right—but I am sure that is nearly the figure, around $60,000 for the 12 weeks. When you compare that to the GP vocational training placement which is almost about the same amount, around $60,000 for 12 months, it was an extremely expensive program. Having looked at that and that fact that the original policy intent of encouraging that look to taking up GP as a career, was actually being met that is what led to the government decision.

**Senator McLUCAS:** So being met by the—

**Senator Nash:** By the number of junior doctors who were moving towards GP as their career—

**Senator McLUCAS:** So we have got enough doctors—

**Senator Nash:** No we have not got enough, Senator. I am not saying we have enough and you know that I would never say that. What I am saying is the move towards GP careers increased significantly over that period of time, coupled with the significant expense from that particular program, and led to the government decision.

**Senator McLUCAS:** The problem is not fixed, Minister.

**Ms Flanagan:** To add to that, the other piece was that we were seriously oversubscribed for GP training places. As a student goes through, they need to do various parts of their training. With the cohort going through it was seen, because we had an oversubscription for in effect the final part of training, that it would be worthwhile increasing the number of training places so that we could actually work the pipeline of students going through. I think Ms Shakespeare can give you the figures, but I think we have created another 300.

**Ms Shakespeare:** That is right. The funding for the PGPPP program is being redirected into the Australian General Practice Training program to create an additional 300 vocational general practice training placements. That is sensible when demand is so high. Current figures indicate that 800 eligible applicants will miss out on general practice training placements this year.

**Senator McLUCAS:** What proportion of those have to be in regional areas?

**Ms Shakespeare:** Over 50 per cent.

**Senator Nash:** I was just going to add—I think Ms Shakespeare might be able to help me—I think it is already at 65 per cent of those rural and regional, but I will come back to you with the correct figure.

**Senator McLUCAS:** I understand that is from PGPPP?

**Senator Nash:** No. That is the current GP vocational with the ones they have done already—as I understand it.

**Ms Shakespeare:** The vocational training places are still being allocated so we do not have a final figure, but certainly more than 50 per cent will be in RA2-5 areas once the allocation of places is completed in November.

**Senator McLUCAS:** My understanding is the 65 per cent refers to the PGPPP places that were in regional, rural and remote areas rather than the GP training program training places.

**Ms Shakespeare:** Around 65 per cent of PGPPP places were in RA2-5 areas. However, the first cut of AGPT training places, the additional places, was a similar sort of figure.

**Senator McLUCAS:** Alright. Good. Thank you for your evidence to us today.

**CHAIR:** We have finished outcome 8. We will move onto outcome 6: Private Health.

[21:44]

**Senator McLUCAS:** When does the department expect to receive proposals from private health insurers for the next round of premium settings?

**Dr Bartlett:** The premium round timings are being finalised at the moment. We would expect to be notifying insurers of those sorts of things within the next couple of weeks, but it will be very similar to last year.

**Senator McLUCAS:** Right.

**Dr Bartlett:** The timetable will be released—

**Senator McLUCAS:** Is that a timetable set by the department?

**Dr Bartlett:** It is set by the department. Sorry, it is recommended by the department and approved by the minister.

**Senator McLUCAS:** And undertaken by?

**Dr Bartlett:** The analysis of applications for increase is done by the Private Health Insurance Administration Council.

**Senator McLUCAS:** Has any work been undertaken on how it might be done differently?

**Dr Bartlett:** There has been a fair amount of work done on the premium round over the last three or four years. There have been a number of changes made which have been designed to streamline the process. There is an ongoing interest in continuing to do that. There have been discussions with the sector on a number of occasions seeking to ascertain their views about ways in which that could be done. I can think of at least three in the last three years, as informal consultations, plus any number of other conversations.

**Senator McLUCAS:** And there are current conversations occurring around how we might be able to do this differently?

**Dr Bartlett:** There have been discussions about this process. Clearly at the moment we are focused on the premium round that is due to occur in the next little while. It will be a process very similar to last year's process. Any discussions about future changes will obviously occur after this one is finished.

**Senator McLUCAS:** Can you talk to me about a price monitoring scheme. How would that work?

**Dr Bartlett:** I am not quite sure. You would have to give me a bit more information.

**Senator McLUCAS:** I understand that the Harper review into competition policy noted:

… price regulation of premiums could be replaced with a price monitoring scheme and health funds could be allowed to expand their coverage to primary care settings.

Leaving the second bit to one side, how would a price monitoring scheme work?

**Mr Learmonth:** I think if Professor Harper had a model in mind he would be best placed to answer that one.

**Senator McLUCAS:** I dare say you have done some analysis of the recommendation—or the commentary. I do not know that it is a recommendation.

**Mr Learmonth:** No.

**Dr Bartlett:** No.

**Senator McLUCAS:** You did not do any work or anything? Okay. Let us go back to the current round. You set the timetable. How do you publish that?

**Dr Bartlett:** Our private health insurance circular will go out to tell people what the time frames will be. In fact I think the Private Health Insurance Administration Council will publish it.

**Senator McLUCAS:** PHIAC publishes it?

**Dr Bartlett:** Yes.

**Senator McLUCAS:** And then they receive applications from the insurers. Then at the moment they currently recommend—

**Dr Bartlett:** They provide advice to the minister.

**Senator McLUCAS:** advice to the minister.

**Dr Bartlett:** And the minister essentially under the legislation is obliged to approve the increases that are sought unless he forms the view that they are not in the public interest.

**Senator McLUCAS:** And last year the minister very quickly formed the view that they were in the public interest?

**Dr Bartlett:** The minister formed the view that they were in the public interest. I cannot comment on whether it was quickly or not.

**Senator McLUCAS:** But it did not take very long. A couple of weeks or even less, I understand.

**Dr Bartlett:** That is not my recollection.

**Senator McLUCAS:** So what time of the year do you usually get the report from PHIAC?

**Dr Bartlett:** The applications come in early to mid-November. PHIAC does its assessment of them. It provides advice to the minister. It can provide it at once; it can provide it in stages. As I understand it, it provided advice to the minister across a significant part of December last year.

**Senator McLUCAS:** You do not have to defend it.

**Dr Bartlett:** No, that is just my recollection of the way in which the process worked.

**Senator McLUCAS:** When were the insurance increases announced?

**Dr Bartlett:** 23 December, if I recollect.

**Senator McLUCAS:** It was a couple of weeks, wasn't it? How long was the previous one the previous year? My recollection is some months—maybe three months.

**Dr Bartlett:** The previous year, from memory, the increases were announced on 6 or 7 February.

**Senator McLUCAS:** I thought it was March.

**Dr Bartlett:** No, I think it was February.

**Senator McLUCAS:** You are probably better informed than me.

**Dr Bartlett:** I will check that, but I am pretty sure it was early February.

**Senator McLUCAS:** I do not have any more questions around PHI.

**Senator DI NATALE:** Do you have any update on the progress of the Medibank Private trial?

**Dr Bartlett:** No more than the media reports that I have seen where Medibank are saying it is very successful, as I assume you have seen. I certainly have not received any update from them myself.

**Senator DI NATALE:** Do we know about whether the GP access trial is now operating beyond Brisbane?

**Dr Bartlett:** I do not know.

**Senator DI NATALE:** Are you keeping tabs on it at all?

**Dr Bartlett:** I am not keeping tabs on it personally. I am relying on people in the private health insurance branch to keep tabs on it, and they would obviously let us know if there were areas of concern. I have not heard of any.

[21:51]

**CHAIR:** If there are no further questions for private health, we will move on to outcome 1: Population Health.

**Senator SMITH:** My question refers to the Communicable Disease Prevention and Service Improvements Grants Fund. Am I in the right place?

**Mr Smyth:** It is outcome 9. We may not have them here.

**Mr Bowles:** We may not have anybody here. We brought that one on a bit earlier.

**Senator SMITH:** Sorry, I missed that.

**Mr Bowles:** We have had that one. It was in biosecurity when we were talking about Ebola.

**Senator SMITH:** My apologies for that. They are technical in nature, so I will put them on notice.

**CHAIR:** I had a brief question around Hello Sunday Morning and some of the recent announcements for that in terms of support. Is that here?

**Mr Smyth:** Yes.

**CHAIR:** I note that Minister Dutton announced $1.1 million to help Hello Sunday Morning. Are you able to give us a bit of an update on how you expect that money will help people who might have a negative relationship with alcohol?

**Mr Smyth:** Hello Sunday Morning were funded $1, 076, 000, which is GST inclusive, for 2014-15 for their online alcohol reduction program. The funding for that agreement was executed on 16 October, and it is really around enabling them to put evidence based practices online to assist people to overcome potential episodes of binge drinking and to lower their alcohol risk profile.

**CHAIR:** What kind of assistance—what kinds of things—will go online as a result of this assistance from the Commonwealth?

**Mr Smyth:** There will be key messaging that Hello Sunday Morning and those people who sign up for Hello Sunday Morning as a program will receive. They will receive notifications via SMS, online updates and the like that will continue to encourage them to adopt healthier drinking.

**CHAIR:** Is it similar to those sorts of anti-smoking measures, where it is that constant encouragement for people who are doing their best to cut down on their alcohol consumption?

**Mr Smyth:** That is correct.

**CHAIR:** That sort of thing. Do we know what this represents in terms of how much funding or revenue Hello Sunday Morning gets from other sources?

**Mr Smyth:** I do not have that detail, but I could take it on notice and see if that information is publicly available.

**CHAIR:** Thank you.

**Senator BILYK:** I want to ask about palliative care. Do we have the right people?

**Mr Smyth:** Yes.

**Senator BILYK:** I am aware of the time so as long as I can get the answers in a succinct way I am quite happy! What is the Commonwealth's role in the funding of palliative care?

**Mr Smyth:** The states and territories are service providers for palliative care. They are responsible for the delivery of palliative care services. We provide financial assistance through our hospital agreements and the like for palliative care services. We also provide funding for a range of national palliative care projects, which focus really around education, training, quality improvement—

**Senator BILYK:** I do have some questions about national palliative care projects a bit later, so I was a sort of aware of that.

**Mr Smyth:** Right, yes.

**Senator BILYK:** And I do understand that there is a breakdown with the states. So, hospitals?

**Mr Smyth:** There is funding through the healthcare agreements, obviously, that will go for the purpose of palliative care funding. But, generally, we have a 10 national programs that we actually fund. They go, as I said, to data, quality improvement, training and education and core curriculum for undergraduates and the like. There are a number of programs around experience of palliative care for GPs and the like and nurses. So there is a wide range of programs that effectively also consist of training for people—for instance, in Tasmania—for community related palliative care service delivery as well.

**Senator BILYK:** Yes, great. Is it correct to say that palliative care is provided through subacute beds in hospitals?

**Mr Smyth:** I would have to get my colleague, Ms Anderson, to talk to that.

**Ms Anderson:** The short answer is 'yes'. Typically, a palliative care service in a hospital is coded as a subacute service.

**Senator BILYK:** Can you tell me how they are funded, generally? What is the Commonwealth role in actually funding them?

**Ms Anderson:** If the money is channelled into hospitals then we have no visibility of the way that the jurisdiction, the local hospital network or, indeed, the hospital itself will use it. That is a choice that is made locally, typically by the hospital in their allocation of beds to patients.

**Senator BILYK:** What was the impact of the budget on the level of hospital funding which states understood they would receive with regard to this?

**Ms Anderson:** We do not have visibility of the way the funding flows through to particular services. So we—

**Senator BILYK:** So it is part of an overall package?

**Ms Anderson:** It is.

**Senator BILYK:** Okay. It is not a separate line item, or—

**Ms Anderson:** No. It is allocated as part of the National Health Reform funding to public hospital services.

**Senator BILYK:** When funding is cut to the hospitals do we expect there to be an impact on palliative care services then?

**Ms Anderson:** Not necessarily. Again, that would be a matter for individual hospitals and local hospital networks. They are in charge of identifying local priority needs and the best way of addressing those within the resources they have available to them.

**Ms Flanagan:** Earlier on today, in acute care, we actually gave figures for the increases in hospital funding over the forward estimates to public hospitals. This talk of cuts and—

**Senator BILYK:** I am more concerned about what will happen to patients when palliative care facilities are not available. It is of great concern to me. It is an area I have had an interest in for many years, and I am very concerned that if there are not appropriate palliative care facilities because there is not enough funding, what happens to the patients? Do you reckon there is any sort of risk that the Commonwealth might need to step in and provide additional funding if there are not enough palliative care beds?

**Ms Anderson:** Again, we are not well placed at this distance to judge local need. The states and territories have been very insistent on taking on the role of system manager for public hospital services. We respect that and, by and large, they are far better placed to assess local need and to respond to it. They make decisions weekly, monthly, yearly about the different priorities, the impact on the system and the way it is best to respond to those priorities. That is their job.

**Senator BILYK:** Okay. I will be keeping a close eye on it, and I am now a member of this committee, so I will be keeping an eye on it and probably talking about it next estimates. I did want to go quickly to the national palliative care projects that were mentioned before. I understand that there were applications for new funding for national palliative care projects and they closed on 6 August. Is that correct?

**Mr Smyth:** I am not sure of the actual date that they closed, Senator. They were announced on 30 May; I am not sure when the applications closed, but they are all in. We received 67 applications for the areas that were notified under funding.

**Senator BILYK:** Are you able to give us some general information on the projects and what they are designed for?

**Mr Smyth:** Are you after what applications were received or the areas?

**Senator BILYK:** The areas.

**Mr Smyth:** Those are the areas that I mentioned to you earlier that go to education, training, quality improvement, information availability and the like.

**Senator BILYK:** Are the projects generally nationwide, statewide or more local in nature?

**Mr Smyth:** National.

**Senator BILYK:** With regard to the applications—67, you said?

**Mr Smyth:** That is correct.

**Senator BILYK:** Have they been assessed?

**Mr Smyth:** That process is currently ongoing.

**Senator BILYK:** How much were these applications worth?

**Mr Smyth:** The funding allocated over three years from 2014-15 is $52 million.

**Senator BILYK:** What is the assessment criteria for funding for these projects?

**Mr Smyth:** It would depend on the area of priority and the application that was lodged as to the particular criteria that were applied—

**Senator BILYK:** On the area of priority—geographical, you mean?

**Mr Smyth:** There were areas that were needed to be addressed through the application process, and applications would be assessed against those criteria.

**Senator BILYK:** Are you able, maybe on notice, to give the committee a copy of those assessment criteria?

**Mr Smyth:** I will take that on notice.

**Senator BILYK:** As part of the assessment project, does the minister's office get consulted before funding is finalised, or does the department solely do it?

**Mr Smyth:** The decision to approve the projects is Senator Nash's decision.

**Senator BILYK:** Has the minister's office been provided with a breakdown of the applications on a geographical basis?

**Mr Smyth:** My understanding is not at this point in time. They are still under assessment, as I said.

**Senator BILYK:** Is she likely to be provided with a breakdown of the applications on a geographical basis?

**Mr Smyth:** As I said, they are national programs. They might be based in a particular area, but they have a national applicability, so we would look at various issues around criteria that we used in the assessment and the like. Normally, as part of a process of assessment, we assess against a criteria as to where those programs are funded.

**Senator BILYK:** I am quite interested in the criteria. What is it based on? Population? Age of the population?

**Mr Smyth:** As I said, those priority areas around education, training, advanced care services and the like: I will take that on notice as to what the criteria—

**Senator BILYK:** What about need?

**Mr Smyth:** Need is clearly one of the areas.

**Senator BILYK:** Like a population with a higher death rate—for example, more elderly people. Is that taken into account?

**Mr Smyth:** We do not provide the services, as such. That is the responsibility of state and territory governments for the service provision of palliative care services.

**Senator BILYK:** But you are providing funding for this training. Is that correct?

**Mr Smyth:** We are providing funding for education and training.

**Senator BILYK:** For education purposes. Whatever it gets used for.

**Mr Smyth:** Yes, that is right.

**Senator BILYK:** One presumes that the money will go to the area where there is most need. I am trying to work out how the minister or the department make the decision about where the most need might be.

**Mr Smyth:** As I said, I will take on notice the actual criteria that we use in the assessment.

**Senator BILYK:** Are you able to tell me what measures are in place to ensure that the best projects receive funding, as opposed to those which are politically popular?

**Mr Smyth:** That is not at all part of the criteria that we look at. We look at our obligations under the new PGPA act. They really close to the efficacy really of the project and the viability of the project. It needs to be assessed against value-for-money in particular and it needs to meet the criteria that was set for the evaluation of those projects and the assessment of them.

**Senator BILYK:** I look forward to an update next estimates.

**Ms Flanagan:** I remember you asked a question earlier on about the Medical Research Future Fund.

**Senator WRIGHT:** It is about mental health research generally. I am interested in how much money has been allocated to mental health research in the Medical Research Future Fund.

**Ms Flanagan:** There are probably two parts to this. The National Health and Medical Research Council can probably give you an indication about what sort of money has gone into mental health research in terms of the program they run. Part of the question I think you were asking earlier on today was around what might happen with the Medical Research Future Fund. We are currently discussing with the minister a proposal of how the draw downs from the Medical Research Future Fund would occur and that will need to be agreed to by cabinet. There will need to be some assessment criteria about how to prioritise the draw downs of the Medical Research Future Fund. As I say, that is being discussed with the minister and ultimately will need to be agreed to by government.

**Senator WRIGHT:** That has not been decided yet?

**Ms Flanagan:** No, we are still coming up with the methodology and what sort of governance arrangements and advisory arrangements there might be around how to actually use the funds out of the Medical Research Future Fund.

**Senator WRIGHT:** Earlier today I was asking questions about the freezing of indexation as a budget measure across various programs, including programs in the Department of Health, some of which were mental health programs. The figure I was advised of was about

$20 million worth of money. I was advised that the savings were going into the Medical Research Future Fund. I was asking whether or not those savings from those mental health programs would be devoted to mental health research, but is there no way that I can be told that at this stage?

**Ms Flanagan:** Just to be clear, the savings are going into the research fund. It will gradually build $20 billion. What will occur is that that $20 billion will be secured and it will actually be the draw down, the investment return, on the $20 billion that will be actually used for research. For example, next year I think it is estimated that if the fund managers—the Department of Finance is setting up the fund and there will be fund managers—do a good job in investing this money, the estimated draw down from the fund to be used for research is around $20 million. That will build in time to hopefully be around $1 billion a year.

**Senator WRIGHT:** So the prediction is it may be around $20 million next year as it builds up?

**Ms Flanagan:** Yes, so that would be the total from all of the savings that are being invested.

**Senator WRIGHT:** There are a couple of aspects to my question. One is that, in terms of the burden of disease of mental health, I have been told the figure is about 13 or 14 per cent, and yet the proportion of the health budget given to mental health is about seven per cent. So there is a common view that the funding for mental health is about half of what the burden of disease is. There are always concerns about the underfunding of mental health treatments and programs. Among many, there is also an acknowledged dearth of research funding for mental health as opposed to other conditions and other illnesses, and yet it has a huge effect on productivity and certainly on morbidity and so on. To what extent will those sorts of issues be taken into account when determining how that fund is going to be allocated?

**Ms Flanagan:** These are discussions that we are having at the moment with the minister in terms of how you might set priorities. One of them may be looking at the burden of disease as one of your criteria against which you would say we need to allocate a particular amount of funding. There could be many things that would be chosen in terms of priorities. If there is a particular industry in Australia that is nearly there in terms of finding some sort of a breakthrough, would it be worth investing money in that? Those are the sorts of things that the minister, as well as government, will need to decide on in terms of setting how the fund will draw down.

**Senator WRIGHT:** The other aspect of that question is that it would seem to be a bit of cold comfort for people who have current issues in relation to mental ill health that would benefit but whose needs may not be met because of the freezing of that indexation over a period of time. With the freezing of the indexation, the savings are going into a fund and there is no guarantee that they will end up getting any benefit from it in terms of the money being allocated to mental health research.

**Ms Flanagan:** The freeze has happened right across whole of government. It was a whole-of-government decision. It has impacted not only mental health programs but many others as well.

**Senator WRIGHT:** I understand that. But I am talking about the fact that it is people with mental ill health who may be missing out, and this is a fund in relation to health research.

Potentially, they could get a benefit or they may not. I think you also mentioned that the National Health and Medical Research Council may have some further information they could provide to me about mental health research. Is that right?

**Ms Flanagan:** Now that I have said that they can, I hope that that will be true.

**Senator WRIGHT:** We will see. They may not thank you for that! Professor Anderson, I am just interested in knowing if you can give me any figures or take on notice to provide any information about the extent of funding in the NHMRC budget that is going to mental health related research.

**Prof. Anderson:** I can. There has been some publicity in the last couple of days, so I have been looking at the figures just to make sure. Around 60 per cent of our total funding goes on the national health priority areas, and the proportion of that is pretty much lined up with the burden of disease. So mental health funding is number 3 after cancer and cardiovascular disease in terms of the national health priorities. We would like more applications. Only 10 per cent of our applications are for mental health.

**Senator WRIGHT:** Did you say 10 per cent?

**Prof. Anderson:** Only 10 per cent of applications and about 10 per cent of funding. So it is proportional to the requests for mental health research. Having said that, we have put special effort into some capacity building in mental health research over recent years, with a $26.2 million special package a couple of years ago. That was to build centres of research excellence, a couple of targeted calls for research in early intervention and, because we were concerned about leadership and capacity building in the sector, we have given two very large fellowships—the largest fellowships we give—especially in mental health, and all of that is rolling out. That is only two or three years old, so it will take a while to build capacity.

We have done a couple of additional priority areas in recent years, one on suicide prevention in Aboriginal and Torres Strait Islander people. I have already mentioned the two large fellowships named after John Cade who, as you probably know, was the Australian discoverer of lithium as a treatment for depression. I could give you a breakdown of the various areas of mental health on notice if you like.

**Senator WRIGHT:** I would appreciate that. Thank you. Can I just check this: the suicide prevention funding, would that be something that you would characterise as being mental health funding?

**Prof. Anderson:** It was. It came as a call for help from what we call Principal Committee Indigenous Caucus, who are the Indigenous people on all NHMRC principal committees. They were worried about the causes of mental health problems in Aboriginal communities and wanted some very applied targeted research undertaken.

**Senator SMITH:** I just wanted to the issue of the increased media attention and reporting that is being given to the use of methamphetamine across the Australian community and what the response is of government. In my home state of Western Australia, we have had editorials in *The West Australian* over the last few weeks and we have had front-page stories. If you have a look at the ABC news website this evening, you see there is a bit of a debate in Tasmania about the rise in incidence of it. I am just wondering, what initiatives are the Commonwealth taking a round methamphetamine use in the community?

**Mr Smyth:** The main thing that the Commonwealth funds is treatment services. There are hundreds of millions of dollars to treatment services in all states and territories. We also are working with our national research bodies to look at what are appropriate approaches and interventions that can then be evidence-based approaches so that information can then be passed to communities, made available to communities, made available to law enforcement officers and also made available to treating clinicians as well.

**Senator SMITH:** How would you describe the incidence of methamphetamine use across the Australian community?

**Mr Smyth:** It is the third most common drug of concern in closed-treatment episodes by drug and alcohol services. It accounts for around about 14 per cent of treatment episodes. That has certainly been increasing since 2009-10.

**Senator SMITH:** It is at 14 per cent, but what has it risen from in 2009-10?

**Mr Smyth:** It has from around seven per cent to 14 per cent. We have from the National Drug Strategy Household Survey that there has been no significant increase in the use of methamphetamine from 2010-13, but there has been a change in the nature of the drug that is being consumed.

**Senator SMITH:** Is that a well-accepted point or is that a contested point?

**Mr Smyth:** What we can go on is national survey data. Certainly, the use of powder has decreased significantly from 51 per cent down to 29 per cent, but the use of ice—crystal methamphetamine—has more than doubled from 22 per cent in 2010 to 50 per cent in 2013. The other thing is that the frequency has increased significantly for people using it daily or weekly from around 12.5 per cent in 2010 to 25.3 per cent in 2013. We have a multipronged change in some respects. We have increasing purity being consumed at a greater frequency as well. That is leading to some of the problems that you are seeing in communities.

**Senator SMITH:** In your opening remarks, you talked about Commonwealth responsibility to advise on funding treatments.

**Mr Smyth:** In treatment services, yes. We fund a proportion of the funding. In broad terms, we fund between 20 and 30 per cent of treatment services funding across the country.

**Senator SMITH:** What is that mechanism?

**Mr Smyth:** We have two mechanisms. We have the Substance Misuse Prevention and Service Improvement Grants Fund. and we also have our Non-Government Organisation Treatment Grants Program. They are two significant grant programs that the Commonwealth runs and they are around about $360 million over four years. It is a little over $80 million a year that we put into all those services. They are under those funds. I should say there is substantially more money that was taken out of those funds and there were machinery of government changes to Indigenous-related drug and alcohol services in the Department of the Prime Minister and Cabinet. They would be best placed to talk about those services.

**Senator SMITH:** When we look at the treatment services pool and the research pool, are we seeing an increasing proportion of those funds being made available to deal with the methamphetamine issue or has it been constant? You have articulated quite convincingly a change of behaviour in the community. I am interested to know from a funding perspective if that change is being mirrored in where those funds are being expended?

**Mr Smyth:** As I said, the service presentations for methamphetamine use have doubled from seven to 14 per cent over that period. We fund particular organisations to provide those services. What drug and alcohol related services are provided is up to those organisations based on their need and priorities.

**Senator SMITH:** I do want to touch briefly on the particular risk that presents not just for rural and regional communities but also for Indigenous communities, but you are suggesting that that is best placed for cross portfolio on Friday?

**Mr Smyth:** Yes.

**Senator SMITH:** Thank you very much.

**Senator McLUCAS:** I just want to go to the Health Star Rating system. Is the website supporting the Health Star Rating system live?

**Mr Smyth:** The actual website is not yet live. That will commence when the social marketing campaign is launched. That will occur in the near future. The Health Star Rating calculator, other documentation and style guide is available on the AHMAC website.

**Senator McLUCAS:** You said that the cost-benefit analysis work that was going to be undertaken would not delay the process of putting the website up, so that food manufacturers and consumers could use it. This would say to me that there has been considerable delay.

**Senator Nash:** No, there has not been at all. We had to go through the appropriate process to develop the social marketing campaign. The decision was taken that it was very important to have that education campaign go out at the same time that the website went up. What Mr Smyth has indicated is the actual calculator that industry uses to calculate the star rating for their products has actually been available for some time for them. It is actually available on the AHMAC website. That was made available for them some time ago now.

**Senator McLUCAS:** Quite a number of food manufacturers have actually got the star rating on their products.

**Senator Nash:** I think it is only one of the moment, which is Monster Muesli. Is there more now?

**Mr Smyth:** There is actually a few. There are some Coles home branded products as well.

**Senator McLUCAS:** I understand that Woolies is going to have a go as well.

**Mr Smyth:** That is right.

**Senator Nash:** There has been absolutely nothing—

**Senator McLUCAS:** What is the delay in getting the social marketing program going?

**Senator Nash:** It is just the process of actually getting the information together, developing it and getting it through the approval process—but it is very close.

**Senator McLUCAS:** Which approval process?

**Senator Nash:** The one we have here as government, as previous governments have had, for that type of thing.

**Senator McLUCAS:** This has been going on now since December last year.

**Senator Nash:** No, not quite, Senator.

**Senator McLUCAS:** Yes, it has. I have been asking you questions about this in this committee since the first estimates after the election. You said that this would be up and running by June.

**Senator Nash:** I will have to check the record. I do not think I said it would be up and running by June. I think I said it would be—

**Senator McLUCAS:** That is my recollection.

**Senator Nash:** I think I said it would be up and running when the marketing campaign—the 'education campaign' was the phrase I used at the time—was finalised. And it is not very far away at all, Senator, you will be pleased to hear.

**Senator McLUCAS:** There is a document, a news article, from you that I can quote from. It says that it will be launched in August.

**Senator Nash:** Things do not always run to the exact time, Senator, but I can tell you it is very close.

**Senator McLUCAS:** You gave an absolute undertaking that the request to do a cost-benefit analysis would not affect the progress of putting the health star rating system up so that people could start using it. That has clearly happened.

**Senator Nash:** I will have to check that. We have been through the processes. It is a decision of the forum, and it will be up very soon.

**Senator McLUCAS:** What is the decision of the forum?

**Senator Nash:** I am sorry, Senator?

**Senator McLUCAS:** You said 'It is a decision of the forum'. What is the decision of the forum?

**Senator Nash:** It is the process for the health star rating system.

**Senator McLUCAS:** Are you saying that you have to go back to an actual meeting of the forum before the website will be launched?

**Senator Nash:** No, Senator.

**Senator McLUCAS:** How will that happen?

**Senator Nash:** The website will be launched when the education campaign is finalised.

**Senator McLUCAS:** What is the role of the forum in that decision-making process?

**Senator Nash:** They have been advised and they will be advised that it is going ahead before it goes up.

**Senator McLUCAS:** 'They are going to be advised'—what is your point? Are they decision-makers or not?

**Senator Nash:** They have been involved in the process. As I have just indicated to you, the education campaign will be finalised very shortly and the website will be up.

**Senator McLUCAS:** When?

**Senator Nash:** shortly.

**CHAIR:** We have run out of time there.

**Senator McLUCAS:** Just one last question.

**CHAIR:** We have run out of time. Senator Leyonhjelm.

**Senator LEYONHJELM:** Has the post-implementation review of plain packaging commenced?

**Mr Smyth:** Not yet. It is due to commence by 1 December.

**Senator LEYONHJELM:** By 1 December.

**Mr Smyth:** That is correct. We need to commence that by 1 December.

**Senator LEYONHJELM:** Who will be doing it?

**Mr Smyth:** We are in the process of selecting an organisation to undertake that work.

**Senator LEYONHJELM:** Who will be providing evidence to it?

**Mr Smyth:** It will look at the impact. There will be an opportunity for all interested parties or stakeholders to provide input into that process, and that would include the tobacco industry, retailers, public health groups and the like.

**Senator LEYONHJELM:** When do you think the results will be available?

**Mr Smyth:** That would be a decision of government once the report is finalised.

**Senator LEYONHJELM:** Finally, there is a 2008 publication by Collins and Lapsley, which was prepared for your department, on the costs of alcohol, tobacco and illicit drug use. Are you familiar with it?

**Mr Smyth:** I am familiar with it.

**Senator LEYONHJELM:** It provides estimates of costs for 2004-05 that are reused in the 2013 post-implementation review for the 25 per cent increase in the rate of tobacco increase. Do you have any more up-to-date estimates, particularly for the net healthcare cost of smoking?

**Mr Smyth:** We do not. The $31 billion figure that is quoted by Collins and Lapsley is still the figure that is used. There is currently an update through the Australian Institute of Health and Welfare, and it is looking at a burden of disease study as well.

**Senator LEYONHJELM:** To what extent would you think that that 10-year-old study would still be valid now?

**Mr Smyth:** I think that a lot of the assumptions that were made under it would still be relatively valid today, but I would have to go back and look at any particular questions that you might have in relation to that.

**Senator LEYONHJELM:** I think the figure quoted was $341.8 million, or something along those lines.

**Mr Smyth:** It is around $31 billion per annum.

**Senator LEYONHJELM:** Are you referring to costs?

**Mr Smyth:** That is the impact; the societal impact, and the costs on—

**Senator LEYONHJELM:** Alcohol and tobacco.

**Mr Smyth:** That is tobacco only.

**Senator LEYONHJELM:** Okay. Thank you.

**Senator MADIGAN:** My question is for the NHMRC. Is the NHMRC aware that the Brown County Health Department in Wisconsin in the USA has just declared that the Shirley wind development is a human health hazard? For your information, the exact wording of the resolution is as follows:

To declare the Industrial Wind Turbines at Shirley Wind Project in the Town of Glenmore, Brown County, WI. A Human Health Hazard for all people (residents, workers, visitors, and sensitive passersby) who are exposed to Infrasound/Low Frequency Noise and other emissions potentially harmful to human health.

**Prof. Anderson:** If our expert group is not aware, Senator, I am sure we can make them aware of that. I have not received at this stage the final update of the information paper which, as I think you know, went out to public consultation, and there has been some further work looking at what peer-reviewed papers have been published in the last little while so that we have the last, up-to-date information. So I am not aware personally, but we will make sure that, if indeed it is based on some science and we can analyse it, the committee has a look at that.

**Senator MADIGAN:** Thank you, Professor Anderson. This declaration by the official local health body followed an important acoustic survey at the same location nearly two years earlier, in December 2012, by five acoustic experts, some of whom worked for wind developers, and one of whom is the highly regarded director of acoustic standards in the US, Dr Paul Schomer. Their joint report stated: 'The four investigating firms are of the opinion that enough evidence and hypotheses have been given herein to classify LFN and infrasound as a serious issue, possibly affecting the future of the industry.'

Why is there no mention of this important 2012 acoustic survey in any of the NHMRC documents published recently on this subject? Could it be because of the serious conflict of interest of the sole acoustic expert on the NHMRC panel, Dr Norm Broner, and because of the bias of other experts on the NHMRC panel?

**Prof. Anderson:** Senator, I would like to resist your assumption that the distinguished scientists on our panel are biased. We certainly put in the public domain all the potential conflicts of interest—there are declarations of interest in the public domain. And we are talking about many groups here, Senator: we are talking about the expert group that looks at the evidence; we are talking about the expert group—a different bunch of people—who did the systematic review of the literature; we are talking about a different group who looked the methodological review; we are talking about a different group that looked at the report of the expert group that did the information paper. I would like to resist the hypothesis that these dozens of people, not just in Australia, involving a number of different acoustic experts, not just the one, would collectively come with a bias to this. It is a very serious claim to make of a researcher, that they are not acting as a scientist, and not taking things into account on the basis of the peer-reviewed literature.

As I say, we have not got the final, very thorough, information paper by three or four different expert groups looking at the expert group's work. We have not got that final document yet. We hope to get it soon. We hope to take that to our council meeting in November and then, I am sure, when we release it, there will be many different views on what the hazards or lack of hazards of wind turbines are.

All I can say, and say firmly, is that the NHMRC has no ideological or other view on this. We were brought this issue by a state government with concern for their citizens. We picked up that concern. We have done this on purely scientific grounds, because our role in Australia's health is to look at evidence and to put out our view on the strength of that evidence.

This is a controversial area around the world. There are many different views. There are many different local authorities who have different views. That is perfectly appropriate in a democracy. Our role is to dispassionately, using as much expertise as we can, on both our panels and our review panels, come up with as evidence based a comment as possible. As you know, we have also committed to do additional research should that be required. If the evidence is not clear, we are absolutely committed to do that additional research.

**Senator MADIGAN:** Are you aware of the latest peer reviewed published case definition, with the title 'Diagnostic criteria for adverse health effects in the environs of wind turbines', published in the *Journal of the Royal Society of Medicine*, written by Professor Robert McMurtry and Ms Carmen Krogh from Ontario, Canada, who have identified the same symptoms of sleep disturbance, sleep disruption, and others including increased levels of stress and inner ear symptoms out to a distance of 10 kilometres?

**Prof. Anderson:** Again, the expert group, working with these other groups, are collecting up all the peer reviewed papers that were brought to our attention by the general public and by other experts. After their original draft report they are now undergoing a further scoop up of whatever literature there is. I am not on the expert committee. I cannot answer your specific question as to whether that particular paper has been picked up. You have now alerted us to it. We will make sure that it is part of what is picked up. I can assure you this is being done as thoroughly as possible, at a high scientific level.

**Senator MADIGAN:** Thank you, gentlemen.

**CHAIR:** Unless someone would like to extend, that concludes population health.

**Senator MOORE:** I just want to put something on record. We have run out of time, and I want to put my apologies on record for Cancer Australia, whom I called. Because we have run out of time we will not be able to question them this evening, but I will be in contact with them. I will go and visit and put my questions to them directly. I just wanted to put that on record.

**CHAIR:** Thank you, Senator Moore. We will now move to sport and recreation.

[22:39]

**CHAIR:** I have some brief questions to start on water safety and some related initiatives. Is this the relevant place for that?

**Mr Bowles:** Fire away and we will see where we go.

**CHAIR:** I am interested in a couple of measures if you could give us a quick explanation of them. I know there has been some money announced. I think there is $4 million for the Royal Life Saving Society for the Inland Waterways Drowning Prevention Fund. I am a keep safe ambassador. I am sure others in the parliament are as well. I know the Royal Life Saving Society does a sensational job. Are you able to outline what that money will be used for?

**Mr J Smith:** Absolutely. The $4 million that you are referring to is part of a broader $15 million commitment that was made as part of the 2013 election campaign. It contributes to the river drowning black spot identification program and also to expand the Swim and Survive lessons for children in populations who are known to miss out, such as Indigenous and disadvantaged communities. It was announced on 30 September by the minister, and it is formally known as the Inland Waterways Drowning Prevention Fund. That funding is to Royal Life Saving Society Australia.

Among the other elements of that broader $15 million commitment, Surf Life Saving Australia will also receive an $8 million commitment to fund surf lifesaving clubs and to purchase essential equipment, and there is a further $2 million commitment to Surf Life Saving Australia's Beach Drowning Black Spot Reduction program, which is about identifying coastal areas at risk and targeted programs to reduce drowning.

**CHAIR:** What kinds of programs would be in that $2 million for the beach drowning black spots? Is that warning signs? What kinds of things are we talking about at some of our more notorious beaches?

**Mr J Smith:** Initially it is an identification program, so it is specifically evidence based identification of areas where there are high incidences of drowning or where there are certain risk factors, and then it would involve training around the local area. Without knowing the exact detail of how Surf Life Saving Australia might roll that out, it could involve warning signs and things like that, but it might also go to specific training for the local surf clubs, for example, in what they should be looking for in terms of those particular risk areas.

**CHAIR:** Anecdotally—and this may not be borne out in the stats, because I am not aware of them—it seems that international tourists can be particularly at risk of drowning at beaches. Is that just something I have picked up through news reports that is incorrect, or is that in fact the case? If so, are there programs for dealing with that?

**Mr J Smith:** It is the case. Off the top of my head I would not be able to tell you what the statistics are, but it is certainly the case that there are certain subgroups of the population that are more at risk. In fact, a part of that $15 million commitment is a $1 million commitment to AUSTSWIM, which provides teacher training and accreditation. That will basically provide funding to focus on particular areas where there are issues, such as migrant communities and things like that.

**CHAIR:** Great. It is a great initiative. I commend you for it.

**Australian Sports Commission**

[22:42]

**Senator BILYK:** I want to ask some questions of the Australian Sports Commission. I understand that the AIS has launched a new logo. Can you just outline for the committee what the logo represents.

**Mr Hollingsworth:** Yes, I can.

**Senator BILYK:** Would you like a pretty copy of one I prepared earlier?

**Mr Hollingsworth:** No, thank you. The background to the logo is that the Australian Sports Commission, through our high-performance strategy delivered by the AIS, is changing its approach to high-performance sport. I guess the best way to summarise it is we are taking a

more national approach. The new logo is an abstract representation of Australia—that is one aspect of it. The second is that it represents gold, which is the aspiration for why we are investing in athletes to achieve success on the international stage. The third aspect is that it has a ribbon representing the dynamism of sport and, I guess, the lanes of a track or a swimming pool. The five streams represent our top 5 target at the Olympic and Paralympic games.

**Senator BILYK:** Where will I find my home state of Tasmania on that if it represents Australia and it is a national approach?

**Mr Hollingsworth:** As a Tasmanian myself—

**Senator BILYK:** I understand. I am surprised it has got through this far.

**Mr Hollingsworth:** The logo was not intended to be an exact geographical representation of Australia; it is an abstract—

**Senator BILYK:** But it does, doesn't it? It is very clear that that represents the rest of Australia, no Tasmania. Once again, Tasmania is left off the map. I just think that is atrocious, and it has attracted a lot of attention in Tasmania. You may well scoff, but this happens time and time again.

**CHAIR:** I wouldn't dare scoff.

**Unidentified speaker:** It is 1988 all over again.

**CHAIR:** I wouldn't dare scoff, Senator Bilyk. You have 12 senators to look out for—

**Senator BILYK:** Tasmania had seven people represented in the recent Commonwealth Games. We got a gold, a silver and two bronze out of that. It is high time that people started—

**Unidentified speaker:** Did we?

**Senator BILYK:** Yes, we did—we did, because Tasmanians generally stick together—and I think it is high time that people started taking Tasmania seriously. People from Tasmania have rung my office and Senator Brown's office, although she is not here at the moment, and there is genuine annoyance about it. So how did this logo come about? Was there a focus group? Was there some market research?

**Mr Hollingsworth:** Absolutely. There was significant market research—

**Senator BILYK:** No Tasmanians involved, though?

**CHAIR:** Except the fellow making the decision! Sorry.

**Senator BILYK:** Sorry, who?

**CHAIR:** My apologies, Senator Bilyk.

**Senator BILYK:** I presume I probably did not want to hear that.

**CHAIR:** Quite possibly.

**Senator BILYK:** No Tasmanians in the focus group or in the market research?

**Mr Hollingsworth:** Absolutely. In fact, I was part of a focus group and, as I said, I am a proud Tasmanian—

**Senator BILYK:** Well, how did you leave Tasmania off it?

**Mr Hollingsworth:** and I did represent Australia on a couple of occasions and—

**Senator BILYK:** I understand that, Mr Hollingsworth. But how did you leave Tasmania off that logo?

**Senator SMITH:** When we fix GST distribution reform, Tasmania goes back to—

**Senator BILYK:** You are wasting the very limited time I have! And I know Senator Peris has questions as well. Can you tell me how much the design of the logo cost?

**Mr Hollingsworth:** The total for the design and background work and the commercial that we did was around $230,000.

**Senator BILYK:** $230,000 and they cannot even get all the states and territories of Australia represented.

**Mr Hollingsworth:** As I said, it is an abstract representation open to interpretation—

**Senator BILYK:** What type of tender arrangement was used?

**Mr Hollingsworth:** I beg your pardon?

**Senator BILYK:** What was the tender arrangement that was used for the design of the logo?

**Mr Hollingsworth:** We used a tender process with a number of providers. We used two different providers. One provided the analytics around the commercial aspects of the design and change of the logo to generate more commercial partners for the Australian Institute of Sport—we have a number of commercial partners. The overwhelming feedback, not just from commercial partners but also from athletes and sports, was that the old logo did not adequately represent Australia. You may—

**Senator BILYK:** No, no, I saw that. But the old logo did not show other states and territories; it was someone with their hands above their head as though they had won a medal or done something like that.

**Mr Hollingsworth:** Again, that original logo is an abstract representation of an athlete finishing with a victory salute above their head. But it is an abstract representation—

**Senator BILYK:** Who made the final decision on the logo, then?

**Mr Hollingsworth:** The final decision was made, effectively, by the executive of the commission, although it did go through the board for endorsement and their consideration as well.

**Senator BILYK:** How many programs within the commission have appointed PR companies since the beginning of the year?

**Mr Hollingsworth:** Sorry; how many—

**Senator BILYK:** How many programs within the commission have had PR companies appointed to do stuff with them since the beginning of the year?

**Mr Hollingsworth:** I will have to take that question on notice.

**Senator BILYK:** Okay—and for what purpose, their context, as well.

**Mr Hollingsworth:** Certainly.

**Senator BILYK:** Obviously, it is a bit of a joke to other people, but to Tasmanians it is really not a joke; they are quite disappointed. The other thing I quickly want to talk about is the Commonwealth Games swimming uniforms. Can you people talk to me about that?

**Mr Hollingsworth:** The Commonwealth Games uniforms?

**Senator BILYK:** Yes, the uniforms.

**Mr Hollingsworth:** That is entirely a matter for the Australian Commonwealth Games Association, so I would not be able to answer questions on that.

**Senator BILYK:** Nobody in the department can help at all in regard to that?

**Unidentified speaker:** It is a separate organisation.

**Senator BILYK:** Because once again—you know what I am going to say, don't you?

**Unidentified speaker:** It is a non-government organisation.

**Senator BILYK:** No Tasmania on the uniform. Maps of the rest of Australia, no Tasmania.

**CHAIR:** There is a pattern here! There is a pattern.

**Senator SMITH:** There is a conspiracy here—you are quite right—because the Bicentennial logo did not have Tasmania on it either!

**Senator BILYK:** I am going to finish there and hand over to Senator Peris, because I know she has questions.

**CHAIR:** I will go to Senator Peris, from the great territory of the Northern Territory.

**Senator PERIS:** There's no Tiwi Islands there!

**Senator BILYK:** That is right!

**CHAIR:** Would you like to ask some questions about that?

**Senator PERIS:** Yes, I would! In which term of 2015 will the Sporting Schools program commence?

**Mr Hollingsworth:** It will commence in term 1. It will not be fully rolled out in term 1; we are going to pilot with a number of sports with a view to having it fully implemented by the middle of the year as we transition from the AASC.

**Senator PERIS:** When you say term 1, would that just be getting the staffing in?

**Mr Hollingsworth:** No, it includes partnering with the sports that are ready to deliver the program. If you are familiar with the different design and implementation of the program, effectively, we are asking sports and local clubs to play a greater role in partnership with schools to deliver the program into schools twice a week for a term. So we obviously need to work with sports that have the capability to do that, and we are going to start with a select number of sports—I think the number is 10—and then build from there.

**Senator PERIS:** Ten sports?

**Mr Hollingsworth:** That is right, which does not mean that they will be the only sports offered for children to participate in during school, but they will be the sports that we will be trialling the new model with.

**Senator PERIS:** Predominantly, what you are saying is that the first part of the year will be working out the partnerships. Which actual term will the delivery of the program—

**Mr Hollingsworth:** It will start in term 1 of 2015, yes.

**Senator PERIS:** What will be the number of staff employed through Sporting Schools?

**Mr Hollingsworth:** The staffing?

**Senator PERIS:** Yes.

**Mr Hollingsworth:** Within the Sports Commission?

**Senator PERIS:** Well, delivering the program?

**Mr Hollingsworth:** The total staffing profile for the Sporting Schools will be in the vicinity of between 80 and 90 full-time equivalent staff. Some of those will be based in Canberra, but the majority will be based right around Australia.

**Senator PERIS:** How does that compare to the active after-school program?

**Mr Hollingsworth:** The active after-school program had a full-time equivalent staffing of 175. Obviously, as we move closer to 1 January, that is now reducing. The current staffing is 146, and, as I said, it will move to around 80 to 90 by 1 January.

**Senator PERIS:** So, in terms of the recruitment of the Sporting Schools staff, how is that being handled? Will the active after-school staff be required to automatically transition? Will redundancies be offered? How will it all be managed?

**Mr Hollingsworth:** All of the Active After-school Communities staff were on fixed-term contracts which finished on 31 December this year. There are obviously a lesser number of roles that are available for staff. We are running a very transparent and equitable process to provide people with an opportunity to express an interest in a particular position. Interviews are being conducted at the moment, and staff that are successful will obviously secure those positions. Priority is being given to staff within the existing program.

**Senator PERIS:** In relation to the recently announced $400,000 grant program to encourage women into coaching, can you give a brief explanation of the program, and when will it commence?

**Mr Hollingsworth:** The program has been running for a number of years. We do it in partnership with the Office for Women in the Prime Minister's department, so it is co-funded. It is basically a scholarship program for an opportunity for women to be involved and develop their skills in sport. There are a variety of different opportunities: it could be engaging with professional development opportunities, or secondments into sporting organisations. It depends on the nature of the opportunities.

**Senator PERIS:** You are saying that it has been rolled out for a number of years. Is it the same amount annually that was previously rolled out?

**Mr Hollingsworth:** I can confirm that it is the same amount this year as last year. I do not have the information about prior years. I can take that one on notice.

**Senator PERIS:** Thank you. Are you aware of the numbers of applications that have been received?

**Mr Hollingsworth:** Yes.

**Senator PERIS:** And awarded?

**Mr Hollingsworth:** Applications closed, I understand, either today or tomorrow. So we may have the application number—I do not think that I have that information; I will have to take it on notice. It has not been awarded yet.

**Senator PERIS:** Can you provide a complete breakdown of all the grants programs aimed specifically at women in sport that have been announced and commenced during the period of the Abbott government?

**Mr Hollingsworth:** In terms of new announcements?

**Senator PERIS:** Yes. Collectively or together, what is new and what is existing?

**Mr Hollingsworth:** Obviously, the most significant way we invest in women in sport is through our grants to NSOs. They have continued and been maintained in both high performance and participation. We are also investing in women in sport through the direct athlete support system, which is now called dAIS. In fact, the government, through the Sports Commission, has increased that funding to $12 million per annum for the 2014-15 year, which is $1.6 million higher than the previous year. In many ways it is hard to differentiate. They are not specific women-in-sport programs, but the beneficiaries are significantly women. For example, at least 50 per cent of the recipients of dAIS funding are female athletes. In fact, the Sports Commission is by far and away the biggest investor in women in sport. The government is continuing the women's sport leadership program, as you mentioned. We also maintain a women's register for females interested in being on sports boards, and that is continuing as well.

**Senator PERIS:** How is that going? Is that on the increase?

**Mr Hollingsworth:** There are some very positive developments in some of our sports. In terms of increases in representation of women on boards, athletics—a sport you know well, Senator—has increased its female board representation to 44 per cent; hockey is 55 per cent; and sailing is 38 per cent. So there have been some increases. Basketball and cycling have also both increased over the past six months. There have been some positive developments, partly through the register and also through the Sports Commission promoting more women being involved in boards.

**Senator PERIS:** When you were talking about direct athlete support, athletes in the high performance range can now apply directly to the Sports Commission. Was it previously through their respective sports?

**Mr Hollingsworth:** It is not quite that way. The way that the dAIS, or the direct athletes support, works is that each sport nominates the athletes that they believe are eligible under the criteria for support for dAIS payments, and it is done twice annually. We work closely with the sports; we believe that is important. A moderating panel comprises representatives from sports from the AIS. I believe there are also representatives from the Australian Commonwealth Games Association, the Olympic Committee and the Paralympic Committee. A determination is then made.

The new criteria are focused on a number of quantitative measurable elements, including world ranking; but there are some qualitative aspects as well in terms of emerging talent, which is a new aspect of the dAIS. Part of the restructure that has been announced is really focused on making sure that we are supporting athletes who are in the top 10 in the world and making sure that they are getting the right support but also recognising that there are athletes who sit outside the top 10 who do need some support to make that step up over time. We have created a new category of athlete called 'emerging athletes', which is a fantastic investment that ensures we invest in the short term, the four-year cycle, and the eight-year cycle as well.

**Senator PERIS:** Emerging athletes is a new scheme?

**Mr Hollingsworth:** This is a new category within dAIS. Under the old scheme, if you were ranked one to 10 in the world, you were eligible for a payment, depending on whether you were one to five or six to 10. Now we have changed that to reduce it to eligibility which is generally the top eight in the world, which aligns better with the realities of many of the sports in terms of what it takes to make a final. It has enabled us through increased investment and some reallocation of funds to expand the reach to athletes outside the top 10, who are younger and developing. There are different payments, obviously, depending on the level where the athlete is at.

**CHAIR:** Senator Peris, a final question.

**Senator PERIS:** Okay. On that, in a situation like a Melissa Breen, for example, who last year was not ranked in the top 10 but who was an emerging athlete, she was not eligible for that, but she could be eligible for this process now?

**Mr Hollingsworth:** It would depend on a number factors. It is difficult to comment on an individual athlete. Melissa Breen is a tremendous athlete—Australia's fastest woman. Obviously, her funding from the sport, from Athletics Australia, has attracted some attention. It would really come down to the moderating panel to determine where her profile is. Under the emerging talent athlete category she may be eligible, but that would depend on a range of factors.

**CHAIR:** We started with Tasmania and we have finished with a great Canberra athlete. Mr Hollingsworth, thank you very much for your time. Thank you, Minister, for your time. We thank you, Mr Bowles, and please pass on our thanks to all your officials. I apologise to ASADA and to some of the other agencies who were asked to be here but who have not been called. Senators should reflect on these things from time to time—but we will leave that there. I do apologise; but thank you very much for your time.

**Committee adjourned at 23:00**